The Law on Minors' Consent and Refusal of Medical Treatment: A Critique and Proposals for Reform

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ABSTRACT

Under English law, it is conventional wisdom that no minor has an absolute right to autonomous medical decision-making and that even if the minor is *Gillick* competent or, having reached the age of 16, comes within the purview of section 8(1) of the Family Law Reform Act 1969 (and the Mental Capacity Act 2005), the court, in the exercise of its inherent or wardship jurisdiction, can in cases where the consequences of the minors' decision are likely to put their health or life at risk, overrule the minors' decision, and direct that the minor should undergo the recommended procedure(s). This thesis is primarily concerned with whether the decision of the court to overrule a minor's refusal of medical treatment is in all the circumstances justified. This thesis argues that the balancing of the theoretical models of autonomy and protectionism is decisive in determining whether a minor's treatment refusal is respected. In this regard, and considering recent developments in the law domestically and internationally, such as the increased prominence of human rights and the importance of the decision of the Supreme Court of Canada in *AC v Manitoba*, this thesis establishes a framework based on factors relevant in the medical refusal case law in order to objectively analyse whether the courts, in their welfare assessment, consistently identify the factors that are important in the individual case, gives them each proper weight, robustly balances those factors out, and makes a decision that is best for the individual at the heart of the decision. Thus, this thesis critiques the current legal landscape on minors' medical decision-making and proposes recommendations for how the law should balance the interests of autonomy and protectionism.

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CHAPTER I

INTRODUCTION

I. Overview

The human body cannot escape injury or illness. This is true whether for an adult or a minor. Under the law in England and Wales (English law), 'minors' collectively describe all persons under the age of 18 (adults).[1] In this thesis, where necessary to distinguish between 'minors', 'young persons' encompass 16-17-year-olds, and 'child/children' describes those under 16.[2] The rights of adults and minors in the healthcare context differ in English law. An adult patient has the right to choose whether to consent *or* refuse the proposed medical treatment.[3] This right of choice is not limited to rational or wise decisions, but to exercise such decision-making *autonomy*, one must have the *capacity* to make the decisions.[4] An individual possessing legally recognised decision-making authority is said to have capacity. Generally, this decision-making authority is recognised insofar as the individual is *competent*, i.e. their cognitive faculties are such that they are able to make a decision on a particular issue.[5] While there are some exceptions when treatment may be able to go ahead without the adult patient's consent,[6] even if they are capable of giving consent,[7] doctors are required to receive the patient's consent to

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[1] Family Law Reform Act (FLRA) 1969, ss 1(1) and 12.

[2] It should be noted that 'minor' and 'child' are often used interchangeably in English (and international) case law, statute law and literature. This thesis excludes from its scope 'infants' (ie, a very young child or baby).

[3] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.

[4] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95; Mental Capacity Act (MCA) 2005, ss 1(2), 1(4), 2 and 3.

[5] Shaun Pattinson, *Medical Law and Ethics* (5th edn, Sweet & Maxwell 2017) Ch 5.

[6] For example, the person needs emergency treatment to save their life, but they are incapacitated (eg, unconscious), or the person is unable to make a decision at the material time: see *F v West Berkshire Health Authority* [1990] 2 AC 1; MCA 2005, ss 1-5.

[7] The Mental Health Act (MHA) 1983 permits medical interventions to treat a person's mental disorder without their consent, even if they have capacity: see s 63; *B v Croydon Health Authority* [1995] 1 WLUK 1; *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317. This thesis does not consider the MHA 1983. In addition, in the case of some infectious diseases, acting in the public interest may supersede respect for an individual's decision: see Health and Social Care Act 2008, ss 129 and 130.

perform medical procedures involving anything that interacts with the patient's body,[8] where without the doctor may be liable for an unlawful offence.[9] In contrast to adults, the legal theory concerning minors' medical rights is not so clear. This thesis is a study of the law on minors' medical decision-making.

II. Research Problem

The House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority* ostensibly gave minors under the age of 16 the legal authority to make certain decisions.[10] The *Gillick* competent child of 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed' could independently consent to medical treatment.[11] Subsection 8(1) of the Family Law Reform Act (FLRA) 1969 presumes that young persons are competent to consent to medical treatment. Much of the Mental Capacity Act (MCA) 2005 (and its accompanying Code of Practice[12]), which provides a framework to protect those unable to make decisions, also applies to young persons, including the presumption of capacity.[13] Thus, young persons are presumed competent and capacitous,[14] though both presumptions are rebuttable. When a minor lacks competence, the parents, someone with parental responsibility, or the court can make a decision on their behalf, prioritising their welfare.[15] When a young

[8] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[9] *Chatterton v Gerson* [1981] QB 432 [443]. There are three elements of valid consent: the patient must 1) consent *voluntarily*, 2) have the *capacity* to consent, and 3) must be *informed* in broad terms of the nature of the treatment concerned. See also *Colins v Wilcock* [1984] 1 WLR 1172.
[10] [1986] AC 122. See Chapter III.
[11] ibid [189] (Lord Scarman).
[12] See Department of Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007). See also HM Government, *Draft Mental Capacity Act 2005 Code of Practice Including the Liberty Protection Safeguards* (March 2022).
[13] MCA 2005, ss 1(2) and 2(5).
[14] The terms 'competent' and 'capacitous' are often used interchangeably. In this thesis, unless the context requires otherwise, 'competent' will describe a young person or child who is able to make a decision.
[15] Children Act (CA) 1989, ss 1-3.

person lacks capacity under ss 2(1) and 3(1) MCA 2005, a health care professional will make a best interests decision on their behalf.[16]

Despite *Gillick* and the statutory schemes recognising competent minors as independent rights holders, the development of the law limited the scope of their decision-making authority. The problem gravitates around the premise that minors' mental capacity to make decisions does not necessarily imply the legal capacity to have those decisions respected. This dichotomy is most pronounced when the competent minor refuses medical treatment objectively determined by medical expertise to be in their best interests. In the decisions of *Re R (A Minor) (Wardship: Consent to Treatment)*[17] and *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*,[18] the Court of Appeal held that *no* minor, whether *Gillick* competent or having reached the age of 16 and is presumed competent by s 8(1) FLRA 1969, has the absolute right to autonomous medical decision-making, and the court, in the exercise of its inherent or wardship (interchangeable with '*parens patriae*') jurisdiction, can in appropriate cases, typically when the minor's decision has serious consequences for their health or life, overrule the minors' decision. In general contradistinction to the law on medical consent, the law on medical refusal is problematic. The main thrust of this thesis is to critique how the courts decide to overrule a minor's treatment refusal. It will consider the context and factors that are important to those decisions, evaluate how the court balances, in particular, the tenets of autonomy and paternalism,[19] and determine whether the culminating decision of the court is one that was best for the individual who has to live with the decision made on their behalf. This thesis argues that the strengths of the law on medical consent outweigh its ambiguities and

[16] MCA 2005, s 4.
[17] [1992] Fam 11. See Chapter IV.
[18] [1993] Fam 64. See Chapter IV.
[19] This thesis will distinguish 'paternalism' and 'protectionism' and take forward the latter definition, which is a derivative of the former. Chapter II explains the distinction and provides the working definition of protectionism.

deficiencies, whereas the law on medical refusal, whilst not wholly unjustified in its approach, should nevertheless be reconsidered.

III. Research Questions

In the light of the research problem, the overarching research question is expressed thus:

> Do the courts, when deciding to respect or overrule a minor's medical decision, identify the relevant factors in the case before it, give them proper weight, appropriately balance the interests of autonomy and protectionism, and make a choice that is right for the individual at the heart of the decision?

In exploring this question, this thesis considers several other questions:

> Why does English law not confer full legal capacity to competent minors capable of autonomous decision-making?
>
> What factors do the courts consider relevant and weighty when determining whether to respect or overrule a minor's refusal of medical treatment?
>
> Is there a case for English law to be brought in line, to some extent, with the approaches of other common law jurisdictions to minors' medical decision-making?
>
> In the light of general new legal developments domestically and internationally since *Gillick*, *Re R* and *Re W*, how could and should English law on minors' medical decision-making be taken forward?

IV. Methodology

This thesis applies a doctrinal approach to legal research. The analysis focuses on case law, statutes, and other relevant legal sources in order to understand and clarify ambiguities in the

law.[20] Additionally, this thesis includes theoretical research to examine the concepts, definitions, and theories regarding the theoretical models of autonomy and paternalism. Moreover, this thesis contains a comparative law analysis. This method aims to provide critical insights into different legal practices, highlighting the rationale and justifications underpinning approaches taken by different jurisdictions that attach significance to minors' autonomy in medical decision-making, aiming to help courts fill gaps in English law.[21] The jurisdictions this thesis considers are Canada and Scotland. There are four reasons for this. First, although Canada and Scotland have a hybrid legal system comprising common law and civil law, there is symmetry with England's common law system, which allows for a robust comparative analysis. Secondly, English law on minors' medical decision-making has influenced the development of Canadian and Scottish law on the subject.[22] Thirdly, and flowing from the second, the Canadian and Scottish legal frameworks for minors' medical decision-making have distinct features and strengths, and consequently, they provide lessons for English law. Fourthly, and more specifically to Canada, the Supreme Court of Canada (SCC) is a highly distinguished court of the common law world, and its decisions are internationally significant and persuasive in many contexts.[23] The salient decision of the SCC in *AC v Manitoba (Director of Child and Family Services)*,[24] the leading authority in Canada on minors' medical treatment refusals, has recently seen significant judicial scrutiny in the English domestic courts.[25]

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[20] Paul Chynoweth, 'Legal Research' in Andrew Knight and Les Ruddock (eds), *Advanced Research Methods in the Built Environment* (Wiley-Blackwell 2008) 29.
[21] See Esin Örücü and David Nelken (eds), *Comparative Law: A Handbook* (1st edn, Hart 2021); Uwe Kischel, *Comparative Law* (Andrew Hammel trs, OUP 2019).
[22] See Chapter VI, Parts I and II.
[23] See, eg, *Rodriguez v Attorney General of Canada* [1993] SCR 519 (healthcare), cited by Lord Hope of the House of Lords in *R (on the application of Purdy) v DPP* [2009] UKHL 45; *Cook v Lewis* [1951] SCR 830 (negligence), cited in the UK House of Lords' decision in *Fairchild v Glenhaven Funeral Services Ltd (t/a GH Dovener & Son)* [2003] 1 AC 32; *Pro-Sys Consultants Ltd v Microsoft Corpn* [2013] SCC 57 (competition law), considered persuasive in the UK Supreme Court decision in *Mastercard Inc v Merricks* [2020] UKSC 51.
[24] [2009] SCC 30.
[25] *Re X (A Child) (No 2)* [2021] EWHC 65 (Fam). See Chapter VI, Part I.

V. Thesis Contributions

This thesis makes important contributions to the knowledge of the law on minors' medical decision-making. First, it distinguishes itself by establishing working definitions for 'autonomy' and 'protectionism' for the purposes of having a more consistent analysis of judicial decision-making based on those theoretical models. Secondly, it offers novel interpretations of recent significant English case law. In particular, the analysis gravitates around, on the one hand, the recent gender dysphoria cases challenging the consent principles of *Gillick*,[26] and on the other hand, a series of High Court cases and a milestone Court of Appeal decision, which aimed to challenge the *Re R* and *Re W* principles.[27] Thirdly, the author of this thesis comprehensively analysed all reported English minors' medical refusal case law and relevant comparative case law to identify all the factors that the courts determine as relevant to deciding issues of minors refusing medical treatment. The result of this endeavour is that this thesis details all relevant factors, and those factors also form the basis of a novel framework that objectively analyses whether the courts make consistent judgments in minors' medical refusal cases. Fourthly, it comprehensively explores the implications of human rights law on minors' medical decision-making. The most significant contribution within this exploration is in relation to how the law approaches the issue of minors' refusing medical treatment and deprivations of liberty under Article 5 of the European Convention on Human Rights 1950 (ECHR/the Convention). The subject area has not been satisfactorily scrutinised either in case law or academic literature, and therefore, this research fills an important gap in the existing knowledge. Fifthly, there is a comparative law analysis to increase the knowledge of the lessons that English law can learn from Canadian and Scottish law. This comparative research

[26] See Chapter III.
[27] See Chapter IV.

contributes to the literature by broadening the understanding of minors' medical decision-making rights domestically by looking internationally.

VI. Thesis Outline

A. Chapter II: Autonomy, Paternalism and Medical Decision-Making

Chapter II examines and draws attention to the differences and tensions between the two primary theoretical models that feature prominently in the law on medical decision-making: autonomy and paternalism. Despite their prominence in medical law cases, explicitly or implicitly, the courts often eschew defining the principles. Chapter II will not survey all philosophical taxonomies. Instead, it will elucidate relevant definitions. The objective is to synthesise the general understanding of autonomy and paternalism, culminating in the provision of broad working definitions which will provide a consistent understanding of those theoretical models in subsequent legal analysis. This chapter defines paternalism in terms of its derivative, 'protectionism'. While paternalism and protectionism share many of the same characteristics, the 'protective' jurisdiction of the court and all that relates to that meaning implies that protectionism is the more apt term for evaluating the decisions of the courts in the context of minors' medical decision-making.[28]

B. Chapter III: A Right to Consent?

Chapter III explores the genesis and development of minors' legal rights to *consent* to medical treatment. The focus is on the law pre-*Gillick* with the FLRA 1969, the *Gillick* decision itself and its implications, and post-*Gillick* with how subsequent courts have interpreted children's consent to medical treatment. There has been no shortage of challenges to the *Gillick* principles

[28] It should be noted that in the legal and academic literature, 'paternalism' is the preferred term. After Chapter II, any use of 'paternalism' will, unless the context suggests otherwise, be in reference to the writings of others.

since its inception, with the significance of the decision becoming undermined. However, this thesis argues that the recent Court of Appeal decision in *Bell v Tavistock and Portman NHS Foundation Trust* (*Bell (CA)*)[29] represents a robust affirmation of the orthodox understanding of *Gillick* competence. The thrust of Chapter III is the argument that, although there are some practical ambiguities and complexities implicit in *Gillick* competence, the law on minors' medical consent is theoretically sound.

C. Chapter IV: A Wrong to Refuse?

Chapter IV investigates the approach and development of minors' legal rights to *refuse* medical treatment. It explores the cases of *Re R* and *Re W*, evaluates their legacy, and considers the implications of its recent development in the new Court of Appeal decision in *E & F (Minors: Blood Transfusions)*.[30] Subsequent courts applying *Re R* and *Re W* have traditionally decided medical treatment refusal cases favouring protectionism over respect for the minors' autonomy based on consequentialism (or ideal desire autonomy) analyses. This is problematic because the outcomes in some decisions were not necessarily best for the individual at the heart of the decision.[31] Thus, as a matter of principle, the courts should employ a broader and more nuanced approach to the welfare assessment that more appropriately balances the interests of autonomy and protectionism in minors' treatment refusal cases. Chapter IV develops a framework to objectively analyse the decisions of the courts. The framework also provides a basis for future courts to decide cases more consistently, and it will support litigants on their likely success based on their factual situation. The framework is based on factors that were relevant to the outcomes in the case law.

[29] [2021] EWCA Civ 1363.
[30] [2021] EWCA Civ 1888.
[31] In this thesis, unless the context directs otherwise, 'welfare' and 'best interests' are used interchangeably.

D. Chapter V: The Human Rights Dimension

Chapter V enquires into the impact of the Human Rights Act (HRA) 1998 on minors' medical decision-making. The focus is on whether minors can successfully appeal to their rights under Articles 2, 3, 5, and 8, in conjunction with Article 14 ECHR, to support their refusal of medical treatment. Chapter V suggests that no Convention right of itself nor cumulatively makes a minor's decision to refuse medical treatment determinative. However, they may be significant factors in the courts' welfare assessment. Arguably, Article 8 has the greatest potential of all Convention rights to swing the balance in favour of respecting the minors' decision.

E. Chapter VI: Comparative Law

Chapter VI undertakes a comparative analysis, surveying the legal frameworks governing minors' medical decision-making in Canada and Scotland. The jurisprudence in these jurisdictions provides important lessons for how English law could develop the law on minors' medical refusal. Canadian case law, for instance, presents factors relevant to the welfare assessment not canvassed in English law. Chapter VI suggests that while Canada and Scotland treat children's medical rights in much the same manner as English law, the protection they give to the medical decision-making of young persons is superior to English law.

F. Chapter VII: Thesis Conclusion

Chapter VII concludes by reaffirming the central arguments in this thesis and provides recommendations for developing the law on minors' medical decision-making. In summary, this thesis recommends that the law on medical refusal only requires reconsideration; the common law should be responsible for developing the law; in turn, the courts in the welfare assessment must identify and give proper weight to all relevant factors and robustly balance those factors out, culminating in a decision that is best for the individual at the heart of the decision. These recommendations are theoretically grounded and principled in approach.

VII. Timeline of Relevant Law

TIMELINE OF RELEVANT LAW		
Name	**Law**	**Summary**
Family Law Reform Act 1969	Statutory Principle	This Act provides that a minor who has attained the age of 16 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. This Act was the first piece of law to give minors (16-17-year-olds) the legal right to consent to medical treatment in England & Wales.
Child and Family Services Act, CCSM c C80	Comparative Statutory Principle	This Canadian Act provides, *inter alia*, when a court may authorise a medical examination or any medical or dental treatment that the court considers to be in the best interests of the child.
Re LDK (An Infant) (1985) 48 RFL (2d) 164	Comparative Case Law	This case is an example of a Canadian court supporting the decision of a child to refuse medical treatment even though this decision puts their health or life in jeopardy.
Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 122	Case Law	This landmark House of Lords case held that as a matter of law, the parental right to determine whether or not their child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.

		This case filled an important gap left by the Family Law Reform Act 1969. It is the leading authority on children's medical consent law.
Age of Legal Capacity (Scotland) Act 1991	Comparative Statutory Principle	This Act defines that a person of or over the age of 16 years shall have the legal capacity to enter into any transaction, including the giving of consent to medical treatment. There are exceptions to this general rule, including the provision enabling a person under the age of 16 to have the legal capacity to consent to medical treatment independently.
Re R (A Minor) (Wardship: Consent to Treatment), [1992] Fam 11	Case Law	This Court of Appeal case held that a *Gillick* competent child or one over the age of 16 will have a power to consent, but this will be concurrent with that of a parent or guardian. Furthermore, the court, in the exercise of its wardship jurisdiction, has the power to override the decisions of *Gillick* competent children as much as those of parents or guardians. This case filled an important gap on the issue of medical refusal left by the Family Law Reform Act 1969 and *Gillick*. However, in doing so, it signalled a disjuncture from *Gillick*. This case and the latter case of *Re W* detail the "conventional wisdom" on minors' medical decision-making rights, especially in regard to the law of medical refusal.
Re W (A Minor) (Medical Treatment: Court's	Case Law	The Court of Appeal in this case, following its earlier decision in *Re R*, held that no minor of whatever age or level of competence has the full right to autonomous medical decision-making.

Jurisdiction), [1993] Fam 64		This case addressed the remaining issues left by the Family Law Reform Act 1969, *Gillick* and *Re R*. However, in doing so, like *Re R*, it signalled a disjuncture from *Gillick*. This case and *Re R* detail the "conventional wisdom" on minors' medical decision-making rights, especially in regard to the law of medical refusal.
Re AY (1993) 111 Nfld & PEIR 91	Comparative Case Law	This case is another example of a Canadian court supporting the decision of a child to refuse medical treatment even though this decision puts their health or life in jeopardy.
Houston (Applicant) [1996] SCLR 943	Comparative Case Law	This Scottish Sheriff Court case notably interpreted the consent provision in the Age of Legal Capacity (Scotland) Act 1991 as covering consent and refusal of medical treatment. The case also suggests that a competent child's decision (to consent *or* refuse consent) is paramount and cannot be overridden by a parent or guardian. The reasoning in *Re R* and *Re W* was referred to the Sheriff Court, though this did not impact the court's decision.
Human Rights Act 1998	Statutory Principle	This Act gives further effect to the rights and freedoms guaranteed under the European Convention on Human Rights 1950. Notably, the courts have interpreted the Convention (such as Article 8) to recognise and uphold the medical decision-making autonomy of competent patients. However, the support the Act offers minors in this context, especially regarding medical refusals, is limited.

Mental Capacity Act 2005	Statutory Principle	This Act provides a framework to protect those unable to make decisions. Much of the Act applies to 16-17-year-olds, including the presumption of capacity. Accordingly, 16-17-year-olds are presumed competent under the Family Law Reform Act 1969 and presumed capacitous under the Mental Capacity Act 2005. However, neither Act has been interpreted to give these minors full medical decision-making autonomy.
R (on the application of Axon) v Secretary of State for Health [2006] EWHC 37 (Admin)	Case Law	This High Court case strongly affirmed *Gillick* and held that *Gillick* competence is not limited to only contraceptive advice and treatment. The *Gillick* principles apply to *all* forms of medical treatment.
AC v Manitoba (Director of Child and Family Services) [2009] SCC 30	Comparative Case Law	This Supreme Court of Canada case is the leading authority on minors' medical decision-making in Canada. Crucially, the court held that the impugned provisions of the Child and Family Services Act, CCSM c C80, should be interpreted in such a way to allow children to demonstrate sufficient maturity to have a particular medical treatment decision respected.
PH v Eastern Regional Integrated Health Care Authority and SJL (2010) 294 Nfld & PEIR 248 (NLTD)	Comparative Case Law	This Canadian Trial Court case interpreted *AC v Manitoba* as suggesting that, irrespective of findings or presumptions about competence and the value of autonomy, the court's choice is always to preserve the minor's health or life because that is in their best interests. This case overreached with its interpretation of *AC v Manitoba*.

Ferreira v HM Senior Coroner for Inner South London [2017] EWCA Civ 31	Case Law	This Court of Appeal case, despite not directly concerning minors' medical decision-making, is significant because *Re X (A Child) (No 2)* interpreted it as detailing whether a minor receiving medical treatment against their expressed wishes can be found to be deprived of their liberty.
Re X (A Child) (No 2), [2021] EWHC 65 (Fam)	Case Law	This High Court case is significant because it displayed a robust affirmation of *Re R* and *Re W*, with the case defending the Court of Appeal decisions against a broad set of challenges. In particular, the prominence of medical autonomy domestically and internationally and human rights.
AB v CD [2021] EWHC 741 (Fam)	Case Law	This High Court case confirmed that parents cannot override the decision to consent to medical treatment made by their *Gillick* competent child. However, when a child does not make a decision because they are overwhelmed or they defer the decision to their parents, the parent's right to provide consent continues.
A Teaching Hospitals NHS Trust v DV (A Child) [2021] EWHC 1037 (Fam)	Case Law	This High Court case is the first (and currently only) minors' medical refusal case in English law to respect the decision-making autonomy of a competent minor (17-year-old), even though the consequences of doing so could have resulted in the death or serious injury of the minor. The reasoning in the case was consistent with that of *Re R* and *Re W*. However, the outcome represents a clear disjuncture from conventional wisdom.

Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363	Case Law	This Court of Appeal case overturned the earlier decision at first instance of *Bell* (Divisional Court). The Divisional Court's decision was wholly inconsistent with *Gillick.* The *Bell* (Court of Appeal) decision represented a robust reinstatement of the principles of *Gillick*. Indeed, with this decision, the law on minors' medical consent appears settled.
E & F (Minors: Blood Transfusions) [2021] EWCA Civ 1888	Case Law	This Court of Appeal case held that *Re R* and *Re W* represents good law, all the while seemingly marking a clear shift because its message emphasised respecting competent minors' medical refusals when such a decision reflects the minors' best interests. This Court of Appeal case is the most significant minors' medical refusal case since *Re R* and *Re W*. It provides a basis that develops a broad and nuanced approach to competent minors' refusals that balances competing interests implicit in the court's welfare assessment. The Court of Appeal directed that all future courts hearing cases of minors' medical refusals should refer themselves to its judgment.

CHAPTER II

AUTONOMY, PATERNALISM AND MEDICAL DECISION-MAKING

In order to critique the legal position in respect of minors' medical decision-making capacity, an account of the philosophical principles that underpin legal analysis in this area is required. In discussions on English medical law's responses to cases concerning the treatment and non-treatment of patients, two primary competing concepts feature prominently: *autonomy* and *paternalism*. Both theoretical models have extensive and nuanced literature. The purpose of this chapter is not to encompass all philosophical taxonomies. Instead, this chapter elucidates relevant definitions in order to provide working definitions, which will serve as a basis for subsequent legal analysis of minors' medical decision-making rights. The analysis of this chapter is bipartite.

Part I introduces and delineates various conceptions of autonomy. It expounds on the principle's philosophical and legal significance, as well as highlights the distinction between autonomy and liberty. This part discusses and partially rejects the concept of relational autonomy, which developed in some ways as a response to individualistic notions of autonomy that are assumed to omit the social nexus of the subject. This part also distinguishes the principle of autonomy from the principle of respect for autonomy. In doing so, it enquires into whether the principle of respect for an individual's autonomy is a non-negotiable axiom.

Part II introduces and demarcates different definitions of paternalism and aims to evaluate the merits of paternalistic justifications for limiting patients' autonomy.[32] Part II has three core features. First, it explains the difference between soft and hard paternalism. Secondly, it elucidates the notion of medical paternalism, which will involve a discussion of

[32] Donald Vandeveer, *Paternalistic Intervention: The Moral Bounds on Benevolence* (PUP 2014).

the guiding normative principles of biomedical ethics. Thirdly, it distinguishes paternalism from protectionism. Protectionism is derivative of the definitions that make up the broad understanding of paternalism, though it has its own nuances. This thesis takes forward the concept of protectionism because the definition attached to it is more suitable for the context of minors' medical decision-making.

Chapter II concludes by providing the working definitions for autonomy and protectionism. It explains how the two will help analysis in relation to how the courts have and should decide cases in the context of minors' medical decision-making.

I. Autonomy: The Protagonist?

In medical law, autonomy has traditionally marked the bounds of an individual's bodily integrity. It is a concept that supposes that individuals can decide who shall have access to their body and what shall be done to it. Autonomy thus emerged as a representation of the ethical value underlying consent and refusal of medical treatment.[33] A venerable expression regarding the importance of consent in medical law was delivered by Cardozo J: 'Every human being of adult years and sound mind has the right to determine what shall be done with his own body'.[34]

In general, English law supports adults with capacity to make their own healthcare decisions, even if those decisions are whimsical, irrational, harmful, or fatal.[35] The justification for this position is the protection of the patient's autonomy.[36] In *King's College Hospital NHS Foundation Trust v C*, MacDonald J succinctly expressed that:

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[33] Kenneth Veitch, *The Jurisdiction of Medical Law* (Ashgate 2007) 78.
[34] *Schloendorff v Society of New York Hospital* (1914) 105 NE 92 [93].
[35] See *Sidaway* (n 3) [904] (Lord Templeman); *Re MB (Caesarean Section)* [1997] 2 FLR 426 [436]-[437] (Butler-Sloss LJ); (n 4). See, however, (n 6) and (n 7).
[36] *Chester v Afshar* [2004] UKHL 41 [24] (Lord Bingham); *Airedale NHS Trust v Bland* [1993] AC 789. The courts tend to use the term 'autonomy' interchangeably with the 'right of self-determination'. In this thesis, autonomy is the preferred term.

> A capacitous individual is entitled to decide whether or not to accept medical treatment… This position reflects the value that society places on personal autonomy in matters of medical treatment and the very long established right of the patient to choose to accept or refuse medical treatment from his or her doctor.[37]

The concept of autonomy is familiar within moral, political, and legal philosophies,[38] but it has no universally accepted definition. In the medical law literature, while the importance of autonomy has featured prominently in analysis, this has often been accompanied by the unimportance of the need for reflection upon its meaning.[39] That is because the concept of autonomy is extensive and challenging, so to devote sufficient space to thoroughly explore the concept would leave little room for much else. It also has an assumed meaning that renders detailed inquiry superfluous.[40]

A. Autonomy Typologies

The word *autonomy* derives from the Greek *autos* (self) and *nomos* (rule) and originally referred to the self-rule of independent city-states but has since been extended to individuals. The orthodox definition of autonomy is an individual's capacity to think, decide, and act on that thought and decision freely and independently, without let or hindrance.[41] There are many other contemporary definitions of autonomy, such as those traceable to the libertarianism of

[37] [2015] EWCOP 80 [1]-[2].
[38] See, eg, Gerald Dworkin, *The Theory and Practice of Autonomy* (CUP 1988); Onora O'Neill, *Autonomy and Trust in Bioethics* (CUP 2002); Joseph Raz, *The Morality of Freedom* (OUP 1986); Catriona Mackenzie and Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (OUP 2000); Margaret Brazier, 'Do No Harm–Do Patients Have Responsibilities Too?' (2006) 65(2) CLJ 397.
[39] Charles Foster, 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?' (2013) 22(1) Med L Rev 48.
[40] See, for detailed discussions of 'autonomy' in medical law, Veitch (n 33); Alasdair Maclean, *Autonomy, Informed Consent and Medical Law* (CUP 2009); Charles Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (Hart 2009); Sheila McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish 2010).
[41] Raanan Gillon, 'Autonomy and the Principle of Respect for Autonomy' (1985) 290(6484) BMJ 1806, 1806.

John Stuart Mill[42] and Peter Singer.[43] The autonomous individual has a life plan, acts according to such and endeavours to do so without interference from others, analogous to how a government organises its territories and determines its policies. In other words, the individual is sovereign, and autonomy is the basis that enables the individual to 'make her life her own'.[44]

Unpacking the base premise that autonomy denotes self-government, it arises that its meaning is far from straightforward. Autonomy as the *capacity* to govern oneself implies an all-or-nothing matter: either one has the capacity for self-rule, or one does not. It follows that those who lack capacity are non-autonomous. Such a conclusion by itself would be reductive. It underestimates the weight that should be given to the personal values of those who lack capacity, which could form the basis for (substituted) autarchy.[45] The base premise thus relies on the falsity of a binary understanding that fails to account for the distinction between *mental* and *legal* capacity and the implications of this distinction on autonomous governance. A person may have the mental capacity (i.e. ability to think and decide) and not the legal capacity (i.e. authority) to exercise their autonomy. On the logic therefore that autonomy presupposes the capacity to act on the person's mental deliberation,[46] some mentally capacitous people may be legally non-autonomous.[47] The difficulties that emerge from unpacking the orthodox understanding of autonomy do not delegitimise the concept but illustrate its complexity.

Explaining the premise that autonomy denotes self-government further, Coggon and Miola suggested that autonomy is not so much a normative concept as an empirical question: we do not know *ex ante* that (or how much) autonomy is good. The question is, instead, whether

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[42] John Stuart Mill, *Utilitarianism and On Liberty: Including Mill's 'Essay on Bentham' and Selections from the Writings of Jeremy Bentham and John Austin* (Mary Warnock ed, John Wiley & Sons 2007).
[43] Peter Singer, *Practical Ethics* (CUP 1993).
[44] John Harris, 'Consent and End of Life Decisions' (2003) 29(1) J Med Ethics 10, 10.
[45] *A Local Authority v E* [2012] EWHC 1639 (COP) [124] (Peter Jackson J); *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; MCA 2005, s 4(6). See also John Coggon, 'Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection' (2016) 24(3) Med L Rev 396.
[46] Foster (n 39).
[47] See Chapter IV.

autonomy exists in any action: is a person directing their action?[48] If yes, the person is being autonomous, and if no, they are not. These answers do not, however, suggest whether the person should be self-governing, which is a question that presents different problems. Coggon and Miola posited whether it is 'good' that people govern themselves, or to what extent they should do so; what authority does the 'self' in a self-governor have, or *should* have; is autonomy graded or context-specific where an individual can be more or less autonomous?[49] The normative dimensions that stem from these questions, such as how much information a patient should be informed about the proposed treatment, further complicate a satisfactory analysis because they are not always adequately nuanced.[50] There are other issues, but the purpose of raising such conundrums is to accentuate the difficulties faced with delineating the meaning behind autonomy, even on a purportedly simple conception.

In advance of reviewing broader typologies, it is necessary to distinguish the concept of *autonomy* from *liberty*. These theoretical models are different, and explaining the differences will avoid conflation moving forward; deference is made to the following explanations. First, adopting the approaches of Jennings[51] and Griffin,[52] Coggon and Miola suggested that autonomy relates to a person's 'free will', and liberty relates to 'freedom to act without interference from a third party'.[53] Second, Gillon observed that autonomy falls into three classes: autonomy of *thought*, *will*, and *action*.[54] The former two embrace the idea of 'thinking for oneself' (thought) and the freedom to decide to do things based on one's deliberations (will), whereas the latter is acting on the thought and will without interference (action).[55] Consider the following examples. In the case of some detained mental health hospital patients,

[48] John Coggon and José Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) 70(3) CLJ 523, 524.
[49] ibid 524-525.
[50] ibid 525.
[51] Bruce Jennings, 'Autonomy' in Bonnie Steinbock (ed), *The Oxford Handbook of Bioethics* (OUP 2007).
[52] James Griffin, *On Human Rights* (OUP 2008).
[53] Coggon and Miola (n 48) 525.
[54] Gillon (n 41) 1806.
[55] ibid 1806-1807.

while they may enjoy a level of autonomy, the state can severely (positively) restrict their liberty. Alternatively, a third party's (negative) actions, such as public buildings not accommodating wheelchair access, can interfere with a person's liberty. Conversely, consider people with locked-in syndrome–their autonomy of thought and will may still be active, but their autonomy of action is wholly absent. Because the inaction was not induced by State or third-party interference, the autonomy of action is distinguishable from liberty. In summary, Gillon's autonomy (of thought and will) corresponds with Coggon and Miola's conception of autonomy (free will), whereas Gillon's autonomy (of action) is broader than Coggon and Miola's liberty. A concern for both theoretical models is appropriate, as is recognising their contrast.

There are myriads of descriptions of autonomy that go beyond the basic orthodox definition of self-government due to the equivocal nature of the concept. In his seminal work, Coggon suggested there are three relevant understandings in which autonomous choice may be judged: *current, best,* and *ideal desire autonomy*.[56] The three provide an instructive framework to assess the law that is not achievable when we merely refer to a crude conception of autonomy. He explained that the three definitions of autonomy are important because it is their coexistence that allows confused and inconsistent resolutions of cases to arise in an ostensibly respected system of precedent.[57] The following subsections elucidate each understanding, culminating in an explanation of how the definitions fit within the working definition of autonomy that this thesis will take forward.

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[56] John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15(3) Health Care Analysis 235, 240.
[57] ibid.

1. Current desire autonomy

Current desire autonomy 'leads to an action decided upon because it reflects a person's immediate inclinations, i.e. what he thinks he wants in a given moment without further reflection'.[58] Thus,

> when we say someone is acting in accordance with his current desire autonomy, we suggest a level of conscious choice, but one that is not very (if at all) reflective. If it is reflective, it nonetheless succumbs to the call of the moment, even if that may be a matter of contemporary regret for the agent.[59]

This conception of autonomy reflects the law's purported commitment to value-agnosticism, in which the courts assess the putatively autonomous decision by reference to an individual's value system.[60]

An inherent characteristic of current desire autonomy is that it is permissible for an individual's choices and values to change impetuously. The tension is whether this framework in the context of medical decision-making can be an optimal legal approach. Consider the decision in *HE v A Hospital NHS Trust*.[61] Here, a 24-year-old, D, had fallen seriously ill, and her father, H, applied for a declaration that she could be treated with blood transfusions. She was initially a Muslim until she converted to the Jehovah's Witness faith after her mother, M, separated from H. In her early twenties, D had signed an 'advanced medical directive' stipulating that she was not to receive treatments involving blood transfusions and that the directive could only be revoked in writing.[62] Whilst D was unconscious, M refused to allow the treatment on the ground that the directive was still in force.[63] H argued that since the

[58] ibid.
[59] ibid 241.
[60] Coggon and Miola (n 48) 529. See *Re T* (n 4) [113].
[61] [2003] EWHC 1017 (Fam).
[62] ibid [4].
[63] ibid [7].

directive predated his daughter's reversion to being a Muslim in order to marry her fiancé, the directive could no longer be relied upon given *that* change of faith.[64] Munby J authorised the blood transfusions, stating that since the directive was founded entirely on D's faith as a Jehovah's Witness, 'it seems clear that it cannot have survived her deliberate, implemented, decision to abandon that faith and to revert to being a Muslim'.[65] The decision turned on D's faith, and although she ceased to worship as a Jehovah's Witness before her illness, at no point prior to becoming ill did she amend or withdraw the advance directive despite the ample opportunity. The advance directive, therefore, remained the most convincing evidence of D's wishes. Yet Munby J considered the doubt as to the continued validity and applicability of the advance directive generated from the time that had elapsed between when the advance directive was made and the changes in D's circumstances decisive for the outcome of the case.

Despite some difficulties with Munby J's conclusion, the *HE* decision is a useful example to demonstrate current desire autonomy. A strength of the framework lies in its support for the fluidity in which a person's values, beliefs and decisions can change according to circumstance. Conversely, the volatility intrinsic to current desire autonomy compounds difficulties in legal disputes.

2. Best desire autonomy

The concept of best desire autonomy 'leads to an action decided upon because it reflects a person's overall desire given his own values, even if this runs contrary to his immediate desire'.[66] Best desire autonomy is akin to the conception of autonomy advanced by Frankfurt[67] and Dworkin.[68] These authors distinguished 'first-' and 'second-order desires', arguing that

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[64] ibid [47].
[65] ibid [49].
[66] Coggon (n 56) 240.
[67] Harry G Frankfurt, 'Freedom of the Will and the Concept of a Person' (1971) 68(1) J Philos 5.
[68] Dworkin (n 38).

autonomous choice corresponds with an agents accordance with 'second-order desires', i.e. wanting to have or not to have certain desires and motives; this is more than just having a desire to do or not to do something (first-order desire).[69] It follows that actions from a first-order desire that are not endorsed by a second-order desire are not autonomous. The higher-order capacity is thus what constitutes autonomy. The potential for difficulty with best desire autonomy gravitates around the individual acting against their immediate inclination. Cases of Jehovah's Witnesses who do not wish to die (immediate inclination) but wish to refuse life-saving blood transfusions because it goes against their religious beliefs (acting according to their value system) are clear examples of this conflict.[70] The tension is compounded in cases concerning (religious) minors.[71]

Coggon suggested that an essential feature of best desire autonomy is that the agent's values are settled (although not necessarily permanent), and an agent recognises those values as their values and seeks to act according to those values.[72] Consider the case of *Re B*.[73] Ms B advanced that she felt to deny her choice to refuse life-sustaining mechanical ventilation was tantamount to her rights being eroded–this was something she could not tolerate.[74] The decision to die was not made easily by Ms B, cognisant as she was of the effect it would have on those she would leave behind. Nevertheless, her wishes were clear and well expressed,[75] evidencing the components of best desire autonomy, whose conception compounds reflective reasoning. Butler Sloss P upheld Ms B's refusal–a decision consistent with Ms B's best desire autonomy.

The law has also demonstrated the disposition to support a person's best desire autonomy even when they lack the capacity to decide for themselves. In *Wye Valley NHS Trust*

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[69] Current desire autonomy reflects the idea of 'first-order desires'.
[70] See, eg, *Manchester University NHS Foundation Trust v DE* [2019] EWCOP 19.
[71] See Chapter IV.
[72] Coggon (n 56) 241.
[73] *Re B (Consent to Treatment: Capacity)* [2002] EWHC 429 (Fam).
[74] ibid [50].
[75] ibid [52]-[53].

v B, Peter Jackson J stressed that 'where a patient lacks capacity it is accordingly of great importance to give proper weight to his wishes and feelings and to his beliefs and values'.[76] The patient strongly opposed the proposed operation (amputation of his severely infected leg). Peter Jackson J supported the patient's best desire autonomy by refusing to sanction the amputation because the operation was not in his best interests.[77]

3. Ideal desire autonomy

Ideal desire autonomy 'leads to an action decided upon because it reflects what a person *should* want, measured by reference to some purportedly universal or objective standard of values'.[78] Coggon regarded this conception of autonomy as compatible with a Kantian or neo-Kantian conception of autonomy, which defines autonomous choice as requiring the agent's decision-making to accord with some objective set of ideals.[79] Coggon further suggested that a contemporary account of ideal desire autonomy would fall under the head of O'Neill's *principled* autonomy. As O'Neill presented, principled autonomy is 'a matter of acting on certain sorts of principles, and especially on principles of obligation… principled autonomy is expressed in action whose principle *could be adopted by all others*'.[80] It follows that the theory of ideal desire autonomy calls for agents to consider their reason for acting and only pursue a course of action if it could be made a universal law. Accordingly, if a person decides to act in a way that is incompatible with a universalisable theory, that person is not acting autonomously.[81] This account demonstrates that autonomous choice demands responsible decision-making. Huxtable suggested that 'only decisions that are right (or good)–i.e.

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[76] [2015] EWCOP 60 [10].
[77] ibid [42].
[78] Coggon (n 56) 240 (emphasis in original).
[79] Immanuel Kant, *Groundworks of the Metaphysics of Morals* (Mary Gregor and Jens Timmermann trs and ed, CUP 2012). Kantian autonomy will be revisited in Chapter II, Part I, Section C.
[80] O'Neill (n 38) 84-85 (emphasis in original).
[81] Coggon (n 56) 240-241.

motivated by the right reasons (whatever these are) and/or achieving the right results (whatever these are)–count as autonomous'.[82]

In contrast to the individualism implicit in current and best desire autonomy, ideal desire autonomy takes a more objective, societal and paternalistic stance.[83] Reconsider the decision in *Re B*. Although the decision ultimately respected Ms B's best desire autonomy, Butler Sloss P had difficulties escaping the perceived ideal scenario *for* Ms B, believing that she still had a lot to offer the community at large.[84] Another relevant example is the Court of Appeal decision in *Burke*. Leslie Burke indicated that he wished to be kept alive by the provision of artificial nutrition and hydration (ANH). He wanted confirmation that his wish for ANH would be respected, even if he lost capacity, arguing that it would not be in his best interests for the doctors to withdraw the treatment.[85] The Court of Appeal commented that:

> [T]he right to choose is no more than a reflection of the fact that it is the doctor's duty to provide a treatment that he considers to be in the interests of the patient and that the patient is prepared to accept.[86]

What *Burke* suggests about ideal desire autonomy is that medical law does not exist solely to give patients what they want, but to give them what they want if it was first agreed by the doctors that it is what the patient needs.[87] In other words, a choice is autonomous if it is the *right* choice, objectively verified. *Burke* further represents the dichotomy between autonomy and liberty. Leslie Burke could not act by himself. In this instance, it was for the doctor to fulfil

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[82] Richard Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, Non-Treatment and the Values of Medical Law' (2014) 22(4) Med L Rev 459, 466.
[83] See, for concepts and definitions of 'paternalism', Chapter II, Part II.
[84] *Re B* (n 73) [95].
[85] *R (on the application of Burke) v General Medical Council* [2005] EWCA Civ 1003 [5]-[12].
[86] ibid [51].
[87] Huxtable (n 82) 466.

his wishes. The situation is comparable (only in terms of decision-making, not gravity) to the person denied entry to a public building because there is no wheelchair access.

4. Concluding comment

All three conceptions are plausible understandings of autonomy. There is no necessarily optimal conception: all three may be active when deciding if a person's choice is autonomous, and depending on the context, it may not be obvious, for they can conflict, which conception, if any, should prevail. It is reasonable to argue that current desire autonomy's predisposition towards whim and emotion would cause problems for the judiciary when trying to judge a choice as autonomous. Best desire autonomy appears more balanced and preferable for decisions significant in nature. Some critics suggested that agents may not be acting autonomously when they tie themselves to the mast of their ideals and values.[88] Other critics argued that choosing contrary to one's professed, accepted, and settled values need not constitute an abandonment of autonomy.[89] For example, a patient might opt to accept the life-prolonging treatment they were previously refusing in accordance with their values because they had an epiphany that they wanted to live for a few days longer. Finally, while ideal desire autonomy reflects paternalism, it is the most objective conception and strongly emphasises that multifaceted considerations make up the decision-making process.

In the context of minors' medical-decision making, although judges do not expound on autonomy in the way Coggon presented, the theories of current, best and ideal desire autonomy are discernible in their judgments. In treatment refusal cases, which is the context where philosophical tensions are brought to the fore, the courts generally appear to favour ideal desire

[88] Petr Skrabanek, *The Death of Humane Medicine and the Rise of Coercive Healthism* (Social Affairs Unit 1994) 185-190.
[89] Agnieszka Jaworska, 'Caring, Minimal Autonomy, and the Limits of Liberalism' in Hilde Lindemann, Marian Verkerk, and Margaret Walker (eds), *Naturalized Bioethics: Towards Responsible Knowing and Practice* (CUP 2009).

autonomy analysis, especially where there are concerns over the minors' decision-making ability, such as making irrational decisions.[90] The use of different understandings of autonomy within medical law is unproblematic as long as the courts are explicit about which concept of autonomy they use. However, Chapter IV will demonstrate that the courts are *not* explicit about which concept of autonomy underpins their decision.

For the purposes of this thesis, because ideal desire autonomy reflects paternalism, the latter theoretical model will be taken forward when evaluating judicial analysis (although reframed as protectionism). The definition of 'autonomy' is broad (its development will continue below), with current and best desire autonomy forming constituent parts.

B. Relational Autonomy

The typologies of the principle of autonomy discussed thus far are underpinned by the theory of individualism. This theory presupposes independence and self-reliance, analogous to self-government.[91] Leckey elucidated that the individualistic model 'is predicated upon self-sufficient individuals' independently pursuing their respective life plans'.[92] It is the person's choices, values, preferences, and experiences that mould and develop their character and enables that person to be different from the next.[93] The model emphasises the individual *qua* individual. It traditionally refers to the isolated agent reflecting on their own wishes or desires.[94] The implication is that the human agent is separate from their wider community.

The theories of autonomy that presuppose individualism have come under challenge, most notably from feminist theorists. The feminist critique and reconceptualisation of individual autonomy culminated in the emergence of *relational* autonomy. Rather than being

[90] See Chapter IV.
[91] See, for further discussion on 'individualism', Mackenzie and Stoljar (n 38) 3-32.
[92] Robert Leckey, 'Contracting Claims and Family Law Feuds' (2007) 51(1) Univ Tor Law J 1, 7.
[93] Harris (n 44) 11.
[94] John Christman, 'Relational Autonomy, Liberal Individualism, and the Social Construction of Selves' (2004) 117(1/2) Philos Stud 143.

a single account of autonomy, it is an umbrella term. Mackenzie and Stoljar explained that this conception is premised on the conviction that:

> [P]ersons are socially embedded and that agents' identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity.[95]

In Nedelsky's formulation, people come into being in a social context that is literally constitutive of us, i.e. 'the conceptual framework through which we see the world, are not made by us, but given to us (or developed in us) through our interactions with others'.[96] Christman expanded on these earlier works, explaining that relational views of the autonomous person 'underscore the social embeddedness of selves while not forsaking the basic value commitments of (for the most part, liberal) justice'.[97] The crux of the relational theory is the premise that autonomy is not a capacity capable of being exercised in isolation. It instead recognises that individuals depend on others, thus strengthening claims that autonomous choice is carried out with assistance. Everyone was completely dependent on others at the start of life, and dependency on others throughout one's life will not wholly disappear.[98] Ill health and bad luck are not unavoidable. Relational theory views the individual as a rounded, interdependent agent who is attentive and responds to the interests of society.

The emergence of the relational account and its critique of individualism autonomy raised questions of whether the latter is an appropriate model for healthcare decision-making. Berg et al suggested that 'to take account of how people are interrelated and how individuals' interests are rarely purely self-interested and often reflect social values… may actually bring

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[95] Mackenzie and Stoljar (n 38) 4.
[96] Jennifer Nedelsky, 'Reconceiving Autonomy: Sources, Thoughts and Possibilities' (1989) 1(1) Yale J Law Fem 7, 8.
[97] Christman, (n 94) 143.
[98] Emily Jackson, *Medical Law: Text, Cases and Materials* (6th edn, OUP 2022) 24.

theory in line with practice'.[99] Dodds argued that the individualistic model of autonomy is often unsuited for the kind of decision-making that goes on in medicine because,

> [m]any of the important, but by no means unusual, health-care decisions that individuals, friends, and families make are far removed from the cool, reflective, clear-headed decision making that is the paradigm of this view of autonomy.[100]

The recent decisions in the context of genetic information disclosure appear to endorse a reconceptualisation of autonomy. In *ABC v St George's Healthcare NHS Trust*,[101] the Court of Appeal expressed a relational view rather than the more traditional, individualistic approach to the claimant's autonomy.[102] The High Court in the third chapter of the litigation similarly articulated a relational view of autonomy.[103] The cases recognised that the decisions of individuals affect those beyond themselves. Often those closest to the individual are impacted the most. The reasoning of Irwin LJ, who delivered the judgment of the Court of Appeal, suggested that dealing with inherited diseases such as Huntington's Disease is not an individual challenge but a familial one.[104] In the High Court, Yip J held that the defendant owed the claimant a duty of care to balance her interest in being informed of her genetic risk against her father's interest and the public interest in maintaining confidentiality.[105] The design of the balancing exercise exemplifies the social reality of individuals in healthcare.

Individualism autonomy has its issues, but the relational model also does not come without its own problems. The relational approach implies that individualistic autonomy is not

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[99] Jessica W Berg, Paul S Appelbaum, Charles W Lidz and Lisa S Parker, *Informed Consent: Legal Theory and Clinical Practice* (2nd edn, OUP 2001) 33.
[100] Susan Dodds, 'Choice and Control in Feminist Bioethics' in Mackenzie and Stoljar (n 38) 217.
[101] [2017] EWCA Civ 336.
[102] Roy Gilbar and Charles Foster, 'It's Arrived! Relational Autonomy Comes to Court: *ABC v St. George's Healthcare NHS Trust* [2017] EWCA Civ 336' (2017) 26(1) Med L Rev 125.
[103] *ABC v St George's Healthcare NHS Trust* [2020] EWHC 455 (QB). See also Charles Foster and Roy Gilbar, 'Is There a New Duty to Warn Family Members in English Medical Law? *ABC v St George's Healthcare Trust* [2020] EWHC 455' (2021) 29(2) Med L Rev 359.
[104] *ABC (CA)* (n 101) [43]-[44].
[105] *ABC (QB)* (n 103) [188].

responsive to the importance of social context. This conceptual premise lacks substance because people are not social and cultural vacuums. Rather, understood from a metaphysical claim, because individuals invariably experience interaction and hence relations with other people, institutions and traditions, these are seen as essentially part of the person.[106] On this account, the very critiques of autonomy that presuppose individualism become tenuous. Not only is autonomy (on any conception) not resistant to support from communal and social structures that shape and undergird human identities, it *demands* them.[107] As McLean argued:

> While relational autonomy appears more appealing, the presumption that respect for its individualistic counterpart would result in inattention to the interests of society seems erroneous, not least because we cannot by and large help absorbing lessons from our upbringing, our faith and our experiences that make total isolation, and total indifference to others, implausible.[108]

The case of *Re T* illustrates some of the problems implicit in the relational model. The salient point was that an adult patient formerly of the Jehovah's Witness faith who accepted blood transfusion treatment suddenly reversed this decision following a conversation with her mother, who was a devout member of the faith. One of the issues for the Court of Appeal was whether the patient's change of mind was caused by undue influence, which, if the case, would vitiate her refusal. Lord Donaldson MR expressed a relational view towards medical decision-making in his determination that mere familial influence is insufficient to vitiate the patient's decision when he stated, 'it is wholly acceptable that the patient should have been persuaded by others of the merits of such a decision and have decided accordingly'.[109] Yet Lord Donaldson MR implied that if a person influencing the patient were a relative, this might

[106] Christman (n 94) 145.
[107] ibid 146.
[108] McLean (n 40) 27.
[109] *Re T* (n 4) [113].

increase the likelihood that the influence was undue.[110] Thus, familial relations may potentially jeopardise rather than assist the patient in exercising their autonomy.

The decisions in *ABC* and *Re T* exemplify the positive and negative aspects of the individualistic and relational approaches to autonomy. However, to maintain that the two accounts are mutually exclusive threatens to undermine the usefulness of the concept of autonomy in theoretical and practical contexts in which it often functions,[111] particularly the healthcare context. In the context of consent to treatment, the law takes a broad-brush approach to the principle of autonomy,[112] framing it as an individualistic, relationally contoured account. The decision in *Montgomery v Lanarkshire Health Board* is apposite. In describing the doctor's duty to inform the patient of material risks, the Supreme Court dedicated significant emphasis to the individual patient's right to make informed, autonomous decisions. The reasoning culminated in the test of materiality:

> The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the *particular* patient would be likely to attach significance to it.[113]

The crucial implication of this test is the obligation of the doctor to consider the patient in the round, so they can ostensibly learn what risks the patient would likely attach significance to. This assessment is fact-sensitive and sensitive also to the characteristics of the patient.[114] On the one hand, *Montgomery* accounts for autonomy in the individualistic sense in that it secures the right for the individual to independently reflect and act according to their value systems.

[110] ibid [113]-[114].
[111] Christman (n 94) 146.
[112] Foster (n 39).
[113] *Montgomery* (n 8) [87] (emphasis added).
[114] ibid [89].

On the other hand, *Montgomery* simultaneously accounts for autonomy in the relational sense because understanding the 'characteristics' of the patient implies understanding them beyond a superficial level. This will notionally involve inquiry into or discussions concerning familial and/or broader social interests.

This analysis of the social reconceptualisation of autonomy does not dispute the relevance nor importance of relational elements underpinning its premise. Rather, it aimed to pushback on the hypothesis that an individualistic conception of autonomy is incompatible with its purported social counterpart. The two are not so distinct, at least on a fundamental level. The point was made succinctly by McLean:

> [T]here is nothing to suggest that the individualistic account of autonomy necessarily ignores or rejects the values of others, nor does it necessarily preclude the taking of responsibility for decisions made. In other words, it too may be described as socially contextualised, even if it is more obviously supports self-regarding decisions.[115]

Indeed, this thesis accepts and takes forward McLean's analysis that individualism and relationalism are component elements of autonomy.

In conclusion, with the relevant typologies elucidated, for the purposes of this thesis, references to agents' 'autonomy' (or 'autonomous decision-making') shall assume a broad definition of the capacity to think, decide, and act on that thought and decision without interference, with forming its constituent parts: McLean's interpretation that autonomy comprises individualism and relationalism, as well as Coggon's current and best desire autonomy.

[115] McLean (n 40) 30.

C. The Principle of Respect for Autonomy

This chapter has presented a general understanding of the principle of autonomy (and a thesis-specific working definition). The principle of autonomy, however, must be distinguished from the principle of *respect for* autonomy. The crux of the distinction is whether there should be moral, ethical, and/or legal requirements to not only recognise another person's autonomy but also respect it. In addition, if the principle of autonomy is considered principal,[116] should it be exercisable and respected in an absolute sense?

It is uncontroversial to suggest that autonomy is a crucial principle and that to abandon it would have significant consequences. Some philosophers, such as Benson, allied autonomy with 'virtue'.[117] Yet it is important not to lose one's sense of proportion. The hegemony of autonomy is rightly challengeable and does not necessarily deserve unrestricted support or respect. It becomes a slippery slope if, for example, someone who murdered another could be rendered in any way virtuous because the person autonomously decided to commit murder. Keown and Gormally raised concerns over the ability of autonomy to operate as a rule unaided by other principles (such as the categorical imperative of choosing that which promotes human flourishing).[118] These authors premised their argument on the supposition that autonomy's value is linked intrinsically to beneficial actions. This suggests that autonomous acts of 'self-destruction' are undeserving of respect. It is somewhat unclear, based on the logic of their arguments, whether the authors would regard, for example, that a competent cancer patient who autonomously decides to make the self-serving and 'destructive' choice to forgo any more rounds of chemotherapy (which, for argument's sake, was not intolerable) and accept palliative

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[116] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, OUP 2019). See also Gillon Raanan, 'Medical Ethics: Four Principles Plus Attention to Scope' (1994) 309(6948) BMJ 184.
[117] John Benson, 'Who is the Autonomous Man?' (1983) 58(223) Philosophy 5.
[118] John Keown and Luke Gormally, 'Human Dignity, Autonomy, and Mentally Incapacitated Patients: A Critique of "Who Decides"' (1999) 4 Web JCLI < https://www.bailii.org/uk/other/journals/WebJCLI/1999/issue4/keown4.html > accessed 16 September 2021.

care to ease into death is making a decision worthy of respect. The nature of autonomous action does not and should not be assumed to straightforwardly equal 'good', 'bad', 'virtuous', 'destructive' or any other positive or negative adjective. For autonomy to function as a rule in a liberal and democratic society, it merely requires justifiable restrictions on the respect of autonomous actions to exist.

The theory offered by Harris sees the principle of respect for autonomy as an element comprising the wider fundamental basis of any ethics involving human beings: respect for persons.[119] This concept has two distinct dimensions. The first is respect for *autonomy*, whereas the second is concern for *welfare*. Harris argued that respect for another's autonomy is a crucial element where failure to account for its importance undermines respect for persons. He equally recognised that unfettered exercise of autonomy can not only be self but socially destructive. Hence there must be a counterbalance to autonomy. Harris regarded this as concern for welfare, which is broadly conceived of many aspects, including health, freedom from harm, and physical, emotional, and educational needs, and culminates in providing a minimum scope for autonomy to operate within.[120] Accordingly, if a person's autonomous action conflicts with their own or another's welfare, whether that action is respectable will necessarily be questioned.

The theory that respect for autonomy is a qualified rather than an absolute principle is recognisable in the philosophical writings of John Stuart Mill. In his seminal work, Mill advanced that:

> [T]he principle [of autonomy] requires liberty of tastes and pursuits; of framing the plan of our life to suit our own character; of doing as we like, subject to such consequences

[119] Harris (n 44) 10.
[120] ibid 11.

as may follow: without impediment from our fellow creatures, so long as what we do does not harm them.[121]

When Mill discussed autonomy, he used the term ‘liberty’ in order to imply freedoms and restrictions in the context of society.[122] A person is thus autonomous according to Millian autonomy to the extent that the person directs their actions in accordance with their own values, desires, and preferences. However, the ‘harm principle’ presupposes that the autonomous actions of individuals should only be limited to prevent harm to other individuals. Thus, Millian autonomy holds that individuals should be free to act autonomously and have their actions respected, provided those actions do not breach established universal utilitarian objectives of maximising welfare, such as not causing harm to others.

In seeming contrast to Millian autonomy are ideas based on Kantian autonomy.[123] The theory derived from Kant depends on his metaphysical view of the world, which he divided into two realms: the world of sense perception (phenomenal) and the world of reason (noumenal). In both realms, everything that exists works according to universal laws, and humans, as rational beings, exist in both. Rational beings can act autonomously according to their idea of laws; non-rational beings are heteronomous.[124] Human beings are a synthesis of the rational and non-rational. Kant posited that autonomy is action in accordance with the universal law, and any other action demonstrates servile compliance to the low desires of the phenomenal. An individual is free (i.e. autonomous) only if they follow a law that is the will’s own law, and a will only meets this condition if it satisfies further conditions that Kant imposed on autonomy, such as rationality.[125] Kant’s ‘categorical imperative’ explains what it means to

[121] Mill (n 42) 97.
[122] ibid 88, ‘The subject of this Essay is not the so-called Liberty of the Will, so unfortunately opposed to the misnamed doctrine of Philosophical Necessity; but Civil, or Social Liberty: the nature and limits of the power which can be legitimately exercised by society over the individual’.
[123] Kant (n 79).
[124] Terence Irwin, ‘Kantian Autonomy’ (2004) 55 R Inst Philos Suppl 137, 137-138.
[125] ibid 137.

act rationally as it ascribes to autonomy: people are to 'act only on that maxim through which you can at the same time will that it should be a universal law'.[126] It is not enough to merely act according to this maxim, it also requires a *will* to do so, for otherwise one is heteronomous, and it is a necessity of rational agency that agents act autonomously. Furthermore, because rational agents necessarily have wills they are necessarily ends in themselves, and in the light of this fact and the categorical imperative, it follows that one must act to treat humanity 'always at the same time as an end, never merely as a means'.[127] Thus, respect for autonomy is a logically necessary feature of being a rational agent and also requires that agents act according to a rule that would be valid for all similarly situated rational agents.

In summary, Millian autonomy relates to overt actions based on self-interest, whilst Kantian autonomy is concerned with the essence of a decision and how it is reached. The former describes the external ordering of autonomy, while the latter considers the internal. These theories are hence complementary: autonomy may be seen as a self-determined organisation of the will according to *a priori* universal laws and also a liberty to pursue self-serving actions insofar as they do not harm others.[128] The theories are instructive and provide a working framework for determining whether autonomous actions are deserving of respect, but excessive deference to either model is problematic. The Kantian theory, for example, meshes autonomy with rationality, which, once permeated into prescriptive social norms, creates a concept of autonomy that contradicts the general medical law principle that the decisions of people with capacity can be, amongst other things, irrational. An approach emphasising rationality favours a system of consequentialism, which undermines the

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[126] Kant (n 79) 92.
[127] ibid 87.
[128] Mark S Komrad, 'A Defence of Medical Paternalism: Maximising Patients' Autonomy' (1983) 9(1) J Med Ethics 38, 39.

significance of people's values and renders the individual largely hollow because the system is concerned only with the outcome or consequence of a decision.

The expounded theories demonstrate that autonomy is a principle that generally deserves support and respect. This does not suggest that autonomous choice should be unfettered. Following Mill's 'harm principle', some restrictions on people's autonomy are *prima facie* merited. When can or should a person's autonomous choice be limited can further be explained and potentially justified when contrasted with its correlative theoretical model: paternalism.

II. Paternalism: The Antagonist?

In medical law and ethics, there is tension about whether respect for patient autonomy should have priority over paternalistic interference directed at those patients. The etymology of paternalism, deriving from the term 'paternal', reflects the policy and practice of restricting the freedom and autonomy of people in what is claimed to be their best interests. This definition relies on the analogy with the father. It presumes he makes most of the decisions relating to his child's best interests rather than letting the child take on the decisions, i.e. 'Dad knows best'.[129] In the healthcare setting, the analogy is that the medical professional has superior training, knowledge, experience and insight and is accordingly in a uniquely qualified and authoritative position to determine the patient's best interests and to act so as to advance those interests (if need be, without patient participation). The rationale underpinning paternalism is antithetical to notions of autonomy delineated in the preceding part. Paternalism, like autonomy, is complex and contested, which makes it difficult for an accepted meaning to be ascribed to it.[130] This part abstracts the relevant understandings of paternalism, culminating in the working

[129] Joel Feinberg, 'Legal Paternalism' (1971) 1(1) Can J Philos 105.
[130] Heta Häyry, *The Limits of Medical Paternalism* (Routledge 1991).

definition of protectionism, and evaluates the force of paternalistic/protectionist justifications offered for limiting patients' autonomy.

A. Defining Paternalistic Interference

There have been many attempts towards defining paternalism in the literature. One of the most noteworthy is attributable to the influential philosophical works of Feinberg. In 1971, Feinberg stated that:

> [T]he principle of legal paternalism justifies state coercion to protect individuals from self-inflicted harm, or in its extreme version, to guide them, whether they like it or not, toward their own good.[131]

The definition implies that because individuals often either do not know what is best for them or they know what is best for them, but their decision may not align with that goal, the State (in a somewhat conceited belief that it knows best for all) endeavours to stand as a permanent guardian of its citizens' interests in loco parentis.[132] On the one hand, Feinberg's definition has validity in the strict legal sense because legislators represent the State, and laws can be coercive. On the other hand, the definition has conceptual difficulties. Not all paternalism involves State coercion. Some protective State measures may be paternalistic but not necessarily coercive.

A broader definition of paternalism was provided by Dworkin subsequently. He understood paternalism roughly as 'the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced'.[133] There is no reference to the State in Dworkin's definition, but its

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[131] Feinberg (n 129) 105.
[132] ibid. In relation to healthcare, the State's role may be to 'nudge' people (who are imperfect decision-makers) into making 'healthier' choices: see Ivo Vlaev, Dominic King, Paul Dolan and Ara Darzi, 'The Theory and Practice of "Nudging": Changing Health Behaviors' (2016) 76(4) Public Adm Rev 550.
[133] Gerald Dworkin, 'Paternalism' (1972) 56(1) The Monist 64, 65.

inclusion is implied because the State has the jurisdiction to interfere with people's liberty of action. A similar expression to Dworkin was made by Murphy, who simply viewed that 'paternalism is the coercing of people primarily for what is believed to be their own good'.[134] These commentators presumed that coercion is involved in paternalistic intervention, and coercion is justified when the individual acts against their own good or when they are unsure of their own good.

Gert and Culver have criticised the presumption that paternalism involves coercion.[135] These authors claimed, referring directly to Dworkin's definition, that it is incorrect to omit from the understanding of paternalism that there are non-coercive means of exercising protective control. There is no doubt that paternalism in law involves interference with an individual's liberty, but this is more due to the nature of law, not to the nature of paternalism. The substance of Gert and Culver's arguments, namely their suggested definition of what is involved in paternalistic behaviour,[136] has been heavily criticised,[137] but suggesting paternalism can be coercive and non-coercive was an important contribution to the literature.

A more robust and normatively neutral definition that does not presume that paternalism is either justified or unjustified was offered by Beauchamp and Childress. These authors defined paternalism thus:

> [T]he intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies the action by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences or actions are overridden.[138]

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[134] Jeffrie G Murphy, 'Incompetence and Paternalism' (1974) 60(4) Arch Rechts Sozialphilos 465, 465.
[135] Bernard Gert and Charles Culver, 'Paternalistic Behaviour' (1976) 6(1) Philos Public Aff 45.
[136] ibid 48-50.
[137] Häyry (n 130) 53-55.
[138] Beauchamp and Childress (n 116) 231-232.

This definition does assume an act of beneficence[139] analogous to parental beneficence, but it does not prejudge the nature of the beneficent act. The general thrust of paternalism is interference (coercive or non-coercive) with an individual's autonomy for reasons of protecting their welfare or best interests. This interpretation is stymied however by the dilemma of whether there could be a situation in which someone purports to make a decision on behalf of another, but it is not, in any view, in their best interests. It is unclear whether this person's action is a form of paternalism according to Beauchamp and Childress' definitional framework.

A critical distinction exists between 'soft' (weak) and 'hard' (strong) paternalism.[140] In soft paternalism, an agent intervenes in another person's life with the objective of preventing non-autonomous or substantially non-autonomous conduct. In contrast, hard paternalism involves interventions intended to prevent or reduce harm to, or to benefit, a person, even though the person's (bad) choices and actions are informed, voluntary, and autonomous.[141] On the one hand, soft paternalism is complex because of the inherent difficulty in accurately ascertaining whether the person was non-autonomous at the time of decision-making, but it is ethically defensible in that it only tries to nudge,[142] guide, or incentivise choice and prevent harmful outcomes from substantially non-autonomous decisions. On the other hand, hard paternalism usurps autonomous choice often through coercion or compulsion and is *prima facie* ethically indefensible. To illustrate the distinction, consider Mill's example of a person attempting to cross a dangerous bridge.[143] One cannot tell the person that the bridge is damaged because they do not speak the same language. A soft paternalist might seize the person in order to determine whether they are aware of the bridge's condition. If the person knows and wants

[139] ibid 218, '*Principle of beneficence* refers to a statement of a general moral obligation to act for the benefit of others' (emphasis in original).
[140] Feinberg (n 129) 113, 116. See also Joel Feinberg, *Harm to Self* (OUP 1986).
[141] Beauchamp and Childress (n 116) 233.
[142] Ajay Aggarwal, Joanna Davies, and Richard Sullivan, '"Nudge" in the Clinical Consultation–An Acceptable Form of Medical Paternalism?' (2014) 15(31) BMC Med Ethics 1.
[143] Mill (n 42) 165.

to continue with the venture, they will be permitted to proceed. A hard paternalist by contrast would argue that it is permissible to prevent them from crossing the bridge despite their awareness of its perils. It follows that soft paternalism generally does not require justification, whereas hard paternalism invariably does.

B. Medical Paternalism

In the healthcare context, an important source for understanding the doctor's responsibility towards their patient derives from the Hippocratic work *Epidemics*: 'As to diseases, make a habit of two things–to help, or at least to do no harm'.[144] The Hippocratic tradition marked the bounds of medical ethics, delineating professionally appropriate behaviour. The Hippocratic responsibility of doctors consequently gave rise to notions of *medical* paternalism. This form of paternalism is premised on the idea that treatment decisions should be made for patients by experts.[145] The rationale derives from normatively embedded beliefs that the 'doctor knows best'.[146] The expertise of the doctor and its likely lack in the typical patient pronounced a power imbalance: patients, Teff noted, being essentially passive recipients of medical care.[147] This assumed clinical relationship was soon embedded into law, with courts showing considerable deference to doctors' expert judgment to what is best for the patient in medical cases.[148]

In the post-Hippocratic era, the 'principlism' theory championed by Beauchamp and Childress designates the normative approach to biomedical ethics. It emphasises four fundamental *prima facie* obligations. Each of the four must be fulfilled unless it conflicts in a specific circumstance with another principle. These are:

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[144] *Epidemics* I, XI, *Hippocrates*, vol 1 (WHS Jones tr, Heinemann 1923) 165.
[145] Rob Heywood, Ann Macaskill, and Kevin Williams, 'Informed Consent in Hospital Practice: Health Professionals' Perspectives and Legal Reflections' (2010) 18(2) Med L Rev 152, 163.
[146] Raymond Tallis, *Hippocratic Oaths: Medicine and its Discontents* (Atlantic 2004).
[147] Harvey Teff, *Reasonable Care: Legal Perspectives on the Doctor Patient Relationship* (OUP 1994).
[148] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. See, for discussion, Ian Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (OUP 1988).

i. The principle of *beneficence*–refers to a statement of a general moral obligation to act for the benefit of others.
ii. The principle of *nonmaleficence*–obligates us to abstain from causing harm to others.
iii. The principle of respect for *autonomy*–implies that individuals must be respected as independent moral agents with the right to choose how to live their lives.
iv. The principle of *justice*–suggests that people should be treated fairly, although this does not necessarily imply treating everyone the same.[149]

In instances of conflict, it is incumbent on the doctor to examine the respective weights of the competing *prima facie* obligations based on both content and context. The principle of respect for autonomy is analysed above. The principle of justice is seldom relevant in minors' capacity cases. Conversely, the principles of beneficence and nonmaleficence are significant and thus require expansion.

The principles of beneficence and nonmaleficence tend to be confused or conflated,[150] which Beauchamp and Childress emphasised obscures critical moral distinctions as well as different types of moral theory.[151] Obligations not to harm others, such as killing, are distinct from obligations to help others, such as those prescribing the provision of benefits, protection of interests, and promotion of welfare. While the obligation not to harm others is sometimes more stringent than obligations to help others, the reverse is also true.[152] For example, a nurse bruises a patient's arm–caused by improperly inserting a needlestick–but concurrently provides a significant benefit to the patient's life (e.g. immunity to a harmful disease). It is justified to conclude that, on balance, the obligation of beneficence takes priority over the obligation of

[149] Beauchamp and Childress (n 116) pt II.
[150] William Frankena, *Ethics* (2nd edn, Prentice Hall 1973).
[151] Beauchamp and Childress (n 116) 156.
[152] ibid.

nonmaleficence in this instance.[153] The balance is achieved by weighing the benefits against the burdens of all appropriate treatments, including any reasonable alternative or variant treatments,[154] ideally selecting the course of action with the highest net benefit.

The weight of the biomedical principles varies in different circumstances. There is no *a priori* rank order. In ethical decision-making, the most pronounced conflict is when the principles of beneficence and autonomy collide. As assertions of patients' autonomy rights increased, moral problems of beneficence became increasingly stark. In English medical law, paternalism has historically been favoured and shielded.[155] Those most directly but not exclusively caught by the reach of paternalism are incapacitous adults and, importantly for the purposes of this thesis, minors.[156] However, the current state of play suggests that at the centre of ethical medical practice, the principle of patient autonomy has superseded the paternalism model.[157] But context is important because those caring for or making decisions related to a patient might view autonomy as one of several moral principles governing a therapeutic relationship and not one that resonates best with the circumstances. The dilemma is this: are there legitimate instances in medical practice where it is more important for the doctor to do what is best for patients, even if the price for this is the necessary override of the patient's wishes, feelings, and decisions? If the response is in the affirmative, the question that follows is: in which circumstances? These questions are prevalent in minors' capacity law.

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[153] ibid.
[154] *McCulloch v Forth Valley Health Board* [2023] UKSC 26.
[155] *Bolam* (n 148); *Sidaway* (n 3). See, for discussion, Margaret Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law?' (1987) 7(2) LS 169; Margaret Brazier and José Miola, 'Bye-Bye Bolam: A Medical Litigation Revolution?' (2000) 8(1) Med L Rev 85; Edmund D Pellegrino and David C Thomasma, 'The Conflict Between Autonomy and Beneficence in Medical Ethics: Proposals for a Resolution' (1987) 3 J Contemp Health Law Policy 23; Teff (n 147).
[156] See Chapter IV.
[157] *Montgomery* (n 8); *Chester* (n 36). See also (n 40).

C. Paternalistic Justifications for Limiting Patients' Autonomy

In medical ethics since Hippocratic times, doctors have been required to act for the benefit of their patients. It is this duty too that has seen the principles of beneficence and nonmaleficence paralleled with, and become justifications for, paternalism.[158] Yet it would be remiss to suppose that paternalism–in at least some of its forms–has no basis in medicine. As Ingelfinger posited:

> [I]f you agree that the physician's primary function is to make the patient feel better, a certain amount of authoritarianism, paternalism, and domination are the essence of the physician's effectiveness.[159]

In this sense, paternalism can principally be justified in terms of prospective benefits. The justification presupposes doctors undertake a balance sheet exercise. Where a person's interests in autonomy increase and the benefits of the proposed treatment for that person decrease, the justification of paternalistic intervention becomes untenable. Conversely, where the benefits of treatment for a person increase and that person's interests in autonomy decrease, paternalistic intervention becomes more tenable.[160] Thus, paternalistic actions that would prevent slight harm or provide minor benefits while disrespecting a person's autonomy are reasonably unjustifiable, whereas measures that may prevent death or substantially extend a person's life whilst unfavourably affecting a person's autonomy are *prima facie* merited.

In recent years the doctor-patient relationship has moved towards the position whereby a doctor may be acting negligently for failing to inform their patients fully of the risks of the proposed treatment(s).[161] Yet it is accepted that good medical care requires that, under certain conditions, doctors should not provide full information about their patient's medical situation,

[158] Pellegrino and Thomasma (n 155) 25.
[159] Franz J Ingelfinger, 'Arrogance' (1980) 303(26) NEJM 1507.
[160] Beauchamp and Childress (n 116) 237-238.
[161] *Montgomery* (n 8). See, for discussion, Rob Heywood and José Miola, 'The Changing Face of Pre-Operative Medical Disclosure: Placing the Patient at the Heart of the Matter' (2017) 133 LQR 296.

particularly all at once.[162] Doctors are entitled to withhold information from the patient if they reasonably consider that its disclosure would be 'seriously detrimental to the patient's health'.[163] The context of information disclosure in relation to those with Alzheimer's Disease is apposite.[164] Consider the following example: A woman brings her father, who is in his seventies, to a doctor because she believes he is suffering from Alzheimer's. He has become forgetful, has problems with speaking and writing, and has started to misplace items around the house. The test results are inconclusive, but there is a strong likelihood that the father is indeed suffering from Alzheimer's. The doctor decides to withhold this information based on the knowledge that the man is easily anxious, and evidence indicates that disclosure of the patient's cognitive decline might seriously impact their anxiety and self-esteem.[165] The doctor hence orders subsequent tests to yield a more thorough diagnosis. The temporary act of nondisclosure is morally justified because the doctor determined that to do what was best for this patient required respect for their autonomy to be replaced by (beneficent) hard paternalism.[166] The doctor now faces the dilemma of respecting the man's autonomy by informing him of the now conclusive test results that confirm the presence of the disease–assuming that he has capacity–or acquiescing to the demands of paternalism by withholding the information from him (but not necessarily from his family). The administration of treatment even when the patient objects,[167] involuntary treatment in a mental health institution,[168]

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[162] Beauchamp and Childress (n 116) 330. See also Yusrita Zolkefli, 'The Ethics of Truth-Telling in Health-Care Settings' (2018) 25(3) Malays J Med Sci 135.

[163] *Montgomery* (n 8) [88]. See, for discussion on the seemingly incongruous appearance of an inherently paternalistic exception to a judgment that professes to uphold patients' autonomy rights, Emma Cave, 'The Ill-Informed: Consent to Medical Treatment and the Therapeutic Exception' (2017) 46(2) CLWR 140.

[164] See, for an eloquent discussion on the legal treatment of those suffering from dementia, Jonathan Herring, 'Losing It? Losing What? The Law and Dementia' (2009) 21(1) CFLQ 3.

[165] See Marek Marzanski, 'Would You Like to Know What is Wrong with You? On Telling the Truth to Patients with Dementia' (2000) 26(2) J Med Ethics 108. See also Margaret A Drickamer and Mark S Lachs, 'Should Patients with Alzheimer's Disease Be Told Their Diagnosis?' (1992) 326 NEJM 947.

[166] Beauchamp and Childress (n 116) 238. See also Danny Scoccia, 'In Defence of Hard Paternalism' (2008) 27(4) Law Philos 351.

[167] *Re S (Adult: Refusal of Treatment)* [1993] Fam 123. See also *Bland* (n 36).

[168] *R v Collins, ex p Brady* [2000] 58 BMLR 173. See also *Nottinghamshire Healthcare NHS Trust v RC* (n 7).

confidentiality of genetic disorders,[169] and sterilisation[170] are further paradigm cases of the ethical(-legal) dilemma of when the principle of paternalism may reasonably displace the demands of respect for the patient's autonomy.

The tension between autonomy and paternalism is most pronounced when autonomous choice conflicts with the sanctity of life, as acknowledged in *Bland* by Hoffman LJ:

> A conflict between the principles of the sanctity of life and the individual's right to self-determination may… require a painful compromise to be made. In the case of the person who refuses an operation without which he will certainly die, one or other principle must be sacrificed. We may adopt a paternalist view, deny that his autonomy can be allowed to prevail in so extreme a case, and uphold the sanctity of life. English law is… paternalist towards minors. But it upholds the autonomy of adults.[171]

In relation to minors' healthcare, where the issue is of life or death, Bainham suggested 'virtually unbridled paternalism' reigns.[172] Chapter IV analyses the issue of the courts intervening paternalistically with a minor's (autonomous) decision. For present purposes, it is sufficient to say that the paternalistic attitude towards minors' medical decision-making developed from the decisions in *Re R* and *Re W*, in which the Court of Appeal overruled the refusal of a 15- and 16-year-old girl, respectively.[173] The basis for the paternalist approach that the court is not bound by the wishes of a minor is the proposition that the court has the jurisdiction to give effect to the minors' best interests. The jurisdiction is a protective one. As explained in *Re W* by Nolan LJ:

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[169] *ABC (QB)* (n 103).
[170] *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199.
[171] *Bland* (n 36) [827].
[172] Andrew Bainham, 'Liberal Paternalism in the Courts' (2006) 65(2) CLJ 285, 287-288. See also Chapter IV.
[173] See, for a full account and critical analysis of *Re R* and *Re W*, Chapter IV.

> One must, I think, start from the general premise that the protection of the child's welfare implies at least the protection of the child's life. […] it is the duty of the court to ensure so far as it can that children survive to attain [the age of 18].[174]

The protective duty of the court to intervene is typically engaged whenever the minor's welfare, broadly in terms of their life or health, is threatened by their decision.

In general, therefore, (medical) paternalism (soft or hard) is interference (coercive or non-coercive) with an individual's autonomy for reasons (justified or unjustified) of protecting the individual's welfare or best interests. In relation to the courts' interference with minors' medical decisions, this thesis adopts the term *protectionism*. This is because the courts frame and justify their intervention with minors' decisions on the grounds of, using the language of the courts, 'protection', which has an underlying beneficent and nonmaleficence motivation. But, as Chapter IV will demonstrate, the courts overrule competent, autonomous decisions, meaning its intervention exemplifies hard and coercive paternalism. Protectionism is preferable to paternalism because the elements that make-up protectionism are more focused and suitable to the context of minors' medical decision-making.

Welfare assessments in medical treatment cases concerning minors with decision-making capacity involve the balancing of two transcendent principles: the preservation of health or life (i.e. protectionism) and personal autonomy.[175] The difficulty is that neither theoretical model is obviously superior to the other and has the right to the casting vote. On the one hand, when the minor understands fully the nature and implications of their decision, has sufficient information to make the decision and does so voluntarily, their autonomy interests increase in weight.[176] On the other hand, protectionism should ordinarily be given more weight

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[174] *Re W* (n 18) [94].
[175] *E & F* (n 30) [53]. See also Chapter IV.
[176] *Gillick* (n 10).

because, since minors as a cohort are generally vulnerable and lack the cognitive development comparable to adults,[177] it makes perfect sense that the courts should protect their health and life. However, particularly in the context of medical refusals, the analysis of whether autonomy or protectionism should outweigh the other becomes increasingly complex. The existence of certain factors relevant to the minors' refusal, such as, amongst other things, their (i) age, (ii) competence, (iii) mental disability (fluctuating or permanent), (iv) faith, (v) experience with illness,[178] will either increase or decrease the weight given to autonomy or protectionism in the welfare assessment. This thesis' conceptions of autonomy and protectionism serve as guiding lines for determining whether, on the balance of probabilities, the decision of the court to overrule a minor's treatment refusal decision was justified in the light of the relevant factors in the individual case. Assessed on a case-by-case basis, when the number of factors is sufficiently weighty to suggest, for example, that the court should have respected the minors' autonomous decision, the basis for the court to overrule the minors' decision would have been weak.

Thus, this thesis proposes a sliding scale of justified protectionism, or put another way, supports compromise. As Huxtable emphasised, compromises which seek to afford space to competing perspectives play an important role in difficult legal and ethical disputes.[179] The context of minors refusing medical treatment most certainly falls into that bracket. The dichotomy between protectionism and respect for autonomy is clearly demonstrated in Chapter IV.

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[177] Lynn Hagger, *The Child as Vulnerable Patients: Protection and Empowerment* (Ashgate 2009).
[178] See, for a more comprehensive list of factors relevant to the outcome of minors' medical treatment refusal cases, Chapters IV and VII.
[179] Richard Huxtable, *Law, Ethics and Compromise at the Limits of Life: to Treat or not to Treat?* (Routledge 2013) 124.

III. Concluding Remarks

This chapter has explored and elucidated two prominent and competing conceptual frameworks that underpin English medical law's responses to cases concerning the treatment and non-treatment of patients: *autonomy* and *paternalism*. The conceptualisations of autonomy and paternalism are broad, and neither has a universally accepted definition or typology. In general, this thesis adopts the following working definitions. Regarding the (agent's) 'autonomy' (or 'autonomous decision-making'), this is assumed to mean the person has the capacity to think, decide, and act on that thought and decision without interference. This definition includes McLean's interpretation that autonomy comprises individualism and relationalism. It also adopts Coggon's current and best desire autonomy typologies. In the case of the court's 'paternalism', the derivative–'protectionism'–is the preferred term. This is because the courts justify intervening with minors' decisions on protection-based grounds (reflecting the concept of ideal desire autonomy), which, on the one hand, have underlying beneficent and nonmaleficence motivations; on the other hand, can exemplify hard and coercive paternalism.

There are merits and deficiencies in both theoretical models. Neither by itself is adequate at the legal coalface. Rather both must be weighed in the light of the particular content and context of the situation, and the overall decision should best benefit the patient. However, whether this analysis will yield the best course of action is necessarily a matter of perspective. Where a patient's autonomy and welfare interests pull in different directions, and resolution entails that only one interest prevails, the patient, assuming they have capacity and favour their decision taking precedence, may not find solace when a protectionist-based decision frustrates their autonomy. The inherent tension between the two tenets, complicated by an overarching commitment to the plurality of patients' values,[180] makes this a tricky area of policy

[180] Coggon and Miola (n 48). See also John Coggon, 'Best Interests, Public Interest and the Power of the Medical Profession' (2008) 16(3) Health Care Analysis 219.

development.[181] As subsequent chapters will demonstrate, reconciling the tension between autonomy and protectionism in minors' medical decision-making cases has proved vexing. This thesis suggests that whilst the theoretical models of autonomy and protectionism conflict, the law should adopt a broader and more nuanced analysis of the welfare assessment in which it identifies the relevant factors, gives each of them proper weight, and balances them out to make a decision that is in the specific minors' best interests. Should the court adopt such an approach[182] and still determine that protectionism outweighs respect for autonomy, such an analysis would be more compelling than judgments that imply 'the court knows best'. The development of a framework based on factors relevant to the outcome of minors' medical treatment refusal cases, together with this thesis' conceptions of autonomy and protectionism, provides an objective basis for determining whether the court deciding to overrule a minor's treatment refusal decision was, on balance, justified.

[181] Michael Dunn and Charles Foster, 'Autonomy and Welfare as *Amici Curiae*' (2010) 18(1) Med L Rev 86.
[182] See, for full recommendations, Chapter VII, Part I.

CHAPTER III

A RIGHT TO CONSENT?

In Chapter II the philosophical principles of autonomy and paternalism were explored, with working definitions provided. This chapter turns to a substantive legal analysis of minors' medical decision-making and examines the issue of minors' *consent* to medical treatment. It will analyse the emergence, successes, and weaknesses of the common law and statutory development of minors' rights to consent. This chapter posits that the strengths of medical consent law outweigh the problems related to its more practical ambiguities and complexities.

Part I reviews the genesis of minors' (medical) rights. It begins by exploring the evolution of the common law on the position of the child vis-à-vis their parents. The common law gradually moved away from Victorian notions of absolute parenthood towards increased recognition of minors as independent agents with capacities and rights of their own. This progressive evolution of minors' rights also occurred outside of the common law, with the most significant developments arising in the form of the FLRA 1969. This Act introduced exclusive statutory medical rights for young persons, formally recognising, for the first time, that minors could make independent medical decisions. Yet the construction of the relevant statutory provisions left much to be desired.

Part II analyses the culmination of the developing law: the landmark House of Lords decision in *Gillick*. This decision crystalised a new legal approach that marked the emergence of children's rights,[183] empowering them as autonomous beings.[184] However, there are difficulties inherent to *Gillick* that warrant discussion. Although *Gillick* elevated the status of

[183] John Eekelaar, 'The Emergence of Children's Rights' (1986) 6(2) Oxf J Leg Stud 161.
[184] Jane Fortin, *Children's Rights and the Developing Law* (3rd edn, CUP 2009) 94.

minors, the lacunas left by this case somewhat undermine the autonomy rights it tacitly sought to enhance. Notwithstanding its limitations, *Gillick* was a logical and positive development in the law.

Part III examines the legal instruments which codified *Gillick's* principles. Those are the Children Act (CA) 1989 and the United Nations Convention on the Rights of the Child 1989 (UNCRC). The CA 1989 aimed to strengthen protections for minors and empower those of sufficient understanding to make their own decisions. The Act set out many significant medical rights, which include some rights of refusal. However, the effectiveness of the Act in promoting the competent minors' right to make valid, independent decisions is open to question. In the same year as the CA 1989 came the UNCRC, which developed minors' rights at the international level. The UNCRC was very forward-thinking in promoting minors' autonomy rights: every minor has rights, whatever their status. Yet for all the theoretical niceties it expressed, the UNCRC is demonstrably toothless in its effect.

Part IV considers the recent development and challenges to the *Gillick* principles and reflects on the modern state of minors' medical consent law. The most pronounced challenges involved gender dysphoria cases. The treatment of minors who seek to change their gender is controversial. It raises many significant medical, moral, and social issues.[185] The Court of Appeal decision in *Bell (CA)*, overturning the earlier decision at first instance (*Bell (DC)*[186]), has significant implications for the law on minors' consent to medical treatment. It is suggested the *Bell (CA)* decision was a robust reinstatement of the principles of *Gillick* in the face of its challengers.

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[185] John McMillan and Colin Gavaghan, 'Mature Minors and Gender Dysphoria: A Matter for Clinicians not Courts' (2021) 47(11) J Med Ethics 717.

[186] [2020] EWHC 3274 (Admin).

I. The Developing Rights of Minors Before *Gillick*

A. The Historic Common Law Context

The law arriving at the House of Lords decision in *Gillick* was a gradual process. Early common law cases engaged with the tension of whether minors should have rights and, if so, what rights they should possess. Child custody cases, in particular, set the scene with respect to this tension. They are relevant for present purposes because not only were they constructive in developing the contemporary understanding of the parent-child relationship, but they also influenced the judges in *Gillick* when it came to determining the scope and substance of minors' medical rights.

In the first of two relevant nineteenth-century cases, *R v Howes*, the question was whether a father by habeas corpus was entitled to the custody of his objecting 15-year-old child.[187] Cockburn CJ held that the court would not hand over an unwilling child under the age of 21 to her father, provided that she has 'attained an age of sufficient discretion to enable it to exercise a wise choice for its own interests'.[188] He nevertheless supported the concept of parental rights and considered it 'dangerous' to think that any precocity in a child could lower the age of discretion fixed by Parliament at 16 years.[189] The second case, *In re Agar-Elis*, involved a petition to the court to allow the mother to have unrestricted communication with her daughter.[190] The father strongly opposed the petition. All three judges refused to grant the order. Brett MR stated that the law provided that the 'father has the control over the person, education, and conduct of his children until they are 21'.[191] Bowen LJ emphasised that the 'father knows far better as a rule what is good for his children than a Court of Justice can'.[192]

[187] (1860) 3 E & E 332.
[188] ibid [336].
[189] ibid.
[190] (1883) 24 Ch D 317.
[191] ibid [326].
[192] ibid [338].

The decision in *In re Agar-Elis* drew criticism for its attitudes toward the parent/father-child relationship. A significant denunciation of the judgment was expressed in 1969 by Lord Denning MR in *Hewer v Bryant*:

> I would get rid of the rule in *In re Agar-Elis*, and of the suggested expectations to it… It reflects the attitude of a Victorian parent [expecting] unquestioning obedience to his commands [from his children].[193]

In keeping with the societal attitudes at the time, Lord Denning MR offered the view that whilst parental power ostensibly continues until their child is an adult, 'it is a dwindling right which the courts will be hesitant to enforce against the wishes of the child, and the more so the older s/he is'.[194] What was important with this case was the developing attitudes of judges towards the parent-child relationship and minors having rights of their own. Similarly, the House of Lords in *R v D* rejected the principle of absolute parental authority expressed in *In re Agar-Elis*.[195] This case is further relevant for present consideration because, notwithstanding that it concerned the criminal offence of kidnapping, the reasoning provided by Lord Brandon on parental rights and minors' capacity to give or withhold valid consent represented that *Gillick* was a natural development in the law. In his Lordship's opinion:

> I see no good reason why, in relation to the kidnapping of a child, it should not in all cases be the absence of the child's consent that is material, whatever its age may be… [It will] be a question of fact for a jury whether the child concerned has sufficient understanding and intelligence to give its consent.[196]

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[193] [1970] 1 QB 357 [369].
[194] ibid. See, for the opinions of Lords Fraser and Scarman in *Gillick* (n 10) on the importance of the reasoning in *Hewer v Bryant* (n 193), Chapter III, Part II, Section B.
[195] [1984] AC 778.
[196] ibid [806].

These cases set the wheels in motion towards the law acknowledging minors as autonomous agents who have their own rights, provided they have sufficient understanding and intelligence to make decisions for themselves. To further demonstrate the development of minors' rights before *Gillick*, it is necessary to survey its evolution beyond the common law.

B. The Family Law Reform Act 1969

In 1965 Justice John Latey was chosen as Chairman for a Committee tasked with examining and recommending whether the age of full legal capacity and responsibility should be lowered from 21 to 18 to reflect the changes in society.[197] Amongst other subjects, the Latey Committee considered issues concerning consent to medical treatment.

The age of legal capacity to consent to medical treatment was not a question the Committee expected to consider. But it felt bound to deal with it in the light of evidence that highlighted a general uncertainty about what the legal situation really was.[198] The mischief the Committee aimed at was twofold. The first was that many individuals aged between 16 and 21 were living away from home, and it may be impossible to trace their parents in the time available for them to consent to their child's medical treatment. The delay may have caused the patient to suffer unnecessarily.[199] The second difficulty involved matters that had implications for a girl's right to privacy about her sexual life. A particular trouble concerned what should happen if a girl refused a therapeutic abortion unless she was guaranteed that her parents would not be told about it.[200] In these instances, relying on parental consent was generally impractical. It placed doctors and patients in a difficult position.

[197] *Report of the Committee on the Age of Majority* (Cmnd 3342, 1967).
[198] ibid, para 474.
[199] ibid, para 477.
[200] ibid, para 478.

The clear finding in the Latey Committee Report was that 'the legal position is in itself obscure'.[201] Evidence suggested that it was becoming customary for doctors to accept the consent of minors aged 16 and over, so it was time for the law to keep pace.[202] It was recognised that:

> [T]here is no rigid rule of English law which renders a minor incapable of giving his consent to an operation but there seems to be no direct judicial authority establishing that the consent of such a person is valid.[203]

The Committee consequently recommended that the age of full legal capacity should be reduced from 21 to 18.[204] The Report further noted that all the professional bodies that put forward evidence recommended that effective consent to treatment can be provided by 16-17-year-olds, and all except for the Medical Protection Society recommended that they should also be able to give an effective refusal.[205] In the light of the evidence before it, the Committee recommended that:

> [W]ithout prejudice to any consent that may otherwise be lawful, the consent of young persons aged 16 and over to medical or dental treatment shall be as valid as the consent of a person of full age.[206]

The FLRA 1969 was Parliament's response to the Latey Committee Report. In line with the Committee's recommendation, the Act reduced the age of majority from 21 to 18.[207] It also followed the Committee's suggestions to confer 16-17-year-olds with exclusive medical rights. Thus, under s 8(1) FLRA 1969:

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[201] ibid, para 479.
[202] ibid.
[203] ibid.
[204] ibid, para 134.
[205] ibid, para 480.
[206] ibid, para 484.
[207] FLRA 1969, s 1(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.

The provision under s 8(3) is also significant. It 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'.

Before Chapter IV provides a detailed analysis of the precise scope of s 8(1), its interplay with s 8(3), and their combined effect on refusal cases, there are several important points to note at this stage. First, s 8(1) appears to apply to consent only.[208] Secondly, the meaning of s 8(3) is far from clear.[209] There is a lack of understanding and agreement regarding whose rights are preserved by this provision.[210] Thirdly, whether minors under 16 years old could make independent medical decisions was not addressed in the FLRA 1969. For these minors, the common law prevailed.

II. The *Gillick* Competent Child

A. The Gillick Facts, Issues & Decision

The gradual development in the law climaxed in the watershed House of Lords case of *Gillick*. Their Lordships remedied the gap in the law on the capacity of minors below the age of 16 to make independent (medical) decisions, emphasising tacitly in the process the importance of

[208] Hagger (n 177) 27.
[209] Michael Freeman, 'Rethinking *Gillick*' (2005) 13(1/2) Int J Child Rights 201, 203.
[210] Stephen Gilmore and Jonathan Herring, '"No" is the Hardest Word: Consent and Children's Autonomy' (2011) 23(1) CFLQ 3, 19.

competent children's autonomy. The *Gillick* saga began with Mrs Victoria Gillick's challenge of the guidance issued by the Department of Health and Social Security (DHSS) to doctors, which exceptionally allowed them to provide girls under the age of 16 with contraceptive advice and treatment without parental involvement.[211] Mrs Gillick was a deeply sincere Roman Catholic and a mother to 10 children, 5 of which were girls. She wrote to her local health authority seeking assurance that no contraceptive advice or treatment would be given to her children while they were still under the age of 16, without her prior knowledge or consent. The health authority refused to grant such assurance. Mrs Gillick sought a declaration from the High Court that the DHSS guidance was unlawful. The High Court found against Mrs Gillick's claim,[212] but she successfully appealed to the Court of Appeal,[213] only for that decision to be overturned by the House of Lords by a 3:2 majority.[214]

The main question before the House of Lords was: can a doctor in any circumstances lawfully prescribe contraception for a girl under 16 without the knowledge and consent of a parent? The two core propositions of law considered in relation to the main question were: (i) whether a girl under the age of 16 has the legal capacity to give valid consent to contraceptive advice and treatment, including medical examination, and (ii) whether giving such advice and treatment to such a girl without her parent's consent infringes the parents' rights.[215] In the opinion of Lord Scarman, of which Lords Fraser and Bridge agreed,

> [i]t is that parental right yields 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.[216]

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[211] Department of Health and Social Security, *Health Notice* (1980) (HN (80) 46), section G.
[212] [1984] QB 581.
[213] [1985] 2 WLR 413.
[214] Lords Brandon and Templeman provided dissenting opinions.
[215] *Gillick* (n 10) [166] (Lord Fraser), [177] (Lord Scarman).
[216] ibid [186].

The judgment in *Gillick* ostensibly grants those who are '*Gillick* competent'[217] exclusive decision-making authority.[218] *Gillick* was a significant step for children's autonomy, but that is not to say it was without difficulties. The overarching drawback to the judgment lies in its lack of clarity. Cave suggested deficiencies in the *Gillick* judgment could hollow its purported victory for children's autonomy.[219] The analysis will scrutinise two core aspects of *Gillick* in order to assess the real import of the decision. First, the concept of *Gillick* competence and its effect on children's and parents' rights. Secondly, the theoretical and practical problems with the *Gillick* competence test.

B. The Demarcation of Rights

In the leading majority judgments, while Lord Fraser and Lord Scarman rejected Mrs Gillick's claim, they did so from different viewpoints. The inconsistencies within their judgments have somewhat muddied the true meaning of their Lordships' decision.

In advance of analysing the areas of difference, it is necessary to represent the several unambiguous points of agreement. There was a clear stance that a doctor would not be acting unlawfully in providing a girl under the age of 16 with contraceptive advice or treatment in the absence of her parent's consent or knowledge, provided she was *Gillick* competent.[220] Their Lordships shared the same interpretation of s 8(3) FLRA 1969 as preserving the validity of consents of those under 16 at common law.[221] Their Lordships' opinions contained strong criticisms towards the old attitude of the common law on the position of the child vis-à-vis their parents. Their Lordships firmly supported the reasoning of Lord Denning MR in *Hewer*

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[217] Robert Wheeler, '*Gillick* or Fraser? A Plea for Consistency Over Competence in Children' (2006) 332(7545) BMJ 807.
[218] Eekelaar (n 183) 181.
[219] Emma Cave, 'Competence and Authority: Adolescent Treatment Refusals for Physical and Mental Health Conditions' (2013) 8(2) Contemp Soc Sci 92, 100.
[220] *Gillick* (n 10) [175] (Lord Fraser), [191] (Lord Scarman).
[221] ibid [167] (Lord Fraser), [182] (Lord Scarman).

v Bryant, especially regarding the description of 'dwindling rights'.[222] The applicability of nineteenth-century cases such as *In re Agar-Elis* no longer marked the bounds of parental rights or a child's capacity to make their own decisions.[223] Describing the contemporary standard of parental rights, their Lordships held that parental rights do not exist for the benefit of the parents but for the benefit of the child.[224] Thus, *Gillick* supported the view that the law should respond flexibly to human development and social change,[225] which favoured a strong interest in encouraging children's faculty for independence.[226] The robust rejection of absolute parental authority and preference for developing the law in accordance with progressive attitudes towards children's rights was a positive development in the law.

1. The opinion of Lord Fraser

Lord Fraser viewed parental rights as a dwindling concept, emphasising that wise parents and courts need to encourage children's faculty for independence. With the rule of parents' absolute authority abandoned, what solution was there to fill the gap? Lord Fraser advanced that 'the solution depends upon a judgment of what is best for the welfare of the particular child'–this will, in most cases, be determined by the parents.[227] It emerges from this that Lord Fraser was not prepared to bring an end to parental rights nor grant full decision-making authority to children. Fortin suggested that this is particularly true in general terms–his judgment's headings confined the scope of his decision to the medical context.[228]

Lord Fraser was of the general opinion that the 'consent of parents should normally be asked' when a child under 16 requires medical treatment,[229] considering it 'most unusual' for

[222] ibid [172] (Lord Fraser), [186] (Lord Scarman). See *Hewer v Bryant* (n 193) [369].
[223] ibid [173] (Lord Fraser), [187] (Lord Scarman).
[224] ibid [170] (Lord Fraser), [184] (Lord Scarman).
[225] ibid [186].
[226] ibid [171].
[227] ibid [173].
[228] Jane Fortin, 'The *Gillick* Decision: Not Just a High-Water Mark' in Stephen Gilmore, Jonathan Herring and Rebecca Probert (eds), *Landmark Cases in Family Law* (Hart Publishing 2011) 203.
[229] *Gillick* (n 10) [169].

a doctor to advise a child on medical matters without first acquiring parental consent.[230] Although the idea that parental consent should 'normally' be sought appears to conflict with Lord Fraser's earlier comments which encouraged children's faculty for independence, he did not leave the issue there. Instead, his Lordship concluded that provided the child has the capacity, they can consent to the proposed treatment free from parental interference, be it concerned with contraceptive advice and treatment or some trivial bodily injury.[231] He held that a child has the capacity to authorise the doctor to make the examination or give the treatment which they advised, provided that the child is 'capable of understanding what is proposed, and of expressing his or her own wishes'.[232] In specific respect of the child's capacity to consent to contraceptive advice and treatment, the doctor will, in Lord Fraser's opinion, be justified in proceeding without the parents' consent or even knowledge provided five matters are satisfied,[233] which became known as the 'Fraser guidelines'. It is incumbent on the doctor to satisfy these Fraser guidelines before issuing any contraceptive advice or treatment.[234]

The broad capacity test presented by Lord Fraser raised more questions than it provided answers. For example, what degree of understanding must the child demonstrate? Can the child consent to *any* treatment, provided they have the requisite understanding? What if the child cannot express their wishes, not because they lack the competence to do so but perhaps due to physical limitations? In contrast, the 'Fraser guidelines' are expressed more sharply than the general test of the child's capacity. This inconsistency in the approach to capacity is not irreconcilable. Given the focus on the welfare of the child within his judgment, what Lord

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[230] ibid [173].
[231] ibid [173]-[174].
[232] ibid [169].
[233] ibid [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'.
[234] See General Medical Council (GMC), *0-18 Years: Guidance for all Doctors* (2007), para 63.

Fraser viewed as valid consent was thus: if the child satisfied the relevant test, the consent of the child binds, but the child is only to receive treatment that promotes their welfare, as determined by the doctor acting in the child's best interests.[235] The construction of Lord Fraser's judgment is accordingly welfare driven, with autonomy present but more as a secondary feature.

2. The opinion of Lord Scarman

In contrast to Lord Fraser, Lord Scarman's opinion is potentially more far-reaching and is undeniably more autonomy driven. It is also potentially more problematic as the exact ambit of his decision is unclear. To reiterate, Lord Scarman expressed that:

> It is that parental right yields 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.[236]

This general statement notionally suggests that parental rights to make decisions on the capable child's behalf, in any context, are extinguished.[237] Lord Scarman repeated this general statement of *Gillick* competence when he directly addressed matters of medical treatment:

> I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[238]

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[235] Kennedy (n 148) 94.
[236] *Gillick* (n 10) [186].
[237] Fortin (n 228) 205.
[238] *Gillick* (n 10) [188]-[189].

Lord Scarman also provided doctors with specific guidance for assessing the capacity of girls under 16 who wanted contraceptive advice or treatment without their parent's involvement.[239] Therefore, Lord Scarman's judgment consists of three context-related competence tests: (i) for general decisions, (ii) for general medical decisions, and (iii) for contraceptive advice or treatment decisions. In satisfying the relevant test, the *Gillick* competent child has the *legal capacity* to make the decision. *Gillick* competence is a question of fact, specific to each child.[240]

The reasoning of Lord Scarman implies that once the child is *Gillick* competent, parental rights no longer endure over that child. This interpretation was firmly advanced by Eekelaar, who understood Lord Scarman's general comment to mean that the *Gillick* competent child has the right to make any decision, free from parental interference, regardless of the potential outcome. In other words, *Gillick* provides children with the right to make their own mistakes.[241] A literal reading of Lord Scarman's general comment supports Eekelaar's interpretation. Though considering his judgment more broadly, it is difficult to accept that what Lord Scarman said extends to allowing children to make harmful decisions. If Eekelaar is right in what Lord Scarman advocated, then it is starkly at odds with the fact that he agreed with the opinion of Lord Fraser, who was in favour of protecting the child's welfare. The potential difficulties with Lord Scarman's general comment are further exposed when considering he stated parental rights 'do not wholly disappear until the age of majority'.[242] Gilmore suggested that this statement conflicts with Lord Scarman's comment that *Gillick* competence 'terminates' parental rights and provides evidence that it is erroneous to view the overall message of *Gillick* as authority for providing competent children with anything akin to

[239] ibid [189], 'There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment'.
[240] ibid.
[241] Eekelaar (n 183) 182.
[242] *Gillick* (n 10) [184].

'absolute autonomy'.[243] Bainham similarly suggested that *Gillick* was not a decision that introduced a policy of legal autonomy for competent children.[244]

Although the critiques are cogent, the inconsistencies in Lord Scarman's judgment are marginal. In general, Lord Scarman agreed with Lord Fraser's opinion. Both rejected Mrs Gillick's arguments and condemned aspects of the old common law. Whilst it is conceded that it is difficult to reconcile the conflict between Lord Scarman's autonomy driven construction and Lord Fraser's welfare approach, both opinions are nonetheless united in their philosophy to promote children's independence. In response to Gilmore's criticism, while Lord Scarman was imprecise with his use of the word 'rights', he himself explained that:

> The principle of the law… is that parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child. The principle has been subjected to certain age limits set by statute for certain purposes… But these limitations in no way undermine the principle of the law, and should not be allowed to obscure it.[245]

Finally, challenges towards the intention behind Lord Scarman's comments were rather unpersuasive. His 'underlying principle of law' that 'parental rights yield' to the *Gillick* competent child's right to make his own decisions left little to be misunderstood.[246] Indeed, Lord Scarman repeated his general view in the medical context, using the term 'terminate' instead of 'yield', but the effect is the same. Parental rights to make medical decisions on their child's behalf are extinguished once the child is *Gillick* competent. The acquisition of *Gillick* competence implied independent decision-making autonomy.

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[243] Stephen Gilmore, 'The Limits of Parental Responsibility' in Rebecca Probert, Stephen Gilmore and Jonathan Herring (eds), *Responsible Parents and Parental Responsibility* (Hart Publishing 2009) 63, 75.
[244] Andrew Bainham, 'The Balance of Power in Family Decisions' (1986) 45(2) CLJ 262, 275.
[245] *Gillick* (n 10) [184].
[246] Fortin (n 228) 207.

C. The Problems with Gillick Competence

There are several issues with the construction of *Gillick* competence.[247] First, what is meant by 'understanding'? The Law Lords offered different definitions. This has confused the issue of what the child is required to demonstrate.[248] Secondly, and flowing from the first, is there a minimum age for *Gillick* competence? Thirdly, how is *Gillick* competence practically measured? Whilst the flexible construction of the *Gillick* competence test permits a greater expression of decision-making autonomy for children, the lack of certainty on when and how to use the relevant test has left doctors feeling cautious in capacity assessments.[249]

1. Defining 'understanding'

The Law Lords advanced different definitions of 'understanding'. Lord Fraser merely required the child to be 'capable' only of understanding the doctor's advice.[250] The child must demonstrate the ability to understand what is proposed by way of treatment, and this will vary according to the complexities of the particular decision. Lord Scarman's requirements for understanding depend on the context. In general, Lord Scarman suggested that the child is competent if they are 'capable' of making an independent decision.[251] In the medical setting, he referred to the need for the child to understand 'fully' what is proposed.[252] Whilst in his specific advice on contraceptive matters, he required the child to have a 'full' understanding of what is involved, which included understanding the social consequences of the decision.[253] The standard demanded of a child generally appears lower than were they in the medical setting. There is merit in the distinction insofar as a greater degree of competency is needed, for

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[247] Fortin (n 184) 148, 'the difficulty implicit in the test for assessing *Gillick* competence is its deceptive simplicity'.
[248] Pattinson (n 5) 163.
[249] John Coleman, 'Understanding Adolescence Today: A Review' (1993) 7(2) Child Soc 137, 142.
[250] *Gillick* (n 10) [169].
[251] ibid [186].
[252] ibid [188]-[189].
[253] ibid [189].

example, with respect to a child's decision to receive palliative care treatment for their recurrent osteosarcoma[254] than a child deciding to live with their aunt rather than their mother.[255]

The lack of a coherent position from the Law Lords makes squaring the circle of what a child must understand somewhat difficult, but it is not irreconcilable. In the first place, it is misguided to view the demands of *Gillick* one-dimensionally. If the Law Lords advocated for a test that required *full* understanding, they would presumably have referred to 'whether the child understands…' rather than necessitate a 'capability' to understand. Requiring full understanding of the proposed treatment and its implications would make the test unworkable. For example, it would be illogical and impractical that a child would need to understand the nature of septicaemia as a possible consequence of not having a plaster before consenting to its administration.[256] On the other hand, basing the test on *capability* rather than full understanding reflects the legal presumption that children lack competence.[257] But interpreting *Gillick* competence to relate purely to capability to decide also creates problems because the dynamic process of consent in practice requires consideration of the capability to understand and actual understanding.[258] Academic interpretations of what a child must understand are insightful, despite there being no consensus on the matter. Gilmore and Herring found *Gillick* to suggest that a child's consent to medical treatment is valid so long as the child understands the nature of the treatment proposed.[259] Cave and Wallbank argued that the reasoning in *Gillick* demonstrates that 'understanding' is a multifaceted concept. It is treatment-specific and requires, in general, a broad understanding of the proposed treatment; it

[254] *An NHS Trust v BK* [2016] EWHC 2860 (Fam).
[255] *Sheffield CC v Bradford MBC* [2013] 1 FLR 1027.
[256] Gilmore and Herring (n 210) 11.
[257] Emma Cave, 'Goodbye *Gillick*? Identifying and Resolving Problems with the Concept of Child Competence' (2014) 34(1) LS 103, 107.
[258] ibid.
[259] Gilmore and Herring (n 210) 11.

may also involve understanding the risks, benefits and wider contextual issues relevant to the proposed treatment.[260]

The above discussion demonstrates that *Gillick* generally requires that the child is capable of understanding what is proposed in broad terms. However, a fuller understanding is necessary to make certain treatment decisions, such as consenting to contraception which involves understanding relevant emotional,[261] and social factors.[262] Thus, *Gillick* competence is a sliding scale of scrutiny. The person responsible for assessing the child's decision-making capacity must be convinced that the child's level of understanding is commensurate with the proposed treatment decision. The more serious the nature of the decision, necessarily judged against how significant its possible impact is on the health or life of the child, the greater the degree of scrutiny required.

2. The no minimum age principle

The House of Lords' recognition of children's capacity to consent to medical treatment left open the question of whether there is a minimum age below which a child can never have the legal capacity to consent to medical treatment, however trivial.[263] In the view of Lord Scarman, age limits are undesirable in this branch of law because,

> [i]f the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.[264]

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[260] Emma Cave and Julie Wallbank, 'Minors' Capacity to Refuse Treatment: A Reply to Gilmore and Herring' (2012) 20(3) Med L Rev 423, 429-430.
[261] *Gillick* (n 10) [174] (Lord Fraser).
[262] ibid [189] (Lord Scarman).
[263] Anjali M Ramchand, Chung Han and Janice Lian, 'The *Gillick* Case: A Giant Step for Little People' (1990) 11(1) Sing L Rev 1, 7.
[264] *Gillick* (n 10) [186].

This reasoning implies that if a child's understanding is commensurate to the proposed treatment decision, then the child's age is not an obstruction to providing valid consent.

In *Re C (Looked After Child: Covid-19 Vaccination*),[265] it was before Poole J to determine whether under the CA 1989, Part IV, s 33(3)(b), a local authority could consent to a child in its care being vaccinated against COVID-19 and/or the flu virus despite the objections of the child's mother. The child in question was a 12-year-old boy, C, who wished to be vaccinated against COVID-19 and the flu. Whilst it was unnecessary to the primary question raised for Poole J to assess C's competence, he offered the view that 'C may well be *Gillick* competent to make the decisions to be vaccinated'.[266] Poole J observed that because C had given his consent to the vaccinations, there was no conflict between him and the Local Authority, and held that in any case, a local authority could consent to a child in its care being vaccinated against COVID-19 and/or the flu virus notwithstanding the view of the child's parents.[267] The judgment of Poole J reflected the *Gillick* ethos. It respected the boy's autonomy and safeguarded his welfare. This was manifest in Poole J's concluding remarks, in which he expressed that had it been necessary to exercise the court's inherent jurisdiction, he would have had no hesitation in concluding that it was in C's best interests to have both vaccinations given all the circumstances, including the balance of risks of having and not having the vaccinations and C's own wishes and feelings.[268] The reasoning suggests that had C been some years younger and was *Gillick* competent to make the decisions to be vaccinated, his consent would likely have been respected, irrespective of parental objection.

The case of vaccination exemplifies that while it may be difficult for children to attain *Gillick* competence in medically and socially complex decisions, this does not mean that

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[265] [2021] EWHC 2993 (Fam).
[266] ibid [22].
[267] ibid [22]-[23].
[268] ibid [24].

the standard cannot be reached.[269] The emphasis that courts must carefully consider and balance even the (potentially) incompetent child's wishes[270] demonstrates an important utility of the no minimum age principle. To view *Gillick* squarely as the authority on the exercise of capacity is misplaced because the Law Lords emphasised the importance of nurturing children's faculty for independence, which is a natural, continuous process.[271] There is evidence to suggest that children should be involved in decisions that affect them when they are able to, even if they do not have the final say. For example, children with cancer benefit from being involved in decision-making, and there is evidence this influences their general well-being.[272] Thus, a broad reading of *Gillick* suggests that *Gillick* competent children of whatever age can exercise their autonomy in the form of consenting to treatment.[273] If the child is *Gillick* incompetent, they should still be involved in the decision-making process because it is an important exercise of intrinsic value which will prepare them for future decisions.[274]

3. Practical difficulties

The analysis in this section moves away from the more theoretical implications of the *Gillick* judgment to the practical conundrums. After all, the doctor, who is entrusted with wide discretionary powers,[275] is the one responsible for making capacity determinations of children on a day-to-day basis. This responsibility requires the doctor to provide the child with information to the limit of the child's understanding before assessing the child's capacity in

[269] Victoria Butler-Cole, 'Consent, Children Under 16 and the Covid Vaccine' (*Nuffield Council on Bioethics*, 14 September 2021) < https://www.nuffieldbioethics.org/blog/consent-children-under-16-and-the-covid-vaccine > accessed 28 October 2022.
[270] See, eg, *Re C* (n 265) [22]; *F v F (MMR Vaccine)* [2013] EWHC 2683 (Fam) [18], [22]; *Re C & F (Children)* [2003] EWHC 1376 (Fam) [311], [346].
[271] *Gillick* (n 10) [186].
[272] Imelda Coyne, Aislinn Amory, Gemma Kiernan and Faith Gibson, 'Children's Participation in Shared Decision-Making: Children, Adolescents, Parents and Healthcare Professionals' Perspectives and Experiences' (2014) 18(3) Eur J Oncol Nurs 273, 273- 274.
[273] The judgment in *Bell (CA)* (n 29) supports this interpretation: see Chapter III, Part IV, Section B.
[274] Ingrid Runeson, Karin Enskär, Gunnel Elander and Göran Hermerén, 'Professionals' Perceptions of Children's Participation in Decision Making Healthcare' (2001) 10(1) J Clin Nurs 70, 71.
[275] *Gillick* (n 10) [174].

relation to the proposed treatment.[276] At this stage, one of the following situations will arise: (i) the child has sufficient understanding and maturity to consent, (ii) the child lacks the understanding and maturity to consent; the doctor will make a best interests decision on their behalf or, (iii) the child's capacity to consent is ambiguous, in which case the doctor should 'maximise' the child's capacity to consent[277]; if the doctor remains unconvinced, they will make a best interests decision.

Cave highlighted that when applied by doctors, the difficulties surrounding the assessment of *Gillick* competence, its timing, and value can be accentuated.[278] Indeed, doctors' ambivalence towards understanding and using the *Gillick* test is well-documented.[279] For example, in a study on informed consent concerning 118 healthcare professionals from the United Bristol Healthcare NHS Trust, in which there was a 100% response rate, understanding of *Gillick* competence was identified as a 'significant area of weakness'.[280] Only 56.8% of respondents correctly understood that a minor under 16 may give consent for elective surgical treatment.[281] In another study involving 119 participants, junior medical staff's knowledge of legal issues–including *Gillick* competence–was tested.[282] The results of this study showed that 'few junior staff have adequate knowledge of the basic principles and practice as they relate to children'.[283] Furthermore, it has recently been identified by Griffith that 'nurses must be more

[276] GMC, *0-18 Years: Guidance* (n 234), para 24. See also Emma Cave and Craig Purshouse, 'Think of the Children: Liability for Non-Disclosure of Information Post-Montgomery' (2020) 28(2) Med L Rev 270.
[277] Emma Cave, 'Maximisation of Minors' Capacity' (2011) 23(4) CFLQ 431. The GMC, *0-18 Years: Guidance* (n 234) is permissive of measures that maximise a minor's autonomy. See also GMC, *Treatment and Care Towards the End of Life: Good Practice in Decision Making* (2010). The guidance here is more explicit–one of the five principles is titled 'Maximising Capacity to Make Decisions' (para 12).
[278] Cave (n 257) 113.
[279] See Nigel Zimmermann, '*Gillick* Competence: An Unnecessary Burden' (2019) 25(1) New Bioeth 78.
[280] Neil K Chadha and Costa Repanos, 'How Much Do Healthcare Professionals Know About Informed Consent? A Bristol Experience' (2004) 2(6) Surgeon 328, 328.
[281] ibid 330.
[282] Chetan S Ashtekar, A Hande, E Stallard and David Tuthill, 'How Much Do Junior Staff Know About Common Legal Situations in Paediatrics?' (2007) 33(5) Child Care Health Dev 631.
[283] ibid 634.

confident in assessing *Gillick* competence'.[284] This suggests a general lack of confidence in its assessment. The evidence thus demonstrates a disconnect between the law and clinical practice. Why is this the case? Although the studies and Griffith's commentary offer few reasons for medical staff's issues with *Gillick* competence, explanations are available.

An underlying reason for the disconnect may stem from the variance in the capacity tests as they appear on paper within *Gillick* and professional guidance. The guidance on assessing the capacity to consent provided by the General Medical Council (GMC),[285] British Medical Association[286] and Department of Health,[287] aid doctors in performing their duties. The GMC guidance on assessing the capacity to consent states:

> You must decide whether a young person is able to understand the nature, purpose and possible consequences of investigations or treatments you propose, as well as the consequences of not having treatment. […] You should remember that a young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences.[288]

The GMC guidance offers a clearer and more detailed framework for assessing capacity than that necessarily provided in *Gillick*. This is unsurprising since the common law develops in response to cases that come before the court rather than by reference to clinicians' need for a comprehensive framework.[289] One could suggest that the GMC framework is superior and that recourse to the *Gillick* test is redundant. However, unpacking *Gillick* demonstrates that the law

[284] Richard Griffith, 'Nurses Must be More Confident in Assessing *Gillick* Competence' (2013) 22(12) Br J Nurs 710.
[285] GMC, *0-18 Years: Guidance* (n 234).
[286] British Medical Association, *Consent, Rights and Choices in Health Care for Children and Young People* (2007).
[287] Department of Health, *Reference Guide to Consent for Examination or Treatment* (2nd edn, 2009).
[288] GMC, *0-18 Years: Guidance* (n 234), paras 24 and 26.
[289] Cave (n 257) 113.

and guidance are aligned. Both frameworks advance that the competence assessment takes place on an individual basis according to the complexities of the treatment decision. The difficulty is that coming to this rationalisation requires unravelling the reasoning in *Gillick*. The law should be sufficiently clear so doctors can conveniently understand and exercise their legal duties.[290] The unhelpful lexical differences may therefore explain doctors' inadequate understanding of the legal significance of *Gillick*. At the same time, because the professional guidance reflects the *Gillick* test, lexical differences alone are not enough to justify doctors' issues with assessing *Gillick* competence.

The reality of capacity is that it is a messy concept. No person is the same, and it is impossible to uniform idiosyncrasies and avoid differences in approach and outcome to capacity assessments.[291] One can thus be sympathetic to doctors who are concerned over how to assess children's capacity.[292] However, provided doctors, for example, (i) read, understand and train in applying the law and accompanying guidance and, when undertaking the assessment, they (ii) allow sufficient time for the assessment,[293] (iii) maximise the child's capacity when necessary,[294] and (iv) consider the wishes of parents or guardians if appropriate,[295] they would be working within a framework consistent with the gold standard for ideal consent practice defined by *Gillick* and refined by professional guidelines.[296] Though not a fail-safe method for accurately determining children's capacity, it is a practical solution that accords with the expectations of good medical practice.[297] It would also protect doctors

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[290] Tom Bingham, *The Rule of Law* (Allen Lane 2010) 37, 'The law must be accessible and, so far as possible, intelligible, clear and predictable'.
[291] Alex R Keene, 'Is Mental Capacity in the Eye of the Beholder?' (2017) 11(2) AMHID 30; Kevin Williams, 'Comprehending Disclosure: Must Patients Understand the Risks They Run?' (2000) 4(2) Med L Int 97.
[292] Jonathan Herring, *Medical Law and Ethics* (OUP 2020) 191.
[293] Victor Larcher, 'How Should Paediatricians Assess *Gillick* Competence?' (2009) 95(4) Arch Dis Child 307.
[294] See (n 277).
[295] *Gillick* (n 10) [174].
[296] Chadha and Repanos (n 280) 333.
[297] See GMC, *Good Medical Practice* (2013).

from a claim in battery if they assessed the child to be *Gillick* competent but subsequently found that the child did not fully understand the relevant information.[298]

Their Lordships in *Gillick* also left open to question what kind of treatments a *Gillick* competent child could provide consent to. The advice from the medical bodies neither marks the parameters of *Gillick* competence. On the one hand, it is presumably unproblematic for a *Gillick* competent child to consent to the administration of a plaster or an examination of a broken arm.[299] On the other hand, it is less clear whether they can consent to serious interventionist treatments, such as brain surgery.[300] However, there is nothing in the opinions of Lord Fraser nor Lord Scarman to suggest that the *Gillick* competence test applies only to issues of contraception. The Law Lords both address the child's capacity in relation to 'medical treatment', which appears all-encompassing. The reading of 'understanding' within *Gillick* supports that it would be logically inconsistent for a competent child to consent to some treatments but not to others. Silber J in *Axon* concluded that the Law Lord's speeches could not be confined to contraceptive advice and treatment–the principles apply to *all* forms of medical treatment.[301] Subsequent case law has confirmed this analysis of *Gillick*.[302] Thus, the medical treatments that *Gillick* competent children could provide effective consent are theoretically unrestricted.

[298] It would not, however, provide doctors with a defence to a claim that they negligently advised a particular treatment or negligently carried it out: see *Re W* (n 18) [76].
[299] *Gillick* (n 10) [169], [201] (Lord Templeman), 'a 15-year-old could consent to a tonsillectomy or appendectomy'.
[300] Rob Heywood, 'Mature Teenagers and Medical Intervention Revisited: A Right to Consent, a Wrong to Refuse' (2008) 37(2) CLWR 191, 193.
[301] *R (on the application of Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) [87], [90]. The decision in *Axon* is considered more fully in Chapter V, with respect to Silber J's reasoning on Article 8 of the European Convention on Human Rights 1950 (ECHR).
[302] See Chapter III, Part IV.

D. Concluding Evaluation of Gillick

This chapter has articulated the decision of the House of Lords in *Gillick* and elucidated several difficulties with *Gillick* competence. The most pronounced issues derive from its definitional ambiguities that, in turn, have been suggested to complicate its practicality as an effective legal test. However, there is common sense and pragmatism behind its purported complexity. Lord Scarman's exposition of the competent child was a significant development for minors' (medical) rights and was consistent with the evolving attitudes at the time. Lord Fraser's contribution to the development of the law should also not be overlooked. The significance of *Gillick* competence as a framework has extended beyond healthcare decisions. For example, a 12-year-old was found to have the *Gillick* competence to instruct her own lawyer.[303] Overall, *Gillick* deserves a positive appraisal of how it developed minors' (medical) rights at law. Indeed, in the years following the House of Lords' judgment, English law reflected *Gillick* in statute, and the United Nations incorporated *Gillick's* principles into its Convention on the Rights of the Child, which this chapter turns to next.

III. *Gillick* Codified

Shortly after the decision in *Gillick*, the CA 1989 came into force. The Act broadly establishes the legal framework for all kinds of safeguarding in respect of minors, including the provision of medical treatment.[304] The Act reflected the growing respect for minors' autonomy and, at the time, was heralded as a breakthrough piece of legislation for minors' rights.[305] One of the Act's most important underlying principles was parental responsibility,[306] defined in s 3(1) as 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child

[303] *CS v SBH* [2019] EWHC 634 (Fam).
[304] See Jo Bridgeman, *Medical Treatment of Children and the Law: Beyond Parental Responsibilities* (Routledge 2021); Stephen Gilmore (ed), *Parental Rights and Responsibilities* (Routledge 2017).
[305] Michael Clayton, 'Consent in Children: Legal and Ethical Issues' (2000) 4(2) J Child Health Care 78.
[306] Brenda Hoggett, *Parents and Children: The Law of Parental Responsibility* (Sweet & Maxwell 1993).

has in relation to the child and his property'. The law is premised upon the presumption that parents are the best people to make decisions about a child.[307] However, the rights of parents are not absolute. For example, when parental decisions are contrary to the best interests of the child, the State will intervene.[308] Parents have the right to consent to medical treatment on behalf of their child, though it is one that is limited. The interplay between competence and parental responsibility is important. Insofar as the minor wishes to consent independently and is either competent under s 8(1) FLRA 1969 or *Gillick*, the minor's consent supersedes that of the parent.[309]

Several provisions in the CA 1989 ostensibly empower the minor. Section 1(1) prescribes that 'the child's welfare shall be the court's paramount consideration'. Section 1(3) provides that the court shall have regard to, amongst other things, the minor's 'ascertainable wishes and feelings (considered in light of his age and understanding)'. And s 10(8) allows the minor to apply for leave to make an application for an s 8 order (child arrangement orders) where the court is 'satisfied that he has sufficient understanding to make the proposed application'. Other important provisions are those in the Act giving minors of 'sufficient understanding to make an informed decision' a statutory right to refuse medical or psychiatric examination or other assessments,[310] and in one provision only, to refuse psychiatric or medical treatment.[311] Permeating these provisions is the *Gillick* ethos of encouraging and supporting competent minors to make decisions for themselves,[312] although the actual impact of the Act on minors' autonomy is questionable. The welfare checklist under s 1(3) appears limited in its

[307] *Re King (A Child)* [2014] EWHC 2964 (Fam) [31].
[308] CA 1989, s 1. See also *Portsmouth NHS Trust v Wyatt* [2004] EWHC 2247 (Fam).
[309] See, for the legal situation when the parent's child refuses consent to medical treatment that is in their best interests, Chapter IV.
[310] CA 1989, s 38(6) (interim care or interim supervision order), s 43(8) (child assessment order), s 44(7) (emergency protection order), and Schedule 3 para 4(4)(a) (supervision order).
[311] ibid, Schedule 3 para 5(5)(a).
[312] Freeman (n 209) 204.

scope. It applies only to s 8 applications and Part IV orders.[313] Nolan LJ in *Re W* recognised this limitation but qualified that it is 'common ground' that the checklist has 'general application', implying that the court must have regard for such factors when discharging its responsibility for the minors' welfare.[314] The difficulty with Nolan LJ's interpretation of the scope of s 1(3) was that it appeared at odds with the will of Parliament. If Parliament had intended for the checklist to apply generally, then why was it expressed in terms that suggested it applies *only* in certain defined circumstances? Nolan LJ did not engage with this question. On the basis that Nolan LJ's interpretation was inconsistent with Parliament's intentions, then the message of the Act conflicts with its practical application. It raises questions about why an Act imbued with the *Gillick* philosophy has a narrow focus on when a court should have regard for the minors' wishes and feelings. Thus, there is a significant thrust behind Nolan LJ's interpretation that it must be appropriate that the s 1(3) factors are generally relevant.[315]

The court has the authority under s 100(3) CA 1989 to exercise its inherent jurisdiction with respect to minors. The court may only grant leave for its inherent jurisdiction to be invoked by a local authority if, *inter alia*, there is reasonable cause to believe that if the court's inherent jurisdiction is not exercised with respect to the minor, they are likely to suffer significant harm.[316] Chapter IV will delineate the extent of the court's powers under its inherent jurisdiction but briefly put these powers afford the court to overrule even a competent minor's decision. The nature and breadth of these powers similarly cast some doubts over the ethos of the Act. The Act offers insufficient protection to minors' autonomy if being of 'sufficient understanding to make an informed decision' is of circumstantial value. Alderson and

[313] CA 1989, s 1(4).
[314] *Re W* (n 18) [93].
[315] *Re JA (A Minor) (Medical Treatment: Child Diagnosis with HIV)* [2014] EWHC 1135 (Fam) [82] per Baker J, 'Although section 1(3) [of the CA 1989] does not strictly speaking apply to my decision whether or not to grant a declaration [to start anti-retroviral therapy medication against the child's wishes], I do find the checklist useful in these circumstances'.
[316] CA 1989, s 100(4).

Montgomery suggested that the construction of the Act implies a lack of political will to grant minors true, meaningful power over their own decisions.[317] It is reasonable to suggest that despite the codification of *Gillick's* spirit and all the statutory rights afforded to minors of 'sufficient understanding', the purported progress for minors' rights derivative of the CA 1989 is more limited than initially perceived.

The developments with respect to minors' growing rights were occurring concurrently at the domestic and international levels. The UNCRC was drafted in 1989, signed by the UK in 1990, and ratified in 1991. Whilst it does not form part of UK domestic law, its provisions are binding on State members–though not enforceable by individuals within the domestic courts–and have influenced judicial and administrative decisions that affect minors. This is evidenced, for example, in Silber J's judgment in *Axon*,[318] in legislation in Wales,[319] and in recommendations for the Department of Health to produce a Children's Health Charter based on the principles of the UNCRC and align these with the NHS Constitution.[320]

The UNCRC aimed to empower minors' autonomy by recognising them as independent rights holders.[321] There are three pertinent Articles under the UNCRC that are deserving of examination. The first, Article 3(1) states:

> In all actions concerning [minors], whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the [minor] shall be a primary consideration.

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[317] Priscilla Alderson and Jonathan Montgomery, *Health Care Choices: Making Decisions with Children* (IPPR 1996) 64.
[318] *Axon* (n 301) [79].
[319] Rights of Children and Young Persons (Wales) Measure 2011.
[320] Ian Lewis and Christine Lenehan, *Report of the Children and Young People's Health Outcomes Forum* (July 2012) 25.
[321] United Nations Committee on the Rights of the Child (CRC), 'General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child' (2003) CRC/GC/2003/4, para 6.

The best interests of the minor are merely 'a' rather than 'the' primary consideration. The choice of language is important. It is contradictory given the empowering focus of the UNCRC because, depending on the issue, it suggests that other interests, including those that may necessarily conflict with the minors' autonomy, take precedence.

The second, Article 5, has aspects couched in terms that reflect the principles in *Gillick*. This Article states that:

> State Parties must respect the responsibilities, rights and duties of parents or, where applicable, [carers]… to provide, in a manner consistent with the evolving capacities of the [minor], appropriate direction and guidance in the exercise by the [minor] of the rights recognized in the present Convention.

The term 'evolving capacities' is significant because it implies that the UNCRC recognises and appreciates that minors' capacity is a sliding scale of scrutiny.[322] The more mature the minor, the greater freedom they should have to make their own decisions.[323] However, 'evolving capacities', much like the *Gillick* principles, is a concept itself fraught with difficulties owing to the messy nature of measuring the elusive concept that is 'capacity',[324] and this is despite the UN Committee on the Rights of the Child's (CRC) comments on its definition.[325]

Finally, the most significant provision for minors' autonomy comes within Article 12. The Article provides that:

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[322] Aoife Daly, 'Assessing Children's Capacity: Reconceptualising our Understanding through the UN Convention on the Rights of the Child' (2020) 28(3) Int J Child Rights 471, 479-480.
[323] The phrasing of Article 5 mirrors the concept of 'dwindling [parental] rights' seen in *Hewer v Bryant* (n 193).
[324] Michael Freeman, 'The Future of Children's Rights' (2000) 14(4) Child Soc 277, 289.
[325] CRC, 'General Comment No. 7: Implementing Child Rights in Early Childhood' (2005) CRC/C/GC/7, para 17, '[T]he concept of "evolving capacities" to refer to processes of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realized… Parents (and others) should be encouraged to offer "direction and guidance" in a child-centred way, through dialogue and example, in ways that enhance young children's capacities to exercise their rights, including their right to participation (art. 12)'.

> State Parties shall assure to the [minor] who is capable of forming his or her own views the right to express those views freely in all matters affecting the [minor], the views of the [minor] being given due weight in accordance with the age and maturity of the [minor].

In the opinion of the CRC, this participatory right constitutes one of the four pillars of the UNCRC and is of 'fundamental' value.[326] The CRC emphasises that Article 12 requires consideration of the minors' 'evolving capacities', which necessitates a transformation of those with parental responsibility to yield control over their child as they mature.[327] The drafters of Article 12 were in tune with the developing attitudes towards minors' autonomy. Article 12 recognises the minor not as a parent's puppet but as an autonomous agent capable of exercising independent judgment based on their lived experience. The weight attached to the minor's views when they participate in decision-making about themselves accords with their age and maturity.

The UNCRC advances many ambitious propositions. Freeman suggested it offers the fullest legal statement of minors' rights found anywhere.[328] The difficulty is that despite the theoretical niceties, the UNCRC's provisions are toothless. To take Article 12 as an example, the right within is merely participatory, not decisive. The minors' views do not have to be acted upon because there is no obligation to go beyond listening to their voice once they have freely expressed their views. Thus, under certain circumstances, the rights within Article 12 can be entirely meaningless.[329] It may be the case that taking Articles 3, 5 and 12 together gives teeth to the UNCRC because they recognise that a best interests model does not dominate all

[326] CRC, 'General Comment No. 12: The Right of the Child to be Heard' (2009) CRC/C/GC/12, para 2. The other 'pillars' are Article 2 (non-discrimination), Article 3 (best interests of the child) and Article 6 (right to life survival and development).
[327] ibid, paras 31 and 84.
[328] Freeman (n 324) 277.
[329] Laura Lundy, ''Voice' is Not Enough: Conceptualising Article 12 of the United Nations Convention on the Rights of the Child' (2007) 33(6) BERJ 927, 931.

decisions concerning minors and that due accord should be given to minors' evolving capacity to decide for themselves matters that affect them.[330] However, this cumulative approach is no more than an exercise in analytical gymnastics. It remains the case that the UNCRC is no more than persuasive. Exercisable legal rights cannot be extracted from it to the effect of truly empowering the 'capable' minor to make fully independent decisions.

There was much promise for the CA 1989 and the UNCRC, but for minors in medical-decision making, the frameworks do little more than echo *Gillick's* principles. On the one hand, the CA 1989 contains many significant autonomy-related rights. Most notable are those that imply a minor can refuse medical examinations (and treatments). But it is open to question precisely how far the Act's provisions empower the competent minor. On the other hand, the UNCRC is very progressive, but it not being incorporated into domestic law limits its influence. Indeed, in the most significant minors' medical consent case in the last 20 years, *Bell (CA)*, no remark was made to the UNCRC. Whilst these are notable critiques, looking at the bigger picture, the philosophy of the rights under the CA 1989 and the UNCRC picked up where *Gillick* left off and supported the generalisation that minors' autonomy was propelled into the ascendency. However, the more significant developments regarding minors' rights, particularly with respect to their autonomy to consent to medical treatment, occurred through the common law.

[330] Lisa Young, 'Mature Minors and Parenting Disputes in Australia: Engaging with the Debate on Best Interests v Autonomy' (2019) 42(4) UNSWLJ 1362, 1369.

IV. New Challenges to the *Gillick* Consent Principles

A. The Bell Litigation

Since the House of Lords' judgment in *Gillick,* litigation squarely confronting the ability of *Gillick* competent children to *consent* to medical treatment has been rare.[331] The most pronounced challenge to the *Gillick* consent principles arrived in December 2020, when the Divisional Court handed down a significant judgment in *Bell (DC)*. Notably, the case showed the societal polarisation and tensions concerning transgender (trans) rights and the rights of minors to consent to transitional treatment.[332] The case reached the Court of Appeal,[333] which had the final say in this litigation.

The case of *Bell (DC)* concerned a claim for judicial review of the practice of the Tavistock and Portman NHS Foundation Trust (Tavistock), through its Gender Identity Development Service (GIDS), prescribing puberty blocking drugs (PBs) to persons under the age of 18 who experience gender dysphoria (GD). Those with GD could be referred for assessment to GIDS. In turn, GIDS may refer them to either University College London Hospitals NHS Foundation Trust or Leeds Teaching Hospitals NHS Trust (together the Trusts) to potentially receive the appropriate medical intervention.[334] There were three stages of physical intervention recognised by GIDS: Stage 1 was the administration of PBs, Stage 2 was the administration of cross-sex hormones (CSH), and Stage 3 was gender reassignment surgery.[335] The practice of GIDS and the Trusts was to prescribe PBs on the basis of informed consent of the *Gillick* competent child or young person.[336] The first claimant in the underlying

[331] See, eg, *Axon* (n 301); *Re C* (n 265); *Re JA (A Minor)* (n 315); *An NHS Trust v A* [2014] EWHC 1445 (Fam). The majority of cases challenging the *Gillick* principles have focused on issues of *refusal*: see Chapter IV.
[332] The Cass Review, 'Independent Review of Gender Identity Services for Children and Young People: Interim Report' (February 2022).
[333] (n 29).
[334] *Bell (DC)* (n 186) [16]-[17], [21], [37].
[335] ibid [15].
[336] ibid [5], [36].

judicial review proceedings was Kiera Bell, a former patient of GIDS treated with PBs, CSH and gender reassignment surgery, who went on to de-transition.[337] The second claimant, Mrs A, was the mother of a 15-year-old girl and was concerned that her daughter would be referred to GIDS and prescribed PBs.[338] The issues for the Divisional Court were twofold. First, whether children or young persons under the age of 18 are capable of giving consent to the administration of PBs, and second, whether the information provided by GIDS and the Trusts was misleading and inadequate to form the basis for informed consent to be given.[339]

The Divisional Court did not consider whether the practice of GIDS or the Trusts was illegal, and nor did its judgment disclose the ground for the judicial review.[340] The Divisional Court explained that '[t]he court is not deciding on the benefits or disbenefits of treating children with GD with PBs, whether in the long or short term'.[341] Yet after a thorough examination of the (competing) factual evidence, it held that PBs were an 'experimental' treatment.[342] Consequently, the Divisional Court declared that in order to have *Gillick* competence to consent to treatment with PBs:

> [T]he child or young person would have to understand not simply the implications of taking PBs but those of progressing to cross-sex hormones. The relevant information therefore that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH and therefore that s/he is on a

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[337] ibid [78]-[83].
[338] ibid [89], 'Mrs A's interest in this action is… largely theoretical'.
[339] ibid [90].
[340] Kirsty Moreton, 'A Backwards-step for *Gillick*: Trans Children's Inability to Consent to Treatment for Gender Dysphoria–*Quincy Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust and Ors* [2020] EWHC 3274 (Admin)' (2021) 29(4) Med L Rev 699, 702.
[341] *Bell (DC)* (n 186) [9].
[342] ibid [74], [134].

pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.[343]

In addition, the Divisional Court recognised the difficulties a child would face in understanding and weighing up this information and thus suggested that:

> [I]t is highly unlikely that a child aged 13 or under would ever be *Gillick* competent to give consent to be treated with PBs. In respect of children aged 14 and 15, we are also very doubtful that a child of this age could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent.[344]

The Divisional Court took a different approach to young persons because this cohort is presumed competent to consent to medical treatment under s 8(1) FLRA 1969.[345] The Divisional Court believed that clinicians may well consider that it is not appropriate to prescribe PBs or CSH without the involvement of the court, given the evidence suggesting that such treatments are experimental. The Divisional Court suggested that:

> [I]t would be appropriate for clinicians to involve the court in any case where there may be doubt as to whether the long-term best interests of a 16 or 17 year old would be served by the clinical interventions at issue in this case.[346]

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[343] ibid [138].
[344] ibid [145].
[345] ibid [146]. See also MCA 2005, ss 1-3.
[346] ibid [147].

The declaration and guidance provided by the Divisional Court suggested that the judicial review was partially successful. The immediate response to the judgment was amendments made by the NHS to the GIDS Service Specification. The amendments restricted GIDS from making new referrals for PBs without a best interests order from the court, and also required GIDS to obtain a best interests order before permitting existing patients to continue receiving PBs or CSH.[347] The judgment of the Divisional Court was criticised for its implications on minors' competence to consent to medical treatment.[348] Tavistock appealed against the declaration and submitted that the guidance given by the Divisional Court was wrong in law.

The Court of Appeal allowed the appeal, set aside the Divisional Court's declaration, and held that it was inappropriate for the lower court to provide such guidance.[349] The Court of Appeal was particularly critical of the Divisional Court's approach to the disputed issues of fact and expert evidence,[350] its generalisations of *Gillick* competence (and its effect on trans children),[351] and its guidance requiring applications to the court in circumstances in which the Divisional Court itself recognised that there was no legal obligation to do so.[352] The Court of Appeal recognised that, although driven by the best intentions, the Divisional Court arrived at questionable findings that had placed improper restrictions on *Gillick*.[353] Therefore, it was for them to clarify the law in this area.

B. The Reinstatement of Gillick

The reasoning in *Bell (CA)*, and indeed in several other recent cases, has important implications for the law on minors' consent to medical treatment. The analysis will demonstrate the

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[347] Service Specification for Gender Identity Development Service for Children and Adolescents (E13/S(HSS)/e) (amended 1 December 2020).
[348] See Moreton (n 340). See also Peter Dunne, 'Childhood in Transition: Can Transgender and Non-Binary Minors Provide Lawful Consent to Puberty Blockers?' (2021) 80(1) CLJ 15.
[349] *Bell (CA)* (n 29) [91].
[350] ibid [63]-[65], [72].
[351] ibid [74]-[76], [80], [85].
[352] ibid [86]. See *An NHS Trust v Y* [2018] UKSC 46.
[353] ibid [94].

clarifications and some conundrums for *Gillick* competence and the law on medical consent by addressing the following important questions. First, how did the Court of Appeal interpret the assessment of *Gillick* competence? Secondly, has *Bell (CA)* settled ambiguities regarding the no minimum age principle for *Gillick* competence? Thirdly, what is the scope of parental consent? This issue was marginal in the judgment of the Divisional Court. The High Court decision in *AB v CD*,[354] which followed on from the decision in *Bell (DC)*, provided some clarity on the issue. Finally, what is the role of the court, especially in the case of 16-17-year-olds seeking to consent to treatment with PBs?

1. Assessing Gillick competence

At the heart of the appeal was the submission that, in making the declaration, the Divisional Court 'departed' from *Gillick*.[355] There was no precedent for the Divisional Court to have issued the declaration.[356] The Court of Appeal in any event elucidated the implications of the declaration for *Gillick* competence. The Court of Appeal criticised the declaration because it,

> identifies an exhaustive list of factual circumstances that must be evaluated in seeking consent from a child and specifies some matters as conclusive facts. It comes close to providing a checklist or script that clinicians are required to adopt for the indefinite future in language which is not capable of clear and uniform interpretation and in respect of which there were evidential conflicts.[357]

The Court of Appeal compared the factors stated by the Divisional Court for competent consent to treatment with PBs to the factors Lord Scarman provided in *Gillick* for competent consent to contraceptive treatment.[358] Each factor stated by Lord Scarman was an area for evaluation

[354] [2021] EWHC 741 (Fam).
[355] *Bell (CA)* (n 29) [66].
[356] ibid [69].
[357] ibid [70].
[358] See, for Lord Scarman's factors, (n 239).

rather than a conclusory statement of fact or medical opinion.[359] The Divisional Court largely did not follow this approach. For example, the second of the Divisional Court's factors was a matter of contested fact; and the seventh and eighth factors were also disputed.[360] The declaration implied that clinicians deferred to what amounted to the *clinical* judgment of the *court* on how to assess *Gillick* competence.[361] This was contradictory to the *ratio* of *Gillick*, which the Court of Appeal observed as that 'it was for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment'.[362] Both Lord Fraser and Lord Scarman in *Gillick* offered suggestions about the matter which a clinician could explore with a patient without being prescriptive; they recognised that clinicians must satisfy themselves, in accordance with their expertise, whether the child is *Gillick* competent.[363] The declaration was wholly out of step with *Gillick*, thus the Court of Appeal rightly set it aside.

Chua suggested that whilst the Court of Appeal rightly rejected the declaration, it missed the opportunity to provide non-binding judicial guidance, analogous to the *Gillick* guidance on contraceptive matters, of what information a child would need to understand in order to be *Gillick* competent to consent to PBs.[364] In the light of the purported experimental nature of PBs and suggested clinical reservations about practically applying the *Gillick* competence test, the Court of Appeal could have contributed to the understanding of *Gillick* competent consent in the transgender health context. At the same time, had the Court of Appeal elucidated guidance for assessing *Gillick* competent consent to PBs, given it already emphasised that the responsibility for the assessment of competence sits with the medical

[359] *Bell (CA)* (n 29) [74].
[360] ibid [64], [74]. See, for the Divisional Court's list of factors, *Bell (DC)* (n 186) [138].
[361] ibid [75].
[362] ibid [76].
[363] ibid [80], [87].
[364] Hillary Chua, 'Consent to Treatment for Transgender Youth: The Next Chapter–*Bell & Anor v The Tavistock and Portman NHS Foundation Trust & Ors*' (2023) 86(1) MLR 1, 10.

profession, it might have been understood, contrary to its intentions, as providing clinicians with a judge-made clinical manual.

Furthermore, by rejecting the declaration, the Court of Appeal confirmed that consent to PBs should not be conflated with simultaneously consenting to CSH. *Gillick* competence is decision-specific. A child may be *Gillick* competent to consent to some treatments but not others. The decision in *Re JA (A Minor)* provides a clear example. Baker J found the 14-year-old boy not to be *Gillick* competent to make the decision as to whether or not to take anti-retroviral therapy medication, though he was found *Gillick* competent to consent to undergo monitoring and receive psychotherapy and peer support.[365] Similarly, *Bell (CA)* confirmed that it is open whether the child may be *Gillick* competent to consent to PBs, and as a separate question, to CSH. The principle that the test of *Gillick* competence is decision-specific is hence restored.

2. The no minimum age principle revisited

After rejecting the declaration, the Court of Appeal turned to criticise and reject the guidance provided by the Divisional Court, which generalised the capability of persons of different ages to understand what was necessary for them to be competent to consent to treatment with PBs.[366] The Court of Appeal recognised that the guidance stemmed from the understandable concern the Divisional Court had for the welfare of those with GD. The purported negative implications associated with PBs and its relationship with CSH and reassignment surgery,[367] together with Kiera Bell's testimony, doubtless influenced the Divisional Court to err on the side of caution with its guidance. Indeed, the rationale of the Divisional Court's guidance is analogous to the

[365] *Re JA (A Minor)* (n 315) [76]-[77].
[366] *Bell (CA)* (n 29) [85]. See, for the Divisional Court's age capability generalisations, *Bell (DC)* (n 186) [145].
[367] *Bell (DC)* (n 186) [57], [68]. It is worth noting that the Divisional Court perceived the high correlation between PBs and CSH as destiny, conflating two separate decisions into one. See also Aidan Ricciardo, 'Minors' Capacity to Consent to Puberty Suppressing Treatment' (2022) 38(1) PN 48, 54-55.

protectionism implicit in Lord Templeman's dissent in *Gillick*. His Lordship expressed doubt about whether a girl under the age of 16 was capable of a balanced judgment to engage in sexual intercourse and suggested that the court should be slow to permit children to leap from childhood to adulthood.[368] However, neither the reservations of Lord Templeman nor the generalisations of the Divisional Court carried the day.

The difficulty underlying the Divisional Court's guidance was that it imposed a minimum age for trans children to consent to PBs. The Court of Appeal observed that the reasoning in *Bell (DC)* was inconsistent with Lord Scarman's remark in *Gillick* that the law should not impose upon the process of growing up fixed limits.[369] The Divisional Court may argue that it maintained the no minimum age principle because it left open the possibility that 13- to 15-year-olds, although 'unlikely', *could* be *Gillick* competent to consent to treatment with PBs. The guidance was therefore consistent with *Gillick* because it did not bar children from being *Gillick* competent. However, a broader analysis suggests the threshold for *Gillick* competence was increased because children needed to understand factors relating to CSH to consent to PBs when they are ineligible for the former treatment while they are under 16.[370] The guidance greater reflected a status-based approach over the conventional functional-based approach to capacity, which had the practical effect of obstructing trans children's capability to be *Gillick* competent.

The Court of Appeal found that there was nothing about the nature or implications of the treatment with PBs that allows for a real distinction to be made with contraceptive treatment.[371] A similar conclusion was reached by Silber J in *Axon* that if *Gillick* competent children can consent to contraceptive treatment, they can consent to an abortion.[372] Indeed,

[368] *Gillick* (n 10) [201].
[369] *Bell (CA)* (n 29) [85]. See (n 264).
[370] See Moreton (n 340) 709. See also Ricciardo (n 367) 55.
[371] *Bell (CA)* (n 29) [76].
[372] *Axon* (n 301) [90].

Mostyn J in *An NHS Trust v A* granted a declaration that a 13-year-old had the *Gillick* competence to consent to the continuation or termination of her pregnancy.[373] Moreton suggested the judgment of Mostyn J should be applauded for its unambiguous stance that *Gillick* competence implies decision-making autonomy,[374] summed up by Mostyn J's finding that 'if I am to determine that [the child] does have sufficient understanding and intelligence to know what a termination would involve, then that is the end of the matter'.[375] The decisions of *Axon* and *An NHS Trust v A* illustrate that the *Bell (DC)* guidance was contrary to the law. Thus, by rejecting the guidance, *Bell (CA)* affirmed the functional approach to capacity, the no minimum age principle, and reinstated the orthodox understanding of *Gillick*.

3. Parental responsibility clarified?

The Divisional Court very briefly considered the issue of parental consent. It observed that the normal position of the law would be that someone with parental responsibility could consent on the child's behalf if they lack *Gillick* competence. However, because the Service Specification confirmed that GIDS would not administer PBs to a patient without their consent, the Divisional Court concluded on the matter of parental consent that:

> [I]t is not necessary for us to consider whether parents could consent to the treatment if the child cannot lawfully do so because this is not the policy or practice of the defendant and such a case could not currently arise on the facts.[376]

It was accepted in *Bell (CA)* that the question of prescribing PBs on the say so of parents without the informed consent of the child was a concern which did not arise in these judicial review proceedings.[377] The Court of Appeal did not leave the matter there and relied on the

[373] *An NHS Trust v A* (n 331) [15].
[374] Kirsty Moreton, '*Gillick* Reinstated: Judging Mid-Childhood Competence in Healthcare Law: *An NHS Trust v ABC & A Local Authority* [2014] EWHC 1445 (Fam)' (2014) 23(2) Med L Rev 303.
[375] *An NHS Trust v A* (n 331) [9].
[376] *Bell (DC)* (n 186) [47].
[377] *Bell (CA)* (n 29) [47].

judgment of Lieven J in *AB v CD* to help clarify the position of the parent.[378] In this case, a mother of a 15-year-old, XY, applied for a declaration that she and XY's father had the ability in law to consent on XY's behalf to the administration of PBs. The issue in broad terms was whether XY's parents could consent to the treatment or whether the decision to prescribe XY with PBs was a matter for the High Court to decide.[379] Lieven J emphasised the 'critical role of parents in their children's lives, and decision making about their lives' and observed that parental responsibility extended to granting consent for medical treatment, including the most serious of all decisions.[380] XY's competence was not subject to scrutiny, yet whether she was or was not *Gillick* competent,[381] the issue remained whether her parents could consent to the proposed treatment. After reviewing case law relating to refusals and suggesting that those cases took analysis no further forward,[382] Lieven J turned to *Gillick*. She stated that 'the very essence of *Gillick* is, in my view, that a parent's right to consent or "determine" treatment cannot trump or overbear the decision of the child'.[383] The parent and child were in agreement in this case. The question was thus whether the parents' ability to consent terminated once the child achieved *Gillick* competence in respect of the specific decision even where both the parents and child agree. In the view of Lieven J, 'it does not'.[384] Thus, the premise of *AB v CD* was that if the child does not consent, because of incompetence or being overwhelmed and would prefer their parents to decide on their behalf, the parents retain a concurrent right to consent,[385] but this consent cannot be used to 'trump' a *Gillick* competent child's decision.

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[378] Lieven J was one of the judges on the *Bell (DC)* bench.
[379] *AB v CD* (n 354) [1].
[380] ibid [39], [42]-[43]. Lieven J cited for support Ward LJ in *Re Z (A Minor) (Freedom of Publication)* [1997] Fam 1 [26], 'Giving consent to medical treatment of a child is a clear incident of parental responsibility arising from the duty to protect the child'.
[381] ibid [51]. It was noted at [49] that 'before *Bell [(DC)]* … XY was *Gillick* competent in respect to the decision to take PBs and therefore it was not necessary to ask whether the parents could also consent. However, that view has been cast into doubt by the judgment in *Bell* [*(DC)*] and in particular [138]'.
[382] ibid [59]. See, for a critical analysis of medical refusal cases, Chapter IV.
[383] ibid [67].
[384] ibid [68].
[385] See, for the definition of 'concurrent rights to consent', Chapter IV.

The Court of Appeal respectfully agreed with the assessment of Lieven J on the issue of parental consent and did not take the matter further.[386] In the recent case of *Webberly v General Medical Council*,[387] involving the suspension of a doctor offering treatment for trans patients online, Jay J considered the decision in *AB v CD*. It was submitted to Jay J that the correct analysis of *AB v CD* is that the ability of the parent to consent for their child exists in all circumstances and on all hypotheses. In no uncertain terms, Jay J held in response that:

> It does not. That would be inconsistent with *Gillick* itself. Lieven J's reference to parents retaining the right to consent to treatment was not intended to be of universal application.[388]

Jay J approved of the premise in *AB v CD*. That *Webberly* was consistent with *AB v CD* and *Bell (CA)*, the scope of parental rights in the transgender health context appears settled.

4. The role of the court?

The *Bell (DC)* guidance suggested that it might be appropriate for clinicians to involve the court in cases of doubt over the long-term best interests of a 16-17-year-old. The Divisional Court recognised the existence of the presumption of capacity to consent under s 8(1) FLRA 1969 but observed that the court could still intervene to protect the young person.[389] Moreton criticised the 'protectionist' reasoning in *Bell (DC)* because it implied that the protective role of the court should take priority over the young person's autonomy.[390] Indeed, the guidance undermined the Divisional Court's own statement that they should not 'adopt an intrusive jurisdiction in relation to one form of clinical intervention'.[391] It was inconsistent for the Divisional Court to suggest that a young person's autonomy should be protected and supported,

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[386] *Bell (CA)* (n 29) [48].
[387] [2023] EWHC 734 (Admin).
[388] ibid [115].
[389] *Bell (DC)* (n 186) [146]-[147].
[390] Moreton (n 340) 712-713.
[391] *Bell (DC)* (n 186) [146].

underpinned by the FLRA 1969, and claim there is real benefit in judicial oversight for decisions over PBs[392] without supporting evidence beyond the assumption that PBs are experimental. This reasoning further conflicts with the earlier decision of Keehan J in *PD v SD*, a case involving the issue of whether a trans 16-year-old, PD, was entitled to privacy in respect of his medical treatment. Keehan J observed that because PD was 16, by virtue of s 8(1) FLRA 1969, PD can give effective consent to medical and surgical treatment and, by implication, this includes transitional treatments.[393]

The Court of Appeal found that the *Bell (DC)* guidance placed patients, parents, and clinicians in a difficult position and was inconsistent with established law because, although the guidance did not obligate clinicians to involve the court, the *Bell (DC)* judgment was 'understood by clinicians, and understandably so, as suggesting that an application to the court (by the child, the parents or the Trust in question) should be the norm'.[394] The Divisional Court's guidance, particularly the discussion in paragraphs [134] to [137], suggested that PBs fell into a special category of medical treatment, which would require court authorisation before doctors could prescribe them. The Court of Appeal rejected any suggestion that PBs should be placed in a special category, agreeing with the judgment of Lieven J in *AB v CD*. In her analysis of the case law, Lieven J suggested that the cases supporting a special category of treatment of children which require court approval are very limited.[395] These include where there is a clinical disagreement; possible alternative treatment of the medical condition in issue; or the decision is, in the opinion of clinicians, finely balanced.[396] Lieven J observed that these are fact specific instances rather than examples of any special category of treatment. The only case where the court has found a legal requirement for court approval in respect of the child

[392] ibid [149].
[393] [2015] EWHC 4103 (Fam) [20]. There is nothing to suggest that the FLRA 1969 excludes from its purview treatments such as PBs or CSH. *Re W* (n 18) observed that the FLRA 1969 does not cover organ or blood donation.
[394] *Bell (CA)* (n 29) [10], [86].
[395] *AB v CD* (n 354) [73], [116].
[396] ibid.

where both parents consent (in agreement with the paediatrician) was *Re D*.[397] Lieven J did consider the argument in *Bell (DC)* that PBs are sufficiently different from other forms of treatment to be treated differently,[398] but declared that while 'the gravity of the decision to consent to PBs is very great… it is no more enormous than consenting to a child being allowed to die'.[399] Thus, there was no convincing basis for Lieven J to create an exception that consent to PBs required court approval.

The Court of Appeal declined to create an exception, observing that to do so would be inconsistent with the Supreme Court's decision in *An NHS Trust v Y*.[400] That case concerned whether clinicians must always obtain a court order before withdrawing clinically assisted nutrition and hydration (CANH). The Supreme Court held neither the common law nor the ECHR, in combination or separately, gives rise to the mandatory requirement to involve the court when there is an agreement between medical professionals and families about the withdrawal.[401] Thus, the Court of Appeal rightly suggested the Divisional Court's guidance that there should be an application to the court in circumstances where the child, parents and clinicians all consider the treatment to be in the best interests of the child was out of step with *An NHS Trust v Y*.[402] That was not to say that an application to the court would never be appropriate, with Lieven J in *AB v CD* raising several circumstances in which court involvement would be necessary.[403] The approach in *Bell (CA)*, together with the reasoning of Lieven J in *AB v CD*, to the issue of court involvement was consistent with the case law and,

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[397] *Re D (A Minor) (Wardship: Sterilisation)* [1976] Fam 185. This case involved the non-therapeutic sterilisation of an 11-year-old ward of the court. Heilbron J at [196] held that the operation was 'neither medically indicated nor necessary, and that it would not be in D's best interest for it to be performed'.
[398] *AB v CD* (n 354) [119], Lieven J explained that she was hampered in her ability to explore this argument because no party had raised it. However, she observed that the factors from *Bell (DC)* supporting the argument would likely include, *inter alia*, the experimental nature of PBs. See, for further discussion, Chua (n 364) 7.
[399] ibid [121].
[400] *Bell (CA)* (n 29) [50], [86]. In *AB v CD* (n 354) [121], Lieven J also referred to the judgment of *An NHS Trust v Y* (n 352) and suggested that she was wary of 'becoming too involved in highly complex moral and ethical issues on a generalised, rather than case specific basis'.
[401] *An NHS Trust v Y* (n 352) [126].
[402] *Bell (CA)* (n 29) [86].
[403] *AB v CD* (n 354) [127]-[128].

therefore, confirms the role of the court in treatment decisions over PBs in cases of non-dispute.

5. Concluding evaluation

The decision of the Court of Appeal to set aside the Divisional Court's declaration and reject its guidance has broad significance. First, it delineated the accepted principles about the limited role of the court in judicial review proceedings. Secondly, it confirmed trans minor's right to access medical treatment that, as actually identified in *Bell (DC)*, 'goes to the heart of an individual's identity'.[404] Thirdly, it clarified that it was for clinicians and not the court to decide on competence and, therefore, preserved *Gillick*. Fourthly, the pragmatic and autonomy-affirming no minimum age principle for *Gillick* competence appears settled law. Fifthly, approving Lieven J's judgment in *AB v CD*, the position of parental consent appears settled. Sixthly, it confirmed decisions concerning medical treatment that required court involvement, explaining that PBs did not fall into a special category. The Supreme Court rejected Kiera Bell's application for permission to appeal the Court of Appeal's judgment because the application did not raise an arguable point of law. This decision suggests, at least for now, that *Gillick* has survived the new challenges posed by GD cases.

V. Concluding Remarks

This chapter canvassed the development of *Gillick* competence and the law generally on minors' rights to consent to medical treatment. It began by reviewing the evolution of minors' legal rights and, crucially, how the law defined minors' capacity to make medical decisions. The common law progressed from outdated Victorian attitudes towards the child vis-à-vis their parents. In particular, it was recognised that parental rights are not absolute. Instead, parental

[404] *Bell (DC)* (n 186) [148].

rights increasingly dwindle as the minor ages and matures. The FLRA 1969 presumes that people over the age of 16 have the competence to consent to medical treatment.

The development in the common law climaxed in the House of Lords' decision in *Gillick*. Lord Scarman established the test for children's decision-making capacity. *Gillick* thus remedied the gap in the law on the capacity of children to make independent medical decisions. But issues with *Gillick* competence have been elucidated. Questions about *Gillick* concern the definition of what children must understand, the minimum age for *Gillick* competence, and the practical implications of the test. Notwithstanding the uncertainties implicit in *Gillick*, some of which have been clarified in subsequent case law, those who satisfy Lord Scarman's test are empowered as autonomous decision-makers, having legal rights of their own. The significance of *Gillick* is broad. Its principles were codified in the CA 1989 and the UNCRC, and although their impact on minors' rights and autonomy is open to question, the emphasis on involving the child in decision-making about the child is laudable. Since *Gillick* and its early codification, significant developments of the law on medical consent did not occur until the decision in *Axon* and the *Bell* litigation. The *Bell (CA)* decision was particularly significant because it reversed the departure from *Gillick* in *Bell (DC)*.[405] The position of the law following *Bell (CA)* and the series of High Court judgments that interpreted *Gillick* and consent in a generally consistent manner is that insofar as the minor is competent, either by virtue of *Gillick* or s 8(1) FLRA 1969, their consent to medical treatment is determinative.

The following chapter demonstrates that despite all the positives and progress for minors' rights, the uncertainties implicit in *Gillick* were exposed when two early 1990s Court of Appeal decisions tested the *Gillick* principles. The focal point gravitated around whether minors could not only consent to medical treatment but refuse it as well.

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[405] Kirsty Moreton, 'The Appeal in *Bell v Tavistock* and Beyond: Where are we now with Trans Children's Treatment for Gender Dysphoria?' (2023) 31(4) Med L Rev 594.

CHAPTER IV

A WRONG TO REFUSE?

It was demonstrated in Chapter III that in matters of consent to medical treatment, competent minors, either by virtue of *Gillick* or s 8(1) FLRA 1969, are lawfully recognised as autonomous decision-makers. The *Gillick* competence test has been applied and interpreted in increasingly wider contexts (both medical and non-medical[406]), which has caused it to show signs of strain.[407] In the early 1990s, the decisions of the Court of Appeal in *Re R* and *Re W* put the principles of *Gillick* to the test. The two marked a significant shift in the emphasis on minors' autonomy as ushered by *Gillick* and preserved in the CA 1989 and UNCRC.[408]

The theoretical models of autonomy and protectionism defined in Chapter II underpin the analysis in this chapter. To reiterate, 'autonomy' (or 'autonomous decision-making') means the person has the capacity to think, decide, and act on that thought and decision without interference. This definition is premised on 'individualism' and 'relationalism'. It also includes Coggon's 'current desire autonomy' and 'best desire autonomy' typologies. The former refers to an action which reflects a person's immediate inclination without further reflection. The latter describes actions which reflect a person's overall desire based on their values, even if it does not reflect their immediate desire.[409] 'Protectionism' means interference with the (minor) patient's decisions on protection-based grounds, which, on the one hand, have underlying beneficent and nonmaleficence motivations; on the other hand, can exemplify hard and coercive paternalism. Taken as implicit in the definition of 'protectionism' is Coggon's

[406] *Re Roddy (A Child) (Identification: Restriction on Publication)* [2003] EWHC 2927 (Fam); *Mabon v Mabon* [2005] EWCA Civ 634; *Re D (A Child)* [2019] UKSC 42.
[407] Cave (n 257) 105.
[408] Donna Dickenson, 'Children's Informed Consent to Treatment: Is the Law an Ass?' (1994) 20(4) J Med Ethics 205, 205.
[409] Coggon (n 56) 240. See also Chapter II, Part I, Section A, Subsections 1 and 2.

conception of ‘ideal desire autonomy’.[410] This notion of autonomy is not based on an individual’s actual preferences but on what they (supposedly) *should* want.[411] Having sound definitions of autonomy and protectionism will make arriving at the answer to the issues of minors’ medical decision-making somewhat easier. Against this backdrop, this chapter provides an extensive canvas of the development of minors’ ‘rights’ to refuse medical treatment, highlights the tensions between the competing theoretical models, and critically analyses the decisions and the basis of the decisions of the courts to respect or overrule a minor’s medical decision.

The author of this thesis thoroughly investigated every reported English minor’s medical refusal case since *Re R* and *Re W* established the law in this area. The culmination of this endeavour is a record of factors that the courts consider relevant when determining issues of a minor’s refusal of medical treatment. These factors include:

- age;
- competence;
- expressed wishes and feelings;
- mental disability (fluctuating or permanent);
- risk probability of an event occurring (i.e. how necessary was the proposed treatment?);
- risk consequence from the event occurring (i.e. how serious would the damage to the minors’ health or life be if the treatment was not provided?);
- the principle of preservation of life (alternatively, the sanctity of life);
- type of injury, illness or health condition;

[410] See also Craig Purshouse, ‘How Should Autonomy be Defined in Medical Negligence Cases?’ 2015 10(4) Clinical Ethics 107. He suggested that ideal desire autonomy is indistinguishable from autonomy’s polar opposite, paternalism (111).
[411] Coggon (n 56) 240. See also Chapter II, Part I, Section A, Subsection 3.

- faith (in terms of authenticity and longevity[412]);
- familial support;
- maturity;
- life experience;
- feeling overwhelmed;
- experience with illness and its treatment;
- holism (i.e. the treating of the whole person, taking into account mental and social factors, rather than just the symptoms of an illness);
- psychological harm;
- quality of life; and
- human rights.

The key takeaway from this investigation was that during the welfare assessment in which the courts decide whether to respect or overrule a minor's medical refusal, so long as the case facts indicated that the 'risk probability' and 'risk consequence' were 'high',[413] other relevant factors in the case appeared inconsequential. The consequence was that minors' medical refusal decisions were (almost) universally overruled by the courts. This was the case even if, when viewed on a balance sheet, there were more factors supporting a minor's decision rather than denying it. In every case, the courts justified their decision on grounds of protecting the minors' 'welfare'. This chapter posits that whilst the principles of minors' medical refusal law founded in *Re R* and *Re W* have their strengths, they are also problematic because they provide a basis to restrict competent minors' autonomous decisions and hence require reconsideration.

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[412] See, for a good discussion on authenticity and religiously motivated decisions, Cressida Auckland, 'Authenticity and Identity in Adolescent Decision-Making' (2024) 87(2) MLR 245.

[413] This means the proposed treatment was immediately necessary to treat the minor's condition; without treatment, the consequences to health or life would be serious. This thesis will express the risk probability/consequence level in these terms: low-/high-risk probability and low-/high-risk consequence. In every case reviewed in Chapter IV, Parts II to IV, minors were making high-risk probability and high-risk consequence decisions.

Part I of this chapter explains the asymmetry between the concepts of consent and refusal. Whilst the FLRA 1969 and *Gillick* remedied the law on minors' capacity to consent to medical treatment, the capacity to refuse was left unaddressed. Although the power to give consent notionally implies the power to withhold consent,[414] the concepts have theoretical and practical differences.[415] The premise that consent and refusal are distinct concepts proved imperative in the case law post-*Gillick*.

Parts II and III analyse the Court of Appeal judgments in *Re R* and *Re W*, respectively. The lacunas in the law left by s 8(1) FLRA 1969 and *Gillick* spawned necessary litigation. The primary issue for the Court of Appeal in *Re R* and *Re W* was whether minors could refuse consent to recommended medical treatment. The reasoning in *Re R* and *Re W* in response to the issue of minors' medical refusal was, in general, well grounded.[416] However, Part III suggests that the reasoning in *Re W*, as it related squarely to competent minors and refusal of treatment, disproportionately favoured protectionism and represented a negative development in the law on minors' medical decision-making.

Part IV reviews the legacy of *Re R* and *Re W*, as interpreted by the High Court in a series of successive medical refusal cases. This part divides these cases into two categories for analysis: (i) religiously motivated decisions and (ii) non-religiously motivated decisions. This part argues that the reasoning of the High Court in cases of (non-)religiously motivated decisions made by *competent* minors was inconsistent, whereas when (non-)religiously

[414] Rosy Thornton, 'Multiple Keyholders–Wardship and Consent to Medical Treatment' (1992) 51(1) CLJ 34, 36.
[415] Nigel Lowe and Satvinder Juss, 'Medical Treatment–Pragmatism and the Search for Principle' (1993) 56(6) MLR 865.
[416] The *Re R* and *Re W* decisions have been subject to significant academic critique: see, eg, Gillian Douglas, 'The Retreat from *Gillick*' (1992) 55(4) MLR 569; Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (6th edn, MUP 2016); Fortin (n 228); Michael Freeman, *The Moral Status of Children, Essays on the Rights of the Child* (Martinus Nijhoff 1997) 352; Gilmore and Herring (n 210); Jonathan Montgomery, 'Parents and Children in Dispute: Who has the Final Word?' (1992) 4(2) JCL 85; John K Mason, 'Master of the Balancers; Non-Voluntary Therapy Under the Mantle of Lord Donaldson' (1993) 2 Jur Rev 115; John Seymour, 'An Uncontrollable Child: A Case Study in Children's and Parent's Rights' in Philip Alston, Stephen Parker and John Seymour (eds), *Children, Rights and the Law* (OUP 1992).

motivated decisions were made by, on the balance of probabilities, *incompetent* minors, the High Court was justified in its protectionism. The most pronounced difficulties in the High Court's reasoning across the two categories centred on contradictions that gravitated around balancing the minor's welfare against their autonomy interests.

Part V considers the implications of recent attempts to challenge the principles underpinning conventional wisdom set out by the Court of Appeal in *Re R* and *Re W*. Protectionism remains the dominant interpretation of the courts.[417] However, the decisions of the High Court in *DV (A Child)*[418] and the Court of Appeal in *E & F* demonstrate a judicial trend of an increased emphasis towards respecting competent minors' medical refusals. This part argues that *E & F* and *DV (A Child)* provide a basis that develops a broad and nuanced approach to competent minors' refusals that appropriately balances the autonomy and protectionism interests implicit in the court's welfare assessment.

I. Consent and Refusal Asymmetry

The trouble with defining minors' medical rights is brought to the fore when attempting to reconcile the law's distinction between the concepts of consent and refusal. In the case of 16-17-year-olds, under s 8(1) FLRA 1969, these minors have a rebuttable statutory right to consent to medical treatment, but the Act does not address the issue of refusal. The relevant issue in *Gillick* was whether minors under the age of 16 could consent to medical treatment.

In keeping with the final recommendations of the Latey Committee Report,[419] the drafters of the FLRA 1969 omitted young persons from having a right of refusal. The omission of refusal represented a missed opportunity for Parliament to fill an important gap in the law.

[417] Emma Cave, 'Confirmation of the High Court's Power to Override a Child's Treatment Decision: *A NHS Trust v X (In the matter of X (A Child) (No 2))* [2021] EWHC 65 (Fam)' (2021) 29(3) Med L Rev 537.
[418] *A Teaching Hospitals NHS Trust v DV (A Child)* [2021] EWHC 1037 (Fam).
[419] *Latey Report* (n 197) para 484.

The drafters of the FLRA 1969 went against the majority opinion of the medical profession,[420] and neither the Latey Committee Report nor Parliamentary discussions[421] provided reasons as to why 16-17-year-olds should not have a corollary right of refusal. A clear objective of Parliament was to clarify the 'obscure' legal position on minors' capacity to consent,[422] which it had done so in the case of 16-17-year-olds. It was thus counter-intuitive to leave the legal position obscure on rights of refusal. It may be the case that it was presumed that parents would consent when the child refused, but this would have unravelled the resolved mischief of allowing minors to consent where a parent was not readily available to consent on their behalf.[423] The only logical solution would then be for doctors to rely on the common law defence of necessity[424] where parental consent was not available. However, the scope of this defence only goes so far. For example, what if the minor was refusing treatment that was not yet in their immediate best interests? Accordingly, Parliament resolved one issue (consent) at the expense of another (refusal) when it could have killed two birds with one stone.

The strands of arguments raised for the House of Lords in *Gillick* to consider did not include the issue of refusal.[425] The implication is that *Gillick* competence applies to children's capacity to consent only. Subsequent interpretations of *Gillick* suggest that notwithstanding the lack of refusal's explicit address, the reasoning of Lord Scarman, in particular, could be read as implying that the right to consent carried with it the right to refuse. Brierley and Larcher identified that it was a common professional assumption that a *Gillick* competent child's refusal was as equally valid as their consent.[426] The assumption is premised on the ambiguous wording of Lord Scarman's statement that parents lose their right to determine 'whether or not' their

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[420] ibid, para 480.
[421] HC Deb 20 November 1967, vol 754, cols 956-1028.
[422] *Latey Report* (n 197) para 477.
[423] ibid. See Chapter III, Part I, Section B.
[424] *F v West Berkshire Health Authority* (n 6).
[425] *Gillick* (n 10) [166], [177].
[426] Joe Brierley and Victor Larcher, 'Adolescent Autonomy Revisited: Clinicians Need Clearer Guidance' (2016) 42(8) J Med Ethics 482, 483.

competent child will receive medical treatment.[427] Lord Scarman's comment implies that competence vests children with independent decision-making authority, and therefore, the expression 'whether or not' signifies that this authority extends to decisions to consent *or not* to consent (i.e. refuse). Huxtable suggested that the construction of Lord Scarman's test indicates that a competent child's refusal could bind.[428] Pattinson reasoned that although their Lordships in *Gillick* did not expressly address the capacity to refuse, to respect only one decision-making outcome would make respect for autonomy contingent and artificial.[429] It is reasonable to suggest that *Gillick* competent children should enjoy both rights because consenting to and refusing treatment are merely two sides of the same coin.[430] Applying the *Gillick* competence test but changing the issue of the decision from 'consent' to 'refuse', it would be inconsistent to suggest that the child's competence to refuse is insufficient. This logic was firmly advocated by Harris, who considered 'the idea that a child (or anyone) might competently consent to treatment but not be competent to refuse it is a palpable nonsense'.[431]

There may be theoretical symmetry between consent and refusal, but their practical implications largely justify the distinction. The consequences of refusing treatment recommended by a doctor will usually be significantly more serious than merely accepting the proposed treatment.[432] Theorists have suggested that the difference in risk justifies the asymmetry. They advanced a 'risk-related standard of competence' in which a higher level of competence is demanded when the stakes of the decision are high (e.g. death) compared to when the stakes are low (e.g. bruise).[433] The standard suggests that someone could be

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[427] *Gillick* (n 10) [188]-[189]. See Chapter III.
[428] Richard Huxtable, '*Re M (Medical Treatment: Consent)* Time to Remove the 'Flak Jacket'?' (2000) 12(1) CFLQ 83, 84.
[429] Pattinson (n 5) 163.
[430] John A Devereux, David Jones and Donna Dickenson, 'Can Children Withhold Consent to Treatment?' (1993) 306(8690) BMJ 1459, 1460; Ian Kennedy and Andrew Grubb, *Medical Law* (3rd edn, Butterworths 2000) 986.
[431] Harris (n 44) 12.
[432] Christopher Johnston QC (ed), *Medical Treatment: Decisions and the Law* (3rd edn, Bloomsbury 2016) 91.
[433] See, eg, Allen E Buchanan and Dan W Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (CUP 1989); Ian Wilks, 'The Debate Over Risk-Related Standards of Competence' (1997) 13(2) Bioethics 413.

competent enough to consent to treatment but not competent enough to refuse it. For example, a person consenting to what a doctor has assessed as being in their best interests is unlikely to be at risk of physical harm. This person is likely competent to consent. In contrast, the person refusing treatment that promotes their welfare puts them at greater risk of physical harm and, therefore, a higher degree of competence is required to make that decision. The higher threshold makes it less likely that the person is also competent to refuse.

There are problems with the theory. For example, it can mean that whether a person is considered competent to make a particular decision necessarily depends on the decision they reach. It would be illogical to say that a person has decisional competence because they say 'yes' but not if they say 'no'. A decision may look foolhardy, and the consequences of following through with the decision accentuate the foolhardiness, but because the outcome is disagreeable does not mean that the decision and action were the products of incompetence.[434] Another concern is that it conflates two separate issues: (i) whether person X has the competence to make the decision, and (ii) whether the decision of person X should be interfered with. Herring suggested that 'if the real reason why we wish not to respect a person's decision is that we do not agree with it, then we should be open about doing this'.[435]

The risk-related competence standard is problematic and does not provide a satisfactory justification for the consent and refusal asymmetry. However, in the early 1990s, the Court of Appeal addressing the capacity to make refusal decisions in *Re R* and *Re W* favoured the logic that a minor might be competent enough to consent to treatment but not necessarily refuse it.

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[434] Neil C Mason, 'Transitional Paternalism: How Shared Normative Powers Give Rise to the Asymmetry of Adolescent Consent' (2015) 29(2) Bioethics 66, 68-69.
[435] Herring (n 164) 9.

II. *Re R*: Introducing the Law on Minors' Medical Refusal

A. The Facts and Judgment

In *Re R*, the Court of Appeal had to determine whether the powers of the wardship court could override a refusal by its ward. The case concerned a 15-year-old girl, R, who had a mental disability (fluctuating in effect) and was prone to having suicidal thoughts. Following an episode of violent and suicidal behaviour, R was temporarily but compulsorily admitted to hospital under s 2 of the Mental Health Act 1983.[436] In a period of lucidity, R refused anti-psychotic drugs considered necessary to prevent her from returning to a psychotic state. The local authority initially consented to the treatment's administration but revoked this consent after consulting R's principal social worker, who considered her to be 'lucid and rational' and not 'sectionable'.[437] The treatment unit maintained that treatment was necessary, despite R's refusal. The local authority consequently commenced wardship proceedings to obtain authorisation to administer the treatment. The Court of Appeal observed that, at first instance, Waite J granted the authority's application because the evidence available pointed him to the conclusion that R's mental condition prevented her from achieving the necessary capacity to make the decision.[438] The Official Solicitor appealed Waite J's decision.

The Court of Appeal unanimously dismissed the appeal. In the judgment of Lord Donaldson MR, whom Staughton and Farquharson LJJ (generally) agreed, he concluded that:

> 1. The decision whether to treat is dependent upon an exercise of [the doctor's] own professional judgment, subject only to the threshold requirement that… he has the consent of someone who has authority to give that consent.

[436] *Re R* (n 17) [18].
[437] ibid [19].
[438] ibid [30].

> 2. There can be concurrent powers to consent. If more than one body or person has a power to consent, only a failure to, or refusal of, consent by all having that power will create a veto.
>
> 3. A "*Gillick* competent" child or one over the age of 16 will have a power to consent, but this will be concurrent with that of a parent or guardian.
>
> 4. "*Gillick* competence" is a developmental concept and will not be lost or acquired on a day to day or week to week basis. In the case of mental disability, that disability must also be taken into account, particularly where it is fluctuating in its effect.
>
> 5. The court in the exercise of its wardship or statutory jurisdiction has the power to override the decisions of a "*Gillick* competent" child as much as those of parents or guardians.[439]

The relevant features of the Court of Appeal's review of *Gillick* and its implications for the law on medical refusal are threefold. First, the way in which *Gillick* competence was interpreted. Secondly, the purview of Lord Donaldson MR's proposition that there are concurrent powers to consent. Thirdly, the extent to which the court, under its wardship jurisdiction, can involve itself in decisions that affect the child's health.

B. The Nature of Gillick Competence

All three judges found R to lack the *Gillick* competence to make a decision for herself because her mental disability was such that on some days, she was not only *Gillick* incompetent but sectionable, even if on a good day she was capable of satisfying the *Gillick* criteria. Lord Donaldson MR explained that where the child has a mental disability, 'that disability must be taken into account, particularly where it is fluctuating in its effect'.[440] He viewed the concept

[439] ibid [26].
[440] ibid.

of *Gillick* competence as concerning the 'staged development of a normal child', and it is not something that can 'fluctuate upon a day to day or week to week basis'.[441] Farquharson LJ similarly observed that 'the *Gillick* test is not apt to a situation where the understanding and capacity of a child varies from day to day according to the effect of her illness'.[442] Applying their interpretation of *Gillick* to the present facts, because R likely did not understand the implications of treatment being withheld due to her fluctuating mental disability, the submission that R had the capacity to decide on her treatment could not be sustained.[443]

The implications of mental illness (albeit mitigated by lucid intervals) were not within the contemplation of the House of Lords in *Gillick*.[444] It was thus open for *Re R* to interpret how *Gillick* competence is affected by mental illness. The facts supported the inference that R lacked *Gillick* competence. Although there were times R had sufficient understanding to make her own decisions, the medical evidence suggested that her mental illness was in recession and without the proposed medication, she was likely to be a suicide risk.[445] Although it was somewhat unclear whether R was lucid at the time of her refusal,[446] the Court of Appeal denying her decision-making autonomy because she may lack *Gillick* competence at another point in time contradicted the decision-specific nature of *Gillick* competence. Farquharson LJ reasoned that it 'would be dangerous if… [the court] refused to authorise medication because on a particular day R passed the *Gillick* test when the likely consequences were so serious'.[447]

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[441] ibid [25]-[26].
[442] ibid [32].
[443] ibid [26] (Lord Donaldson MR), [31] (Farquharson LJ).
[444] Andrew Bainham, 'The Judge and the Competent Minor' (1992) 108(Apr) LQR 194, 200.
[445] *Re R* (n 17) [30].
[446] For example, on 3rd July, a mere six days before the application came before Waite J, the doctor first considered R to be a serious suicide risk, when later the same day, he considered she was of sufficient maturity and understanding to comprehend the treatment being recommended: see ibid [29]. See also Stephen Gilmore and Jonathan Herring, 'Children's Refusal of Medical Treatment: Could *Re W* be Distinguished?' (2011) 41(Jul) Fam Law 715, 718.
[447] ibid [31].

In the light of R's general precarious state of mental health, the Court of Appeal erring on the side of caution and overruling her decision to protect her health was justified.

Whilst the finding of R's *Gillick* incompetence was well grounded, the language used by Lord Donaldson MR, in particular, opened the door for criticism of his interpretation of *Gillick* competence. Lord Donaldson MR suggested that a fluctuating mental disability modifies the assessment of mental and emotional age to the extent that 'no child' with a fluctuating mental disability 'can be regarded as "*Gillick* competent"'.[448] The implication that mental disability deprives a child of achieving the status of *Gillick* competence would be unsustainable. The High Court of Australia in *JWB and SMB*, referring to Lord Donaldson MR's judgment, stressed caution over making general comments that children, by virtue of their disability, may be incapable of giving consent to treatment.[449] Whilst a person's capacity to make legally effective decisions can indeed be affected by mental impairments,[450] capacity is a question of fact that is time and decision-specific. What is important is not that a child with a mental illness may be *Gillick* incompetent at one moment in time but whether they are *Gillick* competent at the time when they are required to make the medical decision. Lord Donaldson MR was thus wrong to suggest that no child can be regarded as *Gillick* competent when they may be *Gillick* competent at one moment in time, but *Gillick* incompetent at another.

C. Concurrent Powers to Consent

Gillick held that in disputes between parents and the *Gillick* competent child regarding the child's medical treatment, the *Gillick* competent child's consent takes precedence.[451] However, because Lord Fraser was more tentative in his opinion than Lord Scarman on the endurance of parental rights, the message of *Gillick* was left open to interpretation. Staughton LJ viewed

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[448] ibid [26].
[449] *Secretary, Department of Health and Community Services v JWB and SMB* [1992] HCA 15 [24].
[450] *Re MB* (n 35).
[451] *Gillick* (n 10) [188]-[189].

Lord Scarman's speech, focusing on the words 'whether or not', as implying that parental consent is wholly superseded by that of the competent child. His Lordship went no further on the matter, explaining that in any case the wardship court has the power to override the child's decision.[452] Lord Donaldson MR was of a different view. He explained that Lord Scarman could not have intended to say that, upon the child achieving competence, a parent has no right either to consent to or refuse consent.[453] If correct that *Gillick* competence transfers the right of consent from the parents to the child and there can never be a concurrent right in both, doctors would face an 'intolerable dilemma' when parents offer to consent, but the child refuses to do so.[454]

To reconcile the dilemma, Lord Donaldson MR, picking up on Lord Scarman's words 'to determine', argued that this is wider than 'to consent', as the former implies a right of veto.[455] This means that the parent's *exclusive* right to consent would be lost with *Gillick* competence, but they retain a *concurrent* right to consent that is not supplementary to the child's consent but acts as an alternative to it.[456] To further justify his concurrent consents argument as the solution to the doctor's 'intolerable dilemma', Lord Donaldson MR advanced a 'keyholder' analogy, whereby all parties: the competent child, those with parental responsibility, and the courts have a key, that is a right of consent, 'which unlocks the doors' for the doctor to administer medical treatment lawfully.[457] As long as the doctor receives consent from one of these authorised persons, treatment will not constitute a trespass or a criminal assault.[458]

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[452] *Re R* (n 17) [27]-[28]. See Chapter IV, Part II, Section D.
[453] ibid [23].
[454] ibid [24].
[455] ibid [23].
[456] ibid [24]. See, for commentary, Thornton (n 414) 36; Douglas (n 416) 575; Bainham (n 444) 198.
[457] ibid [22].
[458] ibid. See (n 9).

The trouble with the keyholder analogy was that it contradicted *Gillick*.[459] It suggested that parents could impose their decisions over the *Gillick* competent child. Lord Scarman in *Gillick* was clear in his view that the *Gillick* competent child's consent superseded parental consent.[460] Bainham highlighted that there is nothing in Lord Fraser's speech either, to remotely hint that a parent's consent lawfully prevails over that of the *Gillick* competent child.[461] Given *Re R* involved a child determined to be *Gillick* incompetent, and the issue for the Court of Appeal centred on whether the court, in the exercise of its wardship jurisdiction, could make decisions on behalf of its ward, Lord Donaldson MR could have made conclusions squarely on the question raised, all the while endorsing a legal position of protecting *Gillick* incompetent children from making harmful decisions, without making generalisations on the rights of *Gillick* competent children.

D. The Court's Powers Under its Wardship Jurisdiction

The reasoning in *Gillick* does not assist the understanding of the court's powers under its wardship jurisdiction–it was not an issue for the House of Lords' contemplation. All three judges in *Re R* firmly concluded that, even if the child is *Gillick* competent, and even if the parent loses the power to consent on behalf of their child, the court does not and can authorise medical treatment in the best interests of the ward.[462] Lord Donaldson MR observed that the court's powers are not derivative from the parent's rights and responsibilities but derive from the duties of the Crown to protect its subjects and particularly children.[463] As the court has the power to override parental consent where it is necessary to do so in the ward's best interests, then by logical extension, it can override decisions by *Gillick* competent wards.[464]

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[459] Ian Kennedy, 'Consent to Treatment: The Capable Person' in Clare Dyer (ed), *Doctors, Patients and the Law* (Blackwell Scientific Publications 1992) 60.
[460] See Chapter III, Part II, Section B, Subsection 2.
[461] Bainham (n 444) 199.
[462] *Re R* (n 17) [25]-[26] (Lord Donaldson MR), [28]-[29] (Staughton LJ), [31]-[32] (Farquharson LJ).
[463] ibid [25].
[464] ibid.

In the opinion of Eekelaar, however, the Court of Appeal's conclusion on the court's powers was at odds with the effect of *Gillick*. He argued that, under *Gillick*, where the child is determined competent, parental rights 'yield' to the child's rights, and the child's decision binds even if the parents' decision is more in accord with the child's best interests.[465] Therefore, there is a contradiction that the Crown retains the *parens patriae* jurisdiction when parents themselves have lost it, not through deprivation, but due to a superior right of the child.[466]

Offering an alternative interpretation, Lowe and White submitted that the court is not in the same position as a parent because the court has a protective and a custodial jurisdiction over the child. The court has an obligation under the former to protect wards from harm, but it is not acting in the custodial capacity of a parent thereby.[467] Douglas supported this interpretation, suggesting it would be misplaced to conflate the Crown, under the title of *parens patriae*, with a Crown subject who is a parent.[468] There is logic in Lowe and White's argument, but it simultaneously strikes as a very narrow doctrinal view. It is instead more reasoned to suggest that the law confers on parents a measure of protective jurisdiction not on any comparison with property or ownership but because it is presumed unless disproved, that parents have their child's best interests at heart. This is not to say that the two sets of rights are coterminous, and it is assumed that parents recognise this: that their child might wish to do something that goes against their best interests. In such instances, is it enough for the courts to impose their will because a *Gillick* competent child's decision will go against their presumed best interests? The position becomes tenuous should the parents be united and support their child's decision. Should the courts' opinion supersede a harmonious, familial decision? In spite of this analysis, the interpretation offered by Lowe and White is cogent. It is reasonable that

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[465] Eekelaar (n 183) 181.
[466] ibid.
[467] Nigel Lowe and Richard White, *Wards of Court* (2nd edn, Barry Rose 1986) 132.
[468] Douglas (n 416) 573.

the High Court, exercising its powers under wardship, in deciding any question concerning the upbringing of the ward, has regard for the welfare of the ward as its first and paramount consideration[469] and can plausibly override any decision inconsistent with the ward's best interests.

In contrast to Lord Donaldson MR, Staughton LJ was more openly sympathetic to arguments that the wardship judge should have no greater powers than a natural parent. Although this did not prevent him from agreeing that if the treatment would constitute an important step in the child's life, the court has the power to authorise its administration.[470] To support this view, Staughton LJ relied on several authorities. The difficulty is that those he cited cast doubt over the position that the court has the authority to override the wishes of a *Gillick* competent ward. The cases relied upon were either decided before *Gillick*[471]; concerned wards whose views coincided with those of the court[472] or, related to incompetent minors.[473] This rather puzzling examination of case law could provide a basis for undermining the analysis that the wardship court has the authority to override the wishes made by its *Gillick* competent ward. Notwithstanding the contradictions in Staughton LJ's judgment, *Re R* supports that the court has the technical jurisdiction to override the wishes of its ward, *Gillick* competent or not.

However, it is more pertinent to frame the issue as whether the court *should* exercise its wardship powers in the face of a *Gillick* competent ward.[474] In *Re X (A Minor) (Wardship: Jurisdiction)*, for example, the Court of Appeal suggested that the court's wardship jurisdiction should not be exercised to issue an injunction to suppress the publication of a book whose contents might adversely affect the ward psychologically.[475] Roskill LJ suggested that, as a

[469] *Re R* (n 17) [32].
[470] ibid [29].
[471] *B (BR) v B (J)* [1968] P 466; *Re P (A Minor)* [1986] 1 FLR 272; *Re G-U (A Minor)* [1984] 1 WLUK 195.
[472] *Re P (A Minor)* (n 471); *Re B (Wardship: Abortion)* [1991] 2 FLR 426.
[473] *Re B (Wardship: Abortion)* (n 472).
[474] Bainham (n 444) 196.
[475] [1975] Fam 47.

matter of principle, even if the child is in peril, it would not necessarily be wholly right and proper to invoke the court's powers to protect them.[476] Although the seriousness of harm was not commensurate to the risk in *Re R*, there was an authoritative basis supporting the wardship court to refuse the exercise of its powers to protect its ward from potential harm. Douglas suggested the Court of Appeal could have followed such precedent in *Re R*.[477] Given R was *Gillick* incompetent, and her refusal of medication had serious implications for her health, such suggestions are largely unpersuasive. Alternatively, the Court of Appeal could have noted that it could follow that precedent where the child is *Gillick* competent. Had the Court of Appeal at least reserved its view in *Re R* on whether the court should exercise its wardship powers in the face of a *Gillick* competent ward, limiting its reasoning to *Gillick* incompetence, this would have gone some way to stymie criticisms that it 'retreated'[478] from *Gillick*.

III. *Re W*: Confirming the Law on Minors' Medical Refusal

A. The Facts and Judgment

In the subsequent Court of Appeal decision, *Re W*, the controversy over *Gillick's* effect, the rights of minors, and the distinction between consent and refusal continued. In this case, the Court of Appeal had to determine whether the High Court had the power under its inherent jurisdiction to authorise medical treatment against the express wishes of a 16-year-old girl, W. When W was 14, she developed signs of anorexia.[479] Her condition with this disease was not improving, and when W was approaching her 15th birthday, it was deemed necessary for her to receive in-patient treatment.[480] Her condition deteriorated to such an extent that she temporarily

[476] ibid [61].
[477] Douglas (n 416) 574.
[478] ibid.
[479] *Re W* (n 18) [71]-[72].
[480] ibid [72].

had to be fed by a nasogastric tube and have her arms encased in plaster.[481] Her foster parents felt that if W was discharged, they could not continue to offer her a home.[482]

It was against this backdrop that the local authority caring for W sought leave under s 100(3) CA 1989 to make an application for the exercise by the High Court's inherent jurisdiction to sanction both W's transfer to a specialist clinic for treatment and to give medical treatment without her consent if necessary. At first instance, Thorpe J granted the local authority leave to transfer W to a unit specialising in eating disorders and for treatment to be administered to her there without her consent.[483] W appealed. The substantive grounds for appeal were: (i) whether a parent or someone with parental responsibility can supply a valid consent when a minor aged 16 or 17 refuses to have medical treatment and, (ii) whether the court in the exercise of its inherent jurisdiction can overrule the refusal of such a minor to have medical treatment. In the judgment of Lord Donaldson MR, whom Balcombe and Nolan LJJ (generally) agreed, the conclusions relevant for present purposes are that:

> 4. Section 8 of the Family Law Reform Act 1969 gives minors who have attained the age of 16 a right to consent to surgical, medical or dental treatment. Such a consent cannot be overridden by those with parental responsibility for the minor. It can, however, be overridden by the court.
>
> 5. A minor of any age who is "*Gillick* competent" in the context of particular treatment has a right to consent to that treatment which again cannot be overridden by those with parental responsibility, but can be overridden by the court.
>
> 6. No minor of whatever age has the power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and *a*

[481] ibid [73], Lord Donaldson MR emphasised that W consented to both the insertion and encasement.
[482] ibid.
[483] *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 1 WLUK 463.

> *fortiori* a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.[484]

The Court of Appeal in *Re W* reconsidered the decision in *Gillick* and its previous judgment in *Re R*, intending to resolve any outstanding lacunas in the law on minors' medical refusal. The analysis of *Re W* will, first, scrutinise whether the scope of s 8 FLRA 1969 extends to young persons a right to refuse medical treatment. This issue was only of peripheral attention in *Gillick* and *Re R* because the minors in those cases were under 16. Secondly, like the wardship court, what limits (if any) exist to restrict the court from exercising its powers under its inherent jurisdiction to override a (competent) minors' medical refusal? The final issue is whether the policy concerns which promoted the Court of Appeal's conclusions are tenable.

B. Section 8 of the Family Law Reform Act 1969

The primary issue before the Court of Appeal, as before Thorpe J at first instance, concerned the interpretation of s 8 FLRA 1969. Lord Donaldson MR and Balcombe LJ were of the view that s 8(1) FLRA 1969 unambiguously enables young persons to consent to medical treatment.[485] On an ordinary reading of the provision, there is nothing to suggest that its purpose extends further to confer a co-existing right of refusal. To dispel any further questions around the scope of the provision, their Lordship's drew support from the Latey Committee Report, which recommended that 16-17-year-olds should be able to give effective consent to medical treatment *only*.[486] The limitations of s 8(1) FLRA 1969 meant it was open for the Court of Appeal to remedy the dilemma of what should happen if a young person refused to consent.

[484] *Re W* (n 18) [83]-[84] (Lord Donaldson MR).
[485] ibid [77] (Lord Donaldson MR), [86] (Balcombe LJ).
[486] *Latey Report* (n 197) para 484.

Lord Donaldson MR and Balcombe LJ suggested that the solution was within an interpretation of Lord Scarman's comments in *Gillick* and s 8(3) FLRA 1969. Their Lordships were doubtful of the view that Lord Scarman was intending to mean that the parents of a *Gillick* competent child had no right at all to consent to medical treatment where their child refused to consent.[487] Balcombe LJ was prepared to accept that Lord Scarman had considered that the right to refuse treatment was co-existent with the right to consent to treatment. Indeed, he went on to state that 'in logic there can be no difference between an ability to consent to treatment and an ability to refuse it'.[488] Even Lord Donaldson MR was prepared to assume that, so far as the common law is concerned, it was of 'considerable persuasive authority' that Lord Scarman would have decided that parental consent could not be given in place of their child's refusal.[489] However, Lord Donaldson MR was ultimately of the view that if Lord Scarman did intend *Gillick* competence to provide children with a right of veto, his interpretation of the law was inconsistent with the express words of s 8(3) because this section,

> preserves the common law as it existed immediately before the Act which undoubtedly gave parents an effective power of consent for all children up to the age of 21, the then existing age of consent.[490]

Balcombe LJ's concessions also did not persuade him to view that Lord Scarman intended for parental rights to be wholly terminated, maintaining instead that such an interpretation was inconsistent with s 8(3).[491]

The interpretation offered by Lord Donaldson MR and Balcombe LJ on s 8(3) FLRA 1969 as retaining the parental authority to consent to their child's treatment, despite the child's

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[487] *Re W* (n 18) [77] (Lord Donaldson MR), [87] (Balcombe LJ).
[488] ibid [88].
[489] ibid [76].
[490] ibid [77].
[491] ibid [87].

objections, has been criticised. In his seminal piece, Eekelaar argued that while s 8(3) may retain parental rights to consent, that does not in itself compel the conclusion that such consent can override an express refusal by a minor.[492] The saving in s 8(3) does no more than ensure that if the minor was unable to consent or deferred consent to their parents, doctors could lawfully proceed on the parental consent.[493] Furthermore, even if the FLRA 1969 fully retained parental rights to consent, *Gillick* gave minors rights beyond those endowed by statute. The decision of Lord Donaldson MR in both *Re R* and *Re W* to restrict the rights conferred by *Gillick* as relating only to consent was at odds with Lord Scarman's 'underlying principle' that parental rights 'yield' to the child's right to make their own 'decisions'.[494] The implication of interpreting s 8(3) as barring a right of refusal for young persons meant that children also do not have such a right. Yet s 8(3) should not be construed as 'imposing a restraint in perpetuity on the later development of the common law', for it was the development in *Gillick* that made parental consent ineffective, at least to override an express refusal.[495]

The arguments presented by Eekelaar are largely cogent. However, he relied too heavily on the assumption that the term 'decisions' in *Gillick* encompasses both a right to consent and refuse medical treatment. The debate in academia over the scope and meaning of *Gillick* competence[496] supports the argument that it is unclear whether *Gillick* did confer minors with a binary right. The culmination of doubt over *Gillick's* meaning and effect was rightly expressed by Balcombe LJ, who noted that there was no 'settled' interpretation of s 8(3) FLRA 1969.[497] Balcombe LJ held that Parliament, by virtue of s 8(1), did not confer on 16-17-year-olds absolute autonomy to refuse medical treatment; and that the common law, as interpreted

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[492] John Eekelaar, 'White Coats or Flak Jackets? Children and the Courts–Again' (1993) 109(Apr) LQR 182, 183.
[493] ibid.
[494] *Gillick* (n 10) [186].
[495] Eekelaar (n 492) 183-184.
[496] See, eg, Emma Cave, 'Adolescent Consent and Confidentiality in the UK' (2009) 16(4) Eur J Health Law 309, 316; Huxtable (n 428) 84; Pattinson (n 5) 163; Harris (n 44) 12; (n 430).
[497] *Re W* (n 18) [87].

in *Gillick*, did not do so either.[498] The interpretation of the FLRA 1969 in *Re W* undermined *Gillick*, but *Gillick* did not prevent the legislature from providing some confirmation of the appropriate intention of the common law.[499] In fact, as the scope of the FLRA 1969 was not clarified in *Gillick*, it is somewhat disingenuous to retrospectively suggest that *Re W* limited the rights of minors because, until the present case, their *full* rights were undefined. The Court of Appeal filled an important gap in the law with a convincing analysis that s 8(1) FLRA 1969 does not extend to young persons the right to refuse medical treatment.

C. The Court's Powers Under its Inherent Jurisdiction

In contrast to *Re R*, which concerned the issue of wardship, *Re W* involved the court's powers under its inherent jurisdiction. The CA 1989 provides that a child subject to a care order, as W was, cannot be made a ward of the court.[500] Instead, the local authority must obtain leave from the High Court under its inherent jurisdiction to decide matters.[501] The Court of Appeal clarified that in any case the court's powers under its inherent jurisdiction and wardship jurisdiction are co-extensive.[502] On the more important issue of defining the purview of the court's inherent jurisdiction, the judges were slightly at odds. In Lord Donaldson MR's view, 'the inherent powers of the court under its *parens patriae* jurisdiction are theoretically limitless and… certainly extend beyond the powers of a natural parent'.[503] Balcombe LJ acknowledged that whilst the court's powers may be theoretically limitless, it has long been recognised that there are 'far-reaching limitations in principle on the exercise of that jurisdiction', but maintained that 'the powers of the court are greater than the powers of the natural parent'.[504] Nolan LJ emphasised that 'its exercise must be governed by practical considerations and by a

[498] ibid.
[499] Gilmore and Herring (n 210) 19.
[500] CA 1989, s 100(2).
[501] ibid, s 100(3).
[502] *Re W* (n 18) [73], [84].
[503] ibid [81].
[504] ibid [85].

proper regard for the rights of others'.[505] His support of Sir John Pennycuick's dicta in *Re X*[506] confirmed that he believed the court's powers surpassed that of natural parents.

All three judges emphasised that the court should not only recognise but defend the right of the competent child to make their own choices.[507] When it came to identifying when the court should intervene to protect the child's welfare, Lord Donaldson MR believed that 'good parenting involves giving minors as much rope as they can handle without an unacceptable risk that they will hang themselves'.[508] In other words, it is incumbent on the court to interfere with a minors' decision if that decision has irreparable consequences or which are disproportionate to the benefits which could accrue from taking them.[509] Balcombe LJ suggested the court should be slow to exercise its inherent jurisdiction in relation to a young person who is not mentally incompetent. The presumption should be for the court to approach its decision with a strong predilection to give effect to the young person's wishes. Nevertheless, he observed that:

> [I]f the court's powers are to be meaningful, there must come a point at which the court, while not disregarding the child's wishes, can override them in the child's best interests, objectively considered. Clearly such a point will have to come if the child is seeking to refuse treatment in circumstances which will in all probability lead to the death of the child or to severe permanent injury.[510]

Nolan LJ considered that in the medical sphere, the court can and sometimes must intervene. This is especially the case when the minors' decision would have them 'suffer grave and

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[505] ibid [91].
[506] *Re X (A Minor) (Wardship: Jurisdiction)* (n 475) [61], 'It may well be, and I have no doubt it is so, that the courts, when exercising the parental power of the Crown, have, at any rate in legal theory, an unrestricted jurisdiction to do whatever is considered necessary for the welfare of the ward'.
[507] *Re W* (n 18) [81]-[82] (Lord Donaldson MR), [88] (Balcombe LJ), [93] (Nolan LJ).
[508] ibid [81].
[509] ibid.
[510] ibid [88].

irreversible mental or physical harm', particularly to the extent that they fail to see themselves reach adulthood.[511] The reasoning of the judges clearly suggests that protectionist-based judgments of the court are premised on ideal desire autonomy notions that there is an 'objective' basis for intervening and overriding a minor's medical decision, even if this goes against the competent minor's overall desire in light of their values (i.e. best desire autonomy).

The Court of Appeal observed that by the time the case was before it, the medical evidence suggested that if the pattern of W refusing solid food continued, she would probably die; if not shortly reversed, she would likely suffer permanent damage to her brain and reproductive organs.[512] Lord Donaldson MR disagreed with Thorpe J's assessment that W was 'a child of sufficient understanding to make an informed decision'.[513] Both Lord Donaldson MR and Balcombe LJ emphasised that it is a feature of anorexia that it can destroy the ability to make an informed choice.[514] The implication was that W lacked the decision-making ability to make decisions for herself, and considering her decision would likely seriously endanger her health or life, the Court of Appeal overruled her refusal. Balcombe LJ was robust in his conclusion that the circumstances of W's case meant that 'the court would have been in dereliction of its duty' had it not overridden her wishes.[515] The exercise of the court's inherent jurisdiction was justified in the light of W's circumstances.

Whilst court intervention in W's case was justified, it is argued that the criticism of the Court of Appeal in *Re R* making generalisations not relevant to the question raised in the case equally applies to *Re W*. The conclusion of Lord Donaldson MR that *no* minor of whatever age has the power to refuse consent to treatment that is in their best interests was a sweeping statement whose implications were not fully canvassed in the judgment. It disproportionately

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[511] ibid [94].
[512] ibid [89], [91].
[513] ibid [76]. Balcombe and Nolan LJJ were similarly unconvinced with Thorpe J's view: ibid.
[514] ibid [80]-[81], [89].
[515] ibid [89].

promotes protectionism because it encourages courts to engage in consequentialism analyses. In other words, the reasons justifying the decision to refuse are irrelevant insofar as the consequences of the decision are high-risk in terms of likely impact on health or life. What is lost in these analyses is a broad and nuanced balance between autonomy and protectionism, particularly when the decision is supported by a determination that it is competent. The court thus prioritises protectionist ideal desire autonomy analyses over the more patient-centred conceptions of best and current desire autonomy. Given W's mental disability prevented her from satisfying either *Gillick* or s 8(1) FLRA 1969, Lord Donaldson MR could have remedied the gap in the law regarding whether the parents or the court (in the exercise of its inherent jurisdiction) could overrule decisions made by incompetent young persons, without making generalisations on the rights of competent minors. Whilst it is conjecture whether a court faced with a competent young person's refusal of life-saving treatment would have decided differently to *Re W*, it would have been preferable to invite a court to engage in the issue based on the facts of the case rather than limit how the court should decide the issue. Balcombe LJ conceded that 'it would be difficult to conceive of a case where the court… would authorise an abortion against the wishes of a mentally competent 16-year-old', but this came with the caveat that such a dilemma is more 'apparent than real'.[516] The caveat undermines an important recognition that there may indeed be circumstances in which the court's preference for protectionism does not necessarily outweigh the competent minor's autonomy.

D. Policy Concerns

Similar to *Re R*, Lord Donaldson MR's judgment in *Re W* was primarily motivated by policy concerns. In his concluding summary, Lord Donaldson MR plainly stated that the effect of consent 'is limited to protecting the medical… practitioner from claims for damages to trespass

[516] ibid [90].

to the person'.[517] His Lordship considered that the purpose of consent is twofold. The clinical purpose serves to make treatment proceedings easier, whereas the legal purpose is quite different. It operates to provide the medical profession with armour against criminal charges of assault or battery or a civil claim for damages to trespass to the person.[518] Lord Donaldson MR's preference was support for the legal purpose of consent.

Lord Donaldson MR's interpretation of consent's legal purpose has been criticised. Eekelaar described it as an 'astonishingly narrow view of the requirement'.[519] The backdrop at the time with *Gillick*, the CA 1989, and the UNCRC, signalled that the purpose of consent underwent a metamorphosis. Supposing consent best serves as litigation armour contradicted the increasing support for patients' autonomy in common law and statute law. Indeed, Lord Donaldson MR somewhat undermined his own position only twenty days after his judgment in *Re W* when he expressed in *Re T* that:

> [The] right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.[520]

As a matter of principle, it was a rather significant turnaround for Lord Donaldson MR to later emphatically endorse the patient's right to self-determination in *Re T* when he only offered a tepid description of the concept of patient choice shortly before in *Re R* and *Re W*. Yet the primary concerns of Lord Donaldson MR in *Re W* were tenable when considered in context. An objective of Lord Donaldson MR was to produce a judgment helpful to all those concerned with the treatment of minors and also, implicitly, the minors themselves.[521] His reference to

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[517] ibid [84].
[518] ibid [76].
[519] Eekelaar (n 492) 185.
[520] *Re T* (n 4) [102].
[521] *Re W* (n 18) [79].

the ‘intolerable dilemma’ in *Re R* exemplified that he was not unaware of the concerns within the medical profession over obtaining valid consent to treat a minor patient.[522] To remedy the dilemma, Lord Donaldson MR provided a ‘keyholder’ analogy. On reflection in *Re W*, aware that ‘keys lock as well as unlock’, he reframed his concurrent consents metaphor to that of a legal ‘flak jacket’:

> Anyone who gives him a flak jacket (that is, consent) may take it back, but the doctor only needs one and so long as he continues to have one he has the legal right to proceed.[523]

Lord Donaldson MR suggested that the legal flak jacket analogy remedied the inconceivable situation that the doctor may proceed in the absence of the patient’s consent. The consent of any concurrent holders: the competent child, the parent, or the court lawfully enables the doctor to administer treatment. The flak jacket analogy received mixed reception. Morris argued that its protectionist premise marked a ‘radical departure’ for advocates of minors’ autonomy.[524] On the other hand, Maclean suggested that the security of the legal flak jacket provided healthcare professionals with the confidence that they could facilitate good medical care without fear of legal suit.[525] Gilmore and Herring considered the reasoning in *Re W* pragmatic in the difficult circumstances.[526]

The competing concerns in *Re W* represented the dichotomy between respect for autonomy and protectionism. However, *Re W* did not engage with the philosophical tensions in an entirely satisfactory manner. Had the Court of Appeal interrogated deeply the appropriate balance between the two transcendent principles, the decision to restrict competent minors’

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[522] *Re R* (n 17) [24].
[523] *Re W* (n 18) [78].
[524] Anne Morris, ‘*Gillick*, 20 Years On: Arrested Development or Growing Pains?’ (2005) 21(3) PN 158, 162.
[525] Alasdair Maclean, ‘Keyholders and Flak Jackets: The Method in the Madness of Mixed Metaphors’ (2008) 3(3) Clin Ethics 121, 125.
[526] Gilmore and Herring (n 210).

decision-making autonomy would have had greater weight. For example, after expressing its justified disposition to interfere with incompetent decisions (e.g. minors' mental illness), the Court of Appeal could have broadly suggested that, depending on the risk probability and risk consequence of the treatment decision, and after a broad and nuanced consideration of the reasons underpinning the determinatively competent minor's refusal, the court should be open to respecting the refusal insofar as the culmination of all relevant factors point to respect for autonomy outweighing protectionism. Considerations to this effect would have been preferable to Lord Donaldson MR's sweeping conclusion that protectionism trumps autonomous decision-making.

IV. The Legacy of *Re R* and *Re W*

In just a few years after *Re R* and *Re W,* a series of High Court cases confirmed the wisdom that minors' medical decision-making autonomy is limited because even if *Gillick* competent or presumed competent under s 8(1) FLRA 1969, the court, in the exercise of its *parens patriae* jurisdiction, can overrule the competent minor's decision to refuse medical treatment that would, on the balance of probabilities, put their health or life at serious risk. Therefore, the court can authorise the medical intervention considered by medical experts to be in the minor's best interests despite the minor's objections (reflecting ideal desire autonomy).

In *Re R*, the Court of Appeal overruled the decision made by an incompetent child, by virtue of her fluctuating mental disability, to refuse medication and treatment where without, there was a high-risk probability of an event occurring (i.e. medication was necessary to prevent R being in a psychotic state) and high-risk consequence from the event occurring (i.e. in a psychotic state, she would be a serious suicide risk). In *Re W*, the Court of Appeal overruled the decision made by an incompetent young person, by virtue of her permanent mental

disability (anorexia), to refuse treatment where without, there was a high-risk probability of an event occurring (i.e. treatment necessary to prevent W from continuing to lose weight) and high-risk consequence from the event occurring (i.e. W would likely suffer permanent damage to her brain and reproductive organs and would probably die). In both cases, the balance of the relevant factors weighed towards a finding of protectionism, and therefore, the Court of Appeal overruling R and W's respective refusals was justified.

Since *Re R* and *Re W*, the High Court was presented not only with incompetent minors with mental health issues refusing treatment with high-risk probability and consequence to their health or life but also ((in)competent) minors whose decisions were (non-)religiously motivated and had similar risks.[527] Thus, the High Court contended with factors relevant to factual scenarios not considered by the Court of Appeal. This part argues that the High Court was inconsistent in deciding how much weight certain factors held in its welfare assessment. This is most discernible in the context of religiously motivated decisions, which is a more complex area than, for example, minors with recognisable mental health issues clearly affecting their decision-making capacity. The final part of this section considers the bigger picture of the court's reasoning, which the author of this thesis classifies as the 'welfare dilemma'.

A. Religiously Motivated Decisions

1. Re E (A Minor) (Wardship: Medical Treatment)

The starting point is with the first religiously motivated treatment refusal case, *Re E*.[528] The hospital authority sought leave of the wardship court to treat a 15-year-old, E, suffering from leukaemia who rejected a blood transfusion, with the support from his parents, on the basis that receiving blood went against his religious beliefs as a Jehovah's Witness.[529] The medical

[527] Margaret Brazier and Caroline Bridge, 'Coercion and Caring: Analysing Adolescent Autonomy' (1996) 16(1) LS 84, 101.
[528] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.
[529] ibid [388]-[389].

evidence suggested that E's condition was deteriorating rapidly and, without treatment, within hours or days, his haemoglobin and platelets would fall to dangerous levels; the consequential damage to E without the necessary treatment included suffering a stroke.[530] He was hence made a ward of the court, and the question was whether the court should exercise its wardship jurisdiction to authorise the administration of blood transfusions.

In making the declaration, Ward J considered whether E had the legal capacity to refuse the proposed blood transfusions under s 8(1) FLRA 1969 and/or under *Gillick.* The argument on s 8(1) FLRA 1969 was rightly readily dismissed. The argument was raised by E's counsel that s 8(1) had the meaning that 16-year-olds are treated as an adult for all purposes relating to medical treatment, including a right to veto treatment. Ward J held that even if this was the alleged scope of the section, such a right was unavailable to E because he was not yet 16.[531] The more promising argument came in the form of whether *Gillick's* principles extended to allow competent children to refuse medical treatment. In applying *Gillick* to the present facts, Ward J found E of sufficient intelligence to make decisions about his well-being; he was calm in the discussions on the implications of a refusal to treat and understood that he could die from his choice.[532] Yet Ward J believed there was a range of decisions outside of E's ability to grasp their implications fully:

> [E] does not have any sufficient comprehension of the pain he has yet to suffer, of the fear that he will be undergoing, of the distress not only occasioned by that fear but also–and importantly–the distress he will inevitably suffer as he, a loving son, helplessly watches his parents' and this family's distress… I find that he has no realisation of the full implications which lie before him as to the process of dying. He may have some

[530] ibid.
[531] ibid [390].
[532] ibid [391].

> concept of the fact that he will die, but as to the manner of his death and to the extent of his and his family's suffering I find that he has not the ability to turn his mind to it nor the will to do so.[533]

Finding that s 8(1) FLRA 1969 was not available and, on the view that E was not *Gillick* competent, Ward J exercised the court's wardship powers to authorise blood transfusions.[534]

Whilst Ward J might have considered his assessment of E's welfare compelled the inference that E was not *Gillick* competent,[535] this conclusion was not entirely convincing. The facts were suggestive of a very balanced, mature, and intelligent individual. This was evidenced forcefully in E's decision not to refuse all treatment but to refuse only the one incompatible with his religious beliefs[536] (strongly reflecting best desire autonomy). It is at odds to view the minor as lacking *Gillick* competence when he conscientiously weighed the risks and benefits of the available treatments and chose the one more closely aligned to his devoutly held religious beliefs. The assessment of E's competence disproportionately focused on his understanding of death rather than his cogent, religious reasons for objecting to blood transfusions. This was problematic because it is too easy to label someone incompetent based on their supposed limited understanding of death. It is impossible to understand death *fully*. Further, and contrary to Ward J's claims that he endeavoured to pay every respect to E's faith, some of his statements on the Jehovah's Witness faith are controversial. He was keen to avoid inviting notions of undue influence whilst heavily doubting the authenticity of E's will, expressing that 'the very powerful expressions of the faith' may have conditioned E's volition.[537] It is difficult to ascertain the force of influence E's faith had upon his decision, but even if the influence was

[533] ibid.
[534] ibid [394].
[535] ibid.
[536] ibid [388].
[537] ibid [393].

strong, is that necessarily a problem?[538] A child of faith is, in most cases, going to be influenced by their religion, benignly or otherwise, but this does not necessitate the conclusion that because a child is one of religious conscience, their competence is suspect.[539] Brazier and Bridge argued that E may well have had more understanding of death and less potential for regret than the average person, for his adamant refusal was based on sincere religious belief.[540]

Even though Ward J went through and critiqued E's level of competence, he later asserted that the question of *Gillick* competence 'is not an issue for me'.[541] The vexed matter was what E's welfare demanded. Whilst Ward J suggested that E's wishes weighed very heavily on the scales, he also observed that he had to side in favour of a decision not inimical to the child's well-being.[542] Ward J acknowledged that the court should be slow to interfere with decisions of those nearing the age of majority but held that the court's jurisdiction is ultimately a protective one, meaning the court 'should be very slow to allow an infant to martyr himself'.[543] This rationale may carry considerable weight in the majority of cases, but Ward J's reasoning in this instance exemplified the clearly expressed wishes of a (likely competent) child being overridden in his *perceived* best interests and despite the misgivings of many of those involved[544] (strongly reflecting ideal desire autonomy). The order from Ward J to authorise the blood transfusions violated E's religious beliefs and bodily integrity for no compelling reason other than 'the court knows best'. A broad and nuanced interrogation of what E's best interests necessitated was lacking. This analysis is supported by the fact that, once E turned 18, he refused further blood transfusions and consequently died.[545]

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[538] See Auckland (n 412).
[539] Clayton O'Neill, 'Jehovah's Witnesses and Blood Transfusions: An Analysis of the Legal Protections Afforded to Adults and Children in European/English Human Rights Contexts' (2017) 24(4) Eur J Health Law 368, 386.
[540] Brazier and Bridge (n 527) 104.
[541] *Re E* (n 528) [393].
[542] ibid.
[543] ibid [393]-[394].
[544] Morris (n 524) 168.
[545] As referred to by Johnson J in *Re S (A Minor) (Consent to Medical Treatment)* [1994] 2 FLR 1065 [1075].

2. Re S (A Minor) (Consent to Medical Treatment)

The first case after *Re R* and *Re W* was *Re S*. This case concerned a 15-year-old, S, who had suffered from thalassaemia virtually since birth. Since S was nine years old, she had been kept alive by an arduous course of treatment involving monthly blood transfusions. When S was 10, her mother converted to the Jehovah's Witness faith, and not long after this, she made it clear that S would no longer continue with blood transfusion treatment.[546] Later, S converted, and despite being a new convert, she espoused the beliefs of Jehovah's Witnesses about receiving blood. As she put it, 'having someone else's blood is having someone else's soul' and if blood transfusions were forced upon her, 'it would be like rape and it would be those who had done it who would become sinners'.[547] In a request to the judge, S asked that no transfusions be forced on her (reflecting best desire autonomy). The medical evidence suggested that the treatment was immediately necessary to prevent S from becoming extremely anaemic; the consequential damage to S without the blood transfusions was an inevitable death.[548] The local authority issued an application asking the court to exercise its inherent jurisdiction to authorise the use of blood transfusions.[549]

In his reflection on the delicate circumstances and the relevant law, Johnson J held that S was not *Gillick* competent and was prepared to override her refusal and authorise further blood transfusions despite her and her mother's objections.[550] The reasoning supporting the factual finding of *Gillick* incompetence in this case was tenable. In conversations with S, Johnson J accrued valuable insights into her capacity. There were substantial question marks over her behaviour and statements. Johnson J doubted S's devotion, sincerity, and understanding of the faith as a new convert and thus found her lacking the emotional maturity

[546] *Re S* (n 545) [1065], [1067].
[547] ibid [1068], [1072].
[548] ibid [1072].
[549] ibid [1067].
[550] ibid [1076].

that one would have expected of a girl of her age–she relied on a miracle to save her, and she genuinely believed her diagnosis was a mistake.[551] All this evidence, together with the medical opinion that shared the same mind, firmly supported Johnson J's inference that S was very much a child and not one that was *Gillick* competent.[552] However, Freeman considered that Johnson J took the easy way out in finding S incompetent. He suggested that Johnson J did not attribute sufficient weight to the psychiatric evidence, which doubted S to be seriously immature for someone her age, and criticised his over-reliance on S's predisposition to hope for a miracle because many adults would do the same.[553] Whilst there is some merit to Freeman's arguments, the balance of the medical opinion, the doubts over S expressing her own mind, and her general lack of understanding of her condition rightly favoured a finding of incompetence. Accordingly, Johnson J was justified in his protectionism.

The problem with Johnson J's judgment lies not in the finding of incompetence but in his interpretation of *Gillick* competence relating to refusing medical treatment. Johnson J held:

> [I]t does not seem to me that her capacity is commensurate with the gravity of the decision which she has made. It seems to me that an understanding that she will die is not enough. For the decision to carry weight she should have a greater understanding of the manner of the death and pain and the distress.[554]

On the one hand, Johnson J rightly confirmed the interpretation that *Gillick* competence operates on a sliding scale of scrutiny. On the other hand, the elements considered to compound the threshold for competent refusals were unreasonable. It was already arduous enough to require a minor, or anyone, to understand death. To *also* require an understanding of the manner

[551] ibid [1072]-[1073].
[552] ibid [1076].
[553] Freeman (n 209) 209.
[554] *Re S* (n 545) [1076].

of death and its distressful implications was unrealistic.[555] Thus, even if S could elucidate her wishes where there was no room for doubt over her maturity, she would still falter under the competence threshold set by Johnson J.

3. Re L (Medical Treatment: Gillick Competency)

The decision in *Re L* was the latest in the early trilogy of High Court cases that considered the religiously motivated refusal of medical treatment.[556] This case concerned a 14-year-old Jehovah's Witness, L, who suffered severe burns from an accident. L was a sincere adherent to the faith. She even took the step of carrying 'An Advanced Medical Directive/Release' form, which explicitly expressed the view that she should not be given blood if she sustained injury.[557] The medical evidence suggested that L required urgent plastic surgery and blood transfusions, which, if administered, would give her an 80% chance of survival; the consequential damage to L without the proposed treatments would be an inevitable and agonising death.[558] The NHS trust responsible for her treatment sought an order for L to be given the proposed treatments. The High Court had to decide whether to exercise its inherent jurisdiction to authorise the proposed treatments without the child's consent.

Consistent with the trend of antecedent cases, the judge in *Re L* found the girl to lack the *Gillick* competence to refuse the proposed treatment.[559] The reasoning of Sir Stephen Brown P in this case reflected that of Ward J in *Re E*, though no reference to *Re E* was made despite the similarity in facts. Sir Stephen Brown P accepted that L was mature for her age, sincerely religious, had undoubtedly led an excellent life, and was capable of expressing and justifying her wishes.[560] Notwithstanding this, Sir Stephen Brown P emphasised that L's age

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[555] Andrew Downie, 'Consent to Medical Treatment–Whose View of Welfare?' (1999) 29(Dec) Fam Law 818.
[556] *Re L (Medical Treatment: Gillick Competency)* (2000) 51 BMLR 137.
[557] ibid [138].
[558] ibid [139]-[139].
[559] ibid [140]-[141].
[560] ibid [139].

and her sheltered life were factors that should not be overlooked.[561] In the child psychiatrist's view, L's strongly held religious views did not lend itself in her mind to discussion.[562] Sir Stephen Brown P was clear that the rigidity of L's views caused her to lack the 'constructive formulation of an opinion that occurs with adult experience'.[563] Thus, Sir Stephen Brown P found L not *Gillick* competent and, exercising the inherent jurisdiction of the court, he prepared an order for the surgery (with blood transfusions) to take place.

As a preliminary to whether the order was justified, it is suggested that Sir Stephen Brown P's interpretation of the effect of the Jehovah's Witness faith on *Gillick* competence was inconsistent with established law. A crucial point was made by Lord Donaldson MR in *Re W*–another important judgment not cited in the present case–that:

> I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less "*Gillick* competent".[564]

Sir Stephen Brown P was clearly concerned over the authenticity of L's religious belief, which resulted in him placing less weight on L's conviction and wishes in the welfare assessment. Bridge suggested the judge's mere acceptance of the medical evidence implied that an adult believer would not fall foul of adhering to religious doctrine in a fashion as uncompromisingly as a child would.[565] She further argued that the High Court endorsing the child psychiatrists' view that the concept of belief only arrives once the person's cognitive functioning and maturity is fully developed was problematic because it suggested that belief is distinct from the attributes of intelligence and understanding.[566] This overlooks the nuance of religious

[561] ibid [139]-[140].
[562] ibid [140].
[563] ibid.
[564] *Re W* (n 18) [80].
[565] Caroline Bridge, 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62(4) MLR 585, 588.
[566] ibid 589.

conviction that absolute faith in a very black and white manner is itself a feature of any fundamentalist religious belief. Arguably, what motivated the judge's decision was not a concern for L's competency but rather the authenticity of her refusal based on her religious belief. *Re L* seems to show that L being a child of faith presupposed a protectionist outcome.

Whether Sir Stephen Brown P was justified to overrule L's refusal and authorise treatment with blood transfusions was a finely balanced question. The longevity of L's faith and her maturity for her age held considerable weight in favour of her autonomy, whereas the high-risk consequence of her decision, the questions about the authenticity of her faith and that she lived a sheltered life strongly supported protectionism. The scales fell in favour of protectionism. Whilst this might have been the correct outcome, that L was limited in her ability to demonstrate her maturity because she suffered from an information deficit was problematic. Sir Stephen Brown P considered her not *Gillick* competent 'in the context of all the necessary details which it would be appropriate for her to be able to form a view about' whilst simultaneously recognising that she had not been given all the details which it would be right and appropriate to have in mind when making such a serious decision.[567] Ultimately, however, the added information would have made no difference to Sir Stephen Brown P's conclusion since he would have authorised the blood transfusions even if he found L to be *Gillick* competent.[568] This consequentialism analysis suggests that the welfare assessment was merely performative, which is problematic because it undermines an otherwise balanced welfare assessment. The high-risk consequence of L's decision and the doubts over her decision-making ability were sufficiently weighty factors justifying a preference for protectionism over respect for L's autonomy. The judge did not have to include unconstructive commentary suggesting that it was impossible to respect L's decision.

[567] *Re L* (n 556) [140].
[568] ibid.

B. Non-Religiously Motivated Decisions

1. Re M (Medical Treatment: Consent)

After the trilogy of High Court cases engaging with religiously motivated refusals, a new challenge arrived in the shape of a non-religiously motivated refusal, *Re M*.[569] This case concerned a 15-year-old, M, who suffered from heart failure. The medical evidence suggested that in the light of M's deteriorating condition and there being no other medical option available, she urgently required a heart transplant; the consequential damage to M without the transplant was death within a week.[570] The doctors and nurses informed M of the proposed transplantation and its implications, but M refused to consent.[571] The hospital sought leave from the court to carry out the heart transplant.

In his short judgment, Johnson J observed M to be an intelligent girl whose wishes carried considerable weight, albeit overwhelmed by her circumstances and the decision she had to make.[572] He recognised there was a risk that M would carry with her for the rest of her life resentment about his order. Equally, she did not wish to die.[573] Johnson J emphasised he had to balance M's wishes against not just the risk but the certainty of death. In favour of protecting M's life, Johnson J overruled her refusal and authorised the transplant, believing that this decision was in her best interests[574] (reflecting respect for M's best desire autonomy).

The critical aspect of *Re M* was the lack of any real inquiry into M's competence. Instead, Johnson J focused more on the implications of M's mental state (i.e. M feeling overwhelmed). M's competence was certainly open to debate. A careful study of the reasons M offered to justify her refusal helps to contextualise Johnson J's protectionism:

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[569] *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097.
[570] ibid [1099].
[571] ibid.
[572] ibid [1100].
[573] ibid.
[574] ibid [1100]-[1101].

> I understand what a heart transplant means, procedures explained… check-ups… tablets for the rest of your life. […] If I don't have the operation I will die. […] If I had the transplant, I wouldn't be happy. If I were to die my family would be sad. […] Death is final–I know I can't change my mind. I don't want to die, but I would rather die than have the transplant and have someone else's heart, I would rather die with 15 years of my own heart. […] I would feel different with someone else's heart, that's a good enough reason not to have a heart transplant, even if it saved my life.[575]

On the one hand, there was sufficient evidence that M was satisfactorily *Gillick* competent–a concept Johnson J referred to only when outlining the decision in *Re W*. She was acutely aware of death and its familial implications and cogently weighed this up against ramifications that were of great importance to her. Freeman unreservedly viewed her as competent.[576] On the other hand, the clear internal contradictions in almost every sentence of M's otherwise eloquent statements could equally suggest that she lacked the higher degree of competence required to make an end-of-life decision.[577] In respect of M being overwhelmed, this was an issue underexplored. It is not disputed that a child would be overwhelmed by a swift change of circumstances to health, but M's reasoning suggested that she could reasonably rationalise her situation. In any event, that the facts were finely balanced meant that whatever side Johnson J fell on would have been supportable. There being a shortage of organ donors[578] and that not authorising the transfusion would have denied M her wish to live were weighty factors justifying the judge's protectionism.

[575] ibid [1100].
[576] Freeman (n 209) 210.
[577] Andrew Fergusson, ''Child M' and her Heart Transplant–A Christian Doctor's Reflections' (2000) 140/141 Law & Just 22, 24.
[578] *Re M* (n 569) [1101].

2. The case of Hannah Jones

The case of Hannah Jones did not reach the High Court, but because its facts were remarkably like that in *Re M*, it serves as a worthy comparison.[579] Hannah spent a significant amount of time in the hospital. She was diagnosed with leukaemia at a young age, and because of her intensive drug therapies, she developed a hole in her heart. The medical evidence suggested that although no crisis was likely, the consequential damage to Hannah without a heart transplant was that her long-term survival could not be guaranteed. At 12 years old, Hannah refused the proposed heart transplantation, deciding instead to die with dignity. Hannah's parents both supported her decision. There was evidence that Hannah weighed up the risks for and against the operation, ultimately believing transplantation to be too risky; she preferred instead to enjoy her remaining days in the company of her family and friends.[580] Hannah made this decision in full awareness that non-treatment would result in her death (reflecting best desire autonomy).

The Herefordshire Primary Care Trust (HPCT) initially filed a court application to temporarily remove Hannah from the custody of her parents and force the proposed treatment upon her. The HPCT later dropped the case after a child protection officer interviewed Hannah and concluded that she was competent enough to decide for herself.[581] Hannah's consultant paediatrician reportedly supported her decision, stating that 'no one can be forced to have a heart transplant',[582] which consequently left it open for Hannah to change her mind in the future, which she did, two years later.[583]

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[579] BBC, 'Girl Wins Right to Refuse Heart' (BBC News, England, 11 November 2008) < http://news.bbc.co.uk/1/hi/england/hereford/worcs/7721231.stm > accessed 2 August 2021.
[580] Robert Verkaik, 'Girl, 13, Wins Right to Refuse Heart Transplant' (Independent, 11 November 2008) < https://www.independent.co.uk/life-style/health-and-families/health-news/girl-13-wins-right-to-refuse-heart-transplant-1009569.html > accessed 2 August 2021.
[581] BBC (n 579).
[582] ibid.
[583] BBC, 'Transplant-Refusal Girl Hannah Jones Backs Donors' (BBC News, England, 20 August 2013) < https://www.bbc.co.uk/news/uk-england-hereford-worcester-23770583 > accessed 2 August 2021.

Significant questions arise from Hannah's case, such as, 'Why did the HPCT (in the end) respect Hannah's autonomy'? Heywood highlighted that one must be sympathetic to doctors who must grapple with the concepts preserved in the Hippocratic Oath, such as beneficence and nonmaleficence, with the immediate tension of balancing this against respecting the wishes of the minor.[584] In Hannah's case, the tendency to view children's best interests one-dimensionally, in the sense of preserving life, was eventually reined in because the weighing of the factors relevant to Hannah's situation favoured supporting what *she* believed was in *her* best interests.[585] Cave offered two plausible explanations as to why Hannah's autonomy was prioritised. First, due to Hannah's experience of illness and hospitals, she was in a position better than anyone else to determine how she should choose to live out the remainder of her life. Secondly, whilst the outcome of her refusal was likely life-threatening, the consequences of forcing short and long-term non-consensual treatment would operate against her best interests.[586] Another plausible explanation could be that, in practice, competent minors are allowed to refuse potentially life-saving medical treatment. In other words, there may be a difference between theory and reality. Only a handful of life-saving refusal cases come before the High Court–for example, between 1990 and 2000, when the law was 'active' on the subject, less than 10 cases were reported–meaning case law may be providing a skewed perception of the reality towards respect for minors' medical decision-making autonomy. Hannah's case exemplifies this third plausible explanation.

The other more significant question raised by Hannah's case is, 'Would the High Court have overruled her decision'? Cave conjectured it would have upheld Hannah's decision.[587] The case law does not support this assumption. When compared to its closest case by

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[584] Rob Heywood, 'The Right of the Terminally Ill Teenagers to Make End-of-Life Decisions' (2009) 77(1) Med Leg J 30, 31. See also Chapter II, Part II, Section B.
[585] ibid 31-32.
[586] Cave (n 496) 328.
[587] ibid 318.

analogy, *Re M*, what differences in Hannah's case justify a different outcome? The risk probability and consequence in both cases were similar. Both decisions were not religiously motivated. Hannah was 12 at the time of her refusal, whereas M was 15. Hannah was probably *Gillick* competent, whereas M was likely *Gillick* incompetent. Hannah had more experience with her illness than M. Hannah's parents supported her decision, whereas M's mother was in favour of M having treatment. Unlike M, forcing treatment on Hannah carried a greater risk of being counterproductive to her best interests. In contrast to *Re M*, the weight of certain factors in Hannah's case, such as her competency, experience with illness, familial support, and potential risks to her best interests, strongly supported respecting her autonomy. However, the reasoning in *Re E* suggests that the High Court would have unlikely supported Hannah's decision. This is because the factors in E's case, such as his age, competence, and authentic religious belief, suggested that E's decision probably should have been respected, yet this outcome did not transpire. Thus, in the light of *Re E* and the reasoning in the other High Court cases, it is likely that the High Court would have overruled Hannah's initial decision to refuse the transplant.

The essential context of Hannah's situation was that there was no judicial scrutiny of the issues. It is plausible that had the heart transplant had a better prognosis, and Hannah still refused, the HPCT would have gone ahead with its application. The High Court would have likely overridden Hannah's wishes and authorised the transplant. This situation did not happen, and Hannah's story had a happy ending, with her autonomy being respected both in her initial refusal and subsequent consent to treatment. Thus, whilst Hannah's case has no legitimate effect on the status quo, it nevertheless serves as a persuasive example of a broad and nuanced balance between protectionism and respect for autonomy in the context of a high-risk probability and consequence treatment decision.

C. The Welfare Dilemma

The protectionism based on the balancing of relevant factors was legitimate in *Re S* and was largely justified in *Re L* and *Re M*, whereas the decision to overrule the refusal in *Re E* was less tenable. The nub of judicial inquiry in all those cases principally gravitated to consequentialism analyses of preserving the minors' lives. In other words, preserving the minor's life until adulthood was disproportionately the weightiest factor (reflecting ideal desire autonomy). Reference to the weight of other important factors, such as competence, maturity, and authentic religious belief, merely glossed the welfare assessment. This is problematic. As a matter of principle, rather than deciding cases on blunt consequentialism analyses, the courts should adopt a broader and more nuanced approach to the question of whether overriding the individual's medical refusal *is* acting in the minors' best interests, which requires a careful and critical balancing of the factors relevant to the specific individual's case.[588]

The courts are responsible for the unenvied task of making judgments where the minor's decision is irreversible or fatal. Is it not therefore common sense that any philosophy of autonomy should yield to the pragmatic consideration of preserving life?[589] It is entirely understandable for judges to loathe having to uphold a child's decision to choose death. However, the necessity to make tough decisions should not obfuscate the law. It is similarly too simplistic to presume that denying the child's choice to refuse life-saving treatment on the justification of welfare protection, in all circumstances, is the optimal legal approach. Thus, the welfare dilemma that the courts face is a demanding one. Reconsider the paradigm case of *Re E*. The legal mechanism that purported to act in E's best interests, at best, provided E with an extra two years to realise the implications of his decision more fully; advancements in medical technology could have also provided him with complete remission. But, at worst, the

[588] See, for full reform recommendations, Chapter VII, Part I.
[589] Brazier and Bridge (n 527) 89.

judicial intervention ignored his heartfelt beliefs and prolonged his death, violating his very being by forcing unwanted and possibly distressing treatment on him.[590] *Re L* is another example of the court's narrow interpretation of welfare. The concept does not exclusively cover the minor's health but includes broader factors, such as their wishes, feelings, and emotional needs.[591] Indeed, with respect to health, welfare should adopt the holistic view that treating a patient involves more than just treating the *physical*; it should also consider the *mental*.[592] Sir Stephen Brown P's reliance on *Re R* to decide the matter before him in *Re L* was problematic because, unlike in *Re R*, there was no evidence to show that L suffered from any mental health issues. Would it not have been more respectful to L's emotional (mental) welfare if the judge did not follow the path which impliedly compared her to a teenager with a mental health problem?[593] In his attempt to decide in L's best interests, considering he was already going to override her wishes, it would have been better to do this by, at least, leaving L with as much dignity intact as possible.

The welfare dilemma is accentuated when, for example, the proposed procedure rests heavily on the cooperation of the objecting (competent) patient. In *Re JT*,[594] it had to be determined whether the adult patient had the capacity to refuse renal dialysis for her renal failure. It was held that she had the capacity to refuse treatment under the three-stage test laid down in *Re C*.[595] Had this case involved a competent minor, would the decision of the court be different? The crux of the issue is determining whether authorising the treatment is in the

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[590] ibid 104.
[591] See CA 1989, s 1(3).
[592] See *Aintree* (n 45). Lady Hale made the point at [26] that the MCA 2005 best interests test (s 4) should be interpreted 'in a holistic way'. Lady Hale went on and held at [39] that 'decision-makers must look at… welfare in the widest sense, not just medical but social and psychological… they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would likely to be'.
[593] Charlotte McCafferty, 'Won't Consent? Can't Consent! Refusal of Medical Treatment' (1999) 29(May) Fam Law 335, 336.
[594] *Re JT (Adult: Refusal of Medical Treatment)* [1998] 1 FLR 48.
[595] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290 [292], '(1) to take in and retain treatment information, (2) to believe it and (3) to weigh that information, balancing risks and needs'.

minor's best interests. The doctor provided evidence in *Re JT* that 'dialysis with restraint would be extremely dangerous… [making] monitoring and safety controls impossible to implement and… [constituting] dangers to both nurses and the patient'.[596] Bridge suggested that no court would override any competent minor's wishes and order complex invasive treatment like renal dialysis that would be impossible to administer safely without the minor's cooperation.[597] Justifications for imposing the treatment on an uncooperative, albeit competent individual under the guise of welfare or best interests (understood on the traditional consequentialism analyses) would unlikely carry much persuasion. On the hypothetical balance sheet, whilst the procedure may save the child's life or improve their condition long-term (i.e. cure or arrest their condition), to force such treatment on non-consenting competent minors conflicts not only with their likely ascertainable wishes and feelings but also goes against their welfare on physical and emotional grounds and may cause them significant harm.

The example of renal dialysis demonstrates that consequentialism analyses that the courts typically employ in refusal cases have significant limitations in the delicate context of minors' refusal. This is especially the case when the weight of factors strongly supports respect for the minors' autonomy, meaning the decision of the court to overrule the refusal decision will require significant justification. Yet the courts do not necessarily agree with such a principle. This was palpable in *Re E*, where Ward J expressed that:

> [A]ny emotional trauma in the immediate course of the treatment or in the longer term will not outweigh, in my judgment, the emotional trauma of the pain and the fear of dying in the hideous way he could die.[598]

[596] *Re JT* (n 594) [51].
[597] Bridge (n 565).
[598] *Re E* (n 528) [394].

However, Balcombe LJ in *Re W* dismissed the possibility of a mentally competent 16-year-old being compelled into having an abortion against her objections.[599] The implication is that a court, upon a broad consideration of the facts, could well be inclined to reserve authorising invasive treatments like renal dialysis. This conjecture nevertheless highlights a puzzling state of play. The incoherence of whether the law is indeed permissible towards competent minors making end-of-life decisions makes it difficult for them to understand their legal rights or, at least, have a clear set of expectations.[600] Minors in the taxing situation of deciding whether to refuse life-saving medical treatment deserve a more balanced and nuanced assessment of their welfare than conceived in *Re R* and *Re W* and confirmed by subsequent High Court decisions. However, as the following part of this chapter will demonstrate, the law is developing in such a way that more appropriately balances autonomy and protectionism.

V. An Increasing Judicial Emphasis on Minors' Autonomy?

In the years since *Re R* and *Re W* and the series of cases that quickly followed, attempts have continued to challenge the principles underpinning the conventional wisdom. This part analyses recent cases to determine whether the courts identify the relevant factors in the case before them and give them proper weight, resulting in an autonomy-affirming or protectionist decision consistent with the balance of those factors. The case law raises two core propositions. First, there remains consistent judicial support for the *Re R* and *Re W* principles. Secondly, an increasing number of cases are beginning to develop the *Re R* and *Re W* analysis to medical refusal cases with a more nuanced approach that more appropriately balances the autonomy and protectionism interests implicit in the welfare assessment. This rebalancing goes some way to resolve the welfare dilemma.

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[599] *Re W* (n 18) [90].
[600] Jane Fortin, *Children's Rights and the Developing Law* (2nd edn, LexisNexis 2003) 127.

A. The Continued Challenge to the Law on Medical Refusal

1. Re P (Medical Treatment: Best Interests)

In just five years after the early trilogy of religiously motivated refusals before the High Court came another, *Re P*.[601] There is, therefore, reason to suggest that *Re P* should be considered alongside the trilogy to make a quartet of cases. However, the more positive reasoning towards minors' autonomy distinguishes it. It better serves as a comparator to the trilogy.

The case concerned a 16-year-and-10-month-old Jehovah's Witness, P, who suffered from hypermobility syndrome. The course of treatment proposed to arrest any rupture of major blood vessels included the need to administer blood or blood products. P and his parents jointly and separately expressed objection to the use of such products.[602] The medical evidence indicated a low-risk probability of requiring the proposed treatment, noting no immediate crisis; the consequential damage to P without the treatment could be life-threatening.[603] The hospital sought leave to administer blood to P in the event of an emergency.[604]

In his very short judgment, Johnson J considered the law to be clear and was found in *Re W* and *Re E*, which provided that it is the duty of the court to ensure so far as it can that the minor survives to attain adulthood.[605] In relation to P, Johnson J did not refer to *Gillick* competence, nor did he explicitly suggest that P was indeed competent. He observed that P is a young man nearing 17 years old with established convictions, who strongly expressed his wish not to receive a blood transfusion under any circumstances (reflecting best desire autonomy). Moreover, P's parents, whilst not wishing for their son to die, did not want him to receive blood or blood products.[606] In the light of P and his parent's position, and taking into

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[601] *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam).
[602] ibid [3].
[603] ibid [4]-[6].
[604] ibid [6].
[605] ibid [9].
[606] ibid [10]-[11].

account his interpretation of the law that suggested that 'there may be cases as a child approaches the age of eighteen when his refusal would be determinative', Johnson J found there to be 'weighty and compelling reasons why this order should not be made'.[607] Nevertheless, Johnson J concluded that considering P's interests 'in the widest sense–medical, religious, social, whatever they be', his best interests were served by making the order sought by the hospital[608] (reflecting ideal desire autonomy).

The case of *Re P* demonstrated some positive steps in the law. What distinguishes this case the most from the early trilogy was Johnson J's explicit recognition that P's best interests should be considered in the widest sense. Additionally, Johnson J considered that *Re W* and *Re E* suggest that the court's preference for protectionism does not give it *carte blanche* to overrule autonomous decisions in all circumstances. However, the limitations of Johnson J's reasoning stymies further plaudits. It is argued that *Re P* represented a missed opportunity in the sense of Johnson J developing a framework for balancing the interests that compound a broad best interests assessment. In other words, Johnson J could have made more of the balancing exercise. P's medical interests (i.e. the low-risk probability of needing the proposed treatment), religious interests (i.e. his faith clearly underlined his objection), social interests (i.e. his parents supported P's decision) and other interests (i.e. his age; he was approaching the age of 18) supported Johnson J's observation that there were weighty and compelling reasons *not* to make the order. How Johnson J described P tacitly supported a finding of competence, which would have compounded the conclusion of respect for P's wishes. Thus, notwithstanding that Johnson J's judgment was unduly protectionist in the circumstances, his explicit recognition for courts to engage in broad best interest assessments was at the time a positive though small step towards a more autonomy-affirming development in the law.

[607] ibid [9], [11].
[608] ibid [12].

2. An NHS Trust v CX

The trend of religiously motivated decisions being the primary challenge to *Re R* and *Re W* has not changed since the early High Court challenges. The case of *An NHS Trust v CX* is notable in the legal landscape,[609] not because it did anything radical but because it serves as a good example of a court satisfactorily balancing the interests of protectionism against autonomy.

The case concerned a 14-year-old Jehovah's Witness, CX. At four years old, he was diagnosed and treated for lymphatic cancer. He was in complete remission for several years until, at his present age, his lymphatic cancer returned and progressed to Stage 4.[610] The medical evidence clearly demonstrated that the proposed treatment plan was the best chance of restoring CX to good health. It involved several rounds of chemotherapy, which, to deliver safely, required the support of transfusing blood or blood products, especially during the first round; the consequential damage to CX without chemotherapy with blood transfusion was death by toxicity from the chemotherapy alone; or if left wholly untreated, the cancerous tumour would continue to grow and spread to life-supporting organs.[611] Both CX and his mother were prepared to consent to the proposed treatment plan, except for the part which involved the administration of blood and/or blood products.[612] The NHS Trust sought leave to administer CX with blood and blood products as part of his treatment plan.[613]

In the judgment of Roberts J, CX was *Gillick* competent.[614] Roberts J found him to be an 'intelligent child who is more than capable of making decisions for himself', and in a letter to her as well as in discussions with his treating team, he elucidated his reasons, underpinned by his religious conviction, for deciding not to accept blood transfusions as part of his treatment

[609] [2019] EWHC 3033 (Fam).
[610] ibid [1]-[2].
[611] ibid [3]-[5], [16]-[17], [20]-[21].
[612] ibid [6].
[613] ibid [8].
[614] ibid [22].

plan.[615] CX was determined to understand what was proposed and why use of blood products were recommended and he cogently weighed this information against its implications for his faith. It was significant that CX was not refusing all treatments but those incompatible with his belief system and indicated preference for blood tractions as opposed to blood products.[616] Roberts J undertook a broad best interests assessment balancing CX's reasons for refusing blood transfusions (which weighed heavily on the scales) against the implications of refusing to treat and CX's clearly expressed wish to survive his illness. Roberts J held that despite CX's strong opposition to the use of blood products, given his clear and unequivocal statement that he wished to live and would likely die without blood transfusions, the balance fell in favour of making the declaration that it was lawful and in CX's best interests to receive blood transfusions as part of his treatment plan[617] (reflecting CX's best desire autonomy).

Roberts J overruling CX's wish to refuse treatment that involved the administration of blood and/or blood products should be viewed positively given the circumstances. That (i) CX wished to live and (ii) that any increased suffering which may result from the proposed treatment would likely lead to a very positive and commensurate benefit for CX were the weightiest factors on the scales. Indeed, an outcome contrary to protecting CX's life would have likely been the wrong choice. Thus, based on how Roberts J decided the issue, it is argued that this case serves as a good example of a broad and nuanced balance between autonomy and protectionism, with the decision to overrule the competent refusal justified. This thesis does not argue that a conclusion favouring protectionism should attract criticism insofar as such a conclusion was legitimate in the case-specific circumstances and after a robust balancing exercise of the minors' best interests.

[615] ibid [10], [19].
[616] ibid [19], [23].
[617] ibid [24]-[27].

3. Re X (A Child)

In the development of the law on religiously motivated *Gillick* competent refusals of medical treatment, the decision of Sir James Munby in *Re X (A Child)*[618] and his follow-up judgment in *Re X (A Child) (No 2)* are significant.[619] *Re X (A Child)* involved an urgent application to the court for a declaration permitting the administration of a 'top-up' blood transfusion against the wishes of X, a 15-year-old *Gillick* competent Jehovah's Witness, who suffered from severe sickle cell syndrome.[620] Given the urgency in *Re X (A Child)*, Sir James Munby could not provide a full analysis of the law. That opportunity was presented in *Re X (A Child) (No 2)*; this thesis will consider the significant features of this case in greater detail in later chapters.[621]

In *Re X (A Child)*, Sir James Munby observed from the medical evidence that the 'top-up' transfusion was imperatively needed within a timescale measured in hours rather than days; the consequential damage to X without the treatment was 'potentially catastrophic', including a disabling stroke and potential death.[622] It was suggested to Sir James Munby that because X was determinatively *Gillick* competent, to impose the proposed treatment would impinge impermissibly upon her autonomy.[623] Saving his analysis for the follow-up judgment, Sir James Munby simply applied the principles of *Re R* and *Re W* to the present case and determined that he was obligated to act in the best interests of X. This was interpreted to mean where serious risk to health or life is concerned, the duty of the court, although having regard to the views of a *Gillick* competent child, is to decline to give effect to them.[624] In the circumstances, the decision of Sir James Munby was reasonable, albeit burdensome to X.

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[618] *Re X (A Child) (Medical Treatment)* [2020] EWHC 3003 (Fam).
[619] Cave (n 417).
[620] *Re X (A Child)* (n 618) [2]-[3].
[621] See Chapter V for Sir James Munby's analysis of Convention rights and Chapter VI for his commentary on more general developments in minors' medical refusal law in other common law jurisdictions such as Canada.
[622] *Re X (A Child)* (n 618) [3]-[4].
[623] ibid [8].
[624] ibid [12]-[13].

Sir James Munby's face value assessment that the court 'is to decline to give effect' to the *Gillick* competent child's high-risk consequence treatment decision was an important insight into the general perception of what the courts consider the law to be and what it requires. Although Sir James Munby did emphasise that the court should be 'slow' to overrule *Gillick* competent refusals and suggested 'descriptively rather than definitively' that the court will only intervene where there is clear evidence of a serious risk to health or life,[625] his interpretation of the law nevertheless appeared restrictive. There seems little room that autonomous refusals could outweigh protectionism in high-risk consequence cases. In any event, Sir James Munby had the opportunity to broaden his assessment of the law in *Re X (A Child) (No 2)*, and if any of the two judgments should attract criticism, it is the latter.

It is sufficient to say, for present purposes, that in *Re X (A Child) (No 2)*, after setting out the key passages of *Re R* and *Re W in extenso*, Sir James Munby identified that *Re W*, in particular, makes two things clear as a matter of law:

> (1) that in relation to medical treatment neither the decision of a *Gillick* competent child nor the decision of a child 16 years old or more is determinative in all circumstances; and (2) that there are circumstances in which the decision of such a child can be overridden by the court.[626]

Sir James Munby observed that in relation to some invasive medical procedures, the decision of a *Gillick* competent child would be determinative and referred to the decision in *An NHS Trust v A*.[627] Mostyn J held that a 13-year-old pregnant girl had the *Gillick* competence to decide whether or not to have an abortion.[628] However, Sir James Munby explained that there are cases in which the *Gillick* competent child's decision is not determinative. He cited

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[625] ibid [13].
[626] *Re X (A Child) (No 2)* (n 25) [53].
[627] ibid [30].
[628] *An NHS Trust v A* (n 331) [15].

volumes of case law that have consistently followed the principles set out in *Re R* and *Re W*, demonstrating that the two do not require reconsideration for they represent good law.[629] In the opinion of Cave, Sir James Munby's judgment 'lays bare the adoption of a future-orientated version of autonomy and a protectionist stance that will apply up to adulthood'.[630] In other words, Sir James Munby favoured the ideal desire autonomy approach. Indeed, much like the face value account of the law in *Re X (A Child)*, Sir James Munby's fuller analysis of the law in *Re X (A Child) (No 2)* took a narrow view on the salient issue of how the courts should best approach the balancing of autonomy and protectionism for the purposes of determining the minors' best interests. For example, Sir James Munby made frequent references to 'best interests' but did not offer a sufficient exploration of it. He supported the view of Balcombe LJ in *Re W* that the 'judge should approach the exercise… with a predilection to give effect to the child's wishes' but never elaborated further.[631] In contrast to the explicit view of Johnson J in *Re P* that the courts should approach best interests in the 'widest sense' and the robust balancing exercise of Roberts J in *An NHS Trust v CX*, Sir James Munby neither referred to 'widest sense' or even 'broad' when addressing the interpretation of best interests and his balancing of autonomy and protectionism was rather limited.

Thus, whilst it may be agreed, in principle, that *Re R* and *Re W* represent good law, it is disagreeable that there is no need for any (judicial) evaluation of what they establish. For example, it is questionable whether Lord Donaldson MR's sweeping statement in *Re W* that *no* minor can refuse medical treatment that is in their best interests still holds weight. In the light that *Re X (A Child) (No 2)* provided a broad analysis of the legal landscape, Sir James Munby explaining, for example, how and why the courts have weighed certain factors more heavily in certain cases would have filled an important gap in the existing knowledge. The absence of a

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[629] *Re X (A Child) (No 2)* (n 25) [61].
[630] Cave (n 417) 538.
[631] *Re W* (n 18) [89].

critical address of how the courts should balance the interests of autonomy and protectionism in difficult cases means Sir James Munby's reasoning has done little to delegitimise the criticisms levelled at *Re R* and *Re W*. The decision in *Re X (A Child) (No 2)* was more recent and, therefore, had greater source material to engage with than *Re P* and *An NHS Trust v CX.* Yet the latter two represent a much more positive attempt to develop the law on medical refusals.

4. A Teaching Hospitals NHS Trust v DV (A Child)

The strong support for the reasoning in *Re R* and *Re W* by Sir James Munby in *Re X (A Child) (No 2)* suggested it would be very unlikely that a minor would have their medical refusal respected. However, shortly after the decision in *Re X (A Child) (No 2)*, Cohen J in *DV (A Child)* delivered an important judgment because, it is argued, it represents an anomaly in the case law that could have far-reaching implications for developing the law.

In *DV (A Child)*, Cohen J granted declarations that it was lawful and in the best interests of a competent 17-year-old Jehovah's Witness cancer patient, DV, to have surgery and for the treating clinicians *not* to treat him with blood transfusions against his wishes.[632] The medical evidence suggested that DV required surgery by way of right lung pulmonary metastasectomy, which carried a low risk of haemorrhage, put at about 1%; the consequential damage to DV, in the event there was a haemorrhage in the course of the surgery and blood products were not available in such a crisis, could be very serious and potentially fatal.[633] DV consented to the surgery, except for the part involving the use of blood products, in which he made it very clear that he did not consent to their administration under any circumstances.[634]

[632] *DV (A Child)* (n 418) [36].
[633] ibid [21]-[22].
[634] ibid [3]-[4].

Cohen J approved the plan for treatment *without* blood products despite the high-risk consequences because he found to give DV blood products would be damaging to his welfare.[635] In a broad and nuanced balancing exercise, Cohen J considered the factors for and against the use of blood products. There were strong arguments in favour of their use, including the necessity in the unlikely event of excessive haemorrhaging and that DV wished to live.[636] These arguments were, however, outweighed by the fact that: DV was very close to being an adult; his Jehovah's Witness faith was authentic and long held; risk of psychological harm (having been transfused earlier in his life caused him to suffer from post-traumatic stress disorder); there was a very low risk of requiring blood transfusions presently because there was a 1% chance of an interoperative haemorrhage; it was more important to secure the surgery itself, and forcing treatment on DV, holistically considered, would be counterproductive because it may make him reluctant to have future surgery if needed; the treating team and DV's parents supported DV's decision.[637] Moreover, Cohen J drew attention to the fact that DV 'has been through the wars, enduring repeated cycles of chemotherapy as well as the amputation of his leg'.[638] Recognising DV's experiences of treatment in the hospital supported the finding that he was in a position better than most to make an autonomous decision in the circumstances. The experience of illness and hospitals is an important factor traditionally overlooked or marginalised by the courts in minors' refusal cases.[639] It was thus refreshing that Cohen J attached significance to this point. Overall, the decision of Cohen J clearly supported DV's best desire autonomy to receive treatment without the use of blood products. The overarching consequence is that *DV (A Child)* is the first (and currently only) case in English law in which the judge respected the autonomous decision of a minor to refuse medical treatment.

[635] ibid [23].
[636] ibid [22].
[637] ibid [21], [23].
[638] ibid [25].
[639] The experience of illness and hospitals was suggested to be an important factor influencing the decision to respect Hannah Jones' autonomy: see Chapter IV, Part IV, Section B, Subsection 2.

Another important feature of *DV (A Child)* was the submission to the judge to declare that DV had the requisite decisional capacity to exclusively decide his own medical treatment, including refusing consent to blood transfusions.[640] Cohen J stated that 'it is self-evident that this argument cannot be heard today'[641] and observed that it was not necessary for present purposes. In the first place, DV's treating team sought an anticipatory order, which made no difference to the immediate operation; it may lay the ground for any further operation required before DV reached 18.[642] Cohen J further suggested there was no uncertainty about the law and therefore saw no benefit in a hearing on that particular issue.[643] He was also made aware that to declare that a minor has the right to refuse treatment would overthrow decades of legal authority.[644] The minor's autonomy was determinative in *DV (A Child)*, though, for the reasons articulated, the judgment of Cohen J was consistent with the law. The case confirms that refusal decisions are determinative if the judge decides that respect for autonomy is representative of the minors' best interests according to the balance of factors in the welfare assessment.

The anomalous judgment of Cohen J in *DV (A Child)* serves as a good example of a court undertaking a broad and nuanced welfare assessment, balancing the transcendent principles of autonomy and protectionism proportionately, and making the choice that was right on the specific facts for the individual at the heart of the decision. In this case, the *right* decision was to support what DV's best desire autonomy demanded. Whether *DV (A Child)* remains a lone light in the jurisprudence remains to be seen. There is, however, no good reason why it should.

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[640] *DV (A Child)* (n 418) [37].
[641] ibid [38].
[642] ibid [32].
[643] ibid [39].
[644] ibid [31].

B. E & F: Representing an Emerging Right to Refuse?

Despite the many challenges to the principles of *Re R* and *Re W*, they have not been tested by an appellate court in the context in which those principles originated.[645] In this respect, the decision of the Court of Appeal in *E & F* is a milestone judgment.[646]

Delivering the judgment of the Court of Appeal, Sir Andrew McFarlane introduced that this case involved appeals brought by two young persons against the orders made by judges of the Family Division in which it was declared under the inherent jurisdiction that:

> [A]lthough young persons were competent to decide whether to consent to or refuse medical treatment in the form of blood transfusion, it would nevertheless be lawful for their doctors to administer blood to them in the course of an operation if that became necessary to prevent serious injury or death.[647]

The appellants were E, a 16-years-8 months-old girl who needed an urgent appendectomy, and F, a 17-years-5-months-old boy who required treatment for his lacerated spleen from a motorbike accident.[648] Both were *Gillick* competent Jehovah's Witnesses who independently, though supported by their parents, rejected blood transfusions.[649] The medical evidence in E's case suggested that the possibility of her needing a blood transfusion during surgery was 'extremely rare', her bleeding to death without the transfusion was 'a very theoretical possibility'; the consequential damage to E without the transfusion should she suffer major haemorrhage, would at worst put her life at risk.[650] Similarly, F was in a clinically stable condition, with the risk of primary bleeding past, but was in the window of secondary bleeding,

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[645] See, for examples in which was *Re W* was relevant at the appellate level, *Re T (A Minor) (Wardship: Medical Treatment)* [1997] 1 WLR 242 (best interests of a baby to have liver transplantation despite the objections of the parents); *B v Croydon HA* [1995] Fam 133 (interpretation of MHA 1983, s 63).
[646] *E & F* (n 30).
[647] ibid [2].
[648] ibid [3], [7], [20].
[649] ibid [3].
[650] ibid [8], [13]-[15].

with a risk remaining of circa 10% but decreasing every day and abating after several weeks– the likelihood of a blood transfusion was ‘extremely low’; the consequential damage to F without blood transfusion should he suffer secondary haemorrhage would at worst require F to be in surgery within 30 to 60 minutes.[651] The declarations made it so blood transfusions could be given to both *if* a crisis arose. No crisis arose in either case, transfusion did not occur, and therefore the declarations never formally came into effect.[652] Thus, E and F were *not* treated against their competently expressed wishes.

Nevertheless, E and F were aggrieved that the declarations overruled their (best desire) autonomy. The central argument made by E and F on appeal was that their respective welfare assessments were wrongly approached and, therefore, wrongly decided. The underlying reasons were threefold. First, there is a strong presumption in favour of a young person’s competent decision. Secondly, that presumption should only be rebutted where, on the balance of probabilities, the decision would cause serious harm or death. Thirdly, the presumption was not rebutted because the risks of serious harm or death were improbable, and the young person’s decisions were ‘reasonable and safe ones’.[653] The Court of Appeal rejected E & F’s central argument and dismissed the appeals.[654]

The implications of Sir Andrew McFarlane’s judgment in *E & F* are far-reaching. Sir Andrew McFarlane broadly observed the contemporary understanding of the law on medical refusal and, in turn, offered guidance regarding the court’s exercise of its inherent jurisdiction, especially when it came to identifying ‘risk’. Furthermore, Sir Andrew McFarlane’s analysis of welfare has consequences for the welfare dilemma, and hence it requires reconsideration. Finally, the reasoning in *E & F* represents a positive basis for developing the law.

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[651] ibid [21]-[23], [27].
[652] ibid [4]-[5].
[653] ibid [38(3)-(4)].
[654] ibid [80]. Permission to appeal was refused by the Supreme Court.

1. Exercising the inherent jurisdiction and risk analysis

On the predominant issue of how the court should exercise the inherent jurisdiction in respect of competent young persons, Sir Andrew McFarlane observed guidance was necessary in the light of several recent attempts to persuade the courts to take a different view to conventional wisdom.[655] By way of preliminaries, he confirmed that the inherent jurisdiction is available in all cases concerning minors, and any change must be a matter for Parliament.[656] He then elucidated that when the court is asked to exercise its inherent jurisdiction, there are three stages to this.[657] First, establish the facts. The fact-finding stage identifies the risk in question. There is a distinction of 'risk' between 'risk probability' and 'risk consequence'.[658] Once the factual position is understood, the second question asks: (i) 'Is immediate action necessary?' or (ii) 'Should a decision be postponed?' In cases of 'crisis', intervention would likely be necessary.[659] If the court must intervene, the third and decisive stage is the welfare assessment. This analysis will return to Sir Andrew McFarlane's observations about the welfare assessment in the following subsection. This subsection considers his reasons for rejecting E and F's three-pronged argument.

On the first prong, Sir Andrew McFarlane rightly explained that English law does not have a presumption in favour of the competent minor's decision. Instead, approving the reasoning in the *Re X (A Child)* cases, Sir Andrew McFarlane understood *Re W* as establishing that the courts should ordinarily respect competent decisions unless the gravity of the

[655] See, eg, *Re X (A Child)* (n 618); *Re X (A Child) (No 2)* (n 25); *DV (A Child)* (n 418); *Pennine Care NHS Foundation Trust v T* [2022] EWHC 515 (Fam); *Re GW* [2021] EWHC 2105 (Fam); *An NHS Trust v BK* (n 254); *Re P (A Child)* [2014] EWHC 1650 (Fam).
[656] *E & F* (n 30) [44]. Sir James Munby J in *Re X (A Child) (No 2)* (n 25) at [162] also observed that 'any change to the law being essentially a matter for Parliament'. Cave (n 417) suggested that whilst the courts are rightly reluctant to depart from established principle, there are several examples of them having done so in order to limit medical paternalism and protect patient autonomy (539). The decision of the Supreme Court in *Montgomery* (n 8) to depart from *Sidaway* (n 3) exemplifies Cave's suggestion.
[657] ibid [45].
[658] ibid [46], 'Colloquially, 'risk' can be used to mean the risk *of* an event occurring (its probability) or the risk *from* the event occurring (its consequences)'.
[659] ibid [47].

consequences of the decision seriously threatens health or life.[660] Sir Andrew McFarlane was comparably unconvinced by the second- and third-prongs. The appellants' submission attached particular significance to the reasoning of Balcombe LJ in *Re W* that the court should reject the child's wishes if their decision 'will *in all probability* lead to the death of the child or to severe permanent injury'.[661] At the time of the declarations for both E and F, the use of blood or blood products was not necessary in the course of treatment, with neither likely to suffer severe permanent injury or death without such treatment. Thus, applying *Re W* to their facts would extend its principles too far. Sir Andrew McFarlane rejected this argument, observing that to treat phrases culled from judgments, such as 'likely' and 'in all probability', as if they were universal statements of principle fell into the familiar error of confusing the distinction between 'risk probability' and 'risk consequence'.[662] The implication of conflating the two is that it confuses the 'crisis' issue in the 'second stage', which asks whether court intervention is necessary. The court cannot simply ignore the consequential risk of severe damage merely because its probability of materialising is low.[663] During the 'second stage', the court must undertake a hypothetical exercise that contemplates the position where a crisis *has* arisen and, in turn, how the court should proceed. Thus, according to Sir Andrew McFarlane, the courts:

> [Have] to weigh that future scenario, unlikely as it is, against the present impact on the young person of being overruled, though only with provisional effect, on a matter of such personal significance to them. This asymmetry between an unlikely future and a certain present is a feature of cases where a crisis has not arisen and may never arise but, seen in the light we have suggested, there is no conceptual difficulty in the court making its welfare assessment.[664]

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[660] ibid [63].
[661] *Re W* (n 18) [88] (emphasis added).
[662] *E & F* (n 30) [64].
[663] ibid.
[664] ibid.

It is important to emphasise the context of Sir Andrew McFarlane's statement of principle regarding risk because taking his comment, 'the court cannot simply ignore the risk [of severe consequences]' in isolation may cause problems. The risk analysis is relevant to the 'second stage' *and* the 'third stage'. However, there is the possibility that the courts may take the comment out of context and interpret it as confirming that when the court faces a high-risk consequence treatment decision, they should decide the *whole* issue on that basis. The implication is that the suggested weighing of other relevant factors is a sop before the court's protectionism takes hold. It is not implausible that the courts would seize the opportunity to decide cases purely on consequentialism (or ideal desire autonomy) analyses, considering Fortin has suggested that case law subsequent to *Gillick* found 'it difficult to avoid such temptation' whenever the child's decision endangered their own future well-being.[665] Thus, Sir Andrew McFarlane's reasoning on risk, as set out above, properly understood, confirms that high-risk consequence treatment decisions are decisive at the 'second stage' because crisis invites the question of whether intervention is necessary. But when the court must undertake the welfare assessment, as will be demonstrated, high-risk consequences alone may not necessarily represent justification for the court to overrule an autonomous decision.

2. The welfare dilemma revisited

On the basis the court must intervene in a treatment decision, the third stage–the welfare assessment–is decisive. Sir Andrew McFarlane observed that the approach to the welfare assessment has developed in many cases, spanning persons of all ages, and mandates consideration of the individual's point of view by which the court seeks to identify their best interests in the widest sense; every patient, and every case, is different and must be decided on

[665] Fortin (n 228) 212. See also Bridge (n 565) 591, who suggested that the courts in medical refusal cases post-*Re R* and *Re W* went through a sham process of applying a test of competence when the inevitable result of the court's deliberation was so clearly based on outcome.

its own facts.[666] He further recognised that the law contains authoritative statements about the sanctity of life, which imply a rebuttable presumption that it is in a person's best interests to stay alive.[667] Welfare assessments in medical refusal treatment cases concerning competent minors involve balancing two transcendent principles: the preservation of life and personal autonomy.[668] After his review of the legal landscape, Sir Andrew McFarlane made a critical observation that must be represented verbatim:

> [A]n unfettered welfare assessment does not sit easily with presumptions or starting points. But, approached carefully, these are more matters of form than substance. *What is important is that the court identifies the factors that really matter in the case before it, gives each of them proper weight, and balances them out to make the choice that is right for the individual at the heart of the decision*. If this process is properly carried out so as to arrive at a sound welfare decision, the court will not be acting incompatibly with the rights arising under Articles 2, 3 and 8 (and, here, 9) of the European Convention on Human Rights.[669]

This conclusion of Sir Andrew McFarlane, whilst refreshing in the sense that it was the first time since *Re P* in 2003 that a court so clearly addressed the components and approach to the welfare assessment in the context of minors' refusal, does not necessarily come without problems. Sir Andrew McFarlane did not support his position with any interrogation of the myriad human rights implications potentially relevant to refusal cases. His observation thus comes across as an oversimplification of a rather complex matter. However, Chapter V will demonstrate the strengths of Sir Andrew McFarlane's observation.

[666] *E & F* (n 30) [49]. See *Aintree* (n 45); see also (n 592).
[667] ibid [50]-[51]. See also *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33 [36]; *Bland* (n 36) [808]; *Aintree* (n 45) [35].
[668] ibid [53]. Sir Andrew McFarlane observed that this principle derives from *Re W* (n 18).
[669] ibid [52] (emphasis added).

Regarding the welfare assessments at first instance, in E's case, the judge was aware of E's strong religious views, support from her parents, the impact on her psychologically, and that she was reaching adulthood and understood the nature of her decision. Yet these factors were outweighed by the risk of extremely serious damage to E should she need blood products.[670] Thus, the judge authorised the future use of blood products, which was a decision that reflected what the judge believed E *should* want to happen to her (exemplifying ideal desire autonomy). It appears that the 'right' decision was not made for E, particularly when contextualised against her expressed feelings:

> She then asked me whether I knew that I still have a big future ahead of me… I felt like this question was a bit threatening as she was questioning whether my faith is not as significant as I think it may be and that if I make a decision I could miss out important parts of my life… This decision is more significant than my life… My opinion wasn't taken into account. I tried to do as much as possible but in the end everything I've done wasn't as significant to the Judge as the law. Overall, I felt like me and my beliefs were never going to be taken into account, even though the Judge knew I was mature she still didn't agree with me.[671]

In F's case, the judge concluded that despite F's age, maturity and competence, religious conviction, parental support, and that imposing treatment would be distressing and difficult for him in the long term, these factors were outweighed by the threat of losing the life of a young man with a full potential lifespan ahead to a decision that carried the risk that although very unlikely to materialise, was not insignificant.[672] Like with E's case, the balance of factors falling against respect for F's autonomy was unconvincing, and the judge's reasoning strongly

[670] ibid [15].
[671] ibid [17].
[672] ibid [29]-[30], [33]-[34].

reflected ideal desire autonomy. Beyond the balancing exercise itself, three other reasons support this argument. The first is related to F's age. F was only six months off his 18th birthday and, whilst this meant his decision was not fully determinative, the judge went on to say that '[o]f course the closer a young person gets to their 18th birthday the more and more weight his view must be given'.[673] How much more weight could F's views carry? Had he been only a month off turning 18, would his views have held more weight to the extent that it would have made a difference in the welfare assessment? Secondly, the judge appeared unconvinced of F's faith by repeatedly assuming that whilst F might feel distressed by the 'violation of his personal autonomy', such distress would 'unlikely' remain 'for a significant length of time'.[674] When juxtaposed with F's expressed views that, 'I have thought about this, and I have decided not to have any blood products' and that he would 'think about [the judge's decision] every day',[675] the judge's optimism seems misplaced. Thirdly, the judge appeared to carry a bias. The judge qualified the importance of F's age and intelligence with references to F being in his 'formative' years and being 'a young man with his whole life in front of him'.[676] Whilst reasonable concerns, when considered in the round, the direction of travel pointed to a skewered preference for consequentialism (or ideal desire autonomy) analyses.

In the view of Sir Andrew McFarlane, although there were some unwelcomed deficits in the orders and some references to unhelpful case law,[677] the decisions of the first instance judges were not wrong in law.[678] However, in the light of the disproportionate preference for protectionism in the first instance judge's balancing exercise, Sir Andrew McFarlane's

[673] ibid [33].
[674] ibid [34].
[675] ibid [29], [34].
[676] ibid [34].
[677] ibid [71], Sir Andrew McFarlane suggested that it would be best for future judges to refer to the law as set out in *Re W* and *E & F*. Two recent decisions have cited *E & F* as the law to be applied in the context of the best interests of *Gillick* incompetent children: see *Wirral BC v RT* [2022] EWHC 1869 (Fam) and *Royal National Orthopaedic Hospital Trust v ZY (By His Children's Guardian)* [2022] EWHC 1328 (Fam).
[678] ibid [70]-[79].

judgment to some extent represents a missed opportunity. Whilst he was right to maintain support for the lawfulness of the declarations, it would have been a bold proclamation in support of competent young persons' autonomy had he suggested that it was open for the judges to have reached a *different lawful* conclusion.

3. Supporting anomaly?

In support of his evaluation that high-risk consequence treatment refusal cases do not imply a *carte blanche* preference for protectionism, Sir Andrew McFarlane observed that 'in the majority of reported [refusal] cases, the scales have tipped in favour of treatment, but this is not an invariable outcome', and cited *DV (A Child)* to illustrate an exemption to the rule.[679] Precursory to the implications of *DV (A Child)*, it is worth highlighting the rather optimistic suggestion that the scales have traditionally 'tipped' in favour of treatment in refusal cases. It suggests that the competing factors affecting the outcome of the refusal case were usually finely balanced. Whilst there have been some examples of courts engaging in a more robust balancing exercise that saw a 'tipping' in favour of treatment, many refusal cases, particularly those immediately after *Re R* and *Re W*, had no such tact.[680]

Beyond Sir Andrew McFarlane recognising that the outcome in *DV (A Child)* is anomalous in the case law, analysis of the implications of the case in *E & F* was brief. This could suggest that *DV (A Child)* lacks importance. However, it is suggested that Sir Andrew McFarlane not criticising the decision of Cohen J was telling. Had *DV (A Child)* been so inconsistent within the legal landscape, it is supposed that the Court of Appeal would have restricted its relevance. This not occurring is significant. It suggests that the appellate court approved of the outcome of *DV (A Child)*. That Cohen J arrived at a different conclusion to that supported by Sir Andrew McFarlane in *E & F*, despite the similarities that E, F and DV

[679] ibid [65].
[680] See Chapter IV, Part IV.

were competent young persons refusing treatment with low-risk probability but with high-risk consequences for religiously motivated reasons, does not undermine the suggested support Sir Andrew McFarlane had for Cohen J's judgment. This is because Cohen J identified all the factors that really mattered in the case before him, gave them proper weight, and balanced them out to make the choice that was right for the individual at the heart of the decision. In the case of *DV (A Child)*, the *right* decision was the one that respected DV's refusal of treatment with blood products (i.e. consistent with DV's best desire autonomy). Furthermore, as subsequently confirmed in *E & F*, the interpretation that welfare assessments do not necessarily imply that the presumption of preserving life cannot be rebutted permeated through Cohen J's judgment. Conventional wisdom has traditionally been interpreted to produce an outcome that favours protecting the minors' health or life, especially when irreparable consequences flow from a refusal of treatment.[681] The conditions existed in *DV (A Child)* for a worst-case scenario to materialise, yet Cohen J authorised DV's surgery with the security that blood products not be used. Cohen J did not know any more than other judges in factually similar cases whether the risk from the surgery would materialise. Thus, despite *DV (A Child)* only being a High Court case, the judgment of Cohen J is significant for demonstrating an important legal principle: that best interests do not always imply the preservation of life, which *E & F* confirms is actually a principle which derives from Lord Donaldson's analysis in *Re W*.

Much like in *DV (A Child)*, the question of whether minors can have the right to decide their own medical treatment, or put another way, how 'determinative' should be understood, was addressed in *E & F*. Sir Andrew McFarlane speaking generally on the issue of principle suggested that care must be taken with the word 'determinative', stating that:

[681] See Chapter IV, Part IV. See, in particular, *Re X (A Minor) (No 2)* (n 25).

> Insofar as it is said to mean that the young person is the ultimate decision-maker, that is not so. Their decision may be the determinative factor in the court's welfare evaluation, but that is in the different sense that it is the factor that has been found to predominate.[682]

This statement suggests there is a legal distinction between 'determinative' and 'predominate'. The case law does not support such a distinction. Seldom is 'predominate' referenced in cases concerning the capacity of adults or minors to make medical decisions. The decision of a capacitous adult is determinative in the strict sense of that person being the ultimate decision-maker.[683] There is no *prima facie* right for competent minors' decisions to be determinative in the same sense. This does not imply that competent decisions are never determinative; it is instead that competent consents are normatively determinative, whereas refusals may not be.[684] Minors' decisions to refuse medical treatment are determinative, provided such a decision is in their best interests according to the judge's welfare assessment. Thus, any suggestion from *E & F* that there is a distinction between 'determinative' and 'predominate' is unhelpful.

The reasoning in *E & F* has largely clarified and developed the principles laid down in *Re R* and *Re W* to guide future courts in their evaluation of what is in the best interests of those who refuse consent to medical treatment.

VI. Concluding Remarks

This chapter analysed the law and its development with respect to minors' refusal of medical treatment. It is conventional wisdom that no minor has an absolute right to refuse medical treatment and that even if the child is *Gillick* competent or, having reached the age of 16, comes

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682 *E & F* (n 30) [66].
683 *Re T* (n 4).
684 See Chapter III. See also *Re X (A Child) (No 2)* (n 25) [30], [53]; *DV (A Child)* (n 418); Anthony Skelton, Lisa Forsberg, and Isra Black, 'Overriding Adolescent Refusals of Treatment' (2021) 20(3) J Ethics Soc Philos 221.

within the purview of s 8(1) FLRA 1969 (and the MCA 2005), the court, in the exercise of its inherent or wardship jurisdiction, can in cases where the consequences of the minors' decision are likely to put their health or life at risk, overrule the minors' decision, and direct that the minor should undergo the objected procedure(s).[685] That conventional wisdom was founded in *Re R* and *Re W*, and they represent good law.[686]

The author of this thesis has surveyed every reported English minor's medical refusal case since *Re R* and *Re W* established the law in this area. The culmination of this endeavour is a record of factors that the courts consider relevant and weigh in the welfare assessment when determining whether to respect or overrule a minor's refusal of medical treatment. These factors, in which there is no *a priori* rank order, include:

- age;
- competence;
- expressed wishes and feelings;
- mental disability (fluctuating or permanent);
- risk probability;
- risk consequence;
- the principle of preservation of life (alternatively, the sanctity of life);
- type of injury, illness or health condition;
- faith (in terms of authenticity and longevity);
- familial support;
- maturity;
- life experience;
- feeling overwhelmed;

[685] *Re R* (n 17); *Re W* (n 18); *Re X (A Child) (No 2)* (n 25) [1]-[2].
[686] *E & F* (n 30) [57]; *Re X (A Child) (No 2)* (n 25) [61]. See, however, for academic opinion, (n 416).

- experience with illness and its treatment;
- holism;
- psychological harm;
- quality of life; and
- human rights.[687]

The courts have consistently identified the relevant factors in the case before it. The problem concerns whether the courts give each of them proper weight and balance them out to make a decision that is right for the individual at the heart of the case. On the one hand, factors such as risk probability, risk consequence and the principle of preservation of life consistently weigh heavily on the protectionism side of the scale. On the other hand, the courts have been less consistent when giving weight to factors which support the minors' autonomy, such as age close to adulthood, recognised competency, and authentic, long-held faith. The inconsistent weight attached to the factors is most prevalent in the balancing exercise. Indeed, it is unclear *how* the court determines the weight it gives to each factor, nor is it clear *when* the weight of the factors tilts the scales in favour of a finding for autonomy or protectionism.

The case law suggests that the most decisive factor is risk consequence, which is strongly supported by the principle of preservation of life. Indeed, if the consequence of the minor refusing treatment is serious damage to health or death, other factors hold little weight, even if they outnumber high-risk consequence on the scales. In the unreported lower court decisions that resulted in the appeals in *E & F*, for example, the minors were (i) close in age to adulthood, (ii) competent, (iii) mature, (iv) deeply religious, (v) supported by their families, (vi) making low-risk probability decisions, and (vii) supported by their Convention rights, yet all these factors were outweighed by the greater imperative that lay in the preservation of life

[687] It should be noted that while some factors, such as age, competence, risk probability and risk consequence, are universal, other factors, such as faith or mental disability, are necessarily minor-specific. Thus, what factors are relevant in the welfare assessment is determined on a case-by-case basis.

if danger arose.[688] It seems difficult to deny that the balance of all the factors should have fallen in favour of supporting the minors' (best desire) autonomy. That this was not the case for either E or F suggests that each factor was not given proper weight. This argument is supported by the factually similar case of *DV (A Child)*, in which the factors in favour of respecting the minor's (best desire) autonomy not only outnumbered but also outweighed a finding of protectionism.

Cave suggested that the search for a view that reconciles protectionism and the libertarian values expressed in *Gillick* is not over.[689] The reasoning of Sir Andrew McFarlane in *E & F* and Cohen J in *DV (A Child)* will be significant in this search. *E & F* clarified and confirmed that protectionist or autonomy-favouring decisions deriving from the welfare assessment must be the product of the court identifying and robustly balancing the factors relevant to the specific case. *DV (A Child)* exemplifies that respect for autonomy is a legitimate finding in the welfare assessment.

In *E & F*, Sir Andrew McFarlane suggested that insofar as the court arrives at a sound welfare decision, the court will not be acting incompatibly with rights arising under the ECHR.[690] Chapter V turns to consider whether, in the light of the ECHR and the HRA 1998, minors' medical decision-making autonomy increased in strength. In doing so, it will determine whether Sir Andrew McFarlane's observations on human rights were not without merit.

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[688] *E & F* (n 30) [15], [34], [74], [78]. See also *Re E* (n 528).
[689] Cave (n 417) 546.
[690] *E & F* (n 30) [52].

CHAPTER V

THE HUMAN RIGHTS DIMENSION

In Chapter IV, it was demonstrated that no minor, whether *Gillick* competent or presumed competent by s 8(1) FLRA 1969 (and the MCA 2005), has the legal right to refuse medical treatment that is in their best interests. However, Chapter IV also demonstrated that whilst the courts have the power to overrule a minor's refusal and have consistently done so, more recent case law suggests a change of direction and arguments based on human rights are becoming increasingly prevalent. This chapter considers whether human rights arguments can precipitate greater recognition of minors' autonomy to refuse medical treatment if this decision is best for the minor patient in the light of their particular circumstances broadly considered.

The HRA 1998 came into force in 2000, representing a significant moment for English law.[691] The Act gives 'further effect' to the rights and freedoms guaranteed under the ECHR.[692] It requires a court determining a question which has arisen in connection with a Convention right to take into account the jurisprudence of the European Court of Human Rights (ECtHR/the (Strasbourg) Court).[693] Article 1 ECHR requires that the 'High Contracting Parties shall secure to everyone within their jurisdiction the rights and freedoms defined in Section 1 of this Convention'. There is no reference to 'minors' contained within the HRA 1998, and the Convention only tangentially refers to 'children',[694] so the impact of these instruments on

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[691] See, for detailed discussions on the Act, John Wadham, Helen Mountfield, Elizabeth Prochaska, and Raj Desai, *Blackstone's Guide to the Human Rights Act 1998* (7th edn, OUP 2015); Jack Beatson, Stephen Grosz, Tom Hickman, Rabinder Singh, and Stephanie Palmer, *Human Rights: Judicial Protection in the United Kingdom* (Sweet & Maxwell 2008).

[692] Human Rights Act (HRA) 1998, s 1(1), the 'Convention rights' are the fundamental rights and freedoms set out in Articles 2 to 12 and 14 of the ECHR 1950, Articles 1 to 3 of the First Protocol, and Article 1 of the Thirteenth Protocol, as read with Articles 16 to 18 of the ECHR.

[693] HRA 1998, ss 2 and 6.

[694] ECHR, Protocol No 7, Article 5.

minors' rights was not readily apparent from the texts.[695] Yet the word 'everyone' in Article 1 ECHR is understood to mean that the Convention rights extend to minors as much as anyone else.[696] Strasbourg and English case law confirm that the ECHR undoubtedly applies to minors.[697]

Thus, this chapter analyses the impact of the HRA 1998 on minors' medical rights. In particular, this chapter explores whether minors can refuse life-saving medical treatment based on their rights under the ECHR, namely Articles 2, 3, 5, and 8, in conjunction with Article 14. Part I of this chapter considers whether the right to life under Article 2 includes a corollary right to choose death over life. Part II analyses whether imposing life-saving medical treatment on an objecting minor constitutes inhuman or degrading treatment under Article 3. Part III investigates whether a minor patient receiving treatment in the hospital setting can amount to a deprivation of liberty within the meaning of Article 5 and, if so, whether the deprivation can be justified. Part IV examines whether forcing medical treatment on a minor patient breaches their right to private life under Article 8. The analysis of Article 8 applies *a fortiori* in the case of a challenge under Article 9 (right to freedom of thought, conscience and religion), and therefore, arguments based on Article 9 will not be considered. Finally, Part V considers whether the way in which the law treats competent minors differently from competent adults in medical decision-making amounts to unjustified discrimination within the meaning of Article 14. This chapter argues that no Convention right in itself nor cumulatively provides minors with the legal right to refuse life-saving medical treatment. However, out of all the

[695] Jane Fortin, 'The HRA's Impact in Litigation Involving Children and their Families' (1999) 11(3) CFLQ 237; Jane Fortin, 'Rights Brought Home for Children' (1999) 62(3) MLR 350; Ursula Kilkelly, 'Protecting Children's Rights under the ECHR: The Role of Positive Obligations' (2010) 61(3) NILQ 245.
[696] It should be noted that foetuses are not protected by the ECHR: see *Paton v United Kingdom* (1981) 3 EHRR 408 [19]; *Vo v France* (2005) 40 EHRR 12 [80]-[82]; *R (on the application of Crowter) v Secretary of State for Health and Social Care* [2021] EWHC 2536 (Admin) [62].
[697] *Glass v United Kingdom* (2004) 39 EHRR 15; *Re D (A Child)* (n 406); *Re Roddy* (n 406) [37] (Munby J), 'a child is, of course, as much entitled to the protection of the Convention as anyone else'.

Convention rights, Article 8 may prove the most decisive in the court's welfare assessment determining what is in the minor's best interests.

I. Article 2: Live or Let Die?

A. Article 2 of the Convention

Article 2 provides that '[e]veryone's right to life shall be protected by law'. The provision ranks as one of the most fundamental in the Convention; without it, the other rights and freedoms become nugatory. Article 2 enshrines one of the core values of the democratic societies making up the Council of Europe and, as such, its provisions must be strictly construed.[698] The importance of Article 2 enjoins the State not only to refrain from intentionally and unlawfully taking life but also to take appropriate steps to safeguard the lives of those within its jurisdiction.[699] The ECtHR has considered many important issues relating to protecting the right to life, including issues related to the end of life,[700] albeit not with direct reference to competent minors.

The judgment of the Court in *Pretty v United Kingdom* is significant with respect to the interpretation of Article 2 ECHR. This case concerned Mrs Pretty, who was in the advanced stages of motor neurone disease, and her wish to be assisted in her suicide with the help of her husband. Section 2 of the Suicide Act 1961 makes it an offence to assist suicide. The Director of Public Prosecutions declined to grant immunity against the prosecution of Mr Pretty if he assisted his wife's suicide.[701] Mrs Pretty complained that her rights under Articles 2, 3, 8 and 14 had been infringed; she was unsuccessful on all accounts in the House of Lords and ECtHR.

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[698] *McCann v United Kingdom* (1996) 21 EHRR 97 [147], [150].
[699] *Osman v United Kingdom* (2000) 29 EHRR 245 [115].
[700] See, eg, *Pretty v United Kingdom* (2002) 35 EHRR 1; *Haas v Switzerland* (2011) 53 EHRR 33; *Lambert v France* (2016) 62 EHRR 2.
[701] *R (on the application of Pretty) v DPP* [2001] UKHL 61.

The Strasbourg Court in *Pretty* made several important observations regarding the relationship between Article 2 and issues relating to end-of-life decision-making. It emphasised that Article 2 is unconcerned with issues to do with the quality of living or what a person chooses to do with their life.[702] Of particular significance, the Court observed that:

> Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life.[703]

The Court accordingly found that no right to die, whether at the hands of a third person or with assistance of a public authority, can be derived from Article 2 of the Convention.[704]

The ECtHR suggested there is a distinction between the intentional taking of life (i.e. euthanasia and/or assisted suicide) and therapeutic abstention (i.e. withholding or withdrawing life-sustaining treatment). The significance of the distinction was observed in *Lambert v France*. The Court noted that unlike assisted dying, which was the issue in *Pretty*, withdrawing life-sustaining treatment, even if it results in death, is not an active and intentional taking of life by the State.[705] Indeed, the Court in *Jehovah's Witnesses of Moscow v Russia* further confirmed that a patient refusing treatment, such as blood transfusions, cannot be analogised to assisting suicide.[706] The ECtHR notes that the guiding principle underpinning the approach to therapeutic abstention is the paramountcy of the patient's wishes in the decision-making

[702] These aspects may be guaranteed protection under other Articles of the Convention, such as Article 8.
[703] *Pretty* (n 700) [39].
[704] ibid [40].
[705] *Lambert* (n 700) [119]-[120], [124], [141].
[706] *Jehovah's Witnesses of Moscow v Russia* (2011) 53 EHRR 4 [132]. The domestic courts are of the same mind: see *Bland* (n 36) [864] (Lord Goff), 'there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient's wishes'.

process.[707] The Court in *Lambert* emphasised that States must be afforded a margin of appreciation, not just as to whether to permit therapeutic abstention, but also as regards the means of striking a balance between the protection of the patient's right to life and of their personal autonomy.[708] The ECtHR recognises the *prima facie* principle that, when balancing the patient's competing rights in the sphere of end of life, while the importance of the sanctity of life implicit in Article 2 results in a heavy presumption in favour of preserving life,[709] a capacitous adult is free to make choices–to consent or refuse medical treatment–that accord with their own wishes and values, regardless of how irrational, unwise, or imprudent such decisions may appear to others.[710]

Article 2 primarily imposes negative obligations on the State: the obligation not to deprive a person of their life intentionally. In certain circumstances, Article 2 can impose positive obligations on the State. In *Osman v United Kingdom*, the applicant boy, O, complained that the State failed in its positive obligations under Article 2 to protect the right to life of O and his deceased father, F, from O's former teacher, P, who injured O and killed F. The Court noted that in certain well-defined circumstances, a positive obligation of the State to protect the right to life exists to protect an individual whose life is at risk from criminal acts or another individual.[711] In the opinion of the Court, the State was not in breach of its positive obligation in this case. It was not demonstrated when it could be said that the police knew or ought to have known that the lives of O and F were at real and immediate risk from P.[712] The Court in *Keenan v United Kingdom* followed the reasoning in *Osman* with respect to the positive obligations of the State under Article 2 in the context of prisoners.[713] The Court held

[707] *Lambert* (n 700) [74]-[75], [147].
[708] ibid [148].
[709] *Gard v United Kingdom* (2017) 65 EHRR SE9.
[710] *Jehovah's Witnesses of Moscow* (n 706) [136]; *Pretty* (n 700) [17].
[711] *Osman* (n 699) [115].
[712] ibid [116]-[122].
[713] (2001) 33 EHRR 38.

it could not be concluded that Mr Keenan posed a 'real and immediate risk' of suicide throughout the period of detention, and the authorities nevertheless did all that was reasonably expected of them, having regard to the nature of the risk posed by Mr Keenan.[714] Although *Osman* and *Keenan* were not healthcare cases, the Court in *Pretty* noted that the consistent emphasis in all the cases involving complaints under Article 2 is an obligation of the State to protect life.[715] The ECtHR has more recently suggested that the positive obligations under Article 2 are engaged in the context of any activity, whether public or private, in which the right to life may be at stake.[716]

B. The Article 2 Challenge

In the significant judgment of *Rabone*, the Supreme Court considered the Strasbourg case law and outlined the duties on the State as imposed by Article 2.[717] In particular, the Supreme Court delineated the approach to the positive or operational obligations that derive from Article 2. It noted that although the case law had not considered whether an operational duty existed to protect the risk of suicide by informal patients, it showed that such a duty existed to protect persons from a real and immediate risk of suicide where they were under the State's control.[718] Lord Dyson noted that when finding that the Article 2 operational duty has been breached, the ECtHR has repeatedly emphasised the vulnerability of the victim as a relevant consideration.[719] Lady Hale suggested that there is a difficult balance to be struck between the right of the individual patient to freedom of autonomy and the right to be prevented from taking their own life.[720] Lady Hale held that having regard to the nature and degree of the risk to Mrs Rabone's

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[714] ibid [95]-[101].
[715] *Pretty* (n 700) [39].
[716] *Watts v United Kingdom* (2010) 51 EHRR 66.
[717] *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2.
[718] ibid [12]-[13].
[719] ibid [23].
[720] ibid [107].

life, and the comparative ease of protecting her from it, Mrs Rabone's right to life was violated because the authorities had not prevented her from killing herself.[721]

The jurisprudence on the operational duty is young, meaning its boundaries are still being explored.[722] In *Re P (A Child)*,[723] drawing on the reasoning in *Osman* and *Rabone*, Baker J considered whether the court is under a positive or operational duty arising from Article 2 to take preventative measures to protect a minor whose life was at risk. This case involved an urgent application by the hospital for a declaration that its doctors could lawfully treat a 17-year-old, P, following a drug overdose, notwithstanding her refusal. The medical evidence suggested that P immediately required medication to counteract the effects of the drug overdose; the consequential damage to P without the medication was serious damage to her liver and potential death.[724] Baker J was satisfied that P had decisional capacity within the terms of the MCA 2005 but observed that the court may, in any event, in the exercise of its inherent jurisdiction, overrule a young person's refusal.[725] Baker J acknowledged that there is a strong presumption in favour of protecting life and that the wishes of a young person are important.[726] After balancing the competing factors, Baker J overruled P's refusal, concluding that her Article 2 rights outweighed her rights under Article 8 because the positive or operational duty of the court favoured protecting P's life in the circumstances.[727] The reasoning of Baker J demonstrated that when the transcendent principles of the preservation of life and personal autonomy conflict in cases of crisis, protecting the minors' health or life necessarily carries significantly more weight than respecting their wishes and feelings.

[721] ibid.
[722] ibid [25].
[723] (n 655).
[724] ibid [6].
[725] ibid [9]-[13].
[726] ibid [14], citing Munby J in *R (on the application of Burke) v General Medical Council* [2004] EWHC 1879 (Admin) [116]. Baker J has form for 'favouring' preservation of life: see *W v M* [2011] EWHC 2443 (Fam).
[727] ibid [15]-[16].

In the recent Court of Appeal judgment in *E & F*, Sir Andrew McFarlane considered the approach to a human rights-based analysis. He suggested that to accept the wishes of a competent minor, where respecting those wishes would result in the death or severely injure the minor, is a decision of the court that will not necessarily be incompatible with the ECHR. Sir Andrew McFarlane recognised that there is a strong presumption to keep the patient alive, but he suggested that welfare assessments do not necessarily sit easily with presumptions.[728] In the High Court case of *University Hospitals Plymouth NHS Trust v B (A Child)*, MacDonald J recognised that the presumption of preserving life 'may be outweighed if the pleasures and the quality of life are sufficiently small and the pain and suffering and other burdens are sufficiently great'.[729] Even in *Re P (A Child),* one can infer that Baker J was open to the possibility that he could favour the girl's autonomy but decided against so because '*in this case*', the balance of the competing factors fell in favour of preserving her life.[730]

E & F confirms at the appellate level that the courts are open to supporting minors' autonomy *if* it is in their best interests. Although it is less clear whether *E & F* has support from Strasbourg in its suggestion that 'sound welfare decisions' would not fall foul of Article 2. The closest analogous context to refusing life-saving treatment is the withdrawal of life-saving treatment–both being types of therapeutic abstention. Thus, there is relevant symmetry for the purposes of analysis. In *Gard*, following the earlier decision in *Lambert*, the Court considered the question of withdrawing life-sustaining treatment from the standpoint of the State's positive obligations under Article 2. The Court noted that when there is dispute over whether treatment should be withdrawn, there should be the possibility to approach the courts for a best decision as to the patient's interests.[731] In the recent Court of Appeal decision in *Dance v Barts Health*

[728] *E & F* (n 30) [50]-[53]. See also Chapter IV, Part V, Section B, Subsection 2.
[729] [2019] EWHC 1670 (Fam) [14].
[730] *Re P (A Child)* (n 655) [15] (emphasis added).
[731] *Gard* (n 709) [80]. See also *Lambert* (n 700) [143].

NHS Trust, following the reasoning in *Gard* and *Lambert*, Sir Andrew McFarlane considered Article 2 in the context of whether it was in the best interests of a 12-year-old for his life-sustaining treatment to be withdrawn. Sir Andrew McFarlane agreed with the interpretation that:

> [T]he presumption regarding the preservation of life must, and, on the authorities, does have to yield to stronger counter-prevailing best interests factors in those cases where permission is given to withdraw life-sustaining treatment.[732]

On the basis that the court made a sound welfare decision, based on what is in the specific minor's best interests, even if the decision results in the minor's death, the court likely does not fall foul of its positive obligation to protect the right to life under Article 2. Accordingly, Sir Andrew McFarlane's reasoning in *E & F* is consistent with the interpretations of Article 2. This analysis does not suggest that competent minors' decisions are determinative. Instead, it is submitted that when the courts balance the minors' competing rights in the welfare assessment, it is open for the courts to find the minors' Article 2 rights outweighed by other Convention rights.

II. Article 3: Therapeutic Necessity

A. Article 3 of the Convention

Article 3 provides that '[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment'. This is an absolute right.[733] It enshrines one of the most fundamental values of a democratic society, and is 'a value of civilisation closely bound up with respect for human dignity'.[734] Article 3 primarily imposes a negative obligation on States to refrain from

[732] [2022] EWCA Civ 1055 [41].
[733] *Ireland v United Kingdom* (1978) 2 EHRR 25 [163].
[734] *Bouyid v Belgium* (2016) 62 EHRR 32 [81].

inflicting serious harm on persons within their jurisdiction; it also imposes positive obligations on the State to do what is reasonably possible to prevent harm from occurring.[735] The prohibition under Article 3 does not relate to all instances of ill-treatment.[736] The ECtHR emphasises that ill-treatment must attain a minimum level of severity to fall within the scope of Article 3. According to the ECtHR,

> the assessment of this minimum is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim.[737]

The ECtHR has observed that other factors may be taken into consideration for determining whether the threshold of severity has been reached, in particular: the purpose for which the ill-treatment was inflicted, together with the intention or motivation behind it; the context in which the ill-treatment was inflicted; and whether the victim is in a vulnerable position.[738]

The Court addressed the distinction between the several different types of treatment mentioned in Article 3 in *Ireland v United Kingdom*, which concerned the treatment of IRA suspects by security forces in Northern Ireland. It outlined that inhuman treatment is treatment that deliberately causes severe suffering, mental or physical; degrading treatment is such that arouses in the victim feelings of fear, anguish or inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance; and torture is an aggravated form of inhuman treatment and has a purpose, such as the obtaining of information or a confession.[739] The Court in *Bouyid* considered that even when ill-treatment does not attain the minimum level of severity that necessarily violates Article 3, insofar as the treatment shows a

[735] *X and Other v Bulgaria* (2021) 50 BHRC 344 [388].
[736] *Savran v Denmark* (2021) 53 BHRC 201 [237]. Note, 'ill-treatment' is treated as a catch-all phrase.
[737] See, eg, *Bouyid* (n 734) [86]; *Ireland* (n 733) [162].
[738] ibid.
[739] *Ireland* (n 733) [167].

lack of respect for or diminishes the individual's human dignity, such treatment may be characterised as degrading and therefore fall within the prohibition outlined in Article 3.[740]

The ECtHR has observed the relationship between Article 3 and medical treatment, namely in the context of forced medical or psychiatric interventions and involuntary sterilisation. In the leading case *Herczegfalvy v Austria*, concerning the handcuffing of a psychiatric patient to a security bed in which he was subject to the forceful administration of food as a matter of medical treatment, the Court held that:

> The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.[741]

The Court in this case found the imposed treatment justified by medical necessity and that therefore it did not violate Article 3.[742] Bartlett argued that whilst the reasoning in *Herczegfalvy* has defined the approach of the ECtHR to standards of care and treatment in psychiatric facilities since its inception, its interpretation is problematic–it was not primarily a treatment case at all, but rather one concerned with detention under Article 5.[743] He suggested that the outcome in *Herczegfalvy* was largely a product of its time and, were it litigated today, the outcome might be different.[744] In any event *Herczegfalvy* remains good law, and its principles

[740] *Bouyid* (n 734) [87]-[90]. The Court at [89]-[90] recognised that respect for human dignity has a particularly strong link with Article 3 despite the Convention not mentioning the concept of 'dignity'. The Court at [45]-[47] cited several international texts, instruments, and documents that outline the concept of 'dignity'. The underlying principle is that human dignity should be respected. The Court at [101] emphasised that 'any interference with human dignity strikes at the very essence of the Convention'. The ECtHR has also held that where a measure falls short of Article 3 treatment, it may, however, fall foul of Article 8 in its private life aspect, where interferences with the patient's autonomy and physical and moral integrity exist: see, eg, *Wainwright v United Kingdom* (2007) 44 EHRR 40 [43]; *Bensaid v United Kingdom* (2001) 33 EHRR 10 [46].
[741] (1993) 15 EHRR 437 [82].
[742] ibid [79]-[84].
[743] Peter Bartlett, ''The Necessity Must be Convincingly Shown to Exist': Standards for Compulsory Treatment for Mental Disorders under the Mental Health Act 1983' (2011) 19(4) Med L Rev 514, 524.
[744] Peter Bartlett, 'Rethinking *Herczegfalvy*: The Convention and the Control of Psychiatric Treatment' in Eva Brems, *Diversity and European Human Rights: Rewriting Judgments of the ECHR* (CUP 2012).

were reiterated over a decade later in *Nevmerzhitsky v Ukraine*.[745] The Court found that in the instant case, there was no medical necessity to force feed the applicant to the extent that such treatment amounted to torture and thus violated the applicant's rights under Article 3.[746] In *Gorobet v Moldova*, the Court found no medical necessity to subject the involuntary detainee–who was not mentally ill–to forced psychiatric treatment in a hospital; the treatment aroused feelings of fear, anguish and inferiority sufficient to amount to a violation of Article 3.[747]

In *VC v Slovakia*, the Court held that the sterilisation of a competent Roma woman without her full and informed consent attained the threshold of severity to breach her rights under Article 3.[748] The Court made several important observations in coming to its decision. In particular that,

> in the sphere of medical assistance, even where the refusal to accept a particular treatment might lead to a fatal outcome, the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with his or her right to physical integrity.[749]

The Court noted that sterilisations may be legitimately performed at the request of the person, for therapeutic purposes where the medical necessity has been convincingly established, or in the event of an emergency.[750] The Court observed that sterilisation is generally not considered a life-saving surgery, and there was no indication that the situation was different in the present case.[751] Accordingly, the Court held that since the applicant was a mentally competent adult patient, her informed consent was a prerequisite to the procedure, even assuming that the latter

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[745] (2006) 43 EHRR 32.
[746] ibid [93]-[99].
[747] [2012] MHLR 113 [49]-[53].
[748] (2014) 59 EHRR 29 [120].
[749] ibid [105]. See also *Pretty* (n 700) [63]. However, treatment without consent only amounts to inhuman or degrading treatment if, according to the facts of the individual case, it can be established that it reached the minimum level of severity: see *Akopyan v Ukraine* [2014] 6 WLUK 1017 [105].
[750] ibid [106], [108].
[751] ibid [110].

was a ‘necessity’ from a medical point of view.[752] The woman did not give her informed consent and, indeed, was not in a position to provide her informed consent.[753] Thus, the Court concluded that the sterilisation procedure grossly disregarded her human dignity and choice as a competent patient, culminating in a violation of Article 3.[754]

The case of *NB v Slovakia* comparably considered the sterilisation of a patient without her informed consent, but the patient in this case was a 17-year-old.[755] Applying *VC v Slovakia*, the Court held that in the light of the evidence that the doctors sought the girl’s consent whilst she was in labour when her cognitive faculties were affected by medication, and given the serious nature and consequences of the imposed treatment that was not medically necessary, the circumstances were liable to arouse in the girl feelings of fear, anguish and inferiority sufficient to violate Article 3.[756] This aptly demonstrates that a minor is as much entitled to the protection of Article 3 as an adult. However, paradigm issues of minors’ refusal of medical treatment are largely distinguishable from the facts of the Strasbourg case-law cited, including *NB v Slovakia*. Minors’ refusal cases are often concerned with a decision to refuse consent to life-saving medical procedures.[757] This context is distinct from the ECtHR cases involving treatment for psychiatric patients who were a suicide risk and of the generally non-life-saving intervention of sterilisation. Furthermore, the principle emphasised in *VC v Slovakia* that a competent adult’s consent or refusal is *prima facie* determinative reflects the position in English law. Decisions by competent minors are not equivalent to autonomous adults. Thus, how does Article 3 operate in the context of competent minors refusing life-saving medical treatment?

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[752] ibid.
[753] ibid [112]-[117]. ‘Asking the applicant to consent to such an intervention while she was in labour and shortly before performing a Caesarean section clearly did not permit her to take a decision of her own free will’ ([112]).
[754] ibid [115]-[120].
[755] [2012] ECHR 99. See also *IG v Slovakia* [2012] ECHR 1910.
[756] ibid [77]-[81].
[757] See Chapter IV.

B. The Article 3 Challenge

In the absence of any Strasbourg jurisprudence exploring the issue of whether minors can refuse life-saving medical treatment based on Article 3 ECHR, the case of *Re X (A Child) (No 2)* is instructive. This case concerned a 15-year-old girl, X, who refused consent to blood transfusions because it was against her religious beliefs as a Jehovah's Witness. X relied upon Articles 2, 3, 5, 8, 9 and 14 of the Convention to suggest that she had the requisite decisional capacity to exclusively decide her own medical treatment. In his review of the Strasbourg case law on Article 3, Sir James Munby observed that compulsory medical intervention, which is a therapeutic necessity from the point of view of established principles of medicine, cannot, in principle, be regarded as inhuman or degrading.[758] It was submitted that to impose blood transfusions on X diminishes her human dignity and, picking up on the language of the ECtHR, would arouse in her profound feelings of 'fear, anguish or inferiority'.[759] Sir James Munby was unconvinced by such an argument because whilst it is fair to suggest that imposing on a competent adult treatment to which they are objecting cannot be saved from the reach of Article 3 by claims of medical necessity, English law treats competent minors differently to competent adults.[760] The principles established in *Re R* and *Re W*, in the view of Sir James Munby, do not of itself necessarily involve any breach of Article 3:

> There is… nothing in the jurisprudence of the Strasbourg Court recognising, let alone mandating States to enforce, a principle that a child, even a child who, to use our terminology, is *Gillick* competent or who has reached the age of 16, is in all circumstances autonomous in the sense that a capacitous adult is autonomous; nor,

[758] *Re X (A Child) (No 2)* (n 25) [109]. See Chapter V, Part II, Section A. See also Jane Fortin, 'Accommodating Children's Rights in a Post Human Rights Act Era' (2006) 69(3) MLR 299, 316.
[759] ibid [114].
[760] ibid [115].

specifically, that such a child is autonomous when it comes to deciding whether or not to accept life-saving medical treatment.[761]

The reasoning of Sir James Munby on Article 3 is cogent. Cave suggested that where the treatment is necessary to protect the life or health of the objecting minor, the courts' authorisation of treatment is unlikely to constitute a breach of the minor's human rights.[762] Fortin similarly argued that there is likely no breach of Article 3 when the treatment provided is perfectly medically orthodox and deemed essential by medical experts.[763]

Re X (A Child) (No 2) confirms that the Strasbourg jurisprudence on Article 3 does not undermine the court's ability to, when it is appropriate to do so, make orders in the best interest of the minor, including overruling the minor's refusal of medical treatment on the grounds of preservation of life. The Court of Appeal in *E & F* held the same view, but it also confirmed that *Re R* and *Re W* imply that when the court makes a best interests decision, should other factors relevant to the individual case outweigh the principle of preserving life, the court would not be acting incompatibly with the rights under Article 3 (or any other Convention right) in favouring those other factors.[764] The logic that 'sound welfare decisions' of this kind do not contravene Article 3 is demonstrated in different contexts, such as withholding treatment from infants. In *An NHS Trust v D*, Cazalet J granted the declaration for the Trust to withhold administering a seriously ill 19-month-old infant with resuscitation through artificial ventilation and, instead, provide palliative care to ease the infant into death when necessary.[765] The strong body of medical opinion suggested that given the infant's poor health and prognosis, it was in his best interests not to undergo resuscitation; the parents objected.[766] Cazalet J

[761] ibid [120]-[121].
[762] Cave (n 496) 321.
[763] Fortin (n 184) 159.
[764] *E & F* (n 30) [50]-[53].
[765] [2000] 2 FLR 677 [2], [83].
[766] ibid [5]-[19].

observed that Article 3 of the Convention requires that no person is subjected to inhuman and degrading treatment and includes the right to die with dignity.[767] Those rights of the infant were protected by the declaration because the treatment ordered was in the best interests of the infant. The judgment suggests that depending on the facts of the individual case, allowing a minor to die peacefully with dignity over being invasively treated to sustain life is a decision that does not contravene the rights arising under Article 3. The reasoning of Cazalet J cannot be interpreted, however, as implying there is a carve-out to the principles established in *Re R* and *Re W* in which competent minors have the legal right to exclusively decide to die with dignity.

In conclusion, Article 3 protects minors from inhuman and degrading treatment and, depending on the circumstances, allows them to die with dignity. Although Article 3 does not grant them a right to refuse medical treatment that is, in all probabilities, in their best interests.

III. Article 5: A Secure Challenge?

A. Article 5 of the Convention

Article 5 provides that '(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases [(subparagraphs (a)-(f))] and in accordance with a procedure prescribed by law'. Article 5 is not concerned with mere restrictions on the liberty of movement, which are governed by Article 2 of Protocol No 4 to the Convention.[768] The ECtHR stresses that the difference between deprivation of liberty and mere restrictions of liberty is one of degree or intensity, and not one of nature or substance.[769] No deprivation of liberty will be lawful unless it falls within one of the permissible grounds

[767] ibid [82]. Cazalet J cited *D v United Kingdom* (1997) 24 EHRR 423–concerning the proposed removal of a convicted alien drug courier dying of AIDS to his country of origin, St Kitts, where he had no access to proper medical treatment–for support for the principle that Article 3 includes the right to die with dignity.
[768] *Engel v Netherlands* (1976) 1 EHRR 647 [58]; *HM v Switzerland* (2004) 38 EHRR 17 [40].
[769] *Stanev v Bulgaria* (2012) 55 EHRR 22 [115].

specified in sub-paragraphs (a) to (f) of Article 5(1). This is an exhaustive list that must be interpreted narrowly.[770] The key purpose of Article 5 is to prevent arbitrary or unjustified deprivations of liberty.[771] The ECtHR has emphasised that the right to liberty and security is of the highest importance in a democratic society within the meaning of the Convention.[772]

The Court in *Storck v Germany* explained that the notion of deprivation of liberty within the meaning of Article 5(1) is tripartite:

> [Article 5(1)] does not only comprise the objective element of a person's confinement to a certain limited place for a not negligible length of time. Individuals can only be considered as being deprived of their liberty if, as an additional subjective element, they have not validly consented to the confinement in question… The Court recalls that the question whether a deprivation of liberty is imputable to the State relates to the interpretation and application of Article 5(1) of the Convention.[773]

The classic statement of principle regarding whether the person's confinement amounts to a deprivation of liberty within the meaning of Article 5(1) is found in *Guzzardi v Italy*.[774] The Court held that in order to determine deprivations of liberty,

> the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.[775]

Taking into account the 'type' and 'manner of implementation' of the measure in question enables the ECtHR to not confine findings of deprivations of liberty to paradigm detentions

[770] *Ireland* (n 733) [194].
[771] *McKay v United Kingdom* (2007) 4 EHRR 41 [30].
[772] *Medvedyev v France* (2010) 51 EHRR 39 [76].
[773] (2006) 43 EHRR 6 [74], [89].
[774] (1981) 3 EHRR 333. See also *Engel* (n 768).
[775] ibid [92].

following arrest but to numerous other forms.[776] Even measures designed for protection or taken in the interest of the concerned individual may amount to a deprivation of liberty.[777] While the purpose or motive of measures taken by public authorities has no bearing on whether there has been a deprivation of liberty, it may be relevant when the ECtHR examines the compatibility of the measures with one of the subparagraphs of Article 5(1).[778] The Court in *HL v United Kingdom* noted that relevant objective factors to be considered to determine deprivations of liberty include whether the person 'was under continuous supervision and control and was not free to leave'.[779] The ECtHR has stressed that where the case facts indicate a deprivation of liberty, the relatively short duration of the detention does not affect this conclusion.[780] The ECtHR has also emphasised the importance of considering any lack of valid consent to the confinement in question and, indeed, reiterates the need that the person's deprivation of liberty is imputable to the State owing to the direct involvement of public authorities in the person's confinement.[781]

Thus, against these guiding principles underlying the right to liberty, questions of applicability of Article 5 has arisen in a variety of circumstances, including: taking of a blood test[782]; the placement of individuals in psychiatric or social care institutions[783]; taking of an individual by paramedics and police officers to hospitals[784]; stop and searches by the police[785];

[776] ibid [95].
[777] *Khlaifia v Italy* [2016] ECHR 1124 [71]. See also *Litwa v Poland* (2001) 33 EHRR 53. In this case, the person was detained by the police and taken to a sobering centre, where he remained for six and a half hours. Under Article 5(1)(e), persons who were not medically diagnosed as alcoholics but whose conduct or behaviour under the influence of alcohol posed a threat to themselves or others could be taken into custody for the protection of the person concerned or the wider populace. However, on the facts, the Court held that no consideration had been given to different measures of protection available, with detention in a sobering up centre being the most extreme. Thus, the person's detention was not lawful under Article 5(1)(e), meaning the measure contravened Article 5.
[778] *Austin v United Kingdom* (2012) 55 EHRR 14 [58]. However, see Chapter V, Part III, Section B.
[779] (2005) 40 EHRR 32 [91]. See Chapter V, Part III, Section B.
[780] *Rantsev v Cyprus* (2010) 51 EHRR 1 [317].
[781] See (n 773); *Stanev v Bulgaria* (n 769).
[782] *X v Austria* [1979] ECHR 6.
[783] See, eg, *HL v United Kingdom* (n 779); *Storck v Germany* (n 773); *Stanev v Bulgaria* (n 769).
[784] *Aftanache v Romania* (2021) 72 EHRR 14.
[785] *Gillan v United Kingdom* (2010) 50 EHRR 45.

crowd control measures adopted by the police on public order grounds[786]; and detention of a 5-year-old in an immigration detention centre without her parents.[787]

On the basis that Article 5 is engaged, the question of whether the deprivation of liberty is lawful depends on if it can be justified under one of the six recognised grounds (Art 5(1)(a)-(f)) in which it may be permissible to deprive an individual of their liberty. As an additional requirement for the deprivation of liberty under Article 5 to be lawful, the detention must be 'in accordance with a procedure prescribed by law'. The Court in *Plesó v Hungary* emphasised that the requirement of lawfulness is not satisfied merely by compliance with the relevant domestic law; domestic law must itself conform with the Convention, and existing in domestic law must be adequate legal protections and fair and proper procedures.[788] In the context of minors' rights to consent or refuse medical treatment, the only recognised ground which may be permissible is ground (e): 'the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants'.[789] The Convention allows these individuals to be deprived of their liberty because they may not only be a danger to the public but also to themselves, and there is a link between those persons that they may need to be given medical treatment on medical and/or social grounds.[790] This analysis is concerned with 'persons of unsound mind' only.

The leading case on Article 5(1)(e) is *Winterwerp v Netherlands*,[791] which concerned a Dutch resident committed to a psychiatric hospital. The Court observed that the Convention does not define 'persons of unsound mind'. The term has no definitive interpretation; it continually evolves according to developments in psychiatry and society's attitudes on mental

[786] *Austin v United Kingdom* (n 778).
[787] *Mayeka v Belgium* (2008) 46 EHRR 23.
[788] [2014] MHLR 72 [59].
[789] Article 5(1)(e) was considered in *Re X (A Child) (No 2)* (n 25). See also Fortin (n 758).
[790] *Enhorn v Sweden* (2005) 41 EHRR 30 [43].
[791] (1979) 2 EHRR 387.

illness.[792] However, Article 5(1)(e) cannot be taken to permit the detention of someone merely because their views or behaviour deviate from established norms.[793] Detention on the ground of being of 'unsound mind' implies that three minimum conditions have to be satisfied:

> [T]he individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority–that is, a true mental disorder–calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.[794]

The ECtHR held that no deprivation of liberty of a person considered to be of unsound mind is permissible under Article 5(1)(e) if it was ordered without the opinion of a medical expert.[795] The Court in *Ilnseher v Germany* explained that a mental condition must be of a certain gravity to be considered as a 'true' mental disorder, and for the purposes of Article 5(1)(e), the mental disorder in question must be so serious as to necessitate treatment.[796] Treatment should be provided in a hospital, clinic, or other appropriate institution for the detention of persons of unsound mind.[797] In *Rooman v Belgium*, the Court suggested that the current case-law indicates that the administration of suitable therapy has become a requirement in the context of the wider concept of the 'lawfulness' of the deprivation of liberty.[798] This entails that any detention of mentally ill persons must have a therapeutic purpose aimed at curing or alleviating their mental health condition or social function to prevent them from causing harm to themselves or

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[792] ibid [37].
[793] ibid.
[794] ibid [39].
[795] *Ruiz Rivera v Switzerland* [2015] MHLR 269 [59].
[796] [2019] MHLR 278 [129].
[797] *Ashingdane v United Kingdom* (1985) 7 EHRR 528 [44].
[798] [2019] ECHR 105 [208].

others.[799] Once the person no longer needs to be detained (e.g. the mental disorder no longer persists), they should be released, but not necessarily immediately and unconditionally.[800]

The application of Article 5 to measures of compelled medical treatment onto non-consenting but competent minors has not been considered by the ECtHR. Thus, this analysis turns to consider the domestic interpretation of Article 5.

B. Domestic Interpretation of Article 5

At the domestic level, the leading authority concerning deprivation of liberty under Article 5 ECHR is the Supreme Court decision in two cases in *Cheshire West.*[801] The Supreme Court considered the criteria for determining whether the living arrangements for incapacitated persons amounted to a deprivation of liberty under Article 5. In the first case, two sisters, MIG and MEG, did not have the capacity to consent to the arrangements of their care. MIG, if she attempted to leave her foster mother's house, would be subject to restraint.[802] MEG was in residential care and her care needs required that she was under continuous supervision and control.[803] In the second case, P was a 39-year-old with cerebral palsy and Down's syndrome. He lacked mental capacity and required 24-hour care to meet his personal care needs.[804] Intervention by physical restraint was sometimes necessary to cope with his challenging behaviours.[805] The Court of Appeal in MIG and MEG's case considered that although neither was free to leave, the 'relative normality' of their living arrangements implied no deprivation of liberty under Article 5.[806] Similarly, the Court of Appeal considered that the degree of

[799] ibid; *Hutchison Reid v United Kingdom* (2003) 37 EHRR 9 [51].
[800] See *Johnson v United Kingdom* (1999) 27 EHRR 296 [61]-[63].
[801] *Cheshire West and Chester Council v P* [2014] UKSC 19.
[802] ibid [13].
[803] ibid [14].
[804] ibid [16].
[805] ibid [17].
[806] *Surrey CC v CA* [2011] EWCA Civ 190 [28]-[34].

restraint on P was as 'normal' as it can be for someone in his situation; thus, his case was far removed from anything approaching a deprivation of liberty under Article 5.[807]

The majority of the Supreme Court in *Cheshire West* allowed the appeals.[808] In the leading judgment, Lady Hale prefaced her opinion with the observation that whilst no case in Strasbourg had addressed the issues before the Supreme Court, several relevant decisions elucidate principles for determining cases of deprivation of liberty.[809] Turning to the issue at hand, Lady Hale emphasised that people with disabilities, both mental and physical, have the same rights as everyone else.[810] She rejected the 'relative normality' approach of the Court of Appeal, suggesting that 'the fact that my living arrangements are comfortable, and indeed make my life as enjoyable… [as possible], should make no difference. A gilded cage is still a cage'.[811] In the light of the Strasbourg case law on Article 5, Lady Hale identified an 'acid test' for determining whether someone is deprived of their liberty. She held: the answer is whether 'the person concerned *was under continuous supervision and control and was not free to leave*'.[812] Applying the 'acid test' to the cases before the Supreme Court, Lady Hale found that MIG, MEG, and P were deprived of their liberty.[813]

The universal 'acid test' has many advantages for determining deprivations of liberty.[814] The test appears highly intuitive. Stark suggested that it is common sense that to be under continuous supervision and control and not free to leave implies deprivation of liberty.[815] For example, Sir Mark Hedley in *Local Authority v AB* found that whilst the 36-year-old

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[807] *P v Surrey CC* [2011] EWCA Civ 1257 [116].
[808] Lords Carnwath, Hodge and Clarke dissenting in MIG and MEG's appeals.
[809] *Cheshire West* (n 801) [20]-[32].
[810] ibid [45].
[811] ibid [46]-[47].
[812] ibid [49] (emphasis added). The 'acid test' derives from *HL v United Kingdom* (n 779) [91].
[813] ibid [51], [54], [57]-[58].
[814] Lord Carnwath and Lord Hodge in *Cheshire West* (n 801) at [94] describe the test as 'universal'. *Cheshire West* has reverberated throughout several contexts: see, eg, *Staffordshire CC v K* [2016] EWCA Civ 1317 (private deprivations of liberty and the positive obligations of the State); *Re A-F (Children) (Restrictions on Liberty)* [2018] EWHC 138 (Fam) (foster care).
[815] Shona W Stark, 'Deprivations of Liberty: Beyond the Paradigm' [2019] PL 380, 385.

Asperger's sufferer was 'free to leave' her supported accommodation, she was always subject to State control requiring her return should she be otherwise unwilling to do so.[816] He held that:

> However much these arrangements may be to the benefit of AB, and undoubtedly they are, one has to reflect on how they would be observed by an ordinary member of the public who, I strongly suspect, would regard them as a real deprivation of liberty. The policy that everyone should be treated the same leads me to the conclusion that [AB was deprived of her liberty].[817]

The dissenting judges in *Cheshire West*, however, expressed concerns over the nature and implications of the 'acid test'. Lord Carnwath and Lord Hodge suggested that the approach proposed by Lady Hale was not reflected in the Strasbourg cases and was impliedly inconsistent with the case-specific test outlined in *Guzzardi*.[818] They were additionally concerned that extending the concept of deprivation of liberty to capture situations in which people had a comfortable living, social lives and daily activities, would stretch and confuse its ordinary meaning.[819] Allen suggested that the 'acid test' lacks nuance, is blunt in its application, and generates more uncertainty than it provides clarity.[820] In *A Hospital NHS Trust v CD*, Mostyn J suggested that using the *Cheshire West* test to determine deprivations of liberty can be 'extremely confusing'.[821] He asked, what of the situation where a person is bedridden or in perhaps a coma and thus is physically incapable of exercising the freedom to leave?[822] Such questions illuminate the concerns directed to Lady Hale's 'universal acid test'. Indeed,

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[816] [2020] EWCOP 39 [13].
[817] ibid [14].
[818] *Cheshire West* (n 801) [94]; see also Lord Clarke at [105].
[819] ibid [93], [99].
[820] Neil Allen, 'The (Not So) Great Confinement' (2015) 5(1) Eld LJ 45.
[821] [2015] EWCOP 74 [38]. Indeed, Mostyn J went so far as to suggest that *Cheshire West* 'is wrong', thus reflecting some of the concerns raised by the dissenting opinions in the Supreme Court decision.
[822] ibid.

are there cases where a person loses their liberty but Lady Hale's 'acid test' does not apply, such as in the context of patients receiving medical treatment despite their objections?

In *Ferreira*, the Court of Appeal considered whether a coroner was not obliged to hold an inquest with a jury following the death of Ms Ferreira in a hospital's intensive care unit (ICU).[823] An inquest with a jury depended on whether Ms Ferreira died in 'state detention' under ss 7 and 48 of the Coroners and Justice Act 2009. The key issue was whether 'state detention' equated to deprivation of liberty under Article 5(1). Arden LJ, delivering the leading judgment of the Court of Appeal, concluded that Ms Ferreira was not in state detention and there was no deprivation of liberty. Despite the narrow ICU context, Arden LJ's reasoning in *Ferreira* was couched in terms that sought to provide guidance for the interpretation of deprivation of liberty in the context of life-saving medical treatment. The heading "life-saving treatment: in general no deprivation of liberty" gives a pretty clear steer as to Arden LJ's intentions. Thus, it is Arden LJ's supporting comments on the provision of life-saving medical treatment and deprivation of liberty that this section will analyse, with the central question of the case being beyond the scope of this thesis.

In her consideration of Strasbourg case law applicable to urgent medical care, Arden LJ reiterated the principles deriving from *Guzzardi* and then turned to *Austin v United Kingdom*,[824] in which the Grand Chamber of the ECtHR found no deprivation of liberty of those 'kettled' by the police. The Court in *Austin* considered the imposition of an absolute cordon as 'commonly occurring restrictions on movement', which is distinct from deprivation of liberty, analogising the situation to temporary restrictions that the public generally accepts, such as travel by public transport or on the motorway, culminating in the view that:

[823] *Ferreira v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31.
[824] ibid [79]-[82].

> The Court does not consider that such commonly occurring restrictions on movement, so long as they are rendered unavoidable as a result of circumstances beyond the control of the authorities and are necessary to avert a real risk of serious injury or damage, and are kept to the minimum required for that purpose, can properly be described as "deprivations of liberty" within the meaning of Article 5(1).[825]

The Court in *Austin* further emphasised that whilst an underlying public interest motive, such as public protection, has no bearing on the question of whether that person has been deprived of their liberty, Article 5 cannot be interpreted in a way to make it impractical for the police to fulfil their duties of maintaining order and protecting the public.[826] Mead suggested that the Court, wittingly or not, created a carve-out to the protection guaranteed under Article 5.[827] The reasoning suggests that insofar as the detention measure has a benevolent motive, there is no deprivation of liberty.[828] However, Arden LJ in *Ferreira* regarded the reasoning in *Austin* as consistent with the Strasbourg case law, citing *Nielsen v Denmark* and *HM v Switzerland* in support.[829] Thus, Arden LJ suggested it follows from *Austin* that there are cases in which interferences can be justified and hence outside of Article 5 even though it does not fall within one of the exceptions to Article 5.[830] Arden LJ considered life-saving medical treatment a good case in point. She held that:

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[825] *Austin v United Kingdom* (n 778) [59].
[826] ibid [56]-[58].
[827] David Mead, 'Kettling Comes to the Boil Before the Strasbourg Court: Is it a Deprivation of Liberty to Contain Porestors "*En Masse*"?' (2012) 71(3) CLJ 472.
[828] *Austin v United Kingdom* (n 778) [O-I3], [O-I7]. See also *JE v DE* [2006] EWHC 3459 (Fam). In this case, concerning the deprivation of liberty of a person placed in a residential care home by a local authority, Munby J, considering the Strasbourg jurisprudence at the time, observed that some case law implied that beneficent measures cannot amount to deprivation of liberty. At [46], considering the decision in *HM v Switzerland* (n 768), Munby J commented: 'I have great difficulty in seeing how the question of whether a particular measure amounts to a deprivation of liberty can depend on whether it is intended to serve or actually serves the interests of the person concerned. For surely this is to confuse what I should have thought are, both as a matter of logic and as a matter of legal principle, two quite separate and distinct questions: Has there been a deprivation of liberty? And, if so, can it be justified?'.
[829] *Ferreira* (n 823) [83]-[86]. *Nielsen v Denmark* (1988) 11 EHRR 175; *HM v Switzerland* (n 768).
[830] ibid [83], [87].

> The Strasbourg Court in *Austin* has specifically excepted from Article 5(1) the category of interference described as "commonly occurring restrictions on movement". In my judgment, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls within this category. It is as I see it "commonly occurring" because it is a well-known consequence of a person's condition, when such treatment is required, that decisions may have to be made which interfere with or even remove the liberty she would have been able to exercise for herself before the condition emerged.[831]

On this basis Arden LJ stated that, in general, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside the purview of Article 5(1), provided its administration is (i) to treat the acute condition of the patient, (ii) is necessary to avert a real risk of serious injury or damage, (iii) is kept to the minimum required for that purpose, and (iv) results from circumstances beyond the State's control.[832] This conclusion also suggests that the *Cheshire West* 'acid test' does not apply to all contexts. Indeed, Arden LJ suggested *Cheshire West* is distinguishable in its facts and does not offer guidance on issues about Article 5 in the urgent or ICU context.[833]

The proposition that deprivations of liberty cannot in principle occur in the medical treatment context is sensible because it protects against the implausible corollary of the absence of any lawful basis in Article 5 for depriving persons of sound mind of their liberty for the purposes of administering life-saving treatment. In the light of *Winterwerp*, Article 5(1)(e) requires that the person detained for being of 'unsound mind' must have a 'true mental disorder'. Arden LJ rightly reiterated in *Ferreira* that ground (e) is directed only to the

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[831] ibid [88].
[832] ibid [89]. Arden LJ cited *NHS Trust v FG* [2014] EWCOP 30 as an example of a case where authorisation for a deprivation of liberty for the imposition of serious medical treatment would be necessary.
[833] ibid [91]. Whilst the context was the intensive care unit, the heading 'life-saving medical treatment: in general no deprivation of liberty' suggests that Arden LJ's reasoning appears applicable throughout the healthcare context.

treatment of persons of unsound mind because of their mental impairment; it is not concerned with the treatment of the physical illness of a person of unsound mind.[834] Thus, people who are unconscious or incapacitated–not because of mental impairment but because of physical illness–must fall outside the purview of Article 5(1)(e). It follows that without the general principle, these persons, if treated in a hospital setting, would be deprived of their liberty, and because they are not persons of 'unsound mind', there is no lawful basis for justifying their deprivation. This entails that the State, via healthcare services, could not lawfully provide treatment and care to those persons because the administration of treatment would amount to an unjustified deprivation of liberty. Thus, *Ferreira* is reasonable in its suggestion that any treatment of physical health will *prima facie* not constitute a deprivation of liberty insofar as such treatment would be provided to any patient, regardless of their capacity.

However, *Ferreira* yields questions that make uncertain its relevance in the context of life-saving medical treatment. While treatment in an ICU is a (relatively) commonly occurring situation which can impact persons of sound and unsound mind generally without discrimination and without interference with Article 5, not *all* medical treatment falls within the ICU context. The judgment is likely to be applied to other analogous care settings, such as palliative care, but what is more controversial is that because of the way Arden LJ framed her judgment, it is unclear in which settings her reasoning is inapplicable. Nowhere did Arden LJ attempt to define "life-saving treatment". The onset of life-saving treatment may be straightforward to identify, but determining when the provision of life-saving treatment ends and continuing care begins is much more complicated. The strength of Arden LJ's analysis is further weakened by the fact that it was rather tenuous to rely on *Austin* to the extent she did when the conduct in *Ferreira* was certainly not the same as in *Austin*. Thus, her unqualified suggestion that, in general, any deprivation of liberty resulting from the administration of life-

[834] ibid [95].

saving treatment to a person falls outside the purview of Article 5(1), was an overreach. This can be attributed to a selective reading of the key paragraph from the judgment in *Austin*. Arden LJ emphasised the fact that the ECtHR referred to incidents such as motorway jams as 'commonly occurring', and she concluded that life-saving treatment falls into the same category. The ECtHR also typified such incidents as necessitated by the 'common good'. That would not speak to life-saving treatment of individual value, as it most certainly is, as included in the same category, and indeed would tend to exclude it.

It was clear that underlying Arden LJ's analysis were policy considerations. For example, she was concerned that:

> To require authorisation of the deprivation of liberty in what would be a normal ICU case would involve a significant dilution and distraction of clinical resource, time and attention. That must inevitably risk jeopardising the outcome of all ICU patients, for no apparent policy reason.[835]

Viewed in this light, Arden LJ interpreted the 'common good' principle deriving from *Austin* as broadly as she did to avoid future issues where the threat of deprivation of liberty makes it impossible for certain types of medical intervention to be carried out. The Supreme Court judgment in *Cheshire West* is the root cause for much of the confusion surrounding deprivation of liberty, and what can be taken away from *Ferreira* (if nothing else) is that we seem to be witnessing deprivation of liberty being interpreted differently in different contexts with policy considerations very clearly in play.

Arden LJ's reasoning was nevertheless shortly affirmed by King LJ in the Court of Appeal decision in *Re Briggs (Incapacitated Person)*.[836] This case considered whether an

[835] ibid [111].
[836] [2017] EWCA Civ 1169.

application under s 21A MCA 2005 (which has deprivation of liberty implications) was a legitimate way of seeking a determination whether it was in the best interests of a minimally conscious patient to receive CANH. In the view of King LJ,

> *Ferreira* confirms… that the question of deprivation of liberty does not arise where a person who lacks capacity is so unwell that they are at risk of dying if they were anywhere other than in hospital and therefore, by virtue of their physical condition, they are unable to leave the hospital. It may be the case however that as the treatment progresses and P's physical condition improves, his or her ongoing care becomes a deprivation of liberty.[837]

If a case involves the medical treatment of a patient, where, as a consequence of receiving life-saving treatment, the patient is unable to leave the hospital, King LJ suggested that this situation is not a deprivation of liberty which falls foul of Article 5(1).[838] In the Supreme Court case of *Re D (A Child)*, which confirmed that deprivations of liberty under Article 5 apply to minors,[839] Lady Arden (as she became) reiterated her view expressed in *Ferreira*. *Re D (A Child)* was concerned with whether it was in the scope of parental responsibility for parents to consent to living arrangements for a young person who lacked capacity if those arrangements would otherwise amount to a deprivation of liberty under Article 5. Lady Arden expressed no view on the question of parental consent for medical treatment or other matters outside Article 5.[840] Although she commented on the *Cheshire West* 'acid test', suggesting it does not apply to a child or anyone needing emergency medical treatment for the reasons outlined in *Ferreira.*[841]

[837] ibid [106].
[838] ibid [108].
[839] *Re D (A Child)* (n 406) [29]-[30]. Sir James Munby in *Re A-F* (n 814) at [43] suggested that the concept could apply to children as young as 11.
[840] ibid [117].
[841] ibid [120].

The following section draws on the Strasbourg jurisprudence and the domestic interpretation of Article 5 to answer the underlying question of whether a competent minor can resist unwanted treatment by appealing to their rights under Article 5.

C. Deprivation of Liberty and the Medical Treatment of Minors

The issue of whether a competent minor rejecting life-saving medical treatment in the orthodox hospital setting, whereby the treatment is nevertheless administered, amounts to a deprivation of liberty under Article 5 has not been tested yet.[842] Thus, this section offers two frameworks for analysis. The first follows the conventional application of Article 5. The second considers the Article 5 carve-out set forth in *Ferreira* and reiterated by Lady Arden in *Re D (A Child)*. Despite the limitations of this carve-out, since Sir James Munby suggested in *Re X (A Child) (No 2)* that the carve-out provides the solution to issues of minors' refusals of medical treatment and deprivations of liberty under Article 5(1),[843] this analysis puts Arden LJ's reasoning to the test.

1. The conventional application of Article 5

For present purposes, Article 5 ECHR asks, (i) Is there a deprivation of liberty? (ii) If so, is the deprivation justified under Article 5(1)(e) and is the measure in accordance with a procedure prescribed by law? The Strasbourg and domestic case law demonstrates a tripartite approach to determining a deprivation of liberty: an objective element, a subjective element, and State imputability.[844]

The objective element of Article 5 is that a person is confined in a restricted space (e.g. a hospital, care home or their own home) for a non-negligible period of time. The distinction

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[842] In *Re X (A Child) (No 2)* (n 25), Sir James Munby briefly considered the issue of deprivation of liberty under Article 5 and the medical treatment of minors but considered at [130] that '[t]here is no need for me to decide the point here, and it is better left for decision as and when it arises'.
[843] ibid.
[844] See Chapter V, Part III, Sections A and B. In particular (n 773). State imputability is assumed in this analysis.

between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.[845] The starting point requires considering the concrete situation of the individual, taking into account the type, duration, effects and manner of implementation of the measure in question.[846] In the hospital setting, what plausible concrete situations may exist to represent the confinement of a competent minor refusing life-saving medical treatment? Some possible scenarios are considered below. The 'acid test' of confinement is whether the individual concerned is under continuous supervision and control and is not free to leave.[847] This test has two separate conditions. First, the person is under continuous supervision and control. Second, the person is not free to leave.

The first condition of the 'acid test' asks two separate questions: (i) what is 'continuous supervision', and (ii) what is 'continuous control'? Continuous supervision suggests that the person is monitored or observed for the purpose of protecting them from harm; should the person appear at risk of harm, intervention would plausibly occur. Continuous control refers to another making decisions of importance for (or on behalf of) the person, such as the person's living placement, the people they can have contact with, what they are allowed to do, and whether restraint is used to curtail the person's freedom to carry out their own wishes. In *HL v United Kingdom,* the Court noted as crucial that 'the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements'.[848] In *Cheshire West*, MIG and MEG had the people responsible for their care exercise control over every aspect of their life, such as by controlling who they may see or things they could do.[849] The elements of the first condition are distinct, but there is considerable overlap, and they are often considered together, as in the *Cheshire West* judgment.

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[845] *Stanev v Bulgaria* (n 769) [115].
[846] *Guzzardi* (n 774) [92].
[847] *Cheshire West* (n 801) [49].
[848] *HL v United Kingdom* (n 779) [91].
[849] *Cheshire West* (n 801) [52]-[53].

The second condition of the 'acid test' asks whether the person 'is not free to leave'. By 'free to leave', Munby J in *JE v DE* suggested that this meant the person could leave 'in the sense of removing himself permanently'.[850] 'Freedom' to leave is more decisive than mere 'ability, attempt, or desire' to leave. If a person does not attempt to leave, they may still be deprived of their liberty.[851] Moreover, whether the person is free to roam or leave temporarily or whether the person is kept in 'locked' or 'open' conditions does not imply that they are not deprived of their liberty.[852] The primary question appears to be, what would 'Person B' do if 'Person A' tried to *permanently* remove themselves from their situation? Eldergill offered a different interpretation and suggested rephrasing the requirement to whether the person is '*unable* to leave'.[853] He explained that while the original definition captures those without impaired capacity because it supposes that a person who is free to leave and objects to continuous control and supervision can bring this situation to an end by leaving, it fails to capture those people who do not realise that they can or have a choice to leave. Accordingly, 'unable to leave' includes both those prevented from leaving and those unable to leave because of a lack of capacity.[854] This distinction is necessary because it would be artificial to ask whether an incapacitated person unable to leave is free to leave or consider the hypothetical of what would happen if they attempted to leave.[855] In the case of an incapacitated person unable to leave, Eldergill suggested the crucial issue turns on the intensity of the regime and how it impacts the person's liberty, taking into account the 'manner of implementation, duration and effect' of the regime measures.[856] In *HL v United Kingdom*, for example, HL was compliant and did not want to leave, but at the same time, his concrete situation was one in which he was

[850] *JE v DE* (n 828) [115].
[851] See *HL v United Kingdom* (n 779).
[852] ibid [92]; *JE v DE* (n 828) [118].
[853] Anselm Eldergill, 'Are All Incapacitated People Confined in a Hospital, Care Home or Their Own Home Deprived of Liberty?' (2019) 19(4) ERA Forum 511, 512 (emphasis in original).
[854] ibid.
[855] This logic is recognisable in Mostyn J's judgment in *Rochdale MBC v KW* [2014] EWCOP 45.
[856] Eldergill (n 853) 519.

prevented from leaving through physical restraint and sedation.[857] The intensity and duration of these measures significantly contributed to the decision that HL was deprived of his liberty.

There are two concrete situations worth considering with respect to minors. First, a 15-year-old Jehovah's Witness is so unwell that they are unable to move from their hospital bed due to extreme fatigue caused by very low haemoglobin, and they are administered blood transfusions against their competently expressed wishes. Is this a deprivation of liberty? Applying the 'unable to leave' interpretation, is the minor unable to leave the hospital? By definition, being unable to do something means the person is not able (or does not have the ability) to do something or is incapable of doing something. Does this minor have the ability or capability to leave? It is not likely at present. They may wish or have the desire to leave, but it is their illness which is the cause of their inability to move, not the State preventing them from moving. Mere inability is not a lack of freedom. Thus, the issue becomes whether the measures are so intense that they impact the minor's liberty. In this case the measures to treat the minor's illness appear more akin to continuous care and supervision. On the balance of probabilities, therefore, this example is more a restriction of liberty than a deprivation of liberty. What about a 17-year-old Jehovah's Witness restrained or sedated in order to administer blood transfusions against their competently expressed wishes, where without this treatment, they would die from a haemorrhage within a few hours?[858] The measures this minor is experiencing are somewhat analogous to that in the ECtHR case law, such as in *HL v United Kingdom* and *Storck v Germany*,[859] not necessarily in terms of nature or substance but of degree or intensity. The intensity of the measures suggests that the minor is under continuous

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[857] *HL v United Kingdom* (n 779) [91].
[858] Whilst this situation is unlikely to occur in practice, it is not an implausible example. After all, in *Re P (A Child)* (n 655), Baker J at [17] declared that if 'it is conceivable that in the course of this life-sustaining treatment it may be necessary to sedate or restrain P… I declare that such steps be lawful'.
[859] In *Storck v Germany* (n 773) the applicant, during two periods, was detained in a private clinic and was forcibly medicated and prevented from attempting to escape.

supervision and control and is not (or unable to be) free to leave. Thus, it is more likely in this example that the objective element of Article 5 is satisfied.

The subjective element of Article 5 is that the person has not validly consented to the confinement in question. Valid consent to arrangements that objectively constitute confinement must be voluntary and informed, and the person must have the capacity to give and does give consent.[860] The implication is that a person who lacks capacity to consent to what objectively amounts to confinement is deprived of their liberty. It is unclear whether the person must lack legal capacity, mental capacity, or both. In *Stanev v Bulgaria*, the Court noted that whilst it was accepted that it is sometimes difficult to ascertain the true wishes of a person with impaired mental faculties, this does not mean that they are unable to comprehend their situation.[861] The Court observed that the applicant appeared to be aware of his situation and he never provided consent to his placement. The Court found the situation amounted to a deprivation of liberty within the meaning of Article 5.[862] In *Shtukaturov v Russia*, the Court noted that whilst the applicant lacked the *de jure* legal capacity, he was *de facto* able to understand his situation– evidenced by his objections.[863] This directed the Court to find a lack of consent and, ultimately, a deprivation of liberty.[864] The ECtHR took the same approach in *DD v Lithuania*.[865]

Lady Hale in *Cheshire West* rejected the approach of these ECtHR cases. She suggested that the person's lack of objection is not relevant to the subjective element.[866] This was the correct decision. Otherwise, it would mean that however confining the situation, they could not amount to a deprivation of liberty if the person concerned lacked the capacity to object.[867] At

[860] ibid.
[861] *Stanev v Bulgaria* (n 769) [130].
[862] ibid [130]-[132].
[863] (2008) 54 EHRR 962 [108].
[864] ibid [109].
[865] [2012] MHLR 209 [150].
[866] *Cheshire West* (n 801) [50].
[867] This situation was acknowledged by Lord Neuberger in *Cheshire West* (n 801) at [67].

the same time, suggesting that the person's objections are '*not* relevant' was too definite. Instead, Lady Hale should have held that a person's objections are '*less* relevant' to the question of deprivation of liberty. This is because a person's objections may provide insights to the objective element of Article 5. For example, strong objections may suggest that the 'effects' of the measure were unduly restrictive. But more germane for present purposes is that in all the ECtHR cases and *Cheshire West*, the applicants lacked the legal capacity to consent to the placement. Thus, the case law demonstrates that insofar as a person lacks legal capacity to consent to what objectively amounts to confinement, they are likely to be deprived of their liberty.

The subjective element of Article 5 must also entail that if the person has the legal capacity to consent but refuses, that person is deprived of their liberty if they are in what objectively amounts to confinement. The dilemma for competent minors is that whilst they may have the mental capacity to make the decision to refuse treatment, they lack legal capacity. Is it the case that a minor who refuses objective confinement (in the form of restraint or medication) for the purposes of the administration of treatment, and has the mental capacity to make this decision but not the legal capacity, is deprived of their liberty? There are ambiguities with the subjective element and the case law offers no obvious solution to fill the medical refusal lacuna. Eldergill suggested an approach that limits the attention to the subjective element, focusing more on the objective element, which is generally more decisive.[868] He offered a 'but for' test, which asks: what are the things this person can do and wishes to do but has not done because the State has interfered or is interfering with their freedom to do them? If the answer is 'probably nothing', there is likely a deprivation of liberty.[869] Consider the 'but for' test and *Shtukaturov*. The applicant attempted to flee the hospital, was tied to his bed, and

[868] Eldergill (n 853) does not suggest the subjective element is not relevant to Article 5. Rather, because the objective and subjective conditions overlap, satisfying the former will, by implication, satisfy the latter.
[869] ibid 526.

was given sedative medication.[870] But for this restraint, the applicant would have left. The outcome–a finding of deprivation of liberty–is identical using the 'but for' test, but there is no convoluted discussion on the subjective element.[871] The lack of consent was apparent given the 'effects' and 'manner of implementation' of the measures. Applying the 'but for' test to the competent 17-year-old Jehovah's Witness refusing treatment but being restrained or sedated, the question asks: what are the things this young person can do and wishes to do but has not done because the State has interfered or is interfering with their freedom to do them? The answer is probably nothing. Therefore, there is likely a deprivation of liberty, and the awkward subjective element is circumscribed.

On the basis that plausible concrete situations may demonstrate a deprivation of liberty, the issue turns to whether the deprivation is justified under Article 5(1)(e) and whether the measure is in accordance with a procedure prescribed by law. The problem with justifying deprivations of liberty under Article 5(1)(e) is immediately apparent. How can a competent minor be of 'unsound mind'? The case law confirms that being of 'unsound mind' requires that objective medical expertise has established that the person has a true mental disorder, and confinement is necessary to treat that mental disorder; Article 5(1)(e) is not concerned with the treatment of a person's physical illness.[872] Even if a minor lacks decision-making capacity under *Gillick* or the MCA 2005, this does not necessarily mean that they are of 'unsound mind' under Article 5(1)(e).[873] It is unlikely therefore that Article 5(1)(e) would be available to justify imposing treatment on a competent minor refusing treatment for their physical condition.

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[870] *Shtukaturov* (n 863) [101].
[871] Eldergill (n 853) demonstrated this outcome using several examples, including *HL v United Kingdom* (n 779), *Storck v Germany* (n 773), and *Nielsen v Denmark* (n 829). Interestingly, using the 'but for' test, he arrived at a different outcome for MIG's case in *Cheshire West* (n 801): see 534.
[872] See Chapter V, Part III, Sections A & B.
[873] In *Re JA (A Minor)* (n 315), a 14-year-old boy who was HIV positive lacked the *Gillick* competence to make decisions about the medical treatment he should receive. Baker J found a lack of *Gillick* competence on the sole basis that the boy lacked the understanding necessary to weigh up the information and arrive at a decision ([74]). There was no suggestion at any point in Baker J's judgment that the boy's lack of understanding was born from a mental disorder. See also *A Local Authority v D* [2016] EWHC 3473 (Fam) [35], [54].

Notwithstanding the difficulties in using Article 5(1)(e), the court, in exercise of its inherent jurisdiction, likely has the power to direct that a minor be detained for the purpose of receiving medical treatment that is in their best interests. The requirement in Article 5(1) that the deprivation of liberty must be 'in accordance with a procedure prescribed by law' requires, according to *Winterwerp*, that there exists in domestic law adequate legal protection and fair and proper procedures, which means that any deprivation of a person's liberty should be issued from and executed by an appropriate authority.[874] In *Sunderland City Council v P*, Munby J drew on several authorities and held that:

> [A] judge exercising the inherent jurisdiction of the court… has the power to direct that the child or adult in question shall be placed at and remain in a specified institution such as, for example, a hospital… It is equally clear that the court's powers extend to authorising that person's detention in such a place and the use of reasonable force (if necessary) to detain him and ensure that he remains there.[875]

The court is a public authority–any exercise of its inherent jurisdiction must comply with the requirements of Article 5.[876] In *HL v United Kingdom* the Court debated the adequacy of the inherent jurisdiction in matters of Article 5. The Court considered in the present case that relying on the system of best interest decisions under the inherent jurisdiction was insufficient to justify deprivations of liberty in the absence of proper legal procedures in place, with proper safeguards and rights of appeal.[877] In the light of the Court's observations in *HL v United Kingdom*, Munby J in *Sunderland* suggested that in order for the inherent jurisdiction to be compliant with s 6 HRA 1998 requires judges to 'mould and adapt' the inherent jurisdiction so that it accords with the requirements of Article 5.[878] In *Re C (Detention: Medical Treatment)*,

[874] *Winterwerp* (n 791) [45]. See also *HL v United Kingdom* (n 779) [114]-[115].
[875] [2007] EWHC 623 (Fam) [16].
[876] HRA 1998, s 6(3)(a) and 6(1).
[877] *HL v United Kingdom* (n 779) [134], [141]-[142].
[878] *Sunderland* (n 875) [22].

Wall J established how the courts should use the inherent jurisdiction to the issue of directing the detention of a child in a specified institution for the purposes of medical treatment.[879] Wall J suggested the following considerations, amongst others, should be borne in mind:

> (3) Any order the court makes must be based upon and justified by convincing evidence from appropriate experts that the treatment regime proposed
>
> (a) accords with expert medical opinion, and
>
> (b) is therapeutically necessary.
>
> (4) Any order the court makes should direct or authorise the minimum degree of force or restraint, and in the case of an order directing or authorising the detention of the child the minimum period of detention, consistent with the welfare principle.[880]

Subsequent courts have supported Wall J's reasoning.[881] Keehan J in *A Local Authority v D* suggested that the use of the inherent jurisdiction to authorise the deprivation of liberty of a minor is compliant with the procedural requirements of Article 5, provided the reasoning in *Re C* is followed.[882] Moreover, the 'therapeutically necessary' analysis with respect to Article 3 would also justify the courts using its inherent jurisdiction to authorise any deprivations of liberty of minors for the purposes of administering treatment that is in their best interests.

In the absence of the availability of Article 5(1)(e), the court can authorise what objectively amounts to a deprivation of liberty to treat a minor patient under its inherent jurisdiction. The case law demonstrates that this requires orders to follow the considerations articulated by Wall J in *Re C*.

[879] [1997] 2 FLR 180.
[880] ibid [197]-[198].
[881] See, eg, *Re X (A Child) (No 2)* (n 25); *Re X (A Child) (Capacity to Consent to Termination)* [2014] EWHC 1871 (Fam) [9].
[882] *A Local Authority v D* (n 873) [63]-[65].

2. The Ferreira carve-out

The reasoning of Arden LJ in *Ferreira* suggests that, in general, any purported deprivation of liberty in the context of life-saving medical treatment will fall outside the purview of Article 5(1), provided the four conditions outlined in paragraph [89] are satisfied.

First, is the treatment provided to treat the acute condition of the patient? Acute conditions require urgent or short-term care and generally get better once treated. Examples include serious conditions, such as the patient haemorrhaging or having a low haemoglobin count requiring blood transfusions, or more minor, like a broken arm. The facts in Jehovah's Witnesses cases are paradigm of when treatment is provided to treat the acute conditions of patients. Another clear example is *Re P (A Child)*. Unless the girl's overdose was treated within eight hours, she would have suffered severe damage or death.[883] Less clear is whether the net of the first *Ferreira* element is so wide as to capture conditions that fall within the category of 'chronic'. Chronic conditions develop slowly and may worsen over time–months to years. Heart disease and cancer are typical examples of chronic conditions, and both can be life-threatening. If a minor patient refuses, for example, intravenous chemotherapy treatment that can only be administered in a hospital, lasting a couple of days, is the *Ferreira* carve-out engaged? An answer may be found in the Court of Appeal's reasoning in *Evans*.[884] In deciding that the consequence of the infant receiving treatment at the hospital which restricted his liberty did not amount to a deprivation of liberty under Article 5, the Court of Appeal stated that:

> In *Ferreira* the Court of Appeal decided that a person is not deprived of their liberty where they are receiving treatment and are physically restricted by their physical infirmities and by the treatment they are receiving.[885]

[883] *Re P (A Child)* (n 655) [6].
[884] *Alder Hey Children's NHS Foundation Trust v Evans* [2018] EWCA Civ 805.
[885] ibid [60].

The Court of Appeal in *Evans* interpreted *Ferreira* broadly, suggesting that application of the *Ferreira* carve-out is not necessarily limited to cases involving treatment for acute conditions. Thus, case law suggests that the first *Ferreira* element would likely be satisfied in most cases.

Secondly, is the treatment provided necessary to avert a real risk of serious injury or damage? This element depends on the interpretation of 'serious injury or damage'. In *Re X (A Child)*, for example, there was clear evidence of a serious risk to health or possible death stemming from the child's decision to refuse blood transfusions.[886] There are, however, less straightforward examples. Consider refusing treatment for a broken bone. If a broken bone is left untreated, the patient could develop a serious infection or permanent deformity.[887] The medical evidence will be highly instructive as to whether non-treatment will, on the balance of probabilities, result in serious injury or damage to the patient. Thus, the second *Ferreira* element depends on the health condition and expert medical opinion.

Thirdly, is the treatment provided kept to the minimum required for that purpose? The purpose of treatment is to avert a real risk of serious injury or damage, but what is meant by 'minimum'? The decision in *Re X (A Child) (No 2)* is germane to this question. It was submitted to Sir James Munby that it would be contrary to X's best interests to defer an application for an order to treat her condition with blood transfusions until a further crisis developed. An anticipatory order had the benefit of certainty and predictability, ensuring that X's health was not unnecessarily jeopardised by delays in decisions that would be in her best interests.[888] However, Sir James Munby did not order the 'rolling order' for blood transfusions. Making a two-year rolling order would have gone beyond the minimum required of what was necessary to save X's life at the time. Sir James Munby accepted the argument that such an order risked

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[886] *Re X (A Child)* (n 618) [4]-[5]. See, for other Jehovah Witness cases, Chapter IV.
[887] NHS, 'How Do I Know If I've Broken a Bone?' (NHS, 21 April 2020) < https://www.nhs.uk/common-health-questions/accidents-first-aid-and-treatments/how-do-i-know-if-i-have-broken-a-bone/ > accessed 21 January 2023.
[888] *Re X (A Child) (No 2)* (n 25) [167].

being implemented on the say-so of whoever happened to be the treating clinician and in instances whereby X's condition may not necessarily be life-threatening.[889] Although there was no explanation of what exactly 'minimum' treatment entails in *Ferreira*, the reasoning of Sir James Munby provides a reasonable basis for interpreting what the third *Ferreira* element expects.

Fourthly, does the administration of treatment result from circumstances beyond the State's control? Arden LJ explained in *Ferreira* that the 'acute condition of the patient must not have been the result of action which the State wrongly chose to inflict on [the patient]'.[890] Arden LJ suggested that the true cause of patients in the ICU not being free to leave is their underlying illness. Whilst sedation is a treatment that may be the immediate cause of the patient being unresponsive, it is not necessarily the real cause. The real cause is the patient's illness, a matter for which (unless demonstrated otherwise) the State is not responsible.[891] Thus, satisfying the fourth *Ferreira* element requires that the causal nexus of the patient's condition must be their own illness.

The framework provided by Arden LJ in *Ferreira*, assuming her reasoning actually holds weight, largely resolves the question raised at the start of this section. Being a carve-out to the conventional application of Article 5 means that difficult questions of whether the objective and subjective elements of the deprivation of liberty are satisfied, and if so, whether that deprivation is justified, do not need to be answered. In *Re X (A Child) (No 2)*, Sir James Munby recognised the difficulties implicit in using Article 5(1)(e) to justify the imposition of treatment on a competent minor, finding it implausible that such a minor could be 'of unsound mind'.[892] He declined to decide the point on Article 5, seeing as his order neither prevented X

[889] ibid [168].
[890] *Ferreira* (n 823) [89].
[891] ibid [99].
[892] *Re X (A Child) (No 2)* (n 25) [125].

from leaving the hospital nor did she not go along with the order. But he considered that the solution to arguments suggesting that imposing medical treatment amounts to a deprivation of liberty is to be found in the *Ferreira* carve-out.[893] Applying the *Ferreira* elements to other paradigm refusal cases would likely see the minor struggle to argue that there was a violation of their Article 5 rights.

3. Concluding comment

Fortin suggested that Article 5 provides a basis difficult to counter for allowing competent minors to refuse medical treatment independently.[894] Garwood-Gowers considered that in the sphere of medicine, 'there are clearly going to be interventions on a minor that violate Article 5'.[895] Yet Article 5 is seldom raised in cases involving minors' refusal of medical treatment. When Article 5 arguments are considered, they have thus far offered marginal support. The analysis of the two frameworks largely suggests that, on the balance of probabilities, it would be difficult to convincingly argue there is a breach of competent minors' rights under Article 5 were they to receive treatment despite their objections. A test case would be most welcomed on this issue, though the courts suggest that the solution would most likely be found in the *Ferreira* carve-out.

IV. Article 8: Autonomy in the Ascendency?

A. Article 8 of the Convention

Article 8(1) provides that '[e]veryone has the right to respect for his private and family life'. Article 8(2) provides that limitations of Article 8(1) are allowed if they are 'in accordance with

[893] ibid [130].
[894] Fortin (n 758) 316-317. See also Jane Fortin, 'Children's Rights: Are the Courts Now Taking Them More Seriously?' (2004) 15 KCLJ 253, 261.
[895] Austen Garwood-Gowers, 'Time for Competent Minors to Have the Same Right of Self-Determination as Competent Adults with Respect to Medical Treatment?' in Austen Garwood-Gowers, John Tingle and Tom Lewis (eds), *Healthcare Law: The Impact of the Human Rights Act 1998* (Cavendish 2001) 237.

the law' and are 'necessary in a democratic society' for, *inter alia*, 'the protection of health or morals, or for the protection of the rights and freedoms of others'. Thus, Article 8 sets out rights that are qualified, not absolute. The ECtHR has consistently remarked that the notion of 'private life' guaranteed by Article 8 is a broad term not necessary or susceptible to exhaustive definition.[896] It includes concepts such as physical, psychological and moral integrity and embraces the notion of personal autonomy.[897]

The ECtHR has considered the right to private life in the broad sphere of medicine. This analysis is concerned only with the ECtHR's decisions in two distinct contexts, noting there is overlap in the principles elucidated by the Court that generally apply in the context of medical treatment. These areas concern forced medical treatment or intervention and end-of-life issues (i.e. assisted suicide and the withdrawal of life-sustaining medical treatment).[898]

In decisions related to forced medical treatment or intervention, the ECtHR has determined that a 'person's body concerns the intimate aspect of one's private life. Compulsory medical intervention, even if it is of minor importance, constitutes an interference with [Art 8(1)]'.[899] This was stated in *YF v Turkey*, in which the Court held that the applicant being forced to undergo a gynaecological examination against her will breached her Article 8 rights. Similarly, the Court in *Storck v Germany* determined that the treatment of the applicant by forcefully administering her medications against her will (which had caused serious damage to her health) violated her Article 8 rights.[900] The Court in *Jehovah's Witnesses of Moscow*, considering an applicant refusing to undergo blood transfusions on religious grounds, regarded that the freedom of a competent adult patient to accept or refuse the proposed medical treatment, or to select an alternative or variant treatment, is vital to the principle of personal

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[896] *Niemietz v Germany* (1993) 16 EHRR 97 [29]; *Pretty* (n 700) [61].
[897] *X and Y v Netherlands* (1986) 8 EHRR 235 [22]; ibid.
[898] Other areas include reproductive rights, mental illness, disability, deceased persons, and sexual orientation.
[899] *YF v Turkey* (2004) 39 EHRR 34 [33].
[900] *Storck v Germany* (n 773) [144], [153].

autonomy.[901] This case emphasises that the State should be slow to interfere with competent adults' autonomous healthcare decisions, for such interference would only lessen and not enhance the value of life.

The Court addressed the implications of Article 8 in connection to forced medical treatment on minors in *Glass*. In this case, hospital staff administered diamorphine treatment to a severely physically and mentally disabled child contrary to the express wishes of the boy's mother. The Court noted that the hospital's actions were in accordance with domestic law and pursued the legitimate aim of protecting the boy's health, but it had not been necessary.[902] It held that the hospital's decision to administer the treatment in the circumstances absent court authorisation breached the boy's Article 8 rights.[903] Another example of the Court finding a breach of Article 8 was *MAK and RK v United Kingdom*, in which the doctor's decision to take a blood sample and intimate photographs of a nine-year-old child suspected of being subject to sexual abuse without her parent's consent violated the girl's right to physical integrity.[904]

In the context relating to end-of-life issues, the Court in *Haas* confirmed that the right to decide the manner of one's death is an aspect of private life as guaranteed under Article 8(1) and qualified that it presupposes that the individual is in a position to make up their own mind with respect to the decision of how and when to end their life.[905] The implications of this principle were elucidated clearly in *Pretty.* The Court stated that:

> [T]he refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent

[901] *Jehovah's Witnesses of Moscow* (n 706) [136].
[902] *Glass* (n 697) [73]-[83].
[903] ibid [83].
[904] (2010) 51 EHRR 14 [75]-[80].
[905] *Haas* (n 700) [51].

> adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8(1) of the Convention.[906]

However, the Court in *Pretty* also held that States are entitled, within its margin of appreciation, to prohibit or regulate assisted suicide, in particular when such safeguards are designed to protect the weak and vulnerable and those not in a condition to take informed decision on end-of-life matters.[907] Thus, the Court concluded that whilst England's legislation, which prohibited assisted dying,[908] interfered with the applicant's Article 8(1) rights, such interference was justified under Article 8(2) for the protection of the rights of others.[909]

In *Gard v United Kingdom*, the Court considered the scope of Article 8 in the context of withdrawing life-sustaining treatment from an infant child. The Court observed, citing *Glass,* that when there is a conflict between parents and medical professionals regarding the treatment of the child, such matters should come before a court. The Court determined that:

> The decisive issue is whether the fair balance that must exist between the competing interests at stake–those of the child, of the two parents, and of public order–has been struck, within the margin of appreciation afforded to States in such matters, taking into account… that the best interests of the child must be of primary consideration.[910]

The decision of the doctors to withdraw life-sustaining treatment from the infant child, taken against the parents' wishes, was not one found by the Court to amount to an arbitrary or disproportionate interference in breach of Article 8.[911] This was because there is a broad national and international consensus in support of the idea that in all decisions concerning

[906] *Pretty* (n 700) [63], [67].
[907] ibid [74].
[908] Suicide Act 1961, s 2.
[909] *Pretty* (n 700) [78].
[910] *Gard* (n 709) [106]-[107].
[911] ibid [124].

children, their best interests are paramount.[912] In *Parfitt v United Kingdom*, a case similar in facts to *Gard*, the Court confirmed that the decision to apply the best interests test in withdrawal of life-sustaining treatment cases falls within the margin of appreciation afforded to States in striking a balance between the child's right to life and the protection to their private life and autonomy.[913] Best interests is the guiding principle that the courts must take into account where the interests of the child are at stake, observed on a case-by-case basis. *Parfitt* cited the recent judgment in *Vavrička and others v Czech Republic* in support of the Court's suggestion that States have an obligation 'to place the best interests of the child, and also those of children as a group, at the centre of all decisions affecting their health and development'.[914]

There are no examples in the Strasbourg case law that directly address the approach to the question of whether a competent minor refusing medical treatment can successfully claim support from Article 8. Thus, this analysis turns to consider whether domestic case law provides answers to the underlying question.

B. Domestic Interpretation of Article 8

The impact of Article 8 was tested in *Re Roddy* shortly after the introduction of the HRA 1998. This case concerned a *Gillick* competent mother, R, and raised issues of whether Article 8 (and Article 10) ECHR afforded her the right to freely communicate her story to the press. Even though the issue in this case is not analogous to the potential harms presented in medical refusal cases, the judgment of Munby J provided early insights into the court's perspective on autonomy-related matters of a minor. Underlying his judgment was his view that a child is as much entitled to the protection of the Convention–and specifically Article 8–as anyone else.[915]

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[912] ibid [118]. See also CA 1989, s 1(1); *X v Latvia* (2014) 59 EHRR 3 [37]-[39].
[913] (2021) 73 EHRR SE1 [51].
[914] (2021) 51 BHRC 241 [288]. This case was not concerned with the withdrawal of life-sustaining treatment but instead considered whether both compulsory vaccination and the consequences of non-compliance interfered with the right to private life.
[915] *Re Roddy* (n 406) [37].

This view informed his assessment that, as an important point of principle, minors are not merely passive objects of protectionist parental or judicial decision-making.[916] Human development and social change have moved past Victorian interpretations of minors' autonomy espoused in cases such as *In Re Agar Elis* and, therefore, Munby J emphasised the modern position that:

> [I]t is the responsibility–it is the duty–of the court not merely to recognise but, as Nolan LJ said [in *Re W*], to *defend* what, if I may respectfully say so, he correctly described as the *right* of the child who has sufficient understanding to make an informed decision, to make his or her own choice.[917]

The culmination of Munby J's reasoning directed his conclusion that, in this case, the court must recognise R's autonomy, as protected by Article 8 (and Article 10), and respect her choice over that of her parents or judge who may seek to make a decision on her behalf.[918] This was because R had the *Gillick* competence to make an independent decision. Fortin suggested that Munby J applying a competency test to the present case was consistent with principles deriving from Strasbourg in the medical context, which emphasised that the right to physical integrity entails capacity.[919] It follows that *Re Roddy* splicing the *Gillick* competence test onto Article 8 suggests that competent minors have complete autonomy in all matters that they sufficiently understand, including consenting or refusing medical treatment.[920] The implication is that the rights of competent minors align with the autonomy rights of competent adults. As will be demonstrated below, judges in cases of minors refusing medical treatment have not adopted the approach that minors' rights under Article 8, together with their having capacity, indicate

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[916] ibid [46].
[917] ibid [56]-[57] (emphasis in original).
[918] ibid [57], [59].
[919] Fortin (n 758) 320. Fortin cited *Herczegfalvy* (n 741) as an example of the ECtHR implying that Article 8 was not breached because the applicant had been incapable of making decisions for himself: see [86].
[920] ibid 320-321.

that they can unilaterally make any decision regarding their healthcare. However, Munby J's broad emphasis on minors' rights under the Convention, and specifically Article 8, proved influential. Thorpe LJ's judgment in *Mabon v Mabon* adopted similar reasoning in relation to minors' autonomy. In this case on representation in family proceedings, Thorpe LJ commented that in order for the courts to comply with Article 8, judges must focus on the sufficiency of the minor's understanding and, in measuring that sufficiency, reflect the increasing national and international appreciation of the autonomy of the minor.[921] The respect attached to the minor's autonomy takes into account considerations of 'welfare' in the sense that if risk emanates from participation in the decision-making process and if the minor is incapable of comprehending that risk, the judge is entitled to limit the scope of the minor's autonomy.[922] Wall LJ was in full support of Thorpe LJ's comments on autonomy, so much so that he expressed the desire to associate himself with those views.[923]

The autonomy-driven interpretations of Article 8 in *Re Roddy* and *Mabon* provided the basis for Silber J's decision in *Axon*. The facts in *Axon* were remarkably like to those in *Gillick* itself. The claimant parent, Ms Axon, applied for judicial review of a 2004 Department of Health document that provided guidance to medical professionals on giving confidential advice and treatment to *Gillick* competent children under the age of 16 on sexual matters, including abortion. The grounds of challenge advanced by Ms Axon were threefold: (i) confidentiality, (ii) the lawfulness of the guidance, and (iii) human rights. Silber J rejected each challenge, affirming *Gillick* in the process, and it is his analysis of Article 8 which is germane for present purposes.[924]

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[921] *Mabon v Mabon* (n 406) [26], [32].
[922] ibid [29].
[923] ibid [36]. The views in *Mabon v Mabon* have garnered extrajudicial support: see Mr Justice Munby, 'Families Old and New–The Family and Article 8' (2005) 17(4) CFLQ 487.
[924] See, for robust analyses of *Axon*, particularly on confidentiality, Rachel Taylor, 'Reversing the Retreat from *Gillick*? *R (Axon) v Secretary of State for Health*' (2007) 19(1) CFLQ 81; Cave (n 496); Amanda Hall, 'Children's Rights, Parent's Wishes and the State: The Medical Treatment of Children' (2006) 36(Apr) Fam Law 317.

The nub of Ms Axon's Article 8 challenge largely relied on the ECtHR decision in *Nielsen v Denmark*. This case concerned restrictions on a child's liberty under Article 5 and suggested that parents have the general right to control their child. But because the rights of parents are so broad, including imposing various restrictions on children's liberty, the Court suggested that these rights are also recognised and protected under Article 8.[925] Ms Axon argued that the reasoning in *Nielsen* established that Article 8 guaranteed the broad right to parental authority over children. Thus, the Department of Health's guidance represented an unlawful interference with her parental rights to be informed of any sexual advice and treatment provided to her daughters.[926] Silber J rejected this interpretation, confining *Nielsen* to similar factual situations. He held that *Nielsen* does not deal with any alleged parental right to be informed of advice or treatment on medical matters sought by a competent child, where such a person requests confidentiality.[927] Silber J went on to state that as a matter of principle, parents do not retain an Article 8 right to parental authority relating to a medical decision where the child understands the nature of the proposed treatment and its implications.[928] For this reason, Silber J held that Article 8(1) was not engaged in this case. However, he considered the position if he was wrong on this point, but he provided four reasons to suggest that any interference with parental rights under Article 8(1) could be justified under Article 8(2) as necessary to protect the health or rights of others.[929] Ms Axon's Article 8 claim ultimately failed.

Axon is largely a strong affirmation of *Gillick*. Silber J's interpretation of Article 8 in relation to parental rights in the clinical setting is far-reaching. On the basis that Silber J suggested that parents' Article 8 rights are not engaged once their child is *Gillick* competent,[930]

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925 *Nielsen v Denmark* (n 829) [61].
926 *Axon* (n 301) [122]-[124].
927 ibid [126].
928 ibid [130]. The rationale derives from his interpretation of *Gillick*. See Taylor (n 924) 89-92.
929 ibid [142]-[152].
930 ibid [132], 'There is nothing in the Strasbourg jurisprudence, which persuades me that any parental right or power of control under article 8 is wider than domestic law, which is that the right of parents in the words of Lord Scarman "exist primarily to enable the parent to discharge his duty of maintenance, protection and education until

parents would find it difficult to raise their Article 8(1) rights in disputes over the child's healthcare, including refusal of medical treatment. Taylor suggested that, following Silber J's reasoning, there would be no balancing exercise between the Article 8(1) rights of the parent and child because the parents' rights are extinguished, meaning in cases of medical refusal, the issue would be dealt with in terms of the rights of the child only.[931] It would extend the *Gillick* principles too far if, in matters of medical refusal, an issue not relevant in *Gillick*, parental rights cannot, at least, be balanced against the rights of the child when a child appeals to their Article 8 rights. There is also no Strasbourg case law supporting Silber J's proposition. Following the reasoning in *Paton v United Kingdom*,[932] Fortin suggested that Silber J should have approached Article 8 by determining that the parents' Article 8(1) rights are subordinate to those of the competent child.[933] In *PD v SD*, Keehan J held that the Article 8 rights of a 16-year-old wanting to keep information about his treatment confidential from his parents outweighed the Article 8 rights of his parents to be informed of his treatment.[934] Thus, Silber J's interpretation of Article 8 has had little impact, with subsequent courts preferring an analysis that balances the Article 8 rights of the parent and child.

The ability of the court to overrule the wishes of a competent minor under Article 8 is much less precarious compared to the position of parents. Whilst minors' rights under Article 8 would undoubtedly be engaged in refusal cases, they are not absolute and would have to be balanced against the court's duty to protect the minors' health under Article 8(2) or life under Article 2.[935] The reasoning in *Axon* does not extend to colour the duty of the court in this respect. Sir James Munby in *Re X (A Child) (No 2)* suggested that Silber J's sweeping statement

he reaches such an age to be able to look after himself and make his own decisions"… *The parental right to family life does not continue after that time*' (emphasis added). See, for critique of Silber J's legal analysis of parental rights under Article 8, Taylor (n 924) 91; Hall (n 924) 321.

[931] Taylor (n 924) 95.

[932] *Paton v United Kingdom* (n 696). The husband's Article 8 rights were subordinate to those of his wife.

[933] Jane Fortin, 'Children's Rights–Substance or Spin?' (2006) 36(Sep) Fam Law 759.

[934] *PD v SD* (n 393) [35].

[935] *Re P (A Child)* (n 655) [15]-[16].

that 'the principles of *Gillick* continue to be valid and applicable being unaffected by Article 8' must be read in the context of the specific reference to the parents' Article 8 rights.[936] Sir James Munby held that the best interests analysis in proceedings under the court's inherent jurisdiction has an objective and reasonable justification and pursues a legitimate aim, namely preserving the lives of minors until adulthood.[937] The principles established in *Re R* and *Re W* suggest that the court has the power and duty to overrule a minor's decision insofar as the decision to overrule is consistent with the minor's best interests. In such instances, the court's decision does not of itself involve any breach of Article 8. This was confirmed by the Court of Appeal in *E & F*.[938] Therefore, a court interfering with the minors' Article 8(1) rights is likely to be justified under Article 8(2) for the protection of the minors' health.

C. Article 8 Concluding Remarks

Article 8 *prima facie* offers substantial protection to anyone objecting to treatment, guaranteeing as it does the patient's right to personal autonomy and physical integrity. This protection, however, whilst generally afforded to adults,[939] does not extend in the same way to minors.[940] Infringing minors' rights under Article 8(1) by forcing medical treatment on them on the justification of serving the legitimate aim of protecting their life or health is reasonable, provided the imposed treatment is proportionate to the risk involved in the patient not receiving treatment. Fortin suggested that provided the treatment is perfectly medically orthodox and life-saving, a domestic court might authorise treatment against the minors' wishes without necessarily falling foul of Article 8.[941] Indeed, Cave suggested that the interests of minors are

[936] *Re X (A Child) (No 2)* (n 25) [137].
[937] ibid [134].
[938] *E & F* (n 30) [52]. See also Chapter IV.
[939] See *Laskey, Jaggard and Brown v United Kingdom* (1997) 24 EHRR 39 [41]-[46].
[940] See, eg, Fortin (n 758); Taylor (n 924); Cave (n 496); Morris (n 524); Jean V McHale, 'Health Care Choices, Faith and Belief in the Light of the Human Rights Act 1998: New Hope or Missed Opportunity' (2008) 9(4) Med L Int 331; Brenda Hale and Jane Fortin, 'Legal Issues in the Care and Treatment of Children with Mental Health Problems' in Sir Michael Rutter, *Rutter's Child and Adolescent Psychiatry* (5th edn, John Wiley & Sons 2009).
[941] Fortin (n 758) 316. See also Fortin (n 184) 159.

arguably served by overriding their immediate decision, where a failure to do so would stifle their development into becoming functionally autonomous adults.[942] In *Re X (A Child) (No 2)*, Sir James Munby referred to these works of Fortin and Cave. He suggested their analysis reflects the thinking of Lord Donaldson MR in *Re W*, thus supporting the rationale that it is reasonable for courts to apply future-orientated versions of autonomy in cases where the decision of the minor would likely result in their serious injury or death.[943]

In the light of the reasoning in *E & F*, when courts balance the Article 8 rights of the competent minor against its obligations under Article 8(2) and Article 2, the court will not be acting incompatibly with the ECHR whether it decides to respect the minors' decision or not. The reasoning in *E & F*, read together with the outcome in *DV (A Child)*, suggests that the courts are increasingly recognising and supporting the minor who has the capacity to make life and death decisions.[944] This is not the same as saying that minors have an exclusive right to refuse consent to medical treatment. Thus, the strength of Article 8 remains different for minors as it does for adults. But the weight given to autonomy implicit in Article 8 suggests that, in certain circumstances, respect for the minors' autonomy may outweigh the court preserving their life under Article 8(2) and Article 2.

V. Article 14: The Discriminated Minor?

A. Article 14 of the Convention

Article 14 provides that '[t]he enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground'. The grounds of discrimination include 'sex, race, colour, language, religion, political or other opinion, national

[942] Cave (n 257) 111.
[943] *Re X (A Child) (No 2)* (n 25) [116]-[118]. Future-orientated versions of autonomy is synonymous with 'ideal desire autonomy'.
[944] See Chapter IV, Part V, Section B.

or social origin, association with a national minority, property, birth or other status'. The ECtHR underlines that Article 14 merely complements the other substantive provisions of the Convention and Protocols.[945] For Article 14 to come into play, it only needs to be shown that the facts of the case fall within the purview of one of the Convention's substantive provisions; its applicability does not necessarily presuppose that a substantive provision has been violated.[946] The broad scope of Article 14 has seen this provision applicable in many areas, such as employment,[947] education,[948] paternity,[949] and healthcare.[950]

The ECtHR case law has established that only differences in treatment based on identifiable characteristic, or status, can amount to discrimination within the meaning of Article 14.[951] The list of grounds of prohibited discrimination is illustrative rather than exhaustive, as is shown by the words 'on any grounds such as' and the broad phrase 'any other status'. In *Carson v United Kingdom*, the Court explained the approach to Article 14:

> [I]n order for an issue to arise under Article 14 there must be a difference in the treatment of persons in analogous, or relevantly similar, situations. Such a difference of treatment is discriminatory if it has no objective and reasonable justification; in other words, if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised. The contracting states enjoy a margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment.[952]

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[945] *Marckx v Belgium* (1979) 2 EHRR 330 [32].
[946] *Carson v United Kingdom* (2010) 51 EHRR 13 [63].
[947] *Sidabras v Lithuania* (2017) 65 EHRR 11.
[948] *DH v Czech Republic* (2008) 47 EHRR 3.
[949] *Rasmussen v Denmark* (1985) 7 EHRR 371.
[950] *Pentiacova v Moldova* (2005) 40 EHRR SE23.
[951] *Carson* (n 946) [61].
[952] ibid.

The Court in *Thilmmenos v Greece* held that States treating differently 'persons in analogous, or relevantly similar, situations' is not the only facet of the prohibition of discrimination in Article 14. Article 14 'is also violated when States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different'.[953]

1. Difference in treatment

The Strasbourg case law demonstrates that the applicant has to show that they have been treated (in)differently from another person or group of persons ('comparators') placed in an analogous or relevantly similar or dissimilar situation, taking into account the elements that characterise their circumstances in the particular context.[954] The Court in *Fábián v Hungary* noted that the 'elements which characterise different situations, and determine their compatibility, must be assessed in the light of the subject-matter and purpose of the measure which makes the distinction in question'.[955] The ECtHR has not considered under Article 14 the issue of whether a competent minor (i) is treated differently to an adult person, whose autonomy to make medical decisions is *prima facie* respected, and (ii) is not treated differently from minors who lack the mental capacity to make medical decisions. In both scenarios, the competent minor's age is a consistent element that characterises the context. Whilst age is not referenced explicitly as a ground of prohibited discrimination under Article 14, the Court in *Carvalho* recognised that age constituted 'other status' for the purposes of Article 14, noting that the words 'other status' have generally been given a wide meaning.[956] In *Carvalho,* the Court found a violation of Article 14 with respect to the applicant who underwent gynaecological surgery and brought a civil action against the hospital for medical negligence and was awarded reduced damages.

[953] (2001) 31 EHRR 15 [44].
[954] *Carson* (n 946); *Molla Sali v Greece* (2018) 69 EHRR 57.
[955] (2018) 66 EHRR 26 [121].
[956] *Carvalho Pinto de Sousa Morais v Portugal* (2018) 66 EHRR 25 [45].

The Court held that her age and sex were decisive factors in the decision regarding the award of damages, introducing a difference in treatment based on those grounds.[957]

More directly germane is the reasoning in *Khamtokhu v Russia*, in which the Court held that any difference in treatment between all juvenile offenders and men aged between 18 and 65 or over for sentences of life imprisonment was not discriminatory under Article 14.[958] Minors are exempted from life imprisonment because of the due regard for their presumed immaturity, both mental and emotional, as well as the greater malleability of their capacity for rehabilitation, which forms an objective and reasonable justification for any difference in treatment.[959] The issue of discrimination on the grounds of age in the context of minors on trial for murder was put forward in *T v United Kingdom*, but because the Court found a violation of Article 6(1), it considered that no separate issue arose under Article 14.[960]

2. Legitimate aim

In order to justify a difference in treatment, States first have to demonstrate that the measure at issue is based on a 'legitimate aim'.[961] Moreover, States have to show that a link exists between the legitimate aim pursued and the difference in treatment alleged by the applicant. In *DG v Ireland* and *Bouamar v Belgium*, for example, the Court held that the difference in treatment between minors and adults as regards detention stems from the protective–not punitive–nature of the measures applicable to minors.[962] The legitimate aim was thus protectionism and for the purposes of educational supervision. In *Khamtokhu v Russia,* the Court accepted that the aim to promote the principles of justice and humanity, which required that the sentencing policy takes into account the age and psychological characteristics of various categories of offenders,

[957] ibid [48]-[56].
[958] (2017) 65 EHRR 6 [80].
[959] ibid.
[960] (2000) 30 EHRR 121 [112]-[113].
[961] *Molla Sali v Greece* (n 954) [135].
[962] *DG v Ireland* (2002) 35 EHRR 33 [115]; *Bouamar v Belgium* (1989) 11 EHRR 1 [67].

may be regarded as legitimate.[963] The Strasbourg case law shows that aims that have the underlying rationale of protecting minors in some capacity are often regarded as legitimate.

3. Proportionality test

After establishing a legitimate aim, the ECtHR requires that the difference in treatment strikes a fair balance of community and individual interests.[964] There must be a reasonable relationship of proportionality between the means employed and the intended aim. The proportionality test acknowledges that States enjoy a certain margin of appreciation, and the scope of that margin will vary according to the circumstances, the subject matter and the background of the case.[965] One of the criteria the ECtHR uses to define the State's margin of appreciation in discrimination cases is the existence and the extent of a consensus among Contracting States on the issue at stake.[966] With respect to the age of majority, all EU Member States have set the benchmark for this at 18 years, except for Scotland, where people have full legal capacity from 16 years.[967] While age restrictions for any activity are inherently arbitrary, they are fundamentally purposeful. Implicit in States setting age restrictions is to protect the health, safety and welfare of minors.[968] In *Khamtokhu v Russia*, for example, the Court considered that it was open for the State to extend the exemption from life imprisonment to all categories of offenders but held there was no obligation for the State to do so. Given the practical operation of life imprisonment, the interests of society as a whole and the State's margin of appreciation, the Court was satisfied that there was a reasonable relationship of proportionality between the

[963] *Khamtokhu v Russia* (n 958) [70].
[964] *Belgian Linguistic Case* (1979-80) 1 EHRR 252.
[965] *Molla Sali v Greece* (n 954) [136].
[966] *Stafford v United Kingdom* (2002) 35 EHRR 32 [68].
[967] See Chapter VI, Part II.
[968] Child Rights International Network, 'Age is Arbitrary: Setting Minimum Ages' (CRIN, 11 April 2016) < https://archive.crin.org/en/library/publications/age-arbitrary-discussion-paper-setting-minimum-ages.html > accessed 23 November 2021.

means employed and the legitimate aim pursued. There were objective and reasonable justifications for the difference in treatment between adults and minors.[969]

Thus, the Strasbourg case law demonstrates that when there is an alleged difference in treatment between adults and minors on the grounds of age under Article 14, there is often an objective and reasonable justification for any such difference. Justifications derive from the protective nature of the regime applied to minors.

B. The Article 14 Challenge

Article 14, in conjunction with Articles 3, 5 or 8 ECHR, may be utilised to suggest that because a court does not have authority to override the refusal of a competent adult, to override the refusal of a competent minor would amount to unjustified discrimination on the grounds of age. This proposition was tested in *Re X (A Child) (No 2)*. It was submitted to Sir James Munby that in the context of medical treatment, the difference in treatment between competent minors and adults cannot be objectively and reasonably justified. The premise was that, unlike activities such as voting, driving and marriage, in which administrative convenience justifies a fixed age, administrative convenience can never justify denying the fundamental rights to bodily integrity, autonomy and religious conscience.[970] Sir James Munby did not accept this premise. Rather than administrative convenience, he suggested that the protection of minors' welfare lies at the root of the impugned provisions regulating minors' capacity to refuse medical treatment.[971] Referring to the reasoning in *DG v Ireland* and *Bouamar v Belgium*, Sir James Munby considered that a competent minor,

> is sufficiently different from a capacitous adult to justify a difference in treatment as a matter of law and that any difference in treatment is not discriminatory because it stems

[969] *Khamtokhu v Russia* (n 958) [87].
[970] *Re X (A Child) (No 2)* (n 25) [151].
[971] ibid [152].

> from the protective nature of the procedure applicable to minors. Furthermore… there is an objective and reasonable justification for any such difference in the treatment, namely to uphold the paramountcy principle and to ensure to the maximum extent possible the survival and development of the child.[972]

Developing his analysis further, Sir James Munby took into account the domestic judgment in *Re E (A Child)*, a case of withdrawing life-sustaining treatment from an infant whose parents objected.[973] In this case the Court of Appeal considered an alleged violation of Article 14, together with Article 8. Whilst the alleged discrimination concerned the parents rather than the infant, King LJ's comment on 'reasonable justification' is apposite to the present discussion. She stated that 'the proceedings under the inherent jurisdiction have in my view an objective and reasonable justification and pursue a legitimate aim, namely the care and treatment of desperately ill children'.[974] In *Re X (A Child) (No 2)*, the girl was at imminent risk of suffering catastrophic consequences should her refusal of treatment be respected.[975] She could well be described as a 'desperately ill' child. The basis of Sir James Munby's decision to impose blood transfusions on the girl had an objective and reasonable justification–to save her life. Thus, in the light of the Strasbourg and domestic case law, Sir James Munby held that the *Re R* and *Re W* principles, which aim to protect the health and life of minors and are not disproportionate in pursuit of that aim, are not incompatible with Article 14 of the Convention.[976]

The 'reasonable justification' approach is applied consistently in the Strasbourg and domestic case law. It is thus likely to undermine any challenge based on Article 14. However, Garwood-Gowers suggested that to force treatment on a competent minor, but not generally on

[972] ibid [153].
[973] [2018] EWCA Civ 550.
[974] ibid [118].
[975] See, for facts of the case, *Re X (A Child)* (n 618) [5].
[976] *Re X (A Child) (No 2)* (n 25) [157].

the competent adult, amounts to age discrimination under Article 14.[977] He considered arguments for treating competent minors differently from competent adults to be 'flimsy', suggesting that an adult with commensurate competence to a minor implies no difference in position when it comes to medical decision-making.[978] Thus, he argued that the two should not be treated differently in law–to do so breaches the competent minors' Article 14 rights.[979] Whilst there is some general force behind the competence argument, it does little to undermine the 'reasonable justification' for any difference in treatment. As Nolan LJ held in *Re W*, courts should start from the general premise that the protection of the minor's welfare entails at least the preservation of the minor's life, ensuring so far as the court can that minors survive to adulthood.[980] Laurie et al observed that:

> The English Courts have made a concerted effort to demonstrate their desire to find the balance in [minor's medical refusal] cases and there is little in the jurisprudence of the ECtHR that would lead them to upset that delicate equilibrium.[981]

Fovargue and Ost similarly considered that Article 14 would unlikely support a minor in their refusal of life-saving medical treatment.[982] Few would object to the suggestion that the preservation of minors' lives is a legitimate aim and that the courts approach the doctrine of proportionality consistently. Thus, it is doubtful that age discrimination arguments would succeed within the Article 14 framework.

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[977] Garwood-Gowers (n 895) 231.
[978] ibid 241.
[979] ibid.
[980] *Re W* (n 18) [94].
[981] Graeme T Laurie, Shawn Harmon and Edward S Dove, *Mason and McCall Smith's Law and Medical Ethics* (11th edn, OUP 2019) 341.
[982] Sara Fovargue and Suzanne Ost, 'Does the Theoretical Framework Change the Legal End Result for Mature Minors Refusing Medical Treatment or Creating Self-Generated Pornography' (2013) 13(1) Med L Int 6, 19.

VI. Concluding Remarks

This chapter analysed whether (competent) minors could refuse medical treatment based on their rights under Articles 2, 3, 5, and 8, in conjunction with Article 14 ECHR. In doing so, it has sought to contribute to the existing legal literature which examines the support minors derive from their Convention rights in medical decision-making. This chapter analysed Article 5 in particular because its implications have seldom seen sufficient attention. The 'macro' findings of this chapter suggest that based on their Convention rights, minors do not have, in the same way as adults, the legal right to exclusively determine not to have medical treatment that is in their best interests. However, several significant 'micro' findings have been identified for each relevant Convention right.

Article 2 protects minors' right to life. Article 2 jurisprudence does not indicate that minors have a right to die. The case law suggests that the courts are under a positive or operational duty arising from Article 2 to take preventative measures to ensure the minors' life. Yet more recent case law, namely *E & F*, suggest that when the courts balance the minors' competing rights, it is open for the courts to find that it is in the minor's best interests for their Article 2 rights to be outweighed by other Convention rights.

Article 3 protects minors from inhuman or degrading treatment. It is settled law that compulsory medical treatment, which is a therapeutic necessity according to the established principles of medicine, cannot, in principle, be regarded as inhuman or degrading within the meaning of Article 3. Depending on the individual case facts, Article 3 may support the minor dying with dignity if supporting the minor's death is a decision consistent with their best interests. Article 3 does not therefore provide minors with an exclusive right to die with dignity.

Article 5 protects minors' right to liberty and security. A minor may appeal to their Article 5 rights to argue that the imposition of life-saving medical treatment despite their

objections amounts to a deprivation of liberty. This chapter offered two frameworks to analyse the Article 5 challenge. The first followed the conventional application of Article 5, which asked: is there a deprivation of liberty and, if so, is it justified under Article 5(1)(e) and is the measure in accordance with a procedure prescribed by law? The second applied the elements of the *Ferreira* carve-out. The investigation of the conventional application of Article 5 suggested that while a minor could argue their concrete situation represents a deprivation of liberty, any such deprivation would likely be justified if ordered under the court's inherent jurisdiction. However, the analysis tentatively suggested that a court would not need to follow the conventional approach to Article 5 and could, instead, following *Ferreira*, suggest that any purported deprivation of liberty resulting from the administration of life-saving medical treatment does not, in principle, engage Article 5(1).

Article 8 protects minors' right to private life, although in qualified terms. Implicit in Article 8 is the notion of personal autonomy, and compulsory medical intervention engages Article 8(1). The investigation of the Strasbourg jurisprudence has shown that the courts will support a patient's autonomy as far as possible. Though the level of support is not necessarily proportionate between adults and minors. Domestic case law demonstrates that when a minor refuses treatment that is in their best interests, it is open for the courts to justify the imposition of treatment under Article 8(2) for the protection of the minors' health. However, recent case law signals an increasing judicial emphasis on recognising and respecting minors' autonomy. Considering the need of the courts to balance the minors' autonomy interests against competing interests, Article 8 offers a robust basis for courts supporting minors' autonomy. It was proposed in Chapter IV that the reasoning in *E & F*, read together with the outcome in *DV (A Child)*, suggests that the courts are open to respecting a minor's autonomous decision to choose death if that decision is in their best interests. The implications of this interpretation are not yet

known, but if it holds weight, then Article 8 generally appears to be the most convincing Convention right to support a minor's decision to refuse medical treatment.

Article 14 protects minors from unjustified discrimination. Minors may argue that they are unjustifiably treated differently from adults on the basis of age in medical decision-making. However, the case law in all contexts highlighting a difference in treatment between adults and minors has demonstrated that any such difference in treatment has objective and reasonable justifications. It is a legitimate aim of the State to have protective regimes preserving minors' health or lives, and such measures are likely consistent with the doctrine of proportionality. Thus, age discrimination arguments under Article 14 largely fail to convince.

The next chapter draws on the suggested increase in autonomy-affirming reasoning demonstrated in Chapters III, IV and V and considers the future of minors' medical rights. Chapter VI undertakes a comparative analysis, highlighting the rationale and justifications underpinning approaches taken by the Canadian and Scottish jurisdictions to minors' autonomy in medical decision-making. It suggests that the Canadian and Scottish regimes provide valuable perspectives on how English law should approach issues of minors' medical decision-making.

CHAPTER VI

COMPARATIVE LAW

In Chapter V, it was posited that no Convention right of itself nor cumulatively provides minors with the legal right to refuse life-saving medical treatment. Nevertheless, Chapter V suggested that of all the Convention rights, Article 8 would generally prove most decisive in the court's welfare assessment when determining what is in the minor's best interests, noting the primacy Article 8 attaches to personal autonomy. Building on the arguments in the previous chapters that English law is increasingly, albeit gradually, moving towards a more autonomy-affirming basis in its evaluation of whether to respect the medical decisions of minors, this chapter canvasses other jurisdictions that suggest respect for minors' medical autonomy and evaluates whether English law should develop in accordance with the strengths of their regimes.

Part I of this chapter surveys the decision of the SCC in *AC v Manitoba* and other relevant Canadian cases on minors' medical decision-making. *AC v Manitoba* recognised the capacity of minors to make medical decisions. There are two plausible interpretations of the SCC's judgment, with one account offering a stronger level of protection for minors' autonomy than the other. Notably, even the weaker account goes further than the English position. Thus, contrary to suggestions in English case law reviewing its judgment,[983] the reasoning in *AC v Manitoba* is of significant comparative interest and is considered at length in order to suggest how to develop English law. Moreover, the Canadian courts have considered questions posed by certain factual situations in minors' medical refusal cases that have not seen noteworthy scrutiny in English case law. The novel factors relevant to those cases have included (i) poor life expectancy prognoses and (ii) physical suffering from treatment. The reasoning in

[983] See *Re X (A Child) (No 2)* (n 25).

Canadian case law could help fill gaps in English law, particularly in relation to the welfare dilemma.

Part II reviews the Scottish legal framework governing minors' medical decision-making. In this regard, the Age of Legal Capacity (Scotland) Act (ALCSA) 1991 is the lynchpin piece of law. The relevant provisions under the ALCSA 1991 have seldom been tested in the Scottish courts, save for the decision of the Sheriff Court in *Houston*.[984] This decision provides important insights into children's medical rights; the reasoning also has important implications for young persons' medical rights. Thus, Part II aims to contribute to the literature by exploring and evaluating the lessons learned from Scottish law for the purposes of developing English law. This part suggests that there are merits to developing English law with an eye on the strengths of the Scottish approach.

I. Comparative Analysis I: Canada

A. The Canadian Approach

The case of *AC v Manitoba* concerned a 14-year-and-10-month-old child, AC, who was admitted to the hospital because she suffered an episode of gastrointestinal bleeding as a result of Crohn's disease.[985] AC was a Jehovah's Witness and had completed an Advance Directive instructing that she not receive blood transfusions; her parents fully supported her decision.[986] The treating physician requested a formal assessment of AC's decision-making capacity. The report was completed by three psychiatrists and concluded that AC had 'no psychiatric illness at present' and that she understood 'the reason why a transfusion may be recommended, and the consequences of refusing to have a transfusion'.[987] At the time of the assessment, AC's

[984] *Houston (Applicant)* [1996] SCLR 943.
[985] *AC v Manitoba* (n 24) [5].
[986] ibid [6].
[987] ibid.

condition was stable, but she later experienced more internal bleeding–she still refused the transfusion treatment. Consequently, she was apprehended as a child in need of protection under the Child and Family Services Act, CCSM c C80 (CFSA),[988] and a court order was requested under ss 25(8) and 25(9) CFSA to authorise the administration of blood transfusions to AC as deemed necessary by the treating physician.[989] The medical evidence suggested that blood transfusions were necessary to avoid AC suffering serious oxygen deprivation; the consequential damage to AC without the blood transfusions providing oxygen to her system was a fast demise or death.[990]

In the Provisional Court, Kaufman J assumed that AC had decisional capacity but granted the treatment order because AC was a child under 16 years old, meaning the court could order medical treatment in the child's best interests. The treatment was successful, and AC recovered. AC and her parents appealed the decision of Kaufman J to the Manitoba Court of Appeal, which dismissed the appeal. AC appealed to the SCC, asserting two principal arguments. First, it was argued that s 25(8) CFSA and the 'best interests' test contained within it apply only to minors under the age of 16 without capacity and, therefore, the test should not have applied to her. Alternatively, it was argued that ss 25(8) and 25(9) were unconstitutional because they violated her rights under ss 2(a) (freedom of religion), 7 (right to life, liberty and security) and 15(1) (freedom from discrimination based on age) of the Canadian Charter of Rights and Freedoms (the Charter). The SCC dismissed the appeal.

The majority judgment of the SCC was delivered by Abella J.[991] By way of preliminaries, Abella J outlined the legislative scheme and considered the specific wording of

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[988] See s 17(1), 'For the purposes of this Act, a child is in need of protection where the life, health or emotional well-being of the child is endangered by the act or omission of a person'. See also s 17(2)(b)(iii).
[989] *AC v Manitoba* (n 24) [8]-[9].
[990] ibid [11].
[991] LeBel, Deschamps and Charron JJ concurred with Abella J. McLachlin CJ (Rothstein J concurring) agreed with the majority judgment but provided separate reasoning at [123]-[161]. Binnie J offered a dissenting opinion at [162]-[239]: see Chapter VI, Part I, Section B.

the impugned provisions. In Manitoba, the Age of Majority Act, CCSM c A7, s 1 provides that '[e]very person attains the age of majority, and ceases to be a minor, on attaining the age of 18 years'. Underpinning the conceptual framework of the CFSA is the 'best interests' test found in s 2(1).[992] According to s 2(1),[993] the 'best interests of the [minor] shall be the paramount consideration of the… court'. When determining the minors' best interests under s 2(1), several factors shall be (evenly) considered, including, amongst other things:

> (b) the mental, emotional, physical and educational needs of the [minor] and the appropriate care or treatment, or both, to meet such needs;
>
> (c) the [minor's] mental, emotional and physical stage of development;
>
> (f) the views and preferences of the [minor] where they can reasonably be ascertained;
>
> (h) the [minor's] cultural, linguistic, racial and religious heritage.

Section 25(1)(c) CFSA provides that where a minor has been apprehended,[994] an agency may authorise the medical treatment for the minor if:

> (i) the treatment is recommended by a duly qualified medical practitioner or dentist,
>
> (ii) the consent of a parent or guardian of the [minor] would otherwise be required, and
>
> (iii) no parent or guardian of the [minor] is available to consent to the treatment.

Section 25(2) states that 'if the [minor] is 16 years of age or older, an agency shall not authorize a medical… treatment under clause (1)(c) without the consent of the [minor]'. Where the minor aged 16 or over refuses consent to medical treatment, s 25(3)(b) provides that an agency may apply to court for an order authorising medical treatment for an apprehended minor where:

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[992] See the preambular Declaration of Principles of the Child and Family Services Act, CCSM c C80 (CFSA).
[993] It should be noted that the CFSA was updated on 12 September 2023 and includes changes to s 2.
[994] See (n 988).

(i) the parents or guardians of the [minor] refuse to consent to the treatment, or

(ii) the [minor] is 16 years of age or older and refuses to consent to the treatment.

Sections 25(8) and 25(9) govern when a court can impose medical treatment on the apprehended minor at the request of the agency. These provisions distinguish minors under the age of 16 from those aged 16 and 17. Section 25(8) states that '[s]ubject to subsection (9), upon completion of a hearing, the court may authorize… any medical… treatment that the court considers to be in the best interests of the [minor]'. Section 25(9) provides that:

> The court shall not make an order under subsection (8) with respect to a [minor] who is 16 years of age or older without the [minor's] consent unless the court is satisfied that the [minor] is unable
>
> (a) to understand the information that is relevant to making a decision to consent or not consent to the medical… treatment; or
>
> (b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent to the medical… treatment.

AC was under 16 at the time of the treatment order, meaning s 25(9) did not apply. Notwithstanding this, Abella J analysed the relevance of s 25(9) generally, and this provision is important for the purposes of this part.

Abella J was of the view that merely considering the relevant statutory context, whilst it does frame the constitutional analysis, was not enough to provide the whole picture.[995] Thus, she turned to examine the common law of medical decision-making in relation to adults and minors. Abella J observed that adults are presumptively entitled to consent or refuse medical

[995] *AC v Manitoba* (n 24) [38].

treatment, although this is a rebuttable presumption of capacity.[996] Abella J recognised that the common law treats minors differently to adults, but it has evolved to entitle minors a degree of decision-making autonomy that is reflective of their intelligence, understanding and maturity.[997] In other words, the common law has developed a 'mature minor' doctrine. AC argued that this doctrine implies that mature minors are entitled to make *all* medical decisions, including refusing life-saving treatment.[998] Abella J suggested AC's argument miscast the development and application of the doctrine. The English authorities from where it derives have delineated that competent minors' medical decision-making autonomy is limited.[999]

The 'mature minor' doctrine was applied in Canada in the early case of *JSC v Wren*, in which Kerans JA held that a 16-year-old girl was capable of providing valid consent to the procedure of abortion.[1000] As in England, however, Abella J observed that Canadian case law has largely adopted the position that if the minor's decision would likely put their health or life in jeopardy, the courts would overrule the refusal.[1001] There have been exceptions.[1002] The survey of Canadian and international jurisprudence directed Abella J to conclude that the courts have duly embraced minors' autonomy for medical decision-making but not in an absolute sense.[1003] With the relevant law (and commentary[1004]) extensively observed, Abella J turned to, first, the interpretation of best interests under ss 25(8) and 25(9) CFSA and, second, constitutional diagnosis. For the purposes of analysis, it is the former issue that is of material interest, although there is some overlap.

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[996] See, eg, *Malette v Shulman* (1990) 72 OR (2d) 417; *Fleming v Reid* (1991) 4 OR (3d); *Rodriguez* (n 23); *Ciarlariello v Schacter* [1993] 2 SCR 119; *Nancy B v Hotel Dieu de Quebec* (1992) 86 DLR (4th) 385 (Que SC).
[997] *AC v Manitoba* (n 24) [46].
[998] ibid [47].
[999] ibid [48]-[57]. See Chapters III and IV.
[1000] 1986 ABCA 249.
[1001] See, eg, *H(T) v Children's Aid Society of Metropolitan Toronto* (1996) 138 DLR (4th) 144 (Ont Ct (Gen Div)); *Dueck (Re)* (1999) 171 DLR (4th) 761 (Sask QB); *Alberta (Director of Child Welfare) v H(B)* 2002 ABQB 371.
[1002] See *Re LDK (An Infant)* (1985) 48 RFL (2d) 164. See also *Re AY* (1993) 111 Nfld & PEIR 91. These cases are analysed in Chapter VI, Part I, Section D.
[1003] *AC v Manitoba* (n 24) [69]. Abella J considered the jurisprudence of other jurisdictions at [64]-[68].
[1004] ibid [70]-[79].

Abella J premised her analysis with the guiding principle that the 'best interests' test provides 'the courts with a focus and perspective through which to act on behalf of those who are vulnerable'.[1005] The import of a minor being apprehended under s 25 CFSA is that they are refusing potentially life-saving treatment. Abella J suggested that in these rare cases, the 'ineffability' implicit in the mature minor doctrine justifies the court retaining decision-making authority to determine whether the proposed treatment is actually in the minor's best interests.[1006] Abella J emphasised, however, that this decision-making authority should not be exercised without restraint, and offered guidance for how the courts should approach s 25(8):

> In some cases, courts will inevitably be so convinced of a [minor's] maturity that the principles of welfare and autonomy will collapse altogether and the [minor's] wishes will become the controlling factor. If, after a careful and sophisticated analysis of the [minor's] ability to exercise mature, independent judgment, the court is persuaded that the necessary level of maturity exists, it seems to me necessary to follow that the adolescent's views ought to be respected. Such an approach clarifies that in the context of medical treatment, [minors] under 16 should be permitted to attempt to demonstrate that their views about a particular medical treatment reflect a sufficient degree of independence of thought and maturity.[1007]

The implication of the best interests test, according to Abella J, is that 'it is, by definition, in a [minor's] best interests… [for the court] to respect and promote his or her autonomy to the extent that his or her maturity dictates'.[1008] The factors in s 2(1) CFSA support the judge in determining what is in the minor's best interests, noting (i) that what the amalgamation of the factors yield is necessarily case-specific, and (ii) the minors' input (i.e. ascertainable views and

[1005] ibid [81].
[1006] ibid [86].
[1007] ibid [87].
[1008] ibid [88].

preferences) in the best interests assessment becomes increasingly determinative as the minor matures.[1009] In the serious medical refusal cases, Abella J emphasised that scrutiny of a minor's maturity for autonomous decision-making in the s 25(8) best interest analysis must be undertaken with respect and rigour.[1010] This is because it is in these cases where minors' autonomy interests stand starkly at odds with the court's protective duty. Additionally, as AC argued, if the best interest provisions are interpreted narrowly, such that someone under 16 is deprived of the opportunity to demonstrate their decision-making capacity,[1011] then they are arbitrary and, therefore, unconstitutional.[1012] Abella J suggested a solution to the problem:

> Interpreting the best interests standard so that a [minor] is afforded a degree of bodily autonomy and integrity commensurate with his or her maturity navigates the tension between [minors'] increasing entitlement to autonomy as he or she matures and society's interest in ensuring that [minors] who are vulnerable are protected from harm.[1013]

Abella J suggested this interpretation of the best interests standard in s 25(8) strikes an appropriate balance between upholding the legislative protective goal and respecting the right of minors to have the opportunity to demonstrate their decision-making capacity and have their autonomy duly respected. Abella J thus held that because this interpretation achieves a balance between autonomy and protectionism, the best interest provisions are not arbitrary.[1014] The weight accorded to the views of a minor under or over 16 under s 25 will ultimately correspond to the court's conclusions about the extent to which that minor's decision is consistent with

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[1009] ibid [90]-[92].
[1010] ibid [94]-[96]. At [96], Abella J offered a list of non-exhaustive factors that may be of assistance to judges in the best interests analysis.
[1011] ibid [91], Abella J suggested that this is how Kaufman J seemed to interpret the provisions.
[1012] ibid [103].
[1013] ibid [108].
[1014] ibid.

their best interests.[1015] The s 25(8) best interests analysis, properly interpreted, provides minors with decisional autonomy commensurate with their maturity.[1016] This sliding scale of decision-making autonomy reflects a proportionate response to balancing the State's and individual's competing interests.[1017] Abella J hence found the foregoing analysis as indicating that ss 25(8) and 25(9) neither deprive minors of their decision-making capacity nor are unconstitutional. In the end Abella J held that whilst AC had 'technically' lost her constitutional challenge, she successfully argued that the impugned legislative provisions should be interpreted in such a way to allow children to demonstrate sufficient maturity to have a particular medical treatment decision respected.[1018]

The decision of *AC v Manitoba* exemplifies tensions among the definition and scope of capacity, the significance attached to the notion of autonomy, and the court's role in protecting the interests of minors as a vulnerable group. The relevant features of the *AC v Manitoba* decision are threefold for the purposes of analysis. First, it is necessary to reconcile the reasoning of the majority and the dissenting opinion of Binnie J. His reasoning in *AC v Manitoba* demonstrated the strongest claim that autonomy was principal. It is equally important to consider Binnie J's judgment because he and Abella J both supported the premise that competent children's medical decisions should be respected, albeit for contrasting reasons.[1019] Thus, why did the analysis of Abella J carry the day? Secondly, the case delineates how Canadian law approaches the medical decision-making capacity for young persons and children and is of significant comparative interest since English law similarly distinguishes these cohorts of minors. Thirdly, what general principles from Canadian jurisprudence (if any)

[1015] ibid [111]. A court shall not make an s 25(8) best interests order for a person aged 16 years or older unless s 25(9) is satisfied.
[1016] ibid [114].
[1017] ibid [115].
[1018] ibid [121].
[1019] David C Day, 'Getting Respect: The Mature Minor's Medical Treatment Decisions: *A.C. Manitoba (Director of Child and Family Services)*' (2010) 88(3) Can B Rev 671, 676.

could be adopted to further English domestic legal analysis? In *Re X (A Child) (No 2)*, Sir James Munby suggested that *AC v Manitoba* does not even begin to suggest the need for any judicial re-evaluation of English law.[1020] Sir James Munby's analysis of *AC v Manitoba* was rather limited. English law would benefit from embracing Abella J's analysis, particularly on children's autonomy, as well as adopting some of the reasoning in other important Canadian decisions.

B. The Majority Versus Dissenting Reasoning

In his dissenting view, Binnie J would have allowed the appeal, having found the CFSA 'insufficiently respectful of constitutional limits on the imposition of forced medical treatment on a mature minor'.[1021] Underlying Binnie J's judgment was the interpretation that the impugned provisions of the CFSA prescribe an irrebuttable presumption of incapacity for children. As he understood s 25, the provisions prevent children from establishing that they understand their medical condition and the consequences of refusing treatment, thus distinguishing them from mature young persons who have the right to refuse treatment whether or not the application judge considers such refusal to be in their best interests.[1022] Binnie J's preferred approach was that:

> [I]f a teenager (as in this case) *does* understand the nature and seriousness of her medical condition and is mature enough to appreciate the consequences of refusing consent to treatment, then the justifications for taking away the autonomy of *that* young person in such important matters does not exist.[1023]

The overarching emphasis on respect for the mature child's autonomy permeated Binnie J's judgment. This was the case notwithstanding his concession that children may generally (and

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[1020] *Re X (A Child) (No 2)* (n 25) [104].
[1021] *AC v Manitoba* (n 24) [166].
[1022] ibid [177], [233].
[1023] ibid [207] (emphasis in original).

correctly) be assumed to lack the capacity and maturity to refuse life-saving treatment.[1024] He also accepted that the care and protection of children generally is a pressing and substantial legislative objective that may plausibly and justifiably limit a Charter right.[1025] However, Binnie J considered that the impugned procedure under s 25 CFSA was not rationally connected to that objective. He argued that the CFSA is problematic because it denies children the 'opportunity of *demonstrating* what in the case of the older mature minors is *presumed* in their favour'.[1026] Binnie J did not consider the majority's interpretation of the CFSA as rendering rebuttable the presumption that children lack the capacity to refuse medical treatment.[1027] He suggested the sliding scale principle advanced by Abella J is no more than a gloss because capacity is merely a consideration among others (however much its weight increases in correspondence with the maturity level and the nature of the treatment decision to be made) and is in no way determinative.[1028] Thus, Binnie J held that the irrebuttable presumption of incapacity 'takes away' the autonomy of AC and other mature minors for no valid State purpose because, by having capacity, such children do not fit within the definition of being children 'in need of protection'.[1029]

As a way to resolve the perceived inequity between minors under and over 16, Binnie J suggested that traditional principles of autonomy that apply to adults' decision-making capacity should apply equally to 'mature minors'.[1030] He suggested this approach was adopted in the British Columbia Court of Appeal decision in *Van Mol (Guardian ad Litem of) v Ashmore*.[1031] This case held that once the required capacity to consent has been achieved by the minor, all discussions and decisions regarding the proposed course of treatment 'must all

[1024] ibid [176].
[1025] ibid [233].
[1026] ibid (emphasis in original).
[1027] ibid [194].
[1028] ibid.
[1029] ibid [222].
[1030] ibid [196]-[202].
[1031] 1999 BCCA 006.

take place with and be made by the young person whose bodily integrity is to be invaded and whose life and health will be affected by the outcome'.[1032] Binnie J interpreted the phrase 'and be made by' to mean that children with capacity are entitled to make treatment decisions rather than merely to have an 'input' into a judge's best interests assessment.[1033] It flows from Binnie J's reasoning that, in contrast to Abella J's approach, it is the mature child rather than the judge who is the final arbiter in the decision-making process.

Whilst it may be true that both Abella and Binnie JJ reached the same destination in the sense of suggesting that it should be open for children's medical decisions to be respected, Binnie J's analysis was short-sighted. His underlying argument that s 25 CFSA prevents those under 16 from establishing their decisional capacity was wholly undermined by Abella J's broad analysis, which harmonised the CFSA with the mature minor doctrine. Day suggested that Abella J interpreted the best interests test in s 25(8) as an elastic concept that can be reshaped and redefined by constitutional diagnosis.[1034] It follows that s 25(8) can recognise a mature minor's constitutional right to autonomous medical decision-making. In other words, the principles underpinning the best interests test contained in the CFSA and the mature minor doctrine are not mutually exclusive. Abella J made the point that:

> To divorce the application of the best interests standard from an assessment of the mature child's interest in advancing his or her own autonomous claim would be to endorse a narrow, static and profoundly unrealistic image of the child and of adolescence.[1035]

As Abella J observed, therefore, the proper interpretation of s 25(8) is that if the child demonstrates the necessary level of maturity commensurate with the treatment decision, their

[1032] ibid [75].
[1033] *AC v Manitoba* (n 24) [202].
[1034] Day (n 1019) 680.
[1035] *AC v Manitoba* (n 24) [91].

decision then ought to be respected.[1036] Day went further and suggested that the French language version of Abella J's decision clarifies that what is meant by 'ought to be respected' is that the treatment decision of the mature minor *must* be respected.[1037] The term 'must' is more unqualified in tone than 'ought' and places a greater demand on the court to actually respect the mature minors' treatment decision. Interpreting the impugned provisions as Abella J had done demonstrates that Binnie J's premise that the Act provides an irrebuttable presumption of incapacity for those under 16 held no weight.

The decision in *AC v Manitoba* is not about the unfettered triumph of autonomy,[1038] despite Binnie J's best efforts to perhaps suggest that it should have been. The reasoning of Abella J does not go so far as to find for children a determinative right to refuse treatment, but neither does it signify that not providing such a right makes the impugned provisions unconstitutional. It is equally the case that because the judge is necessarily the final arbiter of what treatment decisions a mature minor can make, that does not *ipso facto* 'take away' the minor's autonomy. Thus, Abella J's opinion was more nuanced in that it recognised competing interests and provided a robust framework for determining what was best for the minor in question.

C. The Rebuttable Presumption of Capacity

The SCC judges all recognised that the CFSA distinguishes between young persons (16-17-year-olds) and children (under 16s) for the purposes of medical decision-making. There was, however, a difference of opinion regarding how the relevant CFSA provisions should be applied, with the crux of the issue concentrated on interpreting the potential interplay and overlap of statutory provisions and common law principles.

[1036] ibid [87].

[1037] Day (n 1019) 678. The French version of 'ought to be respected' is 'qu'il faut respecter ses opinions'.

[1038] Shawn Harmon, 'Body Blow: Mature Minors and the Supreme Court of Canada's Decision in *AC v Manitoba (Director of Child & Family Services)*' (2010) 4 MJLH 83, 89.

Abella J synthesised the mature minor doctrine and the s 25(8) CFSA best interests test. In contrast, the concurring minority opinion delivered by McLachlin CJ agreed with the view of the Court of Appeal and suggested that the CFSA provides a complete statutory scheme for medical decisions of apprehended minors to the extent that it 'displaces the common law regarding medical decision making by "mature minors"'.[1039] The majority judgment of Abella J supersedes that of McLachlin CJ,[1040] yet the dichotomous interpretations of the CFSA have obfuscated the law. There are two plausible ways to interpret the CFSA.

1. Interpretation (1)

On one account, ss 25(2) to 25(9) CFSA provide a rebuttable presumption of decision-making capacity to consent and refuse medical treatment for young persons. All of the judges in *AC v Manitoba* observed that this *prima facie* right of medical choice can only be rebutted if the judge is satisfied that the apprehended young person is unable to understand the nature of the decision and/or its likely consequences.[1041] Harmon suggested that the CFSA empowers young persons to exercise the same autonomy rights as adults.[1042] Daniel similarly understood the CFSA as providing that a young person's decision is 'ordinarily determinative'.[1043] Moreover, interpretation (1) of the CFSA is consistent with other statutory schemes in Manitoba that suggest that young persons have a rebuttable presumption of capacity. The Mental Health Act, CCSM c M110, which regulates the admission and treatment for patients in psychiatric

[1039] *AC v Manitoba* (n 24) [123]-[126].
[1040] See *JI v Alberta (Child, Youth and Family Enhancement Act, Director*) 2022 ABQB 360 [99].
[1041] *AC v Manitoba* (n 24) [24], [35], [37], [111], [130], [132], [139], [172], [177]. There appears to be a lack of consistency between what the CFSA and SCC demand for a young person to lack capacity. Section 25(9) CFSA requires the young person to be unable '(a) to understand the information relevant to making a decision… *or* (b) to appreciate the reasonably foreseeable consequences of making a decision'. In contrast, the judges in *AC v Manitoba* suggest that young persons must be 'unable to understand the nature of the decision *and* its likely consequences'. The threshold for lack of capacity is lower according to the CFSA framework.
[1042] Harmon (n 1038) 89.
[1043] Richard Daniel, 'Mature Minors and Consent to Treatment: Time for Change' (2009) (Nov) IFL 233, 234.

facilities, provides under s 2 that in the absence of evidence to the contrary, it shall be presumed:

> (a) that a person who is 16 years of age or more is mentally competent to make treatment decisions and to consent for the purpose of this Act; and
>
> (b) that a person who is under 16 years of age is not mentally competent to make treatment decisions or to consent for the purposes of this Act.[1044]

The Health Care Directives Act, CCSM c H27, which regulates the making of health care directives regarding health care and treatment decisions, provides under s 4(2) that in the absence of evidence to the contrary, it shall be presumed for the purposes of this Act:

> (a) that a person who is 16 years of age or more has the capacity to make health care decisions; and
>
> (b) that a person who is under 16 years of age does not have the capacity to make health care decisions.[1045]

Whilst no such presumption exists for children, Abella J's interpretation of s 25(8) CFSA and the mature minor doctrine suggests this cohort may still have their medical decision (to consent or refuse) respected insofar as such a decision aligns with their best interests.[1046] Harmon observed that Abella J's judgment exposed a significant appetite for promoting individuals' autonomy, consistent with the growing body of Canadian case law generally,[1047] particularly with its recognition that there comes a time when it is in a child's best interests to exercise

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[1044] See also s 8(2), titled 'Determining competence to consent'.

[1045] See s 1, '"health care decision" means a consent, refusal to consent or withdrawal of consent to treatment'. See also s 4(3), which provides that the '[p]resumption re age' to make a directive is 16 years of age or more.

[1046] *AC v Manitoba* (n 24) [24], [108]-[115].

[1047] Mona Paré, 'Of Minors and the Mentally Ill: Re-Positioning Perspectives on Consent to Health' (2011) 29(1) Windsor Y B Access Just 107, 125, 'Canadian law related to capacity and medical decision-making has moved from a protective model towards a greater appreciation and respect of personal autonomy'.

autonomy, whatever consequences the exercise of that autonomy might result in.[1048] Thus, the approach of Abella J does not undermine the distinction the CFSA makes between young persons and children. It instead clarifies that the CFSA provisions are flexible in order to rightly account for the actual decision-making capabilities of children.

2. Interpretation (2)

An alternative understanding of *AC v Manitoba*, and its implications for interpreting the CFSA, can largely be found in the judgment of LeBlanc J in *PH v Eastern Regional Integrated Health Care Authority and SJL*.[1049] In this case, a mother applied to the court for, and was granted, an order detaining her daughter, SJL, who was just over 16 years old at the time of the hearing, in a mental health hospital in order to prevent her from potentially causing herself serious harm.[1050] The preliminary issue in this case was whether SJL had the legal competence to make her own healthcare decisions.

SJL was a case from the trial division in Newfoundland and Labrador (N&L) and therefore had a different statutory scheme to Manitoba. The age of majority in N&L is 19.[1051] Under the s 7 of the Advance Health Care Directives Act, SNL 1995, c A-4.1, in the absence of evidence to the contrary, it is presumed that a person who is 16 years of age or older is competent to make health care decisions.[1052] LeBlanc J suggested that this legislation is subject to the common law recognition of the mature minor doctrine, as interpreted by Abella J in *AC v Manitoba*.[1053] The legislation established that SJL was not an adult but was presumed

[1048] Harmon (n 1038) 88.
[1049] (2010) 294 Nfld & PEIR 248 (NLTD).
[1050] ibid [1].
[1051] Age of Majority Act, SNL 1995, c A-4.2, s 2.
[1052] Advance Health Care Directives Act, SNL 1995, c A-4.1, s 1(b), '"health care decision" means a consent, refusal to consent, or withdrawal of consent of any care, treatment, service, medication, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health or personal care'. The common law rules regarding the competence of adults to make health care decisions apply in Newfoundland and Labrador: see *Re Strong* (1993) 170 Nfld & PEIR 350.
[1053] *SJL* (n 1049) [32].

competent to make her own healthcare decisions, subject to evidence to the contrary on a balance of probabilities. The SCC case of *Starson v Swayze* set out a two-stage legal test for determining competence (interchangeable with 'capacity'):

> First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information… Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.[1054]

Applying the two-stage test, LeBlanc J found that SJL's presumed competence was not rebutted on the first stage. While SJL did not agree that she had borderline personality disorder, or any mental disorder, she had the ability to understand the relevant information given to her about her condition and the treatment options suggested to her.[1055] On the other hand, LeBlanc J was unable to conclude that SJL had also satisfied the second prong of *Starson*. He found that SJL's mental disorder prevented her from having the ability to appreciate the reasonably foreseeable consequences of her decision to accept treatment or not.[1056] The finding of SJL not being competent would have been enough to invoke the court's *parens patriae* jurisdiction to interfere with her treatment decision and make a best interests decision to protect her welfare.[1057] However, LeBlanc J went on to discuss the best interests standard.

LeBlanc J suggested that 'the best interests standard should have application where the treatment decision is related to the preserving of life of a person who is not legislatively

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[1054] [2003] 1 SCR 722 [78].
[1055] *SJL* (n 1049) [81]-[82], [86].
[1056] ibid [88]-[89], [90].
[1057] *Re Strong* (n 1052); *In re Jane Doe* 2005 NLTD 72 [8]-[9]; *Re Eve* [1986] 2 SCR 388 [73].

recognised as an "adult"'.[1058] The rationale for this approach, he advanced, derives from a proper consideration of the reasoning espoused in *AC v Manitoba.* LeBlanc J suggested that notwithstanding that Abella J's interpretation of the best interests standard was framed against the statutory context in Manitoba, her reasoning was generally 'applicable to those over age 16 up to the time the person reaches the age of majority and is recognised by law as an adult'.[1059] The sliding scale application of the best interests standard remains a consistent consideration for the court, until the minor reached adulthood. In other words,

> where the presumed competency of a young person who is under the age of majority is not rebutted, the Court in the exercise of its *parens patriae* jurisdiction should go further and consider the young person's level of maturity in determining whether it will force treatment in the face of the right of autonomous decision-making given to such a person.[1060]

In his assessment of SJL's maturity under the best interests standard, LeBlanc J was satisfied that her limited life experience was a significant factor preventing her from having the ability to appropriately consider her treatment options and to make healthcare decisions.[1061] Applying his interpretation of *AC v Manitoba*, LeBlanc J held that notwithstanding the recognition of the presumption of competence, it was right to exercise the *parens patriae* authority of the court to protect SJL's future healthcare.[1062]

LeBlanc J's interpretation of *AC v Manitoba* suggests that the competence inquiry is relevant only as a factor in determining the broader question of what is in the minor's best interests.[1063] Mosoff argued that Leblanc J's protective approach was correct because it was

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[1058] *SJL* (n 1049) [45].
[1059] ibid [46].
[1060] ibid [52].
[1061] ibid [93].
[1062] ibid [94].
[1063] Judith Mosoff, '"Why Not Tell It Like It Is?": The Example of *PH v Eastern Regional Integrated Health Authority*, a Minor in a Life-Threatening Context' (2012) 63 UNBLJ 238, 245.

consistent with Abella J's recognition that the history of refusal cases has consistently held that the right to autonomous medical decision-making extends to minors, with the proviso that this does not threaten their life or health.[1064] This flows into the crux of Mosoff's argument, that in the narrow category of cases where the decision of the minor is likely fatal, irrespective of findings or presumptions about competence and the value of autonomy, the court's choice is *always* to preserve the minor's life because that is in their best interests.[1065] Mosoff defended her argument by recognising the trade-off of using best interests as the paramount principle. She noted that whilst the test is paternalistic, it accounts for the right of mature minors to make mistakes, albeit not those with fatal consequences.[1066] The underlying difficulty with Mosoff's analysis, however, is that it assumed Abella J in *AC v Manitoba* was supportive of the principle that the consideration of the preservation of life in the best interests test was necessarily decisive. Instead, Abella J suggested that the level of the minor's maturity may imply that the principles of welfare and autonomy will collapse altogether and such a minor's wishes ought (in the sense of 'must') be respected, even if the result may be death.[1067] Thus, if, as Mosoff suggested, *SJL* is correct in its interpretation that *AC v Manitoba* implies that the court should never let a mature minor make a fatal decision, such an interpretation would be inconsistent with Abella J's judgment.[1068]

SJL was a trial court decision, meaning one should be cautious and not necessarily overvalue LeBlanc J's reasoning and its potential implications. In the recent decision of *SP v BP*, a case involving whether a young person two weeks shy of his 18th birthday should be subjected to compulsory counselling, Devlin J suggested that Abella J's judgment provides that the wishes of the mature minor 'should be accorded *virtually* the same respect and deference

[1064] ibid 251.
[1065] ibid 239, 245, 252.
[1066] ibid 250.
[1067] *AC v Manitoba* (n 24) [87]. See also (n 1037).
[1068] This argument is revisited and developed further in Chapter VI, Part I, Section D.

extended to adults'.[1069] There was no discussion of statutory presumptions of capacity in this case, so it would be a step too far to suggest that Devlin J would have interpreted *AC v Manitoba* against any relevant statutory provisions in the same manner as LeBlanc J. However, Devlin J found that there was no evidence to suggest that the young man lacked capacity,[1070] and applying *AC v Manitoba*, he held that 'there is a high bar to overcome before a *court* could find that a mature minor's refusal of counselling can be overcome'.[1071] Thus, whilst the notion that it is the court who necessarily decides whether to respect the young person's refusal was consistent with LeBlanc J's overriding rhetoric in *SJL*, Devlin J was more autonomy-accepting in his suggestion that the courts may be permissible to respect the treatment decision that is commensurate to the minors' maturity level.

3. Summary

This examination has demonstrated that there are two plausible interpretations of Abella J's approach to the legal mechanisms governing minors' medical decision-making capacity in *AC v Manitoba,* summarised in the following terms:

(1) The CFSA provides a rebuttable presumption of capacity for young persons, not obfuscated by any interplay or overlap between the mature minor doctrine and ss 25(8) and 25(9). Accordingly, 16- to 18-year-olds have the *prima facie* exclusive right to decide their own medical treatment like adults. If the presumption of capacity is rebutted, the court under s 25(8) may authorise medical treatment that the court considers to be in the young person's best interests.

(2) Whilst the CFSA provides a rebuttable presumption of capacity, even when not rebutted (s 25(9)), insofar as the young person is refusing treatment that will have significant

[1069] 2020 ABQB 331 [81] (emphasis added).
[1070] ibid [43].
[1071] ibid [87] (emphasis added).

implications for their health or life (ss 17(1), 17(2)(b)(iii)), the court must still have regard for the young person's best interests (s 2(1)), observing the sliding scale principle, and be the one to decide whether the medical decision is in the young person's best interests (s 25(8)). The court is, therefore, the final arbiter.

Under both interpretations, there is a rebuttable presumption of incapacity for children, in which the courts will make a decision in their best interests under s 25(8), taking together s 2(1) and the sliding scale principle.

D. Evaluating the Canadian Approach

In the case of *Re X (A Child) (No 2)*, in his detailed review of whether the principles established in *Re R* and *Re W* remain valid in the light of domestic and international developments of the law, Sir James Munby thoroughly considered the decision of the SCC in *AC v Manitoba*. The overarching argument (which was rejected) in *Re X (A Child) (No 2)* was that the consent or refusal of treatment by competent persons under the age of 18 should be determinative. It was emphasised to Sir James Munby that all the judges in *AC v Manitoba* agreed that competent minors have the exclusive right to decide their own medical treatment.[1072] Sir James Munby found it far from obvious that all judgments supported such an unqualified proposition and held that Abella J's opinion does not support the contention because, as he read her final analysis, the court *always* has the last word.[1073] In other words, Sir James Munby subscribed to 'interpretation (2)' of *AC v Manitoba*. He concluded that nothing in *AC v Manitoba* throws any doubt on the continued validity of *Re R* and *Re W*, nor does the SCC judgment suggest the need for any judicial re-evaluation of what the Court of Appeal established.[1074] This section suggests that Sir James Munby's analysis was short-sighted.

[1072] *Re X (A Child) (No 2)* (n 25) [95].
[1073] ibid [95], [99].
[1074] ibid [104].

The reasoning of Abella J in *AC v Manitoba* on minors' medical decision-making capacity was nuanced and autonomy-affirming. The second-to-last paragraph exemplifies the point–she emphasised that much was gained from defeat.[1075] Although AC herself might not necessarily see it that way, her litigation brought additional clarity to future medical refusal challenges, constitutional or otherwise. At its most narrow, the Manitoba legislation must be interpreted with an eye on supporting minors' autonomy interests, and more broadly, subsequent courts, including those outside of Manitoba, can rely on Abella J's reasoning to answer questions on rights derivative of autonomy. Daniel argued that *AC v Manitoba* presents cogent and compelling arguments for changing English law to give minors, subject to capacity, the right to consent and refuse medical treatment.[1076] Not so convinced, Harmon suggested that with respect to the autonomy value of the case, *AC v Manitoba's* purported greatest strength left much to be desired. He did not regard the decision as entirely satisfactory because Abella J did not deeply enquire into the appropriate balance between the autonomy and protectionism values in the context of the best interests decision.[1077] However, Harmon's view is rather unpersuasive. Abella J's reasoning was most appealing because she cast an appraising eye on the conflicting values of autonomy and protectionism. Throughout her judgment, although she never explicitly provided definitions for the competing values,[1078] she frequently engaged with, for example, the positive and negative implications of the court's role in deciding whether to support the minors' medical decision.

It is accepted that the interpretation that best represents *AC v Manitoba* is ambiguous. Sir James Munby in *Re X (A Child) (No 2)*, and some Canadian decisions such as *SJL*, favoured 'interpretation (2)'. The problem with 'interpretation (2)' is that it largely reflects the approach

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[1075] *AC v Manitoba* (n 24) [121].
[1076] Daniel (n 1043) 237.
[1077] Harmon (n 1038) 92-93.
[1078] In agreement with Harmon, had Abella J offered authoritative definitions of the competing values, especially autonomy, this would certainly have contributed to a richer analysis.

in *Re R* and *Re W* and, therefore, goes little further than the English approach.[1079] But even if it is accepted that 'interpretation (2)' is the correct way to view *AC v Manitoba*, those critical would likely concede, at least, that Abella J's judgment is less 'paternalistic' than the bulk of English medical refusal cases. For example, Harmon suggested that *AC v Manitoba* represents a judicious effort to 'reconcile the autonomy in younger people with the benevolent and paternalistic desire to protect them, and in doing so shows them sufficient respect'.[1080] Cave suggested *AC v Manitoba* moved beyond the position taken in *Re R* and *Re W* that minors' views are of mere consultative value, meaning if the English courts adopted its reasoning, there might be a change in emphasis regarding the decisiveness of minors' wishes and feelings in the welfare assessment.[1081] Following the argument advanced in Chapter IV as regards the positive, incremental steps taken by *E & F* and *DV (A Child)* to promote respect for competent decisions, the idea that the law is changing its emphasis is gaining traction.

However, the preferable interpretation of *AC v Manitoba* is 'interpretation (1)' because 16-17-year-olds have rights to medical decision-making similar to adults. Abella J observed that under the CFSA, the distinction between promoting autonomy and protecting welfare is presumed to collapse at age 16, subject to evidence to the contrary.[1082] McLachlin CJ also observed that young persons have the right to refuse treatment, provided the s 25(9) presumption of capacity is not rebutted.[1083] There was no divergence of view by Binnie J on this matter.[1084] Thus, unless the presumption of capacity within s 25(9) CFSA is rebutted, the court cannot make medical decisions on behalf of competent 16-17-year-olds. The problem with 'interpretation (1)' is that the protection it offers autonomy is contingent upon the ease

[1079] *E & F* (n 30) [68], '[T]he Supreme Court in Canada expressly preserved its powers in respect of 16- and 17-year-olds. Were it otherwise, its decision would not represent the position in this jurisdiction'.[1079]
[1080] Harmon (n 1038) 96.
[1081] Cave (n 257) 116.
[1082] *AC v Manitoba* (n 24) [111].
[1083] ibid [130], [139].
[1084] ibid [233].

with which the presumption can be rebutted. It will offer little concrete protection to autonomy if capable of being refuted too readily. No case in Canada has put s 25(9) to the test.[1085] This suggests that young persons do not make life-threatening medical decisions or, more likely, those who make fatal refusal decisions are routinely not apprehended as minors in need of protection under the CFSA. Thus, whilst the strength of protection that s 25(9) offers competent young persons is not supported by empirical evidence, it is likely that their decision-making autonomy is supported in practice. Whether English law should take forward whatever interpretation of *AC v Manitoba*, particularly interpretation (1) in the light of it being permissible towards competent young persons making serious treatment refusals, will be considered further in Chapter VII below.

In his analysis of Canadian jurisprudence, Sir James Munby noted that no decision of the Canadian courts predating *AC v Manitoba* was determinative of any of the issues he had to consider.[1086] It was not referenced what cases Sir James Munby dismissed as unimportant. The cases of *Re LDK (An Infant)* and *Re AY* were not considered in his judgment, but they raise an important question that has not received a satisfactory answer in the English courts and would have been worth Sir James Munby's attention. The medical evidence in both cases suggested that the proposed course of treatment, while the best in the circumstances to arrest the progress of the illness to some degree, did not provide for an optimistic prognosis, nor were they curative; they would also cause physical harm.[1087]

In *Re LDK (An Infant)*, a 12-year-old Jehovah's Witness suffering from acute myeloid leukaemia refused to consent to treatment with blood transfusions. Main J observed that the

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[1085] The only case besides *AC v Manitoba* referencing s 25(9) CFSA is *R v BL* 2013 MBQB 89, which concerned a 16-year-old who had committed several crimes. The Court of Queen's Bench of Manitoba observed at [37] that under s 25(9) CFSA, 16-year-olds are 'presumed to be mature enough to make health care and mental health decisions'.
[1086] *Re X (A Child) (No 2)* (n 25) [86].
[1087] *Re LDK (An Infant)* (n 1002) [3]-[4], [11]-[12], [14], [16], [21]-[23], [27]; *Re AY* (n 1002) [3], [14]-[17].

side effects of the recommended drugs were many and extreme, ranging from, amongst other things, nausea, sterility and death from heart failure.[1088] The 12-year-old girl witnessed other children 'begging not to have any further [chemotherapy] treatment' given their effects.[1089] The judge accepted her position that she would 'scream and struggle and would pull the injecting device out of her arm and [would] attempt to destroy the blood in the bag over her bed' if given chemotherapy and blood transfusions.[1090] He vehemently emphasised that he refused to make any order that would put the child through that ordeal, instead believing that she should be allowed to fight her disease with dignity, peace of mind, and in a manner best for her, notwithstanding there were no statistics as to the success rate of her preferred alternative course of treatment.[1091]

The justifications for the decision in *Re AY* were similarly powerful. Accepting the 15-year-old boy's mature and religiously informed decision to refuse the intensive chemotherapy with blood transfusions, Wells J observed that:

> [H]is beliefs are not shared by everyone, but I think that misses the point. The point is that if A has that belief and he believes it with firmness and conviction, then whether that belief is correct or not, in either a medical sense or in a spiritual sense, is beside the point. The point is that it is his belief, and it is a correct belief for him. It is his belief, and it is he who is ill and suffering, and that is what we are concerned with.[1092]

This observation underscored that the approach to this case should be holistic. Wells J considered it important to recognise that without a strong and positive mental attitude towards the treatment, its chances of success decrease significantly.[1093] The boy believed with all his

[1088] ibid [16].
[1089] ibid [17].
[1090] ibid [17]-[18].
[1091] ibid [18], [22], [34]. Her preferred course of treatment was mega-vitamin treatment.
[1092] *Re AY* (n 1002) [20].
[1093] ibid [21].

heart that the blood transfusions would be 'an invasion of his whole being', and Wells J was satisfied that imposition of the treatment would severely affect his strength and ability to cope with the 'dreadful ordeal that he has to undergo, whatever the outcome'.[1094] This observation, together with the fact that there was no evidence other than that indicating that the enforced use of blood products would likely be more harmful than beneficial, supported that it was right and proper to uphold the boy's refusal of treatment with blood transfusions.[1095]

Even though the reasoning in *Re LDK (An Infant)* and *Re AY* were not relevant to the issue raised in *Re X (A Child) (No 2)* as to whether competent minors' refusal of treatment is determinative, that courts should adopt a holistic view to cases is one that the English courts should more closely follow. Indeed, there was little consideration from Sir James Munby of the implications of his decision on X's mental state. The two also serve as examples of a welfare analysis that legitimated the minors' refusal of medical treatment. Thus, their reasoning would be constructive should similar factual dilemmas come before the English courts.

II. Comparative Analysis II: Scotland

A. The Law in Scotland

In an analysis closer to home, the discussion turns to the legal position in Scotland. The Scottish approach to minors' medical decision-making capacity has had rather limited consideration, but sufficient and significant material exists to undertake a robust comparative analysis.

The law in Scotland governing minors' medical decision-making capacity is largely defined in statutes. Under s 1 of the Age of Majority (Scotland) Act 1969, a person shall attain

[1094] ibid [23].
[1095] ibid [27]-[29], [37].

majority at the age of 18 years. The ALCSA 1991 defines when a person in Scotland has legal capacity. It provides under s 1(1) that:

> (a) a person under the age of 16 years shall, subject to section 2 below, have no legal capacity to enter into any transaction;
>
> (b) a person of or over the age of 16 years shall have legal capacity to enter into any transaction.[1096]

The exceptions to the general rule that those under 16 lack legal capacity are contained in s 2 ALCSA 1991, with the relevant provision for present purposes being s 2(4), which provides:

> 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 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 interpretation and implications of these statutory provisions have seldom been scrutinised in the courts. The Sheriff Court decision in *Houston* is an important case in this regard. This case involved a 15-year-old, K, who was refusing hospital treatment for his mental health disorder. The applicant was a mental health officer, H, who applied to the Sheriff Court under s 18 of the Mental Health (Scotland) Act (MHSA) 1984 for the compulsory detention of K.[1097] It was not disputed that K was suffering from a mental disorder, though he was accepted as capable of understanding the nature and possible consequences of the proposed treatment and, therefore, enjoyed legal capacity to consent to the treatment under s 2(4) ALCSA 1991.[1098] He however refused to consent. His mother consented to his continued detention and maintained

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[1096] See Age of Legal Capacity (Scotland) Act (ALCSA) 1991, s 9, 'In this Act, unless the context otherwise requires— … "transaction" means a transaction having legal effect, and includes— … (d) the giving by a person of any consent having legal effect'.

[1097] See also Mental Health (Scotland) Act 1984, s 17(1).

[1098] *Houston* (n 984) [943].

that an s 18 order was unnecessary since, she argued, she retained the capacity to consent on his behalf under s 5(1) ALCSA 1991.[1099] Granting the application, Sheriff McGowan made three crucial observations. First, he found himself in agreement with the view that the patient's 'consent' referred to in s 2(4) 'covers consent or refusal of medical treatment' and did not address the matter further.[1100] Secondly, whilst s 5(1) ALCSA 1991 preserves the existing rights of guardians, a s 2(4) competent child's decision (to consent *or* refuse consent) is paramount and cannot be overridden by a guardian.[1101] Sheriff McGowan suggested it would be 'illogical' that those under 16 should be granted the power to decide upon medical treatment for themselves, but their parents have the right to override their decision.[1102] Thirdly, despite the paramountcy of K's decision, Sheriff McGowan was satisfied on the medical evidence that he was suffering from a mental disorder, being a mental illness of a nature which makes it appropriate for him to receive medical treatment in hospital.[1103]

The body of case law interpreting s 2(4) ALCSA 1991 beyond *Houston* is limited. The only Scottish case referred to Sheriff McGowan in *Houston* was *V v F*.[1104] This case similarly considered a mental health officer's application under s 18 MHSA 1984 for the admission of a 15-year-old to hospital despite the child's objections. Sheriff Poole found that the parents had the right to consent to the treatment (hospitalisation) of their child.[1105] However, at the time of the decision, the law was far from clear, and more importantly, the case was decided before the ALCSA 1991 came into force. Hence it is of little value as a precedent and will not be considered further. In the more recent decision of *City of Edinburgh Council v MS*, although a case about an application for a forced marriage protection order under the Forced Marriage etc.

[1099] ibid.
[1100] ibid [945].
[1101] ibid.
[1102] ibid.
[1103] ibid.
[1104] 1991 SCLR 225.
[1105] ibid [229].

(Protection and Jurisdiction) (Scotland) Act 2011 regarding a 15-year-old girl, the Sheriff Court briefly referred to s 2(4) ALCSA 1991.[1106] It confirmed that the provision provides that s 2(4) competent children have sufficient maturity to assess the risks involved and to determine for themselves whether to take those risks with respect to their medical choices.[1107] This decision does not contribute further to the analysis.

Thus, there are three central issues concerning the relevant Scottish law: First, whether there is the presumption of legal capacity for those aged 16 or over under s 1(1)(b) ALCSA 1991. Second, the principle of the s 2(4) competent child and the implications of this characterisation, focussing on the interplay between relevant statutes and the decision in *Houston*. The final section evaluates and compares the strengths and weaknesses of the Scottish approach to the English position.

B. The Presumption of Legal Capacity

The ALCSA 1991 was influenced by the recommendations of the Scottish Law Commission. The Commission selected the age of 16 as the threshold for legal capacity because it reflected an 'important social reality'. It represented a 'realistic dividing line' between those who required protection because of their immaturity and those who did not. Those above 16 would have 'full legal capacity as if they were adults', whereas those below would, subject to a few exceptions, have no legal capacity.[1108]

Those with legal capacity under the ALCSA 1991 can undertake any legal transaction independently. In other words, the Act abolished curatory on the grounds of age,[1109] meaning young persons are not subject to the control of their parents or guardians. The Children

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[1106] 2015 SCLR 631.
[1107] ibid [85].
[1108] Scottish Law Commission, *Report on the Legal Capacity and Responsibility of Minors and Pupils* (Scots Law Com No 110, 1987), pt III.
[1109] ALCSA 1991, s 5(3).

(Scotland) Act (CSA) 1995, which defines parental responsibilities and rights as they apply to under 18s,[1110] provides that parental rights terminate once the child reaches 16.[1111] It follows from these Acts, according to Norrie, that 16-17-year-olds' have full medical decision-making autonomy.[1112] The ALCSA 1991 provides that a person over the age of 16 but under the age of 18 may make an application to the court to set aside the transaction which is a 'prejudicial transaction'.[1113] A prejudicial transaction is defined by s 3(2) as a transaction which–

> (a) an adult, exercising reasonable prudence, would not have entered into in the circumstances of the applicant at the time of entering into the transaction, and
>
> (b) has caused or is likely to cause substantial prejudice to the applicant.

The Act prescribes several unchallengeable transactions and legal acts. A notable transaction that cannot be set aside for being prejudicial is 'the giving of consent to any surgical, medical, or dental procedures or treatment'.[1114] The ALCSA 1991 does not explicitly define the ambits of consent, making it difficult to make good suggestions that refusal to consent is a transaction having legal effect and is, therefore, captured as an unchallengeable transaction.[1115] It also leaves open to interpretation the role of parents and the courts as regards a young person's medical decision-making capacity. However, examining the broader legal framework, it is possible to address the gaps in the ALCSA 1991. The Adults with Incapacity (Scotland) Act (AWISA) 2000 introduced a statutory framework for the medical treatment of adults who lack capacity in Scotland.[1116] For the general purposes of the Act, 'adult' means a person who has

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[1110] See Chapter VI, Part II, Section C.
[1111] Children (Scotland) Act (CSA) 1995, s 2(7).
[1112] Kenneth McKenzie Norrie, *The Law Relating to Parent and Child in Scotland* (3rd edn, Sweet & Maxwell 2013) para 5.16.
[1113] ALCSA 1991, s 3(1).
[1114] ibid, s 3(3)(e).
[1115] Norrie (n 1112), para 5.16.
[1116] Adults with Incapacity (Scotland) Act 2000, s 1(6), a person is unable to make a decision for themselves if, by reason of mental disorder or of inability to communicate because of physical disability, that person is incapable of (a) acting; or (b) making decisions; or (c) communicating decisions; (d) understanding decisions; or (e) retaining the memory of decisions ("incapacity" shall be construed accordingly). See also s 1(4).

attained the age of 16 years.[1117] The AWISA 2000 acts alongside the common law, which presumes every competent adult has the medical decision-making autonomy to consent or refuse medical treatment, notwithstanding that such a decision may result in death or serious injury.[1118] In *Houston*, Sheriff McGowan accepted that the 'consent' of an s 2(4) competent child also covers refusal and found it would be 'illogical' for a parent to have the right to override the decision of s 2(4) competent children. This reasoning indicates that (i) it would be inconsistent for 'consent' not to be interpreted similarly throughout the ALCSA 1991, and (ii) the logic that parents cannot override the decision of an s 2(4) competent child must apply *a fortiori* to young persons.

In contradistinction to the position in England, the authority of the Scottish courts appears limited with respect to overruling medical decisions by young persons.[1119] The basic framework of modern Scottish child law–i.e. presumption of legal capacity; decision need not be therapeutically beneficial; parental rights terminate once the child turns 16–strongly suggests that the minor of or over 16 is *sui juris*.[1120] Hence, Edwards and Griffiths suggested that it would be highly unlikely that young persons would be subjected to the authority of the court, even via exercise of the *nobile officium*,[1121] which is the extraordinary equitable jurisdiction of the Court of Session (civil matters) and the High Court of Justiciary (criminal matters).[1122] The Scottish court's role would accordingly be limited even when the young person refuses life-saving medical treatment. This is supported by NHS guidance notes to doctors in Scotland. For example, in 1992 it was advised that 'competent young people may

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[1117] ibid.

[1118] See also British Medical Authority, 'Medical Treatment for Adults with Incapacity: Guidance on Ethical and Medico-Legal Issues in Scotland' (BMA, April 2009) < https://www.bma.org.uk/media/1190/bma-guidance-about-medical-treatment-for-adults-with-incapacity-in-scotland.pdf > accessed 20 March 2023.

[1119] See Chapter VI, Part II, Section C: the limitations on the court's powers under the ALCSA 1991 and CSA 1995 as they apply to s 2(4) competent children apply *a fortiori* in relation to 16-17-year-olds.

[1120] Lilian Edwards and Anne Griffiths, *Family Law* (W Green/Sweet & Maxwell 1997) 96.

[1121] ibid.

[1122] *Law Hospital NHS Trust v Lord Advocate* 1996 SCLR 491 [500]. See Chapter VI, Part II, Section C, which analyses the *nobile officium*.

wish to refuse a particular recommended procedure… If the patient then refuses to agree, and he or she is competent, the refusal must be respected'.[1123] In the 2006 replacement guidance, similar advice was provided:

> Generally, people with capacity aged over 16 have the right to say what is or is not going to happen to their bodies and may choose to refuse to have the proposed healthcare intervention.[1124]

The NHS guidance is explicit. Moreover, the Scottish Parliament Information Centre observed in its 2019 Briefing that contrary to English law, in Scotland, the likelihood is that young people of 16 and over with the requisite maturity and understanding can refuse treatment.[1125] A broad reading of relevant Scottish law and guidance suggests that young persons have medical decision-making rights equivalent to traditional adults.

There is a lack of confirmation from the Scottish courts on the legal issue of whether a young person can independently refuse consent to life-saving medical treatment. Yet neither the young person's parents nor even the courts necessarily have a strong argument supporting that their decision should overrule that of the young person.

C. The s 2(4) Competent Child

The capacity rule under s 2(4) ALCSA 1991 raises several important legal questions: Does s 2(4) actually entail the legal capacity to refuse? Can parents override the consent or refusal by an s 2(4) competent child? Finally, if not, do the courts have the authority to overrule the s 2(4) competent child's medical decision?

[1123] Scottish Office NHS in Scotland, *A Guide to Consent to Examination, Investigation, Treatment or Operation* (NHS, MEL (1992) 65, 15 October 1992) 5.
[1124] Scottish Executive Health Department NHS, *A Good Practice Guide on Consent for Health Professionals in NHS Scotland* (NHS, HDL (2006) 34, 16 June 2006) 5.
[1125] Informed Consent in Healthcare Settings, SB 19-01, 10 January 2019, para 6.3.2.

The *Gillick* competence test–the child under the age of 16 achieves a sufficient understanding and intelligence to enable them to understand fully what is proposed–is captured in essence rather than verbatim in s 2(4) ALCSA 1991.[1126] The capacity to consent is a factual question determined by the medical practitioner attending to the child. There are seemingly no limitations on what kind or type of procedure or treatment that *Gillick* is permissible towards.[1127] Section 2(4) is similarly broad. The words 'surgical, medical or dental procedure or treatment' in s 2(4) cast a wide net, capturing all reasonably conceived procedures or treatments and those of a non-invasive nature, such as examination and diagnosis.[1128] Despite the comparisons to *Gillick* competence, s 2(4) has its own identity. For example, welfare considerations are implied in the *ratio* of *Gillick*,[1129] whereas there is no requirement under s 2(4) for the proposed procedure or treatment to be in the child's best interests nor to enhance their welfare.[1130] McConnell suggested that the omission of welfare was deliberate.[1131] It flows from the Scottish Law Commission's recommendations that assuming the 'child may consent if he is of sufficient maturity to understand the treatment proposed[,] then that test should apply whether the treatment concerned is for his benefit or not'.[1132] Thus, the construction of the statutory provision suggests the law allows the s 2(4) competent child to take on the risks of their medical decision. This is under the proviso that before they are determined competent,

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[1126] Scottish Law Commission (n 1108) para 3.77.
[1127] See Chapter III, Part II, Section C, Subsection 3. Indeed, whilst s 8(1) FLRA 1969 does not extend to the donation of organs or blood (see *Re W* (n 18) [78]; see also Scottish Law Commission (n 1108) para 3.78), the *Gillick* competent child can ostensibly consent to those procedures: see Human Tissue Authority, *Code A: Guiding Principles and the Fundamental Principle of Consent: Code of Practice* (2023) paras 87-88. See also Lisa Cherkassky, '*Gillick*, Bone Marrow and Teenagers' (2015) 83(3) Med Leg J 154.
[1128] Norrie (n 1112) para 5.10. See also Lesley-Anne Barnes, 'Transsexuality and "Kidulthood": Treatment and Recognition' (2006) 26 SLT 169.
[1129] See Chapter III, Part II.
[1130] Norrie (n 1112) para 5.10. However, that the child's medical treatment decision does not have to enhance their welfare becomes complicated with respect to the court's duty to the child (see CSA 1995, s 11 (7)), as will be demonstrated below.
[1131] Archibald A McConnell, 'Children's Informed Consent to Treatment: The Scottish Dimension' (1995) 21(3) J Med Ethics 186.
[1132] Scottish Law Commission (n 1108) para 3.77.

they must be capable of understanding the nature and *possible consequences* of the procedure or treatment.

Norrie posited that if the right to consent is an aspect of personal autonomy, then asking the patient to consent to medical treatment must entail the opportunity for the patient to refuse and, for that reason, the capacity to consent under s 2(4) ALCSA 1991 carries with it the capacity to refuse.[1133] He suggested that the ALCSA 1991 offers some support that Scotland does not distinguish between consent and refusal. Section 2(3) of the Act provides that a child 'over the age of 12 shall have the legal capacity to consent to the making of an adoption order in relation to him'. The capacity to refuse, like in s 2(4), is not mentioned, but Norrie argued that because it has never been suggested in that context that the capacity to refuse is not carried by the words granting the capacity to consent to adoption, the capacity to refuse is implicit in s 2(3). It would be inconsistent for the capacity to refuse to be implicit in s 2(3) but not in s 2(4).[1134] In addition, Norrie suggested that s 90 CSA 1995, which provided that nothing in the Act prejudices any capacity of a child enjoyed by virtue of s 2(4) ALCSA 1991,[1135] also supports the view that the capacity to consent necessarily includes the capacity to refuse.[1136]

The interpretation of s 2(4) ALCSA 1991 offered by Norrie is persuasive but also rather ambitious. The immediate difficulty with s 2(4) is that, like with *Gillick* and s 8(1) FLRA 1969 before it, only the decision to *consent* is explicitly addressed. In the same way that *Re R* and *Re W* confirmed it was wrong to assume that implicit in *Gillick* and s 8(1) FLRA 1969 was the right to refuse, it must call into question any similar assumptions in Scotland.[1137] Taylor et al argued that the putative 'right' in s 2(4) is only to consent, not to refuse, which reflects the

[1133] Norrie (n 1112) para 5.10.
[1134] ibid.
[1135] CSA 1995, s 90 has been repealed by the Children's Hearings (Scotland) Act 2011, Sch 6 (with s 186).
[1136] Kenneth McKenzie Norrie, *Children (Scotland) Act 1995* (W Green/Sweet & Maxwell 1995).
[1137] *Houston* (n 984) [946]-[947] (Sheriff Kelbie, in his commentary on *Houston*).

developments subsequent to *Gillick* in England.[1138] The reasoning of Lord Donaldson MR was referred to Sheriff McGowan in *Houston*, but the judge did not engage with *Re R* or *Re W* whatsoever. He merely accepted that the patient's consent under s 2(4) 'covers consent or refusal of medical treatment'.[1139] In his commentary on *Houston*, Sheriff Kelbie was critical of the submissions to Sheriff McGowan that resulted in the lack of engagement with *Re R* and *Re W*, but in any event suggested that discussion of those cases would have been purely academic within the context of the case.[1140] This was largely because it is in the nature of an order under s 18 MHSA 1984 that the treatment is given whether the patient consents or not. The issue of a right to refuse does not arise. Since refusal was not relevant nor fully canvassed in *Houston*, it would have been more practical for Sheriff McGowan to have avoided making *obiter* remarks on the subject. Notwithstanding this, the comments of Lord Donaldson MR in *Re R* and *Re W* are merely of persuasive authority in Scotland. Observing that Scotland has distinguished its law from English law, there would accordingly be no reason why Scotland could not take a different stance to Lord Donaldson MR.

Further in his commentary on *Houston*, Sheriff Kelbie suggested that Norrie was bold to assert that s 2(3) ALCSA 1991 and s 90 CSA 1995 support the view that the s 2(4) competent child has the right to consent and refuse therapeutic procedures or treatments.[1141] Indeed, analogising consent to adoption with consent or refusal of medical treatment was rather tenuous. Sheriff Kelbie considered Norrie's argument that implicit in s 2(3) ALCSA 1991 is a right to refuse was undermined by the fact that the right of refusal was expressly provided by ss 12(8) and 18(8) of the Adoption (Scotland) Act 1978.[1142] No such express provision of a

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[1138] Mark J Taylor, Edward S Dove, Graeme Laurie and David Townend, 'When Can the Child Speak for Herself? The Limits of Parental Consent in Data Protection Law for Health Research' (2017) 26(3) Med L Rev 369, 373.
[1139] *Houston* (n 984) [945].
[1140] ibid [947]-[948].
[1141] ibid [948].
[1142] The Adoption and Children (Scotland) Act 2007 has repealed the whole of the Adoption (Scotland) Act 1978 except for Part IV.

right to refuse medical treatment is available, even with the introduction of the CSA 1995.[1143] Whilst this is true, s 90 CSA 1995 does appear to suggest that s 2(4) ALCSA 1991 covers a right of refusal.[1144] Sheriff Kelbie posited that s 90 made it clear that an s 2(4) competent child had the right to refuse even in the face of a 'requirement', and since this is said to be 'without prejudice to the generality' of s 2(4), it must be that the generality of s 2(4) normally includes the right of refusal.[1145] The analysis of s 90 CSA 1995 offered by Sheriff Kelbie goes some way to support the arguments presented by Norrie. However, Sheriff Kelbie rightly cautioned that the matter is far from clear, considering the issue of rights of refusal has yet to be dealt with authoritatively by the Scottish courts.[1146] Considering Scottish law in the round, s 2(4) ALCSA 1991 likely supports medical refusal decisions. The questions remain whether parents have the right to consent to their child's treatment, overruling the child's refusal, and if not, then can a court overrule that child's wishes?

The CSA 1995 defines the parental 'responsibilities' and 'rights' in relation to the child. Parents have the 'responsibility' under s 1(1)(a) to 'safeguard and promote the child's health, development and welfare', but it is less clear which 'right' under s 2(1) enables the parent to fulfil that responsibility as regards the child's medical treatment.[1147] The most likely right is that of legal representation (s 2(1)(d)).[1148] Under s 15(5)(b) CSA 1995, those acting as legal representatives of the child may give consent to any transaction where the child is incapable of consenting on their own behalf. The effect is that parents exercising their rights as legal

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[1143] *Houston* (n 984) [948].
[1144] 'Nothing in this Part of this Act shall prejudice any capacity of a child enjoyed by virtue of section 2(4) of the [ALCSA 1991]… and without prejudice to that generality where a condition contained, by virtue of— (a) section 66(4)(a), section 67(2) or section 69(9)(a) of this Act, in a warrant; or (b) section 70(5)(a) of this Act, in a supervision requirement, requires a child to submit to any examination or treatment but the child has the capacity mentioned in the said section 2(4), the examination or treatment shall only be carried out if the child consents'. However, see Children's Hearings (Scotland) Act 2011, s 186.
[1145] *Houston* (n 984) [948].
[1146] ibid.
[1147] The responsibilities and rights of parents last until the child reaches the age of 16 years: see ALCSA 1991, s 5(3) and CSA 1995, ss 1(2)(a) and 2(7).
[1148] CSA 1995, s 2(1)(a) (child's residence), (b) (child's upbringing), (c) (personal relations with the child).

representatives can act *only* when their child cannot. Once the child has legal capacity under ss 1(1)(b) or 2(4) ALCSA 1991 to enter into any transaction, the legal representative loses the power to do so on their behalf.[1149] The interplay between the CSA 1995 and the ALCSA 1991 suggests that insofar as the child is s 2(4) competent, the parental right under the CSA 1995 to have the responsibility for safeguarding and promoting the child's health and welfare is extinguished. Together with the reasoning in *Houston*,[1150] the legislation suggests that the doctor can rely on the consent or refusal of the s 2(4) competent child even when the treatment is contrary to the child's welfare and the parents would have otherwise consented to the treatment. However, this analysis remains largely speculative until tested in the Scottish courts.

One outstanding question remains: Do the Scottish courts have the authority to overrule the medical decision of the s 2(4) competent child? Under s 11 CSA 1995, an application may be made to the court by those with parental responsibility or rights in relation to the child or claims an interest in relation to the child (e.g. a doctor) for the court to make a specific issue order regulating the question of medical treatment.[1151] In considering whether to make an order, the court 'shall regard the welfare of the child concerned as its paramount consideration', and taking account of the child's age and maturity, shall so far as practicable, give the child the opportunity to express their views insofar as they wish to do so.[1152] Parents may argue that their s 2(4) competent child's refusal of therapeutically beneficial medical treatment is a decision contrary to their welfare.[1153] Hence the court should overrule the refusal. Edwards and Griffiths posited that the Scottish court would indeed override the refusal on the justification that the

[1149] Norrie (n 1112) para 7.31.
[1150] *Houston* (n 984) [945].
[1151] CSA 1995, ss 1(1), 1(2)(e), 1(3)(a)-(b).
[1152] ibid, s 11(7)(a)-(b).
[1153] The concept of 'welfare' is broadly conceived. Its interpretation is left to the court as 'it thinks fit' to the individual case: see CSA 1995, ss 11(1), (2). See also Scottish Law Commission, *Report on Family Law* (Scots Law Com No 135, 1992) paras 5.20-5.23, which rejected the English approach in Scottish law of considering a 'welfare checklist' to questions of welfare adopted in s 1(3) CA 1989.

decision to do so is consistent with the child's welfare.[1154] Bissett-Johnson and Ferguson made the point that in practice, children may find themselves in a difficult position that should they choose to refuse recommended treatment, the medical practitioner may regard this choice as evidence equivalent to a lack of *Gillick* competence.[1155] They further suggested that even if a court faced an s 2(4) competent child whose treatment decision would, on the balance of probabilities, put their life in jeopardy, the court would likely adopt a best interests analysis, in spite of the Scottish Law Commission's express disapproval of applying such an approach.[1156] Thus, the Scottish courts may adopt a best interests analysis of the s 2(4) competent child's welfare following the approach of Lord Donaldson MR in *Re R* and *Re W*.

However, Norrie contended that any application to the court for a specific issue order under s 11(2)(e) CSA 1995 regulating medical treatment should be dismissed as incompetent once the child is determined to be of sufficient mental maturity to have capacity under s 2(4) ALCSA 1991.[1157] This is because, he argued, an application under s 11 CSA 1995 is competent only in relation to, amongst other things, parental responsibilities and rights. The parental right to give medical consent likely falls within the ambit of the right of legal representation,[1158] and by s 15(5)(b) CSA 1995, parents are limited in their capacity to act as legal representatives 'where the child is incapable of so acting or consenting on his own behalf'. Thus, provided the child is determined to be s 2(4) competent to perform a legal transaction such as make a medical decision, the parents have no right under the CSA 1995 to act as the child's legal representative in that transaction. Norrie argued that since the dispute does not therefore relate to parental responsibilities or rights, s 11 CSA 1995 does not apply.[1159] Norrie's argument is persuasive,

[1154] Edwards and Griffiths (n 1120) 96.
[1155] Alastair Bissett-Johnson and Pamela Ferguson, 'Consent to Medical Treatment by Older Children in English & Scottish Law' (1996) 12(2) J Contemp Health Law Policy 449, 460.
[1156] ibid. See Scottish Law Commission (n 1108) para 3.77, '[t]he best interests test seems too restrictive and would, in our view, be unnecessary… "best interest" protection is unnecessary'.
[1157] Norrie (n 1112) para 7.32.
[1158] CSA 1995, ss 1(1) and 2(1).
[1159] Norrie (n 1112) para 7.32.

observing further that the heading of s 11 is self-explanatory: 'Court orders relating to parental responsibilities, etc.'. If proceedings are unconcerned with parental responsibilities or rights, then the court does not have the jurisdiction to intervene in what appears to be a dispute between parent and child.

The courts' jurisdiction to control the exercise of parental power certainly appears constrained by the limits implicit in the making of orders under s 11 CSA 1995. An avenue circumventing such limitations may exist based on the exercise of the *nobile officium*. The *nobile officium* is a strictly limited jurisdiction of the Court of Session that allows it, in exceptional circumstances, to modify the common law or to grant relief in a situation where no provision exists under the ordinary law.[1160] Lord Hope in *Law Hospital NHS Trust v Lord Advocate* approved the observation of Norrie that:

> [T]he control of parental power is based on the *nobile officium* of the Court of Session which acts as *parens patriae* as does the High Court in England in its wardship jurisdiction, and that it is in principle no less extensive, may be taken to be an accurate statement so far as jurisdiction over minors is concerned.[1161]

The exercise of the *nobile officium* in relation to medical treatment of a s 2(4) competent child has not arisen in Scotland so far as reported decisions reveal. However, in principle, Norrie suggested that it may be open to the Court of Session in the exercise of its *nobile officium* jurisdiction to make orders authorising medical treatment despite the refusal of the child.[1162] The test to be applied in deciding whether or not a course of conduct should be authorised under the *nobile officium* jurisdiction is best interests of the patient.[1163]

[1160] Stephen Thomson, 'Scots Equity and the Nobile Officium' (2010) 2 Jur Rev 93, 104. Indeed, Thomson observed that the *nobile officium* has seen infrequent invocation.
[1161] *Law Hospital NHS Trust* (n 1122) [503]. The concepts '*nobile officium*' and '*parens patriae*' are used interchangeably.
[1162] Norrie (n 1112) para 7.34.
[1163] *Law Hospital NHS Trust* (n 1122).

Although the exercise of the *nobile officium* appears to mitigate the limitations of s 11 CSA 1995, this power has limitations of its own. The primary limitation relates to the *nobile officium's* relationship with the legislative. It is well established that exercise of the *nobile officium* must respect the intentions of Parliament.[1164] The jurisdiction cannot be used to override or to extend express statutory provisions,[1165] circumvent a clear statutory intention,[1166] or direct an individual to act contrary to statutory duty.[1167] The question is thus: Could the *nobile officium* be invoked to authorise the medical treatment of an objecting s 2(4) competent child, or would this be contrary to the intentions of the ALCSA 1991 and CSA 1995? The lack of precedent makes this a difficult question to answer. In the medical case *Law Hospital NHS Trust v Lord Advocate*, it was held that the Court of Session could exercise its *nobile officium* jurisdiction to authorise the discontinuation of life-sustaining treatment from a permanently unconscious patient, assuming this decision was in the best interest of the patient.[1168] This decision does not take the analysis further in relation to the intentions of the ALCSA 1991 or CSA 1995. The Scottish Law Commission's report influencing the ALCSA 1991 was robust in its recommendation that children under 16, determined to have capacity, have the decisional autonomy to consent to any treatment in their best interests or not.[1169] The Scottish Law Commission reserved its view in its report as regards problems of conflict between parent and child.[1170] The CSA 1995 addressed this lacuna by limiting parents in their capacity to act as legal representatives of children with legal capacity, and consequently, the court's role under s 11 CSA 1995 appears restricted. Thus, the exercise of the *nobile officium* would likely either override express statutory provisions or circumvent a clear statutory intention.

[1164] *Fife & Kinross Motor Auctions Ltd v Perth and Kinross District Licensing Board* 1981 SLT 106.
[1165] *Pringle, Petitioner* 1991 SLT 330; *Jamieson, Petitioners* 1997 SC 195 [199].
[1166] *West Lothian Council v McG* 2002 SC 411 [78].
[1167] *B's Executor v Keeper of the Registers and Records Scotland* 1935 SC 745 [752].
[1168] *Law Hospital NHS Trust* (n 1122) [859]-[860].
[1169] Scottish Law Commission (n 1108) paras 3.77-3.78.
[1170] ibid para 3.81.

In summary, (i) s 2(4) competent children ostensibly have the right to consent and refuse medical treatment, (ii) parents are unable to override the medical decision of a s 2(4) competent child, and (iii) there are plausible restrictions on the Scottish court's ability to overrule the medical decision of an s 2(4) competent child based on either s 11 CSA 1995 or exercise of the *nobile officium*. Scottish law in this area remains largely unexplored, meaning one can draw only tentative conclusions at best.

D. Evaluating the Scottish Approach

In the light of the preceding analysis, it is reasonable to suggest that it would be tenuous to develop English law on minors' medical decision-making according to the Scottish approach when it remains judicially undecided whether a 16-17-year-old or an s 2(4) competent child can refuse life-saving medical treatment in Scotland. This section counterargues not to overlook the Scottish approach entirely because it has some strengths that English law lacks.

In the context of refusal of life-saving treatment, the legal definition of adulthood at 18 has largely contributed to an all-or-nothing attitude of 'paternalistic' protection in England.[1171] This problem is not readily apparent in Scottish jurisprudence. The age of majority is similarly 18 in Scotland, but courtesy of s 1(1) ALCSA 1991, a person has full legal capacity from the age of 16, and those under 16 in exceptional circumstances shall have the legal capacity to enter into a legal transaction.[1172] There is greater acceptance in Scotland that implicit in the decision to consent to medical treatment is the freedom to refuse consent, even though reference is made to 'consent' only in the ALCSA 1991. The *obiter* comments in *Houston* go some way to filling the gaps in the ALCSA 1991. Grubb considered the judgment in *Houston* refreshing for Sheriff McGowan's willingness to view 'consent' and 'refusal' as two sides of

[1171] Emma Cave and Hannah Cave, 'Skeleton Keys to Hospital Doors: Adolescent Adults who Refuse Life-Sustaining Medical Treatment' (2023) 86(4) MLR 984, 987. See Chapter IV.
[1172] ALCSA 1991, s 2.

the same coin and that it eschewed from the narrow conceptualisation offered by Lord Donaldson MR in *Re W*.[1173] Indeed, Sheriff McGowan's *obiter* comments and their implications have not (yet) proved controversial.

The tension between the two transcendent principles is less pronounced in Scotland than in England. The Scottish Law Commission's decision that best interests protection is 'unnecessary' and 'irrelevant to the question of consent'[1174] can best be viewed in one of two ways. On one account, its omission implies that judges are not influenced, wittingly or not, into consequentialism analyses, which has traditionally permeated through the majority of English refusal cases. On the other hand, notwithstanding whether the right to refuse is implicit in s 2(4) ALCSA 1991, it is less plausible to make the case that welfare or best interests considerations would be 'unnecessary', 'irrelevant' or even unavoidable to the question of refusal. This argument presupposes the generalisations that consent is the acceptance of therapeutically beneficial treatment proposed by a qualified medical professional, whereas a refusal carries with it negative implications for the patient's life or health. The Scottish Law Commission's suggestion that competent children should be able to decide whether to receive treatment for their benefit supports the view that protectionism is relevant to determining capacity rather than playing a part once the competent child makes a decision.[1175] However, notwithstanding the rationale and justifications supporting the presumed position in Scotland, welfare analyses are firmly entrenched in English jurisprudence,[1176] meaning it would be too radical for English law to jettison its position.

[1173] Andrew Grubb, 'Refusal of Medical Treatment: Competent Child and Parents' (1997) 5(2) Med L Rev 225, 238. See also, for critique of the consent and refusal dichotomy, Chapter IV.
[1174] Scottish Law Commission (n 1108) para 3.77.
[1175] However, if a child is denied the status of s 2(4) competent on the basis that they are refusing treatment, protectionism, by implication, plays a part when the child wants to make the decision. This is because the decision to refuse itself is what may alert the medical professional that the child is not capable of understanding the nature and possible consequences of the procedure or treatment.
[1176] See Chapter IV.

The lack of explicit reference to 'autonomy' is the most pronounced shortcoming of Scottish law. This is in contrast to English case law. Even in cases where the English courts have gone on to overrule the decision to refuse medical treatment, the courts, at least, recognise minors' autonomy interests.[1177] In *Houston*, nowhere in the judgment was 'autonomy' mentioned. Rather, Sheriff McGowan's support for competent children's autonomy to make independent medical decisions was implicit. He was inclined to the view that the s 2(4) competent child's decision is 'paramount' and 'cannot be overridden' by their parents.[1178] Since s 2(4) effectively puts kernel of the decision in *Gillick* on a statutory footing in Scotland, the provision is imbued with the concept of autonomy. It is not only the ALCSA 1991 in which autonomy permeates. Edwards and Griffiths suggested that Article 12 of the UNCRC is 'unequivocally protected and recognised' by the CSA 1995.[1179] When a court considers whether to make an order under s 11(1) CSA 1995, the court shall, so far as practicable, have regard to the views expressed by the minor, taking into account the minor's age and maturity.[1180] In addition, s 11(10) CSA 1995 presumes children aged 12 or over to be of sufficient age and maturity to form a view. Where a person makes a 'major decision' relating to parental responsibilities or rights, they shall have regard so far as practicable to the views expressed by the minor.[1181] The CSA 1995 has clear regard for minors' views, but because the Act incorporates, at least, the message of the UNCRC, the problems inherent with participatory rights are transposed into the Act.[1182] The CSA 1995 appears more concerned with adults' responsibilities and rights towards minors than the minor's rights. Thus, whilst the support for minors' autonomy interests permeates the legislation and is implicit in Sheriff McGowan's

[1177] See, eg, *Re W* (n 18); *Re X (A Child) (No 2)* (n 25); *E & F* (n 30).
[1178] *Houston* (n 984) [945].
[1179] Edwards and Griffiths (n 1120) 91.
[1180] CSA 1995, s 11(7)(b).
[1181] ibid, s 6(1).
[1182] See Chapter III, Part III. The CSA 1995 uses the terminology 'have regard' to the expressed views of the minor. Hence there is no obligation for anyone exercising parental responsibilities and rights to actually respect and carry through the minor's wishes.

judgment in *Houston*, future decisions of the Scottish courts would make the law's support for minors' autonomy more palpable by explicitly recognising and engaging with the concept and its implications.

III. Concluding Remarks

This chapter undertook a comparative analysis, surveying the legal frameworks governing minors' medical decision-making in Canada and Scotland. The first part of this chapter surveyed and analysed the decision of the SCC in *AC v Manitoba* and other relevant Canadian cases and statutory principles. The second part of this chapter investigated the lynchpin pieces of Scottish law, in particular, the ALCSA 1991 and the Sheriff Court decision in *Houston*.

A key finding from the examination of the Canadian jurisprudence was that there are two plausible interpretations of Abella J's approach to the legal mechanisms governing minors' medical decision-making capacity in *AC v Manitoba*, with one account offering a stronger level of protection for minors' autonomy than the other. Notably, both accounts go further than the English position. In summary, 'interpretation (1)', the stronger account for minors' autonomy, suggests that the CFSA provides a rebuttable presumption of capacity for young persons. Accordingly, 16- to 18-year-olds have the *prima facie* right to decide their own medical treatment like adults, including refusing medical treatment. If the presumption of capacity is rebutted, the court under s 25(8) CFSA may authorise medical treatment that the court considers to be in the young person's best interests. The other account, 'interpretation (2)', suggests that while the CFSA provides a rebuttable presumption of capacity, even when not rebutted, provided the young person is refusing treatment that will have significant consequences for their health or life, the court may authorise any medical treatment that the court considers to be in the best interests of the young person (s 25(8) CFSA). Thus, the court

is the final arbiter. Under both interpretations, there is a rebuttable presumption of incapacity for children, in which the courts will make a decision in their best interests under s 25(8) CFSA. Another key finding from the examination of the Canadian jurisprudence was the author of this thesis identifying factors relevant to Canadian minors' medical refusals novel to what has been seen in English law. These factors include (i) poor life expectancy prognoses and (ii) physical suffering from treatment. The significance of this is that Canadian case law will help fill gaps in English law should those factors present themselves in an English case. The factors also broaden the framework that this thesis will finalise in Chapter VII below.

This chapter suggested not to overlook the Scottish approach entirely because it has some strengths that English law lacks. Chapter VII expands upon this argument. However, this assessment comes with an important caveat. The underlying takeaway from the analysis of Scottish law on minors' medical decision-making is that for all it appears to offer minors' autonomy, it is stymied heavily by a lack of judicial scrutiny into the scope and impact of the ALCSA 1991 on whether a 16-17-year-old or an s 2(4) competent child can refuse life-saving medical treatment in Scotland.

The next chapter concludes this thesis by offering recommendations that aim to develop the approach of English law to minors' medical decision-making in a manner consistent with the increasing recognition of minors' autonomy domestically and internationally and, by implication, intends to counterbalance the traditional domination of protectionism. In doing so, Chapter VII will reject suggested limitations, marginalise alternative solutions, and defend that this thesis' recommendations should be the chosen method for developing the law.

CHAPTER VII

THESIS CONCLUSION

This thesis has canvassed the development of English law and considered relevant international perspectives with respect to minors' consent and refusal of medical treatment. Much criticism has surrounded the seemingly incoherent law governing minors' medical decision-making. Legal discourse has concentrated on whether minors *can* and *should* make treatment decisions.

The law on medical consent appears settled and is theoretically sound. *Bell (CA)* has reinstated that *Gillick* and s 8(1) FLRA 1969 competent consent is determinative. There remain practical difficulties with assessing competence for the purposes of obtaining valid consent from minors. Concerns surrounding this assessment are legitimate, but medical professionals are well supported by guidance in case law and professional guidelines.[1183] Consent can also be viewed as mere acceptance of what objective medical expertise considers to be in the patient's best interests.[1184] Thus, the premise of medical consent is ethically defensible since it is presumed that medical professionals act according to the Hippocratic Oath when recommending treatment(s). The *Gillick* principles have been invoked not only in medical consent cases but also in medical refusal cases, giving rise to far more complex ethical and policy questions to which the law has provided incoherent and inconsistent answers. Thus, the recommendations of this thesis concentrate on the law on medical refusal.

The structure of this chapter is fivefold. First, this chapter articulates the recommendations for developing minors' medical refusal law. Secondly, it outlines some potential limitations to the recommendations in this thesis. Thirdly, it presents some alternative

[1183] See Chapter III, Part II, Section C.
[1184] Johnston (n 432).

solutions. Fourthly, it rejects the suggested limitations and marginalises the alternative solutions. Finally, this chapter emphasises that the law should develop in line with this thesis' recommendations.

I. The Law on Medical Refusal: Reform Recommendations

This thesis has argued generally that, as a matter of principle, the law should develop a broader and more nuanced approach to minors' refusals of medical treatment that more appropriately balances the interests of autonomy and protectionism. The reasoning in recent case law signals a change of emphasis away from a disproportionate preference for protectionism through consequentialism (or ideal desire autonomy) analyses towards supporting minors capable of making autonomous decisions. Thus, the responsibility to best develop the law is suggested to fall on the common law, and the recommendations of this thesis aim to support the rebalancing of the two transcendent principles. They will do so by building on contemporary developments in the law (domestically and internationally) and provide a broad framework to evaluate whether, on the given set of facts, the courts are justified in their decision, should they so choose, to overrule a refusal of medical treatment. The recommendations are expressed thus:

No decision of a minor, whether *Gillick* competent or having reached the age of 16 and comes within the purview of s 8 FLRA 1969 and the MCA 2005, is *prima facie* determinative when they refuse recommended medical treatment that objective medical expertise considers on the balance of probabilities to be in their best interests. When the minor refuses to submit to some procedure(s) immediately or prospectively necessary to avoid the risk of serious and irreparable harm or prolong or save their life, and the parents or those in loco parentis are prepared to give consent, the (inherent or wardship) jurisdiction of the court should be

invoked.[1185] The exercise of the court's jurisdiction has three stages, as confirmed in *E & F*. The first is the fact-finding stage which identifies the risk in question. The second stage is to decide whether to intervene or postpone a decision until a crisis arises. The third stage presupposes intervention was necessary, in which case the court must undertake the all-important welfare assessment.[1186] Every patient and every case is different and must be decided on its own facts; the courts have thus been reluctant to lay down general principles that might guide the decision in the welfare assessment.[1187] Even so, Sir Andrew McFarlane in *E & F* held that the welfare assessment in the context of minors' refusal of medical treatment should be considered broadly, in which the court identifies the relevant factors in the case before it, gives each of them proper weight, and balances those factors out to make the choice that is right for the individual at the heart of the decision.[1188] This reasoning is the recommended approach to the law. The author of this thesis has scrutinised all reported English minors' medical refusal case law (as well as relevant medical refusal cases in Canada and Scotland) and has identified the following factors as those the courts have considered relevant, weighed, and balanced in the welfare assessment:

- age;
- competence;
- expressed wishes and feelings;
- mental disability (fluctuating or permanent);
- risk probability;
- risk consequence;

[1185] Alternatively, an application may be made to the Court of Protection if there are doubts over the young person's capacity. On the basis that the young person lacks capacity under ss 2(1) and 3(1) MCA 2005, an s 4 best interests decision should be made on the young person's behalf, which should be approached in materially the same way as a welfare decision (outlined below). The Court of Protection may transfer a case to the Family Court and vice versa: see *B Local Authority v RM* [2010] EWHC 3802 (Fam).
[1186] *E & F* (n 30) [44]-[60].
[1187] ibid [49]; *Aintree* (n 45) [36].
[1188] ibid [52].

- the principle of preservation of life (alternatively, the sanctity of life);
- type of injury, illness, or health condition;
- faith (in terms of authenticity and longevity);
- familial support;
- maturity;
- life experience;
- feeling overwhelmed;
- experience with illness and its treatment;
- holism;
- psychological harm;
- quality of life;
- poor life expectancy prognosis;
- physical harm from treatment; and
- human rights.

The weight that factors relevant to the case hold and how the weight would likely tilt the scales in the balancing exercise turns on the judge. It is entirely reasonable that risk consequence[1189] and the principle of preservation of life are inherently weighted towards protectionism over autonomy, whereas it is a sliding scale for the other factors. For example, the weight of the minors' decision to refuse medical treatment increases with their age and maturity; that they have competence (under *Gillick* or s 8(1) FLRA 1969) and capacity (under the MCA 2005); that their refusal is motivated by their personal experiences with their condition and its treatment and/or is motivated by their authentic faith that has been held for a not insignificant amount of time; treatment has a poor prognosis and/or would likely be counterproductive to

[1189] The risk consequence is presumed to be 'high' since it is unlikely that a case before the court will involve a low-risk consequence decision because, by definition, the risk to the minors' health or life is not serious. There are no examples of low-risk consequences in the case law.

their health defined in terms of their physical and/or mental wellbeing; their cognitive ability is not impacted by mental disability; they are supported in their decision by their family (and perhaps by their wider community); they are not overwhelmed by the gravity of their decision and its implications; and their Convention rights are engaged. This thesis uses these examples descriptively to exemplify how the evaluative framework operates when surveying medical refusal cases. The balance sheet exercise logically suggests that in some cases, one transcendent principle comes to the fore, while elsewhere, its assumed rival is favoured. The reasoning in *E & F*, *An NHS Trust v CX* and *DV (A Child)* demonstrate that, provided the court employs a robust, broad and nuanced welfare assessment, culminating in a choice that is best for the minor at the heart of the decision, a conclusion favouring autonomy *or* protectionism should not necessarily attract criticism. This is a principled approach to the law.

II. Limitations

There are (at least) three plausible limitations that opponents could advance against the proposed recommendations. First, given the delicate challenges present in the context of refusing treatment that may have life-threatening consequences, the courts have suggested that changes in the law may be a matter for Parliament. Secondly, there is tension about whether the law should become more permissible towards respecting an outcome that would likely have severe consequences for minors' health or life, considering the suggestion that minors as a cohort are vulnerable. Thirdly, Cave and Cave have recently presented a novel argument which suggests that the law should be slow to allow 'adolescent adults' to refuse life-sustaining medical treatment.[1190] Their arguments could have implications for advancing the welfare and autonomy rights not just for young adults but also for minors.

[1190] Cave and Cave (n 1171).

A. Judicial Appetite for Change

In the light of support for conventional wisdom, as strongly evidenced by Sir James Munby's recent decision in *Re X (A Child) (No 2)*, there is uncertainty around how likely the courts would embrace the proposed recommendations, which aim to counterbalance the domination of protectionism with autonomy. In other contexts, having as their underlying theme the delicate nature of life-or-death decision-making, the courts have demonstrated a disposition to defer responsibility for change to Parliament. The classic example is *R (on the application of Nicklinson and another) v Ministry of Justice*,[1191] in which the Supreme Court considered whether the current law on assisted suicide was compatible with Article 8 ECHR. For present purposes, it is sufficient to say that there was broad acceptance that the case involved the consideration of matters that Parliament was better placed than the Supreme Court to assess.[1192]

Moreover, the slow development in the law on medical refusal, notwithstanding the changes to the legal landscape with, in particular, the introduction of the HRA 1998 and the autonomy-affirming rhetoric that comes with it,[1193] largely derives from a judicial reluctance to overthrow decades of legal authority. Balcombe LJ in *Re W* observed that whether competent minors should have complete autonomy in the field of medical treatment is a 'matter of social policy with which Parliament can deal by appropriate legislation if it wishes to do so'.[1194] In *Re X (A Child) (No 2)*, Sir James Munby considered that the law was settled and any change, such as introducing legal presumptions of capacity to refuse medical treatment for minors, would be a matter for Parliament, not the courts.[1195] Regarding the role and purview of the court's inherent jurisdiction, Sir Andrew McFarlane in *E & F* emphasised that any change to

[1191] [2014] UKSC 38.
[1192] ibid [113], [190], [197], [232].
[1193] See Chapter V, Part IV.
[1194] *Re W* (n 18) [87].
[1195] *Re X (A Child) (No 2)* (n 25) [162]. See also (n 656).

this power must be a matter for Parliament.[1196] The courts consistently suggest that it is for Parliament to make significant changes to the law.

B. Vulnerability in Minors

There is tension about developing the law and making it, however obliquely, more permissible to the death of young people when maintaining life was a viable alternative. This is particularly the case if the law puts the lives of the 'weak' and 'vulnerable' at risk. Such concerns were observed in *Nicklinson* within the context of assisted suicide.[1197] Similarly, in *Purdy*, Baroness Hale noted that 'it may be justifiable for society to insist that we value their lives even if they do not'.[1198] Minors in the position of contemplating a life-or-death decision may be equally weak and vulnerable. In those cases, the law should reasonably do all it can to provide appropriate safeguarding against risky decisions. Society has traditionally generalised minors as 'vulnerable' and 'impetuous', and by implication, they need adults to secure their welfare.[1199] This perception has contributed to the development of the law on minors' medical refusal.[1200] Empirical evidence supports such characterisations of minors and confirms that generalisations of the cohort needing increased protection are not unfounded. Neuroscientific research suggests that adolescents[1201] demonstrate heightened effects of peer influence on risk-taking, risk-perception and reasoning; adolescents are more impulsive, less future-orientated, emotionally volatile, sensitive to environmental cues, and differ in assessment of risks and

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[1196] *E & F* (n 30) [44].
[1197] *Nicklinson* (n 1191) [85]-[89].
[1198] *Purdy* (n 23) [68].
[1199] David Archard, *Children: Rights and Childhood* (Routledge 2004); Hagger (n 177); Elizabeth Wicks, *Human Rights and Healthcare* (Hart Publishing 2007) 114-115.
[1200] See *Re W* (n 18). See also Heywood (n 584); Eva Brems, 'Children's Rights and Universality' in Jan Willems (ed), *Developmental and Autonomy Rights of Children: Empowering Children, Caregivers and Communities* (2nd edn, Intersentia 2007).
[1201] Adolescence is a period of biological change that takes place over the years from approximately age 10 to 24: see Barbara M Newman and Philip R Newman, *Theories of Adolescent Development* (Elsevier 2020); Susan M Sawyer, Peter S Azzopardi, Dakshitha Wickremarathne and George C Patton, 'The Age of Adolescence' (2018) 2(3) Lancet Child Adolesc Health 223.

rewards compared to adults.[1202] The implications of heightened risk-taking and impulsivity observed in adolescents should not be overlooked. For example, the leading causes of death in adolescence involve accidental injuries, such as dangerous driving and experimentation with drugs and alcohol.[1203] Thus, there is wisdom to the inference that there should be limits on minors' autonomy to make major personal (healthcare) decisions.

The characterisation of minors as vulnerable and impetuous and requiring adult oversight of their welfare has traditionally been reflected in the law. In *Re W*, Lord Donaldson MR suggested that minors do not have the prudence to be free from interference. He reasoned that whilst they should be given the maximum degree of decision-making commensurate to their stage of development, they are not adults.[1204] In *Re L*, Sir Stephen Brown P emphasised the 14-year-old girl's minority: '[S]he is still a child'.[1205] More recently, in *Re X (A Child) (No 2),* whilst Sir James Munby accepted that the family court should not be blind to the changes in society's views and values, he held that he could not overthrow *Re R* and *Re W* 'merely because society's views have changed, even assuming that they have'.[1206] Sir Andrew McFarlane in *E & F* was also of the view that the analysis in *Re W* has not been overtaken by the passage of time, or by the evolution of societal views.[1207]

Neuroscientific evidence supports suggestions that minors are an impetuous and vulnerable cohort that requires protectionist oversight. Thus, it is reasonable to suggest that

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[1202] See, eg, Douglas S Diekema, 'Adolescent Brain Development and Medical Decision-Making' (2020) 146(1) Pediatrics 18; Sarah-Jayne Blakemore, 'Adolescence and Mental Health' (2019) 393(10185) Lancet 2030; Ivy Defoe, Judith Semon Dubas, and Daniel Romer, 'Heightened Adolescent Risk-Taking? Insights from Lab Studies on Age Differences in Decision-Making' (2019) 6(1) PIBBS 56; Laura Wolf, Narges Bazargani, Emma Kilford, Iroise Dumontheil, and Sarah-Jayne Blakemore, 'The Audience Effect in Adolescence Depends on Who's Looking Over Your Shoulder' (2015) 43 J Adolesc 5.

[1203] World Health Organisation, 'Adolescent and Young Adult Health' (*World Health Organisation*, 10 August 2022) < https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions > accessed 6 October 2022; Royal College of Paediatrics and Child Health, 'Adolescent Mortality' (*RCPCH*, March 2020) < https://stateofchildhealth.rcpch.ac.uk/evidence/mortality/adolescent-mortality/ > accessed 6 October 2022.

[1204] *Re W* (n 18) [81]-[82].

[1205] *Re L* (n 556) [140].

[1206] *Re X (A Child) (No 2)* (n 25) [161].

[1207] *E & F* (n 30) [57].

judges today would not be criticised for not developing the law in a manner more libertarian towards minors' autonomy in medical refusal cases.

C. Academic Challenge

This section articulates Cave and Cave's main points germane to the themes of this thesis. They argued that the law can and should better differentiate between young adults who are still going through adolescence and more mature adults. The distinction is important with respect to decisions to refuse life-saving medical treatment. The crux of their argument is that the law should be slow to allow adolescent adults to make decisions refusing life-sustaining treatment insofar as defects in their autonomy are recognised in the decision-making process. They argued that the law is insufficiently cognisant of the impacts of adolescence on adult autonomous decision-making and offered three solutions for how the law should protect vulnerable people with potential agential impediments: (i) the MCA 2005, (ii) exercise of the High Court's inherent jurisdiction, and (iii) statute. In agreement with Cave and Cave's own admission that the second and third solutions are rather tenuous,[1208] outlined below is the first solution only, with its implications also considered.

The authors posited whether the MCA 2005 presumption of capacity could be rebutted if an adult's decision to refuse life-sustaining treatment could be shown to be impacted by developmental immaturity related to adolescence.[1209] Observing this currently to be unlikely, the authors considered whether the presumption *should* be rebutted in the circumstances. By way of preliminaries, drawing on the reasoning of Lord Stephens that the MCA 2005 does not give individuals the right to make unwise decisions if the unwise decision is not autonomous,[1210] Cave and Cave considered that ss 2(3) and 1(4) MCA 2005 would not

[1208] Cave and Cave (n 1171) 1004, 1007.
[1209] ibid 1000.
[1210] *A Local Authority v JB* [2021] UKSC 52 [51].

necessarily bar a finding that a person with developmental immaturity lacks capacity. Turning to the significant issue of the capacity test, the authors argued that vulnerable adolescent adults may be found to lack capacity. Regarding s 2(1), they suggested that 'waves of "syntactic pruning"' could potentially be sufficient, assuming there is a causative nexus between the evidence of adolescence and the inability to decide.[1211] As for s 3(1), they suggested that, with psychological tools, it may be indicated that a person is unable to make a decision because, amongst other factors, their risk perception impacts their ability to use and weigh information.[1212] Thus, based on a finding of incapacity, an s 4 best interests test would be made, which might uphold or overrule the adolescent adults' decision to refuse medical treatment.

The wording of the MCA 2005, subsequent case law,[1213] and the new draft Code[1214] largely support the position Cave and Cave advocated for. Whilst the authors limited the scope of their argument to adults rather than minors, given adolescence spans childhood into adulthood, their arguments cannot be considered in a vacuum. The authors recognised that some would argue their position constitutes an unjustified attack on young people's valid and autonomous decisions.[1215] The authors avoided straying into hard paternalism, but their proposal, whilst well-intentioned, nevertheless encourages paternalism, obliquely or otherwise, by undermining the presumption of capacity insofar as an adult essentially makes an unwise decision. The trouble lies in the triggering of a capacity assessment. Cave and Cave observed that the new draft Code of Practice states that an assessment would be relevant where '[t]he decision of the person is proposing to take appears unwise, especially if they are putting themselves or others at risk'.[1216] Thus, a capacity assessment would be triggered whenever a decision would have serious consequences. In this regard, the new guidance clearly contradicts

[1211] Cave and Cave (n 1171) 1002; see also, for discussion on 'synaptic pruning', 990-991.
[1212] ibid.
[1213] *A Local Authority v JB* (n 1210); *York City Council v C* [2013] EWCA Civ 478.
[1214] *MCA 2005 Draft COP* (n 12).
[1215] Cave and Cave (n 1171) 1010.
[1216] *MCA 2005 Draft COP* (n 12) para 4.5.

s 1(4) MCA 2005 and case law.[1217] Refusals of life-sustaining treatment inherently involve serious consequences, meaning *all* adults who make such a decision will trigger a capacity assessment. The consequence is that vulnerable young adults would likely see greater protection. Yet there is a risk that otherwise autonomous young adults would have their refusal treatment decisions challenged and deliberated in a courtroom because of a perception that their decision was the product of developmental immaturity due to their age and the nature of their decision. In other words, Cave and Cave's proposal may support defensive practices.[1218] Whenever a medical professional has any doubt over an adult's decision-making capacity, which in the light of the new draft Code of Practice is likely whenever a decision has serious consequences, they may challenge the autonomy of the decision. Considering the authors suggested there should be no limits to differentiating between groups of adults,[1219] the practical effect may be that the principle contained in s 1(2) MCA 2005 becomes a presumption of incapacity with respect to medical treatment refusal decisions. This being the case may produce an administrative burden on the courts to deliberate the autonomy of a decision and increase paternalism concerns.

It is beyond the scope of this thesis to engage more fully with Cave and Cave's arguments, but relevant problems have been articulated. In respect of the implications of Cave and Cave's proposal for minors, it may impact young persons, considering much of the MCA 2005 applies to 16-17-year-olds. However, since there is no presumption of capacity to refuse for young persons, whenever a minor of any age refuses treatment that is in their best interests, notionally, the court will test the autonomy of the decision.[1220] Cave and Cave's arguments will thus be relevant to the courts' welfare assessment, which extends to minors of all ages.

[1217] *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP).
[1218] Laura M Finucane, Susan M Greenhalgh, Cristopher Mercer, James Selfe, 'Defensive Medicine: A Symptom of Uncertainty?' (2022) 60 Musculoskelet Sci Pract 102558.
[1219] Cave and Cave (n 1171) 1010.
[1220] See Chapter IV.

Observing the societal generalisations and empirical evidence supporting claims that minors are vulnerable and impetuous, doubts over the autonomy of adolescent adults' refusal of life-saving treatment will only be accentuated with non-adults. Rather than engaging in a broad and nuanced balancing of the transcendent principles of preservation of life and personal autonomy, there is a risk that concerns over developmental maturity may encourage protectionism through consequentialism (or ideal desire autonomy) analyses and, therefore, marginalise otherwise autonomous minors' decision-making.

III. Alternative Solutions

This part considers two alternative solutions. One is to extend the MCA 2005 framework to provide one test for all.[1221] Sticking with the legislative reform theme, another is whether the Canadian and/or Scottish statutory frameworks are preferable to English law, particularly with respect to developing the rights of 16-17-year-olds.

A. Extending the Mental Capacity Act 2005

There is a school of thought in the literature that extending the provisions of the MCA 2005 to apply to those under 16 is the solution that best balances minors' rights to autonomy and protection in both legal and healthcare contexts. Strong proponents of such an approach, Chico and Hagger, suggested that in the light of increased evidence of children's abilities and the trajectory of their interests, the failure to extend MCA 2005 protection to mature children was a missed opportunity.[1222] The structure of the Act's provisions maximises the individual's decision-making ability and ensures that their autonomy is not eroded by the court.[1223] The authors argued that the desire to maximise the capacity for autonomous decision-making is

[1221] Andrew McFarlane, 'Mental Capacity: One Standard for All Ages' (2011) 41 Fam L 479.
[1222] Victoria Chico and Lynn Hagger, 'The Mental Capacity Act 2005 and Mature Minors: A Missed Opportunity?' (2011) 33(2) J Soc Welfare & Fam L 157.
[1223] *York City Council v C* (n 1213) [51].

evident in the Act's principles. In particular, s 1(3) provides that a person is not to be treated as unable to make a decision unless all practicable steps to help them have been taken without success, and s 1(4) emphasises that making an unwise decision does not mean an inability to make a decision. If children were included within the remit of the MCA 2005, their capacity would be taken more seriously.[1224] For example, they suggest that the outcomes in *Re E* and *Re L* might have been different in a post-MCA 2005 context.[1225] The children in those cases were considered mature but had an information deficit.[1226] This would have been remedied by the MCA 2005 requiring all practicable steps be taken to support their decisions. However, observing that the child in *Re S* would likely not be able to make a capacitous decision even if her autonomy was maximised,[1227] Chico and Hagger did not suggest that the outcome of applying the MCA 2005 to children is unrestricted medical decision-making. Rather, what they advocated for was that:

> [A]s with those over 16, [children's] apparently unwise decisions should not be overridden *automatically* and that all practicable steps should be taken to enable them to achieve capacity and corresponding autonomy.[1228]

Mr Justice McFarlane, speaking extra judiciously, also posited that a broad application of the MCA 2005 would remedy problems with children's capacity to refuse medical treatment. Whilst he did not envisage the presumption of capacity applying to children, he suggested that when it came to assessing decisional capacity, there was no reason why the scheme for evaluating capacity should be different between those under and over 16.[1229] He concluded by suggesting that if the MCA 2005 extended to apply one standard of capacity for all ages, it

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[1224] Chico and Hagger (n 1222) 165.
[1225] ibid 166; *Re E* (n 528); *Re L* (n 556).
[1226] See Chapter IV, Part IV, Section A, Subsections 1 and 3. See also McCafferty (n 593).
[1227] *Re S* (n 545).
[1228] Chico and Hagger (n 1222) 166 (emphasis in original).
[1229] McFarlane (n 1221) 484.

would be a welcomed development for several reasons. In particular: (i) the Act does not distinguish between consent and refusal; (ii) it protects against unwise decisions; (iii) it represents a move away from a paternalistic and protectionist approach to a more autonomy-maximising model, and (iv) it would be in tune with the organic development of capacity described by Lord Scarman in *Gillick*.[1230]

The attractiveness of applying relevant MCA 2005 principles to children has been observed in the courts. In *Re S (A Child)*, concerning the competence of a 15-year-old mother, S, to consent to her baby being placed for adoption, Cobb J observed that, whilst the test of children's competence is set out in *Gillick*,

> [a]s the decisions which S faces… are not uncommonly encountered by adults about whom issue is raised as to capacity, the approach of the courts to decision-making by adults and children ought (with appropriate adjustments to reflect age and maturity) in my judgment to be complementary.[1231]

Accordingly, to determine *Gillick* competence, Cobb J regarded it as appropriate and helpful to read across and borrow from the relevant concepts and language of the MCA 2005.[1232] He considered it 'illogical' for the court to apply a materially different capacity test once S turned 16. Therefore, for a *Gillick* competent child to consent to placement for adoption, they would need to, in effect, satisfy s 3(1) MCA 2005.[1233] He suggested that splicing the MCA 2005 capacity test onto *Gillick* competence, whilst remaining cognisant of some fundamental differences between the two frameworks, would 'materially assist' in maintaining consistency of judicial approach to the determination of competence.[1234] In other words, the MCA 2005's

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[1230] ibid 484-485.
[1231] *Re S (A Child) (Child as Parent: Adoption: Consent)* [2017] EWHC 2729 (Fam) [15].
[1232] ibid.
[1233] ibid [18]-[19].
[1234] ibid [19].

functional approach to capacity represents the superior model for developing the law. The reasoning of Cobb J reflects some of the points made by Mr Justice McFarlane, namely that it would be incoherent to apply separate capacity tests across age ranges. There is some overlap between MCA 2005 principles and *Gillick* competence that point towards having one standard for all ages. *Gillick* requires that the determination of the child's competence is decision- and child-specific.[1235] The MCA 2005 similarly requires that the specific factual context is considered when evaluating capacity.[1236] Thus, the theoretical and judicial support for extending some of the MCA 2005 principles to under 16s suggests that a one size fits all approach is a tenable reform proposal.

B. Cross-Border Approach

In respect of under 16s, the legal frameworks of England, Canada and Scotland all employ a rebuttable presumption of incapacity. Those who rebut the presumption–the *Gillick* competent child in England and the mature child in Canada–do not have the *prima facie* determinative right, like traditional adults, to refuse medical treatment in their best interests. In both jurisdictions, the court exercises its *parens patriae* jurisdiction to make a best interests decision of whether to respect or overrule the treatment refusal. In England, *Gillick* competent children's refusals have universally been overruled in the courts, whereas Canadian jurisprudence has produced some cases where the mature child's refusal was respected despite the potentially serious consequences. The s 2(4) competent child in Scotland appears to have the determinative right to refuse medical treatment. Indeed, even the courts appear limited in their ability to overrule the treatment refusal of an s 2(4) competent child.

[1235] *Gillick* (n 10) [189]

[1236] See *York City Council v C* (n 1213) [35] (McFarlane LJ), 'removing the specific factual context from some decisions leaves nothing for the evaluation of capacity to bite upon'. See also *A Local Authority v RS (Capacity)* [2020] EWCOP 29 [30].

Transposing the approach to medical decision-making by s 2(4) competent children into English law is not recommended because of the limited judicial scrutiny of how the law actually operates in Scotland. Should the Scottish courts observe that their role with respect to medical refusals made by s 2(4) competent children is limited, this would make for a convincing argument in favour of the Scottish approach. Thus, is Canada's conception and regulation of the mature minor's refusal rights superior or preferable to the *Gillick* competence model? There is insufficient reason to remodel English law following the Canadian framework. In the light of *E & F*, the courts must undertake a robust welfare assessment with the individual at the heart of the decision, which reflects the guidance Abella J provided for courts determining the best interests of the child under s 25(8) CFSA. Moreover, it would be a waste of time and Parliamentary resources to amend the CA 1989 to mirror the apprehension and best interests model of the CFSA when both legal frameworks reach the same destination in manners represented differently for medical treatment purposes.

Concerning 16-17-year-olds' refusal rights, there is a case that the more autonomy-enhancing legal frameworks–CFSA and ALCSA 1991, respectively–are preferable to English law. In Canada (Manitoba), following 'interpretation (1)' of *AC v Manitoba*, the CFSA provides a rebuttable presumption that medical decisions (to consent or refuse) made by young persons are *prima facie* determinative. If the young person is apprehended as a child in need of protection (ss 17, 21 CFSA) and brought before the court (s 25(3)), the court will not make an s 25(8) best interests decision unless s 25(9) is satisfied. In Scotland, a person of or over the age of 16 years is presumed to have full legal capacity to enter into any transaction (s 1(1)(b) ALCSA 1991), including the giving of consent (s 9(d)) and (most likely) refusing consent.[1237]

[1237] See Chapter VI, Part II, Section B.

The AWISA 2000 defines adults (including young persons) who lack legal capacity and provides a framework for making decisions for those who lack capacity.

Following the CFSA and ACLSA 1991, changes to English law would best come in the form of amending the FLRA 1969. The Act already provides a rebuttable presumption of competence to consent to medical treatment for young persons. It would not be difficult to extend the presumption to include refusals. Section 8(1) FLRA 1969 could be amended thus:

> The consent [or refusal] of a minor who has attained the age of 16 years to any surgical, medical or dental treatment… shall be as effective as it would be if he were of full age…

Under the amended s 8(1) FLRA 1969, the young person has full medical decision-making autonomy unless proven otherwise, like adults. If the young person refuses medical treatment in their best interests and is determined to be *incompetent* by being, for example, overwhelmed or defers their decision to their parents, the parents or the courts could make a decision on the (incompetent) young person's behalf. Alternatively, since the MCA 2005 will still apply to young persons, for the young person who *lacks capacity* under ss 2(1) and 3(1), the courts will make an s 4 best interests decision. This solution is reasonable and practical because it adopts the strengths of the more autonomy-respecting legal frameworks of Canada (Manitoba) and Scotland, and it also safeguards young persons who lack the ability or will to make autonomous decisions by not removing the distinction between minors and adults.

IV. Evaluating the Limitations and Alternative Solutions

This thesis argues that the recommendations advanced represent the preferred method for developing the law for several reasons. First, the recommendations are consistent with the

suggested increased judicial appetite for respecting competent minors' decisions.[1238] This thesis does not recommend the changes submitted to Sir James Munby in *Re X (A Child) (No 2)* (i.e. competent minors' autonomy and decision be in all circumstances determinative) nor to Sir Andrew McFarlane in *E & F* (i.e. limiting the scope of the inherent jurisdiction). Thus, Parliamentary intervention is not required. Whilst it is too soon to evaluate the impact of *E & F*, the interpretation of the decision and the recommendations that flow from reliance on that interpretation are reasonable and represent an organic development of medical refusal law.

Secondly, it is commonplace that when the courts address questions of welfare, they do so with regard to present-day standards.[1239] Out-of-court refusal cases demonstrate that society is permissible towards minors refusing life-saving medical treatment. Hannah Jones had her decision to refuse a heart transplant supported by those involved in her care.[1240] In the case of 15-year-old Joshua McAuley, his decision to refuse blood transfusions after sustaining serious injuries in a car crash was respected by the hospital doctors.[1241] These cases indicate an on-the-ground acceptance of difficult end-of-life decisions made by competent minors. Furthermore, the recommendations do not open the floodgates for allowing any minor to have their refusals of medical treatment respected. The responsibility for determining whether or not the minor should receive the proposed medical treatment rests with the judge, who must undertake a robust, broad and nuanced welfare assessment to determine what is best for the minor patient.

Thirdly, Cave and Cave's proposals will likely have minimal impact in the context of minors' medical refusals. The limitations of their arguments that were within the scope of this thesis to observe have been articulated. Their proposals concern how the law should protect

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[1238] See Chapter IV, Part V.
[1239] *Owens v Owens* [2017] EWCA Civ 182 [40].
[1240] See Chapter IV, Part IV, Section B, Subsection 2.
[1241] The Guardian, 'Jehovah's Witness Teenager Dies After Refusing Blood Transfusion' (*The Guardian*, 18 May 2010) < https://www.theguardian.com/uk/2010/may/18/jehovahs-witness-dies-refuse-blood-transfusion > accessed 29 April 2023.

vulnerable adolescent adults from making non-autonomous decisions. Most importantly, Cave and Cave have shared the same interpretation of *E & F* as this thesis that, insofar as evidence supports that on the balance of probabilities, a treatment decision is autonomous, the minors' view will likely prove determinative in the welfare assessment.[1242]

Fourthly, the potential to extend the MCA 2005 to apply to children has been considered and rejected by the courts and academics. In *Re X (A Child) (No 2)*, Sir James Munby disagreed with the approach of Cobb J in *Re S (A Child)*, suggesting its premise that *Gillick* competence is in any way related to or even analogous to capacity in the sense in which the expression is used in the MCA 2005 was erroneous.[1243] He confirmed that the relevant test of competence for children under the age of 16 is *Gillick* and that to read across and borrow concepts and language from the MCA 2005 would be confusing and unhelpful. Cave considered the arguments presented by Chico and Hagger and Mr Justice McFarlane but concluded that incorporating aspects of the MCA 2005 into *Gillick* competence would be problematic not only for protecting children's autonomy interests but also it would have the effect of limiting the protections afforded by the Act to those over the age of 16.[1244] Moreover, there is a higher threshold to being *Gillick* competent (particularly to refuse medical treatment[1245]) than having mental capacity under the MCA 2005. Lowering the standard would mean that those who are overwhelmed, immature or subject to undue influence would unlikely be caught within the terms of the MCA 2005, in which case they would be deemed capable of medical decision-making. Clearly, this would open the door to subjecting children to considerable danger. There is no compelling reason to splice or replace *Gillick* competence with the MCA 2005.

[1242] Cave and Cave (n 1171) 1009.
[1243] *Re X (A Child) (No 2)* (n 25) [75].
[1244] Cave (n 257) 117-119.
[1245] ibid 106. See also Chapter IV, Part IV, Section A.

Finally, Parliament could amend the FLRA 1969 to extend the rebuttable presumption of legal capacity to consent to include the right to refuse. That it has not already done so is in itself telling. It is the courts who hear challenges to minors' medical decision-making. Yet the judiciary lacks the enthusiasm to develop the law to make competent minors' autonomous decisions prima facie determinative.[1246] There is, instead, an increased judicial appetite to respect autonomous refusals insofar as the court can arbitrate over whether that decision is in the minor's best interests. Sir Andrew McFarlane in *E & F* explicitly held that in future cases that involve weighing the transcendent principles of preservation of life (i.e. protectionism) and autonomy, judges should direct themselves by reference to his decision.[1247] The recommendations emphasise that the development of the law should maintain its current, suggested trajectory. However, should Parliament be called to reform the law, developing s 8(1) FLRA 1969 in the manner proposed above should not be overlooked.

V. Concluding Remarks

In the medical context, minors ordinarily either consent or refuse recommended treatment objectively determined by medical expertise to be in their best interests to ameliorate or arrest or cure injury or illness. The situation is no different for adults. Yet the law is permissible towards the competent adult having their medical decisions *prima facie* determinative in contradistinction to competent minors. The law is conventionally (and generally justifiably) protectionist towards minors because of their age and biological and cognitive stage of development, generalising the cohort of minors as vulnerable and impetuous and implying they require a level of protection. At the same time, because minors are a heterogeneous group, with some members having cognitive reasoning skills commensurate or superior to adults, the law

[1246] See, eg, *Re W* (n 18), *Re X (A Child) (No 2)* (n 25), *E & F* (n 30).
[1247] *E & F* (n 30) [71].

has increased respect for minors capable of autonomous decision-making. Thus, the law faces the ethical dilemma of balancing protectionism and respect for autonomy. The preference for one theoretical model over another largely depends on the context and content of the decision. In its broad canvass of the legal landscape, this thesis addressed how the law balances the interests of autonomy and protectionism in minors' medical decision-making.

This thesis has argued that the law on minors' medical consent, as defined in *Gillick* and developed by *Axon* and *Bell (CA)* and under s 8(1) FLRA 1969, is theoretically sound. The impact of the robust reinstatement of *Gillick* in *Bell (CA)* remains to be seen, though this thesis suggests there is no need for any judicial re-evaluation of what *Gillick* established. Thus, the consent of the competent minor, in which there is no blanket minimum age of this status, to theoretically any medical procedure considered in their best interests is determinative and supported by Article 8 ECHR. The practical difficulties with assessing *Gillick* competence do not undermine this analysis. There is sufficient support for medical professionals to determine children's capacity consistent with the expectations of good medical practice. Nevertheless, this thesis would welcome further empirical research on why *Gillick* competence is an area of doctors' ambivalence, as well as on how to improve doctors' understanding of *Gillick* competence.[1248]

This thesis has argued that the law on minors' medical refusal is problematic and requires reconsideration. The crux of the issue centred on the court's welfare assessment. The courts have consistently identified the relevant factors in the case before it but have been inconsistent in giving each of them proper weight and balancing them out to make a decision best for the minor at the heart of the decision. The author of this thesis investigated all reported English minors' medical refusal case law (as well as relevant medical refusal cases in Canada

[1248] See Chapter III, Part II, Section C, Subsection 3.

and Scotland) and identified all the factors the courts have considered relevant, weighed, and balanced in the welfare assessment. This endeavour contributes to the literature by offering a framework based on the factors relevant to medical refusal case law (domestically and internationally) that objectively evaluates whether the decision of the court to overrule a minor's treatment refusal represents justified protectionism. The framework's sliding scale of justified protectionism demonstrates that where the weight of factors in favour of supporting the minors' refusal increases, the case for interfering with their decision becomes increasingly limited. This thesis has demonstrated that whilst the courts have generally engaged in consequentialism analyses, partly in the light of the HRA 1998, partly in the light of recent international legal developments, and partly in the light of the rise in general respect for autonomy, the courts are increasingly, albeit gradually, adopting a more consistent welfare analysis, which increases the legitimacy of the court's decision to favour protectionism or respect for the minors' autonomy.[1249]

The evaluative framework this thesis advanced is theoretically grounded by conventional wisdom founded in *Re R* and *Re W* and the reasoning in *E & F* and *DV (A Child)* and thus represents an organic and principled method for developing the law. The framework extends to helping the courts structure their approach to the present decision, and potential litigants can assess the likelihood of success based on the relevant factors that support their claim and precedent. The impact of the recommendations is not limited to the courtroom. The elucidation of the law and its suggested development will be of general or specific relevance to appropriate stakeholders interested in medical decision-making, including the minors themselves, parents, medical professionals, and academics.

[1249] See Chapter IV. In particular, Part V.

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APPENDIX I

TIMELINE OF RELEVANT LAW		
Name	**Law**	**Summary**
Family Law Reform Act 1969	Statutory Principle	This Act provides that a minor who has attained the age of 16 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. This Act was the first piece of law to give minors (16-17-year-olds) the legal right to consent to medical treatment in England & Wales.
Child and Family Services Act, CCSM c C80	Comparative Statutory Principle	This Act provides, amongst other things, when a court may authorise a medical examination or any medical or dental treatment that the court considers to be in the best interests of the child.
Re LDK (An Infant) (1985) 48 RFL (2d) 164	Comparative Case Law	This case is an example of a Canadian court supporting the decision of a child to refuse medical treatment even though this decision puts their health or life in jeopardy.
Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 122	Case Law	This landmark House of Lords case held that as a matter of law, the parental right to determine whether or not their child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.

		This case filled an important gap left by the Family Law Reform Act 1969. It is the leading authority on children's medical consent law.
Age of Legal Capacity (Scotland) Act 1991	Comparative Statutory Principle	This Act defines that a person of or over the age of 16 years shall have the legal capacity to enter into any transaction, including the giving of consent to medical treatment. There are exceptions to this general rule, including the provision enabling a person under the age of 16 to have the legal capacity to consent to medical treatment independently.
Re R (A Minor) (Wardship: Consent to Treatment), [1992] Fam 11	Case Law	This Court of Appeal case held that a *Gillick* competent child or one over the age of 16 will have a power to consent, but this will be concurrent with that of a parent or guardian. Furthermore, the court, in the exercise of its wardship jurisdiction, has the power to override the decisions of *Gillick* competent children as much as those of parents or guardians. This case filled an important gap on the issue of medical refusal left by the Family Law Reform Act 1969 and *Gillick*. However, in doing so, it signalled a disjuncture from *Gillick*. This case and the latter case of *Re W* detail the "conventional wisdom" on minors' medical decision-making rights, especially in regard to the law of medical refusal.
Re W (A Minor) (Medical Treatment: Court's	Case Law	The Court of Appeal in this case, following its earlier decision in *Re R*, held that no minor of whatever age or level of competence has the full right to autonomous medical decision-making.

Jurisdiction), [1993] Fam 64		This case addressed the remaining issues left by the Family Law Reform Act 1969, *Gillick* and *Re R*. However, in doing so, like *Re R*, it signalled a disjuncture from *Gillick*. This case and *Re R* detail the "conventional wisdom" on minors' medical decision-making rights, especially in regard to the law of medical refusal.
Re AY (1993) 111 Nfld & PEIR 91	Comparative Case Law	This case is another example of a Canadian court supporting the decision of a child to refuse medical treatment even though this decision puts their health or life in jeopardy.
Houston (Applicant) [1996] SCLR 943	Comparative Case Law	This Scottish Sheriff Court case notably interpreted the consent provision in the Age of Legal Capacity (Scotland) Act 1991 as covering consent and refusal of medical treatment. The case also suggests that a competent child's decision (to consent *or* refuse consent) is paramount and cannot be overridden by a parent or guardian. The reasoning in *Re R* and *Re W* was referred to the Sheriff Court, though this did not impact the court's decision.
Human Rights Act 1998	Statutory Principle	This Act gives further effect to the rights and freedoms guaranteed under the European Convention on Human Rights 1950. Notably, the courts have interpreted the Convention (such as Article 8) to recognise and uphold the medical decision-making autonomy of competent patients. However, the support the Act offers minors in this context, especially regarding medical refusals, is limited.

Mental Capacity Act 2005	Statutory Principle	This Act provides a framework to protect those unable to make decisions. Much of the Act applies to 16-17-year-olds, including the presumption of capacity. Accordingly, 16-17-year-olds are presumed competent under the Family Law Reform Act 1969 and presumed capacitous under the Mental Capacity Act 2005. However, neither Act has been interpreted to give these minors full medical decision-making autonomy.
R (on the application of Axon) v Secretary of State for Health [2006] EWHC 37 (Admin)	Case Law	This High Court case strongly affirmed *Gillick* and held that *Gillick* competence is not limited to only contraceptive advice and treatment. The *Gillick* principles apply to *all* forms of medical treatment.
AC v Manitoba (Director of Child and Family Services) [2009] SCC 30	Comparative Case Law	This Supreme Court of Canada case is the leading authority on minors' medical decision-making in Canada. Crucially, the court held that the impugned provisions of the Child and Family Services Act, CCSM c C80, should be interpreted in such a way to allow children to demonstrate sufficient maturity to have a particular medical treatment decision respected.
PH v Eastern Regional Integrated Health Care Authority and SJL (2010) 294 Nfld & PEIR 248 (NLTD)	Comparative Case Law	This Canadian Trial Court case interpreted *AC v Manitoba* as suggesting that, irrespective of findings or presumptions about competence and the value of autonomy, the court's choice is always to preserve the minor's health or life because that is in their best interests. This case overreached with its interpretation of *AC v Manitoba*.

Ferreira v HM Senior Coroner for Inner South London [2017] EWCA Civ 31	Case Law	This Court of Appeal case, despite not directly concerning minors' medical decision-making, is significant because *Re X (A Child) (No 2)* interpreted it as detailing whether a minor receiving medical treatment against their expressed wishes can be found to be deprived of their liberty.
Re X (A Child) (No 2), [2021] EWHC 65 (Fam)	Case Law	This High Court case is significant because it displayed a robust affirmation of *Re R* and *Re W*, with the case defending the Court of Appeal decisions against a broad set of challenges. In particular, the prominence of medical autonomy domestically and internationally and human rights.
AB v CD [2021] EWHC 741 (Fam)	Case Law	This High Court case confirmed that parents cannot override the decision to consent to medical treatment made by their *Gillick* competent child. However, when a child does not make a decision because they are overwhelmed or they defer the decision to their parents, the parent's right to provide consent continues.
A Teaching Hospitals NHS Trust v DV (A Child) [2021] EWHC 1037 (Fam)	Case Law	This High Court case is the first (and currently only) minors' medical refusal case in English law to respect the decision-making autonomy of a competent minor (17-year-old), even though the consequences of doing so could have resulted in the death or serious injury of the minor. The reasoning in the case was consistent with that of *Re R* and *Re W*. However, the outcome represents a clear disjuncture from conventional wisdom.

Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363	Case Law	This Court of Appeal case overturned the earlier decision at first instance of *Bell* (Divisional Court). The Divisional Court's decision was wholly inconsistent with *Gillick.* The *Bell* (Court of Appeal) decision represented a robust reinstatement of the principles of *Gillick*. Indeed, with this decision, the law on minors' medical consent appears settled.
E & F (Minors: Blood Transfusions) [2021] EWCA Civ 1888	Case Law	This Court of Appeal case held that *Re R* and *Re W* represents good law, all the while seemingly marking a clear shift because its message emphasised respecting competent minors' medical refusals when such a decision reflects the minors' best interests. This Court of Appeal case is the most significant minors' medical refusal case since *Re R* and *Re W*. It provides a basis that develops a broad and nuanced approach to competent minors' refusals that balances competing interests implicit in the court's welfare assessment. The Court of Appeal directed that all future courts hearing cases of minors' medical refusals should refer themselves to its judgment.