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Gillick competence: An unnecessary burden

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Gillick Competence: An unnecessary burden

This study of the ethical significance of childhood is situated within the context of adolescent decision-making and childhood is treated as a neglected topic of ethical reflection. It is argued that Gillick competence is an unnecessary burden with an unethical foundation. The ethics of adolescent medical decision-making is a fraught area for medical ethics because it deals with the threshold boundaries between childhood and adulthood and Gillick adds a burden upon adolescent patients that is unwarranted and through which damage is done to integral human relationships.

Keywords: Gillick; competence; childhood; child; adolescent; decision-making; ethics

Childhood as an ethical problem and the emergence of two radical positions

Children in any kind of need can inspire a personal empathy in a range of circumstances. Images of children in difficult circumstances have universal appeal, and there is an epi-phenomenal experience of shared responsibility for a suffering child; even one in a different country and culture to one's own. This was epitomized on a grand scale when the image of one deceased child moved countless people to become emotionally invested and politically mobilised over the European refugee crisis (The Huffington Post: *This Photo Shows the Horrific Toll of Europe's Refugee Crisis*, 2 September 2015). Moreover in children's literature the loyalty and imaginative power of childhood can be contrasted with adults, even in situations where children are faced with great danger or moral opposition. For example, a character in the first of CS Lewis' Chronicles of Narnia series comments, 'Children have one kind of silliness, as you know, and grown-ups have another kind' (CS Lewis, *The Magicians Nephew*, 6). The difference between the child and the adult becomes less clear or polarized when considering adolescence, the Latin root *adolescere* of which means 'to grow up', a developmental stage (or stages) from puberty to the age of majority, during which a child transitions towards adulthood. Ethical attention upon the child tells us something of the inherent power of the narrative of childhood as a vehicle for directing discussion

1 about how we make major decisions in health care, and it tells a story about shared
2 humanity and personhood.

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4 What is meant by ‘childhood’ or a ‘child’ will be largely framed by age but also
5 indicates a social and mental spectrum of development that is finding its way towards
6 maturity. This is not merely about finding an adequate means of caring for our shared
7 future, which is one obvious way of understanding the significance of children and
8 childhood, but about understanding better what children mean for us now. If childhood
9 carries a significance in its own right, such logic would have us consider those adults
10 with a child-like mentality (for example those with learning disabilities or some form of
11 cognitive impairment), who bear childhood as a reality that is experiential and
12 unavoidable, but not bound to age per se. A change in approaches to the young child
13 and the adolescent child can be apparent in which expressions of affection or protection
14 to the smaller child, both disabled and those who are not, are more common than for the
15 adolescent disabled person. See for example a case in the US in which a disabled child’s
16 parents wished her to receive surgery to maintain her childish looks (CNN: *Report:*
17 *'Pillow angel' surgery broke law*, 8 May 2007). A nine year old girl with the condition
18 known as static encephalopathy was sterilized and the treatment, insisted upon by both
19 parents, resulted in her growth being stunted (‘growth attenuation therapy’), actions
20 which ultimately were deemed to be illegal by the State of Washington. In this case
21 parents had insisted that the actions, including a hysterectomy, were designed to prevent
22 further suffering to their daughter, and the artificial stunting of growth would allow the
23 child to be more positively involved in family love and affection.
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40 What then of the factors involved in the decision-making around medical care
41 for children themselves?
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43 In light of recent developments, two radical positions are apparent and in need
44 of critical attention. These will be referred to as dependency and autonomy, which at
45 first glance might seem to sit in opposition. It is argued below that they are not in
46 opposition or even in simple contradiction, but are oriented against each other in a way
47 in which they feed off and depend on one another, and in some respects overlap:
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53 The first radical position is that of dependency, a significant component of
54 childhood that includes psychological, emotional, physical and intellectual dimensions,
55 that will be assessed as the typical social and economic means in which a child normally
56 relates to family and other social structures, including that of medical care. Dependency
57 has a healthy aspect and is not to be rejected simplistically. Again, the way in which
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dependent persons are treated is not equal; the disabled adolescent child can be treated differently from the very young disabled child, the latter of which might draw an affectionate and benevolent form of pity, and the former, who might be louder, larger, stronger, receiving less overt affection and more of a grim tolerance. Not a new reality in itself, the assumption of dependency has always been found in healthcare delivery, although in the context of widespread paternalism it may have been more the norm than the exception. In many ways the voice of the child is being heard more clearly now despite the radicalized dependency that still takes place, for example the case of Hannah Jones, a 13 year old with a hole in her heart who refused a heart transplant in 2008 (BBC News: *Girl wins right to refuse heart*, 2008). Jones' parents were taken to the High Court by her hospital, the Herefordshire Primary Care Trust who wished the parents decision overturned, but the case was ultimately dropped. The girl's parents are on the record as deferring the decision to their daughter on the basis that she was mature enough to decide on her own medical treatment (or refusal), whereas the hospital had taken the view that this was the wrong decision and the girl should be overruled for her own good. Dependency, when not radicalised, can be given a positive account, such as, for example, in the work of Robert Spaemann, who views dependency as a means of maturity in the human person (see especially *Persons* and summarised helpfully in a shorter article *When does the Human Being begin to be a Person?*). Any child is—legally and socially—dependent upon primary carers (in most cases parents but other kinds of legal guardians and carers serve in a similar capacity) for its basic care and sustenance, as well as for its social and moral formation. At this broad level, dependency is more a fact than a position or a concept at play, however it has increasingly become a vehicle by which childhood is held back and the natural development of maturity is interrupted. Moreover, the 'shady area' of later adolescence, while still treated as a component of childhood, is increasingly viewed as a period of development in which children may have obtained the knowledge and maturity to make their own decisions on medical treatment, eg 'Gillick competence' (*Gillick v West Norfolk & Wisbeck Area Health Authority* (1986) AC 112 House of Lords.). Dependency has become utilised as a position radicalised in the situation of medical decision making such that children, from a very young age, are restricted from raising their own voice in answer to questions about their health and wellbeing.

In contrast to dependency is that of radical autonomy, described by some as a fundamental feature of ethical health care in modernity and in contemporary Western

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medical contexts, such as in the influential text, *Principles of Biomedical Ethics*, where a new way of guiding medical decisions was laid out by Tom Beauchamp and James Childress that focused on nonmaleficence, beneficence, autonomy and justice (2001; first edition published in 1979). For Beauchamp and Childress, these four principles provide a framework for identifying and reflecting on moral problems, and not for generating a new moral theory as such (2001: 15). However, autonomy is viewed as more than a simple principle and can be treated as an ideal for each human being, and some children are granted a form of partial autonomy in decision making at an age that, until recent years, would have been thought too young for such a level of responsibility. Generally, a child might be considered to have a competence for a particular decision (such as contraception) and not for another (such as whether or not to receive a heart transplant). Children are considered as human beings (usually) who have not reached a mature capacity to express their autonomy, which with recent changes can be granted to children at a sudden and unprepared age or point in time (later in this article the age of 18 will be discussed as well as the less clear ages of 16-18 and those under 16). A typical age for this, legally speaking, is that of the sixteenth year, at which point many jurisdictions recognize a full complement of powers over one's decision-making capability. This, alongside the problem of dependency above, makes childhood something of an aberration in the modern and postmodern mind; a process on its way to an adequate level of autonomous self expression rather than a positive stage of development carrying its own ethical significance.

These two radical positions have become enshrined in various legal contexts and in medical practice, indicating that two positions are gaining strength that, on the face of it, have little middle ground. They disregard possibilities for a holistic account of childhood as ethically significant in its own right, whereas a better rounded position can be found in the thought of Alasdair MacIntyre who advocates for an integrated vision of human maturity. In MacIntyre's view, human growth constitutes a spectrum of developmental stages that require a social ecology of mutual responsibility and a keen sense of the right of a child to grow into maturity (See MacIntyre's works *Dependent Rational Animals* and *Ethics and Politics: Selected Essays*, Volume 2). Overlooked between the two positions is, ironically enough, the child itself, as a distinctive person who requires a kind of medical attention and care that respects the particular stage of development being lived through, and the uniqueness of that individual experience of health and wellbeing. It may be that it is this position to which healthcare professionals

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are drawn, and which they naturally feel an allegiance, but the literature does not necessarily reflect this.

The underlying assumption that mitigates against such a social ecology in our ethical vision will be challenged and this article considers both radical positions as, at root, relying on the same negation of childhood as ethically significant according to its own logic and in its own right.

Contemporary bioethics indicates a strong desire to provide for the principle of autonomy in patient care and this can be equally applied to the expectations placed on adolescents (see for example Beauchamp and Childress, 2001; Taylor, 2009; Roubaix, 2008). In itself, autonomy has significant moral value because it can be a cultivation of each human person as an individual whose dignity is owed respect and liberty; it is the ethical principle concerned with the matter of self-governance and of the liberty to think and act independently (Wrenn, 2015). Autonomy can be understood in this broad way, although the limits on autonomy will become evident later in what follows. In the case of pre-adult patients, the matter becomes complicated because in the case of embryos and young children, there is no autonomy that can be manifest. Quite literally, the unborn have no voice, and in the infant and the very young there is no clear verbal articulation of one's views and desires. In the case of adolescents, the principle of autonomy enters murkier territory, because the adolescent patient can indeed be asked what they wish, and they may be able to articulate a clear and thoughtful answer, but the level of their formation and understanding of the risks and opportunities for their health are uneven. Not being able to ask the infant does not mean the infant is marginalized; simply that autonomy cannot be extended to them. Being able to ask the adolescent child is a healthy activity, but if it is done at the cost of other important relationships shared by the child (such as parental and sibling relationships), autonomy becomes not so much a healthy principle that respects human dignity but a principle magnified disproportionately from other principles at stake, regardless of one's view of the actual medical outcome. Illustrative of this danger is an example of a practicing Jehova's Witness family in the US, in which the parents' refusal of a blood transfusion to their eight year old child was overturned by the Court of Appeals in Boston (*In the Matter of Elisha McCauley*. 409 Mass. 134). Here, following a similar pattern in other US jurisdictions, the Court decided that while parents had both responsibility for their child's health and a constitutionally protected liberty of religion, the State had an interest in the health of the child not precluded by the rights and interests of those

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parents. Because of her age, the child was not considered to be adequately mature to have powers of autonomy.

Also of particular relevance is a 2002 study by Kiek Tates et al, ‘Doctor–parent–child relationships: a *‘pas de trois’*’. In Tates’ study of a meeting between under age patients, a parent and a doctor, the parents repeatedly over-ruled and interrupted their child when the Doctor asked he or she directly how they were feeling. Even at a young age, children showed a self-awareness of their condition and state of health that could inform the process of medical diagnoses, but their natural desire to participate in the decision-making process was thwarted by their parents. Autonomy, when not isolated from other principles such that it is radicalised and almost idolised, has a positive good to which it can orient a patient, that being the independent practical reasoning of a person who takes responsibility for their own health. Blame cannot be placed at the feet of the medical community or doctors, and has to be viewed within a broader cultural complicity in working against the good of the child, albeit unintentionally. There is apparent here a lack of imagination as to what a child, in its own right, might be able to teach others about its own health.

Gillick competence and the question as to what is a child?

The influence of a doctor, in their style of address, tone, manner of instruction, and enthusiasm for a proposed medical procedure, can have an effect upon the choices of their patients, both young and old. This is important in the context of young patients, especially in their teenage years, during which a great deal of physiological development and other social pressures might be at work, including that of peer pressure, all with implications for their ethical choices (See Santor et al, 2000).

There are a number of factors which impede the sense of absolute freedom such as the notion of the common good, such as legal restrictions against self-harm or assault. This was made clear in the case of Leslie Burke, a 45 year old gentleman with a degenerative brain condition known as cerebellar ataxia, through which he would lose coordination and control over his speech and limbs, although his mental faculties were likely to remain unaffected (BBC News: *Patient loses right-to-food case*, 28 July 2005). Mr Burke requested that his doctors be prevented from withdrawing artificial nutrition and hydration when the ability to express his own wishes was impeded by his condition, which he feared. The General Medical Council (GMC) successfully appealed against a ruling in the patient’s favour, arguing that doctors would be forced by this decision to

1 provide artificial nutrition even in cases where it would be against their best interests,
2 although this latter feature of the ruling was *obiter dicta* (R Burke v General Medical
3 Council - [2005] All ER (D) 445 [Jul]). Even where a presumption for the sanctity of
4 life is maintained and, as it happened in Burke, the GMC gave assurances to the patient
5 that there was no intention to discriminate against him based on his disability and
6 withdraw what, in effect, is food and hydration, the Court of Appeal sided with the
7 GMC's request that doctors not be forced to do so in every circumstance. Not only are
8 there legislative restrictions on the freedom of patients, but there are presumptions
9 against their freedom which take place in the doctor-patient relationship, and there is a
10 curtailing of freedom apparent in common law.

11 Since *Gillick v West Norfolk* (1986), British Common Law has sided with the
12 right of a child under the age of 16 to be prescribed artificial contraception, in
13 agreement with a healthcare professional, without knowledge or consent of his or her
14 parents, constituting an increased accentuation of the principle of autonomy. In the
15 statement supporting his decision, Lord Fraser said that given the legal recognition of a
16 child's right to enter a contract, be sued, and give evidence under Oath, he could see no
17 basis 'merely on account of her age' to prevent a legal provision for what was deemed
18 decision making power over the child's personal medical care (*Gillick v West Norfolk*
19 & *Wisbeck Area Health Authority* (1986) AC 112 House of Lords). At the time, it was
20 immediately recognized how significant a decision this was, and subsequent courts have
21 referred to 'Gillick competence' as a measure of the ability of a child (under 16) to
22 make under-age medical choices. Three important factors must be present for the
23 measure to have been met, namely the child's maturity, understanding, and the nature of
24 the treatment (Kerr: 1984, 185). However, the measure has been liberally applied and
25 these factors generously assigned, constituting at the age of 16 what one writer has
26 called 'something magical' for underage patients in the United Kingdom, in that the
27 previously creeping increase in responsible faculties of decision-making is assigned in
28 totality at this age, with no regard for the particulars of maturity, understanding, or the
29 nature of the treatment from the age of 16 onwards (Purssell: 1995, 623). There is in
30 effect an event of suddenness in the allocation of full decision-making powers to the
31 young person, whether they are ready or not. The same comment can be made of 18 or
32 indeed any particular age, and it has been assumed that the need for an agreed legally
33 binding age of majority is unavoidable. The fact that the age of 16 has become
34 significant to autonomy indicates an element of gradualness but only marginally.

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Gillick competence became an important precedent for countries like the USA and Australia, bringing with it a difference in the way that an adolescent child is treated under the law, at least in terms of medical decision making. Competence is granted through various tests, which at their most comprehensive can become interrogative in the number and detail of questions put to a particular child patient (Trowse: 2010, 207). Understanding what the likely results are for a particular treatment must always be, in principle, understood alongside possible risks, and this can be a lengthy consultation if it is to avoid a subjective granting of Gillick competence. This is so because informed consent is already a fraught area, even before the difficulties of age are brought into the equation. The Gillick case came about because a mother of ten children, five of them daughters, had wished the courts to side with her in protecting parents from being excluded from medical decision making in the case of children under the age of 16. She was concerned that the contraceptive pill could be prescribed to one of her daughters without her knowledge or consent, and ultimately the House of Lords decided against her, albeit with the above conditions attached. The question of contraceptives are obviously linked to the arena of sexual activity and the question as to whether a doctor could, by prescribing such an item, be complicit in an action that might be illegal (ie a girl under 16 engaging in sexual intercourse with someone over the age of 16 etc), but by extension, this is linked to the larger question about freedom to give informed consent to *any* kind of medical intervention. And what status does a parent have who withholds consent to a particular action? British Courts and legislation have protected any child between the ages of 16-18 from interference from parents who might disagree with their choices, but it is the adolescents below the age of 16 for which various questions can be raised.

Gillick is an important Rubicon moment in modern approaches to adolescents because the court gave preference to a child's ability to make decisions for itself, and reserved the right of overturning said decision to itself against the parents or guardians. In his statement, Lord Fraser stated:

Provided the patient, whether a boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises. After all, a minor under the age of 16 can, within certain limits, enter into a contract. He or she can also sue and be sued, and can give evidence on oath. I am not disposed to hold now, for the first time, that a girl aged less than 16 lacks the power to give valid consent to contraceptive advice or treatment, merely on account of her age.
(Gillick v West Norfolk)

1 Notwithstanding that Lord Fraser referred to a ‘minor’ and then to the person concerned
2 by their gender, a ‘girl’, a complicated question arises at this point as to what is meant
3 by the term ‘child’?
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7 On the face of it, the question of defining what is meant by childhood can appear
8 simple, and even obvious. Instinctively, we might think of a young child, say, earlier
9 than their teenage years and certainly pre-pubescent, who lives with a certain level of
10 immaturity and near-total dependence on its parents and adult carers. Such a person can
11 be designated a child, and not simply on the basis of immaturity, for there are adults
12 who show degrees of comparable immaturity. Nor is the child designated as such
13 exclusively because of its dependence on others, for such a dependence also appears in
14 situations of adults with various forms of disability. Conversely, there are those who are
15 below the age of majority for whom we cannot assign any sense of dependence on
16 adults. (See for example children with no home or those fleeing desperate and violent
17 situations. An excellent account of real crises in this regard is presented in *The Silver
18 Sword* by Ian Serrailler, in which Polish children flee Nazi Germany and must live and
19 make choices as if they were adults). Legally, nations like the United Kingdom of Great
20 Britain define a person as a child or a ‘minor’ until the age of 18, which is not
21 uncommon in comparable countries (data on the legal status of children in the UK here
22 is taken from the National Society for the Prevention of Cruelty to Children [NSPCC],
23 *A Child’s Legal Rights: Legal Definitions*, 2015). Under 18, there are different levels of
24 rights concerning different kinds of responsibility, such as the age for driving,
25 performing military service, consenting to medical treatment, purchasing alcohol etc.
26 This reflects a long tradition of legal practice in Western nations that defines a
27 particular marker year as the recognized boundary between childhood and adulthood.
28 What has come to be called the ‘age of majority’, is the obtaining of years at which a
29 person is recognized as having full faculties to make decisions as an adult, other things
30 being equal. While 18 is the number in most countries, there are notable exceptions,
31 such as in Iran and Saudi Arabia where the age of majority is 8 for females and 14 for
32 males, or where it is 19 (Algeria, Botswana, some States in Canada), 20 (Japan, New
33 Zealand, Taiwan, Thailand), or 21 (various nations in North Africa, Africa, South-East
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Asia and the Middle East).¹ In every country there might be varying rights obtained upon reaching the age of majority, such as marriage, voting and so forth. Notwithstanding other cultural norms and expectations, as well as familial responsibilities and marriage traditions, the age of majority designates a person as having both a set of freedoms and responsibilities recognized by the law. These can include the legal freedom to engage in sexual relations with other adults, the right to apply for a drivers license, and conversely carries responsibilities such as the payment of income tax when drawing a salary and the burden of care for minors conceived by one's sexual congress. In Western countries, the age of majority brings with it a full compliment of associated legal rights over medical decisions, notwithstanding other differences in the quantity and quality of medical freedoms available in various nations.

In jurisdictions shaped by a Western European culture, a distinction has been employed to define two states of legal maturity, as it were, these being childhood and adulthood. Childhood in the United Kingdom has been defined as that state of life up until the age of 18 (General Medical Council, *Definitions of children, young people and parents*, 2015), at which point a full compliment of rights and responsibilities pertaining to adulthood are conferred. The GMC defines children as young people who do not have the 'maturity' and 'understanding' to make decisions themselves, and young people as, '...older or more experienced children who are more likely to be able to make these decisions for themselves' (GMC, 2015). As the GMC also acknowledges, in the UK young people are recognized as having a right to make their own decisions at the age of 16. In most nations that use this distinction (largely now common globally) an intermediary period is recognized (usually somewhere in the vicinity of 14-18) in which various rights and responsibilities are conferred dependent on other factors such as evidence of reason and a capacity to form a coherent understanding of basic ethical norms and requirements of the law. This follows a long and complicated cultural development around the child/adult relationship, and a generally recognized need to protect the young from exploitation from others and from the mistakes and bad judgments they might make due to immaturity and ignorance.

¹ The NSPCC also includes information about other jurisdictions such as these, with the proviso that local and national laws are not applied equally or without discrimination. It might also be noted that on occasion, a law and local custom can be in contradistinction.

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Historian Colin Heywood has commented on the relatively modern interest in children and the period of life referred to as childhood, which has largely been of passing interest for philosophers and writers up until the 19th century (Heywood, 2001, 2). The account of Italian poet Dante Alighieri (1265-1321) is illustrative, in which he identifies an ideal period of moral maturity in the human being between the ages of 25 and 45 (*gioventute*), couched on either side by periods of inadequate moral stature (*adolescenzia* 0-25; *senettute* 45-70 (Heywood, 2-3). The earlier stages of adolescence were mere growth towards adulthood and the older years of decline a series of movements away from a moral peak at the ideal of age 35. This topic can slide easily between the ideal and the pragmatic depending on cultural norms and aspirations.

At a superficial level, the law recognizes a demarcation between childhood and adulthood through the mechanism of the measurement of age and at 18 a person is no longer considered a child. This has pragmatic merit and occasions the time at which most people will have concluded or be concluding late adolescence, and it means that childhood ceases the second a person turns 18 years of age. Notwithstanding the ages of 16-18, the law does not test the childhood of a particular person by a set of character traits or quantifiable scales of knowledge, skills, understanding, or moral accountability, for example. The age of a person – let us say 18 as in Great Britain – is recognized in its universal simplicity as the chief marker that, in most cases, serves as a useful boundary line for the good order of legal rights and responsibilities (18 is the universal marker for adulthood in the UK although 16 is the point at which decisions on matters such as healthcare can be made independently). A child is not so designated by any attendance to the level of its ‘childishness’, any more than adulthood is measured by the ‘adulthood’ of a human person. A person over the age of 18 can display any number of immaturities and an associated abundance of childish traits, but with no identifiable mental impairment will still be recognized as having the full set of normal freedoms and responsibilities of an adult. This is an important first step in beginning to answer the question as to what is a child, because it allows us to see the pragmatic arbitrariness of the law.

The less clear, and altogether less arbitrary area of medical decision making rights is the murkier set of stages in the years immediately prior to 18 (or any designated marker for obtaining the age of majority). In the late teenage years, the ‘child’ is approaching the age of majority, and moves through a set of developmental stages which, cumulatively, are gathered towards what is called adulthood (conflicting

1 theories pervade childhood studies on what are the precise stages of development that
2 can be universally recognized, if any, see: Ruthus *Childhood: Voyages in Development*,
3 2011; Hoboken (Eds). *Childhoods in Context*, 2003; Cannella & Soto (Eds),
4 *Childhoods: A handbook*, 2010). The notion of a child is made difficult to conceptualize
5 clearly by other signs of maturity, including physical development, mental awareness,
6 social engagement and so forth, which will occur at different rates for particular
7 individuals at differing ages. With a complication of factors at play in the late
8 adolescent or immediately pre-adult age, it is not altogether surprising that courts have,
9 in an age in which autonomy is assumed to be of particular value to human flourishing,
10 tended to move the recognition of rights in the direction of an increase for persons in
11 this age bracket.
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20 As referred to above, in the UK the boundary age at which medical decision-
21 making is granted almost universally is not 18 but 16, when the State considers a young
22 person capable of giving informed consent to medical treatment (this is protected in
23 England and Wales by the *Mental Capacity Act 2005* which was introduced by a
24 supporting document by the Office of the Public Guardian titled *Making*
25 *decisions...about your health, welfare or finances. Who decides when you can't?*; in
26 Scotland the age of 16 is protected by *The Age of Legal Capacity (Scotland) Act 1991*;
27 Northern Ireland and other jurisdictions such as Australia have separate legislation, but
28 were receptive to Gillick competence from 2005 onwards). As was outlined above, one
29 writer refers to this milestone rather provocatively as an event in which 'something
30 magical happens as far as the health service in the United Kingdom is concerned',
31 because of its seemingly arbitrary nature (Purssell, 1995, 623). For Edward Purssell, the
32 notion that a particular age can be designated as universally a commonly agreed
33 moment at which the capacity to give informed medical consent is nonsensical. It might
34 be remembered also that at the age of 16 the presumption becomes the norm rather than
35 a verifiably legally recognition that can be taken for granted. In other words, it is not
36 full recognition so much as a presumption unless it is proved otherwise. That is not to
37 say Purssell rejects the idea of 16 year olds or persons of a younger age giving consent;
38 merely that the use of any particular age is unsatisfactorily informed by the experience
39 and evidence of children, some of whom are ready to give informed consent at a
40 younger age and some who appear, on reaching the age of 18, not to have reached such
41 maturity. Purssell takes his lead from an argument made in 1992 that the problem with
42 our approach to granting such faculties of medical decision-making is not confined to
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1 healthcare, but has its roots at a deeper societal level. Margaret Crompton's suggestion,
2 endorsed by Purssell, is that 'we need to consider children as complete entities rather
3 than simply immature adults' (Crompton, 1992). This highlights the need to address the
4 fundamental basis upon which we approach this question in the first place, which is not
5 bound to age. It is not so much a question as to whether a child should be recognized as
6 having a capacity to give informed consent, but whether a person, who happens to be a
7 child, bears such a capacity.² There is a subtle and important difference here, because in
8 the latter the emphasis is on persons, implying an equal dignity without discrimination.
9 The child is not an aberration from personhood, but one who shares in human nature
10 fully and manifestly, albeit in the particular stages of development which belong to
11 children. This is why Purssell wishes to honour approaches to child-patients that are
12 able to explain clearly and, in a relatable manner, what a particular medical treatment
13 will involve, which are not always the ways of explaining that doctors are either trained
14 in or in which they have experience. While he sarcastically comments that 'something
15 magical' happens when a person turns 16 in the UK, Purssell makes a serious point that
16 there is a great deal of wisdom in leaving it to health practitioners who have a
17 relationship with a child and its family already to discern whether informed consent can
18 be given in any particular case. This can be a fraught question given the pressures on
19 time and resources in health care, the various needs for consultation processes, waiting
20 times, and larger more expensive medical delivery institutions. An obvious group that
21 might have a better hope of delivering such a personal service is that of specialist
22 pediatric nurses where, advantageously, they might know the child and family well and
23 have built up a trusting relationship (Purssell, 623). Also, 'context' is the crucial factor
24 that can be argued for and against granting MDM to children (MacDougall, 'Rawls and
25 the Refusal of Medical Treatment to Children', 2010, 142). Even this does not
26 overcome the limitations of a medical situation that comes up suddenly or the context of
27 a crisis, in which no long-term relationship between a nurse and the family has been
28 established. On the other hand, a strong case is made by Sheila McLean who believes
29 that the onus should be on parents to explain why a child does not have the capacity to
30 give informed consent, rather than presuming against the child in the first place
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57 ² A risk here should be apparent: If the culture in which we find ourselves takes something like
58 euthanasia to be a valid medical option, then granting MDM to adolescents opens up the
59 possibility that the pre-adult patient might be granted the right to choose a legally sanctioned
60 death, at the expense of the choices of parents or guardians.
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1 (Purssell, 623; and Alderson 1990). This of course carries a risk that the normal
2 responsibilities of bringing up, educating and protecting their children becomes for
3 parents second tier to the will of the child, and ultimately constructs a situation in which
4 parents and children are pitted against one another. This could be viewed as more
5 radical still, but it provides a counter-narrative to that which is assumed in the *Children*
6 *Act 1989* that makes doctors responsible for deciding if a child patient has the capacity
7 to understand the nature of a proposed treatment, a burden of knowledge that might be
8 well beyond their competence.
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Developmentally speaking, children are complex agents of change, and the field of childhood studies has grown exponentially in recent decades. A major focus of study has been that of language, not merely speech development, and the means by which children learn and communicate their own thoughts, and this is a richly contested arena of research. The philosopher Ludwig Wittgenstein had observed of language:

Language disguises thought. So much so, that, from the outward form of the clothing, it is impossible to infer the form of the thought beneath it, because the outward form of the clothing is not designed to reveal the form of the body, but for entirely different purposes.

(Wittgenstein, 1981: 4.002)

Wittgenstein had noted the manner in which language, despite its external appearance and use, can be as much a cloak to meaning and thought as it is a revelation. If language is understood to be skills of knowledge, comprehension and communication, the stages through which children grow express distinct kinds of such skills, which indicates an important connection between the ‘play’ of children and the more ‘formal’ kinds of skills expressed in young people (Alison Johnson, *Childhood Studies*, 2002, 99). The world of literature, imagination and play are inscrutably linked to the successful processes of learning grappled with daily by educators. The very fact of childhood research as a recent phenomena sits within a much larger historical narrative which in turn is also open to debate. The pioneering work of Philippe Ariés had argued childhood was not discovered as a separate ‘thing’ until the seventeenth century (Ariés, *Centuries of Childhood: A Social History of Family Life*, 1960). Ariés has drawn criticism for overlooking the problems of class and social division, aspects of the medieval family, and changing gender roles, but he has the mark of first attempting a history of childhood that focused on the child as a phenomenon worthy of study in itself, and a lens through which we can understand the societies in which we live (Scruton offers a helpful

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overview of the secondary literature critical of Ariés while honouring the important milestone his work achieved, 1997, 2-4). Academic debate about the place of the child at both the macro historical level, and at the micro social and domestic levels of development, is likely to offer a wealth of different perspectives as related fields develop, all of which have perplexing consequences for medical ethics. In healthcare, children are at once present to some degree in most medical contexts, while expertise in attending to them can vary.

The reality is that many doctors lack consistent or long-standing experience of working with children, and some have made professional decisions against spending more time with child patients. In the UK, pediatricians provide a certain level of specialist attention, but this is not necessarily the case everywhere. It is altogether simpler for doctors and for children if we adopt the standing position of assigning a specific age at which consent is universally recognized; whether or not such simplicity serves patients and society and provides for successful outcomes. With Gillick, there is a new context in which we find ourselves because competence was determined by the Courts as a threshold in British medical care. Its effects have been broader than the UK, and in comparable jurisdictions such as Australia, legislation has been introduced that follows the same basic logic as to protecting what is deemed a child's right to autonomous medical decision making (Eg *Consent to Medical Treatment and Palliative Care Act 1995* (SA)).

Moreover a new awareness of the needs of children from irregular domestic contexts has taken place, with broader acknowledgement that patient groups such as homeless children, the offspring of inaccessible or incompetent parents, siblings who have experienced family breakdown and so forth, are in need of a means of accessing their ability to give informed consent, because, in a way, they have no personal or familial advocate of any maturity who *can* give consent on their behalf.³ Such recognition was of course developing in the lead up to *Gillick v West Norfolk AHA* [1986], but it is important to recognize that Gillick provides a rule for informed consent in Common Law and not through a Parliamentary process. This is not unusual in the Westminster system, but the ramifications are significant because it means that children

³ This illustrates why the Court of Protection, established by the *Mental Capacity Act 2005*, is an important, albeit imperfect, forum of advocacy for some children in situations where no other advocate is available.

1 have obtained a legal protection to the recognition of informed consent (with its
2 accompanying character of privacy) via the courts and not via Parliament and its
3 presumption of the carriage of public opinion. In fact, Gillick competence encompasses
4 both consent and the refusal of medical treatment (albeit in the latter case law tends to
5 presume against a child's absolute right to refuse on the grounds that a refusal poses a
6 risk to the child's health and survival) (See the *Family Law Reform Act* [1987] and in
7 the case of Gillick Competence it must be remembered that parents cannot overturn the
8 decision of a Gillick Competent child whereas the Court can. This was re-asserted in *Re*
9 *JM [A Child]* 2015).

16 Gillick Competence is not merely a form of competence parallel or
17 commensurate with the competence recognized in an adult, but a burden that imposes
18 an unnecessary and problematic set of responsibilities upon children. Moreover, it has
19 been granted in a time of broader debate and discovery about the significance of
20 childhood. In most respects it places a child in the same range of competence, but it can
21 also, inadvertently, place a burden of competence upon a child greater than that of an
22 adult. *Gillick v West Norfolk AHA* includes the provision that a child demonstrates
23 sufficient maturity and intelligence to 'fully understand' the treatment proposed for
24 them (*Gillick v West Norfolk AHA* [1986] AC 112, 189), not something asked of the
25 average adult patient. The Case Law normally demands that an adult be informed in
26 broad terms of the nature of the treatment (*Rogers v Whitaker* [1992] 175 CLR 479,
27 489) and the idea of 'fully' understanding is an onerous burden upon which few
28 patients, children or adults, could truly make a claim. This concerns not only the nature
29 of the treatment but, in fact, it must be shown that a child has the 'sufficient maturity to
30 understand what is involved', in the words of Lord Scarman (*Gillick* 1986, 112, 189),
31 which entails a conceptual grasp of the various consequences of what risks are involved,
32 not to mention the long-term problems involved in the emotional and relational
33 consequences of the medical treatment under consideration.

52 **Conclusion**

54 Gillick competence addresses the adolescent as a child *on its way* to becoming
55 an adult. To some extent, it is appropriate to include the adolescent as an individual
56 capable of having the competence to make decisions on his or her own behalf, but it is
57 neglectful of the child as person to relegate parents and carers to the margins of the
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1 adolescent child's life. This is because the human person is not an individuated monad
2 who is perfectly autonomous, but a dependent animal who learns to become a individual
3 through its maturing interactions with other human beings, and this must necessarily
4 include adult parents or carers who are responsible for the moral formation of the child.
5 With Gillick, the Courts have jurisdiction to overturn a child's decision to the detriment
6 of parental rights, and this magnifies the autonomy of the adolescent in conflict with
7 their social and family relationships, a move that is unwarranted. Gillick in advertently
8 has become a burden that is unnecessary and detrimental to a holistic and integrated
9 ethics of medical decision making and to a comprehensive ethics of the child.
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