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Competence and authority: Adolescent Treatment Refusals for Physical and Mental Health Conditions

Emma Cave

Abstract

This paper explores the relationship between competence and authority in relation to medical treatment refusals. Comparing provisions directed at adults and young people, she explores the options before the court if a test case (called for by the British Medical Association and the Department of Health) is brought before the court to determine the extent of the minor's autonomy rights to be involved in or make medical treatment decisions at common law. At present, the common law rights of competent adults and minors stand in stark contrast. Adults can refuse life saving treatment against the advice of doctors, but minors (even if they pass the legal test for competence) cannot do so if a parent or the court provides the necessary consent in the child's 'best interests'. Since the matter was last tested in court, children's rights - including their autonomy rights- have evolved. In light of this, if a minor can demonstrate his autonomy in relation to the decision should he, like a competent adult, be given the legal authority to decide? Cave asserts that academic arguments against the different levels of competence required to consent to and refuse medical treatment should be distinguished from arguments about the respective authority a decision to consent and refuse may carry. A close examination of the law relating to adults reveals that their decisional authority is context-specific. There are circumstances where adults too are powerless to refuse medical treatment, regardless of their competence. Statutes enacted post-Human Rights Act 1998 which apply to competent minors take a similar approach. Deference to children's autonomy rights does not necessarily require that their competent decisions are respected. In particular the paper considers Mental Health legislation, examining its aims and how they relate to the restrictions on competent adults and minors and the extent to which these provide examples which might be followed when the common law on adolescent treatment refusals is tested in court.

Keywords: Competence, children, minors, consent, medical, treatment

Introduction

The medical treatment of minors is governed by a variety of laws. In some specialist treatment areas statutes and regulations have been enacted: For example, if a minor enters a clinical trial, the Medicines for Human Use (Clinical Trials) Regulations 2004 apply; if he wants to donate an organ, the Human Tissue Act 2004 applies; if he has a mental health problem, the Mental Health Act 1983 might apply. In general, however, the common law decision of *Gillick* [1986] establishes that minors (defined here as those under the age of 16 unless expressly stated) can consent to treatment if they have the requisite maturity and understanding. Lord Scarman said:

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 [p. 188H–189A].

A competent minor will be encouraged to involve his parents, but the doctor gains the requisite authority for treatment from the minor. He need not secure the consent of a parent unless the minor fails to satisfy the test and is deemed incompetent to decide.

Lord Scarman refers specifically to consent but it might be assumed that:

1. A child competent to consent to treatment would also be competent to refuse it.
2. If competence to consent to treatment gives the minor authority to consent, then competence to refuse treatment will give the minor authority to refuse it.

Both assumptions are called into question following two controversial Court of Appeal decisions: *Re R* [1991] and *Re W* [1992]. In both cases adolescents were denied the power to

refuse¹ life-sustaining medical treatment, regardless of their competence. The reasoning rested partly on the role of consent in this situation. The legal doctrine of consent serves to provide the clinician with a defence to a claim in battery. In turn, the law of *battery* protects patients' autonomy rights. Consequently, if the act does not constitute a battery (or another relevant tort) then the invasion of autonomy is lawful. Lord Donaldson said that consent gives doctors a 'flak jacket' against a claim in battery. Doctors can get the flak jacket from the competent minor, but if the minor is unwilling or unable to provide it, it can come from a parent or the court.

Re R and *Re W* were applied in a number of cases in the 1990s and most recently in *Re P* [2003]. Since that time, children's rights have evolved to the extent that aspects of *Re R* and *Re W* are now questionable (Taylor, 2007). The British Medical Association (2009) calls for caution in applying the precedents, and the Department of Health (2009) for a test case. In light of this, the two assumptions referred to above require fresh examination. There has been extensive academic criticism of *Re R* and *Re W* (for example Thornton (1992), Freeman (1995)). Much of it focuses on the first assumption, though Gilmore and Herring (2011) rationalise the asymmetry. They argue that if the competence required to consent is different to the competence required to refuse all treatment, then provided the refusal is not competent, the law can still be said to uphold minors' competent decisions. In other words, in rebutting the first assumption, the law might avoid rebutting the second. A co-author and I have argued elsewhere that their distinction is troubling (Cave and Wallbank, 2012). I shall argue that, if the courts decide that paternalistic judgement of welfare should continue to outweigh the competent minor's right to decisional autonomy, it is preferable to rebut the second assumption.

If a successful challenge of *Re R* and *Re W* results in a test which recognises that a minor who is competent to consent is also competent to refuse treatment, it does not necessarily follow that a competent refusal will carry the same authority as a competent consent. This, I demonstrate by drawing comparisons on two levels. First I contrast the law relating to adults and minors showing that, in contrast to the liberal common law, there are a number of statutory examples where competent adults lack the authority to refuse treatment. Second I contrast the common law with relevant statutes on the medical treatment of minors, in order to demonstrate Human Rights Act-compliant methods of upholding minors' autonomy rights whilst maintaining the distinction between a competent and an authoritative decision. In particular, I examine the 2007 amendments to the Mental Health Act 1983 which insert new provisions to reflect the development of children's autonomy rights but which recognise that competent minors lack the authority to refuse treatment which their welfare interests demand. Through this examination I gain insight into the potential options before a court, in the event that a challenge to *Re R* and *Re W* is mounted.

Competence and the right to decide

One of the criticisms levelled at Lord Donaldson's distinction between consent to and refusal of treatment, is that it offends the principle that negative autonomy rights (rights to refuse intervention) are stronger than positive autonomy rights. The common law enforces this principle in relation to *adult* treatment where, not only must the doctor secure the consent of a competent patient before he treats him, but the patient, if competent, is the only possible source of that authority. In *Re T (Adult: Refusal of treatment)* [1992] Lord Donaldson stated:

An adult patient who, like Miss T., suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered. (at [3])

A link is drawn here between competence, the right to consent and the right to refuse. The link remains, even if the decision is, in the views of the clinicians, against the patients best interests. Lord Goff in *Airedale NHS Trust v Bland* [1993] said:

... [the] principles of self-determination requires that respect must be given to the wishes of the patient, so that if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so. [At 866].

If, as Lord Goff states, the right to refuse treatment flows from the ‘principles of self-determination’, then this as much a right of a competent minor as it is a right of a competent adult.

On this basis there is a strong argument for respecting competent refusals. However, by exploring the law in more detail, it becomes apparent that the dicta in *Re T* is context specific. The link between respect for self-determination, competence and authority to decide (ie to consent or refuse) is not applied universally. This, in turn, has implications for the debate on adolescent treatment refusals.

Autonomy and competence

Autonomy has been hailed the king of the four principles (Gillon, 2003). In its simplest form it involves ‘deliberated self rule’ (Gillon, 1994), but not everyone has the ability to self rule, and those who have the ability do not always have the legal right. Beauchamp and Childress (2001) have famously argued that respect for autonomy incorporates both the right to make a decision and the obligation of others to respect it. For Beauchamp and Childress, what is important is the relationship between autonomy and the *decision* rather than the *outcome* of the decision. Consequently, their conception is as relevant to a decision to consent to treatment as it is to a decision to refuse it. Beauchamp and Childress argue that factors such as disclosure, understanding and voluntariness combine to make a decision more or less competent. The law helps ascertain what is required in a given situation and what authority competence confers on the bearer.

However, the law is influenced by factors which go beyond the autonomy of the bearer. ‘Competence’ and the closely related concept of ‘capacity’ are legal tools reflective of public policy. Consequently, some competent decisions are not autonomous. For example, a decision might be made on behalf of another, on the basis of incomplete information, or by reference to irrational decision making processes. Equally, I will show that some autonomous decisions are not competent. Capacity means different things in different situations. Different definitions of capacity govern an individual’s authority to enter into a contract (*Boughton v Knight* (1873)), make a will (*Banks v Goodfellow* (1870)), or enter into marriage (*Sheffield City Council v E & S* [2005]). In some situations capacity is assumed whereas in others it must be demonstrated. On the basis of *Gillick*, the assessment of maturity and understanding required shifts according to factors such as the risks involved in the procedure, the influences on the minor and the strength and longevity of his view. Contrast this with capacity under the Mental Capacity Act 2005, where a presumption of capacity will be rebutted where the

individual is 'unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain' (s. 2(1)), and lacks the requisite understanding to the extent that the patient is unable to make a decision (s. 3).

Thus, the assumption that a competent decision is necessarily equated to an autonomous decision is flawed. In this section I have shown that what the bearer must do to be considered competent depends on the situation. Legal competence does not equate to natural or *de facto* competence. In the next sections I will make a linked observation - that the *value* of competence in medical treatment decision-making depends on the situation.

Treatment refusals by adult might be vetoed

If it is accepted that the law determines the relationship between self-determination and competence, then Lord Goff's link between competence, the right to consent and the right to refuse is context-specific. Indeed, an examination of relevant statutes reveals that a refusal of consent by a competent adult is not always determinative. First, there are cases where an adult might be forced to undergo treatment in order to protect others. This might be justified on the basis of J.S. Mill's harm principle that the only legitimate reason to interfere with a person's liberty is to prevent harm to others (Mill, 1959). In *Re T* [1992], at 653, Lord Donaldson postulated that a pregnant woman might fall into this category if a failure to treat would harm her viable foetus. Later in *Re MB* [1997] and *St. George's Healthcare NHS Trust v S* [1998] it was confirmed that a pregnant woman is in the same position as other competent adults. Under the Public Health (Control of Disease) Act 1984, section 37 and 38, an adult with a notifiable disease might be forced to undergo hospital treatment if a failure to do so would pose a serious risk of infection to other persons. In addition, an adult might be subject

to compulsory detention under section 47 of the National Assistance Act 1948 to secure care for those who:

- a) are suffering from grave chronic disease, or being aged, infirm or physically incapacitated, are living in unsanitary conditions, and
- b) are unable to devote to themselves, and are not receiving from other persons, proper care and attention.

The legislation is little used and much criticised for its abuse of civil liberties and human rights (eg Hobson, 1998). What is particularly startling is that, whilst it might be utilised to protect the public interest, it might also be invoked to protect the interests of the competent person. Similarly, under section 35 of the Public Health (Control of Disease) Act 1984, a competent adult might be forced to undergo medical examination if ‘*in his own interest, or in the interest of his family, or in the public interest, it is expedient that he should be medically examined*’ (s. 35(1)(b)).

Another situation in which a competent refusal of treatment might be overridden is where the adult has a mental disorder. The Mental Health Act 1983 covers the reception, care and treatment of people in England and Wales with a mental disorder. As we have seen, the Mental Capacity Act 2005 provides a framework for defining when a person lacks capacity to make a decision for themselves, and governs how to make decisions on their behalf. Not all people with a mental disorder will lack the capacity to make a decision. Part IV of the Mental Health Act 1983² permits compulsory ‘medical treatment for mental disorder’ which is defined as ‘any disorder or disability of the mind’ (s. 1(2)). Compulsory admission can be made for assessment (s. 2), treatment (s. 3) and emergency admission (s. 4). Detention under the Mental Health Act might take place even if the patient does not pose a threat to the public. Why compulsory admission of patients with mental capacity should be sanctioned

because their ill health relates to a disorder of the mind is not entirely clear. It paternalistically protects the patient from harm, but so too would a requirement to treat physically ill people refusing treatment. (See Bellhouse, 2003, Richardson, 2002, Scott-Moncrieff, 2004). Section 63 of the Mental Health Act authorises ‘a range of acts ancillary to the core treatment’³ and physical and mental health treatments have proved difficult to separate. For example, ‘ancillary’ treatment has included force feeding in anorexia nervosa cases⁴ and the induction of pregnancy.⁵ Ultimately:

The effect of section 63 is to limit the autonomy of the detained patient whose capacity is unimpaired to treatments that are not related to the mental illness of disorder for which he is detained.⁶

It is clear then, that Lord Goff’s assertion that the principles of self-determination override the state’s duty to act in what doctors determine to be in his best interests is context specific. The right of competent adults to refuse medical treatment which exists at common law is not mirrored in the statutes examined in this section. As we shall see, for minors too, Parliament has decreed that competence does not necessarily give the authority to consent; and even if it does, it is not necessarily the only source of authority.

Treatment refusals by minors may be vetoed

We have seen that there is considerable variation in the rights which flow from a finding in law that an adult’s medical treatment decision is competent. The same applies to children, but in their case, their special legal status is a relevant consideration. There are numerous restrictions on their rights and responsibilities which are lifted when they achieve adult status.

The law balances minors' autonomy interests with their basic interests (for example, their interest in health) and their developmental interests (Eekelaar, 1986). Autonomy interests themselves take different forms. Coggan (2007) distinguishes between three types of autonomy. Ideal desire autonomy (an objective view of what is best) sometimes overrides actual desire autonomy (based on current desires) and even best desire autonomy (reflecting the person's long term values). Compliance with the European Convention on Human Rights helps regulate the extent to which autonomy interests must be balanced with the rights of others and with conflicting individual rights. This balance takes into consideration the facts that children are potentially vulnerable and that their decision is often shared by and will usually impact upon their family (Ribot, 2012). Consequently if an adult and minor are both legally competent to make a similar medical treatment decision, there may be valid reasons for allowing the adult to decide but denying this right to the minor. For both adults and minors, the test and the relevance of a finding of competence is context specific. For minors, however, the context is affected by virtue of their status as children.

For adults and minors alike, the legal consequences which flow from a recognition that a decision is competent vary from one situation to the next. Different legislative frameworks emphasise different principles. For example, the Children Act 1989 emphasises the child's welfare; the Mental Health Act 1983 (as amended in 2007) balances the patient's best interests and public protection (Laing, 2000). From the minor's perspective, the different principles inherent in the various applicable laws make for an inconsistent set of rights. Depending on their age and vulnerability, minors might be affected by laws designed to protect adult rights; children's interests; parental rights; or vulnerabilities by virtue of a mental disorder or impairment. Likewise, there might be divergences between the rights of competent adults and competent children in relation to medical treatment. Arguably the rights

which flow from competence protect different values in each case. For adults, there is greater emphasis on autonomy. For minors the right to autonomy competes with other rights, including the paternalistic protection of their health. In some situations their (perceived) vulnerability has led to restrictions not only on the rights of competent minors to refuse life-sustaining treatment, but also their ability to consent. I have argued elsewhere that the Medicines for Human Use (Clinical Trials) Regulations 2004 are overly restrictive of competent minors' rights to consent or assent (Cave, 2010). A minor under 16 years cannot provide the necessary consent to take part in a clinical trial. Schedule 1, Part 4, Paragraph 13 provides that; 'Informed consent given by a person with parental responsibility or a legal representative to a minor taking part in a clinical trial shall represent the minor's presumed will.' The risks inherent in research might be thought to justify this paternalistic approach, but it is not one which is enforced in all cases where a child is given risky treatment. For example, the same experimental treatment which a child would have no power to consent to or refuse might be given to him 'off label' (unlicensed) in which case his authorisation might be accepted even in the face of parental opposition (Gillick, 2009). Not only are children unable to provide the legal authorisation required to participate in a clinical trial, but they are not necessarily required to assent to it (though their assent, particularly if competent, is encouraged).⁷

The Clinical Trials Regulations were enacted post Human Rights Act 1998 as were amendments to the Mental Health Act 1983. The 2007 amendments give additional protection to competent minors' autonomy rights but interestingly the Act still recognises that the competent minor is not the only potential source of the authority to treat. The Act does not demand that competent refusals are respected, but it limits the list of those who can veto a competent refusal.

Minors and the Mental Health Act 1983 (as amended)

Under the Mental Health Act, formal, compulsory treatment is the option of last resort (DH/NHMHE (2009) para 3.8). In relation to both young persons (aged 16-18) and children (under 16), the Code points out that recent changes in human rights jurisprudence demand greater deference to minors' autonomy rights (Department of Health, 2008: para 36.33 and 36.43). Accordingly, the Code states that where a competent minor refuses treatment, : '... it may be unwise to rely on the consent of a person with parental responsibility' (MHACP, para 36.43). If the minor does not meet the criteria for formal admission under the MHA, the assistance of the High Court might be sought. Naturally, this covers those situations where the child is not *Gillick* competent and the person with parental responsibility cannot be found, or is not acting in the child's best interests, but it also includes situations where the child:

.... Is *Gillick* competent or is a young person who is capable of making a decision on their treatment and is refusing treatment. (MHACP, para 36.66.)

The emphasis of the provisions for treating minors with a mental disorder is less on ensuring that their decision is autonomous and more on ensuring that minors are compliant, and that they get the treatment which doctors consider to be in their best interests. The aim seems to be to reduce the incidences, as far as possible, of coercive treatment and to limit unnecessary restrictions on liberty. Formal detention might be utilised on the basis that the minor is refusing treatment rather than because the minor lacks the *competence* to refuse the treatment. Similarly, a minor who has fluctuating competence but who is expected to refuse consent when they regain competence might be detained under the Mental Health Act rather than

awaiting a return of competence before a decision is made (DH/NIMHE, p. 38). In relation to minors aged 16 and 17, the Guide for Professionals recommends that the Mental Capacity Act is not relied upon where:

There is some other specific identifiable risk that the young person might not receive the treatment they need ... and that either the young person or others might potentially suffer harm as a result. (DH/NIMHE, p. 39).

Relevant Codes require that a minor whose consent is relied upon is not subject to any undue influence (DH/NIMHE, 2.6), but the implication is that it is undue influences which result in a decision which does not reflect the best interests of the minor and society which will not be tolerated. Under this legislation a distinction emerges between different levels of compulsion. In seeking authorisation for treatment, practitioners might promise a minor: ‘consent or we will seek court authorisation and force you to undergo treatment.’ The minor might later thank the doctor in the manner of Odysseus who ordered his crew to tie him to the mast so that he might resist the sirens. A minor whose disease prevents her from recognising the fact that her objection is a short lived product of her illness is not making an autonomous decision, whether she consents or refuses. Nevertheless her consent is likely to be respected and her refusal overridden.

The 2007 amendments respond to developments in the jurisprudence of children’s rights, including their autonomy rights. I have shown that the amendments leave considerable scope for manipulating or overriding the competent decisions of minors to refuse treatment. In the next section I consider the implications for adolescent treatment refusals at common law.

Gillick

If we accept that competence confers different rights and authority on the bearer depending on the purpose of the particular law, then this begs the question: what was the purpose of *Gillick*? Unfortunately, the Law Lords did not make clear whether they intended competence to confer merely a right to consent, or a broader right to decide between relevant options (potentially including the refusal of life-sustaining treatment). *Gillick* competence gives minors decisional authority to agree to treatment which doctors believe to be in their best interests, but the question remains: does it also enable minors to make decisions which are contrary to their medical interests? The test for competence is decision-specific and thus the threshold of understanding and maturity is commensurate with the gravity of the decision. Recall the first assumption. If this is rebutted, a minor who is competent to consent may be held to lack competence to refuse treatment upon which her life depends. On this method, the link between competence and authority is retained - the second assumption is preserved. Paternalistic protection of the minor is achieved by raising the threshold for competence, perhaps even making it impossible to achieve. The problem with this interpretation is that it subjectivises the *Gillick* competence test and makes it outcome- rather than decision-specific. This distances the concept from a reflection of the minor's capacity for self-determination.

Alternatively, it is arguable that, when the case was heard, the intention was not to transfer to minors the authority to decide between treatment and no treatment, but instead to confer a much more limited right. Arguably this right merely enabled minors to provide the authority for a course of action which coincides with their best interests. Harris has scathingly referred to this as a 'a right to acquiesce in a decision which has already been taken' (Harris, 2003). Even on this conception, the power was of some value, for by enabling competent minors to

provide the authority for treatment, parental consent is not necessarily required. Competent minors gain a right to confidentiality.

Maclean (2008) has argued that *Gillick* merely confers a right to make decisions in the child's best interests, and that, on this basis, a distinction can be drawn between powers to consent and to veto treatment. If this is so then *Gillick* is just one of a number of examples where competence confers only limited authority on the bearer – in this case, a right to make a decision which coincides with their best interests.

Rights

Would this position be compatible with human rights arguments? Let us return to Lord Goff's assertion that the right to refuse treatment is part of the right to self-determination. Article 8(1) of the European Convention on Human Rights 1950 (the Articles of which are incorporated into UK law in the Human Rights Act 1998) protects the right to a private and family life. In the European Court of Human Rights decision, *YF v Turkey* (2004), it was stated that 'a compulsory medical intervention [without consent], even if it is of minor importance, constitutes an interference with this [Article 8] right'. However, Article 8(2) limits the Article 8(1) right. It does not require that detention of a competent patient is limited to those cases where public health demands it. It sanctions interference with Article 8 'for the protection of health or morals'. Article 8 does not preclude there being more than one authority for consent, even if the patient is competent, as it recognises that paternalism (be it on grounds of poor physical health, poor mental health, risk of disease, or youth) is a relevant consideration. Likewise, Article 5(1)(e) of the Convention allows deprivation of liberty 'for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics

or drug addicts or vagrants', but requires that the detention must be necessary and proportionate.

Eekelaar (1994) has put forward a related argument in relation to balancing Articles 3 and 12 of the United Nations Convention on the Rights of the Child 1989. This Convention is not legally binding in the UK but establishes recognised standards. Article 3 recognises the importance of the best interests of the child,⁸ whilst Article 12 asserts that:

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

Article 12 does not confer a right to decide, but merely a right to participate in the decision in a manner commensurate with his capacity. In 2009 the Committee on the Rights of the Child issued a *General Comment on the Right of the Child to Be Heard* (2009) emphasising that Article 12 '... applies to individual health-care decisions ...'. Eekelaar argues that tension between Articles 3 and 12 is resolved through 'dynamic self-determinism' whereby the minor's best interests are determined by reference to the values and beliefs of the minor, provided those beliefs coincide with an objective view of the minor's interests. The minor's views have increasing relevance as they mature and the longevity of their opinion is established. If the view is competent it might be determinative.

Limited rights to refuse life-sustaining treatment are unlikely to conflict with the European Convention on Human Rights of the United Nations Convention on the Rights of the Child. Nonetheless, some countries take a different approach, enabling competent minors to make an authoritative refusal of treatment, and linking competence and authority in a wider range

of situations (eg Ribot, 2012). Though there has yet to be a test case, Scotland probably supports such a right (Elliston, 2007)).

Conclusion

I have not entered into the debate as to whether the law *ought* to safeguard the best interests of minors by protecting them from their own competent medical treatment decisions. Indeed I have made brief reference to the questionable morality of laws limiting the rights of competent adults and minors to make decisions which do not comply with a paternalistic judgement of welfare. One option before the court in a test case would be to declare that competent minors have the same rights to consent to and refuse medical treatment as adults. At the opposite end of the spectrum, another option would be to confirm *Re R* and *Re W* so that parents and the court retain the ability to override minors' competent treatment refusals out of respect for their 'best interests'. Alternatively, the court might seek to improve the protection of minors' autonomy rights whilst retaining the option of restricting minors whose decisions are contrary to their best interests. This might be achieved by rebutting one of two assumptions which might be thought to flow from *Gillick*:

1. A child competent to consent to treatment would also be competent to refuse it.
2. If competence to consent to treatment gives the minor authority to consent, then competence to refuse treatment will give the minor authority to refuse it.

I have suggested ways in which a test case might rebut the second assumption and how this might be justified on the basis of precedent and human rights. In addition, I have put forward an argument that this would be a preferable route to protecting minors' interests to rebutting the first assumption by accepting that the threshold for competence to consent is lower than the threshold for competence to refuse medical. Though rebuttal of the first assumption

would enable the court (if it so wished) to uphold the second assumption, the victory for minors' autonomy rights would be hollow, as doctors and courts would be able to raise the competence threshold to very high or impossible levels whenever the outcome of the minor's decision is contrary to (what they perceive to be) his best interests.

I have argued that the distinction between competence and authority is a feature of a number of laws relating to medical treatment decisions of both adults and minors and that this position does not necessarily conflict with the Human Rights Act 1998. Children's autonomy rights have evolved since *Re R* and *Re W* (Perera, 2008). In *Axon* [2006] Justice Silber argued that parental rights under Article 8(1) dwindle until the child is competent to make his own decisions, at which point they disappear altogether (Cave, 2009). The result is that, in a test case, the court might choose to follow the example of the Mental Health Act 2007 and enhance protection of minors' rights by limiting the rights of parents to consent when their child refuses, but retain the jurisdiction of the court to override a competent decision. In theory this would apply to decisions to consent as well as to refuse. Consider, for example, a minor who is offered an abortion which a parent challenges in court on the basis that it is contrary to the minor's best interests. In practice, however, it is more likely to be exercised in relation to refusals of treatment, as doctors rarely offer treatment to a minor which might be perceived as contrary to his best interests.

We have seen that under the Mental Health Act, compulsion is a last resort, but the scheme does not eschew a softer form of paternalism whereby the minor might be persuaded to agree to treatment rather than face possible court authorisation or compulsory treatment under the Mental Health Act. Similar reasoning might be applied to minors who initially refuse to comply with the recommendations of clinicians in relation to treatment for physical health

problems. The fact that the court *can* overrule a competent decision to refuse life saving treatment might be utilised by clinicians to persuade the minor to accept treatment. Nor is this form of paternalism universally reviled. Thaler and Sunstein (2008) argue that investment goods (where the cost is borne immediately but the benefit enjoyed later) are ‘prime candidates for nudges’. They show that no choice is neutral and that a nudge in the right direction is an acceptable form of paternalism.

The law might utilise the concept of competence to control who may claim it; the circumstances in which it might be claimed; and its bearing on who has the authority to make the relevant decision. If the court retains the jurisdiction to override a competent treatment decision by a minor, then competence does not give him a right to self-determination, but a more limited right to have his opinion considered when the court determines what is in his best interests (Cave, 2011). The greater the minor’s competence, the stronger his ‘voice’ will be.

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¹ In this paper, reference to 'refusals' can be taken to mean refusals of life-sustaining treatment.

² Mental Health Act 1983, s. 83 states: '... consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being a form of treatment to which sections 57, 58 or 58A applies, if the treatment is given by or under the direction of the responsible medical officer'.

³ *B v Croydon HA* [1995] Fam 133, at [139].

⁴ *KB v South West Hertfordshire Health Authority* [1994] 2 FCR 1051.

⁵ *Tameside and Glossop v CH* [1996] 1 FLR 762.

⁶ *LB v Croydon DHA* [1995] 1 FCR 332 at 346, Per Thorpe J.

⁷ Medicines for Human Use (Clinical Trials) Regulations 2004, Sched 1, Part 4, Para 7.

⁸ Article 3(1): In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.