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Gillick v West Norfolk and Wisbech AHA: The Right of Adolescents to Make Medical Decisions and the Many Shades of Grey

E. Smaranda OLARINDE [1]
Associate Professor and Provost College of Law, Afe Babalola University Ado-Ekiti, Solicitor and Advocate of the Supreme Court of Nigeria

Ifeoluwayimika BAMIDELE
Ifeoluwayimika Bamidele, Lecturer I, Department of Private and Business Law, College of Law, Afe Babalola University Ado-Ekiti, Solicitor and Advocate of the Supreme Court of Nigeria

Abstract
In the *Gillick* case the lower court decision was challenged by the mother of a child below the age of 16, whose doctor had given advice on the use of contraceptives against the mother's wish. The decision was overruled by the court of appeal and became a threshold for consent and confidentiality for adolescents, who by definition had reached the age of 16. The paper discusses how the *Gillick* decision has affected the right to make decisions especially as it relates to adolescents. In a counterfactual it examined the decisions of the courts pre-*Gillick* and post-*Gillick* to determine whether autonomy exists and the progress made since *Gillick*. The paper examines the ex-post cases of Re-R, Re-M and Re-W, which diverged from *Gillick* direction. For instance, in the case of Re-R, the court ruled that no minor with fluctuating competence could be considered competent, whereas using the *Gillick* criteria competence could be established. It concludes that, although *Gillick* opened doors on competence, it only moved us steps closer but did not solve the problem of adolescent autonomy; since in application, the court has often assumed its *parens patriae* jurisdiction, as in the case of Re-E. The court needs to give more autonomy to adolescents, as it is unfounded to consider that they are more conscious of the present and not the future. They can make their own decisions and therefore mistakes. Sometimes the lack of understanding on the part of the adolescents is premised on insufficient information from the physician or health care professional and this should be addressed.

Introduction

A child is deemed to have rights,[2] which include his right to make some medical decisions, but these rights, like any other, are not absolute.[3] Patient autonomy and consent to medical treatment are complex areas of medical law. This is because there is a set of criterion that must be followed for a medical decision to be deemed as valid, which include information, lack of duress, capacity and voluntariness.[4] The Family Law Reform Act reduced the age of majority, from twenty one to eighteen years. This contributed, in no small measure, to the increase in the number of persons who can make a valid medical decision.[5] Caught in the middle of a right to make an independent decision are adolescents who are no longer children, but the law does not regard them as adults.[6] The Case of *Gillick v West Norfolk* and *Wisbech AHA*[7] was a giant leap in children's right jurisprudence as it was considered to be a pivot for child right autonomy in decision making, but little wonder why post-Gillick cases have either not followed it, been distinguished from it or avoided it through a re-route, by giving judgements that do not necessarily ask the same question as *Gillick*.[8]

This paper will discuss two fundamental tenets of medical law: consent and confidentiality; the *Gillick* decision; and how it has influenced or affected these rights especially as it relates to adolescents. The effects of

[1]Authors: E. Smaranda OLARINDE, Associate Professor and Provost College of Law, Afe Babalola University Ado-Ekiti, Solicitor and Advocate of the Supreme Court of Nigeria; and Ifeoluwayimika Bamidele, Lecturer I, Department of Private and Business Law, College of Law, Afe Babalola University Ado-Ekiti, Solicitor and Advocate of the Supreme Court of Nigeria.
[2] Re Gault. 387 U.S 1 (1967), United Nations Convention on the Rights of a Child, 1989, ratified in the UK, 16th December 1991.
[3] Gerwith A., Are There Any Absolute Rights, *The Philosophical Quarterly* , Vol 31. No 122, January 1981 pf 1-16.
[4] Amit M Patil, Vyankatesh T Anchimane Medico Legal Aspects of Consent in Clinical Practice. Bombay Hospital Journal, Vol 5, No 2, 2011.
[5] Family Law Reform Act, 1987 United Kingdom S.8 (3)
[6] Adolescents and Young Adults Are Not Children: Declaration by German Speaking Sociological Associations on the Pending EU-Child Pornography Directive(accessed via www2.hu.berlin.de/sexology/BIB/adolen.htm. accessed November 6, 2014)
[7] [1985] 3 ALL E R 402, hereafter referred to as Gillick . [1984] QB 581 HC, [1985] 2 WLR 413 CA. [1985] 2 WLR 830 HL.
[8] Eekelaar J., The Emergence of Children's Rights, 6 *Oxford Journal of Legal Studies* 161. (OUP 1986).

the *Gillick* decision and how it affected medical jurisprudence around the time of the judgement, how the courts have reacted to Post-*Gillick* over the years and how the courts have arrived at their decisions without necessarily following *Gillick* will also be examined. This will include the argument as to whether patient autonomy actually does exist at all and, if it does, does this also cover adolescents and some *Gillick* competent children considering decisions Post *Gillick.*

This paper will thus argue that, although there have been detours and diversions; there is still hope for adolescents to have autonomous medical decisions and treatment.

Rights in Medicine, Consent and Confidentiality

Cardozo J in *Schloendorff v Society of New York Hospital* stated that every human being of adult years and sound mind has a right to determine what happens to their body and, therefore an operation by a surgeon without consent is an assault.[1] Non-consensual touching may give rise to a civil action for damages.[2] It is a trite principle of law that medical treatment and physical examination should not take place till there is valid consent. It is this consent that makes medical treatment, which is a potential battery, not to be one.[3] There are exceptions to this rule which include necessity, and status of the patient which may border on age or mental capacity. Nevertheless, this paper is concerned with status as this has direct impact on adolescents and is the criteria for medical treatment and decisions in the treatment of adolescents.

Similarly another fundamental pillar of medical law is confidentiality, which is the responsibility of medical practitioners not to disclose information divulged to them in the course of their duty.[4] The theme of confidentiality is also very important to this discourse because it was one of the fundamental basis for the *Gillick* case and is still a recurring debate with medical treatment in adolescents and children.[5] A challenge arises where the patient is a child or adolescent and there is need for parental notification, or where public interest may be affected.[6] Silber J in *Axon*[7] emphasises the principle of confidentiality by stating that the medical professional remains under a duty to respect confidentiality from a young person and should not inform his or her parents of a medical decision.[8]

In view of these two basic principles that are fundamental to medicine and the patient-doctor fiduciary relationship, it is justified to consider how far the *Gillick* case and other cases with similar themes on adolescents have addressed the issues. Kennedy argues that consent is the legal and ethical expression of having one's human right respected; this posits that the rights of adolescents may be breached if their right to consent or confidentiality is tampered with.[9]

***Gillick* Case**

The Gillick case can be regarded as a landmark case as it dealt with issues of confidentiality, consent as well as parent to child relationships and the role of the law in protecting autonomy of patients with "capacity".[10] The department of Health Guidance on Family Planning, which contained a section for contraceptive advice and treatment for persons under the age of 16, was challenged by Mrs Victoria Gillick (the plaintiff) who sought the order of court for a declaration that the guidance was wrong after having sought an assurance from her local health authority that her daughters would not be given contraceptive advice or treatment without her knowledge.
The High Court in its Judgement per Woolf J. stated that the guidance was not unlawful and that understanding by the patient as well as professional judgement by the medical practitioner as to the risks and best interests of the child was of utmost importance. However the Court of Appeal unanimously agreed that it would be an infringement on the rights of a parent or guardian to advise a girl under 16 on contraceptive steps.[11] This decision was upturned by a slim majority[12] in the House of Lords which upheld the High Court decision stating that understanding and intelligence to give consent as well as a dutiful best interest based appraisal by the medical practitioner are the criteria for contraceptive advise and treatment for children under the age of 16,[13] on

[1] 105 NE 92(NY 1914), Offences Against the Person Act 1861, s.47.
[2] Colins v Wilcock [1984] 3 ALL ER 347 per Lord Goff LJ at 378.
[3] Ibid at n 1 Schloendorff v Society of New York Hospital.
[4] A.G v Guardian Newspaper Ltd (No 2) [1988] 3 ALL E R 545 at 657-659.
[5] R (on the application of Axon) v Secretary of State [2006] EWCA 37 (Admin).
[6] Confidentiality: Protecting and Providing Information (GMC : London, 2004) accessed via www.gmc.uk.org/standards/default.htm on Jan 12 2012.
[7] Ibid at n.5.
[8] Ibid at 109.
[9] Kennedy I., Treat Me Right , Essays in Medical Law and Ethics , (Oxford University Press 1988) 33-35
[10] Ibid at n.9
[11] Ibid at n 8 Gillick at 138.
[12] 5 judges opposed while 4 supported but 3 judges at the Supreme Court ruled in favour of the Health Authority.
[13] Ibid n8, at 174.

the other hand a dissenting opinion was given in the case by Lords Brandon and Templeman. The dissent was based on the Sexual Offences Act 1956,[1] which criminalized carnal knowledge of a girl under the age of 16. Lord Brandon stated that any doctor or parent who consents to contraceptive treatment of a girl under the age of 16 aids the commission of a crime.[2] Lord Templeman was of the opinion that the memorandum by the Department of Health and Social Security was defective in that it gave unabated powers to the doctor over the parent who still had parental rights over a child under the age of 16 and that the only condition upon which such decision could be made by the doctor is when the child has been abandoned or parents have abused their rights.[3]

Pre-*Gillick*

The Family Law Reform Act shows the transformation that occurred pre-*Gillick* and trends that have existed that made *Gillick* landmark and a new dawn in Child rights jurisprudence.[4] Section 1 of the Act reduced the age of majority from 21 to 18 in addition S 8 of the Act provides that consent by a child over 16 shall be effective as if it would be if he were of full age. This provision of the Act creates a new middle ground which gave rise to a contentious group between the age of 16 and 18 which this Act seeks to liberate nevertheless admitting that they had not attained full age.

The Rights accruing to adolescents is also underscored in the NHS (GMC & Pharmaceutical Services) Regulations[5] which provided for the rights of a person who has attained the age of 16 to choose his own doctor which, prior to that age he could not do, as either a parent or the guardian of the child would have had to make such decision on behalf of the child.[6] This shows that the Gillick decision was not an isolated trend as surrounding circumstances were already anticipating the birth of greater autonomy for persons with understanding and competence to accept or reject medical treatment.

Although decisions like *Agar-Ellis*[7] were not upturned, nevertheless the courts reflected that the age of paternalism and subjective parenthood was fading away as the concept of patient autonomy,[8] informed consent and liability for non-consensual touching was increasing. In the same vein, the Education Act [9]provided facilities for medical treatment in schools and colleges for pupils and senior students, as they were then referred to, between the ages of 12 and 19, although the age of majority was 21 at this time.[10] This Act however had a proviso, which states that where a parent or guardian objects to the use of the medical facility by his child or ward, the pupil shall not be encouraged to do so. A similar provision with attempts at distinguishing capacity with age is the Marriage Act,[11] which states that a child over 16 but under the age of 18 cannot generally marry without parent's consent. This notwithstanding in certain circumstances, the court may override the decision of the parents to refuse.[12]

These provisions of the law that preceded the *Gillick* decision illustrate the situation before the decision, however it also reveals that *Gillick* was not an out of the blues decision, as it had preceding provisions of Law to back it up or, at least, to prepare for such a new era.

Post *Gillick*

It is noteworthy that *Gillick* was widely believed and deemed to be a hard won victory for child rights and autonomy in general, even though there were facts that stated otherwise in some parts of the judgement. Firstly the Court of Appeal unanimously upheld the appeal and stated that patients right was crucial as well as a consideration of the criminal law and carnal knowledge.[13] Also the dissents of Lord Brandon and Templeman evinced some arguments that seem to have been of vital consideration as well as being recurring themes even in the Judgement of the court, which was lauded. This showed that the narrow nature of the victory at the courts might influence further decisions and the campaign for an accepted age of majority without diversions like *Gillick* competence, or *Gillick* understanding.[14]

[1] S 6, Sexual Offences Act 1956, which has been replaced with the Sexual Offences Act 2003.
[2] Criminal Law Amendment Act 1885(48&49 Vict.c.69) pt 1, ss 4, 5.
[3] Ibid n.8 at 204.
[4] Sections 1 and 8, seem to have paved the way for a Gillick decision.
[5] 1962 No 2248.
[6] The Children Act 1989, Michael Freedman; Re-thinking Gillick , International Journal of Children's Rights 13: 201-217, 2005.
[7] Re Agar-Ellis(1883) 24 Ch D 317.
[8] Per Lord Scarman qouting Lord Denning in Hewer v Bryant [1970] 1QB 357,369.
[9] Education Act 1944 subs 3, (7 and 8 Geo 6c.31).
[10] Ibid, now repealed by the Education Act 1996.
[11] Marriage Act 1949, section 3 Schedule 2.
[12] Ibid at s 3(1)(b), Family Law Reform Act 1969, section 2.
[13] Criminal Law Amendment Act 1885, an amendment of the Offences Against the Person Act 1861 and 1875, criminalize as a felony or misdemeanour unlawful carnal knowledge of a girl under 13 and 16 respectively.
[14] Re T (A Minor)(Wardship:Medical Treatment)[1997] 1 WLR 242, Marie Fox and Jean McHale "In Whose Best

Pre *Gillick* had bestowed special status on 16 to 18 year olds; nevertheless they were still referred to as minors even when such was in classified terms as mature minors. The *Gillick* judgement used a holistic approach while referring to children. Some of the arguments posited showed clearly that 16 to 18 was definitely different from below 16: Lord Brandon in dismissing potential danger of sexual intercourse without contraceptive advise or treatment to girls under 16, stated the answer of the law to such girl who decides to carry on with sexual intercourse would be, "Wait till you are 16". Does this then infer that 16 and not 18 is the age of majority? This has been the debate on section 8 of the Family Law Reform Act. This debate is a product of grey areas between limitations and abilities recognised by law of persons within the adolescent or matured minor age bracket.[1]
The subsequent case law that followed the *Gillick* case was believed to be a cog in the wheel to progress already made by the *Gillick* decision although some of these decisions were not limited to adolescents but to children, nevertheless its impact has been felt by all groups with its ability to give a coloration of the court's opinion of autonomy in children and adolescents.[2]

***Re-R(a minor)*[3]**
In *Re-R (a minor)* a 15 year old girl was admitted to the hospital under the Mental Health Act 1983, she was to be administered with anti-psychotic medication by an injection. She rejected this procedure and communicated with a social worker in clear and lucid terms which led to the withdrawal of consent of the Local Authority, nevertheless the unit considered it unsafe to keep her without an authorisation to administer the medication.[4] The court obliged the unit by stating that she was a ward of court and incompetent to refuse treatment, however if she was a competent minor she would not be refused, the court emphasised that competence, especially *Gillick* competence, was not to be fluctuating, and also stated that parents still retain power to consent to medical treatment when their *Gillick competent child* refuses treatment.[5]

The effect of *Re-R* on *Gillick* was damaging as the Official Solicitor requested guidance as to whether *R* was *Gillick* competent, this was an opportunity for the courts to walk into the doors that have been created by *Gillick* which was a test of sufficient understanding, Lord Donaldson stated that no minor who had fluctuating competence could be regarded as having had competence.[6] He referred to this right to consent with the key holder analogy where consent is the key and there are multiple key holders.[7] The court claims its decision was based on the best interest of the child, but deliberately avoided the child's competence. Juxtaposed with other cases the principle of autonomy as encapsulated in the Law[8] and by *Re-C*[9], the child could comprehend and retain, believe the information and weighed it to arrive at a choice, also the law states that capacity could be time specific,[10] which infers that a person who has fluctuating capacity can make a decision in his lucid period.
The danger posed with the Judgement in *Re-R* was also carried forward to *Re-W*[11] where the case concerned a 16 year old who is deemed to have capacity by virtue of the Family Law Reform Act.[12] This case was a real test of the provisions of the law combined[13] and a further expression of child autonomy especially with the matured minor, a group shrouded with a lot of uncertainties. W was described as having a troubled upbringing with various challenges, loss and emotional instability to cope with, she was also anorexic. She refused treatment for her condition and was made a ward of court with the court per Thorpe J invoking the inherent jurisdiction of the court and authorising her treatment against her wishes.[14] On appeal the court per Lord Donaldson stated that no minor has power to refuse consent to override consent given by someone who has parental responsibility for the minor. This was a blow to the concept of Gillick competence as this forecloses the ability of the child to be autonomous even when he or she has been declared to have sufficient understanding like in the case of W. It is noteworthy that Lord Donaldson's analogy of the key holder and its dual ownership between child parent and guardian was re-framed and used in its stead a 'flak jacket' concept where the doctor needed just an

Interests?(1996) 60 Modern Law Review 700-709.
[1] Matthew White, The Age of Consent: Young People, Sexuality and Citizenship. (Palgrave Macmillan 2005).
[2] Donna Dickenson: Children's Informed Consent to Treatment: Is the Law an Ass? Journal of Medical Ethics 1994; 20: 205-206.
[3] Re R (a minor)(wardship:medical treatment)[1991]3 WLR 592,[1992] Fam. 11.
[4] Ibid at [1992] Fam. 11 at 19.
[5] Ibid at par 24.
[6] Ibid at par 24 and 26.
[7] Ibid at par 22.
[8] s 3 Mental Capacity Act 2005.
[9] Re C (Adult Refusal of Treatment)[1994] 1 WLR 290.
[10] S 3(3) MCA 2005.
[11] Re W (Consent to Treatment) [1992] 4 ALL ER 627,CA.
[12] s 8 Family Law Reform Act 1969.
[13] Gillick, Family Law Reform Act and Children's Act.
[14] Ibid at 38, Re R

authorisation to be able to carry out treatment of a minor.[1]

Criticisms trailed both the key holder and flak jacket rules as the key holder is regarded as inappropriate a term as it could open as well as close:[2] Also this negated the principle of autonomy that the child who has understanding would be deemed to have had. The principle of the flak jacket is considered paternalistic. It reduces child rights and autonomy to protecting the medical profession, by an attempt to grab a flak jacket, carry out medical treatment as exhibited in consent forms by hospitals, which had earlier been criticised by the courts.[3] The case of *Re- M*[4] also follows the same trend as another 15 year old girl had her wishes overridden by the court in a decision that was regarded to be in her best interests. She had suffered a heart failure and the doctors concluded that only a transplant would save her life, she refused her consent and quoting from notes of what she said, it was obvious she knew the consequences of her action, she knew death was inevitable, and she considered the pain it would bring to her family, yet she chose death which she believed will not make her different from anyone else, which she believed having another person's heart would do, nonetheless the court authorised the transplant. The courts have attempted to exclude *Gillick* competence and the rules of sufficient understanding in addressing some of these issues in a bid to achieve their aim and come to a suitable conclusion, a best interest and wardship jurisdiction of court is seen as paramount and most protective where the child is deemed to attempt a decision the court is not in support of or deems harmful to the child as ward of court.[5]

False Dawn or Clear Skies

The *Gillick* case was indeed a dawn, it was believed to have heralded a new dispensation from which subsequent statute and case law were to derive greater zest for a more autonomous child and a rights based dimension to decision making. The Gillick case can be likened to a door that's been shown to the world with the keys and an opportunity to walk straight into it. Although the cases of *Re-R, Re-W*, and *Re-M*, seem to be a diversion from the Gillick directions it still has not shut the doors opened by Gillick. The Family Law Reform Act, which distinguishes those below the age of 16 deserved a clear interpretation from the Judges in the above mentioned cases but based on what may be fairly referred to as distinguishing factors regarding the specifics of each case, the Gillick dimension is bypassed.

In *Re- E*,[6] a 15 year old, who was going on 16, suffered from leukaemia and was a Jehovah's Witness with his parents, refused a treatment that included blood transfusion with an 80-90 per cent chance of recovery choosing a therapy with drugs that had a 40-50 per cent chance. The courts considering that he was still 3 months away from his sixteenth birthday made him a ward of court and gave the hospital the liberty to treat him with blood products.

Noteworthy is that when he attained the age of 18, he refused this same procedure and died, His parents were of the view while he was some months to his 16th birthday that he was near an age stipulated by the Family Law Reform Act and that this would give him the freedom to make an autonomous decision, nevertheless this was not to be done. The categorisation of such thought in similar grounds with the decision arrived at in the case of *Re-S*[7] where a 15 year old girl who was converted to the Jehovah Witness faith at age 10 by her mother. She was suffering from thalassemia[8] from birth and was required to constantly receive monthly blood transfusions and injections to keep her alive. The Local Authority requested an advanced directive from the court to override S's decision to refuse blood transfusion as she had failed to attend her monthly blood transfusions. The court while acknowledging her high level of understanding nevertheless inferred influence by her mother, her religion and inability to weigh the effect of not attending the monthly blood transfusions.

However, Brazier and Bridge[9] are of the opinion that other factors may be responsible for her decision and for all decisions, the same rule applies in *Re- E*[10] where, at 18, the boy decided to refuse treatment and died. The view in this paper is that it is impossible for human beings to make decisions without influence and whether

[1] Ibid at n 46. Re R at 642-643.
[2] R Thornton 'Multiple Keyholders- Wardship and Consent to Medical Treatment' (1992) CLJ, 34,36.
[3] Lord Donaldson in Re T [1992] 4 ALL E R 649 at 663
[4] Re M (Child Refusal of Medical Treatment). [1999] Fam Law 753 `
[5] Micheal Freedman, Why It Remains Important to take Children's Rights Seriously, in Children's Rights: Progress and Perspectives, Essays from the *International Journal of Children's Rights* edited by Michael Freedman. Pg 5-23 (Martinus Nijhoff 2011).
[6] Re E (A Minor) (Medical Treatment) [1991] 2FLR 585
[7] Re S (A Minor) (Medical Treatment)[1994] 2 FLR 1065.
[8] Thalassemia is a blood disorder passed down through families (inherited) in which the body makes an abnormal form of hemoglobin. Hemoglobin is the protein in red blood cells that carries oxygen. The disorder results in large numbers of red blood cells being destroyed, which leads to anemia. http://www.nlm.nih.gov/medlineplus/ency/article/000587.htm accessed on 28 Nov 2014
[9] M. Brazier and C. Bridge "Analysing Adolescent Autonomy: Coercion or Caring" (1996) 16 Legal Studies 84, at p.106).
[10] Ibid at n 55 and Re P (Medical Treatment: Best Interests) 2004 2 FLR 1117.

as children, adolescents or adults, human beings are motivated for an action courtesy of their faith, beliefs, way of life or what may be regarded as style. This infers that an excuse by the courts as to external influence, to deprive persons who understand sufficiently and have scaled the *Re C* test is only a ploy to re-direct paternalism of the courts and the medical profession as we all are influenced by something and whatever influence we have would shape our orientation and in turn our decisions.

The right Children and adolescents are being deprived of according to Eekelar is a right to make their own mistakes.[1] Although the *parens patriae* jurisdiction of the courts have been dispensed with yet the court assumes a protective dimension in wardship and ensuring that a child or adolescent attains an age that his decisions would be deemed free. However this is not also free of criticism as adults of full age have also been refused a right to make their decisions in the name of best interests which raises the question as to whether autonomy exists at all.[2]

The Autonomy Mirage

Brazier and Bridge described adolescent autonomy as being more of a myth.[3] Also *Gillick* can be described as a door with no entries as subsequent opportunities to walk through the autonomy lane have been avoided and other routes used in arriving at a decision. Section 83 of the Mental Capacity Act[4] provides for treatment without consent for a patient, if the treatment is for the condition suffered. The definition of best interests in Bolam also gives room for a doctor based paternalistic definition of best interest. Also the forced caesarean section[5] for unwilling women and the cases of *T v T*[6], *Re V*[7] and *Re T*[8], all show that the paternalistic approach is not adolescent or child specific, it's a battle of paternalism over autonomy. However Section 2(3) MCA[9] states unequivocally that a person's age or appearance should not be the sole determinant. The MCA clearly states that adolescents (16 and 17 years) cannot make advance directives to treatment,[10] neither can they appoint a lasting power of attorney should they become incompetent.[11] These clearly show that autonomy is not yet a blank cheque, *Gillick* might have moved us some meters forward nevertheless we are still far off from real autonomy in all ramifications.

Right to Consent, Wrong to Refuse

Ross argues that child autonomy is to be limited for various reasons, which include an opportunity for the child to have background knowledge of the world and capacities that will allow him make decisions that better promote his life.[12] The article also states that children need a protected period to develop enabling virtues, and also to increase their limited world experience. While this argument seems sound, it is not balanced against the harm or damage done to the real autonomy that may emerge from a child while trying to doctor his mind. The test of sufficient understanding as well as tests in *Re-C*[13] and *Re MB*[14] must be a universal yardstick if autonomy and child rights are to be given a chance to survive.

A right to consent to medical treatment is one side of a two-sided coin, which infers that the reverse is a right to refuse treatment. Often, autonomy is measured by the right of the individual to refuse treatment as it is widely believed that where a patient complies with treatment or medical advice by professionals, his actions would not be deemed as wrong, or lacking in capacity, but an issue arises where patients refuse treatment. The right of a child to consent to treatment has not availed him the right to refuse as the court has continued to play its role of safeguarding persons assumed incapable of making individual decisions. Also the effect of some decisions are held by courts as irreversible and that where a patient who is a child makes a decision based on information available to him, further information might bring about a desire to change an irreversible decision.

[1] Ibid at n.9 J. Eekelar
[2] Marie F and McHale J. "In Whose Best Interests?(1996) 60 *Modern Law Review* 700-709.
[3] Ibid at 57
[4] Hereafter referred to as MCA
[5] Re S(Adult Refusal of Treatment) [1992] Fam 123
[6] T v T [1988] 1 ALL ER 613.
[7] Re V (1987) Times, 4 June 1987.
[8] Re T (14 May 1987 unreported).
[9] S 2(3) Mental Capacity Act.
[10] S 24(1) MCA 2005.
[11] S 10(1) MCA 2005.
[12] Lianie Freedman Ross, Health Care Decision Making by Children at page 488 of Children, Medicine and The Law edited by Michael Freeman (Ashgate & Darmouth Publishing 2005).
[13] Ibid at 44
[14] Re MB (Adult Refusal of Treatment) [1997] 8 Med LR 217 at 224.

Conclusion

Gillick has opened a door but we have not walked through it, we have seen the direction, yet only few actions have been taken in this direction. The courts have made attempts at distinguishing from *Gillick*, rightly or wrongly, but have not erased the basic principles of sufficient understanding regarded as *Gillick Competence*. Adolescents have been treading grey area paths with decisions that concern them especially in view of Sections 8 and 3 of the Family Law Reform Act. However, the MCA stipulates that age would not be a barrier to autonomy, yet clearly states that persons under 18 cannot make advanced decisions or appoint lasting attorneys. Although the courts have not had to make many decisions on "competent" adolescents, which puts the average adolescent and medical practitioner in doubt as to what rights accrue and which does not in the frame of autonomy pertaining to adolescents.

Adolescence according to Hyun is replete with a lot of pressures and ambiguities; nevertheless it should not be an excuse for limiting the extent to which adolescents can make decisions about their health.[1] The courts should adopt an autonomy based approach to evaluating decisions from adolescents, as the assumption that they are most conscious of the present and not the future; may be unfounded and false. Similarly rather than a paternalistic protection of adolescents from perceived self-destruction, an attempt should be made to convince and inform the adolescent patient as his lack of understanding may be premised on insufficient information from the medical doctor or health care professional.

The gates have been flung open by *Gillick*, the UN Convention on the Rights of a Child as well as European Convention on Human Rights have broadened the scope of the rights of the adolescent. It is however suggested that the courts having been quick to make best interest decisions in persons whose ages are over 18 yet are classified as having the brain or capacity of a 2 year old or 5 year old, now have to do more by considering competence of adolescents as if they were 18 and above where they have shown sufficient understanding.[2]

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