Law reform essay competition 2024: runner up

Restoring the coherence of the law of mental capacity in the context of medical decision-making for children, by reference to *An NHS Trust v C NHS Trust & Ors* by Priyansh Shah

The law of Mental Capacity in medical decision-making is of great consequence patients with partial or no capacity, who are at the mercy of the approach that judges take to determine their fate. Cases involving the medical care of mature children raise especially pertinent questions around the principle of personal autonomyin relation to consequentialist best interests. As a result, it is of utmost importance that this area of law is coherent in its principles and predictable in its results, while striking the right balance between autonomy and best interests.

However, at present, the law in this area is incoherent, outdated, and linguistically imprecise. In this essay, I seek to address three key areas for reform. Firstly, *Gillick* competence[1] is, at its core, an incoherent concept. Secondly, an overly binary approach to the question of capacity has resulted in an approach that struggles in complicated factual situations. Lastly, a failure to explicitly recognise the tension between personal autonomy and best interests for incapacitated patients, and what one must do when the two are in contest, has further confused decision-making. I will recommend a new approach that situates mental capacity on a gradient, defined by various factors, and which would enable judges to make orders that, in both language and substance, respect one's decision-making ability but still safeguard their best interests. While much of this essay will concern children as a case study, the approach recommended is of general applicability to cases involving those lacking full capacity, regardless of age.

To illustrate these difficulties in action, I begin with the case of An *NHS Trust v C NHS Trust & Ors*[2] ("***CX v NHS***"), Mrs Justice Roberts decided in line with her predecessors in cases of this sort (regarding the provision of blood transfusions to non-consenting adolescent Jehovah's Witnesses who are at a risk of death should they not receive such treatment; *Re E (Minors: Blood Transfusions)*[3] is a key example in this respect) and authorised the administration of blood products to a minor (CX) despite his lack of consent. This is, on balance, a justified decision in law and on the

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[1] *Gillick v West Norfolk and Wisbech AHA* [1985] UKHL 7 ("***Gillick***")
[2] [2019] EWHC 3033 (Fam)
[3] [2021] EWCA Civ 1888

moral basis of CX's bestinterest in living and life-saving treatment (even in consideration of his own views). The law as (correctly, I submit) set out in this case was as follows:

In cases involving children, the courts have a duty to decide in their best interests,[4] broadly and subjectively to the interests of **that specific child** and not simply general principles.[5] [6] Since children (under the age of 18)[7] are incompetent by default, their views are not considered definitive, and rather form a component of the best interest test. Additionally, children who are *Gillick* competent may consent to treatment of their own accord, [8][9] generally, but may not refuse consent to life-saving treatment.[10] While parental responsibility is ascribed,[11] and parents can consent on behalf of children,[12] the High Court may override a refusal of consent from both a child and their parents in accordance with best interests. Therefore, parental views are also subsumed into the best interest test.

Applying this framework, Roberts J balanced the CX's interest in maintaining the tenets of his and his mother's religion and the harm that such a treatment would do to his health against CX's interest in getting well and continuing to live a life he considers very meaningful. In this balancing exercise, she also notes several key factors that mitigate both sides of this argument. Firstly, having determined that CX is *Gillick* competent, she places a strong focus on this conflict of his wish to maintain his religion and his desire to live. Secondly, she notes that both CX and his mother intend to be law-abiding and will not resist the treatment should the law require them to pursue it. Thirdly, she notes that the treatment plan takes account of the religious beliefs of CX already and seeks to minimise the offence to his religious principles (even by exceptionally moderating clinical standards so as to only transfuse blood productswhen strictly necessary). Fourthly, she notes that the treatment is unprecedented but widely endorsed. Lastly, considering that CX is *Gillick* competent and not absolutely competent, she notes that CX is competent to consent to treatment but not to refuse it if it is in his best interests and the court retains the ability to override his consent in any event.

In line with the above authority and facts, she decided that, in terms of CX's own enjoyment of life,CX would be best served by receiving the treatment, and particularly would be served by an order requiring him to do so. CX would have the

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[4] Children Act 1989, s.1(1)
[5] *Wyatt* [2005] EWCA Civ 1181
[6] *Plymouth Hospitals NHS Trust v YZ and ZZ* [2017] EWHC 2211 (Fam) ("**YZ and ZZ**")
[7] Children Act 1989, s.105(1)
[8] *Gillick v West Norfolk and Wisbech AHA* [1985] UKHL 7
[9] Family Law Reform Act s.8
[10] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386
[11] Children Act 1989, s.2
[12] *AB v CD* [2021] EWHC 741

best chance possible to make a recovery under such an order, while CX would have a serious riskof death should he not comply with the treatment altogether, or not comply with the transfusions. In fact, it is primarily the order which allows CX to comply with his treatment, something he would want to do but for his religious beliefs, making it all the more crucial that such an order was made.

The incoherence of *Gillick*

From this decision, while the right outcome was eventually reached, it is apparent that the law in this area creates structural limitations on how judgesmust decide cases, which inevitably result in unsatisfying and somewhat incoherent results. In particular, the phenomenon of *Gillick* competence is incoherent in its application to the caselaw. Competence is, in its essence, a pathway to autonomy. When one is competent, one is allowed to make decisions about themselves regardless of the consequences.[13] If one is of-age, they are assumed to be competent unless it is proven otherwise. If one is underage, they are incompetent. Even the Family Law Reform Act s.8 only grants the right to consent to treatment to children over 16, and those children do not receive the competence to reject treatment. It is clear, therefore, that children are presumed in law to not be competent whatsoever.

Yet, in the case of *Gillick*, to enable children lacking competence in law to assent to treatment despite parental objections (in that case, contraceptives), the justices describe the child in that situation as 'competent'. That said, it must be noted that the child was only 'competent' insofar as they were the best judge of their interests and the parent's right to make determinations of that sort had elapsed. Yet, the later cases of *Re W*[14] and *In re R*,[15] cited in *CX v NHS*, hold that *Gillick* competence does not allow strict refusal of treatment, as the court remains capable of consenting on behalf of the child. Plainly, *Gillick* must be wrongly decided. If the wishes of a *Gillick* competent minor only justify assenting to treatment in their best interests (with a margin of appreciation) and not refusing treatment in their best interests, then such wishes are not competent expressions of autonomy, but simply wishes. Granted, the courts seem to suggest that the maturity of a child renders their wishes weightier, but this does not overturn the courts' and the GMC's analysis that a child's competence can only ever be limited in subject matter or degree ([13] - [15] of *CX v NHS*). This results in thebizarre situation where courts in *re R* and other cases in this line describe a child as competent only to consider their views as weighty, rather than binding in any real respect. In effect, *Gillick* competence is an oxymoron - describing the competence that is not accompanied by autonomy.

Therefore, the correct statement of the law in this area is that patients of-age are

[13] *Kings College NHS Foundation Trust v C and V* [2015] EWCOP (“***King’s College Hospital v C***”)
[14] [1992] 3 WLR 758
[15] *In re R (A Minor)(Wardship: Consent to Treatment)* [1992] Fam. 11

competent unless proven otherwise, and underage patients are not. For underage patients, the weight of their wishes increases with increasing maturity, to the point that they could reasonably disagree with their parentsand this view could be upheld in court, but courts remain bound by the best interests test, not the autonomy of a child. *Gillick* competence, in my view, only serves to confuse this discussion.

Deeper conceptual strain in binary legal presumptions of competence

The above analysis reveals a deeper incoherence of the law on mental capacity, best illustrated in the conceptof age-based mental capacity. Crucially, the binary distinctions between the adolescent who is 17 years and 11 months old and the one that is 18 years old, as well as that between the adult lacking capacity and the adult having capacity, are anachronistic and unfit for use.

This binarism in the law on children's medical decision-making results in bizarre determinations wheresometimes a child has competence and decides for themselves and sometimes the court decides for them, and after the age of 18 the court takes no interest in it whatsoever. Crucially, as the GMC and the court in *Re R* note, the competence of any person varies with maturity, mental conditions, and subject matter. Since adolescence and maturing is a long and varied process, starting in one's teenage years and ending often in the mid-twenties, it is not uncommon to have 17-year-olds that are more mature than 20 year olds in particular areas or even in general.[16] Moreover, competence is not singular. Rather, a patient's competence in decision-making can vary significantly according to the subject matter of the decision, as cases concerning anorexia and depression no doubt show.[17] As such, a binary framing of competence in legislation[18] results a framework wherein courts are required to bend over backwards to justify endorsing a patient's decisions only when it is appropriate to do so.

This binary approach criticised by Emily Jackson[19] as essentially forcing the courts in the case of *King's College Hospital v C* to rule that C was wholly and absolutely competent where 2 seasoned psychiatrists reasoned that she was not, so as to give effect to her decision that could generally be considered to be against her best interest (stopping kidney dialysis, leading to death, since life 'had lost its sparkle'). The courts presently not only have to undertake a murky and unclear balancing exercise of consequentialist best interests against autonomy in every case, but they must do so under the guise of established statutory rules on a patient's competence.

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[16] Cave E and Cave H, "Skeleton Keys to Hospital Doors: Adolescent Adults Who Refuse Life-Sustaining Medical Treatment" (2023) 86 Modern Law Review 984

[17] A Local Authority v E [2012] EWHC 1639 (Fam)

[18] Mental Capacity Act 2005 s.1(3)

[19] Jackson E, "From 'Doctor Knows Best' to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions About Their Medical Treatment" (2018) 81 Modern Law Review 247

This deeper problem results in precisely the sort of rationalisation found in the case of *CX v NHS* - that a patient was *Gillick* 'competent' and yet unable to decide for themselves. In this area of law, there is no language for considering a patient's desires as a discrete component of a judge's decision regarding their best interests and thus the language of competence is shoehorned into cases simply to offer authoritative language to the very same exercise. More so, this approach obscures the real locus of these decisions – the fact that the principle of personal autonomy is not solely relevant to those who have total capacity.

The invisible tension between personal autonomy and best interests

The true tension in many of these decisions (*King's College Hospital v C* and *CX v NHS* are clear examples) is between the personal autonomy of those with partial capacity and their own best interests. Under the present framework, however, judges are unable to consider this issue on its own merits. Rather, they must consider capacious those whom they wish to empower, and consider incapacitated those who they wish to restrain, even where both outcomes are reached by balancing the very same factors – the strength of their personal autonomy against the degree of their deviation from their best interests.

When this tension is ignored, or at least not explicitly addressed, in the statutes and the caselaw, the court ends up applying a relatively mechanical process of finding capacity, *Gillick* competence, and best interests separately for any case involving partial competence. From there, a court seeking to uphold the intentions of the patient, for reasons such as but not limited to their general personability[20] or the desirability of their decision compared to their parent or guardian's,[21] would find some manner of competence to be the dominant factor. A court seeking to override the decisions of the patient declares incapacity, or a lack of or limited *Gillick* competence, and then rules in the best interests of the patient. The failure to recognise the true issue at hand results in arcane rulings that are, at least on this reading, unrelated in substance to the principles they are decided according to.

An outline for reform

Judges require the ability to accede to a patient's requests in some cases and reject them in other cases. That the legislation on mental capacity and on children's rights creates the above-described binary is a great hindrance to their ability to do this coherently.

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[20] One reading of *King's College Hospital v C* is that the court found C competent against psychiatric evidence because they sympathized with her exposition.

[21] *Gillick* could be reconsidered in context as a vindication of the public health function of providing appropriate contraceptives and advice to teenagers.

In this light, I take up the evaluative frameworks suggested by Cave[22] and Skowron,[23] writing separately on the two binary distinctions. Both suggest that the legal idea of capacity is simply a pathway to autonomy in one's decision making (which is also why capacity is measured functionally). Therefore, the crucial question of law should be when it is appropriate for patients to exercise autonomy in their decisions, and when this autonomy should trump (or even constitute) their 'best interests'. Factors like outright age, maturity, mental conditions, etc. would simply fall to be considered as factors affecting one's ability to decide for themselves in context. Post-assessment, we would know for sure that a competent patient is ready to make autonomous decisions, even if they are under 18. Where one is incompetent, this holistic assessment would help to guide the court in terms of how much weight is to be given to their personal autonomy in the decision-making process. Thereafter, the court would be able to transparently weigh one's autonomy against their proposed deviation from medically indicated treatment.

This re-conceptualisation sounds radical but is practically not very distant from the existing framework. Firstly, existing legal presumptions and tests could be used. While I have raised issues with the binary situation arising from the age of majority, it is perfectly valid to use an age of majority as a starting point. In the absence of factors mitigating capacity, those aged 18 and above would be presumed to have unencumbered capacity. For this group, according to the holistic "autonomy" conception, circumstances that trigger an assessment (e.g. immaturity, mental illness) could be identified. For those aged below 18, it could be presumed that they lack capacity, but autonomy-based reasoning could be employed by judges in situations where minors disagree with their parents or medical expertise on their treatment (as was the case in *Gillick* and *CX v NHS* respectively). At a very young age, the opinion of the parent should be authoritative unless there is a pressing need to intervene on behalf of a child's best interests.[24] Using these presumptions, the number of "difficult" cases would stay limited as it is today.

Secondly, I would like to point out that the functional capacity assessments that already occur within the present law are just as well suited to an autonomy-based model of capacity, seeing as though the ability to make decisions about their medical treatment in context (the focus of the test) is precisely what my proposed model is concerned with, rather than some abstract concept of capacity. Therefore, the proposed conceptual change in the law of mental capacity is realistic and achievable.

In practice, when a patient lacks capacity, their preference would still tip the scales in decisions. This approach echoes the idea of 'Transitional Paternalism' put forward by

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[22] Ibid n 17

[23] Skowron P, "The Relationship between Autonomy and Adult Mental Capacity in the Law of England and Wales" (2018) 27 Medical Law Review 32

[24] An example of such a case is *Evans & Anor v Alder Hey Children's NHS Foundation Trust & Ors* [2018] EWCA Civ 805

Manson[25] and Tucker[26] in that it essentially argues that all decisions by patients should be considered by the courts, who would accord greater binding force to decisions of people further up the 'autonomy gradient' that I have described. Unlike the previous binary approach, this approach reflects reality – autonomy is a matter of degree. Vindicating the autonomy of an individual, particularly in finely balanced factual situations,[27] is a net positive. People are much happier (and healthier) having been consulted, supported to make a decision, or at least considered.[28]

Through this clearer, more transparent approach to patient autonomy, the courts retain the ability to either give effect to or overrule the autonomy of patients who are young or lacking capacity but need not reason around the old technicalities to justify this. The courts could simply rule according to the needs of the case and the interests of justice, on a holistic assessment, when the wishes of someone who does not have absolute autonomy should or should not be upheld. This would be a much clearer framework, vindicating autonomy without compromising on best interests. Linguistically speaking, less binarism about competence and a greater degree of respect even for wishes that are not binding will likely increase the dignity of patients lacking capacity in their treatment.

Recommendations

It would be best to enact a change of this sort in legislation. The sources of the competence dichotomy are statutory: the Children's Act 1989 and the Mental Capacity Act 2005. Passing an act that replaces the relevant sections of those with a modernised, holistic, capacity assessment in situations that call for departure from clear presumptions, detailed in the last section, would be the ideal model for reform.

In the short term, and in addition to the above, I would recommend that the judiciary reform the common law by eschewing the concept of *Gillick* competence altogether. Children, by default, should lack capacity, but their wishes should still matter and carry weight where their maturity justifies it. In the case of incapacitated adults, there is also room to clarify the caselaw by setting out that competence must be assessed specifically to the issue concerned, and that the wishes of incapacitated adults will similarly have greater or lesser significance depending on their position on the "autonomy gradient".

Recognising that my suggestions replace bright-line rules with discretionary

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[25] Manson NC, "Transitional Paternalism: How Shared Normative Powers Give Rise to the Asymmetry of Adolescent Consent and Refusal" (2014) 29 Bioethics 66

[26] Tucker F, "Developing Autonomy and Transitional Paternalism" (2016) 30 Bioethics 759

[27] In *Rotherdam and Doncaster and South Humber NHS Foundation Trust v NR & Anor* [2024] EWCOP 17, the (incapacitated) patient's choice made the difference.

[28] Richardson G, "Mental Disabilities and the Law: From Substitute to Supported Decision-Making?" (2012) 65 Current Legal Problems 333

guidelines and questions of degree, it is perhaps apt to recall the wisdom of Aristotle some 2400 years ago: "[A]bout some things it is not possible to make a universal statement which shall be correct."[29] I respectfully submit that mental capacity to make medical decisions is just one of those things.

Word Count: 3000

[29] Aristotle, *The Nicomachean Ethics*, (first published around 350 BCE, Cambridge University Press 2000) Book V, Chapter 10