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The language and landscape of the law in relation to consent in minors†

COMMENTARY

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SUMMARY

This commentary reflects on two articles on consent in those under 18 years of age, known in law as 'minors'. I consider why the language and landscape of the law in relation to consent in this age group can be alienating to psychiatrists, interrogate the legal complexities regarding consent in children and adolescents, refer to key aspects of relevant case law and end with practical suggestions that might improve clinical practice with cases that have the potential for legal complexity.

KEYWORDS

Child and adolescent psychiatry; consent and capacity; arts psychiatry; psychiatry and the law; case law.

> 'A rather insistent cross-examiner asks a pathologist whether he can be absolutely sure that a certain patient was dead before he began the autopsy. The pathologist says he's absolutely certain. Oh, but how can you be so sure? Because, the pathologist says, his brain was in a jar sitting on my desk. But, says the cross-examiner, could the patient still have been alive nevertheless? Well, comes the answer, it's possible he could have been alive and practising law somewhere' (McEwan 2014: p. 52).

I am opening with a joke quoted from *The Children Act*, by the critically acclaimed novelist Ian McEwan. I do so not to cast aspersions on lawyers, but to draw attention to the complex, often ambivalent relationship that many doctors have with the law. Psychiatrists speak in hushed tones about frustrations with legal pedantry. This sense of alienation is perpetuated by the different linguistic registers used by psychiatrists and lawyers. Clinicians in child and adolescent mental health services (CAMHS) might refer to patients as children, teenagers, youth or young people, but never as 'minors'. However, the law under which we practise considers people under the age of 18 to be minors, and describes them as such.

A recurring theme in peer group meetings are the widely shared concerns that the clinical shorthand commonly used for efficiency, despite the potential to reduce complex patient experiences to oversimplified, often reductive notions, may be misunderstood or even misconstrued in court. Almost universally among my consultant colleagues, the High Court is a place we think of with dread: at best a place where we will survive unscathed the sort of cross-examination dramatised by novelists such as McEwan, at worst an arena in which systemic failings might be pinned on an individual who loses their linguistic footing. Perhaps it is unsurprising that this finds its way into humour and literature.

The twists and turns of consent

In McEwan's novel *The Children Act*, Fiona Maye, a judge in the Family Division of the High Court of Justice for England and Wales, is presented with the urgent case of Adam, a 17-year-old who is refusing life-saving medical treatment (McEwan 2014).

Why is this a complex issue, with so many plot twists and turns? The source of the legal complexity is described by the authors of two articles in *BJPsych Advances* about consent in minors (Hawkins 2024a, 2024b): those under the age of 18 who have capacity can consent to treatment, but the law confers on them only a limited right to refuse (Hawkins 2024a). This differential legal attitude makes the law in relation to consent in minors complex to apply: at face value, it seems illogical, and perhaps contributes to a sense of unease and uncertainty among clinicians.

The *Gillick* case

Under-18s have had the legal right to consent to treatment since Victoria Gillick, a devout Catholic, took legal action against the Department of Health and Social Services. Gillick's daughter sought and received contraceptive advice from a general practitioner, and did so when she was below the age at which she could lawfully consent to sexual intercourse (Watt 1998). The general practitioner's clinical care was consistent with the advice provided to doctors by the Department of Health and Social Services. Gillick sought a declaration from the court that the advice was unlawful, on the grounds that it overruled her parental rights. This declaration was refused.

Gillick was a defining moment in medico-legal history: in the eyes of the law, 'a minor' is able to give consent in their own right, without parental

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approval or even parental knowledge. The final decision came from the House of Lords, in *Gillick v West Norfolk Area Health Authority* [1986]. The test proposed by Lord Scarman posits that a minor will be able to consent to treatment as long as they can demonstrate 'sufficient understanding and intelligence […] to understand fully what is proposed' (para. 80).

The *Gillick* case continues to have monumental and momentous implications for the life of a young person under the age of 18, and wide-ranging effects on ongoing therapeutic relationships, including work with families who may hold different views. The recent case of *Bell v Tavistock* raised the question of whether puberty blockers could be prescribed to those aged under 16 who are experiencing gender dysphoria. The Court of Appeal overturned the decision of the High Court, saying that the High Court had been incorrect to have issued guidance on the test of Gillick competence in relation to puberty blockers and that instead 'it was for clinicians, rather than the court to decide on competence' (*Bell & Anor v The Tavistock and Portman NHS Foundation Trust* [2021]: para. 87). The court ruled that puberty blockers are 'not experimental treatment justifying special categorisation, and that it was neither the remit of the court to evaluate the evidence underpinning puberty blockers, nor to take part in the moral debate surrounding it' (Moreton 2023).

The Court of Appeal quoted Lord Scarman's words, spoken 40 years earlier in the context of providing contraception to a minor, and applied those words to the issue of puberty blockers:

> 'If the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change' (*Bell v Tavistock* [2021]: para. 56).

In doing so, this ruling effectively repositioned *Gillick* as the landmark case when it comes to considering consent.

The right to refuse

As Hawkins et al remind us, the *Gillick* case, and specifically Lord Scarman's test, applies to treatment consent, not to treatment refusal (Hawkins 2024b). Why is there no similar test for the right to refuse treatment? One answer is that it is impossible to simplify the complex balance of human rights against the particular vulnerabilities of adolescents. Older adolescents who are still considered 'minors' in law are in a developmental stage where the influence of peers can be overarching, where behaviour is routinely nudged by immersion in digital environments, but also by face-to-face encounters, including peer pressure from other patients.

Second, the law on treatment refusal is further complicated by the dynamism of developmental trajectories. In *The Children Act*,

> '[Judge Maye] listed some relevant ingredients, goals towards which a child might grow. Economic and moral freedom, virtue, compassion and altruism, satisfying work through engagement with demanding tasks, a flourishing network of personal relationships, earning the esteem of others, pursuing larger meanings to one's existence, and having at the centre of one's life one or a small number of significant relations defined above all by love' (McEwan 2014: p. 46).

Developmentally trained psychiatrists will recognise these 'goals towards which a child might grow'. Progress towards self-determination is a key task of adolescence. Skilfully supporting growth towards the goals that Judge Maye describes, usually in the coexistence of serious mental illness or neurodivergence, is at the heart of clinical practice with adolescents. It is understandable, therefore, that in case law, greater weight is afforded to the autonomy of those aged under 18 with increasing emotional and cognitive maturity.

Despite Adam's apparent maturity, Judge Maye does not allow him to foreshorten his life. Her judicial intervention overrides his autonomy, a source of dramatic tension in the novel, which mirrors clinical tensions. There is often perceptible tautness between adolescent autonomy, respect for a young patient's wishes and the paternalistic promotion of health. Psychiatrists are used to balancing respect for the autonomy of our patients with concerns about their health and safety. We also know that adolescent cognitive development may be significantly ahead of emotional development.

And yet, despite the knowledge, skills and experience that ought to place consultant psychiatrists confidently at the forefront of complex treatment refusal decisions, as a profession we sometimes struggle to transcend the divide between clinical practice and case law. In my work as an expert witness, I have observed legal issues that have been considered too late, with *post hoc* rationales appearing to be led by in-house legal teams, rather than senior clinical decision makers.

Bringing the law into case formulation

One great strength of multidisciplinary CAMHS practice is in the formulation of a case, a process defined elegantly by Ross:

> 'The biopsychosocial formulation is a creative synthesis of a clinical case, drawing on elements from the levels of biology, psychology and sociology, and expressed chronologically. Expressed more poetically, it has been said that every person's life is a

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novel, and the formulation tells the story' (Ross 2000).

I would like to propose that in an increasingly litigious clinical environment, psychiatrists should seriously consider adding medico-legal considerations to clinical formulations. Incorporating questions such as 'What are the relevant legal issues?', 'What is the up-to-date case law?' and 'What are the implications for the treatment decisions in light of that case law?' may be as important as 'What is the evidence base?' and 'What would a trusted colleague do?'.

The exposition of recent cases will inform those discussions, helping clinicians to synthesise the legal complexities that intersect with clinical decision-making. I found it valuable to do this with the fictional complex cases presented in Hawkins et al's two articles. This practice is more than a satisfying mutual exercise. It should help us to avoid group think and mutual reinforcing biases. It might even help us to think of the law not as a distant, interfering and rigid relative in our clinical practice, but as a helpful close cousin.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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Declaration of interest

None.

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