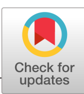

ARTICLE

Consent in minors: the differential treatment of acceptance and refusal. Part 1 Autonomy and children's rights

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SUMMARY

This is the first of two articles reviewing consent in those under the age of 18 (also referred to as 'minors' in UK law). This can be a complex issue in clinical practice because the law endows competent/capacitated minors with the absolute right to accept treatment, but a limited right to refuse. This first article summarises recent cases of refusal of treatment in minors. It uses them to ask two central questions: how do we, as clinicians, think about autonomous self-determination in minors and to what extent does the rights agenda support minors' autonomous self-determination? Autonomy as one of the principles of biomedical ethics is explored. How the minors' rights agenda supports the development of autonomy is considered. The amount of weight given in the domestic courts to the rights of minors with reference to the Human Rights Act 1998 and the United Nations Convention on the Rights of the Child is described. These considerations demonstrate the way that the courts are giving the views of the minor greater weight in decision-making in keeping with age and maturity. This article introduces the second article, which comprehensively reviews decision-making in minors, explores competence and capacity in minors and examines the differential treatment of acceptance and refusal.

KEYWORDS

Psychiatry and law; ethics; childhood experience; consent and capacity; human rights.

LEARNING OBJECTIVES

After reading this article you will be able to:

- give the key definitions of autonomy
- understand the rights agenda, in reference to the United Nations Convention on the Rights of the Child and the European Convention on Human Rights as applied to consent to treatment in minors
- understand the way that UK courts have used relevant articles of the European Convention on Human Rights and the United Nations Convention on the Rights of the Child in their judgments.

This article is the first of two exploring consent in those under the age of 18 ('minors'). Consent to treatment in minors is a complex issue. It presents challenges to clinicians principally because it affords the competent/capacitated minor the absolute right to accept treatment but a limited right to refuse. This position has attracted considerable academic discourse and critique. All clinicians exploring consent must balance two dimensions: respect for autonomy versus concerns about welfare. This article explores autonomy amidst the minors' rights agenda, as well as the credence given to those rights in the domestic courts. It provides an introduction to the second article (Hawkins 2023, this issue), which explores the 'reach' of competence/capacity in minors.

Recent cases

In 2014 P, a 17-year-old diagnosed with a personality disorder, refused life-saving hepatic support following an overdose (*An NHS Foundation Trust v P* [2014]). P was considered to have decision-making capacity. P's mother was prepared to consent to treatment on P's behalf, but the clinical team was reluctant to treat with parental consent. The court gave authorisation for P to be treated against her will:

> 'The wishes and feelings of the child, in particular those of a 17-year-old who is almost an adult, are an important consideration in the analysis of her welfare. They are not, however, decisive' (Justice Baker, para 15).

In 2019 B, a 16-year-old suffering from the life-threatening condition diabetic ketoacidosis, refused insulin (*University Hospitals Plymouth NHS Trust v B* [2019]). B was considered to have decision-making

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capacity, and yet the court gave direction that she be medically treated against her will:

> 'I have also borne in mind B's stated wishes and feelings. However, the law is clear that the court is not mandated to accept the wishes and feelings of a competent child where to honour those wishes and feelings would result in manifest, and even fatal, harm to that child' (Justice MacDonald, para 18).

In 2021 X, a 15-year-old with strong religious beliefs and understood without question to have decision-making capacity (in her case, Gillick competence), sought a rolling legal order preventing blood transfusion should she suffer a life-threatening sickle cell crisis (*Re X (A Child) (No 2): An NHS Trust v X* [2021]). The application for the order was refused:

> 'There is […] nothing […] mandating States to enforce a principle that a child, even a child who, to use our terminology, is Gillick competent or who has reached the age of 16, is in all circumstances autonomous in the sense that a capacitous adult is autonomous' (Sir James Munby, para 120).

In reading these judgments, it is abundantly clear that, should these minors have reached the age of 18, they would have been allowed to self-determine, with likely fatal consequences.

How can we, as child psychiatrists, say that we respect autonomous self-determination in children and young people when such decisions are made? How do we think about their autonomy? What are the principles, what is the guidance and how do such legal judgments read through into everyday practice? Are there any situations in contemporary practice in which we allow a child or young person with decision-making capacity a valid right to refuse, or do we simply bend the will of the child and young person to the position that we think is advisable?

Autonomy

The concept of individual autonomy and its relevance to informed consent

Autonomy is one of the four pivotal 'clusters' of moral principles in relation to biomedical ethics (Beauchamp 2013) (Box 1). It is a philosophical rather than a legal principle. Its definition provides a consistent reference point from which to examine the law in relation to minors' consent.

Dworkin (1988: p 107) noted that autonomy involved 'being more than a passive spectator of one's desires and feelings'. His philosophical definition captured the active ability to reflect on one's immediate inclinations and examine them amidst other preferences and desires (Box 2). Beauchamp & Childress (2013), expanding on Dworkin's definition, but considering autonomy in a biomedical context, analysed autonomous action in terms of their three-condition theory (Box 2). These definitions accord with the views of Berlin (2003), a doyenne of libertarian philosophy (Box 2).

Coggon (2007) thought that autonomy might be considered through three lenses (Box 3). His 'best desire autonomy' aligned most clearly with the three definitions in Box 2 – because it 'sometimes requires him to act against his immediate inclination'. 'Current desire autonomy' suggests impetuosity rather than consideration, making us 'nothing more than slaves to whim and emotion'. 'Ideal desire autonomy' embraces values outside

BOX 1 Four principles in medical ethics

- Respect for patient autonomy – respecting and supporting autonomous decisions
- Non-maleficence – avoiding the causation of harm
- Beneficence – providing benefits and balancing benefits against risks and costs
- Justice – fairly distributing benefits, risks and costs.

(Beauchamp 2013)

BOX 2 Key definitions of autonomy

Dworkin's definition of autonomy

'A second order capacity to reflect critically upon one's first order preferences and desires, and the ability to either identify with these or change them in light of higher-order preferences and values' (Dworkin 1988: p 107)

Beauchamp and Childress's three-condition theory

'We analyze autonomous action in terms of normal choosers who act

(1) intentionally,
(2) with understanding, and
(3) without controlling influences that determine their action' (Beauchamp 2013: p 104)

Berlin's concept of autonomy

'I wish to be the instrument of my own, not of other men's acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes, which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not anybody; a doer – deciding not being decided for, self-directed and not acted upon by external nature or by other men […] I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing responsibility for my choices and able to explain them by reference to my own ideas and purposes. I feel free to the degree that I believe this to be true and enslaved to the degree that I am made to realise that it is not' (Berlin 2003: p 178)

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BOX 3 Coggon's three understandings of autonomy in society

- Ideal desire autonomy – leads to an action decided on because it reflects what a person should want, measured by reference to some purportedly universal or objective standard of values.
- Best desire autonomy – leads to an action decided on because it reflects a person's overall desire given their own values, even if this runs contrary to their immediate desire.
- Current desire autonomy – leads to an action decided on because it reflects a person's immediate inclinations, i.e. what they think they want in a given moment without further reflection.

(Coggon 2007)

the self – which risks best desire autonomy being stretched by questionable universal values.

An illustrative case vignette based on our clinical practice allows these concepts to be explored (Box 4).

Informed consent is 'an individual's *autonomous authorization* of a medical intervention' (Beauchamp 2013: p 122). Although informed consent 'is a creature of law' (Dworkin 1988: p 101), in practice, responsibility for its delivery is distributed to the medical profession. It has two purposes – one clinical and the other legal (*Re W (A Minor)(Medical Treatment)* [1993]):

(a) clinical – to maximise 'cooperation […] and […] faith or at least confidence in the efficacy of treatment';
(b) legal – to provide 'those concerned in […] treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person'.

Within a medical context, it is often argued that autonomy should be afforded supremacy over other concepts and interests (Coggon 2007). The General Medical Council (GMC) holds respect for autonomy as one of its central tenets: 'You must respect your patient's right to decide' (GMC 2020).

The reach of autonomy

Different factors might interfere with 'pure' autonomous decision-making. External influence (see below) is a common culprit, but Harris (1985) described four internal 'defects' of the person with the potential to interfere:

(a) control – this relates to matters internal to the person, for example mental disorder or drug addiction, which might interfere with the ability to reflect on one's immediate wishes or inclinations; in other words, I might crave the use of a drug, while knowing that it will harm me, but I cannot impose my own control over the immediate inclination;
(b) reasoning – this relates to insufficient development of mind;
(c) information – a shortage of available information about the options self-evidently impairs choice;
(d) stability – this captures something of the changes that occur in character, preferences and choices over a lifetime: 'decisions made in one segment of life may […] seem absurd, embarrassing or just wrong, or may even be bitterly regretted later' (Harris 1985: p 199). A perception of instability is often cited as a justification for paternalistic external interference, a factor especially relevant in minors, whose choices are often viewed by observing adults as unstable (see 'Minors' rights in an evolving developmental context'). (Stability of decision-making, judgements of maturity and the reasoning capability

BOX 4 An illustrative case vignette – Bobby

Bobby is 15 and is judged to have a significant and impairing anxiety disorder. He has received cognitive–behavioural therapy and asked for a psychiatric opinion of the potential use of medication. The psychiatrist sees him with his parents, at his request, and agrees that the nature of his problem and the lack of response to high-quality therapy would support a trial of medication. She begins to share information as part of a process of consent. Bobby swiftly interjects and says 'No need for all that – just give me the pills!'

He is expressing his wishes, but he acts impetuously, seizing treatment before consideration. He could be seen as having exercised Coggon's current desire autonomy, acting with Dworkin's first-order consideration and satisfying only Beauchamp & Childress's first condition.

The psychiatrist politely insists that Bobby hears more and goes on to talk through pros and cons of treatment. Bobby's parents support him in taking breaks and coming back into the room to take in the information. While he is out of the room, it becomes clear that his parents are supportive of a trial of medication. He returns, he does not like the sound of the common side-effects but states his wish to continue a further treatment. He declines medication but says that he would like to meet again after a further period of psychological therapy.

He is now expressing his wishes, and acts having reflected on his first-order desire; he exercises Coggon's best desire autonomy and, in declining to act as his parents wish, has taken all the steps of Beauchamp & Childress's three-condition theory.

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of minors are dealt with comprehensively in the second article of this series (Hawkins 2023).

Harris (1985: p 200) concluded that 'fully autonomous individual choices' are, in a sense, an ideal notion 'which we can at best only hope to approach more or less closely'. He noted that the pursuit of autonomy should not be abandoned, but in any situation, it should be maximised. It is, as he put it, vital 'to have as much of it as possible'.

External paternalistic influence imposes 'something on another for the other's own good' – that is, 'what the paternalizer thinks to be the other's own good' (Haworth 1986: p 128). Since it interferes with decision-making, it must 'be a violation of a person's autonomy' (Dworkin 1988: p 123). In such a situation, the 'paternalizer' might justify the transgression of autonomy by using one of the other pillars of medical ethics – beneficence, non-maleficence and justice (Box 1). As minors mature, they flex their muscles of autonomy in the pursuit of competence. Their striving for independence may converge uncomfortably with the paternalistic influence of parents, and in the case of treatment and welfare decisions, that of relevant professionals. 'Confining that paternalism' without 'totally eliminating it' is the fundamental balance to find in the maximisation of minors' autonomy (Freeman 1992).

In practice, finding the balance between autonomy, well-intentioned professional beneficence and parental welfarism can be prone to pitfalls. In the case of Bobby (Box 4), while he is taking a break from the room, his parents might pressurise the psychiatrist to medicate him, leading the psychiatrist to feel that she is being coerced into a convenient but unethical position. Or the psychiatrist might take the same opportunity to impress on the parents her perception of Bobby's foolishness in not taking a treatment that she thinks is in his best interests, thus recruiting their leverage as pressure on Bobby. Both are paternalistic, and the psychiatrist should be aware of and reflective in relation to both potential pitfalls. In such a situation Bobby's autonomy would be compressed by others' values, condition 3 of Beauchamp and Childress (Box 2) would be infringed and he would no longer be acting with best desire autonomy.

Clinical situations may involve temporary incapacity and accompanying but necessary paternalistic acts. The justification for the paternalism would be akin to 'I acted to preserve your possibility of future autonomous action' (Dworkin 1988: p 116). In such situations the 'promotion of autonomy in the long run' requires 'sacrificing autonomy in the short run' (Dworkin 1988: p 116). This concept, of restricting current autonomy to protect future autonomy, is woven into the literature on paternalistic interference in minors' decision-making. Decision makers must find a crucial fulcrum here: on one hand preventing the 'manifestly' irrational act of impairing 'interests in an irreversible way' (in other words allowing minors to self-determine with fatal consequences); on the other, noting that we must respect the need for minors to 'take risks and make mistakes' as part of their developmental trajectory (Freeman 1992). Eekelaar (1986) demanded that those stepping in to make choices for minors take an 'imaginative leap'. In that leap, Freeman (1992) suggests that the threshold for paternalistic intervention would be something like 'looking back, would the child appreciate and accept the reason for the restriction imposed upon him or her, given what he or she now knows as a rationally autonomous and mature adult?'

In clinical practice, we suggest that considering the autonomy of a young person by using a checklist of questions might enable reflection on the ethical 'balance' in a case (Box 5).

Autonomy and the minors' rights agenda

The Children Act 1989, the United Nations Convention on the Rights of the Child (1989) and the European Convention on Human Rights (as instantiated in UK domestic law as the Human Rights Act 1998) all commented on minors' rights to self-determine.

Children Act 1989

When it became statute the Children Act was 'rightly [...] described as the most comprehensive reform of the law relating to children' (Walsh 1991). It was noted to be 'implicitly committed to young people's autonomy' but was 'on the whole [...]

BOX 5 Checklist enabling reflection on the autonomy of a young person and the ethical balance of decision-making

- How am I thinking about the autonomy of this young person?
- How is this young person balancing their immediate inclinations with higher-order considerations?
- Are they acting intentionally and with understanding?
- Are there any factors impairing their autonomy?
- Are those factors internal to them – control, reasoning, sufficient information and stability?
- Is there paternalistic interference from parent or professionals?
- If there is external interference, is it justified using another ethical principle?

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BOX 6 The Children Act 1989 – references to autonomous decision-making in children

- Section 38(6): As part of an interim care order, the court may direct a medical or psychiatric examination.
- Sections 43(7) and 43(8): As part of a child assessment order the court may direct a medical or psychiatric examination.
- Sections 44(6) and 44(7): As part of an emergency protection order the court may direct a medical or psychiatric examination.

In each case, should the child be of 'sufficient understanding to make an informed decision' they may refuse the examination.

ambiguous' in that commitment (Alderson 1996: p 24). Although it allowed a minor of 'sufficient understanding to make an informed decision' limited ability to self-determine (Box 6), its priority was the welfare of the child as viewed by adults. Alderson noted that at section 1 of the Act welfare was its 'paramount' principle, and although at section 1(3) the welfare checklist placed as its first item the 'ascertainable wishes and feelings of the child', no priority was given to this factor, it was just one among others. Delahunty (2019) concluded that despite the great achievements of the Children Act 1989 it had not yet risen to the challenge of 'fully respecting the child's voice'.

United Nations Convention on the Rights of the Child

In 1989 the United Nations adopted the Convention on the Rights of the Child (UNCRC), to which the UK swiftly became a signatory. Signatory status means that the UK has not yet agreed to be bound by the Convention. It has, however, agreed to proceed towards its acceptance and approval and to refrain, in good faith, from acts that would defeat the object and purpose of the Convention. Consequently, and because a formal 'claim' cannot be made against them in UK law, they remain moral, rather than legal rights as defined by MacCormick (1982). The UNCRC is being mentioned in judgments about consent and it is therefore being assimilated into the common law as case law, arguably a gentler and more coherent way to assimilate these rights into UK law than statute (Kilkelly 2011).

The UNCRC established a 'new morality for children' and presented a 'fundamental challenge to the international community' (McGoldrick 1991). Article 3 placed the welfare and best interests of children as a primary consideration, in contrast to welfare being the 'paramount' principle in the Children Act 1989. That subtle difference in wording provides a different emphasis on the gathering abilities of the child to self-determine.

BOX 7 The four fundamental values of the United Nations Convention on the Rights of the Child (UNCRC)

Article 2: Right to non-discrimination

Article 3: Primary consideration of best interests

Article 6: Right to life and development

Article 12: Right to express views

Article 12(1): States 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 of the UNCRC is regarded as one of its four 'fundamental values'. It makes plain the right of the child to express their views freely (Box 7). The key issue in terms of autonomy is the move towards the views of the child being considered and given weight in keeping with age and maturity. However, there is an absence of an unambiguous direction to follow those views. This potentially serves to prevent a minor from making decisions that may be 'contrary to his welfare' (Walsh 1991). Expression of views is not made contingent on age and maturity, but only on the capability of forming views. It is the weight to be accorded to those views that is dependent on age and maturity. This will be further discussed below in the section 'Minors' rights in an evolving developmental context'.

European Convention on Human Rights and the Human Rights Act 1998

In contrast to UNCRC rights, protections afforded by the European Convention on Human Rights (ECHR) can be contested in the UK courts because of their incorporation into the Human Rights Act 1998 (HRA). Article 8, a qualified right, obliges states to respect the individual's 'private and family life'. Following *Pretty v the United Kingdom* (2002), private and family life includes the notion of personal autonomy. Moreover, the European Court of Human Rights (ECtHR) has recognised the minor as a holder of Article 8 rights separately from the Article 8 rights of the family as a unit (*Glass v the United Kingdom* (2004)).

Minors' rights in an evolving developmental context

Article 12 of the UNCRC encompasses consent to treatment. It is recognised within it that minors

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lack the full autonomy of adults. However, in its own guidance (United Nations 2009), the UN sees the development of self-determination as a process, rather than a single act. That process is envisaged as an ongoing exchange between minors and the adults supporting them. Maturity, referred to as the 'ability to understand and assess the implications of a particular matter' is understood to be 'difficult to define' (United Nations 2009: para 30). However, its importance increases when facing situations with a greater potential for 'impact […] on the life of the child' (para 30). It is maturity, however difficult to define, rather than age, that is the key to unlocking the minors' authoritative voice (Lansdown 2005; United Nations 2009). Moreover, views when offered should be taken seriously, and the minor is 'entitled to be provided with clear feedback' on the impact of their participation (United Nations 2009: para 134(i)).

So, the UNCRC at Article 12 empowered both the participation and the autonomous self-determination of the minor. In doing so, the UNCRC in no way intended to isolate them from their family context. Indeed, it advised parents, as minors strengthen their capabilities, to 'transform direction and guidance into reminders and advice, and later to exchange on an equal footing' (United Nations 2009: para 84). The family culture it espoused was clearly one of discourse and debate, in which the views of minors are valued. This is entirely compatible with the balance found in the seminal *Gillick* case (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986]), the implications of which will be explored more fully in the second article (Hawkins 2023). The challenges of adolescence were recognised, as was the need for exposure to greater risk to acquire new skills and responsibilities (Lansdown 2005). The UNCRC, however, never intended the minor to be the 'main (or even joint) decision maker' but to be progressively galvanised by being part of a discussion which valued their opinions (Lansdown 2005: p 4). It envisaged this iterative discourse as a process of honing the authority of the minor until the point of self-determination. In the process of this maturation the UNCRC understood that family life and parental support was needed to be present to provide a safe and protected developmental context.

The interplay of Article 12 of the UNCRC with Articles 3 and 5 (Box 8) is illuminating since they together lay out the duty of the state and parents to provide protection, guidance, supervision and support. Such duties are to be exercised 'in a manner consistent with the evolving capacities of the child'. In this interplay the UNCRC achieved something the Children Act 1989 did not – it mitigated concerns about paternalistic welfarism. It described a reciprocal relationship between the development of maturity and the development of decision-making. It also invited the idea of the protective embrace of parental duty which fills the gaps of understanding and maturity for the minor until they have developed a sufficiency of both.

BOX 8 United Nations Convention on the Rights of the Child (UNCRC) – Articles 3 and 5

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.

(2) States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

Article 5:

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Two further case vignettes illustrate the utilisation of the UNCRC in clinical practice to pursue a suitable balance between Articles 5 and 12 (Box 9).

The UNCRC might be seen to present an ideal model of family life. It is accepted that the pathway through adolescence is far from ideal for many patients and families seen by child and adolescent mental health services. The Convention did, however, establish principles through which to consider the balance of decision-making in families and the locus of the decision made by, with or for the minor. It provides a useful backdrop against which to look at the autonomy of the minor and the protection of the family. It achieved this in a way that the UK parliament did not when it created the Children Act.

Minors' rights and their protection in the UK domestic and European courts

As previously mentioned, the UNCRC is ratified but awaits formal incorporation into UK law. The ECHR is incorporated into UK law by enactment of the HRA. However, as Fortin notes, 'the domestic courts are still only flirting with the idea that

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BOX 9 Case vignettes – balancing UNCRC Articles 5 and 12

Maria is 12 and suffering a non-psychotic depressive disorder. She is a single-minded but socially naive young person, seen with a mother who has suffered repeated episodes of depression and who has been treated only with medication. She sees a psychiatrist and demands to hear about medication options. The psychiatrist explains that it would be wise to have a psychological intervention before medical treatment. Maria discounts that view, insisting that her mother needed only medication and so does she.

At this point Maria has expressed her views in keeping with Article 12 of the UNCRC, but the question remains how much those views should be determinative. Her mother lets Maria know that she wishes that her younger self had not been so single-minded and set on a path of only medication options. She explains that she wishes, as a mother, to support Maria in accessing a trial of psychological treatment. In so doing, she and the psychiatrist have satisfied Article 12 and she as a mother has protectively embraced her daughter's evolving capacities and has given guidance in a clear and unambiguous fashion in keeping with UNCRC Article 5.

Ivy is 15 and suffering a similar depressive disorder. She has tried psychological therapy but did not find it useful. She sees a psychiatrist alone and requests medication for her mood. The psychiatrist wishes to offer a further psychological therapy before medication, but Ivy is insistent. She brings in her mother.

Again, Ivy's views have been heard in keeping with Article 12, but the question as to whether they should be determinative remains. Her mother listens to the two opinions and explains to the psychiatrist how hard her daughter worked in therapy and how impaired she is by her depression in the context of upcoming school examinations. The psychiatrist agrees to go ahead with discussions about medication. Ivy's Article 12 rights have been satisfied, she has been heard and the mother operated her Article 5 rights in 'a manner consistent with the evolving capacities' of Ivy and supported her in declining therapy.

BOX 10 Hearing the child's voice: balancing the ECHR Article 8 rights of the parent and child in European case law

Sahin v Germany (2003) involved a father claiming that the court's decision to refuse access to his child had been a breach of his right to private and family life under Article 8 of the European Convention on Human Rights (ECHR). The parents were separated and the mother disliked the father so intensely that, it was asserted, contact would happen in an emotionally charged atmosphere that would be harmful to the child. Contact had been stopped when the child was aged 2. No violation of Article 8 was found. In this case the child was not heard in court. But the court noted that hearing a child's voice directly in court would depend on the circumstances of the case, having due regard to the age and maturity of the child.

Sommerfield v Germany (2003) also involved a father claiming breach of his ECHR Article 8 rights, having been separated from the child's mother and refused contact. The separation happened when the child was 5 years of age and the mother remarried, with the child and the stepfather developing a close relationship. At age 10, 11 and 13, the child had been heard in court and directly expressed her wish not to have contact with her birth father. To force her to do so was assessed as likely to cause serious psychological disturbance. No Article 8 infringement was found.

Para 64 of *Sommerfield v Germany*:

'Article 8 requires that the domestic authorities should strike a fair balance between the interests of the child and those of the parents and that, in the balancing process, particular importance should be attached to the best interests of the child which, depending on their nature and seriousness, may override those of the parents.'

children are rights holders' and even over a decade following the inception of the HRA, she describes the situation for minors as 'two steps forward, one step back' (Fortin 2011).

A settled view is emerging from the ECtHR that in cases involving children, their voice should be heard directly, and considered. Moreover, where the ECHR Article 8 rights of both the parents and a child are at stake, the child's rights and best interests must be part of the balance and may override those of the parent (Box 10 and Hawkins 2011).

Despite Fortin's (2011) gloomy appraisal (outlined above) of the appreciation by courts of minors' rights, the UK courts are not silent on the matter of minors' UNCRC and ECHR rights. She noted that in some legal jurisdictions, notably education, the judiciary are 'perfectly at ease' in enunciating the rights of minors. Although UK courts can be hesitant, judges are 'reading' rights-based terminology and the guidance of the UN and ECtHR into cases involving autonomy and consent to treatment.

Re (Axon) v Secretary of State for Health (Family Planning Association Intervening) [2006] is generally understood to be a post-HRA review and ratification of the epoch-making *Gillick* [1986] judgment. (These judgments and their full implications are further considered in the second article (Hawkins 2023)). The judge in the *Axon* case noted that 'the European Convention attaches great value to the rights of children'. He also observed 'the general movement towards giving young people greater rights concerning their own future whilst reducing the supervisory role of parents'. *Axon* was thus significant in clearly advocating for minors' ECHR Article 8 and UNCRC Article 12 rights within the UK judicial system.

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Fortin (2011) lamented the fact that more cases involving consent were not brought by minors themselves before the UK courts. She noted that 'few desperately ill adolescents will feel sufficiently litigious to bring a legal challenge'. Hence the low number of such cases.

In the past decade there have been a few such cases. Two of them (P and X) and their judgments were mentioned at the beginning of this article. In relation to the topic of the current section of the article, in both cases the young person's UNCRC and ECHR rights were read into the judgments as follows.

In *An NHS Foundation Trust v P* [2014] the young person's ECHR Article 8 rights to self-determination were considered but were outweighed by her ECHR Article 2 right to life.

In *NHS Trust v X* [2021] the judge confronted the challenge before the court that the principle of autonomy had superseded medical paternalism. The young person's UNCRC and ECHR rights were examined. The judge used the right to life inherent in the ECHR and UNCRC to justify overriding her ECHR Article 8 rights to self-determination.

In practice, as with autonomy (Box 5), we suggest consideration of the young person's rights by using a checklist of questions (Box 11).

Discussion

This article reviews the concept of autonomy in minors, its consideration in the minors' rights agenda and the way that those rights are being read into case law judgments regarding consent to treatment. It is accepted that pure or perfect autonomous decision-making is rarely possible, even in adulthood. At any age, the more realistic aim should be maximisation of autonomy. In relation to minors' rights, the UK courts are slowly overcoming their diffident start and beginning to use rights-based language in their determinations, underpinned by the application of the UNCRC, HRA and Mental Capacity Act 2005. While minors move 'towards' having the maturity to be maximally autonomous, clinicians need to be aware of their autonomy and the ethical balance of clinical cases and to consider that balance with reference to the rights agenda.

This article forms the foundation for the second article (Hawkins 2023), which uses the key threads discussed here as a lens to examine the current position at law in relation to acceptance and refusal of treatment in minors.

BOX 11 Checklist enabling reflection on respect for a minor's rights in a clinical context

- What are the European Convention on Human Rights (ECHR) Article 8 considerations in this case?
- How do the ECHR Article 8 rights of this young person sit with the Article 8 rights of the family?
- Have the UN Convention on the Rights of the Child (UNCRC) Article 12 rights of this young person been considered?
- Has the young person had an opportunity to participate in their care and decision-making?
- Has the young person had feedback on the effect of their participation and the weight given to their views and wishes?
- Have the young person and family understood the way that professionals have 'balanced' rights?

MCQ answers
1 e 2 a 3 d 4 d 5 d

Author contributions

T.H.: lead author, initially developing the original article from his Masters in Mental Health Law dissertation. M.C.: involved in the design of the article, acquisition and analysis of additional information, and lead on developing and critically revising drafts for the final draft. T.A.: involved in the design and conception of the article, provision of comment on drafts of the final article and the development of the MCQs.

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Declaration of interest

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MCQs

Select the single best option for each question stem.

1 Which of the following is not one of four internal 'defects' of the person with the potential to interfere with individual autonomy described by Harris?
- a control
- b reasoning
- c a shortage of available information
- d stability
- e perception.

2 With regard to the Children Act 1989:
- a it was described as the most comprehensive reform of the law relating to children
- b priority was given to the ascertainable wishes and feelings of the child
- c it was described as having risen to the challenge of fully respecting the child's voice
- d it gave the minor absolute decision-making authority
- e it placed the welfare and best interests of children as a 'primary consideration' but not the 'paramount' principle.

3 With regard to the UN Convention on the Rights of the Child (UNCRC):
- a the rights it claims on behalf of children are incorporated in UK statute
- b the rights it claims on behalf of children are legal rights
- c the UK is not a signatory
- d it illustrates a key issue in terms of autonomy, as a move towards the views of the child being considered and given weight in keeping with age and maturity
- e it sees minors' involvement in self-determinism as a single act, rather than a process.

4 The concept of autonomy:
- a emphasises being a passive spectator of one's desires and feelings
- b emphasises not independence, but interdependence
- c emphasises neither independence nor interdependence
- d emphasises not interdependence, but independence
- e is one of the five pivotal clusters of moral principles in biomedical ethics.

5 In relation to the European Convention on Human Rights (ECHR) Article 8 rights of minors:
- a minors are considered rights holders only as part of the Article 8 rights of the family
- b Article 8 does not include autonomy
- c when Article 8 rights of a parent and a minor are at odds, the parents' Article 8 rights always prevail
- d Article 8 encompasses autonomy
- e Article 8 rights of minors are never mentioned in legal judgments.

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