Assessing Gillick competence

Recently released figures from the Office for National Statistics (2016) show that some 4160 girls under 16 became pregnant in England and Wales in 2014. To manage teenage pregnancies effectively, midwives must be able to assess the child's competence to consent to their maternity care.

The United Nations Convention on Children's Rights defines a child as any person under 18. It requires that childhood is recognised as a developmental period and that our domestic laws must be developed 'in a manner consistent with the evolving capacities of the child' (United Nations, 1989). As children grow and develop in maturity, their views and wishes must be given greater weight and their development towards adulthood must be respected and promoted.

This key principle is reflected in consent law as applied to children. Kennedy and Grubb (1998) argue that children pass through three developmental stages on their journey to autonomous adulthood:

- The child of tender years who relies on a person with parental responsibility to consent to treatment.
- The Gillick competent child
- Young persons 16 & 17 years old who are able to consent to treatment as if they 'were of full age' (Family Law Reform Act, 1969; Mental Capacity Act, 2005)

The Gillick competent child

The issue over whether a girl under 16 has the necessary competence to consent to maternity care was decided by the House of Lords in *Gillick v West Norfolk and Wisbech AHA* (1986), when a mother of girls under 16 objected to Department of Health advice that allowed doctors to give contraceptive advice and treatment to children without parental consent. Their Lordships held that a girl under 16 had the legal competence to consent to examination and treatment if they had sufficient maturity and intelligence to understand the nature and implications of that treatment.

'Gillick competence' is the term used by judges and health professionals to identify girls aged under 16 who have the legal competence to consent to midwifery examination and treatment, providing they can demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of action.

Assessing Gillick competence

Midwives must be able to confidently apply the rule in *Gillick* if the child's right to consent to treatment is to be fulfilled. The aim of Gillick competence is to accurately reflect the transition of a child into adulthood. Legal competence to make decisions is conditional on the child's gradually acquisition of both:

- maturity — that takes account of the child's experiences and the child's ability to manage influences on their decision making such as information, peer pressure, family pressure, fear and misgivings
- intelligence — that takes account of the child's understanding, ability to weigh risk and benefit, and consideration of longer term factors such as effect on family life and on such things as schooling

Maturity is a developmental process. It considers the emotional and mental age of the child as opposed to their chronological age. In normal development, it does not fluctuate from day to day or week to week. A relatively young child would have sufficient maturity and intelligence to be competent to consent to a plaster on a small cut. Equally a child who had competence to consent to contraceptive advice may lack competence to consent to a termination of pregnancy *(Re R (A minor) (Wardship Consent to Treatment)*, 1992).

Decision-making competence does not simply arrive with puberty; it depends on the maturity and intelligence of the child and the seriousness of the treatment decision to be made.

When assessing Gillick competence, midwives are evaluating a child's maturity and intelligence in relation to their:

- Ability to understand that there is a choice to be made and that choices have consequences
- Willingness and ability to make a choice (including the option of choosing that someone else makes those decisions)
- Understanding of the nature and purpose of the care and treatment
- Understanding of the risks and potentially adverse effects
- Understanding of any alternatives to the procedure and the risks attached to them
- The consequences of no intervention
- Wider long-term consequences in relation to their family, schooling and welfare
- Freedom from pressure

Specific factors

Midwives must ensure that their assessment of a child's competence is developmentally appropriate. A child's ability to understand language changes with age and so midwives must tailor their communication with the

Richard Griffith
Senior lecturer in health law, College of Health Science, Swansea University
richard.griffith@swan.ac.uk

child to take account of this during the assessment of competence.

Larcher and Hutchinson (2010) suggest that external influences can also have an impact on the assessment of a child's competence. An adult family member with strong views can significantly influence a child's ability to make the free choice required for a valid consent and a midwife must consider whether a child is being unduly influenced during the assessment process. They further suggest that midwives take account of the child's emotional state and its impact on the child's ability to make decisions. A child's ability to fully attend or to process and recall information can be compromised if they are very anxious.

Where, on balance, a midwife is satisfied that a child is Gillick competent then the consent is as effective as that of an adult and treatment can proceed. It cannot be overruled by a parent *(R (on the application of Axon) v Secretary of State for Health*, 2006).

Conclusion

Consent is essential to the propriety of treatment and is necessary to meet the requirements of the law. Midwifery care cannot generally proceed without it.

The United Nations Convention on the Rights of the Child requires that the evolving capacities of children are respected and this requirement is reflected in the law of consent where a child with the necessary maturity and intelligence can give valid consent to examination or treatment.

Midwives must be confident in assessing Gillick competence in order to ensure that the child's rights are respected. That assessment of Gillick competence requires the midwife to evaluate the child's maturity and intelligence when seeking consent. In doing so the midwife must be satisfied that the child understands that there is a decision that needs to be made, that decisions have consequences, that the child understands both the benefits and risks of treatment and the possible wider implications of the treatment. Whilst Gillick competence does not simply materialise along with puberty and midwives cannot simply assume a child is Gillick competent, it is not an overly time-consuming process when undertaken confidently and competently. **BJM**

Family Law Reform Act (1969) Section 8. www.legislation.gov.uk/ukpga/1969/46/section/8

Gillick v West Norfolk and Wisbech AHA, 1986. AC 112 (HL); 1

Kennedy I, Grubb A (1998) *Principles of Medical Law.* OUP, Oxford

Larcher V, Hutchinson A (2010). How should paediatricians assess Gillick competence? *Archives of disease in childhood* **95**(4): 307-311

Mental Capacity Act (2005). Section 1. www.legislation.gov.uk/ukpga/2005/9/part/1

Office for National Statistics (2016) *Conceptions in England and Wales: 2014. Annual statistics on conceptions covering conception counts and rates, by age group including women under 18*. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2014 (accessed 28 March 2017)

R (on the application of Axon) v Secretary of State for Health, 2006. EWHC 37

Re R (A minor) (Wardship Consent to Treatment), 1992. Fam 11 (CA); 1

United Nations (1989) *Convention on the Rights of the Child adopted under General Assembly resolution 44/25*