COMMENTARY

GILLICK REINSTATED: JUDGING MID-CHILDHOOD COMPETENCE IN HEALTHCARE LAW - *An NHS Trust* v *ABC & A Local Authority* [2014] EWHC 1445 (Fam).

SUMMARY

This case commentary discusses a recent case concerning the competence of a 13 year-old girl to consent to the termination of her pregnancy. It critically analyses four specific elements of the judgment - *Gillick* competence, the impact of best interests, judicial deference to medical opinion, and individualism and the construction of undue influence. It concludes by commending the approach taken by the court as a reinstatement of the law as originally intended in *Gillick* but is nonetheless cautious as to its likely overall effect upon child decision-making.

KEY WORDS

ABORTION
BEST INTERESTS
CHILDREN'S DECISION-MAKING
GILLICK COMPETENCE
MEDICAL OPINION
RELATIONAL REASONING

I. INTRODUCTION

The short case of *An NHS Trust* v *ABC & A Local Authority,*[1] appears, at first glance, to contain little more than a declaration from the High Court concerning the competence of a young person, *A*, to make a decision about her own healthcare. Yet its interest lies in the promising signs pertaining to the recognition of adolescent competence. Although in general, case law tends to address the most difficult or novel cases that would perhaps not be representative of the daily decision-making that

1 [2014] EWHC 1445 (Fam).

occurs within the context of the family, the doctors surgery or hospital ward, *ABC* marks the first time that a *court* has held a child as young as *A*- barely aged 13, to be *Gillick* competent. However, I contend that in so doing, the court overlooked the relational considerations that are especially important in mid-childhood decision-making.

The judgment contains four key features that will be discussed in this commentary. First, *ABC* shows that despite academic disquiet over the theoretical coherence of *Gillick* [2] and past judicial reticence about practically applying it,[3] a test for competence *can* be constructed wherein children as young as 13 can meet the criteria, even in an area as potentially controversial as abortion. Second, the judgment represents a striking departure from past case law. By placing a square focus upon *Gillick* competence, it correspondingly sidelines enquires into 'best interests' traditionally seen in cases concerning children in mid-childhood.[4] Third, despite such forward-thinking, the court took a traditional individualised and medicalised approach to establishing *A's* competence, which consequently raises questions about the place and weight of medical opinion in the process of judicial decision-making. Fourth, accordingly, the judgment failed to fully take on board *A's* relational interests, particularly the value that lay in her relationships with and responsibilities to, her parents and grandmother and the wider community. Rather, the court viewed her as an unconnected individual,[5] whose decision-making must remain untainted by familial 'influence'.

In contrast, advocates of a relational model of decision-making consider that a person's competence is constructed within the web of relationships that surround them,[6] that relational influence and collaboration is a practical reality of decision-

[2] For example: Stephen Gilmore and Jonathan Herring, '"No" is the Hardest Word: Consent and Children's Autonomy' (2011) 23 Child & Family Law Quarterly 3.

[3] *Re E (A Minor) (Wardship: Medical Treatment)* [1992] 2 FCR 219; *Re R (A Minor) (Wardship: Consent to Treatment)[1992] Fam 11, [1991] 4 All ER 177,* [1992] 2 FCR 229; *Re W (A Minor)(Medical Treatment)* [1992] 4 All ER 627, [1993] Fam 64; *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810, [1999] 2 FCR 524**.**

[4] I shall define 'mid-childhood' as between the ages of 8 and 14 years old.

[5] See Martha Fineman, 'The Vulnerable Subject and The Responsive State' [2010] 60 Emory Law Journal 251.

[6] Jennifer Nedelsky, *Laws Relations: A Relational Theory of Self, Autonomy and Law* (2012 OUP).

making[7] and that the impact of the decisions on those relationships is of ethical importance.[8] I argue that a consideration of relational interests is all the more vital in mid-childhood, as it is a period characterized by Samantha Brennan as the 'messy but morally important' reality of children who are neither completely dependent nor fully autonomous.[9] This is an area that has been under theorized in the academic literature and largely ignored in the courtroom, yet it raises profound questions concerning the nature of vulnerability, the value of bodily integrity, the importance of relational identity and the value of collaborative decision-making. A consideration of these issues, would have enriched the decision-making process in this case and I propose to discuss them in the light of the above four features that were prominent in the case.

II. BACKGROUND

The starting point when considering decisions relating to the upbringing of a child aged under 16, or the administration of her property, is the Children Act 1989. Section 1(1) states that when a court is called upon to determine such questions, the child's welfare shall be the court's paramount consideration. In order to assist with the determination of the child's welfare, s1(3) of the Act provides a 'welfare checklist' of factors which the court shall have regard to. Further, the welfare or 'best interests' principle can be seen to underpin the operation of the courts inherent jurisdiction,[10] and is enshrined in International Conventions such as the United Nations Convention on the Rights of the Child 1989 (UNCRC). Article 3 (1) states that:

> 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.

However, the test for determining the competence of children aged under 16 to make such decisions for themselves has not been addressed in legislation. In contrast to the

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[7] David Archard, 'Children, Adults, Best Interests and Rights' (2013) 13(1) Medical Law International 55, 60.

[8] Jonathan Herring, *Family Law* (5th edn, 2011 Pearson Education Ltd) 40.

[9] Samantha Brennan, 'Children's Choices or Children's Interests: Which do their Rights Protect?' in David Archard and Colin Macleod (eds), *The Moral and Political Status of Children* (2002 OUP) 65.

[10] See *Re R* and *Re W* (n3).

position of children aged 16 and 17, which is governed by the Family Law Reform Act 1969,[11] for those under 16 the common law prevails, as demonstrated in the leading case of *Gillick v West Norfolk and Wisbech AHA*.[12] The case involved a challenge by Victoria Gillick to the legality of a memorandum of guidance issued by the Department of Health and Social Security to doctors. It stated that they might, in exceptional circumstances, provide contraceptive advice and treatment to girls aged under 16 without parental consent. The judgment of Lord Scarman sums up the majority opinion, that

> (…) the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when, the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[13]

In addition, Lord Scarman asserted that the child must also have 'sufficient maturity' to understand the moral, family, emotional and long-term health implications of her decision. Lord Fraser's approach differed in that he set out a checklist of five factors (the Fraser Guidelines) for doctors to consider in determining whether the child has reached the level of competence required. These hinge on the child's comprehension of the medical advice and require the proposed treatment is in her best interests. For those children who do not meet the threshold for competence, the best interests test continues to apply.

Whilst *Gillick* was hailed as 'remarkably enlightened' in its recognition of the autonomy of children,[14] it has come under increasing strain.[15] As a decision that was made in the specific context of contraceptive advice and treatment, it has been applied to an ever-wider range of scenarios. In these subsequent cases however, it became apparent that judges were reluctant to allow even older adolescents to make determinative decisions. Instead, judges either acknowledged the child's competence

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[11] S8(1) sets out the position that those aged 16 or above are presumed to have the same capacity to consent to their own medical treatment, as if they were adults.
[12] [1986] 1 FLR 224, [1986] AC112, [1985] 3 WLR 830
[13] ibid 189.
[14] Jane Fortin, *Children's Rights and the Developing Law* (2009 CUP) 8. 94.
[15] Emma Cave, 'Goodbye *Gillick*? Identifying and resolving problems with the concept of child competence' (2014) 34(1) Legal Studies 103,105.

but overrode it in the name of best interests,[16] or manipulated the criteria for competence so that the bar was set so high that it was easy to find the child incompetent.[17]

Of course, human rights claims in relation to children's decision-making have been on the agenda since the UK ratified the UNCRC in 1991.[18] Article 12 of the Convention mandates that children capable of forming their own views should be enabled to participate in decision-making in accordance with 'the age and maturity of the child'. This shift in focus has been evidenced in some of the recent case law relating to mid-childhood healthcare decisions where children's voices are more often heard and where judges are much clearer about the importance and weight of children's wishes.[19] This accords with the general trend in the law of greater judicial acceptance of human rights concerns, as required by the Human Rights Act 1998. As Emma Cave contends, such mounting recognition makes the difficulties of *Gillick* all the more pertinent.[20] Yet discussions of rights have largely remained cursory. Until *ABC* judicial reluctance to deem children competent meant that rights were inevitably trumped by welfare concerns.[21] *ABC* marks a clear change of approach.

III. THE CASE – FACTS AND REASONING

The facts of the case are very straightforward. At the time of the hearing on 21st March 2014, *A* was aged 13 years and 1 week. She was living with her parents in the North of England. Four days prior to the hearing, *A's* grandmother had taken *A* to the local GP's surgery after noticing that she had a 'bump at her waist'.[22] A pregnancy test confirmed that she was pregnant. The following day a consultant paediatrician examined *A* and referred her for a scan, which dated her pregnancy at over 21 weeks. *A* expressed her wish to terminate her pregnancy. The case therefore became urgent as *A* was less than 3 weeks away from the 24-week cut off point for termination of pregnancy under ground (a) of section 1(1) Abortion Act 1967. *A* was seen by a

[16] See *Re R; Re W* (n3)*; Re P (A Child)* [2014] EWHC 1650 (Fam).
[17] See *Re E; Re L* (n3).
[18] See also *R (on application of Axon)* v *Secretary of State for Health* [2006] EWHC 37 (Admin), which approved *Gillick*, post the HRA 1998 and in the context of abortion.
[19] See for example, *Re S* (*A Minor)(Refusal of Medical Treatment)* [1995] 1 FCR 604; *Re M (A Child)(Medical Treatment)* [1999] All ER (D) 798; *F* v *F* (n25).
[20] Cave (n15) 104
[21] See *Re C & F (Children)* [2003] EWHC 1376 (fam), para 298.
[22] *ABC* (n1) para 3.

consultant obstetrician and gynaecologist, and a senior midwife. The Trust Safeguarding Team also reviewed the case. Due to the fact that *A* was found to be 'uncommunicative' during these meetings, the healthcare professionals raised doubts concerning her competence.[23] They applied to the High Court for declaratory relief, in order to determine if she possessed the appropriate competence, 'so that the position is put beyond doubt', or in the event that the court found that she lacked competence, that it would be in her best interests to terminate the pregnancy.[24]

The judge in the case, Mostyn J, began by focusing in on the question of *Gillick* competence, citing Lord Fraser's construction of the test that the child will be competent to consent if 'she has sufficient understanding and intelligence to know what they [the proposed treatments] involve.' [25] He relied heavily upon the medical evidence from an interview on the day of the hearing between consultant psychiatrist Dr Ganguly and *A* (a transcript of which was appended to the judgment). In that interview *A* had expressed a 'clear and persistent' wish that her pregnancy be terminated as 'she could not cope with its continuance and it would stress her to a considerable degree'.[26] Mostyn J held that he was fully satisfied that *A* understood the options open to her, the risks attached to them and their implications. He concluded that *A* did meet the threshold to be deemed competent and as such it would 'now be for A to decide what she wishes to do'.[27]

IV. CRITICAL ANALYSIS

A. Gillick Competence

The judgment is to be applauded for its unambiguous stance on the determinative impact of a finding of competence, summed up in the assertion by Mostyn J that '(…) if I am to determine that A does have sufficient understanding and intelligence to know what a termination would involve, then that is the end of the matter'.[28] It could be said that the judgment marks a return to the test for competence as it was initially framed in *Gillick*. It is certainly in the spirit of respect for the child's participatory

[23] ibid para 8.
[24] ibid para 6.
[25] Gillick (n12) 239.
[26] *ABC* (n1) para 13.
[27] ibid para 15.
[28] ibid para 9.

rights as posited in the UNCRC [29] and CA 1989.[30] Within the judgment may also lie a pragmatic recognition of children's increased ability to access information relevant to the decision via modern technology, combined with the fostering of an environment within the legal process in which children are more willing and able to share their viewpoint. Further, allowing the competent child to chose for herself whether or not to have a termination, acknowledges the 'deeply personal' nature of the potential procedure.[31] It also reflects the child's interest in bodily integrity, and respects the notion that in mid-childhood, emotional connection to bodily experience and the impact of the body upon individual self-identity becomes increasingly important.

However, it is questionable on the evidence in this case whether *A* was indeed competent. This, of course, is dependent upon the interpretation of the requirements laid out in *Gillick*. The court in *ABC* used only part of Lord Fraser's test in focusing on whether *A* had 'sufficient understanding and intelligence'. Yet it omitted to consider Lord Scarman's fuller test of competence, which, whilst criticised as requiring a child to show 'greater decision-making skills than the law requires of adults (…)',[32] many consider to constitute the ratio of the case.[33] In the context of abortion Lord Scarman's requirement to include the 'moral and family questions' might require, for example, a consideration of the wishes of the family and the impact of the decision upon their relationship with the girl, the girl's religious or cultural values, the social and emotional impact of the decision, and the implications of either a termination or continued pregnancy upon the girl's future plans. In *ABC* however, evidence from Dr Ganguly apparently focuses upon the biological aspects, by claiming that *A* 'certainly had a good understanding of the fact that she was pregnant and what it involved', whilst neglecting to enquire about relational matters. Indeed, it is noteworthy that Dr Ganguly's method of assessing A's competence by verifying that 'she was able to (…) understand it because she was able to recount', that '(…) she was able to retain the information and tells us what these options were' and that 'she had sufficient option to check out anything that she did not understand (…)',[34]

[29] Article 12.
[30] See S1(3)(a).
[31] Jonathan Herring, 'Children's Abortion Rights' (1997) 5 Medical Law Review 257, 261.
[32] Sarah Elliston, *The Best Interests of the Child in Healthcare* (2007 Routledge-Cavendish) 83.
[33] See *Axon* (n18).
[34] Transcript of Dr Ganguly's evidence.

appears to be much more like the criteria used to determine the capacity of adults under the Mental Capacity Act 2005[35] than those contained in *Gillick*.

Further, it is apparent that allowances were made in the level of understanding required of *A* – for instance Dr Ganguly notes 'whether she understood everything in great detail is questionable, because she is after all, 13 years old',[36] which may conflict with the adult nature of the decision in question. This may be seen as a justified relaxation of the standard for competence, again in the spirit of the MCA where S 3(2) states that a person is not to be construed as unable to understand information relevant to a decision, if it is explained to her using simple language. However, it must be remembered that the MCA test is *not* currently the legal test for determining child competence. This hybrid approach of the court that claims to follow *Gillick* yet accepts medical evidence that appeared to be based upon the MCA criteria,[37] may be indicative of both a judicial acknowledgment of the theoretical incoherence of a strict construction of *Gillick* combined with a pragmatic recognition of the ambiguities of applying it within clinical practice. It certainly stands in contrast to other recent case law on *Gillick* competence, for instance the 2013 case of *F* v *F.*[38] Here Theis J held that a 15 year old girl was 'too naïve' in her views to be competent to refuse consent to the MMR vaccination, even though the procedure proposed was merely preventative healthcare and her refusal was based on her sincere vegan principles.[39] The approach in *ABC* may be seen as a vindication of Cave's recent argument that a strict construction of *Gillick* is an 'inadequate tool' for the court's task of adjudicating between the complexities of protecting welfare and promoting autonomy.[40] I agree with her that a more consistent approach would be to apply the MCA to people of all ages and this could be combined with an additional common law test to protect against the factors that render some adolescents 'functionally incapacitated'.[41] Cave posits a test operating under the court's inherent jurisdiction when 'necessary and proportionate' to guard against the effects of immaturity and

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[35] Mental Capacity Act 2005 s3.
[36] Transcript (n35).
[37] See Victoria Chico and Lynn Hager, 'The Mental Capacity Act 2005 and Mature Minors: A Missed Opportunity' (2011) 33(2) J Soc Welfare & Fam L 157, for a discussion on the use of the MCA for minors.
[38] *F* v *F* [2013] EWHC 2683 (Fam).
[39] ibid para 22 (2).
[40] Cave (n15) 104.
[41] ibid 119-120.

undue influence.[42] I suggest that such a test constructed to consider and protect the child's relational interests, as explored in Section D below, may be the way forward.

B. Best Interests

Mostyn J's reading of the relationship between *Gillick* competence and best interests was also unambiguous, as he noted that if the child reached the required threshold, then she could lawfully make a decision 'even if the result of that would lead her to take steps which are wholly contrary to her best interests'.[43] His subsequent assertion that 'the question of best interests does not really inform the primary decision I have to make, which is whether she has the necessary capacity', may be a truer interpretation of the purpose of the judgment in *Gillick* but stands at odds with the judicial caution that characterises the previous case law.[44] For example, in *Re W* Donaldson LJ claimed that maximizing the child's participation must be subject to the restraints of 'prudence' in the name of welfare,[45] whilst Nolan LJ acknowledged the court's duty to defend a competent child's right to make her own decision, but singled out medical treatment as an area where 'the court can and sometimes must intervene'.[46] One interpretation of *ABC* is that the court was making a genuine statement that the competent child should be treated in the same "present-facing" manner as adults. This would allow them to make decisions, as can adults, which are ultimately not in their best interests but respect the reality of their present situation or viewpoint – in other words the right to make their own mistakes. This is in contrast to the future-orientated, protectionist stance traditionally adopted in children's decision-making.[47]

The fact that *ABC* concerned termination of pregnancy may have made the decision simultaneously trickier and simpler than it might otherwise have been. On the former, I concur with Jonathan Herring that it is difficult to come to an objective decision about best interests in the context of abortion given the strong and often polarized views about the issue, resulting in 'no real consensus on what is best for a child in any

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[42] ibid 121.
[43] *ABC* (n1) para 10.
[44] ibid
[45] *Re W* (n3) 81
[46] ibid 93.
[47] Cave (n19) 111.

particular case'.[48] This is illustrated in the transcript of the evidence of Dr Ganguly, where Mostyn J asks for his opinion on which option - termination or continuation of pregnancy, would be best for *A's* mental health. As a child psychiatrist, the doctor was well-placed to answer. However, he declined to make a clear assessment, stating that it was a 'very difficult thing to comment on' and merely reiterated *A's* view that she 'would not be able to cope'.[49] The fluidity in the notion of 'best' in the context of abortion decision-making is graphically illustrated in the recent case of *X (A child).*[50] Based upon 13 year-old *X's* 'unambiguous hostility' to the prospect of abortion, all of the medical experts gave evidence that it would not be in her best interests for her pregnancy to be terminated.[51] Yet when she apparently changed her mind during the course of the hearing, the court was quick to deem that a termination *would* be in her best interests. The only issue that had changed was the child's views - a 13 year-child who had been declared to be incompetent to decide for herself due to her low IQ and limited vocabulary.[52]

Yet, a more cynical interpretation is that *ABC* is really a best interests decision, dressed up in autonomy language. The judgment appears to be underpinned by a social policy assumption that 13 year-olds should not be parents. Such an argument was seen in the earlier abortion case of *Re B,* where a consultant pediatrician gave evidence that it is 'highly undesirable' for a young adolescent to continue with a pregnancy.[53] The fact that *A's* wish to undergo a termination appeared to accord with not only medical and local authority viewpoints, but also this larger, unspoken, public interest may have made the finding of competence by the court somewhat easier.

C. Judicial Deference to Medical Opinion

Whilst progressive in its approach to *Gillick* competence, in *ABC* we see a re-emergence of judicial deference to medical opinion. Three times in the mere 18 paragraph judgment Mostyn J claims that his attempts to summarise the seemingly straightforward psychiatric evidence would 'not do justice to [its] clarity',[54] 'may lead

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[48] Herring (n31) 261.
[49] Transcript (n35)
[50] [2014] EWHC 1871 (Fam)
[51] ibid para 14
[52] ibid para 13.
[53] *Re B (Child: Termination of Pregnancy)* [1991] FCR 889, 894.
[54] *ABC* (n1) para 11

to its full impact being lost'[55] and was done 'probably inadequately'.[56] This incertitude leads the judge to deem it necessary to append the full transcript of Dr Ganguly's evidence to the judgment. It is possible to see this not a matter of deference in the traditional sense of an unquestioning reliance upon medical opinion,[57] but rather a respect for the expertise of the medical professional. Yet, whilst it is true that Mostyn J did clearly acknowledge that Dr Ganguly was a 'consultant psychiatrist of some considerable experience', [58] it *is* questionable how far a simple assessment of capacity is a matter of medical expertise. From the transcript we see that the psychiatrist had never made a formal assessment of competence in a court setting,[59] and as noted above, found it difficult to make any clear assessment of what was best for *A's* mental health. This indicates the artificial nature of judicial determination of competence, which is but one moment "frozen in time", and stands at variance with the routine capacity assessments that take place 'day in and day out' as part of clinical practice.[60] Furthermore, Mostyn J's reliance is out of step with a more recent trend, as identified by Muireann Quigley, for deference to medical opinion to be supplanted by a form of deference to *judicial* opinion on issues such as capacity and best interests.[61] Although Quigley deems this trend 'worrying',[62] I suggest that on matters which do not require particular medical expertise, as is often the case in capacity assessments, that the judge is probably better placed to consider the full scope of the moral, social, relational and participatory issues as compared to the doctor who will primarily be focused upon clinical interests.

What in fact may be at the root of this 'deference' is a regrettable but somewhat understandable process of mutual legitimization. Underlying the judgment is the suspicion that the case was bought as a result of fear on the part of clinicians about negative public reaction, although ultimately no such reaction was evident in media

[55] ibid para 12
[56] ibid para 15.
[57] See Muireann Quigley, 'Best Interests, the Power of the Medical Profession and the Power of the Judiciary' (2008) 16 Health Care Anal 233.
[58] *ABC* (n1) para 11.
[59] Transcript (n35).
[60] ibid
[61] Quigley (n58) 236.
[62] ibid

reporting of the case.[63] Mostyn J had clearly stated the purpose of the declaration was not so much a statement of respect for *A's* autonomy, than a means whereby 'any later criticisms of the Trust, in taking the steps that they did, can be deflected'.[64] This is a reversion to the provision of the judicial 'flakjacket' posited by Lord Donaldson in *Re W*,[65] where law is being used by doctors as a means of reinforcing their judgments.[66] Equally to be regretted is the court's over-reliance upon medical evidence, to provide 'scientific legitimacy' to a judgment on a morally contentious subject.[67]

D. Individualism and the Construction of Undue Influence

In *ABC* the court construed the test of competence for *A* in a very individualistic way and was keen to stress that the decision was 'hers alone'. [68] This stance is also evidenced by Mostyn J's assertion that his consideration of how *A* might deal with the consequences of her decision within the context of family support was actually 'irrelevant to the primary decision' of competence'.[69] Focusing purely on competence, as an 'all or nothing' issue within the context of abortion obscures the reality that girls in mid-childhood may be competent concerning some aspects of the abortion decision but may need support to make decisions on others.[70] Whilst the MCA s1(3) states that for adults' all practicable steps' must be taken to help a person make a decision and subsequent case-law has confirmed that the test for capacity in adults is issue specific,[71] for children the need for support or desire to consider the impact on others, has been construed as a sign of incompetence.[72] In contrast, the second half of Lord Scarman's test discussed in Section A above, highlights the desirability of relational thinking when considering decision-making by children.

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[63] See Shoba Rao, news.co.au (10 May 2014). The headline was later changed to 'Thirteen year old girl gets legal right to decide to have an abortion for the High Court in London'; Suespicious Minds, 'Thirteen year old has the capacity to terminate pregnancy' (12 May 2014*)* *<suespiciousminds.com/2014/05/page/2/>* Last accessed 16 July 2014.
[64] *ABC* (n1) Para 6
[65] *Re W* (n3) 785.
[66] Andrew Bainham and Stephen Gilmore, *Children: The Modern Law* (4th edn 2013 Family Law) 342.
[67] Elliston (n32) 18.
[68] *ABC* (n1) para 14.
[69] ibid para 16.
[70] Herring (n31) 258.
[71] *Dunhill* v *Burgin* (no's 1 & 2) [2014] UKSC 18.
[72] *Re E* (n3) 224.

Lord Scarman's relational test could draw our attention to the possibilities of a child's competence being achieved and enhanced through consultation with others.[73] The "ideal" scenario for Jonathan Herring would be for her to be able to consult with her parents or other trusted adults so that she could receive 'the necessary information to make the decision and help in deciding what her wishes are and what is her view of the moral issues involved'. This would result in a decision which is 'careful and informed, but also her own'.[74] Yet, this type of collaborative approach was not only rejected by the court, but also treated with suspicion. In Mostyn J's summing up he notes that *A's* decision was 'not the product of influence by adults in her family' and that she showed no signs of 'distress'[75] When Dr Ganguly was questioned by Counsel as to whether *A* had been 'coerced or pressed' by her mother or grandmother, Mostyn J interjected and added 'influenced' to the list.[76] Acknowledging the potential vulnerability of the child to parental opinion within the relational model, Herring suggests that in the absence of 'sensitive' parental communication, undue pressure *could* be guarded against by the child seeking support and information from another adult and her doctor.[77] However it *is* puzzling that the more subtle "influence", which I would argue is entirely natural within close relationships, should be categorized in *ABC* in a like manner to undue pressure.

The fact is that adults and children alike are influenced, and choose to be so influenced in their decision-making, by any number of ideologies, responsibilities and social conventions. To pretend otherwise is to revert to the 'autonomy myth'.[78] Influence in and of itself does not indicate that a child is unable to form a view for herself.[79] Indeed, empirical evidence from a study by Ellie Lee into abortion decisions made by adolescent girls, confirms that 'the experience of these young women who frame their choice as "their own" cannot be understood in separation from parental influence altogether (…)'.[80] She found that maternal influence in particular was very important for undecided younger adolescents by facilitating the potential for

[73] Herring (n31) 260.
[74] ibid 261.
[75] *ABC* (n1) para 14.
[76] Transcript (n35)
[77] Herring (n31) 262.
[78] Fineman (n5)
[79] Jonathan Herring, 'An Injection of Sense' [8 November 2013] New Law Journal 9,10.
[80] Ellie Lee, 'Young Women, Pregnancy and Abortion in Britain: A Discussion of Law in Practice' (2004) 18 Int J of law, Policy & Family 283, 294.

maternity when they may have feared they were too young.[81] She claims that most who experienced parental 'directiveness' either for or against termination did not do so in a negative way,[82] that strong parental reactions against abortion were not typical,[83] and that abortion decisions were most often made within and with an understanding of, the impact on 'intimate, private areas of interaction'.[84]

Finally, there is an irony within *ABC* summed up in Mostyn J's statement that if *A* continued with the pregnancy, then 'her family and, indeed, Social Services will need to give her considerable support and assistance' whilst in the event of a termination 'her family will need to be at her side and to assist her and support her'.[85] It is inconsistent that the law rejects collaboration in the decision-making process only to call upon it to deal with the consequences of that decision.

V. CONCLUDING THOUGHTS

Brief though it is, *ABC* is refreshing in that it is a judgment concerning a child in mid-childhood that places the issue competence at its heart. It has demonstrated for the first time, that a child as young as 13 can be both competent and her wishes held to be determinative. However, although the case should be applauded for its direct approach, it would be wise not to read too much into its scope. As a decision of the High Court it will have limited impact upon the earlier constructions of child competence found in the previous House of Lords and Court of Appeal decisions, which have resulted in much academic criticism.[86] Further, reaching the outcome that it did may have been simpler for the court as the case involved the question of consent rather than refusal. Subsequently, the more contentious issues surrounding adolescent refusal of treatment remain unaddressed.[87]

The judgment is to be commended for its stance that best interests concerns should not override a competent child's wishes. By so doing, it accorded *A* a measure of discretion over a decision which had profound implications for both her immediate

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[81] ibid 291, 293.
[82] ibid 292
[83] ibid
[84] ibid 301.
[85] *ABC* (n1) para 15.
[86] See (n2)
[87] ibid

bodily integrity and her future life plan. But it has to be queried whether the fact that *A's* wishes appeared to have concurred with the opinions of the doctors and the Court that a termination was in her best interests, may have fostered a situation of 'dependent compliance',[88] and thereby facilitated a finding of competence. Although, in the case of abortion, it may be difficult to determine what would be 'best' for a specific 13 year old girl, the subsequent case of *X (A Child),* shows that where the child's view of her welfare does not concur with the judicial and medical assessment, the court *may* be prepared to resort to the use of force to compel her to receive treatment, even in procedures as sensitive as abortion.[89] Finally, the atomistic perspective of the court to decision-making in mid-childhood is regrettable. A preferable approach would be to facilitate collaboration and to begin with a presumption that familial 'influence' is both a usual and necessary part of the process, which for those in mid-childhood both helps to foster competence and is a truer reflection of the real-life nature of decision-making.[90]

[88] Priscilla Alderson and Mary Goodwin, 'Contradictions within Concepts of Children's Competence' (1993) 1 International Journal of Children's Rights 303, 306.
[89] *X (A Child)* (n51) para 9.
[90] James Dwyer, *The Relationship Rights of Children* (2006 CUP) 13.