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CHILDREN'S BODIES: THE BATTLEGROUND FOR THEIR RIGHTS?

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The UNCRC has changed profoundly ideas about adult/child relationships and there is now an acknowledgment in both law and policy that children have a right to be consulted and to participate in decisions made about their lives. This has been widely discussed and critiqued and one of the most significant battlegrounds for debate has been children's rights to consent or refuse medical treatment and the issue of exactly who has the right to control children's bodies. This article will compare several cases where the English and Scottish courts have made various decisions and rulings about the extent to which children do have rights to control their bodies. It will question why, twenty years after the UK ratified the UNCRC, children are still considered incompetent in matters concerning their own bodies, unless proved otherwise, while adults are automatically considered competent unless shown not to be and will analyse whether this situation is compatible with a children's rights agenda.

Keywords: Children's rights over their bodies; participation; reproductive and sexual health; anorexia; UNCRC

Introduction

While there have been criticisms of the United Nations Convention on the Rights of the Child (UNCRC), it is indisputable that it has profoundly changed ideas about adult/child relationships and about the nature of childhood itself, not least through the acknowledgment in both law and policy that children have a right to be consulted and to participate in decisions made about their lives. Yet this right remains contested and this article will examine one particular area – the right of children to control their own bodies – where implementing this right has caused problems. It will argue that there is still profound unease over children's participation in health care decisions and that law and practice are contradictory and ambivalent. It will compare several cases where this right has been debated in the English courts and the various rulings made. In particular it will examine the decisions made about children's rights to control their sexuality and reproduction with those which have sought to impose unwanted medical treatment or intervention, through force-feeding children suffering from anorexia. While all these cases focus on children's rights to consent to, or refuse treatment, the courts tend to come to very different

judgments, suggesting that children's rights over their bodies remain unresolved. This article will question why, twenty years after the UK ratified the UNCRC, children are still considered incompetent in matters concerning their own bodies, unless proved otherwise, while adults are automatically considered competent unless shown not to be. It will end by analysing whether this situation is compatible with a children's rights agenda.

The battleground of the body

The UNCRC introduced an ideology of childhood based on respect for children's dignity and shifted the emphasis when intervening in children's lives 'from protection to autonomy, from nurturance to self-determination, from welfare to justice' (Freeman 1992: 3). Twenty years later however Childhood Studies scholars have suggested that in the UK this ideal has not filtered down into general discourse and that rather than being empowered and justly treated, children are perceived as being at risk as never before and that the institutions of the state, as well as their own parents, are failing them. Furthermore, there is a sense that childhood is in crisis – children are out of control, unhappy and a risk to themselves and others (Kehily 2010). Furedi (2001) locates the trouble spots of contemporary childhood within the family, arguing that the rise of 'experts' in parenting and child rearing has undermined parents' confidence and lead to a pervasive paranoia about childhood being under threat and out of control. The UNICEF well-being tables which regularly put British children near the bottom in terms of happiness and well being (Adamson et al 2007), the surveys by Barnardo's which suggest that 49% of people believe that children are beginning to behave like animals and are a danger to each other and adults (Barnardo's 2011) and the work by some authors which argues that children are put under too much pressure at school and are being made unhappy by the social expectations placed on them (Palmer 2006), all point to the idea that despite the legal protections and the new emphasis on children's rights in local authority, educational and health settings, children are now fundamentally worse off than they were in the past. As England's Children's Commissioner wrote in the forward to his office's Five Year Plan, 'There is a crisis at the heart of our society' and this crisis is focused on childhood (Aynlsey-Green 2007: 12). In short, not only are individual children stressed, miserable and threatening to themselves and others but childhood itself is under attack, increasingly commercialized and pressurized.

This is not a homogenous view of course. It can be argued that adults have always viewed childhood as being in a permanent state of crisis and that there is always a tendency to look back on childhoods in the past as better, more free and happier (Brockliss and Montgomery, 2010). Morrow and Mayall (2009) have questioned the basis on which the UNICEF well-being tables are compiled and argued that the basis of the questioning may well be flawed and similar criticism can be levelled at the Barnardo's survey. It would be too sweeping a generalisation to claim that childhood *is* in crisis and much worse than ever, but

nevertheless there is a powerful discourse in the media, among politicians, and within Childhood Studies circles that there is an acute problem with today's children in the industrialised West. Furthermore the certainty with which the idealised Western childhood, as modelled in the UNCRC, was once held up as a template for the rest of the world to follow is diminishing. It is coming under attack not only from academics but from parents in the global South who reject what they perceive as the imposition of alien models of childhood. As parents in Ghana told one researcher looking at ideas about children's rights - 'We don't want Western children in Ghana' (Twum-Danso 2009).

Within the UK, many of the fears around childhood revolve around children's bodies and their rights over them. According to Furedi and others, there is an obsessive concern with child safety, from paranoia over child abductions to parents who drive behind the school coach to ensure their children arrive safely at their destination. More recently the fears of early sexualisation have resulted in two government enquiries within 18 months,¹ both of which have looked at, among other issues, appropriate clothing for children and dealt with similar concerns about what rights children have over their own bodies and whether or not it is always parents who have the ultimate say in controlling what happens to them. While these concerns of sexualisation and safety are increasingly debated in the media, other issues, especially around consent to medical treatment, have been dealt with by the courts and the rest of this article will look at how these have played out and what impact the UNCRC has had on these decisions.

Some of the highest profile cases of the last thirty years have focused on the precise issue of who can consent to treatment, and what is in children's best interests; issues central to both the Gillick and Axon rulings discussed below. It is perhaps not surprising that these issues have become so prominent in law – the right to control one's own body is fundamental to many civil and social rights agendas. Many of the great battles fought by second-wave feminists focused on women's rights over their own bodies, particularly on their sexuality and on their reproductive rights (Whelehan 1995). 'My body, my choice' became, and remains, a powerful rallying cry still heard in contemporary debates over abortion and rape. Children's rights, however, has never contained such a manifesto even though many current debates over the role and status of children in society focus on exactly the same issues.

Childhood Studies, heavily influenced as it is by the UNCRC, has always placed a great emphasis on children's own understandings of their bodies, their illnesses and on their right to refuse or consent to medical treatment (Christiansen 2000). In one of the first studies carried out on children's own views and understandings of life-shortening illnesses, Myra Bluebond-Langer (1978) showed very clearly how important it was to children to retain some sense of control over what was going on. Her child informants understood very clearly

¹ Sexualisation of Youth People Review and Bailey Review of the Commercialisation and Sexualisation of Childhood, 2011.

that they were dying, even though their parents and doctors had specifically kept the information from them. By looking at the condition of other children and noting the gestures and attitudes of the people caring for them, the children understood that their illnesses were terminal but tended to shield their parents from this knowledge. While children were not always able directly to refuse treatment or make decisions about the remainder of their lives, Bluebond-Langner argued that children were not just the passive recipients of the information that their carers wanted them to have.

Since this groundbreaking study, children's rights to consent or not in certain aspects of their medical treatment have slowly gained ground and have been much discussed in courts and in medical ethics (Miller 2003). From an academic perspective, there is a general presupposition in favour of the view that children can consent and do have the right to refuse treatment. At the far end of the spectrum are those who view all children, whatever their age, as being able to express themselves and able to participate meaningfully in medical treatment. The work of Priscilla Alderson and her colleagues (2005), which looked at premature babies in neo-natal units, claimed that even at this early stage they showed preferences for particular nurses and could communicate their pain and suffering effectively. Some babies, both parents and doctors sometimes believed, decided whether to continue struggling for life or not. Alderson et al argued passionately that for children's rights to be meaningful, even these small babies should be seen as citizens with rights to participation and whose wishes, however they were expressed, should be at least acknowledged in their treatment.

In other cases even those who work for and support children's rights do not see the right to consent as absolute. In Norway in 2001, for example, the then Ombudsman pushed for a legal ban on cosmetic surgery for those under 18, despite protests from girls of 16 who felt fully competent to make decisions about such treatment. The Ombudsman said in an interview:

There was some resistance among girls from sixteen to eighteen when we proposed to higher the age of cosmetic surgery from sixteen to eighteen, and the resistance was about you do not trust us, you don't trust our competence to make a decision about our own lives. And I had to tell them back no, I did not because this industry has an enormous power, and it is defining what is how your body should look like.

(quoted in Montgomery, 2003: 216)

The same children would have the right to consent to sex, be prescribed contraception and also would be able to access abortion on demand but were not deemed competent to decide on cosmetic surgery.²

UNCRC and rights over the body

At first glance it may sound odd to suggest that the UNCRC is silent on the subject of children's bodies – the UNCRC explicitly sets out children's right to bodily freedom in the form of freedom from 'torture or other cruel, inhuman or degrading treatment or punishment' (Article 37) and promotes children's rights to health and access to health care (Articles 6, 17, 23 and 24, among others). Article 12 deals with children's rights to have their views taken into consideration while Article 14 acknowledges that children's capacities for expressing these views evolve throughout childhood and states that the law must take account of these in matters of conscience and freedom of thought. Taken together these Articles suggest a pragmatic approach which assumes that children should be consulted about what happens to them and that they do have rights to bodily autonomy and the freedom to make choices about what happens to their bodies. The UNCRC is, however, silent on the extent of these rights and whether children have the right to make these choices independently, whether parents, guardians, children's commissioners or doctors should overrule them when necessary to ensure other rights and where the balance between protection and participation lies. While the principle of the 'best interest of the child' remains paramount, who has the ultimate right to decide this is left open.

This is not meant as a criticism of the UNCRC. While it has been thoroughly critiqued by many throughout its existence for its ethnocentrism and impracticality, it is important to remember that it was never written as a step by step blueprint of action and many of the details about practical implementation have been written into national country laws after its ratification (the next section will look at this in relation to England, Wales and Scotland in more detail). Indeed in many countries, it is unfortunately true that children's rights to consent and retain control over their bodies are much less important than the fact that healthcare is non-existent, food is scarce and participation rights worth little in contexts where mortality rates remain high and neither children nor adults have basic ontological security. Nevertheless, the rights enshrined in the UNCRC are indivisible and universal and the issue of consent and the underlying philosophy behind who is competent and who is not is central to contemporary studies of childhood, not least because within such discussions we can see how ideas about childhood are worked through in practice. By focusing on cases from the UK it becomes clear that, in this context at least, there is a large gap between the

² In Norway all women over 16 have the right to an abortion up to the 12th week of pregnancy, if they are under 16 parents must be informed (Løkeland 2004).

rhetoric of children's rights and their implementation and that the idea of children as active participants in their own decisions is still a long way from reality.

Position in English law

If the law of England and Wales provides for children to exercise control over their own bodies, it would be expected that this would be expressed in either statute or case law. Looking at these however does not provide definitive answers. The Children Act 1989 provides that anyone under the age of eighteen is a child (section 105) and, as such, has limited rights compared to an adult. At the age of eighteen the right to full autonomy is achieved and, by virtue of the Mental Capacity Act 2005, the presumption is in favour of competence with the onus on proving lack of competence on those who suggest that competence is lacking. One of these limited rights that children have is the right to consent over their own body. Section 8(3) of the Family Law Reform Act 1969 provides that those over the age of sixteen be treated as if they had attained the age of eighteen with regard to their right to consent over matters concerning their own bodies. It is worth noting that this right to consent is exactly as it says: a right to consent. The provision within Section 8 of the Family Law Reform Act 1969 makes no mention of the individual's right to refuse or withhold consent. Indeed if an individual over the age of sixteen but under eighteen refused to consent for a medical procedure, their refusal can be legally overridden by someone with parental responsibility, or by the courts, acting in the individual's best interest.

Thus English law does allow those who have attained the age of sixteen a degree of control over their own bodies, but only where this is in accepting a treatment that is being offered to them. Where they wish to refuse a particular treatment English law does not offer them automatic protection as their refusal can be legally set aside. The provision within the Family Law Reform Act 1969 is a positive step, and should be seen as such. It means that where a sixteen or seventeen year old has provided their consent, there is no legal need to also obtain consent from someone with parental responsibility, allowing the individual the right to be autonomous in this regard and not have their decisions subject to approval from a parent or guardian. However, the provision within Section 8 of the Family Law Reform Act 1969 does not go far enough to be said to meet Article 12 of the UNCRC and allow those who have attained the age of sixteen to be fully autonomous or fully participate in decisions made about their bodies, as any refusal by them is subject to the possibility of being overridden.

There is no such statutory provision or protection for those under sixteen. For this group of individuals, it is case law that has provided legal authority for them to exercise some degree of control over their own bodies. It is no exaggeration to say that the Gillick case (*Gillick v.*

West Norfolk & Wisbech Area Health Authority [1986] AC 112) is a landmark case in this regard. It is this case that provides the legal basis for children under the age of sixteen to provide a valid consent to medical procedures affecting their bodies.

The Gillick case was concerned with whether a circular issued to Health Authorities by the Department of Health and Social Security was lawful, when it advised that a doctor at a Family Planning Clinic could prescribe contraceptives to a girl under the age of sixteen, provided that he was doing so in order to protect the girl from the harmful effects of sexual intercourse. In deciding the case, the courts considered the nature of parental rights over a child and the rights of a child in making decisions about their bodies. With regard to parental rights, the House of Lords were of the view that as a child developed their independence increased and parental control relaxed. Further, that there was no absolute rule that parents had authority over their children until a fixed age. Lord Fraser stated that 'parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child' (at page 170), with Lord Scarman noting that 'parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child' (at page 184). Lord Fraser also indicated that he agreed with the words of Lord Denning in *Hewer v Bryant* [1969] 3 All ER 578, when he stated that 'even up till a young person's 18th birthday, the parental right is a dwindling right which the courts will hesitate to enforce against the wishes of the child and the more so the older he is' (at page 582). Thus it is clear that parental rights are not absolute and that as a child develops so does their ability to exercise their autonomy; although, there needs to be some way of determining how and when a child is capable of exercising autonomy.

It was the intellectual and emotional maturity of the child that was crucial in the Gillick case in determining whether the child was able to make a decision regarding their own body, and whether to take contraceptives. In this regard, it was Lord Fraser who outlined five principles that a doctor must follow to have the protection of the law when providing contraception to a child under 16. These principles have subsequently become known as 'Fraser guidelines'. They state:

- (1) that the girl (although under 16 years of age) will understand his advice;
- (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
- (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;
- (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;
- (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

(per Lord Fraser at page 174)

As a result of the Gillick case, it became legally possible for a child under sixteen to consent to matters concerned with their own bodies, although in the first instance this was only to do with contraceptive matters.

The Gillick case came before the courts prior to the UK ratification of the UNCRC, whilst the Axon case (*R on the application of Axon*) v Secretary of State for Health [2006] EWHC 37 (Admin), was heard after the UK ratification of the UNCRC in November 1989 and, as it deals with many of the same issues of the Gillick case, allows the judgment in Gillick to be read in the light of the UNCRC. In the Axon case, the issue was whether a doctor is under an obligation to keep advice and/or treatment regarding contraception, sexually transmitted infections or abortion in confidence if the patient is less than sixteen years of age. In reaching his judgment, Justice Silber paid attention to articles 5, 12, 16 and 18 of the UNCRC. He noted that the UK ratification of the UNCRC 'was significant as showing a desire to give children greater rights' (at paragraph 64) and that

the UNC provisions provide further support for the general movement towards now giving young people greater rights concerning their own future while reducing the supervisory rights of their parents. In the light of this change in the landscape of family matters, it would be wrong and not acceptable to retreat from Gillick and to impose greater duties on medical professionals to disclose information to parents of their younger patients.

(at paragraph 115)

The judgment in the Axon case reinforced and extended that in Gillick. A child aged less than sixteen is able to provide consent for matters relating to their body in respect of contraception, sexually transmitted infections or abortion, provided that the principles within the Fraser guidelines were followed by the medical practitioner.

Aside from the ability of a child to consent to matters relating to contraception, the Gillick case also provided for a child under sixteen to consent to other matters relating to their bodies and medical treatment. Lord Scarman stated that

I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of sixteen 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.

(Gillick at pages 188 – 189)

This has become known as Gillick competence and it means that once the child has gained the required degree of competence (the sufficient understanding and intelligence referred to by Lord Scarman) the rights of the parents to override the child's wishes cease.

There has been some confusion since the judgment in the Gillick case regarding the difference between Fraser guidelines and Gillick competence, with some commentators using the terms interchangeably. However, 'they are two different concepts: Fraser guidelines referring to specific guidance that must be followed by the health-care professional to provide specific treatment to a child; and Gillick competence referring to the ability of the child to give consent' (Cornock, 2007: 142).

The autonomy for children deemed to be Gillick competent has not been as forthcoming as many have been expected after the judgment in the Gillick case. Firstly there is the fact that Gillick competence itself can be a changing concept. The determination of Gillick competence is undertaken by the healthcare professional who will undertake the proposed medical treatment. Thus, one healthcare professional may deem a particular child to be Gillick competent whilst another may not. In addition, because Gillick competence refers to the understanding and intelligence of the child in relation to a particular medical treatment, it is possible that a child can be deemed to be Gillick competent for one treatment but not seen as being Gillick competent for a more invasive or extensive procedure. It would appear that the more invasive the procedure, the higher that the bar will be set in terms of the child demonstrating their competence. Thus, Gillick competence varies not only with the age and intellectual and emotional maturity of the child but also with the medical treatment involved.

A further obstacle in terms of the autonomy of the child with regard to their own bodies has been the court's acceptance that whilst a child may give their consent when they are Gillick competent, their refusal can be overridden. In the Gillick case it was only the ability of the child to consent that was advanced. There is no right to refuse treatment provided by the Gillick judgment. This has been confirmed in various cases that have come before the courts concerning a child's refusal to accept medical treatment. Lord Donaldson may be said to have been the first to have made the distinction between a competent child's ability to be able to consent to or refuse medical treatment. *Re R (A Minor)(Wardship: Consent to Treatment)* [1992] Fam 11 CA concerned a 15 year 10 month old girl who had been admitted to an adolescent psychiatric unit and, according to the medical staff, needed anti-psychotic medication, which she refused when lucid.

Lord Donaldson made three points in his judgment which can be seen as reducing a child's autonomy over their body:

There can be concurrent powers to consent. If more than one body or person has a power to consent, only a failure to, or refusal of, consent by all having that power will create a veto. A "Gillick competent" child or one over the age of 16 will have a power to consent, but this will be concurrent with that of a parent or guardian. ...The court in the exercise of its wardship

or statutory jurisdiction has power to override the decisions of a "Gillick competent" child as much as those of parents or guardians.

(Re R at page 26)

In *Re W (A Minor)(Medical Treatment)* [1992] 4 All ER 627 this right of the court to overrule a refusal by a competent child was extended to those who are sixteen and in theory protected by Section 8(3) Family Law Reform Act 1969 which, as stated above, provides that those over the age of sixteen be treated as if they had attained the age of eighteen with regard to their right to consent over matters concerning their own bodies. The case concerned a sixteen year old girl who suffered with anorexia nervosa and was refusing necessary treatment. In his judgment Lord Donaldson stated that:

No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.

(Re W at pages 639 – 640)

In summary, as to what English law says about a child's right to exercise control over their bodies: the Family Law Reform Act 1969 established the right of those sixteen and over to consent on their own behalf, the Gillick case made a significant step forward as it established that a person under the age of sixteen may consent for a specific medical treatment if they are deemed to be Gillick competent for that specific medical treatment. However, what may be termed a retrograde step, by those advocating a child's right to autonomy over their bodies, was made in the cases of *Re R* & *Re W* where it was decided that the refusal of anyone under the age of eighteen, even if demonstrably competent, can be overridden by someone with parental responsibility or by the courts.

Position in Scottish law

The section above has considered the position of children in England and Wales regarding their legal right to exercise control over their bodies in relation to medical treatment. In Northern Ireland, the law adopts the same position to that of England and Wales. However, in Scotland there is a different approach which may be said, by those wishing to increase a child's autonomy over their own bodies, to be superior to that which exists within the provisions of English law.

The Age of Legal Capacity (Scotland) Act 1991 effectively puts the common law provision of the Gillick case into statutory effect in Scotland. Section 2(4) states that

A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.

However, in addition to this provision there is a provision within the Children (Scotland) Act 1995 which states that where it is necessary for a child to submit to medical examination or treatment and 'the child has the capacity mentioned in said section 2(4), the examination or treatment shall only be carried out if the child consents' (Section 90). A further section of the Act clarifies that those acting as the child's legal representative, such as those with parental responsibility, may only do so 'where the child is incapable of so acting or consenting on his own behalf' (section 15(5)).

This would appear to go considerably further than English law in that, as well as providing the ability to consent when deemed competent to do so, it provides that a competent child's refusal cannot be overruled as is the case under English law.

It is worth noting that these provisions have not been subject to testing in court and it is always possible that judicial interpretation may be more in line with that existing in English law. However, in the only case to come before the Scottish courts regarding a child's refusal of treatment the judge, Sheriff McGowan made an obiter comment (one which is not legally binding) that supports the proposition that in Scotland, once a child has competence, they are able to consent or refuse medical treatment without either decision being overruled by anyone else. Sheriff McGowan commented that

It seems to me illogical that on the one hand a person under the age of 16 should be granted the power to decide upon medical treatment for himself but his parents have the right to override his decision. I am inclined to the view that the minor's decision is paramount and cannot be overridden. The Act itself does not provide any mechanism for resolving a dispute between minor and guardian but it seems to me that logic demands that the minor's decision is paramount.

(Houston [1996] SCLR 943 at paragraph O)

In whose best interests?

Even allowing for the differences between the English and Scottish legal approach to children's rights to have autonomy over their own bodies, it would appear that these cases represent a move forward in attempts to implement children's rights and enhance their legal position. However, in reading the judgments from cases that consider a child's right to consent over their body, it is tempting to ask whether it is the best interests of the child that are being protected or advanced or those of the adults involved, such as those of the health care professionals?

For instance, in the *Re W* case, Lord Donaldson stated at the end of his judgment that

The effect of consent to treatment by the minor or someone else with authority to give it is limited to protecting the medical or dental practitioner from claims for damages for trespass to the person.

(at page 640)

In the *Gillick* case, Lord Fraser stated that he did not 'doubt that any important medical treatment of a child under 16 would normally only be carried out with the parents' approval' (at page 173), thereby suggesting that consent by a child under sixteen would not be sufficient for certain treatments, even where the child is assessed as being *Gillick* competent.

With a different emphasis Lord Donaldson, in *Re R*, likens the process of obtaining consent to that of a lock and key. He suggests that like the fact that a lock only needs one key to open it, consents only require one person to provide it for it to be legally valid. Furthermore, if one person provides consent and another objects, legally this does not provide any dilemma as one consent is all that is required. This seems to suggest that it does not matter at all where the 'key' comes from as long as one is obtained. If the only reason that those under the age of eighteen were being provided with a mechanism that appears to increase their autonomy with regard to their bodies were to protect others, it would be a very unsatisfactory state of affairs that totally failed to address the provisions of the UNCRC and the needs of children.

Perhaps the issue of consent with regard to medical treatment can be best seen when one considers further comment from Lord Donaldson on the purpose of seeking consent. In *Re W* he stated that

There seems to be some confusion in the minds of some as to the purpose of seeking consent from a patient (whether adult or child) or from someone with authority to give that consent on behalf of the patient. It has

two purposes, the one clinical and the other legal. The clinical purpose stems from the fact that in many instances the co-operation of the patient and the patient's faith or at least confidence in the efficacy of the treatment is a major factor contributing to the treatment's success. Failure to obtain such consent will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment. I appreciate that this purpose may not be served if consent is given on behalf of, rather than by, the patient. However, in the case of young children knowledge of the fact that the parent has consented may help. The legal purpose is quite different. It is to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person. It does not, however, provide them with any defence to a claim that they negligently advised a particular treatment or negligently carried it out.

(at pages 633 – 634)

This at least provides some reassurance as to the purpose of providing children with rights in relation to consenting for medical treatments. The principle is to allow children to participate in the decision making process even where they may not be able to fully participate by having complete autonomy. The current law allows children to have some control and rights over their bodies whilst at the same time providing protection for those who treat them. Children's rights with regard to their bodies remain a very heavily contested area in English law.

Discussion

The length and complexities of the cases discussed here suggest that there are no easy answers to the questions they raise. It is obvious that while everyone involved was doing what they perceived of as being in the child's best interests, there was no consensus about what this was and how it might be best achieved. From a children's rights perspective, the Gillick and Axon cases are perhaps the easiest to deal with. In many respects the actual children involved were peripheral to these judgements, there is no indication that either Mrs Gillick's or Mrs Axon's daughters had asked their doctors for contraception or sought abortions and they remained the passive subjects of the court cases rather than active participants. Their mothers were fighting to enshrine a principle of parental control/responsibility and were arguing that their own children (or indeed other people's children) were not autonomous individuals who could make decisions to control their own bodies, and specifically, their own sexuality and reproductive health. While the Gillick case occurred before the UK ratified the UNCRC, it would be easy to argue that her stance went against the philosophy of the Convention and that its ideals of autonomy, self-determination and justice suggest that children do have rights to bodily autonomy, even if

these are not specifically mentioned. By the time the Axon case came to court it can be argued that there was a presumption of competence unless shown otherwise and the principle was established that in some aspects of medical treatment, it was children, not parents, who could claim the right to control their bodies, as long as they were 'Gillick competent' and that their capacity to consent and their ability to understand the information given were sufficiently evolved. This may not have been because of the UNCRC, but it was certainly in line with its principles.

In the cases concerning anorexia or the refusal to take anti-psychotic medicine however the reverse is true and while in some respects it might appear obvious that children's rights to protection must override children's rights to have due consideration given to their views, it nevertheless raises troubling issues for a children's rights agenda. It would be easy to claim that it is in the child's best interest to be force-fed and that anorexia is a form of illness which needs invasive treatment. Furthermore, as a form of mental illness, it is arguable that child sufferers are by definition not mentally competent to refuse treatment. Yet as long as adult sufferers of anorexia are not automatically force-fed there remains a fundamental dichotomy between adults and children in this field which assumes that adults are competent unless shown not to be while children are automatically assumed to be incompetent unless shown otherwise. Such a stance sits uneasily alongside the idea of children as individuals and social actors and yet allowing children to starve themselves to death without intervention is equally anathema to the humane premise of the UNCRC which is based on protection and nurturance as well as participation.

Perhaps the only workable compromise is to accept that in decisions about certain forms of medical care, children do not have an automatic right to participate, and that in these cases decisions about care or treatment need to be taken out of the hands of doctors, parents and indeed children themselves and settled in the courts on a case by case basis.

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