Gillick or Fraser? A plea for consistency over competence in children

Gillick and Fraser are not interchangeable

In most countries the issue of deciding on the ability of children to make decisions about their own medical treatment causes some dilemmas. In Britain people describe the assessment of competence of children in terms of either Gillick competence or the Fraser guidelines, as if they were interchangeable. However, they are not, and their difference needs to be made clear.

The proponents of each concept have failed to explain the differences between them and are encouraging synonymy where none exists. Research ethics committees are insisting upon the use of "Fraser," motivated by the honourable, but false, belief that the term "Gillick competence" is unwelcome to the woman after whom it is named. National organisations are perpetuating this myth. And teachers of medical law are encountering genuine difficulty in trying to resolve this issue.

In UK law a person's 18th birthday draws the line between childhood and adulthood,[1] so that in healthcare matters an 18 year old enjoys as much autonomy as any other adult. To a more limited extent 16 and 17 year olds can also take medical decisions independently of their parents.[2] The right of younger children to provide independent consent is proportionate to their competence, but a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.

A judgment in the High Court in 1983 laid down criteria for establishing whether a child, irrespective of age, had the capacity to provide valid consent to treatment in specified circumstances.[3] Two years later these criteria were approved in the House of Lords[4] and became widely acknowledged as the "Gillick test," after the name of a mother who had challenged health service guidance that would have allowed her daughters aged under 16 to receive confidential contraceptive advice without her knowledge.

As one of the Law Lords responsible for the Gillick judgment, Lord Fraser specifically addressed the dilemma of providing contraceptive advice to girls without the knowledge of their parents. He was particularly concerned with the welfare of girls who would not abstain from intercourse whether they were given contraception or not. The summary of his judgment referring to the provision of contraceptive advice was presented as the "Fraser guidelines" in books written for doctors.[5] But the three leading legal academic databases[6] and leading legal textbooks[7] do not mention the Fraser guidelines.

An urban myth has emerged that Mrs Gillick wishes to disassociate her name from the assessment of children's capacity, thus carrying the implication that the objective test of a child's competence should be renamed the Fraser guidelines. The myth is becoming dignified by research ethics committees (following the advice of the Central Office for Research Ethics Committees[8]) and is being translated into national practice,[9] although unsupported by any evidence. Indeed, alteration of an established legal test would be unusual, and cause confusion. Consider the implications of the Bolam test (used in negligence cases) being renamed the McNair[10] guidelines, after the judge who commented on it.

For many years the criteria that have been referred to as the test for Gillick competence have provided clinicians with an objective test of competence. This identifies children aged under 16 who have the legal capacity to consent to medical examination and treatment, providing they can demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

Lord Fraser's guidance is narrower and relates only to contraception. The guidance includes the necessity to ensure that the girl understands the advice given to her with respect to contraception, but otherwise concentrates on the desirability of parental involvement and the enhanced risks of unprotected sex.

If Gillick were completely subsumed into Fraser, the detailed assessment of the child's capacity provided by the original case would be lost. If Fraser were completely subsumed into Gillick the particular clinical problem envisaged by Lord Fraser would be lost in the generalities of children's capacity.

Following correspondence with Victoria Gillick, I am clear that she "has never suggested to anyone, publicly or privately, that [she] disliked being associated with the term 'Gillick competent' " (V Gillick, personal communication, December 2005).

Dispelling the myth is important, because it allows us to retain Gillick competence as the central doctrine with which to judge capacity in children. The Fraser guidelines should continue to be used as they were initially described, fusing the Gillick test with specific guidance for children receiving contraceptive advice.

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1 Children Act 1989 s105 (1).
2 Family Law Reform Act 1969 s8.
3 Gillick v West Norfolk & Wisbech AHA & DHSS [1983] 3 WLR (QBD).
4 Gillick v West Norfolk & Wisbech AHA & DHSS [1985] 3 WLR (HL).
5 British Medical Association. *Medical ethics today*. 2nd ed. London: BMJ Publishing Group, 2004:230-1.
6 Lexis Nexus Professional; Lawtel; Westlaw UK.
7 Grubb A. *Principles of medical law*. 2nd ed. Oxford: Oxford University Press, 2004.
8 Central Office for Research Ethics Committees. www.corec.org.uk
9 Medical Protection Society. 2005. www.medicalprotection.org/medical/united_kingdom/publications/gp_registrar/ (accessed 3 Apr 2006).
10 Bolam *v* Friern Hospital Management Committee [1957] 2 All ER 118; per McNair J, instructing the jury.

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