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# Authenticity and Identity in Adolescent Decision-Making

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While much criticism has surrounded the seemingly incoherent law governing decision-making for adolescents, relatively little work has sought to address the question of *whether* and *when* adolescents will be acting autonomously in decisions to refuse treatment, particularly in cases where their choices are motivated by religious beliefs inculcated from a young age. This is important, not just because it goes to the heart of when an adolescent ought to be able to exercise a right to self-determination, but also because an analysis of the case law indicates that judges are taking account of concerns about the authenticity of the values or beliefs which motivate a given decision when deciding cases. This paper will examine how different accounts of autonomy and authentic choice map onto the psychological development of adolescents, and thus the extent to which adolescent's decisions to refuse treatment on religious grounds can be regarded as truly authentic. It will conclude by considering how such cases ought to be approached by the courts, suggesting a modified Mental Capacity Act 2005 test for assessing adolescent capacity, and offering an empirically-grounded justification for overriding the choices of even capacitous adolescents.

## INTRODUCTION

Much criticism has surrounded the seemingly incoherent law governing decision-making for adolescents,[1] according to which minors can be deemed competent to consent to medical treatment, yet have their refusals of that very same treatment overridden. This criticism has often focussed on the failure of the current law to adequately empower adolescents in such decisions, with the law permitting seemingly autonomous refusals to be overridden in circumstances which would not justify intervention in the context of those who had reached maturity.[2] Yet despite this criticism being premised on the assumption

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1 'Adolescents' is used here to refer to those between the ages of around 10 and 18, though it is accepted that it is a contested term which may also apply to those over the age of 18. Emma Cave and Hannah Cave are right to note the mounting evidence that biologically, psychologically and sociologically, the 'adolescent' phase may continue into early adulthood, as some of the evidence relied on later will demonstrate (see Emma Cave and Hannah Cave, 'Skeleton Keys to Hospital Doors: Adolescent Adults who Refuse Life-Sustaining Medical Treatment' (2023) 86 MLR 843). However in this paper, it is being used to denote the intermediate stage between childhood and (legal) adulthood in which a minor begins to develop the capacity for autonomous decision-making and gains greater independence.

2 See for example Jo Bridgman, 'Old enough to know best' (1993) 13 *Legal Studies* 69; Michael Freeman, 'Rethinking Gillick' (2005) 13 *International Journal of Children's Rights* 201. One strand of this focusses on the failure of the current law to appropriately capture the full force of both the

that adolescents are capable of making autonomous decisions in such cases, it is notable that relatively little work has sought to address the question of *whether* and *when* adolescents will be acting autonomously, particularly in cases where their choices are motivated by religious beliefs inculcated from a young age. This is notwithstanding recent acknowledgement by the courts that a *Gillick*-competent child may *not* be 'in all circumstances autonomous in the sense that a capacitous adult is autonomous', and specifically, that they may not be 'autonomous when it comes to deciding whether or not to accept life-saving medical treatment.'[3]

The most detailed consideration of this issue to date is that given by Margaret Brazier and Caroline Bridge, who have questioned the extent to which the test for *Gillick*-competence (whether the child has 'sufficient understanding and intelligence to understand fully what is proposed')[4] fully captures whether the adolescent's decision-making is autonomous or not. They are rightly critical of '*Gillick's* apparent equation that understanding equals autonomy',[5] suggesting the need for assessors to satisfy themselves that the choice of the adolescent is 'maximally autonomous' before giving effect to it.[6] Yet it remains unclear from their work how the law (and the courts) should go about ascertaining this. What, in other words, is a 'maximally autonomous' decision in the context of adolescents, and how should the law seek to test for it? Building on this, Emma Cave advocates 'a new common law test for child incapacity' to replace *Gillick*.[7] But aside from dismissing suggestions to emulate the test contained in the Mental Capacity Act 2005 (MCA 2005), what this test might entail and how it will more fully capture the challenge involved in determining autonomy in adolescence is not elucidated.

In their recent work, Emma and Hannah Cave have addressed this question more directly, drawing on biological, social and psychological evidence to demonstrate that adolescents are 'prone to developmental immaturity which can affect risk taking, impulsivity, and independence in decision making'.[8] This

UN Convention on the Rights of the Child and the Human Rights Act 1998, which also accords adolescents self-determination rights. There has also been criticism of the lack of transparency and conceptual clarity underpinning the cases, with judges adopting different mechanisms to justify court intervention in the face of serious harm: sometimes setting the bar for Gillick-competence so impossibly high that no child (or indeed adult) could reach it, and at other times finding them competent and overriding the decision anyway. See for example Caroline Bridge, 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62 MLR 585; Sara Fovargue and Suzanne Ost, 'Does the theoretical framework change the legal end result' (2013) 13 *Medical Law International* 6; Gillian Douglas, 'The Retreat from Gillick' (1992) 55 MLR 569.

3 *An NHS Trust* v *X* [2021] EWHC 65 (Fam) at [120]. See also the Canadian Supreme Court in *AC* v *Manitoba (Director of Child and Family Services)* 2009 SCC 30, which held that 'while many adolescents may have technical ability to make complex decisions, this does not always mean they will have the necessary maturity and independence of judgment to make truly autonomous choices', *ibid* at [117].

4 *Gillick* v *West Norfolk and Wisbech AHA* [1986] AC 112 (*Gillick*), 189 per Lord Scarman.

5 Margaret Brazier and Caroline Bridge, 'Coercion or caring: analysing adolescent autonomy' (1996) 16 *Legal Studies* 84, 91.

6 *ibid*, 109.

7 Emma Cave, 'Goodbye *Gillick*? Identifying and resolving problems with the concept of child competence' (2014) 34 *Legal Studies* 103, 119-122.

8 Cave and Cave, n 1 above, 843.

is undoubtedly useful evidence in assessing the extent to which adolescents are capable of autonomous decision-making. Yet what remains under-explored in this analysis, is a clear sense of how such developmental 'immaturities' map onto our theoretical understanding of what autonomous decision-making entails. To put it another way, how and why do they render an adolescent less capable of making an autonomous decision, and what does this tell us about how the law ought to respond to such cases?

This question is important, since it goes to the heart of when an adolescent ought to be able to exercise a right to self-determination; a decision which involves a conflict between, on the one hand, a potentially grave interference with their bodily integrity, sometimes their liberty, and often a frustration of their deeply held beliefs and, on the other, destruction of their future opportunities and even their life itself. Perhaps unsurprisingly, it is an issue which has precipitated a number of recent human rights-based challenges in the courts,[9] as well as intense public debate, particularly in relation to whether (and when) adolescents should be deemed capable of consenting to taking puberty blockers. But it is also important because analysis of the case law indicates that many judgments *do* appear to be underpinned by concerns about the autonomous quality of the decisions being taken, with judges often expressing doubt over the authenticity of the values or beliefs which motivate the adolescent's decision and the extent to which these can be said to be truly their 'own', given the inevitable influence of their family and community on their value formation, and on their expression of choice. Given this, it is important to consider the extent to which such concerns are legitimate, and what role doubts about autonomy ought to be playing in such cases.

After analysing the approach of the courts to these cases, this paper will consider how the concerns raised in them map onto the philosophical literature on the concept of autonomy, in particular notions of authenticity as an essential component of autonomous decision-making. It will focus on 'conscience cases', where the adolescent's refusal of treatment is motivated by religious conviction. Although these cases are rare in clinical practice (a more common scenario might involve a minor refusing treatment for a longstanding condition, such as chemotherapy in the context of a terminal cancer diagnosis), these cases have dominated the case law because of the complex legal and ethical issues they raise. Where a treatment decision is clinically finely balanced, the adolescent exhibits a high level of understanding of the consequences of their choice, and their refusal is motivated by their personal experiences of that condition and its treatment, the case for interfering with their choice would seem limited, whether on account of their autonomy or the doctor's duty of beneficence. Doctors thus largely respect the adolescent's wishes in these contexts and so such cases rarely make it to court. In conscience cases, by contrast, the decisions are rarely finely balanced, and far from resting on unique personal experience, they are instead motivated by deeply entrenched value-commitments or beliefs. While familial influence is not the only reason to question the authenticity or

9 *An NHS Trust* v *X* n 3 above; *E & F (Minors: Blood Transfusion)* [2021] EWCA Civ 1888 (*E & F*).

stability of a child's preferences in such cases, it is an important dimension of those cases which reach the courts, since if the parents did not share those value-commitments, they could provide consent to treatment on the minor's behalf.[10] Given that adolescents have been subject to familial and cultural influence from birth, and often continue to live in conditions where the influence of their family's values is pervasive, these cases thus raise difficult conceptual questions about how this influence affects an adolescent's capacity for autonomous decision-making. This is an issue which goes to the heart of what it means to choose autonomously, with different accounts of autonomy advancing different views on whether such influences should be seen as undermining the adolescent's capacity for autonomy, or as crucial formative experiences which help to shape their authentic self. Adolescents thus exemplify a point of tension between the diverging conceptions of autonomy put forward in the philosophical literature.

Ultimately, this paper will argue that while there are some cases in which we might have doubts over the authenticity of an adolescent's decision, most cases are better analysed through the lens of identity development, rather than autonomy. The final section of this paper will thus consider how such cases ought to be approached by the courts. While the focus of the analysis is on conscience cases, the implications of this analysis extend beyond them, and the paper will propose that *Gillick* be replaced with a modified MCA 2005 test for assessing adolescent capacity across the board. It will also offer a clear, empirically-grounded justification for overriding the choices of even capacitious adolescents in conscience cases, based on the psychological literature on identity development.

## *GILLICK* AND ADOLESCENT AUTONOMY

Since the decision of the House of Lords in *Gillick* v *West Norfolk and Wisbech Health Authority*[11] (*Gillick*) to allow minors under the age of sixteen to offer valid consent to medical treatment, much attention has been devoted (both judicially and in the academic literature) to the contours of that right,[12] and in particular, to whether it permits adolescents a corresponding right to refuse treatment providing they demonstrate the requisite level of understanding. In the cases of *Re R (A Minor) (Wardship: Consent to Treatment)*[13] and *In re W*

10 Whether, in the event of such a conflict, doctors would overrule the competent adolescent's refusal based on parental authority is open to question, and it may be that doctors in such cases would bring the case to court regardless, in order to get a determination that the treatment would be in the child's best interests.

11 [1986] AC 112.

12 See for example *In R (Axon)* v *Secretary of State for Health (Family Planning Association Intervening)* [2006] EWHC 37 (Admin) (on its implications for patient confidentiality); *Bell & Anor* v *The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) (*Bell* v *Tavistock* (HC)) (concerning the appropriateness of administering puberty blockers to adolescents with gender dysphoria in the absence of court authorisation); *AB* v *CD* [2021] EWHC 741 (Fam) (which considered whether a parents' authority to consent was 'extinguished' if the child was Gillick-competent).

13 *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11.

*(A Minor) (Medical Treatment: Courts Jurisdiction)*[14] (*Re W*) the Court of Appeal held that it did not, a position recently confirmed by the High Court in *An NHS Trust* v *X*[15] and by the Court of Appeal in *E & F (Minors: Blood Transfusion)*[16] (*E & F*). The court thus retains the authority, under the Inherent Jurisdiction, to consent to treatment on their behalf even where a *Gillick*-competent adolescent refuses it. Given their overarching responsibility for the minor's welfare, it is for the court, and not the child (or indeed their parents)[17] to decide whether a given treatment is ultimately in a minor's best interests. Accordingly, they may authorise (or refuse) treatment even in the face of opposition by the minor or their parents. This, as Sir James Munby explained, will typically occur in circumstances where 'the consequence of the child's decision is likely to be serious risk to health or death.'[18]

Much criticism has been made of these so-called 'retreat cases',[19] often centring around two alleged 'incoherencies' or 'asymmetries' in the law's position. The first relates to the asymmetry between consent and refusal cases, whereby adolescents may be taken to be competent to consent to treatment but not to refuse that same treatment.[20] The second relates to the (seeming) incoherence between the position of adolescents, who despite being found to be *Gillick*-competent, are nonetheless prevented from refusing treatment where that will risk harm to them, and adults, who if capacitious, are free to refuse any treatment, regardless of whether the reasons are 'rational, irrational, unknown or even non-existent',[21] and even where the refusal will result in their death.[22]

While it is unnecessary to explore these criticisms in detail here, both would seem to have traction only to the extent that the adolescents in question *are* deemed capable of autonomous decision-making. If they are *incapable* of autonomous decision-making, then irrespective of their age, or whether they are seeking to consent to or refuse treatment, there is good reason *not* to grant

14 *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64.
15 *An NHS Trust* v *X* n 3 above.
16 *E & F* n 9 above.
17 See for example *Yates & Anor* v *Great Ormond Street Hospital for Children NHS Foundation Trust & Anor* [2017] EWCA Civ 410, and the Supreme Court's rejection of the challenge to this decision: 'Lady Hale's explanation of the Supreme Court's decision' as delivered in Court on 8 June 2017 at https://www.supremecourt.uk/news/permission-to-appeal-hearing-in-the-matter-of-charlie-gard.html [https://perma.cc/VJZ4-TTD3].
18 *An NHS Trust* v *X* n 3 above at [2].
19 See for example Freeman, n 2 above; Bridgman, n 2 above. These cases are described as 'retreat' cases because they seem to 'retreat' from the greater level of respect accorded to adolescent's decisions in *Gillick*.
20 See for example John Harris, 'Consent and end of life decisions' (2003) 29 *Journal of Medical Ethics* 10, 15 when he says, 'The idea that a child (or anyone) might competently consent to a treatment but not be competent to refuse it is palpable nonsense'. Similarly, Andrew Grubb, 'Treatment decisions: keeping it in the family' in Andrew Grubb (ed), *Choices and Decisions in Health Care* (Chichester: John Wiley, 1993) 62: 'Both legally and morally, consent or refusal of consent by a competent child must be opposites of the same coin'. There have also been several attempts to justify this asymmetry. See for example Stephen Gilmore and Jonathan Herring, '"No" is the Hardest Word: Consent and Children's Autonomy' (2011) 23 CFLQ 3. See also Emma Cave and Julie Wallbank, 'Minors' Capacity to Refuse treatment: A reply to Gilmore and Herring' (2012) 2 *Medical Law Review* 423.
21 *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649, 664.
22 *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449.

their decision legal authority, especially in the face of serious countervailing harm. Without seeking to delve too deeply into Enlightenment ideas about the bounds of legitimate state authority (encapsulated in John Stuart Mill's conception of liberty),[23] the law (at least in respect of adults) proceeds on the assumption that while people capable of autonomy ought to have the liberty to make decisions free from state interference, for those who are incapable (which in Mill's view included those not 'in the maturity of their faculties'),[24] the law has a legitimate role in intervening to ensure that the decision made protects the person's interests. It is thus only if the minor is deemed to be capable of autonomous decision-making that issues of parity between adolescents and adults, or between consent and refusals, are really relevant, since it is only in this situation that one would plausibly contend that the minor's refusal of treatment, especially where that is liable to cause grievous or irreversible harm to them, ought to be determinative.

Given this, it is interesting that while academic (and judicial)[25] attention *has* been given to whether the individuals in specific cases were rightly regarded as being *Gillick*-competent or not (some have been quick to point out, for example, that the minor in *Re W* was likely to have lacked *Gillick*-competence because of her anorexia nervosa),[26] relatively little commentary has focused on the extent to which the test for competence in *Gillick* is able to accurately test whether or not a minor is capable of autonomous decision-making. Brazier and Bridge have, as noted above, criticised '*Gillick*'s apparent equation that understanding equals autonomy';[27] while Cave has recognised the value in reforming the test so as to leave 'less extensive' 'gaps' than the current *Gillick* test.[28] Sir James Munby meanwhile, seemed to implicitly accept that *Gillick*-competence did not align entirely with autonomy when he noted that the Strasbourg jurisprudence did not mandate that a *Gillick*-competent child ought to be viewed as fully autonomous in the way that a capacitous adult is.[29] Beyond this, however, there has been limited examination of the issue of when adolescents' refusals can rightly be deemed autonomous, especially when religiously motivated.

As Brazier and Bridge have suggested, it would seem highly doubtful that the test for *Gillick*-competence does fully account for whether an adolescent is capable of autonomous decision-making. Although the 'test' of competence is referred to in the speeches of both Lord Scarman and Lord Fraser in *Gillick*, it is the former's speech which contains the most detailed consideration of what

23 John Stuart Mill, *On Liberty* (New York, NY: Cosimo Classicz, 2005 [1859]); for a more detailed discussion of this see Joel Feinberg, *Harm to Self* (Oxford: OUP, 1986).

24 *ibid*, 12.

25 For example, the fact that W was unlikely to meet the test of Gillick-competence led counsel to argue (unsuccessfully) that the statement in *Re W* n 14 above that the court could override a Gillick-competent refusal of treatment was in fact *obiter* and not binding on the court, see *An NHS Trust* v *X* n 3 above at [59]-[60].

26 See for example Brazier and Bridge, n 5 above.

27 *ibid*, 91.

28 Cave, n 7 above, 122.

29 *An NHS Trust* v *X* n 3 above at [120]. See also the Canadian Supreme Court in *AC* v *Manitoba (Director of Child and Family Services)* n 3 above at [117], which held that 'while many adolescents may have technical ability to make complex decisions, this does not always mean they will have the necessary maturity and independence of judgment to make truly autonomous choices.'

is demanded for a minor to be competent. In the view of Lord Scarman a minor's capacity to make his or her own decision depended upon them 'having sufficient understanding and intelligence to enable him or her to understand fully what is proposed.'[30] This, he later qualified, required not only that 'she should understand the nature of the advice which is being given', but also that she had 'sufficient maturity to understand what is involved.'[31] In the context of that case, which concerned a minor's competence to consent to contraceptives, he further specified that '[t]here are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age'.[32] It seems, therefore, that the minor must be able to understand the nature of the proposed treatment and its consequences, including non-medical implications of the treatment.

While autonomy has been subject to widely diverging interpretations in the philosophical literature,[33] it is doubtful that any accounts would regard autonomy as demanding only that the person understands the nature and consequences of a decision. Rather, most contemporary understandings of autonomy rightly demand that for a decision to be autonomous, it must reflect the person's underlying values and beliefs in some way. Indeed, it is this which often accounts for the value ascribed to the concept of autonomy in contemporary bioethics, with respect for autonomy frequently seen as both instrumentally and intrinsically connected to the promotion of well-being:[34] instrumental in the sense that as Mill explains, individuals are best placed to make choices that are good for them;[35] and intrinsic in the sense that leading our life by our own beliefs and conception of the good is felt to be essential for our fulfilment.[36] As Ronald Dworkin has explained, '[a]utonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction, and interest. It allows us to lead our own lives rather than be led along by them, so that each of us can be, to the extent such a scheme of rights can make this possible, what he has made himself.'[37]

30 *Gillick* n 4 above, 189 per Lord Scarman.
31 *ibid*.
32 *ibid*.
33 For a useful overview see Gerald Dworkin, *The Theory and Practice of Autonomy* (New York, NY: CUP, 1988) in particular, 6. See also Jonathan Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (Oxford: OUP, 2020).
34 David Molyneux, 'Should healthcare professionals respect autonomy just because it promotes welfare?' (2009) 35 JME 245.
35 Mill, n 23 above.
36 It should be noted that while this author finds the role of autonomy in promoting individual well-being to be the most convincing rationale for why it should be respected, not all philosophers who advocate the importance of it regard its value as deriving from its contribution to well-being. For example, Darwall's theory of demand autonomy (Stephen Darwall, 'The Value of Autonomy and Autonomy of the Will' (2006) 116 *Ethics* 263), makes an essentially Kantian argument that there is something fundamentally important about being a person that demands our respect for the person's autonomous choices, not, as David Molyneux explains, 'because the choices are respect-inducing in themselves, but because respect for choices is what one person can reasonably demand of another person.' (Molyneux, n 34 above, 248.) According to such a view, showing respect for a person and their capacity for self-rule demands that we respect their autonomy, even if doing so would not promote their welfare.
37 Ronald Dworkin, 'Autonomy and the Demented Self' (1986) 64 *The Millbank Quarterly* 4, 5.

This is seen most clearly in the accounts of autonomy given by Harry Frankfurt[38] and Gerald Dworkin,[39] who introduced hierarchical models of autonomy, according to which the person must be able to reflect upon and evaluate their first-order desires, deciding which they wish to endorse or promote;[40] but it is also an important feature of most contemporary liberal and relational[41] accounts of autonomy.[42] John Christman, for example, understands autonomy to mean 'to be one's own person, to be directed by considerations, desires, conditions and characteristics that are not simply imposed externally upon one, but are part of what can somehow be considered one's authentic self.'[43]

If this is right, then to be capable of autonomous decision-making demands more than simply being able to understand information about the nature and consequences of a decision, as *Gillick* requires. The person must also be able to evaluate that information in light of their authentically held values, beliefs or desires, so as to form a decision which reflects and furthers these. And this, as Catriona Mackenzie and Wendy Rogers explain, requires the person to be 'able to determine one's *own* beliefs, values, goals and wants, and to make choices regarding matters of practical import to one's life free from undue influence'.[44]

That the test contained in *Gillick* does not provide a comprehensive assessment of the adolescent's capacity for autonomous decision-making is hardly surprising given the context of the case, which involved a judicial review of Department of Health guidance on when doctors could lawfully prescribe contraception to minors without their parent's consent. The judges in the case – which, it should be noted, was heard two decades before the passing of the Mental Capacity Act 2005 – were thus never intending to dictate when a minor *ought* to take treatment decisions themselves, but only what the doctor must satisfy his or herself of in order to avoid committing a battery. The life and death scenarios in which the *Gillick* is now invoked were thus not in contemplation, and any possible harm flowing from such an approach was mitigated by the fact that the doctor would still need to act in accordance with his or her duty of care when offering treatments to the minor, and so could only offer those treatments which were clinically indicated as in the minor's best interests.[45]

38 Harry Frankfurt, *Freedom of the Will and the Concept of a Person* (The Importance of What We Care About ed, Cambridge: CUP, 1987).
39 Dworkin, n 33 above, 15-17.
40 Frankfurt, n 38 above; Dworkin, *ibid*, 15-17.
41 Relational autonomy is, as Catriona Mackenzie and Natalie Stoljar explain, an 'umbrella term', used to describe all views of autonomy that share the assumption that 'persons are socially embedded and that agents' identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity', Catriona Mackenzie and Natalie Stoljar, *Relational Autonomy: Feminist Essays on Autonomy, Agency and Social Self* (Oxford: OUP, 2000) 4.
42 See also John Christman, *The Politics of Persons* (Cambridge: CUP, 2009); Catriona MacKenzie and Wendy Rogers, 'Autonomy, vulnerability and capacity: a philosophical analysis' [2013] Int'l J L Context 37; Pugh, n 33 above.
43 John Christman, 'Autonomy in Moral and Political Philosophy' in Edward Zalta (ed), *The Stanford Encyclopedia of Philosophy* (Spring 2018 Edition) at https://stanford.library.sydney.edu.au/archives/win2015/entries/autonomy-moral/ [https://perma.cc/LG6F-5JHH].
44 MacKenzie and Rogers, n 42 above, 43.
45 See for example *Simms* v *Simms* [2002] EWHC 2743 (Fam).

Four decades on from *Gillick*, and the principle from this case is now being invoked in wholly different territory, giving rise to far more complex ethical and policy questions. The question of whether an adolescent ought to be able to consent to (physiologically largely harmless) contraceptives without their parents' approval is clearly a very different one from whether they ought to be allowed to exercise a right to self-determination, with their parent's support. And with this change, the disjunction between the test for *Gillick*-competence and philosophical accounts of autonomy begins to bite, since if we cannot be sure that a *Gillick*-competent minor is deciding autonomously, it is doubtful that *Gillick*-competence ought to be any kind of touchstone for whether a minor receives treatment or not. While this is particularly pertinent in respect of refusals of treatment, since refusing will generally be contrary to the adolescent's clinical interests and may result in serious harm to them, its import is not limited to refusals, as the invocation of *Gillick* in cases like *Bell* v *Tavistock*[46] demonstrates. Evidence on the consequences of taking puberty blockers remains limited and mixed, with the full extent of implications in the longer term currently unknown.[47] It therefore cannot be said for certain that consenting to such treatment is *harmless*, and thus that it does not matter whether the minor can autonomously consent to it or not.[48] Indeed even if treatment is physiologically harmless and clinically indicated, consent might nonetheless be important, for example, in respect of an early medical abortion.[49]

But this issue also matters because a review of the case law indicates that judges *are* sometimes concerned about a given minor's capacity for autonomy in conscience cases, not because of an inadequate level of understanding (evidence suggests that children suffering from serious illnesses often have considerable

46 *Bell* v *Tavistock* (HC) n 12 above; *Bell* v *Tavistock* [2021] EWCA Civ 1363 (*Bell* v *Tavistock* (CA)).

47 The Cass Review Interim Report at https://cass.independent-review.uk/publications/interim-report/ [https://perma.cc/7FPU-2HG9] for example, found that 'There has been research on the short-term mental health outcomes and physical side effects of puberty blockers for this cohort, but very limited research on the sexual, cognitive or broader developmental outcomes' (*ibid*, 1.27) They also point out that 'data is weak and inconclusive regarding the long-term musculoskeletal impact' (*ibid*, 3.30), and that 'A closely linked concern is the unknown impacts on development, maturation and cognition if a child or young person is not exposed to the physical, psychological, physiological, neurochemical and sexual changes that accompany adolescent hormone surges. It is known that adolescence is a period of significant changes in brain structure, function and connectivity. During this period, the brain strengthens some connections (myelination) and cuts back on others (synaptic pruning). There is maturation and development of frontal lobe functions which control decision making, emotional regulation, judgement and planning ability. Animal research suggests that this development is partially driven by the pubertal sex hormones, but it is unclear whether the same is true in humans. If pubertal sex hormones are essential to these brain maturation processes, this raises a secondary question of whether there is a critical time window for the processes to take place, or whether catch up is possible when oestrogen or testosterone is introduced later' (*ibid*, 3.32).

48 In fact it was GIDS policy that parental agreement was required before puberty blockers would be prescribed, so consent by the minor would not, in practice, have alone been sufficient for the doctors to prescribe puberty blockers. Nonetheless the legal principle remains that the child could give valid consent if deemed *Gillick* competent, *Bell* v *Tavistock* (CA) n 46 above at [81].

49 See for example *In the Matter of X (A Child)* [2014] EWHC 1871 (Fam) at [10], concerning the termination of the pregnancy of a 13-year-old girl, in which Munby J makes it clear that the court is very unlikely to act contrary to the wishes of the minor.

understanding of their condition),[50] but rather because of concerns about the extent to which the values and beliefs being acted upon are truly the adolescent's 'own'. In other words, judges appear to be cognisant of the limitations of *Gillick* when deciding cases and are thus seeking other ways to accommodate perceived impairments in the adolescent's decision-making in the case law. The result – as the following section will explore – is a lack of clarity about the relationship between these concerns and the autonomous quality of the decision in question, as well as a lack of consistency emerging about how these concerns ought to be addressed.

## CONCERNS ABOUT AUTHENTICITY IN THE CASE LAW ON RELIGIOUSLY MOTIVATED REFUSALS

As with all areas of law, the cases that come before the courts on this issue are unlikely to be reflective of the majority of situations in which doctors must determine the *Gillick*-competence of adolescents. Most of the case law concerns refusals of treatment, very often, though not exclusively, driven by religious objection. These refusals may threaten the child's life itself, or at the very least expose them to a risk of harm. The question of where the balance between autonomy and paternalism lies is thus acute, a failure to frustrate the wishes of the minor could result in serious and irreversible harm to them.

Faced with these challenging cases, judges have responded in different ways, with four different approaches (or four different justifications for overriding the adolescent's wishes) discernible from the case law. While these different justifications will be illustrated below, regardless of the mechanism through which the judge reaches their conclusion, two things are clear: firstly, adolescents will *not* be permitted to refuse life-saving treatment where they might otherwise enjoy a full life (at least where the intervention does not involve a very long-term and significant interference with their liberty);[51] and secondly, this can rarely be explained solely in terms of their level of understanding (ie their *Gillick*-competence).

### Justification one: *Gillick*-incompetent and inauthentic

The first justification advanced by (some) judges, particularly in the earlier cases following *Gillick*, has been to find the child *Gillick*-incompetent (often through setting the threshold for *Gillick*-competence very high), but then to draw on doubts about authenticity as part of the justification for giving less weight to

50 See for example Priscilla Alderson, *Children's Consent to Surgery* (Buckingham: Open University Press, 1993).

51 It is possible, for example, that a court might allow an adolescent to refuse life-saving treatment even where they might enjoy a full life, if the treatment was not a short one-off treatment like a blood transfusion but a long-term and invasive treatment, such as chemotherapy, the provision of which entailed depriving them of their liberty for some time. I am grateful to the anonymous reviewer for raising this point.

their wishes in the best interests assessment. *Re E (A Minor) (Wardship: Medical Treatment)*[52] (*Re E*), for example, concerned a 15-year-old boy who was suffering from leukaemia. He and his family were devout Jehovah's Witnesses and accordingly he refused the conventional treatment for his condition (which would necessitate blood transfusions) in favour of a less-effective alternative treatment.[53] Mr Justice Ward described the case as 'excruciatingly difficult'.[54] Despite A's 'obvious intelligence' and his 'calm discussion of the implications' of the decision, including the fact he 'may die as a result', he did not believe A to 'have a full understanding of the whole implication of what the refusal of that treatment involves.'[55] In particular, he raised concerns that A did not fully comprehend how 'frightening' it would be to become 'increasingly breathless' (something which neither the doctor nor the judge had considered it necessary to spell out for him),[56] nor the 'distress he [would] inevitably suffer as he, a loving son, helplessly watches his parents' and his family's distress'.[57] The bar for him to demonstrate *Gillick*-competence would thus seem to have been set impossibly high (requiring far more understanding than would be required of adults).[58]

This is perhaps unsurprising, since Mr Justice Ward goes on to acknowledge that A's level of understanding was 'not the issue for me.'[59] Rather the issue was determining what his welfare dictated, of which his wishes, grounded in religious convictions which the judge found to be 'deeply held and genuine', were an important factor.[60] In deciding this question, the judge had to ask himself to what extent A's decision was the product of his full and free informed thought?[61] Although professing not to wish to 'introduce into the case notions of undue influence', he found ' the influence of the teachings of the Jehovah's Witnesses' to be 'strong and powerful'.[62] A was a boy

> who seeks and needs the love and respect of his parents whom he would wish to honour as the Bible exhorts him to honour them. I am far from satisfied that at the age of 15 his will is fully free. He may assert it, but his volition has been conditioned by the very powerful expressions of faith to which all members of the creed adhere. When making this decision, which is a decision of life or death, I have to take account of the fact that teenagers often express views with vehemence and conviction – all the vehemence and conviction of youth! Those of us who have passed beyond callow youth can all remember the convictions we have loudly proclaimed which now we find somewhat embarrassing. I respect this boy's profession of faith,

52 *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.
53 *ibid*, 388.
54 *ibid*, 389.
55 *ibid*.
56 *ibid*.
57 *ibid*.
58 See for example Emily Jackson, *Medical Law: Text, Cases and Materials* (Oxford: OUP, 4th ed, 2016) 303.
59 *ibid*, 393.
60 *ibid*.
61 *ibid*.
62 *ibid*.

> but I cannot discount at least the possibility that he may in later years suffer some diminution in his convictions.[63]

Accordingly, he found it to be in A's best interests to authorise the administration of blood products. It seems difficult to deny that what motivated the judge's decision was a concern not about the child's competency, but about the authenticity of his decision; given the strong and powerful influence of his family and religious community, was he really meaningfully free to decide otherwise?[64]

Similar concerns underpinned *Re L (Medical Treatment: Gillick Competence)*[65] (*Re L*), involving a 14-year-old Jehovah's Witness who required surgery (including a blood transfusion) following very serious burns. L was a 'sincere adherent to the faith' having taken out (and later replaced) a 'no blood' card,[66] and accordingly refused a blood transfusion, with the support of her family. Once again, the doctor did not feel it 'appropriate' to go into 'detail' with her about the manner of her death, which would, by all accounts, be a 'horrible death', with gangrene supervening,[67] and accordingly the judge found her to lack *Gillick*-competence. However, despite professing not to 'question the sincerity of this girl's belief', Sir Stephen Brown P was clear that it should not 'be overlooked that she is still a child.'[68] She had led a sheltered life, within which her membership of the Jehovah's Witness congregation formed a 'very large part'. In the week before the accident for example, she said she had spent 60 hours 'dealing with matters connected with the church.'[69] This necessarily limited her understanding of 'matters which are as grave as her own present situation.'[70] He thus had no hesitation in authorising the treatment. As in *Re E*, concerns over the familial and cultural influence the adolescent had been subjected to, thus seemed to result in the judge placing less weight on their wishes in the best interest assessments than they might have, for example, for an adult.

### Justification two: *Gillick*-competent, but inauthentic

Implicit in Mr Justice Munby's suggestion that Strasbourg jurisprudence does not mandate that a *Gillick*-competent child ought to be viewed as 'in all circumstances autonomous in the sense that a capacitous adult is autonomous',[71] is the notion that a minor might be *Gillick*-competent and yet their wishes not fully autonomous. This approach can also be discerned from other judgments, in which the courts have found the adolescent *Gillick*-competent and

63 *ibid*.
64 We cannot know whether he was right about this, though in the event, A required more blood products after turning 18, and continued (now lawfully) to refuse them, resulting in his death just two years later.
65 *Re L (Medical Treatment: Gillick Competence)* [1998] 2 FLR 810; (1998) 51 BMLR 137.
66 *ibid*, 137.
67 *ibid*, 138.
68 *ibid*, 140.
69 *ibid*.
70 *ibid*.
71 *An NHS Trust* v *X* n 3 above at [120].

yet overridden their wishes regardless. In *F* v *Somerset NHS Foundation Trust*,[72] for example, F (another Jehovah's Witness) was at risk of needing blood products after suffering a spleen injury during a motorbike accident. By the time of the hearing, F was clinically stable and there was estimated to be only a 10 per cent chance of secondary haemorrhage, making it unlikely that blood products would prove necessary.[73] Nonetheless Mrs Justice Arbuthnot authorised their use, should an emergency arise, concluding ultimately that when balancing 'the possible loss of a healthy young life with a full potential lifespan ahead on the one hand, and the risk of [F] having to suffer a violation of his strongly held religious beliefs on the other … the preservation of life should take precedence.'[74] In explaining her reasoning, however, she clearly cast doubts on the authenticity of F's decision, notwithstanding finding him to be competent. She begins by implicitly questioning whether this really is what F wanted, given the hurried way in which he had had to make a decision.[75] Then, she expressed scepticism that the decision would, as F maintained, plague him 'every day'. She opined that 'it is possible he will feel less concerned about it than he feels now, and it might well be that his distress if he was to receive blood products would lessen over time. [F] is still in his formative years.'[76] The clear implication was that he might feel differently when he moved beyond his 'formative years'. As in those cases above, therefore, doubts about the authenticity or longevity of the adolescent's decision appeared to be a factor in the weight accorded to their wishes when determining their best interests.

### Justification three: *Gillick*-incompetent, assessed by reference to understanding and authenticity

In *Re S (A Minor) (Medical Treatment)*[77] (*Re S*) the court adopted a different approach, deeming the authenticity of the decision (or lack thereof) a component in finding the adolescent to lack *Gillick*-competence, as opposed to a dimension of the best interests assessment. S had suffered from a life-threatening type of thalassaemia from birth, requiring monthly blood transfusions. Although her mother converted to become a Jehovah's Witness when she was ten,[78] it was only after reading a Jehovah's Witness pamphlet aged 15, that S professed to hold the beliefs of Jehovah's Witnesses on receiving blood, and began refusing transfusions.[79]

72 *F* v *Somerset NHS Foundation Trust* (unreported). The judgment was appealed in *E & F* n 9 above, which contains extracts from the judgment.
73 *E & F* n 9 above at [27].
74 *ibid* at [34].
75 *ibid* at [16] per Arbuthnot J: 'Although I entirely accept that he is a thoughtful young man and this is not a frivolous or ill-considered position, even an adult would struggle to grapple with the ramifications of something like this after a serious accident and with only two days to really think about it actually happening to him'.
76 *ibid* at [34].
77 [1994] 2 FLR 1065.
78 *ibid*, 1065.
79 *ibid*, 1068.

Her consultant, Dr J, who had treated her almost since birth, felt 'S to have been under considerable pressure in recent years to stop her transfusions.'[80] He expressed concern that S's mother had, in her presence, made it clear 'that she did not want S to have transfusions and would rather that S died.'[81] Moreover, he felt that 'going to meetings of Jehovah's Witnesses when she is in obvious breach of one of their fundamental beliefs was itself a matter of pressure.'[82] Dr S (a consultant child psychiatrist) found that although S's 'cognitive ability was intact and her intelligence in the normal range', she was not as 'bright as her manner might suggest.'[83] Much of what she said to Dr S seemed to be mere repetition of what she had been told or had read (often using the same phraseology as her mother), which did not bear 'close scrutiny.'[84] She was uncertain, for example, as to why God was against her having blood,[85] and could only express her thoughts as being what 'was said in the Bible.'[86] She also repeatedly mentioned the possibility of a miracle, causing Dr S to doubt that she fully understood the implications of her decision.[87]

Alongside her beliefs, she expressed much distress at her condition, suggesting that if her life was to continue as it was, she 'might as well die'.[88] She was fed up with being treated like a 'pin cushion',[89] which in the view of the doctors, left her more 'susceptible to influence.'[90] Mr Justice Johnson was left with 'no doubt at all' that she was not *Gillick*-competent. She was not 'in-between' childhood and adulthood, but very much still a child,[91] with her integrity and commitment that 'of a child and not of somebody who was competent to make the decision that she tells me she has made.'[92] Importantly, in assessing her *Gillick*-competence, he took account of the effect of the influence of others, holding that

> because she is disillusioned with the treatment – one might say, fed up with it – she is susceptible to influence from outside. I do not believe that the mother or any Jehovah's Witnesses have overborne the wish of S in the Matter, but I do believe that she has been influenced by them in the sense that she has come to share their faith. She does not understand the full implications of what will happen. It does not seem to me that her capacity is commensurate with the gravity of the decision which she has made.[93]

The judgment is not entirely clear here whether the influence of her mother and religious community was thought to undermine her understanding, or just

80 *ibid*.
81 *ibid*, 1073.
82 *ibid*.
83 *ibid*.
84 *ibid*.
85 *ibid*, 1074.
86 *ibid*.
87 *ibid*.
88 *ibid*, 1073.
89 *ibid*.
90 *ibid*.
91 *ibid*, 1075.
92 *ibid*.
93 *ibid*.

her 'competence' more generally, but it certainly contributed to a finding that she lacked *Gillick*-competence.

### Justification four: the presumption of life takes precedence

In the final category of cases, judges have not engaged with the question of what weight the minor's wishes ought to be given in any detail at all, deeming it almost axiomatic that a minor's wishes would not take precedence over their life. In *Re X (A Child)* for example,[94] Mr Justice Munby had no trouble in finding that X – a 15-year-old Jehovah's Witness suffering from sickle cell syndrome – was *Gillick*-competent, describing her as 'mature and wise beyond her years'.[95] However despite recognising 'the profound significance to her of the fact I am overriding her strongly held religious beliefs',[96] he nonetheless held that allowing her to refuse treatment would run a 'an impermissible risk, of really serious harm to, not merely her future health and welfare but, potentially, even to life itself.'[97] The implication is that in a situation in which the minor's life is (needlessly) threatened, this will always take precedence over the minor's wishes in any best interests assessment.

A similar approach was taken in *E* v *Northern Care Alliance NHS Foundation Trust*,[98] also concerning a Jehovah's Witness. Despite the likelihood of severe surgical bleeding requiring a transfusion being low (estimated at between 1:1000 and 1:2000),[99] Mrs Justice Theis authorised the blood transfusion, holding that 'despite her expressed wishes and her age and circumstances, that her best interests will be met by this court granting the declaration that has been sought.'[100] The medical evidence was clear: should a bleed arise, and were the Trust 'not able to use blood products, then that will have fatal consequences for [E].'[101] In these cases then, the authenticity or otherwise of the adolescent's decision would seem immaterial, the presumption in favour of life is determinative.

It is clear from all of these cases, that judges are reluctant to allow adolescents to 'martyr themselves' for their religious beliefs. In many of them, at least one justification offered for overriding the adolescent's wishes was a concern that the decision reached was not truly their own, or at least not something that, with the benefit of adult reflection, they would necessarily have continued to seek for themselves. On one view, such authenticity concerns may simply be a pretext for ends-orientated decisions by judges. Through the inherent jurisdiction, judges are empowered to decide what is best for the child, and thus to prevent them from causing serious harm to themselves. Indeed, perhaps if judges had legal authority to do the same for adults, they would. However, it seems equally

94 [2020] EWHC 3003 (Fam).
95 *ibid* at [3].
96 *ibid* at [15].
97 *ibid*.
98 *E* v *Northern Care Alliance NHS Foundation Trust* (unreported). The judgment was appealed in *E & F* n 9 above, which contains extracts from the judgment.
99 *ibid* at [11], quoted in *E & F ibid* at [15].
100 *ibid* at [19], quoted in *E & F ibid* at [15].
101 *ibid* at [18], quoted in *E & F ibid* at [15].

plausible that these concerns are genuine, and that such a desire to avoid harm may be driven at least in part by concerns about the stability and longevity of the adolescent's views, with judges less willing to tolerate an adolescent harming themselves in adherence to their religious beliefs precisely because they have less confidence in the authenticity of those beliefs or values.

While the legitimacy of such concerns will be examined in the following section, two aspects of the court's current approach warrant noting at this stage. Firstly, as the discussion above has highlighted, such concerns are not being dealt with in a consistent manner, with them sometimes going to the question of competence, sometimes to the issue of best interests, and at other times not being engaged with at all. Secondly, a reticence by the courts to confront what influence the parents or communities are having on the decision explicitly has resulted in them failing to isolate what exactly their concerns about authenticity are in such cases. An important distinction may be drawn between two different situations in which authenticity concerns might arise. The first are those in which there are doubts over whether the adolescent really does believe the religious doctrine at issue, and accordingly whether they really do authentically wish to refuse a blood transfusion, as opposed to feeling some degree of familial or cultural pressure to do so. Such pressure may, of course, be especially pertinent for an adolescent who lives at home with their parents and so must continue to live alongside the family or community which condemns their actions. These will be referred to as cases in which the adolescent's will has been 'overborne'. The second, arguably more complex kind of case, is that where the adolescent does appear to genuinely believe the religious doctrine in question, and yet the court is concerned that the circumstances in which such beliefs have been inculcated effectively amount to indoctrination. Here, the adolescent may genuinely wish to refuse the blood transfusion and yet there may be concerns about the source, origins and perhaps the longevity of that desire (will they still hold it when they move into adulthood and away from the influence of their parents, for example?). These cases (referred to here as 'inculcation' cases) raise distinct issues from the 'overborne will' cases, with different implications for autonomous quality of the decision. Far from conflating these concerns, therefore, the court ought instead to be attempting to isolate the exact nature of their concerns about the authenticity of a decision, and what this means for the adolescent's capacity for autonomous decision-making. This will be undertaken in the following section.

## ARE CONCERNS ABOUT AUTHENTICITY LEGITIMATE?

It appears from the examples given above that judges *are* concerned with the authenticity of the adolescent's decisions in these conscience cases, but should they be? Do we have sufficient reason to doubt the authenticity of these adolescent's decisions and, if we do, are our concerns sufficient to think that the decision being made is not an autonomous one?

While there is widespread agreement among philosophers that autonomy demands some notion of authenticity, such agreement does not extend to what it

means for a decision to *be* authentic. Different accounts of autonomy construct authenticity differently, viewing different things as relevant to the question of whether or not a specific desire can be said to be authentic. Jesper Ahlin provides a useful (if slightly reductionist) taxonomy for engaging with these accounts of authenticity, categorising them as either 'sanctionist theories', 'coherentist theories' or 'originist theories'.[102] While sanctionist theories differ substantially in their demands, broadly they dictate that the authenticity of a desire depends on the person's attitude towards it: do they, after critical reflection, endorse or sanction that desire, either actually or hypothetically.[103] Originist theories, by contrast, focus on the origins or source of the person's desires (does it originate in a cognitive process which is within the control of the person?), while according to coherentist theories, the authenticity of a desire depends upon the extent to which it coheres with the person's character system or autobiographical narrative. It is, of course, not possible to do justice to all theories of authenticity here. Rather, this section will focus on three influential accounts (covering the breadth of Ahler's taxonomy), which have each given detailed consideration to the question of authenticity in the context of social relations and influences, those of Alfred Mele, John Christman and Jonathan Pugh.[104]

Alfred Mele's approach focuses on the origins of a given desire. He regards it a necessary condition of authenticity that an agent is not 'compelled' to hold a given desire. This, he explained, would be the case if they are caused to hold it in a way which bypasses their capacities for control over their mental life. That bypassing must result in the agent being practically unable to shed that desire or value, and it cannot itself have been arranged or performed by the agent.[105] The difficulty with such an approach, is that arguably we have been caused to hold very many of our desires in ways that have bypassed our capacities for control – desires that were 'imputed to us during the pre-critical stages of our development,' and which now, as adults, we are practically unable to

102 Jasper Ahlin, 'The impossibility of reliably determining the authenticity of desires: implications for informed consent' (2017) 21 Med Health Care and Philos 43, 43.

103 Two instrumental sanctionist accounts are those of Gerald Dworkin and Harry Frankfurt. They expressed this requirement slightly differently. Frankfurt, for example, asked whether the person 'endorses reflectively' their desires; while Gerald Dworkin thought the person must be able to question whether they identify with or reject their reasons for acting (before later dropping the requirement of identification). See Frankfurt, n 38 above; Dworkin, n 33 above, 15-17.

104 All three accounts might be seen as responses to the sanctionist approaches of Dworkin and Frankfurt, according to which a desire is authentic where the person has reflected on and evaluated their first order desires and decided which to endorse or identify with. Despite their influence in bioethics, such accounts have faced criticism from those who have questioned why endorsement by second-order volitions is sufficient to render a desire authentic. After all, either this authority derives from an '*even higher* order volition [that] authenticates one's second-order volitions as being one's own' (Pugh, n 33 above, 46) leading to a problem of infinite regress, whereby the authenticity of each desire depends on the volition 'above it'; or that higher order does not require authentication, in which case Christman's 'ab initio' problem arises; how 'a desire can be autonomous if it was evaluated by a desire that was not itself autonomous.' (John Christman, 'Autonomy and Personal History' (1991) 21 *Canadian Journal of Philosophy* 1, 7). For further criticism, see also Gary Watson, 'Free Action and Free Will' (1987) 96 *Mind* 145; Bernard Berofsky, *Liberation from Self* (New York, NY: CUP, 1995). Later theories have thus sought to overcome these problems.

105 Alfred Mele, *Autonomous Agents: From Self-Control to Autonomy* (Oxford: OUP, 2001) 166-171.

shed.[106] After all, no desires arise out of nowhere, and most are a product of (or at least shaped by) our environment and our cultural and familial upbringing. Accordingly, it is arguable that adults, as well as adolescents, lack autonomy in a great many decisions, which rest on desires formed in their very early years – a claim which would seem counter-intuitive, at the very least. As a result, Mele introduces an important qualification: the agent will only be non-autonomous in respect of a desire which he was compelled to have, if he 'neither presently possesses nor earlier possessed pro-attitudes that would support his identifying with [that desire], with the exception of pro-attitudes that are themselves practically unsheddable products of unsolicited bypassing'.[107] The effect is to shift Mele's accounts closer to a sanctionist one: if the desire was formed in a way that bypassed the person's control (for example in early childhood), but the person now identifies with it, the desire is not inauthentic.

John Christman too, adjusted his focus from the origins of a desire, to the person's attitude towards that desire in light of its causal origins. Having initially asked whether the agent would have resisted the process by which a preference was formed,[108] he later revised his theory of authenticity following criticism that one might resist the process by which one came to form a desire and yet still endorse it. In his later account, the question posed was whether the person would feel deeply alienated from a characteristic or desire, if they engaged in critical reflection about it, in a variety of conditions, and in light of the history of that characteristic's development. This critical reflection must entail consideration of 'whether the factor being considered can be taken in as part of the person's overall self-narrative; whether the person can accept this part of herself (without alienation) as part of an autobiographical narrative she embodies and enacts.'[109] Crucially, the reflective non-alienation cannot itself be influenced by manipulating forces.[110]

For a desire to be authentic then, the person must have critically reflected upon it, knowing of its origins, and not felt alienated from it, in the sense of experiencing feelings of 'repudiation and resistance'.[111] Christman's account may therefore be seen as a modified sanctionist theory, but with greater importance attached to the coherence of the desire with the person's wider narrative, since the person must reflect upon the desire and decide whether to accept it as part of their self-narrative.

Later philosophers have gone further to enshrine the importance of coherence between a desire and the person's 'character system'. Building on the work of Laura Ekstrom,[112] Jonathan Pugh, for example, advocates a modified coherentist theory.[113] According to this, an agent is autonomous in acting on a first-order desire if they have a 'personally authorized preference' for that desire to

106 Pugh, n 33 above, 73.
107 Mele, n 105 above, 172.
108 Christman, n 104 above, 10-11.
109 Christman, n 42 above, 155.
110 *ibid*, 146.
111 *ibid*, 144.
112 Laura Ekstrom, 'A Coherence Theory of Autonomy' (1993) 53 *Philosophy and Phenomenological Research* 599, 603.
113 Pugh, n 33 above.

be effective.[114] A preference is a specific type of desire formed in the search for what is good. It will be 'personally authorized' if it 'coheres' with the agent's 'character system', that is, with 'the agent's set of preferences at time *t*, in conjunction with the set of propositions that the agent accepts at *t*.'[115] This will be the case wherever they have sufficient reason to adopt it in light of those preferences and acceptances.[116] Accordingly a person's desire may be inauthentic if they do not endorse it, or if they endorse it with a preference that is incoherent with their character system, in the sense that they do not have sufficient reason for that desire to be effective given what they accept to be true or good. Like the previous theories then, the agent's attitude towards their desire remains important in the sense that the person must endorse that desire and wish for it to be effective. But that is not alone sufficient, since they must also have sufficient reason to seek to do so, given their character system.

Under any of these three theories of authenticity, instances in which the minor's will has been overborne are clearly inauthentic (and thus non-autonomous), since the desire is not one that they endorse or identify with as part of their character system, but rather one that they feel compelled to hold, or at least to express. In these cases, it is therefore right to doubt their autonomy and seek to intervene to protect them from a course of action which does not reflect their authentically held beliefs or values.

Far more difficult, however, are the inculcation cases, which though conceptually distinct from overborne will cases, may not be easily distinguishable in practice. In these cases, the adolescent *is* critically reflecting on their desire and deciding to endorse it. Indeed, one can scarcely think of a situation in which a person would reflect more critically on the significance of their beliefs, than when deciding whether it ought to trump their life. Can there be any greater endorsement of a desire? The decision is one which, in most cases at least, is entirely coherent with their character system, reflecting what they believe and accept to be good and true. And even if the beliefs grounding a desire did originate in processes that bypassed the adolescent's mental control (being acquired during their early developmental years in which they could not reflect on them critically), Mele and Christman are both clear that if the person later identifies with that desire, it can no longer be said to be inauthentic. As Pugh explains, 'the fact that one has been initially manipulated into holding a desire (by emotional means or otherwise) does not entail that one must thereby *forever* lack autonomy with respect to it. One can come to critically reflect on the content

114 *ibid*, 49.

115 *ibid*, 49–50.

116 *ibid*, 54. Note on this issue, Pugh diverges from Ekstrom, who held that to be coherent with their character system, it had to be either '(i) more valuable for the agent to prefer that desire than it is for her to prefer a competing desire, on the basis of their character system, or (ii) as valuable for the agent to prefer the conjunction of that desire and another neutralizing desire *n*, as it is for her to prefer a competing desire.' This modification, Pugh explains, accommodates the idea that they can make sub-optimal choices which still reflect central elements of their character, particularly, as he observes, given the 'imprecise truths governing the strength of our competing practical reasons', *ibid*, 54.

of the manipulated desire, and to decide for oneself whether or not to *sustain* it in the light of one's preferences.'[117]

This must be right. After all, it would seem odd to deem someone's religious beliefs permanently inauthentic throughout adulthood, merely because they had been inculcated in them by their parents and community as a child. Intuitively, it seems that what ought to matter is not how the person came to have a belief, but whether they are capable of reflecting on it and shedding it if they do not identify with it. The key question in these cases, then, is the extent to which we really do think the adolescent has – and indeed *can* – take ownership of their values in this way. Is the adolescent's endorsement at this stage in their life truly free from influence, or independent of these manipulative forces? And why does this matter for the autonomous nature of the decision?

It is on this question which the theories of authenticity above diverge. For both Christman and Mele, the adolescent's reflection and non-alienation must itself be free from manipulative influences. Christman for example, is clear that the person's reflective non-alienation cannot itself be influenced by manipulating forces;[118] while Mele's qualification does not apply where the person's 'pro-attitudes … are themselves practically unsheddable products of unsolicited bypassing.'[119] Pugh, by contrast, takes a different approach to cases in which 'the agent's endorsement of a manipulated psychological characteristic is *itself* a product of elements of one's character system that one has also been compelled to have',[120] considering that in such instances, the person could still be acting autonomously. Pugh discusses Mele's example of Beth and Ann, in which Beth, a talented but unproductive philosopher, is brainwashed to become psychologically identical to Ann, an 'exceptionally industrious philosopher', through an alteration of her hierarchy of values.[121] Whereas for Mele, endorsement of a manipulated desire by compelled values or beliefs would render that desire inauthentic, Pugh doubts this conclusion, suggesting that both Beth and Ann are autonomous, since both are endorsing desires with a preference which is coherent with their character system.[122]

In doing so, Pugh makes an important point which is apposite here. Why, he asks, would we find Beth in his example to lack autonomy, and not the many other ordinary people whose character systems are also unsheddable in relevantly similar ways 'by virtue of their formation in pre-critical periods of their lives?'[123] In other words, is Beth not analogous to the Jehovah's Witness adolescent, whose beliefs were inculcated from a very early age and so are, in a meaningful sense, unsheddable? One response to this (acknowledged by Pugh), would be to draw on Christman's theory of authenticity, and claim that whereas Beth would hypothetically feel alienated from her (philosophy-preoccupied) values if she knew of their causal history, the same cannot be said for a Jehovah's Witness adolescent, who may plausibly not feel the same sense of resistance at having

117 Pugh, n 33 above, 66.
118 Christman, n 42 above, 146.
119 Mele, n 105 above, 172.
120 Pugh, n 33 above, 75.
121 Mele, n 105 above, 172.
122 Pugh, n 33 above, 75-76.
123 *ibid*, 75.

the authentic beliefs of their parents inculcated into them. However, in Pugh's view, a better way of conceptualising the issues in this case is through seeing such instances of global manipulation as 'primarily relevant to questions of personal identity and moral responsibility rather than autonomy.'[124] He gives an example to illustrate this point. Let us suppose that Beth has a medical condition which will result in paralysis unless she undergoes a neurosurgical procedure which is likely to cause mild cognitive impairment. Prior to being brainwashed, Beth would have prioritised the avoidance of paralysis above a small loss of cognitive capacity, but after it, she no longer attaches importance to pursuits other than philosophy, and would prioritise her cognitive capacities above all else. Here, he says, Beth can 'clearly autonomously decide to refuse to consent to the procedure, even though she did not arrange for the global change in values that manipulation evinced, and which now grounds the autonomy of her decision.'[125]

Having been subject to the influence of their families and communities from birth, adolescents thus raise difficult questions about how such influence affects one's capacity for autonomous decision-making, and in particular, whether it should be seen as undermining their capacity for autonomy, or as crucial formative experiences which shape their authentic self, in accordance with which they may then make autonomous choices. They appear to lie at the crossroads of different accounts of autonomy, exemplified in the difference of approach taken between Mele and Christman on the one hand and Pugh on the other. For Mele and Christman, this kind of inculcation of values *can* undermine the adolescent's capacity for autonomy, since it causes them to hold practically unsheddable values in a way that has bypassed their mental control, or renders them unable to critically evaluate them. For Pugh, meanwhile, provided that the adolescent's desires are endorsed by a preference which is coherent with their character system – which is likely in the kinds of cases considered here – the adolescent can still be acting autonomously by deciding in accordance with it.[126]

It is, of course, beyond the scope of this paper to offer a comprehensive answer to the question of what role social influences ought to play in our conception of the authentic self. Indeed, it is notable that while relational theorists have long recognised the difficulties that individualist conceptions of autonomy face in failing to recognise the socially embedded nature of people, this literature has largely focused on identifying problems, rather than offering concrete solutions to the question of how the boundaries of the self ought to be drawn. However, in the context of adolescents, Pugh's account has much intuitive appeal. Drawing a line between those influences which we regard as constitutive of an adolescent's identity (through inculcating values which form a fundamental part of who they are), and those which we consider 'external influences' which undermine a person's autonomy is both theoretically and practically fraught. We neither develop, nor sustain our values and beliefs in a social vacuum, and adults, just like adolescents, will continue to be influenced by their social and familial matrix throughout their lifetime. To the extent that being authentic

124 *ibid*.
125 *ibid*, 76.
126 Provided they also hold that preference in a theoretically rational way, which Pugh accepts can be the case in respect of Jehovah's Witnesses refusing blood transfusions, Pugh, n 33 above, 217-222.

demands that the adolescent can reflect upon or endorse values free from such influences, authenticity would seem little more than a pipe dream. But even applying a higher threshold, such as Mele's requirement that the values must be 'practically unsheddable' for them to be inauthentic, would seem to result in an inquiry that is both artificial and highly speculative.

Mele offers the example of a 'religious fanatic' who indoctrinates his child. While he acknowledges that some children subject to such inculcation will become practically able to shed such beliefs later in life (and thus may become autonomous in respect of them), others will not and will therefore 'not autonomously possess [those convictions]' as an adult.[127] Much, then, turns on whether a given adolescent is deemed 'practically unable to shed' his religious convictions. Mele elaborates on this using the example of 'Al', a parent who holds deeply entrenched 'parental values' about the need to secure the well-being of his children. Given his 'psychological constitution', Mele explains, shedding them 'is not a psychologically genuine option', even if there might be certain exceptional conditions which if they were to arise, would lead him to shed those values. He likens his notion of 'shed-ability' to 'commonsense conceptions of irresistible desires.'[128]

Clearly, applying this to a specific adolescent's religious beliefs risks being highly speculative. However, it is worth noting that the very context in which such beliefs are being evaluated is arguably highly exceptional. The adolescent is being forced – by reasons outside of their control – to decide whether to risk their life in order to demonstrate their commitment to these religious convictions. If they are unable to shed such beliefs in these circumstances then it stands to reason that, at least at present, they are 'practically unsheddable.'

In fact, evidence from the psychological literature indicates that the extent to which adolescents are able to 'shed' beliefs and values inculcated by their parents and to make their own meaningful value commitments on issues such as religion, may depend on a host of factors including the adolescent's stage of development and attachment style. Adolescence is a time both of identity development and of attachment transition, which may affect the nature and stability of their values, including their religious convictions.

Research into identity development has been heavily influenced by the work of Erik Erikson, who regarded adolescence as a period characterised by identity crisis or role confusion.[129] In his view, a crucial part of healthy personality development involves a process of exploration and experimentation with different identities and roles during adolescence,[130] enabling the person to decide which attributes and values to retain as 'one's own' and which to discard'.[131] When the task is complete, the adolescent is capable of making 'identity-defining,

127 Mele, n 105 above, 168.
128 *ibid*, 154.
129 Erik Erikson, *Childhood and Society* (New York, NY: Norton, 2nd ed, 1963); Erik Erikson, *Identity: Youth and Crisis* (New York, NY: Norton, 1968).
130 Erikson, *Identity: Youth and Crisis ibid*.
131 Francoise Alsaker and Jane Kroger, 'Self-concept, self-esteem and identity' in Sandy Jackson and Luc Goosens (eds), *Handbook of Adolescent Development* (London: Psychology Press, 2006) 90, 101.

psychosocial commitments on one's own terms and in accordance with one's own biological givens, psychological needs, and contextual possibilities.'[132]

Building on this, James Marcia sought to identify and empirically validate different ways in which late adolescents may react to this identity crisis,[133] through examining the extent to which they had engaged in identity exploration and formed ideological (and occupational) commitments. He established four identity statuses that an adolescent may have: identity achievement, moratorium, foreclosure and diffusion. Identity achievement occurs when the person has experienced a crisis period, in which they have actively explored different values and beliefs and reflected on their past beliefs, before committing, on their own terms, to a particular ideology or occupation.[134] They had thus made 'important psychosocial identity-defining commitments, following a period of active exploration and decision-making.'[135] Foreclosed individuals, by contrast, have not experienced any such identity crisis and have not engaged in active exploration, instead expressing commitments through identification with significant others, predominantly their parents. As Marcia summarises, for a foreclosed individual, '[i]t is difficult to tell where his parents' goals for him leave off and where his begin. He is becoming what others have prepared or intended him to become as a child. His beliefs (or lack of them) are virtually 'the faith of his fathers living still.'[136]

For those with a 'diffused' identity, the person had not committed to any given ideology, being 'either uninterested in ideological matters or tak[ing] a smorgasbord approach in which one outlook seems as good to him as another and he is not averse to sampling from all.'[137] They thus demonstrate 'little interest in or inclination to develop and make commitments to any personally meaningful, identity-defining psychosocial roles or values.'[138] The moratorium subject, by contrast, is in a crisis period, however their commitments remain rather vague. Unlike identity-diffused subjects, they are engaged in an active struggle to find their identity and make commitments, even if no such commitments have yet been made.[139]

Marcia's empirical approach has been highly influential and garnered widespread support.[140] While there remain a number of unanswered questions regarding the timing and course of identity status change, Kroger and others' meta-analysis found that the mean proportions of those in the identity achievement status generally increased over time, lending broad support for the notion

132 Jane Kroger, 'Why is identity achievement so elusive?' (2007) 7 *Identity: An International Journal of Theory and Research* 331, 331.

133 James Marcia, 'Development and validation of ego identity status' (1966) 3 *Journal of Personality and Social Psychology* 551, 551.

134 *ibid*, 552.

135 Kroger, n 132 above, 332.

136 Marcia, n 133 above, 551.

137 *ibid*, 552.

138 Kroger, n 132 above, 332.

139 Marcia, n 133 above, 552.

140 For example, by 1999, it was represented in 'more than 300 papers, articles, or dissertations', Anne van Hoof, 'The identity status approach: In need of fundamental revision and qualitative change' (1999) 19 *Developmental Review* 622, 622. Subsequent research has shown that particular personality variables are consistently associated with each of these four identity statuses, as are early family conditions or relationships. See for example Alsaker and Kroger, n 131 above, 103.

of progression towards achieved status.[141] Much work has been done on these statuses which is beyond the scope of this paper. However, the key point is that the evidence on adolescent identity development demonstrates overwhelmingly that not all adolescents have constructed a sense of their own identity, and thus have formulated their own value commitments following a period of reflection and exploration. Some (those who are 'diffused') may not hold meaningful commitments, others (those in a 'moratorium') may hold rather vague commitments, and yet more (the 'foreclosed') may attain their values primarily through others, such as their parents. In fact, Alsaker and Kroger highlight a number of longitudinal studies which have consistently shown that among university students, 'at least 50% of adolescents remain foreclosed or diffuse across all identity domains'.[142] And these studies do not stand in isolation, related phenomenon, such as 'self-other differentiation', 'moral reasoning' and 'ego development' 'have all produced similar results',[143] indicating that many seem to reach the age of majority in a state of identity-flux.[144] While various criticisms have been made of the identity status paradigm over the years,[145] none have seriously doubted whether adolescence is an important period of identity development, in which a person's value commitments may be subject to challenge and change. The result is that while some adolescents may be able to make their own authentic value commitments despite the pervasive influence

141 Jane Kroger, Monica Martinussen and James Marcia, 'Identity status change during adolescence and young adulthood; A meta-analysis' (2010) 33 *Journal of Adolescence* 683, 684. By contrast, the mean proportions of those in foreclosure and diffusion statuses generally decreased over time.

142 *ibid*, 106.

143 Kroger, n 132 above, 335.

144 This lends further support for Emma Cave and Hannah Cave's thesis that the 'adolescent' phase may continue into early adulthood, see n 1 above. One reason for this posited by Kroger, *ibid*, is that people respond differently to new experiences which threaten their identity equilibrium. Some respond through identity assimilation (which involves distorting facts which are inconsistent with their sense of identity, in order to protect their sense of self), others through identity accommodation (in which one's sense of identity changes to reflect that new experience). Which strategy one has a preference for may depend on individual factors (such as 'openness to new experiences, use of more mature defense mechanisms, level of ego resilience, information processing style, and type of attachment profile' (*ibid*, 343)), but it may also be the case that certain types of events or experiences (such as stressful life events) are more likely to generate identity accommodation responses, which are then more likely to provoke identity status change. This may therefore explain differences between adolescents in their identity status, as well as why many adolescents have not achieved mature statuses, lacking the necessary range of experiences. See also Kristine Anthis, 'On the calamity theory of growth: The relationship between stressful life events and changes in identity over time.' (2002) 2 *Identity: An International Journal of Theory and Research* 229; and Jane Kroger and Kathy Green, 'Events associated with identity status change' (1996) 19 *Journal of Adolescence*, 477. Kroger and Green found, for example, that 'exposure to new contexts and internal change processes were the two types of events most commonly linked with the transition from less mature (foreclosure and diffusion) to more mature (moratorium and achievement) identity status positions'.

145 See for example Edmund Bourne, 'The state of research on ego identity: A review and appraisal (Part I).' (1978) 7 *Journal of Youth and Adolescence* 223; Edmund Bourne, 'The state of research on ego identity: A review and appraisal (Part II)' (1978) 7 *Journal of Youth and Adolescence* 371; James Cote and Charles Levine, 'A critical examination of the ego identity status paradigm' (1998) 8 *Developmental Review* 147; van Hoof, n 140 above. cf Michael Berzonsky and Gerald Adams, 'Reevaluating the identity status paradigm: Still useful after 35 years' (1999) 19 *Developmental Review* 557.

of their parents, others will continue to acquire their values primarily through their parents, and thus be more susceptible to their influence.

This may be particularly true in the context of religious beliefs. Adolescence has long been accepted as a time of religious transformation, even sometimes being referred to as the 'age of religious awakening.'[146] As Pehr Granqvist explains, it is the life period 'most intimately associated with sudden religious conversions and other significant changes in one's relationship with God',[147] with a noted increase in religiosity that has made adolescents a primary a target for cult recruiters and extremists seeking to radicalise. Interestingly, the converse has also be found, with adolescence and early adulthood also associated with disengagement from religion among those raised in religious homes. While many explanations of this have been offered in the psychological literature, Granqvist posits one possible explanation as being that this increased or decreased religiosity coincides with a period of attachment transition, where adolescents 'relinquish' their parents as attachment figures. This increased vulnerability may lead adolescents to 'turn to God (or perhaps a charismatic religious leader) as a substitute attachment-like figure', or indeed away from God.[148] How this process occurs may depend on the nature of the adolescent's attachment. In cases of secure attachment, Granqvist hypothesised that secure offspring usually adopt their attachment figure's religion: if they are actively religious, the offspring mirrors their behaviour. He cites his earlier empirical research supporting this,[149] which has found that securely-attached adolescents tend to affirm the faith of their parents. Insecurely attached adolescents, by contrast, may seek out alternative surrogate attachment figures, including a relationship with God. Their religious commitments are more typically characterised by instability, often decreasing over time as the adolescent forms other close relationships.[150]

Given this, it would seem difficult to draw any generalised conclusions about the authenticity of an adolescent's religious beliefs; the extent to which they are 'practically sheddable' would seem to depend on the individual, their stage of identity development, and their relationship with and attachment to their parents or religious figures. Emma Cave and Hannah Cave have noted the development of psychological tools to determine an individual's 'development maturity' in the context of criminal law and sentencing, including their susceptibility to influence and identity formation, which could, in time, be used

146 Michael Argyle and Benjamin Beit-Hasllahmi, *The Social Psychology of Religion* (London: Routledge and Kegan Paul, 1975) 59.

147 Pehr Granqvist, 'Attachment and Religious Development in Adolescence' in Gisela Trommsdorff and Xinyin Chen, *Values, Religion and Culture in Adolescent Development* (Cambridge: CUP, 2012) 315, 320.

148 *ibid*, 321.

149 See for example Pehr Granqvist and Lee Kirkpatrick, 'Attachment and religious representations and behaviour' in Jude Cassidy and Phillip Shaver (eds), *Handbook of Adolescence: Theory, Research and Clinical Applications* (New York, NY; London: The Guilford Press, 2nd ed, 2008) 906; Pehr Granqvist and Lee Kirkpatrick, 'Religious conversion and perceived childhood attachment: a meta-analaysis' (2004) 14 *The International Journal for the Psychology of Religion* 223; Pehr Granqvist, 'Attachment and religiosity in adolescence: Cross-sectional and longitudinal evaluations' (2002) 28 *Personality and Social Psychology Bulletin* 260.

150 *ibid*, 325.

to assess adolescents in the medical treatment context.[151] In the absence of these types of individualised evaluations, however, any assessment by the court of whether an adolescent could or could not shed their inculcated religious beliefs would seem rather empirically speculative.

However, this literature also highlights a more fundamental problem with analysing inculcation cases through the lens of autonomy rather than identity; namely that the result seems somewhat artificial. An adolescent, who let us suppose is cognitively able to understand the consequences of refusing treatment,[152] decides to do so, in furtherance of their religious commitments. These values or beliefs, while inculcated from birth, are nonetheless ones that they identify with and endorse as being of fundamental importance to them – so much so, that they are prepared to die for them. And yet we deem their choice inauthentic, because, we suppose, the influence of their parents is so pervasive that these beliefs have become 'practically unsheddable', evidenced perhaps (with a certain circularity), by the very fact they cannot shed them in the face of their own death. One is left with the distinct feeling that somewhere along the path of theoretical analysis, the concept of autonomy here has lost its sense of itself as rooted in the notion of self-government. The core to autonomy – however construed – is the ability to make choices in life which reflect those values and beliefs which are of importance to *you*. While it is true that in childhood, what matters to you will often be dictated by parental values, while adolescence is marked by a period of flux in which adolescents start to 'detach' from their parents and make meaningful value commitments of their own, to regard those values that are held throughout this transition period as 'inauthentic' would seem to deny adolescents any capacity to have an authentic self at all. Adolescents are left in a state of limbo, in which they are deemed unable to make autonomous decisions (in respect of certain things, at least) because as we cannot be sure about precisely where the boundary between the value commitments of their parents and of themselves lies, we also cannot be sure about whether their decision reflects values authentically held by 'them' at all.

When seen through the lens of identity, this state of 'limbo' makes more sense. The adolescent has a sense of self or character system, albeit one inevitably influenced to a very large extent by their upbringing and the values of their parents or attachment figures. They are perfectly capable of reflecting upon their values and beliefs, and deciding upon a course of action that is coherent with those things they value most in life. It is simply that their identity may be in a state of flux, and so what matters to them now may be subject to

151 Cave and Cave, n 1 above, 995-996. They explain that 'core characteristics of developmental maturity have been developed through psychological empirical research. They focus on (i) autonomy, including ability to incorporate and re-evaluate, (ii) cognitive capacities such as the ability to switch goals and make cost-benefit analyses, and (iii) emotional skills such as clear priorities, delayed gratification, psychological insight, identity formation and realistic expectations of self. Tools and scales have been designed to assist clinical assessment of developmental maturity. For example, Randall Salekin and Anne-Marie Iselin have developed a measure that encompasses all three areas of autonomy, cognitive skills and emotional skills, and Laurence Steinberg and Kathryn Monahan have developed a short self-report measure to assess independence' (*ibid*, 995-996).

152 This is likely to be the case, at least for older adolescents, see n 179 below.

change as they develop a stable, self-constructed identity. Seen in this way, there is no need to attempt to artificially disentangle parental influence from some abstract notion of an adolescent's separate, authentic self. It can be accepted that parents and community will have a pervasive influence on the formation of an adolescent's identity, while acknowledging that to the extent that the adolescent has reflected upon these and identified with these 'socially mediated values', they have taken 'ownership' of them to the extent necessary for autonomous action. This is so even if this process of reflection cannot take place in a vacuum; and so we cannot say that they are entirely free from manipulating influences.

The intention here is not to reject these accounts of autonomy absolutely, but rather to recognise their limitations when it comes to evaluating adolescent inculcation cases. Given the role that social influence plays in the development of any adolescent's values, the boundaries of their authentic self remain both conceptually and empirically porous. One must either conclude that because of this the adolescent lacks a fully developed authentic self and so cannot decide autonomously, however strongly held their beliefs may be, or one must abandon attempts to isolate a version of their 'true self' that is free from such influences, and accept these influences as part of the adolescent's authentic self. The latter approach, which allows for the notion that the adolescent can decide autonomously even if their values are subject to change and influence, would seem more consistent with the origins of the concept of autonomy in the notion of self-government. The question then, is how this ought to inform the court's approach to such cases.

## ADDRESSING CONCERNS ABOUT IDENTITY IN ADOLESCENCE

According to the foregoing analysis, while overborne will cases are properly analysed as impairing the adolescent's capacity for autonomous decision-making, inculcation cases are more complex as the adolescent may well be acting autonomously even if they decide on the basis of value commitments that are not part of a fully formed identity, and thus may be susceptible to change. The starting point, therefore, must be an evaluation of the adolescent's capacity for autonomous choice in any given case.

### Assessing competence

It is clear from this discussion that the test for *Gillick*-competence is inadequate since it rests purely on the adolescent's level of understanding without any regard for the authenticity of the decision being taken, and thus does not adequately reflect the minor's capacity for autonomous decision-making. While the focus of the analysis has been on conscience cases, this has implications beyond cases involving religiously motivated refusals of treatment, and so the proposals for change advocated here should not be limited to such cases, but rather should be implemented across the board.

One suggestion for reform has been to invoke the MCA 2005 in *Gillick*'s place, either through emulating the test for capacity in the MCA 2005 or through extending the scope of the Act to apply to those below the age of 16 (rather than being limited to those over 16 as is presently the case). The latter certainly would not work, since there is good reason not to apply *all* aspects of the MCA 2005 to minors, most clearly the presumption of capacity,[153] and the functional requirement that the person's inability to make a decision must be caused by an impairment in the functioning of the mind or brain (rather than merely insufficient developmental maturity).[154] The Act would thus either erroneously characterise even very young minors as capable of autonomous decision-making, or it would have to be amended in a way that threatened the autonomy interests of adults whose capacity was in doubt.

The more plausible suggestion is therefore to amend the common law test for capacity to mirror the provisions in the MCA 2005. In *S (Child as Parent: Adoption: Consent)* for example,[155] which concerned an adoption order rather than medical treatment, Mr Justice Cobb was clear about the benefits of drawing on the 'concepts and language' of the MCA 2005 to determine adolescent capacity,[156] despite differences between the two regimes.[157] In order to be satisfied that S was *Gillick* competent, he held that the child should be 'of sufficient and intelligence to' 'understand the nature and implications of the decision and the process of implementing that decision'; 'understand the implications of not pursuing the decision'; retain that information; weigh it up and come to a decision.[158] Applying the MCA 2005 in this way would, he explained, help to ensure better judicial consistency, since 'it would be illogical if the court applied a materially different test of capacity/competence depending on which side of their 16th birthday the parent fell.'[159]

This approach was cited by both the Divisional Court and the Court of Appeal in *Bell* v *Tavistock*[160] neither of which sought to challenge his conclusions on this point. It also accords with the approach advocated extra-judicially by Lord Justice McFarlane (now President of the Family Division of the High Court), who felt there was 'no reason why the scheme for evaluating capacity should be different as between the two groups of people',[161] when the 'blunt'

153 It would seem odd to apply a presumption of capacity to those young in age, especially given the psychological evidence at n 178 below that it is not until the age of 15 that many adolescents develop the necessary cognitive abilities for decision-making, and the knowledge that adolescents develop at different speeds.

154 Moreover while some adolescents in such cases would fall foul of the MCA requirement that the person's inability to make a decision must be caused by an impairment in the functioning of the mind or brain (*Re W* n 14 above, for example, or *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180 (*Re C*), both involving adolescents with anorexia nervosa), most of the cases most troubling for the courts do not involve such an impairment; the adolescent's cognitive abilities have simply not yet developed sufficiently.

155 *S (Child as Parent: Adoption: Consent)* [2017] EWHC 2729 (Fam).

156 *ibid* at [19].

157 Most notably that the presumption of capacity and the diagnostic threshold only applied in respect of adults, *ibid* at [16].

158 *ibid* at [18].

159 *ibid* at [19].

160 *Bell* v *Tavistock* (HC) n 12 above at [116]-[132]; *Bell* v *Tavistock* (CA) n 46 above at [41] and [83].

161 Mr Justice McFarlane, 'Mental Capacity: One Standard for All Ages' [2011] Fam Law 479.

instruments of 'age', 'intelligence' and 'understanding' of *Gillick* could be replaced with the 'clear, humane, balanced' law of the MCA 2005, which presented a 'flexible and sophisticated' scheme for assessing capacity.[162]

However not everyone shares his enthusiasm for this approach, with Mr Justice Munby explicitly rejecting it in *An NHS Trust* v *X*.[163] In his view, such an approach was premised on the erroneous idea that *Gillick*-competence and capacity were somehow 'related', when in fact they are 'both historically and conceptually quite distinct',[164] 'rooted in different areas of scientific knowledge and understanding.'[165] Capacity (or the lack of it) derives from an impairment or disturbance in mental functioning and thus exists in the realm of psychiatry, he explained, while *Gillick* competence is 'tied to the normal development over time of the typical child and teenager' and is thus a question of adolescent psychology.[166] These differences are, with respect, overstated. While it is true that they derive from historically distinct starting points, and that assessing them might require recourse to different types of clinical evidence, both capacity and competence are engaged in the task of determining the extent to which a person is capable of making an autonomous decision that warrants the respect of the law. The reasons *why* the person may be incapable of autonomous decision-making may be different; for the *Gillick*-incompetent adolescent, they may not yet have developed the cognitive abilities necessary for decision-making, while an incapacitated adult must suffer from an impairment in the functioning of mind or brain that causes them to lack those same abilities, either temporarily or permanently. But it is not clear that they are so conceptually distinct that they could not be elided in some form. Doing so would not only introduce greater consistency, but it would also address some of the ambiguity that currently surrounds the vaguely-framed *Gillick*-competence test, such as whether it demands the child actually understand the information at issue (as the MCA 2005 requires), or rather be capable of doing so.[167] And while legitimate concerns have been raised about 'cherry-picking' provisions from the MCA 2005, which in the absence of the presumption of capacity, could serve to make it harder for minors to prove capacity to consent to or refuse interventions,[168] given the court's approach in cases such as *Re L*,[169] it is not clear how they could conceivably set the bar for understanding higher than they do at present. In fact, having a body of jurisprudence on the relevant information that must be understood for certain treatment decisions by adults (such as the refusal of blood transfusions) might reduce the scope for judges to require implausible levels of understanding.

A more pertinent concern, given the discussion above, may be that the test for capacity is, in its current form, inadequate, since it too fails to capture concerns about the authenticity of the decision. The test focuses only on the person's

162 *ibid*.
163 *An NHS Trust* v *X* n 3 above.
164 *ibid* at [75].
165 *ibid* at [73].
166 *ibid* at [73].
167 See Cave, n 7 above, 106-107.
168 *ibid*, 110.
169 *Re L* n 65 above.

decision-making *process* – whether they can understand the information pertinent to their decision, retain that information, and reason about it. But there is nothing in the MCA 2005 which explicitly addresses whether or not the decision reflects the person's authentically held values and beliefs.[170] In fact, there are at least two ways in which an adolescent's ability to decide according to their authentic values might be undermined. Firstly, as noted above, the adolescent's will may have been overborne by their family or religious community, such that the decision they reach does not really reflect their genuine beliefs. This concern is particularly pertinent in conscience cases. Secondly, there are situations (discussed in detail elsewhere)[171] in which the adolescent may be evaluating the information by reference to values or beliefs which are the product of mental disorder, rather than being authentically held. While it is not possible to consider this category of case in detail here, it is worth noting it since the cases of *Re W*[172] and *Re C*[173] might both be examples of where this could be said to be the case, both involving the appropriate treatment of adolescents with severe anorexia nervosa.[174]

These concerns are not unique to adolescents (as the use of the inherent jurisdiction in order to protect vulnerable adults demonstrates), even if concerns about undue influence may be particularly pertinent in relation to minors, given the level of influence parents have over their children as a matter of course. However, recognising this does not necessarily militate against invoking a variation of the MCA 2005 test; it merely implies a need to modify the test to reflect the adolescent context. For example, the minor might be considered to have capacity in relation to a decision where they are able to understand the relevant information; retain it; and use or weigh it as part of the process of making a decision which reflects authentically held values or beliefs. The latter might be deemed lacking where the values or beliefs by which they are evaluating the information are thought to have been caused by or altered as a consequence of (a) a disorder, illness or impairment from which the person is suffering; or (b) the excessive, overbearing or coercive influence of others. This would ensure that the basis on which the adolescent is being found to lack capacity is clear, avoiding the ambiguity of cases such as *Re S*,[175] through forcing the judge to confront explicitly whether the adolescent lacks capacity because of insufficient understanding or weighing ability, or whether it is because the influence of others prevents them from making a decision which accords with their authentic values or beliefs. Not including the diagnostic threshold contained in

170 For a more detailed discussion of this point, see Cressida Auckland, *Values and Disorder in Mental Capacity Law* (forthcoming) ch 1.
171 *ibid*.
172 *Re W* n 14 above.
173 *Re C* n 154 above.
174 Evidence by Jacinta Tan and others suggests, for example, that anorexia nervosa can alter the person's values, in ways which cause sufferers to attach less value to life, and greater value to remaining thin, with the result that they may then attribute weight differently to certain pieces of information, causing their decisions to be a reflection of 'disordered' rather than 'authentic' values, see Jactina Tan and others, 'Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values' (2006) 13 *Philosophy, Psychiatry & Psychology* 267, 273.
175 n 77 above.

section 2 of the MCA 2005[176] would also allow the judge to consider both temporary factors (such as mental illness, or accident) which affect the person's decision-making, and their level of cognitive and emotional development more generally,[177] although it should be noted that the evidence from psychology on decision-making suggests that by the age of 15, a minor's cognitive abilities are broadly equivalent to those of adults.[178]

Such changes would not, of course, supplant the statutorily endorsed position of those over the age of 16, for whom the MCA 2005 and section 8(1) of the Family Law Reform Act 1969 would continue to apply, unless amended.[179] Asymmetries would thus be created between the position of those over and under the age of 16, with the former not subject to the 'enhanced' test for capacity (which captures the undue influence of others) and latter not benefiting from the presumption of capacity or diagnostic threshold. While it is beyond the scope of this article to set out comprehensively whether, and how, such asymmetries ought to be addressed (which would entail amendments to the decision-making framework for adults), it is worth recalling that the inherent jurisdiction does currently seek to capture some authenticity concerns via its somewhat amorphous 'Vulnerable Adults' jurisdiction, raising the question of whether some such cases would be better brought within the remit of the MCA

176 The threshold being that the inability to make a decision must be caused by an impairment in the functioning of the mind or brain.

177 One concern may be that the removal of the diagnostic threshold gives judges significant leeway to find the minor to lack capacity on the basis that they are unable to make a decision due simply to a lack of developmental maturity. However once again, it is not clear that this will worsen the position of adolescents, who may already be found to lack *Gillick*-competence on the basis that they lack 'sufficient maturity' to understand the information involved, and who may have their decision overridden on the basis of their best interests regardless. The development of tests to identify adolescent's developmental maturity, mentioned by Cave and Cave in the text to n 151 above, would nonetheless be helpful in mitigating the propensity of judges to act in this way.

178 Laurence Steinberg and others, for example, found that studies examining basic information processing skills and logical reasoning 'have found no appreciable differences between adolescents who are at least 15 and adults', with any gains in these domains occurring very early in adolescence with minimal improvements after that, a pattern reported in many similar studies on decision-making, see Laurence Steinberg, 'Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?' (2013) 38 *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 256; Laurence Steinberg and others, 'Are Adolescents Less Mature Than Adults?' (2009) 64 *American Psychologist* 583. In examining the implications of the development literature for minors' consent to treatment, meanwhile, Thomas Grisso and Linda Vierling concluded that while those under the age of 11 could not be deemed capable of giving consent to treatment, 'given the developmental psychological evidence for their diminished psychological capacities', 'there is little evidence that minors of age 15 and above as a group are any less competent to provide consent than are adults.' A transition period occurred between the ages of 11 and 14, in which minors develop a number of important skills for decision-making, but 'existing research suggests caution regarding any assumptions about these minors' abilities to consider intelligently the complexities of treatment alternatives, risks, and benefits, or to provide consent that is voluntary', see Thomas Grisso and Linda Vierling, 'Minors' consent to treatment: A developmental perspective' (1978) 9 *Professional Psychology* 412.

179 The latter provides that 'The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.'

2005, through aligning the test for capacity in the Act more closely with the test advanced for adolescents. This will be explored in future work.

**When should an adolescent's choice be overridden?**

Where the adolescent lacks capacity, the justification for overriding their choice in their best interests is clear. But what of an adolescent who has capacity, can overriding their wishes ever be legitimate, especially in those conscience cases contemplated here? The answer must, in my view, be 'yes'. The value in respecting autonomy lies in its propensity to promote welfare,[180] people are generally best placed to know what is best for them, and how a choice coheres with their self-narrative or personal identity. But where someone's identity is in flux, those beliefs or values may not survive into adulthood, and so the decision may be welfare-maximising only in a temporally limited way; once the values or beliefs which underpin it no longer resonate with that person, their welfare may no longer be promoted by it. This is not to say that an adolescent can never make a welfare-maximising choice, but where that choice has significant implications that extend far into the future, we must feel confident that the values or beliefs underpin it will extend equally far, if we are to feel confident in the longevity of its welfare promotion. Given evidence that *most* adolescents under the age of eighteen have not achieved an identity-achieved status, especially in respect of their religious beliefs, this gives us empirically grounded reasons to question their propensity to accurately define their long-term welfare interests.

Of course, two responses to this could be made. The first is that the fact that a person may not always accurately identify what will promote their welfare in the long-term, does not mean that a doctor or court is any better placed to do so. As cases such as *Re E* demonstrate (A required more blood products after turning 18 and continued to refuse them, resulting in his death just two years later),[181] an adolescent's beliefs or values may change, but equally they may not. To the extent that their identity is in flux, it is not clear that the courts can foresee where the process of identity development may take them better than they themselves can. One might also argue that in the cases considered here, where the treatment being refused is life-sustaining, their decision cannot compromise their future welfare in a meaningful sense anyway, since they will not be alive to experience it. We may therefore question the extent to which the court is really better able to protect the adolescent's future well-being.

Yet it is precisely in those circumstances where it is most difficult to predict whether an adolescent's choice will promote their future well-being or not, that the court plays a crucial role in ensuring that their future choices and opportunities remain open. As Sir James Munby notes in *An NHS Trust* v *X*, the role of the judge in this instance

180 While the author finds this the most compelling rationale for respecting autonomy, see n 36 above for a discussion of this point, and alternative views on the value in respecting autonomy.
181 *Re E* n 52 above.

> must be to bring the child to adulthood in such a way that the child is best equipped both to decide what kind of life they want to lead – what kind of person they want to be – and to give effect so far as practicable to their aspirations. Put shortly, our objective must be to maximise the child's opportunities in every sphere of life as they enter adulthood … the judge must be cautious about approving a regime which may have the effect of foreclosing or unduly limiting the child's ability to make such decisions in future.[182]

This approach is reflected in other areas of family law too, in decisions over the schooling of Ultra-Orthodox Jewish children,[183] or contact arrangements with those outside of the religious community.[184]

It is, of course, impossible to know for certain whether the adolescent's religious convictions will remain the same throughout their life, just as it is for an adult. The key question, however, is how the courts should respond to this uncertainty. Should they give effect to the adolescent's current convictions in a way which forecloses all possibility for future well-being; or should they take a cautious approach which enables the adolescent to continue along the path of identity development, concretising the beliefs and values that will then define their character and identity? In my view, given legitimate doubts the courts may have about the stability of the adolescent's preferences, coupled with our knowledge of adolescence as a time of changing religiosity, a cautious approach is justified. While this might, in some instances, lead to treatment decisions being forced upon an adolescent which *do* continue to plague them throughout life (and greater research into the long-term psychological effects of forced transfusions and treatment would be welcome), the alternative harm – that of causing the adolescent irrevocable harm or death on the basis of beliefs which are known to be held by someone in a state of identity flux – is simply too great to ignore.

This is, of course, not a problem exclusive to adolescents. Adults change their values and beliefs throughout their lifetime, and sometimes that will cause them to regret decisions they made in the past. Cave and Cave provide substantial evidence that casts doubt on the clear line drawn at the age of eighteen,[185] while the evidence on identity development indicates that it often continues throughout a person's life, not necessarily in a linear fashion. In Paivi Fadjukoff and others' longitudinal study examining the identity status of adults, for example, they found that in respect of religious identity, the percentage of women who had achieved identity status rose from 25 per cent aged 27, to 30 per cent aged 36 to 38 per cent aged 42; while for men it was 24 per cent, 30 per cent and 36 per cent at the same ages.[186] This implies instability of religious identity

182 *An NHS Trust* v *X* n 3 above at [21]. See also *Re W* n 14 above, 94 per Nolan LJ: 'the present state of the law is that an individual who has reached the age of 18 is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to attain that age.'

183 *Re G (Children)* [2012] EWCA Civ 1233.

184 *Re M (Children)* [2017] EWCA Civ 2164.

185 Cave and Cave, n 1 above.

186 Paivi Fadjukoff, Lea Pulkkinen and Katja Kokko, 'Identity Processes in Adulthood: Diverging Domains' (2005) 5 *Identity* 20.

continues long into adulthood, and may, therefore, be pertinent in cases involving adults too.[187] While space precludes detailed consideration of the law's treatment of adults in such cases,[188] suffice to say that the very fact that the inherent jurisdiction has been developed to plug a perceived gap in the law where an adult is capacitous but unable to make choices which promote their long-term well-being, ought to be reason to pause before attempting to transpose adults' unfettered rights to refuse treatments onto minors. Indeed this analysis indicates greater exploration of authenticity in the context of adults may be valuable. Moreover, given the evidence above, that judges are consistently preventing adolescents from making life-ending decisions based on religious conviction, such an approach serves merely to bring the reasoning of the judges out into the open, recognising explicitly that although the minor has capacity, it is concerns about the stability of their religious convictions that leads judges to place less weight on their wishes when determining their best interests, and thus underpins the decision to override their choice. The transparent approach taken by Mr Justice Macaulay in the Australian case of *Mercy Hospitals Victoria* v *D1* is instructive in this regard. Having questioned 'the extent to which her choice [to refuse a blood transfusion] is a true reflection of who she really is, and what her beliefs really are, as opposed to the product of other forces', he concluded 'I am not convinced she has based her choice on a maturely formed and entrenched religious conviction. Put another way, I am not convinced that overriding her expressed choice would so rob her of her essential self as to outweigh the loss she would suffer through losing her life or sustaining a catastrophic injury.'[189] His rationale for overriding her refusal could scarcely have been clearer.

## CONCLUSION

Despite the issue of adolescent decision-making having plagued the courts and academics for decades, the question of how philosophical theories of autonomy and authentic choice map onto the psychological development of adolescents

187 Although involving a more extreme set of facts than merely inculcated religious beliefs, there *are* instances in which the capacitious decisions of adults have been overridden by the courts on the basis that the individual's values are being influenced in a pervasive fashion by a family member. *Southend-on-Sea Borough Council* v *Meyers* [2019] EWHC 399 (Fam), for example, concerned whether a 98-year-old man ought to be allowed to resume living in his own home, which he previously shared with his son, KF. Mr Meyers suffered from diabetes and was blind, and had been moved to a Care Home following a court order, after the intimidating and aggressive conduct of his son had prevented him from receiving adequate care, *ibid* at [40]. Mr Justice Hayden found KF's influence on his father to be 'insidious and pervasive' to such a degree that his autonomy was compromised and he was disabled from making a 'truly autonomous decision', *ibid* at [41]. As a result, 'to the extent that the Court's decision encroaches on Mr Meyers' personal autonomy', Mr Justice Hayden felt that this was 'justified and proportionate', *ibid* at [42].

188 A discussion of whether the differential treatment of adults is justifiable is beyond the scope of this article. However, for a good discussion of the issue, see Anthony Skelton, Lisa Forsberg and Isra Black, 'Overriding Adolescent Refusals of Treatment' (2021) 20 J Ethic Social Phil 221.

189 *Mercy Hospitals Victoria* v *D1* [2018] VSC 519 at [76]. I am grateful to the anonymous reviewer for drawing my attention to this case.

has received little focus in the literature to date. This paper has sought to address this, through analysing the extent to which adolescents' decisions to refuse treatment on religious grounds can be regarded as truly authentic. While the paper ultimately concludes that identity, rather than autonomy, is a better lens through which to analyse (most) cases, it is hoped that this exposition will introduce greater conceptual clarity into such cases – a clarity which, as the brief overview of the case law above shows, is severely missing from the current law.