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Abstract: In this article we explore the underpinnings of what we view as a recent "backlash" in English law, a judicial reaction against considering children's and young people's expressions of their own feelings about treatment as their "true" wishes. We use this case law as a springboard to conceptual discussion, rooted in (a) empirical psychological work on child development and (b) three key philosophical ideas: rationality, autonomy and identity. Using these three concepts, we explore different understandings of our central theme, true wishes. These different conceptual interpretations, we argue, help to elucidate important clinical questions in the area of children's informed consent to treatment. For example, how much should a child's own wishes count in making medical decisions? Does it make a difference if the child or young person is undergoing psychiatric treatment? —if in some sense her wishes are abnormal, not "true" expressions of what she really wants? If the child's wishes do not count, why not? If they do matter but count for less, how much less? We conclude by advocating functional tests of a young person's true wishes, applicable on a case-by-case basis, rather than a black-and-white distinction between "incompetent" children and "competent" adults.

Keywords: rationality, personal identity, autonomy, Piaget

Introduction

How much should a child's own wishes count in making medical decisions? Does it make a difference if the child or young person is undergoing psychiatric treatment? —if in some sense her wishes are abnormal, not "true" expressions of what she really wants? If the child's wishes do not count, why not? If they do matter but count for less, how much less?

These and similar questions have recently been given a renewed practical urgency by a growing conflict in the law relating to children's consent in England and Wales. Over some twenty years, statute and case law, reflecting wider social and political trends, had sought to give greater weight to children's expressions of their own feelings about treatment as reflecting their *true* wishes. This trend was made explicit in the Children Act 1989, which emphasized the importance of a child's own choices.

Recent case law, however, has run counter to this trend. Contradicting the spirit (if not the letter) of the Children Act, a succession of judgments has sought to restrict children's choices,

especially where these have been concerned with medical or psychiatric treatment. We will be looking at these in detail in this paper. This conflict, furthermore, begins to look more like confusion if we contrast the increasing paternalism of medical law to the treatment of children in criminal law (Dickenson 1994). In the latter respect, England and Wales have stood against the tide in most other European countries by *reducing* the age of responsibility for criminal action (see note 1).

This conflict in English law can be considered from a number of perspectives. It raises some important questions in comparative law: for instance, courts in the United States had generally resisted allowing even "mature minors" to refuse treatment, but in 1993, a West Virginia case (*Belcher* v. *Charleston Area Medical Center*, 1993) reversed this trend. In *Belcher*, it was held that in a conflict between parents and the mature minor, the physician could claim that a "good faith" assessment of the minor's maturity level immunized him or her from liability for failure to obtain parental consent. The court also held, more constructively, that the trial court should have considered whether the seventeen-year-old patient was mature enough to give or withhold consent to his own treatment under a Do Not Resuscitate order. (See also Commentary, *Medical Law Review* 1993; a second similar case is described in note 2.)

There are also issues of social and political interpretation of the extant laws. It is possible that the courts are reacting against the earlier maturation of young people (the societal consensus about which is expressed in the Children Act). Such a reaction could well be "political," that is, impelled by popular revulsion after a *cause célèbre* such as the murder of two-year-old Jamie Bulger by two ten-year-old boys. We have explored such questions elsewhere, arguing in particular the ethical case for greater autonomy in children's consent to treatment (Dickenson 1994).

But these are not our concerns here. Rather, we use the conflict in English law as a springboard to *conceptual* discussion, rooted in (a) empirical psychological work on child development; and (b) three key philosophical ideas: rationality, identity, and autonomy. Using these three concepts, we explore different understandings of our central theme, "true wishes." We begin by setting out in detail the background changes in English and Welsh law, in particular the key legal cases that have sought incrementally to restrict children's choices in relation to treatment. We then explore the thinking behind these cases in terms of philosophical work on rationality, identity, and autonomy, respectively. Each of these ideas helps to make explicit certain assumptions about children's true wishes, assumptions that can plausibly be considered relevant to the legal cases, and that, once they are made explicit, can then be "tested" against the findings of developmental psychology. In each case we argue that when they are explored in this way, these assumptions are found to be wanting. We conclude with a brief discussion of the practical implications of our findings for legal practice generally in this difficult area.

The Developing Case Law on Informed Consent and Children*

The process by which, through parliamentary legislation, statute law in England and Wales has sought to give children's choices greater weight, began with Section 8 of the Family Law Reform Act 1969. A central provision of this Act was that the consent of a young person aged sixteen or seventeen to medical treatment "shall be as effective as if he were of full age" (i.e., eighteen or older—see the Family Law Reform Act 1969). In case law, the most important development occurred in *Gillick* v. *West Norfolk and Wisbec Area Health Authority* (1986), which established that a child's full consent to examination, treatment, or assessment is required if he or she "is of sufficient understanding to make an informed decision"—to grasp the nature, likely consequences, and risks of treatment. "Gillick competence" looked set to become the criterion by which children and young people were to be judged: a formulation that would enable these minors judged of sufficient understanding to express their own wishes.

The spirit, at least, of the *Gillick* case was incorporated in the Children Act 1989, which

*The main cases cited are summarized in the order in which they were decided in note 3.

came into force on 14 October 1991. This legislation was passed with all-party approval and after an unusually wide-ranging consultation. Both the Act itself and the background consultation focused on the importance of recognizing the status of children as persons in their own right.

It would be overstating the case to call the Act a children's charter, however. The guiding principle of the Act is that on any question falling within its scope, the child's welfare or best interest should be the determining consideration—arguably a paternalistic criterion. Nonetheless, the Act begins by requiring that in determining the child's welfare, particular attention should be paid to "the *ascertainable wishes and feelings* of the child considered in the light of his age and understanding" (see S1 [3] [a]; author's emphasis). The principle that decision making should be influenced by the child's wishes is thus explicit in the Children Act, but the Act also leaves scope for courts to find that the child's expressed wishes are not his "true wishes," those that serve his best interests. The Act states that other factors must also be considered in relation to the child's welfare; including "his physical, emotional and educational needs," "the likely effect on him of any change in his circumstances," and "any harm which he has suffered or is at risk of suffering" (see S1 [3] [b], [c], [e]).

It is this paternalistic side of the Act that has been emphasized in recent case law. "Best interests" has generally been interpreted in a paternalistic manner, ignoring the child's ascertainable wishes and allowing children fewer and fewer choices in matters of medical and psychiatric treatment. Three cases in particular have taken this process to an extreme; creating a situation in which, essentially, children and young people under eighteen now have no right to *refuse* treatment in circumstances under which English law would nonetheless allow them to *consent* to whatever is proposed.

There are of course well-recognized situations in which acts and omissions are felt to have different moral implications. But here at least it seems clear that the right to *give* consent must also entail the right to *refuse* consent (Commentary, *Medical Law Review* 1993). Otherwise, as we have argued elsewhere, the right to consent merely translates into a right to agree with the doctor (Devereux, Jones, and Dickenson 1993). This is exactly what happened in *Re W* (1992). The sixteen-year-old anorexic in this case was cooperating with non-invasive treatment that was keeping her weight low but stable. She was nonetheless transferred against her will to a clinic where she would be force fed. The court determined that she had no right of informed *dissent* to feeding by nasogastric tube, even though she would have been permitted to give her *consent.*

The issue in *W* was not the young person's mental condition. It was held in this instance that even a competent minor could not veto treatment so long as someone with parental responsibility consented to it. A 1991 case (*Re R*), involving a fifteen-year-old girl who was given antipsychotic drugs against her will, had already found that a young person of *intermittent* competence was barred from refusing treatment to which someone with parental responsibility had consented. (Both W and R were in fact not in the care of their parents, but rather that of the local authority, which exercised this parental responsibility.) The effect of *W*, then, was to extend the bar even to a competent young person. This in turn means that "a child or young person whose competence is in doubt will be found competent if he or she accepts the proposal to treat but may be found incompetent if he or she disagrees" (Devereux, Jones, and Dickenson 1993).

A third decision, *South Glamorgan County Council* v. *W and B* (1993), took this idea even further. R and W had at least been formally diagnosed as suffering from mental disorders, borderline though those diagnoses may have been. But the fifteen-year-old girl in the South Glamorgan case—although she was extremely reclusive and had a poor record of school attendance—had not been diagnosed as suffering from any psychiatric or personality disorder at all. Nonetheless she was compelled by the High Court to receive inpatient psychiatric assessment and treatment, although (contra *Gillick*) the judge had found that she was of sufficient understanding to make an informed decision.

We can contrast these cases with corresponding rulings in the same period for adults. Thus in 1993 the Appeal Court held that in the case of

Carolyn Fox, a thirty-seven-year-old woman suffering from anorexia nervosa, doctors had no authority to impose a force-feeding regime (Dyer 1994). The immediate issue was the granting of a temporary declaration, but the Appeal Court took the opportunity to quash a prior High Court ruling that the woman could be force fed, and it laid down guidelines for doctors seeking court approval to treat anorexic patients without their consent.

Another case involving the force-feeding of an adult patient was on appeal at the time this article was written (Dyer 1994). In July 1994 the High Court reluctantly allowed the Croydon Health Authority to force-feed a twenty-four-year-old woman known as Miss B. Miss B was detained for a borderline personality disorder under the Mental Health Act 1983. However, Mr. Justice Thorpe made known his disquiet that the Mental Health Act legalized what common law would not: i.e., feeding by naso-gastric tube could be justified as treatment related to B's mental disorder, even though testimony indicated that force-feeding would reduce the likelihood of psychotherapy being successful. Neither of the young people in *R* and *W* came under the Mental Health Act. Still, they were not protected by the common-law presumption of bodily integrity which, as Mr. Justice Thorpe's judgment made clear, would have applied to B in this case had she been a voluntary patient.

Yet another recent case, this one involving a sixty-eight-year-old man in a secure mental hospital, reiterated the absolute right of even mentally ill adults to determine what happens to their bodies. In *Re C* (1994) a chronic paranoid schizophrenic patient with an I.Q. of 70 refused amputation of a gangrenous leg, under his twin delusions that hospital staff habitually tortured him and that he was a world-renowned doctor with tremendous powers to cure diseased limbs, including his own. Although the hospital doctors emphasized that C had only a 15 percent chance of survival without the amputation, and argued that his schizophrenia caused him to suffer from an incongruity of affect that marred his appraisal of the risks, the court held that C's competence in some other areas, such as personal finances, established his sufficient competence in medical decision making. This ran directly counter to the *R* case, in which Lord Donaldson had held that a young person with fluctuating mental capacity could *never* be said to be competent, even in a lucid moment.

The overall effect of these cases, therefore, is to create a sharp divide between adults and children. Adults are presumed competent to refuse or consent to medical treatment regardless of mental illness; but whether or not they are mentally ill, young people are presumed *in*competent. The principle of competence is rebuttable for adults: that is, there is an initial presumption in favor of competence, but it can be overridden by sufficient contrary evidence. After the all-embracing judgment in the *W* case, however, the principle of *in*competence does not appear to be rebuttable for young people: that is, as long as someone with parental responsibility for the young person consents to treatment on his or her behalf, the young person has no right to refuse consent, whether or not *judged* competent.

The contrast of these court decisions with the Children Act could hardly be more dramatic. The Act was widely understood to give young people a statutory right to refuse treatment or investigations that might lead to treatment. In some sections of the Act this is explicit: S44 (7), for example, gives the child (under an emergency protection order) the right to refuse an examination for suspected sexual abuse. Where the right is not made explicit, the general spirit of the Act still seems to favor the child's expression of wishes. The *R* and *W* cases did not actually come within the scope of the Act, narrowly interpreted: in both, Lord Donaldson held that the right to refuse treatment did not extend to young people outside its purview. But the new legislation had previously been thought to herald a time of greater "children's rights" all around.

It is worth noting the extent to which recent English case law is increasingly out of step with European and international charters and conventions. Article 12 of the United Nations Convention on the Rights of the Child entitles children to make informed decisions consistent with their broader rights of self-determination. Similarly a

European charter of children's rights declares that "children and parents have the right to informed *participation* in all decisions involving their health care. Every child shall be protected from unnecessary medical treatment and investigation" (Alderson 1993a, emphasis added).

Although it might be argued that participation does not necessarily mean the right of veto, it might equally plausibly be said that force-feeding in the *W* case was unnecessary medical treatment, as the young woman was already accepting a different treatment regime. There are indeed indications that the legal proceedings themselves were medically counterproductive: W's weight had been low but stable before the local authority brought suit to authorize her transfer and compulsory feeding, but it began to drop radically during the court hearings. (We return to this point later.)

It is clear that a balance has to be struck. Children, to varying degrees, lack the knowledge and experience of adults. Add to this, in some cases, a possible mental disorder, and it is self-evident that there has to be a balance between the child's right to autonomy and the adult's responsibility for its care and protection. In terms of this balance, it seems clear that the English courts, through case law, are swinging towards care and protection while other jurisdictions are swinging towards autonomy.

Hence we come back to the question: What grounds could there be for the English courts' apparent assumption that, as compared with adults (whether mentally ill or sane), the expressed wishes of a child or young person are not a true reflection of his or her best interests, and hence are not *true wishes*? What philosophical grounds might there be for this assumption? And what clinical grounds might there be in developmental psychology?

In the next section we examine three possible grounds:

1. That children and young people are less *rational* than adults,
2. That children and young people are less secure in their *identity* than adults, and
3. That children and young people are less *autonomous* than adults.

THREE KINDS OF TRUE WISH

These three possibilities form a naturalistic continuum: from an explanation that focuses on something which can, in principle, be factually tested—rationality or decision-making competence—to a moral "ought" rather than a factual "is." Case law illustrates the predominance of the rationality criterion, and much bioethical literature also links rationality to autonomy. In contrast, we want to explore the possibility that the two can be separated: an anti-positivist argument. In examining rationality, autonomy, and identity separately in each of the following sections, we ask first, is this a good criterion for children and young people; second, and more broadly, is it a good criterion for everyone?

Our focus throughout this section will be on currently problematic aspects of the way in which the express wishes of children and young people are dealt with in law. It is clear that simple difficulties in communication may sometimes obscure a person's true wishes, and this is clearly a greater problem for young children and those with physical or mental communication barriers. However, this is an area in which the courts are at one with child psychologists and others concerned with children; both are at present working towards a shared understanding of better practice (Spencer and Flin 1993). Similarly, even for the three grounds we have chosen to consider, we will concentrate only on those aspects of them which are *prima facie* relevant to recent case law decisions, either explicitly so (rationality and, to a lesser extent, autonomy) or implicitly so (identity).

For each of our three possible grounds, then, we will consider the way in which it could have influenced thinking in recent legal cases; the extent to which it is justified or not by philosophical work on the concept on which the ground in question relies; and the extent to which its application (especially to children) is supported by empirical work in developmental psychology. The three grounds, of course, are not mutually exclusive. Indeed, as we will find, although they are relatively distinct theoretically, they point in similar directions for the future development of practice in this area.

1. True Wishes and Rationality

When courts override young people's refusal of consent in circumstances in which a mature adult's refusal might well be upheld, are the judges saying that young people's wishes are more irrational than those of adults? Is that why they are not accepted as "true" wishes? This is *prima facie* plausible. By long tradition, the severe irrationality involved in major mental illnesses has been accepted as an excuse in law; it is one of the two limbs of the Mental Health Act 1983, for instance, under which adult patients may be treated against their express wishes (the other limb of the Act being, broadly, risk of harm to the patient or others). It was this distinction between expressed wishes and true wishes that lay behind the Law Commission's proposals for a "true choice" test in relation to mentally incapacitated adults making medical decisions (Law Commission Paper No. 129, 1993). Similar principles have been held to apply to children. In the U.S.A., for instance, in a case in which an eighteen-year-old boy refused to undergo a biopsy on a tumor that was likely to be malignant, it was held that his wishes should be overridden because his refusal was based "largely on his strong phobia for needles" (In the matter of Thomas B 1991).

Something along these lines certainly appears to have been behind Lord Justice Donaldson's reasoning in the case of W. In assuming that the young woman's clinical condition (anorexia nervosa) necessarily created an irrational desire to refuse beneficial treatment, he implied that her wishes were themselves part of the problem: doctors *reasonably* considered that her best interests required treating the condition that produced those irrational urges. The lower court judge, he argued, should have taken this supposed effect of anorexia into account in determining whether or not W was *Gillick* competent. In this case, *ab initio*, W's wishes were of no weight. Both Lord Justice Donaldson and Lord Justice Balcomb thought the question moot: W could not be *Gillick* competent or rational because, they said, anorexia annihilated her "ability to make an informed choice" (quoted in Masson 1993). More broadly, Donaldson held that regardless of clinical condition, children and young people should be prevented from making irrational decisions—defined as those which may have irreparable consequences or consequences which would be disproportionate to any benefits which might accrue (Masson 1993, 38).

So it is reasonable to support that in some very broad sense, the courts, in overruling the expressed wishes of the children in these cases, were taking them to be among other things, irrational. This is established practice for adults, and, it seems, for children, too. However the very plausibility of this possibility takes us back to the key question, namely "Why children?" If irrationality is a ground for denying that *anyone*'s express wishes are their true wishes, why should children be considered more irrational than adults?

One way to pursue this question is by looking in more detail at the different senses in which people may be said to be irrational. The nature, at least, of rationality, though interestingly not to the same extent as irrationality (Quinton 1985), has been a matter of perennial philosophical interest. One approach, articulated recently by the philosopher Richard Brandt, is that "a rational action is by definition one which avoids all mistakes deriving from inadequate reflection" (1979, 153). This is a high standard! Clearly, we as adults frequently make "mistakes deriving from inadequate reflection." The courts certainly do not always override an adult's wishes when they are "irrational" in this sense, as we can see from the *Fox* and *C* cases. To apply this standard in the case of children then, requires either (inconsistently) that children be subject to *higher* standards of rationality than adults, or that they are in this particular sense of "rational," less rational than adults.

At first glance, developmental psychology might seem to support the latter possibility. After all, reflection is a skill which one expects to improve with practice, and children, overall, will have had less practice than adults. The accompanying table indicates the range of skills falling broadly under this heading that are known to improve with age. And there are, correspondingly, indications that some notion of adequate reflection was operating in recent court decisions. Lord Donaldson clearly

believed that W had reflected inadequately on the consequences of her decision to refuse the new force-feeding regime, particularly since he believed that the mistake would be fatal; and indeed, as we have seen, his view was that her wishes were themselves the result of the condition that had destroyed her capacity for reasoned judgment (see table below).

Closer inspection suggests, however, that in neither *R* nor *W* could the young people concerned be considered irrational in Brandt's sense of inadequate reflection (Dickenson 1994). R had considered the side effects of antipsychotic drugs and found them unacceptable. She was merely demonstrating a different assessment of risk from her physician, not irrational judgment. Similarly W was not refusing all treatment; she wanted to stay in her existing treatment program for anorexia nervosa and had a body of expert opinion behind her wish—the opinions of the clinicians at her preferred center. Nor had she reflected inadequately on her potentially fatal condition; her condition was stable, although her weight was low, until the court case began. Lord Donaldson's belief that her "mistake" would be fatal was far from incontrovertible. Indeed, given that W's weight dropped from $7^1/_2$ to $5^1/_2$ stone (105 to 77 pounds) after the court hearings began, it might be argued that it was the stress of the case itself that produced the supposed clinical necessity of force-feeding (see Practical Implications below).

In any case, do adults "avoid all mistakes deriving from inadequate reflection"? Certainly not, and as already noted, courts do not necessarily override adults when they are "irrational" in this sense, as we saw from the *Fox* and *C* cases.

A SELECTION OF THE SKILLS REQUIRED FOR "ADEQUATE REFLECTION" THAT DEVELOP WITH AGE

Knowledge base:	Breadth and quantity of information about the self and the environment
Skills base:	Both fine motor coordination and (especially) cognitive skills (e.g. use of flexible methods for tackling issues and problems)
Information processing:	Increased speed; capacity to deal with large amounts of information; ability to consider more than one dimension to a problem
Ability to concentrate:	The capacity to resist distraction, which may orient internally or externally
Metacognitive skills:	Including planning; the ability to be systematic; the capacity to formulate problems, to activate rules and strategies: monitoring self-learning about situations and evaluating the product of such thinking strategies
Self-confidence:	Development of faith in one's own capacity for thought; confidence and pleasure in achieving elegant solutions to problems

"Adequate reflection," as a criterion of rationality (see text), requires a wide range of cognitive and related skills. These skills are developed through practice. Hence with increasing developmental age, children show an overall progressive improvement in "rationality," so defined. However, the extent to which these skills are developed in particular individuals is highly variable. Hence a given child may be more "rational" in one or another respect than a given adult.

For adults, the English courts appear to recognize that avoiding all mistakes is an impossibly stringent standard. We are led back, then, to the inconsistent requirement that children maintain a *higher* standard of rationality than adults.

Avoiding all mistakes due to inadequate reflection is thus an unsatisfactory standard of rationality, whether for adults or young people. We cannot possibly foresee all the factors which may make our decisions turn out to be bad ones, as many of these elements are beyond our control or predictive powers. We cannot always weigh up all the factors, have access to all the information we need, process all that information perfectly, and invariably find that our decisions turn out the way we had forecast. Brandt's definition, moreover, leads into paradoxes involving "moral luck." These paradoxes arise from the conflicting commonsense requirements that, on the one hand, we should be held responsible only for actions that we can control; and, on the other, that we should be held responsible for our actions partly according to how they turn out. If my wishes turned out to be prudent or rational in the light of hindsight, they would *ipso facto* be my "true" ones, according to that line of reasoning. But hindsight is no guide to practice (see also note 4, Moral Luck).

So if it was a Brandt-type definition of rationality—avoiding mistakes due to inadequate reflection—that was in the minds of the judges in these cases, this view still would not explain why they refused to accept that the express wishes of the young people concerned were their true wishes. Both young women, R and W, had reflected on their circumstances; they had merely come to different conclusions about relative risks from one body of treatment providers and from the courts.

This takes us to a second sense of "rational," a sense that is perhaps closer to the notion of true wishes with which we are concerned here: namely that it involves adequate judgment of probable outcomes (Dickenson 1991, chap. 3). This sense of "rational" acknowledges that neither patients nor physicians can ever have anything more than an incomplete and probabilistic knowledge of outcomes. At most a procedure will offer a probability of a certain benefit.

What does this model of rationality suggest about discerning whether children's expressed wishes are "true"? Children and young people are often less well calibrated in judging chances and probabilities (Donaldson 1978). This is most likely because they have had less experience of decision making and have less knowledge of the world than adults. Indeed lack of experience may well count for more than any fixed, Piagetian age-based stage of cognitive development (Lyon 1993). Nonetheless, concrete operational thought, restricted to immediate contingencies, does tend to give way with increasing age to the more abstract and flexible possibilities of formal operational thought. Somewhere between the ages of twelve and sixteen, most children gradually acquire a cognitive ability that allows them to generate many possible solutions to a problem, and to think about these varied possibilities hypothetically, weighing one against another. In this probabilistic sense of rational, then, children's choices will tend to become more rational as they grow older.

This approach, however, still fails to support recent legal case decisions. The point, as for the "adequate reflection" criterion of rationality, is that, even if this definition of rationality were correct, it would lead directly to a requirement for an individual, case-by-case assessment of the validity of a given child's express wishes, rather than to a general denial of children's right to choose.

Here, in particular, the psychological evidence contradicts the approach of recent case law. It has been shown that approximately only half of all adults have reached the Piaget stage of formal operational thought (Byrnes 1988). On the other hand, many children younger than the age of twelve have developed some elements of this ability. They may, therefore, be able to generate hypotheses and to weigh up different options (Lyon 1993). The difference in this capacity between younger and older children—and indeed adults—is thus relative rather than absolute. Younger children generate fewer options and hypotheses and give fewer explanations of their various reasons for different choices when asked to do so. But the difference is one of degree. Hence if this

standard were applied consistently by the courts, some children should be judged rational, some adults not; rather than, as in recent English case law, a categorical distinction being drawn between them.

At all events, there is a problem of a general nature with this approach to rationality, pointed out by Robert Mnookin (1975, 226): namely that predictions of what will be in someone's best interests are necessarily speculative and that they reflect individual differences. What he means by this is that predictions can be true only in statistical agglomerates. They cannot provide definite guidance of what will happen in a particular case. This is not just a matter of one's calculations being incomplete, as has been argued by some utilitarians (such as J. J. C. Smart in Smart and Williams [1973, 40]). It is inherent in the nature of prediction. Doctors sometimes have specialized knowledge that can improve the accuracy of prediction. But even within medical specialties, opinion may be divided. As to judgments of probability in general, doctors are demonstrably no better calibrated than others (Bursztajn et al. 1990).

All in all, then, shifting the criterion of rationality from "adequate reflection" to "judgment of probability" does little to support the courts' shift towards a categorical distinction between children and adults in matters of medical and psychiatric treatment. There is, though, one further sense of rationality that could be relevant. This view of rationality arises from the fact that, even if the doctor has assessed the probable outcomes correctly—not always possible with comparatively untested procedures—the patient's degree of risk aversion or acceptance may be quite different from the physician's. The doctor cannot judge the patient's rating of the utility of the procedure: that really is a matter of individual values. A rational decision, then, in these terms, is one that stands a good chance of promoting the patient's own values, whether or not the doctor's values agree (Brock and Wartman 1993, 80–92). Values, though, have as much to do with personal identity—with what it is that marks us out as unique individuals—as with rationality as such. It is thus to identity that we turn next.

2. True Wishes and Identity

The nature of personal identity, like that of rationality, has been the subject of widely differing philosophical interpretations. Many philosophers have adopted essentially cognitive criteria—continuity and connectedness of psychological functions such as memory, for instance (Parfit 1984). Such criteria are of course closely related to the mainly cognitive criteria of rationality with which we were concerned in the last section. Others, though, have emphasized the importance of affective and conative criteria. Recent movements in feminist philosophy and psychology in particular have argued against the narrowness of concepts of adult identity that focus purely on the cognitive aspects of rational thought (Gilligan 1982; Noddings 1984; Harding 1986; Lloyd 1984). Relatedness and connection—aspects of that difficult concept "emotional maturity"—are also part of our moral identity.

Perhaps, then, the relevant distinction between young people and adults is not that they are less rational, but that their identities are less securely formed. Their wishes and intentions, their motives, their emotions, the whole structure of values within which they make choices, may be less secure, less stable, than those of adults. In particular, children may have less sense of connection, of responsibility, and of a socially constructed identity. Erikson, for example, views the essence of adolescence as the attempt to establish a self that can be seen as continuous and unified (1968). Perhaps it is misleading to talk of self-determination when a young person's sense of self is perishable and transient?

One important advantage of using identity as a criterion is that it is an internal, not an external, criterion: it belongs to the individual agent. In this it differs from rationality. In Brandt's formulation, rationality is a matter of how well one measures up to external events, whether one makes mistakes which would have been avoided with "adequate reflection." Under cover of its supposed objectivity, a definition like Brandt's encourages courts to impose values paternalistically. It permits judges or welfare officers to assume that their "reflections" are *ipso facto* more ad-

equate than those of young persons and hence that their decision-making is more rational. An identity criterion would help to avoid this possibility. Identity being "inner," a matter of the personality of the individual concerned, it encourages courts to ask whether the child's choices are consistent with her identity as *she* construes it, not whether the courts happen to find that identity attractive.

An obvious disadvantage to this criterion is the difficulty of defining identity. As we noted earlier, philosophers differ widely on this concept. Western culture no longer conceives of identity as conferred at birth by class status, sex, race, or ranking in the "Great Chain of Being." We have lost that Aristotelian and medieval view of the world as full of fixed essences. Yet we must be careful to distinguish temporary identities from those more likely to be lasting. Of particular importance in the legal context is the fact that disturbance or trauma may render children's feelings and wishes unstable, at least as revealed by comparison with previously expressed wishes (Eekelaar 1994, 56). The very trauma of the case itself may thus distort a child's system of values.

This difficulty, and the vulnerability of personality and identity to external factors, may seem to leave identity in a void. Yet in another sense—a rather existentialist one—personal identity becomes all the more relevant as a criterion. If we view identity, particularly our identity as moral agents, as created and constructed by the very process of making decisions, then as "authentic" beings we must recognize our responsibility for making choices (Sartre 1956). To an existentialist, there is no exterior source of value or identity at all, beyong that which is conferred through the very process of making choices. To claim that there is one merely shows *mauvaise foi*, bad faith. This is a rather extreme position, but it helps to explain what makes "true wishes" so special in the first place. It is the very process of making decision and "owning" them that gives them moral primacy, not their alleged conformity with some external standard.

Children and young people, it is true, have had less practice at making choices, and this is one reason why their identities are not fully formed. Further, to the extent that identity is created through defining oneself in relationships, young people will probably have fewer relationships on which to draw. Once formed, these identites may or may not turn out to be those of rational beings; but they will at least be "true" identities, and the agents' wishes really theirs. However, children cannot form their identities without the chance to make decisions and to make mistakes, if need be. Again, there is a question of balance. At some point, a child has to be allowed on the road on her own; the problem is at what point this should be. But recognition of the need for independent decision making, which is encouraged by a criterion of identity, is a useful corrective to the understandable concerns of those who have responsibilty for young people, and who may feel that they have to prevent them from making mistakes altogether.

Identity, then, like rationality, fails to provide grounds for the recent swing in the English courts away from recognizing children's choices as their "true" choices. Some adults are less secure in their identity than some young people, just as some adults are less skilled at (Piagetian) formal operational thought than some young people. So when is the identity fully formed? Is it ever? Is it credible to take it to be automatically fully formed at sixteen, eighteen, or whatever age one may choose? Identity, like rationality, points to the need for a developmental, case-by-case approach in legal decision making. This is a very different matter from comparison with some "objective" standard of "best interests." But like rationality, identity continues to evolve—in adults as well as in children.

Identity, though, as an "inner" criterion, has a further feature that sets it in one respect at a disadvantage compared with the more "objective" criteria suggested by rationality. Recall that our discussion of identity started from the idea that we should understand a rational decision as one which stands a good chance of achieving the patient's own utilities, values, or aims, whether or not those are the doctor's utilities, values, or aims. Values themselves are not rational or irrational, though they may be ethical or unethical. Values may strike us as peculiar or distorted, such

as the desire to die; but nonetheless may still be genuinely the "property" of the individuals who hold them.

Courts generally recognize this principle in the case of adults (as with Jehovah's Witnesses, for example [Watch Tower 1995]). But in the *T* decision (*Re T* 1992; *Lancet* 1992) a twenty-year-old woman's refusal of a transfusion was overridden on the grounds that she was too much under her mother's influence. Her values, according to the court's view, were those of her mother. In this sense, her values were not her own, and her expressed wishes were not a reflection of her true identity. What she lacked, then, was neither rationality nor identity but *autonomy*. This leads into a third possible interpretation of why courts might view the wishes expressed by young people as less than "true": because they see children and young people as being less autonomous than adults.

3. True Wishes, Autonomy, and Rights

A longstanding tradition in philosophy, embodied recently in the work of Richard Brandt (1979) and Ronald Dworkin (1977), claims that it is because people are rational agents that they have rights, and hence that their right to autonomy should be respected. This is consistent with the line taken in much of the recent bioethics literature in relation to patient autonomy. Beauchamp and Childress (1989), for example, take rationality to be one of the conditions of autonomous choice, an internal condition standing alongside external conditions, such as freedom from constraint. This is a helpful approach to the extent that it leads to a detailed account of the relevant components of rationality, so conceived: components which could in principle, and perhaps also in practice, be measured in individual cases, whether adult or child. Beauchamp and Childress include, for example, understanding, coherence, and deliberative capacity among the key "competencies" necessary for rational choice.

There is though a quite different and perhaps more fundamental sense in which autonomy *cannot* be grounded in rationality in this philosophically naturalistic fashion. This could indeed be argued to be the correct sense in which autonomy is connected with rights. Thus the notion of rights is primarily a normative rather than a descriptive concept. People do not have rights because they pass a rationality test, and they should not lose them whenever they do something silly. The reason we have to recognize each other as autonomous is not because autonomy is an *empirical* fact but because it is a *conceptual* necessity. It is one of the rules of the ethical game. If I want you to respect my choices, I have to agree to respect yours. The nature of the ethical enterprise—of having any system of ethics at all—requires that we agree to treat each other as self-determining beings whose decisions deserve respect. This is more or less the argument about autonomy and rights in Kant, although Kant is often wrongly accused of equating moral identity with rationality.

So where does this leave children and young people? Children do begin to develop notions of fairness and rights, the corollaries of autonomy, from middle childhood, usually at about age six or seven (Smetana, Killen, and Turiel 1991). A paternalistically inclined court might argue that children's sense of themselves as autonomous, and as possessing rights, does not necessarily make them autonomous or give them rights—any more than C's conviction that he was a world-renowned physician actually made him one. The difference, however, is that autonomy (in the sense considered here) is a moral "ought" rather than a factual "is" (like rationality). Hence whether or not someone is rational, we might still want to say that they should be treated as if they were self-determining. Indeed, the High Court was making exactly this distinction in the C case. With adults, then, the courts appear more willing to accept that autonomy can and should be separated from rationality. So why not for children?

The presumption that the autonomy of adults should not be infringed mirrors the presumption of competence in adults. Similarly, the presumption of competence in children is twinned with the apparent judicial assumption that children are not fully autonomous. This reflects an essential confusion in our view. Autonomy is the same for everyone. It is not an empirical concept that can be measured; it is a norm of how we treat

people. It implies that we treat them as equally "competent," so far as possible. The autonomy of children and young people deserves respect as much as the autonomy of adults. A liberal political system is loath to insist on overriding the express wishes of people beyond the legal age of majority as "untrue," not what they really want (Hart 1965). It is prepared to do this only where they fall into certain categories on the margin of that system: the intellectually impaired, for example. In an individualistic legal system, founded on liberal postulates about rights and autonomy, it must be the case that children and young people, too, have a right to determine their own values and goals. There is no good reason why the attainment of any set age should magically transform young people from outsiders to insiders in a rights-oriented legal system.

It is worth looking briefly at the reasons why a liberal political system is generally cautious about overriding a person's right to autonomy in the name of his or her "best interests." We have already suggested the theoretical Kantian grounding for preferring autonomy in the name of an ethical system's universalisability and consistency. There is also a practical reason for skepticism about taking expressed wishes at other than their face value, namely that the best interest of the vulnerable person tends to get confused with the self-interest of the more powerful party.

The philosopher of law John Eekelaar has provided some telling historical examples of this syndrome. For instance, slavery and apartheid used to be justified as being in the best interests of the oppressed race; and the phrase "best interests of the child" has often cloaked the real (sometimes pecuniary) interests of the child's guardian, usually the father (Eekelaar 1994). Perhaps the clearest examples in relation to children are the nineteenth-century cases in which fathers' rights to the custody of their legitimate children, as against those of their wives, were justified on the basis of the children's best interests (Eekelaar 1994; Stone 1990). A *principle* of autonomy, then, as distinct from empirical considerations—whether of (cognitive) rationality or of (emotional and conative) identity—is an important counterbalance to abuses of power in the name of best interests.

SOME PRACTICAL COROLLARIES

None of the three possible grounds we have considered justify the English courts' apparent swing against accepting a child's expressed wishes as his or her true wishes. All three show the need for a balance to be struck. But all three suggest that this balance should be achieved on a case-by-case, individual basis, rather than by taking an arbitrary line at some particular age to separate adults from children.

Granted that the three grounds are indeed relevant to finding the right balance, and hence relevant as much to case law as to statute law, they also point to the need for certain changes in legal proceedings. This arises from the fact that, leaving aside for the moment issues of *moral* autonomy, rationality and identity develop not only with age but with *practice*. Hence, in court proceedings, greater emphasis should be given to the need for children to be allowed to make choices in order to develop this very capacity for mature decision making! Otherwise, their rationality (and identity) will remain impaired, which of course "justifies" continued paternalism in a circular fashion.

Is there any real evidence for this claim? In the case of rationality, at least, giving children greater choice and permitting them the experience of living with their choices, has been found to aid the development of rational decision making at an earlier age. Conversely, Lyon argues that an adaptive response to coercive intervention is to refuse cooperation and deny problems, responses which may well then be labeled as proof of incompetence (Lyon 1993). In many situations, children do not perceive that they have a choice in the first place, and therefore their rational decision-making capacities may well be underused.

If children are given choices, then, they will be more likely to use and expand their rational capacities. These capacities do depend to some extent on age, but also, crucially, on whether the child has actually been given a real choice and permitted to exercise it. Young people will develop an interest in being well-informed, well-calibrated, and knowledgeable only if their choices count. Although there are differences between

young people relating to socio-economic status, education, and perhaps family style, the capacity for making well-grounded decisions can be improved through giving young people practice, and devolving decision making to them under controlled conditions.

Somewhat similar considerations apply to identity. Experimental psychological studies have demonstrated the discrepancies between what people would do in real life compared with what they think or say they would do in hypothetical situations. In real life, of course, people change their opinions and grow. In one such situation where young people were making a choice about whether to have a termination of pregnancy, some youngsters changed to "lower" and others to "higher" levels of reasoning on a Piagetian scale.

The psychologist Carol Gilligan has provided some narrative illustrations of this process (Gilligan 1982, 76–77). For example, Josie, a pregnant seventeen-year-old, was able to move from what she herself described as a egoistic outlook to one more concerned with her responsibilities to others. In Josie's own words,

> I started feeling really good about being pregnant instead of feeling really bad, because I wasn't looking at the situation realistically. I was looking at it from my own sort of selfish needs, because I was lonely. Things weren't really going good for me, so I was looking at it that I could have a baby that I could take care of or something that was part of me, and that made me feel good.
>
> But I wasn't looking at the realistic side, at the responsibility I would have to take on. I came to this decision that I was going to have an abortion because I realised how much responsibility goes with having a child. Like you have to be there; you can't be out of the house all the time, which is one thing I like to do. And I decided that I have to take on responsibility for myself and I have to work out a lot of things.
>
> What I want to do is to have the baby, but what I feel I should do, which is what I need to do, is have an abortion right now, because sometimes what you want isn't right.
>
> Sometimes what is necessary comes before what you want, because it might not always lead to the right thing.

An outsider's view of what would be in Josie's self-interest might also lean towards abortion, depending, of course, on the observer's religious convictions. But in other cases (*R* and *W* among them) the "objective" view of what is in someone else's self-interest may well collide with the individual's own evaluation. This is where the normative principle (as opposed to empirical assessment) of autonomy may be important. We recognize this for adults, who may choose to sacrifice their own comfort, health, or lives against their objective "best interests," in the name of some higher concern. This is the whole point of autonomy: it is meant to be contrasted with best interests in the extreme case, though in most ordinary cases there will be no tension.

The Children Act, by allowing young people to retain independent counsel or to obtain assistance from the Official Solicitor, could be said to contain mechanisms for enhancing young people's rationality. But, as we have seen, in case law the trend has been in an opposite direction. Is there, then, anything more than an intuitive weighing of these considerations that could help to resolve difficult cases? John Eekelaar has put forward one well-worked-out set of proposals, which he calls "dynamic self-determinism." The essence of this process is that decision making is devolved to the child (recognizing her right to *autonomy*) but under controlled conditions (reflecting the extent to which her values and other aspects of her *identity* are well established), the overall intention being to enhance her capacity for mature, well-founded choices (*rationality*).

Dynamic self-determinism merits looking at in a little more detail as it is relevant to procedure in several areas, including adult mental health legislation, where the right to autonomy is tempered by reduced rationality and/or identity. Draft legislation proposed for individuals aged sixteen and over who are possibly mentally incapacitated contains a presumption against lack of capacity but also gives prominence to best interests (Law Commission Report No. 231, 1995). Similarly, Eekelaar recognizes that children's lower stages of development require some serious consideration of "best interests." This is particularly true in the area of child protection, his main concern, but it is also true of medical decisions, particularly those concerning life and death.

Children and young people, of course, do not have as much experience as adults in determining how to go about putting their values into practice and attaining their goals. Even if their values are consistent and solidly formed, they may not fully understand the implications of adhering to them. In *Re E* (1992) for example, Justice Ward ordered a boy who was a Jehovah's Witness to have a blood transfusion because, after a hospital interview with the boy, he felt that the young man did not understand the suffering he would undergo as a consequence of that decision. Eekelaar has therefore proposed that we should value the child's autonomy separately from his or her rationality. In dynamic self-determinism, a built-in process of review gives the child and the courts a means of checking on this learning process. The court makes its initial determination in the knowledge that it may not be a final one. Welfare professionals, child psychologists, psychiatrists, and others monitor changes in the child's wishes and in the external situation. The overall goal is to reconcile the best interests of the child with the child's autonomy: "treating children as possessors of rights" (Eekelaar 1994, 42).

Eekelaar's proposals are attractive in part because of their link to Raz's view of autonomy as consistent with an individual's self-determined goals rather than his or her objectively determined self-interest (Raz 1986). Raz also stipulates that these goals must be attainable within existing social institutions, and it may well be said that children's knowledge of social mores is likely to be inferior to that of adults. Children's goals may simply be unrealistic, and in that sense their wishes could be "untrue." But this is intended as a caveat in the exercise of autonomy, not a reason for riding roughshod over rights in the name of "best interests."

Actually, Eekelaar presents dynamic self-determinism as a modification of the "best interests" principle rather than an alternative to it: an interesting tactic to side-step the conflict between paternalism and rights. Self-determinism allows children to develop their own perceptions of well-being as they enter adulthood rather than foreclosing on their potential for such development. Perceived in this way, the "best interests" principle is not a threat to children's rights but a mode of enhancing them (Eekelaar 1994, 55). The very fact that, as Eekelaar writes (1994, 48), "the outcome has been, at least partly determined by the child, is taken to demonstrate that the outcome is in the child's best interests."

CONCLUSION

It could be argued that the importance of recent case law can be overstated: that hard cases make bad practice, so to speak. On this view, ordinary clinical practice of the sort which does not concern matters of life and death will continue to be dictated by the "medical professional's responsibility carefully to consider the views of the child in conjunction with those of the parents or guardians" (Shield and Brown 1994). Only time will tell whether this proves to be the case, or whether the paternalistic caution induced by recent decisions spills over into more and more areas of practice. In any case, our concern in this article has been the philosophical dilemma raised for good practice by these cases, not forecasts of their probable effects.

By determining that children have *no* right to refuse consent to medical treatment, the courts could be said to have deflected attention from the very real problems that can affect the expression of a child's true wishes. We do not maintain that any expression of wishes is a "true" expression. Indeed, in addition to developmental age, there are many factors that can deflect children and young people from their essential capacities for decision making: for example, attachment problems, difficult divorce and custody settlements, or child abuse and neglect. Pathological conditions such as autism and other communication disorders may distort or affect the expression of a child's true wishes and feelings. But if all children and young people under age eighteen are to be taken as incompetent to withhold consent to treatment, there is little incentive for clinicians to make the relevant distinctions when appearing before the courts. Clinicians need to use direct and indirect sources of information in order to access their patients' wishes and feelings; the courts need to listen to what physicians have learned

about children's true wishes; and cases should then be decided accordingly.

This may seem radical to some jurists, and indeed to some practitioners. Surely, some will say, this is to swing the pendulum too far towards autonomy, with potentially fatal results. But we believe that children's own good sense and the scrupulousness of most clinicians (Elton 1995) will ensure that there is no tidal wave of treatment refusals. There is support for this from children themselves. Alderson (1993a), for example, asked 120 children (average age = 14) having orthopedic surgery to set the age at which they thought children were competent to consent to or refuse such operations. The children set a mean age of 14 years against health professionals' threshold of 10.3 years. Ironically, then, if we listen carefully to children's true wishes, we may find that they do not always want autonomy, that they recognize their possible irrationality, and that they do not always feel secure enough in their identity to give or withhold their consent in such matters.

It might well be true, then, that children and young people sometimes wish to be more rational in the sense of being better calibrated with reality, better able to make predictions that are likely to bring them the outcomes they desire. This desire might even be seen as a deeper wish, one which could be taken to override an expressed "irrational" one. It may also be true that young people's rationality can be affected by stress, if they are making medical decisions while in pain or on capacity-reducing medication, just as it can for adults. The age of the child, the stress of the situation, the complexity of the decisions to be made, are important. But all these factors are situation-specific determinants which should lead, as our discussions of rationality, identity, and autonomy lead, to functional tests of a child's true wishes, applicable on a case-by-case basis, rather than to the categorical distinction between children and adults in recent English case law.

ENDNOTES

1. *The age of criminal responsibility:* In March 1994 the case of *C (a Minor)* overturned the long-standing common law principle that a child between the ages of ten and fourteen was *doli incapax*; presumed incapable of committing a crime unless specifically proved otherwise. The effect of this decision has been to reduce the age of criminal responsibility in England to ten. The trend elsewhere has been towards raising the age: from seven to twelve in Canada, nine to thirteen in Israel, fourteen to fifteen in Norway, twelve to sixteen in Cuba, and fourteen to eighteen in Romania (see Levy 1994).

2. *The case of Benito Agrelo:* Also in contrast with U.K. Law are certain cases in the U.S.A. For example, Benito Agrelo was a fifteen-year-old Florida boy who refused a third liver transplant (for which the usual length of survival is one year). After his second transplant in 1992, he took the immunosuppressant drug FK506, as prescribed, but he found the side effects intolerable (leg and back pain, headache, irritability, depression, inability to walk or play with friends, and to relax or read). With his mother's support, he stopped taking the drug in October 1993. Administrators at the hospital where the transplant had taken place called the child-abuse hotline of the Florida State Department of Health and Rehabilitation, who issued a detention order on the basis of neglect, and forcibly moved Benito into the hospital. During his stay he refused to give a blood sample or to submit to any examinations other than a basic physical. On 11 June 1994 Judge Arthur Birkin, who had interviewed Benito in hospital, ordered that he be allowed to return home and to refuse the immunosuppressant drug. His mother said, "Benny was granted exactly what he deserves. He will get to live his life the way he wants." Benito died in August 1994, having said, "I'd rather stay home and live as close as I can to a natural life and die without having side-effects."

3. *Main legal cases cited:* The main legal cases referred to in the text are as follows:

Re R (1991). This case concerned a fifteen-year-old girl who had voluntarily entered local authority care after a fight with her father. She was admitted to the psychiatric unit of a hospital and then to a specialist adolescent care unit, which sought to give her antipsychotic drugs. She refused, on the grounds of unwelcome side effects. The local authority initially gave permission for the drugs to be administered but withdrew consent after deciding that R was competent to give or withhold consent. The Court of Appeal, however, held that a child with fluctuating mental capacity could never be said to be competent, even in her lucid moments, and it ordered that the drugs should be administered. Further, Lord Donaldson noted that the right to consent which a *competent* child enjoyed under *Gillick* v. *West Norfolk and Wisbech Area Health Authority* (1986) did not include the right to *veto* treatment.

Re W (1992). W, a sixteen-year-old young woman suffering from anorexia nervosa, was, like R, in the care of the local authority. She was accepting treatment at one center, which was keeping her weight stable but low. The local authority, however, sought leave to move her to a second center where she would be subject to compulsory feeding. Unlike R, W was judged to be competent, but the Court of Appeal went one step further than it had in the earlier case by holding that it could override the wishes of even a competent minor. It found that *even a competent young person* could never withhold consent to treatment if someone with parental responsibility gave consent (in this case, the local authority).

South Glamorgan County Council v. *W and B (1993).* Unlike R and W, both of whom had been diagnosed as suffering from mental disorders, the fifteen-year-old girl in this case was not said to be suffering from any psychiatric or personality disorder. She was extremely reclusive, however, and had a very poor record of school attendance. The High Court ordered that she could be compelled to receive in-patient psychiatric assessment and guidance, even though it found she was "Gillick competent."

The case of Carolyn Fox (1993). In this case, in sharp contrast to *Re W*, the Appeal Court held that doctors had no authority to impose compulsory feeding on an adult (thirty-seven-year-old) anorexic woman. Although the immediate issue was the granting of a temporary declaration, the court explicitly quashed a previous High Court ruling that the woman could be force fed, and it laid down guidelines for doctors seeking compulsory feeding orders for adult patients. See Dyer (1994).

Re C (1993). C was a chronic paranoid schizophrenic patient with an I.Q. of 70 in a secure hospital, who had delusions that he was being tortured by hospital staff. He refused amputation of a gangrenous leg and sought a court order to prevent doctors from carrying out the amputation to save his life should be become unconscious. Hospital physicians emphasized that C had only a 15 percent chance of survival without the amputation and argued that his schizophrenia caused him to suffer from incongruity of affect, which marred his appraisal of the risks. The High Court found that C was competent to withhold consent, despite his psychiatric status, basing its finding on C's competence in other areas such as personal finance. This ruling ran directly counter to the *R* case, in which it was held that a young person with fluctuating mental capacity could never be said to be competent.

The case of Miss B (1994). Miss B was detained for borderline personality disorder under the Mental Health Act 1983. The High Court reluctantly allowed Croydon Health Authority to force-feed Miss B, but Mr. Justice Thorpe explicitly stated that he was constrained by the Mental Health Act, which legalized what common law would not. In contrast, neither R nor W came under the Mental Health Act, but they were not protected by the common-law presumption of bodily integrity which would have applied to B, had she not been detained under the Act. See Dyer (1994).

4. *Moral Luck:* Moral luck is an important ethical concept that has not been sufficiently examined in jurisprudence. Recent philosophical treatments include: Dickenson 1991; Williams 1981; Zimmerman 1987; Nagel 1979; and Nussbaum 1986.

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