Potential Termination of Pregnancy in a Non-Consenting Minor

John Unsworth-Webb

Key words: best interests; competence; patient-centredness; substituted judgement

The pregnancy of a 12-year-old girl provides the basis for a consideration of approaches to a dilemma brought about by conflicting expectations. Here, medical opinion is to reject action implied by the lack of Gillick competence and by a 'parental responsibility' claim adopted by the girl's mother. Construction of the dilemma and the subsequent process, which sought resolution, illustrates that the Gillick ruling, and other guidelines intended to be helpful, can prove to be less so.

Introduction

In a recent case presented at a British NHS trust, it was confirmed that a 12-year old girl was six weeks pregnant. The girl strongly rejected the option of a termination, although this immediately caused conflict with her mother who equally strongly argued for the pregnancy to be terminated. It is usually accepted that the responsible parent or guardian can make decisions affecting a minor, particularly one who, as in this case, was deemed to have insufficient capacity either to consent to or refuse any medical intervention. After two sessions with a child psychotherapist, this pregnant minor was not considered to be competent as understood in 'Gillick competence'[1] terms. (This refers to case law developed from *Gillick* v. *West Norfolk and Wisbech Area Health Authority* (1985), which held that 'the parental right to determine whether or not a minor below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to enable him to understand fully what is proposed'. It has become a matter for medical professionals to judge whether a child under 16 is 'Gillick competent'.) The case might therefore have been relatively straightforward but other elements added complexity. These included the following:

Address for correspondence: John Unsworth-Webb, Faculty of Health and Life Sciences, Charles Frears Campus, DeMonfort University, 266 London Road, Leicester LE2 1RQ, UK. Tel: + 44 (0)116 201 3827; E-mail: juwebb@dmu.ac.uk

  10.1191/0969733006ne884oa

- The girl's refusal was such that medical staff (doctors) who would ordinarily perform the termination declared during emerging events that they would not undertake the procedure and this was stated as the position they would continue to adopt regardless of any subsequent legal ruling. Faced with a physically mature girl who steadfastly refused to accept a termination meant that, if medical staff were to decide that a termination was necessary, they would then be obliged to carry it out forcibly, which they were not prepared to do. Instead they adopted the principle of patient centredness where the patient at the centre of this case was the pregnant girl and not her mother. This principle they considered to be both paramount and not outweighed by the fact that she was a minor. They believed very strongly that the principle of patient centredness should not be overridden regardless of the circumstances.
- Nurses (the group with the highest level of contact) found it difficult to engage with the mother, who appeared not to want to consider any other view than the one she held. Her interactions with her daughter were thought by a number of different health care professionals to be less than sensitive and there was a suspicion (voiced by social services) that this may be an abusive relationship.
- NHS trust managers, recognizing the potential ramifications of the case, were keen to follow Department of Health guidelines[2] (which recommend judicial review in complex cases) about whether or not termination would be in the interests of the pregnant girl and, indeed, whether and to what extent other interests were to be taken into account.

Anticipated potential ramifications included those arising from both of the two likely decisions: if the termination were to take place, the girl, when she comes of age, could sue the trust for assault; and if the termination did not take place, the mother could sue the trust for wrongful life on the basis of the burden that this would undoubtedly place on her (and in some respects on her daughter for whom she is responsible), even though up to now such claims have received little sympathy in British courts.

The case in its entirety provides an example of a practical conflict that could be assisted by a consideration of the inherent moral questions. In fact, as staff of the trust proceeded to address the situation, it became increasingly clear that no satisfactory solution could be achieved without doing so.

The inherent dilemma

The dilemma in this case can be stated as:

- If we deny that an abortion is necessary, then we breach principles of parental responsibility and a mother's otherwise recognized authority to make decisions regarding the welfare of her dependent daughter. Additionally we potentially limit freedom and life opportunities for both the mother and the pregnant minor.
- If we insist on an abortion on social grounds, we subject a minor to a medical intervention from which she can perceive no benefit. We also take the life of an otherwise healthy fetus that is wanted by its natural mother.

Starting points

The dilemma was manifest by strongly voiced contradictory views, thus both doctors and nurses adopted the position that some initial negotiation would be necessary if only to ensure that those directly involved could feel they were being heard and that their view was being afforded some value. As is commonly the case, it was nursing staff who principally adopted the role of arbiter, seeking to achieve some level of satisfaction in those who felt they would be most affected by health care decisions. It is similarly common, however, for this to have as much to do with attempts to reduce conflict and potential complaint as it has with any analysis of morally right action. Even though these are not mutually exclusive, an attention to process epitomizes a focus on means rather than outcome, on right process rather than right decision. In the case under consideration, however, this was accepted as a necessary and defensible precursor to outcome because, rather co-incidentally, it led to the recognition of a need to be clear about health care intent and exactly what may or may not be considered as therapeutic. The aim, therefore, became twofold:

- To determine how best to proceed (related to clarity of therapeutic intent);
- To seek a consensus (by majority opinion) on the basis that, although right decisions are not dependent on consensus, the weight of this, if it were to be reached, could be considerable.

Thus it was the adopted approach more than the consequences of resultant decisions that was seen to constitute right action.

In an approach that seeks solutions using ethical principles, consideration of the consequences of decisions can appear unavoidable because therapeutic intent alone, or the rightness of means as ends in themselves, however objective, does not always appear to be satisfactory to those affected. It is far more likely that, for those involved, subjectivity becomes unavoidable and intent interrelated with likely effect. Practically, it is difficult not to consider means and ends together. It is difficult, for example, to conceive how a principle could be a moral principle and stand outside the minimal social arrangements of a respect for the feelings of those affected.

When this is accepted, deliberations can begin to look for indicators of good or even acceptable effect, achievable by justified means and thereby indicative of both right intention and action. This would allow the feelings of those involved, their understandings and sense of satisfaction (elements of well-being that are themselves indicative of effective health care) all to be determining factors throughout the deliberations.

To bring about these ends we may consider meta-ethical theories such as utilitarianism, because despite a far reaching nature (extending to the benefit or otherwise incurred by humankind of any decision) it does appear to provide a scale against which conflicting positions can be weighed. In this type of approach, for example, a birth would be favoured as a straightforward beneficence gain, insofar as the lives of three rather than two are more likely to result in increased welfare and well-being. However, alternative ethical constructs such as those that emphasize rights and obligations sit uncomfortably with utilitarian decisions. For example, when legitimate rights are claimed, they automatically generate obligations in those providing health care and, although it may be possible, it is difficult to see how one could weigh the apparent priority of rights and obligations over utility, with the

creation of a scale becoming a difficulty in itself. In time-limited deliberations, therefore, the focus for measures and balances is more usually found using a casuistic approach,[3] which is a bottom-up approach with the thinking developed from the specific circumstances of a case.

Circumstantial focus

In cases where there is lack of Gillick competence, it is usual for the family, together with the non-competent minor, to be given substantial counselling with the expectation that the minor will be guided towards acceptance of, or compliance with, what is considered to be an adult decision: usually the wishes of the minor's parents. In this case, the mother's overriding concern (there was no other parental view because the father had been absent for some years) was to avoid her daughter having a child herself at such a young age and, indeed, the mother was insistent that all medical expertise be directed towards performing a termination of pregnancy. Although her determination did not lend itself particularly well to any kind of sensitive counselling, her view is not uncommon. This is seen in similar cases where parents readily risk the repercussions of their expressed anger and absolute paternalism rather than, as they see it, that the life of their own child be unduly burdened by childbirth and its consequences. This presupposes that under-aged childbirth is burdensome, but the point of the Gillick decision is that the pregnant minor is not in a position to determine whether or not this would be so.

In support of the dominance of a mature parental view it is commonly supposed that there are obligations owed by a child to his or her parents.[4] Even though children cannot usually choose their parents or guardians, they commit to a parental relationship for many reasons beneficial to themselves and this requires some reciprocal obligation to both their futures. Here, however, the girl's obligations to her mother may be in direct conflict with the rights possessed by the girl to freedom from assault (into which category an enforced abortion could fall) and from coercion to undergo an abortion with which she does not agree. The question of whether one set of rights, for example, the mother's right to exercise responsibility for her child and to a liberty free from the burden of another dependent being, sufficiently outweighs the rights of a minor or the fetus (or their potentially combined rights) appears initially at least to be the key to any debate.

In this, as in other dilemmas whose resolution involves negotiation, there is an attempt to consider the relative weight of conflicting positions and it is perhaps worth stating at this stage that, in certain conflicts, decisions can legitimately be arbitrary on the basis that the rightness of either of the possible actions (inaction essentially resulting in a continuation of the pregnancy) may be evenly weighed. This is in full recognition of the fact that an arbitrary decision in such circumstances would act against some reasons without being able to say that they are outweighed.

The attempt to consider relative weight in this case necessarily became conflated with attempts to reconcile the views of the parties directly affected, including those adopted by the doctors. The negotiating mantle initially adopted by nurses increasingly became the role of trust managers, but with the effect that, once freed from this role, nurses adopted the same stance as the doctors. The trust managers therefore tried to engage all involved in a single meeting to discuss the case. This met

with little success and a subsequent approach in which the parties were seen separately began to establish how things were being experienced. The latter issue coincidentally is in keeping with the view that one characterization of goodness is the ability to see things from the point of view of another.[5] It may also have some value as a mechanism for establishing whether or not the positions held carry differing or equal weight.

Medical viewpoint: an issue of duty

Any termination of pregnancy, particularly in the case of a healthy fetus, requires considerable justification, and medical intervention in such circumstances is subject to much scrutiny.

According to the 1967 Abortion Act[6] as amended in 1990,[7] the fetus is not regarded as a legal personality and a termination may be justified on the grounds that it is carried out to protect the health or life of the mother. Because of this, the case for abortion rests on the likely effects brought about by the birth. This is usually more than a claim that childbirth is not risk free in a physical sense.

Among the grounds cited in the Act in its current form (which requires two doctors to agree in good faith to a termination of pregnancy) has arisen the category of so-called 'social reasons' for abortion, in that it relies on issues beyond the threat to life or health of the mother or the good of the fetus. It is this category that has included 'rape resulting in pregnancy' as a justifiable reason for abortion, and could legally apply in this case because sexual intercourse with a 12-year old could constitute statutory rape. Even so, because this was apparently consensual sex, we may consider this an insufficient reason morally to terminate the life of a healthy fetus.

In refusing to carry out a procedure with which they were unhappy, both doctors and nurses determined that, if a procedure were to be enforced, that is, to accept the authority of the mother, then their role as health care professionals would be misdirected. Ordinarily, in the case of an illness or disorder, they might have accepted the mother's position, but pregnancy is not a disorder and health carers are justifiably cautious in situations where health care could be construed as some sort of punishment.[8]

In the circumstances of this case there is no duty of care that requires enforcement, despite the wishes of the mother, and indeed this would contrast entirely with the affording of rights. In addressing the concept of rights, however, one could assume a differential in accordance with an entity's status (eg potentially with the rights of the girl's mother carrying more weight than those of the girl herself or the fetus).

If, however, there is a question regarding the legitimacy of the mother's authority (because of abuse) and thereby her right to safeguard, as she sees it, the welfare of her daughter, or to freedom from the burden of another dependent, her rights may then become insufficient to outweigh the girl's right to self-determination or the fetus's right to life. If this is the case then the roles of doctors and nurses become more significant because, if rights were to appear more evenly balanced, the consequences of action would become more significant. Here, any consideration of the consequences of intervention must take account of the medical knowledge available and the insights of professional health carers into the patient's physical and emotional well-being, currently and consequently, as well as of what we can properly ask of health care.

It remained the case throughout, however, that although there were indicators of abuse it was never proven and the balance of rights favoured the mother's position.

The minor's mother: an issue of obligation

The mother's concern appears to relate as much to her own future, with unwanted additional responsibility and financial and freedom limitations, as to those of her daughter. Nonetheless, it is relatively easy to recognize the concerns she has for the potential burdens and limitations placed on her daughter. This presents us with a strong case for considering as paramount the mother's rights both to fulfil her role as parent and to be protected from such burdens.

The mother clearly sees herself as responsible for decisions affecting her child who, it has been agreed, is not (yet) competent to make significant choices that may affect or help to formulate a life plan, that is, to form lasting intentions, develop long-term desires and so on. In *Re W.*, the judge stated:

> No minor of whatever age has power by refusing to consent to treatment, to override a consent to treatment by someone who has parental responsibility for the minor. Nevertheless such a refusal was a very important consideration in making clinical judgements and for parents and the court in deciding whether themselves to give consent.[9]

It is because we recognize the mother's greater right as an adult that she also incurs a greater sense of obligation to the child than perhaps the child owes to her. The fact that the child will become competent at a point not too far in the future should indicate to the mother that she should make decisions on the girl's part in such a way as to maximize those interests that will make it possible for the girl to develop a life plan of her own. Here, interests become those opportunities that competent persons would want to pursue whatever life plan they ultimately chose, but in this case the duration of the incompetence matters significantly.

With respect to competent persons, when their choices conflict with their interests, their choice ought usually to be respected,[10] which is the opposite of paternalism. This is not the case with minors and their desires, which may need formulation with guidance. It is to be remembered, however, that this minor has particularly strong views that could indicate these being carried to the age of competence.

The viewpoint of the pregnant girl: an issue of rights and interests

The lack of competence of the pregnant girl in Gillick terms means that although she may well be the focus for treatment and have her preferences usually taken into account, there remains a question regarding what Dworkin[11] calls 'authenticity of desire'. By this is meant the difficulty of establishing what is and what is not a truly held or genuine belief as opposed to one that may be held because of other influences. In this case, however, the question appears to be almost side-stepped by an acceptance that the girl does not have the capacity to formulate any desire that could be considered authentic. This effectively invokes a limitation of rights and substantiates

the position whereby rights are afforded in their fullest sense only to sentient adult human beings. This is essentially the Gillick position.

However, ideas expressed in health care may conflict with the authority expressed in the Gillick ruling. Surely it is not enough simply to recognize the limitations of being a minor (or indeed any other less than competent individual). It is necessary in addition to promote the interests of those at the centre of care whatever their competence and, if necessary, to protect their rights as part of a health care process. This is essentially the position taken by the medical staff. Therefore, if we are to consider a third party authority, a role usually afforded to the parent or legal guardian, we must be sure that this third party will fulfil the role in a reasoned and responsible manner. This is more akin to accepting a substituted judgement rather than the personalized authority expressed in Gillick. Substituted judgement[12] is based on what the individual whose authority has been delegated would have chosen to do if he or she were sufficiently competent (or here, to what the child would approve or consent to on reaching the age of competence). Because this requires a difficult prediction that may not be possible in all circumstances, it is often refined by the notion of 'best interests'. Although decisions may be made that are not necessarily what the incompetent person would have chosen to do, because he or she might not be able to recognize his or her best interests, any decision must still meet the criteria of reasonableness. Here we are at least suspicious concerning whether this mother is in the best position to know the effect of decisions so made. Indeed, if it had been proved that the mother's relationship with her daughter was abusive, then it would seem more appropriate to appoint a guardian *ad litem* (a guardian at law: an independent officer of the court, appointed to safeguard the interests of children during the course of legal proceedings).

Were this to be the case, we would still be presented with a difficulty in determining the best interests of the girl, particularly given the strength of her refusal. In part this is because we cannot know future positions, but it also relates to the imbalance of power invoked when overruling a strongly objecting minor. Consent provided in such a way must be recognized for what it could conclude for health care as much as for what it may conclude for the girl. Dworkin,[11] for example, asks the question of whether a parent (or guardian) can ever consent to a child undergoing a procedure that is of no direct benefit to the child itself. It seems unreasonable, therefore, to ask doctors and nurses to carry out a termination, which would ostensibly be a forced procedure.

It is recognized that consent is not necessary to explain legitimate authority because, if we insist on actual consent with regard to every minor subjected to health care, then there is a possibility that no risky procedures intended to benefit a child would ever be performed. The difference in this case is that any benefit would be in longer term social consequences that are at best difficult to predict.

In most cases, however, we accept proxy decisions; but even when there are authorized proxy decision makers, their role and our expectations need to be particularly clear. Do we, for example, expect decision makers to act as the child might desire if we could predict their competence (substituted judgement), or should the decision be an objective judgement based on what is considered to be in the child's best interests?

Weighing the positions

It may appear that what is really needed is some sort of formula by which to gauge the relative weight of the various positions. This is a technique adopted and developed by Seedhouse.[13] He utilizes a grid formula to enable reflection from an objective viewpoint on whether or not an argument is convincing. This objective view embraces detachment and adopts or propounds the position of those who, although affected, can consider the situation with a degree of emotional detachment. This results in an impersonal process of discernment that is not so much to do with what happens in a particular case, but with what happens in an overall sense.

It is a good thing for people's rights not to be violated, and a calculation could be made that allows for the greater right, objectively constructed, to prevail. In so doing, however, a greater violation may be risked, being caused by any duty so incurred by health care to uphold prevailing rights and consequently enforcing a termination on a particularly unwilling girl.

The possibility of having to drag a minor kicking and screaming into the operating theatre invokes the subjective, but subjectivity recognizes that our concern is a patient-centred rather than an outcome-centred one.

Although rights, duties, interests and obligations appear to need a summation in order to judge their relative merit, decisions, even arbitrary ones that we have suggested could be appropriate, are all dependent not only on the weight afforded to them objectively but to their application to subjective circumstances. Here, summations appear even more difficult to reach because although we may be able to treat the situation as a constant, we are seeking to achieve a shift in the values adopted or propounded by the immediate actors, already not representative of a single good. Such circumstances now increasingly appear to require a subjective, patient-centred decision.

In proposing such a decision, however, we might also need to afford a system of priorities to subjective factors that in every respect could be similarly formulaic. It could simply result in a short list of prohibitions and injunctions as proposed by Nagel:[14]

> . . . never infringe general rights and undertake only those special obligations that cannot lead to the infringement of anyone's rights; maximize utility within the range of actions left free by the constraints of rights and obligations; where utility would be equally served by various policies . . . and finally where this leaves anything unsettled, decide on grounds of personal commitment or even simple preference.

However, this is also unsatisfactory because, as Nagel himself recognizes, it is absurd to hold that obligations can never outweigh rights, or that utility, however large, can never outweigh obligation.

When other things appear equal (and there is a decision to be made about the sufficiency of similarity) or where the positions are simply incomparable, then we must rely on a judgement that by its nature encompasses the subjective, even if this means that the judgement cannot always provide absolute justification. To employ the fundamentals of judgement is not only to reason on the basis of such factors as personal liberty, economic consequences, procedural fairness, the broader interests of humanity and rights and duties (despite this not being an exhaustive list), it is to

consider the emotional consequences and psychological well-being of those most closely involved as well as to accept the risk involved in such decisions.

The reasoning behind the trust managers' request for a judicial review or indeed referral to any external body in order to increase objectivity is to dismiss the personal emotions already understood, particularly by nurses. Emotionally complex though these cases are, a sadder prospect is that they end up in a courtroom or that relationships develop with lawyers in direct proportion to the erosion of infinitely more desirable relationships with health care professionals. Such a referral therefore, recognizably defensive, is not only to omit the subjective but it may leave unresolved the issue of what is to happen should a judgement support the Gillick ruling, medical staff having already indicated that they would not perform a termination even if legally required to do so. These circumstances surely justify a degree of medical paternalism that should not be too readily surrendered.

Given the factors outlined, it is therefore quite possible that judgement would be in favour of a continued pregnancy, although the actual outcome was perhaps less satisfactorily reached.

Outcome

As deliberations continued it became evident that the girl's mother was becoming frustrated with what she perceived to be a lack of progress. She took this to be the fault of trust staff and as a consequence withdrew herself and her daughter from NHS care in favour of a private care facility. This may well have been because she had previously voiced that 'privately funded health care professionals are more likely to be on the side of the individual meeting payment for those services'. If this were to have been the case, it is a position that could avoid any *parens patriae* ruling[15,16] (parent of his country: refers to the State as guardian of minors and other incompetent individuals).

The NHS trust considered their duty of care to have been discharged when it became clear, in their judgement, that care had passed from them. This judgement was based on the number of documented telephone calls that remained unanswered and the fact that Social Services personnel (who had continued their involvement) informed the trust that the pregnancy had indeed been terminated. Continuation of care in the form of a conveying of deliberations between one agency and another was therefore assumed to be the responsibility of Social Services but, even assuming that the subsequent decision in favour of termination was based on similar deliberations, at the very least this is repetitive.

It is the issue of choice, however, and the practical free rein afforded to the responsible adult by the notion of autonomy, in the end trumping all other factors, which overwhelmed deliberation. Here, as in the Millian antagonism to paternalism,[17] this version of responsible autonomy is apparently entirely accepted in Gillick.[1]

References

[1] *Gillick* v. *West Norfolk and Wisbech AHA* 1986 AC 112
[2] Department of Health. *Seeking consent: working with children*. DoH, 2001: 18.

[3] Dickenson D, Fulford KWM. *In two minds: a casebook of psychiatric ethics*. Oxford University Press, 2000: 27.
[4] The Children Act 1989: 5. 3 (1). HMSO, 1989.
[5] Hope RA, Fulford KWM. Medical education: patients, principles and practice skills. In: Gillon R ed. *Principles of health care ethics*. Wiley, 1993: 27–28.
[6] The Abortion Act 1967. HMSO, 1967.
[7] The Human Fertilisation and Embryology Act 1990. HMSO, 1967.
[8] Lifton RJ. *The Nazi doctors: medical killing and the psychology of genocide*. Papermac (Macmillan), 1987.
[9] *Re W (a minor) (medical treatment)* 1992 4 All ER 627
[10] Dimond B. *Legal aspects of nursing*, fourth edition. Pearson Education, 2005: 142–46.
[11] Dworkin G. *The theory and practice of autonomy*. Cambridge University Press, 1988: 19–25.
[12] Mason JK, McCall Smith RA, Laurie GT. *Law and medical ethics*. Butterworths, 2002.
[13] Seedhouse D. *Ethics: the heart of health care*. Wiley, 1988: 127–49.
[14] Nagel T. *Mortal questions*, ninth edition. Cambridge University Press, 2004: 128–46.
[15] Laurie GT. *Parens patriae in the medico-legal context: The vagaries of judicial activism* 1999 3 ELR 95
[16] Seymour J. Parens patriae and wardship powers: their nature and origins. *Oxford Journal of Legal Studies* 1994; **14**: 159–88.
[17] Pitkin H. *Representation*. Atherton, 1969.