

# The Best Interest and Gillick Competence Principle

## Application in Adolescent Health



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### Opening vignette

John is a 16-year-old boy who is currently schooling and preparing for his upcoming national examination. He is known to place unrealistically high expectations on himself, and his stress is made worse by parental expectations. John is currently experiencing severe anxiety from academic stress and has trouble sleeping. He visited a clinic recently to seek medical advice and was referred to the psychiatry department, where he was diagnosed with generalised anxiety disorder. John is keen to start treatment with oral anxiolytics. During the consultation, John specifically requested for the doctor to not inform his parents as they would not understand, inferring that they are part of the problem. The psychiatry team has several concerns regarding his request: (a) whether John, an adolescent, has the capacity to give consent on his own; and (b) whether involving his parents without his consent would be in his best interest.

### Introduction

In medical practice, the legal basis permitting doctors to provide any form of medical intervention is informed consent. Every adult patient of sound mind has the right to self-determination. Medical interventions with a person's body are unlawful battery unless the patient has

voluntarily given informed consent.<sup>1</sup> The age of majority is the age at which an individual is legally considered an adult with full legal rights. In Singapore, that age is 21 years old under the common law. An adult aged 21 and above, barring any physical or mental incapacity, is legally empowered to provide consent or refuse medical treatments.<sup>2</sup>

However, for those below 21, Singapore has no statute law that defines the legal age for medical consent.<sup>3</sup> Under Singapore law, there is no presumption of capacity for adolescents, and most hospitals have consent processes that involve parents or guardians for adolescents.<sup>4</sup> However, with the rising incidence of mental health disorders in adolescents, they may not want to involve their parents in the consultation process for such sensitive and stigmatising matters.<sup>2</sup> This presents a conundrum for healthcare professionals (HCPs) when adolescents do not wish to involve their parents: whether to respect the adolescent's wishes, involve the parents nonetheless, or act according to what the HCPs believe is in the adolescent's best interest.

There are also scenarios where relying on parental authority for consent may be impractical or undesirable: parents may be uncontactable or may make treatment decisions against the best interest of the adolescent; or the



adolescent may have concerns they wish to keep confidential from their parents. Hence, this article aims to outline the perspectives of various stakeholders involved in adolescent medical decision-making, as well as ethical and legal considerations in accordance with statutes and professional ethical codes and guidelines. This article has relevance for doctors, clinicians, parents, adolescents, as well as policymakers. Let us first understand the background and perspective of the main stakeholders in adolescent health.

## Stakeholder perspectives

The key stakeholders involved in adolescent medical decision-making are the adolescent, the parent and the healthcare professional.

1. **The adolescent:** The key underlying principle is that adolescents have an evolving capacity to participate, and naturally, they should be supported as active participants in decisions about their health. However, an adolescent should have a certain level of maturity and understanding so as to avoid making decisions that risk harming themselves and to participate constructively in making medical decisions.
2. **The parent:** Parents have an obligation of beneficence to optimise the welfare of the adolescent. In order to exercise this responsibility, they must be given certain authority and access to information, because society expects them to be responsible for their child's welfare. Traditionally, parents are expected to make treatment decisions on behalf of minors.<sup>5</sup> However, parental authority is not absolute and is subject to the "best interest" standard. The general presumption is that parents, as caregivers of the minor, would know what is best for their child and would act in the child's best interest. The courts retain the authority to intervene when a parent or guardian fails to protect the interests of the adolescent.<sup>5</sup>
3. **Healthcare professionals:** HCPs have a duty to act in the best interest of the minor and to safeguard their welfare, respecting their views and upholding their desire to participate in decisions

about their health. Where it is in the adolescent's best interests, HCPs would involve both the parent and the minor in making medical decisions. While consent for minors is typically obtained from a parent or legal guardian, as outlined in the professional ethical codes and guidelines, HCPs should still inform the minor about their medical condition and give due consideration to their views.<sup>5</sup>

Although there is no specific legal age for minors to give consent, an adolescent under the age of majority (21 years) can independently consent to treatment if they are "Gillick competent" and demonstrate sufficient maturity and understanding. Under routine circumstances, HCPs should be able to assess the capacity and maturity of the adolescent. In complex cases where there is uncertainty in assessing an adolescent's level of maturity, HCPs should seek guidance from a senior colleague, psychiatrist or psychologist.<sup>5</sup>

## The "best interest" principle

Rather than just defaulting to parental authority in adolescent medical decision-making, the starting point for minors should be the "best interest" principle. This overarching legal principle, as written in the Children and Young Persons Act, states that the minor's welfare, care and protection must be the first and paramount consideration.<sup>6</sup> When deciding what is in the best interest of an adolescent, the decision-maker must not rely solely on the minor's age, appearance, or assumptions drawn from an aspect of the minor's behaviour.<sup>7</sup> Best interest can be defined as a comprehensive evaluation that takes into account the adolescent's medical, psychological, emotional, moral, religious and overall well-being in both the short and long term.<sup>4</sup> Taking corollary from the Mental Capacity Act, in applying the "best interest" principle, reasonable consideration must also have been given to the past and present wishes, as well as the views of the parent or legal guardian and significant others, in so far as they have been involved in the adolescent's care.<sup>7</sup> This approach is often called the "Checklist and Balance Sheet" method, where the checklist

refers to the collection and collation of data and the balance sheet refers to the weighing of the benefits and harms to the minor's best interests.<sup>8</sup>

In practice, pursuing the adolescent's best interest should involve a collaborative care model that emphasises open communication, active listening and negotiation between all stakeholders: the adolescent, the parent and the HCP. The collaborative care model is more likely to produce better clinical outcomes and build lasting trustworthy relationships.<sup>9</sup> In this collaborative care model, more skills and effort are necessary, as adolescent medical decision-making can be complex and contested due to diverging stakeholder interests and power asymmetries. The adolescent phase is marked by an evolving sense of autonomy and identity, which begins a change in the doctor-adolescent-patient relationship.<sup>10</sup> Adolescents who are on the verge of legal adulthood have a growing desire to express autonomy and self-determination, which may be inevitably encroached by parental responsibility seeking to protect them.<sup>10</sup>

Where the adolescent, the parent and/or the HCP hold differing views, a third party (such as an ethics committee, a senior colleague, or a judge) may be called upon to determine an appropriate course of action. Before referring to the third party, HCPs must make a structured effort to understand the perspectives and interests of the stakeholders so as to harmonise and reach a consensus. In such cases, it is essential to understand the principles, interests and point of contention of all stakeholders involved in adolescent medical decision-making.

## Legal basis of Gillick competency

Gillick competency is an English Law concept from the House of Lords Decision in *Gillick v West Norfolk and Wisbech Health Authority* [1986], which addressed whether girls under the age of 16 could obtain contraceptive advice or treatment without parental knowledge or consent.<sup>11</sup> In its judgement, the court found that under certain provisions, the adolescent may be legally competent to give valid consent independently: the adolescent





must be able to understand the doctor's advice and weigh the benefit and risk; identify and distinguish important relevant information from non-factual, inaccurate misrepresentations; and have a level of maturity and intelligence that enables him/her to arrive at an informed and reasoned conclusion.<sup>11</sup> Maturity can be defined as psychological or emotional development which involves several criteria: self-awareness and understanding one's own thoughts and emotions; self-regulation and managing emotional reactions; and ability to decide on the best approach to cope with challenging situations.

The level of maturity required to be Gillick competent depends on the gravity of the specific medical decision in question and the context in which it is made. An adolescent may be capable of making minor decisions independently, while major decisions (such as consenting to heart surgery) may require external support.<sup>12</sup> Furthermore, the level of maturity and understanding varies widely between adolescents depending on age, the presence of physical or psychological comorbidities, as well as the support system available to the adolescent. An adolescent is not Gillick competent simply because he/she has reached a certain age threshold. Rather, Gillick competence is an assessment of the adolescent's maturity, intelligence and ability to make an informed medical decision.

The legal precedent in Singapore concerning Gillick competence is not extensive. Singapore's first judgement came in 2021, where a disagreement between parents about whether their 16-year-old daughter should receive the COVID-19 vaccination was resolved in court. In deciding whether the vaccine was in the adolescent's best interests, the court gave "full weight" to the daughter's preferences after finding her Gillick competent and sufficiently mature to make an informed decision about being vaccinated. The court's recognition that Gillick-competent adolescents can consent to treatment represents a constructive development in Singapore statute, yet there remains no general legislative guidance on consent to medical treatment by adolescents under 21.<sup>4</sup>

## Professional basis of Gillick competency

The ethical ethics basis of adolescent medical decision-making rests on the principles underpinning the doctor-patient relationship: primacy of patient's welfare, respect for persons, duty of care, non-abandonment and confidentiality. Involving the adolescent in decisions about their health is necessary to respect their need to know about their medical conditions, to be heard, and to participate in decisions regarding their care.<sup>13</sup> According to the Singapore Medical Council (SMC) Handbook on Medical Ethics, HCPs should give due consideration to the opinions of minors who are able to understand and decide for themselves.<sup>5</sup> It also recognises Gillick competence as an ethical matter, stating that young children may have the capacity to understand medical information sufficiently to make their own decisions about their care.<sup>5</sup>

## Professional practices for consent in adolescence

In clinical practice, HCPs should encourage adolescents to involve their parents or caregivers in medical decisions. If they refuse, HCPs should explore why, and if appropriate, discuss how they could help inform their parents or caregivers. If they remain resolute about not involving their parents or legal guardians, the Gillick principle and Fraser guidelines should then be considered.

The assessment of capacity in adolescence is not far different from that used in adults. HCPs can gain a better understanding of the adolescent's intellectual and emotional maturity by asking open-ended questions and observing their responses. These include, but are not limited to:

- The adolescent's understanding of the medical issue, relevant information and alternatives.
- The adolescent's ability to weigh and evaluate the benefits and risks of treatment, both in the short and long term.
- The adolescent's ability to reason, consolidate and come to a reasoned conclusion.

- The adolescent's ability to clearly communicate and express their decision.
- Whether the adolescent is under any undue external influence or pressure that is affecting their decision.

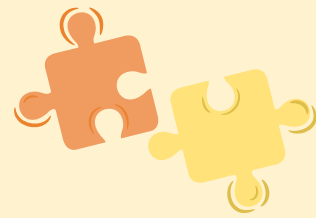
HCPs can use the teach-back technique to assess if the adolescent has correctly understood the information and advice given. They can also use the ICE tool (Ideas [and beliefs on their illness], Concerns and Expectations) during the consultation to elicit and better understand the adolescent's knowledge, understanding, values and preferences. HCPs should clearly document the assessment process, including the adolescent's responses, thought processes and decision-making ability.

In addition, HCPs can make use of a modified Fraser guidelines process to determine if it is appropriate to give such advice and treatment to adolescents without parental knowledge or consent.<sup>14</sup> The criteria include:

- The adolescent remains adamant about not involving their parents or guardians despite the doctor's attempts at persuasion.
- The adolescent has a sufficient level of maturity and intelligence to understand the medical advice given.
- The adolescent's physical or mental health is likely to suffer unless they receive the advice or treatment.
- It is in the adolescent's best interest to receive the advice or treatment without parental knowledge or consent.
- The adolescent is at high risk of complications if mental health treatment is withheld.

## The primacy of the best interest principle

In all medical decisions, whether the adolescent is Gillick competent or not, or when decisions are made by parents, the overarching principle of the best interest of the minor – welfare, care and protection – must be upheld. In some cases, a Gillick-competent adolescent may make a medical decision that is against their best interests, such as refusing a



life-saving or beneficial treatment due to emotional distress, lack of understanding of the consequences or undue influence of peers. In the same vein, parents may end up making a decision that does not serve the adolescent's best interests. HCPs should be aware that the rights of Gillick-competent adolescents and their parents to make medical decisions on behalf of the minor are not absolute, and are subject to the "best interest" standard.<sup>3</sup> In order to fulfil their duty to prevent unnecessary harm and act in the adolescent's best interest, HCPs may apply to the ethics committee or the courts to overrule any decision they assess to objectively not be in the adolescent's best interest.<sup>5</sup>

### Medical confidentiality and trustworthy relationships

HCPs also regularly struggle with issues of confidentiality surrounding adolescents. While it is generally in a minor's best interest for parents or guardians to be involved, adolescents are more likely to discuss private health matters (such as mental health, contraceptive advice, drug use and sexually transmitted infections) if they believe their confidentiality will be respected.<sup>2</sup> According to the SMC Ethical Code and Ethical Guidelines, HCPs are obliged to maintain the medical confidentiality of minors (the same as adults), except when it is in the minor's best interests for their parents or guardians to be informed and involved.<sup>5</sup>

Parents may also make a request to doctors to not inform the adolescent of their condition, especially if they suffer from a life-threatening illness or the prognosis is bleak. On the one hand, HCPs may be hesitant to share information with the adolescent to prevent emotional pain or helplessness. On the other hand, withholding information risks compromising the adolescent's understanding of the illness and treatment, thus decreasing the level of trust in the doctor-patient relationship.<sup>15</sup> HCPs and parents may also disagree as to what information should be provided to the adolescent. In these cases, HCPs would do well to engage in discourse to encourage disclosure.<sup>10</sup>

### Box 1. Important questions for HCPs to consider on involving parents

1. Does the adolescent want to involve parents or legal guardians?
2. Is the adolescent Gillick competent?
3. Is it in the adolescent's best interest for parents to be involved?

### Box 2. Best interest checklist questions for HCPs

#### Questions that HCPs can use to determine adolescents' best interest:

##### Medical indications and benefits

1. Is there good evidence that treatment will improve the medical condition?
2. Does benefit outweigh side effects or harm?
3. What are the alternatives to the proposed treatment?
4. Is the proposed treatment the least intrusive intervention?

##### Emotional and psychological well-being

1. Will the treatment reduce psychological suffering or distress?
2. What are the long-term impact of having the treatment?
  - (a) Does it impact future autonomy outcomes?
3. Will quality of life be enhanced or impaired in daily functioning?

##### Social, cultural and other factors

1. Will the treatment support the social health and family relationships of the adolescent?
2. What is the impact on other relationships, schooling and culture?
3. Have the cultural, religious and social factors been considered, respected and balanced with the treatment and care needs?

##### Views of the stakeholders

1. Were the views of the adolescent supportive of the treatment?
2. Were the views of the parents supportive of the treatment?

3. Are the views of the parents consistent with the child's welfare?
4. Were the views of the members of the healthcare team supportive of the treatment?

### Box 3. Possible scenarios and appropriate responses

1. The adolescent does not want to involve their parents and is assessed to be Gillick competent. However, it is also in their best interest for their parents to be involved.
  - (a) In order to fulfil their duty to act in the adolescent's best interest, HCPs can inform the minor of their intention and reasons for involving parents, nonetheless.
2. The parents refuse consent for a beneficial and necessary treatment. The treatment is assessed to be in the adolescent's best interest. The adolescent is assessed to be Gillick competent and offers their consent.
  - (a) HCPs can obtain valid consent from the Gillick-competent adolescent and proceed with treatment if urgent.
  - (b) In elective situations, HCPs should continue to engage the parents and seek consensus or refer to the clinical ethics committee.
3. The parents refuse consent for a beneficial and necessary treatment. The treatment is assessed to be in the adolescent's best interest. The adolescent is assessed to not be Gillick competent.
  - (a) In order to act in the adolescent's best interests, HCPs may need to involve the ethics committees or the courts to get support and sanction to proceed with life-saving treatment.
4. The adolescent is assessed to be Gillick competent and refuses treatment. The treatment is considered to be in the adolescent's best interest. The parents are involved and provide consent for treatment.
  - (a) In accordance with the best interest principle, HCPs may treat the adolescent with valid consent from the parent.





## Conclusion

Adolescent medical decision-making in Singapore is complex and contested, as existing medical laws and regulations do not specify a legal age for individuals under 21 to provide independent, valid consent. The overarching legal standard guiding such decisions should be the "best interest" principle. A collaborative care model emphasising dialogue among all stakeholders – including the adolescent, parent and HCP – can help achieve a satisfactory outcome.

However, determining what constitutes an adolescent's best interest would be best done using the "Checklist and Balance Sheet" tool.

For adolescents lacking capacity, parents with legal authority are expected to act in their child's best interest. Decisions that go against the minor's best interest can be overruled in the courts. Moreover, the assessment of Gillick competence is patient-centric, context-specific, and may be conducted by a doctor or a child representative appointed by the courts. ♦



## Take-home messages

1. In Singapore, the age of majority, which is the age at which an individual is legally empowered to provide valid consent or refusal for medical treatment, is 21 years old. Consent for adolescents under 21 is usually taken from parents or legal guardians.
2. Adolescents under 21 who demonstrate sufficient maturity and intelligence to understand the doctor's advice and weigh the benefit and risk may be deemed Gillick competent. Gillick-competent adolescents may independently consent to medical treatments but may not refuse beneficial treatment that is in their best interest. The assessment of Gillick competence by a HCP is patient-centric, context-specific, and based on the adolescent's level of maturity.
3. Medical decisions and consent for adolescent health, whether obtained from a Gillick-competent adolescent, parents, or legal guardians, must adhere to the best interest standard. HCPs can use the "Checklist and Balance Sheet" tool to determine the adolescent's best interest. HCPs can apply to the ethics committees or the courts to overrule a decision not in the adolescent's best interest.
4. Pursuing the adolescent's best interest in medical decision-making should involve a collaborative care model that emphasises open communication, active listening, and negotiation between all stakeholders: the adolescent, parent and HCP.

## Closing vignette

The first step is to recognise that John, who is 16 years old, is under the age of majority. Therefore, the treating team must determine whether John is Gillick competent and able to sufficiently understand the nature and consequences of the medical decisions at hand. A psychiatrist should conduct a proper assessment of John's level of understanding by asking open-ended questions to elicit his understanding, maturity and ability to appreciate the consequences of his decision. The second step is to assess if disclosure to his parents would be in John's best interests. To assess this, the psychiatrist should engage with John to elicit his thoughts and rationale for not wanting to involve his parents. Involving his parents may be in his best interest, particularly if it helps create a supportive and conducive healing environment for his mental health recovery. If so, attempts should be made to persuade John to involve his parents. If John is assessed to be at risk of suicide, the medical team may break confidentiality in his best interest to protect him from self-harm. Throughout the consultation process, the medical team should uphold John's welfare as the first priority.

## References

1. Chervenak J, McCullough LB, Chervenak FA. Surgery without consent or miscommunication? A new look at a landmark legal case. *Am J Obstet Gynecol* 2015; 212(5):586-90.
2. Chan TE. Revisiting consent, Gillick competency, parens patriae, and the access of minors to mental health services in Singapore. *Medical Law International* 2025; 25(3):221-47.
3. Thirumoorthy T, Loke P. Consent in Medical Practice 3 – Dealing with Persons Lacking Capacity. *SMA News* 2013; 45(8):16-9.
4. Chua H. Competence, Capacity and Consent to Medical Treatment: VYG V VYH [2021] SGFC 124. *Singapore Journal of Legal Studies* 2024; March:159-69.
5. Singapore Medical Council. SMC Handbook on Medical Ethics 2016 edition. Available at: <https://bit.ly/4l3gNjC>.
6. Singapore Statutes Online. Children and Young Persons Act 1993 (2020 Rev Ed). Available at: <https://bit.ly/3z1ewSB>.
7. Singapore Statutes Online. Mental Capacity Act 2008 (Cap 177A, 2010 Rev Ed). Available at: <https://bit.ly/3rYAFsf>.
8. Kong C, Coggon J, Dunn M, Keene AR. An Aide Memoire for a Balancing Act? Critiquing The 'Balance Sheet' Approach to Best Interests Decision-Making. *Med Law Rev* 2020; 28(4):753-80.
9. Nagra A, Fuller ID, Connett G, Reynolds BC, Tyerman K, Wallace D, et al. Fifteen-minute consultation: empowering children, young people and families through shared decision-making: a practical guide. *Arch Dis Child Educ Pract Ed* 2024; 109(6):264-70.
10. Sobode OR, Jegan R, Toelen J, Dierickx K. Shared decision-making in adolescent healthcare: A literature review of ethical considerations. *Eur J Pediatr* 2024; 183(10):4195-203.
11. Griffith R. What is Gillick competence? *Hum Vaccin Immunother* 2016; 12(1):244-7.
12. Jeremic V, Sénécal K, Borry P, Chokoshvili D, Vears DF. Participation of children in medical decision-making: Challenges and potential solutions. *J Bioeth Inq* 2016; 13(4):525-34.
13. Singapore Medical Council. SMC Ethical Code and Ethical Guidelines 2016 edition. Available at: <https://bit.ly/4rJ8LiD>.
14. Samuels A. Contraception, pregnancy, childbirth--when things go wrong. *Med Sci Law* 1986; 26(1):39-47.
15. Salter EK. Should we tell Annie?: Preparing for death at the intersection of parental authority and adolescent autonomy. *Narrat Inq Bioeth* 2013; 3(1):81-8.

