Of Gillick Competence and Mature Minors

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All countries, except Somalia and the USA, have adopted the United Nations Convention on the Rights of the Child (CRC). The Convention, adopted in a UN General Assembly in November 1989, defines as a child: "every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier." Article 5 of the Convention requires that "state parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family … or other persons legally responsible for the child, to provide, *in a manner consistent with the evolving capacities of the child*, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention". It is important to note this article provides recognition for children to exercise rights even before they reach 18 years of age, and that children develop evolving capacities (1).

The World Health Organization (WHO) defines adolescence as occurring between the ages of 10 and 19 years, hence largely overlapping with the definition of the child under the CRC. The current trend of reproductive and sexual health needs of the world's adolescent population present a serious challenge for gynaecologists. Most adolescent sexual activity remains unprotected worldwide, giving rise to unwanted pregnancies, many of which ends with unsafe abortion, and a plethora of sexually transmitted diseases, including HIV infection (2). Uncertainty over ethical and legal rights and responsibilities may lead professionals to refuse to see under-aged adolescents on their own, for fear of incurring parental wrath or even legal action (3).

The rule of the "mature minor" is a manifestation of the acknowledgment of some legal systems of the "evolving capacities of the child" as endorsed in the CRC, and takes root in a historical case in England in which Mrs Victoria Gillick, as a parent, challenged governmental guidance to physicians that they could exceptionally prescribe contraceptives to females (her daughters) under 16 years of age who were or were about to become sexually active, and were competent to apply the contraceptive method appropriately (4). This British House of Lords' empowerment of an adolescent who is said to be "Gillick competent" has been embraced in commonwealth countries such as Australia and Canada and increasingly widely beyond. The case of Gillick vs West Norfolk and Wisbech Area Health Authority (1985) gave rise to the Fraser guidelines (3), which states that a young person is competent to consent to contraceptive advice or treatment if:

- The young person understands the doctor's advice;
- The doctor cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice;
- The young person is very likely to begin or continue having sexual intercourse with or without contraceptive treatment;
- The young person's physical or mental health or both are likely to deteriorate if he or she does not receive contraceptive advice or treatment;
- The young person's best interests require the doctor to give contraceptive advice or treatment, or both, without parental consent.

References

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3. Larcher V (2005). ABC of adolescence: consent, competence and confidentiality. *British Medical Journal* 330:353-356.
4. Dickens BM & Cook RJ (2005). Adolescents and consent to treatment. *International Journal of Gynecology and Obstetrics* 89:179-184.