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COMPETENCE, CAPACITY AND CONSENT TO MEDICAL TREATMENT

VYG v VYH

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As it is in medicine, so it is in law: the rules for when one can give legally valid consent to medical treatment differ for minors and adults. This paper analyses Singapore's first judgment concerning medical decision-making by and on behalf of mature minors: a Family Court decision on *Gillick* competence in the context of COVID-19 vaccination. This paper also discusses its implications for medical practice and critiques the age of majority in Singapore.

"Children are not small adults".[1] As it is in medicine, so it is in law: the criteria for giving legally valid consent to medical treatment are different for minors and adults. What rules apply at different ages? For years it was assumed that Singapore might follow English law since there was no local test case.[2] Yet can this be right when the legislative frameworks and age of majority (18 in England and Wales versus 21 in Singapore) differ in these jurisdictions? A 2021 judgment of the Singapore Family Court; *VYG v VYH*,[3] has shed some light on this issue. It is the first reported local judgment to recognise that *Gillick* competence – a threshold for minors to give valid consent if they have sufficient intelligence and understanding to know what is involved[4] – forms part of Singaporean common law.

The case is significant for three reasons. First, it fills a gap in Singapore's statutory regime, by implying that *Gillick* competent minors can give consent to medical treatment. Second, it confirms that 21 is the age of majority in Singapore. Third, it suggests that parental authority recedes but does not terminate when a minor attains competence. *VYG* does not address the right of minors to refuse clinically indicated treatment but lays down principles which could guide a future case. This paper will

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1 Vic Larcher, "Children Are Not Small Adults: Significance of Biological and Cognitive Development in Medical Practice" in Thomas Schramme & Steven Edwards, eds, *Handbook of the Philosophy of Medicine* (Dordrecht: Springer, 2017) 371 [Larcher].

2 Yeo Khee Quan *et al*, *Essentials of Medical Law* (Singapore: Sweet & Maxwell Asia, 2004) at 254–260 [Yeo *et al*].

3 [2021] SGFC 124 [*VYG*].

4 *Gillick v West Norfolk and Wisbech Health Authority* [1986] 1 FLR 224 at 253 [*Gillick*].

analyse the *VYG* judgment (Part I), explain the local legal framework for making medical treatment decisions for adolescents (Part II), and critique the age of majority (Part III) in Singapore.

I. The *VYG v VYH* Decision

In *VYG*, the Singapore Family Court heard a dispute between parents over whether their 16-year-old daughter should be vaccinated against COVID-19. At the height of the global pandemic, the father wanted the girl to receive the COVID-19 vaccine, despite the mother's belief that the vaccines carried adverse side effects such as injury or death for adolescents.[5] Therefore, the father filed an application for the girl to receive the Pfizer-BioNTech vaccine in her best interests and upon the girl's consent.[6] This was opposed by the mother, who was unvaccinated and preferred to "wait and see" if a better treatment would be developed. The girl's British father and Singaporean mother had divorced in 2015, and they shared joint custody over her. Care and control had been awarded to the mother, and the girl resided with each parent on different days of the week.[7] The hearing concerned a second dose of the vaccine because, while proceedings were ongoing, the father had surreptitiously brought her to receive the first dose without her mother's knowledge or consent.[8]

The father filed his application under section 5 of the Guardianship of Infants Act 1934.[9] However, the existing joint custody arrangement meant that he should have sought a variation of ancillary orders instead. Therefore, District Judge Kenneth Yap converted the application to a summons under section 128 of the Women's Charter 1961.[10] Given the custody dispute, this was an odd case for *Gillick* competence (which is usually associated with independent decision-making by minors) to first appear in Singaporean common law. Tellingly, the parties did not refer to this concept until DJ Yap asked them to consider its relevance before the hearing.[11] Ultimately, the court ruled in the father's favour. A condition was attached to the custody order that entitled him to authorise COVID-19 vaccination for the girl, with her consent.[12] However, it was unclear why overlapping consents from both father and daughter were required, when a parent can typically authorise treatment on behalf of a child who simply *assents*.[13] Consent from both a child and at least one parent/guardian has been exceptionally required by law for contentious procedures

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5 *VYG*, *supra* note 3 at [12].
6 *Ibid* at [5]–[6].
7 *Ibid* at [4].
8 *Ibid* at [16].
9 Guardianship of Infants Act 1934 (2020 Rev Ed), s 5 [GIA].
10 *VYG*, *supra* note 3 at [35]–[37]; Women's Charter 1961 (2020 Rev Ed) [Women's Charter].
11 *VYG*, *supra* note 3 at [40].
12 *Ibid* at [78].
13 Assent, unlike "consent", lacks legal effect. Aviva L Katz, Sally A Webb & AAP Committee on Bioethics, "Informed Consent in Decision-Making in Pediatric Practice" (2016) 138(2) Pediatrics e1 at e8 [Katz *et al*].

like sterilisation,[14] but the judgment did not explain why this should be the case for COVID-19 vaccination. It would have been conceptually neater if the judgment had identified who is ordinarily entitled to give consent to childhood vaccination (*eg*, a parent or a competent minor),[15] then rationalised whether individual or joint authorisation is needed and from whom when family disagreements arise.

A. *Minors' Views and Welfare Assessments*

Section 125(2) of the Women's Charter provides that in "deciding whose custody … a child should be placed, the paramount consideration is to be the [child's] welfare" and the court should have regard to (a) "the wishes of the parents of the child"; and (b) "the wishes of the child, where he or she is of an age to express an independent opinion". Since *VYG* featured a custody dispute, this provision applied. DJ Yap had to decide the matter with reference to best interests: a holistic assessment which considers the child's psychological, emotional, moral, religious, and all other welfare interests in both the short and long term.[16] The girl's wishes were a relevant consideration, so DJ Yap drew upon the concept of *Gillick* competence to decide how much weight to give to her views on vaccination.[17]

An independent child representative was rightly appointed to ascertain the girl's maturity in appreciating the risks and benefits of vaccination, among other things.[18] Based on their interactions, the child representative reported that she "was sufficiently mature to appreciate the risks compared to the gains of vaccination" and recommended that she be fully vaccinated.[19] For example, the girl acknowledged her mother's concern for her wellbeing but respectfully took a different view; she appreciated the government's reasons for recommending COVID-19 vaccination for teenagers; and she wished to be immunised in order to socialise freely, travel to the UK to visit her grandparents, and avoid serious illnesses from contracting the virus. Agreeing with the report, DJ Yap deemed her sufficiently mature to make an informed decision and gave "full weight" to her views. Upon considering both parents' views and medical/policy arguments for and against vaccination, the court concluded that there were sound reasons to uphold the girl's preference for being vaccinated.[20]

While the judgment emphasised the preferences of a sufficiently mature minor, the actual basis of DJ Yap's decision on custody was unclear. Was it respect for the girl's autonomy *per se*, or respect for her decision insofar as it matched the judge's assessment of what was best for her? DJ Yap stated that "the choice [on whether to

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14 Voluntary Sterilisation Act 1974 (2020 Rev Ed), s 3(2)(*c*) [VSA].

15 Note that vaccination of children against diphtheria and measles is compulsory, so neither parents nor children have a choice for these diseases: Infectious Diseases Act 1976 (2020 Rev Ed), s 46(1) read with the Fourth Schedule.

16 *UKM v Attorney-General* [2019] 3 SLR 874 at [45].

17 *VYG*, *supra* note 3 at [54].

18 *Ibid* at [18]–[19]; Family Justice Rules 2014, r 30(1).

19 *VYG*, *supra* note 3 at [20]–[23].

20 *Ibid* at [62]–[63], [71], [76].

undergo vaccination] is ultimately a personal one", but this is misleading, because in his final analysis he does *not* uphold the girl's right to make decisions independently of her father or the court's oversight. The judge's subsequent emphasis on the girl's "informed and reasoned manner" towards deciding on vaccination and suggestion that minors' decisions "demonstrably made in error" can be overridden,[21] imply that minors have a qualified right to self-determination: their autonomy will only be respected if how they weigh up the relevant factors and the outcome of their decisions can withstand objective scrutiny.

Since section 125(2) of the Women's Charter required the court to decide the matter from the perspective of the child's welfare, *VYG* should be interpreted as a decision on how to exercise custody in the girl's holistic best interests. Within this analysis, her views as a mature minor were given presumptive weight. In light of the judgment's implicit support for official immunisation policies, it would have been more transparent for DJ Yap to explicitly state that vaccination was in the girl's best interests all things considered. Perhaps the judge was hesitant to attract controversy by ruling on the merits of COVID-19 vaccination *in general* when this was a divisive issue, but he could have simply emphasised that his assessment pertained to the specific child. In an English case with similar facts, Poole J ventured to declare that national vaccination programmes are "based on evidence that [the vaccines] are in the best interests of the children covered by the programmes" despite not being free from risk.[22] Both cases stressed the absence of known contraindications for vaccinating the individual child.[23]

Stepping back to examine custody disputes more generally, must children pass a threshold of *Gillick* competence before their views can be considered by a judge? In *ZO v ZP*, the Singapore Court of Appeal held that whether a child "is of an age to express an independent opinion" under section 125(2)(*b*) of the Women's Charter depends on his/her maturity.[24] *VYG* suggests that maturity should be assessed with reference to *Gillick* competence. Yet the High Court (Family Division) has considered children's views in ancillary matters hearings without assessing their competence before,[25] so a requirement of competence should not operate as a gloss on the statute. In disputes over care and control, it may be inappropriate to query a child's competence to decide who to live with and better to emphasise the child's non-determinative preferences, to shield the child from the non-resident parent's blame. Competence assessments are more pertinent in cases where minors assert their right to decide on personal matters like their healthcare and privacy.[26] This is because the House of Lords had originally developed the *Gillick* criteria as a threshold for children to receive contraceptive advice and treatment without parental involvement, as discussed below.

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21 *Ibid* at [70], [76].

22 *Re C (Looked After Child) (Covid-19 Vaccination)* [2022] 2 FLR 194 at [20]–[21].

23 *Ibid*; *VYG*, *supra* note 3 at [72].

24 *ZO v ZP* [2011] 3 SLR 647 at [15].

25 *AZB v AZC* [2016] SGHCF 1 at [26], [38]; *AMB v AMC* [2014] SGHC 169 at [10].

26 *Roddy (a child) (identification: restriction on publication)* [2004] 2 FLR 949 at [56].

B. *Joint Custody and Consent to Vaccination*

The father's application muddied the analytical waters by putting the girl's consent in issue, when this was not necessary since he was willing to authorise treatment on her behalf. The custody order could have simply been amended to let him give unilateral consent to the girl's vaccination in her best interests. A further condition could have stated that the girl may give the operative consent instead of her father, *if* a doctor confirms that she is *Gillick* competent to do so. Once a child attains competence to make a decision, the need for parents' consent typically falls away to reflect their diminished authority over him/her in that particular matter;[27] and the English Court of Appeal has held that assessing competence for consent to medical treatment is properly the domain of doctors, not judges.[28] If the district judge had deemed it appropriate for both father and daughter to give dual consent, an explanation of why this should exceptionally be required for COVID-19 vaccination and a statement that doctors should assess the girl's competence would have been ideal.

Section 46 of the Women's Charter requires parents/guardians to "cooperate … in … caring and providing for the children", unless a custody order says otherwise. Therefore, the mother submitted that both parents' consent to vaccination was needed because they shared joint custody.[29] Yet the Singapore Ministry of Health's policy had only required *one* parent/guardian's consent to COVID-19 vaccination on behalf of children under 18.[30] While this makes sense as a general rule, the father's mere reliance on this policy would have caused injustice to the mother given their disagreement on how to exercise their custodial duties. Therefore, the court's intervention as an objective third party was necessary. By varying the terms of the custody order, DJ Yap effectively disentitled the mother from deciding on the girl's COVID-19 vaccination. In this regard, the court could have looked beyond the present case and made a *general* pronouncement on the expected behaviour of parents in disputes about children's medical treatment. For example, the judge could have held that parents/guardians may not act unilaterally to authorise a disputed treatment but should first seek a court order on whether it can be provided in the child's best interests. Such a rule exists in respect of changing children's surnames.[31] Neither party considered relevant English cases on this point, which have exceptionally required consent from both parents to immunisation and male circumcision, and a best interests declaration when they disagree.[32] Despite the missed opportunity in *VYG*, I suggest that out of respect for shared parental responsibility, parents/guardians should seek a custody order (or variation of ancillary orders) whenever

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27 Leong Wai Kum, *Elements of Family Law in Singapore*, 3rd ed (Singapore: LexisNexis, 2018) at [8.094] [Leong]; *Gillick*, *supra* note 4 at 251.

28 *Bell v The Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363 at [87].

29 *VYG*, *supra* note 3 at [11].

30 *Ibid* at [58].

31 *UPD v UPC* [2020] 4 SLR 699 at [96]–[97]; *L v L* [1996] 2 SLR(R) 529 at [22].

32 *Re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision)* [2000] 1 FLR 571 at 576–577; *Re C (Welfare of Child: Immunisation)* [2003] 2 FLR 1095 at [17].

they intractably disagree on treatment for their children which is "irreversible", "of considerable consequence" or "hotly contested" in the public domain.[33]

II. The Medical Treatment of Minors

VYG contains principles on medical decision-making for minors which, despite the judgment's limited precedential value as a first-instance decision, fill longstanding gaps in Singaporean medical law. DJ Yap conducted a brief overview of the law. While statutes permit minors to give consent to abortion, sterilisation, and organ donation,[34] the court observed that there is "no general legislative guidance" on consent by under-21s to other forms of medical treatment.[35] The Singapore Medical Council's Ethical Code and Ethical Guidelines 2016, which has disciplinary force for doctors,[36] acknowledges a standard practice of obtaining consent from parents/guardians on behalf of under-21s. Yet the accompanying Handbook on Medical Ethics suggests that young persons who have attained competence can give consent on their own.[37] Therefore, DJ Yap held that:

> [From] the age of 12 and above … the question of how much weight should be given to any consent provided by the child on an issue of medical intervention would very much depend on the application of the principle in *Gillick*.[38]

Reference to "the age of 12" comes from the criminal law, which provides that consent from a parent/guardian is a defence to causing harm in good faith for the benefit of a person below 12; and consent from a person under 12 is invalid "unless the contrary appears from the context".[39] Singaporean medical guidelines have proposed that 14 is the minimum age for consent and those aged 16 to 18 are presumed competent,[40] but these rules of thumb and foreign maturity thresholds (*eg*, the "Rule of Sevens" in the United States, or the English statutory presumption of competence for 16- to 17-year-olds) have not been endorsed by the local courts. Rather, any patient below 21 may be found *Gillick* competent to give valid consent to treatment.[41] There are no fixed limits under civil law for when a minor may be deemed

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[33] *Ibid;* Hillary Chua, "Healthcare Decision Making for Children in Singapore: The Missing Chapter in Comparison with English Law" (2023) 37(1) Intl JL Pol'y & Fam 1 at 5.

[34] Termination of Pregnancy Act 1974 (2020 Rev Ed), s 3(1); Termination of Pregnancy Regulations (1999 Rev Ed), Schedule, Form III; VSA, s 3(2); Human Organ Transplant Act 1987 (2020 Rev Ed), s 15.

[35] *VYG*, *supra* note 3 at [55].

[36] Medical Registration Act 1997 (2020 Rev Ed), s 59D.

[37] Singapore Medical Council, *Ethical Code and Ethical Guidelines* (SMC, 2016) at C6(14)-(18), C8; Singapore Medical Council, *Handbook on Medical Ethics* (SMC, 2016) at 89.

[38] *VYG*, *supra* note 3 at [59].

[39] Penal Code 1871 (2020 Rev Ed), ss 89–90(*c*).

[40] Yeo *et al*, *supra* note 2 at 254–260; T Thirumoorthy & Peter Loke, "Consent in Medical Practice 3 - Dealing with Persons Lacking Capacity", *Singapore Medical Association News* (August 2013) at 19 [Thirumoorthy & Loke].

[41] Leong, *supra* note 27 at [8.088].

competent,[42] but the criminal law envisions that a parent/guardian's consent would generally be required for children below 12 for invasive procedures.

A. *Competence vs Capacity*

The age of majority is the legal boundary between "childhood" and "adulthood" and the dividing line between two legal frameworks for consent to medical treatment.[43] Under the United Nations Convention on the Rights of the Child and in several jurisdictions, adulthood starts from 18, but Singapore has adopted the common law age of majority of 21.[44] The Mental Capacity Act 2008[45] reflects this threshold. Mental capacity is a prerequisite for a person's healthcare decisions to have legal effect and encompasses functional decision-making ability.[46] Adults with capacity are entitled to determine what should be done with their bodies. Medical interference with their bodily integrity is an unlawful battery, unless they have voluntarily given consent.[47] They are entitled to make unwise decisions, including refusing medical treatment for idiosyncratic reasons even when this results in death.[48] Under the MCA, adults aged 21 and above are presumed to have mental capacity, but if they are found to lack capacity (*ie*, unable to make a decision because of an impairment of or disturbance in the functioning of the mind or brain) then a "best interests" decision must be made on their behalf.[49] Parliament has not applied the MCA framework to under-21s except in specific contexts.[50]

The presumption is reversed for under-21s. The starting point for minors is that decisions shall be made in their best interests, unless exceptions apply in statute or common law. The overarching legal principle is that minors' welfare shall be the first and paramount consideration in proceedings concerning their upbringing.[51] There is no general presumption of "capacity" for minors under Singapore law, and parents/guardians have authority to make medical decisions on their behalf. Yet insisting on parental consent is not always practical: parents may be uncontactable, and minors may only be willing to seek help from recognised healthcare providers

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42 *Gillick*, *supra* note 4 at 250–251.

43 Admittedly, "capacity" and "competence" have been used interchangeably and there is some conceptual overlap between these terms. However, this section highlights the relevance of parental authority and best interests over children but not capacitous adults.

44 Convention on the Rights of the Child (20 November 1989), 1577 UNTS 3 (entered into force 2 September 1990) [CRC]; *Rai Bahadur Singh r v Bank of India* [1992] 3 SLR(R) 127 at [43]–[44]; *Bank of India v Rai Bahadur Singh* [1994] 1 SLR(R) 89 at [8].

45 Mental Capacity Act 2008 (2020 Rev Ed) [MCA].

46 Genevra Richardson, "Mental Disabilities and the Law: From Substitute to Supported Decision-Making?" (2012) 65(1) Current Leg Probs 333 at 340.

47 *Schloendorff v Society of New York Hospital* 211 NYR 125 at 129 (NY, 1914).

48 MCA, s 3(4); *In re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541 at 553, 561.

49 MCA, ss 3(2), 4–6.

50 *Ibid* at ss 4(5), 21; VSA, s 3(4); Human Biomedical Research Act 2015 (2020 Rev Ed), s 8(1)(*d*) [HBRA].

51 GIA, s 3.

if they are assured of respect for their confidentiality,[52] *eg*, for sensitive matters like sexual or mental health. Hence, *VYG's* recognition that *Gillick* competence forms part of Singapore law is a welcome development.

Prior to the decision in *VYG*, legislation had permitted mature minors to give valid consent to participate in biomedical research (in addition to consent from at least one parent/guardian unless this requirement had been waived);[53] pregnant girls with sufficient understanding were entitled to give consent to abortion regardless of age;[54] and official guidelines on the use/disclosure of personal data had recognised that *Gillick* competence was a useful concept.[55] As Lord Scarman held in *Gillick*: "parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child."[56] Thus, children who have acquired the competence to make specific decisions can decide on these matters for themselves.[57] Article 12(1) of the CRC similarly provides that due weight should be given to developing minors' views "in accordance with [their] age and maturity". In summary, adults are presumed to have capacity to opt for and refuse clinically indicated treatment. The best interests standard only applies if they are incapacitated due to a mental impairment. Contrastingly, minors can only decide for themselves if they attain competence, which depends on a finding of intellectual ability, emotional maturity, *and* that parental powers of protection can be safely abandoned in the circumstances as Gilmore has observed.[58]

B. *The Implications of Gillick Competence*

Although the court in *VYG* did not explore whether the girl could give consent to vaccination independently of her father, that attaining *Gillick* competence should have this effect has practical importance and reflects the original House of Lords decision. Yet questions persist about whether competent minors should be allowed to make "unwise" decisions – such as refusing life-sustaining or medically necessary treatment – on the same basis as capacitous adults. The English cases of *Re R*, *Re W*, and several involving refusals of blood transfusion by Jehovah's Witness children, have rejected the notion that *Gillick* competence grants children "the right to make their own mistakes".[59] These cases have established that: (1) even when minors have competence or presumed capacity under statute, they have no absolute right to refuse medical treatment;[60] and (2) even where parents support their refusal,

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52 *R (Axon) v Secretary of State for Health (Family Planning Association intervening)* [2006] EWHC 37 (Admin) at [68]–[70].

53 HBRA, s 8(1)(*a*)–(*b*).

54 See *supra* note 34.

55 PDPC, *Advisory Guidelines on the Personal Data Protection Act for Selected Topics* (2013) at 56–57.

56 *Gillick*, *supra* note 4 at 249.

57 Stephen Gilmore, "The Limits of Parental Responsibility" in Rebecca Probert, Stephen Gilmore & Jonathan Herring, eds, *Responsible Parents and Parental Responsibility* (Oxford: Hart Publishing, 2009) 63.

58 *Ibid*.

59 John Eekelaar, "The Emergence of Children's Rights" (1986) 6(1) Oxford J Leg Stud 161 at 182.

60 *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 at 26 [*Re R*]; *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 at 77–78 [*Re W*]; *An NHS Trust v X* [2021] 4

this can be overridden by a court order on best interests.[61] The Australian, New Zealand, and Canadian courts have also held that the child's welfare prevails over minors' and parents' refusals of life-sustaining treatment.[62]

On the one hand, this commonwealth consensus on refusals of treatment appears to be a retreat from *Gillick*, which the Singapore courts are not bound to follow. On the other hand, the conceptual foundation for restricting a minor's right to refuse treatment exists in the *Gillick* judgment and is consistent with key principles in Singapore law. In *Gillick*, the leading judgments adopted distinct rationales for their decision.[63] Lord Scarman radically held that the parental right to make medical decisions for a child *terminates* once he/she "achieves a sufficient understanding and intelligence to enable [him/her] to understand fully what is proposed",[64] but Lord Fraser took a more welfare-based approach. Specifically, his guidelines for assessing competence required doctors to consider whether it is in the child's *best interests* to receive treatment/advice without parental consent, among other criteria.[65] This emphasis on welfare has prevailed in the "refusal" cases and reflects the duty of parents and the state to safeguard minors' interests so that they can reach adulthood without disadvantage.[66]

In Singapore, application of the statutory welfare principle makes it difficult to assert that minors should have their way when the consequences would contradict an objective assessment of their best interests.[67] Moreover, the court in *VYG* endorsed family law Professor Leong Wai Kum's view that parental authority recedes but *does not terminate* when a child becomes capable of making her own choice.[68] Not only is this more conservative than Lord Scarman's stance in *Gillick,* it implies that parents/guardians retain concurrent rights to give consent on behalf of competent minors who refuse treatment.[69] Singapore appears poised to follow other commonwealth jurisdictions in recognising parents' and judges' power to override the decisions of minors (competent or otherwise) in their best interests. Judges may be inclined to subject minors to paternalistic interventions, because the state has a duty to protect their interests and should be slow to let them martyr themselves.[70]

Nevertheless, there is scope to prioritise a competent minor's views *within* a best interests analysis. The "full weight" which DJ Yap gave to the girl's views in *VYG* reflects this approach.[71] In *Aintree*, the UK Supreme Court's formulation of the "best interests" test for incapacitated adults came close to a "substituted judgment"

WLR 11 at [104].

61 *E & F (Minors: Blood Transfusion)* [2022] 2 WLR 395.

62 Ian Freckelton & Simon McGregor, "Refusal of Potentially Life-Saving Treatment for Minors: The Emerging International Consensus by Courts" (2016) 23(4) JL Med 813.

63 Jane Fortin, "The Gillick Decision - Not Just a High-Water Mark" in Stephen Gilmore, Jonathan Herring & Rebecca Probert, eds, *Landmark Cases in Family Law* (Oxford and Portland, Oregon: Hart Publishing, 2011) 203.

64 *Gillick*, *supra* note 4 at 253.

65 *Ibid* at 239.

66 Larcher, *supra* note 1 at 387.

67 John Eekelaar, "The Eclipse of Parental Rights" (1986) 102 Law Q Rev 4 at 8.

68 Leong, *supra* note 27 at [8.094].

69 *VYG*, *supra* note 3 at [53]–[54]; *Re R*, *supra* note 60 at 26.

70 *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386 at 394.

71 *VYG*, *supra* note 3 at [76].

standard which asks what P would have wanted if he/she had capacity.[72] Although the correctness of this approach is debatable, when a competent minor refuses medical treatment, respecting her wishes could be justified if other relevant considerations support her decision. For example, if the proposed intervention carries high risks with uncertain benefits (*eg*, experimental treatment), and the use of long-term or aggressive restraints to enforce treatment would cause the minor to suffer excessive physical/psychological harm. Until a test case arises, *VYG* suggests drawing the line at letting minors arbitrarily expose themselves to a substantial risk of death or serious injury.[73]

III. The Age of Majority in Singapore: Time for a Rethink?

An 18-year-old in Singapore is apparently not entitled to make "unwise" medical decisions, but that same person would be an adult and enjoy full autonomy to do so in England and Wales or Malaysia, so long as he/she has capacity. Singapore's 21-year threshold for legal adulthood and presumed mental capacity under the MCA may be questioned. After all, Parliament has lowered the minimum age for minors to engage in comparable activities. In criminal law, consent from persons above 18 is a defence to causing grievous hurt.[74] Under the statutory regime for child and adult protection orders, the Children and Young Persons Act 1993[75] applies to those below 18, whilst the Vulnerable Adults Act 2018[76] applies to "vulnerable *adults*" [emphasis added] aged 18 and older who are incapable of protecting themselves from abuse, neglect or self-neglect, due to "mental or physical infirmity, disability or incapacity". Vulnerable adults are presumed to have capacity to consent to medical or dental treatment before/during a period of being taken into care.[77] If the VAA presumptively recognises such persons' autonomy to consent to medical treatment, is it not logical to extend this right to others aged 18 and above?

At 18, Singaporean men undergo compulsory military conscription ("National Service") and 18-year-olds can be subjected to capital punishment.[78] Since the law allows those aged 18 and above to face the dangers of military training and death itself,[79] Chan argues that this group should be entitled to decide on their own medical treatment and take risks with their health.[80] Recognising 18 as the new minimum age for consent (and refusals) in healthcare has several advantages. It would harmonise Singapore law with international standards in the CRC. It would align the age for consent to harm under civil law more closely with the criminal law. It would match existing healthcare practices: some doctors have regarded 18 as the *de facto*

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[72] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at [24], [39], [45] [*Aintree*].

[73] *VYG*, *supra* note 3 at [70].

[74] Penal Code, s 87.

[75] Children and Young Persons Act 1993 (2020 Rev Ed).

[76] Vulnerable Adults Act 2018 (2020 Rev Ed) [VAA].

[77] VAA, ss 2(1), 18(2).

[78] Enlistment Act 1970 (2020 Rev Ed), s 10; Criminal Procedure Code 2010 (2020 Rev Ed), s 314.

[79] Leong, *supra* note 27 at [8.025]–[8.027].

[80] Tracey E Chan, "Minors and Biomedical Research in Singapore" (2008) 28(3) LS 396 at 425–426.

minimum age for consent to treatment,[81] and have transferred patients out of paediatric care from age 18 or earlier.[82] A legal presumption of capacity for patients in the 18-to-21 age bracket would save doctors the trouble of assessing their *Gillick* competence and provide certainty. Since Singaporeans can marry at 18 (albeit with parental consent) and make medical decisions for *their* children from that age, it makes sense to also confer upon married minors a right to decide on treatment for themselves.[83] As Larcher argues, "[once] a child has acquired the level of competency to achieve a particular right, she/he should not be refused another kind of right that presupposes the same level of competence."[84]

However, legal age limits may depend more on policy rather than ability. Despite making 18 the new legal age for forming commercial contracts,[85] Parliament refused to lower the voting age from 21 to 18 and preferred to calibrate different age thresholds for different activities.[86] Yet in line with the VAA, the MCA could be amended such that its core provisions apply from 18 onwards. The definition of "children" and "minors" could also be standardised to mean persons below 18 across all statutes affecting their interests, while laws which raise the threshold to 21 (*eg*, for voting or advance directives) can be retained and reframed as exceptions to the rule.[87]

In Singapore, a person aged 18 and above but below 21 is an "infant", "child" or "minor" under one statute but an "adult" in another.[88] How can this be? In an area not regulated by statute like consent to (most forms of) medical treatment for minors, where Singapore also lacks case law, piecing the rules together is a legal minefield. *VYG* indicates that *Gillick* competence forms part of Singapore law, but it adopts a traditional approach of upholding a minor's autonomous choice where this aligns with a judicial assessment of her best interests. The full implications of attaining competence have yet to be explored in Singapore, and the issue of whether to lower the age of majority to 18 (in the MCA or more broadly) is ripe for public consultation and potential law reform.

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81 Thirumoorthy & Loke, *supra* note 40 at 19.

82 "Children's Services", *KK Women's and Children's Hospital* <https://www.kkh.com.sg:443/patient-care/areas-of-care/childrens-services/Pages/overview.aspx> (2021).

83 Women's Charter, ss 9, 17(2)(*b*)(ii); Katz *et al*, *supra* note 13 at e10.

84 Larcher, *supra* note 1 at 386.

85 Civil Law Act 1909 (2020 Rev Ed), ss 35–36.

86 *Singapore Parliamentary Debates, Official Report* (19 January 2009), vol 85 at col 1136 (Assoc Prof Ho Peng Kee, Senior Minister of State for Law).

87 Advance Medical Directive Act 1996 (2020 Rev Ed), s 3.

88 The Women's Charter defines a "minor" as a person below 21 who has not been married (s 2) and "child" as someone under 21 (s 122). The GIA does not define "infants", but Leong deems this to mean under-21s, in line with the Women's Charter: Leong, *supra* note 27 at [8.022].