

## Children's rights in Europe

Rights are ways of acting or being treated that are beneficial to the holder. The benchmark for human rights standards is the Universal Declaration by the United Nations General Assembly, which stated in 1948 in Article 1 that 'all human beings are born free and equal in dignity and rights' [1]. In Europe the main concern is on the individual's civil rights, focusing on liberty, personal autonomy and informed consent. From an international perspective the 'claim rights', i.e. the exertion of a positive claim to a particular service, are potentially as important.

Children also have rights and societies' attitudes to these are changing, becoming more child-centred and conferring more rights on children as individuals. A child or minor in most European jurisdictions means every human being below the age of majority, in most cases currently 18 yr. However, a child's rights are not uniform across different countries and it is our aim to explore these subtle differences.

A good starting point for our discussion is the United Nations Convention on the Rights of the Child (UNCRC) [2]. This is the most widely ratified international human rights treaty (a notable exclusion being the USA, which has signed but not yet ratified the convention to date [3]). It exemplifies the international communities' aspiration to achieve universal standards for human rights. In contrast to the Human Rights Act 1998 [4], which focuses on individuals' rights and, to some extent, parental autonomy, the UNCRC's main concern is the child. In 1996 The Parliamentary Assembly of the Council of Europe urged member states to ratify the UNCRC if they had not already done so. The member states were also strongly urged to 'inform children and their parents of their rights' and 'enable the views of children to be heard in all decision making which affects them' [5].

Article 3 of the UNCRC imposes responsibilities on the state and parents to provide adequate healthcare ensuring that 'the best interests of the child shall be a primary consideration' in all actions concerning

children. However, 'a child's best interests' appears open to interpretation, and may not necessarily reflect their rights nor promote their autonomy. Article 12 of the Convention also states that '... parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'. This issue bears heavily on the rights of a child to be involved in decisions about his or her healthcare. How much real influence a child has (especially the right to refuse treatment) is controversial and varies between countries. The 'weight' given to a child's views is based on determining whether a child is competent to make decisions. Assessing whether a child clearly understands the nature and implications of a particular medical intervention is difficult. A child may be deemed competent to consent to one treatment but incompetent to refuse another. This appears to be a reflection of society's desire to encourage child autonomy and yet ensure that children are protected from the consequences of decisions that (in society's view) put them at risk.

We discuss the different approaches of some individual legal systems across Europe. It has, unfortunately, not been possible to examine every country in Europe due to difficulties in obtaining information regarding consent of the child.

*Finland* is one country that seems to have loyally adhered to the text of the UNCRC. The Child Custody and Right of Access Act 1983 provides that, before a parent who has custody 'makes any decision on a matter relating to the person of the child, he or she shall, where possible, discuss the matter with the child taking into account the child's age and maturity and the nature of the matter'. In making a decision the custodian shall give 'due consideration to the child's feelings, opinions and wishes' [6]. This act takes Article 12 of the UNCRC to the extreme by appearing to impose legislative duties on parents and carers to give due consideration to the child's views. However, the weight given to the child's views is determined by judgement of their capacity to form an opinion and their age and maturity. Children in Finland of 15 yr or older can give consent to medical treatment.

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For younger children either the guardian and/or competent young person can give consent. If a child of <15 yr refuses treatment then the decision to proceed or not is based on assessing the age, maturity and competence of the child.

In *Italy* the age of majority is 18 yr. Below this age either the parent or competent child can give consent. In any case where the child or their parents disagree with a treatment decision considered necessary by the physician, the physician must ask the opinion of the competent Tribunale per Minori (Tribunal for Minors). The judge must then seek a second opinion from a consultant (legal medicine or/and doctor) before making his decision. If a child is deemed to be competent then they may have the final word in matters of consent, even if this is against the wishes of their parents/guardian.

*Spain* also has an age of majority of 18 but no legal age of consent. Consent is based on the child being considered competent to decide.

In *Portugal*, parents represent the interests of their children up to the age of 14 yr. Older children may decide for themselves. There is a legal obligation to inform and, if possible, obtain consent from minors who have capacity to understand what affects them. In life-saving situations, in which the parents disagree with essential medical management, it is possible for the physician to contact a judge quickly, 24 h a day, who then has the authority to suspend parental power to allow treatment of the child to continue.

The age of consent in *Switzerland* depends on the maturity of the child. Below the age of 18 yr the child has the right to consent to medical treatment and, in some issues, the same right of confidentiality as adults (e.g. prescription of contraceptive treatment without parental knowledge). Similarly, the child has the right to refuse non-essential or cosmetic surgery, but not life-saving surgery.

Children aged 14 yr or older in *Austria* are authorized by law to give their own informed consent for medical treatment. They may also refuse any treatment deemed not necessary to their health or life. Younger children can influence decisions about their medical management, although this does not have legal standing. For life-threatening situations, parents and doctors can overrule the decisions of 14-yr olds (and sometimes even older children). However, if the child is a Jehovah's Witness, he or she can be treated without the informed consent of the parents. In these cases the parents are not legally responsible for the child during the period of medical treatment (e.g. resuscitation with blood products). A 14-yr-old Jehovah's Witness is legally competent to refuse blood products provided it is not a life-threatening situation.

In *Denmark*, competent children of 15 yr or older can give informed consent for treatment. If the medical

authority believes the child does not understand the consequences of their decision, or they are <15 yr, the parents can give informed consent on their behalf. Parents are generally informed and involved in any decisions of a minor until the age of 18 yr.

*France*, which claims to be the country of human rights 'par excellence', was one of the first countries to sign, ratify and implement the UNCRC. French law, however, is preoccupied with the child's 'best interests' and, paradoxically, this may diminish their rights. The courts have emphasized the idea that parental power was more the recognition of a function than a right, since it was a right that should be exercised in the best interests of the child. However, under present French law, a young person has no power to initiate a lawsuit until he or she is 18 yr. If in conflict with parents, the child has no recourse to the law. Furthermore, some courts have chosen not to listen to the views of the child when deciding the custody and visiting rights of parents following divorce. In these cases, the 'parents know best' test has been utilized. Thus, despite claiming to have sanctioned the UNCRC, France does not appear to give children the autonomy mandated by the convention.

The *United Kingdom* ratified the UNCRC in 1991 accepting responsibility for the development of rights-based and child-centred healthcare. However, legislation has given rise to differing approaches to implementing the rights of the child. The age of majority in the UK is 18 yr. *England, Wales and Northern Ireland* are governed by a common law approach to consent issues. These are judge made and set on precedents from previous cases. Following the Family Reform Act 1969, Section 8, competent young people of 16 or 17 yr of age can give consent to any surgical, medical or dental intervention. Their decision has the same legal standing as if the patient was an adult and it is not necessary to obtain consent from a parent or guardian. This principle was further defined following the Gillick case in 1984 [7]. The Gillick case held that where a young person had sufficient understanding and intelligence to understand fully what was proposed, their consent to treatment would be considered legally valid. It is the responsibility of the doctor to assess whether a child is competent and satisfies the 'mature minor' test. If this is the case, consent from parents is not legally necessary, although it is thought to be good clinical practice to encourage the child to allow the involvement of the parent or guardian in this process. Where a young person under the age of 18 yr is not felt to be competent to give consent then consent from a parent or legal guardian must be sought.

The main problem with the Family Reform Act 1969 has been interpretation of Section 8.3. This appears to allow a competent child's decision to

withhold consent to be overridden by a parent, legal guardian or court if the proposed treatment is considered to be in the child's best interests. This has been tested in case law [8] where the Courts were prepared to override the wishes of a 16-yr old. In keeping with virtually all legal systems, in a life-saving situation necessary treatment may be lawfully given even if no consent is available from the child or parents in order to promote the child's best interests.

In the *Republic of Ireland* the age of majority is 18 yr. The Irish Constitution places great importance on the rights of the family. The result is an emphasis on parental autonomy when decisions arise regarding the treatment of their child. As a consequence, the courts may tend to side with the parents and doctors may find it difficult to override the wishes of the parents except in treatment necessary to prevent death or permanent injury [9].

*Scottish law* is based on statutes. The Age of Legal Capacity Act 1991 allows young people to consent when, in the opinion of a medical practitioner, they fully understand the nature and consequences of the intervention. The Children (Scotland) Act 1995 suggests that a child of 12 yr or more shall be presumed to be of sufficient age and maturity to form a view and that a parent must, in reaching a decision regarding the child, have regard, as far as is practicable, to the views of the child concerned. This contrasts with England's paternalistic approach where the parent has no obligation to consider the views of the child concerned. At 16 yr the child in Scotland is assumed to be competent and the parent can no longer legally represent them in legal or consent issues. In Scotland a competent child under 16 yr can both give consent and withhold consent to treatment. This may not be overridden except in life-saving circumstances. To date, this has not been tested in the courts in Scotland and so currently competent children appear to have the same rights of autonomy as adults. If a child of <16 yr was not considered to be competent, the parent or guardian would be responsible for consenting to medical interventions.

## Conclusion

The right for children to consent is changing in many countries in line with increasing autonomy rights. The emphasis is changing from a proscribed age of consent to interest in an individual's ability to understand the implications of the proposed surgical or medical intervention. When children are considered able to communicate and participate in decisions affecting them, society is increasingly encouraging them to express their views. For this to happen information must be presented to the child in a way that they understand, explaining the implications of a

proposed treatment, side-effects and any alternatives that may be available. With appropriate support from their family and health professionals children are then in a position to give their informed consent to treatment. The right of autonomy should allow an individual to both give consent and refuse consent. However, here lies an area of conflict between a child's autonomy and right to protection. Children need to be protected from choices that may be harmful to themselves while at the same time respecting their autonomy and right to be involved in decision making. Much controversy surrounds the ability of a child to refuse treatment. Overriding a child's decision to refuse non life-saving treatment goes against all ethical principles of autonomy. Only in Scottish and Finnish law, from those systems described here, does it appear that the competent child is given full rights to consent and refuse medical treatment. However, even in Scotland, to date, the right of a competent child to refuse medical treatment considered necessary by their parents and medical staff has not been tested in the courts. It is not clear whether cases of this nature in England, where the courts were prepared to ignore the rights of legally competent children, will have any influence on the outcome of any future case held in Scotland. However, for the present, Scottish and Finnish law appears to be nearest to the gold standard of promoting autonomy and the right to self-determination of competent young people when making decisions based on advice given by the medical profession.

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