

## **A comparative assessment of minors' competence to consent to treatment in Polish and English law**

Bagan-Kurluta K.<sup>1\*</sup>, Drozdowska U.<sup>2</sup>

1. Faculty of Law, University of Białystok, Białystok, Poland

2. lecturer at the Faculty of Law, University of Białystok, Białystok, Poland

### **ABSTRACT**

---

The publication concerns the problem of minors' consent in regard to health services. The authors have provided legal solutions adopted in the UK and Poland. The British case law presented in the first part of the article provides that minors have the opportunity to decide on issues relevant to their own health. The ruling which made a breakthrough in automatic treatment of all children (0-16) in the same way was the Gillick case. Since then the test of actual competence has depended on whether the child is able to make a reasonable assessment of the advantages and disadvantages of the proposed treatment and the type of medical intervention, not on age. The British Medical Association has developed manuals to facilitate proceedings of assessing the ability by the physicians. In turn, the Polish legislator in relation to the consent of minors under 16 to treatment introduces only one criterion: the age. Children under 16 years of age, even if they are competent, are not asked for permission to

violate their physical integrity. Legal representatives (in the case of medical examination -- actual custodians) are solely entitled to express the consent. In turn, minors above the age of 16 are entitled to consent together with their legal representatives (the actual custodians). In the case of dual consent, in principle, both entities should actually be capable of expressing it. Reading of the provisions of Polish medical law, however, leads to the conclusion that, in fact, the competence of parents is the most important. In the case of a minor patient's (over 16 years of age) incompetence, consent is made only by his legal representative. In contrast, in the case of a minor's opposition, the doctor does not examine his actual competence, only whether the patient is acting with sufficient discernment and refers the matter to the guardianship court.

**Key words:** minor, capacity, consent, medical intervention, Gillick competence, maturity, test

---

#### **\*Corresponding author:**

Department of Civil Law. Faculty of Law University of Białystok.

1 Mickiewicz str., 15- 213 Białystok, Poland,

Tel.: + 48 662 065 222; e-mail: kbkurluta@wp.pl

Received: 21.05.2015

Accepted: 10.10.2015

Progress in Health Sciences

Vol. 5(2) 2015 pp 149-159

© Medical University of Białystok, Poland

## INTRODUCTION

Provisions of international conventions and rules of national law guarantee the right of every person to express his/her opinions freely and to make decisions concerning his/her own health. In Poland these guarantees are embedded in the Constitution and acts of law, whereas in the England they stem primarily from statutes and case law. This study examines the position of the rights of the child within these two legal systems and the limits imposed on their implementation in the context of the child-parent relationship.

Following the definition of the 1989 Convention on the Rights of the Child (Act 1) that a child is a person under 18 years of age we will examine the following questions:

- 1) What are the limitations imposed on an underage person's capacity to make decisions about issues concerning his/her health within the Polish and the English systems of law? (NB. The United Kingdom consists of three jurisdictions - Scotland, Northern Ireland, and England and Wales; this article is concerned solely with English law, i.e. the law of England and Wales)
- 2) What are the differences between the solutions to problems of child's competence within the Polish and English legal systems (representing the tradition of common law and civil law respectively)? Do they ensure the same level of opportunity for children to decide, if only in a restricted manner, on issues relevant to their own health (in view of contemporary changes in the understanding of the child-parent relationship and the role of parental responsibility)? [1].

### The Gillick case and its consequences in the UK

According to the Family Law Reform Act 1969, an adult is a person who has attained the age of eighteen [2]. He is fully competent to decide for himself, entitled to consent to treatment and to refuse the treatment. He may refuse it for rational, irrational reasons or even for no reason [3]. However the consent of a minor who has attained the age of sixteen to any surgical, medical or dental treatment, ie. any procedure undertaken for the purposes of diagnosis, also any procedure (including, in particular, the administration of an anesthetic) which is ancillary to any treatment as it applies to that treatment) which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; it shall not be necessary to obtain any consent therefor from his parent or guardian. Parents shall be responsible for children under the age of sixteen and have the decision-making authority in all cases concerning them [4]. The relationship between parent and child is shaped by the institution of parental responsibility and by the standard of the best interests of the child.

The rights that have been granted to the parents in relation to their offspring are for the benefit of the latter, and are justified by the execution of the parents' duties towards children [5]. This means that parents rather than children should make decisions where the best interests' standard is applicable.

This simple model of treatment of all children in this age group has been undermined by case law, most notably by the ground-breaking judgment in the case of *Gillick v. West Norfolk & Wisbech Area Health Authority* [6]. The facts of the case are as follows. In December 1980 the Department of Health and Social Security issued a revised guidance on family planning services. One of its sections, entitled 'The Young', stated that in some cases (to be treated as exceptional) a doctor or any other professional worker could lawfully prescribe contraception for girls under 16 without parental consent or knowledge. Mrs. Gillick, who was the mother of five daughters under the age of 16, objected to the guidance and instituted a series of proceedings, seeking a declaration that the guidance was unlawful.

Ultimately, the issue was settled on appeal to the highest court of the land, the House of Lords. The applicant raised three issues. The first one concerned parental rights: Mrs. Gillick argued that parental rights should be protected against any infringement, no matter whether authorized by a court ruling or a reference to statutory provision. The second objection concerned criminal law: a regulation that sanctioned the prescription of contraceptives to girls under the age of sixteen *had* to violate public order since a doctor applying the guidelines would commit the offence of aiding and abetting the commission of unlawful sexual intercourse. Finally, the applicant raised the problem of minors' competence, claiming that a girl under the age of sixteen was incapable of an effective expression of consent to treatment, especially with regard to such grave issues as contraception and abortion. Underpinning all these legal challenges was her profound objection to the extension of the principle of confidentiality of doctor-patient relationship to child minors (like her daughters) behind the back of their parents [7].

The Law Lords set aside the Court of Appeal ruling in favour of Mrs Gillick's action by a narrow majority 3:2. In their judgments Lord Fraser, Lord Scarman and Lord Bridge reaffirmed both the right of doctors to prescribe contraceptives to minors under sixteen without parental consent and the right of parents to control a child deriving from parental duty. Yet their statements neither outline the scope of that control nor relate it in any precise terms to the age of the child, besides stating that parental oversight was 'a dwindling right'. The judges merely agree with an earlier ruling that the child's right to make important decisions depends on the child's sufficient maturity and understanding as well as the

type of the consent required. Only if the child is able to make a rational assessment of the advantages and disadvantages of the proposed treatment can his/her consent, if expressed, be properly and fairly described as valid.

In his judgment Lord Fraser lays down some specific guidelines for doctors making an assessment of the competence of the child (ie. a test of the child's sufficient understanding and maturity). The doctor is justified in proceeding without the parents' consent or even knowledge, provided he is satisfied on the following points:

1. that the girl (although under 16 years of age) will understand his advice;
2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
3. that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;
4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;
5. that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

According to Lord Scarman, parental consent must be sought if the child in question is not competent to provide it, yet once the competence of the child has been established (ie. the child is found to be 'Gillick competent') the parents cannot revoke the consent of the child by their decision. One very significant consequence of the final ruling in the Gillick case was the undermining of the generally held presumption that children under sixteen lack the capacity to consent [8]. However, it is by no means clear that the Fraser Test addresses in a satisfactory manner the problem of consent.

*The New Oxford Dictionary of English* (1998) defines consent merely as a "permission for something to happen or agreement to do something". But, as C. P. Selinger points out, this definition has to be distinguished from 'informed consent', namely an understanding of an action agreed to, usually for medical purposes, or, in other words, "*permission granted in the knowledge of possible consequences*" [9].

According to C. Moloney, legally valid consent should consist of the following three elements: it should be given by a competent person, voluntarily and it should be 'informed' [10]. In the case of a child, we must make sure that his/her consent is true (ie. not obtained by deception or threat) [11], that he/she can compare and balance the benefits and the harms of the treatment proposed [12], and is able to understand the advice (its nature and what is involved), including the moral and emotional implications of the treatment [13].

The House of Lords judgement in the Gillick case not only acknowledged the fact that

maturity was an evolving concept which entailed a gradual attainment of rights and the child's growing independence from the custodial control of parents but also challenged the medical profession to work out practical measures of assessing child's competence to make decisions for oneself. The challenge did not go unheeded. There followed a spate of guidance and resources that addressed this issue, among them a series of manuals published under the auspices of the General Medical Council and the British Medical Association [14].

According to the BMA Children and Young People Tool Kit, the welfare of children and young people should be the paramount consideration in decisions about their care. Consequently, children and young people can expect:

1. to be kept as fully informed as they wish, and as it is possible, about their care and treatment
2. health professionals to act as their advocates
3. to have their views and wishes sought and taken into account as part of promoting their welfare in the widest sense
4. to be the individual who consents to treatment when they are competent to do so
5. to be encouraged to take decisions in collaboration with other family members, especially parents, if this is feasible
6. to be able to expect that information provided will remain confidential unless there are exceptional reasons that require confidentiality to be breached. In each case the competence of a person under the age of 16 needs to be assessed on a continual basis.

A complementary set of desiderata are addressed to doctors. They are aimed at involving all children and young people in decisions relating to their medical treatment. It is important to recognize when a young person is able to make a valid choice regarding a proposed medical intervention or disclosure of personal medical data and is therefore competent to make a personal decision. Doctors should not judge the ability of a particular child or young person solely on the basis of his or her age. For a young person under the age of 16 to be competent, he/she should have:

1. the ability to understand that there is a choice and that choices have consequences
2. the ability to weigh the information and arrive at a decision
3. a willingness to make a choice (including the choice that someone else should make the decision)
4. an understanding of the nature and purpose of the proposed intervention
5. an understanding of the proposed intervention's risks and side effects
6. an understanding of the alternatives to the proposed intervention, and the risks attached to them
7. freedom from undue pressure.

When assessing a child's competence it is important to explain the issues at hand in a way that is suitable for their age. A young patient may be competent to make some, but not all decisions, and clinical staff should promote an environment in which young patients are enabled to engage in decisions as much as they are able. The child's or young person's ability to play a full part in decision-making can be enhanced by allowing time for discussion [15]. The competence of a child is assessed by a doctor or other member of the medical staff [16]. General practitioners who have known the young patient for a long time should assess it – they are well placed to assess their development and maturity but because these change, it is unwise to rely on any assessment that is not contemporaneous. Health professionals who assess competence need to be skilled and experienced in interviewing young patients and eliciting their views without distortion. The treating doctor may be the most appropriate person, but other members of the health care team who have a close rapport with the patient may also have a valuable contribution to make [17].

The evidence provided by guidance and advice materials like BMA Children and Young People leaves no doubt that we are in the midst of a massive change in the way children are involved in the decisions concerning their health and wellbeing. Arguably, one of the catalysts of this transformation was the Gillick case, a legal dispute that went all the way to the highest court where it was decided by the narrowest of margins. As the judgement in that case rebalanced the parent-child relationship, paving the way for 'child emancipation', we may wonder if, as a consequence, it has left the parents with little or no chance to effectively oppose a decision of their child, even if they are convinced it is unreasonable and harmful to the child's best interests.

One of the key issues in the subsequent developments is the applicability and 'bite' of the concept of the Gillick competent child. From a logical point of view it would seem that once the Gillick competency is resorted to it should work both ways – with regard to the child's capacity to consent to treatment and his/her capacity to decline it. In practice, that would mean the adoption of the same procedure in either case, i.e. when the child consents to or refuses treatment. Although this principle was expressly formulated in *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] FCR 785 [18], the two types of situation are indeed treated differently in case law. When a child gives his/her consent, neither the parents nor the court are able to override it. However, when a child refuses treatment while his/her parents (or guardians) and ultimately the court take the view that the treatment should be gone through, the child's refusal can well be overridden. The typical justification of the decision to dismiss the refusal is that (only) the proposed treatment will safeguard the child's best interest.

This argument is evoked in a number of cases, including *Re R (a Minor) (Wardship: Consent to Treatment)* [19], *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*[20] and *Re C (a minor) (Detention for medical treatment)* [21].

Apart from the judicial affirmations of the best interest standard, probably the most important attempt to specify it can be found in the BMA Children and Young People Tool Kit. The authors of that guidance gave it the form of an ambitiously broad test aimed at ascertaining with maximum objectivity of what would be in the child's actual best interests. It follows the generally held assumption that a person's interests are best served by measures that offer the hope of prolonging life or preventing damage to health, but admits that these considerations do not suffice in each and every case. So, in addition to the basic postulates, a comprehensive best interest judgement should take into account [22]:

1. the patient's own wishes, feelings and values (where these can be ascertained)
2. the patient's ability to understand what is proposed and to weigh up the alternatives
3. the patient's potential to participate more actively in the decision, if he is provided with additional support or explanations
4. the patient's physical and emotional needs
5. the clinical opinion about the effectiveness of the proposed treatment, particularly in relation to other options, and where there is more than one option, which option is least restrictive of the patient's future choices
6. the likelihood and the extent of any degree of improvement in the patient's condition if treatment is provided
7. the risks and likely side effects of the treatment or non-treatment
8. the views of parents and others who are close to the patient about what is likely to benefit the patient
9. relevant information about the patient's religious or cultural background
10. the views of other health care professionals involved in providing care to that person, and of any other professionals who have an interest in juvenile welfare.

It seems, however, that the appearance of such an impressive instrument to assess the child's best interests has not persuaded the courts to give up their discretionary approach, especially when they deal with contested refusals of treatment by self-willed minors. So the judgement in *Re C (a minor) (detention for medical treatment)* [1997] 2 FLR 180 [23] expressly affirms the court's right to set up its own kit to test child competence. One such test, distinctly suited to situations with recalcitrant youngsters refusing treatment and thus putting their lives in danger (as in a case of an anorexic teenager), was devised the judges in *Re C (refusal of*

treatment)[24] and *Re MB* (medical treatment) [25]. That test crucially requires the patient to “*show an ability to comprehend and retain treatment information relevant to the decision, especially as to the likely consequences of having or not having the treatment in question, to use it, and to weigh it in the balance when arriving at a decision*”[26]. The test has three stages: 1) comprehending and retaining the information relevant to decision, 2) believing it, 3) weighing it in the balance to arrive at a choice [27].

Finally, in exceptional cases where there is a real threat to the life of the patient refusing treatment, the court may adopt a paternalistic attitude and put aside not only all both liberal-minded competence tests but also the veto of noncompliant parents, eg. in *Re M* (Medical Treatment: Consent)[28] (the refusal of a 15-year-old girl to the planned heart transplant was overthrown by the consent of her mother), *Re S* (A Minor) (Consent to Medical Treatment) [29] (the court overruled the refusal to undergo a blood transfusion for a 15-year-old girl suffering from a rare blood disease, life-threatening if left untreated), and *Re E* (A Minor) (Wardship: Medical treatment) [30] (when a 15-year-old Jehovah's Witness and his parents refused a blood transfusion, the court replaced the child's decision with its own). These examples, though exceptional, show that in situations where the best interests of child are directly and gravely endangered the court can intervene and set aside not only the Gillick test, but also override the rights of parents to decide for (and even with) their child.

#### **Assessing actual competence of minors under Polish law**

A notable difference between the English and the Polish systems of law concerns the treatment of minors' consent. Under English law the full right of consent to treatment – medical, surgical or dental – is acquired at the age of sixteen, while under Polish law a person in the 16 to 18 age bracket still needs the additional consent from his/her parent or guardian. Nevertheless, the English approach, as defined by a succession of court judgments, leaves room for exceptions. Even in situations when the child is over sixteen and fully competent by virtue of the Gillick test the courts, as the foregoing examples demonstrate, can override his/her refusal to treatment. It seems then that a crucial point in any comparative analysis of the two systems – the English, rooted in common law, and the Polish civil law – in this area is the actual competence of minors. The differences are most pronounced in their treatment of minors under sixteen. In the following review of the Polish legislation, this issue will be discussed first. Next, we will try to find out how the actual competence of minors is defined in Polish law.

(I) Under Polish medical law, there is no need to refer to the test for actual competence for

patients under the age of 16. In accordance with Article 17 (2) of the Act of 6 November on Patients' Rights and the Commissioner for Patient's Rights 31] in relation to Article 32 (2) of the Act of 5 December 1996 on the Professions of Doctor and Dentist [32], a declaration of intent made by a minor's legal representative or actual custodian substitutes his/her declaration of intent; consequently, the latter's competence test is not needed [33]. If however the need to examine a minor under 16 does arise [34] the consent to medical intervention might also be given by his/her custodian [35].

Article 25 (2) of 5 December 1996 Act on the Profession of Doctor and Dentist, is an exception here [36]. In the event of a medical experiment involving a minor under 16, it imposes a mandatory assessment of his/her competence to give informed consent for his/her participation in the experiment. Other pieces of legislation that deal with specific medical matters, for example the Act of 1 July 2005 on Harvesting, Preserving and Transplanting Cells, Tissues and Organs [37] state that a designated bone marrow or haematopoietic cells donor who is a minor with no full legal capacity cannot be subjected to treatment (eg. harvesting) unless his/her legal representative gives the appropriate consent backed by permission from the local Family Court. Art 12 (2) stipulates further that for interventions of this kind consent is required from minors who have attained the age of 13. The competence test invoked in this legislation is one performed by the Family Court as part of its judicial proceedings, and not by a medical practitioner.

However, the Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and Conditions for the Permissibility of Abortion defines the status of a minor in a slightly different way [38]. In accordance with Article 4a (4) of the Act, the pregnancy of a minor over 13 may be lawfully terminated [39] if due consent in writing is obtained from both the minor and her legal representative; in cases where the pregnant girl is under thirteen, she has the right to express her opinion, but it is the Family Court that is authorized to make a decision. A literal interpretation of the provisions of this Act suggests that the competence test on a minor over thirteen may as well be administered by a doctor [40].

As the foregoing examples indicate in the case of some distinct types of medical intervention the Polish legislator permits the lowering of the age threshold for informed consent, though not without bringing in some additional conditions to ensure its validity and effectiveness. At the same time, with regard to more common, run-of-the mill medical interventions, Polish law de facto tends to simplify, or deemphasize, the procedure of getting consent from minors under sixteen. So for instance, children, even if they are competent, are not asked to give their

consent to acts that may amount to the violation of their physical integrity [41]. And, Article 31 (7) of the Act on the Profession of Doctor and Dentist obliges the doctor to give a patient under sixteen appropriate information (adequate to his/her age and understanding), but only if that information is believed to be important for the carrying out of the diagnosis or the therapy. There can little doubt that this provision was intended primarily to ease the child's cooperation with the medical staff during treatment rather than to obtain his/her informed consent.

A different, and more reasonable, approach to the problem of minors' consent is taken by Code of Medical Ethics (*Kodeks Etyki Lekarskiej*) [42]. In accordance with Article 15 (2) of the Code doctors should try to obtain also a minor's consent if he/she is able to give informed consent. The discrepancy between the demands of Code and the rules laid down in statutory legislation with regard to doctor's duties in treating a minor has eventually been resolved by the Constitutional Tribunal. In a ruling from in 1993 the Tribunal upheld the principle that statutory law should have priority over professional ethical guidelines. The latter have no binding force even though they are agreed upon by the medical community [43].

Another dispute, which has been raging in the literature on medical law, [44] concerns the rigidity with which Polish law treats the issue of minors' age. So Professor Marek Safjan has long argued that the fixed age threshold is no more than an ancillary reference point, which merely creates the presumption that a person is able to make autonomous decisions, and should give way as to the actual competence to take autonomous decisions (i.e. give one's consent) as the most important competence determinant [45]. He believes that this reevaluation carries no risk of excessive empowerment of a minor because his/her consent will always be balanced by that of his/her parent (legal representative), and the potential conflict between them will have to be resolved by the Family Court.

Similarly, Professor Małgorzata Świdorska points out that children have different degrees of competence and it is vital to take it into account when a medical intervention is planned. A child that can understand what is being done him/her when his/her physical integrity is invaded without prior explanation and permission may develop a lasting trauma [46]. Meanwhile, Professor Rafał Kubiak criticises the fixed age threshold from yet another perspective. He claims that the law is inconsistent in allowing a child as young as thirteen to co-decide on abortion and at the same time denying older children their say on relatively less serious issues like the use of contraception or undergoing a gynaecological examination [47].

The problem of reasonable involvement of minor patients in medical decision-making that affects them was also examined by the Constitutional Tribunal. In its judgment of 11 October 2011 [48] the Tribunal found that the wording of a number of Polish legislative acts concerned with the rights of minor patients [49] was not incompatible with the Polish Constitution or the Convention on the Rights of the Child [50]. It should be noted that the Tribunal assesses solely the compatibility of various legal acts; assessments of their subject matter, purpose or adequacy are beyond its remit [51]. This reminder does not imply that the Polish laws fall short of the minimum standards and goals formulated in international conventions. It merely indicates that there are things the Tribunal's judgment does not say, namely that the Polish legislator still has some way to go to implement the *de lege ferenda* postulates of increasing the autonomy of minor patients, especially those who are below sixteen. [52].

(II) Only minors over sixteen years of age are eligible for an assessment of the actual capacity to give consent. For those below sixteen the institution of independent consent is unavailable under Polish law. A child in that age bracket is not denied the right to give consent, but he/she can only exercise it jointly with his/her legal representative (and, if a medical examination is required, also with his/her actual custodian) [53]. The concept of dual consent is aimed at involving the minor in the decision making process related to the medical treatment provided to him/her. At the same time, dual consent, which bundles two declarations of will, invites the adult participant to examine the minor's decision. So far this procedure looks both respectfully reciprocal, yet if the two are not able to come to an agreement, the Family Court takes over and puts an end to a consensual settlement. All previous decisions become invalid and the discordant duo have to submit to the decision of the Court, a third party with the sole authority to give consent [54].

The issue of patient's actual competence is debated both in the field of medical law [55] and medical ethics [56]. The view of medical ethics that has focused most attention starts with the premise that informed consent may be provided solely by a patient capable of giving consent, i.e. a patient who is able to understand the information provided to him/her, and who, after thinking it over, freely and voluntarily consents to the medical intervention [57].

Such an obligation is not stipulated *expressis verbis* in medical law. That the Polish legislator did grant minors above sixteen the right to express his/her objection, but did not cast it in stone may result from a certain distrust about allowing too much autonomy to the underage patient. It has to do with a widespread and rather prejudiced perception of the patient's reaction to information about

treatment and his/her competence. When he/she objects, people tend to think that he/she is incompetent (otherwise why would he refuse to give permission for a medically justified intervention) and the matter must be referred to the Family Court for a final, correct decision. Alternately, when the patient follows medical advice and gives his/her consent to the suggested treatment, this decision is treated as proof of his competence. Yet the perceived rightness or wrongness of the patient's decision is not a criterion of actual competence [58]. This misperception, which consists in looking to the outcomes for proof of competence, is characteristic of both Polish and English jurisprudence, as demonstrated by the Gillick case.

That patient should not only fulfil the formal conditions laid down in civil law (the capacity to perform acts in law is dependent on the age and the fact of being incapacitated or not), but also possess the actual competence to give consent [59]. The latter is in fact a process outlined in Article 31 (1) of the Act on the Profession of Doctor and Dentist: the doctor should disclose to the patient all the relevant information about the treatment and allow him to consider it from various personal and health-related perspectives before he makes up his mind. At the same time the doctor should talk to the patient to see whether his/her awareness and understanding is sufficient for informed consent. This formula of building and testing informed consent is generally accepted for adult patients, but it is not clear whether doctors are obliged to conduct a similar competence test for minor patients who have attained the age of sixteen.

Article 32 of the Act on the Profession of Doctor and Dentist obliges a medical practitioner who is to treat an underage patient or a patient incapable of giving informed consent to seek consent from their legal representatives. If the patient does not have such a representative or it is impossible to overcome the patient's objections to treatment, the necessary permission must be obtained from the Family Court. The wording of these clauses indicates beyond any doubt that the legislator distinguishes between two categories of patients, those that are incapable of giving informed consent and minors (patients of or above sixteen are also considered minors). Similarly, Article 17 (2) of the Act on Patients' Rights states that the treatment of minors, the completely incapacitated or those incapable of giving informed consent requires in each case the consent of their legal representative. These direct references make it absolutely clear that Polish medical law does recognize the actual competence of the patient as a criterion – separate from the criterion of age – of assessing the effectiveness of consent [60].

However, this clarification of the priorities of the law does not make things easier for the doctor in charge of the competence test, especially when he

deals with an underage patient who declines treatment. Polish law declares respect for an objection from a minor who has attained the age of sixteen, but, as soon as it is raised, suspends its validity by referring the issue to the Family Court, which takes over, irrespective of the decision of the minor's legal representative [61]. If the court then asks for a medical opinion, the doctor's remit is hardly clear. Both Article 17 (3) of the Act on Patients' Rights and Article 32 (6) of the Act on the Profession of Doctor and Dentist define the competence in question as "having sufficient understanding", while in other texts dealing with the institution of consent the legislator uses the term "incapability to give informed consent". Obviously, the incongruous legal formulas cause uncertainty about the focus and content of the actual competence test.

Minors in the sixteen to eighteen age bracket are just one of many groups – such as the incapacitated, the mentally ill or the mentally handicapped – entitled to use their right to refuse a proposed medical treatment. Such solution for the problem of patient's competence to state an objection is justified axiologically [62].

However, their objection is not allowed to stand. Each veto triggers a court hearing aimed at reviewing the standpoints presented by the doctor, the patient and the patient's legal representative. The court's role is to conduct a comprehensible and reliable assessment of personal and health-related situation of the patient and, if possible, use the proceedings to convince the parties that a particular medical intervention is purposeful [63].

There are also other arguments raised which allow to limit oneself to assessment of "sufficient understanding" instead of "actual competence". In the course of such proceedings the court may wish to clarify what kind of medical opinion it wants, an assessment of sufficient understanding or an assessment of actual competence. The need for recognizing differences and making distinctions is not limited to the area of judicial practice. So Beata Janiszewska argues that the justification of the right to object and the right to give consent must be based on two different sets of premises. Furthermore, the assessment of their validity could also be done in more ways than one, taking into account the Polish legal context. For instance, the objections raised by minors need not be verified too rigorously [64] for they do derail the medical intervention (as in the case of an objection by a competent adult): it is merely suspended pending the decision of the Family Court [65].

The practical conclusion would be that the objection by a minor above sixteen does not require a prior assessment of his/her actual competence to give consent. It is enough to make sure that he/she has sufficient understanding of the facts and consequences of the treatment. Finally, it may be

noted that both Polish and in English British law make a telling distinction between the negative and the affirmative realization of the right to give consent. Moreover, in both the legal systems as a rule objections raised by minors are not subjected to as rigorous a scrutiny (the assessment of the minor's actual competence) as are controversial cases of affirmative consent.

## CONCLUSIONS

National systems of law are supposed to reflect rights encased in the framework of international conventions. The UK seems to have gone further than Poland in carrying out the postulate of adopting national legal norms to the requirements of the European Convention on Bioethics, which dispenses with rigid age limits and calls for greater involvement of the minor in the decision-making process concerning treatment.

Fixed-aged limits guarantee certainty and consistency in treatment, and the administration of the test depends on adult assessment, which may result in arbitrary and unprincipled behavior toward a child [66]. Whether it has the capacity to consent depends less on its maturity – the capacity to understand, more on court's or doctor's decision – whether the child is making a wise decision [67].

The Polish legislator in relation to the consent of minors above sixteen introduces the right to decide on their medical treatment without having to undergo any competence test. However, that implies a presumption that they are all competent, although we know that some of them are not. The latter would only lose their right to decide if they submitted themselves to a test and were found 'incapable of giving informed consent'. Professor B. Janiszewska sums up and explains the apparent incongruity as follows: in the eyes of the law the assessment of a person's *incapability* to give informed consent is highly relevant, while the assessment of a person's very capability to give consent is not (presumably it can be taken for granted) [68].

## Conflicts of interest

The authors declared no conflicts of interest.

## REFERENCES

1. Bekink M. "Child Divorce": A Break from Parental Responsibilities and Rights Due to the Traditional Socio-Cultural Practices and Beliefs of the Parents. *Potchefstroom Elec. L. J.* 2012; 15: 178, Moloney C. Childrens' Capacity to Consent to Medical Treatment. When are Children Entitled to Respect for Their Autonomous Rights? *ISLR* 2010;17:17.
2. Section 8. 1. As from the date on which this

section comes into force a person shall attain full age on attaining the age of eighteen instead of on attaining the age of twenty-one; and a person shall attain full age on that date if he has then already attained the age of eighteen but not the age of twenty-one. Family Law Reform Act 1969. Available from: <http://www.legislation.gov.uk/ukpga/1969/46/enacted> [cited 2014 Aug 5].

3. *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] UKHL 1 (21 February 1985).
4. Moloney C. Childrens' Capacity to Consent to Medical Treatment. When are Children Entitled to Respect for Their Autonomous Rights? *ISLR* 2010;17:27. Also: *R v Howes* (1860) 3 E&E 332.
5. Blackstone W. Commentaries. 17th Edition. Oxford, Clarendon Press, 1830, vol. 1; p. 452.
6. [1985] UKHL 7 (17 October 1985).
7. Hope R. A. *The Birth of Medical Law*. Oxford J. Legal Stud. 1991;11:248.
8. Moloney C. Childrens' Capacity to Consent to Medical Treatment. When are Children Entitled to Respect for Their Autonomous Rights? *ISLR* 2010;17:20.
9. Selinger CP. The right to consent: Is it absolute? *BJMP* 2009 Dec;2(2)50-4.
10. Moloney C. Childrens' Capacity to Consent to Medical Treatment. When are Children Entitled to Respect for Their Autonomous Rights? *ISLR* 2010;17:19.
11. Devereux J. Capacity of a Child in Australia to Consent to Medical Treatment – Gillick Revisited. *Oxford J. Legal Stud.* 1991;11:291.
12. Montgomery J. Child as Property? *Mod L Rev.* 1988;55:338.
13. Moloney C. Childrens' Capacity to Consent to Medical Treatment. When are Children Entitled to Respect for Their Autonomous Rights? *ISLR* 2010;17:28.
14. General Medical Council. 0-18 years: guidance for all doctors. Available at [www.gmc-uk.org](http://www.gmc-uk.org), BMA. Consent, rights and choices in health care for children and young people, information available at [www.bma.org.uk/ethics](http://www.bma.org.uk/ethics) [cited 2014 Aug 5]. Also Department of Health, Reference guide to consent for examination or treatment. Second edition, published July 2009, available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/138296/dh\\_103653\\_\\_1\\_.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf) [cited 2015 March 3].
15. Children and Young People Tool Kit, British Medical Association, First Edition, p. 6-9. Available from: [www.bma.org.uk](http://www.bma.org.uk) [cited 2014 Aug 5].
16. Moloney C. Childrens' Capacity to Consent to Medical Treatment. When are Children Entitled to Respect for Their Autonomous Rights? *ISLR* 2010;17:28.
17. Children and Young People Tool Kit, British



- Medical Association, First Edition, p. 6-9. Available from: [www.bma.org.uk](http://www.bma.org.uk) [cited 2014 Aug 5]. However speaking about children in general one has to remember about the regulations of Mental Capacity Act 2005 (and 2007) provided for those who lack mental capacity. While most of the Act (with three exceptions) applies to young people aged 16–17 years, who may lack capacity within section 2(1) of the Act to make specific decisions, it does not generally apply to people under the age of 16. There are two exceptions: 1) the Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if the child lacks capacity to make such decisions within section 2(1) of the Act and is likely to still lack capacity to make financial decisions when they reach the age of 18 (section 18(3)); 2) offences of ill treatment or willful neglect of a person who lacks capacity within section 2(1) can also apply to victims younger than 16 (section 44). See: Department of Constitutional Affairs, Mental Capacity Act 2005. Code of Practice. Issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act, [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/224660/Mental\\_Capacity\\_Act\\_code\\_of\\_practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf):216, 217 [cited 2015 March 3].
18. [1992] FCR 785.
  19. (1993) 3 WLR 592, [1993] Fam 64 (Court of Appeal). It was found that 15-year-old girl struggling with repeated attacks of mental illness and suicidal behaviour was not competent to consent or refuse so-called anti-psychotic treatment.
  20. [1992] FCR 785. The court ordered the 16-year-old girl suffering from anorexia nervosa to be transferred, against her will, from the residential center for young people to a hospital specializing in the treatment of eating disorders. Although she showed intelligence and understanding sufficient to give an informed consent, placing her in a special hospital was in her best interest.
  21. Family Division (Mr Justice Wall) 5 March 1997. See Magrath P. Law Report: Court may order anorexic to be detained for treatment; *The Independent*, 20th March 1997. Available from: <http://www.independent.co.uk/news/people/law-report-court-may-order-anorexic-to-be-detained-for-treatment-1273927.html> [cited 2014 Aug 5].
  22. Children and Young People Tool Kit, British Medical Association, First Edition, p. 20-22, 25. Available from: [www.bma.org.uk](http://www.bma.org.uk) [cited 2014 Aug 5].
  23. [1997] 2 FLR 180, 195.
  24. [1994] 1 FLK 31.
  25. [1997] 2 FLR 426, 437.
  26. Fortin J. Accommodating Children's Rights in a Post Human Rights Era. *The Modern Law Review Limited* 2006;69(3):321.
  27. de Cruz P. Adolescent Autonomy, Detention for Medical Treatment and Re C. Mod. L. Rev.1999; 62:597.
  28. (1999) 2 FLR 1027.
  29. (1994) 1 FCR 604.
  30. (1993)1 FLR 386.
  31. T. jedn. Dz. U. z 2012 r., poz. 259 ze zm., hereinafter referred to as the Act on Patients' Rights
  32. T. jedn. Dz. U. z 2008 r., Nr 136, poz. 857 ze zm. hereinafter referred to as the Act on the Profession of Physician.
  33. See. M. Świdarska, *Zgoda pacjenta na zabieg medyczny*, Toruń 2007, p. 43; B. Janiszewska, *Zgoda na udzielanie świadczenia zdrowotnego. Ujęcie wewnątrzsystemowe*, Warszawa 2013, pp. 476-77, 483; K. Szczygieł, T. Szekalski, *Pozycja małoletniego pacjenta w procesie wyrażania zgody na zabieg leczniczy*, Przegląd Prawniczy Uniwersytetu Warszawskiego 2013; 1-2: 298; A. Gałęska-Śliwka, *Zgoda małoletniego na zabieg medyczny*, Lex/el 2013. (Polish)
  34. Examination is the easiest medical intervention which means both visual inspection and physical examination, see. T. Dukiet-Nagórska, *Świadoma zgoda pacjenta w ustawodawstwie polskim*. *Prawo Med.* 2000;6-7:78. (Polish)
  35. Actual custodian – within the meaning of Article 3(1)(1) of the Act on Patients' Rights – is a person who, without statutory obligation, provides a permanent care over the patient who requires such a care due to his/her age, the state of health or/and mental health.
  36. More information on participation of minors in medical experiments see: A. Wnukiewicz-Kozłowska, *Badanie kliniczne z udziałem małoletnich - wybrane problemy prawne*, in: *Prawo badań klinicznych w zarysie*, ed. M. Śliwki, Toruń 2013, p. 33 ff. (Polish)
  37. Dz. U. Nr 169, poz. 1411 ze zm. (Polish)
  38. Dz. U. Nr 17, poz. 78 ze zm. (Polish)
  39. Under Polish law, abortion is permitted if pregnancy results from prohibited act (like rape), or constitutes a threat to pregnant woman's life and health; there is high probability of severe and irretrievable damage on foetus or incurable disease which poses threat his/her life. (Polish)
  40. See the grounds for 30 October 2012 ECHR judgment on P and S versus Poland, (application no. 57375/08) which can be interpreted in that way that to perform a legal abortion, in practice, a written declaration of minor over 13 made in the presence of three witnesses was required along with a notarial confirmation. (Polish)
  41. However, the intervention of the guardianship court is required if, in the doctor's opinion, legal representatives (or actual custodians in relation

- to that examination) refuse to give the consent hence act against the child's interest. The intervention is possible particularly in the situation stipulated in Article 34 (6) of the Act on the Profession of Physician i.e. if undertaking particular medical actions on the minor is crucial to remove the danger of loss of life, heavily body damage or heavy health disorder. See: K. Baron, *Zgoda pacjenta*, Prawo i Prokuratura 2010, No 9, p. 42 ff. K. Baron suggests that the intervention of the guardianship court is also needed when such a danger does not exist. The issue, however contrary to what she thinks, is regulated in the Polish Family and Guardianship Code (Art. 97 § 2 KRiO, Art. 109 KRiO).
42. The Code of Doctor's Practice of 2 January 2004 (a uniform text including the amendments adopted on 20 September 2003 by the Extraordinary 7<sup>th</sup> National Convention of Doctors) <http://www.mp.pl/etyka/dokumenty/> hereinafter referred as KEL.
  43. See the 17 March 1993 judgment of the Constitutional Tribunal W 16/92, Dz. U. No. 23, poz. 103, which states that in the case of a collision a doctor cannot be held liable for breaching deontological duties stipulated in KEL when s/he performed his/her statutory duties.
  44. Different opinions are presented in M. Śliwka, *Prawa pacjenta na tle prawnoporównawczym*, Toruń 2010, p. 250 ff. (Polish)
  45. Safjan M. *Prawo i medycyna. Ochrona praw jednostki a dylematy współczesnej medycyny*, Warszawa 1998, pp. 56-7. (Polish)
  46. Świdarska M. *Zgoda pacjenta*, op. cit., p. 63.
  47. Kubiak R, *Prawo medyczne*, Warszawa 2010, p. 345. Also A. Michałek-Janiczek, *Autonomia małoletniego w zakresie leczenia*. Państwo i Prawo. 2009;10:65.
  48. Sygn. K 16/10, OTK -A 2011, No 8, poz. 80. (Polish)
  49. The provisions of the aforesaid Act on the Profession of Physician and of the Act on Patients' Rights were challenged. In addition, the petitioner referred to Article 22 (4) of 19 August 1994 Act on the Protection of Mental Health (Dz. U. Nr 111, poz. 535 ze zm.) which also stipulates a fixed age threshold i.e. 16 years of age, after which the patient is entitled to express his/her parallel consent to be admitted to a psychiatric hospital.
  50. The convention adopted by the UN General Assembly on 20 November 1989 Dz. U. of 1991, No. 120, poz. 526 and of 2000, No. 2, poz. 11. (Polish)
  51. See: Śliwka M. *Uwagi krytyczne do orzeczenia TK z 11 października 2011 r. dotyczącego leczenia małoletnich pacjentów*, Lex No. 142282, Also K. Szczygieł, T. Szekalski, *Pozycja małoletniego*, op. cit., pp. 300-302; K. Bagan-Kurluta U. Drozdowska, *Prawo do samostanowienia dziecka w zakresie leczenia*. Orzecznictwo sądów angielskich w sprawach zgody dziecka na leczenie i zabiegi medyczne z polskiej perspektywy, in: *Człowiek i prawo międzynarodowe*. The book dedicated to Professor Bogdan Wierzbicki, eds. M. Perkowski, J. Szymański, M. Zdanowicz, Białystok 2014. (Polish)
  52. For example, Prof. E. Zielińska suggested, in relation to works on the Act of the Patients' Rights, that the child below 16 should be entitled to receive medical treatment without the need to obtain permission from his/her legal representatives if due to medical problem s/he suffers it would not be in the child's interest (i.e. it would not serve his/her good) to notify the legal representatives. E. Zielińska, *Ekspertyza na temat poselskiego projektu ustawy o ochronie indywidualnych i zbiorowych praw pacjenta oraz o Rzeczniku Praw Pacjenta* (druk sejmowy No 283), *Zeszyty Biura Analiz Sejmowych Kancelarii Sejmu* 2008;2:38. (Polish)
  53. See: Art. 17 (1) and (2) of the Act on Patients' Rights in relation to Art. 32 (5) and Art. 34 (4) of the Act on the Profession of Physician.
  54. See: Art. 32 (6) of the Act on the Profession of Physician and Art.17 (3) of the Act on Patients' Rights.
  55. See: Safjan M. *Prawo i medycyna*, op. cit., p. 55; K. Michałowska, *Charakter prawny i znaczenie zgody pacjenta na zabieg medyczny* Warszawa 2014, p. 100 ff.; B. Janiszewska, *Zgoda na udzielenie świadczenia zdrowotnego*, op. cit., p. 432 ff.; U. Drozdowska, W. Wojtal, *Zgoda i informowanie*, Warszawa 2010., pp. 19-24. (Polish)
  56. Beauchamps TL, Childress JF. *Zasady etyki medycznej*, Warszawa 1996, p. 157. (Polish)
  57. Ibidem.
  58. M. Boratyńska, P. Konieczniak, *Prawa pacjenta*, Warszawa 2001, p. 230. (Polish)
  59. It makes the institution of consent in medical law closer to so called natural capacity to perform acts in law, see more: W. Krzymowski, *Naturalna zdolność do czynności prawnych w prawie medycznym*, *Przegląd Prawniczy Uniwersytetu Warszawskiego* 2013, vol. 1-2, p. 298 ff. (Polish)
  60. A contrario B. Janiszewska, *Zgoda na udzielenie świadczenia zdrowotnego*, op. cit., p. 477 ff. (Polish)
  61. It is worth highlighting that the aforementioned provisions are formulated differently, therefore, some problems in interpretation arise, see more: T. Dukiet-Nagórska, *Świadoma zgoda pacjenta w ustawodawstwie polskim*, *Prawo i medycyna* 2000;6-7:92. (Polish)
  62. Similar solutions are presented in the Act on the Protection of Mental Health, see Art. 22 (2) of the 19 September 1994 Act, *Dziennik Ustaw*, 2011, No. 231, poz. 1375 ze zm. See more: M. Safjan,

- Prawo i medycyna, op. cit., p. 41 ff. (Polish)
63. Moreover, overcoming the objection with court's ruling does not lead to compulsory treatment of such a patient. Thus, such ruling would be unfeasible if it was not of persuasive character.
64. Janiszewska B. Zgoda na udzielenie świadczenia zdrowotnego, op. cit., p. 577 ff. (Polish)
65. Ibidem, p. 596.
66. Bainham A. The Balance of Power in Family Decisions. Cambridge L. J. 1986;45:277.
67. Devereux J. Capacity of a Child in Australia to Consent to Medical Treatment – Gillick Revisited. Oxford J. Legal Stud. 1991;11:292  
Ibidem.
68. Janiszewska B. Zgoda na udzielenie świadczenia zdrowotnego, op. cit., p. 596 ff.. (Polish)