Children’s consent to medical treatment
- With emphasis on essential treatments and the procedural protection of children’s rights

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Abstract

It is widely acknowledged in Swedish healthcare law that doctors need to obtain consent from their patient before performing medical treatment or examination. Based on the autonomous right to decide what happens to one’s own body, adult patients are free to accept or decline any proposed treatment, regardless if such decision would result in serious consequences for the patient. However, when the patient in question is a child, the situation becomes far more complicated.

The purpose of this thesis is to clarify and specify the child’s status in the Swedish healthcare, with emphasis on the complex situations that can arise when child, parents and doctors disagree over proposed treatment. The current law regarding children’s consent in Sweden is unclear and for the moment, there is a legislative bill for a new Patient Act proposed. If the act is passed, it will clarify the law on many areas of healthcare in Sweden. However, this thesis will argue that many important questions regarding children’s consent to treatment still will remain unanswered. To elucidate the Swedish law, and particularly give perspective on the areas where there is not much guidance, a comparative study with children’s consent in English law will be carried out. The thesis will also discuss the principle of the child’s best interest and evaluate its suitability in healthcare issues. Furthermore, ethics and procedural protection of children’s rights will be discussed. Finally, the thesis will argue that more has to be done when it comes to children’s consent to treatment in Sweden, not only because the law is unclear, but also to avoid a deprival of children’s fundamental human rights.
Preface

My interest for children’s consent to medical treatment started in the autumn 2013, which I spent as an exchange student at Oxford Brookes University in the UK. One of the modules I chose to study was Medical Law, which I found highly interesting. Especially the law regarding children’s consent, with its ethical aspects and legally unclear areas, fascinated me. When I came back to Sweden after the exchange, I wanted to look up how the matter is legally regulated here. To my surprise, I found out that the Swedish law does not provide much guidance at all on this subject and I decided to write this thesis about children’s consent to medical treatment.

I would like to thank my family and friends for their continuous support and patience throughout my four and a half years of studying Law at Stockholm University. I would also like to thank my supervisor Jameson Garland for great feedback and guidance while writing this thesis.

Michaela Wik

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# Abbreviations

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<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>CA</td>
<td>Children Act 1989 (UK)</td>
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<td>CRC</td>
<td>United Nations’ Convention on the Rights of the Child</td>
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<td>BrB</td>
<td>Penal Code (<em>Brottsbalk</em> (SFS1962:700))</td>
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<td>ECHR</td>
<td>European Convention of Human Rights</td>
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<td>ECtHR</td>
<td>European Court of Human Rights</td>
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<td>EU</td>
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<td>FB</td>
<td>Parental Code (<em>Föräldrabalen</em> (SFS 1949:381))</td>
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<td>FLRA</td>
<td>Family Law Reform Act 1969 (UK)</td>
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<td>HSAN</td>
<td>Medical Responsibility Board (<em>Hälso- och sjukvårdens ansvarsnämnd</em>)</td>
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<td>HSL</td>
<td>Health and Medical Services Act (<em>Hälso- och sjukvårdslagen</em> (SFS 1982:763))</td>
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<tr>
<td>JK</td>
<td>Chancelllor of Justice (<em>Justitiekanslern</em>)</td>
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<td>JO</td>
<td>Parliamentary Ombudsmen (<em>Justitieombudsmannen</em>)</td>
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<tr>
<td>LVU</td>
<td>Care of Young People Act (<em>Lag med visa särskilda bestämmelser om vård av unga</em> (SFS 1990:52))</td>
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<tr>
<td>MCA</td>
<td>Mental Capacity Act (UK)</td>
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<td>PL</td>
<td>Patient Act (Patientlagen)</td>
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<td>PSL</td>
<td>Patient Safety Act (<em>Patientssäkerhetslagen</em> (SFS 2010:659))</td>
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<td>UN</td>
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1. Introduction

In most medical situations, patients who seek treatment tacitly consent to treatment without any formal process. However, consent is an essential part of healthcare and represents the fundamental right of all patients to determine what happens to their own bodies. Medical examinations and treatments are seen as justified when we, through our consent, give the doctor permission to perform treatment, often because of the expected positive outcome. A competent adult can freely choose to accept or refuse proposed treatment and consequently, medical treatment would never be forced upon a patient who does not consent to it. However, the situation becomes more complicated when the patient is a child. Can a minor individually decide if he or she wants treatment or not? How much can parents\(^1\) decide over their children when it comes to treatment? These are just the basic issues and situations can get far more complicated. What happens if the child and the parents disagree over treatment? What if the child is so young that the parents can decide, but the parents disagree between each other? The parents and the doctor might also disagree over appropriate treatment. For example, some parents would not allow their child to receive a life-saving blood transfusion because of religious views that such is strictly prohibited. Should such opinions be respected, even if it would result in the death of the child?

When assessing these questions, two important factors are the right of children to express their view and the principle of the child’s best interest. The first one is a human right that is increasingly recognised in both international conventions and Swedish law while the second is a broader principle that governs in multiple situations when children are involved. Even with these norms as guidance, many issues will still be complicated to solve. I can give you an example to demonstrate the several issues involved. Imagine a 15-year-old girl who is in hospital because of cancer she have had for years. The doctors wish to give the child another round of chemotherapy, which would give her a couple of years more to live and maybe even a slight chance for recovery. The chemotherapy would, however, result in several more years for the girl to be hospitalized, suffering from all the horrific side effects from the treatment. The doctor says chemotherapy is in the best interest of the child, it clearly provides her with a chance to survive she will not have otherwise. But what if the girl does not want to undergo further treatment? What if he would rather want to live one more year without

\(^1\) ‘Parents’ will through this thesis refer to the person, or persons, with parental responsibility for a child.
horrific treatment, than five years hospitalized feeling ill every day? Can the she refuse such possibly life-saving treatment? If not, can chemotherapy simply be forced upon the refusing child? What difference does the parents’ opinion make? This example will be further discussed later in this thesis.

I consider myself lucky to write about such an interesting subject, but the writing process has not been easy at all times. First, on some areas it has been difficult to find relevant sources. Second, the subject often requires that both legal and ethical aspects must be taken into account. Another circumstance that have made the process a slightly complex, but also interesting, is the fact that a new Patient Act\(^2\) (*Patientlagen*, PL) currently is proposed by the government. The parliament will vote on the proposed Act on the 12\(^{th}\) of June 2014\(^3\), which is less than a month after deadline for this thesis. If passed, the act will result in several changes in the Swedish healthcare legislation, for example when it comes to consent for treatment and children’s influence over healthcare. This thesis will naturally be based on the current law. However, there is no opposition in the preparatory works to relevant provisions and no motions to amend the proposed legislation in this regard.\(^4\) Consequently, the act is extremely likely to pass and will, for that reason, also be evaluated and presented in this thesis. Even in the unlikely event of the act not passing, the preparatory works related to it are still of importance because they provide the governments opinion on the subject. In conclusion, both the current law and the proposed legislation will be discussed to clearly present the law position as it is now.

### 1.1. Background

As a historical matter, it is only recently that many European nations have begun to expressly clarify patients’ rights in healthcare and the patient has historically had a weak position in healthcare relative to healthcare professionals. A sick person can often find himself in a situation dependant on the doctor by virtue of the doctor’s stronger status, because of his or her knowledge and authority.\(^5\) However, the view on patients and doctors has changed significantly over time and there is an ongoing movement in

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\(^4\)Ibid.

\(^5\)SOU 2013:2, p. 65.
the Western world towards a more patient-centered healthcare, which aims to give the patient a more active role in the relationship between patient and doctor.\textsuperscript{6} Studies conducted on patient-centered care have shown generally positive effects in healthcare, both for patients and healthcare authorities.\textsuperscript{7} However in Sweden, reports have shown that from a legal perspective, the approach to health care is still quite disease-centered.\textsuperscript{8} In July 2012, the Authority for Health Analysis (\textit{Myndigheten för vårdanalys}) presented a report which showed that there is room for improvement when it comes to provide patients with sufficient information as well as respect the patient’s individual needs and values. The disease-centered approach of the patient must be replaced by a patient-centered perspective.\textsuperscript{9} Also the National Board of Health and Welfare (\textit{Socialstyrelsen}) has evaluated the patient-centeredness of the healthcare in Sweden and according to this, there are deficiencies when it comes to informing and discussing treatment alternatives with patients.\textsuperscript{10} Much indicates that healthcare in Sweden is still dominated by a work and profession perspective according to the Board.

One of the main reasons why the law is complicated in questions about children’s consent to treatment is the many different competing interests involved. First, patients wish to make their own decisions regarding their healthcare and do not want to get their integrity violated. If the patient is a child, parents often decide when it comes to treatment and presumably want what is in the best interest of their child. The child’s own opinions must also be taken into account. Doctors and medical professionals on the other hand might have more paternalistic interests, possibly because of prestige reasons but also because they want what is in the best interest of their patient. Apart from this, there is the community, which aims to protect different interests like individual autonomy, integrity, life and health, but at the same time wants to avoid health care system costs.\textsuperscript{11}

\textsuperscript{6} SOU 2013:2, p. 76.
\textsuperscript{7} Ibid, p. 77.
\textsuperscript{8} The Authority for Health Analysis (2012:3) Highlight report – Patient-centeredness in Sweden’s health system – an external assessment and six steps for progress.
\textsuperscript{9} SOU 2013:2, p. 77-78.
\textsuperscript{10} National Board of Health and Welfare Hälso- och sjukvårdsrapport 2009, p. 75.
\textsuperscript{11} Rynning, p. 20.
In the matter of children’s consent to treatment, there are two different important issues, what treatment a child as a patient can consent to as well as refuse\textsuperscript{12}. Different factors, as for example the best interest of the child as well as the child’s own opinion, must be taken into account. Usually, in straightforward situations with agreement between the doctor, child and parents regarding proposed treatment, no difficulties might arise and the doctor can provide the child with requested treatment. However, if there is disagreement between the different parties about what treatment that should be given to the child, situations can get exceptionally complex.

Sweden is the last of the Nordic countries to not have a particular act providing rights for patients.\textsuperscript{13} However, the government decided on the 24th of March 2011 to appoint a special inquiry (särskild utredare) to suggest how the patient’s position in healthcare can be strengthened.\textsuperscript{14} The inquiry report, the Patient Power Inquiry\textsuperscript{15} (patientmaktsutredningen), was completed in January 2013 and the Government has submitted a legislative bill for the new act on the 6\textsuperscript{th} of March 2014.\textsuperscript{16} According to the inquiry report, the patient has largely fallen out of focus together with the work on making healthcare more efficient in Sweden.\textsuperscript{17} The proposed Act strives to achieve a shift of power from health care principals and professionals to the patient.\textsuperscript{18} However, according to the inquiry report, this has been attempted previously through a variety of reforms, but the implementations have been insufficient and the desired effects not achieved. The studies and evaluations of these earlier, failed reforms have been taken into account in the report, which now therefore can propose new possible ways to address the identified weaknesses on the area of healthcare.\textsuperscript{19}

\textbf{1.2. Purpose and research questions}

The purpose of this thesis is to investigate the consent of children and reflect on the child’s legal status when it comes to healthcare. The focus is set on essential and life-saving treatment and such complicated situations that may arise when child, parents and doctors disagree with each other. However, there is not much guidance in either law or

\textsuperscript{12} Often called ’positiv bestämmanderätt’ and ’negativ bestämmanderätt’ in Swedish. See Svensson, p. 29.

\textsuperscript{13} Svensson, pp. 36-39.

\textsuperscript{14} Dir. 2011:25.

\textsuperscript{15} SOU 2013:2.

\textsuperscript{16} Prop. 2013/14:106.

\textsuperscript{17} SOU 2013:2, p. 75.

\textsuperscript{18} Ibid, p. 63.

\textsuperscript{19} Ibid.
case law on some of these more specific legal areas in Sweden and therefore the Swedish law will be compared with the law in England\textsuperscript{20}, which gives comparative perspective on the Swedish legal situation and development.

There are a couple of reasons why I chose English law for this comparative study. First, Medical Law has been focused on for a long time in England and it is clearly an older subject than in Sweden, where it is quite new compared to many other countries\textsuperscript{21}. In England issues regarding consent in particular have been discussed for a longer time and there is a considerable amount of case law, hence it is interesting to see how these issues have been attempted to be solved there. The large amount of case law, along with arguments for and against certain solutions, is of significant interest when it comes to this relatively undeveloped area of law in Sweden. Comparisons with the law regarding consent to treatment in the other Nordic countries also already exist in both preparatory work\textsuperscript{22} and legal scholarship\textsuperscript{23} and therefore I chose England in regard to present some new comparative material. In addition, a case of significant importance when it comes to children’s consent was judged by the House of Lords in England and the case has also been embraced in other common law countries such as Canada, Australia and New Zealand. Furthermore, even if Sweden has a ‘civil law’ system and England ‘common law’, and these systems are very different from each other, both have to adhere to international conventions which are considered fundamental in this field.

The law on the area of children’s consent to treatment in Sweden is rather vague and the aim with this thesis is accordingly to clarify the current legal position. Further research questions are:

1. To what extent can a child decide about medical treatment and when do the parents decide on the behalf of their children?
2. How is the law going to change with the proposed Patient Act?
3. Is the legal system in Sweden in a sufficient manner protecting children’s rights guaranteed in international conventions?

\textsuperscript{20} The UK does not have a single unified judicial system but courts in the UK are separated into three jurisdictions, the Courts of England and Wales, Courts of Scotland and the Courts of Northern Ireland. ‘England’ will therefore throughout this thesis in a technical perspective refer to both England and Wales. However, only English case law will be presented and therefore focus is set on English law.

\textsuperscript{21} Rynning, p. 21.

\textsuperscript{22} SOU 2013:2, p. 88.

\textsuperscript{23} See Rynning, p. 58, 147 and Svensson, pp. 36, 90.
1.3. Demarcations

Consent to medical treatment in general will be explained in brief but after that focus is set on children’s consent. When it comes to children’s consent, the thesis focuses on life-saving treatment and serious conditions, often such situations give rise to the most problematic questions. Some medical operations that are regulated in special legislation, as for example transplants, sterilisations and abortions, are not included. Additionally, some aspects regarding psychiatric treatment are mentioned but focus is set on somatic treatment. The doctrine of informed consent is going to be explained but due to space constraints not further evaluated. The doctrine is also in practice a separate legal question regarding what the patient has consented to and this thesis is rather dealing with a more basic question, whether a child can consent at all. The thesis will not cover questions about confidentiality and who should be informed about a child’s condition. Some relevant ethical perspectives are going to be discussed but to a limited extent. The ethical discussion obviously gives perspective to the questions but ethical issues are based on values and it is hard to say which values that applies in a legal area.

1.4. Method and Material

The thesis is based upon the traditional legal method, which means that the essential issues are identified and analysed in the light of the legal sources that are included in the hierarchy of legal sources (rättskälleläran). The thesis will mainly be devoted to investigate and clarify what the law is today, following this hierarchy of legal sources. Furthermore, a comparative study of Swedish and English law regarding children’s consent to treatment will be presented. The basic methodological principle of comparative law has been held to be that of functionality \(^{24}\) and for the comparative study in this thesis, this functional method will be utilized. However, there is not one functional method but many \(^{25}\) and the functional approach is therefore not easy to explain. The functional method generally focuses on what the law does, its functionality, instead of what the law is \(^{26}\) and to compare two different legal systems can therefore be difficult. However, consent functions similarly in Swedish and English law and hence a comparison is useful. The lack of judicial access in healthcare cases however makes comparisons difficult and recommendations challenging. The functional

\(^{24}\) Zweiger & Kötz, p. 34, see Michaels, p. 343.
\(^{25}\) Michaels, p. 343.
\(^{26}\) Ibid, p. 363.
approach has been criticized for being too rule-centered\textsuperscript{27} and instead of simply comparing the law, the thesis will also discuss ethics and human rights influences.

Regarding the material used in the thesis, mainly the traditional legal sources but also other sources will be presented. First, international material and conventions will be discussed. Second, when it comes to Sweden, the thesis will follow the doctrine of the hierarchy of legal sources, which provides an order of precedence for the traditional legal sources (standardkällor). First, the Instrument of Government (regeringsformen), which is one of the four Constitutional Acts (grundlagar), will be discussed. Thereafter, legislation (lagstiftning), which consists of parliamentary acts (lagar), government regulations (förordningar) and agency regulations (föreskrifter), relevant when it comes to consent to treatment will be analysed. Legislative preparatory works (förarbeten) are also an important part of the material, certainly because such have a high degree of authority in the Swedish legal system. These provide details that the statutory legislation is missing and courts often research if they can find the answer to an issue in them. Some preparatory works that explains the proposed Patient Act are also exceptionally important in this thesis. These preparatory works present the government’s view on what the law is and should be on the area of healthcare. Furthermore, there is almost no case law (rättspraxis) in Sweden on the area of consent to treatment but a couple of cases are going to be named and these are decisions from the Supreme Court (Högsta Domstolen) and the Supreme Administrative Court (Högsta förvaltningsdomstolen). As a last traditional legal source, a large amount of legal scholarship (doktrin) will be referred to, generally because of the lack of both legislation and case law on the subject. Legal scholarship is also an important source in Sweden and both the courts and legislature using it in their work. In this thesis, mainly the works of Elisabeth Rynning and Gustav Svensson, whose opinions are also frequently mentioned in the preparatory work for the Patient Act, are explored.

Usually only case law from the Supreme Courts would be presented when aiming to describe the current legal situation. However, the area of law evaluated in this thesis is special because there is almost no case law regarding it and consequently, also cases from lower courts will be presented even if such are not seen as precedent. In addition to the traditional legal sources, decisions from the Medical Responsibility Board,

\textsuperscript{27} See, for instance, Michaels, p. 364.
Questions about children’s consent have sometimes arisen in disciplinary cases for health care professionals and these were previously decided in the first instance at HSAN. These could be appealed to the Administrative Court in Stockholm, and if leave to appeal was granted, also to the Administrative Court of Appeal as well as the Administrative Supreme Court. Clearly, the decisions of HSAN represent a lower level of the hierarchy in the trial chain and therefore have little formal legal significance. However, these cases have considerably authority among medical health professionals and therefore, relevant HSAN decisions will be presented to show how the law has been interpreted in individual cases. There is no official publication for these but the ones mentioned are found in relevant legal scholarship.

Furthermore, statements from the Parliamentary Ombudsmen, (Justitieombudsmannen, JO)\textsuperscript{29}, will also be presented. JO supervises the application of the laws and can direct criticism against actions taken by a court or other national or local authorities\textsuperscript{30}. JO is not one of the traditional legal sources and the statements, which consist of JOs own interpretation of the law, are not legally binding. However, the statements are of great importance because authorities normally follow them carefully.\textsuperscript{31} These are often perceived as authoritative interpretations of the law and are used by both the legislature in preparatory work and the Supreme Administrative Court in its judgements.\textsuperscript{32} In this thesis, the statements of JO are especially important since these sometimes are the only guidance on what applies in a particular area.

When it comes to England, common law and statutes are the two major domestic sources of law which both will be utilized in this thesis. Common law constitutes the case law contained in judicial decisions while statutory law refers to legislation made by Parliament in the form of Parliamentary Acts.\textsuperscript{33} Sometimes common law developments lead to statutory reforms or to codifications of the case law in statutory forms.\textsuperscript{34} Foundations are often made by common law and afterwards incorporated in statute,

\textsuperscript{28} Also here the Swedish abbreviation will be used, because it is commonly established in Sweden and the thesis is largely written for Swedish readers.

\textsuperscript{29} Ibid.

\textsuperscript{30} Bernitz \textit{et al.}, p. 127.

\textsuperscript{31} Ibid.

\textsuperscript{32} Warnling-Nerep, p. 18.

\textsuperscript{33} Wilson, p. 7.

\textsuperscript{34} Ibid, p. 10.
which then will have priority over the case law since statutes are the most important source of domestic law and override all conflicting common law provisions.\textsuperscript{35} However, statutes do not replace all the common law. For example, common law can, in a flexible way, fill gaps where statutory provisions cannot contemplate all the situations in which their correct application may rise.\textsuperscript{36} Furthermore, common law still provides the main legal rules applicable in many important areas of law.\textsuperscript{37} Common law and statutory legislation must therefore be evaluated together and can never be considered as existing in isolation from one another. The parliament makes statutes and judges can thereafter shape the impact of this legislation, for example where its provisions are ambiguous, vague or not drafted with a particular scenario in mind. As a consequence, statute is given its practical meaning and effect through case law.\textsuperscript{38} A great amount of case law is therefore still important, for example when the courts are interpreting statute or making judgements on areas that are not covered by statute.

Regarding the case law, a short introduction to the courts of England is needed to understand the system of the courts considering that, in addition to administering justice, the courts also make law. House of Lords is the Upper House of Parliament of the United Kingdom where some of the bills are introduced. In addition to the legislative function, House of Lords historically also had a judicial function but after the Constitutional Reform Act 2005 the Supreme Court of the United Kingdom took over that function. The Supreme Court has been the highest court of appeal in England and Wales since 2009. The relevant Senior Courts of England and Wales consist of the Court of Appeal, which only deals with appeals from other courts, and the High Court of Justice, which in civil matters is a court of first instance as well as an appellate court.

These courts are, in accordance with the doctrine of judicial precedent, ordinarily required to follow decisions in previous cases sharing the same material facts.\textsuperscript{39} Decisions of higher courts are binding upon courts below and therefore the court hierarchy is central to the operation of binding precedent.\textsuperscript{40} Consequently, the Supreme Court’s decisions bind the Court of Appeal, which decisions in turn are binding upon

\textsuperscript{35} Judges cannot question the validity of statutes, unless a question of compatibility with European law is raised. See Wilson, p. 8.
\textsuperscript{36} Wilson, p. 48.
\textsuperscript{37} Ibid, p. 9.
\textsuperscript{38} Ibid.
\textsuperscript{39} Ibid, p. 9.
\textsuperscript{40} Ibid, p. 40.
the courts below it. Furthermore, whereas the Supreme Court is not obliged to follow its own previous decisions, the Court of Appeal must generally do so. Also the High Court is generally bound by its own previous decisions, while the courts below are only bound by the decisions of higher courts. Consequently, decisions from the Court of Appeal are binding for all other courts including itself, apart from the Supreme Court. These decisions are still important as the Court of Appeal in most cases is the final appeal court, as very few cases reach the Supreme Court. The English material in this thesis will be case law from the different courts based on this system, along with statutes and legal scholarship. Naturally, the most important case law in this thesis is from the House of Lords or the Supreme Court but also cases from lower courts will be presented as illustrations.

1.5. Disposition

The paper started with a brief introduction of the subject of children’s consent along with an explanation of its complexity. Relevant international law on the area of children and health care is presented in the second chapter, followed by current Swedish law in chapter 3 and English law in chapter 4. When it comes to the most complicated situations, Swedish and English law is going to be evaluated at the same time in chapter 5, mainly because it is easier to compare them simultaneously regarding similar situations and Swedish law does rarely have any legislation or case law to present. Chapter 6 sets out to declare, compare and analyse the current law in Sweden and England and a short explanation of the ethical problems involved will be presented. The thesis ends with a conclusion in chapter 7.

2. International law

In international law, there are conventions that should be adhered to by both Sweden and England. The two important international conventions that may be relevant when it

41 Since Lord Gardiner’s 1966 Practice Statement which stated that the Supreme Court is free to depart from its own previous when it considers it appropriate to do so.
42 A general rule, that also was re-stated in the case Young v Bristol Aeroplane [1944] KB 718 and maintained by the House of Lords in for example the case Davis v Johnson [1978] 2 WLR 553. Young v Bristol provided three exceptions where the Court of Appeal can depart from its own decisions; if there are two previous conflicting decisions from the court, if a previous decision conflicts with a later decision of the Supreme Court or if a previous decision has been made per incuriam, taken in ignorance of some relevant legal authority. The Court of Appeal must also ignore its own previous decisions that conflicts with a provision of EU law.
43 Wilson, p. 43.

2.1. The Convention on the Rights of the Child

The United Nation’s Convention on the Rights of the Child (CRC) contains the basic human rights for children everywhere in the world. The CRC entered in force on September 2, 1990\(^{44}\) and involves different rights of the child, as for example, social, economic, cultural, civil and political rights. It is commonly thought that the four basic principles of the Convention are the prohibition of discrimination in Article 2, the best interest of the child in Article 3, the right to life and development in Article 6 and the child’s right to be heard in Article 12.\(^{45}\) Almost all nations in the world have ratified the CRC, including Sweden and the UK. The CRC is binding in international law between states that has ratified it, as Sweden did in 1990 and the UK in December 1991. However, the ratification does not make the convention a part of domestic law. It is, rather, an agreement for the states to undertake obligations to develop policies and change domestic legislation to be in accordance with the principles in the CRC.

Regarding the relevant procedural rights of the Convention and its implementation, Article 2 CRC states that all ‘states parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind’. According to Article 4 CRC, all states involved must take all appropriate legislative and administrative measures to implement the rights recognized in the CRC through exploiting all available resources to the limit. Nothing stops a state from giving children more rights according to Article 41 and the convention can therefore be seen as expressing a minimum when it comes to children’s rights. When it comes to control over the implementation, the states have committed themselves to regularly report to the UN Committee on the Rights of the Child about the measures taken to implement the rights recognized in the Convention according to Article 44 CRC. In Sweden, the government has in a letter to parliament\(^{46}\) unveiled how it intends to continue to pursue the strategic work of the implementation and the Ombudsman for Children has a key

\(^{44}\) See the preamble of the CRC.

\(^{45}\) Ewerlöf et al., p. 22.

\(^{46}\) Skr. 2003/04:47.
role when it comes to pursuing the implementation and monitoring of compliance with the CRC.\textsuperscript{47}

When it comes to the material rights, a ‘child’ according to Article 1 in the CRC is a person under 18 years of age. The child’s rights regarding health care are defined in several articles in the CRC. First, Article 24 states the right of the child to the enjoyment of the highest attainable standard of health and to the facilities for treatment and rehabilitation. The states shall also strive to ensure that no child is deprived of his or her right to access these healthcare services. Furthermore, Article 6 affirms the right to life, survival and development for children while Article 9 requires protection of children from any form of physical or mental violence, injury or abuse. The central rights regarding the assessment of children’s competency for consenting to treatment are the Articles 3 and 12 CRC. Article 3 represents the principle of the child’s best interest and states that in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration. Furthermore, according to Article 12, the child should, in all matters affecting the child, be able to express his or her views freely and these should be given due weight in accordance with the age and maturity of the child. Two other articles that can be of great relevance in the context of compulsory treatment are articles the 16 and 37 CRC. Article 16 protects the right of private life while Article 37 states that no child should be subjected to inhuman or degrading treatment or unlawfully be deprived of his liberty.

The CRC does not have the same status as other legislation in Sweden but it has been discussed if the convention should be incorporated in Swedish law. For example UNICEF Sweden holds the opinion that the current ratification is not enough to ensure children the rights provided in the convention and would like to have the CRC incorporated in Swedish law.\textsuperscript{48} The UN’s Committee on the Rights of the Child, with the task to examine if the states are living up to the Convention, has also criticized Sweden on several points.\textsuperscript{49} In March 2013 the government decided in a mandate (kommitteedirektiv) to appoint an inquiry to analyse how the application of laws and

\textsuperscript{47} Ewerlöf \textit{et al.}, p. 22.
\textsuperscript{49} Committee on the Rights of the Child fourth periodic report with concluding observations regarding Sweden from 2009 (CRC/C/SWE/CO/4)
regulations in Sweden are consistent with the child’s rights according to the CRC. The investigation, which will be finished in March 2015, will also analyse advantages and disadvantages of incorporating the CRC into Swedish law. Incorporated or not, Swedish law must still be interpreted in the light of the principles and purpose of the CRC and the legislature is required to ensure that the Swedish legislation conforms to the articles of the convention. Therefore, the Convention should have a great influence on courts and other decision-making authorities. The CRC has a similar status in England as in Sweden, it is implemented but not incorporated. The UK Government agreed to make all laws, policy and practice compatible with the CRC when it was ratified in 1991. Owing to this, the CRC is meant to be followed by courts, tribunals and other administrative processes when making decisions that affect children.

2.2. European Convention on Human Rights

The other important international convention relevant to children’s consent is the Convention for the Protection of Human Rights and Fundamental Freedoms, also called the European Convention on Human Rights (ECHR). The ECHR is developed and applied by the Council of Europe (Europarådet), an intergovernmental organisation which seeks to create a common democratic legal area throughout the European region, ensuring respect for human rights, democracy and the rule of law. The ECHR does not state rights in particular for children but the rights included in the convention are naturally applicable on both adults and minors. The ECHR came into force in 1953 and Article 1 of the ECHR obligates the contracting parties to secure everyone within their jurisdiction the rights and freedoms defined in the Convention. In comparison to the CRC, the ECHR is binding in Sweden and constitutes a part of Swedish law since 1995. Also the Swedish Constitution, chapter 2 section 19 of the Instrument of Government (Regeringsformen, RF), states that law or other regulation may not be issued in violation of Sweden’s commitments under the ECHR. Violation of these rights is therefore also unconstitutional and the ECHR shall be applied directly by Swedish courts and authorities. The British government has enacted relevant legislation and

50 Dir. 2013:35.
51 Ewerlöf et al., p. 23.
52 Toebes et al., p. 23.
54 Regeringsformen (SFS1974:152)
55 Since this thesis is primarily written for Swedish readers, the Swedish well-established abbreviations for the relevant acts are going to be used.
incorporated most of the ECHR in The Human Rights Act 1998 (HRA). The HRA came into force on 2 October 2000 and enables the Convention to be pleaded in domestic courts.

In the event that an individual believes that the state has violated his or her rights under the ECHR, primarily domestic courts and authorities should examine the complaint. However, complaints can also be raised in the European Court of Human Rights (ECtHR) in Strasbourg. The ECtHR ensures that the respect for the rules in the ECHR is upheld and may in individual cases decide whether a violation has occurred and impose damages to the complainant. The court is, however, not appellate to national courts and cannot therefore repeal decisions taken by national courts or authorities. The ECtHR has nevertheless, on the basis of the ECHR, developed a very extensive and important body of case law and the judgements of the ECtHR are binding on the state concerned. In a Swedish case about the courts’ interpretation of the articles in ECHR, the Supreme Court stated that Swedish courts can interpret the articles independently, but this cannot result in that an individual is given weaker rights than under the ECtHR practice. Decisions from the court are therefore relevant for all states involved because it sets the limits of what is acceptable national law development. The Supreme Court has also stated that the Swedish system of remedies (rättsmedelssystemet), by a certain margin shall live up to the requirements imposed by the ECHR and case law from the ECtHR, which according to the Supreme Court is a given starting point for domestic law. The Supreme Courts also states that the ECHR, as interpreted and developed by the European Court for Human Rights, only constitutes a minimum guarantee of rights and freedom in Sweden. In England, section 2 HRA requires domestic courts to take account of the jurisprudence of the ECtHR. This does not make all the decisions of the ECtHR binding upon domestic courts but they are likely to over time affect domestic judicial decision-making on matters under the HRA. According to the Belgian Linguistic Case, the ECtHR allows national authorities a certain margin to make their own assessment on how the human rights best can be protected in a particular situation,

56 Toebes et al., p. 28.
57 Bernitz et al., p. 57.
58 B 1982-11, § 15.
60 Wilson, p. 41.
the ‘margin of appreciation’.\textsuperscript{61} To conclude, the human rights in the ECHR cannot be correctly understood without taking into account the case law of the ECtHR.\textsuperscript{62}

Regarding healthcare, the ECHR does not include any right to the highest attainable standard of health but the ECtHR implies that States have a special responsibility to protect, respect and promote the health of its individuals.\textsuperscript{63} Articles relevant to children’s consent in medical situations are the right to life in Article 2, the prohibition of torture and degrading treatment in Article 3 and the right to respect for private and family life in Article 8 ECHR. The court has also emphasized that it is the medical authorities that decide, on the basis of their professional standards, what treatment a patient should receive.\textsuperscript{64} The court is cautious to impose its own views, especially when it comes to sensitive moral and ethical issues, but it requires states to comply with the emerging standards of the human rights law.\textsuperscript{65} States are obligated to formulate adequate legislation to protect the life and physical, mental and sexual integrity of individuals against threats from other individuals according to the case X & Y v. Netherlands\textsuperscript{66}. According to the case Glass v. the UK, violating a person’s private life in the context of healthcare is, in principle, only permitted after the voluntary, explicit and informed consent of the person concerned.\textsuperscript{67} However, this does not mean that such consent always strictly is required to provide treatment, since the right to private life in Article 8 can be limited in accordance with section 2 of Article 8 ECHR.\textsuperscript{68} Most of the rights in the ECHR allow a balancing of interests that can lead to restrictions as only a few of the articles are absolute, for example the right to life in Article 2 and the prohibition of torture and degrading treatment in article 3.

3. Sweden

The Constitution of Sweden protects its citizens against physical violation and forced body examination in chapter 2, section 6 RF. When it comes to medical matters, the term ‘physical violation’ according to preparatory work refers to also minor procedures

\textsuperscript{61} ECtHR 23 July 1968, Belgian Linguistic Case, no. 1474/62, § 10.
\textsuperscript{62} Toebes et al., p. 27.
\textsuperscript{63} Toebes et al., p. 30.
\textsuperscript{64} ECtHR 24 September 1992, Herczeegfalvy v Austria, no 10533/83, §82; ECtHR 16 December 2007, Dybeku v. Albania, no. 41153/06, §47 and ECtHR 28 February 2006, Wilkinson v. the UK (dec.), no. 14659/02.
\textsuperscript{65} Toebes et al., p. 27.
\textsuperscript{66} ECtHR 26 March 1985, X & Y v. Netherlands, no. 8978/80, § 23.
\textsuperscript{67} ECtHR 9 March 2004, Glass v. the UK, no. 61827/00, §82.
\textsuperscript{68} Garwood-Gowers et al., p. 39.
like vaccinations, blood sampling and other body examinations\textsuperscript{69} and consequently, these are not legal if forced upon a patient. According to legal scholarship and Rynning, all forms of surgery and probably also different forms of medication and medical examinations should be included\textsuperscript{70} as well as psychiatric examinations according to Svensson and Rynning.\textsuperscript{71} These views have also been adopted in the preparatory work for the new PL.\textsuperscript{72} Also chapter 2 section 8 in RF concerning unlawful imprisonment (\textit{frihetsberövande}) could become relevant, for example when keeping a refusing patient in hospital. However, these protections against physical violation and unlawful imprisonment are not absolute but can be restricted according to chapter 2, section 20 clause 2 and 3 RF. According to section 21 RF, restrictions can only be made to meet purposes acceptable in a democratic society and never go beyond what is necessary with regard to the purpose which caused it. Limitations of the rights also strictly require legal support in accordance with the second paragraph in 2:20 RF.

Accordingly, treatment should never without legal support be forced upon anyone according to the protection from physical violation in the Constitution. There are areas where the government have provided such legal support, for example when it comes to compulsory psychiatric care and care of abusers\textsuperscript{73}. However, when it comes to healthcare in general, there are two important statutory acts concerning healthcare in Sweden, the Health and Medical Services Act (\textit{Hälso- och sjukvårdslagen}\textsuperscript{74}, HSL) and the Patient Safety Act (\textit{Patientsäkerhetslagen}\textsuperscript{75}, PSL). Neither of these provides possibilities to restrict the constitutional rights in RF. As a result, healthcare can be held as a voluntary benefit a patient normally can choose to accept or refuse. However, the situation becomes more complicated when the patient is a child, but also procedures which are carried out against the will of incompetent persons are held as unconstitutional unless supported in law.

\textsuperscript{69} Prop. 1975/76:209, p.147.
\textsuperscript{70} Rynning, p. 100.
\textsuperscript{71} Svensson, p. 42 and Rynning, pp. 100-101.
\textsuperscript{72} SOU 2013:2, p. 174.
\textsuperscript{73} See the Compulsory Psychiatric Care Act (\textit{Lag om psykiatrisk tvångsvård} (SFS 1991:1128)) and the Care of Abusers Act (\textit{Lag om vård av missbrukare i vissa fall} (SFS 1988:870)). Legal support to restrict the rights in RF is also expressed in the Forensic Mental Care Act (\textit{Lag om rättspsykiatrisk vård} (SFS 1991:1129)) and the Swedish Communicable Diseases Act (\textit{Smittskyddslagen} (SFS 2004:168)).
\textsuperscript{74} \textit{Hälso- och sjukvårdslagen} (SFS 1982:763).
\textsuperscript{75} \textit{Patientsäkerhetslagen} (SFS 2010:659).
The protection of life, health and freedom in the Penal Code (Brottsbalken76, BrB) includes criminal liability that can arise for all healthcare professionals if treating a patient without consent. Relevant crimes are manslaughter or involuntary manslaughter, injury or illness.77 However, it is unusual that the prerequisites for these crimes are fulfilled and thus relatively rare for prosecution of acts that are committed within occupation in health care.78 If healthcare professionals are suspected on good grounds (skäligen misstänkt) of professional misconduct to have committed a crime for which imprisonment is prescribed, the Agency for Health Care (Inspektionen för vård och omsorg) should apply for legal action, according to the 2nd paragraph of 7:29 PSL. Also HSAN can do this according to 9:17 in the PSL.

An noteworthy aspect of the health care system in Sweden is that there are both public and private health care services available. The state, together with the county councils (landsting) and municipalities (kommuner) are responsible for the public healthcare. Private healthcare can be provided in the forms of companies, trusts and business associations and also the public actors can provide private health care in this way.79 Consequently, it is important to clarify which legislation applies on which areas. To start with, the RF assures the individual rights against the public. The criminal liability in the BrB is naturally valid for everyone, whether working for private or public services. When it comes to the HSL, the act is binding for all caregivers, regardless if they are public or private, but it also includes specific rules for county councils and municipal healthcare. PSL is addressed to healthcare providers, healthcare professionals and the Agency for Health Care and HSAN.80 To conclude, most of the health care legislation is applicable on both public and private healthcare. However, only the public health services are covered by JO and the Chancellor of Justice’s (Justitiekanslern, JK) oversight. JK is the ombudsman for the Government and has jurisdiction over the courts, national authorities and their respective personnel.81

It is interesting to look into how this legal protection works in practice. The protection against physical violation and unlawful imprisonment in chapter 2, section 6 and 8 RF,

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76 Brottsbalk (SFS 1962:700).
77 Sections 2, 7 and 8 in chapter 3 BrB.
78 Johnsson, p. 81.
80 See Sections 1-4 in chapter 1 PSL.
81 Bernitz et al., p. 127.
also just covers, as the other rights in chapter 2, the relationship between the individual and the public. Consequently, it does not provide any direct protection against abuse a patient may be exposed to from other individuals, which can occur if healthcare is provided privately. The constitutional rights in the RF can be seen to constitute the most authoritative rights in the legal system but in fact, there is no guarantee that the individual is assured these rights in Sweden. According to Rynning, to provide a full protection of the law, the rights in the Constitution would also need to be manifested, specified and sanctioned in ‘normal’ legislation. Furthermore, prosecutions resulting in criminal liability are rare and under the HSL there are no possibilities to get obligations of the caregivers tried in court. In addition, the public discipline responsibility was also abolished in January 1, 2011, and therefore there is now no easy way to get actions of health care professionals evaluated in court. The National Board of Health and Welfare can however still express criticism against caregivers and health care professionals. There is also a possibility to bring an action to court with the claim for damages under tort law, but this is rarely successful and therefore hardly used. If a patient is harmed in connection with healthcare in Sweden, he or she can get compensation for the injuries that occurred. For this reason, every healthcare provider has a patient insurance and this regulated in the Patient Injury Act. However, this remedy is only a question of compensation and involves no judicial review.

In other words, it is legally difficult for patients to challenge medical decision-makers in judicial agencies. Patients, who have comments or complaints about the care received, or not received, should first turn to the treating medical professional. If that does not lead to a desired action, the patient should contact the operations manager. If there is still no opportunity to solve the issue, Patient Boards (patientnämnder) can offer support and assistance for patients in various ways. Previously, patients could turn to the supervisory authority the National Board of Health and Welfare that would receive and investigate complaints. This task, supervision of the healthcare, has now been transferred to the Agency for Health Care, according to 7:10 in the PSL, which shall examine complaints against healthcare services and its healthcare professionals. This includes all staff, whether they work in healthcare offered by the municipalities, county councils or private health care companies. However, this can only be done on

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82 Rynning, p. 71-72.
83 Patientskadelag (SFS 1996:799).
84 Johnsson & Arvill, p. 121.
application from caregivers and there is also no longer any opportunity for the patient to file a complaint to HSAN.

3.1. Foundations of the Swedish law on consent

Treatment given to a patient might technically constitute an injury covered by the criminal law, but the act can be seen as justified because of valid consent and the social adequacy of medical treatment.85 The doctrine of consent is in Swedish law based on the criminal law, an otherwise criminal act might be justified if the victim consents to it according to the general defence in section 24:7 of the BrB. As a consequence, patients can consent to treatment and thereby give a doctor the permission to touch them. This covers medical actions that are justifiable because of the patient’s consent, the fact that the act is performed in a professional manner of an authorized person and that the purpose of the act has been treatment or prevention.86

Nevertheless, consenting to medical treatment is not that simple. A complicated part of consenting to healthcare and treatment is that a valid consent requires the patients understanding of relevant circumstances and risks. According to preparatory work from when the section about consent as a general defence was introduced in the BrB, consent also has to be given by someone who is authorised to dispose over the current interest.87 The consenting person also have to be capable to understand the meaning of the consent, have full knowledge and understanding about relevant circumstances and the consent also must be given freely and be seriously meant.88 When it comes to medical matters, an important aspect is the doctrine of informed consent; the patient should receive enough information to be able to make a well-informed decision.89 Clearly a patient’s consent made without sufficient information to make the right decision is not a valid consent.90

3.2. Consent to treatment

The principle that healthcare cannot be given without the patient’s consent is not expressly stated in the Swedish healthcare legislation. Nevertheless, the principle can be

85 See, for instance, Rynning, p. 374 and Asp, pp. 255-256.
86 Rynning, p. 32.
89 Rynning, p. 23.
90 The question of information is also evaluated in preparatory work for the new PL, SOU 2013:2, p. 65, p. 143.
seen indirectly in an interpretation of the HSL and the PSL and is also explained in preparatory work. 91 Section 2a HSL states that healthcare and treatment as far as possible should be performed in consultation with the patient and that the patient should be treated with care and respect. Similarly, section 1 of chapter 6 PSL, regarding duties of health care professionals, states that the care shall as far as possible be designed and implemented in consultation with the patient and he or she should be shown consideration and respect. Preparatory work declared already in 1979 that basically all treatment requires consent from a patient, and this was also already previously held to be a valid principle according to case law. 92 Furthermore, the preparatory work of section 2a HSL also stated that a patient basically has an unlimited right to refuse treatment and this includes both the right to require an action immediately cancelled or never started at the first place 93, which is also mentioned in preparatory work for the proposed PL. 94

The proposed PL will, if passed, include a separate chapter about consent and a section stating that health care shall not be given without the patient’s consent, subject to other legislation. 95 According to the preparatory works it is important that this fundamental right should be known, not just for patients, but also for family members and health care professionals and therefore the requirement on consent should be clearly expressed in section 4:2 in the Act. 96 The inquiry report also states that a patient can, subject to legislation stating otherwise, consent to treatment in writing, orally or in another way express that he or she is consenting to the actual treatment (3rd paragraph in 4:2 PL). 97 The patient can also withdraw their consent at any time (2nd paragraph in 4:2 PL). 98 To conclude, even if the principle that treatment requires the patients consent is not expressly stated in statutory legislation yet, it can be seen indirectly in the constitution and legislation 99 and is also undoubtedly supported by legislative preparatory work.

The HSL and PSL also contain more provisions relevant for consent to treatment. The HSL imposes obligations on the caregivers to organize healthcare and contains general

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95 SOU 2013:2, pp. 13, 24.
97 SOU 2013:2, p. 176.
99 Svensson, p. 51.
rules for patients influence over their healthcare. To start with, section 2a in the HSL states that health services should be conducted in a way that they fulfil the requirements of ‘good health’. Good health is defined in the next paragraph and includes the requirement that healthcare services must be based on the respect for the patient’s autonomy and integrity. Also PSL states in section 1 of chapter 3 that the caregiver has to plan, direct and control all operations in a way that fulfils the requirement of good health in the HSL. These provisions are relevant for the patient’s ability to exercise influence over their healthcare and according to the second paragraph in 2a HSL, care and treatment should as far as possible be planned and carried through in consultation with the patient. Furthermore, the patient shall be given sufficient information according to section 2b HSL, which is important to enable meaningful consent. Also the PL, if passed, will codify this in chapter 3. If there are many treatments or options available, the patient should also be allowed to choose from these, according to section 3a HSL. To conclude, the current legislation, at least now prior to the PL, is rather vague but it is held to be clear that a competent patient formally is free to accept or decline any offered treatment.

The remaining principles regarding consent are only expressed in preparatory work and legal scholars. One of the requirements for consent to have exculpatory effect is, as mentioned, that it is given by someone who is authorized to dispose over the current interest. Furthermore, the patient must be able to understand the purpose of the consent and all relevant circumstances and the consent has to be freely given and seriously meant. For the consent to be valid, the patient giving it also has to be competent. The fact that adults normally are competent is presumed in Swedish law but an adult can lose this competency because of the influence of pain, shock, mental illness or severe physical illness. It is the doctor responsible for the patient who primarily has to decide whether the patient is competent to consent or not but the Chief of Medicin (chefsöverläkare) has the ultimate responsibility for the staff to fulfil their duties. If the situation is not urgent, it might be appropriate for a doctor to consult another medical professional or specialist in the field. Although, the decision often

100 3rd point in 2a HSL.
103 Rynning, p. 282.
105 Rynning, Barns rätt, p. 126.
has to be made by the treating doctor alone and there are no explicit rules in the Swedish law about how this procedure should be carried out.\textsuperscript{106}

### 3.3. Children’s consent to treatment

There is no definition of ‘child’ in general in the Swedish law. However, according to the Parental Code (\textit{Föräldrabalken}\textsuperscript{107}, FB) section 9:1, a child is a person who has not reached the age of 18, which is in accordance with the CRC.\textsuperscript{108} The proposed PL is very likely to come into force in January 2015\textsuperscript{109} but at the present, there is nothing explicitly stated in the Swedish healthcare legislation about children’s consent to treatment. However, an interpretation of the general rules for healthcare in the HSL in combination with the rules concerning the relationship between child and parents in FB shows how the decision-making process works. As mentioned, consent to some operations and treatments are also especially regulated, for example abortion, sterilisation, and transplants.\textsuperscript{110}

According to chapter 6 section 1 FB, children are entitled to care, security and a good upbringing. Children should also be treated with respect for their person and individuality and should not be subjected to degrading treatment according to the second sentence in 6:1 FB. According to the first paragraph in 6:2 FB, it is the person with custody for the child who has responsibility for its personal conditions and that the rights under section 1, which includes adequate health care\textsuperscript{111}, are satisfied. Consequently, the starting point in Swedish law is that the parents have the primary responsibility that their child’s needs are satisfied, which includes the right to decide in the child’s personal matters until the child turns 18. Failing to ensure that a child receives medical treatment or healthcare when such is needed can also constitute a criminal offense under chapter 3 BrB.

The HSL does not say anything about the child’s influence over their own care and, consequently, when it comes to other forms of health care that are not regulated specifically, the main rule is section 6:11 in the FB which states that the child’s own

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\textsuperscript{106}Ibid.

\textsuperscript{107}\textit{Föräldrabalken} (SFS 1949:381).

\textsuperscript{108}SOU 2013:2, p. 184.

\textsuperscript{109}Prop. 2013/14:106, p. 104.


\textsuperscript{111}SOU 1989:98, p. 185.
opinions should be given greater importance in line with rising age and development. Under this section parents have both the right and duty to decide in matters regarding the child’s personal concerns but should, in pace with the child’s increasing age and development, take greater account of its own views and wishes. The meaning of the section is, in light of the basic requirements of consent in the HSL, accordingly that even minors in some cases can be considered competent to decide for themselves on issues related to medical care and treatment.\footnote{Rynning, p. 286.} It is the young patient’s level of maturity related to, for example, the severity and importance of the decisions to be made which will be decisive for the assessment of the minor patient’s decision making competence. If a minor patient is found to possess enough maturity that he or she can understand the information and identify the consequences of the decision, the right to decide is his or hers alone and the parent’s opinion should not even have to be heard.\footnote{Ibid.} To conclude, 6:11 FB has in practice been interpreted in a way that, if a child is held as mature enough in a certain situation, it is given not only influence in the matter but a right to decide by themselves.\footnote{Prop. 2013/14:106, p. 65. See also Svensson, p. 156.} This opinion is also supported in preparatory work for the PL,\footnote{The proposal for the Patient Act to the Council on Legislation, p. 64.} which suggests a section (4:3 PL) stating that the child’s attitude for the proposed treatment as far as possible should be clarified and that the child’s own opinion shall be given due weight in accordance with his or her age and maturity. According to the government in the legislative bill, the new provision is based on 6:11 FB and will codify what has developed in practice regarding children’s influence in healthcare.\footnote{Prop. 2013/14:106, p. 119.} Preparatory work also states that healthcare professionals together with the guardians currently have the responsibility to investigate the child’s view in the situation.\footnote{The proposal for the Patient Act to the Council on Legislation, p. 63.} It ought to be clear that such situation does not arise when the patient is an infant.\footnote{Ibid.} However, it does not mean that very young children cannot have their own opinion on certain treatment and thus it is important to also give these children chance to express their opinion.

When assessing the patient’s competency the child should, as adults, receive information about the treatment. According to preparatory work for the PL, important in the assessment of the child is considered as mature enough to consent to treatment alone
is whether the child understands the treatment and its consequences or not.\textsuperscript{119} Furthermore, because of the various situations that can arise, it is the actual decision the patient is facing, based on the patient’s ability in the current situation that should be assessed. As a consequence, the level of sufficient maturity for a child’s opinion to be taken into account has to be assessed in each individual case and depends on the nature and urgency of the treatment.\textsuperscript{120} For example, there might be a difference in maturity required for consenting to medication or to surgery.\textsuperscript{121} Accordingly, the assessment regarding a child’s maturity has to be done on a case by case basis and this approach is held to be consistent with the principles in Article 12 CRC.

Consequently, when assessing a child’s competence, the problem is almost the same as when an adult’s decision skill is evaluated. One difference however, is the presumption for or against competency. There is no legislation on this area but it is discussed in legal scholarship and case law from HSAN. According to Rynning, when it comes to really young children and toddlers, the presumption is held to be against competency. With the increasing age of the child, this presumption is changing towards a presumption in favour of competency, and older teens are often presumed to be competent. When it comes to the most difficult and radical decisions, it might be that the presumption for competency does not occur before the 18\textsuperscript{th} birthday.\textsuperscript{122} According to preparatory work for PL, the focus in the assessment of if the child should be considered as mature enough to consent to treatment alone, is whether the child understand the proposed treatment and its possible consequences. Even a small child should be able to ask a doctor to put a plaster on a wound, whereas more extensive treatments require a considerable degree of maturity of the child.\textsuperscript{123} However, a parent should not give a child too much responsibility either, as for example let it decide to an extent it is not ready for.\textsuperscript{124} If a minor patient achieved some maturity, but not enough for consenting alone, a united consent from both child and parents might be needed.\textsuperscript{125} In such situations, when a child cannot be seen as mature enough to decide all by itself, but neither would it be fair to just let the parents decide, the decision must be made by both parties.

\textsuperscript{119} Prop. 2013/14:106, p. 67.
\textsuperscript{120} Prop. 2013/14:106, p. 66. See also the proposal for the Patient Act to the Council on Legislation, p. 63.
\textsuperscript{121} Prop. 2013/14:106, p. 67.
\textsuperscript{122} Rynning, p. 288.
\textsuperscript{123} The proposal for the Patient Act to the Council on Legislation, p. 64.
\textsuperscript{124} Prop. 1981/82:168, p. 25.
\textsuperscript{125} SOU 2013:2, p. 275 and Rynning, p. 287.
Case law shows that parents decide about both treatments and examinations in healthcare when it comes to infants and really young children, and consequently, children in this age cannot receive treatment without their parent’s consent. In the Swedish case RÅ 1996 ref. 65 the Supreme Administrative Court stated that the parent’s consent has to be obtained when it comes to blood samples on young children, the case concerned a 3-year-old. Parents consent was also needed for an intelligence test on a 5-year-old in a JO-decision and the HSAN committee has stated that parents has the right to refuse that certain treatment is given to their child. According to Svensson, when it comes to young children, the parents should also be able to give valid legal consent to medically motivated treatment even if the child refuses.

In the case JO 1995/96 p 89, JO agrees with an opinion from the National Board of Health and Welfare that, with consent from children over the age of 12, it might be possible to carry out medical examination even if the parents are not informed. Svensson stated that it seemed to be, according to JO, that children over 12 can consent to examination while nothing is said about consenting to treatment. Svensson also points out that the assessment should depend on the type of the treatment as well as how extensive (ingripande) it is. Regarding the type of the treatment, according to another case from JO, it was appropriate that the parents would be informed when a 13-year-old girl requested to get contraception. JO however stated that there could naturally also be situations regarding girls under 15 where doctors have to assess the question about the ordination of contraception without informing the carers. When it comes to how extensive the treatment is, it was lawful of a doctor to prescribe antibiotics to a 13-year-old boy with a hand infection without informing the parents in the case HSAN 955/88. According to Svensson, ordination of antibiotics can hardly be seen as a radical or extensive treatment, but when it comes to treatment for very serious conditions the parents must at least be informed about the situation.

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126 JO 2000/01 p. 478.
127 HSAN 706/04:A2.
128 Svensson, pp. 141, 287.
129 Ibid, p. 146.
130 Ibid, p. 146 -147.
131 JO 1992/93 s. 439.
132 Svensson, p. 147.
133 Ibid.
Regarding older minors over 16, they are usually held to possess enough maturity to be regarded as competent to consent to treatment.\textsuperscript{134} This was pointed out in the case HSAN 2747/00 where a doctor prescribed an addictive drug to a 17-year old without any prior discussion with the parents. According to HSAN, it was lawful to prescribe drugs to an older teen after their request without obtaining consent from their parents. According to Svensson, it seems to be possible for older minors to get medical treatment, not only without consent from their parents, but also in the event that their parents object.\textsuperscript{135} Reasoning from two JO cases, Svensson argues that older teens are also seen as capable to refuse offered treatment even if both the doctors and parents insist.\textsuperscript{136} However, according to Svensson, it seems to be that children under 14 cannot consent to extensive medical treatment without their parent’s consent.\textsuperscript{137} Rynning also states that it probably requires more maturity to make decisions of life-changing character than less important ones.\textsuperscript{138} When it comes to life-saving treatment, the law is unclear and this will be further evaluated in chapter 5.3.

In conclusion, healthcare is seen as a voluntary benefit a patient normally can accept or decline, health services should be based on respect for patient autonomy and integrity and no one should be subject to coercion without support in law. However, the situation becomes a bit different when it comes to children. The parent’s right and obligation to determine their child’s personal affairs and ensure that their needs are met\textsuperscript{139} as well as the best interest of the child must be taken into account.\textsuperscript{140} However, the law explicitly states that the child should also be treated with respect for their person and should not be subject to degrading treatment.\textsuperscript{141} These principles must collectively result in that direct coercion against children as far as possible should be avoided, but the principles of the best interest of the child and need of health might sometimes lead to a coercion considered as justified. Also according to Rynning, physical force against a child should always be avoided as far as possible even when it comes to treatment that parents want, and all patients should be treated with care and respect, regardless of their age and

\begin{flushleft}
\textsuperscript{134} Svensson, p. 142. \\
\textsuperscript{135} Ibid, p. 143. \\
\textsuperscript{136} JO 1975/76 p. 244, JO 1995/96 p. 89 and Svensson, p. 142. \\
\textsuperscript{137} Svensson, p. 147. \\
\textsuperscript{138} Rynning, p. 288. \\
\textsuperscript{139} 2\textsuperscript{nd} paragraph in 6.2 FB. \\
\textsuperscript{140} 6:2a FB. \\
\textsuperscript{141} 2\textsuperscript{nd} sentence in 6:1 FB.
\end{flushleft}
maturity. Important in the discussion regarding forced treatment, is the importance of the action, possible alternatives as well as negative effects such as the invasion of privacy. Nevertheless, constraint that restricts the constitutional protection against physical violation cannot, in order to be lawful, go beyond what is necessary regards to the purpose which led to it according to the 2nd sentence of 2:21 of RF. If there are various options available the one that includes the mildest coercion is preferred. In addition, violation of privacy should be perceived as more severe the older the child becomes and hereby, the use of coercion against older children and teenagers is likely to only be seen as justifiable when it comes to emergencies and situations, where there is no room for motivational discussions or other forms of assistance. For really young children, it can sometimes be difficult to motivate them to participate in treatment, especially if they do not really understand the meaning of it. According to Rynning, such opposition can be regarded as instinctive rather than a rational decision in many cases and milder physical coercion such as restraint must be accepted to a greater extent for young children than older ones.

3.4. Exceptions from the requirement of consent

There are situations where doctors do not need consent from the child or its parents to provide treatment, namely when interventions through statutory compulsory care can be carried out or if the doctor is treating a patient in a life-threatening condition with emergency care. These are both regulated in law and, as a consequence, treatment in accordance with the provisions is not unconstitutional.

3.4.1. Statutory compulsory treatment

All decisions regarding children made by health care professionals and parents must be in compliance with the best interest of the child. However, no intervention through the Social Services Act (Socialtjänstlagen) in Sweden can force treatment upon a child because the act is based on voluntariness and cannot change the legal relation between parents and child. The parent will, in the event of an intervention, still be the carer for the child as well as have parental responsibility and all the rights and duties

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142 Rynning, Barns rätt, p. 124.
144 Ibid.
145 See section 6:2a FB and section 1:2 in the Social Services Act.
146 Socialtjänstlag (SFS 2001:453).
147 According to 1:1 in the act, the social services’ work must be based on respect for the autonomy and integrity of individuals.
that come with it.\textsuperscript{148} Therefore, in cases where the Social Welfare Committee (socialnämnden) cannot voluntarily provide the help and support children and young people are in need of, society must be empowered to intervene to protect children. Such possibility is provided in the Care of Young Persons Act (lagen om särskild vård av unga\textsuperscript{149}, LVU). Psychiatric compulsory treatment is also regulated specifically in the Compulsory Mental Care Act\textsuperscript{150}. Healthcare professionals also have an obligation, in accordance with the 2\textsuperscript{nd} paragraph in section 14:1 of the Social Services Act, to immediately notify the Social Welfare Committee if they would be aware of anything which might mean that the Social Welfare Committee would have to intervene for protection of a child.\textsuperscript{151}

If a parent would not act in the best interest of the child, there is a possibility for authorities to intervene and resort to coercion through LVU in child protection cases. For example, if a parent refuses to consent to a treatment important for the child, this could enable an intervention under section 2 or 3 in the Act. Consequently, in cases involving a palpable risk for harm of the child’s health or development, the Social Welfare might take over the authority and right to decide over the child. The first sentence of section 1 in the LVU states that all interventions should be characterized by respect for the young person’s human dignity and integrity. The fifth sentence in the same section also states that what is in the best interest of the young person should be definitive for decisions under the Act. For the Social Welfare to take over the authority for a child, a court order from the Administrative Trial Court (förvaltningsrätten) is required according to section 4. However, in very urgent situations, interim decisions can be made by the Social Welfare Committee or even the chairman of the Social Welfare Committee alone, according to section 6. Such decision applies immediately according to section 40. In imminent situations, when not even an interim decision can be awaited for, emergency care might justify treatment without consent instead.

3.4.2. Emergency care

The other situation when a doctor might be able to treat patients, both adults and children, without consent is in very urgent situations, when life or health is in danger. This doctrine is not expressed in the Swedish health care legislation but section 24:3

\textsuperscript{148} Svensson, p. 78.
\textsuperscript{149} Lag med särskilda bestämmelser om vård av unga (SFS 1990:52).
\textsuperscript{150} Lag om psykiatrisk tvångsvård (SFS 1991:1128).
\textsuperscript{151} The National Board of Health and Welfare’s Information letter (meddelandeblad) Nr. 7/2010 p. 3.
BrB, which states that when acting out of necessity (nöd) an otherwise wrongful act might still be legitimate. This provision can be also be applied in medical situations, even if it traditionally is a general defence from criminal liability and was not enacted with health care in mind. Nevertheless, it is discussed in preparatory work for the PL to enact a provision representing emergency care in 3:4 PL. But for the moment, 24:3 BrB can be applied on medical situations when life and health is at stake, and can give the doctor a right to operate even without consent of the patient.

However, it is important to understand that the defence of necessity cannot protect a doctor for a longer time; it is only valid as long as there is a proper threat to life. Furthermore, according to 24:3 BrB, the actual act cannot be considered as ‘unjustifiable’ (oförsvarlig). Even in an emergency situation, an act is still criminal if such is held to be unjustifiable. Specifically which acts that would be regarded as unjustifiable are not clear. When assessing if an act is justified or not, both the patient’s health and autonomy must be taken into consideration and balanced against each other. However, the law also requires that the act performed cannot be regarded as unjustifiable compared to the interest violated in the specific situation. Therefore, for an act to be considered as not unjustifiable, the value the doctor seeks to protect, such as life, has to be of significant greater weight than the patient’s right to autonomy and right to not be treated without consent. According to Asp, it is clear that the area of discharge (ansvarsfrihet) in the BrB is considerably wider concerning measures in health care than in other fields, justified because of the benefits of medical actions. Asp also states that here is no other area where it is equally clear that an otherwise unlawful act still can be accepted.

A Swedish case that can be seen as an example of the defence of necessity is HSAN 90/84:3, ref 1:6/1986 where a 21-year-old woman during a late abortion was bleeding so much that the operating doctors had to remove her uterus in order to save her life. The act was seen as justified because the removal of the uterus was the last resort, when there were no other possibilities or options available in order to save the patient’s life.

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152 Rynning, pp. 365, 367.
154 24:4 BrB 2nd paragraph. See also Rynning, pp. 372, 379.
156 Asp et al., p. 293.
157 Rynning compares this to a Danish case (U 1989 1007 H), Rynning, p. 368. In the case, a 21-year-old woman suffered bleeding complications while having a caesarean operation. The doctor who performed
Consequently, it is clear that the defence of necessity can be used in situations where consent is impossible to obtain, for example if the patient is unconscious, but can it also legitimise actions where the patient objects? According to Rynning, such approach is not supported by Swedish law. The principal rule must be that a competent and conscious person can decide if he or she wants to take the risk of dying and, as Rynning states, the defence of necessity cannot justify forced treatment on a patient in such situation. However, when it comes to incompetent patients, who are not unconditionally autonomous, the interest of life and health might outweigh the protection of the patient’s autonomy. Therefore, when it comes to children, the rule of necessity can according to Rynning actually be able to justify a lawful medical procedure to be forced upon an objecting child. This approach is also supported in preparatory work for the Compulsory Mental Care Act concerning patients treated in psychiatric compulsory care. Issues regarding children that refuse treatment will be further evaluated in chapter 5.

3.5. The proposed Patient Act

If passed, the new PL will come into force in January 2015 and includes provisions regarding consent. The overall purpose of the new act is to strengthen and clarify the status of the patient as well as promote the patient’s integrity, autonomy and participation in healthcare. According to the legislative bill, since Sweden has no legislation that in an integrated manner describes the patient’s status in healthcare, it is difficult for citizens, patients, caregivers and principals to get a clear view of the rules on the area. The new legislation is meant to be perspicuous and easy to access and understand. Some of the sections in the PL will not cover privately funded care, i.e. healthcare paid by the patient, an insurance company or similar.

158 Rynning, p. 376.
159 Ibid, p. 378.
161 SOU 2013:2, p. 11.
163 SOU 2013:2, p. 11.
164 Ibid, p. 266.
According to the first paragraph of 5:1 in the new PL, healthcare should as far as possible be designed and implemented in consultation with the patient. The proposed PL also includes a separate chapter regarding consent and a section stating that healthcare shall not be given without the patients consent, subject to other legislation. The inquiry also noticed that there is nothing stated about children and healthcare in the HSL and therefore suggests that the principle of the child’s best interest should be expressed in the PL. Also the fact that the child’s attitude to proposed treatment as far as possible will be codified, along with the principle that the child’s own opinion shall be given due weight in accordance with his or her age and maturity in 4:3 PL.

Preparatory work for the PL also suggests a provision representing emergency care in the PL. The preparatory work states that operations within healthcare in this type of situations should be supported by legislation regarding the patient’s status in healthcare and not by an interpretation of the general rules of the BrB. However, the new section, 4:4 PL, should not be applied in order to continuously provide an incompetent patient healthcare but is only meant for the most urgent situations. The inquiry report also suggested enacting another provision which would justify treatment for patients who are not just temporarily lacking capacity to consent. However, this was rejected by the government in the legislative bill, which states that because of the difficult ethical considerations, there are reasons to await conclusions from the ongoing work on the inquiry report investigating incompetent persons’ status in healthcare.

When it comes to the assessment of children’s competency, it was considered in the inquiry report to establish specific age limits for a child’s possibility to be competent. In several of the Nordic countries children are held to be decision competent from a certain age and also Swedish law contains some fixed ages limits, both in and outside healthcare. However, the investigation concluded that fixed age limits for health care in general could result in that some children would be assigned greater responsibility

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167 Ibid, p. 15.
169 Prop. 2013/14:106, s. 60 and SOU 2013:2, p.181.
171 Ibid, p. 66.
172 SOU 2013:2, p. 15. For example, a child have to be 15 years old to participate in some medical research according to lagen om etikprövning av forskning som avser människor (SFS 2003:460) and children that are 16 or over can, in some cases, sign employment contracts without their parents consent according to 6:12 FB.
than they are mature enough to handle, whereas others may be denied autonomy in matters they are capable to decide about. The difference in individual maturity can also be significant under the teenage years. Furthermore, fixed age limits could also cause difficulties when also the nature and urgency of proposed treatment has to be taken into account. As a result, the government and several of the consultation bodies (remsinstanser) shared the conclusive opinion of the inquiry that fixed age limits regarding children’s influence over their health care should not be established in the PL.

As a consequence, the assessment of children’s competence is not going to be further regulated in the Act. The inquiry report therefore took the view that enforcement regulations (verkställighetsföreskrifter) concerning consent to treatment should be developed in order to support staff and caregivers. The inquiry further suggested, that a section stating that the government or an authority appointed by the government, will issue more detailed regulations on how the patient’s attitude to treatment should be obtained, should be established in the Act. The government is of the opinion that such section is not necessary but will return to the question of in which form the relevant authorities should provide guidance regarding the maturity assessments. Several consultation bodies also stated that there is a need to provide guidance for healthcare professionals on how the maturity assessment should be done when health care is given to children.

A final noteworthy aspect of the new Act is that none of the rights included are intended to be actionable against practioners. According to the preparatory work, laws and regulations in healthcare should continue to define responsibilities for healthcare principals, caregivers and professionals and some not actionable rights for the patients. The possibility to change the legislation into a rights-based legislation, which would give the patient’s rights that can be tested in court, has been up for discussion in earlier preparatory work. In the interim report (delbetänkande) SOU 1997:154, the Committee on Healthcare Financing and Organization (HSU 2000) noted

173 Rynning, Barns rätt, p. 135.
175 SOU 2013:2, p 178.
177 SOU 2013:2, p. 63.
that there are a number of difficulties in introducing rights actionable in court in the healthcare field. For example, trial court proceedings would include very complicated medical assessment that would require extensive expert participation and thus become both time and resource consuming for both the judicial system and health services. According to the committee, such construction where resources would be utilized for court trials, would inevitably affect the healthcare services negatively. The inquiry also highlighted the difficulty of constructing appropriate sanctions beneficial to the individual patient.179 Furthermore, the Priority Inquiry SOU 1995:5 also stated that a healthcare system based on rights narrows the scope for municipal democratic decisions about priorities in healthcare relating to existing resources, which would be difficult to combine with the healthcare principals’ responsibilities to plan healthcare in general.180 Owing to the described difficulties above, the government agreed with previous inquiries that the PL should not involve actionable rights. However, the government already made this clear in the directives to the Patient Power Inquiry, which therefore chose not to argue either for or against legislation based on rights instead of obligations. To sum up, the opinion of the government is that the Patient Act may not contain actionable rights in the sense that decisions made in the health sector should be able to review by the court and this means that the legislation essentially shall be based on the obligations care providers and health care professionals have towards patients.181

4. England

The legal framework for children’s consent in England and Wales is built on common law but also a few important statutes.182 Especially important is the Human Rights Act, enacted in 1998, the purpose of which is to give further effect to the rights contained in the ECHR in English law. The Children Act 1989 allocates duties to parents, courts, local authorities and other agencies to ensure that children are safeguarded and that their welfare is promoted. The Family Law Reform Act was enacted in 1969 to amend the law relating to different areas of family law, as for example children’s consent, and has also been amended to reflect court decisions in the 1990s.183 At last, also the Mental Capacity Act 2005 (MCA) is relevant because it provides a legal framework for acting

179 Ibid.
180 Ibid.
182 All acts included in this thesis can be found on the government’s webpage http://www.legislation.gov.uk.
183 See the Gillick analysis in chapter 4.3.2.
and making decisions on behalf of adults who lack the capacity to make particular decisions themselves. The act does usually not apply to children but sets out many important principles about consent. The Mental Health Act (MHA) can however be used to detain children in hospital if it is justified by the risk posed by their mental disorder and all the relevant criteria are met.\textsuperscript{184} According to the Code of Practice of the MHA, if the primary purpose is not to give medical treatment for mental disorder and there is no real need for him or her to be hospitalised, it might be more appropriate for the child to be put in secure accommodation according to section 25 of the CA.\textsuperscript{185} Furthermore, even if statute has priority over case law, a great amount of case law is still important on this area, especially in situations when common law fills statutory gaps.

4.1. Foundations of the English law on consent

The principle that every person has the right to have his bodily integrity protected against invasion by others has been long recognized by the common law.\textsuperscript{186} As a consequence, medical professionals cannot touch a patient without the patient’s consent. According to Neill J in the English case House of Lords case \textit{F v West Berkshire Health Authority},\textsuperscript{187} consent permits ‘treatment or surgery which would otherwise be unlawful as a trespass is made lawful by the consent of the patient’. The principle was also recognized by the Court of Appeal in \textit{Re MB (1997)}\textsuperscript{188}. In the well-known House of Lords decision \textit{Chester v Afshar} from 2004, Lord Steyn explained that the rule requiring a doctor to obtain a patient’s consent before performing an operation has two purposes; to avoid the occurring of physical injury the patient is not prepared to accept and ensure that due respect is given to the autonomy and dignity of each patient.\textsuperscript{189} Furthermore, according to the High Court in a case from 2002, to operate on a competent patient without consent would be to contravene a patient’s right in Article 3 of the ECHR to not suffer torture or inhuman or degrading treatment.\textsuperscript{190}

The starting point in English law is that if a doctor touches a patient without consent, issues might arise in the crime of battery or in the tort of trespass to the person or

\textsuperscript{184} MHA Code of Practice, p. 332, clause 36.16.
\textsuperscript{185} MHA Code of Practice, p. 332, clause 36.17-18.
\textsuperscript{186} Mason and Laurie, p. 349.
\textsuperscript{187} F v West Berkshire Health Authority [1990] HL.
\textsuperscript{188} Re MB (an adult: medical treatment) (1997) 38 BMLR 175.
\textsuperscript{189} Chester v Afshar [2004] UKHL 41 at 18.
\textsuperscript{190} R (N) v Dr M, A Health Authority Trust and Dr O [2002] EWHC 1911.
negligence. The crime battery has no statutory definition but is, along with all other elements of the offence, set out in the case *R v Ireland* where Lord Steyn defined battery as ‘unlawful application of force by the defendant upon the victim’. ¹⁹¹ Consequently, there is a risk that a doctor who has performed treatment without obtaining the patient’s consent will face a criminal prosecution. However, the risk that this would actually happen in the practice of medicine in good faith is very small and there have also been relatively few successful cases in England regarding non-consent and the tort of battery. ¹⁹² Proceedings in the tort of negligence are more common ¹⁹³ and the possible move away from the tort of battery to negligence is reflected in the courts concern more with the quality of the information imparted to gain the consent than whether the touching was consented to at all. ¹⁹⁴

4.2. Consent to treatment

Case law has shown that consent can be either expressed or implied and it does not need to be set out in any specific form or writing. ¹⁹⁵ However, it is needed before a doctor can provide treatment or undertake an examination. Consent is also a continuous process and a patient is therefore free to withdraw consent at any time. ¹⁹⁶ For consent from a patient to be effective, there must be a genuine agreement to receive the treatment and for this three requirements must be fulfilled; the consenting person must be competent, sufficiently informed and not subjected to coercion or undue influence. ¹⁹⁷

Regarding the question whether the patient is competent, the Court of Appeal ruled in the case *Re T* ¹⁹⁸ that autonomy and the right to decide presuppose an ability or capacity to do so, otherwise consent is invalid. An adult patient is assumed to have capacity unless it is established that he or she lacks it according to s. 1(2) MCA. However, this is a presumption and some conditions, for example, impairment of the mind or brain, can have the capacity rebutted. To lack capacity in relation to a matter is defined in section 2(1) MCA to be if, at the material time, he is unable to make a decision for himself in

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¹⁹¹ *R v Ireland [1997] 3 WLR 543.* The punishment for battery is however set out in statute and is maximum 6 months imprisonment according to section 39 Criminal Justice Act 1988.

¹⁹² *Kennedy & Grubb,* p. 578.

¹⁹³ See, for instance, the cases Chatterton v Gerson [1981] 1 All ER 257; Freeman v Home Office [1984] 1 All ER 1036; Sidaway v Bethlem RHG [1985] 1 All ER 643; Williamson v East London and City HA (1998) 41 BMLR 85; Blyth v Bloomsbury AHA [1993] 4 Med LR 151.

¹⁹⁴ *Kennedy & Grubb,* p. 580.

¹⁹⁵ *Re T (adult: refusal of treatment) [1992] 4 All ER 649 at 653 per Lord Donaldson.*

¹⁹⁶ *Herring,* p. 167.

¹⁹⁷ *Herring,* p. 155.

¹⁹⁸ *Re T (adult: refusal of treatment) [1992] 4 All ER 649.*
relation to the matter because of an impairment of or disturbance in the functioning of the mind or brain. The fact that this assumption of capacity can be rebutted was pointed out by Lord Donaldson in the case Re T.\(^\text{199}\) When it comes to the assessment of capacity, a mental capacity test for establishing competence for adults was established in the case Re C\(^\text{200}\) and involved a three-stage test adopted by Thorpe J. The test for capacity required that the patient could retain the necessary information, weigh the information and balance risks and needs and arrive at a choice. The Court of Appeal subsequently adopted this test in Re MB\(^\text{201}\), which is now also included in the MCA.\(^\text{202}\) The patient also has to be able to communicate the decision, whether by talking using sign language or any other means. Furthermore, the case Re C mentioned above also developed the law that even if a patient’s decision is unwise or irrational, this does not negate capacity.\(^\text{203}\) Section 1(4) in the MCA now maintains this common law position and states that merely because a person makes an unwise decision he or she is not automatically unable to make a decision. Consequently, an adult patient should be able to refuse treatment even if it will lead to harmful consequences or even the patient’s death.

When it comes to the requirement that the patient has to be sufficiently informed, the law in England does not recognise the doctrine of informed consent as a specific requirement to give detailed information as in other countries. In England, the patient only needs to understand in broad terms the nature of the procedure which is intended.\(^\text{204}\) According to the case Hills v Potter, the patient must be reasonably informed so that he or she can understand the treatment proposed and make a rational choice.\(^\text{205}\) However, if a competent, sufficiently informed patient consents, such consent is still not valid if not freely given. Regarding that the consenting person cannot be subject to coercion or undue influence, the earlier mentioned case Re T\(^\text{206}\) also stated that a patient freely has to reach a decision without any external person forcing them.

The case concerned an adult woman that was held as incompetent and not able to refuse

\(^\text{199}\) Ibid, at 661. See also Re MB (an adult: refusal of treatment) [1997] 38. BMLR 175 (CA) per Butler Sloss LJ at 186.

\(^\text{200}\) Re C (adult: refusal of treatment) (1994) 1 WLR 290.

\(^\text{201}\) Re MB (an adult: medical treatment) (1997) 38 BMLR 175.

\(^\text{202}\) According to section 3(1) in the MCA, a person is unable to make a decision for himself if he is unable to understand the information relevant to the decision, retain that information, use or weigh the information as a part of the process of making the decision.

\(^\text{203}\) Kennedy & Grubb, p. 621.

\(^\text{204}\) Chatterton v Gerson [1981] 1 All ER 257.

\(^\text{205}\) Hills v Potter [1983] 3All ER 716.

\(^\text{206}\) Re T (adult: refusal of treatment) [1992] 4 All ER 649.
a life-saving blood transfusion because her decision was seen as made undue influence by her Jehovah Witness mother.

4.3. Children’s consent to treatment

The child patient is a child under the age of 18 according to section 1 in the Family Law Reform Act 1969 (FLRA). When it comes to children, their parents can consent on their behalf unless the child is competent and can make the decision itself. A ‘parent’ in English law is any person with ‘parental responsibility’ according to section 3(1) Children Act 1989 (CA). There is a statutory presumption in the FLRA in favour of competence where the child is aged 16-18 years but also children under 16 might be able to consent if they are regarded as ‘Gillick competent’ after the decision Gillick v West Norfolk and Wisbech207, as explained in chapter 4.3.2.

4.3.1. Minors in the age of 16-18

In England, children aged 16 to 18 can consent to medical treatment in the same way as adults according to section 8(1) in the FLRA, which states that consent to any surgical, medical or dental treatment from a 16-18 year old minor shall be as effective as it would be for an adult. Consequently, if the young person is capable of giving valid consent and does so, it is not necessary to obtain consent from the child’s parents as well. However, it is good practice to involve parents in the decision-making process if the young person consents to their information being shared.208 Furthermore, this presumption of competency is also rebuttable (which is going to be discussed in chapter 5) and when assessing whether the young person is capable of consenting, the same criteria should be used as for adults.209 If the young person is held to lack capacity, the MCA will apply in the same way as it does for adults.210 However, section 8 (1) FLRA does not cover all possible treatment. It applies only to the young person’s own treatment and not to interventions that is not potentially of direct health benefit for the young person, as for example tissue donation or medical research.211 According to Herring, cosmetic surgery is also very unlikely to be included.212 However, a minor might still be able to consent to these but must then be held as Gillick competent instead.213 Section 8 (3) FLRA states

207 Gillick v West Norfolk and Wisbech AHA [1986] AC 112 (UKHL).
208 MHA Code of Practice, p. 336 clause 36.32.
209 Ibid, clause 36.31.
210 Ibid, clause 36.35.
211 MHA Code of Practice, p. 335, clause 36.30.
212 Herring, p. 191.
213 See next chapter 4.3.2.
that ‘nothing in this section shall be construed as making ineffective any consent which would have been effective had the section not been enacted’. This seems, in Lord Donaldson’s opinion, to explain that parents still have the right to consent for their underage child, as before the act was passed. It has also been widely assumed that the section only confirms the common law right of competent minors to decide these questions for themselves, which however can be doubted because then it would never have been a need of section 8 (1).

4.3.2. Children under 16

As mentioned, children under 16 might also be competent to consent to treatment, if they are regarded as mature enough. The guidance regarding this has since 1985 in England been the Gillick principle after the case Gillick v West Norfolk and Wisbech. In the case a mother, Mrs Gillick, challenged a doctor’s decision to give her girl aged under 16 contraceptive advice without her consent or knowledge. Mrs Gillick argued that children under 16 were unable to give consent valid in law and the Court of Appeal agreed with her. However, on appeal, the House of Lords by majority held that a child under 16 could have capacity to consent to treatment. In the judgement, the House of Lords focused on the girl’s maturity and ability to understand and Lord Fraser set down five criteria that need to be considered in order for an underage child to be provided with contraception without parental consent or knowledge. The first criteria required that the child must understand the advice. Second, the doctor must be unable to persuade the child to talk to the parents about contraceptive advice or to talk to the parents himself. It also has to be considered whether the child will continue to have sexual intercourse and, if she does not receive contraceptive advice, her physical or mental health could be harmed. Finally, it has to be considered if it would be in the child’s best interest to receive contraceptive advice without the parent’s consent. The House of Lords also stated that it is a question of fact to be decided in each case whether a child has sufficient understanding to give consent valid in law. As a consequence, the child only need to have the maturity required for the particular issue in question.

As a result, a child is deemed as Gillick competent if he or she has sufficient maturity and understanding and can, if the criteria set down in the case Gillick are satisfied,

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214 Re R (wardship) (a minor; consent to treatment) (1992) 7 BMLR 147 at 156.
215 Mason and Laurie, p. 370.
216 Gillick v West Norfolk and Wisbech AHA [1986] AC 112.
217 Mason and Laurie, p. 360.
provide a legal consent for medical procedures. There are a few points commonly held for doctors or courts to consider when deciding whether a child is *Gillick* competent or not. First, the child must understand the medical issues and this includes understanding of the proposed treatment and the effects of it, as well as the consequences of not having treatment. According to Lord Scarman, the child must have ‘sufficient understanding and intelligence to enable him or her to understand fully what is proposed’.218 As a consequence, this might result in that it is harder to show that a child is *Gillick* competent the more complex a medical procedure is.219 Furthermore, if a child is fluctuating between competence and incompetence, the child should be held as incompetent.220 According to case law, the court cannot reason that children, as for adults, are not competent just because their actual decision is seen as irrational.221 According to Lord Scarman, the child must also understand the ‘moral and family’ issues and questions,222 but there has been some disagreement in legal scholarship regarding this,223 partly because it would require an extremely deep and perceptive understanding of the consequences of treatment.

The child must also be sufficiently mature to reach his or her own decision and not merely be repeating the views of her or his parents224, which often has to be considered when it comes to decisions based on religious grounds. In the case *Re S*225 a 15-year-old Jehovah’s Witness refused a blood transfusion but she was not able to explain clearly why and therefore the court was not confident that she was sufficiently competent to make the decision for herself. The same outcome was obtained in the case *Re L*226 concerning a 14-year-old Jehovah Witness, who because of severe burns needed operations that would involve blood transfusions. The court thought that the girl, as she matured, would question her religion further and could therefore not be held as *Gillick* competent. An expert stated that the child’s religious views were merely a reflection of her parent’s and local church’s, even though he had not actually seen the girl, and her consent was overridden. Consequently, when courts are of the opinion that a child, because of a strict religious upbringing has not been made sufficiently aware of a

218 *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112, at 423 per Lord Scarman.
219 Herring, p. 191.
220 *Re R* (a minor) (wardship: medical treatment) [1991] 4 All ER 177.
221 *South Glamorgan CC v B* [1993] 1 FLR 574.
222 *Gillick v West Norfolk and Wisbech AHA* [1985] 3 All ER 402 at 424.
223 Herring, p. 191.
224 Ibid, p. 192.
variety of ways of understanding the world, a similar consideration might be relevant in the future to consider a child not to be competent.

4.4. Exceptions from the requirement of consent

In England there are similar situations as in Sweden where a doctor can provide treatment even if consent from neither the child nor parents has been obtained. The exceptions from the requirement of consent are when authorities can intervene through a court order and when a doctor is acting under the defence of necessity.

4.4.1. Court orders

When a child is very young or not mature enough to consent to treatment, a parent with responsibility under the CA can consent to treatment on behalf of the child. However, this responsibility and right to consent is not absolute, but exists for the benefit of the child and must therefore be exercised in the child’s best interest. If the right is not exercised in accordance with the best interest of the child, the power to consent might be given a local authority instead. The CA contains provisions for when parents do not co-operate with statutory bodies and the court can for example make an order for treatment that the parents are not consenting to. There are different forms of jurisdictions for the court to intervene under the inherent jurisdiction and under section 8 of the CA. A local authority may also acquire parental responsibility by obtaining a care order. This is possible through initiating care proceedings according to section 31 in the CA. However, parents will in such cases still retain parental responsibility unless the local authority restricts their powers as parents according to section 33 (3) and (4) of the CA.

Through the inherent jurisdiction and its power to make a declaration according to the best interest of the child, the court can exercise a supervisory role over parental decision making and also overrule parental decisions if these are not in the best interest of the child. The inherent jurisdiction of the courts, and especially the power to make a declaration on a best interest basis, will probably be used in emergencies when speed is of essence. An example of this was the case *Camden LBC v R* where a child’s parents refused to allow a blood transfusion for the treatment of B-cell lymphoblastic...

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227 See section 100 CA.
228 Mason and Laurie, p. 355.
229 *Camden LBC v R (a minor) (blood transfusion) [1993] 2 FLR 757.*
leukaemia because of their religious beliefs. The court took the view that when the life of a child was at risk, it was important to act urgently and authorised treatment for the child. However, authorising treatment against the wishes of a child’s parents is reserved for the most serious cases and this will be further explained in chapter 5.

If there is a dispute concerning an issue between people with parental responsibility over the child, the court also has the power to intervene and settle the dispute under the private law provisions of section 8 CA 1989. There are several orders available, including the specific issue order and prohibited steps order, which are relevant when it comes to issues concerning children’s healthcare. These are not a question of child protection and therefore there is no threshold criterion of significant harm that has to be engaged for the court to have jurisdiction. Consequently, as long as there is a dispute regarding an issue of parental responsibility, the court can intervene. The specific issue order can be applied to request the court to give particularly order a certain treatment to resolve a dispute over proposed medical treatment for the child. The procedure makes it possible for the matter to be brought before a High Court judge who can order the specific treatment without delay and without transferring parental responsibility. The prohibited steps order, on the other hand, can be applied to prevent and prohibit a specific procedure to be carried out without the court’s permission. An example was the case J230 where the English mother of a 5-year-old was granted an order preventing the child’s Muslim father from making arrangements to have him circumcised without an order from the court.

4.4.2. The defence of necessity

In emergencies, a doctor might be able to provide treatment based on the defence of necessity instead of consent or a court order. The doctrine of necessity was in England recognised by the House of Lords in the case Re F231 in 1990. It is widely held that in English law that there are times when acting out of necessity legitimates an otherwise wrongful act and acting unlawfully is justified if the resulting good effect materially outweighs the consequences of adhering strictly to the law.232 The doctor’s action is justified and should not have criminal or civil liability imposed upon him if the value he seeks to protect is of greater weight than the wrongful act he performs, treating without

231 Re F (mental patient: sterilisation) [1990] 2 AC 1.
232 Mason and Laurie, p. 351.
consent, and there is no alternative means by which the end can be achieved. As a consequence, a doctor can perform urgent treatment for a child to avoid death or serious harm even without the protection of consent or court order. Although, the treatment cannot be more extensive than is required by the exigencies of the situation.  

Furthermore, a doctor can under no circumstances take advantage of unconsciousness to perform procedures which are not essential for the patient’s immediate survival or well-being. This principle was established in two Canadian cases where the court explored the distinction between procedures that are justified by necessity and those which are merely ‘convenient’. This distinction has also been applied by the British courts, for example per Lord Goff in the case Re F. From these cases emerged a principle that a medical professional is justified by necessity in proceeding without the patient’s consent if a condition is discovered in an unconscious patient and it would be unreasonable to postpone the operation. Postponement of treatment is, however, to be preferred if it is possible to wait until the patient is in a position to give consent. But can emergency treatment also be given to a conscious patient? According to the Code of Practice of the MHA, courts have stated that doubt should be resolved in favour of the preservation of life in life-threatening emergencies and therefore it can be acceptable to undertake treatment to preserve life or prevent irreversible serious deterioration of the patient’s condition. Furthermore, this should also apply when a child under 18 is competent to consent but refuses to do so. If the child is not competent, emergency treatment can be provided if there is not enough time to seek the parent’s consent. Treatment might also be justified where the parents are refusing treatment and there is no time to seek authorisation from the court. These complex situations are further discussed in the next chapter.

233 Ibid.
234 The first case, Murray v McMurphy [1949] 2 DLR 442, was very similar to the Danish case mentioned previously regarding the Swedish defence of necessity. A plaintiff succeeded in an action for battery against a doctor who sterilized her without consent. During a caesarean section, the doctor discovered that the woman’s uterus would make it hazardous for her to go through another pregnancy and carried out a sterilisation even if there was no pressing need for this procedure to be undertaken. The court took the view that it would not have been unreasonable to postpone the sterilisation until consent had been obtained, in spite of the convenience of doing it on the spot. By contrast, in the other Canadian case Marshall v Curry [1933] 3 DLR 260, where the doctor’s act was held as necessary, a surgeon removed a testicle in the course of an operation for a hernia. According to the doctor, this removal was essential to a successful operation and also the testicle itself was diseased so the patient’s health and life would have been imperilled if the operation would not have been undertaken. This act was held as necessary and it would have been unreasonable to put the procedure off until a later date according to the court.
235 Re F [1990] 2 AC 1 esp. 74-77.
237 Ibid.
5. **Problematic distinctions**

As mentioned before, there are many situations where the decision about children’s consent is exceptionally complicated. Both Swedish and English law have shown that a sufficiently mature child can consent to treatment, but what happens if the child and parents do not want the same treatment? Or if the child is very young and the two parents can consent on behalf of the child, but they cannot come to an agreement about treatment? First in this chapter, these situations, where the child is so young that most of the decision-making is going to be done by the parents, are discussed. This consists of situations where the parents disagree with each other in chapter 5.1 and when parents and doctors disagree in chapter 5.2. Chapter 5.3 evaluates situations regarding older and more mature children, who could possibly be competent to consent but wants to refuse treatment that the doctors or parents think the child should have.

Before assessing the different problematic situations, a short description of the important principle of the child’s best interest is useful. The best interest of the child is a main principle in both Swedish and English law as well as in the CRC. In Sweden, the principle is not expressly stated in the HSL but appears in more general regulation in the FB\textsuperscript{238} as well as the Social Services Act\textsuperscript{239} As already discussed, the principle will also be expressed in section 1:8 in the new PL. In England, section 1(1) of the CA 1989 states that a court, when determining any question with respect to a child’s upbringing, the child’s welfare shall be the paramount consideration. The court has also insisted that all proxies, including parents, must adopt the same approach, to act in the child’s best interest.\textsuperscript{240} This guiding principle - that both parents and doctors must act out of a concern for the child’s welfare - has consequently been repeatedly asserted by both the courts and parliament. The principle of the best interest of the child is therefore clear in both Swedish and English healthcare law.

However, the principle of the child’s best interest does not simply solve all the problematic situations. For example, one problem is that there is no definition of the principle in Swedish law or in the CRC. In Sweden, the government has in preparatory work to the PL stated that the assessment of the child’s best interest is a process with several steps and that healthcare professionals need to take science and proven...
experience (vetenskap och beprövad erfarenhet) in consideration and, depending on the child’s age, also obtain information from the parents.\textsuperscript{241} Information from other professionals with knowledge about the child should also be considered, as well as what the child expresses in accordance with Article 12 CRC. The evaluation about what is in the child’s best interest must therefore be decided in each individual case\textsuperscript{242} but there is no further guidance in the legislation or case law on how. However, there are some statements in legal scholarship and preparatory work on the matter. Rynning has acknowledged that there may be palpable difficulties in determining what may be regarded as the best interest of the child in accordance with CRC in a particular case. Usually many different aspects must be considered in an integrated assessment and such will therefore inevitably become dependent on subjective evaluations.\textsuperscript{243} However, regarding the proposed PL, the proposal to the Council on Legislation has stated that the principle of the best interest for the child cannot be met if the true views of the child are not ascertained. In the assessment of the best interest a rather large weight should therefore be given to the child’s wishes and parents’ potential influence. Furthermore, the proposal states that the child’s life and health must be protected in accordance with the principle but that the child’s integrity, right to express an opinion and the right to influence treatment also must be considered in each individual situation.\textsuperscript{244}

In English law, section 1 (3) a-g in the CA provides examples that a court shall have regard to when judging on some orders concerning children\textsuperscript{245}. According to 1 (3)(a) CA a court shall have regard in particular to the ascertainable wishes and feelings of the child concerned, considered in light of his age and understanding. Furthermore, according to (b) and (c), the child’s physical, emotional and educational needs, along with the likely effect on the child of any change in his circumstances, are important. The age, sex, background and any other relevant characteristics are mentioned in (d) as well as any harm the child’s has suffered or is at risk of suffering in (e). According to (f), also how capable each parent is of meeting the child’s needs matters. At last, 1 (3) (g) states that the range of powers available to the court under the CA in the proceedings in has to be considered. To conclude, English law has set out factors that shall be considered in particular when deciding what is in the best interest of the child. However,

\textsuperscript{241} Prop 2013/14:106, pp. 62-63.
\textsuperscript{242} Ibid, p. 63.
\textsuperscript{243} Rynning, p. 296.
\textsuperscript{244} The proposal for the Patient Act to the Council on Legislation, p. 60.
\textsuperscript{245} See 1 (4) CA.
nothing is stated about which factors are most important. Consequently, the best interest of the child is clearly recognized in both Swedish and English law but the difficulties lies in the question what actually is in the child’s best interest, and how this ‘best interest test’ should be carried out.

In England, based on the best interest test, the courts are allowed to override both the views of the child and parents, if these do not accord with the welfare of the child. For example in the case Re C the court had decided a remedy when both parents rejected contemporary medical thinking on the causes and treatment of HIV. The mother would not let her child to be tested for HIV, arguing that such would be a breach of the right to private life in Article 8 ECHR. Relying on section 2 of Article 8, the court concluded that the child’s welfare in this case outweighed the parent’s rights and ordered that a blood sample would be taken for the child because it was in the best interest of the child that her HIV status would be known. The will of parents can in other words be overridden by the court exercising its inherent jurisdiction to act in the child’s best interest.

5.1. Parents disagree

There are situations when consent from one parent is not enough to provide treatment for a child but a united consent from both parent is required. In such situations parents might, for different reasons, disagree about what treatment their child should receive. The rules to solve these issues are different in Sweden and England.

In Sweden, according to chapter 6, section 11 and 13 FB, the general rule is that if a child has two legal guardians, the right and duty to decide about the child’s personal conditions is theirs together. However, if one of the parents cannot participate in the decision making and the question cannot be postponed without inconvenience, the other parent can decide alone according to the second paragraph of 6:13 FB. On the contrary, if the decision is regarding something of considerable importance of the child’s future, it is enough with just one parent consenting if best interest of the child clearly requires it. Accordingly, in very urgent cases, one of the parent’s consent may be enough if the situation involves more radical or fundamental treatment. In England, the starting point is the opposite. According to the CA Section 2 (7), each parent with parental

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246 Re C (a child) (HIV testing) [2000] 2 WLR 270.
247 6:13 FB 2nd sentence of the 2nd paragraph.
responsibility can act alone and consent to treatment without having to consult the other parent. However, courts have decided that both parents must be consulted when it comes to decisions about important issues.\(^{248}\)

The next question is clearly which issues that are important enough to require the consent of both parents. The Swedish law does not give much guidance about this. Exactly what issues that are regarded as important are not clear in England either, although in the case \textit{Re G}\(^{249}\) a decision about change of school for a child was seen by the Court of Appeal as a major or long-term decision which implies a duty to consult the other parent. Furthermore, both circumcision\(^{250}\) and a decision not to give a child the MMR vaccine\(^{251}\) have been included as issues important enough to require consent of both parents according to English case law. Abortion and cosmetic surgery would also, according to Herring\(^{252}\) fall under this category. Nothing is expressed about life-saving or essential treatment, but based on the importance of the decision in such situation it would probably require both parents’ consent, as long as there is no need for emergency treatment. Accordingly, in cases that are considered as sufficiently important, both parents must be consulted in Sweden and England. The next problem is however, what would happen if the parents disagree between each other about what treatment should be given to their child.

In Sweden, there is no legislation or case law certainly on this matter but according to Rynning, the correct interpretation of the law is that a doctor normally should not be able to carry out treatment that is not medically indicated, e.g. circumcision, against one of the parent’s will.\(^{253}\) According medically indicated actions, Rynning states that not even these should be performed if one parent objects, if not the prerequisites for the defence of necessity are fulfilled. In these situations, the problem should in first hand be solved through an intervention supported by the LVU or in more long-term problems, through the transferring of the child’s custody from one parent to the other for better care of the child’s interest.\(^{254}\) The defence of necessity can justify emergency treatment without consent from anyone if the requirements are fulfilled.

\(^{248}\) Herring, p. 195.
\(^{249}\) Re G (parental responsibility: education) [1994] 2 FLR 964 (CA).
\(^{250}\) Re J (a minor) (prohibited steps order: circumcision) [2000] 1 FLR 571, (2000) 52 BMLR 82.
\(^{251}\) Re B (a child) [2003] EWCA Civ 1148.
\(^{252}\) Herring, p. 195.
\(^{253}\) Rynning, p. 292.
\(^{254}\) Ibid.
However, in cases where there is no emergency situation or no significant risk that the child’s health and development is going to be harmed, it might be very difficult to ensure treatment for a child if one parent objects. Accordingly, in Sweden because of the main rule that parents decide together about their children’s personal matters, treatment that could improve a child’s condition can actually be stopped by one refusing parent even if the other one consented and this happened in a JO-case. Afterwards, attention was drawn to the fact that the requirement of the parent’s consensus resulted in that some children might not get the help they need. The discussion included if the current law was compatible with Article 4 in the CRC about duty for states to take all appropriate legislative measures for the implementation of children’s rights. At last, the problem was addressed in the inquiry report SOU 2007:52, which suggested changes in the legislation and since the 1st of May 2012, there is a new section in the FB regarding children’s possibility to receive treatment when one of the parents are refusing. The new section, 6:13a FB, states that the Social Welfare Committee can decide that treatment should be carried out even without one of the parent’s consent in cases where the best interest of the child requires it. However, according to the 1st clause in the section, this procedure is only available if the treatment is concerning psychiatric or psychological evaluation or treatment covered by the HSL. In the preparatory work this is explained as referring only to psychiatric or psychological treatment and somatic care and treatment are not covered by the section. This limitation was justified in the preparatory works by that the legal change is of relatively great importance and should therefore be restricted to areas where there is a clear practical need for it. Somatic care was excluded on the grounds that there were not sufficient signs for a real need for it to be covered by the provision. Consequently, when a child in a severe somatic medical condition requires treatment, the only available solutions besides emergency care are still either to apply LVU or consider transferring the custody of the child to one parent alone.

255 In JO 2003/04 s 311, there was no legal support for giving a 3-year-old girl psychiatric treatment because the father, who was suspected for battery and sexual abuse of the girl, did not consent to the treatment.
257 Prop 2011/12:53 p. 27.
258 Ibid, p. 16.
In England, if the parents disagree and are unable to reach an agreement an application to the court to determine the issue is required under section 8 CA. Under the private law provisions of section 8 CA the court has the power to settle a dispute between two persons with parental responsibility through the specific issues order or a prohibited steps order.260

It is important to understand that these disputes and how they are solved may not only affect the rights of the parents, but are also directly relevant to children. For instance, even a very young child might agree with one of the parents that he or she wants treatment. In England, if the child and one of the parents wants treatment but the other parent refuses, the parent and the child can take the issue to court. In Sweden, there is no legislation or case law on the matter and it seems to be that, to some extent, a refusing parent could prevent treatment that both the child and the other parent want.

5.2. Parents and doctor disagree

There are also complicated situations when it comes to disagreement between parents and doctors. There are mainly two different types of situations involved; when parents are refusing treatment that doctors think the child would benefit from and when parents are requesting treatment that doctors think is not appropriate for the child.

The ECtHR has ruled in a case regarding situations of disagreement between parents and doctors. In the case, Glass v the UK261 from 2004, the court found that there had been a violation of Article 8 ECHR where doctors had overridden a mother’s wishes in their care of a disabled child. The severely physically and mentally disabled child complained that the UK had violated his right to bodily integrity under article 8. On his readmission with respiratory failure, the doctors insisted that he was dying and that morphine should be given to relieve his obvious distress. His mother disagreed and objected in the belief that it would harm his chances of recovery. Despite her objection, morphine was administered and later the child’s condition improved and he returned home. This restriction of article 8 had support in law and was intended to serve the child’s best interest but the question was whether the act could be regarded as necessary in a democratic society. The ECtHR upheld the complaint, as treatment contrary to his mother’s wishes breached his right to physical integrity under article 8, and the hospital

260 These are explained in chapter 4.3.1.
261 ECtHR 9 March 2004, Glass v. the UK, no. 61827/00.
had failed to seek the High Court’s approval for the proposed treatment. Consequently, *Glass* made it clear that, when parents strongly oppose the giving or withholding of treatment by a health professional to a child, there is an obligation on the health authority to seek the advice of the courts. Failing to seek the court’s approval for treatment in these circumstances would be a breach of the child’s right to respect for a private and family life under article 8 in ECHR. An interesting question is how *Glass* should be applied in Sweden and this will be discussed in chapter 6.

5.2.1. **Parents refusing treatment**

There are also situations when parents might refuse treatment for their child even if the doctor tells them it is in the best interest of the child to receive proposed treatment. Such situations are, for example, when parents choose to refuse treatment because of the risks involved, when they simply do not believe proposed treatment will be to any help or when they refuse treatment because of religious reasons. Always when a child is not mature enough to give valid consent to treatment, the parents’ views have to be considered, as long as they are not objecting treatment only because of their own personal reasons. A well-known example where parents might possibly refuse treatment for their child, even against a doctor’s advice, is when it comes to Jehovah Witnesses and blood transfusions. According to Jehovah Witnesses, the bible prohibits ingesting of blood and therefore they do not accept blood transfusions or donations. Such religious view should, when it comes to adults, normally be respected. No adult, in either Sweden or England, should, in accordance with the right to decide about one’s own body, be legally forced to receive a blood transfusion against his or her will. Nevertheless, when children are concerned, the decision is a bit more complex. A difficult situation might be, for example, if a small child has been in an accident and therefore is in need of an urgent blood transfusion in order to survive, but the parents are refusing such on religious grounds.

In Sweden, as discussed in chapter 3, parental authority over a child is not unlimited in the same way as a competent adult’s rights to decide over him- or herself and society has a responsibility to intervene and protect children. Regarding the situation if both parents refuse an opposed treatment, there is nothing stated in the Swedish healthcare legislation or case law. However, according to the National Board of Health and Welfare and legal scholars, there are possibilities to carry out treatment without consent
through the LVU or the defence of necessity. However, it is important to remember that the purpose of parent’s right to decide over their children is to meet the needs of the child and the best interest of the child should always be paramount. The National Board of Health and Welfare has commented on the situation in 2010\textsuperscript{262} and stated that the child’s right to health care should take precedence over parents’ refusal, if there is an obvious risk that the child’s health and development is going to be harmed. Rynning states similarly that less weight should be put on the will of parents if there is a conflict between the interest of a parent to decide over the child and the child’s best interest, for example if the parents refuse treatment.\textsuperscript{263} Also the interventions in LVU indicate that the parent’s interest must be put aside in such situations. In cases where the child is not competent to make its own decision, an action under the LVU might be necessary to transfer the right to decide over the child from the parents to the Social Welfare Committee. For example, if parents refuse necessary treatment for their child, an intervention might be needed.\textsuperscript{264} If the parents exercise their authority in a way that involves a palpable risk that a child’s health or development may be harmed, the responsibility for the child might be transferred from the parents to the Social Welfare Committee According to section 2 LVU. Accordingly, parents who do not consent to important treatment for their child needs might get their authority over the child removed.

The National Board of Health and Welfare also states that the defence of necessity in 24:4 BrB can be applicable in emergency cases.\textsuperscript{265} Rynning is of the same opinion and states that, if none of the interventions through LVU\textsuperscript{266} would be possible to carry out, for example in situations where there is not enough time for such actions, the defence of necessity must be invoked to protect the life and health of the child.\textsuperscript{267} Regarding when the defence of necessity might be applicable, the parent’s authority over their child has to be weighed against the public interest to protect children’s life and health.\textsuperscript{268} This reflects the child’s best interest principle which can allow necessary treatment against the parents will. However, the question is how important the treatment in question has to be to justify that less weight is given to the parents’ views. Does this only apply

\textsuperscript{262} The National Board of Health and Welfare’s Information letter (meddelandeblad) nr. 7/2010 p. 3.
\textsuperscript{263} Rynning, p. 379.
\textsuperscript{264} Ibid.
\textsuperscript{265} The National Board of Health and Welfare’s Information letter (meddelandeblad) nr. 7/2010 p. 3.
\textsuperscript{266} When there is not even time for interim decisions, see kap 3.3.1.
\textsuperscript{267} Rynning, p. 379.
\textsuperscript{268} See discussion about the defence of necessity in chapter 3.3.2.
strictly on urgent emergency treatment or can doctors also justify other operations they think are in the best interest of the child, even if such is against the parents’ wishes? The law regarding this is unclear and will be further discussed in chapter 6. According to Rynning, the defence of necessity should also be applicable to some extent in situations while waiting for a decision however intervention through the LVU should be carried out or not. The motives of both the child and parents always have to be considered but it is important to remember that the child’s own opinion might also been influenced by the parents.

In England, there is a significant amount of case law on this matter. Lord Fraser stated already in 1986 in the case Gillick that ‘the parent’s right to control a child exist not for the benefit of the parents but for the child’. In the case Re B from 1990, parent’s refusal to consent to a life-saving operation for their daughter who suffered from Down’s syndrome was overruled by the Court of Appeal the operation was held to be in the best interest of the child. When it comes to parents refusing treatment for their child on religious grounds, a famous statement of Ward LJ from the case Re E was that ‘parents may be free to become martyrs themselves, but it does not follow that they are free in identical circumstances to make martyrs of their children’. Consequently, it seems that the courts are willing to order that life-saving treatment should be given to a child even if the parents are refusing.

However, the case Re T that concerned an infant suffering from biliary atresia, a life-threatening liver defect, had a somewhat surprising outcome. The child’s parents refused a liver transplant, even if without such operation the child would die, because they thought it would be better that their child had a short and peaceful life than had to be exposed to such invasive surgery with all the risks, pain and suffering involved. In the judgement, the court focused on the effect of forced treatment in the relationship between the child and its parents and decided not to overrule the parent’s refusal. The mother was strongly opposing treatment and the court’s decision represents an argument that it was in the child’s overall best interest not to receive the said treatment. But

269 Rynning, p. 380.
270 Ibid.
271 Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, [1985] 3 All ER 402.
272 Re B (a minor) (wardship: medical treatment) [1990] 3 All ER 927.
273 Re E (a minor) (wardship: medical treatment) [1993] 1 FLR 386.
274 Re T (a minor) (wardship: medical treatment) [1997] 1 WLR 242 CA.
275 Mason and Laurie, p. 359.
should in fact the mother’s view on her child be able to have such a significant impact on the decision if a child will get life-saving treatment or not? According to some legal scholars, the court in *Re T* did not examine all relevant information necessary for a complete assessment of the risks and effect of the medical treatment and therefore the decision does not comply with human rights standards.  

However, it should not be forgotten that these cases were decided before the HRA 1998 came into force. First, parents can complain over the state’s interference with their upbringing of their children and argue that proposed treatment would infringe their rights to respect for private and family life in article 8 ECHR. In a post HRA case, *A&D v B&E 2003*\(^\text{277}\), the High Court accepted that, in general, there is wide scope for parental objection to medical intervention. However, when it comes to life-saving treatment, the parents’ qualified right in Article 8 cannot outweigh the child’s absolute right to life in article 2 ECHR. Article 9 ECHR protects the freedom of religion but neither that can restrict the child’s absolute right to life. But how was the court in *Re T* able to let the parents refuse life-saving treatment for their child, because it was in the child’s best interest? This will be further discussed in chapter 6 when evaluating the principle in particular.

As earlier mentioned, article 8 of the ECHR has in the case *Glass v UK* been given the effect that it is for the court to decide about the child’s treatment in a dispute between parents and the child’s doctor. Emergency treatment under the defence of necessity can however also justify life-saving treatment without consent or court intervention under section 2 of article 8 ECHR, but only if there is no time to refer the case to the court, according to the *Glass v UK* case.\(^\text{278}\) Case law,\(^\text{279}\) as well as the Code of Practice for the MHA\(^\text{280}\), are consistent this outcome, that emergency treatment can be provided if there is not enough time to seek authorisation from the court. Consequently, all disputes over care between parents and doctor should be referred to the courts, in all but the most urgent of circumstances.

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\(^{276}\) Michalowski, see Garwood-Gowers *et al.*, p. 254.

\(^{277}\) A&D v B&E [2003] EWHC 1376 (Fam).

\(^{278}\) Mason and Laurie, p. 354.

\(^{279}\) See, for instance, *Re O (a minor) (medical treatment) [1993] 2 FLR 149*.

\(^{280}\) MHA Code of Practice, p. 340, clause 36.51.
5.2.2. Parents asking for treatment

The other situation parents and doctors might disagree about is when parents requesting treatment for their child that, according to the doctors, would be pointless or not appropriate. This situation is becoming more and more common, for example because modern technology and medical skill now enables babies born in much earlier stages of gestation to survive. These scientific advances give rise to ethical dilemmas that never existed before. For example, if a prematurely born baby is seriously ill and treated with life-sustaining methods, a doctor may be of the opinion that the suffering involved in further treatment would outweigh the possible benefits. The child might have almost no chance to survive but parents might want to keep the child alive no matter what.

There is no legislation or case law on how these situations are handled in Sweden.\(^\text{281}\) However, according to the 1\(^{\text{st}}\) sentence in 6:1 PSL, there is an obligation on healthcare professional to perform their work in accordance with science and proven experience. According to the 2\(^{\text{nd}}\) sentence, a patient should be given expert and diligent care that meets these requirements. Furthermore, the child’s best interest always has to be taken into consideration. If life-saving treatment for a suffering child would not be held as in accordance with science and proven experience, these provisions could possibly imply that a request from parents of such treatment would not be successful.

In English law, there is a presumption that parents are the best judges of their child’s best interest, but parents do not always have the final say on the child’s treatment. If the parents and doctor disagree, it is left to the court to decide according to the case Glass. Also on this question there is a large amount of case law in England. For instance, in the case Re J\(^\text{282}\) from 1992, doctors considered it inappropriate to provide invasive care in the event that a 16-month-old brain damaged girl suffered a life-threatening event. Her mother wanted the treatment to be given if it could prolong the girl’s life so she sought and obtained an order for this. However, the order was immediately stayed and later upheld on appeal. The Court of Appeal approved the doctor’s decision not to ventilate the baby if the need would arise, partly because of the baby’s expected bleak future with severe mental and physical disabilities. The child’s quality of life was consequently a major consideration during the decision making progress and the doctors needed to seek

\(^{281}\) At least not what I have been able to find.

\(^{282}\) Re J (a minor) (wardship:medical treatment) [1990] 3 All ER 930 CA.
advice from the courts to prevent death being prolonged. Also of importance was that the case clearly stated the fact that a doctor cannot be required to undertake treatment against his or her clinical judgement. As a result, while consent is essential to receive treatment, there is no concurrent right to demand treatment.

This approach was also applied in Re C283, which concerned a 16-month-old child suffering from spinal muscular atrophy and it was only a matter of time before a fatal collapse for the child. The parents insisted, on religious grounds, that the child should be ventilated in the event of further collapse but the doctors felt that continued ventilation would only result in suffering for the child. The child was made a ward of the court and the English High Court considered that it would not be appropriate for the child to remain ventilated. The court’s paramount consideration in the case was the best interest of the child which argued that, despite the parents overwhelming desire for their child to live, it was not held to be in the child’s best interests to receive continued ventilation. According to the court, the decision presented an objective assessment of the best interest of the child but it is clear that such assessment always involves value judgements to some extent.

Re Wyatt284 from 2006 is another case about a severely disabled baby, born prematurely at 26 weeks. The baby, Charlotte Wyatt, had chronic respiratory and kidney problems coupled with profound severe brain damage. According to doctors, she experienced pain and distress and was placed in an incubator. When Charlotte was 11 months old, doctors caring for the child asked for court permission so that they should not have to ventilate her the next time she stopped breathing. This was opposed by the child’s parents, who were committed Christians and believed that she, even if she had already stopped breathing three times, should be given every chance to survive. Mr Justice Hedley however ruled, that the child should be allowed to die in the event that she stopped breathing again to end her suffering and pain. Even if the parents disagreed with the doctors on the course of treatment, the doctors should not be obliged to send the child for artificial ventilation or similar aggressive treatment. Furthermore, in the judgement the court acknowledged that the assessment of the best interest in the final analysis is a

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284 Re Wyatt [2006] EWCH 319 (Fam); Re Wyatt (a child) (medical treatment: parent’s consent) [2004] EWHC 2247.
subjective matter. The case remained subject to review and was, depending on the baby’s condition and other circumstances, later reversed but then reversed back again in accordance to the first ruling. Mr Justice Hedley stated that the parent’s views had been canvassed with a considerable degree of care but that the current position was that ventilation would simply not achieve the end for which no doubt the parents would wish and indeed that Charlotte would be unlikely to survive such procedure. To conclude, the case had the same outcome as earlier case law, but the approach showed more sensitivity to the parents and their values than, for example, Re C. The case can also be seen to illustrate that medical treatment which might lengthen a life with a short period of time for a dying person might not necessarily be in the best interest of the patient.

The rights in the ECHR are of significance also in these situations. In the case NHS Trust v D it was argued that the decision to withdraw and withhold life-sustaining treatment from an irreversibly brain damaged girl against the parents’ wishes would be a breach of the right to life in article 2 ECHR and the prohibition of cruel and inhuman treatment in article 3. However, Cazalet J stated that there could be no such breach if the proposed action was in the best interest of the patient. The court ruled, supported by medical opinion, that withdrawal of treatment was in the best interest of the child. Also subsequent case law regarding both minors and incapable adults have shown that such decision should not been held as a breach of HRA. The appropriate test is the best interest for the patient but the question is if the test is acceptable according to the rights in ECHR. This will be further discussed in the next chapter. In the case NHS Trust v D Cazalet J also confirmed that Article 3 encompassed the right to die with dignity. Mason and Laurie stated that the right to die with dignity seems to be becoming equivalent to “without the encumbrance of invasive forms of treatment”.

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285 Mason and Laurie, p. 357.
286 In 2005, when baby Charlotte was aged 22 months, she had made far more improvement that the medical experts predicted. Hedley J reversed his earlier ruling at a review of the baby’s condition. However, in 2006 Mr Justice Hedley gave his fifth judgement in the family division of the High Court and the ruling was reversed again. Charlotte Wyatt was now 2½ years old and the circumstances around the case had changed. The parents of the Charlotte had separated, and there had also been a significant deterioration in the girl’s condition. The court held, in the best interest of Charlotte, the medical profession should be free to refrain from intervention by way of intubation and ventilation. However, the ruling is permissive, not mandatory, and medical authorities must use their best judgement in Charlotte’s best interest at the moment the decision arises.
288 Mason and Laurie, p. 358.
289 Ibid. The case Wyatt and Re Winston-Jones (a child)(medical treatment: parent’s consent)[2004] All ER (D) 313 largely confirm this already well-established precedents outlined above.
290 Ibid, p. 554.
Accordingly, forced medical treatment can possibly also violate the absolute prohibition of degrading treatment under Article 3 ECHR. The question of whether or not treatment must be regarded as inhuman cannot exclusively be regarded as a medical question but also other factors must be assessed, as for example the parents opinions.\textsuperscript{291} Important to remember is also that the ECHR provides the absolute right to life in Article 2 ECHR. According to Garwood-Govers, this right to life can only exceptionally be overridden if complying with the high threshold of Article 3 ECHR.\textsuperscript{292} For this, a careful analysis of all factors of the individual case must be performed in regard to decide if a certain treatment can be held as inhuman or not.

5.3. The child’s right to refuse treatment

Children in both Sweden and England, who are held as competent, seem to be able to consent to treatment even if the parents object. It is when the child refuses to consent to treatment which parents or doctors think is in his or her best interest that the situation becomes complicated, especially when it comes to treatment of potentially life-saving or life sustaining character. When does a teenager possess sufficient maturity to take such a radical decision? This could, for instance, be a young cancer patient who does not want to undergo more chemotherapy, a young Jehovah’s Witness who refuses a blood transfusion on religious grounds or a child that refuses to undergo a very risky surgery. In life-changing decisions there has to be very high demands on the assessment of the patient’s competence, while it is important to remember that young people can make insightful considerations as well, especially in situations of severe disease. The cancer patient might, in accordance with a rational way of thinking, honestly prefer to live just one more year than three but with constant suffering because of chemotherapy.

According to Asp, the respect for the individual’s self-determination precludes that life-saving treatment can be given to a conscious, competent person who expresses that he or she does not want it. However, when it comes to an incompetent refusing patient, for example a child, treatment might be justified against his or her will.\textsuperscript{293} Regarding children’s possibility to refuse healthcare, and certainly life-saving treatment, the law is unclear. There is no law or case law in Sweden regarding this and the preparatory works for the PL does not state anything certainly about the situation either. However, JO has

\textsuperscript{291} Garwood-Gowers \textit{et al.}, pp. 255-256.
\textsuperscript{292} Ibid, p. 254.
\textsuperscript{293} Asp \textit{et al.}, p. 292.
stated that in a life-threatening situation the parents at least have to be informed about their child’s condition.\textsuperscript{294} As already discussed, in the assessment of whether the child is competent or not, the level of maturity required depends on both the urgency and nature of the intervention proposed. It seems to be in Swedish law, that once a child is competent to consent to not to receive treatment, he or she can refuse that certain treatment. The level of maturity that is required for decision-making competence for treatment varies depending on how important the treatment is for the child’s health and the severity of the possible risks. However, according to preparatory work, it requires a ‘considerable degree’ of maturity for a child to be considered to decide alone over more extensive treatments and interventions and there are possibly higher demands for maturity on a minor’s decision to refuse treatment than to simply consent to it.\textsuperscript{295}

The fact that there might be a difference in the level of maturity required for consenting or refusing treatment has been discussed in legal scholarship. The main discussion is if the fact that it seems to be harder to refuse than accept treatment is acceptable or not; if a child is competent to accept treatment should he or she not be able to refuse such as well? In Sweden, Rynning has commented that it might be justified that a higher level of competence and maturity is required for patients in general when it comes to refusing treatment instead of just accepting it. There is a difference between just accepting what the doctor thinks is best than to make a decision to refuse treatment which might have serious negative consequences for one’s health.\textsuperscript{296} It might therefore require greater maturity of a patient to make a decision with possible serious negative consequences for his or her health than a decision to simply submit to the measures recommended by the doctor.\textsuperscript{297} This opinion can be held to be consistent with the statements in preparatory works for PL that the maturity required for treatment must be decided in each individual situation and depends on the nature and urgency of the treatment.\textsuperscript{298} Consequently, it seems to be that competent minors in Sweden are able to refuse treatment, and maybe also life-saving treatment, but the requirements of maturity are very high. However, Rynning also states that when it comes to incompetent patients, the interest of life and health might outweigh the protection of the patient’s autonomy and therefore, when it

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{294} JO 1992/93 p. 439.  
\item\textsuperscript{295} The proposal for the Patient Act to the Council on Legislation, p. 64.  
\item\textsuperscript{296} Rynning, p. 281.  
\item\textsuperscript{297} Ibid, pp. 281, 288.  
\item\textsuperscript{298} Prop. 2013/14:106, p. 66. See also the proposal for the Patient Act to the Council on Legislation, p. 63 and SOU 2013:2, p. 192.  
\end{enumerate}
\end{footnotesize}
comes to children, the rule of necessity can actually be able to justify a lawful medical procedure to be forced upon an objecting child.\textsuperscript{299}

It has also been discussed in Sweden in which age a child possibly can be competent to refuse treatment. Regarding this, there are different opinions from JO, the National Board of Health and Welfare and legal scholars. In JO 1995/96 p. 89, JO agreed with the National Board of Health and Welfare that the age 12 is important when it comes to the child’s influence and ability to refuse healthcare. According to Schiratzki, children over 15 years should have the right to refuse treatment\textsuperscript{300} while Svensson’s interpretation of the law is that children as young as 12 years can be able to refuse treatment, but possibly not life-saving treatment.\textsuperscript{301} Also according to Svensson, to force treatment upon a child is violating both the self-determination and the integrity of the child and therefore there is strong grounds for that the older teenagers should be able to use their veto against also life-saving treatment even if the parents are consenting to it.\textsuperscript{302} Particularly if the treatment is risky, the minor should be able to refuse it. There is no reported case where the child’s wishes have been overridden by parents in such situation in Sweden, but then again, there is no case law on this matter at all. According to Svensson and preparatory work, the question if children in their early teenage years can refuse treatment is depending partly on the nature of the treatment or operation.\textsuperscript{303} There is simply not anymore guidance on this area and issues have to be solved according to the specific situation, as stated in the preparatory work for PL.

One area where there actually is some guidance is on the complex situation when it comes to children that are refusing blood transfusion on religious grounds. Even if it is always the patient’s individual maturity that is definitive, both the Ethical Delegation of the Medical Society (\textit{Läkarsällskapets etiska delegation}) and the National Board of Health and Welfare have stated that a limit on 15 years of age could serve as a benchmark for decision-making competence in these situations. Although, this has been subject to criticism from Rynning who doubts that the age of 15 is a suitable age\textsuperscript{304} because children in that age are probably to a high degree influenced by their parents’

\textsuperscript{299} Rynning, pp. 378-379.
\textsuperscript{300} Schiratzki, p. 187.
\textsuperscript{301} Svensson, p. 146.
\textsuperscript{302} Ibid, p. 143.
\textsuperscript{303} Ibid, p. 146.
\textsuperscript{304} Rynning, p. 289.
religious views. The risk is that the child’s decision would be based more on wishes to live up to its parents expectations than an independent decision according to his or her own belief. Rynning also doubts that many doctors in practice would accept a refusal of blood transfusion from a 15 year old without contacting the Social Welfare Committee or try to justify the treatment against the child’s wishes by virtue of the defence of necessity.\textsuperscript{305}

In England, the \textit{Gillick} case in 1985 seemed to speak for children’s rights and autonomy. However, regarding situations where the child and parents disagree over proposed treatment, two Court of Appeal cases after \textit{Gillick} are particularly relevant. The first case, \textit{Re R}\textsuperscript{306} from 1991, concerned a fifteen year old girl with psychiatric disturbance including suicidal thoughts and physically aggressive behaviour. She was earlier sectionable under the Mental Act 1983 but by the time the case reached the Court of Appeal, doctors considered her to be \textit{Gillick} competent. The court on the other hand disagreed, reasoning that \textit{Gillick} competence requires a notion of stability as a part of the ability to make a rational decision. In the case, Lord Donaldson explained a ‘keyholder approach’ which consists of looking at consent like it is a key that can unlock doors. The child, as well as the parents, might be ‘keyholders’, and therefore the parent’s will can possibly override the child’s veto against treatment. The decision seemed to make it clear that a \textit{Gillick} competent child can consent to treatment but if the child does not wish to do so, consent can be given by someone with parental rights as well.

In the next Court of Appeal case, \textit{Re W}\textsuperscript{307} from 1992, a sixteen-year-old anorectic girl was in care of the local authority unit and refused to be moved to a unit where she would be force fed. Because of her age, according to section 8 in the Family Reform Act she should have been able to give effective consent but the local authority sought to treat her nevertheless, without consent, under section 100 (3) of the CA. According to Lord Donaldson, section 8 FLRA presumed that a 16-18 year-old was competent but that it did not give the minor an absolute right to refuse treatment.\textsuperscript{308} The provision merely puts the child in the same position as an adult patient and the presumption of competence is therefore rebuttable for children as it is for adults, as Lord Donaldson

\begin{itemize}
\item \textsuperscript{305}Ibid.
\item \textsuperscript{306}Re R (a minor) (wardship: medical treatment) [1991] 4 All ER 177.
\item \textsuperscript{307}Re W (a minor) (wardship: medical treatment) [1992] 4 All ER 627.
\item \textsuperscript{308}Kennedy & Grubb, p. 617.
\end{itemize}
also asserted in *Re R* above. The Court of Appeal stated that proper weight must be
given to objections made by minors but if there is a serious and imminent risk of grave
or irreversible mental or physical harm to their welfare a parent or the court can
authorize treatment. In this case the same judge, Lord Donaldson, revised his
‘keyholder’ principle to an analogy of consent acting as a legal ‘flakjacket’309, avoiding
any threat of an action for battery for doctors. According to the court, the teenager’s
ability to make real choices was affected by her experience and condition and therefore
she was not *Gillick* competent.

Consequently, the Court of Appeal took the approach in these cases that doctors only
need either consent from the child or parents as protection to perform treatment. As a
result, a doctor could treat a consenting *Gillick* competent child even if the parents
object and likewise if the parents’ consent but the *Gillick* competent child is refusing.
Important to remember is, however, that a doctor always can provide treatment after a
court authorization despite objections from both parents and child. Both *Re R* and *Re W*
raised much academic protest, mainly because of the fact that a child’s refusal and
rights can simply be overridden by the parent’s consent. The two Court of Appeal cases
seem to significantly curtail children’ and teenager’s right to refuse treatment. What is
the point of the assessment of competence, if the courts simply carry it through to then
go on and declare that irrespective of the outcome, treatment can be justified because of
the parents will if it is in the child’s best interest? Why adopt a functional test of
capacity unless it is going to be used?310 The ‘flakjacket’ approach in *Re W* has also
been criticized for focusing too much on the doctors. According to Mason and Laurie,
both cases focus too much on the concern to protect the medical profession from
litigation and taking insufficient notice of the developing autonomy of minors.311

*Gilmore and Herring*312 have discussed if the concerns that children’s rights easily can
be overridden might be overstated and suggested that *Re R* and *Re W* dealt with minors
seen by the court as competent to consent but lacking capacity to refuse all treatment.
They are arguing that it makes sense because the requirements on the child’s
understanding might be greater when it comes to refusing treatment than accepting, as
discussed above. For example, when consenting to treatment, the patient only needs to

310 *Gilmore and Glennon*, p. 442.
311 Mason and Laurie, p. 372.
312 *Gilmore and Herring*, see Herring, p. 194.
understand the proposed treatment in broad terms while to refuse all treatment all the potential consequences of the refusing needs to be understood and this can be complicated and therefore hard for children. In accordance with the Gillick case, the child needs to understand the medical issues, including both the treatment and the consequences of not having it. Accordingly, some complex procedures might be hard to understand for children and this argument has been used in cases to declare refusing teenagers as not competent. For example, in the case Re E, an almost 16-year-old Jehovah Witness with leukaemia that refused a blood transfusion was seen to be incompetent because he could not understand the painful and slow process of dying he would face if he would not get a transfusion. The court therefore permitted the treatment because his lack of capacity to refuse life-saving treatment and Ward J stated that courts ‘should be very slow to allow an infant to martyr himself’. The boy’s refusal of blood transfusion was overridden by the courts until he turned 18 and was allowed to die. Another case involving minors refusing life-saving treatment that showed a similar argumentation is Re S. The case concerned a 15-year-old patient with a blood disorder that lacked competence to refuse further blood transfusions because she failed to appreciate the true nature of her inevitable death if she refused treatment. Here Johnson J explained that for the teenager’s decision to carry weight she should have a greater understanding of the manner of the death, pain and the distress.

All these cases above were however also decided before the HRA came into force in 2000. In the case R (Axon) v Secretary of Health from the High Court 2006, Silber J expressed a suggestion that once a child becomes Gillick competent the parents should lose any rights under the HRA article 8 to respect for family life and to make decisions for the child. This was according to Silber J justified because ‘as a matter of principle, it is difficult to see why a parent should still retain an Article 8 right to parental authority relating to medical decision where the young person concerned understands the advice provided by the medical professional and its implications’. However, Taylor’s interpretation of the case is that it would be reading too much into it to conclude that courts will not follow Re R and Re W in the future but that it does suggest that courts are becoming more open to arguments based on the rights of children. Mason and Laurie

313 Re E (a minor) (wardship: medical treatment) [1993] FLR 386.
315 R (Axon) v Secretary of State for Health [2006] EWHC 37.
316 Ibid, at 129-130.
317 Taylor, see Herring, p. 194.
also acknowledged the fact that the legal matters might have changed since the introduction of the HRA 1998 and a failure to respect a refusal by a mature minor can possibly now be a breach of a considerable number of fundamental rights. However, they are discussing that the doctrine of proportionality\footnote{318 Requires a balance between community and individual interests.} and the margin of appreciation that countries enjoy under the ECHR also matter.\footnote{Mason and Laurie, p. 372.} When it comes to Article 8 in the ECHR, which deals with the right to respect for private and family life, it could form a basis for challenge to the court’s existing approach to young people and refusal of treatment. The courts have generally interpreted it very widely and it has been seen to cover many different complaints.\footnote{For example physical integrity in Pretty v UK [2001] 2FCR 97, privacy regarding medical information in Campbell v MGN Ltd [2006] EWHC 166.} Therefore, issues regarding children’s consent that have to do with autonomy are easy to place within the protection of the article. However, Article 8 is not an absolute right but can be restricted in accordance with section 2 of Article 8. For example, it can be discussed if the courts have infringed the child’s right in Article 8 ECHR in Re E but the breach can be seen as justified by section 2 as a proportionate act to safeguard the child’s life. The child also has a right to life under Article 2 ECHR and the State has a positive duty to protect this. When it comes to the absolute prohibition of degrading treatment in Article 3 ECHR, the assessment will be difficult in the event that it contradicts with the absolute right to life in article 2. This situation could arise for example if a teenager ill with cancer refuses more chemotherapy, like the situation explained in the introduction to this thesis. There is no easy answer to this question and it is also legally unclear what applies. However, the child’s rights have to be carefully balanced against each other in the individual context. For example when it comes to the prohibition of degrading treatment and force-feeding, the ECtHR has stated that as a general rule, a measure which is of therapeutic necessity cannot be regarded as inhuman or degrading.\footnote{ECtHR 24 September 1992, Herczegfalvy v. Austria, no. 10533/83, §82 an ECtHR 19 June 2007, Ciorap v. Moldova no. 12066/02, § 77. Furthermore, the ECtHR has interpreted ‘therapeutic necessity’ considerably broader than ‘life saving’ according to ECtHR 28 February 2006, Wilkinson v. the UK (dec.) , no. 14659/02.} There are no post-HRA decisions in this field but the Code of Practice for the MHA, which was revisited in 2008, states that the trend in recent cases is to reflect greater autonomy for competent children under 18.\footnote{MHA Code of Practice, p. 338, clause 36.43.} In the Department of Health’s view ‘it may be unwise to rely on consent of a person with parental responsibility’ and treat a
young person who refuses treatment in these circumstances.\textsuperscript{323} According to the Code of Practice for the MHA, if the child does not meet the criteria for detention under the MHA, it may be necessary to seek authorisation from the court.\textsuperscript{324} It is also likely that a decision from a young person that is capable to refuse treatment can be overruled in an emergency where the clinician can act without anyone’s consent. This also applies on children in the age 16-17 that are capable of consenting, but only if the refusal would in all likelihood lead to the child’s death or to severe permanent injury.\textsuperscript{325} In such cases, according to the MHA, the child can be admitted to hospital and treated without consent.\textsuperscript{326}

A post-HRA case, which does not involve a medical situation but points in the direction that competent children should have the same autonomous rights as adults, will be presented. In the case, \textit{Re Roddy}\textsuperscript{327}, regarding a 17-year old teenage mother who wanted to share her story with media, many articles in the ECHR were involved. The girl became pregnant when she was 12, her Catholic school prohibited abortion and she gave birth to the baby. The baby was adopted and the girl was taken into care until she was 17 years old. In the decision, the courts balanced the freedom of expression in article 10 with her article 8 right to share what would otherwise be private, with her ex-boyfriend’s (who was the father of the child) article 8 rights. Even if the girl was under 18, she was declared as \textit{Gillick} competent and was accorded full convention rights, and especially article 8 rights. As already mentioned, the case does not concern medical consent but it suggests that \textit{Gillick} competent teenagers should have complete autonomy, just like adults.

6. Analysis and ethics

There are significant differences on both how different issues regarding children’s consent are solved in Sweden and England and how the judicial review concerning this is organised. When it comes to parents disagreeing with each other, there is a mutual opinion in both Swedish and English law that both parents must be consulted concerning important issues. Regarding the process, the only opportunity to treat a child

\textsuperscript{323} MHA Code of Practice, p. 338, clause 36.43 and p. 336, clause 36.33.
\textsuperscript{324} MHA Code of Practice, p. 336, clause 36.33 and p. 338, clause 36.44
\textsuperscript{325} MHA Code of Practice, p. 336, clause 36.34
\textsuperscript{326} MHA Code of Practice, p. 339, clause 36.44
\textsuperscript{327} Re Roddy (a child) (identification: restrictions on publication) [2003] EWHC 2927 (Fam) [2004] 2FLR 949.
in Sweden is through LVU or through transferring the custody for the child to one of the parents alone. In England the issue can be solved through a court order to settle the dispute. In the event of disagreement between the parents, there is generally no legal opportunity for one of the parent’s opinion to prevail in Sweden, while in England the court can settle the dispute through a specific issues order or prohibited steps order. According to preparatory work in Sweden the current solutions may also be more appropriate for the situation which is questionable. If parents cannot agree with each other on such a fundamental matter as healthcare for their child, there might be a need of transferring the custody to one parent. However, this is probably not the case in all situations. Generally, if the parent’s right to decide is in conflict with the child’s right to care, the child’s interest in relation to the parents should prevail. There is also a desire in general to maintain custody between parents. Owing to this, there should be an easier way to solve the problem in Sweden than through LVU or transferring of custody. The future will show how successful the new section, 6:13a FB, regarding psychiatric care will be. It could also be questioned if the Social Welfare Committee has the knowledge needed for this task. There are no guidelines on how the process should be carried out but the Committee have to make a decision based on the general principles it adheres to. However, this would clearly be a faster process than to go to court and if the provision turns out to be a good solution on the issue, it could, in my opinion, cover somatic treatment as well.

Concerning situations when the problem lies in the fact that parents and doctors cannot agree with each other, there is not much guidance in Swedish law. However, if both parents refuse treatment, there are possibilities to carry such treatment out anyway through LVU. When applying LVU, the responsibility of the child might be transferred from the parents to the Social Welfare Committee instead. If there is not enough time for interventions through LVU, the defence of necessity may be applicable according to the National Board of Health and Welfare and legal scholars. Regarding the assessment, the Board has also stated that the child’s right to healthcare should take precedence over parent’s refusal if there is a risk that the child’s health is going to be harmed. In England there are numerous cases regarding these situations and it seems to be that treatment can be authorised against the wishes of parents, but only in the most serious cases. When it comes to the other situation when parents are requesting treatment the doctors regards

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328 Prop 2011/12:53 p. 16.
as pointless, there is no guidance in the Swedish law or case law and it does not seem as it has been up for discussion in legal scholars either. In an interpretation of the English case law on the area, it seems to be that courts are deciding based on the child’s best interest principle that further treatment, if considered as pointless, should not be given to a seriously ill child.

In England if parents oppose the giving of important treatment to their child, the matter will be referred to the courts in accordance with the discussed case *Glass*. The ECtHR made it clear in the case that health authorities must seek the advice of courts in the event of serious disagreement between parents and doctor in regard to avoid a violation of Article 8 ECHR. The case concerned the UK and is clearly easiest to apply there, however also Sweden must take it into account because the decisions from the court show how the ECHR, which is binding as law in Sweden, should be interpreted. It is however, not easy to apply the *Glass* case on Swedish law because of the lack of legal possibility in Sweden to refer an issue regarding consent for treatment to the court. However, it is clear that not only the doctors should be able to independently decide what treatment that should be carried out and how much weight should be put on the will of the parents. Furthermore, according to *Glass*, even without consent and court intervention life-saving treatment can be justified in emergency situations but only if there is no time to refer the case to court. As discussed earlier, this means that disputes over healthcare between parents and doctor should be referred to court in all but the most urgent of circumstances. Not in any medical contexts, besides emergencies, can a doctor touch a patient without consent or an order from court. Doctors should therefore not be able to force treatment on a child based on the principle of the child’s best interest of the child, if there is time to get the issue examined. When applied on the procedural legal system of healthcare in Sweden, the question should in these situations at least be referred to the Social Welfare to evaluate the case.

It is difficult to come to a conclusion regarding under which circumstances, if any, parental views should be decisive when it comes to children’s healthcare. According to English case law, it seems to be that as soon as the court is involved in the decision

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329 Mason and Laurie, p. 354.
330 See chapter 5.2.
making process, it is not bound by the views of the parents.\footnote{Garwood-Gowers et al., p. 256 which refers to Re T (Wardship:Medical Treatment) [1997] 1 FLR 502, p 509 per Butler-Sloss LJ; Re A (Conjoined Twins:Medical Treatment) [2001] 1 FLR 1, p 51, per Ward LJ.} However, if the parent’s views are overridden by the court, it might violate their rights to family life according to article 8 ECHR. However, such violation will always be justified if the parents’ decision would have endangered the child’s right to life.\footnote{Garwood-Gowers et al., p. 256.} According to Fortin, parents and court sometimes seem to forget that it is the children who are the focus of the dispute and it is their own rights and interests that need to be assessed.\footnote{Fortin, p. 300.} Mason and Laurie argue that the opinion that the respect for parental freedom in the UK more often has been outweighed by a redefinition of the parents’ role when it comes to control over their children.\footnote{Mason and Laurie, p. 355 which refers to for instance Re J (a minor)(prohibited steps order: circumcision) [2000] 1 FLR 571, (2000) 52 BMLR 82 where a ritual circumcision on a 5-year-old boy was considered not to be in the child’s best interest.} Also according to Garwood-Govers, the parent’s wishes will only be of subordinate significance when it comes to the child’s rights under RHA.\footnote{Garwood-Gowers et al., p. 256.}

Finally, considering more mature children and situations when the child’s own opinion has a greater impact, it seems in both Sweden and England that a competent child can consent to treatment even if the parents object. The matter becomes more complicated if the child refuses healthcare, especially if the treatment is essential. In Sweden, there is in practice only legal scholarship as guidance on this matter. Furthermore, the opinions of these scholars differ. Even in this context, despite of the sometimes urgent situations, the only options to solve these situations in Sweden are through contacting the Social Welfare Committee or if emergency treatment can be justified through the defence of necessity. In England, there are numerous cases for guidance, but these are pointing in different directions as well. First Gillick was decided and seen as the beginning of a new era regarding children’s rights, but in subsequent cases Re R and Re W children’s refusal of treatment were simply overridden. Of interest is however, that there is no post HRA case law on the matter and it has been argued that competent children should be able to consent also to refusing life-saving treatment. But yet in England, and also in Sweden, courts have never allowed a minor to refuse life-saving treatment. In Re: Roddy however, the court was evaluating the risks for a teenage girl to tell her story to media, but decided that she was capable to take the choice herself. This suggests that competent children also should have complete autonomous rights and, if applied in medical law, it
would result in a possibility for children to refuse treatment. The case clearly indicates a desire to abolish the court’s paternal control over these competent children. Consequently, if a Gillick competent child who refuses life-saving treatment should legally be accorded full article 8 rights and respect to autonomy, it would not be possible to argue that the breach of article 8 ECHR is justified by necessity to safeguard life of if section 2 in Article 8 ECHR. As a result, a Gillick competent child should be able to consent or refuse medical treatment, just as a competent adult would. However, it is for the future to show if this approach will be applied on medical consent. Furthermore, there is still the dilemma that no child has ever even been deemed as Gillick competent when it comes to refusal of life-saving treatment.

Accordingly, as long as children do not even have a chance to be considered as Gillick competent to refuse life-saving treatment, they are not going to be assigned full autonomous rights either. In legal scholarship it has been argued that the test for capacity when the child wishes to refuse treatment is set so high that basically no child can be held as sufficiently competent. Because of the strong ethical influences on this matter, it is especially difficult to draw any conclusions. Decisions regarding death must require an extensive understanding of the situation and therefore, a very high level of maturity is needed. Most minors will probably not possess this maturity, but surely there are some that would. The question is whether the existing case law is representing and unfair level of maturity and understanding that the courts require in order to see a minor as competent to refuse treatment. Most importantly, if there is not even a possibility for children to be seen as competent in practice, this could possibly deprive children’s fundamental human rights.

Another problem in Sweden is the uncertainty on forced treatment. Consequently, it seems to be that in some situations in general healthcare, treatment can be forced upon a child. However, there are no explicit provisions about how this coercive treatment in practice should be carried out. LVU states that minors can be taken into care without consent, but nothing about how actual treatment can be given. Some situations might not be that problematic in this aspect, for example if child is unconscious after an accident and the doctors need to perform surgery quickly in order to save his or her life. But what about if the child is a conscious and says he will rather die than receive

336 Jackson, p. 266.
proposed treatment and screams and kicks and does everything to prevent it? What are the doctors, in legal terms, allowed to do here? How far can a doctor go in forcing treatment upon a refusing child and how far is too far? There is simply not any answer on this question in the current law.

6.1. Autonomy vs paternalism

Autonomy is the doctrine of self-determination which constitutes the grounds for consent. Autonomy, when it comes to health care, requires respect for the patient’s wishes and also means that we cannot force treatment upon someone who does not want it even if it would actually improve the patient’s health. This is supported in both Swedish and English law and consequently, the respect for an adult’s autonomous decision should not be interfered with, even if it would lead to the death of a patient. In contrast to autonomy, there is paternalism which has derived from Latin for father, ‘pater’. Paternalism means that society, or a person, is deciding on behalf of someone else in the way a father does for his children, to satisfy their needs and decide over their life situation. Historically, medical practice was paternalistic and medical professionals simply acted in the way they perceived was in the patient’s best interest. In doing so, the doctor may have overruled and ignored the patient’s autonomous decision, but at that time such act was seen as justified because of the doctor’s knowledge, experience and skill. A modern example of paternalism in medical law is when a doctor treats a patient contrary to his wishes because of the patient’s best interest. In the already mentioned case Chester v Afshar, which concerned the doctrine of informed consent, Lord Steyn however stated that ‘in modern law paternalism no longer rules’. And yet, English case law and especially the controversial cases Re R and Re W have shown a tendency towards judicial paternalism. However, newer cases like Re: Roddy represents a less paternalistic view that gives more weight to children’s autonomy.

Associated with paternalism is the principle of the best interest of the child, which is involved in most questions about children’s consent. The principle is a main principle in Swedish, English and international law and expressly stated in Article 3 in the CRC, section 6:2a in the Swedish FB and section 1 in the English CA. Also the proposed Patient Act includes a section regarding the best interest of children. As seen in both

337 Rynning, p. 76.
338 Chester v Afshar [2004] UKHL 41
Swedish and English law, the principle of the best interest is paramount when it comes to decisions about children’s treatment. A concerning fact when it comes to the principle of the best interest is however that the principle is very vaguely presented in both English and Swedish law. As earlier seen, the English CA provides a couple of examples to consider when assessing the best interest of the child but it provides no order in which these should be taken into account. Swedish legislation does not define the principle at all regarding healthcare; it is only discussed in legal scholars and briefly mentioned in preparatory works. For example, the legislative work for PL discusses the fact that the principle should be clarified but then only comes to the conclusion that the principle should be enacted in a provision in PL. According to the government, the principle is based on the respect for the child’s full human dignity and integrity. However, by not defining the principle further, it is not clear how it works in practice and therefore the principle simply constitutes a norm.

There is ongoing and well-known criticism of the best interest principle in England, namely that the principle is too indeterminate, and lacks consistent criteria that need to be considered when applying it, and therefore an outcome may seem arbitrary or may not show transparency as to the reasons on which the outcome is based. For example, it was the application of the best interest test that made it possible to merge the child’s interest with those of the mother in Re T, where the decision not to give a child life-saving treatment was influenced by the risk that the mother would treat the child differently afterwards. Consequently, Fortin has argued that the vagueness of the principle allows the courts to reach a decision without having to “perform a careful analysis of the different rights or interests of the child which may be affected by the outcome of the case”.

According to Fortin, the family judiciary seems to assume that the best interest principle requires them to determine all cases by reference to children’s welfare rather than by reference to their Convention rights. For example, it has been argued that section 2 of Article 8 ECHR sometimes just mentions the child’s welfare principle which then

\[\text{340} \text{ Prop. 2013/14:106, p. 63.} \]
\[\text{341} \text{ Fortin, p. 309.} \]
\[\text{342} \text{ Garwood-Gowers et al., p. 257.} \]
\[\text{343} \text{ Ibid.} \]
\[\text{344} \text{ Fortin, p. 306.} \]
simply overrides article 8. Fortin also points out that there is a big difference between starting from the premise that a parent’s right must not be infringed unless the courts can fulfil the detailed requirements of Article 8(2) ECHR and starting from the premise that the outcome of the dispute must be determined by the child’s best interest and then considering the rights of the parties involved. If the best interest principle can be used to easily override all other factors, it might also have negative effects on the assessment of the child’s own different rights and it has therefore also been questioned if even the principle of the best interest is acceptable according to the ECHR. Accordingly, it has in English law been discussed that the best interest principle itself may not be the best instrument for addressing issues concerning children’s consent. A possible solution for the problem that has been submitted is that the HRA would provide a better framework to resolve cases regarding medical treatment in accordance with the welfare of the child. According to Garwood-Gowers, the HRA would force courts to consider the different rights of the child, limit the rights of parents to the right to be involved in the decision making process, and the right to make decisions on behalf of the child that will not violate the child’s health and other rights. HRA would therefore be a useful vehicle to promote children’s rights according to Garwood-Gowers.

Finally, the possibility to get a court order for or against treatment in England allows one to bring proceedings to court concerning treatment in a certain situation, while in Sweden this decision is simply in the hands of the doctors. Courts might possibly be just as paternalistic as doctors, but even so court involvement acts as a safeguard for children’s rights and represents legal certainty (rättssäkerhet). Even if doctors naturally possesses the medical knowledge required, a court would in general be more appropriate to decide when, for example, it comes to questions where human rights are involved. As already mentioned, the Social Welfare should get involved in situations of disagreement in Sweden. The following question is however, if even this would be enough or if there is a need for possibilities to go to court, similar to in England? There should be a legal possibility to challenge these questions in court in Sweden, first because of the need for legal certainty and also because of the procedural right to go to court, namely the right to a fair trial in Article 6 or the right to effective remedy in Article 13. Article 6 ECHR states that in the determination of civil rights and

345 Ibid, p. 309.
346 Garwood-Gowers et al., p. 257.
obligations, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. The ECtHR has held that Sweden has violated this right in two well-known cases. The first case, *Sporrong and Lönorroth v Sweden*348, regarded the effects of long term expropriation permit and prohibition construction on two estates. The ECtHR stated that the applicants’ right of property without doubt is a ‘civil right’ and that it gave rise to a dispute within the meaning of Article 6 ECHR.349 The case of the applicants could not be heard by a tribunal competent to determine all the aspects of the matter and therefore there had been a violation of section 1 in Article 6 ECHR.350 In the other case, *Mendel v Sweden*351, the applicant took part in a programme organised by the State for long-term unemployed and complained that she had not been able to make an appeal against a decision which had withdrawn her permission to participate in such. The ECtHR held that the applicant did not have a practical, effective right of access to court and therefore there had been a breach of Article 6 ECHR.352 Article 13, the right to an effective remedy, states that everyone whose rights and freedoms set forth in the ECHR are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity. In both cases discussed above, the ECtHR held that it was not necessary to examine the case under Article 13 ECHR because its requirements are less strict than and therefore absorbed by those of Article 6.353 Based on the decisions of the ECtHR in these cases, there is a risk that the procedural legal system and lack of possibilities of judicial review regarding healthcare issues in Sweden is violating the rights under Article 6 or 13 of the ECHR.

7. **Concluding remarks**

The current law in Sweden about children’s consent is to a great extent unclear. There is no law or case law on many areas, but sometimes cases from HSAN or JO or legal scholarship for guidance. The proposed PL, which is extremely likely to come into force the 1st of January 2015, will significantly clarify the law regarding many parts of healthcare in Sweden. For example, it expressly states that consent is needed before treatment is given to a patient, which is a fundamental principle that advantageously can

348 ECtHR 23 July 1969, Sporrong and Lönorroth v Sweden, no. 7151/75, 7152/75.
349 Ibid., § 79, § 83.
350 Ibid., § 87.
351 ECtHR 7 April 2009, Mendel v Sweden, no. 28426/06.
352 Ibid., § 81.
353 ECtHR 23 July 1969, Sporrong and Lönorroth v Sweden, no. 7151/75, 7152/75, § 88 and ECtHR 7 April 2009, Mendel v Sweden, no. 28426/06, § 84.
be expressed in law. Also provisions regarding the best interest of the child and the child’s right to be heard will be enacted, which reflects both Article 3 and 12 in the CRC. Furthermore, a section about emergency care will be included, which is satisfying because the current emergency care based on the BrB is not the most legally natural solution for a healthcare procedure. All these provisions elucidate the current law regarding children’s consent.

As a consequence, the new PL will be helpful in many respects, for example to strengthen knowledge and patient awareness. The proposed act might be able to increase both patients’ and health care professionals’ awareness on these matters, because the act is clear and easy to understand. However, the new act will practically only codify principles that already apply today. Naturally, this is satisfying as neither the HSL nor PSL includes any provisions regarding children’s consent to treatment and therefore the PL would make the law considerably clearer on this area. However, there are still many situations left regarding children’s consent to treatment where Swedish law does not provide any answers, for example all the issues that this comparative analysis between Sweden and England has provided perspective on. These questions, regarding children’s consent to treatment in more complex situations, will still remain unanswered in Sweden and even if the PL comes into force 2015, there are still no rules that specify the legal status of children within healthcare. Situations will even in the future be characterized by considerable uncertainty for healthcare professionals that now and then actually have to make important decisions in situations where parents, doctors and child disagree. Also situations where children refuse life-saving treatment will continue to be an area of significant confusion.

Regarding the assessment of competency, preparatory work for the PL states that it is better not to set out age limits for competence. Instead, the proposed act states that the child’s view on the matter should be taken into account in pace with the child’s increasing maturity. Because of the clear difficulty in stating appropriate age limits that would work in all situations, this individual assessment of competency may be a pleasing solution. However, it sets very high standards on health care professionals, who carefully must be able to evaluate all relevant factors in the individual situation. The critical point of the individual assessment is that it carefully must take all of the child’s opinions, interests and rights in account. If this is not performed appropriately in
practice, the provision may simply result in doctors asking for the children’s opinion, to then simply choose the treatment they think is in the best interest for the child. In other words, paternalistic views could possibly outweigh the child’s will, autonomy and rights. Consequently, the question is how we can ensure that these assessments will be performed appropriately, especially in an area where there is almost no guidance for healthcare professionals to rely on. In my opinion, the process needs a significant clarification and more accurate guidelines for the assessment are needed. The government discusses guidelines in the legislative bill for the PL but it remains to be seen how such will be implemented.

Even if general rules on how doctors can act in these complicated situations are undoubtedly difficult to establish, it might be possible to enact some provisions or limits for guidance. For example, it might be possible to legislate regarding how much force doctors are allowed to use in healthcare. The Swedish law seems to suggest that physical force should be avoided but it is not clear what this means and there is no legal guidance on the area regarding what doctors in general can do to force treatment upon a child. Given that forced treatment is a serious restriction in the child’s integrity and other human rights, a clarification of the law is needed and this may be a matter where it actually could be possible to enact guidelines. These would not have to be specific rules for every possible situation but some outer limits on what can be seen as justified when it comes to forced treatment. I my opinion it could also be legislated that doctors cannot force treatment on a refusing child in situations that doesn’t involve emergencies without involvement of the Social Welfare. Similarly, when it comes to young children, it could possibly also be decided that doctors, who are disagreeing with the child’s parents on what treatment the child should have, need to get the Social Welfare involved before he or she can touch the child. In accordance with the *Glass* decision from the ECtHR, treatment should never be forced upon a child, unless it is an emergency situation which involves an imminent risk for the child’s life or health.

Of concern regarding children and healthcare is also the principle of the best interest, which has a large impact on the decision-making regarding what treatment a child will receive. The principle, which only soon will be codified in Swedish healthcare legislation, has already been subject to vast criticism in England. Such criticism is clearly not directly applicable in Swedish law but reflects the difficulties that can occur
in the application of the principle here as well. The principle is very vaguely explained but stated in Article 3 CRC, hence it should be adhered to in both Sweden and England. The criticism is mainly based on the fact that the principle is too indeterminate in England, where it in fact is more specified than in Sweden. It has been discussed, if it is acceptable that this vague principle sometimes seems to be able to override all other considerations when evaluating children’s consent. The principle must not only be clarified by being explicitly stated in the PL, it also needs a comprehensive explanation of what it actually means. As the law is now, the principle of the best interest of the child could possibly also in Sweden in paternalistic forms overrule all other important considerations on the matter. As a consequence, it seems to be that the principle, which has derived from the will to achieve whatever is best for the child, instead might violate not only the child’s own values, but also fundamental human rights. In England it has been discussed to abandon the best interest principle for an assessment of competence based on the ECHR rights in the HRA instead. According to this discussion, a rights-based approach would more effectively protect the child’s different interests and rights involved. The suitability of the principle for the assessment in healthcare questions regarding children should be discussed in Sweden as well. The current law gives the impression that forced treatment, which is a highly unclear intervention, can be justified by the equally vague principle of best interest, and this clearly gives rise to questions regarding the legal certainty on the matter.

Preparatory works for the PL also argues against a rights-based healthcare legislation and the rights in the act are not intended to be actionable in court. However, the provisions in the act are deeply connected to both constitutional civil rights and fundamental human rights that children are guaranteed by the ECHR. It is important to be aware of that the actual value of legal rights depends widely on the possibilities of enforcing the rights and to respond to any violations of such. The preparatory works for PL seems to focus more on the questions regarding legal organization and economic factors than the fact that fundamental human rights might be at stake. Regarding the rights to a fair trial and effective remedy in Articles 6 and 13 ECHR, it is questionable if the protection of children’s human rights regarding consent to treatment and the possibilities to challenge such decisions in Sweden live up to the requirements on this matter. Furthermore, because specific rules regarding the assessment of children’s consent is highly difficult to enact in law, case law would also be a good alternative to
develop and specify the legal guidance in the field. However, if the patient’s rights are not actionable in court, and the judicial review therefore rather limited, there will never be any case law.

There is no easy conclusion or definite answer on how children’s consent to treatment should be legally regulated. To some extent, it is a question of ethics and different values which naturally varies between individuals and nations. The law in England possibly seems to give less weight to paternalism for the respect of children’s rights and autonomy. What is happening on this area in Sweden is, because of the lack of sources, highly unclear. However, there seems to be a desire for values as autonomy and integrity in Sweden in general, but this does not show in healthcare legislation regarding children. To conclude, the central question is how the Swedish healthcare system legally in practice can ensure what is promised about good healthcare, autonomy and the protection of children’s rights. With this thesis, I am not saying the English legal system does this better, but at least the problematic areas are acknowledged. It is easy to see that something still needs to be done on this legal area in Sweden and the Patient Act could be a step in the right direction. However, when it comes to children’s health care and especially consent, some work remains.
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