

INFORMED CONSENT OF MINORS WITH A SPECIAL FOCUS ON THE CZECH LEGAL REGULATION

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Abstract: This article is focused on the examination of the law concerning medical treatment of minors, that is, persons under the age of 18. The first part of this article brings a short overview of the international documents regulating the rights of the child and specifically children's rights within the area of health care provision. This article analyzes the issue of the maturity and competence of children and discusses whether persons under the age of 18 may be regarded as being capable of consenting to medical treatment. Furthermore this article brings a short comparative overview of the laws concerning medical treatment of minors in different countries and tries to extract the common features of the regulations in the different countries. Finally, the last and longest part of this article analyzes the issue of the capacity of minors to consent to medical treatment in the territory of the Czech Republic from the historical perspective and brings a structured overview of this issue under the current Czech laws.

Keywords: informed consent, medical treatment, minors, capacity

INTRODUCTION

Last year marked 30 years since the United Nations General Assembly adopted the Convention on the Rights of the Child¹ (hereinafter only the “Convention”). Over time, it has been ratified by all countries of the world (except the US) and has become the most widespread treaty declaring human rights throughout history.² Of course, this Convention has helped to improve the position of children and guarantee their rights in a whole range of areas. Given the focus of this article, the key role of the Convention in the field of health-care provision cannot be overlooked. Here, it is necessary to mention not only the right of the child to achieve the highest attainable standard of health and the use of treatment and rehabilitation facilities under Article 24 of the Convention³ but also anchoring the child's participation rights in Article 12, according to which states that a child who is able to formulate his/her own views has the right to express these views freely in all matters that concern him/her, paying due attention to the child's views age and level.⁴ Consequently, the Convention is very important in the area of health care provision, since it confers significant participation rights in the decision-making process and emphasizes the possibil-

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¹ The Convention was adopted on 20 November, 1989. See 30th Anniversary of the UN Convention on the Rights of the Child. In: *Child Rights Connect* [online]. 2019 [2021-01-31]. Available at: <<https://www.childrightsconnect.org/30th-anniversary-of-the-un-convention-on-the-rights-of-the-child/>>.

² Convention on the Rights of the Child. In: *UNICEF* [online]. [2021-01-31]. Available at: <<https://www.unicef.org/child-rights-convention>>.

³ HODGKIN, R., NEWELL, P. *Implementation Handbook for the Convention on the Rights of the Child*. UNICEF, 2007, pp. 343 and seqq.

⁴ Respect for the views of the child. In: R. Hodgkin – P. Newell. *Implementation Handbook for the Convention on the Rights of the Child*. UNICEF, 2007, pp. 149 and seqq.

ity for the child to make independent decisions. The Convention is a kind of imaginary accomplishment of international efforts to create conditions for greater involvement of children in decision-making regarding their own affairs.

In general, four levels of participation in the decision-making processes are distinguished: to be informed; to express an informed view; to have that view taken into account when decisions are made; to be the chief decision-maker about proposed interventions.⁵ The Convention then provides for the first three significant participation rights but leaves the right to make autonomous decisions to the national legislation of the Member States.

It is clear that the Convention has taken a significant step towards protecting children's rights in the provision of health care and increasing their role in decision-making. The last step to make children independent actors (if this is possible) within decision-making processes, is up to individual states. And this is where ambiguities and differences often occur.

It can, therefore, be concluded that, despite these relatively clear rules of the Convention, in many countries, national legislation is no longer unequivocal and often in practice giving informed consent by a minor (or determining the degree of exercise of his/her participation rights) is problematic. This situation does not only apply to the Czech Republic but in the past, most developed countries were forced to address this issue and adopt appropriate solutions.⁶ In the Czech Republic, however, there has never been a major debate on the issue of informed consent by minors and the successful resolution of the issue is currently being complicated by the relatively unclear relationship between some provisions of the Health Services Act and the Civil Code.

1. MEDICAL TREATMENT OF MINORS⁷ – FRAMING THE PROBLEM⁸

A. General remarks

The time has already passed when the minor was fully dependent on their parents in legal proceedings until they reached the age of majority.⁹ Over time, not only has the age of majority been gradually reduced,¹⁰ but even minors themselves were granted an

⁵ ALDERSON, P. Competent children? Minors' consent to health care treatment and research. *Social Science and Medicine*. 2007, Vol. 65, No.11, pp. 2272–2283.

⁶ Many other states dealt with this issue by means of special acts, see the part 2 of this article. From comparative perspective. STULTIËNS, L., GOFFIN, T., BORRY, P., DIERICKX, K., NYS, H. Minors and Informed Consent: A Comparative Approach. *European Journal of Health Law*. 2007, Vol. 14, No. 1, pp. 21–46.

⁷ The Civil Code follows from the fact that a minor is a person, who has not reached the age of 18 years – see Section 30 (1) of the Civil Code, which connects acquisition of legal capacity with reaching the age of 18 years.

⁸ This article does not analyze the capacity of a minor to conclude a contract on medical care, but deals exclusively with the issue of granting consent to medical treatment (medical intervention).

⁹ Formerly in Roman law even further – see *patria potestas*. On *patria potestas* in Roman law, e.g. KINCL, J., URFUS, V., SKŘEJPEK, M., *Římské právo [Roman Law]*, 2. edition. Prague: C. H. Beck, 1995, pp. 408.

¹⁰ There was an influential initiative from the Council of Europe. In 1970 the Council of Europe's Committee on Legal Co-operation established a committee to consider the question of full legal capacity in relationship with the age of children. Following the analysis of the committee, the Committee of Ministers accepted the Resolution on lowering of the age of full legal capacity (72) 29, which recommended the lowering of the age of majority. For further example SCHLAM, L., WOOD, J. P. Informed Consent to the Medical Treatment of Minors: Law and Practice, Health Matrix. *The Journal of Law-Medicine*. 2000, Vol. 10, No. 2, pp. 141–174; ŠÍNOVÁ, R. In: F. Melzer – P. Těgl a kol. *Občanský zákoník – velký komentář. Svazek I. §1-117. [Civil Code – Great commentary. Volume I - § 1-117 General Provisions]*. Prague: Leges, 2013, pp. 353 and seq.

increasing degree of autonomy in their own decisions. Also, many international documents and recommendations¹¹ pleaded not only for the granting of the so-called participatory rights of minors but also for the granting of an increased possibility of independent decision-making of minors (depending on the maturity of an individual).

This trend of increased respect for autonomous decision-making is salient for the medical treatment of minors, but, given the difficulty in making decisions regarding interventions to their personal integrity in medical treatment, it constitutes a very difficult subject-matter to deal with. Even the capacity to make autonomous decisions to health care treatment by adults is also broadly discussed in the literature¹² and in the case of minors, this ability is even more complicated. The ability is related to the sufficient understanding and maturity of the child.¹³

B. Assessment of the competence of minors

But how can we, in general, assess the competence of the child? There are three basic approaches to assessing the competence of children. The first is based on the status, usually age, the second is based on an assessment of capacity to perform the function of taking the decision in question, and the third relies on considering the wisdom of the outcome of the decision.¹⁴ It's true that legislators often try to simplify the issue of assessing the competence of minors to make decisions by using the status approach – by setting the age limits.¹⁵ However, these boundaries are highly arbitrary, and, on a broader scale, there is no consensus on the age from which a minor should be judged as legally competent (albeit to a limited extent).¹⁶ Given this inconsistency, empirical studies were carried out to help determine the age limit from which minors could be considered competent for particular decisions. A minor's capacity to make independent decisions can be defined using four criteria: 1) *expressing a choice*; 2) *understanding*; 3) *reasoning* and

¹¹ A list of basic documents see further in the text.

¹² FADEN, R., BEAUCHAMP, T. L. *A history and theory of informed consent*. New York: Oxford University Press, 1986, pp. 408; WHITE, B., C. *Competence to consent*. Washington, D.C.: Georgetown University Press, 1994, pp. 224; DOLEŽAL, A. Kritická analýza autonomie v bioetice. [Critical Analysis of Autonomy in Bioethics]. *Filosofický časopis*. 2014, Vol. 62, No. 6, pp. 877 and seq.; DOLEŽAL, A. Princip autonomie nebo navazování důvěry ve vztahu pacienta a lékaře? Přehodnocení některých moderních trendů v bioetických teoriích. [The Principle of Autonomy or Establishing Trust in the Patient-Doctor Relationship? Reassessment of Some Modern Trends in Bioethical Theories.]. In: I. Humeník – Z. Zoláková. *Áké principy vládnou zdravotnictvu?* Bratislava: Eurokódex, 2013, pp. 219–248.

¹³ For example see: the Gillick case and the mature minor rule – case *Gillick v West Norfolk and Wisbech AHA and DHSS* from 1985.

¹⁴ ANDERSON, P., MONTGOMERY, R. J. Health Care Choices: Making Decisions with Children. *Institute for Public Policy Research*. 1996, p. 54; WHITE, B., C. *Competence to consent*. Washington, D.C.: Georgetown University Press, 1994, pp. 82 and seq.

¹⁵ See further in the text.

¹⁶ “the different ages of maturity and consent be reviewed, and kept under continuing review, in order to ensure consistency and coherence, and to ensure that sufficient recognition is given to the dawning maturity of children at appropriate ages”, UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15.

finally also 4) ability to assess the consequences of decisions (*appreciation*).¹⁷ Several studies then focused specifically on the ability of minors to make decisions in the area of medical treatment.¹⁸ In medical treatment, however, the fact that when seeking the threshold for granting a minor's ability to make independent decisions on a particular medical matter, respect for the minor's autonomy must also be balanced by protecting the patient as a vulnerable person.¹⁹ At the same time, it is necessary to realize that in medical treatment the ability of a minor to make decisions is far more situationally conditioned²⁰ than in other juridical acts.²¹ This means that not only the ability to make decisions but also the circumstances, in which the decision is to be made (illness, stress, risks, influence of another person, etc.) are vital for assessing the minor's ability to make relevant decisions.²² Therefore, the ability to make decisions is essential, however not a sufficient condition for classifying a minor as having the legal capacity for an act in question.²³

Most performed studies show that minors acquire the ability to make necessary decisions at a relatively early age. For example, Weithorn and Campbell argue that even 9-year-olds are able to make informed choices and express their medical treatment preferences.²⁴ The ability of 14-year-olds to make treatment decisions is no different from adults.²⁵ Another study also seeks, by assessing the development of cognitive abilities of children, to arrive at a certain age limit, which would indicate the achievement of a substantial degree of cognitive abilities of children for their participation in the decision-making process.²⁶ Some other studies suggest that minors aged 14-15 are fully

¹⁷ GROOTENS-WIEGERS, P. et al. Medical decision-making in children and adolescents: developmental and neuroscientific aspects. *BMC Paediatrics*. 2017, Vol. 17, No. 120, pp. 3 and seq. In the German literature the terms "*Einsichtsfähigkeit*" and "*Urteilsfähigkeit*" are used.

¹⁸ WEITHORN, L. A., CAMPBELL, S. B. The Competency of Children and Adolescents to Make Informed Treatment Decisions. *Child Development*. 1982, Vol. 53; MILLER V. A., DROTAR, D., KODISH, E. Children's competence for assent and consent: a review of empirical findings. *Ethics Behav.* 2004, Vol. 14, No. 255–95; GROOTENS-WIEGERS, P. et al. Medical decision-making in children and adolescents: developmental and neuroscientific aspects. *BMC Paediatrics*. 2017, Vol. 17, No. 120 and other titles.

¹⁹ APPELBAUM, P. S. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007, No. 357, p. 1834.

²⁰ "*The findings indicate that the issue of decision-making should be seen as being a continuum rather than on an 'all or nothing' basis. It should also be viewed as a process that is dependent on the type of decision, child, parents and health professional's opinions, and the situational context.*" CONSULTATION PAPER CHILDREN AND THE LAW: medical treatment (LRC CP 59-2009), The Law Reform Commission Ireland, 2009.

²¹ For the discussion about the legal nature of informed consent OHLY, A. "*Volenti non fit iniuria*": die Einwilligung im Privatrecht. Tübingen: Mohr Siebeck, 2002, p. 207. KOZIOL, H. *Fehlende Einwilligung des Patienten und Haftung in Österreich – Notwendigkeit neuer Lösungen?* C.H. Beck, 2019, p. 105.

²² For the complexity see AAP COMMITTEE ON BIOETHICS. *Informed Consent in Decision-Making in Pediatric Practice*. *Pediatrics*. 2016; 138(2):e20161484.

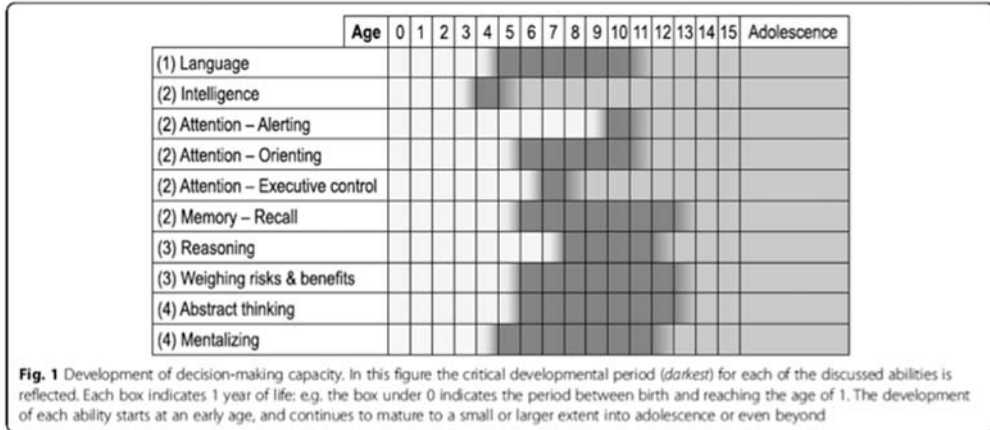
²³ GROOTENS-WIEGERS, P. et al. Medical decision-making in children and adolescents: developmental and neuroscientific aspects. *BMC Paediatrics*. 2017, Vol. 17, No. 120, p. 2.

²⁴ WEITHORN, L. A., CAMPBELL, S. B. *The Competency of Children and Adolescents to Make Informed Treatment Decisions*. p. 1589.

²⁵ *Ibid.*, p. 1589.

²⁶ HEIN, I. M., *Children's competence to consent to medical treatment or research*. Amsterdam: Amsterdam University Press, 2015, pp. 65–101

competent to make decisions in the area of medical treatment.²⁷ According to the study by Grootens-Wiegers et al. this imaginary threshold is 13-14 years when most of the abilities necessary for the actual decision-making process have been already acquired to some extent:



Source: GROOTENS-WIEGERS, P. et al., *Medical decision-making in children and adolescents: developmental and neuroscientific aspects*, *BMC Pediatrics* (2017) 17:120, p. 5.

The above studies suggest that most children are able to make decisions on medical treatment before reaching adulthood in terms of cognitive abilities. In view of this finding, it is in particular up to the law to determine the rules for taking account of participatory rights or for recognizing actual decision-making capacity.

2. CAPACITY OF MINORS TO CONSENT TO MEDICAL TREATMENT – LEGAL REGULATIONS FROM A COMPARATIVE VIEW

A. Regulations on an international level

In the second half of the 20th century, the emphasis on the international involvement of minors in the decision-making process on their own affairs has increased considerably. This trend was particularly evident in the 1972 Council of Europe Resolution (72) 29 on the reduction of the age for legal capacity,²⁸ where it was recommended to reduce the age from 21 to 18 years and to increase the possibility to act independently in regular mat-

²⁷ STEINBERG L. Does recent research on adolescent brain development inform the mature minor doctrine? *J Med Philos.* 2013, Vol. 38, No. 3, pp. 256–67; HEIN, I. M., TROOST, P.W., LINDEBOOM, R. Accuracy of MacArthur Competence Assessment Tool for measuring children's competence to consent to clinical research. *JAMA Pediatr.* 2014, Vol. 12, No. 168, pp. 1147–53.

²⁸ Council of Europe: Resolution on lowering of the age of full legal capacity (72) 29.

ters.²⁹ However, the 1989 Convention on the Rights of the Child and the subsequent recommendations and comments on the Convention should be seen as an essential document on the rights of minors. The Convention strives to achieve a balance between the participation and the protection of the child. Crucial to this matter are Articles 5 and 12 of the Convention, which recognize the parental rights and responsibility on one side and the rights of the children to participate in decisions affecting them on the other.³⁰ This active participation³¹ facilitates to develop and enhance the children's capacities to exercise their rights³² and finally to make their own decisions.³³

The rights of the child are further mentioned in the large body of international human rights laws. For the members of the European Union, the most important is the Charter of Fundamental Rights of the European Union which forms part of EC law under the Lisbon Treaty, and recognizes the rights of children expressly in Article 24. According to this article, the children shall have the right to express their views and have their views considered in accordance with their age and maturity.

In a medical context, the Council of Europe Convention for the Protection of Human Rights and the Dignity of the Human Being in connection with the Application of Biology and Medicine: the Convention on Human Rights and Biomedicine (hereinafter referred to as the "Convention on Human Rights and Biomedicine") from 1997 plays a major role. Respect for the voice of the child can be found in Article 6 of this Convention. Article 6 provides for a representative to give consent where a minor does not have the capacity, and states that the opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.

In accordance with the special needs of children in a health care system, the Committee of Ministers of the Council of Europe adopted the Guidelines on child-friendly health care in 2011, and recently (in 2020) established the Steering Committee for the Rights of the

²⁹ "The more the child himself or herself knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for the child have to transform direction and guidance into reminders and advice and later to an exchange on an equal footing. This transformation will not take place at a fixed point in a child's development, but will steadily increase as the child is encouraged to contribute her or his views.", UN Committee on the Rights of the Child (CRC), *General comment No. 12 (2009): The right of the child to be heard*, 20 July 2009, CRC/C/GC/12.

³⁰ The General Comment on the *Right of the Child to be Heard*, clearly stated that Article 12 must be allocated a place of respect and deference within the medical arena: "The realisation of the provisions of the Convention requires respect for the child's right to express his or her views and to participate in promoting the healthy development and well-being of children. This applies to individual health-care decisions, as well as to children's involvement in the development of health policy and services." UN Committee on the Rights of the Child (CRC), *General comment No. 12 (2009): The right of the child to be heard*, 20 July 2009, CRC/C/GC/12, p.98.

³¹ This approach is based on the theory of dynamic self-determinism.

³² "Dynamic self-determinism does not simply state that decisions are delegated to the child – rather, the theory aims to establish the most propitious environment for the child to develop his or her personality. Unless the child is competent there is no question of the child's opinion being determinative." Children and the Law: Medical Treatment (Consultation Paper), Law Reform Commission, 2009, Section 48.

³³ As Lord Denning stated: "It should declare ... that the legal right of a parent to the custody of a child ends at the eighteenth birthday; and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with a right of control and ends with little more than advice." *Gillick v West Norfolk and Wisbech Health Authority* 1985.

Child (CDENF) as the intergovernmental body responsible for the standard-setting activities in the field of the rights of the child.

The UN Committee on the Rights of the Child (CRC)³⁴ is essential to the monitoring of the implementation of the Convention on the Rights of the Child.

B. Regulations on a national level

At the level of national law, there have also been significant shifts in the area of age limits governing the age of majority and the age of full legal capacity during the 20th century. In most countries this threshold has stabilized overtime to reach eighteen years of age. However, for a number of juridical acts lower age limits are established within individual jurisdictions – either through specific provisions regulating the legal capacity of a particular juridical act or through rules regulating limited legal capacity with regard to the minor's maturity; this also applies to capacity to consent to medical treatment. In principle, three basic approaches to the regulation of capacity to consent to medical treatment can thus be traced in national law:

- 1) regulation by a special law that sets the age limit for the capacity to consent to medical treatment – e.g., New Zealand,³⁵ Great Britain;³⁶ regulation through the general rules of the Civil Code on the assessment of the legal capacity of minors to make juridical acts- e.g. the Czech Republic, Germany, etc.;
- 2) regulation through special rules of the Civil Code for the capacity to consent to medical treatment – e.g. Austria.³⁷

³⁴ E.g. UN Committee on the Rights of the Child (CRC), *General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4 clearly mentioned the respect to the decision-making capacity of the child in Art. III. Section 28: “*Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the “best interest of the child” (Art.3).*”

³⁵ *Care of Children Act 2004*. Section 36: “*A consent, or refusal to consent, to any of the following, if given by a child of or over the age of 16 years, has effect as if the child were of full age:*

(a) any donation of blood by the child:

(b) any medical, surgical, or dental treatment or procedure (including a blood transfusion, which, in this section, has the meaning given to it by section 37(1)) to be carried out on the child for the child's benefit by a person professionally qualified to carry it out.”

³⁶ Section 8 *Family Law Reform Act 1969*:

“(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

(2) In this section “surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.”

³⁷ § 173 ABGB:

“(1) Consent to medical treatment can only be given by the child who is capable of understanding and judgement; in case of doubt, the existence of this capacity for understanding and judgement is presumed in the case of minors of age. If the child lacks the necessary capacity to understand and judge, the consent of the person entrusted with care and education shall be required.

In some cases, the aforementioned approaches are still intertwined and modified – for example, most common law states have an age limit for competence to consent to medical treatment, but at the same time allow for even younger children³⁸ to agree to treatment in special cases. In these cases, the decision-making capacity depends on the ability of the individual child to understand the nature and possible consequences of the treatment.³⁹ Within the common law countries, the very famous Gillick's West Norfolk and Wisbech AHA and DHSS case of 1985⁴⁰ significantly contributed to this concept of minors competence. Lord Fraser stated in the matter: *"no statutory provision which compels me to hold that a girl under the age of 16 lacks the legal capacity to consent to contraceptive advice, examination and treatment provided she has sufficient understanding and intelligence to know what they involve."*, and Lord Scarman added: *"child acquires capacity when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."*⁴¹

According to the aforementioned regulations it is necessary to mention, that in many countries there exists semantic differences between the terms legal capacity⁴² and mental capacity⁴³ and the legal capacity is not the prerequisite for the ability to consent to the medical treatment (the only prerequisite is mental capacity).⁴⁴ Other countries, e.g. Czech Republic, require for valid consent to the medical treatment in a legal capacity. Therefore deeper comparative analysis would be very complicated and in the next part, I will focus predominantly on the regulation in the Czech Republic.

(2) If a minor who is capable of understanding and judgement consents to a treatment which is usually associated with a serious or lasting impairment of physical integrity or personality, the treatment may only be carried out if the person entrusted with care and education also consents.

(3) The consent of the child capable of understanding and judgment and the consent of the person entrusted with care and education shall not be required if the treatment is so urgently necessary that the delay in obtaining consent or approval would endanger the life of the child or would be associated with a risk of serious harm to health."

³⁸ This is an application of the so-called. *"mature minor rule"*, i.e. it is assessed, whether a minor is already intellectually and volitionally mature for granting consent. The expression *"Gillick competent"* is also sometimes used to express this intellectual and volitional maturity in minors, according to the judgment of British courts, *Gillick v West Norfolk and Wisbech AHA and DHSS* from 1985.

³⁹ Good example is Scottish *Age of Legal Capacity Act* from 1991, where Section 2(4) stipulates: *"A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences."*

⁴⁰ When a physician prescribed contraception at her request to a 15-year-old girl. The girl's mother subsequently sued that the doctor had prescribed contraception illegally and required that the daughter be prescribed contraception only with her consent. In this case, the House of Lords decided by a 3: 2 ratio that a 15-year-old girl can independently give her permission to prescribe contraception if she has sufficient intellectual and voluntary maturity regardless of the statutory limit of 16 years.

⁴¹ *Gillick v West Norfolk and Wisbech AHA and DHSS* from 1985.

⁴² For example in some countries means the term *"legal capacity"* the formal ability to hold and to exercise rights and duties, in other countries only the formal ability to hold rights and duties (*"Rechtsfähigkeit"*) and the ability to exercise them is separated (*"Handlungsfähigkeit"*).

⁴³ The decision-making skills and competencies of a person.

⁴⁴ In German speaking countries is used for this different situations the term *"Handlungsfähigkeit"* and *"Einwilligungsfähigkeit"*.

3. ASSESSMENT OF CAPACITY OF MINORS TO CONSENT TO MEDICAL TREATMENT IN THE TERRITORY OF THE CZECH REPUBLIC

3.1 History in the Czech Republic (former Czechoslovakia)

As mentioned above, there are basically three models of determining the eligibility of minors to consent to medical treatment. The Czech Republic⁴⁵ has always been included in a group of states that do not have special legislation in this area, but when determining the legal capacity of minors to consent to medical treatment, it was based on the general civil legal regulation of legal capacity.

During the period of 1918–1950 the regulation of the status of minors was carried out in the General Civil Code⁴⁶ in Section 21, which distinguished three categories of individuals: 1) children, i.e. persons who have not yet completed the seventh year; 2) juveniles who have not yet completed the fourteenth year; 3) minors who have not yet completed their twenty-fourth year of life.⁴⁷ Persons under seven years of age were not legally competent at all. Children and minors could legally act in a very limited manner and the regulation of their status was not uniform and was contained in a myriad of regulations.⁴⁸ There were no special rules for governing the area of provision of healthcare services. Similarly, the Civil Code from 1950⁴⁹ followed the previous General Civil Code and set objectively determined age limits for legal capacity.

From the point of view of further development and understanding of the legal capacity to consent to medical treatment, the Civil Code from 1964,⁵⁰ which coexisted for a long time with Act No. 20/1966 Coll. on the Care of People's Health (hereinafter only "the Act on the Care of People's Health"), was truly substantial. The Act on the Care of People's Health did not contain any special regulation on the capacity of minors to consent to medical treatment, and therefore the provisions of Section 9 of the Civil Code from 1964 were applied. According to this provision, the minors had capacity to consent to such legal acts, the nature of which is appropriate to their intellectual and volitional maturity corresponding to their age.⁵¹ The Civil Code from 1964 left out various age limits, leaving only the age of 18, i.e. the age of majority, and instead emphasized the "*intellectual and moral maturity*⁵² of minors and the nature of the legal act to be undertaken."⁵³ For the area of medical treatment, two criteria were used – first of all, the provisions of § 9 of the Civil Code from

⁴⁵ Including its predecessors – Czechoslovakia, ČSSR and ČSFR.

⁴⁶ General Civil Code (*Allgemeines bürgerliches Gesetzbuch*) of 1811 (hereinafter ABGB).

⁴⁷ Subsequently the age limit was lowered from 24 to 21 years.

⁴⁸ ROUČEK, E., SEDLÁČEK, J. a kol. *Komentář k československému obecnému zákoníku občanskému a občanské právo platné na Slovensku a v Podkarpatské Rusi. Díl první. [Commentary on the Czechoslovak Civil Code Civil and Civil Law applicable in Slovakia and Sub-Carpathian Russia. Volume One]*. Prague: I-VI. Linhart, 1935, p. 211.

⁴⁹ Civil Code, Act No. 141/1950 Coll.

⁵⁰ Civil Code, Act No. 40/1964 Coll., as amended

⁵¹ Civil Code, Act No. 40/1964 Coll., Section 9: "*Minors shall be capable only to such legal acts that are adequate to the maturity of their reason and will with regard to their age.*"

⁵² The former moral maturity was subsequently changed to volitional maturity.

⁵³ See the explanatory report to Civil Code from 1964.

1964 and also of the nature and consequences of the medical intervention.⁵⁴ An essential aspect of assessing intellectual and volitional maturity was the fact that this ability was assessed objectively with respect to an average level of mental maturity of an individual corresponding to the age of the minor.⁵⁵

Thus, although healthcare providers were allowed, due to relatively flexible legal regulation, to be satisfied only with the consent of the minor in many cases, in practice there was some scepticism regarding the independent consent of the minor. That is why legal doctrine, in particular, has resorted to recommending certain age limits to guide everyday practice⁵⁶. The adoption of the Convention on Human Rights and Biomedicine in 2001 has brought a significant shift in emphasizing the role of an independent minor within the framework of medical treatment. Although Article 6 (2), the second sentence, places primarily an emphasis on the participation rights of minors, there was a significant emphasis placed on autonomous decisions of patients, including minor patients in connection with the adoption of the Convention of Human Rights and Biomedicine.

3.2 Current legislation in the Czech Republic

The current legal regulation of the legal capacity of minors to consent to medical treatment follows on from the previous legal regulation and is based on the general civil regulation of legal capacity. Pursuant to the provisions of Section 35 of the Act No. 372/2011 Coll., on health services (hereinafter only “the Health Services Act”), the law governing legal capacity of natural persons shall apply to the granting of consent to medical treatment to a minor patient and at the same time intended medical treatment can be provided to a minor patient based on their consent, in the event that performance of such an act is appropriate to their intellectual and volitional maturity corresponding to their age. Pursuant to Section 35 (2), the provision of medical treatment on the basis of the minor’s consent shall not prevent the attending healthcare professional from providing the legal representative with information about the health services provided or the health condition of the minor patient.

⁵⁴ ŠUSTEK, P., HOLČAPEK, T. *Informovaný souhlas: teorie a praxe informovaného souhlasu ve zdravotnictví. [Informed consent: theory and practice of informed consent in health care]*. Prague: ASPI, 2007, p. 148.

⁵⁵ ŠUSTEK, P., HOLČAPEK, T. *Informovaný souhlas: teorie a praxe informovaného souhlasu ve zdravotnictví. [Informed consent: theory and practice of informed consent in health care]*; ŠÍNOVÁ, R. In: F. Melzer – P. Těgl a kol. *Občanský zákoník – velký komentář. Svazek I. §1-117. [Civil Code - Great commentary. Volume I - § 1-117 General Provisions]*. Prague: Leges, 2013, p. 357.

⁵⁶ “The starting age limit for independent decision-making of a minor patient is considered to be completed sixteen years of age.” ŠUSTEK, P., HOLČAPEK, T. *Informovaný souhlas: teorie a praxe informovaného souhlasu ve zdravotnictví. [Informed consent: theory and practice of informed consent in health care.]* p. 152 or “The age of 15 years is not set by a legal regulation, however it can be recommended as a certain reasonable limit...” STOLÍNOVÁ, J., MACH J. *Právní odpovědnost v medicíně. [Legal liability in medicine]*. Prague: Galén, 1998, p. 222. Šustek and Holčapek then defined a certain minimum age limit in their recommendation, from which we can consider capacity of a minor to consent independently to a medical intervention: “On the other hand, we recommend to consider an objective limit of fourteen years of age, below which we would not consider intellectual maturity of a child with respect to the nature of intervention and we would always insist on consenting declaration of parents.” ŠUSTEK, P., HOLČAPEK, T. *Informovaný souhlas: teorie a praxe informovaného souhlasu ve zdravotnictví. [Informed consent: theory and practice of informed consent in health care]*. p. 154.

The current regulation of legal capacity of minors is generally implemented in the provisions of Sections 30–36 of the Civil Code. These provisions are further supplemented by general provisions concerning interference with integrity, especially by Section 95 of the Civil Code.⁵⁷ In determining the legal capacity of minors, the most important is the regulation of Section 31 of the Civil Code, according to which any minor who has not acquired full legal capacity is presumed to be capable of making juridical acts which are, as to their nature, appropriate to the intellectual and volitional maturity of the minors of his age. Although the new Civil Code follows on from the Civil Code from 1964 in the sense that there are no age limits from which minors would be competent for certain juridical acts and it is always necessary to assess whether a minor is able to consent, it differs significantly from previous Civil Code. First, the Civil Code – in contrast to the Civil Code from 1964 – combines the regulation of the limited minor's legal capacity (Section 31 Civil Code) and the partial capacity (Section 32 Civil Code).⁵⁸ In addition, however, it brings a different assessment of the criterion of the intellectual and voluntary maturity of the minor. While the original regulation of Section 9 of the Civil Code from 1964 was based on the fact that intellectual and volitional maturity was assessed objectively with respect to the average level of mental maturity of an individual corresponding to the age of the minor,⁵⁹ the current adjustment is based on an individual assessment of the maturity of a particular minor.⁶⁰ Therefore, the current regulation is better suited to the protection of human rights and their autonomy but places greater demands on the actual review of the maturity of a particular minor. The legislator, however, was aware of these practical pitfalls and therefore conceived the provision of Section 31 CC as a rebuttable legal presumption. This presumption will therefore play a role in evidence in civil proceeding since the minor will have to provide counterevidence. For healthcare professionals, this construction of Section 31 Civil Code is crucial as they can continue to work with certain age categories as clues, they only need to pay more attention to the individuality of a particular minor patient.⁶¹ In the case of minors, however, the provision of medical treatment, such as act interfering with the integrity of a person, shall also be subject to the provisions of Section 95 of the Civil Code, which is a special provision regulating the minor's capacity to consent (as a juridical act) to interfere with integrity.

According to current legislation, there are two conditions under which minors themselves can consent to medical treatment:

- 1) the minor is reasonably and volitionally mature and
- 2) an intervention is not resulting in any permanent or serious consequences.

⁵⁷ Section 95 Civil Code: "A minor without full legal capacity may, in usual matters, also give his consent to an intervention on his body himself, if this is adequate to the intellectual and volitional maturity of minors of his age, and if it is an intervention not resulting in any permanent or serious consequences."

⁵⁸ ŠÍNOVÁ, R. In: F. Melzer – P. Tégl a kol. *Občanský zákoník – velký komentář. Svazek I. §1-117. [Civil Code - Great commentary. Volume I - § 1-117 General Provisions]*. p. 356.

⁵⁹ Therefore, this is an objective standard of assessment – a specific child is not considered *in concreto*.

⁶⁰ ŠÍNOVÁ, R. In: F. Melzer – P. Tégl a kol. *Občanský zákoník – velký komentář. Svazek I. §1-117. [Civil Code - Great commentary. Volume I - § 1-117 General Provisions]*. p. 357.

⁶¹ Therefore, if there is agreement that 13-year-olds are generally in a position to give consent to preventive screening or some non-invasive diagnostic intervention, then a particular child will be capable to grant such consent unless there is an apparent individual deviation from the maturity of children of that age.

However, in a lot of cases, we will find that minors will not be able to consent to proposed medical treatment because the nature or the consequences of the intervention are deemed not to be proportionate to their intellectual and volitional maturity, or because a particular minor is not capable of consenting within the framework of individualized assessment. In this case, the consent of the minor's legal representatives is required, but neither can he/she be left outside the decision-making process. The decision-making process must take into account the participatory rights of the minor, i.e. the right to exercise influence over the decision-making activities of legal representatives. In the field of healthcare provision, this right is reflected in Article 6 (1) of the Convention on Human Rights and Biomedicine. On a national level, a similar rule but normatively more straightforward, is also contained in the first and second sentences of Section 35 (1) of the Health Services Act.⁶²

3.2.1 Factors affecting an assessment of the minor's capability to consent to medical treatment

The maturity of the minor and the severity of the intervention shall be considered as the basic criteria affecting an assessment of the minor's capability to consent to medical treatment.⁶³ By combining these two criteria, we get an overview of whether a particular minor is capable of independently consenting to a particular intervention. Although it has been stated above that the minor's legal capacity must be assessed *in concreto*, i.e. as the intellectual and volitional maturity of a particular individual, age also plays an essential role as an auxiliary criterion. In general, it can be stated that the higher the age of a minor, the higher their intellectual and volitional maturity and hence their capacity to consent. Although the law does not explicitly set any age limit from which minors would be capable to consent to medical treatment,⁶⁴ it is possible to find certain age limits in the Civil Code itself, which can serve as certain guidelines.⁶⁵ In practice, it seems appropriate to set an auxiliary threshold of 14 years for assessing the capability of a minor to make independent decisions in case of routine interventions;⁶⁶ the age of 12 years can be then considered as non-exceedable age for consent to medical treatment.⁶⁷

⁶² "In providing medical treatment to a minor patient, his or her opinion on the provision of the intended medical treatment should be ascertained, provided that this is proportionate to the intellectual and volitional maturity of his or her age. This view must be taken into account as a factor whose severity increases in proportion to the age and degree of intellectual and volitional maturity of the minor patient."

⁶³ In the Czech Republic. ŠUSTEK, P., HOLČAPEK, T. *Informovaný souhlas: teorie a praxe informovaného souhlasu ve zdravotnictví*. [Informed consent: theory and practice of informed consent in health care]. p. 149.

⁶⁴ As in many foreign states.

⁶⁵ E.g. the provision of Civil Code, Section 867(2), which states, that a child over the age of twelve is considered to be able to receive the information, to form his own opinion and to communicate it, or the limit of 14 years in Section 100 Civil Code.

⁶⁶ Not only with respect to the provision of Section 100 Civil Code, but also with respect to e.g. the Austrian regulation, which according to Section 146c ABGB presumes intellectual and volitional maturity (ability to understand and make judgments) in children since 14 years of age. Similarly, the Quebec legal regulation. However this limit also relates to really routine interventions – in more complex cases, it is possible to consider a higher age limit (e.g. 16 years of age).

⁶⁷ This will most likely concern exceptional cases.

The second essential criterion is the severity of the intervention⁶⁸ – even here a certain auxiliary rule can be set: the more serious intervention, the higher the intellectual and volitional maturity of the minor and vice versa. A 12-year-old can agree to a completely normal, non-serious intervention in exceptional cases. However, with respect to the provisions of Section 95 of the CC, there is also an objective restriction in relation to the gravity of the intervention, i.e. no minor can independently consent to the intervention leaving permanent or serious consequences.

4. COLLISIONS OF OPINION BETWEEN MINORS AND THEIR LEGAL REPRESENTATIVES

From a practical point of view, it is critical to deal with cases of the so-called collisions, i.e. differences of opinion between the minor and his/her legal representatives. The Civil Code from 1964 did not contain any special provisions on the resolution of such collisions in case of interference with the integrity of a minor. According to the original regulation of the Civil Code from 1964,⁶⁹ the court was to determine the so-called guardian ad litem, which was to represent the best interests of the child. Often, however, the appointed guardian ad litem did not sufficiently protect the interests of the persons concerned.⁷⁰

The existing Civil Code already contains special provisions for the cases of collision in Section 100 of the Civil Code.⁷¹ In comparison with the former regulation, the current Civil Code requires in the cases of collision the intervention of the court in the decision-making process and assumes that higher court intervention will ensure a genuine resolution of the conflict and will take into account rational arguments of the person concerned or, their legal representative and it will contribute to the better protection of the integrity of the minor. Section 100 of the Civil Code is a major safeguard in cases of interference with the minor's integrity.

In which cases will this provision apply? The provisions of Section 100 of the Civil Code cannot be interpreted in isolation from other provisions regulating the concept of the limited legal capacity of minors. In assessing the capacity of minors to consent to medical treatment, it must be assumed that two situations may arise: (1) either the minor is capa-

⁶⁸ WHITE, B. C. *Competence to consent*. Washington, D.C.: Georgetown University Press, 1994, p. 66 – discussion about consequence-dependent and consequence-independent competence. FADEN, R., BEAUCHAMP, T., L. *A history and theory of informed consent*. p. 292. Drane, J. The Many Faces of Competency. *The Hastings Center Report*. 1985, Vol. 15, No. 2, pp. 17–21. Who takes about “sliding scale concept”.

⁶⁹ See provision of Section 30 Civil Code from 1964.

⁷⁰ DOLEŽAL, T. In: F. Melzer – P. Tégel a kol. *Občanský zákoník – velký komentář. Svazek I. §1-117. [Civil Code - Great commentary. Volume I - § 1-117 General Provisions]*. p. 598.

⁷¹ § 100 Civil Code:

“(1) In the event of interfering with the integrity of a minor who has reached at least the age of fourteen years and has not acquired full legal capacity, and who seriously objects to the intervention, although his legal representative consents to it, the intervention may not be performed without court approval. This also applies where an intervention is carried out on an adult person without full legal capacity.

(2) If the legal representative does not consent to an interference with the integrity of a person under Subsection (1), although the person so wishes, the intervention may be performed on the application of the person concerned or his close person only with court approval.”

ble to consent independently, or 2) the minor is not capable to consent independently and the consent is given by the legal representative taking into account the minor's opinion. These general rules governing the capacity of minors to consent to medical treatment also define the limits of application of Section 100 of the Civil Code in specific cases. In the case of a minor who is capable to consent to medical treatment (regardless of whether they reached the age of 14 years or not), there is no space for the application of Section 100 of the Civil Code, even in the case of a conflict of opinion between them and their legal representatives, as the minor is able to consent to proposed medical treatment independently. Thus, the application of Section 100 of the Civil Code is only applicable in situations where a minor, who has reached the age of 14, is unable to consent independently.⁷² Through this rule, the legislator emphasized the protection of these persons by acknowledging the high level of participation and even by formalizing the obligation to resolve any conflict between the minor and the legal representative while accepting the fact that their decisional capacity increases with their age. For this reason the legislator set the decisive limit of 14 years,⁷³ as it is accepted that minors from this age are able to make qualified decisions.

The provisions of Section 100 of the Civil Code shall not apply also in the case of a conflict between the opinion of minors under 14 years and their legal representatives, because such persons are not presumed to have such high decision-making (although participatory) ability. The decision-making in situations when a minor is not able to consent independently, is left entirely to legal representatives – parents in the exercise of parental responsibility.

CONCLUSION

The issue of assessment of minor's capacity to consent to medical treatment is relatively little analyzed in the Czech legal literature, despite the fact that this is an area with a significant practical impact. As this short comparison has shown, there are different approaches to addressing this issue abroad, and there is no reason to believe that the approach chosen by our legislature would be wrong. Further it is worth mentioning that this issue underwent some developments and older legal doctrinal views are already overcome.⁷⁴ From a wider, comparative view it is paramount that minors' legal capacity must be assessed *in concreto* and this approach emphasizes the role of an independent minor within the framework of the decision-making process in the area of medical treatment. In assessing minors' capacity to consent to medical treatment, two conditions for independent decision-making can be inferred from the existing legislation:

⁷² This interpretation will also prevent absurd situations, when it depends on whether the minor over the age of 14 comes to the doctor's office with a parent, or without a parent.

⁷³ This limit seems to be relevant also from the comparative perspective - see above.

⁷⁴ STULTIËNS, L., GOFFIN, T., BORRY, P., DIERICKX, K., NYS, H. Minors and Informed Consent: A Comparative Approach. *European Journal of Health Law*. 2007, Vol. 14, No. 1, p. 24.

- 1) intellectual and volitional maturity (Section 31 of the Civil Code)
- 2) an intervention is not resulting in any permanent or serious consequences (Section 95 Civil Code).

In other cases, when the minor doesn't have the capacity to consent independently, the consent is given by a legal representative, taking into account the opinion of a minor. In the event of a conflict of interest between the minor, who has reached at least the age of fourteen years and is not competent to consent independently, and his/her representative, any intervention may not be performed without court approval.