The Right To Say No:

Jehovah's Witness Adolescents between a Bio-Ethical Dilemma and a Legal Conundrum

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Marta Zito
Italy

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Members of the examining committee:

Prof. Karin Arts (Supervisor)
SL Rachel Kurian (Reader)

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Inquiries:

Postal address:

Institute of Social Studies
P.O. Box 29776
2502 LT The Hague
The Netherlands

Location:

Kortenaerkade 12
2518 AX The Hague
The Netherlands

Telephone: +31 70 426 0460
Fax: +31 70 426 0799

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List of Acronyms

ALC(S)A	Age of Legal Capacity (Scotland) Act
AJWRB	Association of Jehovah's Witnesses for Reform on Blood
AAGBI	Association of Anaesthetists of Great Britain and Ireland
BMA	British Medical Association
CESP	Confederation of European Specialists in Paediatrics
C(S)A	Children (Scotland) Act
DOH	Department of Health
ECHR	European Convention of Human Rights
FLRA	Family Law Reform Act
GB	Governing Body
HRA	Human Right Act
JW	Jehovah's Witness
MCA	Mental Capacity Act
NHS	National Health Service
UK	United Kingdom
WTS	The WatchTower Society
UNCRC	The United Nations Convention of the Rights of the Child
USA	United States of America

Abstract

Imagine a scenario where a adolescent (14-17) is sick and his condition strongly require a certain medical operation, however the procedure goes against the patient's will. What of the views should prevail?

In law, if not ethically, competence to make autonomous decision about one's own body has been considered as a function of age. If this adolescent were a competent adult, his wishes would be crucial on procedural grounds: a competent adult has the right to accept/refuse all treatments, including life-saving treatments. However, because this adolescent is a minor, determining who is the appropriate decision-maker is a more complex matter. In fact, while the difference between a 5 months old baby and a 16 years old boy is self-evident, the same cannot be said when confronting someone of 18 years-and-a-day with someone of 17 years-and-364 days.

In the healthcare context adolescent's decision-making competence has been a subject of study both from a theoretical and a legal practical point of view. This paper frames adolescents as rights holders in between a right to protection and a right to self-determination. Although a full consensus is missing, there is a legal and bio-ethical perspective that considers adolescents as individuals with potential competence, rather than viewing them simply as incompetent children/minors.

This paper choose to deal with this ethical and legal dilemma by focusing on the assessment of the extent to which the general principles of law recognize an adolescent's capacity to consent to and refuse medical treatment in the UK; then, by considering the application of the general principles in the specific court cases concerning Jehovah's Witness adolescents. Jehovah's Witnesses are a religious group that refuse blood transfusion on the basis of religious beliefs. However, protecting the right to express and live a religious identity clashes with the duty and responsibility to protect minors from abuse and neglect since blood transfusions remain a potentially life-saving treatment. The study will focus on the question whether these teenagers have the possibility to refuse life-saving treatments on the base of specific religious beliefs.

It will be shown how children who are capable of forming their own autonomous views, based on good information and a certain level of maturity, may have a legitimate right to see those views respected. However, this may not be the approach that English courts followed when competent children were concerned. In fact, in the context of refusal of medical treatments, respect for autonomy and decision-making capacity tend to be trampled by the idea that children should receive the medical treatments if highly recommended, even if the child is strongly against such treatments and even if his/her wishes are based on potentially serious reasons such as religious beliefs. Although the courts' intent is noble, the English current approach does not give the due importance to the adolescent's right to self-determination and autonomy, sustained by a part of the academic world and guaranteed by both international and domestic legal standards.

Relevance to Development Studies

Doesn't matter how young a person is, all human beings are entitled to have rights. When it comes about adolescents, the pertinent discussion regards two set of different rights, protective and self-determination. To find a fair balance between them is relevant for the human rights development discourse and practice. Adolescents are persons who are fastly approaching adults and their potential maturity and capacity to make fundamental decision about themselves have to be taken into consideration. In particular, adolescents that hold emotional, cognitive and psycho-social maturity, combined with a deep rooted religious identity, makes an interesting population for the field of development studies in terms of self-determination rights. The concept of development doesn't exclusively affect macroeconomics variables. What concerns the conflicts between religious cultures and coverage of healthcare system is definitely part of the game.

Keywords

Adolescence, Competence, Self-Determination, Religious Freedom, Protection, Best Interests, Jehovah's Witnesses, Blood, UK, UNCRC

In former times thousands of youths died for putting God first. They are still doing it, only today the drama is played out in hospitals and courtrooms, with blood transfusions the issue.

Awake! - May 22, 1994: 2

Chapter 1 Introduction

1.1 Problem Statement

I would like to introduce this research by presenting the problem. Imagine John as a person who suffers from an illness that has a 90% survival rate. This hypothetical scenario presents two options. One represents the patient's expressed wish; the other represents the authoritative opinion of the relevant professionals. According to relevant professionals, the second option is necessary to defeat the illness. However, performing the first option entails discarding the second one. How to weigh and consider these different and incompatible options?

If *John were a competent adult*, his wishes would be crucial on procedural grounds: a competent adult has the right to accept/refuse all treatments, including life-saving treatments. However, because *John is a minor*, determining who is the appropriate decision-maker is a more complex matter. If *John were 5-years-old*, few who would argue that such a young boy has the capacity to assess independently the risks and benefits of a life-saving treatment.

In the medical domain, there used to be a clear separation between the decision-making capabilities of adults and minors. At the heart of this division was the presumption that adults are competent to make these decisions while minors are not, because minors are 'assumed to lack sufficient cognitive and conative maturity to craft autonomous healthcare choices, therefore being deemed legally incapable of giving genuine informed consent to medical treatment' (Will 2006: 239). But now imagine that *John is an adolescent of 16-years-old*. Why would a teenager refuse a life-saving treatment?

Jehovah's Witnesses (JWs) are a religious minority that, according to recently published guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI 2005), counts around 6.5 million members around the world. Their religious faith requires a lifestyle based on a strict moral code of conduct. The moral law relevant for this context is known as the Blood Ban. It prohibits taking alien blood into the body because accepting whole blood transfusions is seen as a violation of certain Biblical commandments. For a JW, conscious and unrepentant acceptance of blood will entail very serious theological and social consequences both for a child and his/her family.

Firstly, it means breaking their personal covenant with Jehovah (God) and so loosing the chance of everlasting life in his Kingdom. Secondly, members who violate the fundamental moral principles, or who dispute doctrinal matters, may be subject to disciplinary action including disfellowshipping, a particular form of punishment that forces JWs to sever association with even their own family members and relatives who have been expelled. However, protecting the right to express and live a religious identity and family privacy

clashes here with the duty and responsibility to protect minors from abuse and neglect since blood transfusions remain a potentially life-saving treatment. The study focuses on the question of whether these teenagers have the right to refuse life-saving treatments on the basis of specific religious beliefs.

A dominant school of experts (Coleman and Hendry 1999, Diekema 2011, Grisso and Vierling 1978, Rosato 2002, Rutter and Rutter 1993, Ross 1995) considers this claim for autonomy to be morally inconsistent with parental and state obligations to protect and promote the basic medical needs and rights of minors especially with regard to effective treatments in case of life-threatening illness. However, there is also an increasing number of professionals -in developmental psychology, paediatrics, biomedical ethics and health law- who would argue that some teenagers are competent to make healthcare decisions, based on their own judgment of what is in their best interest, just like their adult counterpart (Alderson 2007, Hartman 2000, Mann et all 1989, Scherer & Repucci 1988, Weithorn & Cambpell 1982).

This conflict of opinions is reflected in the legal approach. Competence used to be considered as a function of age. However, this notion is increasingly challenged by a more relativist approach, which entails an assessment of the single individual's actual skills. International and national laws have begun to reflect this approach by according a more significant influence to children's views and increasing capacity. The UN Convention of the Rights of the Child (UNCRC), the most widely ratified international human rights treaty, supports a position that stresses the importance of involving children in the decision-making process.

In some states the concept of 'mature minor' has been introduced, at least in the healthcare context. This concept entails that, even though the age of majority remains generally 18 years old, 'younger children may, according to laws of individual states, be able to consent to treatment especially if they have enough maturity and ability to understand the benefits and risks of the proposed treatment and its alternatives' (CESP 2003: 631). However, international and domestic law show a substantial degree of ambiguity about the extent to which adolescent's autonomy in healthcare decision-making should be respected and about the implications of an adolescent's refusal to consent to treatment.

1.2 Justification and Relevance

A discussion of the JW case provides an interesting perspective on the wider issue of minors' decision-making competence in healthcare. The right to self-determination of minors, in such a context of life/death, represents a bioethical dilemma and a legal conundrum that deserve further consideration. This paper chooses to locate its research in the specific legal domain of United Kingdom (UK). The choice of this country is motivated by the fact that it has generated a common law legal principle, the *Gillick* principle, which is highly relevant for the issue at stake, and that there is a good amount of case law available.

The aim of this research is to dive into the dilemmas arising from the JW case and analyze how 'competence' was considered in the UK in relation to the specific case of minor adolescent JW patients. The objective is to generate a constructive reflection on the conceptualization of competence and its application in the legal reality, so has to build an answer to the question whether JW adolescents have a right to refuse medical treatment.

1.3 Research Objectives and Questions

The aim of this paper is to explore the legal and ethical ambiguity involved in decision-making on life-saving treatments for adolescents, and to analyse issues relating to decision-making capacity and legal competence in the context of healthcare related issues in the specific legal domain of the UK.
Starting from the presumption that adolescents cannot simply considered be incompetent children, the research objective is to investigate to what extent legally and ethically JW adolescents have the right, legally and ethically, to refuse life saving treatments on the ground of religious beliefs.

Therefore, the main research question is:

Do JW adolescents have a right to refuse blood transfusions on the ground of religious beliefs?
And my relevant sub-questions are:

- Can an adolescent minor be ethically and legally competent to make relevant decision over his own life?
- Does a competent minor have the right to refuse blood treatment even if that may result in his/her death or serious harm and is not deemed in his/her best interest?
- What role do religious beliefs play in the assessment of competence?

1.4 Scope and Limitation

This research focuses exclusively on adolescence. Since adolescence has not been recognized as a legal category yet, the definition adopted by developmental psychologists, that targets as 'older minors' teenagers aged from 14 to 17, is used in this paper. This choice is justified by the fact that the age of fourteen has been acknowledged as the threshold above which, cognitive ability and maturity, both necessary for decision-making capacity, has been found.

To focus the scope of the research, I conducted a concrete legal analysis of an intertwined study case: the JW adolescents' group in the English legal context. I chose this focus for the centrality that religion holds for many people. In particular JWs with their Blood Ban doctrine are considered one of the most relevant and serious examples of the potential conflict between religion and healthcare (Singelenberg 1990).

Given the potential geographical extent of the issue at stake (JWs are a religious group that is spread worldwide), this research is limited to a western legal system, in particular that of the UK. To be fair, Canada and the USA also constituted interesting cases in this regard. However the timespan within which this research paper had to be written did not provide space for a comparative study. This paper therefore does not represent an all-encompassing and exhaustive discussion of the issue of competence. It concentrates on some of its many facets bound to a very specific and limited reality.

1.5 Methodology and Data

The main methodology applied in this research consisted of a multidisciplinary literature review. I critically engaged with relevant academic points of views and knowledge on the leading concepts of rights, competence and adolescence, to build a substantive line of argument. In order to do that, I also substantiated the theoretical discussion with data gathered by primary and secondary sources. Moreover, a modest and limited use of primary data helped to furnish a symbolic representative voice of the study group: the JWs.

The sources of knowledge that I considered for this study are multidisciplinary. The second chapter builds a theoretical framework through reviewing academic literature concerning relevant legal and bio-ethical concepts and theories, a rights perspective of childhood, the legal and ethical concept of competence and relevant legal and ethical theories concerning adolescents' cognitive and moral development. Moreover, I gathered primary and secondary data on the international legal perspective for analyzing the UNCRC and the General Comments of the CRC Committee relevant to the specific issue of Adolescent Health and Development.

The third, fourth and fifth chapters build a more detailed analysis of the two elements of my case example. Firstly, concerning JWs and the Blood Doctrine, three main bodies of information sources were considered: the abundant religious literature produced by the Society itself; memoirs and critical literature produced by former JWs; and academic literature concerning JWs from e.g. historical, bio-ethical and sociological perspectives. Moreover some primary data were collected so as to support and back up information gathered from literature and secondary data review.

Two symbolic interviews were conducted. I used a mixture of different methodologies for these interviews, necessitated by logistical problems and the sensitivity of the issues at stake. The interviews involved a practicing JW and a former JW now head of AJWBR (Association of JWs for Reform on Blood), the most famous and engaged web-based group that fights for a fundamental doctrinal reform inside the JW community. Both the interviews focused on the Blood Doctrine so as to capture an inside and outside perspective.

The first was a semi-structured qualitative interview in two meetings, conducted in The Hague. The other was based on a pre-agreed questionnaire with open-ended questions, sent by emails.

Two interviews could never be representative of the entire collective of JWs and former members. For this reason, the data gathered through the interviews were only used to back up some information gathered from other sources. This is further motivated by the fact that this paper focuses on the legal side of the issues involved rather than that it engages in an ethnographic analysis.

Finally, the dominant legal practice in international and domestic (UK) law and the concept of religion was analyzed by reviewing relevant international treaties (UNCRC and European Convention of Human Rights [ECHR]), relevant UK legislations (the Age of Legal Capacity (Scotland) Act [ALC(S)A], the Mental Capacity Act [MCA], the Family Law Reform Act [FLRA] and the Human Rights Act [MRA]) and seminal court cases[1].

[1] See table of cases for details.

Chapter 2 A Theoretical Framework

This chapter theorizes the right of adolescents to self-determination in a healthcare context. It analyzes adolescents' decision-making capacity from a double perspective: the rights discourse and the bioethical debate. This will lead to the position that, even though the debate is still open, today adolescents' capacity to self-determination in healthcare is recognized to a certain extent, at least in theory.

2.1 Children's Rights

The UNCRC[2] defines a child as 'every human being below the age of 18 years unless, under the law applicable, majority is attained earlier' (art.1). The child's rights debate has of course been framed in international human rights law. The UNCRC is considered the 'touchstone' for children's rights and the arena for pursuing future debates about them (Fortin 2009). There are two main and potentially competing commitments when it comes to children: to promote the child's best interests, and to respect the child's views on any matters affecting his/her interests in proportion with his/her maturity, age and capacity.

2.1.1 Will and Interest: Between the Right to Self-Determination and the Right to Protection

The idea that children are rights holders has been the topic of speculation among moral philosophers for over thirty years (Fortin 2009). Concerning the abstract concept of 'right' and the subsequent dilemma of what it entails to be a rights holder, there have been doubts whether the rights talk is applicable to children.

The Will Theory, one of the seminal theoretical analysis of the concept of right, sees a right as the protected exercise of choice. In order to have a right, a person has to have the power to enforce it or waive the correspondent duty. According to this theory, young children cannot be rights holders because unable of autonomous decision-making (Hart, Sumner, Steiner in Elliston 2007).

The other main relevant theory, the Interest Theory, proposes instead that a person does not have to prove any decision-making capacity in order to be considered a legitimate bearer of rights. Rights should be conceived as 'interests' and human rights are inherent to being human. The rationale is that a right entails the protection of an interest which is sufficiently important to force on others certain duties whose fulfilment allows the right-holder to enjoy the interest in question. Children of any age have important interests, and thus

[2] see annex 1

may have corresponding rights which need to be safeguarded by normative rules or standards. The way children's rights are addressed under domestic and international law suggests an approach more in line with the Interest Theory, since recognized duties are imposed on others towards children irrespective of a child's decision-making capacity (Fremaan in Freeman (ed.) 2004). However, substantial philosophical criticism surrounds certain areas such as where is the boundary between adults and children's rights, and how to deal when one set of rights clashes with another one.

Several classifications of children's interests were developed. Eekelaar (1986), an exponent of the interests theory, adopted a valuable classification of children's interests. He divided children's interests into three categories: basic, developmental and autonomy interests. Those interests will clash. Most relevantly, he stated that in case of conflict between a child's basic or developmental interest with an autonomy interest, the former should prevail. The rationale behind his assertion was that few adults would let their autonomy interests jeopardize their future life-chances by trumping basic or developmental interests (Eekelar 1986).

Similarly, other writers have formulated their classifications (Freeman, Wald and Campbell in Fortin 2009). All these frameworks share a fundamental tension between protection and respect for children's emerging autonomy. This tension is still marking the development of child law at large. This is illustrated most pragmatically by Bevan (in Elliston 2007) who categorized children's rights into protective and self-assertive rights. Protective rights link with the child's dependence and vulnerability, which require physical and psychological protection and assistance. They may include, for example, the right to protection from neglect or mistreatment and the right to state intervention to achieve such a protection.

Self-assertive rights on the other hand, enable the claim of adult-like rights, such as the right to bodily integrity and to freedom of expression and thought, conscience and religion, and of course rights of decision-making. This classification, in line with the Interest Theory, recognizes that children have specific interests that require protection and that others have the responsibility to provide protection. The Interest Theory asserts that although children may have an interest in making choices, this interest does not necessary reflect a 'moral right'[3] to do so. As was already mentioned above, an interest can be considered a moral right just if it holds importance to the child such that it would be wrong in itself to deny it to him/her.

At the same time, it should be equally recognized that the ability to make an autonomous choice does not magically spring up at whatever the legally set age of adulthood is. Thus, when there is an evident clash between children's rights to protection and self-determination, there is an ongoing debate about which takes priority.

2.2 From the Philosophical Debate to Conventional International Law

The contrast between the two different perspectives sketched above is enshrined in two UNCRC articles that are amongst the most important of the Convention: articles 3 and 12 of the Convention encapsulate the tension

[3] There is a fundamental distinction between legal and moral rights. Legal rights are rights recognized in law, while moral rights are rights recognized by moral theory.

between the child's best interest and respecting his/her views. Article 3(1) prioritizes concerns of welfare by stating that the best interests of the child shall be a primary consideration in making decisions that may effect him/her. Article 12(1) stresses the centrality that should be given to a child's views. When decisions that affect children are made, children have the right to see their views considered in accordance with their age and maturity.

2.3 On the Best Interests Perspective

2.3.1 Article 3 and The Best Interests Perspective

The UNCRC stresses the importance of considering all rights indivisible and of equal importance (art. 2.1). However, according to certain authors, the so-called protective rights, embodied in the best interests standard, have enjoyed greater importance than the self-assertive/participation rights which promote children's autonomy and are seen as more controversial (Elliston 2007). Fortin (2009) observed that, even though article 3 does not provide a specific meaning to best interests and avoids associating it with a paramountcy criterion, the UNCRC Committee has constantly stressed that all children rights must be interpreted in accordance with it.

2.3.2 The Best Interests Debate

Minority as a legal status is traditionally characterized by the fact that adults have a generalized legal power to decide a course of action for minors, based on their assessment of the minors' best interests (Eekelar 1994). The justification of this approach lies in the assumption that minors need time to develop a coherent conception of self and well being, and that thus they need a period of protection and guidance.

The following question to discuss is who is the appropriate surrogate decision-maker on behalf of children. Traditionally, both in law and ethics, parents hold a natural right to be the proper surrogate decision-maker. Goldestein (as cited in Wald in Freeman(ed) 2004: 116), one of the most prominent proponents of expanded parental rights, argued that 'to be a *child* is to be at risk, dependent, and without capacity to decide what is best for oneself. To be an *adult* is to be a risk-taker, independent, and with capacity and authority to decide and to do what is best for oneself. To be an *adult who is a parent* is to be presumed in law to have the capacity, authority, and responsibility to determine and to do what is good for one's children'.

In fact, parental authority includes determining the upbringing of the offspring. This entails a parent's right to act in accordance with his/her own values to promote the interests of the family. This includes education of their children about certain religious values and making medical decisions on behalf of their children. As a consequence, in healthcare practice, physicians are

generally requested to obtain consent from the minor's parents before fostering care. Otherwise they can be liable for battery[4]. However, parental authority is not absolute and legal restrictions are numerous and in different domains (Herrera 2005). The standard practice entails that parental wishes will be tolerated until they will be qualified as neglectful because they fall below a certain threshold of tolerance. The establishment of a threshold of adequate parenting is quite complex, because it involves considering various factors, including, for example, the extent to which one should tolerate different cultural and religious norms (Krause in Kopelman 1997). Commentators have advocated a more stringent state monitoring on the adequacy of the parental authority in the name of children's rights (Wald in Fortin 2009).

This legal interference comes from the idea that children are not their parents' property but should be respected primarily as individuals and as citizens within a society. So the state is considered the ultimate guardian of all minors within its jurisdiction, which means that state courts are entitled to intervene in certain situations, when the best interests of a child are jeopardized by parents or legal guardians. This entails that the child was harmed or put in danger of suffering serious physical and/or emotional harm (Kopelman 1997). What is of interest now is the use of the term best interests. The best interests principle is used as a main standard in most family law systems throughout the world and it is also at the heart of the UNCRC. According to Kopelman (1997) the standard has been successfully used in three ways that are conceptually connected: as an ideal to promote children's good; as a threshold for intervention and judgment to articulate others' *prima facie* duties to them; and, especially for in medical care decisions, as a standard of reasonableness, which 'guides us to select what most informed, rational people of good will would regard as maximizing net benefits and minimizing net harms for children, given the legitimate interests and rights of others and the available' (Kopelman 1997: 287).

2.3.3 Problematic Issues about Parental Authority

The best interests principle is controversial for a host of reasons. There are at least two main kinds of problems for accepting this standard. The first of these problems concerns the content and the meaning of the principle. A substantial definition of best interests, that is a precise definition based on a particular moral perspective, is missing. On the contrary, the concept presents itself as a empty procedural standard. There is then an ambiguity that gives little guidance in decision-making. Mnookin and Szwed (as cited in Skivenes 2010: 339)

[4] In civil law, battery is an intentional tort. For a tortious battery to occur, the requisite intent is merely to touch or make contact without consent. There need not be an intention to do wrong (http://injury.findlaw.com/assault-and-battery/battery-basics.html)

pointed out that 'the flaw is that what is best for any child or even children in general is often indeterminate and speculative and requires a highly individualized choice between alternatives'. The result is that decision-makers hold a certain leeway in weighing different arguments and positions when deciding on the best interests of a child. This could be potentially problematic for all persons affected by the decision.

This is all the more true because the child's best interests are a relative concept, which differs across cultures, religion and states. In fact, all democratic states legitimize the existence of different ways of raising a child and so protect the parents' right to establish a personal view about what good life is for their family (Skivenes 2010). Moreover, it has to be considered that determining a child's best interests entails foreseeing outcomes that are difficult to calculate (Archard and Skivenes 2009). Mnookin (in Eekelar 1994: 45) underlines this indeterminacy by arguing that 'predictions of the effects of present dispositions on the future of children were necessarily speculative in the present state of knowledge and, even if they were not, there was no consensus on the values inherent in choosing between outcomes'. This is particularly relevant when children and medical treatment are concerned. Best interests are not completely dependent on medical evidence but 'encompasses medical, emotional and all other welfare issues' (*Re A* 2000 1 FLR 549: 555). In fact, 'what is best from a medical point of view may be least acceptable to the child or parents when taking into account other factors such a respect for autonomy, parental choice and the impact upon the child and the family of the decision' (Elliston 2007: 18). Those factors clearly play a role in influencing decisions about a child's treatment to a certain extent, so establishing the best interests may prove tricky.

A second problem relating to the best interests standard relates to the perspective by which the best interests of the child should be interpreted. Archard (2011) has suggested two competing approaches: the first one is the objective approach where decisions are based on an adult conception of the best for the child that independent of the child's actual or hypothetical desires. The second one is the hypothetical choice approach where decisions are based on what a child himself would choose for him. The objectivist interpretation of the best interests principle suffers from the above-mentioned problem of indeterminacy. Even though a general consensus on what is best for a child can probably be reached, what it is best for any individual child will mostly depend on the particular conditions and environment in which that child finds him/herself.

On the other hand, the hypothetical choice test suggests making a decision applying a substituted judgment. This kind of approach has paternalistic features and was supported by various scholars, *in primis* by Rawls. He formulated his definition of acceptable paternalism over a child as follows: 'We

must choose for others as we have reason to believe they would choose for themselves if they were at the age of reason and deciding rationally' (Rawls 1999: 183). In this wake, Freeman (1983) advocated the idea of liberal paternalism suggesting that protecting adolescents from making dangerous and life-threatening mistakes is justified by the idea that children's future capacity to be autonomous should be respected more than their rights of actual autonomy. In other words, the decisions made by adults on behalf of the children would find agreement with the children themselves, once they too became mature adults.

However, this idea of paternalism is not simplistic. Instead it can be prone to different interpretations, each of which brings own difficulties. First, it could mean that the decision-makers would choose according to what an imagined adult version of the child would choose for him/herself. However, the particular adult a child will become depends on the choices made while he/she is still a child, so the decision-maker is not left with one possible choice but may have to choose from among a range of different possibilities (see also Lowy 1992). Second, the decision-maker could decide what is best for the child by assuming what any rational and mature adult would choose in that situation regardless of the child in question.

Here again there is an overestimation of the adult's tendency to make the same kind of choices. Mature and competent adults are still different people with different systems of values. This leads to the third possible interpretation, which entails trying to envisage the child as an already mature person. In this case, an obvious criticism could be that 'it is not clear what remains of the child in any choice situation rendered hypothetical in this fashion. For the child just is someone who has these childish beliefs and desires. What is it to be a child if not to think and want as a child does?' (Archard as cited in Elliston 2007: 24).

However, this criticism does not take consider the possibility that children may be capable of having views and beliefs that are not childish at all. This hypothesis is particularly cogent when considering older children. Then, a final concern may be whether the best interests test permits to make decisions that override an eventual right of a child to self-determination (Elliston: 2007). One of the dilemmas that will be analyzed in this paper is how decisions over the best interests of the child were taken, and especially to what extent the child's views were weighed in making decisions concerning their lives.

2.4 On the Child's Autonomy Perspective

2.4.1 Article 12 and the Child's Autonomy Perspective

UNCRC Article 12 is considered to be a most significant innovation in the children's rights field. Its significance derives from the actual content of this article, but also from the fact that it explicitly pursues a vision of the child as a

full human being, with integrity and personality, with the capacity to participate fully in society and entitlements to respect and dignity (Freeman in Freeman(ed) 2004). The UNCRC Committee itself often stressed that article 12 should be seen as a properly enforceable right and not a matter of discretion for governments (Fortin 2009).

In addition UNCRC article 5, on parental guidance, stresses the paramount importance of respecting and taking into account the 'evolving capacity of the child'. The rights to freedom of thought, conscience and religion (art.14.1), to privacy (art.16), to freedom to assemble and mix with others and share views (art.15) and the right to information (art.17) strengthen this view. Furthermore, under UNCRC article 4, concerning legal and judicial measures, States parties need to set a minimum age for certain medical situations including the possibility of medical treatment without parental consent for adolescents. These provisions 'reflect the recognition of the status of human beings under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity (5 and 12-17)' (CRC Committee 2003: 3). The UNCRC Committee went even further by stating that adolescents should have a right to receive confidential information on possible treatments in order to be able to give informed consent, and that this process should be guaranteed from a specific age or relative to the evolving capacity of the child (CRC Committee 2003: 9).

2.4.2 The Evolving Capacity of the Child, i.e. The Relationship between Child and Autonomy

2.4.2.1 The Liberationist Point of View

The American children's liberationists considered childhood as a relatively recent Western social invention specifically conceived to discriminate and exclude children from the adult world. They argued that children's capacity for self-determination was underestimated, and that they deserved a right to enjoy the same freedoms granted by the state to adults. According to Farson (as cited in Wald in Freeman(ed) 2004: 115), children's rights could be fulfilled only when children enjoyed an absolute freedom to decide what is best for themselves.

The refusal to see any difference between adulthood and childhood received very little support. Nonetheless, their ideas were influential in generating a valuable debate about the extent to which children's autonomy rights should be encouraged and paternalistic restrictions on children's freedom extended (Fortin 2009). This view becomes more cogent when adolescents are concerned.

2.4.2.2 The Peculiar Case of Adolescence

Freeman made the point by saying that 'no one can seriously believe that there is a real distinction...between someone of 18 years-and-a-day and someone of 17 years-and-364 days' (Freeman as cited in Fortin 2007: 26). The idea that adolescence is a peculiar stage between infancy and adulthood that artificially extends the inferior status of childhood has a more consistent basis than viewing childhood as a Western social construct. As Archard (cited in Fortin 2009: 27) noted:

> 'While it is easy to represent an infant as evidently not an adult, lacking all but the most basic, and unimportant, characteristics of the mature human being, it is correspondingly harder to do so for a late adolescent. What it is true of the six-month-old baby by contrast with an adult is false of a sixteen-year-old adolescent. To the extent that this is true it is problematic to deny to the adolescent that standing which is denied to all children in virtue of their not being adults.'

In fact, there is, among adults, a quite widespread consensus acknowledging the right of adolescents to reach certain major decisions for themselves and so having a degree of personal autonomy (Fortin 2009). This discourse inevitably produces a debate around setting a limit to the decisions that should be respected. Paternal guidance is generally seen as crucial in restricting adolescents' powers and claims of self-determination. Most of the theorists support the necessity of finding an acceptable balance between respecting a certainly fair greater autonomy and supporting state power to override certain self-destructive decisions (Fortin 2009). In any case, the potential of adolescents for autonomy may deserve some further consideration.

2.5 Children and Competent Decision-Making in Healthcare Issues

2.5.1 The Importance of Autonomy

The importance of autonomy has been justified both by deontological and utilitarian theories. The Kantian deontological view conceives persons as ends in themselves rather than means to an end. So, respect for autonomy is supported by the moral imperative that gives priority to an individual's own beliefs and values, as the only way to treat that person as 'having ends of her own' (Kant as cited in Elliston 2007: 26).

In a different way, utilitarian philosophers, such as Mill (cited in Elliston 2007: 26), contributed to supporting the principle of autonomy by giving it a status of a liberty interest: 'the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant.'

2.5.2 Autonomous Decision-Making and Healthcare

The right to autonomy is one of the fundamental theoretical concepts concerning competence and capacities in the specific context of healthcare decision-making. In the past, medical care was performed following the paternalistic logic that only physicians were the ones in charge to know what was best for their patients. This presumption started to be tottered in the late 1950s (Will 2006). Little by little, the predominant idea became that competent individuals were able to exercise self-determination and therefore should be permitted to make medical decisions for themselves. International human rights law also recognized that having control over one's body was a fundamental aspect of an adult right to self determination since 'medical treatments often involved an invasion of bodily and personal privacy which would be intolerable if patients had no right to control its delivery' (Fortin 2009: 146).

The concept of competence entailed the idea that individual decisions were governed by an independent self-conception. This means that, even if it is necessary to be aware that a personal identity always develops in connection with social and cultural experiences, individual decisions shouldn't be constrained by third parties. All those presumption are enclosed in the bioethical principle of respect for autonomy.

2.5.3 Information, Voluntariness and Competence: How Autonomy Unfolds

The cardinal aspects of autonomy that spontaneously arise in the discussion are whether individuals are free to make_their own decisions and whether they are entitled to have a legitimate expectation that their decisions will be respected by others (Elliston 2007). To respect an individual as autonomous means to recognize his/her right to make decisions based on his/her personal belief system. In order to do that, people have to be provided with the necessary conditions and opportunities for exercising their autonomy.

In the practice of healthcare, protecting the competent individual -not only from coercion but also from ignorance- fulfills those conditions. The legal principle of informed consent was conceived precisely to empower the patient to take a conscious decision, by providing all the relevant information about his/her medical condition and treatments. Naturally, the legal consensus is two-fold, it entails also the corollary right to refuse life-saving/sustaining treatments (Hartman 2000).

Beauchamp and Childress have recognized seven elements of informed consent. They divide them into three main groups (Beauchamp and Childress 1994):

- The threshold elements, namely patient competence to make decisions and patient voluntariness in deciding.
- The information elements, namely adequate disclosure of information, recommendation of an action, and patient comprehension of information and of the recommended action.
- The consent elements, namely decision in favour of an action and authorization of the chosen action.

The elements relevant for this analysis, together with information, are the threshold elements.

Voluntariness entails the idea of liberty. The legal interpretations of voluntariness fit into two categories. The first focuses on the intrinsic capacity of a person, so 'a person's assent must constitute something more than mere acquiescence. It must be a proactive consequence of the will' (Waltz and Schunneman as cited in Scherer and Reppucci 1988: 124). The second element focus instead on the external variables that influence a person's freedom of choice. A voluntary action should be spontaneous to the extent that it can be asserted as completely free from any kind of external influences. However, this last is quite incompatible with a more realistic perspective over voluntariness, which cannot abstract persons from environmental interaction (Scherer and Repucci 1988). All human beings are, for the most part, the results of their physical, social and cultural environment. Treatment decisions cannot be made outside of social contexts free from social influence and pressures. Rather, a person should instead be considered autonomous if he possesses a "substantial degree" of liberty that allows him to behave in a "self governing fashion" (Beauchamp and Childress as cited in Elliston 2007: 71).

On the other hand, if a person is to be provided with information, it is an essential prerequisite that she/he is competent. As I will show below, the law provides little guidance on what exactly constitutes competence and what criteria should be employed in its evaluation (Weithorn and Campbell 1982). However, according to various scholars three kinds of capacities guarantee that decision-making competence is met (Appelbaum 2007, Buchanan and Brock 1986):

- Capacities to communicate a choice and to understand relevant information.
- Capacities for reasoning and deliberation about the choice made, and
- Capacities to have and apply a certain set of values.

Beyond exceptions, those requirements are presumed in individuals who have attained the legal status of adulthood. In general, adults are considered able to judge what is in their best interests, so their decisions must stand whatever the outcome or the content is. However, when considering children, the fundamental matter becomes whether those competence standards can or should also be applied to them.

2.5.4 Age and Ability: Determination of Competence?

2.5.4.1 The Legal Approach

. The legal approach draws an age-based line between adulthood and childhood. This clearly shows a positive side in terms of transparency, consistency and ease of application; it has also been supported by some academics that consider the gaps between children and adults too wide. Nonetheless, there are two major points against an age-based criterion. The first criticism argues that this kind of criterion is defective because 'it is bound to create errors at the margins' (Archard as cited in Elliston 2007: 72). While the abyss of difference between the decision-making capacity of a 50-year-old man and of a 5-year-old child is crystal-clear; the same cannot be assessed in a comparison between an adolescent aged 17-year-old and a young adult aged 18-year-old. Setting an age threshold to acquire rights can easily be accused of arbitrariness (Archard and Skivenes 2009).

The second criticism concerns the fact that determining an age limit is not free from difficulties. There have been some attempts in the field of psychology, backed by empirical research, to study cognitive and evaluative developmental capabilities in children, which have reached positive conclusions in terms of capacity to make fundamental choices in healthcare (Archard in Elliston 2007).

2.5.4.2 Cognitive Development

The undeniable arbitrariness of age limits has been justified by the argument that all lines will essentially be arbitrary, but still they have to be drawn somewhere (Fortin: 2009). However the studies that support this criticism deserve deeper exploration. Cognitive development concerns the advancement of thinking skills and can be divided into:

- Developing advanced reasoning skills, which entails the ability to conceive hypothetical situations and think and plan about the future.
- Developing abstract thinking skills, where "abstract" entails conceptual things like faith, beliefs and spirituality.
- Developing the process of "meta-cognition", which means becaming aware of your own thought processes and so more self-assertive and even introspective.

These changes affect adolescents in different ways. They tend to demonstrate an increased level of self-consciousness; to assume risky behaviours because they exhibit the "personal fable" syndrome (it won't happen to me); and to become very cause -oriented, idealistic and tend to exhibit a "justice" orientation.

Psychosocial development entails some issues that teenagers deal with during their adolescent years. The ones relevant to the discussion are:

- Establishing a personal identity.
- Establishing autonomy, which means becoming an independent and self-governing person within relationships.

Those changes may make adolescents more argumentative about values and judgments; they may begin to consider parents more as people and in generally to interact with adults more as equals (Ruffin 2009: 1-2).

2.5.4.3 In Favour of a Full Competence for Adolescents

Several empirical studies defined competence in decision-making in terms of cognitive development processes. They considered adolescents aged 14/15 already able to show an adult-like maturity in metacognitive understanding of decision-making, problem solving, correctness of choice and commitment to a course of action (Alderson 2007, Mann et all 1989, Weithorn and Cambpell 1982). One of the most widely cited was the study done by Weithorn and Campbell (1982) in the USA. They designed an empirical research to evaluate the correspondance between a legal age standard and effective medical decisional capacity. By comparing the decision-making capacities of minors and young people of different ages, they discovered that their findings support precedent concepts of cognitive development developed by Jean Piaget[5], that is 'in general minors aged 14 were found to demonstrate a level of competence equivalent to that of adults, according to four standards of competency (evidence of choice, reasonable outcome, rational reasons, and understanding)' (Weithorn and Campbell 1982: 1595). The authors admitted that the final findings had to be mitigated by the fact that the subjects were only healthy individuals of high-intelligence and middle class background that treatment decisions were made in hypothetical settings, and that indeed more research was necessary.

However, they (like many of those who cited their work) also declared that the research was against those streams of thought and policies that deny older children the right to self-determination in health care decision-making on the basis of a presumption of incapacity. The official legal age of majority does not automatically reflect the psychological capacities of most adolescents.

2.5.4.4 Adolescents and End of Life Decisions

In the field of bioethics and psychology, some scholars have been fascinated by those empirical studies of developmental ability mentioned above (Blustein 2009, Holder 1985, Leikin 1983, Lewis 1980, Orr 2007, Weir and Peters 1997). The pediactricist Sanford Leikin (1983), and later on the bioethicists Orr and Blustein (in Diekema 2011), dealed with the dilemma about whether adolescent decisions to refuse life-sustaining treatment should be respected or not. They argued that, taking 14 as the age of reference, it could not be excluded *a priori*

[5] One of the most important developmental psychologists.

but depended on a range of factors. More recently, Robert Weir and Charles Peters (1997: 36) made a further step by affirming that:

> '...the presumption on the part of physicians and other health professionals should be that *all* adolescent patients between 14 and 17 have the capacity to make healthcare decisions, including end-of-life decisions'.

Alderson (1993: 190) went even further by declaring that her research with children in hospital led her to conclude that 'differences between adults and children lie mainly in social beliefs about childhood, rather than in children's actual abilities'.

Although these studies certainly challenge the appropriateness of applying a presumption of incompetence to all adolescents, very few scholars will be ready to assert that all adolescents should be considered intellectually capable of providing independent consent (Will 2006).

2.5.4.5 Against Full Competence for Adolescents

On the opposite, there is a quite nourished stream of bioethicists and developmental psychologist, which support a different approach (Coleman & Hendry 1999, Diekema 2011, Grisso and Vierling 1978, Rosato 2002, Ross 1995, Rutter and Rutter 1993). According to Diekema (2011), a model of decision-making capacity that focuses only on the assessment of cognitive skills is quite problematic. Basing his argument on recent neuroanalytical and neuropsychiatric studies, he supported the theory that there is an imbalance between the integration of the more mature socio-emotional area with the less developed cognitive area of the adolescent's brain. So even though adolescents may be capable of adult-like decisions, they frequently do not use that ability optimally. Instead, they tend to rely more heavily on their instincts and impulses when confronted with stressful or emotional decisions situated in a context of real life medical decision-making. They show a reduced ability in regulating and understanding their emotions, and they are more impacted by certain psychosocial elements. For example, they are susceptible to peer influence and may be less able to resist social or family pressure; they are less future-oriented and more vulnerable to engage in risky behaviour since they have the ability to perceive risk but they weigh it differently because they focus on immediate reward rather than on future costs.

Other authors argued that any law that seeks to protect an adolescent's right to self-determination in life-threatening medical decisions may withhold a child the chance to fully develop his decision-making skills, values and life goals. They relied on the fact that children's opinions and preferences are not as solid as those of adults and so can easily change over time. Moreover, those opinions are too easily influenced by others to be considered autonomous choices to be relied on (Grisso and Vierling 1978). For this reason, according

to Ross (1995) they are 'morally unjustified'.

To sum up, it can be said that the majority of older children possess in a potential form the developmental skills for relatively sophisticated decision-making. Whether they make good use of them can only be assessed on a case-by-case basis. Researchers have not restrained their considerations to the study of cognitive skills development. They have observed that the capacity to be rational doesn't necessarily correlate with maturity. A wide range of authors agrees that a mature decision-making is highly influenced by other factors, such as the environment around the adolescent and personal emotional and social development. However, this doesn't diminish the consideration that not all adolescents develop in the same way and that there is the possibility that some adolescents are competent of making reasonable, mature and authentic decision about, for example, significant medical issues.

2.6 Final Remarks

This section framed adolescents as rights holders in between a right to protection and a right to self-determination. Although a full consensus is missing, today there is a legal and bio-ethical perspective that considers adolescents as individuals with potential competence, rather than viewing them simply as incompetent children/minors. In this regard, the importance of UNCRC article 12 and the concept of evolving capacity were highlighted. The chapter also showed that there were many attempts to pour content into the best interests principle, without reaching a unanimous consensus.

The UNCRC itself opted for keeping article 3 indeterminate since it is impossible and also desirable to give any comprehensive statement given the peculiarity of every specific situation (Alston 1992). So, it could be said that defining the best interests of the child is a question, which should be evaluated on a case-by-case basis. Then, children who are capable of forming their own autonomous views, based on good information and a certain level of maturity, may have those views respected.

However, as chapter 4 will show, this may not be the approach that courts follow when competent children are concerned. In fact, in the context of refusal of medical treatments, respect for autonomy and decision-making capacity tend to be trampled by the idea that children should receive the medical treatments if highly recommended, even if the child is strongly against such treatments and even if his/her wishes are based on potentially serious reasons such as religious beliefs.

Chapter 3 The First Element of Analysis: The Religious Dimension

3.1 The Religious Dimension in the Discussion over Competence

A further complex dimension is added when the adolescent's decision is based upon religious beliefs. The relationship between children and religion is interesting both from a legal and ethical point of view. The topic is quite complicated since it involves theorizations over rights, the controversial concept of childhood and the complex nature of religion in itself. The aim of this section is to introduce the religious element into the analysis and present the group featuring in the case example considered in this research: the Jehovah's Witnesses.

3.1.1 A Legal Right to Religious Freedom

According to Langlaude (2007), the interest theory is the best theoretical model for conceiving a right of the child to religious freedom. She identified the most important interest of the child in being raised as a religious person and belonging to a religious community.

However, there are also scholars that claim this kind of right must necessarily be tied to the autonomy of the child in religious matters. In particular, they stressed the importance of preventing religious indoctrination in order to enjoy religious freedom. Thus, they proposed the imposition of 'neutrality' in the education of children, in order to enable them to make a conscious religious choice when they reach the right age. For example, , Feinberg (1992) has argued that religious freedom falls into the sub-category of adult-like rights. Those rights are the ones peculiar to adults, and in particular cases also to adolescents, which thus require a substantial grade of autonomy to be exercised.

However, in most of the situations, a child will be raised in his parental religion. In fact, the child holds a right to be protected from interference in the enjoyment of religious freedom. This entails both negative and positive duties for the state. The negative duty regards refraining from interference in the nurture of the child, whether informal (family) or formal (religious community). The positive duty entails protecting the same child from both parents and religious community interference. At a certain point, a child reaches the level of maturity that enables him to make personal choices in religious matters (Langlaude 2007). Even though it is certainly not free from difficulties to establish whether the child's religious identity is already shaped by the religious community to which either the parents or the child belong, or whether is it effectively shaped according to a personal and independent choice

of the child, freedom of choice is, without any doubt, a crucial element of religious freedom, which must be guaranteed at a certain point. However, what about the correlative aspect of freedom of worship?

3.1.2 The Concept of Religious Development in Adolescence

For adults the right to religious freedom would entail freedom of worship (Langlaude 2007). This aspect of the right clearly requires autonomy and capacity to make a choice and so it may not be valid for younger children. However, what about adolescents? In fact, a substantial stream of the development psychology has focused on religious thinking.

Some authors, such as Elkind and Goldman, have adopted the Piagetian view that see the progressive evolution of religious thinking in specific stages of cognitive development related to the age of the child. Elkind studied how the child formed the idea of religious identity and generalized the existence of three stages of development. It is in the last stage, which occurs during pre-adolescence (around 10-12), that children fully develop a new level of thinking, from intuitive to abstract and reflective, towards their own religious identity. They interiorize beliefs and convictions, which transform their religious membership from an unquestionable and ascribed characteristic of their being to something more meaningful, a chosen identity, which eventually requires engagement in active study and the observance of a moral and an ethical code (Elkind 1964).

Similarly, Goldman (in Will 2006) mapped the evolution of religious thinking and discovered that, by age fourteen, many minors were already able of abstract religious thinking. Therefore, he sustained the idea that age was not a fair indicator to assess religious thinking development, just as it was not for cognitive development. In addition, other studies on adolescent religious commitment pointed out its intrinsic relationship with moral development, identity formation and family relationship. Different scholars observed that, for many youth, religious commitment was central in framing and shaping basic moral judgments, ideologies and life goals.

Therefore, religious development could also be a key element for the context and content of identity formation, to which, as further evidence suggested, it was linked developmentally. Logically, religious commitment did not regard just the individual adolescent but most likely affected also the entire family dimension and dynamics (Layton et all 2010). In fact, Will reminded that 'religious development does not occur in a vacuum' (Will 2006: 294) and so there is no doubt that family and religious community are essential and very influential components in the formation and development of a child's religious identity.

However, centrality of religion, which can characterize the life of any very religious family, cannot be the only element; religious beliefs should also be deeply rooted in the adolescent sense of identity of well being to the extent

that the emotional distress caused by forcing the minor to disrespect his/her beliefs, for example by forcing certain medical treatment, will offset the medical benefits of the treatment itself. So, one of the core questions, relevant for this discussion, will be whether adolescents are able to conceive a truly independent and deeply rooted religious identity. And, more specifically, whether they are able to formulate a deeply entrenched self-conception of their well being built upon a true and binding understanding of their religious values. The studies reported above that concern religious development seem to suggest that adolescents have this capacity, at least potentially (see e.g. Coles in Will 2006).

3.1.3 The CRC Approach to Religious Freedom

The child's right to religious freedom has not been just the subject of theoretical speculation, but it has been substantiated by different sources of international legal material. Most of all, protection of religious liberty has been guaranteed by the UNCRC. Article 14 provides the child with a right to freedom of thought, conscience and religion (1). Parents have a correlative right to guide their children in these matters 'in a manner consistent with the evolving capacities of the child' (2). Children have thus the right to believe and practice their beliefs to the extent that they are not preventing other people from enjoying their rights (3).

In the interpretation of the article, the UNCRC Committee has shown a certain analytical inconsistency (Langlaude: 2007). The dilemma, already highlighted in the previous chapter about the tension between article 3 (the best interest) and articles 12 and 5 (children's views and evolving capacity), is again reflected in the interpretation of article 14.

Actually, 14(2) about parental guidance, seems to suggest that the 'evolving capacity of the child' should be the guiding principle in the interpretation of the article. However, Langlaude (2007) pointed out that the concept has been interpreted too broadly and vaguely, since there was no clear indication regarding whether or how this guiding principle should prevail or be balanced with the other principles. The Committee hardly referred to the best interests of the child and it didn't even explain what 'evolving capacity' meant in practical terms.

Moreover, the Committee put particular emphasis on challenging age-limits imposed by states, which are considered too high (Langlaude 2007). The overall impression seems to suggest a will to orient the interpretation of religious freedom in favour of an increasing child's autonomy. However, this has be done without giving any concrete propositions.

3.2 Jehovah's Witnesses as a Relevant Study Case

JWs furnish an interesting perspective on the wider debate regarding minors' decision-making competence in healthcare. The reason lies in a particular religious doctrine, the Blood Ban, which constitutes one of the most direct examples of the potential tension between secular medicine, the right to participate in medical decision-making and religious beliefs.

3.2.1 The Jehovah's Witnesses

JWs are a religious minority that counts around 6.5 million members around the world. They are a millenarian Christian restorationist group that has shown a significant rate of growth in the western world (Stark and Iannacone 1997). They base their beliefs solely on the principles found in their version of the Bible, the inerrant word of Jehovah, which they consider historically and

scientifically accurate.

They present a worldwide organization framed in a highly centralized pyramidal structure. At the top, there is Jehovah Almighty God; at the bottom, there is the Worldwide Association of JWs divided into districts, which in turn are divided into circuits. Each circuit has about 20 congregations. Those congregations, shepherded by local elders, are geographically and linguistic based and are usually limited to fewer than 150 to 200 members in order to maintain a community atmosphere.

The communication channel between Jehovah and his people is represented by the Watch Tower Society (WTS) ruled by the Governing Body (GB). Beckford has spoken in this regard about the establishment of a 'WatchTower Theocracy'. In fact, they define themselves as ' a theocratic organization, ruled from the divine Top down, and not from the rank and file up' (*The Watchtower* 1971: 754). In other words, Jehovah communicates and rules humanity thorough this system. the GB is the extension of God's government on earth. Thus, the GB is in charge of interpreting the scriptures, which JWs think are progressively revealed thanks to a systematic and perpetual studying, and takes the only and final responsibility and accountability for all legal and moral issues, since 'the Bible cannot be properly understood without Jehovah's visible organization in mind' (*The Watchtower* 1967: 587).

The Society is the official legal organization used to direct, administer and develop all the doctrines directly from the headquarters in Brooklyn (NY) or through various levels of authority. At the same time, it is the major publisher of religious publications, including books, tracts, articles, magazines and pamphlets. WTS's authority cannot be contested since disobedience to the decisions emanated by the GB is compared with disobeying Jehovah himself. The adepts are required to publicly submit themselves to the Society's absolute authority during the baptism and, as a consequence, are strongly requested to read only WTS-produced or approved religious literature.

Loyality to the organization requires also a deep engagement in congregational activities such as public preaching and regular meeting attendance, as well as to conduct a lifestyle based on a strict moral code. JWs consider themselves as the only and true holders of Christianity in a morally corrupted world, and for this reason they seek to refuse all ecumenical relations with other religious denominations and apostates, and also to remain separate to the greater extent possible from secular society. The strict moral code is deemed inspired by biblical teachings and regards norms that go from sexual and comportmental behaviour to abstaining from blood transfusion. Members who violate the moral codes or who dispute doctrinal matters may be subjected to judicial committees, which have the power to take disciplinary actions.

"Disfellowship" is the most severe sanction since entails the act of congregational expulsion and subsequent shunning (i.e.: no communication or contact with other witnesses). This means that JW members are required to sever any association with them. This imposition encompasses even family members and relatives. Quoting The Watchtower (1988: 29): '[An ex-JW] can no longer converse with members of the [JW] congregation. [Disfellowshiped JWs are] totally cut off from loved ones and from close contact with the [JW] congregation'. This measure serves the double purpose of warning other members from engaging dissident behaviour and protecting the congregation from polluted thinking.

JWs are a millenarist religion. This entails believing in the end of the current world system (Armageddon) and the establishment of a new God's Kingdom. Salvation is possible because Jesus Christ's sacrifice has provided atonement for the sins of humanity. However, in order to receive it, the believer has to show and prove real faith through a proper Christian conduct of adherence to the biblical teachings. Among the saved, there is an elected group of 144,000, once belonging to GB, whom will have the privilege to go straight to Heaven to rule at the side of Jesus over Earth. The others preserve the hope of an everlasting life in an earthly paradise. In fact, after the epic battle of Armageddon, just the most deserving people will be resurrected. During a period of a thousand years, Jesus Christ will start his reign in a paradisiacal earth while Satan will be neutralized. At the end of this time, Satan will have the last chance to tempt humanity. Then the final judgment will take place in which Satan and all the indomitable sinners will be destroyed forever such as evil will never occur again. Those who survive that final test will finally enjoy everlasting life.

3.2.2 Jehovah's Witnesses Children and Adolescents

I previously illustrated how certain authors would like to deny any religious identity to children until they are a certain age. Concerning this case, children born in JW families become JWs only after baptism, which is performed only if the child has made a conscious decision to join the faith and become an active member in the meetings and preaching activities. However, for most of the cases, religious identity is formed before. There are few doubts that children born in JW families grow up in very sheltered environment in which they are heavily exposed to religious beliefs. According to Aldrige (as cited in Langlaude 2007: 30), these children tend to be protected 'against contamination by the false teachings and ungodly practices of the wider society', which include 'withdrawing children from acts of religious worship and assembly in state schools (and) discouraging close friendships with children born outside the faith'; and filling the child's life with religious activities. In fact, 70% of children born in JW families become JW as well, one of the highest rate among religious organizations (Introvigne 2002).

3.2.3 The Blood Doctrine

The moral law relevant in this context is known as the "Blood Ban", which is considered one of the most controversial issues over which when religion meets healthcare (Singelenberg 1990).

The doctrine prohibits the ingestion and misuse of blood, including donation, storage and transfusion for medical purposes, even in cases of medical emergency, because the GB has conceived them as a form of nutriment or improper use. The biblical exegesis lies in the modern interpretation of certain old testamentary dietary law (Genesis 9:3-6, Leviticus 17: 13-14, Deuteronomy 12:16,23-24,15:23 and Acts 15:22-29), which rule to 'abstain from eating blood in any form' and instead 'poured out onto the ground'. The doctrine was introduced in the 40es and has attracted considerable criticism both inside and outside this religious community.

In 1945, the Watchtower officially listed blood transfusion as an unscriptural practice. A decisive step was then taken in 1961 when to be treated with transfusion became a sin punishable with disfellowshipping (*The Watchtower* 1961). It was further specified that the blood ban applied to whole blood as well as all its components[6]. However, as from from the 1980s, significant amendments were gradually introduced. In 1982, a fundamental distinction was drawn between major and minor components; the idea that minor fractions of blood should still be considered 'nourishment' was cast into doubt, and so certain of them were finally allowed. However JW religious understanding does not absolutely prohibit the use of components such as

[6] There are 4 major components : plasma, red and white cells and platelets.

albumin, immune globulins and haemophiliac preparations; each Witness 'must decide individually if he/she can accept these' (*Awake!* 1982: 25).

In the following 10 years further concessions were made. This stream of thought progressed until, in 2000, the doctrine was greatly simplified by leaving all minor fractions to the individual's conscience 'after careful and prayerful meditation' (*The Watchtower* 2000: 31). The Society has justified those exceptions by depicting the allowed components as minute, disregarding that, if added together, those components will total the entire volume of blood they come from. At the same time, it also declared that 'some products derived from one of the four primary components may be so similar to the function of the whole component and carry on such a life-sustaining role in the body hat most Christians would find them objectionable' (*The Watchtower* 2004: 24). The same confusion and lack of logic is reflected also in specific medical procedures that involve blood. For example autologous blood transfusions[7] are forbidden since JWs believe that any blood removed from the body should be 'poured on the ground'. However, medical procedures where blood is taken out of the body but reinfused continuously (i.e. hemodialysis, heart-lung bypass machine, and intraoperative cell saver) are again left to the individual conscience (Remmers et all 2006).

It must be said that JWs do not simply reject the use of blood but they have become very interested in, and supportive of, the field of bloodless medicine, which, by the way, made important technological progress (Wah 2001). For this purpose, hospitals were provided with Hospital Information Services, which are responsible for informing the medical staff about bloodless surgery, and with Hospital Liaison Committees, whose role instead is to provide spiritual assistance to JW patients (Morrison et al. 1997).

The official source of information for JWs regarding the Blood Ban is represented by a WTS pamphlet (1990) "How Can Blood Save Your Life?". In this pamphlet the Society engaged itself in providing support to its position with extra-doctrinal argumentations, which rely on quotes from historians, scientists, secular writers and medical professionals. Louderback-Wood (2005) accused the pamphlet of being too selective in the information presented and to misquote the secular writers to support its position. As a result, medical risk, the necessity of blood transfusions and medical alternatives have been misrepresented. While it may be legitimate to demand a follower to obey to a certain religious doctrine, since JWs rely only on WTS literature, they should at least receive all relevant and complete information about treatment options.

However, beyond criticism, for a JW, conscious and unrepentant acceptance of blood will entail very serious theological and social consequences. Firstly, it means breaking their personal covenant with Jehovah

[7] In blood transfusion, autologous means a situation in which the donor and the recipient are the same person.
http://www.medterms.com/script/main/art.asp?articlekey=13210

and so loosing the chance of everlasting life in his Kingdom. As explained by an elder of a JW Dutch congregation, 'This life on earth is very short and irrelevant if compared with eternal life..and JWs choose to save their eternal life. Physicians cannot promise to save you, only your Creator can give you the guarantee that if you manage to live in the will of God then you will have the security of salvation' (Ten Have, personal communication, 2011). So, there is a relative conception of "life" that must be taken into consideration: in this perspective earthly life is brief and insignificant if compared to the prospect of eternity. Secondly, members who violate the fundamental moral principles, or who dispute doctrinal matters, may be subject to disciplinary action including disfellowshipping. This means that JW members are required to sever association with even their own family members and relatives who have been expelled. The consequences of this doctrinal policy are extreme, shattering family relationships and leaving people emotionally and spiritually devastated (Elder 2000, Ridley 1999).

In an interview, the Head of AJWBR expressed particularly harsh words: 'It is a cruel, family destroying practice that has caused suicide, murder, homelessness, depression and every other sort of social ill that may befall a person when their whole world has been ripped apart' (Dean, personal comunication, 2011) .
However blood transfusions are also considered potentially life-saving treatments.[8]

It is not in my intention to give a value judgment. I simply wanted to point out that the blood doctrine is surely highly controversial, ambiguous and accused to misrepresent secular information (Louderback-Wood 2005). However, in the attempt to give a functionalist analysis of the doctrine, the sociologist Singelenberg hypothesized that the blood prohibition comes from the concepts of purity and pollution. It is a taboo that serves the purpose of a dichotomization of "us" and "them", which epitomizes the Society's "ideological concept of anti-worldliness" and form the moral character of Jehovah's clean people. In other words, he suggested that the importance of this doctrine should not be underestimated because it serves the purpose of providing and keeping the cohesiveness of a worldwide movement (Singelenberg 1990).

[8] Life-saving medical treatment refers to curative treatment that promises that the patient's short- and long-term prognoses are excellent. (Harvey in Will 2006)

Chapter 4 The Second Element of Analysis: Judicial Practice in the UK

This chapter introduces the second element of analysis relating to the JW case example. The study of JW adolescents is contextualized in the English legal system. The chapter is divided into two sections: the first one assesses the extent to which the general principles of law recognize an adolescent's capacity to consent to and refuse medical treatment in the UK. Then, the final part considers the application of the general principles in the specific court cases concerning JW adolescents and blood transfusion.

4.1 Legal Competence in the UK[9]

The UK ratified the UNCRC. It tried to adapt its legal approach to the international vision of the "evolving capacity" of childhood entrenched in article 12 and to the idea of giving "due weight" to the child's views in accordance with age and maturity. Moreover, the implementation of the Human Rights Act (HRA 1998), which puts a particular emphasis on adult autonomy, has produced a judicial willingness to consider the same approach when dealing with older children's interests. However there is a clear indeterminacy about how to weigh a child's views and interests and also about how to define a best interests/welfare standard. In the UK there has been a tendency to view the commitments embodied in articles 12 and 3 as discrete matters, leaving the question of how to balance the two commitments to the state party's personal discretion (Fortin 2009).

England and Wales have one unified legal system, Northern Ireland and Scotland form single jurisdictions. However, while Northern Ireland adopts a very similar legislation to that of England and Wales, Scotland has an independent legal tradition that, for example, has a quite different view over children's capacity, and so provides for some interesting points of comparison. The cardinal principle endorsed in UK law is that the welfare/best interests of the child must be the first and paramount consideration of courts' in all decisions regarding children. This principle forms the basis of the respect for the child's decision (Elliston 2007). However, the question whether empowering children should be seen in their best interests is a matter that has given rise to several cases and attracted substantial controversy in England and Wales.

Concerning presumptive competence, the English law decided that the age of majority is 18. However, the FLRA (1969) established that adolescents could be assumed to possess sufficient capacity to make their own health choices since 'the consent of a minor who has attained the age of sixteen years

[9] see annex 2-5

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' (8(1)).

In Scotland the age of majority is still 18; however, the ALC(S)A (1991) gives the statutory presumption that a 16 years old child can make an important number of legally binding decisions, including giving consent to medical treatment (1(1)b e (2), 3(3)e, 9). The same statute considers also the position of children under 16 years old and provides a standard for their evidential competence. According to provision 2(4),

> 'A person under the age of 16 years shall have legal capacity to consent.. where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.'

The type of understanding required is no further specified, but the report by the Scottish Law Commission seems to suggest that this "understanding" should entail certain maturity and not merely a cognitive capacity. (SLC 1987 in Elliston 2007).

In a similar way, England and Wales also consider the idea that children below 16 lack a presumption of capacity, they have to give proof of competence in order to have their consent to treatment be legally valid. However, the position is here covered by common law. The seminal case in this regard *is Gillick vs West Norfolk and Wisbech Area Health Authority* (1985) which established the legality of prescribing contraceptives to a girl aged less than 16 years without the knowledge or consent of her parents. This decision opened the way to a much more liberal approach towards adolescence as a diversified category, and especially towards teenagers' 'evolving autonomy' in decision-making[10]. On this purpose, Lord Scarman commented:

> 'If the law should impose on the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change' (*Gillick* 1985: 186).

Although the decision focused specifically on contraception, the term "*Gillick* competence" established some principles that became of general applicability to all forms of medical treatment. Its importance lies in the fact that it promoted a legal approach which looked at children's consent relating it to competence, rather than age. In fact, The *Gillick* ruling defined a competent child as one whom,

> 'Achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed (and has) sufficient discretion

[10] The judgment was quickly followed by the ratification of the CRC and by domestic legislative measures which focused on enhancing the status of children's wishes and feelings (Children Act 1[3])

to enable him or her to make a wise choice in his or her own interests' (*Gillick* 1985: 187), without specifying any relevant age.

So, where a child is deemed *Gillick* competent, his/her consent to a proposed medical treatment is sufficient to permit the treatment to be lawfully delivered and nobody with parental responsibility should be able to remove it. Parental rights correspond to their duty to protect their child, so these rights must be conceived as proportionally inversed to children's growing competence and terminate when the child achieves it fully.

However, a common criticism concerns the indeterminacy of the content of *Gillick* competence despite the widespread use of it. The British Medical Association (BMA) recognized that the case does not show a clear ratio. In fact, there appear to be two leading judgements. On one hand, Lord Fraser set the threshold for competence at the basic and narrow level of understanding medical advice but specified that competent children's decisions are limited and bound to their best interests. On the other hand, Lord Scarman constrained children's decision-making by setting a higher threshold for competence. Full capacity required cognitive understanding to be enriched with emotional maturity. The BMA seems to have start considering with greater consideration Lord Scarman's line. However it remains unclear to what extent social and emotional skills should be considered in assessing competence (BMA 2001). The idea seems to be that, since children lack presumptive capacity, they need to demonstrate not only that they *can* understand the decision they want to make, but also that they *do* understand that decision. So, the standard of intelligence and depth of understanding that the child needs to display to pass the *Gillick* test is relative to the magnitude of the risk and gravity of the particular choice to be made (Mohindra 2008).

This reasoning is reflected in the perception of the refusal of consent. In fact, the logical conclusion from the definition will suggest that *Gillick* competent children should be capable to both accept and refuse treatments.. However, under English and Welsh law, the focus is upon a child's right to consent to treatment, not his right to refuse it; on the contrary a minor's refusal cannot be generally considered conclusive.

According to the principles explored in *Re R* (1992) and then fully developed in *Re W* (1992) by Lord Donaldson, a minor *Gillick* competent patient has a right to refusal which can be easily overridden, by adjusting the level of competence required, if another source of legal justification can be secured from the people with parental responsibility or from the court itself (inherent jurisdiction) in the name of the child's best interests (Fortin 2009). As Brazier and Bridge (as cited in Fortin 2009: 156) noted 'the right to be wrong applies only when minors say yes to treatment'. This position indeed seems to be a step back forward from the progress made in the *Gillick* case, since it put a clear limit to the extent to which the law should value children's rights to autonomy, and gives leeway to the possibility to force competent

children to medical treatment against their will, even if they have the competence to make their own choices.

On the opposite, Scotland seems to have a more supportive approach towards competent children's autonomy. Provision 2(4) of the ALC(S)A 1991 seems to support Lord Scarman's approach since there is no reference to a best interests standard but only to assessing children's capabilities. This position, which considers the idea that a competent child is entitled also to a right to refuse, is further supported by other statutory provisions such as provision 15(5), and especially provision 90 of The C(S)A (1995).

However, this has still to be determined by the Scottish courts. To date, the case of Houston is the sole case discussing the issue of child's right to refuse medical treatment and it seemed to support the right of a competent Scottish child to refuse medical treatments (Houston 1996: SCLR 945). However, the issue remains open to speculation.

4.2 Jehovah's Witness Adolescents and the English Judicial Practice

The issue of adolescent's competence to refuse treatment has become particularly relevant in the context of the study case above presented, that is the one involving adolescents whom opposed treatment on religious grounds. I have shown that neither the statutory framework nor the common law system for determining the competence of children has directly addressed the issue of refusal. As a result, the courts had potential leeway to deal freely with this issue. The English approach seems to suggest that, either adults vested with parental authority nor the court itself, have the power to veto a refusal of consent by a child, since 'in no reported English case has a child's refusal of consent been respected' (Elliston 2007: 134).

Generally, the cases concerning adolescent's refusal to accept treatment appear to fit into two categories (Bridge 1999): the first category concerns adolescents with mental disorders; the second one concerns religious adolescents which refuse treatments because of their beliefs. The second category shows particularly complex problem when it comes about imposing a treatment.

> 'When a mature, intelligent child makes a medical decision on the basis of sincerely held religious conviction, a decision which the law would be obliged to accept were he 18, on what grounds is coercion justified?' (Bridge 1999: 586).

The Department of Health (UK) has clearly stated that 'welfare does not just mean physical health. The psychological effect of having the decision over ruled must also be considered' (DOH 2001a: para 8.1). In addition to that, in *Re W* (1992 All ER 627: 635) Judge Donaldson declared about the relation between competence and values:

> 'I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less *Gillick* competent.'

Following this thread of reasoning, it seems that religious beliefs in themselves shouldn't make a child incompetent. However, the aim of this paragraph is to show how, religious values of children seem not to have the same weight as adults when court cases are considered in practice, at least for what is concerning the JW study case.

Recently published guidelines from the AAGBI (2005) estimated that there are about 150000 JWs in Great Britain and Ireland. In all cases brought before the English courts, *Re E (A Minor)(Wardship: Medical Treatment)* [1993], *Re S (A Minor)(Medical Treatment)* [1993], *Re L (Medical Treatment: Gillick Competence)* [1999] and *Re P (Medical Treatment)* [2003], the JW adolescents, which were involved in very serious and often life-threatening medical conditions, were deemed *Gillick* incompetent and forced to have blood transfusion in the name of their best interests.

In *Re E* (1993), an almost 16 years old boy was suffering from a form of acute leukaemia. Without blood transfusions as part of the treatment his chances of complete remission were 40-50%. He and his parents, as JWs, refused the blood transfusion component and asked the child to be declared competent according to the *Gillick* criteria. The boy was declared *Gillick* incompetent because unable to understand the effect of his refusal. The hospital was then empowered to administer blood transfusion, as essential part of his treatment, in the name of his best interests.

In *Re S* (1993) too, a 15 1/2 year old girl was suffering from a chronic illness, beta minor thalassemia, a genetic blood disorder, which required frequent blood transfusions and desferroxamine infusions. The case was brought to court when the girl became a JW and started rejecting further treatment. Her JW parents supported her decision. The child was deemed *Gillick* incompetent because uncapable of understand the gravity of her decision. The imposition of treatment was considered in the girl's best interests.

In *Re L* (1999), the court faced an emergency situation. A 14-year-old girl suffered very severe scalds after an accident. There was a life-and-death situation that required at least three surgical interventions that necessarily involved blood transfusions. However, the girl had adopted the blood policy since she was 12 year old. She had just renewed an advance medical directive refusing transfusions two months before the accident. The Hospital Authority, confronted with an emergency, invoked the court's inherent jurisdiction to authorize the treatment. The girl was not deemed *Gillick* competent to take such a decision since her capacity was reduced by ' her limited experience of life' (Mohindra 2008: 78).

Re P (2003) however represents the most peculiar case. A child of almost 17 years old was affected by a chronic illness that, at a certain point, required blood transfusions. He legitimately witheld his consent to any treatment that involved blood transfusion and his JW parents supported him. However, in the final judgment the judge 'did recognise that there might be cases where the child is nearing 18 where respecting his competent refusal might be appropriate, especially where treatment will merely postpone inevitable death' (2003 EWHC 2327: 9). However this didn't seem one of those cases. On the contrary, despite these comments and despite the age of the child, competence did not bring a corollary right to decide what was in his best interests: the court "reluctantly" stated that it was in the best interests to receive a life-saving blood transfusion.

4.2.1 Insight Gained From The Case Law

4.2.1.1 The Consideration of Religious Commitment

Religious commitment did not seem a crucial element in favour of the assessment of competence. In *Re S*, the girl clearly lacked a long-standing commitment to her faith. She had only recently converted under the influence and pressure of her mother. She showed an impaired and superficial understanding of her religion, which could not form the true basis of her medical decision-making (Bridge 1999). For these reasons, the lack of true religious commitment became a strong element to deny her competence.

However, the same could not be said in the cases of *Re E* and *Re L*. Both the teenagers were devout believers and they seemed perfectly able to sustain

their refusing of treatment with deeply embedded beliefs. In her essay on the *Re L* case, Bridge (1999: 587) reported

> 'There is no doubt that *L* had embraced these religious convictions sincerely and firmly. She was very religious, mature, a model of a young person...not attracted by some of the more undisciplined pursuits of youth'

Moreover, *L* had signed and constantly renewed a "no blood card" in which she stated the wish to not receive blood in case of injury. In *Re E* any doubt about his commitment was erased when the adolescent turned 18 and started to lawfully reject the treatment that eventually result in his death (Bridge 1999). Nevertheless, the final court decision was quite similar in all the cases mentioned. The courts' approach seems to suggest that a child's spiritual well-being cannot take precedence over the physical one.

4.2.1.2 The Test for Competence: The Threshold Elements (Competence and Voluntariness) and Disclosure of Information

In all cases that regarded children under 16 *(*all but *Re P*), the evidential standard for declaring competence became crucial to the judgment. In *Re E*, the test for competence was very demanding and rigorous since it required the boy to be able to realise the full implications of the manner of his death including the potential physical pain and the psychological suffering of his family. This test was very demanding even for a competent adult, however the main problematic was in the fact that *E* was not even put into the condition to direct his thought to such matters because the necessary information was not provided. Ward J, on this purpose, declared that: 'I did not judge it right to probe with him whether or not he knew how frightening [the dying process] would be' (1993 1 FCR 219: 224).

So, the court promoted a quite original and paternalistic way for denying competence: it approved the withholding of essential information for the decision-making process, and declared the boy, although adequately intelligent and able to make most of the decisions regarding his own well-being, not *Gillick* competent for inability to fully comprehend the implications of that particular decision (Elliston 2007). The same approach was used in *Re L*. Even though there were no apparent reasons for which *L* could be unable to cope with all the relevant information regarding the drastic implications of her choice, she was not informed about her condition. She was thus not in the position to give informed consent. As a consequence, she was unable to properly understand her situation and make a valid decision. The judge, sir Stephen Brown, was quite happy with the situation, since the clear information deficit, albeit deliberate, made the decision to deny her autonomy perfectly legitimate. The real position of the court came out even more clearly in the final comment made by the President of the Family Division, which stated that the decision would have remained the same in any case. The logical conclusion

is then that the principle governing the exercise of the court's inherent jurisdiction seems to be the welfare principle rather than a realistic assessment of competence.

Another issue raised in the assessment of competence, which was treated in an earlier paragraph about children's developmental capacity, regarded the presumption that children's views should not be respected because their views are not as solid as those of adults since they may change, as they get older. In the case of *Re E* (1992 2 FCR 219: 226), Ward J put it strictly:

> '...I respect this boy's profession of faith, but I cannot discount at least the possibility that he may in later years suffer from diminution in his convictions.'

A similar presumption was raised about the voluntariness of those views since those teenagers' religious beliefs were formed within the context of the strong influence of their family and religious communities. Therefore, there was the possibility that their decisions were not the fruit of a free and autonomous choice. Again Ward J, in *Re E* (1992 2 FCR 219: 226), commented about the boy's wishes:

> 'I am far from satisfied that at age of 15 his will is fully free. He may assert it, but his volition has been conditioned by the very powerful expressions of faith to which all members of the creed adhere.'

At the end, *E* was still deemed *Gillick* incompetent, even though the court rejected this presumption that his beliefs were not genuine. Similar concerns about the voluntariness and free will of JW teenagers have permeated also the other cases of *Re S* and *Re L* (Elliston 2007).

Concerning *Re L*, I already underlined how the reliability of her beliefs was fully recognized by the court. Moreover, there were no apparent suggestions that her decision was forced or strongly influenced by either the parents or religious community. Rather, her stepfather's declaration that '[the family] shall support her whatever the order of the court may be' (Bridge 1999: 587) seems to suggest that she did not run the risk to be rejected by her family or congregation if she failed to adhere to the no blood' belief. This was a case were the parents did not expressively refuse to give their consent for the treatment, thus nullifying any possible claim of indirect influence on the girl.

However, the court still took into consideration the possibility that *L*'s exercise of free will could be undermined by religious indoctrination. Her devotion was seen more as the result of a dangerous mix of the enthusiasm of youth with the powerful influence of a sheltered religious community, since 'The 'JW congregation [formed] a very large part of her life' and 'she had spent some 60 hours in the week before her accident dealing with matters connected with the church' (1998 2 FLR: 813). In fact, this judgment was based upon the opinion provided by a psychiatrist, which considered her religious view and

position as to rigid to be the fruit of a 'constructive formulation of an opinion, which can occur only with adult experience' (1998 2 FLR: 812).

To sum up, even though the court acknowledged the strength of her wishes, the dominant position was that her sheltered life left her with a limited experience of life. Hence she was necessarily restricted in her 'understanding of matters which are as grave as her medical situation.'(1998 2 FLR: 813).
So, the court's final suggestion was that the importance of religious beliefs was strictly interconnected with the full development of maturity, rationality, understanding and life experience. It is noteworthy to consider that this stringent approach in assessing competence has been proposed even in *Re P*, where the boy was 17 and so deemed presumptively competent (Bradney 2009).

4.2.1.3 The Life-Saving Factor as the Best Interest for the Child

A final theme I would like to consider is the use of the best interest principle in courts. I have shown so far how the arguments used by the courts to approach competence varied from case to case. The overall conclusion is that respect for autonomy seemed not the deciding factor. This finding is further supported by an analysis of the best interests element. In fact, the courts showed a unanimous consensus in identifying the best for the child with the life-saving/prolonging proposed medical treatment rather than his/her wishes for self-determination. The possibility of survival was regarded as the crucial factor. In the judgment of *Re P* (as cited in Bradney 2009: 119), the court ruled that:

> 'To overrule the wishes of John seems to me to be an order that I should be (as indeed I am) reluctant to make...Nonetheless, looking at the interests of John in the widest possible sense –medical, religious, social whatever these may be – my decision is that John's best interests will be met if I make an order in the terms sought by the National Health Service Trust [that would allow the use of blood transfusions].'

In *Re E* (1993 1 FCR 219: 227) too Ward J admitted 'when therefore, I have to balance the wishes of a father and son against the need for a chance to save a precious life, then I have to conclude that their decision is inimical to [*E*'s] well being'. In the attempt to balance the two opposing views, the extent of *E*'s resistance to the treatment and the potential emotional trauma deriving from the imposition of it, were also taken into consideration as relevant factors (Archard and Skivenes 2009). In fact, the emotional trauma of forcing a blood transfusion to an unwilling adolescent could have a negative effect on the overall treatment and provoke also a harsh and active reaction. However, the court concluded that, in any case, this eventuality was more bearable than the alternative:

> 'Any emotional trauma in the immediate or in the long term will not outweigh, in my judgment, the emotional trauma of the pain and the fear of dying in the hideous way he could die (1993 2 FCR 219: 227).

Another general observation was made on the fact that, if the original form of treatment with blood was considered the most effective in terms of physical benefits, the court did not seem disposed to negotiate an alternative form of treatment that would suit better the JW adolescents' needs (Elliston 2007). An example of this attitude was shown in *Re E*. The boy was under treatment, which held some prospect of success. At a certain point, a more effective combination of medications was found to cure his acute leukemia. However the new drugs involved had side effects that required blood transfusion. When the case was herd in court, the original treatment had a 40% perspective of success against 70% of the new one. Even though the difference

was not abyssal, the court rejected the original treatment in the name of his best interest.

To sum up, the best interest test used by the courts seemed to allow only one interpretation of the concept of what is best for the child. This interpretation focused on the health interests of the child, the principle of sanctity of life and, as a consequence, placed a primary consideration on doctors' medical opinions.

Chapter 5 Conclusion

The findings on competence tracked in the various cases analyzed are quite difficult to be reconciled in one sentence. In my opinion, the courts failed to adequately assess the issue of adolescent capacity. Even when there was evidence that the adolescent's choice was mature and autonomous, as in the case of *Re E*, expedients were found to apply a specific and narrow conceptualization of the child's best interests that is physical survival. I have shown that, in certain cases, the doctors have used this expedient as a means of withholding certain relevant information from the minor patient. Even though the rationale behind this was a good one, such as sparing further distress to an already sick child, having all the information is a crucial part for making a competent decision. For this reason alone, information should always be given to a potentially competent minor. The MCA (2005) established clearly that the assessment of a person's decision-making capacity could be done only when 'the information relevant to the decision' was given (prov.3 [1]).

It is true that a protective approach towards adolescents has been extensively sustained and promoted by legal and ethical theory. In fact, this paternalistic approach is in line with an interest theory of rights and a hypothetical choice test. The desire to protect a child's future choice is certainly noble. However it remains highly controversial whether the thresholds of legal competence should be adjusted every time at the court's pleasure. And, in any case, as I have shown, using the deliberate withholding of important information as an excuse to deny competence is unacceptable. The right to self-determination is fundamental and should be considered more seriously.

Concerning the presumption over the potential volubility and weakness of children's views, some reflection still needs to be done. It is perfectly reasonable to consider that decision-making capacities need time to develop and that adolescence is a period of life in which most people begin the process to establish, through experimentation, their own identity and values. However, if those considerations are generalized, the focus shifts from the patient as a particular child with his individual capacities to the patient as a member of a wide class of people (children). This approach is problematic if it has to be considered in the light of a legal competence test, which aimed to be calibrated on the effective abilities of the patient rather than his/her age.

While extreme caution has to be used in granting competence, the possibility to face a situation of an already solid and mature judgment must be taken into consideration. *Re E* in this regard represents a relevant example, where the boy maintained his beliefs until he turned 18 and had a legal right to die for them. So, the presumption that children's views will change over time

must at least be open to challenge. There is the concrete possibility that they will change, but this argument is applicable to adults as well. It can be said that children's views are more vulnerable to external influences. However, this is again an assumption that needs to be substantiated for each case. Moreover, a realistic perspective over voluntariness, which cannot abstract persons from environmental interaction, should remind us that a decision can be the expression of a person's own true will even if the person in question has been influenced by others to a certain extent. Being influenced is not in itself a reason to deny free will; it must be supported by other factors.

My final reflection concerns the court's consideration of religious beliefs. The courts allow religious beliefs play an ambiguous role in the assessment of competence. It does not seem to be a determining factor but, in some cases, they associated adolescents' faith and devotion with the most common bias of adolescence, such as impetuosity and superficiality. For example in the case of *Re L* it was said that her request should not be seriously considered because an adult believer in her place would have been more keen to enter into a constructive dialogue and consider to modify his position. However, the assumption that teenagers' beliefs lack the validity of adult faith is wrong, since the espousal of religious beliefs in a very black and white manner is more a feature of any fundamentalist view of religion[11], rather than a peculiarity of the impetuosity and enthusiasm of adolescence.

Religious conviction tends to spring from faith and is not always based on rationality, maturity, intelligence or understanding. It simply impossible to pretend that religious beliefs should be the fruit of a long reasoned reasoning or of an universal and objective truth. Thus, adolescents should have a right to religious beliefs just as any other adult human being. Religious beliefs should not form part of the assessment of adolescent's competence because a competent choice does not demand rationality, but just a reasoned explanation. However, they should certainly be taken into consideration in the evaluation of the strength and validity of the personal commitment to a certain choice. After all, when it comes to JWs, the courts are not facing a capricious teenager girl that refuses chemotherapy for the fear to loose her hair.

However, when cases such *as Re E, Re L* and *Re P* are examined, it seems that children's religious values wont have the same consideration as in the adults' situations. This legal-ethical dilemma is complicated and resolvable only after reaching a real consensus on what really constitutes an autonomous choice and after finding a good balance between the right to protection and self-determination of young people. At this point, it is maybe more honest to state clearly that a concept such as "*Gillick* competence" does not exist when it

[11] the use of 'fundamentalism' to describe JW faith is justified only in the sense that they follow a literal exegesis of their Bible which doesn't allow compromises for what is concerning important moral rules.

comes to refusal of life-saving/prolonging treatments. Or, at least, to recognize the eventual adolescent's competence, but take responsibility to override his wishes anyway, such as in the case of *Re P* and *Re L*.

To conclude, as discussed in chapter 2, there used to be a clear-cut separation between the medical decision-making capabilities of adults and minors. The rationale behind this separation is the presumption that adults are competent to make these decisions while minors are not. However, recent academic research in the healthcare setting has challenged the notion that the legal age for majority is not a solid indicator for assessing the threshold of maturity, and the consequent right to self-determination in healthcare decisions. In a nutshell, the legal definition of adulthood does not reflect the child's development reality.

Therefore, I am of the opinion that adolescents should not be considered incompetent *a priori,* but they should have the right to prove their maturity. Then, what does it mean to be competent? The minor has to possess capacities for communication and understanding of information, capacities for independent reasoning and deliberation and capacities to have and apply a certain set of values. If the minor possess those capacities, than he should be considered competent to make important medical choices. Those choices should be respected because they reflect his real conception of well being, and, in any case, a competent choice does not demand rationality, but just a reasoned explanation.

However, this doesn't seem the approach adopted by the English courts in the cases concerning JW adolescents and refusal to consent. In fact, the legal concept of competence has been manipulated to fit the court's conceptualization of the child's best interests, which is to guarantee the physical survival. Though, it is very difficult to reach a consensus about what really is the child's best interest. The education of a child shapes the values of the future adult: he will evaluates and consider his life in the light of those values. Moreover, attitudes to death are cultural. The dominant secularist humanist mentality conceived death as a definitive end, but for many religions, and JWs are one of them, there is an important connection between life, death and what comes after (Montgomery in Bradney 2009). Controversial or not, understandable or not, there is the possibility that a JW adolescent strongly believe that accepting a blood transfusion will jeopardize his/her future chance of everlasting life. The will to refuse blood transfusion should not be used as a proof to show the incompetence of a minor. The European community has adopted a highly tolerant view towards religious training (Wah 2001).

In England, the court confirmed this approach in the case *Re T (Minors) (Custody: Religious Upbringing)* [1981] (as cited in Wah 2001: 596)

> '...We live in a tolerant society. There is no reason at all why the mother should not espouse the beliefs and practice of JWs. It is

> conceded that there is nothing immoral or socially obnoxious in the beliefs and practices of this sect.'

Therefore, if the state allows JWs parents to raise their children with certain beliefs, then a minor cannot be considered immature just because he/she wishes to die for them. A clear distinction should be drawn between the effective capacities to make fundamental decision and where the best interests of the child really lie. Following the same reasoning, whether the result of a certain choice made by a competent and mature minor is consent or refusal to consent should not be relevant to whether that choice should be respected. This is arguable because an individual conception of well-being can be deeply bonded with his religious beliefs and adolescents are potentially capable to hold a sufficient level of maturity to determine a coherent and solid sense of self.

Therefore, if those beliefs are genuine, if they are an integral part of the child's identity and if the child meets all the original criteria of the competence test, his/her will should be taken into serious consideration. Although the court's intent is noble, the current approach does not give the due importance to the adolescent's right to self-determination and autonomy, guaranteed by both international and domestic legal standards. In this regard, Fortin has hypothesized that English adolescents could rely in future on the ECHR, which have been given further strength after the HRA came full into force in 2000. The Convention applies to all human beings and has embodied some human rights, which reflect the increasing importance of autonomy. In Fortin's opinion, art. 3 (prohibition of torture), 5 (right to liberty and security) and 8 (right to respect for private and family life)[12] could provide adolescents with protection from being forced to have unwanted medical treatment, thus enhancing their potential competence to refuse consent (Fortin 2009).

However, for what is concerning the current times, the answer to whether adolescent Jehovah's Witnesses have a right to refuse blood transfusions on the ground of religious beliefs, seems to be that "the right to say yes [*does not*][13] carry the right to say no" (Norrie in Elliston 2007: 111).

[12] see annex 6

[13] word and emphasys added by the author

Appendices

1. The UN Convention on the Rights of the Child

Art. 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Art. 2

1. 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, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Art. 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Art. 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties

shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Art. 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Art. 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Art. 14

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.

2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Art. 16

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

Art. 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.

To this end, States Parties shall:

(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;

(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;

(c) Encourage the production and dissemination of children's books;

(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;

(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

2. The Age of Legal Capacity (Scotland) Act

Art. 1

Age of Legal Capacity

1. As from the commencement of this Act—

(a) a person under the age of 16 years shall, subject to section 2 below, have no legal capacity to enter into any transaction;

(b) a person of or over the age of 16 years shall have legal capacity to enter into any transaction.

2. Subject to section 8 below, any reference in any enactment to a pupil (other than in the context of education or training) or to a person under legal disability or incapacity by reason of nonage shall, insofar as it relates to any

time after the commencement of this Act, be construed as a reference to a person under the age of 16 years.

3. Nothing in this Act shall—

(a) apply to any transaction entered into before the commencement of this Act;

(b) confer any legal capacity on any person who is under legal disability or incapacity other than by reason of nonage;

(c) affect the delictual or criminal responsibility of any person;

(d) affect any enactment which lays down an age limit expressed in years for any particular purpose;

(e) prevent any person under the age of 16 years from receiving or holding any right, title or interest;

(f) affect any existing rule of law or practice whereby—

(i) any civil proceedings may be brought or defended, or any step in civil proceedings may be taken, in the name of a person under the age of 16 years who has no guardian or whose guardian is unable (whether by reason of conflict of interest or otherwise) or refuses to bring or defend such proceedings or take such step;

(ii) the court may, in any civil proceedings, appoint a curator ad litem to a person under the age of 16 years;

(iii) the court may, in relation to the approval of an arrangement under section 1 of the Trusts (Scotland) Act 1961, appoint a curator ad litem to a person of or over the age of 16 years but under the age of 18 years;

(iv) the court may appoint a curator bonis to any person;

(g) prevent any person under the age of 16 years from—

(i) being appointed as guardian to any child of his, or

(ii) exercising parental rights in relation to any child of his.

4. Any existing rule of law relating to the legal capacity of minors and pupils which is inconsistent with the provisions of this Act shall cease to have effect.

5. Any existing rule of law relating to reduction of a transaction on the ground of minority and lesion shall cease to have effect.

Art. 2

Exceptions to General Rule

l. A person under the age of 16 years shall have legal capacity to enter into a transaction—

(a) of a kind commonly entered into by persons of his age and circumstances,

and

(b) on terms which are not unreasonable.

2. A person of or over the age of 12 years shall have testamentary capacity, including legal capacity to exercise by testamentary writing any power of appointment.

3. A person of or over the age of 12 years shall have legal capacity to consent to the making of an adoption order in relation to him; and accordingly—

(a) for section 12(8) (adoption orders) of the Adoption (Scotland) Act 1978 there shall be substituted the following subsection—

"(8) An adoption order shall not be made in relation to a child of or over the age of 12 years unless with the child's consent; except that, where the court is satisfied that the child is incapable of giving his consent to the making of the order, it may dispense with that consent."; and

(b) for section 18(8) (freeing child for adoption) of that Act there shall be substituted the following subsection—

"(8) An order under this section shall not be made in relation to a child of or over the age of 12 years unless with the child's consent; except that where the court is satisfied that the child is incapable of giving his consent to the making of the order, it may dispense with that consent."

4. 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 of the procedure or treatment.

5. Any transaction—

(a) which a person under the age of 16 years purports to enter into after the commencement of this Act, and

(b) in relation to which that person does not have legal capacity by virtue of this section, shall be void.

Art. 3

Setting Aside of Transiction

1. A person under the age of 2l years ("the applicant") may make application to the court to set aside a transaction which he entered into while he was of or over the age of 16 years but under the age of 18 years and which is a prejudicial transaction.

2. In this section "prejudicial transaction" means a transaction which—

(a) an adult, exercising reasonable prudence, would not have entered into in the circumstances of the applicant at the time of entering into the transaction, and

(b) has caused or is likely to cause substantial prejudice to the applicant.

3. Subsection (1) above shall not apply to—

(a) the exercise of testamentary capacity;

(b) the exercise by testamentary writing of any power of appointment;

(c) the giving of consent to the making of an adoption order;

(d) the bringing or defending of, or the taking of any step in, civil proceedings;

(e) thegivingofconsenttoanysurgical,medicalordentalprocedure or treatment;

(f) a transaction in the course of the applicant's trade, business or profession;

(g) a transaction into which any other party was induced to enter by virtue of any fraudulent misrepresentation by the applicant as to age or other material fact;

(h) a transaction ratified by the applicant after he attained the age of 18 years and in the knowledge that it could be the subject of an application to the court under this section to set it aside; or

(j) a transaction ratified by the court under section 4 below.

4. Where an application to set aside a transaction can be made or could have been made under this section by the person referred to in subsection (1) above, such application may instead be made by that person's executor, trustee in bankruptcy, trustee acting under a trust deed for creditors or curator bonis at any time prior to the date on which that person attains or would have attained the age of 21 years.

5. An application under this section to set aside a transaction may be made—

(a) by an action in the Court of Session or the sheriff court, or

(b) by an incidental application in other proceedings in such court,

and the court may make an order setting aside the transaction and such further order, if any, as seems appropriate to the court in order to give effect to the rights of the parties.

Art. 9

Interpretation

In this Act, unless the context otherwise requires— "existing" means existing

immediately before the commencement of this Act;

"parental rights" has the same meaning as in section 8 (interpretation) of the Law Reform (Parent and Child) (Scotland) Act 1986;

"transaction" means a transaction having legal effect, and includes—

(a) any unilateral transaction;

(b)the exercise of testamentary capacity;

(c) the exercise of any power of appointment;

(d) the giving by a person of any consent having legal effect;

(e) the bringing or defending of, or the taking of any step in, civil proceedings;

(f) acting as arbiter or trustee;

(g) acting as an instrumentary witness.

3. The Children (Scotland) Act

Provision 15

Interpretation Part I

1. In this Part of this Act-

"child" means, where the expression is not otherwise defined, a person under the age of eighteen years;

"contact order" has the meaning given by section 11(2)(d) of this Act;

"parent", in relation to any person, means, subject to Part IV of the Adoption (Scotland) Act 1978 and sections 27 to 30 of the Human Fertilisation and Embryology Act 1990 and any regulations made under subsection (9) of the said section 30, someone, of whatever age, who is that person's genetic father or mother;

"parental responsibilities" has the meaning given by section 1(3) of this Act;

"parental rights" has the meaning given by section 2(4) of this Act;

"residence order" has the meaning given by section 11(2)(c) of this Act;

"specific issue order" has the meaning given by section 11(2)(e) of this Act; and

"transaction" has the meaning given by section 9 of the Age of Legal Capacity (Scotland) Act 1991 (except that, for the purposes of subsection (5)(b) below, paragraph (d) of the definition in question shall be disregarded).

2. No provision in this Part of this Act shall affect any legal proceedings commenced, or any application made to a court, before that provision comes into effect; except that where, before section 11 of this Act comes into force, there has been final decree in a cause in which, as respects a child, an order for

custody or access, or an order which is analogous to any such order as is mentioned in subsection (2) of that section, has been made, any application on or after the date on which the section does come into force for variation or recall of the order shall proceed as if the order had been made under that section.

3. In subsection (2) above, the reference to final decree is to a decree or interlocutor which, taken by itself or along with previous interlocutors, disposes of the whole subject matter of the cause.

4. Any reference in this Part of this Act to a person—

(a) having parental rights or responsibilities;

(b) acting as a legal representative; or

(c) being appointed a guardian, is to a natural person only.

5. Any reference in this Part of this Act to a person acting as the legal representative of a child is a reference to that person, in the interests of the child—

(a) administering any property belonging to the child; and

(b) acting in, or giving consent to, any transaction where the child is incapable of so acting or consenting on his own behalf.

6. Where a child has legal capacity to sue, or to defend, in any civil proceedings, he may nevertheless consent to be represented in those proceedings by any person who, had the child lacked that capacity, would have had the responsibility to act as his legal representative

Provision 90

Consent of child to certain procedures.

Nothing in this Part of this Act shall prejudice any capacity of a child enjoyed by virtue of section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 (capacity of child with sufficient understanding to consent to surgical, medical or dental procedure or treatment; and without prejudice to that generality where a condition contained, by virtue of—

(a) section 66(4)(a), section 67(2) or section 69(9)(a) of this Act, in a warrant; or

(b) section 70(5)(a) of this Act, in a supervision requirement,

requires a child to submit to any examination or treatment but the child has the capacity mentioned in the said section 2(4), the examination or treatment shall only be carried out if the child consents.

4. The Family Law Reform Act

Art. 8

Consent by Persons over 16 to Surgical, Medical and Dental Treatment

1. The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment 16 to surgical, 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 par- ticular, 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.

5. The Mental Capacity Act

Provision 3

Inability to Make Decisions

1.For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

2. A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

3.The fact that a person is able to retain the information relevant to a decision

for a short period only does not prevent him from being regarded as able to make the decision.

4. The information relevant to a decision includes information about the reasonably foreseeable consequences of—

(a)deciding one way or another, or

(b)failing to make the decision.

6. The European Convention on Human Rights

Art. 3

Prohibition of Torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Art. 5

Right to Liberty and Security

1.Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;

(b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;

(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of un- sound mind, alcoholics or drug addicts or vagrants;

(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

3. Everyone arrested or detained in accordance with the provisions of paragraph 1 (c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

Art. 8
Freedom of Expression

1.Everyone has the right to respect for his private and family life, his home and his correspondence.

2.There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

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