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Abstract

The Article raises questions concerning the validity of the age of eighteen years as the youngest age allowing independent consent of a minor in Israel to his or her medical treatment. One of the primary suggestions in the Article is that there is a need to apply the informed consent doctrine to the medical treatment of Israeli and other minors who possess the appropriate capacities deemed necessary for comprehending the full implication of their consent. The authors believe that the doctrine of "developing capacities," as formulated in Article 12 of the U.N. Convention on the Rights of the Child, to which Israel is a signatory and which Israel ratified in 1991, should be implemented as the major doctrine on the right of a minor to participate in the decision-making process concerning his/her medical treatment.

THE RIGHT OF A MINOR IN ISRAEL TO PARTICIPATE IN THE DECISION-MAKING PROCESS CONCERNING HIS OR HER MEDICAL TREATMENT

*Dr. Yehiel S. Kaplan**

INTRODUCTION

A. *New Trends in Israeli Law*

The birth of the civil rights doctrine in the modern sense of the concept dates back to the seventeenth century, to the teachings of the liberal English philosopher John Locke. Locke's ideas, which were revolutionary at the time, attempted to re-evaluate the sources of political power and were founded on the belief that the initial source of political power is the consent of the governed.[1]

The post-Second World War era has been distinguished by an escalation in the status of human rights matters throughout the world. Chief Justice Barak of the Israeli Supreme Court, refers to this phenomenon as the "human rights revolution."[2] During this era, human rights issues have been emphasized in political and legal agendas worldwide. International treaties and conventions concerning human rights matters have been ratified by numerous countries, an international court has been established, and newly-created constitutions contain sections designated to ensure and promote civil rights and liberties. The aforementioned "human rights revolution" and the new legal atmosphere surrounding it have been reflected in the Israeli legal system.

A new normative system of rights has recently developed in the State of Israel. It is founded on liberal approaches to human rights issues and focuses on the right to autonomy, privacy, freedom, and the right to preserve one's physical well-being. These fundamental rights were formulated by the Supreme Court prior

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1. JOHN LOCKE, TWO TREATISES OF CIVIL GOVERNMENT (1955) (1690).

2. AHARON BARAK, INTERPRETATION IN LAW III: CONSTITUTIONAL INTERPRETATION 261 (1994).

to the legislation of the new Basic Laws,[3] but were further emphasized with their enactment.

In 1992, the Basic Law: Freedom of Occupation[4] and Basic Law: Human Dignity and Freedom[5] ("Basic Laws") were enacted, bringing about the "Constitutional Revolution in Human Rights."[6] The legislation of these Basic Laws has brought about a fundamental change in the normative status of freedom of occupation and human dignity and freedom in Israel. Since the acknowledgment of the existence of these rights was in Basic Laws, the legislator granted a higher normative status to these rights and elevated them to the level of constitutional rights.

Section 4 of the Basic Law: Human Dignity and Freedom establishes that: "Every person is entitled to protection of their life, body, and dignity."[7]

An individual's right to protection of his/her life, body, and dignity is linked directly to the issue of consent to medical treatment. The desire to protect the right to privacy as well as the right over one's body and freedom of choice concerning his/her fate has resulted in the establishment of the doctrine of "informed consent" in many countries, including Israel.[8] The primary purpose of this doctrine is to ensure that an individual is free to make choices concerning his/her personal destiny, his/her life, and his/her well-being, including the issue of his/her medical treatment. The informed consent doctrine protects the patient's autonomy and maximizes his/her ability to choose.

This new doctrine is basically contrary to the paternalistic approach to medical treatment, according to which the doctor and other persons are more competent in obtaining and

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3. *See* A. RUBINSTEIN, THE CONSTITUTIONAL LAW OF THE STATE OF ISRAEL 711 (1991)

4. Basic Law: Freedom of Occupation (1992) (Isr.) [hereinafter Freedom of Occupation Law], *available at* 26 ISR. L. REV. 247 (1992). This law is also available at http://www.israel.org/mfa/go.asp?MFAH00hj0.

5. Basic Law: Human Dignity and Freedom (1992) (Isr.) [hereinafter Human Dignity Law], *available at* 26 ISR. L. REV. 248 (1992). This law is also available at http://www.israel.org/mfa/go.asp?MFAH00hi0.

6. C.A. 94/1908, 3363, Mizrahi Bank Ltd. v. Migdal et al., (1995) 49(4) P.D. 221, 353 (author's trans.).

7. Freedom of Occupation Law, *supra* note 4, § 4.

8. On this doctrine, see JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 48-84 (1984). On the doctrine in some common law legal systems (Australia, Canada, and Great Britain), see J. KENYON MASON & R. ALEXANDRA MCCALL SMITH, LAW AND MEDICAL ETHICS 111-25 (1983); Margaret A. Somerville, *Structuring the Issues in Informed Consent*, 26 MCGILL L.J. 740 (1981).

processing the medical information and diagnosis, and are therefore entitled to make choices regarding a patient's treatment. This paternalistic approach is not consistent with the liberal civil rights revolution, which places individual rights and liberties at the center.

The informed consent doctrine received recognition by the Israeli legislator when the Patients' Rights Law, 5756-1996[9] ("Patients' Law") was enacted. Section 13(a) of this law establishes that: "No Medical treatment shall be given to any patient, unless he gave his informed consent to it under provisions of this Chapter."[10]

The informed consent doctrine does not apply to all patients.[11] Israeli case law as well as legal scholars and the Israeli legislator all acknowledge the existence of cases in which it is impossible, or problematic, to obtain a patient's informed consent. For instance, the informed consent doctrine does not apply to an unconscious patient, or a patient suffering from severe mental disorders.

B. *Including Minors in Decision-Making Process Concerning their Medical Treatment*

The issue of including minors in decisions concerning their medical treatment raises conflicting interests and rationales. On the one hand, the law in many countries, including Israel, reflects a new international trend of growing recognition of the minor's civil rights. This new trend is an inseparable part of the general human rights revolution mentioned above, which acknowledges the autonomy of children, views every human being, including minors, as a separate human entity, and attempts to protect his/her freedom of choice. Medical treatment enforced on minors without their informed consent, in instances where the age and maturity of the minor justify the obtaining of such consent, is unjustifiable within the framework of this liberal human rights-oriented approach.

On the other hand, it is claimed that the burden of deci-

9. Patients' Rights Law, 5756-1996 (Isr.) [hereinafter Patients' Law].

10. *Id.* § 13(a).

11. For cases where the doctrine does not apply, see KEN MASON & R. ALEXANDRA MCCALL SMITH, BUTTERWORTH'S MEDICO-LEGAL ENCYCLOPEDIA 121 (1987). For the restriction of adult rights, see James E. Birren & Wendy L. Loucks, *Age Related Change and the Individual*, 57 CHI-KENT L. REV. 833, 833-50 (1981).

sion-making, especially in the context of medical treatment, should be shifted from the child to the parent, to the legal guardian, or to the doctor, in order to protect the minor from self-inflicted harm. Minors are generally presumed to be vulnerable due to their lack of worldly experience and insufficient skills in the decision-making process.[12] It is society's duty to protect children from their own decisions, thereby promoting their interests. In addition, there is reluctance to bestow on a minor the responsibilities of adult decision-making.[13]

Perhaps due to this claim the human rights revolution seems to have had minimal effect in the area of minors' consent to medical treatment in many countries, including Israel. The legislators in these countries hold that minors are usually incapable of intelligent and mature consent to medical treatment.

Professor Redding explains: "Children traditionally have been treated as second-class citizens, viewed by our society and in our courts as incapable of mature decision-making."[14]

Such reasons are used to justify a conservative, paternalistic approach to consent to medical treatment of all minors, which may also be termed the "best interest" or "welfarist" approach.

One of the main purposes of this Article is to raise questions concerning the validity of the age of eighteen years as the youngest age allowing independent consent of a minor in Israel to his/her medical treatment. One of the primary suggestions that will be raised here is that there is a need to apply the informed consent doctrine to the medical treatment of Israeli and other minors who possess the appropriate capacities deemed necessary for comprehending the full implication of their consent. We believe that the doctrine of "developing capacities," as formulated in Article 12 of the U.N. Convention on the Rights of the Child,[15] to which Israel is a signatory and which Israel ratified in 1991, should be implemented as the major doctrine on the right

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12. Elizabeth S. Scott & Thomas Grisso, *The Evolution of Adolescence: A Developmental Perspective on Juvenile Justice Reform*, 88 J. CRIM. L. & CRIMINOLOGY 137, 164 (1997) ("In general, the fact that adolescents have less experience than adults seems likely to affect decision-making in tangible and intangible ways.").

13. *See infra* Part I.A.

14. Richard E. Redding, *Children's Competence to Provide Informed Consent to Mental Health Treatment*, 50 WASH. & LEE L. REV. 695 (1993).

15. Convention on the Rights of the Child, 28 I.L.M. 1448 (1989) [hereinafter Convention].

of a minor to participate in the decision-making process concerning his/her medical treatment.

We devote special attention to Israeli law, but we also propose that this doctrine may be used within the framework of other legal systems, such as English and American law. These legal systems could reassess some paternalistic legal rules and doctrines which still exist within their legal framework. Article 12 of the Convention[16] should be the main source of inspiration when legislators, or the courts, decide on the relationship between minors and their parents, guardians, doctors, nurses, etc.

I. *THE RIGHT OF A MINOR TO PARTICIPATE IN THE DECISION-MAKING PROCESS: THEORETICAL BASIS*

When we attempt to address the issue of children's right to participate in the process of decision-making concerning their medical treatment, in the first stage of this Article it is imperative to clarify the differences between the main approaches of current law to the legal status of children; namely to compare the paternalistic "best-interest of the child" principle with the concept of "children's rights," which seems to be an alternative to the "best-interest" principle in an effort to grant more individual autonomy to minors.[17] These two opposing approaches may be viewed as offshoots of the "welfarist" and "liberationists" schools of thought.

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16. *Id.* art. 12. Article 12 states:

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.

Id.

17. *See* THE IDEOLOGIES OF CHILDREN'S RIGHTS (Michael Freeman & Philip Veerman eds., 1992); LAURA PURDY, IN THEIR BEST INTEREST? THE CASE AGAINST EQUAL RIGHTS FOR CHILDREN 21-54 (1992); John Eekelaar, *The Emergence of Children's Rights*, OXFORD J.L. STUD. 161 (1986). Michael S. Wald, *Children's Rights: A Framework for Analysis*, 12 U.C. DAVIS L. REV. 255, 282 (1979).

A. *The Rationale of Restricting the Rights of Minors: Paternalism and the Welfarist Theorists*

For centuries, children were considered little more than chattel, subject to the often tyrannical and unrestricted rule of their fathers. Male heads of patriarchal societies were free to do as they wished with their children, and sometimes even to punish them by death for grave disobedience.[18] The domestic status of children reflected the political status of adults: both were subject to totalitarian regimes that could—and often did—dictate their every move. Not until the twentieth century could one comfortably assert that children had special legal rights; previously, at best, they had special protections.

It is not surprising, therefore, that John Locke, in his revolutionary *Second Treatise of Civil Government*, felt the need to address the sources of parental power as part of his re-evaluation of the sources of political power.[19] Just as political power derives from the consent of the governed, so too parental power derives from the need children have to be cared for and educated during the limited period of their minority. As one of the founders of liberal political thought, Locke sought to limit parental power, and in doing so he recognized the humanity of children. However, like other early liberal thinkers Locke did not view children as individuals that can act in an autonomous manner, but believed it was proper that adults should make decisions on their behalf.[20] What was important for Locke, rather, was the leap to viewing children as separate human beings, deserving proper

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18. *See* Eekelaar, *supra* note 17, at 161. *See also* 2 LEGAL RIGHTS OF CHILDREN—FAMILY LAW SERIES (Robert M. Horowitz & Howard A. Davidson eds., 1984); Martha Minow, *Rights for the Next Generation: A Feminist Approach to Children's Rights*, *in* CHILD LAW—PARENT, CHILD AND THE STATE 59 (Harry D. Krause ed., 1992).

19. LOCKE, *supra* note 1, at 141-54. *See also* Edmund Leites, *Locke's Liberal Theory of Parenthood*, *in* HAVING CHILDREN: PHILOSOPHICAL AND LEGAL REFLECTIONS ON PARENTHOOD (Onora O'Neil & William Ruddick eds., 1979).

20. Leites, *supra* note 19, at 142-43; *See* JOHN STUART MILL, ON LIBERTY (David Spitz ed., 1975).

> It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury.

Id. at 13-14. Mill applied this reasoning to members of what he referred to as "backward races" or civilizations that he deemed unprepared for liberty. *Id.* at 14.

treatment. Locke and the welfarist view concerning children and their needs had much in common: both emphasized adults' obligations to treat children well, and both de-emphasized the issue of children's autonomy.

This welfarist approach formed the basis of the "best-interest of the child" principle, utilized in the jurisdictions of many countries in the twentieth century, including Israel. This principle establishes that decisions must be made on behalf of children. The "best-interest of the child" principle views children as small human beings whose interests must be considered separately. It recognizes the limited authority of parental rule and aims to find the solution that will maximize the welfare of the child. As will be shown later, it is a paternalistic principle that shifts the burden of decision-making from the child to the relevant adult—such as a parent, guardian, State employee, or judge, who makes decisions for children in their best interests.[21]

The welfarists argue that the reasons for limiting the legal capacity of minors are quite plausible and justified. They hold that it should be virtually accepted by all that children simply may not exercise the right to vote and/or to be elected. The basic premise behind the notion of curbing the rights of children is the duty and responsibility to protect them—even from their very own actions and decisions. This is predicated on the notion that children are weak and vulnerable, lack worldly experience, are unable to protect themselves, and are susceptible to exploitation.

Additionally, it is believed that minors cannot properly attend to their own best interests or exercise the rights conferred upon them because they have not attained full intellectual and physical development.[22] Therefore, they cannot act in an autonomous manner, or think in a reasonable, logical way, which would enhance their best interest. This, in a nutshell, is the fun-

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21. *See* Robert H. Mnookin, *Thinking About Children's Rights—Beyond Kiddie Libbers and Child Savers* 16 STANFORD LAWYER 24 (1981); *see also* ANDREW BAINHAM & STEPHEN MICHAEL CRETNEY, CHILDREN—THE MODERN LAW 77-78 (1993) [hereinafter BAINHAM-CRETNEY]; T. Morag, *New Challenges in Defining Childhood and Adulthood in Light of the International Convention on the Rights of the Child*, 44 BITACHON SOZIALI 109-11 (1995).

22. *See* Morag, *supra* note 21. This idea is also presented in the conclusions of the Scottish Law Commission, Consultative Memorandum, no. 65: Legal Capacity and Responsibility of Minors and Pupils (1985).

damental basis of paternalism regarding including minors in the decision-making process concerning their fate.

The anxiety of many paternalists that conferring upon the child an entire array of rights and duties would endanger society and the child himself or herself, was phrased succinctly by the American scholar Hafen, who wrote that we should not "abandon youth to their rights."[23]

B. *The Relationship Between Rights of Parents Concerning their Minor Children and Paternalism*

Another principle, which prevailed for many decades, and whose vestiges can still be felt with regard to the restriction of minors' rights at present, is the doctrine of "parents' rights."[24] The concept of parents' rights, in its modern form, is based on the assumption that in addition to duties *vis-à-vis* their children, parents also possess rights. This doctrine has found expression in Section 15 of the Israeli Capacity and Guardianship Law, 5722-1962[25] ("Capacity Law"), which uses the terminology "right" as well as the word "duty" concerning the guardianship of parents, the natural guardians.[26]

Professor Pinchas Shifman explains:

> Although we stress the duties of parents, we may not deny their rights. Parents' right to raise their children is a basic, natural right, whose importance cannot be exaggerated. Nonetheless, this right does not by any means render children their parents' property; rather, it expresses the vital and

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23. *See* Bruce C. Hafen, *Children's Liberation and the New Egalitarianism: Some Reservations About Abandoning Youth to Their 'Rights'*, 3 BYU L. REV. 605 (1976).

24. *See* S.L. Brackshaw, *Health Care of Children Over Objections of the Parents: Clash of Rights*, MED. LAW 221 (1983); K.B. Tavolaro, *Effectively and Efficiently Protecting Children in Faith Healing Cases: A Proposed Statutory Revision for State Intervention*, MED. LAW 311 (1991). *See also* A. Bainham, *Growing Up in Britain: Adolescence in the Post-Gillick Era*, *in* PARENTHOOD IN MODERN SOCIETY: LEGAL AND SOCIAL ISSUES FOR THE TWENTY-FIRST CENTURY (John Eekelaar & Peter Sarcevic eds., 1993).

25. Capacity and Guardianship Law, 1962, 16 L.S.I 106, 106-18 (Isr.) [hereinafter Capacity Law].

26. The Capacity Law states:

> The guardianship of the parents shall include the duty and the right to take care of the needs of the minor, including his education, studies, vocational and occupational training and work, and to preserve, manage and develop his property; it shall also include the right to the custody of the minor, to determine his place of residence and the authority to act on his behalf.

Id. § 15.

> natural bond which exists between parents and their children . . . Perhaps the most accurate formulation of this concept is that parents are entitled to fulfill the duty of parenting. A philosophical approach which views all matters through the prism of "children's best interests" while overlooking any other factor is too simplistic and artificial.[27]

The logic of this idea is that only if parents have rights, which enable them to exercise discipline and guidance over the actions of their children, can they actualize their right to raise, educate, and influence the lives of their children. As the legal capacity granted to children is greater, so the parents' ability to exercise authority over their children diminishes. In the triangular relationship of the child-parent-State, when the State bestows legal capacity on children it is at the expense of the parents' rights, and consequently the parents' standing in this triangle is weakened.[28]

Moreover, another rationale for limiting children's rights is based on the fact that parents are liable for the actions of their children.[29]

C. *Children's Rights Doctrine and Liberal Children's Rights Theorists*

The "best-interest of the children" approach has been contrasted with the autonomy-oriented approach. The most radical representatives of the latter doctrine, such as Farson,[30] writing in the 1970s, advocated treating children exactly like adults and allowing them to make their own decisions.[31] They argued that all children are not only separate individuals, they are also autonomous human beings who have rights. Therefore, paternalistic treatment of all minors is unjustifiable within a liberal framework.[32]

While today few embrace this somewhat extreme approach,

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27. PINCHAS SHIFMAN, 2 FAMILY LAW IN ISRAEL 219-20 (1989) (author's trans.).

28. *See* Gary B. Melton, *Decision Making by Children: Psychological Risks and Benefits*, *in* CHILDREN'S COMPETENCE TO CONSENT 21 (1983). Melton argues that the State consciously made a value judgment and decided that protecting the family institution takes precedence over children's rights.

29. *See* Penal Law, 5737–1977, at § 323 (Isr.). *See also* A. COODE, THE LAW OF THE INDIVIDUAL—ACCORDING TO AGE AND SEX (1968).

30. RICHARD FARSON, BIRTHRIGHTS (1978).

31. For more on Farson's point of view, see P.E. VEERMAN, THE RIGHTS OF THE CHILD AND THE CHANGING IMAGE OF CHILDHOOD 134 (1992).

32. *See also* BAINHAM-CRETNEY, *supra* note 21, at 77.

and while some scholars hold that no serious thinker could really advocate complete autonomy for all children,[33] more moderate versions of this approach, such as those of Eekelaar and Freeman,[34] have widely emerged.

Sometimes these more moderate versions of this approach are based upon Ronald Dworkin's Rights Theory. According to Dworkin,[35] while rights may be, in fact, simple correlatives of existing duties applied to others, *fundamental* rights are something more than that—a moral alternative to utilitarianism. A fundamental right overrides utilitarian calculations of social good. It is not merely an interest protected by the imposition of some duty on another, but an overriding *moral* interest which deserves protection.[36]

Rights are fundamental, according to Dworkin, where they are necessary to protect one of the two basic notions—human dignity and equality—and any theory of rights that fails to account for these very basic and very powerful ideals is inadequate.[37] But why should the concepts of human dignity and equality require the recognition of personal decision-making autonomy as a fundamental right, and why should they require that this right be extended to children?[38] For Dworkin, it is impossible to respect equality and dignity without also respecting autonomy, and consequently this point of view repudiates pater-

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33. *Id.* at 79.

34. *See* Michael Freeman, *Taking Children's Rights More Seriously*, 6 INT'L J.L. & FAM. 52 (1992) [hereinafter Freeman—*Children's Rights*]; Eekelaar, *supra* note 17, at 162; John Eekelaar, *The Importance of Thinking that Children have Rights*, 6 INT'L J.L. & FAM. 221 (1992) [hereinafter *Importance of Thinking*]; Michael Freeman, *The Limits of Children Rights*, *in* THE IDEOLOGIES OF CHILDREN'S RIGHTS, *supra* note 17 [hereinafter Freeman—*Limits of Children's Rights*].

35. RONALD DWORKIN, TAKING RIGHTS SERIOUSLY xi-xii (1978).

36. Like Dworkin, John Eekelaar seeks to go beyond the formalistic conception of rights, whereby rights are mere correlates of obligations. Embracing a version of the will theory of rights, Eekelaar rejects the interest-based welfarist approach. A person can be said to have a right, he argues, only when he has the power to make a claim that he can enforce or decide to waive. To say that adults have the obligation to advance children's welfare is to say nothing at all with regard to the question of children's rights, unless the child is recognized as having an autonomous claim. Interests determined by society, and regarding which obligations are imposed on others, are not rights at all. *See Importance of Thinking*, *supra* note 34, at 228-31.

37. Freeman—*Children's Rights*, *supra* note 34, at 63.

38. Professor Freeman criticizes Dworkin for failing to include autonomy alongside equality and dignity as the basic values that justify the recognition of fundamental rights. *Id.* at 64.

nalism.[39]

Dworkin views personal autonomy, at least in terms of an individual's right to choose his/her goals, as inherent to human dignity and equality.[40] For Dworkin, therefore, a rights theory that fails to account for individual autonomy in this sense would be a contradiction in terms and would betray its very own foundations.[41]

Dworkin's emphasis on equality, together with his recognition of autonomy as an integral part of his basic system of rights, also forces us to grapple with how we justify the rules of various legal systems that differentiate between adults and children with regard to autonomy. Indeed, the very topic of "*children's* rights" can be said to be a contradiction in terms. Recognizing an individual as a rights holder means, first and foremost—according to the Dworkinian theory of rights—recognizing that person's human dignity. Talking about people as members of groups, children and adults, rather than as individuals who should be evaluated separately on the basis of their own merit, is among the most fundamental violations of the principles of equality and human dignity. It is well known that children vary tremendously. Saying, "children are all alike" is no better and no more useful than saying: "forty-year olds are alike."

This problem can be solved by an approach that differentiates between children whose rational capabilities are and are not adequately developed. Children whose decision-making capabilities are comparable to those of adults—regardless of their

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39. *See* Ronald Dworkin, *Liberal Community*, 77 CAL. L. REV. 479, 484-87 (1989) [hereinafter Dworkin—*Liberal Community*].

40. Freeman adopts a liberal Dworkinian approach to rights. Rights, he claims, help to ensure that children will not become victims, and that their interests are not replaced by utilitarian calculations. *See* Freeman—*Children's Rights*, *supra* note 34, at 53-54.

41. Dworkin's approach to autonomy can be contrasted with that of Neil MacCormick, which seems to be rooted in John Stuart Mill's utilitarian approach to paternalism. *See* NEIL MACCORMICK, LEGAL RIGHT AND SOCIAL DEMOCRACY: ESSAYS IN LEGAL AND POLITICAL PHILOSOPHY ch. 8 (1982). MacCormick bases his respect for individual autonomy on the empirical assumption that the individual is generally the best judge of his/her own good. *See* BAINHAM-CRETNEY, *supra* note 21, at 82-84. Therefore, MacCormick finds it relatively easy to deny children autonomy, given that children, empirically, are often not the best judges of what is good for them. If, on the other hand, autonomy is viewed as constitutive of one's good, it becomes far more difficult to justify limiting it simply because a person lacks a rational capacity for decision-making. Therefore, liberal children's rights theorists must search for ways to care for children without violating their own liberal principles.

ages—would simply be treated as adults, for all intents and purposes.[42] In this regard, children who lack legal capacity would be narrowly defined. They are only those children who at present lack the required rational capability.

A far more basic question is yet unanswered. On what basis and to what extent can required rational capabilities be viewed as the basis for the aforementioned relevant difference between the two groups of children? Denying children who at present lack a certain, required rational capability their right to autonomous decision-making presents a problem of equality requiring careful justification. Given that smarter adults are not given preference over less gifted ones in terms of the autonomy granted to them, on what basis can rational capabilities be used to differentiate children and adults in this regard? Daniel Winkler deals with this very question, in a slightly different context.[43] Why should we treat slightly retarded individuals differently, he asks, on the basis of their limited rational faculties, when we would never dream of differentiating in like manner between normal and gifted adults? No one suggests appointing gifted adults to run the affairs of other normal adults who have trouble making sound self-regarding decisions. Why, therefore, does society view itself as justified—or even obligated—to run the affairs of the mildly retarded? The answer, he concludes, lies in the way competence is defined. The issue is one of competence rather than intelligence, and that competence is a quality possessed in equal measure by all those who have it.[44] If X intelligence is required to do task Y, then X would be the required level of competence. Normal and gifted people, both of whom have at least X intelligence, are equally capable of performing task Y. The gifted person's "added power is simply unused surplus."[45] This answer justifies a new policy concerning the competence of children. X intelligence, which is required to do a

42. John Stuart Mill wrote: "Neither one person, nor any number of persons, is warranted in saying to another human creature *of ripe years*, that he shall not do with his life for his own benefit what he chooses to do with it." MILL, *supra* note 20, at 71 (emphasis added).

43. Daniel Winkler, *Paternalism and the Mildly Retarded*, *in* PATERNALISM 84 (Rolf Satorus ed., 1983).

44. *Id.* at 87.

45. *Id.*

certain task, should be the required level of competence of children.

D. *Justified and Unjustified Paternalism*

Joel Feinberg explores the issue of when and how the State is justified in interfering in the lives of individuals, whether to protect them from self-inflicted harm, or to guide them towards their own good. He attempts to reconcile "our general repugnance for paternalism with the reasonable nature of some paternalistic regulations."[46]

Feinberg differentiates "weak paternalism," from "strong paternalism.[47] He holds that "strong paternalism" is unacceptable. The strong anti-paternalistic thesis is, as he puts it, that fully voluntary choice or consent of a mature and rational human being concerning matters that affect the individual's own interests is such a precious thing that no one else (and certainly not the State) has a right to interfere with it simply for the person's "own good."[48]

Some actions create a presumption that the person so choosing to act must not be acting voluntarily, in the full, rational meaning of the word. "Patently self-damaging" behavior would be an example of behavior creating this kind of presumption.[49] According to his theory "weak paternalism" is possible in appropriate circumstances: the State has the right to prevent self-regarding harmful conduct when but only when it is substantially non-voluntary or when temporary intervention is necessary to establish whether it is voluntary or not.[50]

Feinberg does not deal with the voluntary nature of the acts

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46. Joel Feinberg, *Legal Paternalism*, *in* PATERNALISM 3 (Rolf Sartorius ed., 1983).

47. Feinberg discusses the example of a woman who wishes to ingest a powerful, harmful drug. In the first instance she denies factually that the drug is harmful—this is the quintessential "non-voluntary act"—for the woman does not wish to ingest a harmful drug. She is simply factually mistaken about the nature of the drug she wishes to take. *See id.* at 10. In the second instance the woman says she is aware of the dangerous nature of the drug, but insists that she wants to take it. Here the presumption of non-voluntariness comes into place: if she can prove her act to be truly voluntary, she ought to be allowed to proceed. In the third instance the woman says she is indifferent to physical harm, and explains that the short-term pleasure as a result of the drug is worth the risk involved. Here, the reasonableness of the risk taken will determine the extent to which the presumption of non-voluntariness of action is activated. *See id.* at 9-12.

48. *Id.* at 8.

49. *Id.*

50. *Id.* at 9.

of certain classes of people who *a priori* are thought to be particularly susceptible to non-voluntary behavior, in the rational sense. Can children who as yet lack rational capacity be defined as individuals whose actions are necessarily suspect, or in relation to whom a more exacting standard of voluntariness would be applied? Although Feinberg does not address this issue, it seems that most liberal children's rights theorists accept in principle that such children can be subject to a more intensive version of "weak" paternalism. They would agree that young children, who are not emotionally mature, can be subject to this version of paternalism.

Gerald Dworkin analyzes the character of paternalism. He divides paternalistic interferences into "pure" and "impure" cases. In "pure" paternalism the class of persons whose freedom is restricted is identical with the class of persons whose benefit is intended to be promoted by such restrictions. In the case of "impure" paternalism in trying to protect the welfare of a class of persons we find that the only way to do so will involve restricting the freedom of other persons besides those who are benefited.[51]

He holds that what justifies applying paternalism to children is the fact that they lack some of the emotional and cognitive capacities required in order to make fully rational decisions.[52] However, children that do not lack these capacities should not be subject to paternalism.

Gerald Dworkin held:

> The easiest cases to handle are those which can be argued about in terms which all thought to be so important—a concern not just for the happiness or welfare, in some broad sense, of the individual, but rather a concern for the autonomy and freedom of the person. I suggest that we would be most likely to consent to paternalism in those instances in which it preserves and enhances for the individual his ability to rationally consider and carry out his own decisions. In all cases of paternalistic legislation there must be a heavy and clear burden of proof placed on the authorities to demonstrate the exact nature of the harmful effects (or beneficial

51. GERALD DWORKIN, PATERNALISM, FROM MORALITY AND THE LAW 111 (1971). Dworkin explains: "Paternalism then will always involve limitations on the liberty of some individuals in their own interest, but it may also extend to interference with the liberty of parties whose interests are not in question." *Id.*

52. *Id.* at 118-19.

> consequences) to be avoided (or achieved) and the probability of their occurrence. I suggest a principle of the least restrictive alternative. If there is an alternative way to accomplishing the desired and without restricting liberty, although it may involve great expense, inconvenience, etc., the society must adopt it.[53]

E. *Theoretical Conclusion*

The aforementioned theories concerning rights, autonomy, and paternalism, lead to similar conclusions regarding the right of a minor to participate in the decision-making process. These principles are applicable also concerning the relationship between the State, court, guardians, including natural guardians, and minors.

While welfarists attempt to formulate a rights approach that allows for paternalism, liberationists embrace a liberal rights approach that emphasizes autonomy and attempts "to confine paternalism . . . without totally eliminating it."[54] The significance of the idea of rights is that children are entitled to make moral claims and to demand that which they deserve. Liberal rights theory focuses on listening to children. Only when it is absolutely impossible or unreasonable to respect the child's autonomy can society—or parents—intervene. Children are to be minimally guided and encouraged to produce genuine endorsements of their own. Liberal thinkers try to encourage children to think for themselves. This approach allows children to speak for themselves. It grants children that are able to decide the right to participate in the decision-making process.

We have noted that liberal rights advocates believe autonomy to be an essential part of their philosophy of rights. We have observed that for Dworkin due respect should be given to human dignity and equality. We have seen that liberal rights advocates regard enhancement of the individual's ability to rationally consider and implement his/her own decisions more relevant and acceptable criterion than paternalism, especially "strong" paternalism. Paternalism is not desirable when an alternative way exists to accomplish the desired end. We should accomplish the desired end regarding children without restricting

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53. *Id.* at 125-26.

54. Freeman—*Children's Rights*, *supra* note 34, at 67.

liberty.[55] These should be the guidelines in the sphere of consent of minors to their medical treatment.

II. *CURRENT ISRAELI LAW*

A. *Israeli Legislation*

1. The Capacity Law

The relationship between parents and their minor children, in the rules of the main Israeli law concerning the legal capacity of children, the Capacity Law, is paternalistic. In general the paternalistic attitude, whose aim is to protect the minor and other vulnerable individuals from their own decisions, is the basis for all the rules of Capacity Law. In his commentary on the Capacity Law, Professor Izhak Englard[56] writes that the purpose of the rules of the Capacity Law regarding minors is to protect the minor due to his/her feeble intelligence which impairs the minor's decision-making process.[57]

Some Israeli scholars have noted that the unequal and paternalistic format of the Capacity Law and its aim to protect certain individuals may be inferred from the very name of the law (Capacity and Legal Guardianship). One of the meanings of the Hebrew word for Guardianship, as found in the law's title—*apotropsoot*—is paternalism.[58]

The definition of minority and majority in Section 3 of the Capacity Law, which establishes the age of legal capacity as eighteen years, is relevant also concerning matters mentioned in

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55. *See* Dworkin—*Liberal Community*, *supra* note 39, at 484-87; Joel Feinberg, *Legal Paternalism*, 1 CAN. J. PHIL. 105, 111-24 (1971).

56. Currently an Israeli Supreme Court Justice.

57. *See* IZHAK ENGLARD, CAPACITY AND GUARDIANSHIP LAW, 5722-1962, § 1-13 (Commentary on Laws Relating to Contracts—Founded by G. Tedeschi) 49 (1995). Englard notes that:

> the central idea behind the fundamental concept of the capacity to perform legal acts as established by the Capacity Law is the concern for a person's ability to formulate his/her will by means of executing proper judgment. The Law's sole objective in restricting the capacity of certain individuals is to protect the performer of a legal act from his/her own act. Hence, the existence of legal capacity is contingent upon the personal attributes of the performer (maturity, sanity, etc.).

Id.

It seems that in Englard's view, the aim of rules in regard to the Capacity Law is to protect the minor from his/her act.

58. D. FRIEDMAN & N. COHEN, 2 CONTRACTS (HEBREW) 1009 (Tel Aviv, 1991).

other sections of the Capacity Law that bear on the involvement of the minor in decisions affecting him or her.

Section 4 of the Capacity Law establishes that: "Legal acts of a minor require the consent of his representative. Consent may be given in advance or subsequently, for a particular act or for a particular class of acts. The representative may withdraw his consent as long as the act has not been performed."[59] Moreover, Section 5 of the Capacity Law establishes that:

> A legal act of a minor performed without the consent of his representative may be voided
> 1. By his representative or, if he has no representative, by the Attorney-General, within a month after the act has come to the knowledge of the representative or the Attorney-General, as the case may be;
> 2. If the act has not come to the knowledge of the representative of the Attorney-General—by the minor, within a month from his attaining full age.[60]

Section 6 of the Capacity Law establishes that:

> A legal act of a minor of a kind commonly performed by minors of his age, or a legal act between a minor and a person who neither knew nor ought to have known that he was a minor, may not be avoided under section 5 even if performed without the consent of the representative of the minor, unless substantial harm to the minor or his property was caused thereby.[61]

Moreover, it seems, that the Capacity Law does not grant due weight to the minor's desires. Section 44 states that:

> The Court may, at any time, on application of the guardian or of the Attorney General or his representative or of an interested party, or of its own motion, issue directions to the guardian in any matter relating to the carrying out of his duties. The Court may also, on the application of the guardian, approve an act performed by him.[62]

The Court, the Attorney General, or an interested party, may also be involved in this decision-making process when they are granted authority that stems from their status according to

59. Capacity Law, *supra* note 25, § 4.
60. *Id.* § 5.
61. *Id.* § 6.
62. *Id.* § 44.

Sections 68 and 69 of the Capacity Law. Involvement of a welfare officer is also possible. He or she can apply his/her authority mentioned in Section 70 of the Capacity Law.

The general rule, in Section 68(a) of the Capacity Law, states:

> The Court may, at any time, on application of the Attorney General or his representative or of an interested party or of its own motion, take temporary or permanent measures which seem to it appropriate for protecting the interests of a minor, a legally incompetent person or a ward, either by appointing a temporary or permanent guardian, or a guardian ad litem, or otherwise. The Court may also do so on application of a minor, the legally incompetent person, or the ward himself.[63]

The authority is granted to the court. The minor does not have to participate in the decision-making process in such matters, nor does he or she necessarily have the legal right to do so. The court *may* act on application of the minor.

From the sections cited above, it can be concluded that generally, in the rules of the Capacity Law, a minor is unauthorized to independently perform legal acts in various areas, including expressing his/her consent regarding his/her medical treatment. According to the Capacity Law, the medical treatment of a minor, as well as many other actions, require the consent of the minor's representative. A special rule in regard to consent of a minor to medical treatment was enacted in Section 68(b) of the Capacity Law.

Section 68(b) of the Capacity Law serves as the specific rule which deals with the powers of the court *vis-à-vis* the governance of the decision-making process of medical treatment administered to minors:

> Where the application is for a direction to perform surgery or to take any other medical measure, the court shall not issue the direction unless it is satisfied, on the basis of a medical opinion, that the measure is necessary in order to protect the physical or mental well-being of the minor, legally incompetent person or ward.[64]

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63. *Id.* § 68(a).

64. *Id.* § 68(b). The rule in Section 68 allows the authorized court, which nowadays is often the Court of Family Matters, to take any temporary or permanent actions necessary in order to protect the minor. The Israeli courts have ruled in a few cases

This rule is paternalistic. The independent right of the minor, legally incompetent person, or ward, to be involved in the decision-making process, is not granted recognition. The Capacity Law does not require that a minor be given an opportunity to express his/her own will and consent to medical treatment. The viewpoint of the natural guardians, the minor's parents, and sometimes that of the court, is of greater importance.

The denial of the legal right of children to express their wishes reflects the general paternalistic approach of the rules of the Capacity Law. The Israeli legislator expressed his point of view in the rules of this law, that children are in need of protection due to their vulnerability, and also that parents must retain their special task of child rearing. The assumption is that decision-making about the child's affairs should be entrusted to his/her "natural guardians"—the parents, who are older and more experienced, and so will better serve the child's interests than if he or she were to make his/her decisions himself/herself.

The Capacity Law grants the minor's parents the right to take part in the decision-making process concerning medical treatment of their minor child. According to Sections 14 and 15 of the Capacity Law, parents, who are "the natural guardians of their minor children," have the duty and the right to take care of the minor's needs. The Israeli Supreme Court ruled that the "minor's needs" include medical and health needs.[65] Parents who attend to those needs of the minor are obligated to "act in the best interests of the minor in such manner as devoted parents would act in the circumstances."[66] As mentioned above, the legislator revealed his position through the intentional omission of a possible rule granting weight to the minor's desires. Hence, questions regarding the child's best interests must be answered by the child's parents, guardian, or the court.

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that when the circumstances of the case justify the ruling that the specific requirement of this law are relevant, the court will implement the rules of this law. Yet, when the court is not persuaded that the factual basis of the case justifies the implementation of specific rules, the court will not implement the rules of this specific law, and will prefer to act within its general authority based upon the rule in abovementioned section 68. *See* HARRY BOAZ, LEGAL CAPACITY AND GUARDIANSHIP (Hebrew) 209-18(8) (1994); *see also* C.A. 3236/90, Plonim v. Attorney General (1991) 45(3) P.D. 460, 472.

65. *See* C.A. 5587/97, Attorney General v. Ben Ikar, Minor (1997) 51(4) P.D. 830, 846.

66. Capacity Law, *supra* note 25, § 17.

a. Best Interest of the Child

The rules of the Capacity law coincide with other rules of the Israeli legislator and rules in international conventions that state that decisions with regard to children, in various spheres, should be in the best interest of the relevant children.

This welfarist assumption is the general rule in Israel in many laws concerning the fate of children. In current Israeli legislation the paternalistic principle of the child's best interest is the main principle that should guide the minor's parents or guardian when they are required to decide on the child's behalf. Section 3 of the Women's Equal Rights Law, 5711–1951,[67] Section 1(b) of the Adoption of Children Law, 5756-1996,[68] as well as Section 17 of the Capacity Law, obligate parents, the guardian, or the court, to act in a manner that will enhance the child's best interest. The Israeli legislator also states, in the Welfare (Procedures in Matters of Minors, Sick Persons and Absent Person) Law, 5715–1955,[69] that the Israeli Attorney-General, or his representative, can act on behalf of a minor, when he believes he should do so in the best interest of the child.[70]

In addition, Israel has signed and ratified the United Nations Convention on the Rights of the Child, which states in Article 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 interest of the child shall be a primary consideration.[71]

These regulations and articles grant certain persons, or the

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67. Women's Equal Rights Law, 5711-1951, 5 L.S.I. 171, § 3 (Isr.). Section 3 states:

(a) The mother and the father jointly are their children's natural guardians; if one parent died, then the survivor is the natural guardian.

(b) The provisions of subsection (a) shall not infringe the power of a competent Court or Tribunal to deal with matters of guardianship of children—of their persons, as well as their property—while considering only the welfare of the children.

Id.

68. Adoption of Children Law, 5741-1981, § 1(b) (Isr.). Section 1(b) states: "An adoption order and any other decision under this Law shall be made if the court is satisfied that they are to the adoptee's benefit."

69. Welfare (Procedures in Matters of Minors, Mentally Sick Persons and Absent Persons) Law, 5715-1955 (Isr.).

70. *See id.* § 8.

71. Convention, *supra* note 15, art. 3(1).

court, a right to decide regarding the fate of minors in their "best interest."

The paternalistic, welfarist, point of view is evident in additional Israeli legislation concerning the fate of children. Section 11(A) of the Youth (Care and Supervision) Law, 5720-1960[72] states:

> Where a welfare officer is of the opinion that a minor is in need of protection and that he is in immediate danger or that he requires medical or other treatment which admits of no delay, he may take any measures which in his opinion are necessary in order to obviate that danger or to provide that treatment even without the consent of the person responsible for the minor: Provided that a minor shall not be withheld from the control of the person responsible for him for more than a week save with the approval of the court.[73]

Section 2 of the Youth (Care and Supervision) Law, 5720-1960 states:

> A minor is in need of protection if—
> (1) there is no person responsible for him; or
> (2) the person responsible for him is not capable of taking care of him or supervising him or neglects such care or supervision; or
> (3) he has done an act which is a criminal offence and has not been brought to trial; or
> (4) he has been found vagrant or begging or hawking in contravention of the Youth Labour Law, 5713-1953; or
> (5) he is exposed to any bad influence or lives in a place regularly used for illicit purposes; or
> (6) his physical or psychical well-being is impaired or likely to become impaired from any other cause; or
> (7) he was born suffering from drug addiction.[74]

Some scholars claim that interpreting the term "neglects," in Section 2(2), broadly will lead to a greater intervention of the legal system in the autonomy of the family and will weaken the status of parents in the family. According to this broad interpretation, whenever parents refuse to grant their minor child medical treatment they actually could be considered guardians that "neglect" this child and violate their duty in the above men-

72. Youth (Care and Supervision) Law (5720-1960) (Isr.).
73. *Id.* § 11(A).
74. *Id.* § 2.

tioned law to care for their minor children and supervise them. Therefore their son/daughter could be regarded as a "minor in need of protection."[75]

2. The Patients' Rights Law, 5756-1996

In 1996, the *Knesset* (Israeli Parliament) enacted the Patients' Law.[76] The rules of this law reflect a shift from paternalism to autonomy with regard to adults, but paternalism remains concerning minors. This law maintains the paternalistic relationship between the minor and his/her parents, guardian, doctor, etc., concerning his/her medical treatment.

Section 1 of the Patients' Law states: "The objective of this Law is to lay down the rights of persons who seek medical treatment or who are under medical treatment, and to protect his dignity and his privacy."[77] Chapter 4 of the Patients' Law adopts the doctrine of "informed consent" in the field of administering medical treatment.[78] According to the doctrine of "informed consent," the decision of the patient must be informed, including information about the risks and benefits of alternative treatments.[79] The legal standard for informed consent to medical treatment requires that the consenter be informed, competent, and acting voluntarily.[80]

Section 13 of the Patients' Law establishes that:

> (a) No Medical treatment shall be given to any patient,[81] unless he gave his informed consent to it under the provisions of this Chapter;
> (b) In order to obtain informed consent, the practitioner shall give[82] the patient the medical information, which he reasonably requires in order to be able to decide

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75. *See* A. BEN DROR, THE LAW OF PROTEGES 318 (1998).

76. Patients' Law, *supra* note 9.

77. *Id.* § 1.

78. *Id.* ch. 4.

79. *See* M.A. McCabe, *Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations*, 21 J. PEDIATRIC PSYCHOL. 506 (1996).

80. *See id.* at 506; David .G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 LAW & HUM. BEHAV. 431 (1991).

81. Section 2 of the Patients' Law defines "patient" as "a sick person and any person who seeks or is under medical treatment." Patients' Law, *supra* note 9, § 2.

82. Section 2 of the Patients' Law defines "practitioner" as "physician, dentist, intern, nurse, midwife, psychologist and any other professional recognized by the Director-General, by notice in Reshumot, as practitioner in the medical services." *Id.*

whether to consent to the proposed treatment.[83]

Section 15 of the Patients' Law sanctions the performance of non-consensual medical treatment under certain circumstances. Section 15(2) establishes that:

> Under circumstances in which the patient is in severe danger, and in which he objects to medical treatment which, under the circumstances of the case, should be provided quickly, the practitioner may provide the treatment even against the patient's will, if an Ethics Committee—having heard the practitioner—approved the provision of the treatment, provided it was convinced that all the following apply:
> (a) The patient was given the medical information, as required, in order to obtain informed consent;
> (b) It is expected that the medical treatment will improve the patient's medical condition significantly;
> (c) There are reasonable grounds to assume that the patient will give his retroactive approval after the medical treatment has been given.[84]

Generally, the autonomy of the minor is limited. When the consent of the minor's guardian, may be obtained, it is incumbent upon the treating physician to obtain this consent prior to the performance of medical treatment upon the minor. The minor's consent is sufficient only in the event that the consent of his/her guardian or representative cannot be obtained.[85]

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83. *Id.* § 13.

84. *Id.* § 15(2). This rule is in spirit of the principles of Jewish Law. In Jewish Laws the principle of Sacredness of Life is dominant. Therefore it is obvious that the mother and father do not have a right to risk their child's life and to prevent the treatment by a doctor which is essential for him or her. *See* RABBI DAVID ZVI HOFFMAN, 2 RESPONSA MELAMED LEHOIL, Yoreh Deah, 104. Some Jewish Scholars in the twentieth century held that when a court determines what the "welfare" of the minor is, it should reach its conclusion after an investigation of the estimated will of the minor. *See* RABBI MOSHE HERSHLER, 2 HALACHAH AND MEDICINE 122 (1981).

85. The patient's remedy against a physician who violates this duty is a legal suit based on grounds of breach of legal duty. *See* Civil Wrongs Ordinance (New Version), §63 (1968):

> (a) Breach of statutory duty consist of a failure by any person to perform a duty imposed upon him by any enactment other than this Ordinance, being an enactment which, on a proper construction thereof, was intended to be for the benefit or protection of any other person, whereby such other person suffers damage of a kind or nature contemplated by such enactment: provided that such other person shall not be entitled by reason of such failure to any remedy specified in this Ordinance if, on a proper construction of such enactment, the intention thereof was to exclude such remedy.

The legislator of the Patients' Law consciously chose to not grant the minor the autonomous right to express his/her informed consent with respect to his/her medical treatment.

It can be inferred that this was the policy of the legislator regarding the extent of autonomy granted to minors concerning their medical treatment from the fact that Sections 2 and 15(d) of the Patients' Rights Bill, 5752-1992 were eventually eliminated by the legislator and do not appear in the final version of the Patients' Law.

Section 2(a) of the Patients' Rights Bill prohibited discrimination with regard to patients' rights by stating: "There shall be no discrimination among patients on grounds of religion, race, nationality, or age."[86] Notably, Section 4 of the Patients' Law establishes that: "Practitioners or medical institutions shall not discriminate between patients because of religion, race, sex, nationality, country of origin, or any other *similar grounds*."[87]

As clearly shown, the Patients' Rights Bill specified, among other things, discrimination on grounds of the patient's age. However, the Patients' Law did not include age as a potential ground for discrimination. The deliberate omission of this type of discrimination from the Patients' Law requires explanation. Apparently, the legislator indicated, through this omission in the Patients' Law, his/her opinion that minor patients are not granted the same rights as adult patients. This discrimination is manifested, *inter alia*, by the Patients' Law policy concerning the minor's right to express his/her consent to medical treatment.

Section 15(d) of the Patients' Rights Bill states:

> The informed consent of a minor or of a legally incompetent person shall be obtained under the provisions of the Capacity Law as long as other special provisions are not estab-

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Id.

Another legal aspect that should be taken into consideration is that the Israeli legislation protects rights of privacy. Justices Bach and Beiski held that according to one possible interpretation of Israeli law, medical treatment that is granted to a patient without his/her consent is "other nuisance," mentioned in Section 2(1) of the Israeli law regarding defense of the right of privacy. *See* C.C. 527, 480/85, Cortam v. State of Israel (1986) 40(3) P.D. 673, 694-95. However, when the life of a minor can be saved by an operation, and the parent refuses to approve it without a reasonable justification, preservation of life should be granted supreme value. This is true especially when it is not likely that the operation itself will harm or disable the patient.

86. Patients' Rights Bill, 5752-1992 (Isr.) (author's trans.).

87. Patients' Law, *supra* note 9, § 4 (emphasis added).

lished in this respect in a different law.[88]

The fact that this Section was omitted from the Patients' Law, again, leads one to the conclusion that the legislator deliberately did not wish to impart to minors the right of personal autonomy with respect to the decision-making process regarding their own medical treatment.

Justice Orr explained, in *Attorney General v. Ben Ikar, Minor*[89] case:

> The fact that the Patients' Law, 5756-1996, does not include regulations concerning medical treatment of minors is significant. This law did not abolish old Israeli regulations concerning minors. One can easily see that the legislator of the Patients' Law was aware of the fact that there are patients who have a representative or guardian (Section 15(1) of the law).
>
> I do not hold that the rules of the new law—the Patients' Law—abolish the rule in section 68(b) (of the Capacity Law) concerning medical treatment to minors.[90]

3. Basic Law: Human Dignity and Freedom

Basic Law: Human Dignity and Freedom[91] was enacted in 1992. Since the enactment of this Basic Law, the legal status of personal autonomy has essentially been elevated to the level of a constitutional right. This Basic Law applies to all people, regardless of their age.[92] The new constitutional law sets a new agenda: autonomy should replace paternalism, as much as possible.

Section 2 of the Basic Law establishes: "The life, body or dignity of any person shall not be violated."[93] Section 4 of the Basic Law establishes: "Every person is entitled to protection of his life, body and dignity."[94] Section 5 of the Basic Law states: "The liberty of a person shall not be deprived or restricted through imprisonment, detention, extradition, or in any other manner."[95]

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88. Patients' Rights Bill, *supra* note 86 (author's trans.).
89. *See* 5587/97, Attorney General v. Ben Ikar, Minor, (1997) 51(4) P.D. 830.
90. *See id.* at 845 (author's trans.).
91. Human Dignity Law, *supra* note 5.
92. *See* BARAK, *supra* note 2, at 435.
93. Human Dignity Law, *supra* note 5, § 2.
94. *Id.* § 4.
95. *Id.* § 5.

It may be argued that in light of the values of human dignity and freedom, and/or the rights of persons upon their bodies, that the Basic Law implements the doctrine of informed consent with respect to the medical treatment of minors.

The Patients' Law, which generally does not grant minors the right of personal autonomy to express their informed consent to the performance of medical treatment upon them, is a specific law (*lex speciales*) enacted in 1996, after the enactment of the important constitutional law: the Basic Law. Since the paternalistic rule in the Patients' Law regarding consent of minors to treatment is in dissonance with the provisions of the Basic Law in this regard, one must refer to Section 8 of the Basic Law which should be implemented in the event of legislation of a new law, subsequent to the Basic Law, which includes rules that are in violation of rights established by the Basic Law.

Section 8 of the Basic Law states:

> The rights according to this Basic Law shall not be infringed except by a statute that befits the values of the State of Israel and is directed towards a worthy purpose, and then only to an extent that does not exceed what is necessary.[96]

Hence, the Patients' Law's denial of the right of informed consent to minors must be examined carefully in light of the requirement of the legislator in Section 8 of the Basic Law.

Another important relevant principle is interpretation in light of the rules of the Basic Law. The paternalistic rules of the Capacity Law concerning the consent of a minor to his/her medical treatment were enacted in 1962. However in light of the *Ganimat*[97] case, the provisions of "old" legislation, which were enacted prior to the enactment of the recent Basic Laws, must be interpreted in accordance with the values and rights established by the Basic Laws. In the *Ganimat* case, two schools of thought, a broad approach and a narrow approach with respect to the interpretation of legislation enacted prior to the enactment of the Basic Laws, emanated from the different decisions handed down by the Supreme Court of Israel. According to the majority opinion in this case, interpretation, in the spirit of the Basic Law, of an old law enacted before the Basic Law, is required when it is possible to interpret sections of the "old" law

96. *Id.* § 8.

97. C.C. 537/95 Ganimat v. State of Israel (1995) 49(3) P.D. 355, 412-21.

(including the Capacity Law) in this manner. Justice Barak explained that this type of interpretation is not judicial legislation. It is an attempt to find new meanings in old legislation.[98] However, Justice Cheshin, in a minority opinion, held that since the Israeli legislator stated in Section 10 of the Basic Law that "this Basic Law shall not affect the validity of any law (*din*) in force prior to the commencement of the Basic Law," the Supreme Court should not use the method of interpretation in a manner that could affect the validity of a law in force prior to the commencement of the Basic Law.[99]

Consequently, the approach of the majority in the *Ganimat* case should be applied regarding medical treatment of minors. The legal principles of "old" legislation, including the rules of the Capacity Law that are relevant concerning medical treatment of minors, should be interpreted in the spirit of the new principles of the Basic Law.

The legislator of the Capacity Law—an "old law", enacted before the enactment of the "new" Basic Law—did not explicitly establish a formula which balances the right and duty of parents to ensure the welfare of their children and the limited right of their minor children, in Section 6 of this law, to enhance their independence and personal autonomy.

One can argue that when courts examine what precisely is included in the phrase "a legal act of a minor of a kind commonly performed by minors of his age"[100] in Section 6 of the Capacity Law, it is incumbent upon them to take into account the values of human dignity and freedom, and grant autonomy to the minor, as much as possible, in accordance with the minor's age and level of intellectual maturity. The position of the minor's parents with respect to his/her medical treatment is not of sole importance. The proper process of decision-making, which safeguards the minor's fundamental rights that are granted to him or her by the Basic Law, is an important consideration that should be taken into account, and is more important than granting due weight to the point of view of the parents. This interpretation, in light of the rules of the Basic Law, should promote the designed goal of making the rigid legal framework

98. *See id.* at 414. *See also* BARAK, *supra* note 2, at 560-61.

99. C.C. 537/95, Ganimat v. State of Israel (1995), 49(3) P.D. 355, at 388-99.

100. Capacity Law, *supra* note 25, § 6.

of the capacity law, concerning the limitation of minors' legal acts, more flexible. In addition, this interpretation advances the notion of autonomy of minors. The courts must determine, in each case, the proper degree of autonomy that may be bestowed on the minor with respect to medical treatment that affects him or her.

The Author shares the point of view of Professor Englard that when one considers what is included in the term in the Capacity Law "a legal action commonly performed by minors," the court should grant attention to the dignity and freedom of the minor. Therefore, not only the general attitude of the parents towards the character of the action is important, but the perspective of the minor is also important. Society should promote his/her basic right to be treated in a manner that will enhance his/her human dignity and freedom.

Consequently, the court should grant weight to the idea of independence of the minor. Therefore, the court should consider the extent of autonomy that should be granted to the minor in the process of decision-making concerning his/her medical treatment.[101] Professor Englard held that the original, paternalistic intention of the legislator of the Capacity Law regarding the purpose of the legislation of this law is not significant nowadays. At present, the interpreter of this law should take into consideration the fact that this aforementioned Basic Law was enacted and is a source of interpretation of Israeli legislation.[102]

Perhaps, the verdict in the *Daaka* case should also be considered. Recently, in C.A. 2781/93 *Daaka v. Carmel Hospital*[103] case, the Israeli Supreme Court ruled concerning a thirty-nine-year old woman, who was hospitalized for a surgery in her left leg. However, the surgery was performed in her right shoulder, since there was a medical justification—a fear of severe consequences as a result of a tumor. The doctors reached the decision that this change was necessary, without receiving the woman's consent in the required manner. Due to the surgery, her shoulder was hurt. The court held it was not a case of negligence; however, there was not a full consent of the patient. The court de-

101. *See* ENGLARD, *supra* note 57, at 179.

102. *See* C.C. 537/95, Ganimat v. State of Israel (1995), 49(3) P.D. 355, at 412-21.

103. *See* C.C. 2781/93 Daaka v. Carmel Hospital, et al., (1999), 53(4) P.D. 526-624.

cided that this violation of the patient's right to consent justified a verdict that the victim should receive due compensation.

The main origin of the acknowledgment of the right to receive compensation was the rule that every person has a fundamental right to act autonomously. This right was defined as "his/her independence, self-reliance and self-contained ability to decide."[104] It can be derived from this right that each person has the freedom that his consent must be given before intruding on his body.

In the *Ganam*[105] case, Justice Barak held that the right to autonomy is one of the main expressions of the constitutional right of every person in Israel, which is derived from the Basic Law: Human Dignity and Liberty. This right was granted to adults in this case; however, the Israeli Supreme Court granted the right of personal autonomy to every person, including minors.

B. *International Law*

1. The United Nations Convention on the Rights of the Child

The 1989 U.N. Convention on the Rights of the Child ("Convention") was signed by Israel on July 3, 1990, and ratified by Israel on August 4, 1991.[106] In light of the ratification of the Convention, one must examine if Israeli law adopted the doctrine of including children in the decision-making process on matters concerning them grounded in the Convention. This doctrine requires the collaboration of a defined group of minors in the decision-making process affecting them.

Article 12 of the Convention states:

> 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.[107]

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104. *Id.* at 107; Fran Carnerie, *Crisis and Informed Consent: Analysis of a Law-Medicine Malocclusion*, 12 AM. J. OF L. & MED. 55 (1986).

105. Bagatz 4330/93, Ganam v. Head of the Bar (1996), 50(4) P.D. 221, 233.

106. *See* 31 KITVEI AMANA, 1038, at 221 (1991).

107. Convention, *supra* note 15, art. 12(1). For the historical background to the legislation concerning children's rights, see GERALDINE VAN BUEREN, THE INTERNATIONAL LAW ON THE RIGHTS OF THE CHILD 45 (1995). For the ratification and the implications of the Convention in the United States, see Barbara J. Nauck, *Implications of the*

The establishment of the principle concerning the right of the child to express his/her own wishes, in Article 12 of the Convention, is an important innovation which imposes an obligation upon those whose decisions and actions bear an influence upon children to take their opinions into consideration.

The social value of the rules of the Convention is evident. The Convention recognizes the status of the minor as a possessor of rights (and not solely as an object of paternalistic protection). It establishes that children must be imparted with rights in accordance with their varying stages of development, and hence, the legal weight attached to their opinions will be related to an objective factor, their age, and a subjective factor, their intellectual maturity. Article 12 enhances the notion that there is development, or there are stages, in the competency of minors.

The Convention also provides weight to the child's family unit and the social-cultural framework wherein he or she resides. The Convention strives to strike a balance between the recognition of the minor as a possessor of rights and the need to circumscribe these rights in order to promote two values: (1) the child's best interests;[108] and (2) the need to enhance the relationship of respect and honor between the child and his/her parents and the autonomy and privacy of parents as the heads of the family unit.

Are the rules of the Convention binding law in Israel? Certain articles in the Convention grant minors rights in the sphere of medical treatment for themselves.[109] However, they are not

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United States Ratification of the United Nations Convention on the Rights of the Child: Civil Rights, the Constitution and the Family, 42 CLEVE. ST. L. REV. 675, 676-78 (1994).

108. *See* Convention, *supra* note 15, art. 3. Article 3 of the Convention establishes that in all actions performed on behalf of children, the best interests of the child shall be a primary consideration.

109. *See id.* art. 6. Article 6 establishes:

1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Id. Article 23 states:

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for

which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his/her cultural and spiritual development.
4. States Parties shall promote, in the spirit of international co-operation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Id. Article 24 states:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right to access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
   (a) To diminish infant and child mortality;
   (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   (c) To combat disease and malnutrition including, within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
   (d) To ensure appropriate pre-natal and post-natal care for mothers;
   (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
   (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Id. Article 25 states:

States Parties recognize the right of a child who has been placed by the competent authorities for the purpose of care are, protection or treatment of his or her physical or mental health, to a periodic view of the treatment provided to the child and all other circumstances relevant to his or her placement.

binding to the same extent as Israeli internal law. Israel became a signatory to the Convention, and ratified it; however, it has not incorporated the rules of the Convention into Israel's internal law. The official status of the Convention is merely that of a source of interpretive inspiration and the legal rules in the Convention do not have the status of an enforceable norm in Israel.[110]

When a non-profit organization requested that the Minister of Education not stop the funding of its activity of education of young children, and mentioned the right of children to education in the Convention, the Supreme Court quoted a statement in an earlier decision:

> The provisions of the Convention are not included in the laws of the State of Israel, rather they constitute international legal norms.[111]

Justice Orr explained that:

> The persons at hand did not acquire any tangible right on the basis of the treaty and they cannot actualize such a right in a court of law as beneficiaries or in any other manner.[112]

The Supreme Court held that due to this and other reasons, the petitioners—the non-profit organization—could not draw from the Convention the concrete rights which they claimed.[113]

In order to endow the principles of the Convention with the legal status of internal Israeli law, the Israel Ministry of Justice presented a proposal of legislation, to be entitled the Rights of the Child Law, 1995. Ms. Yehudit Karp, Deputy Attorney-General at the Ministry of Justice, explained that the legislator's goal was that after the enactment of this legislation, this Convention would serve as the chief source of interpretation in Israel with respect to the rights of the child and his/her well-being, and this legislation would infuse the concept of children's rights in Israel with substantive legal meaning, and would advance social con-

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Id.

110. Y. Zilbershats, *The Adoption of International Law into Israeli Law: The Real is Ideal*, MISHPATIM, 24 (2) 317, 321-22, 344 (1994).

111. Bagatz 419/83, Doron v. Supervisor of Foreign Currency (1983), 38(2) P.D. 323, 333.

112. C.A. 25/55, Custodian of Absentee Property v. Samara (1955), 10(3) P.D. 1824, 1829.

113. *See* Bagatz 1554/95, Friends of Gilat, Non-Profit Organization v. Minister of Education et al., (1996) 50(3) P.D. 2, at 25.

sciousness to the rights of children.[114]

As of the time of writing this Article, the Israeli House of Representatives, the *Knesset*, has not enacted the Rights of the Child Law. Therefore, the general right of minors to be incorporated in the decision-making process concerning matters affecting them, in Article 12 of the Convention, is not recognized in Israeli internal Law.

However, interpretation can lead to the granting of rights to minor patents. The informed consent doctrine applies to minors, as much as possible, as a result of interpretation in light of the rules of the Basic Law and the Convention.

a. The Combined Criterion: Age and Maturity of Minors in Israeli Law

The Israeli legislator states that the parents are the minor's natural guardians.[115] They, *de facto*, usually decide for him or her. Are they in the best position to decide concerning his/her fate due to their close and intimate acquaintance and familiarity with the matter at hand? The context is important. In areas that remain under parental jurisdiction, there are situations in which a contradiction may arise between the parents' interest and the child's best interests, and their decision will not reflect the child's best interests. Additionally, even if parents' sole concern is their child's best interests, one may conclude that were the children to voice their interests, they would be more accurately met, and therefore, naturally, due weight should be granted to the children's expressed desires. The right to express their decision should be granted in accordance with their true competence.

At present, this is desirable law. The general rule is paternalistic. However, in certain rules in Israeli legislation, parents are no longer presumed to be the best protectors of their chil-

114. Ms. Yehudit Karp, Israeli Deputy Attorney-General, explained in a letter to the Israeli Minister of Justice, of December 27, 1995, that a Basic Law governing fundamental social, economic, and cultural rights has not yet been enacted in Israel, hence the Convention constitutes, *inter alia*, a statement (albeit a relative one, as it is contingent on available resources) on heightened societal awareness of these fundamental rights on behalf of the child. The rights to the enjoyment of basic health, education, and welfare, and their substantive manifestations, are not anchored in an Israeli Basic Law. At present, the imperative to legislate them, as mandated in the Convention, lacks the formal normative foundation toward this end.

115. *See* Capacity Law, *supra* note 25, §§ 14-15.

dren's best interests, and at times parents have ostensibly been stripped of their authority. According to Section 7 of the Adoption of Children Law, 5741-1981,[116] an adoption order will not be granted for a child who is at least nine years old, unless the court is sufficiently certain that the candidate for adoption wants to be adopted by the adoptive parents. If the adoptee is younger than nine, yet the court is under the impression that the child "is able to understand the matter," an adoption order will only be made if the court is satisfied that the candidate wishes to be adopted by the adopter.

Additionally, according to Section 13A(b) of the Capacity Law, a child that reaches the age of ten may not undergo conversion to another religion without his/her advanced written consent, in addition to his/her parents' consent and consent of the court. The age of the minor is the relevant criterion. His/her maturity is not taken into consideration. This rule grants the minor autonomy to an extent, but is basically paternalistic; the child's will is essential yet it is not sufficient.

At present, only in specific and special areas, when the legislator holds that it is important that the minor act independently, the legislator enacts specific and limited legal rules, which grant the minor the right to decide independently concerning matters that affect his or her life.

Some of these rules are in the field of medical treatment. For example, with respect to detection of the AIDS virus among minors, the law permits a minor aged fourteen years or older to be the exclusive decider. The examination, requested by the minor, will be performed without the approval of his/her parents or guardian. The minor's parents may not intervene in his/her decision. The Israeli legislator takes into account the minor's decision-making capability: his/her age and comprehension level.[117] The doctor should be convinced, after he or she takes into consideration the minor's age, his/her emotional maturity, and his/her ability to form an independent will, that the best interest of the minor requires an examination without approval of his/her representative. This rule essentially adopts the princi-

116. Adoption of Children Law, 5741-1981, § 7 (Isr.).

117. *See* Law Concerning Detection of the AIDS Virus Among Minors, 5756-1996, Law Book, 5756-1996, (Hebrew) § 1, at 252 (Isr.).

ple of developing stages of competency, formulated in Article 12 of the Convention.

Additionally, with regard to the performance of an abortion on a minor, probably since the intervention of the minor's parents may sometimes place the minor in jeopardy, the Israeli legislator conferred on the minor the exclusive right to make decisions concerning the cessation of pregnancy.[118] In this case the comprehension level of the minor is not a relevant factor.

Another rule concerning psychiatric treatment, which is an exception intended to ensure the granting of necessary treatment to minors, grants them more autonomy. The rule regarding psychiatric treatment of minors, in an amendment to the Youth (Care and Supervision) Law, 5720-1960, of 1996, enables the court to accept the request of a minor aged fifteen years or older to be hospitalized, or psychiatrically examined or treated, even though his/her representative does not approve this act. The age and the level of comprehension of the minor are important here. The court must be convinced that the minor understands the essence of this examination.[119] Likewise, for psychiatric hospitalization the law enables the court to consent to the request of a minor aged fifteen years or older who requests a psychiatric hospitalization for examination or treatment, even if his representatives object to the hospitalization. This rule is relevant when the court is convinced that the minor understands the essence of the examination.[120]

Section 3(4) of the Family Matters Court Law, 5755-1995,[121] grants a minor, in certain circumstances, the right to represent himself or herself in certain litigation in family matters. This general rule is one small step in the right direction: granting more autonomy to minors. However, it is relevant only in certain circumstances and only in the Family Matters Court.

In all the matters mentioned above, the right to make a decision in appropriate circumstances was granted to the minor alone. However, it must be stressed that this is not the norm but the exception. The legislator could also have included other

118. *See* Penal Law, 5737-1977, § 316(b) (Isr.): "the informed consent to the interruption of her pregnancy . . . the consent of a minor does not require the approval of her representative."

119. *See* Youth (Care and Supervision) Law, 5720-1960 (Isr.).

120. Amendment (1996) of § 3 of the Youth (Care and Supervision) Law (Isr.).

121. Family Matters Court Law, 5755-1995 (Isr.).

special rules in this departure from the norm, such as rules concerning psychological counseling, drug consumption, and incest. Parents who have conservative beliefs on these issues may endanger their minor children or cause them harm due to improper treatment of these problems. Consequently, there is a special justification for conferring on minors the sole right to make decisions in these sensitive areas in their best interest.

The general rule should reflect the shift from paternalism to autonomy. All minors who are mature and able to decide on their own should be granted the right to decide about their fate, including decisions concerning their medical treatment. The relevant consideration concerning the capacity of minors should be the doctrine of "developing capacities," as formulated in Article 12 of the Convention, which states:

> States Parties shall assure to the child who is capable of forming his/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.[122]

The attempt of the legislation in these sections in Israeli law to grant minors more autonomy should not be an exception to the general rule. An amendment of the Capacity Law, and other legislation concerning the fate of children, which will enhance autonomy of minors and reduce paternalism, is necessary.

C. *Interpretation of Law*

1. Interpretation of the Capacity Law

Some scholars are of the opinion that certain provisions of the Capacity Law enable a minor to participate in the decision-making process concerning his/her medical treatment. They hold that the source of the Israeli doctrine of informed consent to medical treatment performed on minors who are capable of comprehending the possible risks and dangers of the medical treatment they should receive is grounded in Section 6 of the Capacity Law.[123] This Section states that a legal act of a minor of a type commonly performed by minors of a certain age cannot

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122. Convention, *supra* note 15, art. 12.

123. *See* A. Oltzwaler, *Consent of a Minor for Medical Treatment* (Hebrew), 14 REFUA U'MISHPAT 23, 26 (1996).

be annulled by the representative of the minor, although this act has been performed without the consent of this representative, "unless substantial harm to the minor or to his/her property was caused thereby."[124]

However, this interpretation of Israeli law—that this Section is relevant concerning the consent of minors to medical treatment—is far from being universally accepted. In the past, the Israeli Supreme Court interpreted the phrase in Section 6 of the Capacity Law "a legal act of a minor of a kind commonly performed by minors of his age."[125] It did not hold that this phrase grants the minor an independent right to consent to medical treatment. In the opinion of Justice Ariel, in the *Shefer* case, it is incumbent upon the parents to represent the interests of their minor child concerning his/her medical treatment.[126] The role of the representative of the minor is important.

It is not easy to harmonize between the general commercial-economic trend of Sections 4-6 of the Capacity Law and the specific rule concerning medical treatment in Section 68(b) of this Law. Section 6 of the Capacity Law establishes an exception to the general rule—an act which is commonly performed by minors of the said minor's age, may not be voided by the minor's representative.[127] However, this arrangement was primarily designed to handle regular commercial transactions. The issue of medical treatment is of a special nature since consequences stemming from the minor's consent are not limited to the commercial domain. They have direct repercussions on the criminal and tort liability of the doctor with regard to the actual performance of the treatment and its outcome.[128] Therefore, according to Professor Englard, the rules of the Capacity Law applied in

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124. Capacity Law, *supra* note 25, § 6.

125. *Id.*

126. C.A. 506/88, Shefer (minor) v. State of Israel (1994), 48 (1) P.D. 87, at 198-99.

127. *See* Capacity Law, *supra* note 25, § 6. Professor Englard wrote that the main purpose of the first requirement of this section is the protection of the other participant of the legal transaction with a minor. He also held that the burden of proof that the legal act is valid is imposed on the person relying on this phrase. This is proven by showing evidence of the practice of performing such actions by minors who do not ask for their parents' permission before they perform the act. In addition, the person relying on this phrase has to prove that the performance of such actions is a phenomenon that is known to many parents, and they do not usually oppose to the performance of such actions. *See* ENGLARD, *supra* note 57, at 98-100.

128. Non-consensual medical treatment in Israeli law constitutes an assault. Penal

matters of medical treatment performed on minors cause a great degree of uncertainty with regard to the validity of the minor's consent, and hence place a heavy burden on the doctor's shoulders.[129]

Indeed, the main question does not revolve around the economic aspects of the agreement between the treating doctor and the patient. The key issue is the autonomy of the latter versus the interests and rights of his/her parents. The rule concerning medical treatment, in Section 68(b) of Capacity Law is not a full comprehensive regulation of the relevant rights and duties of all parties to consent to medical treatment. The current legal arrangement, as mandated by all relevant rules of the Capacity Law, does not create the necessary *modus operandi* for balancing competing interests. Nor does it distinguish between regular, commercial, or medical matters, and special urgent matters, such as crucial decisions concerning life and death.

The legislator of the Capacity Law was primarily concerned with the legal acts performed by minors in the economic sphere. The commercial-economic approach of the Capacity Law, in Sections 4-6, does not provide the proper framework for the legal regulation of the special, very sensitive issue of a minor's consent to medical treatment. The minor himself or herself is sometimes capable of performing the act of consenting to medical treatment, yet, as we have seen, under the current law, the general rule states that the parents are authorized to retroactively void the minor's consent.

We can conclude that the rules of Capacity laws in regard to minors are paternalistic. It seems that according to the current law one cannot find in Section 6 of the Capacity Law the source

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Law, 5737-1977, §§ 378, 379; Civil Wrongs Ordinance, §§ 23 (assault), 35 (negligence), 63 (breach of statutory duty).

Section 9(b) of the Civil Wrongs Ordinance states that a minor, who is less than 18 years old, can sue when he/she holds that the rules of the Civil Wrongs Ordinance were violated. Therefore, although the minor cannot consent to the treatment, he can sue when he was harmed and holds that a suit based upon the cause of assault is justified.

When the minor cannot consent to medical treatment, his/her guardian can consent. The Israeli Supreme Court, in C.A. 2781/93, *Daaka v. Carmel Hospital*, (1999), 53 (4) P.D. 526, granted compensation as a result of the fact that consent of a patient to medical treatment was not granted, and harm was caused. In this case, the autonomy of the individual was granted recognition as an independent right, and the breach of this right justified compensation. The rule is also relevant with regard to consent of a minor or his/her legal representative.

129. *See* ENGLARD, *supra* note 57, at 49-51.

of the Israeli doctrine of informed consent to medical treatment performed on minors who are capable of comprehending the possible risks and dangers of this medical treatment

2. Medical Treatment: Paternalism

The courts in Israel try to determine, in each case, according to the relevant circumstances, whether the parent, representative, or guardian, who consents or does not consent to medical treatment is acting in the best interest of the minor or of the retarded person.

Prior to the legislation of Section 68(b) of the Capacity Law a paternalistic point of view that granted little (if any) importance to the personal autonomy of a minor patient prevailed in Israeli Case Law.

Justice Agranat ruled[130] that the refusal of the parents of a minor to authorize the lifesaving operation of amputating their daughter's leg constituted a breach of their duties as guardians of the minor child that should enhance her well-being. He held that they were not acting in the best interest of their daughter. The doctors held this operation was a matter of life and death. Therefore, the Court granted due importance to the preservation of the minor's body and life.

After the enactment of the Capacity Law, in the case of *Attorney General v. Ploni*,[131] the Supreme Court challenged the issue of authorization of a lower court of a kidney donation from a mentally retarded person, with the status of limited capacity. The purpose of this donation was a transplant of the kidney into the body of the retarded person's father, who raised him. The judgment of the Supreme Court established that Section 68(b) of the Capacity Law empowered the court to approve certain medical measures that although not medically necessary for the minor or for the retarded protected citizen, are intended to have a positive impact upon this person's mental and/or general health. Among these measures is the removal of an organ from the body of this person for the purpose of transplantation, on condition that the benefit of the organ donation for his/her mental and/or general health will be "to an immeasurable degree" greater than the harm which will be caused as a result of

130. C.A. 322/63, Gerty v. State of Israel (1964), 18(2) P.D. 449.

131. R.A. 698/86, Attorney General v. Ploni et al. (1998) 42(2) P.D. 661.

the donation. This is a paternalistic attitude, which attributes great importance to the view of the court concerning measures that enhance the physical and mental health of the patient, and less importance to his/her autonomy.

In the case of *Association in Favor of the Right of the Citizen to Decide Concerning His Life. v. Ziv Government Hospital, Safed,*[132] the District Court Judge, E. Matza,[133] held, that Section 15 of the Capacity Law did not grant the parents the right to request that certain life saving medical treatment should not be granted to their daughter, at the final, painful, stage of her fatal illness, the Tay-Sacs disease.[134] He held that Section 15 of the Capacity Law does not grant them, as representatives of the minor, authority to request this termination of medical treatment. His outlook was paternalistic. He emphasized the obligation of natural guardians, in Section 17 of the Capacity Law, to act in the minor's best interest.[135]

In the court decision *Shefer (Minor) v. State of Israel,*[136] the Supreme Court discussed the right of a natural guardian to deny medical treatment to his/her minor child in his/her custody. The court analyzed the nature of the right and obligation of the parent to act on behalf of his/her minor child as a natural guardian. It held that this right and obligation includes the right to deny medical treatment, although the refusal to consent to this treatment may lead to the death of the minor.[137] However, a decision of this nature requires the authorization of the court.[138] The doctor is relieved from his/her obligation to treat

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132. O.M. 779/88 (Tel-Aviv), Association in Favor of the Right of the Citizen to Decide Concerning his Life v. Ziv Government Hospital, Safed, P.S.M. (1988-1989)(2), at 240.

133. At present a Justice in the Supreme Court of Israel.

134. *See* O.M. 779/88 (Tel-Aviv), Association in Favor of the Right of the Citizen to Decide Concerning his Life v. Ziv Government Hospital, Safed, P.S.M. (1988-1989)(2), at 247-48.

135. The same policy could be also applicable with regard to the Attorney General, since the duty to act in the best interest of the minor is relevant in certain cases concerning the Attorney General, who is responsible for the public's welfare. *See* Capacity Law, *supra* note 25, § 69.

136. C.A. 506/88, Shefer (minor) v. State of Israel, (1994) 48(1) P.D. 87.

137. Active Euthanasia is forbidden in Israeli Penal Law. Penal Law, 5737-1977, §§ 300, 302, 309(4), 378. The *Shefer* case, *supra* note 126, focused upon the option of Passive Euthanasia. The dilemma was whether the doctor has any obligation to lengthen the patient's life, against his/her will.

138. In the *Shefer* and *Gerty* cases, the Israeli Supreme Court held that the guardianship of parents includes the right to refuse to medical care, even if the refusal would

the minor only after the court approves explicitly the policy of not granting treatment to the minor. In the *Shefer* case, the Israeli Supreme Court ruled that in certain circumstances the decision to deny a minor medical treatment may be perceived as a breach of the parental obligation to act "in the best interest of the minor in such manner as devoted parents would act in the circumstances."[139] The decision may also be considered a violation of the parent's obligation of protecting the minor's body and mental health. The court's point of view was paternalistic. It granted authorization concerning medical treatment and acted on behalf of the child in her best interest. The Supreme Court held that the court was empowered to grant such an authorization since the Israeli legislator stated, in Sections 68(b) and 44 of the Capacity Law that the court can decide regarding these matters. Justice Elon held in the *Shefer* case that Jewish Law is an important source of inspiration concerning these bioethical matters. His paternalistic outlook in the *Shefer* case was based upon the adoption of the supreme principle in Jewish Law—the holiness of life, as well as other principles of Jewish law such as the value of preventing suffering of patient and the rule of loving your fellow man.

In the *Shefer* case, the court held that the minor's life was of value, her dignity was upheld, and she was not suffering. Given this reality, Justice M. Elon ruled that the sanctity of life should be the decisive value.[140] The minor's life must be preserved, and all harm or hindrance to it is contrary to the values of the State of Israel as a Jewish and democratic State.

The paternalistic point of view in the *Shefer* case is contrary

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lead to the death of the minor; but a refusal of this kind is considered justified only after receiving the approval of the court. This refusal could be considered unjustified when the court considers it a violation of the parents' duty to act "in the best interests of the minor in such manner as devoted parents would act in the circumstances." Capacity Law, *supra* note 25, § 17.

139. C.A. 506/88, Shefer (minor) v. State of Israel, (1994) 48(1) P.D. 87.

140. In general, the practitioner has an obligation in the law to grant any medical treatment to a patient that he treats. Patients' Law, *supra* note 9, § 11; Penal Law, 5737-1977, § 322. And yet, the extent of the practitioner's duties to grant medical treatment to a patient have not been clarified in Israeli legislation, since the law acknowledges, in certain circumstances, the patient's right to refuse medical treatment. The person's right not to get physically hurt without his/her consent means, among other things, that a person is entitled not to go through any medical procedure that naturally hurts the body without his/her consent. C.A. 3108/91, Raybi et al. v. Weigel et al., (1993) 47(2) P.D. 497. 505-06, 512-13.

to the view of scholars that emphasize the value of granting autonomy to a suffering patient. According to Gerald Dworkin, there are several reasons for favoring physician-assisted suicide: (1) the interest of the dying patient that the process of dying will be as painless and dignified as possible; (2) his interest in determining the time and manner of his death; and (3) enhancement of autonomy and relief of suffering.[141] Advocates in favor of euthanasia argue that patients ought to have the right to take their own lives, or, if they so desire, to be put peacefully to death by a physician.[142] On the other hand these advocates would probably hold that there are special exceptions.[143]

The principle of personal autonomy to choose, which is mentioned in Dworkin's writing, is not adopted in the *Shefer* case. Perhaps there could be exceptions to the verdict in this case. Paternalism in the *Shefer* case might be a result of the patient's young age, which prevented the possibility of granting due weight to her will and informed consent.

In the case of the *Attorney General v. Shani*,[144] the court examined the legal validity of a minor's consent to a bone marrow donation. An eight-year old minor donated bone marrow for the purpose of saving his six-year old sister, who faced a "clear and certain" danger of death. Judge Dorner[145] decided that due to the great psychological tension that the minor was liable to encounter in his relationship with his family, as a result of the minor's refusal to donate bone marrow, a judicial refusal to authorize the donation was likely to cause a great mental blow to the child, while at the same time, the medical risks of a bone marrow transplant were quite slim in light of the body's regeneration of bone marrow. The judge, therefore, authorized the medical procedure. This is a continuation of a paternalistic approach that imparts little importance to personal autonomy.

The *Ploni v. The Welfare Officer* case[146] involved an adolescent, aged seventeen years and seven months, who suffered from

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141. GERALD DWORKIN ET. AL., EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE, FOR AND AGAINST 3 (1998). *See also* Richard Fenigsen, *A Case Against Dutch Euthanasia*, HASTING CENTER REP., 19 Special Suppl. 22-30 (1989).

142. DWORKIN, *supra* note 141, at 110.

143. *Id.*

144. C.C. Jerusalem, 349/90, 90(2) Takdin-District, 482.

145. Currently a Justice of the Israel Supreme Court.

146. *See* Bagatz 2098/91, Ploni v. Welfare Officer Jerusalem et al. (1991), 45(3) P.D. 217.

cancer. The minor's parents implored their son to undergo chemotherapy but he refused to accept the treatment out of fear of the accompanying pain and suffering. To avoid this treatment he ran away from home. The minor was eventually located by the police, and the juvenile court which ruled concerning the matter ordered that the medical treatment, chemotherapy, be forcibly administered to the minor at the psychiatric ward, for coerced treatment may be administered only in the psychiatric ward.[147] The minor petitioned the Israeli Supreme Court, the High Court of Justice, and requested that it should order the cessation of these forced treatments. The court did not decide the exact balance between the will of the minor and the will of his parents, his natural guardians, which requested he should undergo chemotherapy in his best interest, since the circumstances were as follows:

> We had the opportunity to speak at length with the petitioner and to stress before him the importance and grave necessity of chemotherapy for treating his illness, the high chances of being cured, and his personal responsibility to fulfill the supreme commandment of "you shall protect your lives" (Deuteronomy 4:15). Towards the end of our exchange of words, the petitioner informed us that indeed his initial desire was to refuse to undergo the treatments due to the pain they would cause him; however, he has now consented to obey the court order concerning the treatments for the entire duration of the order, and he has promised to appear in the medical institution in order to receive the treatments. Thank You! After conducting this heart to heart discussion with the petitioner, we are convinced, to the best of our abilities of understanding, which the petitioner spoke to us truthfully. The petitioner is indeed a minor and only near the age of legal adulthood, yet, when taking into account his appearance before us, his manner of speech, and his sincerity, we deem him to be an adult and that his words are genuine . . . This suffices us, so we do not hold there is a necessity to delve into the legal questions at hand that were raised before us which touch upon the fundamental values of human liberties, on the one hand, and the individual's best interests on the other hand, and the balance between these

147. According to Joel Feinberg, soft or weak paternalism justifies intervention in self-regarding conduct, which may properly be defined as non-voluntary (because of distortions caused by ignorance, compulsion etc.). *See* Feinberg, *supra* note 46, at 3.

competing values.[148]

The court reasoned that this approach was the ideal solution for resolving this specific case. The Justices felt that the petitioner spoke truthfully and therefore did not delve into relevant legal questions. The young man was not granted the legal right to make a decision regarding his medical treatment since he was a minor. However, the epilogue to this story was not as rosy as the judges anticipated. The petitioner fled abroad, and when his condition worsened he returned to Israel, where he died shortly afterwards. The minor did not justify the trust of the justices. However, it must be added that the justices who spoke to the minor held "we deem him to be an adult," and that had the petitioner been a few months older, the matter would surely have not been decided by a court. The justices did not grant him rights of an adult but took into consideration the fact that he was almost an adult who can decide his own fate autonomously.

The general rule is that every person in Israel, including a minor, has the right to receive medical treatment, or to refuse medical treatment or medical examination, in suitable circumstances, provided only that there is no legal order demanding the performance of that treatment or examination.[149] In suitable circumstances the court can render that medical treatment should be granted to a minor or an adult.[150]

When the court decides whether to enforce the treatment, it should compare the benefit of the treatment with the possible harm that could be caused to the minor. Only when the expected benefit of the treatment is greater than the possible harm that can be caused by it, the court will be able to state that the medical treatment is required for the minor, and the court will enforce its performance.[151] This rule is flexible and undefined.[152] The court is careful, and analyzes each case in light of its particular circumstances. It also takes into consideration the values of society.

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148. Bagatz 2098/91, Ploni v. Welfare Officer Jerusalem et al. (1991), 45(3) P.D. 217, at 219 (author's trans.).

149. *See* 548/78, Sharon et al. v. Levy, (1989) 35(1) P.D. 736, 755.

150. *See* 480/85, Cortam v. State of Israel, (1986) 40(3) P.D. 673.

151. *See* R.A. 698/86, Attorney General v. Ploni, (1988) 42(2) P.D. 661, at 689.

152. *See* Case 5587/97, Attorney General v. Ben Ikar, Minor, (1997) 51(4) P.D. 830, at 847.

The general trend is evident. The minor or retarded person is not an independent, autonomous, human being, who has a right to decide concerning his/her own fate. Others decide concerning his/her medical treatment in his/her best interest.

3. Age and Maturity of Minors in Israel: Case Law

Sometimes the relevant principle is paternalistic, namely the best interest of the child,[153] but the court holds that the independent wishes of the child should be taken into consideration, in his/her best interest.

Israeli courts recognize the right of a minor to be involved in the decision-making process under certain circumstances with respect to child custody. It is customary to take the child's opinion into consideration regarding his/her preferable custodian beginning from age ten or eleven and older, when the child possesses sufficient understanding and discretion to form a responsible opinion with regard to custody and visitation arrangements that optimally serve his/her best interests.[154] Israeli courts tend not to force a child, after reaching the age of ten or eleven, to be

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153. *See* Capacity Law, *supra* note 25, §§ 24-25. Section 24 states:

> Where the parents of the minor live separately—whether the marriage has been annulled or dissolved or still exists—they may agree between them as to which of them shall exercise the guardianship of the minor, wholly or in part, which shall have custody of the minor and what shall be the right of the other parent with regard to having contact with him. Such an agreement shall be subject to the approval of the Court, and upon such approval shall, for all purposes, other than for the purpose of an appeal, have the effect of a judgment of the Court.

Id. § 24; Section 25 states:

> Where the parents have not reached an agreement as provided in section 24, or where they have reached an agreement but it has not been carried out, the Court may determine the matters referred to in section 24 as may appear to it to be in the best interest of the minor provided that children up to the age of six shall be with their mother unless there are special reasons for directing otherwise.

Id. § 25.

154. This Israeli legislation includes the phrase: "in the best interests of the minor." The age of maturity is not mentioned. It was the courts that specified a particular age of maturity of the child at which he or she is deemed able to understand all the relevant considerations in custody cases. *See* A.H. Shaki, *Rethinking Parental 'Right' of Custody*, 9 TEL AVIV UNIV. L. REV. 59 (1983) [hereinafter *Rethinking Parental 'Right'*]; A.H. Shaki, *Main Characteristics of the Law of Child Custody in Israel*, 10 TEL AVIV UNIV. L. REV. 5 (1984) [hereinafter *Main Characteristics*]; Y. RONEN, INCLUDING THE CHILD IN CUSTODY DECISIONS 34-46 (1997).

in the custody of a guardian against his/her will.[155] They take into consideration not only the child's age but also individual subjective factors, such as the intensity of the child's determination and his/her mental development, which enables him or her to discern and judge in a proper manner. However, this policy does not stem from an attempt to grant minors more autonomy: it is paternalistic. The welfarist point of view leads to the conclusion that this rule is necessary in order to prevent placement of the child in an undesirable environment and consequently sadness and stress.[156]

Many writers have focused on the doctrine of Israeli courts that consider the wishes of some minors (e.g., in custody disputes) as the most important practical result of adopting a children's rights approach that emphasizes autonomy.[157] After all, what could be more respectful of autonomy than, as Eekelaar put it, actually listening to what the child has to say? Listening, however, is not enough: the very fact that there is someone who must listen and the fact that the child does not make his/her decisions independently, serve to emphasize the child's dependence. The real question is whether the child's input has a decisive effect in the outcome. In practice, the opinion of the pro-

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155. *See* Justices Olshan, Zilberg, and Vitkon in Bagatz 89/52, Levi v. The Head of the Execution by Court Officer, Jerusalem (1952) 6 P.D. 1264, 1265; Justice Cheshin in Bagatz 39/55, Bar v. Bar, (1955) 9 P.D. 1367, 1370-71; Justices Sussman and Cheshin in C.A. 241/57, Paltiel v. Paltiel, (1959) 13(1) P.D. at 599, 604-05, 606-07; Justices Kister and Kahan in Bagatz 391/71, Plonit v. Almoni, (1972) 26(1) P.D. at 85, 99, 102-03; Justice Cohn in C.A. 653/72, Yahalomi v. Yahalomi, (1973) 27(2) P.D. 434, 441-44; Justice Kister in C.A. 433/67, Tzabar v. Tzabar et al., (1969) 22(1) P.D. 162, 166-67; Justice Ben-Ito in C.A. 352/80, Tzukerman v. Tzukerman, (1980) 34(4) P.D. 689, 694; Justice Netanyahu in C.A. 687/83, Mazor v. Mazor, (1984) 38(3) P.D. 29, 36; Justice Beiski in C.A. 113/89, Mazar v. Kavilio, (1989) 43(1) P.D. 661, 666-67; *Main Characteristics*, *supra* note 154, at 33.

156. The obligation to take into consideration the wishes of the child, at a suitable age, stems from the interpretation of the obligation in Section 25 of the Capacity Law, to enhance the best interest of the child. The court will not want to distress the child and cause unnecessary emotional stress and harm. Therefore, it will tend not to rule in a manner contrary to the child's feelings and wishes. *See* C.A. 424/70, Yelin v. Yelin 2 5(1) P.D. 172, 173 (1971); *Rethinking Parental 'Right'*, *supra* note 154, at 78-81; RONEN, *supra* note 154, at 121-31.

157. Many scholars have emphasized that independent counsel, in child custody disputes, is the most important expression of any recognition of children's rights. *See, e.g.*, Emile Kruzick & David Zemans, *In the Best Interests of the Child: Mandatory Independent Representation*, 69 DENV. U.L. REV. 605 (1992); Shannan Wilber, *Independent Counsel for Children*, 27 FAM. L.Q. 349 (1993); Linda Elrod, *Counsel for the Child in Custody Disputes: The Time is Now*, 26 FAM. L.Q. 53 (1992).

fessional experts such as social workers and psychologists is more important than the child's opinion.

Is Article 12 of the Convention, which includes the phrase "in accordance with the age and the maturity of the child,"[158] a binding legal rule in Israel? At present Israeli proposals of legislation are intended to enhance children's rights in Israel. One proposal is intended to elevate the legal status of the Convention to the level of internal Israeli law. An additional proposal suggests that the legislator will explicitly mandate all State authorities to uphold the rights of the child as delineated by the Convention.[159] As of the time of writing, the Israeli legislator has still not adopted these proposals as valid legislation. However, in light of the ratification of the Convention by Israel, all Israeli State organs are bound by the Convention as long as its principles do not clash with the principles of internal Israel law.[160] If and when such a conflict arises, the paternalistic point of view of domestic legislation—such as the rules of the Capacity Law and the Patients' Law—is preferred to the principles of the Convention that grant more autonomy to the minor.[161]

As mentioned, only in a few specific areas, such as adoption, does the Israeli legislator state that the court should take into consideration the wishes of minors. In general, despite having ratified the Convention in 1991, Israel has not yet enacted any general legislation explicitly adopting the children's rights doctrine. The best interest of the child principle and paternalistic rules of the Capacity Law remain at the core of most decision-making with regard to minors, regardless of their ages.[162] The custom in the field of child custody is based upon one criterion: an age differentiation between children—younger and older than ten or eleven years old, with all the paternalism it implies. It does not take into account the specific maturity level of the child.

It is important to remember that the courts are obligated to interpret the domestic legislation concerning minors in light of the rules of the Basic Law and the Convention. The channel of

158. Convention, *supra* note 15, art. 12.

159. *See supra* note 110 and accompanying text.

160. *See supra* note 111 and accompanying text.

161. *See supra* notes 85-115 and accompanying text.

162. *See supra* Part II.A.1 of this Article—The Capacity Law, and subsection II.A.1.a—Best Interest of the Child.

interpretation of the Capacity Law and the Patient Law in light the principles of this Convention should lead to the conclusion that minors should be granted more autonomy, including the right to participate in the decision-making process concerning their medical treatment, when these principles do not clash with the principles of Israeli internal Law, such as the principles of the Capacity Law and the Patients' Law.

4. Children's Rights in Israeli Case Law

Despite this lack of substantial legislative progress in the direction of the introduction of a general rule in internal Israeli law that adopts the principles of the abovementioned Convention and the doctrine of children's rights, some effort has been made to place the concept of children's rights on the legal agenda in Israel in decisions of the Israeli Supreme Court.

In the landmark *Ploni, Minor v. Ploni* case,[163] the former Chief Justice, Shamgar—facing a conflict between parents regarding the religious education of their children—discussed the importance of utilizing rights discourse in making decisions regarding children. He differentiated between the best interest of the child principle and the concept of children's rights. Shamgar attempted to present the new agenda—children's rights—as a remedy for the shortcoming of the best interest of the child principle. However, Shamgar, without addressing the issue directly, adopted an interest-oriented approach to children's rights that devalued autonomy. In doing so, he failed to formulate a children's rights approach that truly improves upon the best interest of the child principle. As his analysis shows, the formula he applied is based upon a narrow definition of rights, so he was unable to live up to his own stated goal.

In the *Ploni* case, the wife decided to become a Jehovah Witness. The District Court issued an order, on request of the husband, forbidding the wife to expose her children to her activities and beliefs as a member of the Jehovah Witnesses. The wife appealed to the Supreme Court, arguing that the lower court order violated the freedom of religion of herself and of her children. Appealing to Article 14 of the Convention, the mother argued that her freedom of religion included her right to impart her religious values to her children, and that their freedom of relig-

163. C.A. 2266/93, Ploni, Minor v. Ploni, (1995) 49(1) P.D. 221.

ion, protected by the Convention, included their right to learn about the principles of the religion of their parents.[164]

Portraying the dilemma as a triangular one, involving the State, the parents, and the child, Justice Shamgar held that children, regardless of the current legal validity of rights mentioned in the Convention, possess constitutional rights according to Israeli internal law.[165] Like all fundamental rights, children's rights are not absolute and must be balanced against competing interests and rights.[166]

Shamgar divided children's rights into two categories: general constitutional rights possessed by adults that should be extended to children as well, and rights deriving from the family context that are particular to minors as such.[167] Children's rights theory, he argued, does not replace the best interest of the child concept but expands and encompasses it.[168] Unlike the best interest of the child principle, which he refers to as an "emotional-subjective" concept, the alternative of children's rights provides decision makers with a "constitutional-normative" standard that ensures neutrality and recognition by the legal system that the child is a party to the conflict with independent interests and needs.[169]

Justice Shamgar reiterated his distinction between fundamental constitutional rights of children and rights that children

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164. *Id.* at 233.

165. *Id.* at 251-54.

166. Justice Shamgar uses the best interest of the child principle as his starting point. Citing Professor Shifman, he points out that the best interest of the child principle is a paternalistic one that makes decisions for children rather than stating that there is an obligation to listen to what children have to say or recognize their status as parties to the conflict. When a conflict arises between parents, the best interest of the child principle is appealed to as a supposedly "neutral" one that helps the court decide between legitimate competing claims. He says, further relying on Professor Shifman, that the best interest of the child principle has its drawbacks. First, it fails to address the tension between the interests of the actual child in question and the interests of the potential child or children in general. Second, and here Shamgar's criticisms are more relevant to the circumstances of the *Ploni* case, it fails to prevent ideological or subjective criteria from being introduced into the decision-making process. In a democratic society, courts are supposed to remain neutral on substantive issues of religion and are to remain utterly impartial in deciding between parents who disagree about the religious upbringing of their children. As Shamgar points out, the best interest of the child principle makes it virtually impossible for judges to remain impartial in conflicts regarding religious education.

167. C.A. 2266/93, Ploni, Minor v. Ploni, (1995) 49(1) P.D. 221, at 255.

168. *Id.* at 254; *see also* RONEN, *supra* note 154, at 20.

169. C.A. 2266/93, Ploni, Minor v. Ploni, (1995) 49(1) P.D. 221, at 254.

have within the family, arguing that with regard to the second category, the children's rights discourse may not be appropriate at all, and that courts will have to define precisely which interests within the family can be described as "rights."[170]

Where does Justice Shamgar's approach to children's rights lie with regard to the distinctions outlined above, between welfarist and interest-oriented theories on the one hand, and liberationist and liberal oriented theories on the other? Justice Shamgar introduced the concept of children's rights as a means of ensuring impartiality in the decisions of the court. He held that courts are required to state the correct balance between the wishes and interests of the parents, the child, and the State. However, he made it very difficult for readers of his legal verdict to determine what he meant when he used the term "rights." He referred in passing to the diversity in children's rights approaches, but never developed his own particular theory of rights. He preferred to state laconically that all rights theories in essence recognize:

> That the child has become an autonomous individual, no longer a "possession" of his/her parents, and that he or she is entitled to the protection of his/her basic constitutional rights, both from their violation by the state and from their violation by his parents.[171]

It is important to be aware of the gap between the terminology and the essence. The rhetoric of Justice Shamgar in the *Ploni* case is individualistic-liberal. Justice Shamgar used the term "autonomous." However, it would appear from his later analysis that he embraced, in fact, a paternalistic interest-theory of rights that views the rights discourse primarily as a means of isolating and protecting the minor's interests, as defined by the court, and ensuring that he or she is treated as the subject, rather than the object, of others. This is why Justice Shamgar presented the paternalistic best interest of the child principle as inherently bound up with the children's rights discourse, and while he wished to recognize children as possessing constitu-

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170. *Id.* at 255-56.

171. *Id.* at 252, 254. There, Justice Shamgar explains that those who adhere to the doctrine of children's rights hold that: "The child is an autonomous human being. He or she has rights and interests that are independent and separate from the rights and interests of his/her parents."

tional rights, he could see no use for children's rights theory in custody disputes.

The whole notion of children having a "right" to be taught their parents' religious beliefs rings strange in the ears of liberal rights theorists, and the notion of this "right" limiting the child's own right to choose his/her religious or non-religious education rings even stranger. Only if children's rights are understood in terms of interests defined externally to the minor, does this approach make sense. A rights theory that emphasizes autonomy cannot tolerate such a rigid and externally defined account of children's rights. For liberal rights theorists, it is precisely in disputes concerning education or custody, where objective interests are difficult to define, that children's rights theory can make all the difference.[172] Children's rights, for liberal theorists, do not mean defining and protecting the interests of children. They mean listening to what children have to say and, as far as possible, allowing them to make their own decisions.

The point of departure of Justice Shamgar is paternalistic. Justice Shamgar wrote:

> The goal of this type of discussion is the granting of defense to a child from choices which are in contradiction to his/her best interest or rights. The point of departure is the assumption that the minor cannot decide independently concerning various matters, and therefore his/her parents decide concerning these matters, and at times, concerning a dispute between the minor and his/her parents—the court decides. The parents and the court, when they choose between possibilities and decide which is preferable, are guided by the principle of the best interest of the child. Best interest of the child is the goal but not necessarily the criterion or the mechanism of decision-making. The approach of children's rights does not favor the 'rights' of the child over his 'Best interest' . . . The purpose is not the development of a mechanism which infringes upon the rights of parents and narrows the autonomy of the family.[173]

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172. *See, e.g.*, John Eekelaar, *The Interests of the Child and the Child's Wishes: The Role of Dynamic Self-Determinism*, 8 INTERNAT'L J.L. & FAM. 42 (1994).

173. C.A. 2266/93, Ploni, Minor v. Ploni, (1995) 49(1) P.D. 221 (author's trans.). Justice Shamgar held that sometimes the court will not enhance the child's rights when the violation of those rights is insignificant. This policy was the result of the balance between the insignificant violation of the rights of the child and the possibility of grave damage to the family.

Justice Shamgar pointed out that sometimes children are unable to make their own intelligent decisions.[174] However, he did not state that autonomy of children should be limited only in situations that justify this limitation. In addition to devaluing autonomy, Justice Shamgar's approach also devalues equality. Instead of attempting to justify in coherent terms the use of rational capacity as a distinguishing factor between children Shamgar simply assumed that the general category "children" could be treated in a paternalistic manner. He did not apply, in the *Ploni* case, Feinberg's distinctions between strong and weak paternalism, or Dworkin's distinctions between critical and volitional autonomy. Even if Justice Shamgar assumes that rational capacity should not be a relevant factor when a court determines the scope of an individual's religious freedom,[175] some thought should have been given in this case to a subjective factor: the rational capacities possessed by the specific children at issue.[176]

Rights approaches that devalue autonomy can do little to remedy the indeterminacy and subjective nature of the best interest of the child principle. The same subjective criterion that is usually implemented when a court applies the best interest of the child standard is merely transferred to a different stage of the decision-making process—the stage of defining which of the child's interests are to be granted the status of rights.

The above decision of Justice Shamgar was the minority decision concerning the status of children's rights in Israel in the *Ploni* case. Justice Strasborg-Cohen, while utilizing a different theoretical framework for her decision, reached the very same result as Justice Shamgar. Although she acknowledged the importance of granting autonomy to children and recognizing the status of children as rights holders, and admitting that rights discourse can in part remedy the indeterminacy and subjective nature of the best interest of the child principle, Strasborg-Cohen concluded that the idea of children's rights should be one of the

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174. *Id.* at 256-57.

175. An assumption that should, at the very least, require justification.

176. Interestingly, Justice Shamgar was not aware of the development in the articles written by Professor Eekelaar concerning children's rights. He relied heavily on Eekelaar, *supra* note 17. Unlike Eekelaar's later article, discussed above, which clearly advocates a will-theory and emphasizes the importance of autonomy in children's rights, Eekelaar's earlier article avoids confronting the issue of whether autonomy should be recognized as part of the "deep structure" of rights, preferring to adopt a theory that defines and recognizes various interests as rights for children.

considerations when the courts decide the fate of children. However, this should not be the primary consideration. The main consideration is the best interest of the child. Therefore, she held that disputes regarding religious education should not be decided on the basis of the principle of children's rights. In this case, and other cases concerning the fate of children, the final test must always be the child's best interests. She held that in this case it was ineffectual to speak in terms of rights.[177] Her general conclusion, as well as the conclusions of most of the justices in the *Ploni* case, was that the principle of best interest of the child should remain the leading principle in legal decisions on the fate of children, and should be considered preferable to the principle of children's rights.

The philosophical basis of the viewpoint of Justice Strasborg-Cohen is vague. One possible interpretation of the rhetoric is as follows. While Justice Shamgar can be viewed as a sort of interest theorist, who attempts to tailor his rights approach to what he sees as the special needs of children, Strasborg-Cohen can be seen as a welfarist who rejects rights rhetoric in the context of children. To some extent Justice Shamgar's approach resembles Justice Strasborg-Cohen's. One uses rights theory, the other the best interest of the child principle, but both are basically committed to the ideology of welfarists.

Three other justices also expressed their point of view concerning the relationship between the best interest of the child principle and the new principle, namely children's rights. They preferred not to focus upon the differences between these principles. They held that there are similarities between the principles of the best interest of children and their rights.

Justice Zamir held that the paths of the best interest of the child and children's rights lead to the same goal: the essence is important and not the terminology. He did not address the issue of paternalism. Justice Zamir held that when the best interest principle leads to a different result than that of the principle of children's rights, the best interest principle prevails. When the rights granted to the child are harmful to the child, the court should prefer his/her interests. The principle of best interests is known and accepted. It is also a principle mentioned by the Israeli legislator in Section 17 of the Capacity Law con-

177. C.A. 2266/93, Ploni, Minor v. Ploni, (1995) 49(1) P.D. 221, at 266-68.

cerning the relationship between parents and children. Paternalism is preferred when the two principles, paternalism and autonomy, do not coincide.

Justice Orr shared the position of Justice Strasborg-Cohen and Justice Zamir, that the best interest of the child principle should be granted more weight than the principle of children's rights when there is a clash between the two.

Justice Matza held that the best interest principle and the principle of children's rights are equally important. Sometimes, when there is a clash between them, the court should prefer the outlook of the latter principle. He held that some sections of Israeli Law concerning children reflect a preference of the principle of children's rights and others reflect a preference for the best interest of the child.

The majority view in this case was conservative and paternalistic. However, the debate among the judges in this case, and the discussion and explanations concerning children's rights, sharpened the awareness of jurists in Israel to a new legal perspective, which grants minors the legal status of an independent party in disputes concerning them, and more autonomy.[178] This was one small step in a new direction, not a revolutionary change. Even the minority justice, Shamgar, did not speak in a clear, decisive voice in favor of the adoption of the doctrine of children's rights. He had his own doubts and reservations. It is not clear whether Justice Shamgar held that a minor is granted certain rights, such as participation in the process of decision-making regarding his/her medical treatment.

Justices Dorner and Cheshin continued the paternalistic policy concerning children's rights in the *Plonit* case.[179] Their terminology was that of autonomy and/or children's rights. However, their view was that the essence of the relationship between parents and their minor children is paternalistic.

The son of Plonit was adopted by a loving and devoted family. Eventually his mother requested that her son be returned to her custody. Psychologists held that the transfer of the child from his adopting parents to his biological mother would cause

178. *Id.* "The general aim is the strengthening of the status of the child. There is great importance in strengthening of the status of the child in family disputes, although to an extent, this process is only declarative and educational."

179. *See* A.C.A. 7015/94, Attorney General v. Plonit, (1996) 50(1) P.D. 48.

irreversible harm. Justices Dorner and Cheshin held that the child should remain in the custody of his adopting parents.

Justice Dorner used the terminology "rights" and "interests of the child," and tried to define the criterion in regard to proper balance between that right of the child and the right of the natural parent to raise his/her child. She granted priority to the right of every child to be raised in an environment that would enhance his/her physical and emotional needs, which would ensure his/her proper development. She mentioned Articles 3 and 12 of the Convention. Article 3(1) states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative institutions, the best interests of the child shall be a primary consideration."[180] Article 12(1) states: "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."[181]

Justice Dorner did not distinguish children's rights from the best interest of the child. She wrote:

> The superiority of the right of the child has been expressed in Adoption of Children Law, 5741-1981, which states that the best interest of the child is a primary consideration. Section 1(b) of this law states: 'An adoption order and any other decision under this law shall be made if the court is satisfied that they are in the interest of the adoptee.'[182]

She wrote that the aim of adoption is the realization of the superior right of the child, and quoted from the decision of Justice Netanyahu, who wrote: "The child and his/her best interest are the main consideration."[183]

Justice Cheshin was not sure that there was a substantial dispute between the Justices in the abovementioned *Ploni, minor* case.[184] He held that perhaps the differences of opinion between the Justices were merely differences in terminology and

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180. Convention, *supra* note 15, art. 3.

181. *Id.* art. 12. *See also* Case 7015/94, Attorney General v. Plonit, (1996) 50(1) P.D. 48, at 65-67.

182. Case 7015/94, Attorney General v. Plonit, (1996) 50(1) P.D. 48, at 66.

183. *Id.* at 67.

184. *Id.* at 94

not of essence. He held that there is a basic assumption that every person has interests, wishes, and a will. The legal system grants some interests the status of protected interests, and then these interests are "rights."[185]

Justice Cheshin wrote that children should be granted rights, and the individual should decide about his/her welfare:

> His/her welfare is his/her will, and his/her will is his/her welfare.[186] The concept of interest—in contrast to welfare—emphasizes the right of the minor in his/her relationship with his/her parents and the surrounding world, and at the same time weakens the paternalism which is embedded in the concept 'welfare' . . . When we speak about 'interest' of a minor we treat him as a human being, and we emphasize the independent status of the minor as a bearer of legal rights and interests . . . The status of the minor as a bearer of rights and as an independent legal personality will strengthen them. We shall refrain from (the old habit of) putting on the robe of the patriarch who enhances the welfare of his subjects. We shall fulfill our obligation to contest with the rights of the minor. There will be the right of the mother and father on one hand and the right of the minor on the other hand.[187]

However, Justice Cheshin held that the aformentioned "rights" are implemented in a paternalistic manner. He wrote:

> What should be the legal rule concerning a minor, a small human being that could have rights but his will and discretion are not fully developed? . . .
>
> In these circumstances we shall implement the good and constructive paternalism of the legal system, and we shall say: In principle we are willing to acknowledge the validity of the idea that the will of an individual reflects his/her interest, and we shall grant this will–interest (that the legal system is willing to recognize) the protection of 'right'. This shall be the policy concerning an adult. However, regarding a minor, we shall pay attention to the extent of his ability to decide in a mature manner about the relevant specific matter . . . When the minor is not able to express his own mature will, we shall create his 'will', we shall act on behalf of the minor. In order to protect this constructive will—a will we will ascribe to the minor, a will that is not a [real, subjective] will [of the mi-

185. *Id.* at 94-95.
186. *Id.* at 96 (author's trans.).
187. *Id.* at 131-32 (author's trans.).

> nor]—we shall grant him [or her] a right. How will we create this 'will'? The basis shall be the minor's best interest. The 'best interest' of the minor is raw material that is the basis of our creation of a right or lack of a right of the minor . . . The best interest of the minor is the interest of the minor . . . When society and its legal system hold that a minor is not mature enough to express his/her own will, we shall express his/her 'will'. The basis of this 'will' shall be our conviction regarding his/her best interest. This best interest is an expression of the minor's best interest. We shall use the title 'best interest' of the minor when we will want to describe the 'interest of the minor'.[188]

This is a paternalistic point of view concerning the rights of a minor. He or she is not mature enough. Therefore, others decide what is "his/her will," in the minor's best interest. "The good and constructive paternalism of the legal system" prevails.

Justice Cheshin wrote again, in a similar manner, in the consequent *David* case,[189] concerning a dispute between parents whether their son's education should be religious or non-religious. He held that the primary consideration in such disputes, in regard to the fate of children, is the best interest of the child. He explained that some judges and scholars preferred the terms "interests" or "right" of the minor, rather than the term his/her "best interest." However, he held that the circumstances in this specific case did not require his decision in the dispute between the Justices in the *Ploni, minor* case.

In the *David* case, Justice Cheshin used the words "right" and "best interest" of children, or "children's interests" and "best interest" as synonyms although the terminology in one paragraph of this decision is that of rights: "The issue is the right of the child—his/her independent right—not the right of his parents or someone who wants to enhance the child's best interests. Sometimes the right of the child is superior to the rights of his/her parents."[190] The best interest of the minor was the primary consideration in Justice Cheshin's decision. The paternalistic trend concerning the fate of children prevailed.

These decisions of the Supreme Court lead to the same con-

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188. *Id.* at 96-97 (author's trans.).

189. Bagatz 5227/97, David v. High Rabbinical Court et al., (2001) 55(1) P.D. 453-79.

190. *Id.* at 461 (author's trans.).

clusion: the basic paternalistic point of view regarding the fate of children prevails. When Justices use the terminology "rights" of children they mean that adults decide what are their best interests. However, these verdicts of the Justices enhanced the awareness of the legal community of the concept "children's rights."

III. *THE DESIRED LEGAL SITUATION*

Is the current legal situation desirable? The Israeli legislator granted minors a few rights only in certain areas. We wish to suggest that the general policy should change. In every decision which concerns minors, especially important decisions involving medical treatment, that are sometimes decisions regarding to matters of life and death, minors should be granted more autonomy. There should be an all-inclusive obligation to incorporate minors in these decisions, in the spirit of Article 12 of the Convention, which at least should serve as a source of interpretative inspiration.[191] In addition, the current legal rules concerning capacity should change. The legislator should rely upon contemporary empirical and psychological findings of scientific research relating to children's abilities to participate in the decision-making process at various ages.[192]

Before extensively discussing the desired legal situation as we see it, we would like to summarize some of the psychological theories and empirical findings on this matter.

A. *Empirical Findings and the Psychological Basis: Studies on the Level of Decision-Making Capacity Among Minors*

One social approach, which is reflected in the rules of various legal systems, is paternalistic. The legislation in these legal systems holds that minors are in general incompetent and there-

191. In the case of C.A. 3077/90, Plonit v. Ploni, (1997) 49(2) P.D. 578, at 593 (1997), Justice Cheshin relied upon the Convention as an interpretive source with respect to conferring rights to minors.

192. Concerning the application of research on children's capacities in the field of legal doctrine and legislation, see J.L. Woolard et al., *Theoretical and Methodological Issues in Studying Children's Capacities in Legal Contexts*, 20 LAW & HUM. BEHAV. 219, 226 (1996). *See* S.B. Billick et al., *A Clinical Study of Competency in Child Psychiatric Inpatients*, 26 J. AM. ACAD. OF PSYCH. & L. 587, 592 (1998); C.C. Peterson & M. Siegal, *Cognitive Development and the Competence to Consent to Medical and Psychotherapeutic Treatment*, *in* CHILDREN'S UNDERSTANDING OF BIOLOGY AND HEALTH 257 (1999).

fore cannot supply informed consent, which is based upon a rational and coherent process of decision making.

Empirical research, however, suggests that even young children, ages twelve to fourteen, can usually participate in a meaningful and rational manner in decision-making about their medical treatment.[193]

Justice Douglas wrote that a consensus exists among child psychologists that the emotional and intellectual maturity of fourteen-year old adolescents is approximate to that of adults.[194] This theory is grounded in psychological studies.[195] Piaget researched adolescence from the viewpoint of human intellectual development, and proposed that the adolescence consists of four stages. Every child undergoes all stages in chronological order, yet the specific age at which every child reaches each respective stage varies.[196] The third stage, that of concrete thinking, is followed by the fourth stage, of formal thinking, at which the adolescent reaches the height of his/her intellectual development and the vestiges of the limitations of the prior stages disappear: his/her thinking becomes more logical and systematic, and he or she become capable of a high level of abstraction. The child is considered to possess a "thought lever," namely he or she is able to construct in his/her imagination sketches of possible outcomes that stem from his/her decisions, to mentally explore various speculations, and to plan for the future. At this stage, according to this theory, the thinking process of adolescents is identical to that of adults. When he or she reaches this fourth stage, the teenager is at the height of his/her intellectual abilities.

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193. Redding, *supra* note 14, at 708-09, 727.

194. Wisconsin v. Yoder, 406 U.S. 205, 246 (1972). Regarding the question whether Justice Douglas' characterization of children's capacities can withstand empirical scrutiny, see N.D. Reppucci & C.A. Crosby, *Law, Psychology and Children: Overarching Issues*, 17 LAW & HUM. BEHAV. 1, 7 (1993).

195. *See* Jean Piaget, *The Intellectual Development of the Adolescent*, *in* ADOLESCENCE: PSYCHOLOGICAL PERSPECTIVES 122 (G. Caplan & S. Lebovici eds., 1969); Lois A. Weithorn & David G. Scherer, *Children's Involvement in Research Participation Decisions: Psychological Considerations*, *in* CHILDREN AS RESEARCH SUBJECTS: SCIENCE, ETHICS AND LAW 133 (Michael A. Gordin & Leonard H. Glantz eds., 1994); Billick et al., *supra* note 192, at 592; C.C. Peterson & M. Siegal, *Becoming Mindful of Biology and Health: An Introduction*, *in* CHILDREN'S UNDERSTANDING OF BIOLOGY AND HEALTH 1, 4-6 (1999).

196. For a summary of children's abilities at various ages according to Piagetian approach, see Thomas Grisso & L. Vierling, *Minor's Consent to Treatment: A Developmental Perspective*, 9 Prof. Psychol. 412 (1978).

This psychological theory, concerning the four stages, should lead Israeli and other legislators to a reassessment of existing rules which set one objective age of majority, such as eighteen years in Israeli law, as the age of full legal capacity.

Additionally, many studies have investigated the assumption that all minors are not competent to make decisions about their own medical treatment. Researchers generally did not support such a conclusion. These studies cast doubt on the justification of the current Israeli law, which regards eighteen years as the age of full capacity to consent to medical treatment. The following is a brief summary.

Weithorn and Campbell conducted a study on minors and adults ages nine, fourteen, eighteen, and twenty-one years.[197] The subjects were presented with several hypothetical medical dilemmas and were required to decide which medical treatment was most appropriate. Generally, the fourteen year-old subjects exhibited the same level of competency as adults. This result was based upon four standards used by the researchers to measure competence for proper decision-making: (1) evidence of choice; (2) reasonable outcome of choice; (3) reasonable decision-making process; and (4) understanding.

The youngest subjects, the nine-year olds, were generally less capable of making decisions about medical treatment. They displayed difficulty primarily in forming a rational and logical process of decision-making, although they showed ability to understand what was required of them when asked to choose from a list of options. Hence, the results attest that even minors as young as nine are able to participate *meaningfully* in medical decisions concerning themselves, although their competence is not sufficiently developed to an extent that could justify granting them personal autonomy in decision-making.[198]

Another case study, conducted by Scherer, investigated the decision-making capabilities of people ages ten, fifteen, and

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197. *See* Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982). *See also* Lois A. Weithorn, *Involving Children in Decisions Affecting Their Own Welfare: Guidelines for Professionals*, *in* CHILDREN'S COMPETENCE TO CONSENT, *supra* note 28, at 235. *See also* Michael A. Grodin & Joel J. Alpert, *Informed Consent and Pediatric Care*, *in* CHILDREN'S COMPETENCE TO CONSENT, *supra* note 28, at 93.

198. For criticism on this study, see P.A. King, *Treatment and Minors: Issues not Involving Lifesaving Treatment*, 23 J. FAM. L. 241 (1984-85).

twenty-two, namely, groups of pre-adolescents, adolescents, and adults. The study also sought to investigate the degree of influence of varying degrees of parental pressure on the subjects when they are required to make decisions and the effect of the pressure on their level of confidence about the decision. The subjects were asked to choose among medical options (withholding treatment was one) and their long-range ramifications, regarding three hypothetical medical conditions: tonsillitis, removal of a blister, and kidney donation. The subjects were rated by their choice and the level of confidence exhibited in their argument for it in each of these situations: (1) without parental influence; (2) with coercive parental influence; and (3) with non-coercive parental influence.

The results were as follows. In regard to two of the three medical conditions, no significant differences were found between decisions of adolescents (fifteen year-olds) and of adults (twenty-two year-olds). In the third condition differences were discovered when non-coercive parental pressure was applied.[199] Yet no differences resulted when there was no parental pressure at all, or when there was coercive parental pressure.

With regard to the pre-adolescents group, this study revealed that only in one medical condition—the kidney donation—was a substantive difference found between them and the adults, yet this was true only when parental pressure was exerted. In all three conditions no essential difference was discovered among the various age groups when no parental influence was exerted.[200]

A different study investigated the capacity for rational decision-making of children ages five to twelve who had free access to the medical facilities in their elementary school, namely a situation of decision-making without adult supervision. The study also investigated whether the very inclusion of this group of children in the process of decision-making positively influenced their general outlook and behavior regarding medical treat-

199. This concerned the tonsillitis operation, i.e., non-lifesaving medical treatment, and in this case the adolescents were more inclined to adhere to the dictates of their own opinion and not succumb to the will of their parents.

200. Concerning the capacities of minors that are 14-15 years old to exercise voluntariness in medical treatment decisions and the influence of parents on their minor children, see David Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 L. & HUM. BEHAV. 431, 431-49 (1991).

ment. The subjects were granted wide leeway in choosing the appropriate medical treatment needed to remedy their disorders, except in matters that created a concrete risk to their health, such as high fever or deep wounds. The results were that the children speedily learned the rules of the system, and their rate of usage of medical facilities was comparable to that of adults. For example, the ratio between the sexes was maintained (women use medical treatment at a higher rate than men, but when children at these ages are brought in by an adult for medical treatment, the ratio between the sexes is inverse: boys are taken to the doctor more often than girls). Hence, the findings of the research were that the children in the study were ready and able to take personal responsibility for their health. Moreover, involvement in the process of decision-making was shown to increase the subjects' own awareness of personal responsibility. Some scholars claim that imposing personal responsibility exerts a positive influence and sharpens the abilities required for decision-making in other areas.[201]

However, the study also showed that the subjects' pattern of behavior regarding the medical facilities system remained unaltered. Children who previously had made excessive use of the health system continued to do so. A background check of these subjects highlighted abnormal behavioral patterns in all aspects of daily life. The essential importance of this study lies in the finding that children and adults, of similar socio-economic backgrounds, tend to act in similar patterns of behavior. As stated, the accessibility of medical services (without adult supervision) for children ages five to twelve was similar to that for adults of the same socio-economic groups.

There are important psychological differences between early adolescents and adults[202] that probably have implications in the sphere of judgment. Therefore, distinction must be drawn between older and younger adolescents.[203] A survey of the existing scientific literature conducted by Lawrence Steinberg and Elizabeth Cauffman supports the notion that the differ-

201. C.E. Lewis, *Decision Making Related to Health*, *in* CHILDREN'S COMPETENCE TO CONSENT, *supra* note 28, at 75-91.

202. Lawrence Steinberg & Elizabeth Cauffman, *Maturity of Judgment in Adolescence: Psychosocial Factors in Adolescent Decision Making*, 20 LAW & HUM. BEHAV. 249, 253-54 (1996).

203. *Id.* at 268.

ences between older adolescents and younger adolescents are more prominent than the differences between older adolescents and adults. Other studies, focusing upon the ability to make decisions independently, prove that while peer group pressure clearly increases in early adolescence, both peer group pressure and parental influence diminish during the high school years. Older adolescents exercise more independent judgment than younger adolescents. However, studies that establish this distinction between younger and older adolescents do not usually compare older adolescents to younger adults.[204]

Steinberg and Cauffman conclude that there is significant evidence of a difference between the group of early and middle adolescents in the sphere of decision-making. Their policy conclusion is: "there would appear to be a scientific basis within the psychological literature on adolescent development for distinguishing under the law between individuals who have, versus [those who] have not, reached the age of seventeen."[205]

The researchers Scott, Reppucci, and Woolard stated regarding current developmental theory and results of research: "Developmental theory and empirical research demonstrate that by mid-adolescence minors are indistinguishable from adults in their decision making. Their capacity for reasoning and understanding is similar to that of adults, and thus, they meet adult's standards of legal competence under informed consent doctrine."[206]

Scholars explain that research leads to the following conclusions:

1. There is a little evidence that minors of age fifteen and above as a group are any less competent to provide consent than are adults.

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204. *See* Donald L. Beschle, *The Juvenile Justice Counterrevolution: Responding to Cognitive Dissonance in the Law's View of the Decision-Making Capacity of Minors*, 48 EMORY L.J. 65, 99 (1999).

205. Steinberg & Cauffman, *supra* note 202, at 267-69. *See also* Beschle, *supra* note 204, at 100.

206. E.F. Scott et al., *Evaluating Adolescent Decision Making in Legal Context*, 19 L. & HUM. BEHAV. 221, 221-22 (1995). The authors also state: "Adolescents pose a dilemma for legal policymaker. Traditionally they have been classified with younger children as minors . . . . Some observers have argued that they should be given more of the rights and privileges accorded to adults." *Id.*; *see also* Thomas Grisso, *Society's Retributive Response to Juvenile Violence: A Developmental Perspective*, 20 L. & HUM. BEHAV. 229, 233 (1996).

2. In the age range of eleven to fourteen years, existing research suggests caution regarding any assumptions about these minors' abilities to consider intelligently the complexities of treatment alternatives, risks and benefits, or to provide consent that is voluntary.
3. Most research suggests that minors below age eleven generally do not have the intellectual abilities or are too prone to deferent response to satisfy a psychological interpretation of the legal standard for competent consent.
4. In the formation of legal and ethical policy regarding consent by minors, psychological competence is but one circumstance that must be weighed.

Other circumstances should be: the liability of parents regarding their children's behaviors, the accountability of professionals in the process of informing children about treatments and risks, the fact that different treatment situations may vary in complexity . . . and the degree to which various treatments are likely to be essential to the well-being of the child, and more.[207]

Scholars suggest:

A. There may be no circumstances that would justify sanctioning independent consent by minors less than eleven years of age, given the developmental psychological evidence for their diminished psychological capacities.
B. There appear to be no psychological grounds for maintaining the general legal assumption that minors at age fifteen and above can not provide competent consent.
C. Ages eleven to fourteen appear to be the transition period in the development of important cognitive abilities and perceptions of social expectations, but there may be some circumstances that would justify the sanction of independent consent by these minors for limited purposes, especially when competence can be demonstrated in individual cases.[208]

The findings of studies provide an important empirical basis for our theoretical conclusion and our practical recommendation. Several additional points favor the inclusion of the group of mature minors in the decision-making process on their own medical treatment:

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207. T. Grisso & L. Vierling, *supra* note 196, at 412-27.
208. *Id.*

1. When minors are granted the authority to seek treatment independently for medical problems that are liable to place them in an uncomfortable position or to cause problems with their parents (e.g., treatment for sexually transmitted diseases), they will be inclined to receive the necessary treatment. This runs counter to the possible alternative: a paternalistic legal situation, on account of which minors are likely to opt not to seek treatment for these conditions in order to avoid possible conflict with their parents.[209]
2. Many experts claim that granting minors greater control in medical issues is likely to elicit positive responses (physical and emotional) to medical treatment, since this facilitates the child's willingness to cooperate.[210]
3. Imparting greater responsibility to minors for their medical treatment and other matters trains them properly for the future task of assuming responsibility for themselves in their adult lives.[211]

However, proponents of granting children rights, as well as researchers, admit that there are shortcomings in these studies. Several inherent problems arise from the manner and conditions in which these experiments were performed, and some hold that these could minimize the reliability of the results.[212] The shortcomings are as follows.

1. In the majority of these studies, the child subjects were Caucasian, and members of the upper-middle class. The conclusions may relate only to children belonging to certain socio-economic classes, and do not reflect a cross-section of society,[213] especially since some experts posit that children of different socio-economic and ethnic groups

209. *See* FRANKLIN E. ZIMRING, THE CHANGING LEGAL WORLD OF ADOLESCENCE 64 (1982); Walter Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOODE HALL L.J 115, 124 (1973).

210. *See* G.B. Melton, *Decision Making by Children: Psychological Risks and Benfits*, *in* CHILDREN'S COMPETENCE TO CONSENT, *supra* note 28, at 21-40; D.E. Putnam et al., *Commitment Improves Adherence to a Medical Regimen*, 62 J. CONSULTING & CLINICAL PSYCH. 191-94 (1994); Redding, *supra* note 14, at 708; McCabe, *supra* note 79.

211. *See* Redding, *supra* note 14, at 709.

212. *See* Scherer, *supra* note 200, at 431; Weitorn & Campbell, *supra* note 197, at 1589; *see also* G.B. Melton, *Children's Concepts of Their Rights*, 9 J. CLINICAL CHILD PSYCH. 186 (1980); King, *supra* note 198, at 254.

213. *See* Scherer, *supra* note 200, at 445-46; Weitorn & S.B. Campbell, *supra* note 197, at 1596; M.J. Dolgin et al., *Caregivers' Perceptions of Medical Compliance in Adolescents with Cancer*, 7 J. ADOLESCENT HEALTH CARE 22, 25-26 (1986).

mature at different rates of development.[214] In the United States, for instance, minorities are indicated to mature at a slower pace, and this can perhaps be attributed to their lower economic status or their minority status. Children from minority groups are expected to be slower in their conception of how to exercise their legal rights.[215]

2. Some studies indicate that adolescents attribute great importance to the aesthetic side effects of medical treatment. For example, many teenagers are concerned that certain medication may cause excessive hair growth or other visible side effects, so they take a lower dosage. Adults assign far less importance to such aesthetic side effects;[216]
3. Adolescents are more likely to respond to external effect. Their fellow adolescents are their role model. Minors are more impulsive than adults. They tend to be more influenced by moods. The strong tendency of teenagers to take part in high-risk activities does not originate from rational thinking, but is a result of a cognitive tendency, that probably disappears with age. These facts lead to question marks regarding the ability of minors to participate in the process of decision-making, especially concerning critical decisions;[217]
4. In several of these studies, the subjects were presented with hypothetical medical conditions; this greatly differs from a situation of real, painful illness, which is generally accompanied by symptoms of stress and fear that are liable to alter the behavior and decision-making of individuals of different ages;[218] and
5. The ramifications of allowing decision-making are unclear, in that *inter alia* these decisions are a product of economic ability with regard to an individual who is not financially independent. To affect his/her decision, he or she must rely upon others. The effects on the family and parents of granting children authority in the sphere of decision-making, when at the same time they are financially dependent, have been insufficiently probed.[219] By granting children

214. *See* Melton, *supra* note 212, at 186-90; Scott et al., *supra* note 206, at 226.

215. *See* Melton, *supra* note 212, at 186.

216. *See* Weithorn & Campbell, *supra* note 197, at 1596.

217. Steinberg & Cauffman, *supra* note 202, at 253-54; E.P. Mulvey & F.L. Peeples, *Are Disturbed and Normal Adolescents Equally Competent to Make Decision About Mental Health Treatments?*, 20 L. & HUM. BEHAV. 273 (1996).

218. *See* Weithorn & Campbell, *supra* note 197, at 1596; Scherer, *supra* note 200, at 445-46; Woolard, *supra* note 206, at 226.

219. *See* Scherer, *supra* note 200, at 446.

> the right of decision-making, parents are stripped of powers concerning their family. Parents may view this loss as a challenge to their authority as protectors of the family unit, hence when health insurance does not cover all the medical expenses, their assumed commitment to finance medical treatment may wrongly be taken for granted.

These shortcomings should be taken into consideration when children are granted the right to participate in the decision-making process concerning their treatment. This right should be limited when the aesthetic side effects of medical treatment are evident or when there are significant medical expenses that are not covered by national and/or health insurance.

B. *Models for Including Children in Decisions Concerning Their Medical Treatment*

At the first stage, the Israeli law that regulated the legal relationship between parents and their minor children—the Capacity Law, 5722-1962[220]—reflected the conservative, paternalistic, approach. According to this law, minors, as a whole, are statutorily banned from executing independent legal actions.

Section 3 of the Capacity Law establishes the age of legal capacity as eighteen years.[221] A number of specific results derive from this limitation on the legal capacity of minors, namely their incapacity to act in an independent manner. They cannot be parties that obligate themselves and benefit from binding contracts or perform many other legal actions. Consent to undergo medical treatment is one of these legal acts. The legal definition of a minor is relevant, *inter alia*, with regard to the inclusion, or perhaps non-inclusion, of the minor in the decision-making process concerning the administering of medical treatment affecting him or her.

Nevertheless, the legislator is not consistent with this legal definition, in Section 3 of the Capacity Law. Upon examining various laws dealing with the established minimum age which entitles minors to be involved in the decision-making process in matters affecting them, one at once discovers that the age established by the legislator is not always eighteen. The law concerning adoption of children distinguish between children above

220. Capacity Law, *supra* note 25.
221. *Id.* § 3.

and under nine years.[222] The law regarding religious conversion of a minor grants due weight to the view of a minor that is "ten years age or over."[223]

Perhaps, concerning consent to medical treatment, the Israeli legislator could establish a new legal rule which takes into consideration the ability of each minor to comprehend and analyze the pros and cons of medical treatment in a rational manner.

In Israel, several specific laws exist, *inter alia*, regarding the age of legal competency to assume obligations and rights. These legal rules grant rights and impose obligations upon children that are younger than the general competency age in Israel. According to Section 12 of the Penal Law 5737-1977, a child is held criminally culpable for criminal behavior from age twelve. Minors above age twelve may be tried for crimes and be sentenced to punishment, except for imprisonment.[224] The age at which a female adolescent may wed is seventeen,[225] and a female minor is entitled to receive a judicial authorization to marry at age sixteen.[226] With regard to a male adolescent there is no age limit with respect to marriage. The minimal age for consensual sexual relations with a male or female minor is fourteen according to Section 345(a) and Section 347(b) of the Israeli Penal Law.

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222. For example, as Section 7 of the Adoption of Children Law, 5741-1981, *supra* note 68, at 360, establishes that:

> If the adoptee has reached age nine, or if he had not yet reached age nine, but is capable of understanding the matter, then the Court shall make an adoption order only after it is satisfied that the adoptee wants that adopter to adopt him.

223. As abovementioned, with regard to the conversion of a minor to another religion, Section 13A of the Capacity Law establishes that:

> The religion of the minor shall not be changed unless both his parents have given their written consent in advance or the Court, on the application of one of the parents or of the guardian of the minor, has given prior approval to the change of religion.
>
> If the minor has completed his tenth year, his religion shall not be changed unless, in addition to the consent of his parents or the approval of the Court under subsection (a), he, too, has given his prior written consent.

See also M. Shawa, *Legal Questions Regarding Change of Religion in the Area of Matters of Personal Status*, 4 TEL AVIV UNIV. L. REV. 302, 306-08 (1974-75).

224. Penal Law, 5737-1977, 34(f) (Isr.); Youth (Trial; Punishment and Models of Treatment) Law, 5731-1971, *supra* note 72, § 10: Imprisonment may be decreed if at the time of sentencing the minor was already fourteen years old.

225. Marriage Age Law, 5710-1950, 4 L.S.I, § 1 (Isr.).

226. *Id.* at § 5.

Additional exceptions are contained in Section 316(b) of the Penal Law, which establishes that the consent of a minor to terminate her pregnancy does not require the consent of her guardian, and Section 8(c) of the Adoption of Children Law, 5741-1981 establishes that the consent of a minor to submit her child for adoption does not necessitate the consent of her parents.

Additionally, the Israeli Ministry of Justice is currently drafting a bill that will grant minors from age twelve the authority to consent to various treatments, among them various medical treatments, for example, psychotherapy, pregnancy prevention, and treatments for sexual assault.

The Author has reached the conclusion that the current legal rules and doctrines in Israel and other countries that share the view of the Israeli legislator that minors, as a whole, are banned from executing many independent legal actions, are not desirable from an ideological viewpoint, and do not even faithfully reflect the status of the child, and especially the adolescent, in society and within his/her family, as a partner in the decision-making process concerning his/her activities and life. The following suggestions focus on involving minors, especially adolescents (teenagers), in making medical decisions concerning them, and are limited to medical procedures that are not emergency or life-saving, since we hold that paternalism is justified in regard to emergency or life-saving medical treatment.[227] How-

227. Justice Agranat, in the *Gerty* case, and Justice Beiski, in the *Cortam* case, held that a minor should not be granted the right to make his/her own decision to receive or not to receive medical treatment, when doctors hold that this medical treatment is necessary in order to save the minor's life. *See* C.C. 527, 480/85, *supra* note 85, at 696-98.

Justice Elon, in the *Shefer* case, and Justice Beiski, in the *Cortam* case, emphasized the fact that in Judaism, the sanctity of life is a very important value. Justice Zusman held, in the *Eli* case, that the claim that the State should "leave the citizen alone," and not intervene when he or she chooses to risk his/her life or act in an impossible manner, that could cause him or her bodily harm, is unacceptable. *See* Bagatz 332/71, M. Eli et al., v. Minister of Transportation et al., 26(1) P.D. 105, 112 (1972). We share his point of view that paternalism is justified in certain circumstances. The minor should not be granted the right to decide to endanger his/her life or choose to die. Consent of a minor to such an act might be considered as uninformed and coerced, as Dworkin wrote: "If it was plainly not in my self-interest [to have consented] this might suggest, though it does not prove, that my consent was either uninformed or coerced." Ronald Dworkin, *Why Efficiency?*, 8 HOFSTRA L. REV. 563, 574 (1980); RONALD DWORKIN, A MATTER OF PRINCIPLE 276 (1985).

Sometimes consent to medical treatment is not based upon rational considerations. Desperate patients are willing to try a very dangerous treatment. In these circum-

ever, in other aspects of medical treatment concerning children they should be granted more autonomy. In suitable circumstances, they should be granted the right to speak for themselves.[228]

The involvement of children in essential decisions is likely to be beneficial for them. The child perceives his/her involvement as an honorable expression of his/her independence and privacy. The child perceives himself or herself as an active partner in decisions concerning himself/herself. This will probably contribute to his/her self-confidence and intellectual maturity.[229]

Some experts argue that non-inclusion of children and adolescents in decisions concerning themselves is liable to increase depression, cases of suicide, and anti-social behavior among them, while increasing their involvement should curb these manifestations.[230] Additionally, experience in making decisions (even if they are few in number) constitutes the first steps on the path of garnering life experience, which is a major characteristic of "maturity." It is unjust to claim that society may deny a person the exercise of free will solely because he or she may err in judgment. This view may lead adults to being barred from making decisions on new experiences when they lack the necessary tools to choose properly.[231]

Three models come to mind for including children in medical decisions that are not emergency or life-saving decisions.

1. Determination by the legislator that the minor's opinion must be considered.
2. Lowering the statutory age of capacity with regard to the execution of legal acts.
3. Granting the minor the possibility of proving that he or she possesses the same true capability for decision-making as that of an adult concerning certain legal actions (or regarding all legal actions).

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stances, the request of the patient to endanger himself or herself should not be honored. *See* Bagatz 30/82, Maayan et al. v. Director General of the Ministry of Health, (1982) 36(2) P.D. 477-82.

228. *See* Grisso & Vierling, *supra* note 196, at 412, 424.

229. Children who are given decision-making responsibility mature in their ability to make decisions; while those who are sheltered from such responsibilities develop habits of "acting-out" behavior. *See* Melton, *supra* note 28, at 21, 27-28.

230. *See* Weithorn, *supra* note 197, at 245.

231. *Id.*

1. Statutory Obligation to Consider Minors' Opinion

The first model recognizes that the minor is a natural partner in decision-making about his/her affairs. In the daily lives of children, the external element of control (primarily, by parents) is dominant. However, life experience indicates that within the family unit children considerably influence their parents and family life, and they do express their opinions and participate in the process of family decision-making. Israeli law and law in many other countries lags far behind the prevalent reality, and for the most part does not recognize the child's right to play a significant part in the decision-making process. It must be stressed that consequently, at present, in these legal systems, minor children do not bear responsibility for the consequences of the decisions in which they have participated.

In Israel, the basic legal framework, especially in the Capacity Law, is paternalistic. Until now, in Israel, the authority of parents over their minor children has been restricted only in specific matters. In those matters a statutory restriction has been established. Those matters include child matrimony,[232] compulsory education,[233] and severe deprivation.[234] In recent years, these special areas have been expanded to cover certain new specific matters, concerning minors, such as detection of the AIDS virus,[235] psychiatric examination and treatment, and more.[236]

How could the minor enhance his/her autonomy in a new legal framework? One possibility is a more radical change. The special cases should become the general rule. According to this point of view there should be a general statutory obligation to take into consideration the minor's wishes in every issue that concerns him or her.

In the United States, judicial decisions have been rendered in which the presiding judges established that the child's consent concerning his/her medical treatment must play a significant role in the decision-making process. In the *Green* case, the

232. Marriage Age Law, *supra* note 225, § 5, 5(a).

233. *See* Capacity Law, *supra* note 25, § 15; Compulsory Education Law, 5709-1949, 3 L.S.I. 125.

234. *See* Capacity Law, *supra* note 25, §§ 15, 17; Youth (Care and Supervision) Law, 5720-1960, *supra* note 72, 2 L.S.I 44,; Penal Law, 5737-1977, § 323 (Isr.).

235. Detection of HIV in Minors Law, 5756-1996, 49 L.S.I. 252, § 1 (Isr.).

236. Youth (Care and Supervision) Law, 5720-1960, 14 L.S.I. 44, *supra* 72, § 3(G) (Isr.).

Supreme Court of Pennsylvania ruled that the opinion of a fifteen-year old boy must be taken into account concerning the treatment of his non-life-threatening medical condition.[237] In the *Sampson* case, a New York court dissented from this Pennsylvania judgment, ruling that the opinion of a fifteen-year old boy regarding a non-emergency medical procedure was not required and was deemed non-relevant.[238] In this case, the court refused to take the approach of the court in the *Seiferth* case, which preceded it by fifteen years. In *Seiferth*, it was ruled that a great deal of weight must be attached to the preference of a fourteen-year old boy concerning the performance of a non-emergency operation since the treatment following the operation demanded the child's full cooperation.[239]

The policy of judges, who hold that a child should be a full partner in decisions concerning his/her medical treatment, and perhaps in all matters concerning his/her fate, could be the new policy that should result in a necessary amendment of legislation in Israel and in other countries.

2. Lowering the Age of Capacity

The ideological basis of the model of lowering the age of capacity lies in the argument that no rational reason justifies the arbitrary establishment of one age for legal competency in each and every matter. Although adolescents are presumably not sufficiently mature to make decisions which affect society, and thus receive the right to vote in Israel only from age eighteen, one should not infer that they cannot make competent decisions on some other matters, such as their own medical treatment. Our claim is that if solid scientific research proves that minors from a certain age are capable of making certain decisions, they should be empowered with this very right. In the field of medical treatment the age of capacity should be established in light of the abovementioned research concerning the ability of children and adults to participate in a meaningful manner in the process of decision-making concerning their medical treatment.

The results that stem from the application of this model might not lead to the non-inclusion of parents in the medical

237. *See* In re Green, 292 A.2d 387 (Pa. 1972).
238. *See* In re Sampson, 317 N.Y.S.2d 641 (1970).
239. *See* In re Seiferth, 127 N.E.2d 820 (N.Y. 1955).

decisions concerning their children. Scherer's research indicates that the degree of influence of parents' opinions on their children's decisions is highly significant at all ages. Their parents' opinion influenced the decisions of fifteen-year old youngsters and twenty-two year old adults to almost the same degree. Therefore, the legislator should not distinguish between fifteen-year old and twenty-two year old human beings in the field of consent to medical treatment. The assumption is that the majority of medical decisions made by minors will inevitably be jointly made with parental input. Parental involvement will also certainly be expressed through payment for medical treatment or insurance, while the child exercises his/her right to make medical decisions on his/her own behalf.

From this and other studies one can conclude that generally children who have reached the age of fourteen (some claim twelve) possess the necessary skills and level of maturity that enable them to make decisions about their own medical treatment that are rational and reasonable to the same extent, or almost the same extent, as the decisions of adults.[240]

Fourteen is generally acknowledged as the age when most children can participate in decision-making on medical treatment. An alternative is the age of fifteen. The general presumption is that children aged fifteen and older are capable of providing informed consent.[241] These presumptions should be the basis of legislation in the sphere of the age of capacity to make decisions concerning medical treatment.

Perhaps some would claim that this conclusion appears to be too radical. However, these studies require us to question the basic assumption of the Israeli legislator and many other modern legal systems that fourteen or fifteen-year old children are not capable of making decisions concerning their bodies and lives.

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240. A common criticism in relation to the psychological studies is that they were largely conducted with reference to middle-class populations, and so applying these findings to other socio-economic populations is problematic, since they may be slower in their mental and moral reasoning development. *See* Weithorn & Campbell, *supra* note 197, at 1596.

241. *See* Thomas Grisso, *Juvenile's Capacity to Waive Miranda Rights: An Empirical Analysis*, 68 CAL. L. REV. 1134, 1160-66 (1980); Redding, *supra* note 14, at 726, 735. Concerning the capacity of minors that are 14-15 years old in the field of decision-making, see David G. Scherer & N. Dickon Reppucci, *Adolescent's Capacities to Provide Voluntary Informed Consent*, 12 LAW AND HUM. BEHAV. 123 (1998).

The lowering of the age of capacity, in the sphere of consent to medical treatment, could be more radical. From the findings of some scholars we could conclude that the age of legal competency to decide upon or to accept medical treatment should be lowered to ages twelve or thirteen.[242]

It should also be noted that Jewish law is one of the sources of inspiration when the Israeli Ministry of Justice drafts new laws. Jewish law recognizes the concept of the developing stages of competency. At the age of twelve the female child is bestowed with complete legal competence; this occurs at the age of thirteen for the male child. However, at a younger age, the child is also sometimes presumed competent, although to a limited degree. An ancient Jewish Text, the Talmud, expresses the method of determining this legal competence with the phrase: "everyone according to his degree of sharpness."[243] Every minor is treated according to his/her level of intellectual maturity. This criterion is applicable in certain individual cases, and should not be applied as a broad, absolute rule.

We hold that it is sufficient to lower the age of competence to consent to medical treatment to fifteen. However, the legislator should apply the same rule for adolescents and adults, namely that the presumed competency of any individual could not be sufficient as a result of judicial reassessment. The court could decide that a specific individual is not legally capable of making reasonable decisions. This approach grants the minor *rights* as opposed to patronization. The child who is fifteen years old should not be required to take legal action and petition the courts in order to actualize his/her rights.[244]

Those who wish to advance this approach want to bestow upon the minor the concrete right to make medical decisions concerning him or her, without the need to seek approval of his/her request in Court. The minor is not required to expose himself or herself in court and his/her problems (and perhaps

242. JEAN PIAGET, THE MORAL JUDGMENT OF THE CHILD 96-97 (1932); B.M. Korsch et al., *Noncompliance in Children with Renal Transplants*, 61 PEDIATRIC 872, 873 (1978); O. Nakajima & M. Hotta, *A Development Study of Cognitive Processes in Decision Making: Information Searching as a Function of Task Complexity*, 64 PSYCOL. REP. 67, 77 (1989); Wallace J. Mlyniec, *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 FORDHAM L. REV. 1873, 1881-83 (1996).

243. BABYLONIAN TALMUD, *Ketuboth* 60A; *Gitin*, 59A.

244. Bellotti v. Baird, 443 U.S. 622 (1979).

also the disagreement on this matter with his/her parents).[245] An additional detriment of the method which obligates minors to enter into the judicial arena in order to achieve the right of making decisions concerning their medical treatment is the fact that essentially the court substitutes the paternalistic role of the parent as the one who decides on the minor's behalf, so this does not manifest the granting of rights that are readily made available to minors. Moreover, the court does not necessarily possess the proper means for rendering judgment of whether the minor is sufficiently mature or what weight should be attributed to his/her opinions.

This model can be perceived as a more complex and moderate version of the child liberation doctrine, which strives for the emancipation of all human beings of all ages.[246] It is similar, to an extent, to the model of Article 12 of the Convention: "The views of the child being given due weight in accordance with the age and maturity of the child."[247] It adopts one of the two components in the latter model: "the age."

The application of this approach can be demonstrated through various provisions of Scottish law. In Scotland, a minor is defined as such when he or she is under age eighteen.[248] However, specific laws grant minors a right to make major decisions concerning their lives at the age of sixteen. From age sixteen, a minor may get married,[249] terminate his/her formal studies,[250] work full time,[251] and leave the home of his family.[252] All these

245. In the *Bellotti* case, the United States Supreme Court recognized the right of the minor, in certain situations, to decide concerning medical treatment. This right is independent and separate from the right of his/her parents to participate in the decision-making process. *See id.* at 643, 648, 654. However, the Court also established that the method of exercising this right should only be through appearing before the courts. Every minor should have the opportunity to go directly to court without first consulting or notifying his/her parents. The constitutional right to have an abortion (which was established in this case) affords protection of privacy interests. *Id.* at 655.

246. *See* DONALD T. KRAMER, LEGAL RIGHTS OF CHILDREN 664-667 (1994); HOWARD COHEN, EQUAL RIGHTS FOR CHILDREN 42-55(1980) (arguing that children should have same rights as adults); THE RIGHTS OF CHILDREN (Bob Franklin ed., 1986); Farson, *supra* note 30, at 9.

247. Convention, *supra* note 15, art. 12(1).

248. Age of Majority Act 1969, § 1(1) (Scot.).

249. Marriage Act 1977, § 1 (Scot.).

250. Education Act 1980, §§ 30-31 (Scot.).

251. Children and Young Persons Act 1937, §§ 28-31 (Scot.).

252. Elaine E. Sutherland, *The Role of Children in the Making of Decisions Which Affect Them*, *in* THE IDEOLOGIES OF CHILDREN'S RIGHTS, *supra* note 28, at 156.

acts are independent. The minor is not required to seek parental consent.[253] Additionally, court orders regarding child custody are valid only until age sixteen.[254]

With regard to decisions concerning medical treatment, Scottish law establishes an internal division within minority: "pupils" are girls up to age twelve and boys up to age fourteen, and "minors" are young people from these ages until age eighteen.[255] Until recently, minors were granted the right to agree or to refuse to medical treatment.[256] However, in the last few years, following clarifications by the Scottish Ministry of Health, the right to agree or to refuse medical treatment is granted to those ages sixteen and up.[257]

In the United States, legislation exists in certain states that lowers the age of legal competency concerning decision-making in specific situations: pregnancy, sexually transmitted diseases, and drug and alcohol addiction.[258]

As mentioned above, there were special exceptions in Israel to the rule in regard to age of legal capacity. Perhaps the Israeli legislator could consider granting this authority of independent decision-making to all minors concerning medical treatment in general, after the minor reaches the age of fifteen or sixteen years.

3. Enabling the Minor to Prove Competency

The basic presumption of the model of enabling the minor to prove competency is that minors younger than eighteen generally have not attained complete intellectual maturity, and lack the necessary competence for making sound decisions concerning medical treatment on their own behalf. However, under this model, the minor will be entitled to challenge this presumption and be allowed to prove in court, or to a professional expert,

253. *Id.*

254. Law Reform (Parent and Child) Act 1986, § 3(2) (Scot.).

255. Sutherland, *supra* note 252, at 156.

256. *Id.* at 160.

257. *Id.*

258. *See* American Academy of Pediatrics—Committee on Pediatric Emergency Medicine, *Consent for Medical Services for Children and Adolescents*, 92 PEDIATRICS 290, 290-91 (1993); Abigail English, *Legal Aspects of Care*, *in* TEXTBOOK OF ADOLESCENT MEDICINE (Elizabeth R. McAnarney et al. eds., 1992); Abigail English, *Runaway and Street Youth of Risk for HIV Infection: Legal and Ethical Issues in Access to Care*, 12 J. ADOLESCENT HEALTH 504-10 (1991).

that he or she possesses that legal competence. The minor will be required to demonstrate intellectual maturity, independence, and the capability of making decisions and bearing their consequences. The outcome of recognizing the minor's competence is likely to be expressed in granting the minor autonomy to decide upon the specific matter concerning him or her (e.g., refusal to undergo a certain operation); autonomy within a limited range of decisions (e.g., concerning his/her medical well-being); or in certain situations the minor is to be empowered with full autonomy.

The shortcomings of this model have been discussed above. We shall briefly enumerate a few: the minor's loss of privacy; the need to seek judicial recognition through the courts as to level of maturity; the lack of financial capability to petition the courts for a right which the minor already possesses; and the toll of this entire ordeal in the sphere of the minor's relationship with his/her parents.

In the United States this model has already been adopted in a number of states. In *Bellotti v. Baird*,[259] the U.S. Supreme Court recognized a distinction between mature and immature minors, in the matter of restricting the ability to consent or not consent to undergo abortions. In the case of *Younts v. St. Francis Hospital*,[260] parental consent for a medical procedure to be performed on a seventeen-year old minor could not be obtained. The court ruled that under the specific circumstances a seventeen-year old minor was sufficiently mature to comprehend the options and ramifications of her decision to agree to the medical treatment: "The sufficiency of a minor's consent depends upon his ability to understand and to comprehend the nature of the surgical procedure, the risks involved and the probability of attaining the desired results in the light of the circumstances."[261]

In the state of Illinois, rights have been granted to the "Mature Minor."

> Where the minor is at least sixteen years of age . . . a 'mature minor' who has demonstrated the ability and capacity to manage his/her own affairs and live wholly or partially indepen-

259. Bellotti v. Baird, 443 U.S. 622, 648-49 (1979).

260. Younts v. St. Francis Hosp. & Sch. of Nursing Inc., 492 P.2d 330 (Kan. 1970).

261. *Id.* at 300. *See* W.J. Wadlington, *Consent to Medical Care for Minors: The Legal Framework*, *in* CHILDREN'S COMPETENCE TO CONSENT 60, *supra* note 28.

> dent of his/her parents, may petition the court to obtain the legal status of an emancipated person.[262]

When a minor has proven his/her maturity to the court, he or she receives full emancipation concerning all aspects of life.

In the state of Nevada, minors are given the opportunity to make their own decisions concerning medical treatment if they have lived apart from their parents for a period longer than four months. When the minor lives with his/her parents, parental consent is not required when the minor: "understands the nature and purpose of the proposed examination or treatment and its . . . probable outcome and voluntarily requests it."[263]

Additionally, the American Bar Association has established a series of standards intended to provide direction and to serve as a model for state legislation. It recommended that the American legislator and courts grant recognition to the "Mature Minor" doctrine.[264] Under this doctrine, a minor over the age of sixteen, who has sufficient capability to comprehend the nature and the consequences of the proposed medical treatment, may express his/her consent to the procedure, and his/her consent shall be considered as binding.[265]

The American Academy of Pediatricians recommended that in addition to the consent of the minor's parents, a minor who has reached the age of thirteen years should grant his/her consent to surgery or medical treatment.[266] The Academy also recommended that the participation in medical research of a minor who has reached the age of seven will be permitted only after he or she has received a verbal explanation regarding the research procedure to be performed upon him/her and has consented to the application of such a procedure upon him/her. The decision of the minor to end his/her participation in the research should always be honored.

In any event, according to this recommendation, the doctor's decision as to the ability of the minor to decide in a mature

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262. Estate of Johnson v. Johnson, 673 N.E.2d 386, 393 (Ill. 1996).

263. *See* Nev. Rev. Stat. Ann. § 129.030(2) (1993).

264. American Bar Association, Juvenile Justice Center, Juvenile Justice Standards Project, Rights of Minors 4.6A.

265. *See id.*; WHO SPEAKS FOR THE CHILD—THE PROBLEM OF PROXY CONSENT 69 (Willard Gaylin & Ruth Macklin eds., 1982).

266. Lainie Friedman Ross, *Health Care Decision-Making by Children: Is it in Their Best Interest?* 27 HASTINGS CENTER REP. 41, 42 (1997).

manner, should be based on individual factors, such as the minor's exact age, the specific illness and its severity, the possible risk of treatment, and its expected medical potential. The doctor should assess the extent of intelligence ability, of rational thinking, and the emotional state of the minor concerned. He or she should be guided by his/her professional experience regarding treatment of minors, and the history of treatment of the minor in regard to decisions concerning medical treatment.[267]

The rules and suggestions in American law and of American groups regarding a mature or understanding minor require clarification. We suggest that our recommendation in regard to the exact criterion that determines maturity and understanding, and especially that based upon psychological theories and empirical research findings on consent to medical treatment, should be the basis of any criteria, regarding proof of maturity, which enables a minor to consent to medical treatment.

Another option is the adoption of the model in England. In England, in Section 8(1) of the Family Law Reform Act, 1969, the British legislator stated as follows:

> The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age, and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.[268]

However, the age of sixteen years, is not the only criterion. The case of *Gillick*[269] serves as a monumental turning point in English law in terms of the balance between children's autonomy and parental powers. The rule handed down in the *Gillick* case establishes that a minor that is less than the age of sixteen acquires the ability to execute legal actions if he or she is determined as being of appropriate intellectual maturity.[270] This is

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267. *See* Committee on Bioethics, American Academy of Pediatrics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 314-17 (1995).

268. Family Law Reform Act, 1969, c. 46 § 8(1) (Eng.). For the legal environment in England after the 1969 reform, see J. MONTGOMERY, HEALTH CARE LAW (1997).

269. Gillick v. West Norfolk and Wisbech Area Health Authority, [1985] 3 All E.R. 402 (HL) (1985) (UK).

270. In the *Gillick* case the court ruled concerning a 15-year old minor. Her mother requested that she should not receive pills for prevention of pregnancy. The

ascertained through a concrete examination based upon the factual evidence of the specific situation that may be administered by the court. The majority opinion ruled that the rights of the parent over his/her child end at the very moment that the child is deemed competent to make decisions in this area. Even the dissenting opinion, that of Lord Templeton, argued with the majority opinion only with regard to the specific issue addressed in the case (usage of birth control pills). Templeton held in principle that it was legitimate for a doctor to rely upon the minor's consent concerning other medical procedures (e.g., the removal of tonsils).

The scholar Michael Freeman claims[271] that the importance of this case lies in heightening public awareness to the topic of the recognition of children's rights; furthermore, this case had a decisive impact upon the enactment of the Children Act, 1989. However, it is not readily apparent that from the *Gillick* case one may infer any conclusion concerning the rights of minors to agree to *all* medical treatment at *all* ages.

The scholar John Eekelaar held that the fact that the majority in the *Gillick* case ruled in favor of the minor was an indication of the current new trend to enable children to realize rights that will grant them autonomy. However, although the majority in the House of the Lords held that the extent of understanding of the minor is a relevant factor concerning the granting of the right of decision-making to minors with respect to their medical treatment, this case does not offer any clear and obvious criteria for determining a minor's level of maturity and understanding.

Perhaps the suggestions regarding such criteria in this Article, based upon findings of solid research, could be imple-

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House of Lords ruled that the child's parents could not prevent the granting of the pills despite the age of the child. The legal subjection of a minor to his/her parent exists only until he or she is able to care for his/her matters. The age of the minor, an objective criterion, is not a decisive factor, when the subjective legal capacity of the minor is determined. The relevant factor is his/her ability to be of settled mind and to reach full understanding of what is suggested to him or her, its results, and dangers. This ability can exist in a minor although he/she has not yet reached the age of 16 years.

271. *See* Freeman—*Limits of Children's Rights*, *supra* note 34, at 40. Professor Eekelaar explains that once the court has decided whether the child has sufficient capacity, the child's decision should determine the matter, whether or not the court thinks this is for his best interest. *See* John Eekelaar, *The Eclipse of Parental Rights*, 102 L.Q. REV. 4, 8 (1986).

mented regarding minors in England, as well as in Israel and in other countries.

We are aware of the fact that five years later, in the *re R*[272] case, this legal doctrine was limited and restricted. According to the new doctrine of the *re R* case, a minor under the age of sixteen can consent to medical treatment without the consent of his/her parents, in certain circumstances. However, concerning the refusal of a minor to consent to medical treatment, the minor's parents have a veto power. We suggest that the policy in this case should not be the general rule. The ruling of the Lords in the *Gillick* case is coherent. However, in the *re R* case there is a lack of satisfactory explanation of a distinction between consent of a minor to medical treatment and his/her refusal to be treated. If the relevant criterion is the ability of a minor to comprehend the matter, in the above-mentioned manner, the distinction of the *re R* case is problematic. The minor's understanding is the important factor, not his/her acceptance or rejection of medical treatment.[273]

The trend of granting mature and understanding minors certain rights of decision-making concerning their medical treatment should be the main model adopted in Israeli law. It is in the spirit of Article 12 of the Convention: "in accordance with the age *and maturity* of the child."[274]

4. Establishing a Minimum Age

In the cases outlined above that applied one of the above-mentioned models, at times a minimum age was established, and minors younger than that age were barred of the opportunity to prove their competency.[275] It may be argued that the purpose of establishing a minimum age stems from practical interests, in order to rule out baseless claims that the very young minor is ma-

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272. [1991] 4 All E.R. 177 (UK).

273. It seems that a narrow interpretation of the right of the minor in Section 8 of the Family Law Reform Act, 1969, concerning children led the court to this reform. This section includes the words "who has attained the age of sixteen years." The court in the *re R* case felt it should take these words into consideration, and therefore limited the right of the minor under this age to reject medical treatment.

274. Convention, *supra* note 15, art. 12(1) (emphasis added).

275. The mature minor doctrine, the age of 15 in the *Gillick* case, the age of 16 in the Scottish law. *See* Cardwell v. Bechtol, 724 S.W.2d 739, 749 (Tenn. 1987). The court held that between the ages of 14 and 18, a "presumption of capacity" arises. That presumption can be rebutted by evidence of incapacity.

ture enough and able to understand the pros and cons of his/her medical treatment. A similar principle was adopted in Article 12 of the Convention: "in accordance with *the age* and maturity of the child."[276]

Accordingly, we would like to suggest that only after a child reaches a minimal age, which will be determined by the legislator that takes into consideration the theories of developmental psychology and results of empirical research, will he or she be able to prove his/her level of maturity and understanding.[277]

C. *Additional Considerations*

1. Different Categories of Medical Treatment

Another criterion for determining whether a minor can participate in the process of decision-making concerning his/her medical treatment is the criterion of the category of medical treatment.[278] This parameter should be implemented in addition to the above guidelines. The combination of the specifications we mentioned concerning the minor, his/her personality, maturity, and understanding, etc., with the type of medical treatment, could lead to the proper verdict. We have already suggested that minors should not be granted the right to decide concerning emergency or life-saving treatment. Perhaps they should not be allowed to decide when there are significant aesthetic side effects to medical treatment.[279]

In the United States, state legislatures have also established exceptions unrelated to the common law pattern, many of which focus on specific diseases, conditions, or treatments. The most common of these statutory exceptions, now found almost universally, allows treatment of a minor for venereal disease without parental consent.[280]

Professor Redding justifies this policy:

> Although the terms competence and capacity are sometimes used interchangeably, capacity is a legal term of art which is used to denote competence to consent to a particular treat-

276. Convention, *supra* note 15, art. 12(1).

277. *See* Billick et al., *supra* note 192, at 592.

278. *See* Redding, *supra* note 14, at 728-39.

279. *See* Weithorn & Campbell, *supra* note 197, at 1596.

280. Tania E. Wright, *A Minor's Right to Consent to Medical Care*, 25 How. L.J. 525, 531 (1982).

> ment . . . Thus the term "capacity" will be used in the context of children's ability to provide informed consent to a specific treatment.[281]

Distinctions between consent of minors to different types of medical treatment are prevalent in American caselaw.[282]

In Israel, it may be inferred from a number of statutory provisions that they enable medical treatment without the patient's consent in particular circumstances.[283] Justice Bach held that in Israel, the exemption to the rule that a person rules his own body, and a person may not be treated physically, let alone operated on, without his consent, will tend to be broader than the exemption in the United States and in England, in part because of the sanctity of human life in the eyes of Jewish Law. There is also room to distinguish between a life-saving operation that may severely and substantially alter a person's physical appearance, lifestyle, and quality of life (such as amputation or transplant) and one that does not bear such risks and implication. The former should generally be left to the patient's decision and the latter to the doctor's.[284]

2. Financial Means

Perhaps a minor should not be granted the independent right to consent to medical treatment that will incur substantial financial expenses to his/her parents.[285]

With regard to payment for medical care, when discussing rights in general one must distinguish "rights" as liberties from other legal rights, such as the right to sue (Hohfeld). When society grants rights in the broadest sense, as in the case of the right to demand legal action, not only will the actual right be

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281. Redding, *supra* note 14, at 709.

282. *See* Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976). *See also* Redding, *supra* note 14, at 717; Alexander Morgan Capron, *The Competence of Children as Self Deciders in Biomedical Intervention*, *in* WHO SPEAKS FOR THE CHILD?—THE PROBLEM OF PROXY CONSENT, *supra* note 265, at 68.

283. Civil Wrongs Ordinance [New Version] 2 L.S.I. [New Version] 5, §24(8) (Isr.); Military Justice Law, 1955, 9 L.S.I. 184, § 20(a) *amended by* 18 L.S.I. 140 (Isr.); Prisons Regulations, 1978 (K.T. No. 3882, at 1958), reg. 10 (Isr.).

284. *See* Case 527, 480/85, Cortam v. State of Israel, (1986), 40(3) P.D. 673, at 687-88.

285. A number of states have statutes that "emancipate" minors for purposes of consenting to medical care if they are living separate from their parents and managing their own financial affairs, for example, Mass. Gen. Laws ch. 112, § 12F (1996).

bestowed, but the necessary means will be also provided. In general terms, this concept of rights in the sense of the right to sue requires a proper economic and organized infrastructure to enable minors to utilize them. The actualization of rights in the sense of liberties is indeed contingent on the financial support of parents and the health system in each given country.

CONCLUSION

The common point of view nowadays is that one should grant the child as much autonomy as possible, and to prevent paternalism when it is not necessary. We should consider the opinions of Professor Dworkin and other scholars about paternalism. The desirable aim, especially considering the fact that Israeli law adopted the rules of Basic Law: Human Dignity and Liberty, and Article 12 of the Convention, is to grant minors the right to take part in the decision-making process regarding their medical treatment, as much as possible. The right should be granted in light of the doctrine of the developing capacity of the minor in the Convention, that is based upon two parameters: (1) the objective parameter—the age of the minor; and (2) the subjective parameter—his/her level of understanding. In this context, one should consider psychological theories and research regarding the ability of minors, of the ages of twelve, fourteen, and fifteen, to decide in a rational manner and consider all the pros and cons regarding their medical treatment.