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The Minor's Independence of Medical Decision-Making: *De lege ferenda* Comments in Connection with the Draft Act Amending the Act on Doctors and Dentists Professions (Sejm Paper No. 1432)*

Samodzielność decyzyjna małoletniego w kwestiach zdrowotnych. Uwagi de lege ferenda w związku z projektem ustawy o zmianie ustawy o zawodach lekarza i lekarza dentysty (druk sejmowy nr 1432)

ABSTRACT

The article analyzes the scope of the minor's decision-making independence within medical procedures. As the child, who is the patient, does not have actual and formal possibilities to make independent decisions and give consent, the legal system has developed instruments for the protection of the minor's health interest, and the implementation of health-related well-being was entrusted to parents (statutory representatives). The provisions of the applicable law provide for the existence of age limits for making decisions within the patient's health situation. This fact is criticized. Proposals for changes and lowering the age of the minor's decision-making independence are presented. The author analyzes the assumptions of the draft amendments to the Act on doctors and dentists professions and addresses the problem of a minor's independence in gynecological, dermatological, and urological procedures. Considerations are carried out both under Polish medical law and family

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law, and the author accuses the authors of the project of lack of knowledge of system solutions and proposes *de lege ferenda* postulates.

Keywords: consent; minor; statutory representatives; medical procedures

INTRODUCTION

The minor's independence of decision-making is a sensitive matter, especially when goods such as life, health, or freedom are the subject of decisions. Minors would like to make certain health decisions independently of their parents, which is understandable from their points of view. It applies in particular to intimate matters and those related to the protection of reproductive health. So far, this independence has been limited to a significant extent by parental authority and the custody and representation exercised within it. Nevertheless, a draft act has appeared in the public space amending the Act on doctors and dentists professions (Sejm Paper no. 1432[1]) related to defining the rules for providing certain health services to minors over the age of 15. Taking into consideration the fact that it is not a new postulate and that, in the public discussion, there are more suggestions to lower the age of independent medical appointments in case of a child, it seems crucial to start a discussion in this regard. The draft of legislative amendments presented on the website of the Sejm of the Republic of Poland forms part of this discussion and it is an example of broader tendencies observed in the literature.[2] The fate of the draft may be different,[3] but it contributes to the legislative work which will undoubtedly await the legislator in the future.

[1] See Opinie Biura Analiz Sejmowych, Opinia prawna i merytoryczna dotycząca poselskiego projektu ustawy o zmianie ustawy o zawodzie lekarza i lekarza dentysty (druk nr 1432), https://www.sejm.gov.pl/Sejm9.nsf/opinieBAS.xsp?nr=1432 (access: 10.2.2022). The name of the act was incorrectly given in the Sejm Paper. This is, of course, the Act on doctors and dentists professions, and not the Act on doctors and dentists profession.

[2] There is a view in the literature that "the premise of independent effective consent (in gynecological matters) should be the physiological criterion together with the material one: the first menstruation and sufficient discernment". See M. Boratyńska, *Wolny wybór. Gwarancje i granice prawa pacjenta do samodecydowania*, Warszawa 2012, especially p. 559. See also J. Haberko, *Trudny wybór pacjenta. Recenzja książki Marii Boratyńskiej „Wolny wybór. Gwarancje i granice prawa pacjenta do samodecydowania"*, "Forum Prawnicze" 2013, no. 2, pp. 61–67; K. Mularski, *Recenzja: M. Boratyńska „Wolny wybór. Gwarancje i granice prawa pacjenta do samodecydowania", ss. 733*, "Kwartalnik Prawa Prywatnego" 2013, no. 3, pp. 796–806. In this context, see also T. Sokołowski, *Władza rodzicielska nad dorastającym dzieckiem*, Poznań 1987, passim; N. Sochacki-Wójcicka, *Nastolatka u ginekologa – jak powinna wyglądać wizyta?*, 14.2.2019, https://mamaginekolog.pl/czy-nastolatka-moze-isc-sama-do-ginekologa (access: 1.12.2021).

[3] See Opinie Biura Analiz Sejmowych, *op. cit.*; Uwagi Sądu Najwyższego do poselskiego projektu ustawy o zmianie ustawy o zawodach lekarza i lekarza dentysty, 21.7.2021, https://www.sejm.gov.pl/Sejm9.nsf/druk.xsp?documentId=6FFDCD51966AD381C125872600336209 (access:

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The entirety of the proposed legislative amendments, although it is included only in two substantive editorial units and the provision on the entry into force of the amendments, has considerable systemic consequences. It is worth having a closer look at the proposal and answering the question about the scope of possible amendments and systemic coherence both in the context of the principles governing the provision of health services and the principles of family law.

It is proposed to introduce into Article 32 of the Act of 5 December 1996 on doctors and dentists professions[4] the following changes. Firstly, the current item 2 shall be amended to read as follows: "If the patient is a minor or is incapable of expressing a deliberate consent, the consent of the legal representative is required, and if the patient does not have a legal representative or it is impossible to establish communication – the consent of the guardianship court, subject to the section 2a". Secondly, item 2a, which introduces the significant change, would be added. The provision would be the following: "A doctor may perform an examination or provide other health services to a minor patient over the age of 15 after obtaining the consent in the field of dermatology, gynecology or urology, excluding the performance invasive medical procedures and treatment or diagnostic methods which pose an increased risk to the patient. In the cases mentioned in the preceding sentence, the consent of a minor patient over the age of 15 is sufficient and the consent of the legal representative or legal guardian is not required".

The main objective of the considerations is a dogmatic analysis of the proposed amendments and the submission of *de lege ferenda* postulates regarding the regulation of the medical decision-making independence of a minor. The considerations include both the consequences of exercising parental authority, in particular of exercising custody and representation over the minor in the situation of adopting the suggested solutions, as well as changes in the provision of health services. It is not an attempt to discredit the proposal – there will be probably arguments to support social importance. While creating the law, it is not possible to disregard the fact that the new regulations must be compatible with those already existing in the legal system. In the case of our interest, it concerns the principles of providing health services to a minor and the principles of exercising parental authority. The legislator may, of course, change the law, determine the entity's autonomy,[5]

1.10.2021); Stanowisko nr 86/21/P-VIII Prezydium Naczelnej Rady Lekarskiej w sprawie poselskiego projektu ustawy o zmianie ustawy o zawodach lekarza i lekarza, 8.6.2021, https://www.sejm.gov.pl/Sejm9.nsf/druk.xsp?documentId=29D3A671BD7C8784C125872C002CF2D1 (access: 10.2.2022); Stanowisko Rządu wobec poselskiego projektu ustawy o zmianie ustawy o zawodzie lekarza i lekarza dentysty (druk nr 1432), 30.9.2021, https://www.sejm.gov.pl/Sejm9.nsf/druk.xsp?documentId=FB2B88852A46FCADC1258760003F0BC2 (access: 1.10.2021).

[4] Consolidated text, Journal of Laws 2020, item 514, as amended, hereinafter: the ADDP.

[5] For autonomy, see especially M. Safjan, *Prawo i medycyna. Ochrona praw jednostki a dylematy współczesnej medycyny*, Warszawa 1998, p. 42; R. Krajewski, *Funkcjonowanie świadomej*

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including, e.g., decreasing or increasing the age at which a person becomes an adult, they may introduce changes in the performance of the information obligation or consent (independent or cumulative) as a part of medical or other procedures. However, a comprehensive regulation and changes to a wider extent are required. Every proposed amendment, which changes only a certain part of already regulated social relations, must take into consideration the existing solutions and the proposed provisions, even if they seem inconspicuous, they must be interpreted in the context of the principles already defined in the legal system.

EXPLANATORY STATEMENT TO THE AMENDMENT

Both the essence of the amendment in question and the positions expressed above in the field of lowering the age of decision-making by a minor come down to accepting the independence of a minor patient in the scope of selected procedures within selected medical specialties. The independence should be treated as a possibility of making unlimited decisions on medical advice and consent to carry out activities such as an examination or the provision of other health services, excluding the performance invasive medical procedures and treatment or diagnostic methods which pose an increased risk to the patient. To put it differently, the point is that minors over the age of 15 should be able to go to a dermatologist, gynecologist, or urologist by themselves and make their own decisions and consent to the method of prevention and treatment.[6]

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zgody w relacjach lekarz–pacjent, [in:] *Realizacja zasady informed consent w kontekście relacji lekarz–pacjent. Wyzwania i bariery rozwojowe w Polsce*, ed. S. Torciuk, Warszawa 2012, p. 75 ff.; M. Nowacka, *Filozoficzne podstawy zasady autonomii pacjenta*, "Problemy Higieny i Epidemiologii" 2008, no. 3, pp. 326–329; P. Łuków, *Granice zgody. Autonomia zasad i dobro pacjenta*, Warszawa 2005, p. 126 ff.; M. Tenenbaum, *Zakres autonomii osób fizycznych w możliwości dysponowania komórkami, tkankami i narządami dla celów transplantologicznych za życia oraz na wypadek śmierci*, [in:] *Prace z prawa cywilnego dla uczczenia pamięci Profesora Jana Kosika*, ed. P. Machnikowski, Wrocław 2009, p. 525 ff.; A. Kołodziej, *Stopień autonomii woli pacjenta na tle ustawy o zawodzie lekarza i ustawy o ochronie zdrowia psychicznego*, "Prawo i Medycyna" 2002, no. 11, p. 74 ff.; A. Liszewska, *Zgoda pacjenta na zabieg leczniczy*, "Państwo i Prawo" 1997, no. 1, p. 36 ff.; A. Michałek-Janiczek, *Autonomia małoletniego w zakresie leczenia*, "Państwo i Prawo" 2009, no. 10, p. 57 ff.

[6] T. Dukiet-Nagórska, *Świadoma zgoda pacjenta w ustawodawstwie polskim*, "Prawo i Medycyna" 2000, no. 6–7; M. Czarkowski, J. Różyńska, *Świadoma zgoda na udział w eksperymencie medycznym. Poradnik dla badacza*, Warszawa 2008, p. 4; M. Świderska, *Zgoda pacjenta na zabieg medyczny*, Toruń 2007, passim; S. Niemczyk, A. Łazarska, *Medyczno-prawne rozważania o konkretyzacji przedmiotu zgody pacjenta*, "Prawo i Medycyna" 2008, no. 32, pp. 65–80; K. Bączyk-Rozwadowska, *Prawo pacjenta do informacji według przepisów polskiego prawa medycznego*, "Studia Iuridica Toruniensia" 2011, vol. 9, p. 60.

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The aim of the draft[7] is to enable minor patients over the age of 15 to receive health services in the field of the above-mentioned medical specialities after obtaining their consent, excluding the performance of invasive medical procedures and treatment or diagnostic methods which pose an increased risk to the patient. The consent of a minor patient to these procedures would be effective, final and sufficient at the same time, without the need to receive the consent of a legal representative or a guardianship court.

Firstly, according to the authors of the draft, the indicated fields of medicine are particularly important due to hormonal changes which occur in adolescence. Enabling people over the age of 15 to obtain health services in the field of dermatology, gynecology or urology without their parents' consent will help to "increase the availability of these health services in this social group, as a result of which, there should be a systematic increase in the awareness of adolescents in the area of health and preventive healthcare".

Secondly, the explanatory statement to the draft compares the proposed amendments with the current legal status in which the legal situation of minors who are over the age of 15 is different than the situation of minors who have not reached this age. The draft sets up specific rules of liability for committing a prohibited act by a minor who has reached the age of 15 (Article 10 § 2 of the Penal Code[8]). The regulation provided for in Article 190 § 1 of the Labor Code[9] is also indicated.

Thirdly, the authors of the draft justify that the entry into force of the act will have positive social effects. As they claim "increasing the availability of the health services in question in the social group of adolescents shall influence on a systematic increase in their awareness in the area of health and preventive healthcare, as well as strengthen shaping and building their sense of responsibility for their health and lives. Thanks to this, the habit of taking care of health and regular medical check--ups among adolescents will develop faster and more effectively. Adolescents will be able to do it on their own and, which should be emphasized, independently of the level of awareness of their parents in this regard and they will be also able to set a positive example for their parents with their attitude".

Among the social effects, the preventive factor was indicated. It assumes that "the consequence of easier access to a dermatologist, gynecologist and urologist for

[7] If no footnote is given, all texts enclosed in quotation marks come from the justification of the bill amending the Act on the doctors and dentists professions (Sejm Paper no. 1432). See Uzasadnienie projektu ustawy o zmianie ustawy o zawodach lekarza i lekarza dentysty (druk nr 1432), https://www.sejm.gov.pl/Sejm9.nsf/druk.xsp?nr=1432 (access: 4.9.2022).

[8] Act of 6 June 1997 – Penal Code (consolidated text, Journal of Laws 2020, item 1444, as amended).

[9] Act of 26 June 1974 – Labor Code (consolidated text, Journal of Laws 2020, item 1320, as amended).

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people over the age of 15 will be a faster detection and diagnosis of diseases".[10] The data elaborated by the Obstetrics and Gynecology Forum shows an upward trend in sexual activity and initiation age.[11] Approximately 27.3% of boys and 18.8% of girls up to the age of 15, and 40.0% of boys and 31.9% of girls in the age group of 17–18 declare that they have already started to be sexually active.[12]

Fourthly, the explanatory statement shows that the arguments in favor for the amendment are not only matters related to contraception and independence in this regard, but also matters of reproductive health. In this respect, a speech made by the Commissioner for Human Rights to the Minister of Health of 29 July 2016 was called. It was stated in the speech that "minor patients with serious intimate health negligence, which in extreme cases may even cause sterility, go to and seek help in social organizations".[13]

Fifthly, the independence of going to an appointment with a urologist or gynecologist has "special importance when an adolescent is a victim of domestic violence or sexual abuse by the parents or legal guardians. In this case, it is difficult to expect that the parent will support the child in having such an appointment".[14] The number of cases of minor victims of sexual abuse in Poland, only in the case of initiated proceedings, reached over 2,000 annually in recent years.[15] The amendment to the act may have a positive effect on unhampered access to medical services for people belonging to this group of minors, and therefore it may improve their life situations, often preventing further harm.

And finally, the arguments are based on respect for the intimate sphere, the assumption of shame and the lack of openness to parents. As observed "the proposed amendments to the act are not aimed at limiting parental authority or shifting responsibility for their health onto a minor. They also do not apply to the scope of

[10] M. Matzke, *Coraz więcej młodzieży choruje na raka. Naukowcy bezradni*, 15.3.2017, https://www.dw.com/pl/coraz-wi%C4%99cej-m%C5%82odzie%C5%BCy-choruje-na-raka-naukowcy-bezradni/a-37944674 (access: 1.10.2021); *Ginekolog dla dziecka potrzebny. Rozmowa z prof. Agnieszką Drosdzol-Cop*, "Polityka" 2021, no. 19, p. 63.

[11] UNICEF, *Odbycie inicjacji seksualnej przez młodzież*, https://dzieciwpolsce.pl/statystyka/101/odbycie-inicjacji-seksualnej-przez-mlodziez/wykresy/glowny/2014 (access: 1.10.2021).

[12] K. Ludwikowska, L. Szenborn, M. Karlikowska-Skwarnik, *Choroby przenoszone drogą płciową u nastolatków*, "Forum Położnictwa i Ginekologii" 2017, no. 33, pp. 20–32.

[13] Wystąpienie Rzecznika Praw Obywatelskich do Ministra Zdrowia w sprawie zasad dostępu osób niepełnoletnich, w wieku powyżej 15. roku życia, do świadczeń ginekologicznych i urologicznych, 29.7.2016, https://bip.brpo.gov.pl/pl/content/wystapienie-do-ministra-zdrowia-w-sprawie-zasad-dostepu-mlodziezy-do-swiadczen-ginekologicznych-i-urologicznych (access: 1.10.2021).

[14] Dane statystyczne Policji, *Przemoc w rodzinie – dane od 2012 roku*, https://statystyka.policja.pl/st/wybrane-statystyki/przemoc-w-rodzinie/201373,Przemoc-w-rodzinie-dane-od-2012-roku.html (access: 15.5.2021).

[15] UNICEF, *Seksualne wykorzystanie małoletniego*, https://dzieciwpolsce.pl/statystyka/115/seksualne-wykorzystanie-maloletniego/wykresy/glowny (access: 1.10.2021).

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medical services related to high-risk procedures, but they are a response to progressive social changes, whose development is not being followed by the current legal regulations".

THE ANALYSIS OF THE DRAFT WITH THE EXPLANATORY STATEMENT

Moving on to the analysis of the draft and the above-mentioned explanatory statement, the following facts shall be indicated. The draft is fairly economical, laconic, regarding the proposed solutions. The amendment in the scope of Article 32 of the ADDP does not take into account several significant issues related to the introduction of new solutions to the act. The ADDP, important in the legal system, especially in the field of medical law, is not the only act relating to the provision of health services, including providing them to minors. The authors of the draft not only do not see this fact, but also they do not see the need of taking into account the solutions included in the act itself. Obviously, it is possible to introduce the postulated provision without making any other changes. However, it will make it difficult for people of medical professions to apply these provisions and it will certainly not affect the increase of the legal awareness of the society.

As an example, it is worth noting the doubts in the scope of the information obligation provided for in Article 31 and, especially, in Article 31 (6) of the ADDP.[16] This provision stipulates that if a patient is under the age of 16, unconscious or unable to understand the meaning of the information, the doctor provides information to a close person within the meaning of Article 3 (1) (3) of the Act of 6 November 2008 on patient rights and the Patient Rights Ombudsman.[17] There is no final decision in the draft: whether this regulation shall also apply to patients over the age of 15, or whether the intention of the authors of the draft is different. While we may agree with the interpretation of informing a close person of the patient, it assumes, firstly, the lack of independence of the patient over the age of 15 and before the age of 16, and secondly, it requires indicating to whom (and for what purpose) this information could be given. Apart from the purpose of providing information, the key doubt which arises here concerns the determination of the subjective scope of a close person. If a close person may be, according to Article 3 (1) (2) of the Act of 6 November 2008 on patient rights and the Patient Rights Ombudsman, a person

[16] J. Haberko, *Tajemnica lekarska a poszanowanie prawa do samostanowienia i prywatności małoletniego pacjenta*, "Białostockie Studia Prawnicze" 2020, no. 2, pp. 123–140.

[17] Act of 6 November 2008 on patient rights and Patient Rights Ombudsman (consolidated text, Journal of Laws 2020, item 849).

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indicated by the patient (including a minor) or whether the intention of the authors of the draft is to leave Article 31 (6) of the ADDP as it is, and if so, will the statutory requirement be met if a minor over the age of 15 indicated a person who is 14 or even younger as a close person? While adopting the amendment, it should be considered *de lege ferenda* to limit, in this case, the scope of a close person to an adult and an incapacitated adult who is, e.g., a relative by blood (an elder sister, an aunt, a grandmother, etc.) or by marriage (e.g., a stepmother or a sister-in-law, etc.) Obviously, the above assumption will be justified only if the minor is not accompanied by a legal representative and if the legislator decides to change the scope and purpose of fulfilling the information obligation.

However, doubts are raised by the further draft regulation in conjunction with Article 31 (7) of the ADDP which is a natural consequence of the adopted decision structure based on a substitute consent for a minor patient before reaching the age of 16. The doctor provides information to a patient *de lege lata* under the age of 16 on the scope and form necessary for the proper conduct of the diagnostic or therapeutic process and listens to their opinion.[18] The construction adopted in this regard has two serious consequences. Firstly, the scope of information which is provided to a minor between the age of 15 and 16 is not, or at least do not have to be, complete and it is essentially not for giving their consent as it is for informing about the course of diagnostic or therapeutic procedures. Secondly, it assumes a full information competence and thus also a decision-making competence of an adult. It is due to the fact that children may not understand the transmitted information, they may misunderstand it, as well as the fact that they can make decisions by negating the position of the parents or the doctor, driven by emotions or by the will to do something out of spite. The actual situation of a minor may finally make it impossible to provide information about ailments or diseases. Children simply do not know what may and may not be significant in the context of healthcare. Sometimes they may falsify information, even unconsciously, due to a lack of life experience.[19] Therefore, bearing in mind the code assumptions, it is assumed, taking into consideration a certain contractual age limit, that the entity, which participates

[18] See Article 72 (3) of the Constitution of the Republic of Poland of 2 April 1997 (Journal of Laws 1997, no. 78, item 483, as amended) and Article 95 § 4 of the Act of 25 February 1964 – Family and Guardianship Code (consolidated text, Journal of Laws 2020, item 1359). This means that both public authorities and persons responsible for the child (parents, guardians) are obliged to listen and, if possible, take into account the child's opinion, and parents should listen to them before making decisions on more important matters concerning the child, if the mental development, the child's state of health and maturity allow this, and take their reasonable wishes into account as far as possible. See W. Borysiak, *Komentarz do art. 72*, [in:] *Konstytucja. Komentarz*, eds. M. Safjan, L. Bosek, Warszawa 2016, p. 1511 ff.

[19] J. Haberko, *Prawnomedyczne relacje rodzice – dziecko – państwo*, [in:] *Dziecko – rodzice – państwo w kontekście świadczeń zdrowotnych, edukacyjnych i przemocy domowej*, ed. M. Łączkowska-Porawska, Warszawa 2020, pp. 13–39.

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in the process of providing health services to a minor, is the parent exercising parental authority (legal representative).

However, while respecting the subjectivity of minors up to 16 years of age, they are provided with information to the extent necessary to carry out the procedure. Obviously, it is adjusted to the child's age, state of maturity, sensitivity and health and it results from the above-mentioned lack of formal and sometimes factual competences to make decisions,[20] sometimes even to accept and understand the meaning of information. It is supposed not to cause additional stress for a minor, not to increase fear, not to burden with unnecessary information or to calm down when the child is without parents in an unknown and hostile place.

The introduction of decision-making independence based on the drafted Article 32 (2a) of the ADDP requires resolving the matter of the objective and subjective scope of the information obligation and indicating who can be a close person. The authors of the draft do not present any proposals in this regard. However, it must be resolved, if Article 31 (6) and (7) of the ADDP remained intact and determined who could receive information as a close person and what scope of information a minor over the age of 15 and before turning the age of 16 could obtain. Above all, the construction should be based on the premise of the minor's sufficient discernment. Moreover, it is necessary to answer the question what to do if the minor who is over the age of 15 does not agree to have a service provided. Are the general rules applicable, i.e., until the age of 16, is the consent given by the legal representative or is it given immediately by the guardianship court as a substitute?

The introduction of the amendments without appropriate references in the act on patient rights and the Patient Rights Ombudsman seems to be a solution, which will undoubtedly complicate the application of the law by facilities providing health services. As an example, it is necessary to mention the following two provisions: Article 9 (2) and Article 17 (1) of the Act on patient rights and the Patient Rights Ombudsman. We would like to remind that the patient, including a minor who is over the age of 16, or the legal representative, have the right to obtain from a medical professional accessible information about the patient's health, diagnosis, proposed and possible diagnostic and treatment methods, foreseen consequences of their use or omissions, treatment results and prognosis in the scope of the health service provided by that person and in accordance with the competences (Article 9 (2) of the Act on patient rights and the Patient Rights Ombudsman); and the patient, including a minor who is over the age of 16, has the right to consent to the

[20] J. Zajdel, R. Zajdel, *Dzieci i ryby głosu nie mają – prawa małoletniego w procesie leczenia*, "Standardy Medyczne. Pediatria" 2009, vol. 6, pp. 657–665.

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examination or the provision of other health services (Article 17 (1) of the Act on patient rights and the Patient Rights Ombudsman).[21]

Therefore, also under this act, the issue which remains to be resolved is the question of the fulfillment of the information obligation in relation to a minor who is over the age of 15 and before turning the age of 16. As it seems, the highlighting of the above-mentioned procedure does not constitute the base to conclude that we are dealing with *lex specialis*, because whenever the legislator lowers the age of medical procedures, he does it consistently within the cumulative scope of consent,[22] and never leaves the minor as an entity entitled to independent decision-making.

The authors of the draft assume that it will not change the rules of exercising parental authority over minors. It is impossible to share this view. We are children until reaching a certain, contractual age. *De lege lata* is the age of 18. Parents (legal representatives) play the main role in exercising the minor's subjective rights. In this regard, it is worth mentioning the provision of Article 95 § 4 of the Family and Guardianship Code which implies not only the obligation of exercising the principle of the child's best interest, but also exercising it in the best interest of the child and taking into account their position and compliance of the parents' decisions with the assumption resulting from Article 97 § 2 of the Family and Guardianship Code.[23] The above information justifies the accuracy of the statement that, first of all, the parent (if the matter is important: both parents) – no one else, in particular a doctor, or even a minor, can decide about the child's health situation. This fact does not result from the lack of respect for the dignity of a minor, but it derives from it.[24] It is difficult to imagine the implementation of the right and the obligation of the custody of a child in terms of health without recognizing the accuracy of the above assumption.

Admitting parents to information about the health or health details of a minor's life is not an act outside the child, but an act in the child's best interest. It serves to implement the right to protect the minor's health by obtaining information about the health of the child and consenting to medical actions. It is necessary to highlight that while exercising the parental authority and representing the child, the parents

[21] B. Janiszewska, *Komentarz do art. 9*, [in:] *Ustawa o prawach pacjenta i Rzeczniku Praw Pacjenta*, ed. L. Bosek, Warszawa 2020, p. 225 ff.

[22] See Article 25 (3) of the ADDP; Article 4a (4) of the Act of 7 January 1993 on family planning, protection of the human fetus and conditions for the admissibility of termination of pregnancy (Journal of Laws 1993, no. 17, item 78, as amended); Article 12 (3) of the Act of 1 July 2005 on the collection, storage and transplantation of cells, tissues and organs (consolidated text, Journal of Laws 2020, item 2134).

[23] J. Gajda, *Kodeks rodzinny i opiekuńczy. Akty stanu cywilnego. Komentarz*, Warszawa 2002, p. 389; idem, [in:] *Kodeks rodzinny i opiekuńczy, Komentarz*, ed. K. Pietrzykowski, Warszawa 2020, p. 804.

[24] A. Wojcieszak, *On Respect for Human Dignity on the Example of Polish Guarantees of Its Protection and the Judicature of the Supreme Court of the United States of America*, "Studia Iuridica Lublinensia" 2021, vol. 30(5), pp. 701–721.

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remain autonomous. Of course, it does not mean that a parent can act without taking into consideration the child's best interests and objective medical criteria in the light of evidence-based medicine. On the contrary, if the parent's behavior threatens the health interests of a minor (e.g., the parent will not subject the child to medical check-ups, will treat the child with methods not considered in the light of evidence-based medicine or will not subject the child to preventive vaccinations), the state will implement the principle of the child's best interest through its actions. It will be manifested in the issuance of substitute decisions concerning the treatment and in the parent's permanent removal from the possibility of making them (e.g., by depriving parental authority). However, the uniqueness of these actions does not invalidate the assumption stating that all the decisions and activities of adults, especially parents, shall be aimed at achieving the child's welfare, also in terms of health well-being. A possible limitation of the parent's decision-making and participation in medical procedures should be added here, if, due to the nature of the procedure, it would expose children to violation of their dignity or intimacy. We are talking about such behaviors of parents (legal representatives) which, in the light of an experienced doctor or midwife, could be considered to exceed certain customary norms of a parent's behavior towards a child (e.g., the presence of the father during an examination involving revealing private parts of his adolescent daughter and watching, especially when a sexual abuse situation is suspected, etc.).

The authors of the draft do not seem to notice the obvious connection between consent and information. It is the parent (legal representative) who has the right to obtain information about the minor's health, as it is obviously related to the right to consent to the health services provided to the child.[25] Depriving a parent of this right or even violating it may result in the liability of the entity which has violated these rights.

In this context, the question arises whether the proposed *de lege ferenda* amendment may be introduced to the act without violating the principles governing the exercise of parental authority, in particular the custody. Without a doubt, the legislator may introduce such amendments, as at a given stage of societal development and practice of law application, are considered to be the most beneficial. However, the question arises whether the achievement of the purpose, as it seems to be the greater independence of the minor in the case of medical appointments involving showing private parts and telling the doctor about matters embarrassing for the child, may take place while retaining the current regulations related to reaching the age of majority, custody and representing a minor in terms of exercising parental authority.

It seems necessary to refer to the structure which assumes reaching the age of becoming an adult after turning a certain age, as well as to the structure determining the scope of activities permitted for a minor despite the fact that they are not of age.

[25] A. Michałek-Janiczek, *op. cit.*, p. 57 ff.

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If so, in the light of the provisions of Articles 14–22 of the Civil Code,[26] the child may make decisions and declarations of will which will affect their legal situation, they may do so to the extent provided for by the law, even without the consent of the parents.[27] The legislator's reasoning is based on the argument included in the provision of Article 95 § 2 of the Family and Guardianship Code which states that: "and in matters where a minor can independently make decisions and declarations of will, we should listen to the opinions and recommendations of the parents formulated for the minor's best interest".[28] It means that if minors would like to perform an action, they should listen to the parents. Minors may, of course, perform actions, but the child's best interest justifies the fact they should listen to the parents and do it sooner.[29] It will allow, in the light of life experience, to protect the minor, e.g., against committing a legal act which is unfavorable to them, in other words, against making a mistake. Moreover, in situations where a legal act would require consent or confirmation by the legal representative, the mere hearing of the parents was not included as the only requirement for the validity of the legal act or declaration made. A minor, performing certain actions resulting in their legal sphere, is not independent.[30]

Although the general obligation of minors' obedience towards the parents results from Article 95 § 2 of the Family and Guardianship Code, there is, however, a group of activities and statements in the system which do not include the obligation of obedience, and in the case of which the minor may act independently on the basis of separate provisions. We are talking about actions similar to legal acts such as consent to change the last name (Article 89 § 1 *in fine*, Article 89 § 2 sentence 2, Article 90 § 1 *in fine* of the Family and Guardianship Code), consent to adoption (Article 118 §§ 1–3 of the Family and Guardianship Code) or a number of consents or objections expressed in medical procedures, in which independence is limited to the possibility of expressing a legally binding, but not final, position.

In the above-mentioned cases, the minor is allowed to act independently and make decisions unhampered by the will of the legal representative. However, it is completely unique in the scope of certain groups of activities recognized by the

[26] Act of 23 April 1964 – Civil Code (consolidated text, Journal of Laws 2020, item 1740, as amended).

[27] M. Gutowski, *Komentarz do art. 14*, [in:] *Kodeks cywilny. Komentarz*, ed. M. Gutowski, vol. 1, Warszawa 2016, p. 90 ff.

[28] See J. Ignatowicz *Komentarz do art. 95*, [in:] *Kodeks rodzinny i opiekuńczy. Komentarz*, ed. K. Pietrzykowski, Warszawa 2012, p. 874.

[29] M. Andrzejewski, *Application of the Clause of the Good of the Child: Reflections Inspired by the Decision of the Supreme Court on the Creation of Foster Families*, "Studia Iuridica Lublinensia" 2021, vol. 30(5), pp. 29–51.

[30] Exceptions in this respect are introduced by the provisions of the Civil Code. They concern independent disposal of earnings, independence in taking legal actions regarding items that the legal representative gave the minor for free use or the so-called trivial activities. See Z. Radwański, A. Olejniczak, *Prawo cywilne. Część ogólna*, Warszawa 2019, p. 275 and the literature cited therein.

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legislator. Certain values are respected here, which, in combination with the exercise of parental authority in the field of custody and representation, gain greater recognition in society. Significantly, these activities regulated in the Civil Code do not usually belong to the important matters of the child, and, in the scope regulated by specific laws, they protect the child's welfare against certain situations which take place without the minor's will.[31] In this context, the question of the scope of the minor's decision-making independence and the scope of matters covered by this independence remains to be resolved.

It is impossible to exclude *de lege ferenda* and such a solution in which the age of becoming an adult with all its consequences will be lowered, nevertheless, while adopting the systemic solutions, it shall be indicated that there are no grounds for excluding parental authority in the event of a minor's appointment at a dermatologist, gynecologist or urologist. We should repeat that it is not about the minor's "consent", but about shaping his health situation, the protection of which has been entrusted to the parents (legal representatives). Even if the case is not, exceptionally, counted among the crucial matters of the child, it will certainly not be included – in the case of any of the appointments covered by the draft – as trivial actions.[32]

The assumption adopted by the authors of the draft, according to which enabling people over the age of 15 to receive health services in the field of dermatology, gynecology or urology, without the consent of the parent will contribute to "increasing the availability of these health services in this social group, as a result of which, there should be a systematic increase in the awareness of adolescents in the area of health and preventive healthcare", was not supported in any ways by research. Moreover, this solution is based only on the age criterion and disregards the minor's state of consciousness or discernment. The introduction of the *de lege ferenda* amendment will cause an interpretative difficulty of the kind that a person over the age of 15 will be able to go to a gynecologist-obstetrician regardless of the medical diagnosis (assuming that the interpretative doubts are resolved under Article 31 (6) of the ADDP), what is more, to make a legally-binding decision and express effective and final consent to the examination and use of therapy, including hormonal therapy, and people over the age of 17, in the case of preventive dental or ophthalmic examination, will require cumulative consent and the presence of their legal representative.

The authors of the draft notice a special situation of minors who are over the age of 15. Besides the specific principles of criminal liability and the possibility of employing people over the age of 15, it is impossible not to refer to this special

[31] In this respect, the above-mentioned expression of the opinion regarding the change of surname or consent to adoption can be indicated. About shaping the legal, family, and personal situation of a child by parents see J. Strzebinczyk, *Prawo rodzinne*, Warszawa 2010, p. 251.

[32] See J. Haberko, *Dopuszczalność wydania z apteki środków antykoncepcyjnych małoletnim. Postulaty de lege ferenda*, "Forum Prawnicze" 2016, no. 3, pp. 23–36.

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situation of a minor specified in Article 200 § 1 of the Penal Code, the assumption on which a part of the explanatory statement in this draft was based.[33] It is true that under a certain contractual age, intercourse with a minor or subjecting him to other sexual activities is punishable by criminal law. This assumption is based on life experience and the adoption of a certain level of human sexual maturity within it. However, it does not prepare grounds for accepting the admissibility of unlimited sexual intercourse by a person over the age of 15. The idea implemented by the penal provision is to exclude the punishability of such activity.[34] It does not mean either a general consent to intercourse after reaching the age of 15 or a subjective right in this regard. The fact that sexual intercourse with a person who has reached the age of 15 is not punishable does not change the rules of exercising parental authority or does not exclude the rules of legal representation in this area.[35] This argument is related to another one indicated in the explanatory statement, it is the prophylactic factor combined with the decreasing age of sexual initiation of minors, the use of contraception and independence in this respect. There are probably minors who start to be sexually active after reaching the age of 15 as a part of an emotionally mature, stable relationship in which partners remain faithful to each other, and sexual intercourse is a form of partnership that complements their relationship in the spiritual and economic sphere. Of course, it is impossible to exclude such situation *ad casum*, nevertheless, life experience, supported by scientific knowledge, suggests that it is extremely difficult to find arguments supporting the early sexual initiation[36] and risky sexual behaviors in children.[37] The uniqueness of the above-mentioned case, which of course is possible, does not change the general principles of exercising parental responsibility, at least until the minor reaches 16 and marries, with the permission of the court. *Ad casum*, an answer to the ques-

[33] See also M. Mozgawa, *Komentarz do art. 200*, [in:] *Kodeks karny. Komentarz*, ed. M. Mozgawa, LEX/el. 2014; T. Sroka, *Kodeks karny. Wybór orzecznictwa*, LEX/el. 2014; N. Kłączyńska, *Komentarz do art. 200*, [in:] *Kodeks karny. Część szczegółowa. Komentarz*, ed. J.W. Giezek, LEX/el. 2014; A. Marek, *Kodeks karny. Komentarz*, LEX/el. 2010.

[34] For example, see judgment of the Court of Appeal in Katowice of 14 March 2014, II AKa 27/14; judgment of the Court of Appeal in Kraków of 27 February 2014, II AKa 3/14, KZS 2014, no. 4, item 45; judgment of the Court of Appeal in Wrocław of 9 October 2012, II AKa 276/12, KZS 2014, no. 4, item 55.

[35] J. Haberko, *Dopuszczalność…*, pp. 23–36.

[36] B. Jankowiak, A. Gulczyńska, *Wczesna inicjacja seksualna młodzieży – przyczyny i konsekwencje*, "Kultura – Społeczeństwo – Edukacja" 2014, no. 1, pp. 171–187; A. Bartnik, A. Cichowska, *Psychospołeczne następstwa wczesnej inicjacji seksualnej*, "Przegląd Seksuologiczny" 2015, no. 11, pp. 2–6; M. Nieckula, P.I. Jabłońska, A.A. Duda, K. Fecko-Gałowicz, *Inicjacja seksualna wśród młodzieży szkół ponadgimnazjalnych*, "Pielęgniarstwo Polskie" 2019, no. 2, pp. 148–155.

[37] J. Imacka, M. Bulsa, *Ryzykowne zachowania seksualne młodzieży jako czynnik zwiększający ryzyko zakażenia chorobami przenoszonymi drogą płciową*, "Hygeia Public Health" 2012, vol. 47(3), pp. 272–276.

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tion, whether the parent accepting such a state of affairs does not act in a way that threatens the child's welfare, shall be provided.

It is possible to defend the position represented by the authors of the draft stating that the entry into force of the analysed legislative change will have positive social effects and will influence the systematic increase of teenagers' awareness in the area of health and preventive healthcare, it will strengthen the shaping and building their sense of responsibility for their health and life. However, in the light of life experience, it is difficult to accept the argument which states that the introduction of a change, which essentially excludes parental authority in terms of custody and representation, would be supported by the fact that a 15-year-old child, regardless of the state of diagnosis, will "give their parents a positive example with their attitude" by the possibility of independent appointments at a gynecologist-obstetrician or a dermatologist. It is an ideal, but a naive, assumption. The legislator, guided by life experience and assuming the obligation of minors' obedience towards the parents, seems to adopt different reasoning. It is based on the argument included in the provision of Article 95 § 2 of the Family and Guardianship Code in the following words: "and in matters where a minor can independently make decisions and declarations of will, we should listen to the opinions and recommendations of the parents formulated for the minor's best interest", and Article 95 § 4 of the Family and Guardianship Code where it is adopted that the parents should hear the minor out before taking decisions on more important matters concerning them, if the child's mental development, state of health and maturity allow it, and if it is possible, should take into account their reasonable wishes.[38] The project seems to assume a role reversal.

The position is wrong and it is not confirmed *de lege lata* in the applicable law declaring that the lack of consent of the legal representative or the inability to obtain it due to, e.g., the parents' departure may lead, in the case of a minor, to a long-term inability to benefit from the medical care of a professional facility (e.g., gynecologist-obstetrician). Article 32 (3), (6) and (8) of the ADDP is helpful in this regard.[39]

And finally, the argument of a medical appointment in relation to domestic violence or sexual abuse by parents.[40] It is undoubtedly significant, but in this area the arguments were in no way supported by research, and the statement which declares that "the amendment to the act may positively affect the unrestricted access to medical services for persons belonging to this group of minors, and thus improve their life situation, often preventing further harm" is based solely on the belief of

[38] See J. Ignatowicz, *op. cit.*, p. 874.

[39] J. Słyk, *Zezwolenie (zgoda) sądu opiekuńczego na udzielenie świadczenia zdrowotnego małoletniemu pacjentowi (art. 32 i 34 ustawy o zawodach lekarza i lekarza dentysty)*, "Prawo w Działaniu. Sprawy Cywilne" 2016, no. 25, pp. 156–157.

[40] K. Łakomy, *Minor Victim Representation in Cases of Crimes Committed by Family Members in Polish Law*, "Studia Iuridica Lublinensia" 2020, vol. 29(5), pp. 181–196.

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the applicants. It is worth noting that the legal system has protective instruments in this regard and life experience suggests that the child should be supported by an adult and not left alone in such a situation.[41]

CONCLUSIONS

The assumption which is fundamental for the draft of the act, among other factors, is based on the fact that minors, starting to be sexually active, would like to decide about the intimate sphere of life also in the health context. They would like to do it independently without informing their parents. The necessity of changes, regarding the maturity and independence of minors, lowering the age of sexual initiation and greater life experience, as shown by the drafters, is inevitable. It cannot be denied. We should take into consideration the fact that the legal system is a set of interconnected institutions which have not been regulated in one or two legal acts. The change in the provisions on granting consent by a minor must result in a change of the rules for providing information and exercising parental authority, or at least indicating that this type of activity, similar to legal action, falls within the scope of the exceptions. It requires a broader change than the proposal presented in the Sejm Paper no. 1432.

The discussion in this respect must certainly include a number of important arguments. Maintaining the current state *de lege ferenda* as well as lowering the age of becoming an adult do not seem possible. Refining the draft of the act on doctors and dentists professions in the current form of the Sejm Paper no. 1432 may also arise fundamental difficulties, as it was attempted to show in the presented considerations. *De lege ferenda*, the simplest way, which obviously does not mean the best, would be to base the amendment on the assumption of changing Article 32 (3) of the ADDP and adopting the following provision: "If there is a need to examine the person referred to in item 2, the consent to conduct the examination may also be expressed by the actual guardian or the minor who is over the age of 16, provided that the minor acts with sufficient knowledge and the legal representative has previously authorized/approved the admission of the minor by this doctor". The linguistic form requires, as well as specifying the manner of fulfilling the information obligation, an obvious elaboration, but it gives the minor the possibility of both an independent medical appointment and consent to the examination. It allows the legal representative to control the scope of medical appointments. The legal representative would choose both a doctor and decide whether or not the minor can have an independent medical appointment. Obviously, it would have to take place assuming that it is a public healthcare facility, because if it is a private

[41] *Ibidem*.

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healthcare facility, a minor would still be blocked by Article 18 of the Civil Code and lack of independence in concluding a contract with a doctor for the provision of health services. The form of the legal representative's declaration, which the doctor should have at their disposal while securing the evidence in the event of an examination, should be defined. It would also be necessary to specify the method of action in the event of the need to undertake further preventive healthcare or therapy in a situation where, according to medical knowledge and life experience, they should be included among the important matters of the child.[42]

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ABSTRAKT

W artykule analizą objęto zakres samodzielności decyzyjnej małoletniego w ramach procedur medycznych. Jako że dziecko będące pacjentem nie ma faktycznych i formalnych możliwości samodzielnego podejmowania decyzji i wyrażania zgody, system prawny wykształcił instrumenty ochrony zdrowotnego interesu małoletniego, a realizacja zdrowotnego dobrostanu powierzona została rodzicom (przedstawicielom ustawowym). Przepisy obowiązującego prawa zakładają istnienie granic wiekowych dla podejmowania decyzji w ramach sytuacji zdrowotnej pacjenta. Fakt ten spotyka się z krytyką. Przedstawiane są propozycje zmian i obniżenia wieku samodzielności decyzyjnej małoletniego. Autorka analizie poddała założenia projektu zmian ustawy o zawodach lekarza i lekarza dentysty oraz podjęła problem samodzielności małoletniego w procedurach ginekologicznych, dermatologicznych i urologicznych. Rozważania prowadzone są w ramach zarówno polskiego prawa medycznego, jak i prawa rodzinnego, a autorka zarzuca twórcom projektu brak znajomości rozwiązań systemowych oraz zgłasza postulaty *de lege ferenda*.

Słowa kluczowe: zgoda; małoletni; przedstawiciel ustawowy; procedury medyczne