THE LEGAL POSITION OF MINORS IN HEALTHCARE: A COMPARATIVE ANALYSIS OF EUROPEAN JURISDICTIONS

Authors

Marie Goemaere, PhD, Faculty of Law and Criminology, KU Leuven

Ingrid Boone, Full Professor, Faculty of Law and Criminology, KU Leuven

Steven Lierman, Full Professor, Faculty of Law and Criminology, KU Leuven

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I. INTRODUCTION

Both the European Convention on Human Rights and Biomedicine (Article 6) and the UN Convention on the Rights of the Child (Article 12) require that minors' views be taken into account according to their age and maturity. While these instruments establish a shared normative framework, European jurisdictions differ substantially in how they regulate the legal position of minors in healthcare, each reflecting a distinct balance between autonomy and protection.

At present, no up-to-date and comprehensive overview exists of how European jurisdictions regulate consent, confidentiality, and parental involvement in healthcare for minors. To address this gap, we developed and distributed a detailed questionnaire to experts across Europe.

Experts from a total of twenty jurisdictions were participating:

- **EU (17):** Austria, Belgium, Cyprus, Denmark, France, Germany, Ireland, Italy, Latvia, Luxembourg, Malta, The Netherlands, Romania, Slovak Republic, Slovenia, Spain, Sweden
- **Non-EU (3):** England and Wales[1], Norway, Switzerland

Each national expert was asked to complete an in-depth questionnaire and prepare a report outlining the legal position of minors in healthcare in their jurisdiction. The analysis focused primarily on legislation, supplemented where possible by case law and legal doctrine. The collected data were subsequently examined through a systematic comparative mapping approach, resulting in a structured and visual overview of the legal frameworks across the twenty jurisdictions.

The findings reveal a highly fragmented European regulatory landscape. Although all jurisdictions recognise that minors should be involved in healthcare decision-making, they translate this involvement into markedly different legal models.

By offering a structured comparative overview, this report demonstrates how shared children's rights principles take shape in divergent legal solutions across Europe. This report is structured into a series of thematic sections, each accompanied by explanatory comparative maps. The report first examines the rules governing consent to medical treatment, focusing on when a minor's consent is required, whether competent minors may consent autonomously, and whether a distinction is made between consent to and refusal of treatment. It then turns to the role of parents, addressing if parents need to consent together or alone, the resolution of conflicts where parents refuse necessary treatment, the legal framework applicable in emergency situations, and the position of stepparents. A subsequent section analyses the rules on confidentiality, in particular whether and when minors are entitled to confidential care. Finally, the report explores specific categories of medical decision-making —

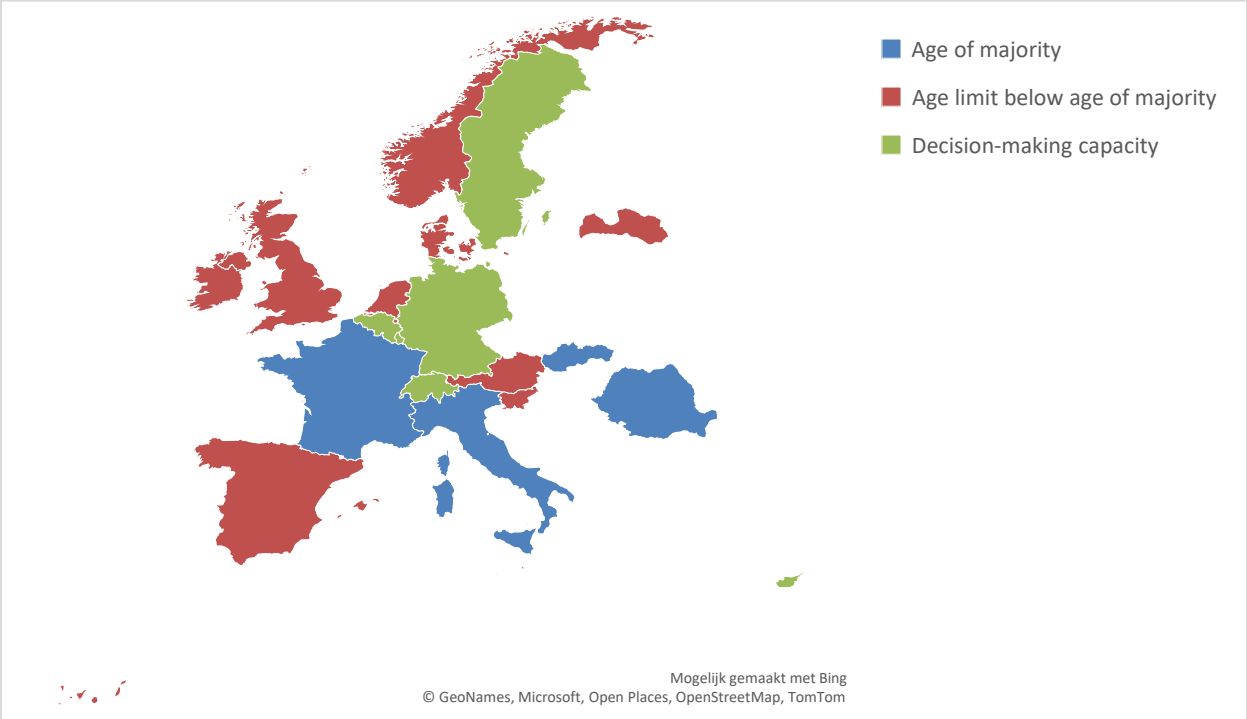
[1] This analysis is confined to England and Wales. Scotland and Northern Ireland fall outside its scope, as they are subject to distinct legal frameworks governing minors' consent to medical treatment. The comparative maps nevertheless depict the entire United Kingdom, due to technical limitations preventing the separate visualisation of England and Wales.

namely abortion, sexual and reproductive healthcare, euthanasia, end-of-life decisions, mental health treatment and cosmetic procedures — in order to assess whether these areas are governed by special regimes that depart from the general legal framework.

II. COMPARATIVE ANALYSIS

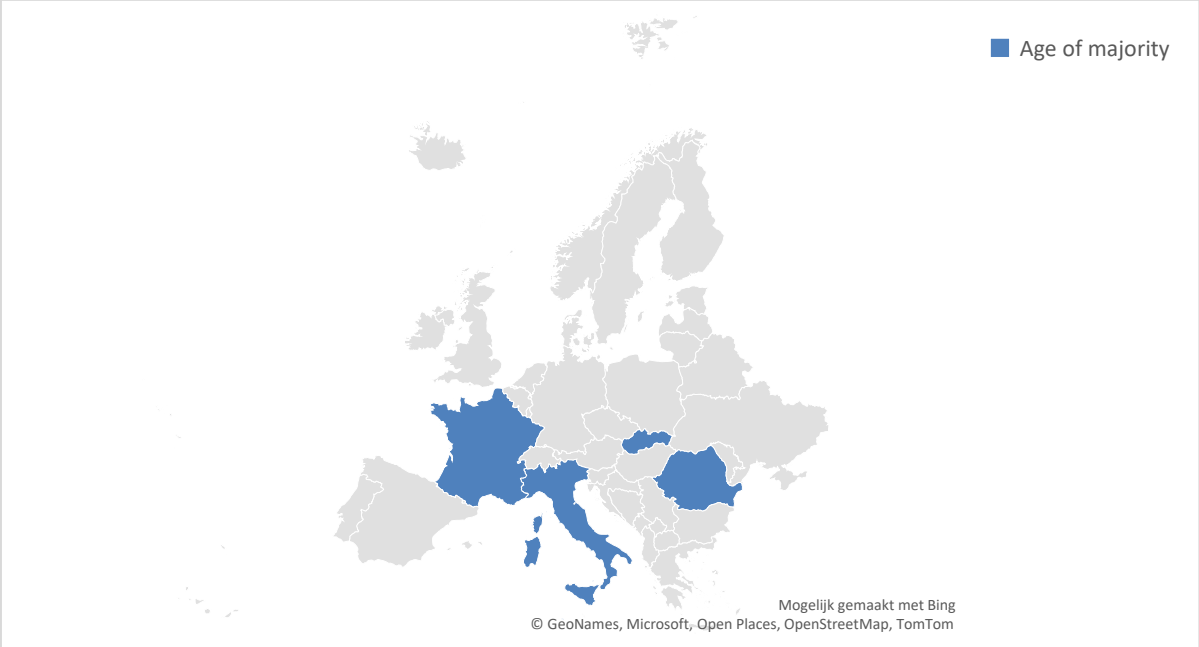
§1. Consent

A. When is a minor's consent required for medical treatment?



The first issue examined is the requirement of a minor's consent for medical treatment. The map distinguishes between three categories: (1) legal systems that require minors to reach the age of majority before they can make medical decisions; (2) legal systems that apply specific age thresholds below the legal age of majority; and (3) legal systems that assess the decision-making capacity on a case-by-case basis.

1. Age of Majority



The first category comprises legal systems that require minors to reach the age of majority before they can make their own medical decisions. This category includes **France, Italy, Romania** and **Slovak Republic**. In these jurisdictions, minors can only give legally valid informed consent once they have reached adulthood. Consequently, parental consent is required until the age of eighteen.

However, this does *not* mean that minors have no role in the decision-making process. In all four jurisdictions, minors must be involved in accordance with their age and level of maturity.

- **France:** Minors have the right to receive information themselves and to participate in decisions concerning them, in a manner adapted to their degree of maturity.
- **Italy**: The views of the minor must be taken into account, particularly where minors over the age of sixteen demonstrate sufficient understanding, enabling them to influence decisions concerning their life and healthcare. The law further provides that minors have the right to receive age-appropriate information about their health in order to express their wishes.
- **Romania** similarly requires that the minor be involved in the decision-making process, with the physician taking the minor's opinion into account.
- **Slovak Republic:** A minor patient is entitled to participate in the decision-making process regarding the provision of health care to a minimal extent, in accordance with his age and mental maturity.

Despite the general requirement of parental consent until the age of eighteen, some exceptions exist:

- **France**: A doctor or midwife may proceed without parental consent where medical care is necessary to safeguard the minor's health and the minor expressly refuses parental involvement in order to maintain confidentiality. The healthcare professional must first encourage the minor to involve their parents. If the minor persists, treatment may proceed without parental consent, provided that the minor is accompanied by an adult of their choice**.**

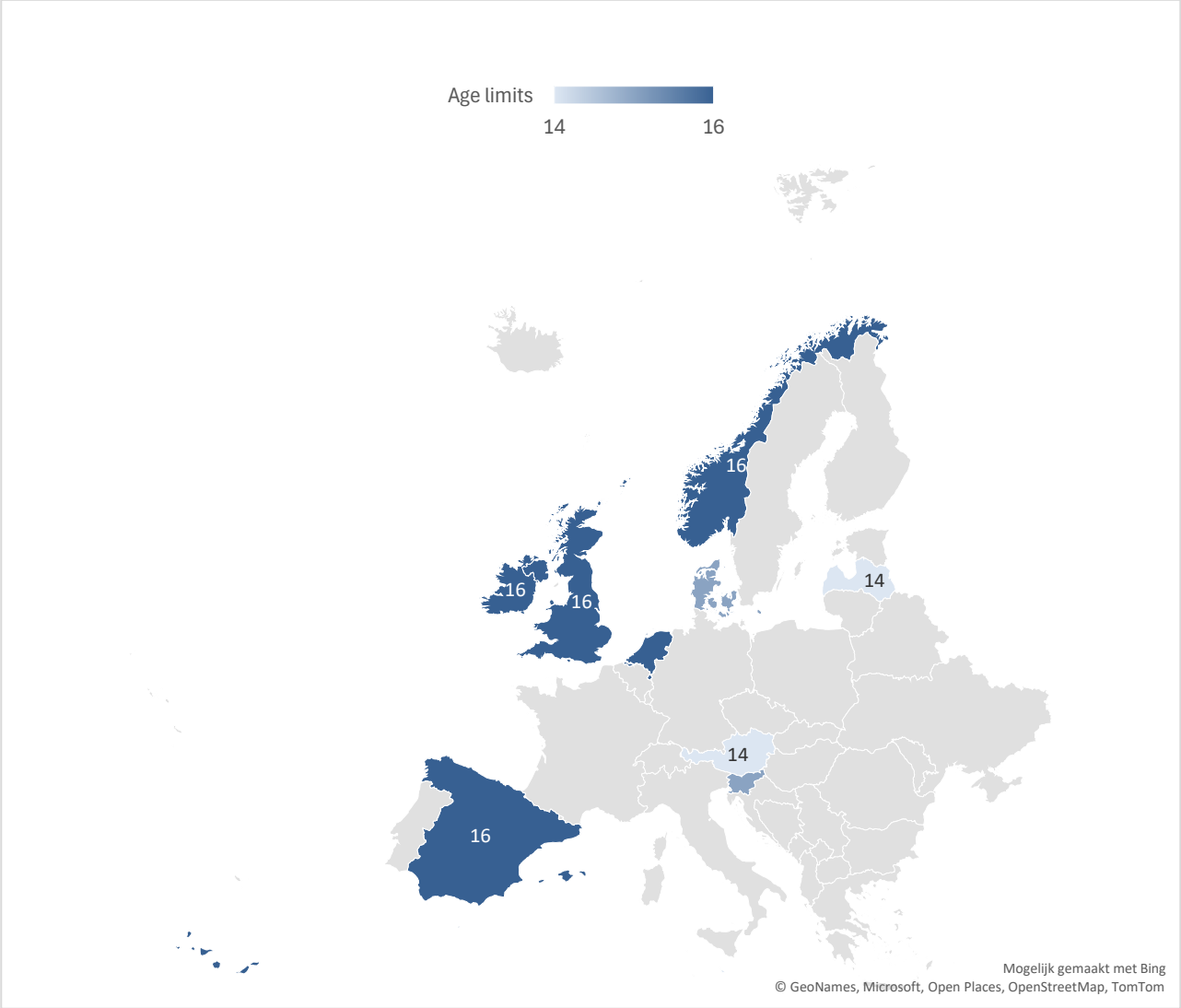
- **Romania** recognises two situations in which a minor may consent autonomously:

    - In emergencies, where parents cannot be contacted and a minor has sufficient discernment to understand their medical condition.

    - In the context of sexual and reproductive healthcare, where the minor is over sixteen years old and explicitly requests confidentiality.

Interestingly, the exceptions to the requirement of parental consent are closely linked to considerations of confidentiality and frequently arise in the context of sexual and reproductive healthcare.

2. Age limits below the age of majority



Legal systems in this second category apply specific age limits below the legal age of majority at which minors' consent to medical treatment is required. At these ages, minors are *in principle* entitled to provide autonomous consent without the requirement of parental consent. This is discussed in more detail in section B on who gives consent for a competent minor.

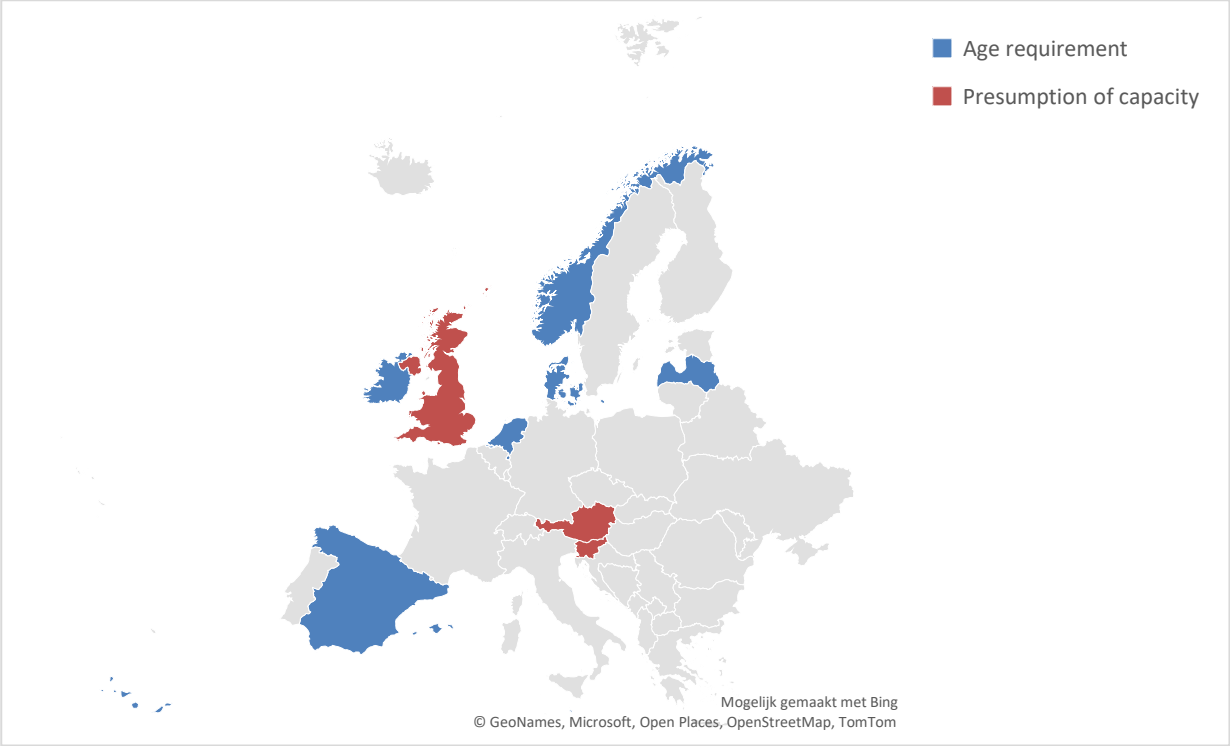
- **14 years**: Austria, Latvia, Malta
- **15 years:** Denmark, Slovenia
- **16 years:** England and Wales, Ireland, Spain
- **Two-tier systems:** Norway and The Netherlands
    - **Norway**:
        - From 16 years**:** Adolescents aged sixteen and above are generally entitled to provide autonomous consent to healthcare, provided they are capable of understanding the nature and consequences of the intervention.

- Between 12 and 16 years: While parents typically retain the right to consent on behalf of the minor, the adolescent may in certain circumstances provide autonomous consent — particularly where the intervention is minor or where involving the parents would not be in the adolescent's best interests.

- **The Netherlands:** Minors aged sixteen and older may give consent autonomously. For children aged twelve to sixteen, a system of double consent applies; both the parents and the child must give consent. Minors under the age of twelve are considered incapable of giving consent for medical treatment.

Importantly, in all these systems, the age threshold operates only as a rebuttable presumption of capacity. Actual decision-making capacity remains decisive. Where a minor lacks such capacity, they cannot provide informed consent.

Within this group of legal systems, a further distinction can be made between (a) legal systems that impose a strict age requirement combined with a capacity assessment, and (b) legal systems that operate on a presumption of capacity from a certain age.



a. Strict age requirement

In these legal systems, minors can only provide consent if they meet both the statutory age threshold and are deemed competent. Below the threshold, consent is not possible, regardless of the minor's actual decision-making capacity.

- **Denmark**: Adolescents aged fifteen have the right to provide informed consent. Minors under the age of fifteen cannot provide legally valid consent, regardless of their level of maturity.

- **Ireland**: Minors aged sixteen and seventeen have a legal right to consent to medical treatment, subject to capacity. Under sixteen, parental consent is required. However, case law suggests that in some circumstances, a minor aged fifteen may be deemed as having the capacity to consent to medical treatment.

- **Latvia**: Medical treatment of a minor from the age of fourteen is permissible if the minor's consent has been obtained. The physician must assess the minor's maturity and ability to understand the information and give informed consent.

- **Malta**: A minor who has attained the age of fourteen may consent to or refuse medical treatment, provided the medical practitioner considers that the minor has sufficient maturity and understanding to do so.

- **Norway**: Adolescents aged sixteen and above may provide autonomous consent, unless they are clearly unable to understand the consequences due to physical or psychological factors. For those aged twelve to sixteen, a more flexible regime applies: while parents generally consent, minors may in certain cases consent autonomously, for example where the intervention is minor or parental involvement is not in their best interests.

- **Spain**: Minors aged sixteen and above may consent to medical treatment. Below the age of sixteen, even if the child demonstrates sufficient understanding, only assent can be given; parental consent remains required, although the child's views must be given due weight.

- **The Netherlands:** Capacity is presumed from the age of twelve. Children under that age cannot be assumed to have a reasonable appreciation of their own interests in relation to medical procedures.

Key implication: If a minor meets the age threshold but lacks decision-making capacity, they cannot provide informed consent. Conversely, a younger minor who has not reached the statutory age cannot provide consent, even if they are factually competent.

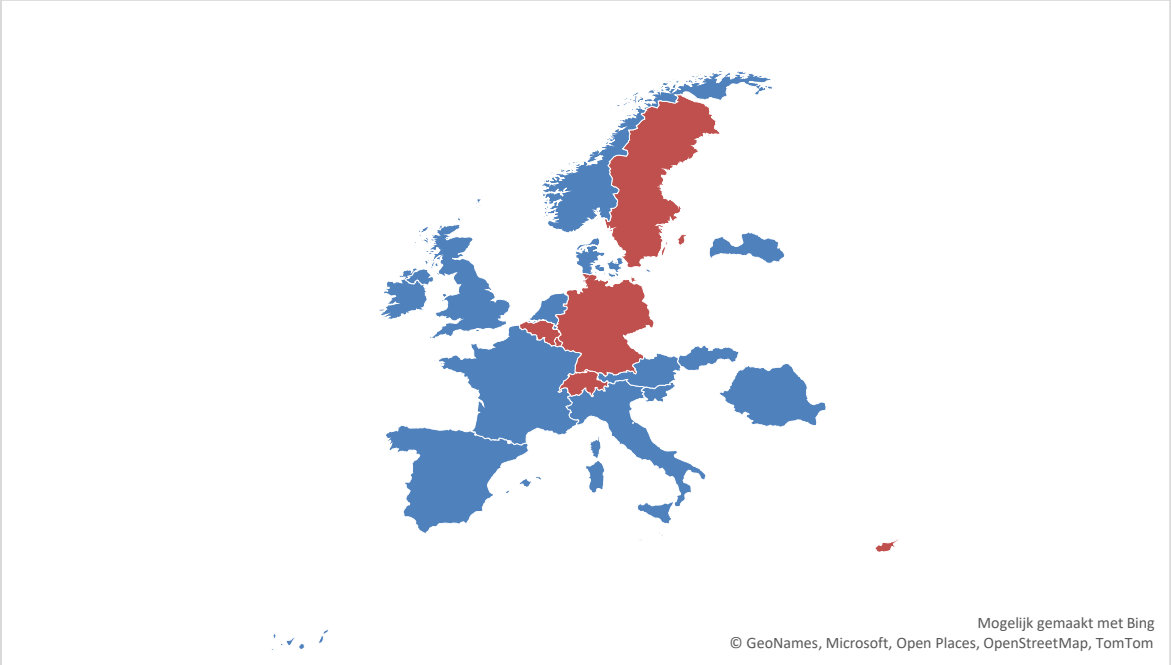
b. Presumption of competence

In **Austria** (14), **Slovenia** (15), **England and Wales** (16) the age threshold functions as a presumption of decision-making capacity rather than a age requirement. Consequently, younger minors may also provide valid consent if they are deemed to possess sufficient decision-making capacity.

For example, in England and Wales minors from the age sixteen are presumed capable of consenting. Under sixteen, minors may still consent if they meet the standard of Gillick competence, meaning they have sufficient understanding and intelligence to fully comprehend the proposed treatment.

Key implication: Unlike age requirement systems, these regimes allow for the possibility that younger minors may consent if they possess sufficient decision-making capacity.

3. Case-by-case assessment



In this third category, whether a minor's consent is required depends on their decision-making capacity, rather than on a fixed age threshold. Unlike age-based systems, these jurisdictions rely on an in concreto assessment of the minor's capacity. This group includes **Belgium, Cyprus, Germany, Luxembourg, Sweden** and **Switzerland**.

Across these legal systems, the decisive factor is whether the minor is considered capable of making an informed decision; where this is the case, the minor's consent is required. No formal age threshold is established. However, important nuances can be identified.

- **Cyprus:** In Cyprus, the law provides that the opinion of the minor must be taken into account as a determining factor, with increasing weight attached in accordance with the minor's age and maturity. Further clarification is offered by the Commissioner for Children's Rights, who has indicated that minors aged sixteen and above should, in principle, be considered capable of making autonomous healthcare decisions, even in the absence of parental consent.

- In **Sweden**, the law provides that, where the patient is a minor, the child's views regarding the proposed care or treatment must be clarified as far as possible and given due weight in accordance with the child's age and maturity. Although the legislation does not establish a fixed age threshold for decision-making capacity, the Parliamentary Ombudsman has indicated that, in practice, such capacity is generally presumed from around the age of fifteen.

A notable feature of several of these jurisdictions, particularly **Germany** and **Switzerland,** is the absence of a specific statutory provision governing medical decisions regarding minor patients.

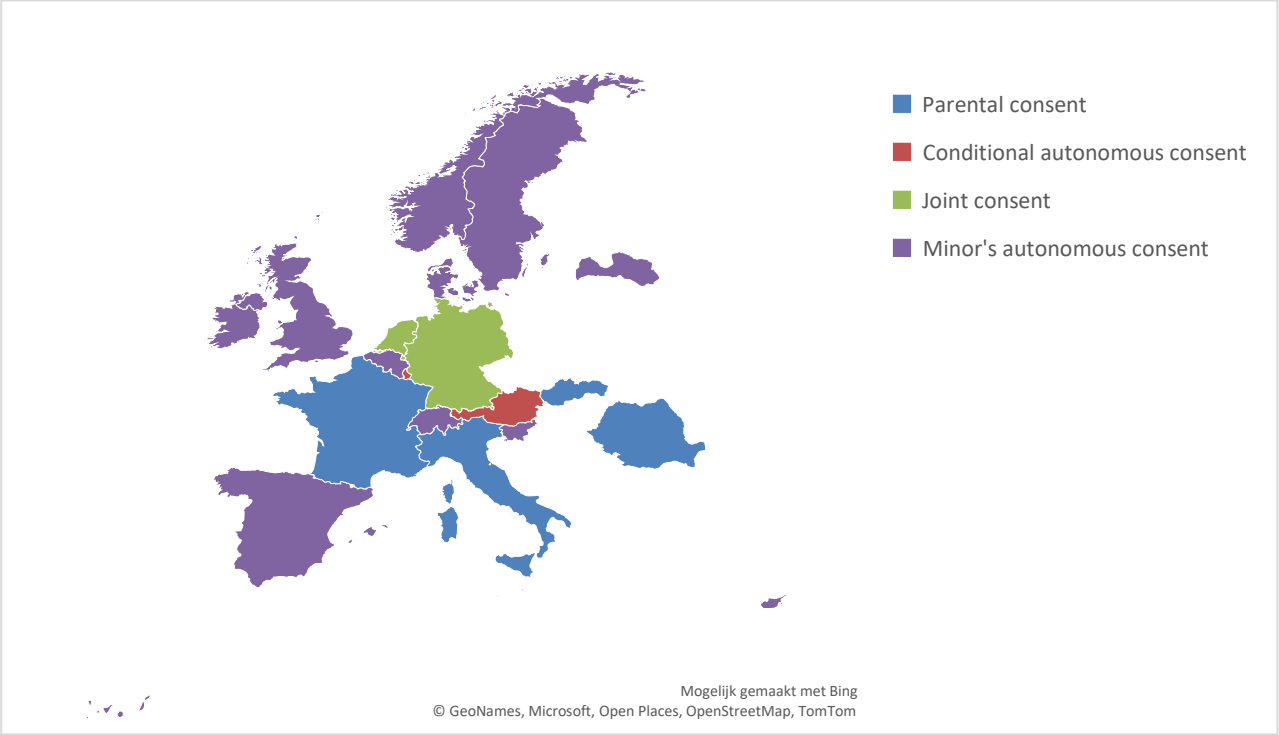
- **Germany:** The German legal framework does not explicitly regulate the position of minors in healthcare decision-making. According to the jurisprudence of the civil courts, a minor's consent is required where the minor is capable of understanding the nature and implications

of the medical intervention and of forming an independent judgment. This approach is derived from the parents' obligation to respect the child's evolving capacities and autonomy.

- **Switzerland:** Similarly, no specific legislation regulates the legal position of minors in healthcare in Switzerland. Consequently, the general framework applies to minors. Healthcare decisions are considered strictly personal rights and do not require the age of majority, but only decision-making capacity. Swiss law has no age limit for decision-making capacity. Following the jurisprudence, a minor with decision-making capacity can exercise strictly personal rights, including the right to decide on his healthcare.

B. Who gives consent for a competent minor?

The fact that consent of the minor patient is required, does *not* always mean they can consent autonomously.



In legal systems that rely on the age of majority, minors are not considered competent to make medical decisions; consequently, parental consent is, in principle, required for the medical treatment of minors. In legal systems that rely on age thresholds or case-by-case assessments, minors are generally granted the right to consent to medical treatment autonomously once they either reach a specified age and/or are considered to possess decision-making capacity.

However, not all legal systems grant minors a right to autonomous consent.

- **Joint consent**
    - In **Germany**, a system of so-called *co-consent* applies. This means that, where a minor is deemed capable, both the minor and the parents must consent to the treatment. This

dual requirement effectively grants the minor a veto right: even if the parents have given their consent, the intervention cannot proceed without the minor's agreement.

- For minors between the ages of twelve and fifteen, **The Netherlands** applies a system of joint consent, meaning that both the minor and the parents must agree to the treatment. From the age of sixteen onwards, minors are generally considered capable of consenting autonomously.

- **Conditional autonomous consent**

  - In **Austria**, competent minors are, in principle, entitled to consent to medical treatment autonomously. However, this autonomy is limited in cases involving particularly serious interventions. For medical treatment usually associated with serious or lasting impairment to physical integrity or personality, the consent of parents is also required.

  - In **Luxembourg** a minor who has attained sufficient discernment *may* exercise their healthcare rights autonomously. The use of the term "may" highlights that this is a discretionary decision of the treating physician. Where such autonomy is granted, only the minor's consent is required. However, even where a minor is considered capable of understanding the treatment and assessing their own interests, the physician may still decide to require parental consent. In such cases, the minor must at least be involved in the decision-making process. This entails seeking the minor's assent, and their views should not be disregarded or overridden. This approach may result in a form of shared or co-decision-making between the minor and the parents.

C. Consent vs. refusal

A further important distinction concerns the difference between a minor's right to give consent and their right to refuse treatment. In several legal systems, this distinction is explicitly recognised and treated differently. This is the case in **Cyprus, England and Wales, Ireland, Italy, Latvia, Malta** and **Spain**.

In these jurisdictions, while a minor may be considered competent to consent to treatment, their refusal of treatment — particularly in serious or life-threatening situations — may be subject to stricter scrutiny and can, in certain circumstances, be overridden. Some examples:

- **Italy**: Where an adolescent demonstrates sufficient discernment, their views must be taken into account. However, if a minor refuses necessary treatment, this decision may be overridden by the parents or by a court, where this is considered to be in the best interests of the child.

- **Latvia**: Under Latvian law, if a minor aged fourteen or older refuses medical treatment, but the treatment is deemed to be in their best interests or necessary to prevent serious harm to their health or life, the minor's legal representative must provide consent on their behalf.

- **England and Wales**: A clear distinction exists between a minor's right to consent and their right to refuse treatment. Even where a minor is considered competent, their refusal may be overridden if the treatment is deemed to be in their best interests. In such cases, parental consent or a court order may authorise the treatment despite the minor's refusal.

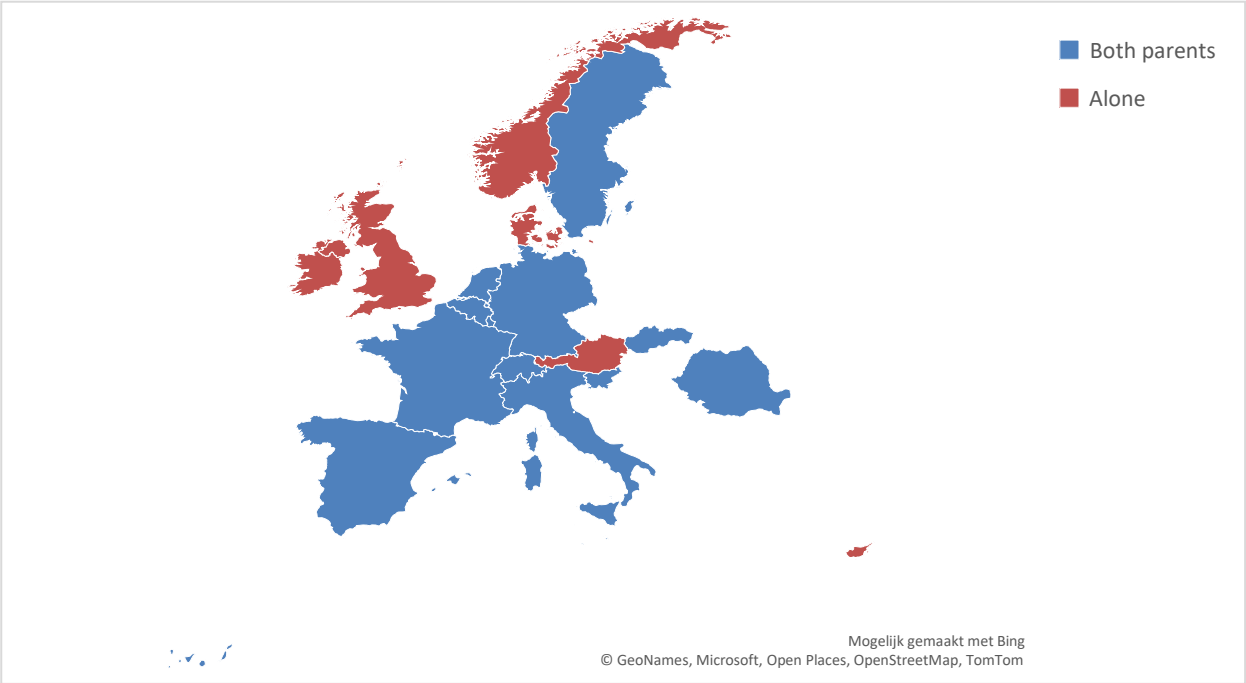
- **Spain** : In cases of serious risk to the life or health of the minor, even where a minor is aged sixteen or seventeen and would normally be able to consent autonomously, parental consent may be used to authorise treatment.

In jurisdictions that rely on an case-by-case assessment of decision-making capacity, there is, in principle, no formal distinction between a minor's right to consent and their right to refuse treatment. However, in practice, a difference may arise. Refusals are often subject to a more stringent assessment of maturity, and the surrounding circumstances tend to be examined with greater care. This approach can be observed in jurisdictions such as **Belgium, Luxembourg,** and **Switzerland**.

In **Norway**, the approach is in some respects the reverse. Minors aged sixteen and above are presumed to have the capacity to consent to healthcare. However, if a minor lacks such capacity, parents or guardians may consent on their behalf. Importantly, even where parental consent is given, healthcare cannot be provided against the minor's opposition, unless specific legal provisions provide otherwise. This means that, in practice, a minor's refusal is given significant weight: treatment generally cannot proceed without the minor's agreement, even where they are not deemed fully competent to consent. A notable nuance applies in the context of end-of-life decisions. Norwegian law recognises the right of a patient to refuse life-prolonging treatment, but this right is limited to patients who have reached the age of eighteen.

§2. Role of the Parents

A. Parents decide together or alone



Where parental consent is required for medical treatment of their child, a key distinction can be made between jurisdictions that require the consent of both parents and those in which consent of one parent suffices.

In the majority of legal systems, consent from both parents is required for medical treatment of a minor. This approach can be found in **Belgium, France, Germany, Italy, Luxembourg, Malta, The Netherlands Romania, Slovak Republic, Slovenia, Spain, Sweden** and **Switzerland**.

In these jurisdictions, there is generally also a presumption of parental agreement. However, in most of these legal systems this presumption is typically limited to routine medical treatments. For more serious or invasive medical decisions, explicit consent from both parents is often required. In contrast, legal systems such as **Belgium**, **Malta** and **Switzerland** do not explicitly distinguish between routine and more serious treatments in their legal framework.

In other jurisdictions, the starting point is that the consent of **one parent** is sufficient to authorise medical treatment. This is the case in **Austria, Cyprus, Denmark, England and Wales, Ireland** and **Norway**. However, even in these systems, important exceptions apply (with the notable exception of **Austria**):

- **Cyprus:** Consent from one parent is generally sufficient for routine or urgent medical care.
- **Denmark:** In principle, consent from one parent is sufficient. However, for decisions of a substantial nature, consent from both parents is required.

- **Engeland and Wales:** Consent from one parent is generally sufficient. However, for more controversial or sensitive decisions, such as vaccinations or circumcision, involvement of both parents is required.

- **Ireland:** Consent from one parent is usually sufficient, unless the parents have requested that both parents are involved in the decision-making process for their child's medical treatment.

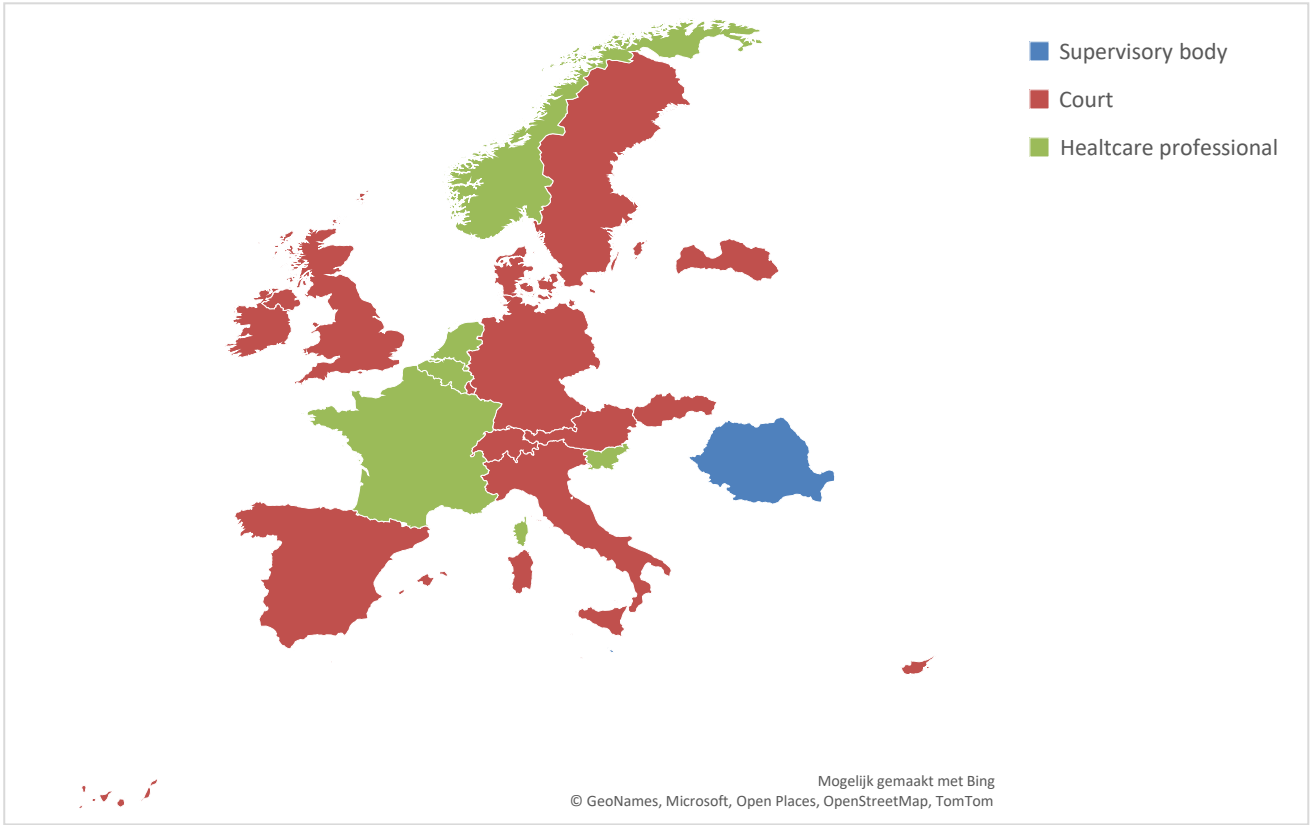
- **Norway:** In cases involving serious, irreversible, or ethically complex interventions, consent from both parents is typically required.

- **Austria:** The Austrian legal system only requires the consent of one parent with custody. The law does not provide for any exceptions in cases involving major or irreversible medical treatments.

Although the legal starting points differ — either requiring one or both parents to consent — many jurisdictions converge in practice. In general, routine medical decisions can often be taken by one parent, while more serious or invasive interventions require the involvement of both parents.

Only a limited number of jurisdictions, such as **Austria, Belgium, Malta,** and **Switzerland**, do not explicitly distinguish between routine and serious decisions in their legislation, although such distinctions may still emerge in practice through interpretation or medical guidelines.

B. Parents refuse necessary treatment



When parents refuse necessary medical treatment for their child, most legal systems require the healthcare professional to seek intervention from a court or judicial authority, which will then decide in the best interests of the child. This is the case in **Austria, Cyprus, Denmark, England and Wales, Germany, Ireland Italy, Latvia, Luxembourg, Slovak Republic, Spain, Sweden** and **Switzerland.**

In some jurisdictions, however, a court is not involved. Instead, a specialised administrative or supervisory body may be competent to take a decision. For example, in **Romania**, such cases may be submitted to a specialised arbitration committee composed of medical professionals (three doctors for inpatients and two for outpatients). In **Malta**, the decision-making authority lies with the Director for Child Protection.

In a smaller number of jurisdictions, the healthcare professional is empowered to override the parents' refusal without prior judicial authorisation. This is, however, typically subject to certain conditions. In jurisdictions such as **France, Norway and Slovenia**, the intervention must be urgent in order to justify proceeding without court involvement. By contrast, in jurisdictions such as **Belgium** and **The Netherlands**, healthcare professionals may, under certain circumstances, proceed with treatment in the child's best interests without an 'urgent'-requirement.

C. Emergencies

In emergency situations, all jurisdictions generally allow healthcare professionals to act without parental consent and without prior court intervention.

Despite this shared core principle, some jurisdictions provide additional procedural nuances:

- **Ireland**: Although there is no explicit statutory provision governing emergencies, guidance from the Medical Council provides that, in such circumstances, healthcare professionals should deliver only the minimum treatment necessary to preserve life or prevent serious harm. Furthermore, they are required to document the reasons for their assessment that immediate intervention was necessary, as well as the steps taken in response.

- **Latvia**: In emergency cases, the decision is taken by a medical council of doctors, and the custody court must be informed.

D. Stepparents

As a general rule, stepparents do not hold legal rights in relation to a child's healthcare. This means that they cannot give valid consent for medical treatment and do not have a right to receive medical information about the child. In many jurisdictions, stepparents can only act if their relationship with the child is formally recognised: guardianship, adoption, or legal custody may confer parental authority, enabling stepparents to make healthcare decisions on behalf of the child.

While stepparents generally lack formal decision-making authority in healthcare matters, many legal systems recognise their practical role in the child's daily life. This has led to the development of flexible legal mechanisms that enable their involvement.

- **England and Wales:** Stepparents can acquire parental responsibility either by agreement with the parent(s) or through a parental responsibility order issued by a court.

- **France**: Stepparents may perform routine acts of daily life with the consent of the parent holding parental authority, particularly when they have been significantly involved in the child's life. Moreover, parental authority may be partially or fully delegated to a stepparent under the Civil Code, subject to judicial approval and provided that this serves the child's best interests.

- **Germany:** A stepparent married to the custodial parent has limited custody rights (*kleines Sorgerecht*). This allows them to participate in decisions concerning everyday matters, including routine healthcare. However, decisions involving serious medical interventions, such as surgery or long-term hospitalisation, remain reserved for the custodial parent.

- **Luxembourg**: The 2018 reform introduced the possibility of granting a mandate for daily upbringing (*mandat d'éducation quotidienne*) to a stepparent. This allows the stepparent to consent to ordinary, routine healthcare decisions as defined by the parents. The scope of the mandate can be specified in advance, which is particularly useful when a child requires ongoing medical care.

- In jurisdictions such as **Belgium**, **Romania**, and **Luxembourg**, stepparents can be appointed as a trusted person, allowing them to receive medical information about the child.

§3. Confidentiality

A. Legal systems in which minors cannot consent autonomously

In legal systems where minors are not entitled to consent autonomously to medical treatment, confidentiality vis-à-vis parents is, as a general rule, not possible. This is the case in **France**, **Germany**, **Italy, Romania** and **Slovak Republic**, where parental consent remains a prerequisite for medical treatment until the minor reaches the age of eighteen. As a result, parents are generally entitled to be informed and involved, which significantly limits the scope for confidential care.

However, several important exceptions can be identified.

In **France**, if a minor wishes to keep their medical treatment confidential from their parents, the doctor may respect this request, provided that the treatment is necessary for the minor's health and the minor has expressly objected to parental consultation or consent. In such cases, confidentiality is preserved vis-à-vis the parents, however the minor must be accompanied by an adult of their choice throughout the care process. Accordingly, confidentiality remains limited, as the parents are excluded but the minor must still be accompanied by a third person.

In **Romania**, confidentiality is recognised in specific contexts.

- First, in the field of sexual and reproductive healthcare, minors aged sixteen and above may explicitly request confidentiality.

- Second, a minor — particularly an adolescent — may request to be treated without the presence of their parents during a medical consultation, even if they were initially accompanied by them. Information disclosed in this context, including sensitive details relating to sexuality, substance use, or other private behaviours, must be treated as confidential and respected accordingly.

B. Legal systems in which minors can consent autonomously

In legal systems that recognise the minor's capacity to consent autonomously to medical treatment, rules on confidentiality generally align with the right to consent. Where a minor is deemed competent to decide autonomously, they will, in principle, also enjoy a corresponding right to confidentiality vis-à-vis their parents.

A widely recognised exception concerns situations in which the health of the minor poses a serious risk to themselves or others. In such cases, healthcare professionals may invoke a state of necessity to justify breaching medical confidentiality in order to prevent harm. This approach can be observed, for example in **Belgium**, **England and Wales** and **Spain**.

At the same time, however, a number of legal systems introduce important nuances to the right to confidentiality of minors.

- In **Denmark**, minors aged fifteen and above have the right to provide informed consent. However, holders of parental responsibility retain a right to be informed and to participate in the decision-making process. This limits confidentiality vis-à-vis parents.
    - Administrative guidelines issued by the Danish Health Authority mitigate this by clarifying that prior consultation with parents is not always necessary, except in cases involving high-risk interventions or particularly complex information (such as cancer treatment). Whether parents should be informed after treatment depends on the circumstances of the case and the minor's maturity.

- **Ireland**: While minors may consult a healthcare professional without parental knowledge or consent, practitioners are generally expected to encourage parental involvement. If the minor refuses and disclosure is considered necessary in the child's best interests, healthcare professionals may decide to inform the parents, provided that they carefully document their reasoning. This reflects a best-interests-based limitation on confidentiality.

- **Norway**: In principle competent minors are permitted to consult healthcare professionals without their parents' knowledge or consent. But information necessary to fulfill parental responsibility shall nevertheless be given to the parents when the patient is under eighteen years old. The minor shall in such situations be informed that the parents will receive information. Such decisions require a careful assessment of the minor's maturity and the nature of the medical issue.

Conversely, the requirement of parental consent is accompanied by a corresponding right to be informed. However, this right is not absolute and is also subject to important exceptions.

- In **Norway**, information must not be disclosed to parents where there are compelling reasons against this in the interest of the minor.

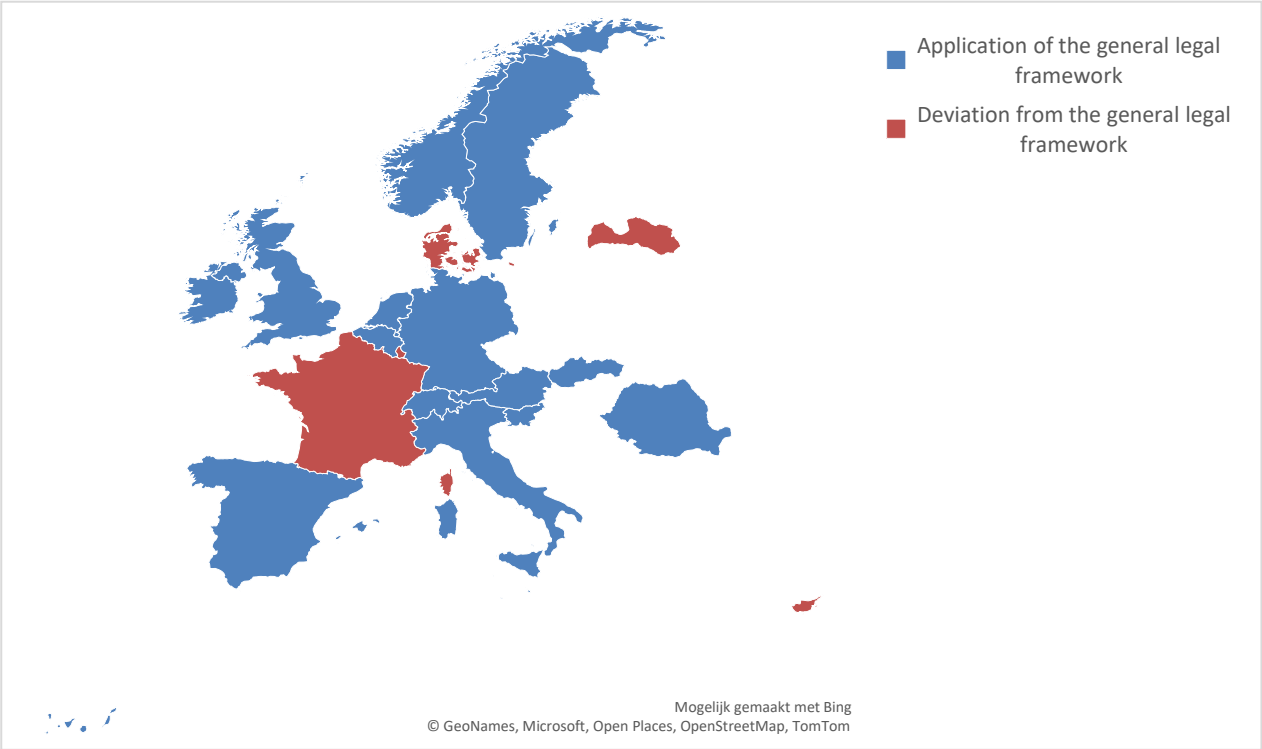
- In **Sweden**, information is generally shared with legal representatives, unless disclosure would be likely to cause significant harm to the child.

- Similarly, in **The Netherlands**, a physician may, on the basis of good care refrain from informing parents, even where such information would normally be required for consent.

Finally, even where confidentiality is recognised in principle, practical constraints may limit its effectiveness. In **Belgium** and **Switzerland**, for example, parents remain responsible for covering medical costs, which may indirectly undermine confidentiality. In certain Swiss cantons, the law explicitly provides that, although a competent minor is entitled to confidentiality, parental consent may still be required for costly treatments. This illustrates how financial and organisational factors can impede the realisation of confidential care in practice.

§4. Specific medical decisions

A. Abortion



In the majority of jurisdictions, the consent regime governing abortion follows the general legal framework applicable to minors' medical decision-making. However, several jurisdictions provide for specific derogations.

- In **Cyprus**, while a competent minor may in principle make medical decisions autonomously under the general legal framework, a written declaration by one parent or legal guardian is required where the pregnant woman is a minor seeking an abortion.

- In **Denmark**, the general obligation to inform holders of parental responsibility does not apply in the context of abortion. Moreover, even minors under the age of fifteen may obtain an abortion without parental consent upon authorisation by an abortion board, where this is deemed to be in the minor's best interests. In such cases, parental notification is excluded.

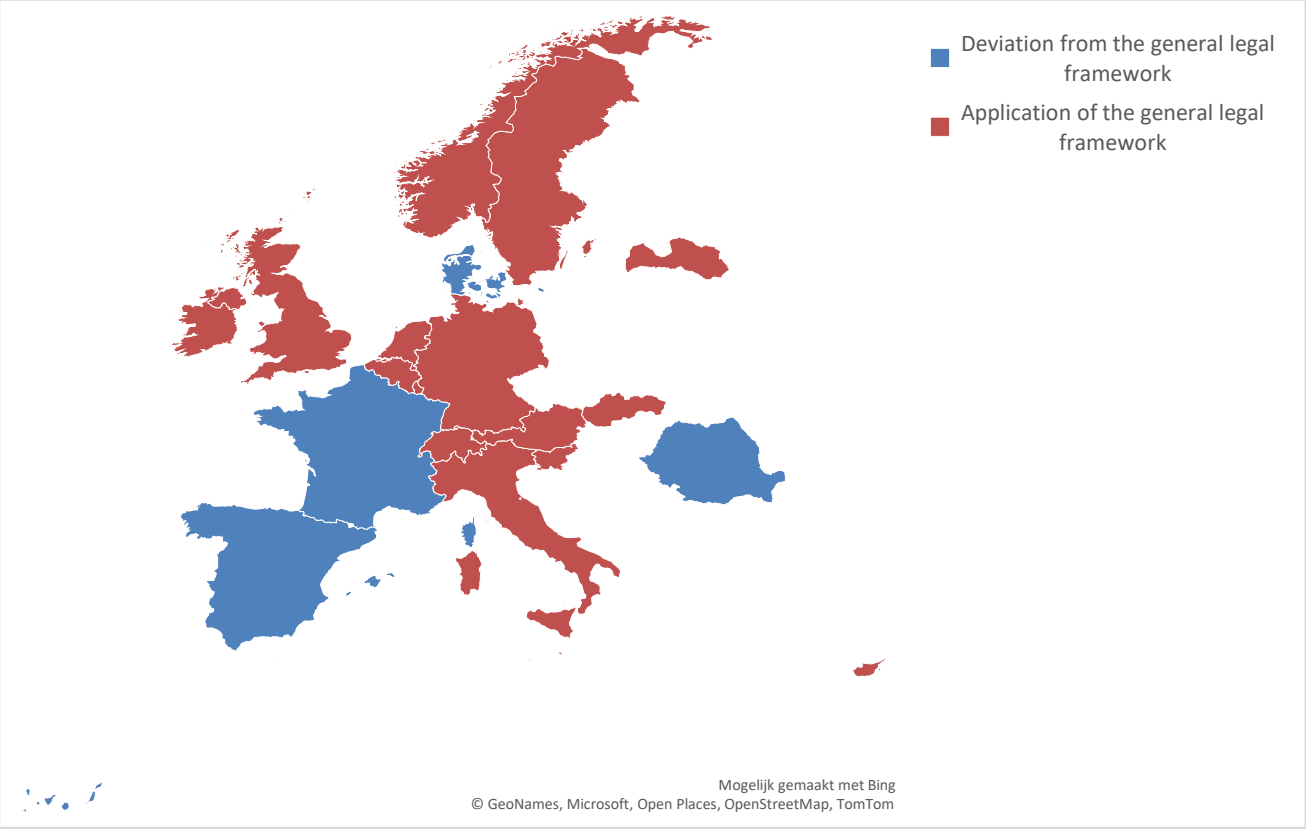
- **France**: Parental consent is required in principle. However, if a minor wishes to keep the procedure confidential, the law permits the abortion to go ahead, provided the minor is accompanied by an adult of their choice.

- In **Latvia**, abortion for minors under the age of sixteen requires both a request by the minor and the consent of at least one parent. This constitutes a deviation from the general legal framework, which permits autonomous consent from the age of fourteen.

- Finally, in **Luxembourg**, the written consent of one parent is generally required for an abortion, in contrast to other medical decisions. However, where the minor wishes to keep the

abortion confidential, the procedure may proceed provided that she is accompanied by a trusted adult of her choice.

B. Sexual and reproductive healthcare



In the majority of jurisdictions, the consent regime governing sexual and reproductive healthcare follows the general legal framework applicable to minors' medical decision-making. However, several jurisdictions provide for specific arrangements in this field, often aimed at facilitating access to care and safeguarding confidentiality.

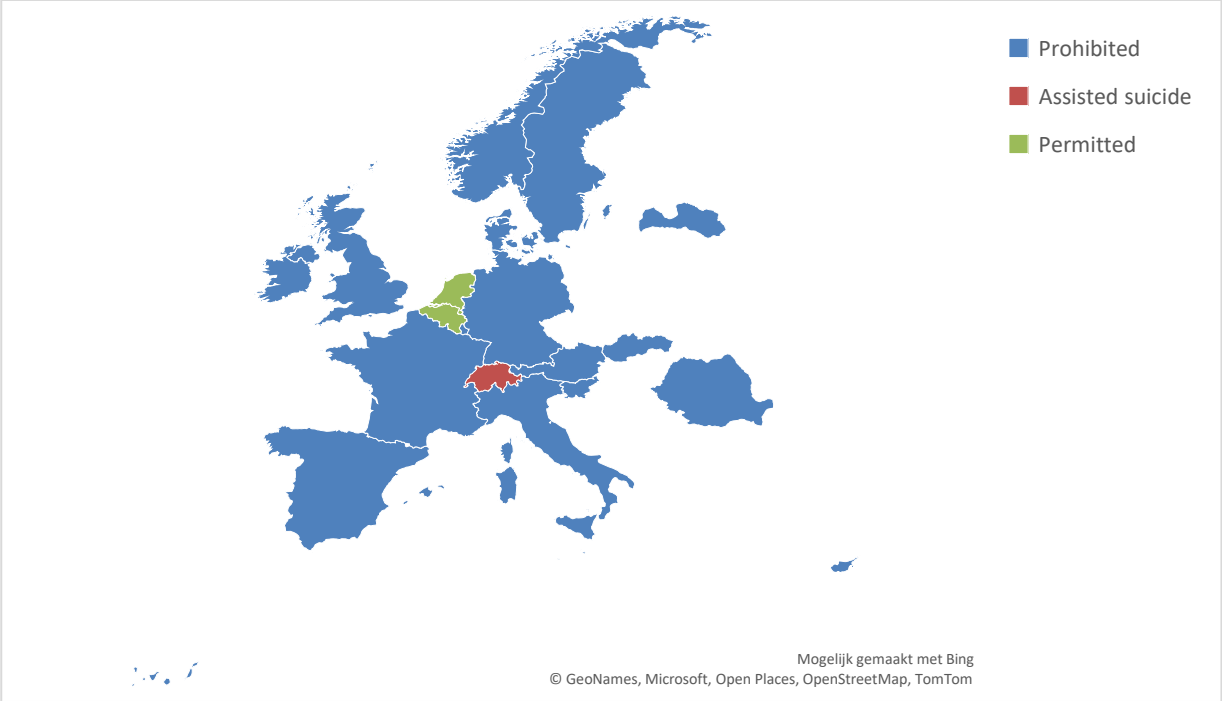
- In **Denmark**, minors under the age of fifteen may receive confidential *guidance* on contraception. However, this exception is limited in scope, as it does not extend to the prescription of contraceptives, which remains subject to the general rules.

- In **France**, parental consent is not required for the prescription, provision, or administration of contraceptives to minors, thereby creating a clear exception to the general consent regime.

- In **Spain**, the general legal framework provides that minors aged sixteen and above may consent to medical treatment. In practice, however, access to contraception is more flexible. Minors under sixteen may also be granted access where they are deemed sufficiently mature. Although parental consent is, in principle, required for minors under sixteen for prescription medication or more invasive interventions, sexual health services often operate with a degree of confidentiality. This practice is supported by national policy frameworks that emphasise accessibility and confidentiality in order to prevent minors from avoiding necessary care.

- **Romania**: a minor may consent autonomously in the context of *sexual and reproductive* healthcare, where the minor is over sixteen years old and explicitly requests confidentiality.

C. Euthanasia and assisted suicide



In most jurisdictions, euthanasia and assisted suicide is prohibited for minors. Only a limited number of jurisdictions provide for exceptions.

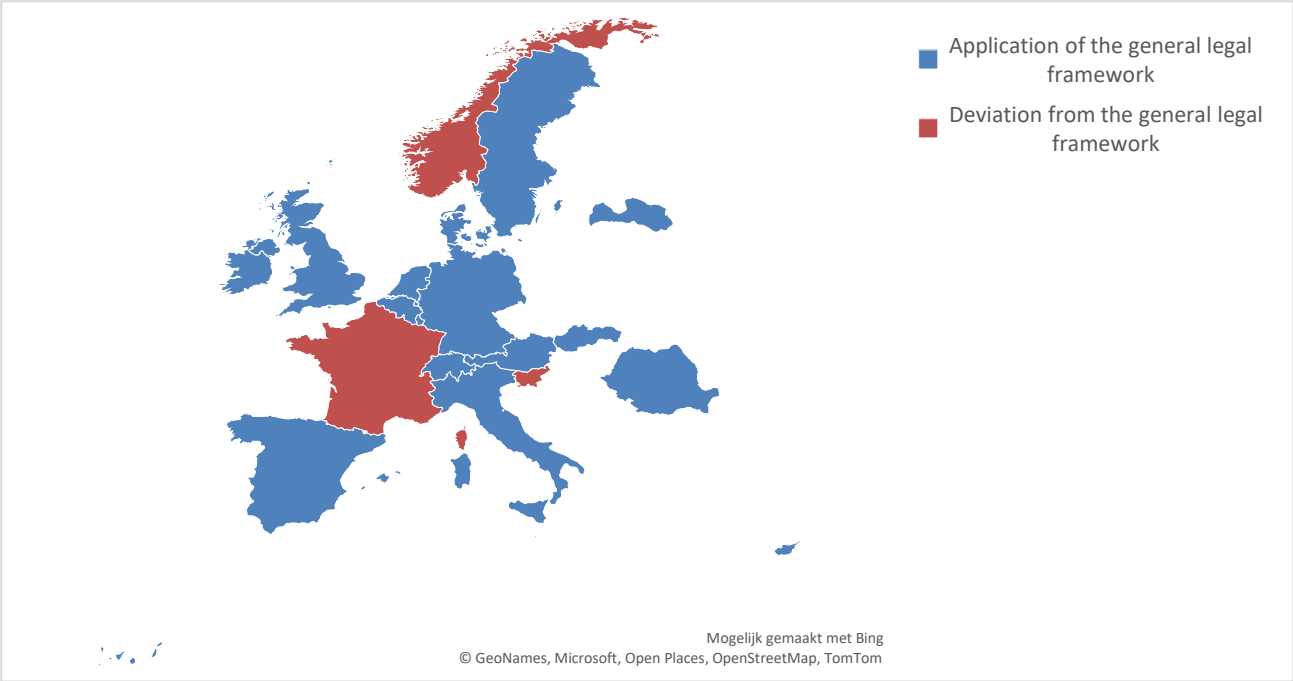
In **Belgium**, euthanasia is also available to minors, but under particularly strict conditions. Only minors who are deemed capable of discernment may submit a request, and they must be in a medically hopeless situation involving constant and unbearable physical suffering resulting from a serious and incurable condition, with death expected in the foreseeable future. Crucially, the law requires dual consent: both the minor and the parents must provide written consent. The parents thus retain a de facto veto, meaning that euthanasia cannot be carried out without their agreement, even where the minor is considered capable.

In **The Netherlands**, minors aged sixteen to eighteen who possess decision-making capacity may request euthanasia under the same criteria as apply to adults. While their legal representatives must be involved in the decision-making process, their consent is not required. By contrast, for minors aged twelve to fifteen, both the consent of the minor and that of the legal representatives is required, and euthanasia cannot be carried out without it. Minors under the age of twelve are deemed incapable of making such a request under the law and are therefore excluded from access.

By contrast, in **Switzerland**, euthanasia is prohibited, but certain forms of *assisted suicide* are permitted. In the absence of a specific legal framework for minors, the general regime applies. Assisted suicide is lawful provided that the individual has decision-making capacity, administers the lethal act themselves, and the caregiver does not have a selfish motive. Professional guidelines issued by the Swiss Academy of Medical Sciences explicitly extend to children and adolescents, recognising

their ability to express a wish to die. Given the sensitivity of such situations, conflicts with legal representatives may arise; in such cases, dialogue is required, and, if necessary, the competent child protection authority must be involved. To date, however, no reported cases of assisted suicide involving minors have occurred.

D. End of life decisions



In the majority of jurisdictions, the consent regime governing end-of-life decision-making for minors follows the general legal framework applicable to medical treatment. Nevertheless, several legal systems introduce specific rules in situations involving end-of-life decisions.

In **France**, end-of-life decisions are typically reached through a process of medical consensus. However, in cases of disagreement, the medical team may decide to withdraw or withhold treatment where continued intervention would amount to "unreasonable obstinacy". While the parents must be consulted, their consent is not required.

In **Norway**, end-of-life decision-making is governed by specific legislation. The law grants competent adult patients the right to refuse life-prolonging treatment on grounds of strong personal convictions, including refusal of blood transfusions or continuation of a hunger strike. However, this right is explicitly limited to individuals over the age of eighteen.

In **Slovenia**, a competent individual has the right to refuse a proposed medical procedure or healthcare treatment, unless such refusal would endanger live or cause significant harm to the health of others. Where the treating physician considers that the patient's decision is contrary to their best medical interests and may endanger the patient's life or lead to severe and irreversible deterioration of their health, the physician is required to attempt to persuade the patient of the necessity of the procedure. If necessary, the physician may involve close family members or advise the patient to seek a second

opinion. This implies that the healthcare professional may, in such circumstances, depart from the minor's right to confidentiality.

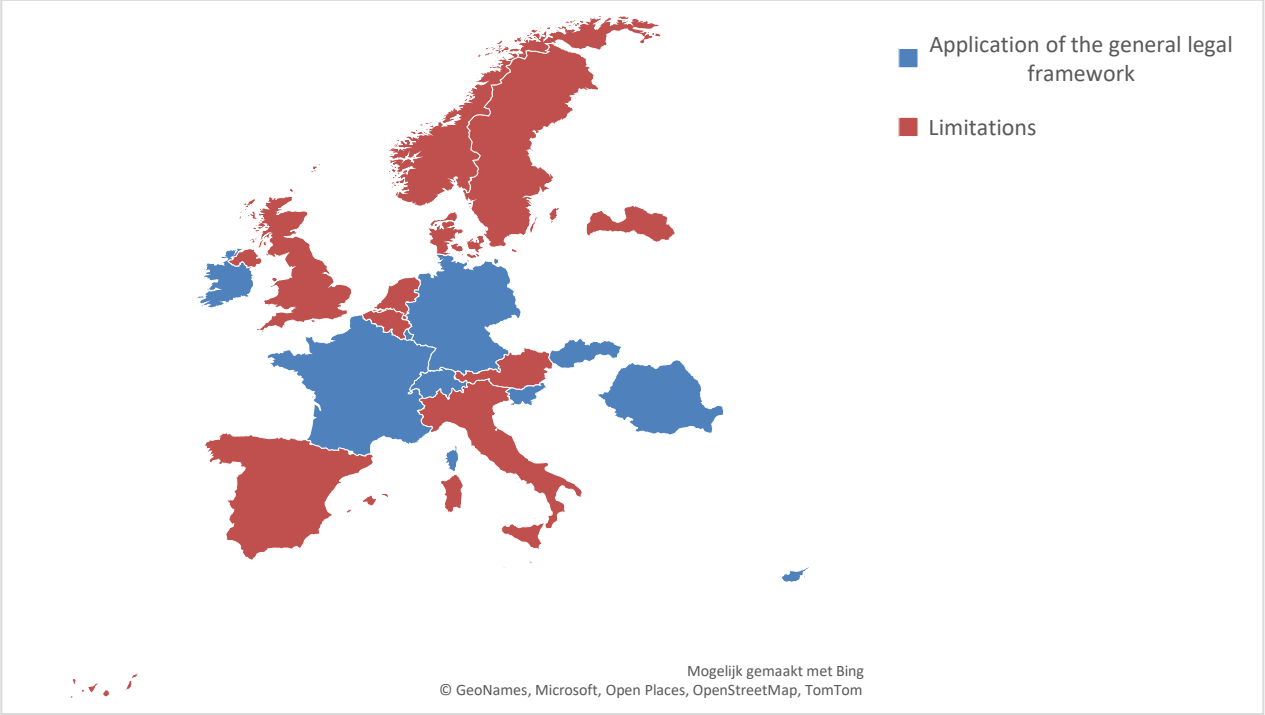
As noted above, a number of jurisdictions **distinguish** between the competence to **consent** to treatment and the competence to **refuse** it. This distinction is particularly relevant in the context of end-of-life decision-making. In such systems, a minor's refusal of life-sustaining treatment may be overridden where this is considered to be in the child's best interests. This approach can be observed, for example, in **England and Wales, Italy, Latvia** and **Spain.**

E. Mental Health

For voluntary mental health treatment, such as psychological counselling, most jurisdictions apply the same rules as those governing the general legal framework for medical treatment. An exception can be found in **Malta**. Under the Mental Health Act, where, in the opinion of the responsible specialist, a minor has sufficient maturity and understanding to consent to treatment, no treatment or care shall be given to the minor unless the minor consents to it. This approach does not rely on the fixed age threshold applicable to general medical treatment (fourteen years), but instead requires a case-by-case assessment of the minor's maturity and capacity.

A significant proportion of the national reports also address involuntary treatment. In this context, it is clear that all jurisdictions implement additional safeguards, which often mirror those applicable to adults. These safeguards usually comprise substantive and procedural conditions designed to protect the autonomy of minors, with some jurisdictions extending this to include mandatory judicial oversight or intervention (see **Belgium, France, Germany, Ireland, Italy, Luxembourg** and **Switzerland**).

F. Cosmetic medical procedures



When it comes to cosmetic medical procedures, the majority of legal systems deviate from the general legal framework by introducing specific restrictions that limit minors' access to such interventions.

- In **Austria**, the general age of medical decision-making autonomy is fourteen. However, the Aesthetic Surgery Act establishes a stricter regime for cosmetic procedures. Cosmetic treatment or surgery is prohibited for persons under the age of sixteen. For those aged sixteen and over, such procedures are only permitted with the written consent of both the individual and their legal guardian, and following an assessment by a specialist to rule out any underlying mental disorder.

- In **Belgium** cosmetic procedures are legally permitted for minors but may only be performed with the written consent of the minor's legal representatives. Before a cosmetic procedure, a mandatory consultation must take place involving the minor, the legal representatives, and a specialist in psychiatry or a psychologist.

- In **Denmark**, cosmetic procedures are generally prohibited for individuals under the age of eighteen, with the exception of dental treatments, which remain subject to the ordinary consent rules applicable to minors.

- In **England and Wales**, it has been a criminal offence since 2021 to administer botox or fillers to individuals under the age of eighteen.

- In **Italy**, non-essential or high-risk procedures are, in principle, prohibited for minors unless they are medically justified.

- In **Latvia**, parental consent is required for high-risk beauty treatments, with at least one parent having to approve the intervention.

- In **Norway**, the Health Personnel Act establishes a general prohibition on cosmetic procedures for persons under eighteen years old, unless the intervention is medically or dentally indicated.

- In **Spain**, although the general legal framework may allow mature minors aged sixteen and above to consent to medical treatment, in practice plastic surgeons typically require parental authorisation for cosmetic surgery, relying on professional and ethical considerations.

- in **Sweden**, the Act on Aesthetic Surgical Procedures and Aesthetic Injection Treatments provides that aesthetic surgical procedures and injection treatments may not be performed on persons under the age of eighteen.

- In **The Netherlands**, although no specific statutory provision prohibits cosmetic procedures for minors, professional standards under the Quality Framework for Cosmetic Care effectively restrict such treatments to individuals aged eighteen and above.

III. CONCLUSION

The findings reveal a highly fragmented European regulatory landscape. Although all jurisdictions recognise that minors should be involved in healthcare decision-making, they operationalise this principle through markedly different legal models. Three main approaches can be identified: legal systems that rely on the age of majority, systems that introduce specific age thresholds below the age of majority, and systems that assess decision-making capacity on a case-by-case basis. Furthermore, significant variations exist within these models, particularly with regard to the autonomy granted to minors, the extent of parental involvement, and the distinction between consenting to and refusing treatment. The resulting landscape reflects not only fragmentation, but also underlying normative choices regarding the balance between autonomy and protection.

By systematically mapping these variations across twenty jurisdictions, this study provides a nuanced comparative framework that moves beyond simplified or binary classifications. It not only demonstrates where legal systems diverge, but also how they respond to similar underlying tensions through different legal mechanisms. In doing so, it provides a structured basis for further reflection on best practices, legal coherence and the evolving role of minors in healthcare decision-making.

A key limitation of this mapping exercise is that it focuses primarily on the formal legal frameworks in the selected jurisdictions. It does not systematically assess the extent to which these legal rules are consistently reflected in clinical practice. Consequently, potential discrepancies between the law in the books and the law in action are beyond the scope of this analysis and require further empirical investigation.