

## Chapter 8 Children's Health Matters in Custody Conflicts: Best Interests of the Child and Decisions on Health Matters

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### Abstract

This chapter addresses conflicts of interest that might arise when there are ongoing custody disputes and, in particular, how legal instruments can be used where parents disagree regarding a decision concerning a child's health. When a child is younger than 16 years, their parents must, as a rule, give consent regarding health matters. The child has a right, however, to be heard, and the parents must act in the best interests of the child. Through the analysis of several potential scenarios, the authors discuss, from a Norwegian legal context, whether parents in conflict are in fact *able* to act in the best interests of the child, and whether the child's right to participation is respected. The authors conclude that the limited legal or other tools provided to parents and/or health institutions can lead to sole custody being the only way to resolve the disagreement. However, the authors also point out the dilemma in cases where the custody dispute or the parental conflict is the *reason* behind the child's need for treatment.

**Keywords:** Health decisions, parental conflict, participation rights, consent, Norwegian health legislation

### 8.1. Introduction

A conflict between parents can cause both psychological and physical health problems for their children.<sup>1</sup> It can also lead to a situation where the parents are unable to cooperate on decision-making in the best interests of the child—irrespective of whether the child's health problems result from the family conflict or other sources. Ultimately, conflicts concerning the

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<sup>1</sup> Cf Anna Norlén, 'Children's health matters in custody conflicts – What do we know?' in Anna Kaldal, Agnes Hellner and Titti Mattsson (eds), *Children in Custody Disputes: Matching Legal Proceedings to Problems* (Palgrave 2023).

health-care of a child can result in a custody dispute, where parents file for sole custody.<sup>2</sup> With this in mind, our main question is: how should legal instruments be used to reach a decision concerning a child's health when the parents disagree?

In this article, we present current Norwegian legislation and discuss how children's and parents' rights are balanced when the parents are in conflict and the child needs healthcare. This situation presents different scenarios depending on:

- the severity of the medical intervention and its potential consequences;
- the child's age and maturity;
- the consistency of the child's view regarding the medical intervention; [and](#)
- ~~and~~ the nature of the family conflict.

Therefore, we present four scenarios and explore current legal challenges using these examples. There is an underlying question of whether current legislation is more family-oriented than child-oriented and, if so, whether the child's right to healthcare, under Article 24 of the Convention on the Rights of the Child (CRC), is challenged.<sup>3</sup>

These questions are rarely presented before the Norwegian courts or any other conflict-resolving bodies, due to the character of Norway's decision-making system in healthcare situations.<sup>4</sup> The overall purpose of this article is to visualize the complexity of the legislation in this area, and to emphasize that these are difficult legal questions. Further, the intention is to show how little attention is paid in legislation to differing opinions between parents about health matters concerning their children, and to highlight the fact that parents and children do not necessarily have concurrent interests and views. Consequently, this system may have harmful effects for children.

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<sup>2</sup> See for example, Annika Rejmer, 'Custody Disputes from a Socio-Legal Perspective' in Anna Kaldal, Agnes Hellner and Titti Mattsson, *Children in Custody Disputes: Matching the Legal Proceedings to Problems* (Palgrave 2023).

<sup>3</sup> The UN Convention on the Rights of the Child (CRC) adopted by the General Assembly 20 November 1989. Committee on the Rights of the Child, *General Comment no. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)* (17 April 2013) CRC/C/G.

<sup>4</sup> For more details, see Karl Harald Søvig, 'Reviewing Medical Decisions Concerning Infants within the Norwegian Healthcare System; A Public Law Approach' in Imogen Goold, Cressida Auckland and Jonathan Herring (eds), *Medical Decision-Making on Behalf of Young Children. A Comparative Perspective* (Hart Publishing 2020) 259–268.

## 8.2. Method Used, Structure of the Contribution, and Main Findings

The article begins by presenting current Norwegian legislation on health matters. The interpretation is based on the wording of the provisions, the preparatory works, relevant literature, and basic principles in child law (the best interests of the child, Article 3 CRC; the right to life and development, Article 6 CRC; participation rights, Article 12 CRC), and health law (availability, accessibility, acceptability, equality, agency, accountability, and quality).<sup>5</sup> The nature of the Norwegian system means that there is a lack of relevant case law for reference in this area.

The remainder of the chapter is structured as follows: After an introduction to the legal system and relevant legal provisions, is a discussion of our main questions based on the scenarios. These are arranged according to the seriousness of the health matters involved. Using the example scenarios, the article analyses the main findings in the light of the general principle of participation rights. The main finding is that the set of rules is complicated, and partly inaccessible; top legal competence is needed to comprehend the rules, yet it is health personnel, children, and parents who are supposed to apply them. The lack of a suitable conflict resolution system can cause harm or unnecessary risk to children's health, and ultimately, escalate parental conflicts.

## 8.3. Relevant Norwegian Legislation

Article 104 of the Norwegian Constitution<sup>6</sup> is intended to safeguard children's human rights. It includes the four principles from the CRC and a reference to an obligation to ensure that children receive necessary healthcare.<sup>7</sup> The European Convention on Human Rights (ECHR) and CRC are incorporated into Norwegian law; consequently, the state has undertaken clear

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<sup>5</sup> World Health Organization, "Advancing the Right to Health: the Vital Role of Law" (2016) <http://www.who.int/iris/handle/10665/252815> accessed 25 February 2023; Asbjørn Kjønstad, "Twelve main Principles in Norwegian Health Law" (2010) *Retfærd* 60–78.

<sup>6</sup> Constitution of the Kingdom of Norway 17 May 1814.

<sup>7</sup> Report from the Human Rights Commission to the Presidium of the Parliament on Human Rights in the Constitution, 19 December 2011 (Dokument 16) Sections 32.5.2–32.5.6; Trude Haugli, 'Constitutional Rights for Children in Norway' in Trude Haugli, Anna Nylund, Randi Sigurdson and Lena R L Bendiksen (eds), *Children's Constitutional Rights in the Nordic Countries* (Brill Nijhoff 2019) 39–57. The wording is 'health security' in the Norwegian Constitution 104.

obligations to secure both the rights of the child and the parents' right to respect for their privacy and family life, Article 8 ECHR.<sup>8</sup> Until the child reaches the age of maturity, the parents have the right and duty to make decisions in personal matters on the child's behalf.<sup>9</sup> Still, Norwegian law is built upon the principle of the evolving capacity of the child. According to the Norwegian Act Related to Children and Parents (Children's Act), the child has a right to co-determination: parents shall, as and when the child becomes able to form their own point of view on matters that concern them, consider the child's opinion before deciding on the child's personal situation.<sup>10</sup> Importance is attached to the opinion of the child according to their age and maturity. The same applies to other persons with custody of the child or who are involved with the child.

Children aged seven and younger, who are able to form their own points of view, must be provided with information and opportunities to express their opinions before decisions are made concerning personal matters affecting the child, including parental responsibility, custody, and contact rights. The opinions of the child shall be given due weight according to their age and maturity, thus the opinions of children aged 12 and above, carry significant weight.<sup>11</sup>

Regarding children's right to decide for themselves, parents shall steadily extend the child's right to make their own decisions as they get older and until they reach the age of 18.<sup>12</sup> Specific age limits have been set for self-determination in various areas, including education, religious matters, using the internet and social media, and for the child as a consumer. Health is one area where there is a specific regulation, and this is the topic for the following text. However specific such rules may be, they must be read in the light of the general principles stated in the Children's Act.

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<sup>8</sup> European Convention on Human Rights and UN Convention on the Rights of the Child.

<sup>9</sup> Norwegian Act related to Children and Parents (Children's Act) Section 30 Subsection 1.

<sup>10</sup> Children's Act Section 31 Subsection 1.

<sup>11</sup> Section 31 Subsection 2 Children's Act.

<sup>12</sup> Section 33 Children's Act.

In health matters, with a few exceptions, the age of maturity in Norwegian law is 16 years.<sup>13</sup> Even if children younger than 16 have reached a sufficient level of maturity to decide for themselves, the competence to decide lies with the parents. However, the child's maturity is a factor to be considered when parents or health personnel determine the weight of the child's opinion. In this text, we concentrate on children younger than 16; there is a potential conflict for this group between the child's right to the highest attainable standard of health, Article 24 CRC and Patient and Service User Rights Act (PRA),<sup>14</sup> and the parents' right and duty to make decisions on the child's behalf, keeping in mind the principle of the evolving capacity of the child, Article 5 CRC.

The parental right to consent to or refuse healthcare on behalf of their child deviates from the general rule in Norwegian legislation, which stipulates that the individual who is to receive healthcare shall provide informed consent before receiving this care. This principle<sup>15</sup> is linked to ethical and legal aspects, including the right to respect for human dignity and bodily integrity and the right to respect of private life—all core values in human-rights legislation.<sup>16</sup> Moreover, healthcare is easier to provide and often more efficient when the patient is well informed and wishes to receive the treatment.

For the child to be able to express their view and have an influence in these matters, it is crucial for them to receive information adapted to their age and maturity. Children's general right to participate may be constrained by the fact that, in Norwegian legislation, their right to information is not very clear. The main problem is linked to the law's ambiguity regarding who is responsible for informing the child: is it the parents or health personnel? Another challenge is the lack of an official system to ensure that children have their say.

In Norway, most parents have joint parental responsibility, even if they are not living together. Thus, both have the right to receive relevant information from health personnel and, as a rule,

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<sup>13</sup> Section 4-3 Subsection 1 Norwegian Patient and Service User Rights Act

<sup>14</sup> Section 2-1 b Subsection 2 Patient and Service User Rights Act.

<sup>15</sup> Section 4-1 Patient and Service User Rights Act.

<sup>16</sup> Jonathan Herring, *Medical Law and Ethics* (3rd edn, Oxford University Press 2010) Chapter 1, Item 6 and 7; Henriette Sinding Aasen, *Pasientens rett til selvbestemmelse ved medisinsk behandling* (Fagbokforlaget 2000) 43–44.

the right to give their consent to medical treatment.<sup>17</sup> Even if the parents are in conflict, they are generally expected to be able to set aside their personal conflicts and act in the best interests of the child regarding health matters.<sup>18</sup>

#### 8.4. Four Scenarios

##### *Scenario 1: Healthcare as [a](#) Part of Daily Care – Consent From Only One Parent*

***Maria** is six years old and has lived with her mother since her parents divorced two years earlier. Her parents have a high conflict level. Maria stays with her father every second weekend. During one such stay, she has an accident and sustains a deep cut on her knee.*

Consent from both parents is not required in all situations. If the child needs healthcare that is regarded as a part of the daily care of the child, consent from one parent is sufficient.<sup>19</sup> Whether the parents have joint parental responsibility is not at issue here. When Maria stays with her father, he is obliged to provide for her wellbeing.<sup>20</sup> Accordingly, when the decision cannot be postponed, Maria's father must act; he must decide whether the cut requires medical assistance and, if so, he must take Maria to a medical facility. Consent from the father is sufficient for further medical treatment in this case, and the law does not require that consent is obtained from the mother or that she is informed of the matter. The law requires that Maria shall be listened to, even if her view is not decisive. The father and health personnel are obliged to make a decision based on the best interests of the child.

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<sup>17</sup> Section 4-4 Subsection 1 Patient and Service User Rights Act.

<sup>18</sup> The relationship between the child and the parents is generally not questioned, except in cases requiring intervention into the family's life in the interest of the child. The parents are expected to have a key role in realization of children's rights; see Jaap E Doek, "The Human Rights of Children: An Introduction" in Ursula Kilikelly and Ton Liefwaard (eds) *International Human Rights of Children* (Springer 2019) 3, 4, 14–15.

<sup>19</sup> Section 4-4 Subsection 2 Patient and Service User Rights Act.

<sup>20</sup> Section 42 Children's Act.

As the wound is very deep and there is a risk of infection, the doctor recommends a course of antibiotics. The father knows that Maria's mother vehemently opposes treatment with antibiotics except in life-threatening situations. This scenario must be viewed as a common situation that a parent must address as part of the daily care responsibility. Thus, in accordance with the same provision, the decision rests with Maria's father.

The preparatory work gives no indication that the provision is in place to prevent parental conflict in health matters; rather, the provision's purpose is to provide an easy way to ensure that the child, at any given time, shall receive adequate healthcare related to daily life. A precondition is that the parent who gives consent will follow the medical advice given by qualified health personnel. Consequently, this precondition could have a moderating effect on the potential conflict between the parents. The provision may help parents who are in conflict about other matters regarding the child to avoid conflict in health situations, even though this outcome is not the legislator's intention with the provision.

However, because the authority to decide on behalf of the child lies with the parent in whose custody the child resides at the time of the decision, consent to ongoing medical treatment given by one parent might subsequently be withdrawn by the other. In Maria's case, her mother might stop the antibiotics treatment when Maria returns to her home, contrary to medical advice. Hence, within day-to-day care, the residing parent is free to turn down treatment, irrespective of the advice of medical authorities.

#### *Scenario 2: Need of Significant Healthcare – Both Parents Refuse*

***Peter, 14, is depressed due to the high level of conflict between his parents. Over the past few months, he has skipped school several times and has stayed at home instead of participating in his usual activities. He has had a few talks with the school nurse, who is of the opinion that Peter needs specialized psychiatric treatment. As Peter is below the age of 16, his parents must give their consent; moreover, in a case of referral to a specialist health service, both must consent. However, Peter's parents refuse to give their consent.***

Peter has a right to receive treatment but needs consent from both of his parents.<sup>21</sup> Although the parents are in conflict, they might agree not to consent to psychiatric treatment for Peter. It is conceivable that parental conflict with an obvious negative effect on the child's right to healthcare could occur even when parents live together. In addition, parents' resistance might stem from a desire to avoid illuminating domestic problems. Especially in cases of sexual abuse, or where parents struggle with their own health issues, addiction problems, or domestic violence, at least one parent may be reluctant to let the child receive medical or psychiatric treatment. In the current scenario, the parental conflict is putting Peter's right to healthcare at risk.

As a rule, when parents refuse to consent, health personnel are obliged to respect this refusal. Still, an alternative is available in situations where parents deny their child healthcare, even when health personnel have strongly advised it. In these cases, health personnel are obliged to consider carefully whether the child has a significant need for the healthcare.<sup>22</sup> Even if health personnel are bound by a strict duty of confidentiality, in some situations they have a right and a duty to inform the child-welfare services (*Barnvernstjenesten*) in order to help secure the child's rights.<sup>23</sup> A prerequisite for sharing information is that the health personnel have a *reason to believe* that the child has a *life-threatening* or other *serious* medical condition for which the child is not currently receiving sufficient treatment.<sup>24</sup>

The threshold for giving information to child-welfare services without the parent's agreement is quite high. In Peter's case, health personnel must consider whether his condition is serious enough to involve child-welfare services. If health personnel conclude that the law does *not* permit them to give information to welfare services, they must either wait to see whether Peter's health condition meets the requirements in the law; or try to give the parents more information to persuade them to consent. For health personnel, this can be a challenging situation. The legal text confers a degree of discretion with respect to determining whether to inform the child-welfare services. When health personnel are in doubt about whether they

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<sup>21</sup> Section 2-1 b Subsection 2 Patient and Service User Rights Act.

<sup>22</sup> Sjøvig (n 4) 263.

<sup>23</sup> Section 33 Norwegian Health Personnel Act.

<sup>24</sup> Section 33 Subsection 2 Litra b Health Personnel Act. See also Section 13-2 Norwegian Child Welfare Act (*Barnvernsløven*).



are free to involve child-welfare services without the parents' permission, some will choose to hold to the rule of confidentiality as a way out of the dilemma. Whether information is to be given or not, implies difficult assessments and consequences; thus, when health personnel are aware of the high conflict level between the parents, they may refrain from alerting child-welfare services to avoid escalating the conflict. In such a case, children in Peter's situation would have their right to healthcare violated.

On the other hand, if child-welfare services are informed, they are obliged to investigate the case.<sup>25</sup> If the conditions stated in the act seem to be fulfilled, child-welfare services may bring the case before the Child protection and health board (*barneverns- og helsenemnda*), which is an administrative body, and has much in common with a court of law.<sup>26</sup> The board is competent to decide whether the child shall receive healthcare if they are suffering from a life-threatening illness or other profoundly serious illness or injury, even if the parents do not cooperate.<sup>27</sup> If an order to start healthcare is issued, parental rights are limited; for example, they are obliged to bring the child to hospital for medical examination and treatment. If they do not respond to the order, their parental responsibility may be questioned, and the next step could be a care order and placement of the child in foster care, if the other conditions for such an order are fulfilled.<sup>28</sup>

Case law shows the above possibilities are very seldom applied.<sup>29</sup> If health matters are mentioned in a child-welfare order, they are usually related to maltreatment or serious neglect by the parents. This begs the question of whether the threshold in Norwegian legislation to secure adequate medical services for children is too high. The preparatory works do not discuss the possibility that a parental conflict might be the cause of the reluctance to consent to medical treatment for children.<sup>30</sup> Nor do the preparatory works address how a child might influence a parental decision to refuse him or her medical treatment. A right follows for children older than 12 to have party rights in cases related to healthcare.<sup>31</sup>

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<sup>25</sup> Section 2-2 Child Welfare Act.

<sup>26</sup> Section 14-1 Child Welfare Act.

<sup>27</sup> Ibid Section 3-7.

<sup>28</sup> Ibid Section 5-1.

<sup>29</sup> Ibid Section 3-7.

<sup>30</sup> Proposition to the Odelsting (Ot.prp.) nr 12 (1998–1999).

<sup>31</sup> Section 6-5 Patient and Service User Rights Act.

However, the contents of the provision are unclear; there is no presentation in the preparatory works and the provision is barely discussed in the literature.<sup>32</sup>

Peter's own voice could be a crucial factor in a case like this. Even if his right to complain was limited, it might have helped him nevertheless, but this is an unresolved question. As long as Peter has no right to complain and the school nurse finds that she must respect the rule of confidence, no official organ will be informed of Peter's need for psychiatric assistance. Peter's right to healthcare is at risk.

The CRC does not directly address the possible conflict of interest between children and parents in health matters.<sup>33</sup> In the above scenario, Peter wants help, and the parents are obliged to give considerable weight to his view; still, the final decision rests with the parents, unless the rather serious conditions specified in the Child Welfare Act are present. Since the threshold is so high, one can argue that in these situations, the rights and interests of the parents prevail over the best interests of the child.

### *Scenario 3: Need of Significant Healthcare – Parents With Differing Opinions*

*David is twelve years old and has long suffered from leukaemia. His parents live together but have had periods of living apart due to cohabitation difficulties. Both parents have supported David during his long period of cancer treatment. After the COVID-19 vaccine was introduced, David's principal doctor at the hospital recommended that the parents should consent to vaccination for David, and they accepted. However, when David heard about this, he said no. In his opinion, there was too little information about the vaccine, especially regarding long-term effects. After hearing what David had to say, his father changed his mind. The mother continues to uphold her decision to consent to the vaccination.*

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<sup>32</sup> Aslak Syse, *Pasient- og brukerrettighetsloven* (4th edn, Gyldendal 2015) 548–549.

<sup>33</sup> John Tobin, 'Fixed Concepts but Changing Conceptions: Understanding the Relationship Between Children and Parents' in Martin D Ruck, Michele Peterson-Dadali and Michael Freeman (eds) *Handbook of Children's Rights: Global and Multidisciplinary Perspectives* (Routledge 2017) 53–67.

When medical treatment is given within the specialist healthcare system, it cannot be characterized as a part of the child's daily care. Therefore, the starting point in this case is a requirement on consent from both of David's parents. David's mother agrees, but the father declines vaccination. In a situation like this, we might use an exception in the law (PRA Section 4-4 ss. 3) stating that if only one parent gives consent, the considered opinion of qualified health personnel is decisive for whether healthcare should be provided. In other words, the opinion of qualified health personnel is crucial.

A prerequisite is that the treatment is *necessary* to avoid any *injury* to the child, which is a medical question. There are no further qualification terms for the concept of *injury*. This provision is a result of experience gained in situations where children did not receive necessary medical treatment due to one parent's refusal to consent.<sup>34</sup> Parental conflict was pointed out as one explanation. A decisive factor here is how 'qualified' health personnel are identified to determine whether the treatment is necessary to avoid injury. In most cases, the opinion of a medical doctor is needed, perhaps a doctor with special qualification in a medical field. In David's case, a medical doctor must decide whether David needs the vaccination. If after professional consideration qualified health personnel give an opinion that the child's condition meets the criteria set in the Patient and Service User Rights Act,<sup>35</sup> and examination and/or treatment is in the child's best interest, this treatment can start when one of the parents has given her/his consent.<sup>36</sup> To a certain degree, the decision to give or refrain from giving medical treatment can be regarded as taken out of the hands of the parents, as health personnel's assessment is essential. This might be a positive factor in a conflict situation between the parents.

But how can the child's own opinion be included here? The parents have an obligation to inform the child.<sup>37</sup> This might be difficult when they are of different opinions, as in this case, with a newly introduced vaccine. There is a risk that their information is affected by their attitude to the vaccine. Whether health personnel have any obligations to inform the child

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<sup>34</sup> Norwegian Official Report (NOU) 2008:9 *Med barnet i fokus*, 49.

<sup>35</sup> Section 4-4 Subsection 3.

<sup>36</sup> Norwegian Official Report (NOU) 2008:9 *Med barnet i fokus*, 51 and Proposition to the Odelsting nr 104 (2008–2009) 63.

<sup>37</sup> Section 4-4 Subsection 5 Patient and Service User Rights Act.

when parents are unable to give the child factual and objective information is not clear in Norwegian *health* legislation. Still, the child's right to be heard follows clearly from the Norwegian Constitution, CRC<sub>2</sub> and the Children's Act, and indirectly from the principle of due diligence in healthcare. According to the principle of the best interests of the child, and the right to the highest attainable standard of health, there are several reasons to impose obligations on health personnel. Another reason is the respect for the child's right to participate. For David, it might be easier to talk to a professional, thus involving as little emotion as possible. In our opinion, if David still refuses to get the vaccine, even after being informed, he must have the right to have his view respected and to refuse the treatment. However, current law in this respect is unclear.<sup>38</sup>

The preparatory works emphasize that both parents shall be informed and heard when they have joint parental responsibility.<sup>39</sup> The law does not discriminate between the parents. This brings us back to Peter's story.

#### *Scenario 4: Parents' Right to Information*

***Peter**, now age 15, suffers from serious depression. His parents have separated; he lives with his mother and has no contact with his father. The parents still have joint parental responsibility, and Peter's mother has given her consent to psychiatric treatment. Because healthcare professionals strongly advise healthcare for Peter, the consent of only one parent is needed.<sup>40</sup> Peter's father abuses alcohol and has outbursts of anger. The challenge in this case is the main rule stating that both parents shall be informed and can speak out, even if their consent is not required. However, the mother will withdraw her consent if the father is informed, because she is afraid of the father's reaction and she believes that Peter's treatment will reveal the father's problems. The relevant question then becomes: Are the health personnel obliged to inform the father?*

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<sup>38</sup> Marit Hellebostad, Aslak Syse and Reidun Førde, 'Når en mindreårig pasient nekter livreddende behandling' (2017) *Tidsskrift for den norske legeforening*; Stephen Gilmore and Jonathan Herring, "'No' is the Hardest Word: Consent and Children's Autonomy' (2011) 23(1) *Child and Family Law Quarterly* 3–28.

<sup>39</sup> Proposition to the Odelsting nr 104 (2008–2009) 63.

<sup>40</sup> Section 4-4 Subsection 3 Patient and Service User Rights Act.

If the parents have joint parental responsibility, both parents have the right to be heard, which implies a right to information. The right of both parents to receive information and express their views is normally of essential value, even in a conflict situation. By receiving comments from both parents on all aspects of the wellbeing of the child, healthcare personnel will be able to evaluate the severity of the child's condition.

However, in Peter's situation, the father's right to information conflicts with Peter's right to healthcare, because his mother will withdraw her consent to treatment if the father is informed. This type of conflict is not given attention in the preparatory works. Indeed, it seems that parental rights are given more weight than the child's rights.

The strength of parental rights is also demonstrated in the declining parent's right to bring the decision about healthcare to the County Governor's office for appeal. This opportunity is illusory without information. However, the right to information may be limited according to the wording 'as far as possible'.<sup>41</sup> The wording indicates a reservation concerning the duty to inform both parents, and this is the intention according to the preparatory works.<sup>42</sup> There is no absolute obligation to inform both parents, but there must be legitimate reasons for *not* doing so. The preparatory works point out various practical aspects as obstacles (for example, a lack of time or ability to consult the other parent).<sup>43</sup>

In the case of Peter, there are no practical obstacles. Instead, the reason for not informing the father is to shield Peter from an escalation of the conflict between the parents and perhaps to shield Peter from his father's temper. In our opinion, there are legal reasons not to inform the father based on the principles of best interests of the child and the child's right to participation.<sup>44</sup> Peter is 15 and has no contact with his father, and the parental conflict has caused him serious health problems. If Peter's mother withdraws her consent to avoid

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<sup>41</sup> Section 4-4 Subsection 3 Patient and Service User Rights Act.

<sup>42</sup> Proposition to the Odelsting nr 104 (2008–2009) 63.

<sup>43</sup> Proposition to the Odelsting nr 104 (2008–2009) 63.

<sup>44</sup> E Kay M Tisdall, 'Challenging Competency and Capacity?' (2018) 26(1) *International Journal of Children's Rights* 159–182; David Archard and Marit Skivenes, 'Balancing a Child's Best Interests and Child's Views' (2019) 17(1) *The International Journal of Children's Rights* 1–21; Jaap E Doek, 'Children's Rights in Health Care and the General Principles of the CRC', in Jozef Dorscheidt, H H M and Jaap E Doek (eds), *Children's rights in health care* (Brill Nijhoff 2019) 48–70.

escalating the conflict, Peter's right to healthcare will be jeopardized. Moreover, the law gives Peter no opportunity to bring the question of whether his father shall be informed to the County Governor's office for appeal, as this right is reserved for the parents.<sup>45</sup> Still, health personnel should ask Peter about the involvement of his father in the matter.

This scenario exemplifies the fact that although core child human-law principles are not communicated in the Patient and Service User Rights Act, they must be included in the assessment of whether a parent shall be informed.<sup>46</sup> Not taking these principles into account may result in a violation of the Norwegian Constitution, 'Children have the right to respect for their human dignity'.<sup>47</sup> They have the right to be heard in questions that concern them, and due weight shall be attached to their views in accordance with their age and development' and 'For actions and decisions that affect children, the best interests of the child shall be a fundamental consideration'.<sup>48</sup>

## 8.5. Concluding Observations

Our main question was: how should legal instruments be used to reach a decision concerning a child's health when the child's parents disagree? By presenting different scenarios, we have shown, in current Norwegian legislation, how children's and parents' rights are balanced when the parents are in conflict and the child needs healthcare. Even if the purpose here is not to provide broader and more general considerations relating to children's capacity to decide for themselves, we will add a few comments regarding this broader view—because both social—and family-law aspects might become relevant in the scenarios we have analysed.

There is no doubt about the child's right to participate in decision-making according to human-rights instruments and domestic Norwegian law.<sup>49</sup> This right is clearly stated in the

<sup>45</sup> Ursula Kilkelly and Mary Donnelly, 'Participation in Healthcare: the Views and Experiences of Children and Young People' (2011) 28(1) *International Journal of Children's Rights* 107–125.

<sup>46</sup> Aoife Daly, 'No Weight for "Due Weight"? A Children's autonomy principle in Best interests Proceedings' (2018) 26(1) *International Journal of Children's Rights* 61–92; Aoife Daly, 'Children, Autonomy and the Courts: Beyond the right to be heard' (2018) 26(4) *International journal of children's rights* 843–847.

<sup>47</sup> Section 104 Subsection 1.

<sup>48</sup> Haugli and others (n 7).

<sup>49</sup> Henriette Sinding Aasen, 'Barns rett til selvbestemmelse og medbestemmelse i beslutninger om helsehjelp' (2008) *Tidsskrift for familierett, arverett og barnevernrettslige spørsmål* 3–26; Kirsten Sandberg, 'Children's Right

Constitution, the CRC, the Children's Act, and the Child Welfare Act. However, several challenges emerge when the right of the child is supposed to be exercised within the family sphere.<sup>50</sup> One of those relates to the topic we have discussed: when the parents have different opinions about health issues concerning the child, or the child and his or her parent have different views. Another challenge is the lack of children's agency, and the lack of bodies or institutions to which the child can direct a complaint about violations of their right to participate.<sup>51</sup> If the child has the right to co-determination in personal matters, and is not heard before authorities make decisions, this will be a violation of the rules of procedure and may influence the lawfulness of the decision. However, in health matters, there are no such decision-making bodies. Hence, the decisions are more informal and made in cooperation with the parents, medical personnel, and ideally, also in cooperation with the child. This raises concerns with respect to the child's access to justice.

The legislation presented above is based on an assumption that parents will act in a responsible way.<sup>52</sup> Yet, we have seen that conflicting parents' actions may harm their children's health. Some steps have been taken by the legislator to try and avoid this consequence—as we have seen in Scenario 1 about daily care, and in Scenario 3 about the need for significant healthcare. The purpose is to make healthcare available and accessible for children. Even if the child does not have the right to self-determination, there could be other agency rights available, such as the right to refuse and the right to complain.<sup>53</sup>

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to Participate in Health Care Decisions' in Henriette Sinding Aasen, Antonio Barbosa da Silva, Rune Halvorsen and Bjorn Hvinden (eds), *Human Rights, Dignity and Autonomy in Health Care and Social Services: Nordic Perspectives* (1st edn, Intersentia 2009) Chapter 3; Kristin Skjærten, 'Mellom beskyttelse og selvbestemmelse' in Ingunn Ikdahl and Vibeke Blaker Strand (eds) *Rettigheter i velferdsstaten. Begreper, trender, teorier* (Gyldendal Oslo 2016) 167–182; Anna Nylund, 'Children's Right to Participate in Decision-Making in Norway: Paternalism and Autonomy' in Haugli and others (n 7) Chapter 11; Kristin Skjærten, 'Normer i endring. Barns rettigheter og domstolspraksis i foreldretvister med påstander om vold', in Reidun Førde, Morten Kjelland and Ulf Stridbeck (eds) *Cand.mag., cand.med., cand.jur., cand.alt Festskrift til Aslak Syse* (Gyldendal 2016) 421–434; Syse (n 32).

<sup>50</sup> Caroline Adolpsen, *Mindreåriges retsstilling i relation til behandling* (Jurist- og Økonomforbundets Forlag 2013); Priscilla Alderson, 'Giving Children's View "Due Weight" in Medical Law' (2018) 26(1) *International Journal of Children's Rights* 16–37; Marianne K Bahus, Pål Friis and Terje Mesel, 'Pasientautonomi – en rettighet med moralske implikasjoner' *Kritisk Juss* 2018 56–78.

<sup>51</sup> Irma Hein, 'Children's Competence in Medical Care Decision-Making', in Joseph H H M Dorscheidt and Jaap E Doek (eds), *Children's Rights in Health Care* (Brill Nijhoff 2019) 150–172.

<sup>52</sup> Lucinda Ferguson, 'The Jurisprudence of Making Decisions Affecting Children: An Argument to Prefer Duty to Children's Rights and Welfare' in Alison Diduck, Noam Peleg and Helen Reece (eds), *Law in Society: Reflections on Children, Family, Culture and Philosophy: essays in honour of Michael Freeman* (Brill Nijhoff 2015) 141–189.

<sup>53</sup> Ursula Kilkelly and Mary Donnelly, 'Child-Friendly Healthcare: Delivering on the Right to be Heard' (2011) 19 *International Journal of Children's Rights* 27–54; Rosalind Dixon and Martha C Nussbaum, 'Children's Rights and a Capabilities Approach: The Question of Special Priority' (2012) 97 *Cornell Law Review* 549–593.

The situation where both parents deny healthcare for their child, thus posing the risk of harm to the child, is complicated (Scenario 2). Healthcare will not be available for the child unless the situation is of a rather serious nature. The parents have a clear right to decide for their child and to be involved (Scenario 4). The duty of health personnel and the health authorities to influence which decisions the parents make is rather weak, perhaps out of respect for the family's privacy and respect for the basic principle of autonomy; however, in this perspective, there is no autonomy for the child. Any underlying conflict between the parents or a threatening situation for any of the parents, or even the child, risks remaining unresolved.

The scenarios presented here show that lawmakers designing health legislation have not always directed their attention to potential conflicts between parents' and children's rights and interests. The right of the parents is based on a presumption that they will act in the best interests of the child, and that the parents are best suited to make decisions on behalf of their children who are under 16 years of age.<sup>54</sup> The family shall be effectively protected as a fundamental unit in society, and this is reflected in several CRC provisions and the ECHR.<sup>55</sup> As we have shown, one cannot rely on the assumption that parents will always act in the interests of their children, particularly when there is a high level of conflict between the parents. The current Norwegian health-law legislation is, in our opinion, more family-oriented than child-oriented, and consequently, several conflict situations are not given any attention in the founding documents. Thus, the right to respect for family life and the child's right to healthcare do not fully coincide. Furthermore, this can provide a parent with a dichotomy: either choose to file for sole custody or submit to the other parent's will. This conflict requires further investigation.<sup>56</sup>

Even if children younger than 16 are not free to give their own consent to healthcare, the right to participation should be respected. To fulfil this right, children have a right to relevant information that is provided in an individually adapted way. In general, health personnel are

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<sup>54</sup> See e.g. Proposition to the Odelsting nr 104 (2008–2009) 63.

<sup>55</sup> Tobin (n 33) 53–67, 56.

<sup>56</sup> E Kay M Tisdall, 'Conceptualising Children and Young People's Participation: Examining Vulnerability, Social Accountability and Co-production' (2017) 21(1) *The International Journal of Human Rights* 59–75.



obliged to give adapted information to each patient individually, and then listen to their views and decisions.<sup>57</sup> However, in the case of children younger than 16, the main obligation seems to be placed on the parents — another sign of family-oriented legislation.<sup>58</sup> The position of co-parenthood, joint custody, or even shared residence after divorce is well established in Norwegian family law. It is built upon the rights and principles of gender equality, but also on the idea that parents will take a common responsibility for their child, acting in the child's best interests. In those situations where this is not the case, there is a lack of services to help the parents solve their conflict and reach a decision in the best interests of the child.

It should be remembered that parents may have factual, unbiased disagreements on health questions, even if they are not in any conflicting situation. It could be the vaccination of children, for example, in cases such as COVID-19 vaccination, where the vaccine is not established as a standard offering to all children in child-vaccination programmes. There could be good arguments both for and against. In these situations, upholding the status quo is in accordance with the legislator's intention, and could be a good solution.<sup>59</sup>

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<sup>57</sup> Section 10 Health Personnel Act.

<sup>58</sup> Section 4-4 Subsection 5 Patient and Service User Rights Act.

<sup>59</sup> John Eekelaar, 'The Importance of Thinking that Children have Rights' (1992) 6(1) *International Journal of Family Law* 221–235; Jane Fortin, *Children's Rights and the Developing Law* (Cambridge University Press 2009); John Tobin, 'Taking Children's Rights Seriously: Need for a Multilingual Approach' in Alison Diduck, Noam Peleg and Helen Reece (eds), *Law in Society: Reflections on Children, Family, Culture and Philosophy: essays in honour of Michael Freeman* (Brill Nijhoff 2015) 127–140; Njål Høstmælingen, Elin S Kjørholdt, and Kirsten Sandberg, *Barnekonvensjonen, barns rettigheter i Norge* (4th edn, Universitetsforlaget 2020).

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