Ethics, Medicine and Public Health 33 (2025) 101089

Contents lists available at ScienceDirect

Ethics, Medicine and Public Health

journal homepage: www.sciencedirect.com/journal/ethics-medicine-and-public-health

Humanities in health

The minor's healthcare

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ARTICLE INFO

Keywords:
Child's autonomy
Healthcare
French law
Minor parental authority

ABSTRACT

This article explores the regulation of children's healthcare under French law, taking into consideration the role of parents, the welfare of the child, and the child's autonomy. Parents primarily make healthcare decisions on behalf of their child's, acting as representatives of the child's best interests within the framework of parental authority. The level of consent required depends on the seriousness of the medical decision at hand; for everyday medical matters, one parent's consent may suffice, while decisions involving the child's physical well-being may necessitate consent from both parents. Despite the central role of parents, French law underscores that all parental decisions must prioritise the child's welfare. Consequently, parents cannot make arbitrary decisions, and certain actions are mandatory, even if parents are unwilling to carry them out. Furthermore, in the past four decades, there has been a growing emphasis on children's rights, prompting the French legislator to increasingly acknowledge children's voices, especially in healthcare-related matters. Today, the legislator grants various rights to the child, such as the right to veto, the right to consent to decisions alongside their parents, and sometimes the right to act independently without consulting their parents. In sum, French legislation has aimed to strike a balance between recognising the child's autonomy and the imperative of protecting them from their own decisions.

Minors, or children, are defined legally as individuals under the age of 18 [1]. Due to their youth, they are considered vulnerable and are safeguarded by specific healthcare regulations. Under French law, the special protection of children is primarily entrusted to their parents, and the legislator has chosen to associate the child's healthcare with the exercise of parental authority. Indeed, article 371-1 of the Civil Code defines parental authority as:

> "a cluster of rights and duties whose finality is the interest of the child. It is vested in the parents until the majority or emancipation of the child to protect them in their security, health, and morality, to ensure their education and allow their development, with all due respect owed to their person.
> Parental authority is exercised without physical or psychological violence.
> The parents shall make a child a party to decisions that concern them, according to their age and degree of maturity."

This article delineates three essential principles. Firstly, decisions pertaining to a minor's healthcare are made by those holding parental authority, namely the child's parent(s) or guardian(s). One of the primary objectives of parental responsibility is to safeguard the child's well-being, necessitating parents or guardians to make decisions that protect their child's health. Secondly, children sometimes become active participants in decisions that affect them. Over the past four decades, children's rights have become increasingly important, prompting legislator to progressively accord more significance to children's voice, particularly in matters relating to their healthcare. The principle of parental authority, specifically the notion that parents should make decisions on behalf of their child, has come under scrutiny, especially concerning issues like contraception and abortion. Thirdly, parental authority must always be exercised in the best interests of the child. As a result, the State occasionally intervenes to restrict parental powers in order to safeguard the child's welfare.

This article, based on the provisions of Article 371-1 of the Civil Code, explores three key aspects in sequence: parental prerogatives concerning the child's healthcare, the fundamental concept of the "child's interest", and the rights accorded to the child within this framework.

The predominance of parents' role in children's healthcare

Since minors are legally considered incapable, the responsibility for

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https://doi.org/10.1016/j.jemep.2025.101089
Received 4 September 2024; Accepted 28 March 2025
Available online 7 April 2025

safeguarding their healthcare is entrusted to their parents, who act as representatives of the children's best interests within the framework of parental authority.

Parental duty

Ensuring the health of their children is one of the duties assigned to parents. Failure to fulfil this obligation can lead to specific measures that restrict their exercise of parental authority. For instance, when a minor's health is at risk, a judge may issue educational assistance measures [2]. In more severe cases, parents can have their parental authority partially or entirely revoked if their neglect clearly endanger their child's well-being [3]. In such situations, they may also face criminal penalties and be found guilty of a deprivation of care offense [4].

Parental prerogative

Protecting children's health is not only a duty for parents, but also a prerogative. As such, parents have the right to access to their child's medical records [5], with the exception of information related to confidential care [6]. Doctors are obliged to share information in relation to their child's health when requested by parents, except for matters such as contraception or abortion, which fail under "confidential care". Parents also have the authority to make decisions regarding their child's healthcare, treatment, and necessary medical procedures for their well-being. As a general rule, they can enforce a medical decision on their child, as the child's consent is not required unless expressly mandated by a specific legal provision.

Usual and serious acts

Decisions can be made by either one or both parents, depending on who holds parental authority and the significance of the decision. In principle, both parents of a child jointly exercise parental authority [7]. This means that, even if the parents are separated, they are required to make decisions concerning their child together. French law distinguishes between "usual" and "serious" acts of parental authority and assumes that there is an agreement between the parents regarding "usual acts" [8]. The law does not provide a specific definition of usual and serious acts, but it is commonly understood that usual acts do not break with the past and do not have a profound impact on the child's future or fundamental rights [9]. When it comes to children's health, usual acts encompass minor injuries, dental care, common childhood illnesses, authorisation for a blood test, routine doctor visits… Conversely, substantial medical treatments or extended hospitalisation are considered serious acts, requiring the consent of both parents. Non-usual acts are described as "*acts deemed serious, with potential implications for the patient's future and a non-negligible probability of adverse effects (such as prolonged hospitalisation, treatments with side effects or disabling consequences, invasive procedures like anaesthesia or surgery)*" [10]. For instance, providing an antidepressant to a 16-year-old girl would be considered as a non-usual act and would necessitate authorisation from both parents [11].

Certain decisions may be classified as either usual or serious, depending on the context [12]. For instance, circumcision may be regarded as a usual act when necessitated by medical reasons, but as a serious act when performed for ritual purposes [13]. Similarly, vaccination may be placed in either of these categories, depending on whether it is mandatory or discretionary [14].

Third parties performing a serious act with the consent of only one parent assume liability for their actions. For example, a doctor who performed ritual circumcision on a child at the request of the father, without obtaining the mother's consent, was held civilly liable [15]. Likewise, in a case where the mother consulted a psychiatrist despite the father's objections, believing that her child could have been sexually abused by the father, the Court condemned the psychiatrist. According to the Court, there was no emergency situation that would justify the doctor overriding the father's refusal [16].

In some exceptional situations, serious actions may be taken with the consent of only one parent. For example, in non-emergency situations, hospitalising a minor necessitates the consent of just one parent [17]. Similarly, the collection and preservation of gametes, in cases where treatment may lead to sterility, only requires the consent of one parent and the child [18]. The underlying rationale for these exceptions is that these actions are typically in line with the minor's best interests [9] [9; p 467]. In the case of a child's hospitalisation, the doctor would have already planned it, and the medical team would recognise its necessity. Likewise, the preservation of gametes and germ cells is carried out for the minor's benefit with the intention of using them for medically assisted procreation interests [9].

When there is a parental disagreement, the family judge ("*juge aux affaire familiales*") has authority to resolve the dispute. The judge's primary consideration is the child's best interest. For instance, in a case where a child's height was below average for their age, the mother sought a growth hormone treatment, but the father opposed it. The judges based their decision on three criteria: the medical risk, the necessity of the treatment, and the child's opinion. Because the mother failed to establish the necessity of the treatment, and the child was reluctant to undergo it, the Court followed the father's opinion, and objected to the treatment in the child's best interest [19].

When only one parent exercises parental authority, their consent is sufficient to authorise a medical decision. However, the other parent retains a right of supervision and control, which entails being informed about any significant or substantial medical treatment or intervention. Additionally, they have the option to notify the family judge of their opposition to such treatment [9].

The necessity to obtain the consent of both parents for serious medical acts strengthens the safeguarding of the child's physical integrity. This requirement encourages dialogue between the parents with the expectation that their joint-decision making will lead to the best outcome for their child [20]. However, because it may be challenging for the medical team to systematically obtain the consent of both parents, usual acts can be executed with the consent of just one parent. Therefore, the legislator has sought to strike a balance between protecting the child's physical integrity and facilitating the performance of daily medical decisions. Moreover, despite the significance of parental prerogatives, parents are not unlimited in their authority to make medical decisions: the law places constraints on their powers with the aim of protecting the child's best interest.

Limits to parental prerogatives: protecting the child's best interest

As previously discussed, parental prerogatives aim to serve the child's best interests. Every parental decision must align with the child's welfare. Consequently, some actions are prohibited or necessitate more than just parental consent, while others are compulsory and must be carried out by the parents, even if they are unwilling. Additionally, specific rules govern cases involving a critically ill child and the termination of medical treatments.

Prohibited acts and acts requiring specific authorisation

When parents are making healthcare decisions for their child, the child's best interest must be objectively evaluated, and the decision must demonstrate both a personal and medical benefit for the child. Consequently, some non-therapeutic actions are prohibited because they lack any medical interest for the child. For example, organ donations by minors are prohibited [21]. Other actions related to the child's body inherently contradict the child's welfare and are strictly prohibited. This includes practices like female genital mutilation (excision), which inflicts severe suffering on the child and constitutes a criminal offense that

can never be justified, either by therapeutic necessity or any other medical reason. Therefore, according to Article 3 of the European Convention on Human Rights, excision of a child is considered inhuman and degrading treatment [22]. Similarly, sterilisation of a child for contraceptive purposes is strictly prohibited [23].

Certain acts are not inherently prohibited but are considered so critical that they necessitate the authorisation of an "ad hoc" administrator instead of relying solely on the parents' consent. For instance, in very specific circumstances where no other therapeutic alternatives are available, it is permissible to extract hematopoietic stem cells from a child's bone marrow in favour of a close relative [24]. The exceptional nature of this gift is justified by the difficulty in finding a compatible donor outside the child's immediate family. Since the enactment of the Law of 2 August 2021 [25], this stem cell sample may be given to one of the child's parents. However, when this happens, the benefiting parent cannot impartially advocate for the child's best interests. Therefore, to proceed with the extraction of the child's hematopoietic stem cells, the law mandates authorisation from an "ad hoc" administrator. Appointed by the Court, the "ad hoc" administrator represents the child in lieu of the parents.

Mandatory acts

In the best interest of the child, parents are obliged to provide specific care to their children. For example, parents are required to ensure their children receive mandatory vaccinations [26]. Parents must also ensure that their child undergoes a preventive follow-up, which includes twenty compulsory medical examinations throughout the child's minority [27]. Furthermore, parental consent is not required in cases of emergencies: doctors are exempt from the obligation to communicate necessary information to parents and obtain their consent [28]. Similarly, when a medical procedure is deemed necessary for the minor's health and parental refusal could lead to serious consequences for the minor's well-being, a doctor has the authority to override such refusal or the absence of parental consent [29], serving as a protector of the child's best interests [30]. In these situations, the doctor assumes the role of an advocate for the child and takes a leading role in decision-making [31, 32]. This principle is well articulated in Article R. 2132-1 of the French Public Health Code: *"The doctor must act as a defender of the child when he or she determines that the child's health interests are not adequately understood or protected by those around the child."* For example, in a case where a medical team administered a blood transfusion to a minor despite the parents' refusal, the Administrative Court of Appeal of Bordeaux ruled that the doctors did not commit a fault, as the child exhibited clinical signs of imminent peril, and the blood transfusion was the only viable solution to save the child [33].

The termination of treatment

The child's healthcare inevitably raises the painful question of the end of a minor's life. As F. Vialla puts it, *"The ordeal of a child's death can be seen as the most profound injustice. (…) There is no crueller drama, nor a more insurmountable tragedy."* [32] Despite several legal provisions that establish a framework regarding the termination of medical treatment [34], the French legislator has not established specific rules concerning the end of a minor's life. The only specific guidance is provided by Article R. 4127-37-2 of the French Public Health Code, which stipulates that, to make a decision to limit or terminate a child's treatment, the medical team must first seek the parents' opinion, unless circumstances prevent such consultation due to an emergency. In most cases, the decision to terminate a child's treatment is made in consensus, with the medical team and parents jointly arriving at this difficult decision [35]. However, in cases where disagreements arise, the medical team has the authority to impose the termination of the child's medical treatment when there is an "unreasonable obstinacy". It is important to note that the law only mandates consultation with the parents, but does not require their consent [36].

In the "Marwa" case, a ten-month-old baby was placed in a state of artificial coma after contracting an enterovirus. The medical team had determined that continuing the treatments amounted to an "unreasonable obstinacy". However, the infant's parents were adamantly opposed to terminating the treatments. Following the results of a medical assessment, the Conseil d'État ruled that the treatments should be continued, emphasising the significance of the parents' opinion. Despite the child being in an irreversible state of loss of autonomy and dependent on life-sustaining measures, the circumstances did not render the treatments unnecessary or disproportionate, and their continuation could not be characterised as an "unreasonable obstinacy" [37].

However, a few months later, the Conseil d'État clarified that it is the role of the medical team to assess the necessity of a therapeutic treatment [38]. The doctor ultimately holds the authority to make decisions regarding the termination of medical treatments. Similarly, in a case known as "Inès", a fourteen-year-old girl fell into a persistent vegetative state after a heart attack. The Conseil d'État had to deliberate on the termination of care, despite strong opposition from the parents. The Conseil d'État indicated that *"given her age, it was possible to inquire about the wishes of the teenager. However, the conflicting information in the records regarding the opinions expressed by the young girl makes it impossible to determine her will. The opinion of the parents, who hold parental authority, is therefore of particular importance."* Nevertheless, the Conseil held that, in these specific circumstances, "*continuing treatment was likely to be considered unreasonable obstinacy."* Consequently, the doctors had the authority to override the parents' opinion and decide to terminate the young girl's treatment [39].

When examining these cases, three observations can be made. Firstly, holders of parental authority can provide their opinions, but these opinions are not legally binding for the doctors. Secondly, when a minor is deemed mature enough, judges consistently seek the minor's own wishes before making a decision. Nevertheless, in numerous cases, the minor's condition is so deteriorated that they cannot express their wishes. Allowing sufficiently mature minors to create advance directives could be a way to consider their autonomy in these critical decisions, although this may prove challenging in practice, as children often have a distinct perception of death [40]. Consequently, the child's decision-making autonomy remains quite limited. Thirdly, given that the child's best interests may not align with the parents' desires (who may wish to keep their child alive), the decision is too unique to permit parents to fully represent their child. The parents' expressed opinion may diverge from the child's own preferences; parents should not act as the child's representatives but should function as their protectors, a role they may not fulfil in this context [41]. To recognise that the child is a legal entity, entitled to the right to be shielded from unreasonable obstinacy as a patient, the doctor must ultimately make the decision with the child's best interests in mind [35].

The need for doctors to safeguard the child's best interests represents one of the primary constraints on parental prerogatives. A second constraint arises from the evolving landscape of healthcare law, which increasingly promotes and values the autonomy of children.

The role played by the child: the child's autonomy

In French law, the fundamental principle remains that minors are legally incapable. Therefore, with a few exceptions, the consent of the individuals holding parental authority remains a prerequisite for carrying out a medical procedure. This principle gives rise to several important considerations. Firstly, children's level of maturity naturally progresses in tandem with their age, making it seem illogical to treat a young infant and a teenager in the same manner. Over time, minors are expected to become increasingly capable of safeguarding their own interests. Consequently, minority should be viewed as a transitional phase during which a minor's capacity gradually develops, thus avoiding an abrupt transition to adulthood [20]. Secondly, in practice, doctors may

encounter challenging situations where "older minors" seek medical consultation on their own. In theory, they cannot provide treatment without parental consent. In such cases, doctors are faced with the dilemma of fulfilling their professional duties (but facing potential litigations), or adhering to the law and asking the minor to come back accompanied by their parents, taking the risk that the minor may never return [20]. To address these practical challenges and protect the child's autonomy, certain exceptions to the principle have been recently introduced.

Healthcare involves some essential principles, such as the integrity of the human body and the dignity of the person. When it comes to a child's health, it is necessary to strike a balance between involving the child in the decision-making process and ensuring the child's safety in such a sensitive area. This balance is strongly connected to the child's age and maturity, as autonomy is the ability of individuals to create their own laws, establish their own rules, and define their own values [42]. In other words, children's autonomy in relation to their healthcare is linked to their ability to act without requiring parental consent and make their own decisions.

In the last four decades, since the Law of 4 December 1974 authorised family planning centres to provide contraceptives confidentially to minors [43], the rights of children have been advancing in France. Minors are recognised as "subjects of law". This acknowledgement of the child's legal personality under French law has its origin in international law, particularly the Geneva Declaration 1924, the Declaration of the Rights of the Child in 1959, and the "best interest of the child" principle established by the International Convention on the Rights of the Child in 1990 [44]. The Law of 4 March 2002 relating to patients' rights marks a significant step toward recognising the child's autonomy in matters related to their health [45]. Since then, children have the right to be informed and consulted in healthcare decision. Depending on the circumstances, the legislator grants various rights to the child, including the right of veto, the right to consent to decisions alongside their parents, and sometimes the right to act without consulting their parents.

The right to be informed

A key development of children's autonomy is the necessity for the doctor to inform the child of any healthcare decision to come, in a manner appropriate to their maturity [46]. This information is independent from the one given to the holders of parental authority [47].

The right to be informed is a prerequisite to allow the child to be involved in the medical decision-making process. However, the child is in a situation drastically different from that of an adult, as the minor will not consent to the act. Therefore, informing the children does not aim to obtain their consent but rather to prepare them for the treatment or the medical intervention to come, and to obtain their approbation. The purpose of the information is not to convince the minors but to explain the way in which the treatment will take place, as their acceptance of the care helps to make the treatment more effective [9]. The information is therefore given to the parents – whose consent will be necessary to allow the treatment to take place – and to the child – for the child to get a better understanding of the treatment to come. The scope of the information increases with the age of the child, as the right of the child depends on their maturity. In agreement with the parents, the doctor can decide not to reveal certain aspects of the diagnosis to the minor, if the doctor considers that this could harm the child's wellbeing and reduce the chances of recovery. In addition to the psychological maturity of the minor, the doctor, therefore, considers the seriousness of the pathology [9].

The right to be consulted

The general rule is that parents should involve their children in decisions that affect them, considering their age and maturity [48]. When it comes to healthcare, the law places even greater emphasis on the child's rights: the consent of the minor must be systematically sought if the minor is capable of expressing their will and participating in the decision [49]. To provide consent, the minor should have the ability to understand the information.

However, there is a significant limitation to the weight of a child's consent: the child's consent is actively sought but is not obligatory, allowing the doctor to override the child's refusal if the parents have granted their consent. The sole consent of the minor is not adequate to authorise a medical procedure. The child possesses only a form of "participatory autonomy," and theoretically, doctors are not obligated to align their actions with the child's opinion [9].

Nevertheless, in practice, doctors tend to honour the child's preferences. The child's "participatory autonomy" is often regarded as residing on the outskirts of the decision-making autonomy explicitly granted to the child by the law in other domains [50]. Patient consent is typically considered essential, especially for medical treatments that affect the integrity of the human body. Administering a medical procedure to a child under duress would run counter to the principles of human dignity and the inviolability of the human body, as enshrined in Article 16-3 of the Civil Code and Article 3 of the ECHR. Such an act would also infringe upon the respect owed to the minor [51]. These principles appear straightforward when applied to procedures lacking therapeutic purposes, such as religious circumcision or cosmetic surgery.

However, conflicts can arise when a medical intervention is deemed necessary to protect the child's health, pitting the parents' duty to ensure their child's safety against the child's right to bodily integrity. As a result, doctors and parents may proceed without the child's consent in such situations. In this context, the child's autonomy is constrained in the interest of their own well-being [9].

The right to veto

In cases involving medical procedures that are not essential for a child's healthcare, children possess the right of veto. It is crucial to distinguish between the right to consent and the right of veto. The right to consent is applicable only when the law mandates the child's consent. In contrast, the right of veto comes into play when the child has been consulted about a specific procedure and has explicitly refused it [9]. For instance, in a case concerning ritual circumcision, a court ruled that this significant procedure could only proceed with the agreement of both parents and the consent of the child, who was eleven years old. The child had the right of veto and could decline this non-therapeutic procedure, given their sufficient maturity to make such a decision [52].

Another example pertains to the collection of hematopoietic stem cells for the benefit of a close relative [53]. This collection cannot proceed if the child refuses. In other words, a sufficiently mature child has the right of veto in this context. Similarly, the child also holds the right of veto with respect to biomedical research [54]. Such research can only occur in highly exceptional circumstances and necessitates the consent of both parents as well as the absence of any objection from the sufficiently mature child. Since it does not directly benefit the child, the child's refusal to participate cannot be overridden.

The right to provide consent alongside the parents

In certain cases, the law mandates the necessity of obtaining consent from one of the parents and the child. For example, minors aged 16 or older can select their general practitioner with the consent of just one parent [55]. Likewise, preserving gametes necessitates consent from the child and one of their parents [56]. In these particular scenarios, the child's autonomy is duly acknowledged.

The right to act without parental authorization

In all the situations previously discussed, the children can participate

in the decision-making process, but their powers are limited. In contrast, certain actions empower children to make fully independent decisions, without the necessity of notifying their parents. The Law of 4 July 2001 marked a significant milestone by granting genuine autonomy to children concerning contraception and abortion [57].

Firstly, access to contraception is both free and confidential, and it does not necessitate parental consent. *"The consent of those with parental authority is not required for the prescription, distribution, or administration of contraceptives to minors"* [58]. This means that minors can also access emergency contraception (commonly referred to as the "morning-after" pill) at no cost in pharmacies. Furthermore, nurses in secondary schools can provide emergency contraception to minors when they have no immediate access to a doctor or a family planning centre.

Similarly, abortion is cost-free and can be carried out without requiring parental consent [59]. In cases where a minor seeks confidentiality from her parents, the doctor will make an effort to encourage her to consult her parents. If this proves unsuccessful, the doctor will request that the minor be accompanied by an adult of her choosing.

Despite the seriousness of these procedures, minors can undergo abortions or obtain contraception without parental consent. Nevertheless, the minor will still benefit from adult guidance and counselling, and to ensure the minor's autonomy is adequately supervised, the law mandates that the doctor must provide the minor with comprehensive information [44]. These measures are not primarily intended to bypass potential parental objections. Their principal aim is to genuinely empower the minor to make decisions independently. The law enables minors to choose not to involve their parents and provides them with the resources to act autonomously, ensuring anonymous and cost-free access to contraception and abortion [60].

The Law of 4 March 2002 further extended this development by granting children the right to make their own decisions regarding actions necessary for the preservation of their healthcare, in the event that the minor expressly opposes the consultation of their parents in order to keep their health condition confidential. Upon the request of a minor, a doctor can carry out a procedure essential for their health without obtaining parental authorisation and while maintaining the confidentiality of this act [61]. In such cases, the doctor must make efforts to persuade the minor to reconsider their request. Failing that, the minor must be accompanied by an adult of their choice.

In these situations, parents can be entirely excluded from the decision-making process. However, the autonomy of the minor is limited to the nature of the medical procedures, as it pertains solely to actions necessary for the preservation of the minor's health [60].These circumstances should be considered as exceptional, as the provisions exclude actions driven by mere desire or enhancement. To determine whether an action is "essential" for the child's healthcare, the doctor must assess the reasoning and motives behind the minor's request for parental confidentiality. *"The legislator's overarching intention is not to grant purely whimsical requests lacking a sound justification"* [30].

Conclusion

The autonomy of the child has become increasingly significant in recent decades, particularly in the realm of healthcare. When it comes to a child's healthcare, the actions taken and decisions made directly concern the child's body. Given that these decisions can impact the child's physical well-being, it is crucial to consider the child's wishes, especially when the child is mature enough to express them.

However, the role of parents and the medical team remains essential for the same reasons. Since a child's life may be at risk, and these decisions can be life-changing, it is imperative that responsible adults ensure the protection and well-being of the child. The French legislature has thus sought to strike a balance between recognising the child's autonomy and the necessity of safeguarding them from their own decisions.

Funding

This work did not receive any grant from funding agencies in the public, commercial, or not-for-profit sectors.

Declaration of competing interest

The authors declare that they have no known competing financial or personal relationships that could be viewed as influencing the work reported in this paper.

The author declares that she has no conflict of interest.

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[56] Article L. 2414-11, Code de la Santé Publique.
[57] Loi n° 2001-2588 du 4 juillet 2001 relative à l'interruption volontaire de grossesse et à la contraception.
[58] Article L.5134-1, Code de la Santé Publique.
[59] Article L. 2212-7, Code de la Santé Publique.
[60] Paricard S. Quelle autonomie pour l'enfant au sein d'un couple parental uni?. Mélanges en l'honneur du professeur Claire Neirinck. Paris: Lexis Nexis; 2015. p. 755–78.
[61] Article L. 1111-5, Code de la Santé Publique.