

LETTERS

The Dutch legal approach regarding health care decisions involving minors in the NGS days

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We thank Sénécal and colleagues for addressing the important issue of the legal position of minors, involved in healthcare decisions, with particular attention to the context of next-generation sequencing.¹ The authors conclude that the legal frameworks of the 28 Member States of the European Union and Canada differ on the minor's right to provide consent for medical treatment. As to the latter, they identify three different approaches: 1) Legally-fixed age for capacity to consent to medical interventions; 2) competence-based approach; 3) mixed approaches. The Dutch legal framework fits within the first approach. In this respect, the authors further distinguish between frameworks using merely a fixed age threshold, from which minors should provide consent for medical treatment, and frameworks which include additional conditions and/or exceptions. According to the authors, the Netherlands fit within this first category. We would like to stress that this is not an accurate representation of Dutch law. On the basis

of the Dutch Medical Treatment Contract Act of 1995, minors aged 16 and older are in principle capable to decide on their own about medical treatment. However, children aged 12–16 have the right to consent to medical treatment (unless they are not yet capable to do so, for instance, due to a cognitive impairment), but they cannot exercise this right independently: their parents need to consent too.² This 'dual consent system' is not absolute, that is, situations could occur, in which a refusal by (one of) the parents can be ignored, for instance, if a refusal would have serious negative consequences for the health (prospects) of the child. We think it is important to add these principles to the article of Sénécal *et al*¹ because they constitute a core element of the Dutch legal framework regarding the legal position of minors, both in care and research.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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1 Sénécal K, Thys K, Vears DF, Van Assche K, Knoppers BM, Borry P: Legal approaches regarding health-care decisions involving minors: implications for next-generation sequencing. *Eur J Hum Genet* 2016; **24**: 1559–1564.

2 Kranendonk EJ, Ploem MC, Hennekam RC: Regulating biobanking with children's tissue: a legal analysis and the experts' view. *Eur J Hum Genet* 2016; **24**: 30–36.

Reply to Kranendonk *et al*

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We appreciate the comments provided by Kranendonk *et al.*¹ on our published article describing the existing legal approaches regarding the rights of minors to consent to health-care interventions,² including how laws in the 28 member states of the European Union and in Canada consider competent minors. We are in agreement with the nuances provided by Kranendonk *et al.* concerning minors aged 12–16 years in the Netherlands. As a matter of fact, this nuance was clearly included in the Supplementary Information that accompanies our manuscript, and available online since the publication of the manuscript. (<http://www.nature.com/ejhg/journal/vaop/ncurrent/supinfo/ejhg201661s1.html>). These nuances are also found in a 2015 article to be published in the November/December 2016 issue of *IRB: Ethics & Human Research*.³

In our *EJHG* article, the objective was to present the general approaches that state the question of whether, and from what age,

minors can generally provide lawful consent to health-care interventions. We have taken the Dutch law as an example to demonstrate that the fixed age of capacity to consent to medical care is sometimes set at a different age than the age of legal majority. In no case did we intend to over-simplify the Dutch law. However, presenting an in-depth analysis of all legal complexities surrounding the concept of mature minors in each of the countries under study was not possible. Well aware of the importance of these nuances and exceptions, we did include them in our publication by attaching them to our analysis tables that contain such legal nuances and exceptions. We invite the readers to refer to the Supplementary Information and to note that our article aims to present the general legal approach, but not an exhaustive legal analysis for each country included in this research.

The other point raised by Kranendonk *et al.* concerning parental refusal which would have serious negative consequences for the child, describes a situation foreseen in most child protection legislation around the world and would constitute reportable 'medical neglect'. The *EJHG* article neither included a systematic review of this subject nor of such legislation.

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