10

On Sharing the Normative Power of Consent

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Betty, who is 13 years of age, validly refuses to undergo treatment that would save her life. Betty's refusal is valid because she has decision-making capacity, is adequately informed, and she acts voluntarily. According to the law governing medical treatment decisions in England and Wales, valid consent is normally required for treatment to be lawful. This is true as much for minors as it is for adults, but in the case of minors, legal power to consent to treatment may be possessed or shared by others.[1] Children aged 15 years and younger are presumed to lack the normative power to consent to medical treatment. Treatment decisions are taken on their behalf by those who exercise parental responsibility. However, these minors may acquire the legal power to consent to medical treatment if it has been confirmed that they possess the requisite decision-making capacity. Children 16- and 17-year-olds are rebuttably presumed to possess the normative and legal power to consent to treatment.[2] Thus a competent minor's consent will, other things equal, make the provision of medical treatment lawful. However, a minor's possession of the normative power to consent to treatment does not extinguish the normative—and legal—power to consent to treatment on an adolescent's behalf held by those who exercise parental responsibility. As Anthony Skelton, Lisa Forsberg, and Isra Black observe, '[r]ather, parents and the courts retain the power to consent concurrently with the adolescent'.[3] Parents or the courts, therefore, have the normative power to consent to treatment that adolescents validly refuse.[4] Whereas decisions of competent adults regarding their own treatment is 'normatively determinative',[5] an adolescent's

[1] For a detailed outline of the law governing children's medical treatment in England and Wales, see Anthony Skelton, Lisa Forsberg, and Isra Black, 'Overriding Adolescent Refusals of Treatment', *Journal of Ethics and Social Philosophy*, 20 (2021), 221–47.

[2] The presumption will be rebutted, other things equal, if a minor is found to lack decision-making capacity.

[3] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment', 224.

[4] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment', 224.

[5] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment', 221.

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refusal is not treated as normatively determinative in law. So, Betty's refusal does not settle the matter of whether she receives life-saving treatment. Her parents or the courts may intervene and consent, overriding her refusal of treatment.

Neil Manson describes the situation above as one where the normative and legal power of consent is *shared* between adolescents and other parties. As he puts it: '(T)here is an intermediate, transitional period where the adolescent shares the normative power to permit her own treatment.'[6] A child who lacks decision-making capacity has no normative and legal power to consent; adults with capacity have, other things equal, an unshared normative and legal power to consent to treatment; and adolescents with capacity, other things equal, share their normative and legal power to consent to medical treatment with others. But what does it mean to share the legal power to consent with others? And how could the sharing of adolescents' normative and legal power to consent with others be justified? I shall treat these two questions in this chapter. I will argue that the limited power to refuse arguably serves the adolescent's interest to be protected from being severely harmed. The (shared) normative power to consent serves a normative control interest adolescents arguably (also) have. The limitation of their normative power to refuse is justified in cases where the interest in having normative control the full power of consent serves is outweighed by the interest to be protected from being severely harmed. If Betty validly refuses to consent to a minor medical treatment, no one should step in and overturn her refusal. In the life-saving treatment case, however, parents or the courts should have the normative power to consent to the medical treatment and thereby make it permissible. Adolescents sharing their normative power to consent with parents or courts when the choice made is greatly contrary to the adolescent's interest. These other parties should not share normative powers with adolescents with regard to decisions whose impact is relatively minor.

The chapter has four sections. The first section explains the concept of normative powers. The second section proposes an understanding of what it means to share a normative power with others. The third section discusses the question of whether the English legal regime on adolescent consent involves shared normative powers and whether—as Manson thinks—an asymmetry between the adolescent's consent being normatively determinative and the adolescent's refusal to consent not being normatively determinative can be defended. The fourth section addresses the justification for adolescents sharing their normative power to consent with others.

Normative powers

Before discussing the question of what it means to share a normative power, we need to be clear about what it means to have a normative power. I'll focus here on consent as a paradigm case of a normative power.

[6] N. Manson, 'Transitional Paternalism: How Shared Normative Powers Give Rise to the Asymmetry of Adolescent Consent', *Bioethics*, 29 (2015), 66–73 at 70.

Normative powers are powers to bring about normative changes.[7] More precisely, it is the exercise of a normative power that brings about a normative change. If A consents to a medical treatment, A exercises the normative power of consent. A thereby makes permissible a treatment that would otherwise have been impermissible. It is A's act of consent that creates the normative change. It does so if it meets the practical requirements of being adequately informed, voluntary, and given by a competent person.[8] The consenter is properly informed if she knows the relevant facts and her consent is not based on mistaken beliefs. Consent is voluntary if it is not brought about by deception, coercion, or manipulation. The consenter is competent to consent if she is able to understand the relevant information, and to apply it to herself, to reason with the information, and to express a choice. (Much more needs to be said about these validity requirements. This is just to give a rough idea of their content.)

Consent is the exercise of a normative power, one might say, if it creates the normative change of making permissible an act that would otherwise be impermissible. It must be noted here that the change brought about by consent does not have to consist in making an act all things considered permissible. An act that harms third parties, for instance, remains impermissible, even if it is first-personally consented to. The normative change brought about by consent in this case consists in making it the case that the consenter is not wronged by the act. The consenter is not wronged because the consent-receiver acts with her valid consent. She would be wronged if that other person acted without her valid consent. However, the act is wrong, but not as an act performed without valid consent; rather as an act inflicting harm upon third parties. Morally effective consent involves eliminating the wronging the act would have been if not consented to by the consenter. If no wronging of a third party is involved and no one else has a normative power over the act in question, consent makes the act permissible. This is, for instance, the case when adults consent to medical treatment (provided their consent is valid).

Note here that valid consent is only morally effective if the duty the consent refers to is a consent-sensitive duty. Consent-sensitive duties are conditional duties. They do not have the form (1) 'You ought not do x to A'; they rather have the form (2) 'You ought not do x to A if A does not consent to you doing x to her'. If you consent to a consent-insensitive duty no moral change is created. For instance, if one has consent-insensitive duty not to exploit people, a party's consent to an exploitative transaction can't be morally effective.[9]

[7] See R. Chang, 'Do We Have Normative Powers?', *Proceedings of the Aristotelian Society*, Supplementary Volume, 94 (2020), 275–300; D. Owens, *Shaping the Normative Landscape* (Oxford, Oxford University Press, 2012), pp. 127–9; and V. Tadros, 'Appropriate Normative Powers', *Proceedings of the Aristotelian Society*, Supplementary Volume, 94 (2020), 301–26.

[8] E. Bullock, 'Valid Consent', in A. Müller and P. Schaber (eds), *The Routledge Handbook the Ethics of Consent* (London, Routledge, 2018), pp. 85–94.

[9] See P. Schaber, 'The Volenti Maxim', *The Journal of Ethics*, 24 (2020), 79–89 at 86; also V. Tadros, *Wrongs and Crimes* (Oxford, Oxford University Press, 2016), p. 20.

Exercises of normative powers are acts that bring about normative changes. But more needs to be said to clarify the concept of a normative power. Many acts create normative changes without being the exercises of normative powers. We are able to change the normative landscape by—among other things—harming, benefiting, threatening people.[10] Take the case of harming. By harming another person, I change the situation so that I am bound by the duty to make amends. Yet, harming another person is not an exercise of a normative power. It is the impact my harming has on the well-being of the victim that brings about the normative change by creating a duty to make amends. The normative change is brought about indirectly. It is ultimately grounded in a further fact, a fact about the victim's well-being, not in the act of harming itself. The normative change brought about by the exercise of a normative power of consent, on the other hand, is ultimately grounded in the act of consent itself, not in a further fact.

The normative change created by the exercise of a normative power such as the normative power to consent is not brought about by chance. It is the result of an act that is based on an intention to bring about the normative change. As Victor Tadros puts it: '[T]he exercise of a normative power is a distinctive kind of intentional activity, where one directly alters the rights and duties of oneself and others.'[11] The rights and duties are altered by the act itself, or as Tadros writes: '[T]he execution of the power itself generates the relationship between duty holder and right holder …'[12] The exercise of a normative power of consent is an act that aims at changing the rights and duties of the consenter and the consent-receiver. And it is an exercise of the normative power to consent if and only if the consent-giver intends to create a normative change between consenter and consent-receiver.

Thus, one could define the exercise of a normative power in the following way: '(NP). An act is an exercise of a normative power if it is performed with the intention to bring about a certain normative change and the normative change is brought about by the act itself.'

However, this definition of normative powers faces a difficulty. It is still too broad and covers cases that should not be understood as exercises of normative power. Consider this example: Brenda is doing Kate a favour. Brenda does not do Kate a favour because she is concerned about Kate's well-being. Rather, Brenda does Kate a favour because Brenda wants to create a duty of gratitude. Assume that what Brenda does for Kate creates such a duty of gratitude. It is thus the act of doing a favour itself that created the normative change, an act that is based on the intention to bring about a certain normative change. This fits the description of the exercise of a normative power. Yet, Brenda's doing Kate a favour is not the exercise of a normative power.

[10] For other examples of this kind, see J. Raz, 'Normative Powers', in U. Heuer (ed.), *The Roots of Normativity* (Oxford, Oxford University Press, 2022), 162–78.
[11] Tadros, 'Appropriate Normative Powers', 313.
[12] Tadros, 'Appropriate Normative Powers', 314.

How does doing a favour differ from the exercise of a normative power like giving consent such that the latter unlike the former is an exercise of a normative power? What we have in mind when we talk of exercises of normative powers is something acts of consenting, making requests and promises, and giving orders have in common, and other ways of creating normative changes lack. Consider the 'doing Kate a favour' example again. Doing Kate a favour might be based on many different intentions. Brenda might want to promote Kate's well-being, or do something for her own reputation, or create a duty of gratitude, and other things more. The intention to create a normative change is not constitutive of the act performed by Brenda being an act of doing a favour. By contrast, the intention to create a normative change is constitutive for an act to be an act of consent. Consent is given with the intention of creating a certain normative change. When Brenda consents to Kate's doing x Brenda wants to make it the case that she is not wronged by Kate doing x. As David Owens puts it: 'I propose … to reserve "consent to φ-ing" for cases where you (intentionally) communicate the intention of hereby making it the case that someone would not wrong you by φ-ing.'[13]

An act is an exercise of a normative power if and only if the communicated intention to create a normative change is constitutive of the type of act it is. Let me explain. Consider the case of Mary consenting to lend John her phone. She might do so for various reasons. She might want to do him a favour or she might want to show him that she is a generous person. These are motivating reasons to give consent. Mary would, however, not consent to John taking her phone if she did not want to release him from his duty not to take her phone. Consent is about releasing another person from a duty. What Mary does can be taken as an act of consent only if she communicates that she wants to release him from a duty he has towards her. Otherwise, it would not be consent. To consent to John's taking her phone is for Jill to communicate that she does not want to be wronged by John's doing so. Whether Mary wants to be wronged by John is not an open question for him once he takes her act as an act of consent. She might, of course, communicate this intention without really having it. However, if John takes her communicative act as consent he believes that she wants to permit him to take her phone. Whether she wants to do him a favour by consenting to him taking her phone is on the other hand an open question. She might consent to John for this and other reasons. However, in saying 'Mary consents to lending John her phone because she does not want to be wronged by him' we refer to the fact she communicates her intention to release John from his duty not to use her phone. This is what constitutes consent. Thus, the exercise of a normative power should be understood in the following way (NP*):

> (NP*). An act is an exercise of a normative power if the agent communicates the intention to bring about a certain normative change and would not be the particular type of act if this intention to bring about the particular normative change was not communicated and the normative change is brought about by the act itself.

[13] Owens, *Shaping*, p. 166.

It is constitutive for the act performed by Mary to be an act of consent that she communicates that she wants to release John from his duty not to take her phone. In contrast, Brenda's doing Kate a favour could be based on different intentions. Brenda might want to create a duty of gratitude. But it would count as an act of doing Kate a favour even if it was based on a completely different intention. Many acts change the normative situation directly. And they might even do it intentionally without being an exercise of a normative power. As long as the communication of the intention to change the normative situation is not constitutive for the act being a certain type of act (like consenting, promising, or requesting), it is not an exercise of a normative power. It is the exercise of a normative power if this is the case. An act is the exercise of certain normative power if the agent communicates the intention to create a particular normative change: for consent, the intention not to be wronged by the act consented to, for promises to be under an obligation to keep the promise, and for requests to create a reason for the request-receiver to do as requested.

Sharing normative powers

Individuals have normative powers and, as Manson puts it, they 'can have normative powers that are shared with others'.[14] But what does it mean to share normative powers with others? Here is a proposal about how this should be understood: '(SNP). A and B share a normative power x if they are both able to bring about the same normative change by performing the same type of act.'

This holds for two different types of shared normative power situations: (1) When two or more people have full normative powers and (2) when the relevant normative power is jointly shared such that only collective exercise of the normative power brings about the normative change. Here is an example of the first type of shared normative power (1): Jay and Paul jointly own a car. They both can make it permissible for third parties to use the car by consenting. Susan may not use the car if neither Jay nor Paul consents to Susan using it. However, if Jay consents to Susan using the car Susan may use it. If Paul consents to Susan using the car Susan may also use it. Jay and Paul share the normative power to consent because they both can make it permissible for third parties to use their car by giving their consent. If Jay consents to Susan using the car and Paul refuses consent, it would be permissible for Susan to use the car because either Jay or Paul can make it permissible to use their car.

Here is an example of the second type of shared normative power (2): John is allowed to borrow the car Jill owns with Christine, Jack, and Sibyl only if the three also consent to John borrowing the car. If Jill has given her consent but Christine, Jack, and Sibyl have not been asked yet, John is not allowed to take the car. The

[14] Manson, 'Transitional Paternalism', 69.

other three must give their consent to make this permissible. Jill's consent thus does not make it permissible. Yet, her consent does make a moral difference. If John took the car he would commit a wrong, but he would not wrong Jill. By giving consent, Jill has waived her right and therefore is not wronged by John's taking the car. John would wrong Christine, Jack, and Sibyl. The moral change Jill's consent brings about consists in making it the case that she is not wronged by John's taking the car. Jill cannot release John from his duties he has towards the three other owners of the car. Jill can make it the case that only she is not wronged by John. She makes this the case by consenting. If Jill consents to John taking the car, Jill is not wronged by John's taking the car, even if the other three do not consent to it. But her consent can't make it the case that one of the three others is not wronged by John doing so.

Christine, Jack, Jill, and Sibyl share the normative power to make it permissible for John to take the car by jointly consenting to him doing so. The four, together, have the right to give permission. None of them, however, has the normative power individually to lend or sell the car. But individually, they have a right to release another person from a duty they have towards them that they do not share with the others.

Sharing the normative power to consent to medical treatment

Let us consider again the case of Betty. She does not give consent to life-saving treatment. Her parents step in, consent to the treatment, thereby waiving her right not to receive treatment. Does Betty share her normative power to consent with her parents? The parents' consent makes the treatment in question legally permissible. Betty is not wronged by the treatment if her parent's consent waives her right.

Her parents' consent has the power to waive her right not to receive medical treatment. Her consent is also able to waive this right. If she consents to the medical treatment, the treatment is permissible. This fits the definition of what it means to share a normative power. Parents as well as adolescents are able to create the same normative change (making an impermissible act permissible) by the same type of act, namely, by giving their consent. Betty's consent makes the treatment permissible and her parents' consent makes the treatment permissible.

Manson thinks that intervention when the adolescents refuse consent is more likely to be justified in the refusal than in the consent case and that the normative power to consent thus rather be shared in the refusal than in the consent case. 'The fact that an agent has refused a treatment which seems to be in her best, vital, interest should be a prompt for closer investigation' and might be a good reason to overrule the refusal to consent.[15] Take the case of a refusal of life-saving treatment. Parents or courts need to have the legal power to override such a refusal to prevent the adolescent from being severely harmed. To prevent this from happening,

[15] Manson, 'Transitional Paternalism', 69.

parents or courts should have the legal power to override the adolescent's refusal to consent. Thus, Manson writes, 'in the adolescent case, the child's own decision about her treatment is overridden in her best interests'.[16]

This is on Manson's view the reason why there should be a transitional period where the adolescent shares her normative power with her parents or the courts. It is preceded by a period where they have no normative power to consent and is (expected to be) followed by a period where they have unshared normative power. This transitional paternalistic period is in the best interests of the adolescent: '[a]dolescence is a period where there is a gradual expansion of autonomy, more and more options become open … new powers are acquired …'.[17] But with the gradual expansion of autonomy and new autonomy powers comes the risk of harm. It is this risk of harm that gives us reasons not to respect adolescents' decisions fully in a 'small set of decision-making contexts: that is, ones where the refusal would be severely harmful'.[18] Manson concedes that harm might also obtain in the consent case; however, this seems to be less likely to be the case.

If one took Manson's view to be a defence of a strict asymmetry between refusal and consent,[19] one would face the following difficulty. If the protection from being severely harmed is a reason to override a refusal to consent to treatment, it is at the same time a reason to override the adolescent's consent. Thus Manson's justification of paternalistic intervention is not a justification of the asymmetry between refusal to consent and consent. The reference to the child's best interests would only justify the asymmetry if only refusals to consent posed a risk of severe harm. This, however, is not the case. Consent can also pose the risk of severe harm. Consider a case of an adolescent seeking cosmetic breast enlargement. Were there a case of a physician offering an adolescent such an intervention and the adolescent consented, we might expect consent in the same way as cases of refusal to consent not to be normatively determinative. Thus, if transitional paternalism is about protecting adolescents' fundamental interests, it ought to apply to consent as well as to refusals to consent. (Though this position has not, as yet, manifested in legal doctrine.) As Skelton, Forsberg, and Black put it: 'We would stress that it need not, of course, be the case that consent is prudentially unproblematic all things considered … we might envisage cases in which the converse is true.'[20]

Since physicians are obliged to offer only treatments that are in the best interest of the patient, the case for paternalistic interference in adolescents' exercise of

[16] Manson, 'Transitional Paternalism', 70.

[17] Manson, 'Transitional Paternalism', 72. A similar justification of the asymmetry between the right to consent and the right to refuse to consent can be found in F. Tucker, 'Developing Autonomy and Transitional Paternalism', *Bioethics*, 30 (2016), 759–66 at 766: 'Transitional paternalism … offers guiding principles that can protect and promote adolescents' fundamental interests …'

[18] Manson, 'Transitional Paternalism', 72.

[19] An interpretation Manson would quite likely not be happy with.

[20] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment', 240.

consent may be rare.[21] Yet, it is not impossible. And if intervention by parents or courts is about protecting adolescents from being severely harmed, an adolescent's consent perhaps ought to be as provisional in the case of consenting as it is in the case of them refusing to give consent. Then adolescents would share the power of consent (and refusal) with parents and the courts.

I suggest here that it would be easier to justify intervening in the consent case than in the refusal case. If Betty does not consent to the life-saving treatment and her parents intervene and consent, treatment will be undertaken without her consent and presumably also against her will. (Consenting to an act and wanting the act to be performed are not the same. You can consent to an act and hope that the consent-receiver will not perform it. You can want someone to do something without consenting to her doing it.) If, on the other hand, Betty consents to a medical treatment, yet her parents step in and override her consent, nothing will be done without Betty's consent. It will be true that something Betty wants done will not be done. But if something she consented to is not done, nothing is done to her without her consent. The medical treatment simply would not be undertaken.

Intervening in the refusal case would lead to an act performed without an adolescent's consent. This is harder to justify. Stronger reasons must speak in favour of intervening when adolescents refuse to consent than when they consent to medical treatment. Why is this the case? If Betty consented, but received no treatment, the physician would not act according to her will, but would also not perform an act without her consent. The physician is in any case free not to undertake the treatment. In the consent case, one has to justify not acting according to Betty's will and compelling her to remain in some state. In the refusal case, one has to justify not acting according to Betty's will and in addition performing an act without her consent. The latter has two potentially problematic features, the former only one. This makes it more difficult to justify the latter than the former. This is not due to higher costs brought about by the latter, it is due to the fact that the latter has not just one but two wrong-making features, (1) 'acting against Betty's will' and (2) 'acting without Betty's consent'.

Should the normative power to consent be shared?

According to the doctrine we are discussing here, adolescents have the power to change the normative situation by giving consent. However, their power to consent is conditional on their parents or the courts not overriding their refusal (or possibly their consent). The question is whether a moral justification can be found for this form of sharing the normative power with others.

[21] As David Wendler puts it: 'The principle that physicians should always act in the best interests of the patient is widely endorsed.' See D. Wendler, 'Are Physicians Obligated Always to Act in the Patient's Best Interest?', *Journal of Medical Ethics*, 36 (2010), 66–70 at 66.

Rob Lawlor thinks that the position faces a serious difficulty. It 'relies on deception, letting adolescents believe that they have a choice when, in reality, they do not'.[22] Take the case of the 13-year-old Brenda who consents to a life-saving treatment. Her consent makes a treatment permissible that would otherwise have been impermissible. She chose consent over refusal to consent. However, if she had chosen refusal over consent, her parents would have stepped in and permitted the treatment. Lawlor thinks that Brenda might have thought that she was free to consent. But, in fact, she had no choice. Her refusal would have been overridden by her parents.

Does Brenda have no choice? Her consent is provisional. But she is able to make a medical treatment permissible. She has the choice between consenting and not consenting to the treatment. Her consent might in both cases be overruled. But this does not mean that she has no choice. It means only that she does not have the final word with regard to whether the medical treatment is permissible or not. Brenda has a choice as far as she is able to make the treatment permissible. She may consent to the treatment and neither parents nor courts may step in. Brenda would bring about the normative change. Brenda therefore has a choice. She can freely choose to consent. This is what she does if she decides to consent even if she has no genuine option to refuse consent. But can it be justified that she does not have the full power to consent?

Skelton, Forsberg, and Black develop a justification of the legal doctrine in question by backing it with a substantive theory of welfare. They argue that the doctrine may be accounted for if one focuses on the unique features of the well-being of adolescents.[23] The fact that what is good for adolescents differs from what is good for adults may, on Skelton *et al*.'s view, provide us with a justification of the differential treatment of adolescents. Subjective experience plays a different role in the well-being of an adolescent and adult. They write:

> It seems that much less of what makes an adult's life go well is due to the possession of objective goods, though such goods may be in part what an adult cares about … By contrast, it is plausible that what is good for a young child lies in part in the possession of so-called 'objective' goods, things good for an individual regardless of her subjective attitudes toward them … Adolescents occupy a middle position between young children … and typical adults …[24]

Subjective considerations as well objective goods matter for adolescents. As the adolescent ages 'her well-being becomes increasingly based on subjective considerations or the passage of events meeting her expectations or aligning with her values'.[25] Still, important aspects of her well-being will remain objective. Skelton

[22] R. Lawlor, 'Ambiguities and Asymmetries in Consent and Refusal: Reply to Manson', *Bioethics*, 30 (2016), 353–7 at 355.
[23] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment'.
[24] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment', 236.
[25] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment', 237.

et al. argue that, among other things, shielding adolescents from taking full responsibility for their actions may be objectively good for them.[26] They take this 'shielding' to be 'a variety of freedom: freedom from making certain kinds of decisions in the absence of a safety net of scrutiny and possible limitation on action'.[27] This, on Skelton *et al*.'s view, may imply the freedom from having the full power to refuse to consent to medical treatment. It is objectively good for adolescents not to possess the unlimited power to refuse to consent. Thus, they conclude that their 'welfarist view' may support the concurrent consent doctrine.[28]

Does the fact that it is objectively good for adolescents to be shielded from taking full responsibility for their actions justify the sharing of the normative power to consent between the adolescent and other parties? The question is whether there is an interest of the adolescent that is served by the normative power to share their normative power to consent. Skelton *et al*. argue that it might be objectively good to have such a limited power to consent. The question is how the different interests that are at stake here are to be weighed against each other. Limiting the normative power to consent is justified only if the interests served by the full power to consent are outweighed by the interests served by having only a limited power to consent.

The power of consent serves a control interest over what others do to us. David Owens holds that there are different reasons for a person to have an interest in controlling what happens to her.[29] First, the fact that someone decides to undergo medical treatment is a good sign that it is also in her interest to do so. Second, in addition, it is often the case that something is in the interest of a person *because* she has decided to do it: 'The fact that I have chosen to φ may actually make it the case that φ-ing is in my interests rather than merely indicate that this is so.'[30] Finally, our decisions also have a social dimension. Owens gives this example: 'Often it is not embarrassing to be observed naked (…) provided one has chosen to be so observed.'[31]

Tadros also argues that our interest in controlling what others do to us plays a central role in explaining why we have the normative power of consent: '(T)he idea that we value having control over our lives, including, importantly, control over the actions of others who would interfere with us, is central to explaining these wrongs.'[32] And he adds: 'We value having this control, and other people respecting our control, simply in itself. When we are subject to consent-sensitive duties, and we respect those duties, we are independent of each other, just in the sense that we can restrict bodily interference by others.'[33]

[26] It has to be noted that this is on their view not the only prudential good and also not the only prudential good at play in these decisions.
[27] Skelton *et al*., 'Overriding Adolescent Refusals of Treatment', 237.
[28] Skelton *et al.*, 'Overriding Adolescent Refusals of Treatment', 237.
[29] Owens, *Shaping*, p. 166.
[30] Owens, *Shaping*, p. 167.
[31] Owens, *Shaping*, p. 167.
[32] Tadros, *Wrongs and Crimes*, p. 222.
[33] Tadros, *Wrongs and Crimes*, p. 222.

Recall that A has a consent-sensitive duty towards B not to do x if A is obliged not to do x unless B consents to A doing x. We value having control over our consent-sensitive duties for various reasons. Having this control serves the different interests Owens mentions.

The main interest consent serves is what Owens calls a normative interest.[34] The full power of consent adults have serves an interest in having normative control over the actions that would interfere with our lives. It is the interest in being able to decide what others may or may not do to us. Having such a normative interest explains how it could be good to allow another person to perform an act even if that is not in the interest of the consent-giver: it is good for her so far as it is controlled by her. And this is in the interest the normative power of consent serves: it enables us to control what others may do or not do to us.

Adults have this interest in having normative control. But do adolescents have such an interest, too? Due to the gradual expansion of their autonomy, they also have such a normative interest. This is an interest the power to consent the adolescents have serves. It is also a reason why they have this power. Children do not have such a control interest because they are not capable of exerting control that is in their interest, and this is why they do not have the power to consent to medical treatment.

Adolescents have an interest in having normative control and arguably an interest in being shielded from taking full responsibility for some of their actions. Their normative power to consent serves their interest in having normative control. That their consent can be overridden by their parents or by the courts serves their welfare interest. Their consent is justifiably overridden if it is in their best interest. The intervention might serve what is objectively good for them, but it is only justified if the welfare interest served by the intervention is more weighty than the control interest it thwarts. That is to say, the sharing of the normative power is justified only if having normative control over what others do to us and other people respecting this control is not as valuable for adolescents as it is for adults, and in particular if it is of less value for adolescents than not being shielded from taking full responsibility in cases where basic interests are at stake. This is what justifies the sharing of the normative power to consent between adolescents and their parents or the courts. The given view of well-being shows that the control interests of adolescents are in certain cases outweighed by their interests to be protected from being severely harmed. Intervention is justified in cases where the interest in being protected from being severely harmed outweighs the interest in having normative control. It is justified when a life-saving treatment is at stake. It is also likely justified when the adolescent would, without treatment, suffer from a permanent loss of limb or disfigurement. It might, on the other hand, not be justified if the adolescent refused to consent to knee surgery, preferring physiotherapy as an alternative treatment. Shared normative power is justified when the control interest an individual has is

[34] Owens, *Shaping*, p. 6.

less important than the welfare interest they have in being shielded or protected from the full effects or consequences of their medical decisions.

Conclusion

Thirteen-year-old Betty validly refuses to consent to a life-saving treatment. If she had the full normative power to consent, the treatment would be impermissible. According to the legal doctrine I have discussed in this paper, adolescents have the limited normative power to give provisional consent. They share the normative power to consent with others. People share a normative power if they are able to create the same type of normative change by the same type of act. This is what adolescents, parents and courts are able to do with regard to medical treatments. By consenting they can make a particular medical treatment permissible. The adolescent's consent is provisional, while the consent of the parents or the courts is normatively determinative. However, all parties are able to bring about the same normative change. The limited power of consent arguably serves the adolescents' interest to be protected from being severely harmed. The normative power to consent serves a control interest adolescents arguably also have. The limitation of their normative power of consent is justified in cases where the interest in having normative control the full power of consent serves is outweighed by the interest in being protected from being severely harmed. If Betty validly refused to consent to a minor medical treatment no one could step in and overturn her refusal. In the life-saving treatment case, however, parents or the courts have the normative power to consent to the medical treatment and make it thereby permissible.