Published in final edited form as:

Perspect Biol Med. 2016 ; 58(3): 290–305. doi:10.1353/pbm.2016.0012.

The Potential Value of the U.N. Convention on the Rights of the Child in Pediatric Bioethics Settings

Michael Da Silva*, Cheryl D. Lew[†], Laura Lundy[‡], Kellie R. Lang[§], Irene Melamed^{**}, Randi Zlotnik Shaul^{††}

*SJD Candidate, University of Toronto Faculty of Law, and Training Fellow and Vanier Canada Graduate Scholar, Canadian Institutes of Health Research (CIHR), Toronto.

[†]Department of Pediatrics, Keck School of Medicine, University of Southern California.

[‡]School of Education and Centre for Children's Rights, Queen's University, Belfast.

[§]Center for Bioethics and Medical Humanities Institute for Health and Society, Medical College of Wisconsin, Milwaukee.

^{**}Bioethics and Health and Social Sciences Programs, Latin American Faculty of Social Sciences (FLACSO), Buenos Aires.

^{††}Department of Bioethics and Child Health Evaluative Services, The Hospital for Sick Children, University of Toronto.

Abstract

This article provides support for the use of a particular international human rights law document, the U.N. Convention on the Rights of the Child (CRC), in contemporary pediatric bioethics practice without relying on the legally binding force of the document. It first demonstrates that the CRC's core commitments and values substantially overlap with the core commitments and values of mainstream bioethics and with the laws of many domestic jurisdictions where mainstream bioethics are currently practiced. It then explores some implications of this overlap. For instance, the substantial international human rights law scholarship on how to understand these commitments and values can be helpful in suggesting ways to operationalize them in domestic bioethics practice and can offer insightful, internationally generated ethical perspectives that may not have been considered. The article also argues that the CRC can help health-care organizations develop policies consistent with the best interests of children and that the CRC can serve as a common language of values for transnational health-care collaborations. However, as a final case discussion demonstrates, whatever the merits of the CRC, one may face practical difficulties in trying to use it.

In this article, we examine how the U.N. Convention on the Rights of the Child (CRC) can be useful in pediatric bioethics. Adopted in 1989, the CRC reflects norms that have been deliberated upon for a long period of time and endorsed by most nations. The United States is now the only country that has not ratified the CRC.¹ International human rights law shares

many key moral concepts with clinical pediatric bioethics, and the CRC provides a considered language common to many jurisdictions that can assist bioethicists in their daily practice and help health-care organizations in their policy development and international interactions. There may, however, be practical challenges with using the CRC in the practice of bioethics. While international human rights law in general may not be sufficiently nuanced or ethically authoritative to effectively resolve many bioethical disputes (a point on which we take no definitive stand here), we argue that the CRC in particular provides a resource for engaging global normative moral concepts and values that are useful for clinical pediatric bioethical analysis, policy development, and international collaborative activity aimed at the health of children.

The Role of Rights in Bioethics and the CRC

The term *rights* may refer to several conceptually distinct entities. A key conceptual distinction depends on distinguishing between the realm of the legal and the realm of the ethical (see, for example, Kant 1797). Rights may be divided into two classes: those that are legally entrenched, and those held as a matter of ethical principle, irrespective of legal status. Each class of rights can then be divided into categories. For example, legally entrenched rights can take at least four forms: common law rights that exist in a nation in the absence of statutes; statutory rights that exist by virtue of a given nation's legislation; rights that are constitutionally entrenched; and rights that exist under international law. Those who view written constitutions as mere "special statutes" or live where a constitution only exists as common law may view the third category as a special instance of either the first or second categories. Rights held as a matter of ethical principle may also be variously categorized. For instance, in the social rights context, Jeffrey King (2012) not only recognizes three (rather than four) types of legal social rights (omitting the common law) but also identifies two forms of non-legal moral rights.

In this article, unless otherwise indicated, the term *rights* refers to international rights. We seek to address claims concerning the appropriateness of consulting or invoking international legal rights and international legal rights discourse in clinical bioethics. Granting that moral rights are relevant and connected to the specific elements within international law, we then go on to argue that consideration of at least one international human rights document, the CRC, may be useful for stimulating refinement of these moral concepts. We build on existing work on the role of statutory and constitutional rights in bioethics (e.g., Zlotnik Shaul and Vitale 2009) to examine the role that the role a specific international human rights law, the CRC, can and should play in clinical pediatric bioethics. We conclude that the CRC's text and subsequent interpretations and applications offer insights that can be useful in pediatric bioethics.

¹The most recent (2015) U.N. Treaty Series ratification list does not list South Sudan as a signatory and further states that Somalia and the United States have yet to ratify. However, the United Nations has released news story lauding Somalian and South Sudanese ratification (UN 2015a, 2015b).

The CRC and Modern Bioethical Principles

The CRC, like most international human rights legal documents, is an explicitly normative document committed to a set of values at the core of human rights practice. The CRC is the result of decades of debate and advocacy. While drafting of the CRC began in 1979, the International Year of the Child, it was preceded by a 1959 U.N. General Assembly declaration, which itself succeeded a much shorter 1920s League of Nations equivalent (Cohen 1990; Hart 1991; League of Nations 1926; Van Bueren 1998). The CRC thus builds on a tradition of advocacy towards human rights dating back until at least the end of World War I. The CRC also builds on a post–World War II tradition of internationally protected rights, which includes the Universal Declaration of Human Rights (UDHR, 1948), the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966b), and the International Covenant on Civil and Political Rights (ICCPR, 1966a). Children, as human beings, enjoy many rights set out in the earlier international human rights treaties. The modern CRC, a product of the late 1980s, then adopts and adapts them, articulating the rights in ways that are relevant to children’s lives and experiences and ultimately providing a bespoke statement of human rights for those who have not reached legal adulthood. Regardless of what one thinks the implications should be of the near-universal ratification of the CRC within an individual domestic context, the statement of values the CRC sets forth has taken on the air of moral prescription in some countries, and in many countries the CRC is regarded to be of strong legal or interpretative force (Davidson 2014; Lundy, Kilkelly, and Byrne 2013). The CRC provides a set of standards that can—and in some contexts must—contribute to the creation and implementation of public and institutional policy.

The values embodied in the CRC are congruent with those articulated in traditional Anglo-European bioethics, and the CRC provides a platform for articulating the meaning of those traditional bioethics values, such as inherent dignity and equal and inalienable rights. The preamble to the 1945 Charter of the United Nations states that the organization is required partly “to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small.” The value of dignity is articulated in Article 3 of the ICESCR and in the preambles to the ICCPR and the Declaration on the Elimination of Violence Against Women (1993), while equality guarantees are included in Article 1 of the UDHR, Article 3 of the ICESCR, and Article 11 of the Convention on the Elimination of All Forms of Discrimination Against Women (1979). In this vein, the first paragraph of the preamble to the CRC refers to “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family,” suggesting that the articles that follow provide an articulation of how such concepts should be understood in relation to children. The international understanding of these articles provides a framework for understanding *dignity* and *equality* that can help inform critical analysis of how the terms can and should be used in clinical bioethics.

Beyond the articles themselves, CRC commentary reflects further engagement with these and other child-relevant values. Commentary on the CRC values provides perspectives that may be useful for those working to understand, refine, and operationalize values central to bioethics. The decades of interpretation are the product of internationally representative committees, specialized independent rapporteurs, and scholars. For instance, the Committee

on the Rights of the Child (Committee) produced a number of General Comments that provide interpretative perspective. One of the most recent, No. 14, focuses on the best interests of the child standard (UNCRC 2013). While interpreted differently in different parts of the world, the concept of “best interests of the child” is central to Western pediatric bioethics (Eekelaar 1992, 1994; Gibson et al. 2012; Kieckhefer and Trahms 2000). An expansive understanding of international human rights law (that includes commentaries and scholarship thereon) related to the CRC provides a large trove of materials by recognized experts on key values. These include discussion of practical, real world issues and how international human rights law values could and should be applied to resolve them.

The CRC further serves to provide a framework for the realization of several key moral values in pediatrics. For example, Articles 3, 9, 18, 21, and 37 of the CRC all explicitly refer to “best interests,” and the CRC implicitly incorporates best interests considerations in Article 23, which states that a child with disabilities should “enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community.” This understanding of the best interests standard is broadly consistent with its use in interdisciplinary bioethics literature (in, for example, Gibson et al. 2012; Kieckhefer and Trahms 2000) and could help to inform it. Similarly, the CRC’s recognition of children’s evolving capacity and the correlating affirmation of the child’s voice in Articles 5 and 12 developed in parallel with these concerns in pediatric bioethics (Harrison 2010; Harrison et al. 1997; Hesson, Bakal, and Dobson 1993; Larcher and Hutchinson 2010; Kenny, Downie, and Harrison 2008; Tillett 2005).

One may suggest that many bioethical principles are so sufficiently settled that the CRC (and similar documents) have nothing to add, but even those principles for which the literature is rich may benefit from further clarity or refinement. For instance, the notion of patient-centered care has an extensive literature linked to the conceptualization of patients as individuals with rights (Chapman 2014; Nicholas, Keilty, and Karmali 2014; Sheahan et al. 2014). While this conceptualization finds some support in the CRC, the CRC goes on to offer support for the articulation of family-centered care. The preamble states that “the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.” Article 3(2) provides certain rights to parents. Article 7 guarantees a right to know and be cared for by one’s parents “as far as possible.” Other provisions, such as Articles 5, 11, 18, and 27, go on to nuance those statements. Looking at those provisions in context, as well as their interpretations and challenges (Engelhardt 2010; Salter 2014), could be helpful for understanding how family-centered care ought to develop and be applied in clinical bioethics—a context where there is a common focus on the rights of the individual (McCullough 2014).

Rights Entrenched in Domestic Laws

The value of international human rights law for bioethics may also apply to domestic law, which some bioethicists may consider as an additional resource in developing pragmatic frameworks for the practice of clinical bioethics. The CRC can be useful in facilitating

interpretation of statutes or policies and their application to pediatric contexts. Examples of values or principles that are shared by the CRC and domestic law include “best interests” and “family-centered care,” as well as “respect,” “autonomy,” and “patient-centered care.”

We provide examples from three countries here, though this does not exhaust international and domestic overlap. In Canada, examples of domestic law where such concepts are central include Ontario’s 1996 Health Care Consent Act and the 2014 Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2), issued jointly by the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research Council of Canada, and the Social Sciences and Humanities Research Council of Canada. In the United States, there are several key examples of case law in which the value of “respect” (for parents and the family) and concept of “best interests” are articulated. These include *Parham v. J.R. et al.* (442 U.S. 584 (1979)), in which the court states that “Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children ... natural bonds of affection lead parents to act in the best interests of their children,” and *Troxel v. Granville* (530 U.S. 57 (2000)), in which the court states that “we have recognized the fundamental right of parents to make decisions concerning the care, custody, and control of their children.”² In Argentina, examples of domestic law referring to similar rights include *Derechos de los Pacientes* (Patients’ Rights; Ley 26.529 n.d. 26529/26812) and *Ley de Protección Integral de los Derechos de la Niñas, Niños, y Adolescentes* (Protection of the Rights of Children and Adolescents; Ley 26.061).

While the actual content (and context) of the CRC and domestic law will be different, their underlying values and principles are remarkably similar. Some courts already recognize this overlap and use international law to frame their domestic judgments. For instance, the concept of best interests of the child was a focus of a Supreme Court of Canada decision, *A.C. v. Manitoba (Director of Child and Family Services)* ([2009] 2 S.C.R. 181). The Court directly refers to its interpretation of the concept as being consistent with Article 3 of the CRC, and the decision also describes how the CRC sets out a framework under which the child’s input will inform the content of the best interests standard, with the weight accorded to these views increasing in relation to the child’s developing maturity. For example, Articles 5 and 14 of the CRC require states parties to respect the responsibilities, rights, and duties of parents to provide direction to the child in exercising his or her rights “in a manner consistent with the evolving capacities of the child,” while Article 12 requires states parties to “assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.” Interestingly, the relevance of international human rights documents was deemed so important by the Court that the decision quotes Article 6 of the Council of Europe’s 1997 Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine: “The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity” (para. 93).

²For a more complete history and analysis of U.S. law related to best interests, see Kohm 2008.

There is, then, widespread overlap between the CRC and values entrenched in many domestic spheres. Just as domestic law can be relevant to clinical bioethical analysis, the CRC and its commentaries can be a useful source for better understanding these values and how they should apply in the domestic sphere. International human rights law has, for instance, been used to help courts interpret rights to dignity and equality under domestic jurisdictions. Similar laws have, in turn, been used to help guide clinical decision-making. For example, while the right to equality under Section 15 of the 1982 Canadian Charter of Rights and Freedoms may not be binding in individual relationships, the case law and literature linked to the provision can provide ethically sensitive insights for other bioethical deliberations related to equality (Zlotnik Shaul and Vitale 2009). The CRC and the literature thereon can play a similar role in helping us understand alternative ways of understanding values in both domestic law and clinical decision-making. This includes the special authoritative commentaries on the CRC produced by the U.N. Committee on the Rights of the Child (Committee), the 17 “General Comments” that provide interpretative guidance on the CRC. These explorations of the key values and principles in the CRC could provide insights on how best to understand their equivalents in domestic law and mainstream bioethics. Indeed, one of the most recent General Comments focuses on the best interests of the child standard mentioned above (UNCRC 2013) and could be valuable in the domestic clinic sphere.

The status of the CRC in particular national contexts will, of course, depend on that jurisdiction’s individual legal framework (Lundy, Kilkelly, and Byrne 2013), but this does not make the CRC irrelevant for bioethicists. Article 41 of the CRC recognizes that domestic rights are not reducible to their international equivalents, clearly stating that: “Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in: a) The law of a State party; or b) International law in force for that State.” However, scrutinizing domestic values, rights, and laws in light of their international equivalents should allow one to better understand the persuasiveness and justifiability of domestic laws and thus assist bioethicists in assessing the domestic legal limits of decision-making.

International human rights law is also *legally* relevant in many jurisdictions, including some jurisdictions where it is not domestically entrenched. For some states, ratification of international law triggers its simultaneous adoption as domestic law. Other states require formal adoption through domestic proceedings after ratification, yet even some of these states acknowledge the domestic relevance of international human rights law before its actual adoption. For instance, according to Article 39 of the 1996 Constitution of the Republic of South Africa, the Constitutional Court of South Africa is required to use international law as an interpretive tool in its domestic decisions. While not required to do so, the Supreme Court of Canada has viewed the CRC as a relevant tool for interpretation, as in *Baker v. Canada (Minister of Citizenship and Immigration)* ([1999] 2 S.C.R. 18). The valuable role of international human rights law as an aid in interpreting domestic law has also been recognized in other common law countries, including New Zealand and India; see, for example, *Taviata v. Minister of Immigration* ([1994] 2 N.Z.L.R. 257 (C.A.)) and *Vishaka v. Rajasthan* ([1997] 3 L.R.C. 361 (S.C. India)). International human rights law has even been recognized as important for interpreting the scope of the rights included in the

Canadian Charter of Rights and Freedoms, with important cases including *Slaight Communications Inc. v. Davidson* ([1989] 1 S.C.R. 1038) and *R v. Keegstra* ([1990] 3 S.C.R. 697). Those who take the persuasiveness of domestic laws in clinical practice for granted may thus have a reason to reconsider any lingering skepticism about the persuasiveness of international law. International law is not binding in all states at the point of ratification, but this exploration of the ways that the CRC can be relevant even prior to full adoption suggests that legal persuasiveness may precede adoption; ethical relevance may similarly precede domestic adoption, particularly given the consistency between the CRC and traditional bioethics outlined above.

None of this is meant to suggest that there is unanimity around the merit of values included in the CRC, or the extent to which these values should guide all clinical bioethics deliberations. Just as a clinical bioethicist can disagree with domestic law or the perspective of a colleague, so too might a clinical bioethicist disagree with a provision in an international human rights convention. The guarantee of a right to a paid vacation in the UDHR's Article 24 is a widely cited example of where such disagreement exists even among human rights scholars (Cranston 1967). Bioethicists may also question whether provisions of the CRC are consonant with or remain current in their context. For example, some critics hold that the sense of family enshrined in international law may be culturally dependent, providing one example of a potential lack of contextual consonance (Sirvastava 2014). There are also substantive moral statements in the CRC about which some may debate, such as the protection of the child "before ... birth," stated in the preamble. Though there may be vocal or public disagreement about some of the rights listed in the CRC, these conflicts should not negate the normative weight, and strength, of values where there is widespread agreement.

The CRC, then, can help one better understand concepts already present in the bioethics literature and domestic law and identify other values that ought to be considered, but this does not mean that the CRC should be dispositive in any given debate. Even where international human rights law provides guidance, bioethicists will still need to weigh international values against other types—particularly in light of international human rights law's known limitations. Clinicians and clinical bioethicists can use the CRC and similar documents to inform their analysis (Kasper 2004), but they must still assess its claims and ultimately resolve the disputes they encounter. While the CRC may further help identify potentially relevant values, it is not a panacea.

The CRC in Health-Care Organizations

Bioethicists are no longer consulted solely about issues related to individual patient care situations; they are also consulted regularly regarding organizational issues, policy development, and research ethics questions (Bean 2011). In such situations, it can be helpful to have guidance documents like the CRC that reflect internationally endorsed values when analyzing or developing policies and procedural frameworks.

For instance, one notoriously difficult aspect of policy design in the pediatric health care setting is religious accommodation. The CRC offers guidance relevant to those aiming to address such issues through policy development. Article 14 of the CRC states that:

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.
2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.
3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

This view is nuanced in, for instance, Article 30, which states:

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practice his or her own religion, or to use his or her own language.

Article 14 of the CRC clearly supports the role of children in their decision-making as their capacities evolve, and thereby constrains the extent to which *parents'* religious beliefs should play a role in decision-making.

The passage from Article 14 outlines what limitations on religious freedom are allowed at international law. Where governments assent to these strictures, they implicitly endorse a series of proscriptions for what types of freedom-limiting policies a health-care organization can create. This effectively constrains the number of solutions to the problem of religious accommodation. It does not endorse a specific solution for all contexts. It does not even bar some solutions that many ethicists would find problematic. For instance, the language is not specific enough to protect children from long-standing cultural and religious practices that can result in serious long-term and lifelong injury, such as female genital cutting. Presented with these limited solutions, bioethicists may then consult traditional (philosophical and interdisciplinary) sources in order to weigh in on which solution is most ethically defensible.

The CRC provides similar guidance on a variety of additional issues about which health-care organizations sometimes struggle to develop policies. For instance, it has clear statements on children's right to privacy and access to information in Articles 16, 17 and 42. Although the CRC may be unclear or otherwise normatively unsettled in certain cases, its broader statements about such policy issues allow a plethora of solutions to survive and thereby minimize the number of potentially erroneous proscriptions that can be made.

The CRC and Health-Care Organizations' International Interactions

Just as the CRC articles and commentaries can challenge and enhance reflection on practices within a health-care organization, it can do the same for practices beyond an organization's

walls. Where support for the values reflected by the CRC is sufficiently high to constitute common practice, the CRC could be a helpful tool for health-care organizations' international interactions, and bioethicists involved in such activities could benefit from advising the adoption of CRC-based policies for international work. In short, the CRC offers a values-based common ground helpful for interactions and joint initiatives, between persons or organizations representing distinct contexts. As Robert Baker (2001) points out, human rights discourse is already "the lingua franca of the international community" (250). The relationship between bioethics and human rights allows us to extend a vision of human rights that universally integrates principles and shared values together with contextual and cultural specificities.

Baker (2001) rightly goes on to note that this international language must itself be subject to critical scrutiny, but if the CRC in particular has this level of shared acceptance, it can make two types of health-care organizations' international interactions easier. First, the CRC can provide a set of norms that can ease access to other nations, providing much-needed guidance on how to successfully develop or collaborate in programs abroad. While bringing domestic knowledge or programs to other nations with required cultural sensitivity can be challenging, recognized consensus on values may eliminate some cultural barriers (Dogra, Reitmanova, and Carter-Pokras 2010). Second, the CRC can ease the transition of international trainees, staff, and families into a new clinical setting. The same cultural barriers that make international ventures difficult can also make it difficult for international workers to enter the domestic sphere, so it stands to reason that if shared standards ease those barriers for health-care practitioners and organizations going abroad, they will also ease the barriers for international workers arriving in a new setting.

The CRC also provides pediatric clinical bioethicists with a foundation and public moral voice to advocate for children at institutional and national levels and an approach to how to attend to the rights and best interests of children. A reasonably common scenario illustrates this point. At the bedside, when a critical decision has to be made about the ultimate well-being of a child, many factors and values are weighed. It is in this setting that direct care providers and pediatric ethicists alike witness the struggles and suffering of a child and her or his family. This suffering is not limited to the reason for hospitalization or clinic visit, but extends to concerns for how the child will (or can) be cared for at home or in an institution; how the family will cope; and whether (and how) the child and family will flourish. For example, a nurse may witness loving, concerned parents whose child may be placed in medical foster care because the parents no longer have consistent housing. Since removing children from their homes under these circumstances arguably violates a number of the CRC articles, the CRC could be cited as justification for advocating a change in policy or law.

The CRC may be helpful to pediatric bioethicists when calling upon pediatric health-care institutions to formulate policy and practices that support access of children to the CRC's standards of living and to advocate for children through their respective government relations departments. Given our increasingly global social system and economy, the CRC could serve as a useful guide for advancing health and social policies that benefit children and families—without regard to political affiliations.

The CRC in Nations Where It Has Not Been Ratified: Some Thoughts and an Example

International human rights law is criticized on a variety of grounds. For instance, international human rights law is charged with being non-authoritative in the absence of clear consent or with being an aspirational ideal that lacks the proper institutional mechanisms to ensure compliance. Some may think that the CRC cannot or should not be used by bioethicists where it has not been ratified. The United States offers an interesting case study (Davidson 2014). Over the last century it has not been unusual for the United States to sign treaties and then wait for a significant number of years to pass before ratification; the CRC is one of many such treaties (Bradley 2007). Since the United States has not ratified the CRC, no one in the country—let alone pediatric health-care workers and bioethicists—is *bound* to use the CRC in practice.

The CRC may nevertheless be used as a persuasive authority. While no one is bound to use it, individuals can still consult it in their moral decision-making (and indeed in a wide variety of contexts where its relevance is less obvious) and refer to the values it expresses. The fact that a text has not been ratified by a government does not mean that bioethicists cannot recognize its ethical significance. Notwithstanding the fact that the work of Kant or Aristotle has not been legally endorsed by America's government, clinical bioethicists can use values articulated in their texts to inform their analysis. Similarly, notwithstanding non-ratification, some governmental institutions in the United States appeal to the CRC for authority. For example, CRC values have been recognized by the Supreme Court of the United States. In the majority opinion in *Roper v. Simmons* (543 U.S. 551 (2005)), the Court cited Article 37 of the CRC when prohibiting the use of the death penalty for offenders under 18 years of age. Although the Supreme Court of the United States cites international law less frequently than some other major courts, and the use of non-American materials by that Court is the topic of a great deal of debate, *Roper v. Simmons* nevertheless reflects the Court's recognition of the value (if not the legitimacy) of the CRC in American law.

The claim that clinical bioethicists in a state that has not ratified the CRC should not use it in their analysis is undermined by multiple factors. First, the claim that ratification is required for a legal document to have moral force rests on an understanding of the relationship between law and morality that is not obviously correct. In the absence of further argument, it seems odd that a government can bind a citizen's domain of moral authorities through inaction alone. It may turn out that non-ratification has some implications for the moral authority of the CRC, but this is not obvious on its face. If a strong argument for this relationship can be provided, we are open to revising our view.

Yet, second, the particular case of the United States provides practical support that undermines the claim that bioethicists there should not consult the CRC. The overlap between CRC values and mainstream bioethical values is an important first factor, as traditional bioethical principles are used in the United States and many were developed by Americans (see, for example, Beauchamp and Childress 2013; Engelhardt 2010). In addition, there is some overlap between CRC values and values expressed through American law. As suggested above, the CRC is consistent with American clinical pediatric bioethics

practice in a number of areas—including respecting the child’s voice through assent, respecting the role of parents, and preventing and reporting child abuse/neglect—and there is also an extensive network of federal and state-determined child protective regulations, with an associated social and health-care infrastructure, which address many of the tenets of the CRC. Given these points of moral and legal convergence, it should not surprise us that there is a history of American involvement in CRC-related activities. The fact that U.S. Presidents Ronald Reagan and George H.W. Bush directed their administrations to participate actively in the drafting of the CRC, inserting many of the values significant for Americans (Davidson 2014), strongly suggests Americans view legality as separate from respect of particular moral values. That the U.S. government also voted adoption of the Declaration on the Rights of Children in 1959 and became a participant in the ICCPR in 1966 supports arguments for the power of the content of the CRC, even if ratification has not occurred. Much of the language of the CRC was drafted by American presidential staff and is deeply reflective of many of the values of the American people. Therefore the claim that there is in the United States a lack of respect or reliance on the basic values of the CRC in healthcare because of failure to ratify it as of yet is deeply flawed.

But even if the CRC does not exert legal force in the United States, nothing in domestic American law undermines our theoretical argument for the use of the CRC in bioethics practice. It is true that our point about a common language for international interactions may not apply in the United States, as that argument rests on shared values or at least the recognition of some consensus on authority. Nothing, however, suggests that it is inappropriate to consult the CRC in one’s clinical decision-making or domestic health systems and policy development. Although one may not be able to convince others about the value of the CRC if one’s interlocutors mistake moral value and legal legitimacy, there is ample reason to consult it for moral guidance in general. Perhaps one can raise these points when political facts make it difficult for one to consult the CRC.

Conclusion

There are, then, significant reasons why and ways in which the CRC may be useful to the work of pediatric bioethics:

1. The CRC is a considered articulation of the responsibilities nations have to children and has been legally ratified by all nations except the United States.
2. The CRC provides support for bioethical principles as it identifies, incorporates, and helps to develop these principles and shared moral values.
3. Where bioethics is incomplete or unclear, the CRC provides further development of the concepts embodied in those principles.
4. The CRC serves as a useful source of normative values that have been well-considered and that receive widespread assent, thus bringing the weight of law to the recognition of morally based individual rights for children.

These reasons do not, of course, imply that international human rights law provides all the answers pediatric bioethicists need when addressing the issues they are consulted about and

engage with in health-care organizations. International human rights law cannot provide a complete account of how to deal with a given moral issue and may not be dispositive in any particular case. However, the CRC is a valuable resource for identifying values, examining their content, and addressing both the consistency of one's own jurisdiction's norms with those values and the potential benefit of questioning one's own values in light of internationally recognized norms. If the foregoing is correct, the CRC can also provide increased conceptual clarity and a widely endorsed language that can assist pediatric bioethicists in clinical, organizational, and international consultations, as well as in education and policy development. Recognizing the multiple areas where the CRC is germane to the work of pediatric bioethics will assist those in health-care organizations to increase the overall health and well-being of children.

References

- Baker Robert. 2001 "Bioethics and Human Rights: A Historical Perspective." *Camb Q Healthc Ethics* 10: 241–52. [PubMed: 11414180]
- Bean Sally. 2011 "Navigating the Murky Intersection Between Clinical and Organizational Ethics: A Hybrid Case Taxonomy." *Bioethics* 25 (6): 320–25. [PubMed: 20002069]
- Beauchamp Tom L., and Childress James F.. 2013 *Principles of Biomedical Ethics*. 7th ed New York: Oxford University Press.
- Bradley CA 2007 "Unratified Treaties, Domestic Policies, and the U.S. Constitution." *Harvard Int Law J* 48 (2): 307–36.
- Canadian Charter of Rights and Freedoms, Part I of the Constitution Act. 1982 Canada Act 1982 (U.K.) (Canada).
- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada. 2014 *Tri-County Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2)*.
- Chapman Lee A. 2014 "Accounting for the Family in Law: An Impartial but Not Impersonal Point of View" In *Paediatric Patient and Family-Centered Care: Ethical and Legal Issues*, ed. Zlotnik-Shaul Randi, 97–114. New York: Springer.
- Cohen Cynthia P. 1990 "The Role of Nongovernmental Organizations in the Drafting of the Convention on the Rights of the Child." *Hum Rights Q* 12 (1): 137–47.
- Council of Europe. 1997 *Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*. Eur. T.S. No 164, c. II.
- Cranston Maurice. 1967 "Human Rights, Real and Supposed" In *Political Theory and the Rights of Man*, ed. Raphael DD, 43–53. Bloomington: Indiana University Press.
- Davidson Howard. 2014 "Does the U.N. Convention on the Rights of the Child Make a Difference?" *Michigan State Int Law Rev* 22 (2): 497–530.
- Dogra Nisha, Reitmanova Sylvia, and Carter-Pokras Olivia. 2010 "Teaching Cultural Diversity: Current Status in U.K., U.S. A., and Canadian Medical Schools." *J Gen Intern Med* 25 (Suppl. 2): 164–68.
- Eekelaar John. 1992 "The Importance of Thinking That Children Have Rights." *Int J Law Policy Family* 6 (1): 221–35.
- Eekelaar John. 1994 "The Interest of the Child and the Child's Wishes: The Role of Dynamic Self-Determinism." *Int J Law Policy Family* 8 (1): 42–61.
- Engelhardt H. Tristram. 2010 "Beyond the Best Interests of Children: Four Views of the Family and of Foundational Disagreements Regarding Pediatric Decision Making." *J Med Philos* 35 (5): 499–517. [PubMed: 20923929]
- Gibson Barbara E., et al. 2012 "Disability and Dignity: Enabling Home Environments." *Soc Sci Med* 74: 211–19. [PubMed: 22142787]

- Harrison Christine. 2010 "Truth Telling in Pediatrics: What They Don't Know Might Hurt Them" In *Pediatric Bioethics*, ed. Geoffrey Miller, 73–86. New York: Cambridge University Press.
- Harrison Christine, et al. 1997 "Bioethics for Clinicians: 9. Involving Children in Medical Decisions." *CMAJ* 156 (6): 825–28. [PubMed: 9084389]
- Hart Stuart N. 1991 "From Property to Person Status: Historical Perspective on Children's Rights." *Am Psychol* 46 (1): 53–59.
- Hesson Kathlyn, Bakal Donald, and Dobson Keith S.. 1993 "Legal and Ethical Issues Concerning Children's Rights of Consent." *Can Psychol* 34 (3): 317–28. [PubMed: 11652841]
- Kant Immanuel. 1797 *The Metaphysics of Morals*. Trans Gregor Mary. Cambridge: Cambridge University Press, 1996.
- Kasper Jennifer. 2004 "Pediatricians and the Rights of the Child, U.N. Convention Provides Blueprint for Monitoring the Well-Being of Children Worldwide." *Pediatr Ann* 33 (1): 712–15. [PubMed: 15515359]
- Kenny Nuala, Downie Jocelyn, and Harrison Christine. 2008 "Respectful Involvement of Children in Medical Decision-Making" In *Cambridge Textbook of Bioethics*, ed. Singer Peter A. and Viens AM, 121–26. Cambridge: Cambridge University Press.
- Kieckhefer Gail M., and Trahms Cristine M.. 2000 "Supporting Development of Children with Chronic Conditions: From Compliance Toward Shared Management." *Pediatr Nurs* 26 (4): 354–63. [PubMed: 12026469]
- King Jeff. 2012 *Judging Social Rights*. Cambridge: Cambridge University Press.
- Kohm Lynne M. 2008 "Tracing the Foundations of the Best Interests of the Child Standard in American Jurisprudence." *J Law Family Stud* 10 (2): 337–76.
- Larcher Vic, and Hutchinson Anna. 2010 "How Should Paediatricians Assess Gillick Competence?" *Arch Dis Child* 95: 307–11. [PubMed: 19948515]
- League of Nations. 1926 Geneva Declaration on the Rights of the Child. League of Nations General Assembly.
- Lundy Laura, Kilkelly Ursula, and Byrne Bronagh. 2013 "Incorporation of the United Nations Convention on the Rights of the Child in Law: A Comparative Review." *Int J Children's Rights* 21 (3): 442–63.
- McCullough Laurence B. 2014 "Deliberative Clinical Ethics: Getting Back to Basics in the Work of Clinical Ethics and Clinical Ethicists." *J Med Philos* 39 (1): 1–7. [PubMed: 24408500]
- Nicholas David B., Keilty Krista, and Karmali Karima. 2014 "Paediatric Patient-Centered Care: Evidence and Evolution" In *Paediatric Patient and Family-Centered Care: Ethical and Legal Issues*, ed. Zlotnik Shaul Randi, 3–18. New York: Springer.
- Republic of South Africa. 1996 Constitution of the Republic of South Africa, Act 108. Substituted by s. 1 (1) of the Citation of Constitutional Laws, 2005 (Act No. 5 of 2005).
- Salter Erica K. 2014 "Resisting the Siren Call of Individualism in Pediatric Decision Making and the Role of Relational Interests." *J Med Philos* 39 (1): 26–40. [PubMed: 24363445]
- Sheahan Linda, et al. 2014 "A Canadian Perspective on a Child's Consent to Research Within a Context of Family-Centered Care: From Incompatibility to Synergy" In *Paediatric Patient and Family-Centered Care: Ethical and Legal Issues*, ed. Zlotnik-Shaul Randi, 19–34. New York: Springer.
- Sirvastava Rani H. 2014 "Culture, Religion and Family-Centered Care" In *Paediatric Patient and Family-Centered Care: Ethical and Legal Issues*, ed. Zlotnik-Shaul Randi, 57–77. New York: Springer.
- Tillett Jackie. 2005 "Adolescents and Informed Consent: Ethical and Legal Issues." *J Perinat Neonatal Nurs* 19 (2): 112–21. [PubMed: 15923960]
- United Nations (UN). 1945 Charter of the United Nations. 1 UNTS XVI.
- United Nations (UN). 1948 Universal Declaration of Human Rights. GA Res 217 (111) UNGAOR 3rd Sess Supp No 13, UN Doc A/810.
- United Nations (UN). 1959 Declaration on the Rights of the Child. GA Res 1386 (XIV), UNGA, 14th Sess 1386 (XIV).
- United Nations (UN). 1966a International Covenant on Civil and Political Rights. 999 UNTS 171.

- United Nations (UN). 1966b International Covenant on Economic, Social and Cultural Rights. 993 UNTS 3.
- United Nations (UN). 1979 Convention on the Elimination of All Forms of Discrimination Against Women. 1249 UNTS 13.
- United Nations (UN). 1989 Convention on the Rights of the Child. 1577 UNTS 3.
- United Nations (UN). 1993 Declaration on the Elimination of Violence Against Women. UNGA GA Res 48/104, UNGAOR, 48th Sess, UN Doc A/RES/108/44.
- United Nations (UN). 2014 “Chapter IV Human Rights 11. Convention on the Rights of the Child.” United Nations Treaty Collection. <https://treaties.un.org/pages/Treaties.aspx?id=4&subid=A&lang=en>.
- United Nations (UN). 2015a “UN Lauds Somalia as Country Ratifies Landmark Children’s Rights Treaty.” U.N. News Centre. <http://www.un.org/apps/news/story.asp?NewsID=49845#.VPOVmHboZe8>.
- United Nations (UN). 2015b “UN Lauds South Sudan as Country Ratifies Landmark Child Rights Treaty.” U.N. News Centre. http://www.un.org/apps/news/story.asp?NewsID=50759#.Vrv_MvIrLIV.
- U.N. Committee on the Rights of the Child (UNCRC). 2013 General Comment No. 14. Geneva: United Nations.
- Van Bueren Geraldine. 1998 The International Law on the Rights of the Child (International Studies in Human Rights). The Hague: Martinus Nijhoff.
- Zlotnik Shaul Randi, and David Vitale. 2009 “Can We Afford it? Ethical Consideration of Expensive Drug Treatment for Neonates and Infants.” Clin Pharmacol Ther 86 (6): 587–89. [PubMed: 19915601]