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A Case for Autonomy: an Examination into an Adolescent's Right to Refuse Treatment

Imagine being a fourteen year old sitting inside your doctor's office in a large hospital. The hospital is one you know very well. Having been diagnosed with cancer at the age of five, you have been in and out of this hospital for almost ten years. But for the past year you have been in remission. Now imagine your doctor comes to tell you the cancer is back and worse than ever. Your parents are crying as the doctor explains that you can start chemotherapy again. With chemotherapy, you could gain six months to a year in life expectancy, if you're lucky two years. But you will spend that time undergoing chemotherapy in and out of the hospital and dealing with all of the side effects. If you were an adult, you could weigh whether or not you wanted treatment. But you are not an adult. At fourteen, you sit there and your parents make the final decision. While the doctors and your parents will probably discuss your options with you, and a doctor will probably not force treatment on you, at fourteen, you have no legal right to refuse treatment. Instead of making an informed decision, you may end up in a court room with a judge making the ultimate decision for you.

This story is one that happens across the United States. This paper seeks to explore what should happen in a scenario such as the one above. The decision whether to discontinue life-sustaining treatment¹ is one of the most important decisions an individual can make.² A

¹ For the purposes of this paper life sustaining treatment is defined as medical treatment that would prevent or forestall the patient's death. It can include treatment to prevent death where the risk is imminent such as a respirator

competent adult has the right to refuse treatment. For a competent adult, it is a decision that can be made independently. When the patient receiving life-sustaining treatment is a minor, however, that decision rests with the child's parents or guardian, or in some cases, the state itself. The minor patient does not, for the most part, have the ability to consent to medical treatment or the cessation of medical treatment. Thus, the all-important decision on whether to continue life sustaining treatment is removed from the person it most affects, the patient.

This paper examines the current legal climate regarding competency and capability of an adolescent minor³ to consent to or refuse medical treatment. The paper further weighs the potentially conflicting interests among the minor, the parent and the state and then analyzes the ethical and moral issues that those conflicting interests create. Finally, this paper argues that the legislature should adopt a rebuttable presumption that an adolescent minor is competent and capable of deciding to consent to or refuse medical treatment.

Part II of this paper will examine the current law regarding the competency and capabilities of adolescent minors to consent to treatment. It will further compare the consent laws for minors across different medical fields and treatments. Finally this section will examine the mature minor exceptions which exist in American jurisprudence and how those exceptions take the interests of minors into consideration.

or cardio pulmonary resuscitation. It can also include treatment to prevent death where the risk is less imminent such as chemotherapy or bone marrow transplants. The analysis and discussion in this paper are confined to a minor's right to terminate or refuse life sustaining treatment. The paper will not deal with a minor's right, or lack of right physician assisted suicide, and voluntary active euthanasia.

² See *Compassion in Dying v. Washington*, 79 F.3d 790, 837 (9th Cir. 1996) (stating that no decision is as painful or important than how and when one's life should end).

³ An adolescent minor is defined as an individual aged thirteen to eighteen. See generally Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: a Developmental Perspective*, PROF. PSYCHO. 412 (1978).

Part III of this paper will weigh the conflicting interests of a minor in the ability to consent or refuse treatment, the interests of their parents and the interests of the state and will analyze the problems created when those interests conflict.

Part IV will examine the cognitive abilities of a minor to consent to or refuse treatment. This section will examine several psychological and neurological studies to determine at what age someone can truly make informed consent to or refusal of treatment.

Part V of this paper will then argue that there should be a rebuttable presumption that an adolescent minor should be able to consent to and refuse to treatment, just as a competent adult can. Part VI of the paper summarizes and concludes the paper.

PART II: The Law Governing Treatment Consent and Refusal Laws for Minors

In the United States, physicians and treating health care professionals have a duty to disclose all information to competent patients or their authorized surrogates and obtain informed consent. This practice is rooted in the respect for and deference to an individual's autonomy⁴ and self-determination. While important exceptions exist,⁵ the law vests the authority to make decisions about children's health care in their parents.⁶ Unlike competent adult patients, minors are not always given the benefit of this deference to individual autonomy. Jurisdictions differ on how much weight to give the decision of a minor. Some jurisdictions provide great deference to the choices of a minor while others provide none at all.⁷ Minors are presumed incompetent. They cannot give informed consent or refuse to consent to treatment. Instead their medical decisions

⁴ *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body.")

⁵ These exceptions include emancipated minors, mature minors, decisions regarding reproductive health, and emergency care. *See* discussion *infra*, pp. 4-8.

⁶ The Supreme Court has held that parents have a constitutional right to rear their child as they see fit. *See Wisconsin v. Yoder*, 406 U.S. 205, 214 (1972).

⁷ *See* N.Y. PUBLIC HEALTH LAW § 2994-e (McKinney 2010); *Compare with In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (Sup. Ct. 1990) (refusing to adopt a mature minor exception for refusal of medical treatment.)

are made by a surrogate, typically a parent.⁸ The United States has a long history of treating minors as incompetent to consent too many medical decisions. Frequently, the law treats minors as incapable of mature decision making.⁹ In *Belotti v. Baird*, Supreme Court reasoned that

states validly may limit the freedom of children to choose for themselves in the making of important affirmative choices with potentially serious consequences [because] during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them.¹⁰

Despite that reasoning, the court there held that law which required parental notification unconstitutionally burdened the right of the pregnant teenager to have an abortion.¹¹

Within the United States, the right for children to consent to or refuse medical treatment is limited in some instances. The right to control one's body and mind is a fundamental right protected by the constitutional protections of the Due Process Clause.¹² In contrast, the Supreme Court has continuously held that parents have a constitutional right to childrearing without government interference unless the child is at risk and the state must interfere to protect the child.¹³ The law seems to weigh the parents' constitutional rights in parenting their children over children's rights to privacy. A child's right to privacy is not as broad as the adult counterpart. Indeed a parents' right to care for their children will often override the child's right to privacy.¹⁴ Children lose much of their rights when in the care of others, such as their parents or their

⁸ See *Rosebush v. Oakland Cnty. Prosecutor*, 491 N.W.2d 633, 636 (Mich. Ct. App. 1992); *Parham v. J.R.*, 442 U.S. 584, 603 (1979).

⁹ See generally, Gary B. Melton, *Toward "Personhood" for Adolescents: Autonomy and Privacy as Values in Public Policy*, 38 AM. PSYCHOLOGIST 99 (1983).

¹⁰ See *Belotti v. Baird*, 443 U.S. 622, 623 (1979).

¹¹ *Id.* at 625

¹² See *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905); See also *Roe v. Wade*, 410 U.S. 113,164 (1973).

¹³ See *Wisconsin v. Yoder*, 406 U.S. 205, 214 (1972); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923).

¹⁴ Richard C. Boldt, *Adolescent Decision Making: Legal Issues with Respect to Treatment for Substance Misuse and Mental Illness*, 15 J. HEALTH CARE L. & POL'Y 75, 79-81 (2012)(citing Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 147-49 (2000)).

schools.¹⁵ However, children do have some of the same rights of privacy as adults. As such, with some exceptions, the law generally views that minors are less competent than adults and are therefore less capable of making the same decisions.¹⁶

A. Exceptions to the Rule

There are several exceptions to the rule that a minor cannot consent to treatment. Some examples are specific condition exceptions. These exceptions are statutory exceptions to the presumption that minors are incompetent for specific conditions and treatments. Most of these statutes relate to abortions, treatment/testing for STD's and birth control and treatment for substance abuse. For abortion, some states rely on the mature minor doctrine, discussed more fully in Part III. A showing of maturity to a judge in these states will allow a minor to obtain an abortion without consent of the parent.¹⁷ Other states permit minor children to get abortions at the age of sixteen without parental consent.

Additionally, many states allow for minors to consent for testing and treatment of STD's without consent of a parent. The state's health and safety concerns in preventing the spread of sexually transmitted diseases weighs heavily in allowing these minors to obtain testing and treatment without consent.¹⁸ Likewise, many states allow minors to obtain birth control without parental consent. Again, the state's interest in minors obtaining birth control if they will be engaging in sexual conduct militates in favor of allowing minors to obtain birth control without

¹⁵ N.J. v. T.L.O, 469 U.S. 325, 340 (1985).

¹⁶ Generally, the courts recognize adolescents ability to make decisions regarding reproductive rights as the same as adults. *See Carey v. Population Servs. Int'l*, 431 U.S. 678, 693 n.15 (1977).

¹⁷ *See Id.* at 647-48; *See also Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 899-900 (1992).

¹⁸ Grisso, *supra* note 3, at 413-416.

consent.¹⁹ The specific condition exceptions are very limited, however. They apply solely to the condition for which they were statutorily created and do not extend to other treatments.

The second exception which allows treatment for a minor without parental consent is the emergency treatment exception. The emergency doctrine is one of the oldest exceptions to requiring parental consent for medical treatment. Under the emergency doctrine, a doctor has a right to treat a minor in an emergency without parental consent, because consent is presumed.²⁰ However, the emergency doctrine does not allow a minor to refuse that same medical treatment without parental consent.²¹ The emergency doctrine does not give a minor autonomy so much as it protects a doctor from committing assault and battery when providing emergency care to a minor.²²

Additionally, many states have status exceptions allowing minors' consent to medical treatment. There are typically three different statuses that allow for a minor to consent to medical treatment. The first is a minor is or was previously married. Consent to medical treatment or refuse medical treatment in the same manner in which an adult could consent to medical treatment or refuse medical treatment.²³ Likewise, a second status is for minors who are parents themselves. A minor who is a parent can also consent to medical treatment or refuse medical treatment for herself or her child.²⁴ The third status exception is for minors who have become emancipated. An emancipated minor is typically defined as a minor who has received a court order of emancipation from her parents.²⁵ Some jurisdictions, however, also provide an

¹⁹ *Id.* at 420.

²⁰ *See* *Jackovach v. Yocom*, 237 N.W. 444, 448 (Iowa 1931).

²¹ *In re Thomas B.*, 574 N.Y.S.2d 659, 660—61 (N.Y. Fam. Ct. 1991) (holding that the court was justified in overruling a fifteen year old's "vigorous objection" to surgery because it was in his best interests).

²² *Derry Ridgeway, Innocent of Empirical Rigor*, 14 ST. THOMAS L.REV. 165, 188-90 (2001).

²³ *Id.* at 195.

²⁴ *Id.* at 169.

²⁵ *See e.g.*, N. M. STAT. ANN., § 32A-21-7 (1995).

emancipation status exception where the minor has been living independently from their parents.²⁶ Where a minor is sufficiently emancipated from her parents, she can make medical decisions for herself.²⁷

Because they are presumed incompetent, minors who do not fall into one of the above exceptions cannot make their own medical decisions whether they are general decisions or decisions regarding life-saving or life sustaining treatment. Despite this, courts will take consideration of a minor's wishes into account when considering whether to continue or remove life sustaining treatment. The Maine Supreme Court in *In re Swan* allowed for the refusal of a feeding tube for a 17 1/3 year old PVS patient who had clearly indicated prior to that that he would not want to live like that. The Court invoked a clear and convincing evidence standard of the patient's wishes. The Maine Supreme Court said that the age of the patient would only be a factor in that decision and would not be solely dispositive.²⁸ However, in *In re Swan*, the parents were, in their capacity as co-guardians, seeking a declaratory judgment to terminate treatment.

Likewise, the court in *In re Myers* permitted the removal of a feeding tube presumably from a minor.²⁹ Myers had previously had indicated that she did not want to be on a feeding tube. Her parents disagreed over the removal of the feeding tube. Her father and step mother, the guardian ad litem and her doctors all agreed removing tube was the best. The court applied a best interest standard. Myer's wishes were not dispositive but instead were only one factor in the

²⁶ See N.Y. PUBLIC HEALTH LAW § 2994-e (McKinney 2010).

²⁷ See *Smith v. Seibly*, 431 P.2d 719, 723 (Wash. 1967); *Ison v. Florida Sanitarium & Benevolent Ass'n*, 302 So. 2d 200, 201-02 (Fla. Dist. Ct. App. 1974).

²⁸ *In re Chad Eric Swan*, 569 A.2d 1202, 1205 (Me. 1990) (“[a] minor acquires capacity to consent to different kinds of invasions and conduct at different stages of his development. Capacity exists when the minor has the ability of the average person to understand and weigh the risks and benefits.” (quoting PROSSER AND KEATON ON TORTS § 18, at 115 (5th ed. 1984).).

²⁹ *In re Guardianship of Myers*, 62 Ohio Misc.2d 763, (Ohio Ct C.P.1993).

decision.³⁰ Again, like Swan, the all the parties involved agreed that removing the tube was for the best. The court was not faced with conflict between doctors and parents, or parents and the patient.

Additionally, in *In Re E.G.*, the court held that a 17 year old Jehovah's Witness had a common law right to refuse treatment. In that case, the adolescent boy refused blood treatments for his Leukemia. His parents agreed with his decision. The state charged his parents with neglect. The court performed a balancing test. Again, here the court was not dealing with a conflict between the patient and his parents. However, the court also said that if his parents had refused to acquiesce to his refusal that the court should defer to the parent's interests.³¹ On the other hand, in a case with an adolescent male, an Oregon court held that the wishes of the minor did not matter for purposes of refusal of treatment and permitted homicide charges to be brought against the parents.³²

The current statutory law and case law throughout the United States for the most part leave adolescent minors without autonomy in their medical decisions and without a right to consent to or refuse life sustaining medical treatment. While there are exceptions to the rule, for the most part, minors have no right to refuse life sustaining treatment. Consent, on the other hand, does have more exceptions and more ability for minors to make their own autonomous decisions.

B. The Doctrine of the "Mature Minor"

Some states have adopted a mature minor, either by statute or within the common law, to solve the problems created by conflicting interests of parents, minors and the state in allowing

³⁰ *Id.*

³¹ *In re E.G.*, 133 Ill.2d 98, 112 (Ill. 1989).

³² *State v. Beagley*, 305 P.3d 147, 153-55 (Or. Ct. App. 2013).

consent or refusal of treatment while other states have adopted mature minor exceptions within their common law. Mature Minor Statutes allow a minor to consent to a medical decision if the minor can prove competency to consent. The physician, or in some cases the court, makes a determination on whether the minor sufficiently understands the consequences of the medical decisions.³³

Two different types of mature minor exceptions exist: statutory mature minor exceptions and common law mature minor exceptions. A minor statute is a statute in which a minor is presumed to be competent to consent to medical decisions once they reach a certain age.³⁴ These statutes essentially allow minors who have reached a certain age to be treated as adults when consenting to medical treatment. However, most presumed mature minor statutes do not carve out an exception for refusal of treatment.³⁵ Because most presumed mature minor statutes do not carve out an exception for the refusal of treatment, in those states which have enacted these statutes, a minor may be left in a position where they can consent to beginning a treatment but will be unable to stop that same treatment.³⁶

While some states have implemented statutory mature minor exceptions, other states rely on the common law. The common law exceptions allow a minor to overcome the presumption of incompetence but the burden of shifting the presumption stays on the minor. Some states have essentially codified the common law mature minor doctrine with mature minor statutes. A showing of maturity to a judge will enable a minor to obtain medical treatment without consent

³³ See *Younts v. Saint Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337-38 (Kan. 1970); *Gulf & S.I.R. Co. v. Sullivan*, 119 So. 501, 502 (Miss. 1928)

³⁴ See, e.g., N.Y. PUBLIC HEALTH LAW § 2994-e (McKinney 2010).

³⁵ See *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (Sup. Ct. 1990) (refusing to adopt a mature minor exception for refusal of medical treatment); See also, *Beagley*, 305 P.3d at 153-157 (holding that the Oregon statute allowing minors over the age of 15 the right to consent to medical care did grant 16-year-old the right to refuse medical care).

³⁶ *Beagley*, 305 P.3d at 159.

of a parent. Like the presumed mature minor doctrine, these exceptions typically only apply to consent to treatment not refusal of treatment.³⁷ For the most part, it leaves minors without a reliable mechanism to refuse treatment.

Both mature minor statutes and the mature minor exceptions in state common law are inadequate to solve the problems created by conflicting interests in the refusal of life sustaining or life saving treatment. Because many mature minor exceptions do not apply to refusal of treatment, they instead focus mainly on the consent to treatment. A minor's interest in the ability to consent to treatment is already protected by the state's interest in the protection of children and the state's interest in life. As such, the mature minor statutes that apply solely to consent for treatment do not address any of the problems created by conflicting interest. Additionally, those statutes that do apply to refusal of treatment place the burden on the minor to overcome the presumption of incompetence. The minor is placed in a position where it is much more difficult to have their interests in bodily integrity and privacy respected. For instance, in *Cardwell v. Bechtol*, a judge held that a seventeen year old was not mature enough to consent to a do not resuscitate order. Despite the fact that in less than a year, that same minor could consent to a do not resuscitate order, the court would not permit it. Discussed more completely below, the difference in cognitive ability between a seventeen year old and an eighteen year old is negligible.³⁸ A seventeen year old is just as competent to make an informed decision.³⁹

³⁷ *Id.*

³⁸ See Grisso, *supra* note 3, at 412

³⁹ *Id.*

Other states have not adopted mature minor exceptions.⁴⁰ Some courts reason that if a legislature has not adopted an explicit mature minor exception, there is no room for exceptions to age of majority statutes.⁴¹ Additionally, presumed Mature Minor exceptions that do not include a refusal of treatment provision also do not solve the issue.⁴² While the presumption of competence allows for the minor to consent, without the statutory explicit presumption of competence for refusal of treatment, minors are left without a valid avenue to protect their rights and interests.

PART III: Conflicting Interests of the Adolescent Minor, the Parent and the State

Whether an adolescent minor should have autonomy and a right to consent or refuse medical treatment depends greatly on what the interests of the minor, the parent and the state respectively are and if those interests conflict.

A. The Interests of an Adolescent Minor in their Medical Treatment

First and foremost, the adolescent minor has two primary interests in the right to consent or refuse to treatment: bodily integrity or autonomy and the right to privacy.⁴³ Like an adult, an adolescent minor has an interest in bodily integrity. For adults, the Supreme Court has held that “no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”⁴⁴ While they may not have the same rights and protections to possession and control of their body, adolescent

⁴⁰ See *Novak v. Cobb County Hospital Authority*, 849 F. Supp. 1559, 1575-1576 (D. Ga. 1994) (holding that the exceptions for consent to medical treatment for minors to abortion, substance abuse, STD treatment did not permit a mature minor exception).

⁴¹ See, e.g., *Commonwealth v. Nixon*, 761 A.2d 1151, 1154-1156 (Pa. 2000) (holding that had the legislature intended a mature minor exception it would have included one in the statute).

⁴² See *infra* note 28.

⁴³ *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 274 (1990).

⁴⁴ *Id.* at 269 (quoting *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

minors still have an interest in that possession and control of their body.⁴⁵ Adolescents are in the stage between childhood and adulthood. Personhood and self-determination become a large part of who an adolescent is.⁴⁶ As adolescents go through the changes of puberty and their changing body, their interests in their body, their privacy, and their autonomy continue to grow.⁴⁷ Additionally, while minors do not have the same rights to privacy, they have an interest in privacy. The Supreme Court has consistently held the importance of privacy in an adult's decision making for medical procedures.⁴⁸ While courts have not extended all of those rights to minors, some courts have used the right to privacy to support an incompetent individual's ability to refuse treatment through a surrogate.⁴⁹ While there are many differences between a previously competent but currently incompetent person and a minor who is always presumed competent, the incompetent individual still has an interest in their privacy. Thus it is clear that even if incompetent, minors maintain an interest in their privacy and their bodily integrity and those interests should be taken into account along with the health of a child.

B. Parental and State Interests in Medical Treatment of an Adolescent Minor

When dealing with a minor patient, the parent's interests must also be examined. A parent has two main interests: their right to raise their child as they see fit⁵⁰ and their responsibility for their child. As discussed, the Supreme Court consistently holds that a parent has a constitutional right to raise a child without government interference except in the most

⁴⁵ John Eekelaar, *The Emergence of Children's Rights*, 6 O.J.L.S. 161, 170-71 (1986) (noting that autonomy interests can be important to children).

⁴⁶ *Id.*

⁴⁷ Ridgeway, *supra* note 22, at 188-90.

⁴⁸ *Roe v. Wade*, 410 U.S. 113,127 (1973).

⁴⁹ *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985).

⁵⁰ *See Wisconsin v. Yoder*, 406 U.S. 205, 214 (1972); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923).

extreme cases.⁵¹ Because parents have an interest in their child's life and upbringing, they have an interest in deciding the medical treatment which their child should receive. In addition to that, parents also have a duty to provide care to their child. Thus, their interest in medical care for their child stems from the legal obligations they maintain for their child. Legally, a parent is responsible for the wellbeing of their child. Neglect and abuse statutes exist to protect children and hold parents accountable for that responsibility.

Finally, the state has its own interests in the medical treatment for children. The doctrine of parents patriae, or parent of the nation, comes into play.⁵² The state steps into the role of caretaker for children or other incompetent individuals to protect them. Traditionally the state has five main interests: the protection of children, interest in life, interest in suicide prevention, interest in third parties and interest in the sanctity of the medical profession.⁵³

C. When Interests Conflict

The interests of the state, minor child and the parents sometimes conflict. When the interests of these parties conflict, the courts are left to solve the problems that may arise. The primary question the courts must consider is whose interests should be considered and whose interests are most important. With the treatment of adults, the decision is easier. Their interest in the right to privacy, self determination, bodily integrity and informed consent generally outweigh the state's interest and allow for competent adults to refuse medical treatment.⁵⁴ On the other hand, with minors, the balancing of interests becomes much more difficult. First of all, there are more interests and more parties involved. For the most part, case law dealing with consent to treatment or refusal of treatment for minors involves situations where the parents and the minor

⁵¹ *Yoder*, 406 U.S. at 214.

⁵² *Ridgeway*, *supra* note 22, at 197-200.

⁵³ *Id.*

⁵⁴ *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261,274 (1990).

agree on the course of treatment.⁵⁵ In two cases, however, the parents and child did disagree as to treatment path.⁵⁶ In *In re Hudson*, a minor sought to consent to treatment and her parent refused, the state followed the parent's wishes. Likewise in *In re Thomas B*, where a child wished to refuse treatment and the parent consented to treatment, the state again followed the wishes of the parent, weighing the interests in favor of the parent's decision.⁵⁷ In that situation, the minor is left without a mechanism for their interests when there is a conflict between themselves and their parents.

One example of where parental interests can conflict with the interest of the minor is donor siblings. When a parent seeks to consent to an organ, or bone marrow donation for one sibling to another sibling, the parent's interests are clearly in conflict with the interest of the child.⁵⁸ This example has made more prevalent with the rise of assisted reproductive technology and the creation of "designer babies" or "spare parts babies".⁵⁹ In these situations, parents use assisted reproductive technology and genetic testing to create genetic matches to children who are already sick. In situations such as these, the interests of the one child may be being sacrificed for the interest of the other child.⁶⁰ Indeed, the conflicts raised in these scenarios have even been popularized in modern fiction.⁶¹ In these scenarios, courts must respect autonomous rights of the

⁵⁵ Ridgeway, *supra* note 22, at 185-187.

⁵⁶ See *In re Hudson*, 126 P.2d 765, 767-68 (Wash. 1942) (en banc).

⁵⁷ See *In re Thomas B.*, 574 N.Y.S.2d 659, 660 (Fam. Ct. 1991).

⁵⁸ Ridgeway, *supra* note 22, at 188-190.

⁵⁹ Stephen L. Baird, *Designer Babies: Eugenics Repackaged*, BIOTECHNOLOGY/MED. 28, 30-35 (2012).

⁶⁰ See *Hart v. Brown*, 289 A.2d 386, 388-390 (Conn. Super. Ct. 1972)(comparing the interests of the a ten month old twin in donating a kidney to his brother with those of his parents); See also, *Little v. Little*, 576 S.W.2d 493, 494-495 (Tex. Civ. App. 1979)(discussing the appointment of a guardian ad litem to determine interests of a fourteen year old potential donor with Down Syndrome).

⁶¹ See generally, JODI PICCOULT, *MY SISTER'S KEEPER*, Simon & Schuster, 2004. (examining the conflicts caused by reliance on one sibling for donation materials for a sick sibling as well as the problems created when a chronically ill minor wishes to cease treatment.)

child donor and appoint a guardian ad litem for the potential donor.⁶² Even with the court's response to the conflict of interest, it is clear that the interests of children and parents, at times, can and do conflict.

Additionally, problems arise when physicians and parents disagree over treatment. Where a minor and physician agree in removal of treatment but a parent disagrees, conflicts over treatment are likely to arise. Because of the permanency involved with ending life sustaining treatment, the conflicts are likely to continue and grow. Typically when a parent and a physician disagree over treatment, the issue will go to a court.⁶³ Courts will also intervene when parents cannot agree on a course of treatment.⁶⁴ Physicians also run into issues with forcing treatment on an adolescent minor who does not consent to treatment.⁶⁵

While currently, less focus is given to the minor's interests, for adolescent minors, their interests should be weighed more heavily. Their age and maturity should be taken into consideration when weighing their interests, especially where their interests are competing against the state and their parents' interest. Minors should have a mechanism to protect their interests in the event that they disagree with their parents.

⁶² Ridgeway, *supra* note 22, at 188.

⁶³ See e.g., *In re Baby K.*, 832 F. Supp 1022, 1031 (E.D. Va. 1993), (refusing hospital permission to withhold ventilator treatment of an anencephalic infant where mother objected). Compare *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633, 634-35, 693 (Mich. Ct. App. 1992) (allowing discontinuance of respirator a ten-year-old girl, paralyzed, respirator dependent, and comatose following an automobile accident over objections of the hospital and district attorney.).

⁶⁴ See *In re Jane Doe*, 418 S.E.2d 3, 4-7 (Ga. 1992) (refusing hospital's petition for a do-not-resuscitate order of a thirteen-year-old girl with progressive neurological deterioration where the mother agreed but the father did not).

⁶⁵ See Richard Ashcroft, Trudy Goodenough, Emma Williamson, & Julia Kent, *Children's Consent to Research Participation: Social Context and Personal Experience Invalidate Fixed Cutoff Rules*, 3 AM. J. BIOETHICS 17, 18-23 (2003).

PART IV: Adolescent Minors' Cognitive Ability to Consent to or Refuse Treatment

The presumption that minors are incompetent is grounded in the idea that minors and adults have different levels of cognitive functioning and psychological abilities. This premise is flawed. While minors under the age of 11 have limited ability to consent to treatment, there is no psychological reason why minors aged 15 and above cannot provide meaningful consent.⁶⁶ In *Minors' Consent to Treatment: a Developmental Perspective*, Grasso and Vierling discuss that the law should look to adolescents' actual capabilities, "lest in our zeal we burden some minors with decisions that they cannot make intelligently (sometimes to their detriment) or inadvertently deny to some the opportunity to make decisions of which they are fully capable."⁶⁷

A. What is Consent?

Psychology recognizes three types of consent for minors making medical decisions: consent independent of parental consent, dissent to treatment, and right to know and participate in consent discussions.⁶⁸ Under the first type of consent, some physicians argue that classes of minors should be allowed to consent to and refuse treatment independent from their parents.⁶⁹ This type of consent can already be seen through current law in the consent allowances for abortion, psychiatric treatment, STD treatment and substance abuse.⁷⁰ Additionally, some states allow for classes of minors based on age, to consent to any treatment as a whole.⁷¹

Under the second type of consent, physicians argue that minors by law, and as an ethical principal, should be allowed to dissent to treatment for which their parents have consented. The idea is that a patient should not be treated against their will. One example of this type of consent

⁶⁶ Grisso, *supra* note 3 at, 412.

⁶⁷ *Id.*

⁶⁸ *Id.* at 413-416

⁶⁹ *Id.* at 413

⁷⁰ See discussion *supra* pp. 4-8.

⁷¹ OR. REV. STAT. § 109.640 (West 2005) (this needs a parenthetical)

can be seen through psychiatric holds. The Supreme Court has held that while a parent has the right to have their child placed in psychiatric care against their will, children have a due process right to have those holds reviewed if they are against treatment.⁷² Another example is seen through a minor's right to refuse an abortion. Courts have held that a minor has a right to dissent from a therapeutic abortion to which the minor's parent has already consented.⁷³ This theory of consent raises both ethical and legal issues. First, there is a question whether physicians have or should have an ethical obligation not to perform procedures on minors who dissent from treatment.⁷⁴ Second, the legal question is raised, should minors have a legal right to dissent.⁷⁵ There is growing support from physicians for allowing dissent for minors, especially where the treatment is nonessential or the benefits are questionable.⁷⁶ The support can greatly be seen in the field of medical research where the benefits of using subjects who assent, as opposed to dissent, are seen.⁷⁷

Both the first and second type of consent implicates the legal rights that minors have or should have. As such, both independent consent and dissent to treatment both implicate the capacity of minors to consent to treatment. On the other hand, the third type is not a legal consent issue but instead reflects solely physicians' ethical obligations to inform patients, including minors, of the treatment options and allow them to at least participate in the conversation.⁷⁸

Physicians argue that to whatever extent possible minors should be permitted to take an active

⁷² Parham v. J.R., 442 U.S. 584, 589 (1979).

⁷³ *In re Smith*, 295 A.2d 238, (Md. 1972).

⁷⁴ Grisso, *supra* note 3, at 414

⁷⁵ *Id.* at 414-415

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

part in evaluating options, even without the capacity to grant or withhold consent.⁷⁹ The third type of consent, however, does not include any legal rights and thus no implications of a child's capacity to consent.

A minor's capacity for meaningful consent must first turn on the definition of consent. Typically consent must be knowing, intelligent, and voluntary.⁸⁰ A child may have a different capacity for making knowing consent versus intelligent consent versus voluntary consent. As such, to determine what capacity a minor has to consent or refuse consent for a medical procedure, the cognitive abilities of a minor must be examined for their ability to know and understand, make intelligent decisions and make voluntary decisions.⁸¹

B. A Minor's Capacity for "Knowing"

Knowledge is the first aspect of consent. "Knowing can be interpreted as one's understanding of the semantic content of the information that is provided by the professional. That is the patient knows if he/she understands the consensual meanings of the words and phrases of the message"⁸² In order to determine a minor's capacity for knowledge, the developmental progress of a minor should be examined. Development can hinder knowledge and thus the capacity to consent.⁸³ With regard to medical terminology, it is unclear exactly how much minors can understand when receiving the information. However, likewise, adults not trained in the medical field, also may have the same lack of understanding. As such, physicians can be tasked with informing minors the same way they would inform adults. The doctrine of informed consent solves the issues created by a lack of underlying knowledge of the medical

⁷⁹ Boldt, *supra* note 14 , at 305, 309

⁸⁰ Grisso, *supra* note 3, at 416.

⁸¹ *Id.*

⁸² *Id.* 416.

⁸³ *Id.* 416-17.

terminology. While some terminology may be hard for a minor to learn,⁸⁴ a system, such as a patient synthesizing what they have been told and repeating it back to the doctor, can be implemented by doctors to ensure that decisions are truly being made knowingly.

C. A Minor's Capacity for Intelligent Consent

In addition to the requirement that consent be knowing, consent must be given intelligently. Psychologically intelligent decisions are those decisions which are made rationally. Intelligence and the ability to make rational decision are tied to child development. The stage at which rational decisions are made is called Formal Operations. Several researchers have noted that minors who are aged 11-13, typically have reached the formal operations stage.⁸⁵ Not all minors aged 11-13 will enter formal operations by that time and as such not all minors will have rational thought by that time. However, research shows that some adults never reach formal operations. Despite this there is

some evidence that around 12, a substantial percentage of minors have attained a stage of cognitive development (formal operations) that predominates in the general adult population. Thus there may be no clear rationale for denying minors over 12 (as a group) the privilege of independent consent or veto of parental consent solely on the basis of intellectual capacity.⁸⁶

It is clear that psychological evidence supports the idea that minors aged 12 and over can make an intelligent decision regarding consent of treatment.

In contrast with the psychological studies that minors aged 12 and over can make intelligent rational decisions, some neurological studies show that because of an

⁸⁴ *Id.* at 418-421.

⁸⁵ *Id.* at 420.

⁸⁶ *Id.* at 420-21.

underdeveloped prefrontal cortex, minors are more likely to make impulsive decisions.⁸⁷ These studies show that minors are less likely to carefully consider the implications of the decisions they make and may not even have the ability to view decisions in the far future.⁸⁸ However, even if the neurological deficits do exist, the less developed prefrontal cortex does not prevent minors from being held accountable from other long term decisions. Indeed, an adolescent minor may be charged as an adult for crimes they make despite of the alleged increase in impulsivity.⁸⁹

D. A Minor's Capacity for Voluntary Consent

Even after determining that minors around age 12 can make an intelligent consent decision, that decision must still be voluntary. The voluntariness of consent decisions for minors brings in the issues of social externalities.⁹⁰ Studies show that minors have a less developed pre-frontal cortex which leads to decisions that are more influenced by how they will be perceived socially.⁹¹ Studies have shown that when asked to respond to questions gauging whether it is a good plan to do dangerous activities, such as swimming with sharks, adolescent minors neurological activity showed that the regions gauging social response were triggered where the adult neurological activity showed fear signals.⁹² Adolescents are more likely to make decision based on social pressures. Indeed, the

⁸⁷ Amanda C. Pustilnik & Leslie Meltzer Henry, *Introduction: Adolescent Medical Decision Making and the Law of the Horse*, 15 J. HEALTH CARE L. & POL'Y 2, 7 (year)

⁸⁸ *Id.* at 8.

⁸⁹ *Id.* at 7.

⁹⁰ Grisso, *supra* note 3, at 423.

⁹¹ Pustilnik, *supra* note 85, at 8.

⁹² *Id.*

externality of young adolescents, around age 13, is more similar to that of 9-10 year olds than to adolescents ranged 15-16.⁹³

On the other hand, the psychological studies of Jesness and Loveinger and Wessler show that there are developmental levels in children with regard to social interaction. The systems contain developmental levels with high conformity as well as categories with negative and oppositional responses to social demands.⁹⁴ High conformity stages would make minors more likely to acquiesce and provide involuntary consent. The oppositional stages would have the opposite effect and likely cause unwillful dissent by minors. Loveninger and Wessler showed that 87% of their sample of 12 years old function at or below the conformity stage, compared with only 55% of 14 year olds and 10% of 17 year olds.⁹⁵ Thus minors in their preadolescent years are most likely to have deferent responses to authority and make involuntary consent decisions.⁹⁶ That level remains high in the early adolescent years and is augmented by an increased concern for social expectations. The risk for deferent responses remains high through the age of 15. Minors aged 15 and above can typically manifest voluntary consent.⁹⁷

Thus psychological and neurological studies seem to support the contention that there is no reason to disallow a minor over the age of 15 from consenting to or refusing medical treatments independently of their parents. Additionally, the studies support the contention that children under the age of 11 should not be able to consent to or refuse

⁹³ Grisso, *supra* note 3, at 422.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶

⁹⁷

treatment because of their underdeveloped cognitive functions. Finally, the studies support the idea that children 11-14 may be able to cognitively provide knowing, intelligent and voluntary consent to medical treatments in certain circumstances.

PART VI: Expansion of Adolescents' Rights to Consent through Expanded Presumed

Mature Minor Exceptions

In order to solve the conflicts created by the competing interests of minor patients', their parents, and the state, the legislature should expand an adolescent minor's right to consent to or refuse medical treatment. Specifically, there should be rebuttable presumption that an adolescent minor is competent to consent to or refuse medical treatment also known as a presumed mature minor law. A well crafted rebuttable presumption would give adolescents the autonomy that they deserve, especially when dealing with the prospect of the end of life. The presumption would be rebuttable with clear and convincing evidence that the minor is incompetent (either from mental illness, including severe depression, or from lack of understanding about the consequences of refusal of treatment.) The rebuttable presumption would place the burden on those with more power in the system, the doctor or the parent as opposed to the individual with the least amount of power in the system, the minor.

Presumptive mature minor statutes already function and are successful in several states regarding consent for treatment. Extending those statutes to refusal of treatment would solve the conflicting interests of the parents of minors, minors themselves and the state. As discussed, there is no psychological reason why a minor over the age of 15 should not be permitted to consent to or refuse treatment and minors aged 13-14 may be able to make competent decisions. While it is true that not all adolescents are intellectually capable of providing independent consent, the same could be said for the adult population. Despite that, with adolescents there is a

presumption of incompetence that must be overcome with a showing of maturity while adults receive the opposite: a presumption that they are competent that can be overcome by a showing of incompetence. Allowing adolescent minors the same presumption, would respect the decision making cognitive and psychological abilities of minors as well while providing a mechanism to rebut the presumption for those adolescent minors who are truly incapable of making these important decisions.

Adolescents have the understanding to make decisions regarding life sustaining treatments or life saving treatment.⁹⁸ Studies show that adolescents can and should be given autonomy over their own medical decisions. Furthermore, the rebuttable presumption is supported by the mental capacity of adolescents. By making the presumption a rebuttable presumption, the statute would also leave room for the possibility that not all adolescents are created the same. Essentially, the rebuttable presumption would treat adolescent minors as adults for the purposes of consenting to or refusing medical treatment. The presumption would leave the opportunity of rebuttal with evidence of incompetence.

The rebuttable presumption shifts the burden to the state, physicians, or parents to prove a minor's incompetence. By placing burden on the party contesting competence, the presumption forces those individuals with more resources (the state, the parents, and the doctors) to sustain the burden. When examining court proceedings between physicians and parents, it is clear that physicians and hospitals are more likely to have the resources to go to court quickly and efficiently.⁹⁹ If parents of minors can lack the resource to fight the physicians and hospitals, how can the courts expect a minor to sustain the resources to prove their own competence? Instead, the minors should be given the benefit of the presumption of competence. Even the most mature

⁹⁸ Grisso, *supra* note 3, at 417-24.

⁹⁹ Ridgeway, *supra* note 22, at 214-16.

minor, without any resources, may struggle to show competence. It also encourages conversation between parties by providing the minor with more bargaining power. In the current system, because it is so difficult for a minor to make a decision regarding their end of life care, a minor has no way to assert their view point. By providing the minor a better position, they can more easily try and make their own decisions regarding life sustaining treatment.

A presumptive mature minor exception would not discourage a minor from making their own medical decisions. A presumption in favor of a minor would prevent that minor from having to try and find a way to proceed in court to gain rights to their own body. The presumptive statute recognizes that there is a difference between the maturity to make a medical decision and the resources and ability to involve oneself in a court proceeding. The presumption would give many more minors an easier opportunity to make their own medical decisions. A minor who more involved in the decision is making process for their treatment is more likely to succeed in that treatment if it is taken.

The rebuttable presumption of competence will further act as a safeguard for those adolescents who truly should not be making a decision or for those who are suffering from depression or other mental illness at the time. By permitting the presumption to be rebutted, the proposed statute would still support the interests of the parents and the state. The parent's interest in parenting their children would be supported by their ability to go to court and prove their child is not mature enough to make the medical decision. Furthermore, a parent would be protected from prosecution under neglect and abuse statutes if their child was responsible for their own decisions. Finally, the state's interest in protection of children and life can be fulfilled in the cases where it is necessary through the rebuttable presumption. Finally, a rebuttable mature

minor presumption allows for the legal system to be avoided in cases where there is no debate between the parents and the minor.

PART VI: Conclusion

Because of the problems created in the current system through the conflicting interests of the parents, minors and states in refusal of life sustaining treatment by minors, a presumptive rebuttable mature minor statute should be implemented in the United States. This rebuttable presumptive statute would provide the autonomy for adolescent minors while protecting a parent's interests in the life of their child and the states interests in protecting children. Currently in the United States, the law does not adequately protect the interests of adolescent minors. Judicial decisions are varied and the law is a mismatched patchwork of different rules. While physicians generally cannot ethically perform procedures on a patient who is on willing, adolescent minors are still left without a legal mechanism to protect their rights.

Psychology is clear in that there is no reason an adolescent minor aged 15 or older should be unable to consent to or refuse treatment independent of their parents. Furthermore, adolescent minors aged 13-14 are also capable of consent, albeit more inconsistently than those a year or two older. These adolescent minors have the capacity to consent and they have a growing interest in their personal autonomy and self determination as well as the privacy of their body. While the rights of a minor to privacy and autonomy are limited, their interest is ever growing in adolescence. As such, because the cognitive abilities to knowingly, voluntarily and intelligently consent are there, the legislatures should adopt a rebuttable presumption which views all adolescent minors aged 14 or higher as able to consent to or refuse medical treatment.