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TEEN HEALTH CARE DECISIONS: HOW MATURITY AND SOCIAL POLICY AFFECT FOUR HARD CASES

Leslie Joan Harris

ABSTRACT

Legal standards that allow teens to make health care decisions, or any important decisions, must account for the contingency and variability of minors' capacity. Traditional law denied minors' legal authority to make any decisions, giving all power to parents. This rule goes too far; the Supreme Court has held that minors have constitutionally protected autonomy-based rights, and modern views about adolescence are inconsistent with the rule. The question is how and where to draw lines.

Legal standards are based on minors' evolving maturity, policy favoring decisions that follow medical advice, and policy supporting parental authority. This paper uses four hard cases to show how these considerations factor into legal rules.

Keywords: Health care; teenagers; social policy; rights of minors; maturity

In 1979, the Supreme Court decided two cases that to this day provide the basic framework for analyzing minors' constitutional rights to make decisions for themselves; both concerned health care. In *Bellotti v. Baird* (1979), the Court held that minors have a constitutional right to decide to have an abortion, subject to limits to serve state interests in protecting the minors and preserving parental rights. A few weeks earlier, in *Parham v. J.R.* (1979) the Court held that minors have a constitutionally protected liberty interest in resisting mental health treatment in an institution, subject to the state's interests in protecting parental rights and in insuring that minors get needed health care.

The opinions make assertions about minors' relative incapacity, compared to adults, to make sound decisions, which justify treating the minors differently than adults, but they do not provide much support for these assertions. The decisions, along with another case in the 1979 term that concerned minors' capacity to waive *Miranda* rights, *Fare v. Michael C.* (1979), spurred social scientists to study how and the extent to which minors make decisions differently from adults, and they inspired lawyers to use this new information to reevaluate how the law should treat adolescents' claims to make decisions for themselves (Cunningham, 2006; Preston & Crowther, 2012; Scott, 2000). As a result of these efforts, more than 20 years later the Supreme Court again considered minors' decision-making abilities, but in the very different context of their responsibility for violations of the criminal law. In these cases, the Court relied heavily on new knowledge about how teens make decisions differently from adults to justify new constitutional limits on how harshly minors can be punished. (*Graham v. Florida*, 2010; *Miller v. Alabama*, 2012; *Roper v. Simmons*, 2005).

Not surprisingly, in light of the prominence that the Supreme Court has given to this research, scholars and court are reconsidering whether legal rules about whether teens can make any important decisions, including for health care, should be revised. Traditionally, the law of decision-making for children was, for the most part, not very nuanced. It denied minors legal authority to make most decisions, instead giving all power to parents. When a young person attained the age of majority, all authority instantly shifted to him or her (Preston & Crowther, 2012). The recognition that young people have constitutionally protected autonomy rights before they reach the age of majority (*Brown v. Entertainment Merchants Association*, 2011; *Goss v. Lopez*, 1975; *Hazelwood School District v. Kuhlmeier*, 1988; *In re Gault*, 1967; *New Jersey v. T.L.O.*, 1985; *Tinker v. Des Moines Independent Community School District*, 1969), as well as modern understanding that adolescent decision-making ability varies

significantly with the complexity, uncertainty, and context of the decision make this blanket rule untenable, at least in some situations.¹ Particularly, where a decision has great and long-lasting consequences and can only be made within a narrow window of time, adolescents' claims to make their own choices are particularly likely to be considered seriously. The question is how and where to draw lines.

This chapter uses health care choices as a vehicle for analyzing how to apply the new science to the law of adolescent decision-making. Other scholars have also considered how to apply the new research to health care decision-making. Most of this work focuses on the science, and proposes changes in the law based on it. These proposals range from lowering the age of consent for all types of medical care to allowing mature minors to consent to low-risk treatments, sometimes allowing more control as a child ages (Arshagouni, 2006; Mutcherson, 2005; Rosato, 2002).

This chapter argues that maturity is not the only factor that should determine when minors are allowed to make their own health care decisions. Three important social policies do and should play into the legal rules. First, policy generally favors individual decisions that are consistent with medical advice because our society understands such decisions to be rational and to promote individual well-being. This policy sometimes manifests itself in the substance of legal rules about health care decision-making and sometimes in how the rules are actually applied. Second, policy also supports shoring up parental authority and responsibility, since our society relies on parents to care for children in almost all circumstances. Third, legal rules should support adolescents as they develop decision-making capacities as is appropriate in particular situations.

To demonstrate how these policies interact with the science of adolescent decision-making capacity, this chapter uses four scenarios in which an adolescent claims the right to make a health care decision when the issues are complicated and emotionally loaded and the consequences of the decisions are very significant. The first scenario has been the subject of several law review articles and is inspired by well-publicized cases in which seriously ill teens wanted to forego therapies that might or might not be effective and that also have severe side effects (Driggs, 2001). The second case is also drawn from current events; an adolescent claims the right to refuse medical care for religious reasons. The third and fourth cases return to the original Supreme Court decisions about adolescent decision-making regarding health care to reconsider whether and how *Bellotti* and *Parham* might be analyzed differently. These are the four cases:

Case One: A 15-year-old boy has had two liver transplants and must take a powerful drug to prevent his body from being rejected by the transplanted organ. The drug causes him so much pain that he cannot walk, and even with the drug his transplanted liver is failing. His odds of surviving a third transplant are less than 50 percent, but a transplant is his only chance to stay alive while doctors seek new medications that may be more effective. The boy has decided he wants to quit taking the anti-rejection drug and live out the rest of his life with less pain. He lives with his three siblings and their mother who is uncertain about what is best for her son.²

Case Two: A 16-year-old boy who belongs to a religious group that believes in faith-healing dies from a bladder obstruction resulting from an untreated congenital condition. His family lives in a small community composed only of members of the religion, and they have little contact with the outside world. When his death is discovered, his parents are charged with manslaughter. At trial they claim that their son chose to decline treatment as a result of his own religious beliefs, which should be respected (and exonerate them).³

Case Three: A 15-year-old girl is two months pregnant. She is a sophomore in high school and thinks she is way too young to have a baby. She does not want to tell her parents about her pregnancy because she is afraid that they will be disappointed and angry with her. She wants to have an abortion.

Case Four: The parents of a 15-year-old boy who has been having trouble in school and at home propose to admit him to an in-patient residential treatment center for minors with psychiatric and emotional problems. The boy resists.

In all four of these cases, the young person would not have authority to make the decision under traditional legal principles, though some jurisdictions have adopted the mature minor doctrine, which might authorize the young person to decide. The doctrine allows a minor who is not fully independent of the parents to make a decision because someone — a health care provider or a court — has concluded that he or she is mature enough to do so. Applying the mature minor doctrine requires an individualized assessment of the minor's maturity and ability to make the decision at stake, but the thesis of this chapter is that a sound application of the doctrine does not depend on this alone. Application of the rule also depends greatly on the context in which the decision is made, including the minor's family and

other circumstances, the consequences of allowing the minor to make the decision, and who will make the decision and on what basis if the minor is not allowed to decide.

The section “The Rules for Competent Adults and the Preference for Following Medical Advice” of this chapter sets the stage by explaining the law that governs competent adults’ authority to make their own health care decisions. It shows that while the law expresses a strong preference for individual autonomy, in practice patients’ choices may not be followed when a patient rejects medical advice. The section “The Rules for Minors: Parental Authority, Following Medical Advice, and Teen Capacity” discusses the law that governs health care decision-making for minors, beginning with the presumption of parental authority, and three exceptions to that requirement that allow minors to make their own decisions. The section “The Traditional Rules Applied to the Four Hard Cases” describes how the four hard cases have been analyzed under traditional legal principles. The section “The Evolving Understanding of Maturity” describes the current state of psychological and neurological research about adolescents’ developing decision-making capacities, and the section “Applying Maturity Research and Policy to Teens’ Decision-Making” uses these materials to develop principles for determining when adolescents should be allowed to make their own health care decisions, and applies these principles to the four hard cases.

THE RULES FOR COMPETENT ADULTS AND THE PREFERENCE FOR FOLLOWING MEDICAL ADVICE

Patient autonomy is the premiere governing principle of the law of medical consent for competent adults. Adults may legally reject medical care, even if the consequence will be death (*Barber v. Superior Court*, 1983; *Bartling v. Glendale Adventist Medical Center*, 1986; *Matter of Storar*, 1981). This principle developed in response to remarkable medical developments in the last half of the 20th century that can save the lives of people who would surely have died in an earlier age, but which often have adverse side effects and result in people who are alive but with diminished quality of life. In this kind of situation, reasonable people can differ about whether the treatment is worthwhile, and the principle of patient autonomy allows individuals faced with these decisions to act on their own value judgments. However, to be able to make this decision, the patient must be competent, and the determination of whether a particular patient is competent to make a decision

emphasizes cognitive capacity, in part because it avoids value judgments about the wisdom of the decisions themselves (Cauffman & Steinberg, 1995).

Medical decision-making, like all decision-making, is sometimes not wholly voluntary and uncoerced. In older areas of the law, legal doctrines such as undue influence and insane delusion in the law of wills deal with these problems (Garrison, 2007). The law of medical decision-making has not developed similar doctrines. Perhaps the most important reason is that most of the time patients follow medical advice, and medical providers do not bother to question competence (Garrison, 2007). So long as the patient-decision maker is acting in the legally preferred way, no one challenges the decision or the patient's capacity. Indeed, as a practical matter, health care providers routinely accept consents to proposed treatment from patients of questionable competence (Garrison, 2007). The law of informed consent does not even require that patients accept information about their condition and proposed treatment before giving legally effective consent to a treatment (Dickens & Cook, 2015, p. 105).

On the other hand, at least as a practical matter, health care providers must provide information to a patient before accepting the patient's refusal of recommended treatment for two reasons. First, the patient's proposed choice asks the doctor to act against his or her professional training and judgment, and second, if the patient or a third party later challenges the denial of care, informed consent will protect the provider against liability. In practice, when adult patients disagree with medical advice, health care providers not infrequently ignore their wishes. Sometimes, health care providers frankly admit that they are ignoring what they regard as an ill-considered decision (Garrison, 2007; Grisso & Appelbaum, 1995; Gurian et al., 1990; Saks & Jeste, 2006; Vars, 2008) and sometimes they are just more willing to challenge a dissenting patient's decision-making capacity (Farnsworth, 1990; Grisso & Appelbaum, 1995).

This brief discussion of the differences in law and practice between adults' decisions that agree and deviate from medical advice sets the stage for similar issues when patients are adolescents.

THE RULES FOR MINORS: PARENTAL AUTHORITY, FOLLOWING MEDICAL ADVICE, AND TEEN CAPACITY

The law of medical decision-making for minors is consistent with the legal principles that govern adults' decisions, which uphold patient autonomy so

long as the decision is consistent with medical advice but hesitate to accept or even reject patient autonomy when it is not. Ordinarily parents have authority to make health care decisions for their children, consistent with the assumption that minors generally lack legal decision-making capacity. This rule works most of the time because most of the time parents accept medical advice, and their children do not object (Scott, 2000).⁴ The alternative – requiring care providers to assess a minor patient’s capacity to decide for him or herself on a case-by-case basis – would be expensive and fraught with the potential for generating unnecessary conflict between the child, the parents, and the care providers.

The major limit on parental authority is that a juvenile court may override a parent’s decision if it falls below a minimally adequate standard, resulting in its characterization as child abuse or neglect. Health care providers most often bring child abuse and neglect claims when parents disagree with doctors, the recommended treatment is not controversial, and the parents do not give reasons for rejecting medical advice that the health care professional regard as rational. (Some cases of medical neglect are cases in which parents are generally neglecting their children’s basic needs, including health care. They do not involve conflicts between doctors and parents over treatment and so are not the subject of this chapter.) If a case goes to court, parents usually lose when they do not have a medically based argument that their position is reasonable, that is, not supported by respected medical authority, and they win when they do (*A.D.H. v. State Dept. Hum. Resources*, 1994; *In re Nikolas E.*, 1998; *In re Phillip B.*, 1979; *In re S.H.*, 2013). Often, the parents’ objection is based in substantial part, if not entirely, on their religious belief in faith healing. In application, a parent’s claimed right to refuse medical care for religious reasons alone is usually rejected, at least if the child risks death or serious injury (*In re Cabrera*, 1989; *In re Hauser*, 2009; *In re Willman*, 1986; *Newmark v. Williams*, 1991; *State v. Hays*, 1998; *Walker v. Superior Court*, 1988). A purely religious objection to care is not sufficient to justify rejecting medical advice.⁵

A parent’s consent may not be required if the child agrees to proposed medical care in one of three circumstances: (1) a special statute authorizes minors above a certain age or all minors to consent to the particular treatment; (2) the child is legally emancipated, or (3) in some states, the child is a “mature minor,” that is, capable of making this particular decision. These exceptions to the requirement of parental consent solve problems that the usual legal rules do not address satisfactorily and are intended to insure that children, particularly teens, get medical care that they might forego if they had to tell their parents of the need for the care.

First, all states have special statutes that allow minors to consent to particular kinds of care that are both socially desirable and highly sensitive, such as contraception and prenatal care, and treatment for mental health problems, sexually transmitted infections, and drug and alcohol problems. In 32 states and the District of Columbia, all minors can consent to prenatal care, one more allows minors to consent during the first trimester, and four allow minors who are mature to consent. In 26 states and D.C., all minors can consent to contraceptive treatment, and 20 more allow some categories of minors to consent. All states and the District of Columbia allow minors to consent to treatment for sexually transmitted infections (Guttmacher Institute, June 1, 2016; Guttmacher Institute, September 1, 2016). In 47 states, minors acting alone can consent to outpatient drug treatment, and in 34 they can consent to outpatient mental health treatment. In 40 states, minors alone can consent to inpatient drug treatment, and in 28 states to inpatient mental health treatment. The minimum ages vary from no minimum to age 16 (Kerwin et al., 2015).

The reason for these statutes is that a significant number of adolescents would forego treatment for these conditions rather than tell their parents (Reddy et al., 2002; Torres et al., 1980). For these teens, the result of applying the usual requirement of parental consent does not produce an informed decision to refuse treatment, but rather the absence of meaningful decision-making. The statutes solve this problem.

The second exception to the general rule allows emancipated minors and is explained by the nature of emancipation itself. These minors are, by definition, living separately and apart from their parents, who may not even be available. Again, allowing these minors to consent to their own care solves the problem.

Finally, in 14 states mature minors can consent to medical treatment in all or limited circumstances, and in three more states all minors can consent to treatment in all or limited circumstances. Thirty-four states have no exception for mature minors (Coleman & Rosoff, 2015). Broadly speaking, the mature minor rule allows a minor to consent to medical care even though he or she is not fully independent but is capable of making a reasoned decision.⁶ The rule requires an assessment of capacity on a case-by-case basis, and most discussions of the rule assume that the health care provider will make the assessment. However, courts may become involved if the provider seeks a judicial determination that the child has capacity, as a matter of caution, or if the child suffers harm or dies and the case comes to the attention of the authorities after the fact.

The mature minor doctrine was originally developed to protect health care providers against tort liability when they treated minors without

parental consent when the providers had a sympathetic position, such as a reasonable belief that the young person was an adult (*Belcher v. Charleston Area Medical Center*, 1992; *Bishop v. Shurly*, 1926; *Cardwell v. Bechtol*, 1987; *Gulf & S.I.R. Co. v. Sullivan*, 1928; *Younts v. St. Francis Hospital & School of Nursing, Inc.*, 1970). Since the 1980s, the doctrine has been extended to apply in other situations. For example, sometimes the parents and the doctors disagree about treatment for the child, and it seems likely that if the doctors take the case to juvenile court, the parents will lose. The parents may claim that their child is old enough to make the decision under the mature minor rule, on the assumption that child will make the same decision that the parents would. Parents have also sought to invoke the doctrine when they didn't take their children to doctors at all, the children suffered harm or died, and the parents were criminally prosecuted. In either situation, the parent will lose if the usual requirement of parental consent with the medical neglect limitation is applied, and they invoke the mature minor rule in an effort to avoid this outcome. The doctrine might also be invoked when the parents, child and health care provider are in agreement, but the provider is concerned that the preferred course of treatment could be considered neglectful (*In re Guardianship of Crum*, 1991). If the court concludes that the minor is mature, this problem is solved.

As is true for adults, in practice health care providers and courts are more likely to find that a minor has decision-making capacity if the minor consents to health care than if the minor refuses (*Dickens & Cook*, 2015). And, again mirroring medical practice with adult patients, doctors are less likely to honor a child's refusal, the younger the patient is and the more promising the treatment. They are least likely to accept refusals when a minor with a life-threatening condition refuses a favorable treatment (*Talati et al.*, 2010; *Mosoff*, 2012; *MacIntosh*, 2016). Similarly, courts rarely find the mature minor rule applicable when the child has already suffered injury or died for lack of treatment (*Commonwealth v. Cottam*, 1992; *Commonwealth v. Nixon*, 2000). On the other hand, doctors are more likely to honor a refusal when the parent and child agree. When the treatment's efficacy and side effects are more ambiguous, doctors tend to honor the views of older children, regardless of whether they accept or decline treatment, provided that the consequences are not too severe (*Talati et al.*, 2010). The next section discusses how the traditional principles would probably apply in the four hard cases that this chapter addresses.

THE TRADITIONAL RULES APPLIED TO THE FOUR HARD CASES

This section illustrates the law of health care decision-making for adolescents by applying it to the four hard cases. The analyses also include how the minors' claims that they have a constitutional right to make the decision were or would probably be addressed.

Hard Case One: A Terminally Ill Minor Wants to Refuse Treatment

A 15-year-old boy with a life-threatening condition wants to refuse treatments of uncertain efficacy that are painful and debilitating. If the patient were an adult, this would be regarded as a classic right to refuse treatment case, and unless there were concerns about the patient's competence, his or her wishes would control, even though the doctors say that the treatment has a chance of prolonging the patient's life in the hope that new drugs will become available. However, doctors may be more uncertain about letting a child die, both ethically and legally. Minors may have a constitutional right to refuse treatment, as adults do, but only if they are competent, which leads to the same question that the mature minor doctrine raises, that is, whether the minor has the capacity to make the decision.

As a practical matter, cases like this arise surprisingly often but rarely go to court. Twenty years ago, the chief of psychology at Boston Children's Hospital said that once or twice a year a teenage patient did not want to go through with treatment. However, unless the patient was clearly terminally ill, treatment was resumed in all the cases, often with modifications to address the patient's concerns (Knox, 1994). Where teen patients are terminally ill and proposed treatments are experimental or of uncertain efficacy and the teen and the parents agree to stop treatment, the cases rarely go to court today, as doctors and hospital ethics review committees support decisions to stop treatment in such situations (Cave & Stavrinides, 2013; MacIntosh, 2016).

In the uncommon situation that the child's parent decided to support the child's refusal and the doctors filed a medical neglect suit against the parent, the outcome would depend on whether the court found that the parent's decision was medically supportable and rational. Where such cases are litigated, courts sometimes invoke the mature minor doctrine to support the conclusion that treatment can be refused. This approach is

especially attractive when the child's prospects for recovery are negligible, as when the child is in a persistent vegetative state (*In re Guardianship of Crum*, 1991; *In re Guardianship of Myers*, 1993; *In re Swan*, 1990; Rosato, 1996).

Hard Case Two: A Teen Wants to Reject Effective Medical Care for a Serious Condition for Religious Reasons

In this case, a minor who belongs to and lives within an isolated religious group that believes in faith healing has a medical problem that will be fatal, or that will at least cause serious suffering, and that can almost certainly be cured with standard, highly effective medical procedures. Often, this kind of case comes to the attention of the authorities only after the child has died. Before 1980, parents were generally not criminally prosecuted for medical neglect when they practiced faith healing. The First Amendment protection for the free exercise of religion was regarded as protecting them (Abraham, 1993). The 1974 federal Child Abuse Treatment and Prevention Act required states to exempt parents who practiced faith healing from child abuse reporting laws (42 U.S.C. § 5101).

However, social judgments about parental prerogatives changed as information about the number of children who died or were hurt by faith-healing practices became more widely known. According to one study, between 1975 and 1995, at least 172 children died after their parents rejected medical care on religious grounds; most had treatable conditions with high survival rates⁷ (Asser & Swan, 1998). This survey did not include 78 child deaths reported in Oregon from 1955 to 1998 or 12 deaths in Idaho between 1980 and 1998, resulting from faith-healing practices that occurred among the Followers of Christ Church; of the Oregon children, probably 21 could have lived if they had received medical treatment, according to Oregon newspaper reporters (Hughes, 2004–2005). Society no longer excuses faith-healing parents if they allow children to die. The exemption for faith healing was removed from the Child Abuse Treatment and Prevention Act in 1983 (45 C.F.R. § 1340.2(d)(i)). Today, if the child died and the parents were prosecuted, courts would almost certainly reject claims that the parents' conduct was protected by the constitutional right to freedom of religion. If such a case came to the attention of authorities before a child died and they filed suit in juvenile court alleging medical neglect against the parents, the parents would almost certainly lose, and the treatment would be ordered. The parents might claim that the minor is

mature in an effort to make an end-run around this limitation on parental authority.

In fact, not long after faith-healing parents began to be prosecuted when their children died from lack of medical care, cases alleging that adolescents could make their own decisions to reject medical care for religious reasons began to reach the appellate courts. Beginning in the mid-1980s, adolescents ranging in age from 12 to 17 or their parents attempted to invoke the mature minor rule to claim that the minors legally could and did choose to forego medical care for religious reasons (*In re E.G.*, 1989; *In re J.J.*, 1990; *O.G. v. Baum*, 1990; *In re Long Island Jewish Medical Center*, 1990; *Commonwealth v. Cottam*, 2000; *State v. Beagley*, 2013; *In re Cassandra C.*, 2015). In all but one of these cases, the court either rejected the mature minor rule altogether or held that it did not apply because the minor was not sufficiently mature. Where the child had died and the parents were trying to escape conviction by invoking the mature minor rule, courts consistently held against the parents (*Commonwealth v. Cottam*, 1992; *Commonwealth v. Nixon*, 2000; *State v. Beagley*, 2013). In such cases, it is simply impossible for a court to determine whether the child was, in fact, mature enough to make a choice.

However, in one of the earliest cases involving a living child, the court accepted the mature minor claim. In *In re E.G.* (1989), the Illinois Supreme Court held that a 17-year-old Jehovah's Witness could validly refuse a transfusion necessary for chemotherapy, even though without the chemotherapy she would almost surely die of cancer. While the chances of remission were 80 percent with transfusions and chemotherapy, the long-term survival rate of people with this kind of cancer was 20–25 percent. The court's decision to allow the minor to make the decision, though not based on the constitution, was affected by this claim. It observes that adult Jehovah's Witnesses have a constitutional right to refuse blood transfusions and that the intermediate appellate court concluded that a mature minor has the same right, and it discussed other cases holding that minors have constitutionally protected autonomy rights.

The next year, though, courts in Ohio, Texas, and New York refused to adopt the mature minor rule or held that even if the rule was part of state law, it did not apply to the facts of the case. The Ohio court in *In re J.J.* (1990) discussed the 14-year-old boy's claim that he was constitutionally entitled to make the decision to refuse treated for gonorrhea for religious reasons but rejected it on the basis that the state's interest in protecting others from communicable diseases and in protecting his health justified

overriding his objection. In the Texas case, *O.G. v. Baum* (1990), the court refused to reach the constitutional claim of a 17-year-old Jehovah's Witness who objected to a blood transfusion, saying it was not certain that he would in fact be required to have a transfusion. In *Application of Long Island Jewish Medical Center* (1990), the New York Court ruled that even if the mature minor doctrine was the law, the 17-year-old Jehovah's Witness who wanted to refuse a transfusion was not in fact mature enough to make the decision, which also justified rejecting any constitutional claim.

*Hard Case Three: A Teenager Wants to Have an Abortion without
Telling her Parents*

When a minor can obtain an abortion without at least notifying the parents has been debated since shortly after the Supreme held in *Roe v. Wade* (1973) that the right to choose an abortion is constitutionally protected for adult women. Only three years later the Court held that minors also have a constitutionally protected right to choose to have an abortion and that the state cannot require all minors to obtain parental consent (*Planned Parenthood of Central Missouri v. Danforth*, 1976). Three years later, in *Bellotti v. Baird* (1979) the Court laid out a scheme for requiring parental or judicial consent that survives to this day.

The Court said that the state's interests in protecting a minor from the consequences of her own immature decisions, in protecting minors from their vulnerability, and in supporting parental rights justify limitations on a minor's rights that could not be imposed on an adult. For these reasons, the Court said, state law can provide that a minor's consent alone is insufficient to permit an abortion. However, the Court recognized that sometimes parents do not act in children's best interests and that, therefore, minors must have the legal ability to obtain authorization for an abortion without parental involvement. Specifically, the Court said, a state may require a minor to obtain parental consent or a ruling from a judge that she is either mature enough to make her own choice or, if not, that the abortion is in her best interests. In *Planned Parenthood of Kansas City, Mo. v. Ashcroft* (1983), the Court affirmed that these requirements are constitutional, and in *Hodgson v. Minnesota* (1990), it held that the same requirements apply to a requirement of parental notice.

Today, most states require parental consent or notice before a minor can have an abortion; 21 require parental consent, 11 require parental notification, and 5 require both consent and notification. All but one of these

states have a statutory judicial bypass procedure; the exception, Maryland allows health professionals to waive parental involvement in some circumstances (Guttmacher Institute, September 1, 2016). The specifics and efficacy of the bypass procedures vary significantly, and researchers have reported that in most states they are not effective and timely (Rebouche, 2011; Silverstein & Spetiel, 2002).

Hard Case Four: A Teenager Wants to Avoid In-Patient Mental Health Care that His Parents Seek

This case is essentially the setting of *Parham v. J.R.*, the second of the major 1979 Supreme Court decisions about health care decision-making for adolescents. Though *Parham* is often cited today for its powerful endorsement of parental rights, it is first and foremost a case about adolescents' rights to avoid unnecessary mental hospitalization. The Court ruled that minors, like adults, have a constitutionally protected right to avoid the stigma and loss of liberty that come with commitment to a mental hospital. It rejected the argument that parents can waive this right on their children's behalf by voluntarily committing their children, just as an adult can waive the right by voluntarily admitting himself or herself to a mental hospital. The reason, the Court said, is that sometimes parents do not act consistently with the interests of their children. However, even adults do not have an absolute right to refuse mental health treatment because one consequence of mental illness or disability may be impaired decision-making ability. The same is true for minors, but in *Parham* the Court did not hold that children have the same right that adults do to a due process civil commitment hearing if they resist in-patient treatment.

Instead, the Court held that the state could constitutionally defer to parental judgments about when to seek mental hospitalization for their children, provided that procedural safeguards were in place to detect situations in which the parents' choice was not in the child's interests. Regarding the decision as essentially medical, the Court held that this procedural safeguard could also have a medical character. Rather than a legal civil commitment proceeding before a judge or administrative hearing officer, which is required if an adult resists mental hospitalization, all that is required is that a staff physician at the facility conduct a thorough and independent assessment to determine if admission is medically appropriate. While many states provide no greater procedural safeguards than the minimum established by *Parham*, others have statutes that provide for

commitment hearings or have interpreted their state constitutions as requiring greater safeguards (Boldt, 2012; *In re Roger S.*, 1978).

In all four of these hard cases, courts have recognized that a teenager may have the right to decide or be heard about his or her medical care because of the teen's growing maturity and the possibility that the constitution protects the teen's right to participate in the decision, though they have handled that claim in different ways. All the cases beg the question of what "mature" means for purposes of health care decision-making. The next section addresses this issue.

THE EVOLVING UNDERSTANDING OF MATURITY

Since the Supreme Court first addressed adolescent decision-making in a serious way in *Bellotti* (1979) and *Fare* (1979), scholars have studied adolescent decision-making extensively. This research shows that in some ways beginning in mid-adolescence children are as able as adults to make decisions, while in other ways they are far less capable.

The first important studies focused on teens' cognitive abilities to understand *Miranda* warnings and their own legal vulnerability during police interrogation. Led by Dr. Thomas Grisso, these researchers concluded that by the time they are 15 or 16, most adolescents' cognitive ability to understand police warnings is similar to that of adults (Grisso, 1980).⁸ By the late 1980s, the American Psychological Association was relying on this and other research about minors' cognitive abilities in a brief in support of legal recognition of minors' ability to make decisions regarding abortion (Brief for the American Psychological Association et al., 1990).

However, psychologists concerned about the harsh treatment of juveniles charged with crime questioned whether cognitive maturity is all that should go into decisions about legal treatment of teens. They expanded their studies to examine social and emotional dimensions of decision-making and learned that a person's social and emotional maturity develops throughout adolescence into young adulthood (Cauuffman & Steinberg, 1995). These studies are complemented by new neurological research showing that adolescents experience dramatic brain growth and changes that continue into early adulthood.

This research was analyzed, summarized, and applied to issues of adolescents' criminal responsibility in two amicus briefs to the Supreme Court in *Miller v. Alabama* (2012), the 2012 case in which the Court held that

mandatory prison sentences of life without parole for minors convicted of murder are unconstitutional. The briefs were submitted on behalf of the American Medical Association and the American Academy of Child and Adolescent Psychiatry ([Brief for the American Medical Association, 2012](#)) and the American Psychological Association, the American Psychiatric Association, and the National Association of Social Workers ([Brief for the American Psychological Association et al., 2012](#)). The APA Brief summarizes the behavioral evidence:

Compared to adults, juveniles are less able to restraint their impulses and exercise self-control; less capable of considering alternative courses of action and avoiding unduly risky behaviors; and less oriented to the future and thus less attentive to the consequences of their often-impulsive actions. Research also continues to demonstrate that “juveniles are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure,” while at the same time they lack the freedom and autonomy that adults possess to escape such pressures. (citation omitted) Thus, even after their general cognitive abilities approximate those of adults, juveniles are less capable than adults of mature judgment and decision-making, especially in the social contexts in which criminal behavior is most likely to arise.

([Brief for the American Psychological Association et al., 2012](#), pp. 3–4)

The AMA Brief explains that teens have a propensity toward risk-taking because they “tend to experience heightened levels of sensitivity to rewards, especially to immediate rewards In other words, adolescents take more risks because they overvalue the potential reward, not because they are less able to appreciate the risks, as was once believed” ([Brief for the American Medical Association, 2012](#), p. 8). The brief adds that adolescents’ relatively inability to control their impulses and regulate their emotions is “especially pronounced when other factors – such as stress, emotions, and peer pressure – enter the equation The interplay among stress, emotion, cognition, and voluntary behavior control in teenagers is particularly complex – and different from adults Adolescents are more susceptible to stress from daily events than adults, which translates into a further distortion of their already skewed cost-benefit analysis. Because of their greater stress, greater influx of gonadal hormones, and their relative inability to consistently regulate their emotional responses, adolescents are more emotionally volatile than adults – and children, for that matter” ([Brief for the American Medical Association, 2012](#), pp. 13–14).

The briefs also discuss the likely physical basis for these characteristics. The APA Brief explains, “It is increasingly clear that adolescent brains are not yet fully mature in regions and systems related to higher-order executive functions such as impulse control, planning ahead, and risk avoidance”

(Brief for the American Psychological Association et al., 2012, p. 4). Four kinds of physical changes in the brain during adolescence are relevant: changes in the parts of the brain associated with rewards and incentives that are linked to increased risk-taking and socially motivated behaviors (Brief for the American Psychological Association et al., 2012); “pruning” of unused “grey matter,” particularly in the prefrontal cortex, and increased myelination, both of which are associated with more effective executive functioning (Brief for the American Psychological Association et al., 2012); and increases in connections between areas of the brain that are important for regulating emotions, and which are, therefore, associated with ability to make judgments about risks and rewards and to control emotions (Brief for the American Medical Association, 2012; Brief for the American Psychological Association et al., 2012). Both pruning of neurons and myelination increase the efficiency and effectiveness of brain functioning and improved connections between the regions of the brain, and both processes continue into adulthood.

The AMA Brief explains how these changes relate to behavior: “[T]he motivational system, which underlies risky and reward-based behavior, develops earlier than the cognitive control system, which regulates such behavior. Furthermore, during adolescence, the motivational system continues to develop more quickly than the cognitive control system” (Brief for the American Medical Association, 2012, p. 29). This means that middle adolescence (roughly 14–17) is “a period of especially heightened vulnerability to risky behavior, because sensation-seeking is high and self-regulation is immature” (Brief for the American Psychological Association et al., 2012, p. 30).⁹

The APA brief examines the implications of these findings, some of which are particularly relevant to this chapter. “Because of their developmental immaturity, adolescents are more susceptible than adults to the negative influences of their environment, and their actions are shaped directly by family and peers in ways that adults’ are not. ‘Adolescents are dependent on living circumstances of their parents and families and hence are vulnerable to the impact of conditions well beyond their control’” (Brief for the American Psychological Association et al., 2012, p. 15).

More broadly, these studies support the conclusion that adolescents’ decision-making abilities are likely to vary, not just with age but also with the kind of decision being made and its context. As a 2010 study focusing on this issue found, adolescents are much worse at making decisions with significant emotional consequences and better at making decisions that are not so highly charged (van Duijvenvoorde, Jansen, Visser, & Huizenga, 2010).

Studies of teens' health care decision-making, though limited, are consistent with the general findings about adolescent decision-making. Adolescents' cognitive abilities to make health care decisions are similar to that of adults (Office of Technology Assessment, 1991). However, teens are heavily influenced by parents' values, and there is reason to question the voluntariness of minors' decisions when parents press them to make a decision a particular way (Hartman, 2001; Scherer, 1991).

APPLYING MATURITY RESEARCH AND POLICY TO TEENS' DECISION-MAKING

Because of adolescents' decision-making vulnerabilities, the law might provide that teens cannot make legally binding decisions for themselves at all. However, the scientific evidence does not support such a blanket rule, and both wise public policy and constitutional considerations militate against it. First, the evidence shows that in the right kind of circumstances, that is, when the situation is not highly emotionally charged, the teen is not under peer, parental pressure or other serious pressure, and there is time to think, 15- and 16-year-olds are capable of making competent decisions. However, in many situations, including all four of the hard cases in this chapter, one or more of these conditions are missing.

Some scholars have argued that the psychological and neurological evidence about minors' developing decision-making capacities means that minors should be allowed to make low-risk decisions, but not ones carrying great risk (Arshagouni, 2006; Unguru, 2012). Under this approach, a teen could not make any of the decisions posed by the hard cases described in this chapter, since all carry significant medical or social risks. As we have seen, such an outcome is unconstitutional, at least sometimes, and it is not consistent with the evidence that teens can make hard, emotionally charged decisions given the right circumstances.

Instead, the law should say that a minor can make the decision if it is possible to alleviate the conditions that create the danger that the minor's decision will be unduly risky, short-sighted, emotion-driven, or pressured. To this end, the law should require that the minor's circumstances be evaluated to determine whether they provide support or can be modified to provide support for the minor that will mitigate the conditions that undermine the minor's decision-making ability. When it is not possible to do this, so that the minor will not be regarded as mature enough to make the decision,

the law will have to provide for someone else to make the decision. The usual rule that gives parents authority to make legal decisions for minor children should be the first alternative considered. We expect that good parents will involve their children in decision-making as part of educating and rearing them, including allowing them to make mistakes, but only if the consequences are not too dire. Since parents normally do a decent job of supporting their children's evolving decision-making capacity, the law should and does protect parent-child relationships and the authority of parents to make decisions for their children. However, the law must also provide safeguards against parents who do not act in their children's interests and, equally important, against the children's own refusal to involve parents in decisions even when the parents might well be protective and supportive. The next section considers how the mature minor rule could be modified and applied to comport with these principles.

Principles for Applying the Mature Minor Rule

Applying the mature minor rule in way that supports teens' emerging autonomy while protecting them against their vulnerabilities requires an inquiry into how teens' immature decision-making abilities are likely to manifest themselves in light of the nature of the specific decision to be made and the context in which it must be made. The psychological and physical evidence about teens' developing decision-making tells us that highly charged emotional decisions, that is, ones with significant emotional consequences, are particularly problematic. If the parents are involved in the decision-making process and do not appear to have interests that conflict with those of the child, they may provide this kind of support. If the parents are not involved or have conflicting interests, other means of reducing the stress on the child and allowing him or her to think the decision through carefully should be considered. If such supports exist, the minor should be allowed to make the decision unless it is apparent that the child is not making a reasoned, deliberate, and free choice.

For decisions that parents are likely to know about, the first issue is whether there is a significant risk that the parents will not act consistently with their children's best interests. If this problem does not arise, allowing the minor to make a decision with the advice and support of parents seems generally justified. However, if the parents have an unacceptable conflict of interest, the minor may need to be protected from the parents' influence as well as his or her own immaturity. For a decision that the minor is

unwilling to bring to the parents, the minor may well need support from other sources. This could include providing the minor access to other sources of advice, slowing down the decision-making process, and exploring other treatment alternatives. Finally, as discussed above, in most situations, for public policy reasons a decision that is consistent with medical advice is preferred and should be the default decision. This means that in the face of uncertainty about the adequacy of supports for the minor, medical advice should prevail. In the absence of clear medical advice, the default decision should be designed to protect the child's life and health, support the parent-child relationship if possible, and promote the child's development of autonomy if possible.

The next section applies these principles to the four hard cases that began this chapter. In the first two hard problems, children's parents know about and are closely involved in the health care decision at stake. The difference between them is the extent to which we are concerned that the parents may not be acting in the child's interests. In the third hard problem, the minor is unwilling to bring the issue to the parents at all, and the issue is emotionally charged and socially risky. In the fourth hard problem, the parent and child are expressly at odds, making the situation inherently emotionally charged, and the minor's medical needs are uncertain.

Hard Case One: A Terminally Ill Minor Wants to Refuse Treatment

In this problem, a 15-year-old wants to refuse painful and debilitating medical treatments that provide his only chance for survival but that may fail. Where the child's life is at stake but the recommended care is not clearly efficacious and the side effects are severe, the parent and child face a very difficult, terrible decision. In this situation, there is no reason to fear that the parent is not acting with the child's interests at heart, and a decision to refuse treatment is not clearly contrary to public policy, since reasonable people could differ about whether the side effects and risks are worthwhile, given the uncertain outcome. If the minor and parent agree, the analysis proposed in this chapter would allow them to choose to refuse treatment.

What, though, if the parent and child disagree? Empirical studies have found that often parents of a very ill child persist in seeking treatment after it has become futile, clinging to the hope that the child can be saved (Hartman, 2012; Hinds et al., 2009). Often these cases are resolved by doctors giving the parents clear and complete information about the child's situation and options, which increases the parents' amenability to palliative

care without eroding hope (Hartman, 2012; Hinds et al., 2009; Wolfe et al., 2000) and clarifying that parents do have authority to decline lifesaving care on behalf of their children when this decision will lessen the children's suffering (Hartman, 2012). If the parents persist in wanting treatment despite the doctors' efforts, some authors argue that a child's wish to terminate treatment should ultimately prevail (Hartman). I disagree. This decision is emotionally highly charged, and the child faces real dangers if left to make a decision alone, including the risk of emotional abandonment if the child were to prevail. The policy preference for preserving life favors treatment, though it should include all measures necessary to keep the child as comfortable as possible and counseling for both the parent and child as the situation evolves.

This view is supported by the approach to the mature minor rule taken in Great Britain and in several Commonwealth countries. Courts in these countries apply the rule differently, depending on whether the question is whether the minor can consent to or refuse recommended care, with courts requiring evidence of greater maturity for refusals or holding simply that a court may override a minor's refusal to protect the child's best interests. The distinction was first developed in Great Britain (*Gillick v. West Norfolk & Wisbech Health Authority*, 1985; *In re R (A Minor) (Wardship: Consent to Treatment)*, 1991; *In re W (A Minor) (Medical Treatment)*, 1992)¹⁰ and has since then been adopted in Australia (*Secretary (Dept. of Health & Community Serv.) v. J.W.B.*, 1992; *X v. Sydney Children's Hospital Network*, 2013), and Canada (*Manitoba (Director of Child and Family Service) v. C(A)*, 2009). A recent opinion from the court of appeal of New South Wales, applying the distinction, explained:

The court is not balancing the interests of the individual against broader public or governmental interests, but is balancing fundamental principles which are in tension in their application to an individual.

The interest of the state in preserving life is at its highest with respect to children and young persons who are inherently vulnerable, in varying degrees. Physical vulnerability diminishes (usually) with age and is at its height with respect to babies. Intellectual and emotional vulnerability also diminish with age but ... may be a function of experience (including but by no means limited to education) as well as age. Vulnerability lies at the heart of the disability identified by legal incapacity. (*X v. Sydney Children's Hospital Network*, 2013, pp. 57, 60).

The ethical argument in favor of this position is that the harm prevented by overriding the minor's refusal is greater than the harm done to the child's autonomy (Dickens & Cook, 2015).

Hard Case Two: A Teen Wants to Reject Effective Medical Care for a Serious, Condition Because of Religious Reasons

If a minor suffering from a serious, even life-threatening condition asserts that he or she wants to decline highly effective, widely accepted medical treatment for religious reasons, should that claim be honored in a state that recognizes the mature minor rule? If the parents do not seek medical care and the child dies, can they successfully claim that they are not criminally liable for the child's death because of the child's own religious beliefs under the mature minor doctrine?

If the child were younger, it is practically certain that the parent acting alone would not be allowed to refuse the care. If the parents consented to care on the child's behalf, they would have to reject their religious beliefs and risk estrangement from the religious community. On the other hand, at least for some groups, if the medical care were court-ordered, the parent, child, or both would not be regarded as having violated the religious obligations (McAninch, 1987; Note, 1990; Weisbrod, 1992). Thus, even though the parent knows about the child's medical problem and supports the child's position, this is a clear case for concluding that the parents cannot be relied upon to help the teen make his or her own decision.¹¹

Because the default rule described above favors requiring the minor to follow medical advice, the law might simply provide that a minor cannot decline care in this situation. On the other hand, adolescents younger than the age of majority have constitutionally protected rights, including the right to religious freedom, and some of them are capable of acting independently and making their own decisions about some kinds of medical care. Thus, a blanket rule prohibiting minors from rejecting medical care for religious reasons in all circumstances is not defensible. Instead, an individualized judicial assessment of the minor's circumstances should be required. However, this is a very emotionally charged decision, since the child's life may be at stake, and the child would risk severe parental disapproval or even being disowned if he or she decided to accept the treatment. Therefore, the presumption should be that the child cannot be acting independently and maturely. Both the consequences of the decision, however it goes, and the great pressure on the child militate against the child being able to act freely and maturely. Only if the minor can establish to a court's satisfaction not only his or her developmental maturity but also independence, by clear and convincing evidence, should the minor be allowed to decide to forego treatment. Since this inquiry is impossible if the child has died, the law should not allow parents who are being prosecuted to claim

that they are not criminally responsible because the child was a mature minor make the decision.

*Hard Case Three: A Teenager Wants to Have an Abortion without
Telling her Parents*

Teen access to abortion presents a problem similar to that which prompted states to enact statutes allowing minors to consent to drug, mental health and other sensitive kinds of care: at least some teens will be so unwilling to involve their parents that they will seek illegal and often dangerous abortion providers, or they will freeze and not make a reasoned decision about what to do at all. However, the solution for abortion is not as easy as for these other issues.

Social policy favors teens obtaining treatment for the conditions that are the subject of the special statutes because treatment is medically advisable and its benefits greatly outweigh the risks. Therefore, if the teen seeks care, he or she is making the legally and socially preferred choice, and close inquiry into the adequacy of the teen's decision-making process is not warranted. In contrast, the abortion question has no clearly preferred answer, although in general early abortion is much safer medically than childbearing (Raymond & Grimes, 2012). However, abortion is not controversial for medical reasons but because of competing values and political views. These are the reasons that the Supreme Court adopted the classic mature minor rule for determining when a minor can have an abortion without involving parents. However, instead of allowing the care provider to decide if the minor is mature enough in the first instance, the Court said the decision must always be made by a judge, who must also decide if the abortion is in the minor's best interests if she is too immature to decide for herself. In principle, this solution seems to respond appropriately to the problem by calling for individualized decision-making.

The Supreme Court's solution in *Bellotti* provides nothing to help the minor make her own decision that might be accepted with more confidence, and as a practical matter it does not always insure that a reasoned decision about each young woman's situation will be made. The process of going before a judge unaccompanied to explain the intimate details about oneself that the maturity and best interests inquiries can require would be daunting even for an adult. Critics argue that the process "leads to costly delay and seems likely to result in later abortions in many cases – in part, because it will be viewed as an obstacle by many girls. Moreover, judicial attitudes

about abortion may color decisions about maturity and best interest, creating uncertainty and inconsistency” (Sanger, 2009; Scott, 2000, pp. 575–576). When the judicial system is not even set up to handle a petition from a minor seeking an abortion, as is the case in many jurisdictions, the minor is effectively precluded from having an abortion without parental consent, regardless of what the law says (Rebouche, 2011; Silverstein & Speitel, 2002).

In a brief to the Supreme Court in *Hodgson*, the American Psychological Association argued that minors generally are capable of making valid decisions regarding abortion (Brief for the American Psychological Association et al., 1990). However, this brief focused on minors’ cognitive capacities and did not address the psychosocial dimensions of decision-making. In defense of that brief, and of the APA’s later brief to the Supreme Court opposing the death penalty for juveniles, leading researchers acknowledged that abortion is an emotion-laden decision but argued that young women’s need for support is provided by consultations with friendly adults or by mandatory counseling, and that waiting periods make it less likely that decisions will be hasty and ill-considered (Steinberg et al., 2009). After reviewing the psychological research, they argued that generally adolescents 16 and older are as capable of making medical decisions as adults with the assistance of “consultants who can provide objective information about the costs and benefits of alternative courses of action” (Steinberg et al., 2009, p. 592).

The analysis proposed in this chapter suggests that the traditional mature minor rule, which requires the provider to determine whether the young woman is mature enough to decide, protects minors better than the procedure set out in *Bellotti*. If abortion providers are not trusted to make this decision, minors could be required to participate in counseling beforehand, and certainly if the provider thinks a minor is immature, she should be referred to counseling. The option of seeking judicial approval without notifying parents, based on a finding that the minor is mature enough to decide or, if not, that the abortion is in her best interests, needs to be preserved, but as a last resort rather than the first solution.

*Hard Case Four: A Teen Objects to Residential Mental Health Care
that the Parents Seek*

The conflict between the parent and child is at the heart of this problem, and the potential for the parents’ judgment to be affected by their own

interests or the interests of others, such as other children, to the detriment of the allegedly ill child is clear. The Supreme Court recognized these problems and decided that due process required procedural safeguards but that a medical admitting process was satisfactory because the problem is essentially a matter of medical diagnosis and prescription. Under the analysis proposed in this chapter, the decision in *Parham* does not protect children adequately for several reasons.

First, the decision of when, if ever, residential treatment is the best alternative is contested among mental health professionals, and there is evidence that especially private residential treatment facilities promote themselves to parents of troubled children without careful attention to the actual needs of the children (Bazelon Center for Mental Health Law, n.d.; Polanco, 1989). Many treatment facilities are unregulated, and children have been seriously abused in some of them, resulting in injuries and some deaths (Committee on Education and Labor, 2007; Committee on Education and Labor, 2008). Further, the process of forcing a young person into residential treatment does not promote the development of his or her capacity to participate in this kind of decision and may even be countertherapeutic (Boldt, 2012).

This does not necessarily mean, however, that a civil commitment hearing before a judge or administrative hearing officer is required, especially since such a hearing may not elicit information about these kinds of problems. At the time *Parham* was decided, some states provided children greater procedural safeguards than *Parham* required. A lawyer who represented children in such a system reported that he and his fellow attorneys were often able to keep children out of institutions by finding less restrictive placements and funding for those placements, as well as exploring community-based alternatives, opening funding channels, and facilitating family contact with community services (Perlin, 1981). This kind of assistance, which combines development of alternative solutions and help for parents and children who are at loggerheads, should be required before a child can be admitted to a residential treatment facility on other than a temporary emergency basis. Well-trained attorneys could provide this help, but so could others, including community mental health workers. This approach protect the interests of parents in seeing that children get needed mental health care while protecting and promoting the children's own developing autonomy where appropriate. It also has a better chance of protecting children from inappropriate or dangerous residential placements than relying on admitting doctors at facilities, as permitted by *Parham*.

CONCLUSION – A REVISED APPROACH TO THE MATURE MINOR DOCTRINE

Fifteen- to sixteen-year olds have the cognitive ability to make competent decisions, but their capacity to do so wise varies with the context. They are physiologically vulnerable in situations that are highly emotionally charged and stressful and when they are subject to pressure from important people in their lives. For these reasons, just as the law should not say that capacity to make binding legal decisions depends rigidly on attaining a certain age, it should not say that a teen always can (or cannot) make a certain type of decision, such as one about health care. While some health care decisions are simple enough that fairly young children can make them, such as whether to have a broken bone set, others are as difficult as any decisions that most individuals will ever have to make. That a decision is difficult does not, however, mean that a minor should never be allowed to make it. The circumstances can make all the difference.

The starting point for analyzing a minor's capacity to make a particular decision should be whether the situation suggests that the minor's abilities may be undermined, as when the decision is highly emotionally charged, the situation is stressful, or others whose views matter to the minor are pressing for the minor to make the decision in a particular way. If one of more of these conditions exist, as is true in the hard cases discussed in this chapter, the next question is whether the parents are available and likely to provide good support to the minor. Parents usually are the best providers of support for their children's emerging competence, and they have the primary responsibility to care for their children. However, if the minor will not consult with the parents or there is reason to be concerned that the parents might not act in the child's best interests, other sources of support that might allow the minor to make the decision should be explored. If the minor cannot be adequately supported, for public policy reasons a decision that is consistent with medical advice is preferred and should be the default decision. If there is no medically preferred outcome, the default should be designed to protect the child's health, support the parent-child relationship if possible, and support the child's emerging autonomy.

This chapter has shown how these principles might play out in applying the mature minor doctrine to four difficult cases. The cases are difficult for different reasons, resulting in different analyses and outcomes.

In the first case, involving medical care of uncertain efficacy with severe side effects, where there is no reason to be concerned that a parent has a

conflict of interest, the parent and child together should be allowed to decide, including deciding not to follow medical advice.

In contrast, in the second case, where the child and parent belong to a faith-healing religion, the parent acting alone would not be allowed to deny the child medical care. Trying to invoke the mature minor rule to allow the child to make the decision seems like an end-run around the limit on parental authority, since the child would be hard-pressed to disagree with the parents and the religious community to which they belong. The parents cannot provide the support the child needs to act wisely and independently. Because of the importance of the decision, the minor probably has a constitutionally protected right to make the decision, subject to limitations necessary to serve the state's interest in protecting the minor's health and well-being. Protecting the minor's physical life and health is the dominant consideration as a policy matter, and therefore, only if the minor convinces a judge that he or she is mature and acting freely of parental and group pressure can the minor make the decision to forego the medically indicated treatment.

The third and fourth cases, like the second, involve an actual or potential conflict of interest between the parent and child where there is no clear medically preferred outcome. In the third case, which concerns the teen who wants to have an abortion without telling her parents, the parents might or might not act inconsistently with the child's best interests. More importantly, the child fears they will not and refuses to run the risk of telling them. Since this dilemma is not primarily medical, medical advice provides no default decision. In this situation, the child needs support to help make the decision, which is very emotionally charged and time sensitive. The Supreme Court's ruling in *Bellotti v. Baird* that the minor should be allowed to go to court to get authorization is not responsive to this need, and making informed and friendly counseling available would be much more helpful in the first instance. This would support the minor's own decision-making process and might shore up the parent-child relationship. However, since efforts to help the minor make the decision maturely might not work, the Bellotti judicial bypass procedure needs to be available so that if necessary a judge can decide if the minor is mature enough or that the abortion is in her best interests.

The fourth case illustrates the situation where the parent and child are most clearly at odds and the child is most at need of protection from the parents making an unwise or conflicted decision. As in the third case, there is no clearly preferable decision as a medical matter. The best solution here is to provide resources that might help resolve the conflict between the

parent's and the child's interests, as by redefining the situation and providing alternative solutions. These solutions should support the minor's developing capacities for independence, as well as supporting parents who realize the child needs some kind of medical help.

NOTES

1. This conclusion is not unique to American jurisprudence; for example, European scholars have argued that fundamental human rights principles protect minors' religious freedom, including the right to refuse medical treatment for religious reasons (Cave, 2011).

2. This case is based on the story of Benny Agrelo, whose case did not reach an appellate court but was widely reported (San Martin, 1994).

3. This case is based on *State v. Beagley* (2013).

4. The rule also "encourages parents to fulfill their general responsibilities to provide for their children's welfare – and to pay their children's medical bills!" (Scott, 2000, p. 566).

5. In contrast, in 2014 an Ontario trial judge ruled that an aboriginal mother's decision to treat her 11-year-old child's leukemia with traditional medicine rather than chemotherapy could not be overridden because of constitutionally protected parental authority. Rather than appeal, the government worked with the parents to develop a compromise – treatment with both chemotherapy and traditional medicine (Grant, 2015).

6. The mature minor rule, which allows minors to make legally binding decisions, should be distinguished from the ethical principle that a health care provider should obtain the assent of older children to health care, which provides that though the parents have legal decision-making authority, the child should be consulted. As an ethical matter, the American Academy of Pediatrics recommends that doctors should obtain parental permission and patient assent, when this is developmentally appropriate. Doctors should obtain informed consent from minor patients who are emancipated or mature minors with adequate decision-making capacity (American Academy of Pediatrics, 2016).

7. The authors write that this figure comes from publicly documented sources, and the actual number of child deaths may be greater. Parents belonging to five churches that practice faith or spiritual healing methods accounted for 83 percent of the deaths: the Indiana-based Faith Assembly, Christian Science Church, Church of the First Born in the Western states, Faith Tabernacle of Philadelphia, and the End Time Ministry of South Dakota.

8. This work was based on the foundational work of Jean Piaget, who found that cognitive abilities to think like adults emerge during early adolescence (Inhelder & Piaget, 1958).

9. The AMA brief discusses another phenomenon that points to the same conclusion: "Top-down connectivity refers to the ability for executive regions, such as in the prefrontal cortex, to exert executive control on response regions. fMRI has shown that the strength and number of top-down functional connections continues

to increase into adulthood. In addition, the organization of functional brain connections forming networks continues to optimize into adulthood. ... The protracted development of top-down connectivity therefore 'may reflect a period of particular vulnerability to ... the peak in risk-taking behavior during adolescence' (Brief for the American Medical Association, 2012, p. 27).

10. In the United Kingdom, a statute provides that children 16 and older can consent to all medical care (Family Law Reform Act, 1969).

11. This problem can also arise when the parent's objection is not based on religion, and the child follows and accepts the parent's views. See, for example, In re Cassandra C. (2015).

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