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NOTE

STATE V. PHYSICIANS ET AL.: LEGAL STANDARDS GUIDING THE MATURE MINOR DOCTRINE AND THE BIOETHICAL JUDGMENT OF PEDIATRICIANS IN LIFE-SUSTAINING MEDICAL TREATMENT

Mary Irene Slonina[†]

Neither Youth nor Childhood is Folly or Incapacity

Some Children are Fools & so are some Old Men.

—William Blake

INTRODUCTION

Every year approximately 53,000 children die in the United States from trauma, lethal congenital conditions, extreme prematurity, heritable disorders, or acquired illnesses.¹ American society's fear of discussing and facing the realities of death are compounded when the dying patient is a child,² a human being whose full potential will never be realized. Unfortunately, child patients, parents, and physicians face questions of treatment and the near-certain death of a child everyday.³ Often all three parties will agree to the proper course of

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¹ Comm. on Bioethics & Comm. on Hosp. Care, Am. Acad. of Pediatrics, *Palliative Care for Children*, 106 PEDIATRICS 351, 351 (2000) (footnote omitted).

² See Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109, 110 (2000) (stating that “[p]atients with life-threatening diseases often do not have frank discussions with their physician about what will happen if the treatment options fail and death is likely . . . Physicians and parents rarely do discuss death with chronically ill children.”).

³ Some of these questions might include: What treatment will be most suc-

treatment and will be a fairly unified entity until the end.⁴ But conflict can and does arise in these emotionally-charged situations. The interdependence of these three parties in making medical decisions that will technically affect only one of the parties can result in pitting a physically and emotionally suffering child against her emotionally suffering parents; an ethically minded physician against parents who want to save their child at any cost; or a child who wants to enjoy the last days of her life free from medication, invasive tests, and stark hospitals against a physician who is holding out hope that one final treatment might give the patient more time to her life.

There is no question of an adult's right to make decisions concerning life-sustaining medical treatments, regardless of whether the decisions are in line with the opinions of doctors and society's norms.⁵ Once a person has reached the age of eighteen,⁶ she is legally inde-

cessful?; What are the side-effects of treatment?; Do the benefits of treatment outweigh the risks of treatment?; Is treatment in the best interests of the child?; At what point is treatment futile?; When should the quality of life trump the quantity of life? The list of questions is endless, but, in general, parents and physicians must confront issues questioning the balance of benefit and risk to the child in treatment plans.

⁴ See Claire Amy Bartholome, *The Rights of a Young Patient*, 11 *BIOETHICS FORUM* 35, 35 (1995) ("In my experience, most minors, no matter what respect they have for their parents, doctors, and other care givers, ask for help in making important decisions."). See also Kathleen G. Davis, *Teaching the Three Rs: Rights, Roles and Responsibilities – A Curriculum for Pediatric Patient Rights*, 11 *BIOETHICS FORUM* 27, 29 (1995) (discussing how some adolescents may not want to make their own medical decisions, rather passing the decision making to their parents).

⁵ See Sanford Leikin, *A Proposal Concerning Decisions to Forgo Life-Sustaining Treatment for Young People*, 115 *J. PEDIATRICS* 17, 17-19 (1989). The author distinguishes adolescent patients from the groupings of adult and infant patients:

Case law and living wills enunciate the right of the competent adult to make decisions concerning life-sustaining treatment. Similar decisions for newborn infants are assigned to parents or guardians. Guidelines on the termination of life-sustaining treatment and the care of dying patients have been published for these two extreme age groups, but it is less clear how to proceed in situations involving dying adolescents.

Id. at 17 (citations omitted). See also Tara L. Kuther, *Medical Decision-Making and Minors: Issues of Consent and Assent*, 38 *ADOLESCENCE* 343, 343 (2003) ("Although adults receive considerable encouragement to become active participants in healthcare decisions, children and adolescents often have little voice in decisions about their medical treatment." (footnote omitted)).

⁶ Some states do not have a statute directly addressing the age of majority but, rather, incorporate eighteen as the age of majority into section definitions. This allows the legislature to change the age of majority, from the traditional eighteen years of age, to other age thresholds when appropriate, such as for reproduction issues and alcohol consumption. *E.g.*, OHIO REV. CODE ANN. § 2151.011(B)(2) (West Supp. 1999); N.Y. PUB. HEALTH LAW § 2980 (McKinney 2002). Other states define the age of majority in a stand alone statute. *E.g.*, CAL. FAM. CODE § 6501 (West 2004).

pendent to make her own medical decisions without interference.⁷ On the opposite side of the age spectrum, there is little debate as to parents' rights to make medical decisions for their newborn or infant child.⁸ Somewhere in between young child and adult patient floats the adolescent patient. Adolescence is the time span when a person tries to develop a sense of independence and self-sufficiency, while utilizing the guidance, knowledge, and experience of older persons, usually parents.⁹ Inconsistencies abound in the levels of respect and responsibility society provides to adolescents:

The laws devised to govern teenagers are layered, reflecting society's alternating perceptions of teenagers as adult-like and child-like, and our accompanying impulses to respect as well as to protect this population . . . [W]e trust eighteen year olds enough to let them fight and die in the military, but not enough to let them drink alcoholic beverages.¹⁰

A life-stage fraught with conflict, the addition of a life-threatening illness brings the independence issues of an adolescent to the foreground, as the patient, parents, and physicians ask who has the final decision in how this minor's illness should or should not be treated?

State statutes and common law have created exceptions to parental consent for minors in particular areas of medical conditions including sexually transmitted diseases, drug abuse, and mental health.¹¹

⁷ The Patient Self-Determination Act of 1990 requires all health care agencies to recognize an individual's living will and durable power of attorney. The Act also requires health care agencies to ask whether an individual has an advanced directive and must advise the individual about her medical rights under state law. See Pub. L. No. 101-508, § 4206, 104 Stat. 1388-115 (1990); Pub. L. No. 101-508, § 4751, 104 Stat. 1388-204 (1990).

⁸ Leikin, *supra* note 5, at 17. *But see* Comm. on Bioethics, Am. Acad. of Pediatrics, *Ethics and the Care of Critically Ill Infants and Children*, 98 PEDIATRICS 149, 149-51 (1996) (discussing concerns that parents and physicians might not always act in the best interest of the infant patient, thus raising a debate whether the parents and physicians should be the only decision-makers of an infant's medical care); Jennifer L. Rosato, *Using Bioethics Discourse to Determine When Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 TEMP. L. REV. 1, 43 (2000) ("Although generally families are the favored decision-makers, exceptions may exist where the family member is unlikely to make decisions in the patient's best interests.").

⁹ See discussion *infra* pp. 190-93.

¹⁰ Michelle Oberman, *Minor Rights and Wrongs*, 24 J.L. MED. & ETHICS 127, 127 (1996).

¹¹ See Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 163-66 (2000); Oberman, *supra* note 10, at 130-31 ("Today, every state has a statute that permits

Criminal courts often take little or no issue with declaring a minor competent to be tried as an adult. As one commentator has noted, "Many criminal courts certainly are convinced that juveniles can be tried as adults. Can we thus say that the 16-year-old has the right to be treated as an adult and make his or her own medical decisions?"¹² The analogy may not be perfect, but it is one that further indicates the inconsistencies the legal community has created in handling adolescents' rights.

The development of the mature minor doctrine at common law was intended to create an exception to the general rule that parental consent was always needed to medically treat minors.¹³ Minors that demonstrate "maturity" could provide consent without their parents. But the unintended result of the application of the mature minor doctrine can be found in the majority of mature minor cases: there are so many factors a judge (or jury) must take into consideration when determining if a minor is mature that a well-reasoned, unambiguous, and uniform standard has failed to emerge. A trial judge's discretion, not guidelines, determines maturity.¹⁴ Accordingly, the concept of matu-

unemancipated minors, ranging in age from fourteen to seventeen, to consent to care for sexually transmitted diseases."); Linda Sorenson Ewald, *Medical Decision Making for Children: An Analysis of Competing Interests*, 25 ST. LOUIS U. L.J. 689, 700-04 (1982). For statutory examples, see OHIO REV. CODE ANN. §§ 3709.241, 3719.012, 5122.04 (West 2002).

¹² Andrew Newman, *Adolescent Consent to Routine Medical and Surgical Treatment*, 22 J. LEGAL MED. 501, 501-02 (2001) (arguing there should be a bright-line statutory rule that any minor over the age of 16 should be allowed to make her own medical decisions). The practice of trying minors as adults has been on the rise. "Between 1988-1998, the number of juveniles prosecuted as adults for major violent felonies rose 47%." *Id.* at 522. In raising questions as to the arguments that can be made from trying minors as adults and then not allowing minors to make their own medical decisions, the author qualifies his analogy by stating "there is probably only a tenuous relationship between the concepts and values brought to bear on the area of teen-criminal defendants and on teens who are looking to make their own medical decisions." *Id.* at 525.

¹³ The mature minor exception joined three previously common law exceptions to treat a minor without parental consent: (1) medical emergencies, (2) legal emancipation, and (3) minor treatment statutes. See discussion *infra* pp. 188-93.

¹⁴ Two commentators have summarized the issue:

Trial judges exercise discretion in determining when a minor is mature, and do not have to articulate how they ascertained that fact. . . . "[N]othing in law school and little in an average judge's experience provide a meaningful framework for making such a decision [regarding whether the minor is mature]." Therefore, because each judge will tend to have her own opinion as to whether a child is mature, critics argue, applications of the doctrine have been inconsistent

Schlam & Wood, *supra* note 11, at 162 (footnotes omitted).

rity is not easily defined,¹⁵ but there has been no movement within the judiciary or legislatures to clarify or simplify the doctrine's standards so minors, parents, and physicians know what to expect when legal action is necessary.

This Note will argue that a sufficient new standard for the mature minor doctrine should be based on the determination of the treating physician and medical team as to the minor patient's capacity and, thus, maturity to make her own medical decisions when faced with a life-threatening affliction.¹⁶ The medical community's policies on a minor's consent and bioethical guidelines place the physician in the best position, as compared to a judge or the parents, to gauge the minor's maturity. These factors are in addition to a physician's medical training and experience that comes with his profession. A physician has more tools to determine the maturity of a minor than any other party who would be involved in life-sustaining medical treatment decisions.

Part I of this Note will outline the development of the mature minor doctrine. Part II will discuss three court decisions that establish standards to determine application of the mature minor doctrine and the ultimate failure of these standards to create a defined, uniform application of the doctrine. Part III discusses how the medical community judges and determines the capacity of an adolescent to make medical decisions. This section also discusses the medical community's debate as to how much deference an adolescent patient's opinion should be given in deciding whether the minor should undergo life-sustaining treatments when facing a deadly disease. Finally, Part IV will argue that incorporating or giving substantial deference to the medical community's standards and opinions for maturity evaluation would provide the law with a standard that is more rational and better-suited than the current haphazard standards enunciated in the common law.¹⁷

¹⁵ Jessica A. Penkower, Comment, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment – Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1167 (1996).

¹⁶ For a discussion on terminal illnesses, see David R. Freyer, *Care of the Dying Adolescent: Special Considerations*, 113 PEDIATRICS 381, 386 (2004).

¹⁷ This Note will not discuss the rights of minors to make decisions regarding reproductive rights, sexually transmitted diseases, or other medical areas that statutory law has already created definite age exceptions because those medical exceptions are settled.

I. MEDICAL PROCEDURES AND THE LEGAL RIGHTS OF MINORS TO CONSENT

A. Brief History of Children's Rights

Historically, common law defined children as the chattel, or property, of their parents.¹⁸ Children were thought to be incompetent and devoid of the capacity to make their own legitimate decisions.¹⁹ Anglo-American societies have long held a person to be a child until her twenty-first birthday.²⁰ It was not until the onset of puberty that various societies would recognize the beginning of a status change of a person from child to adult, slowly becoming responsible for her own being.²¹ Legal recognition of adulthood evolved around the concept of adolescence marking the beginning of adulthood. The Rule of Sevens, an ancient Anglo-Saxon law that can still be found woven into American law, did not hold children responsible for criminal acts before the age of seven.²² After the age of fourteen, children were completely responsible for their actions.²³ Between the ages of seven and fourteen, "courts adopted a rebuttable presumption that [children] possess an adult capacity to do evil."²⁴

This historical perspective on children's rights transferred to developing American law. In the case of *Morrissey v. Perry*,²⁵ the Supreme Court commented on a provision of the federal code that allowed persons under the age of twenty-one to enlist in the military *only after* obtaining the written consent of a parent or guardian. The petitioner had been only seventeen when he enlisted in the military

¹⁸ Newman, *supra* note 12, at 502.

¹⁹ Ann Eileen Driggs, *The Mature Minor Doctrine: Do Adolescents Have The Right to Die?*, 11 HEALTH MATRIX 687, 689 (2001).

²⁰ Wallace J. Mlyniec, *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 FORDHAM L. REV. 1873, 1877 (1996).

²¹ *Id.* at 1876.

²² *Id.*

²³ *Id.* Align this fact with the traditional Anglo-American rule that a person obtains legal adulthood at age twenty-one, and one may note that most adult responsibilities are passed on to a person from the age of fourteen through her twenty-first birthday (e.g. working outside the home, driving, voting, marrying, and consuming alcohol).

²⁴ *Id.* The early teenage years are often the beginning of puberty for children. As the Rule of Sevens marked age fourteen as the onset of complete adult responsibility, this age was also viewed as the line between childhood and adulthood by other societies. The Romans presumed that people understood the law at age fourteen. The Christian and Jewish faiths have often "accorded a child responsibilities to the community around age thirteen." *Id.*

²⁵ 137 U.S. 157 (1890).

without his mother's consent. He argued that his mother's non-consent meant his enlistment was illegal, and, thus, he should be discharged. But the Court ruled that the provision requiring parental consent was for the benefit of the parents, not the minor; if the parent had not attempted to bring the consent provision before a court after petitioner's enlistment, the provision was waived and the minor had to serve out his time in the military.²⁶ In its opinion, the Court commented on government interference with parental rights: "[The provision] means simply that the government will not disturb the control of [a] parent or guardian over his or her child without consent."²⁷

The onset of the Industrial Revolution saw the emergence of children's advocacy groups and the promotion of child labor law, resulting in the state taking away some parental right to control the actions of children.²⁸ But major recognition of children's rights in the United States did not occur until the 1960s and 1970s. In *In re Gault*,²⁹ the Supreme Court held that the Due Process Clause of the Fourteenth Amendment extended to children. In *Tinker v. Des Moines Independent Community School District*,³⁰ the Court recognized the fundamental rights of minors (high school students in that particular case) and stated that "[s]tudents in school as well as out of school are 'persons' under our Constitution."³¹ Reproductive and privacy rights that had been constitutionally guaranteed to adults³² were extended to minors, although often in some limited form.³³ In 1971, ratification of the

²⁶ *Id.* at 158-60.

²⁷ *Id.*

²⁸ See Newman, *supra* note 12, at 503. See also Schlam & Wood, *supra* note 11, at 147 (stating that, along with child labor laws, societal changes from the Industrial Revolution prompted legislatures to pass compulsory education laws).

²⁹ 387 U.S. 1 (1967).

³⁰ 393 U.S. 503 (1969) (holding that a school district's prohibition on black arm bands, which students wore in protest of the Vietnam War, without proof that the arm bands would lead to a substantial disruption or material interference with school activities, was a violation of the students' constitutional right to freedom of expression). *But see* Ginsberg v. New York, 390 U.S. 629 (1968) (holding that a New York State law that prohibited the sale of sexually oriented magazines to minors was not in violation of the First Amendment because the state has a heightened authority to protect minors as opposed to adults).

³¹ *Tinker*, 393 U.S. at 511.

³² See generally *Griswold v. Connecticut*, 381 U.S. 479 (1965) (declaring unconstitutional a state law that prohibited contraceptives); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (declaring unconstitutional a state law that prohibited the distribution of contraceptives to non-married individuals); *Roe v. Wade*, 410 U.S. 113 (1973) (holding that the Constitution protects a woman's right to terminate a pregnancy before the fetus has reached viability).

³³ See *Bellotti v. Baird*, 443 U.S. 622 (1979) (holding that if a minor sought and was granted judicial approval for an abortion, the state could not further require

Twenty-Sixth Amendment lowered the voting age from twenty-one to eighteen.³⁴ But, even with these decisions, there remained the general rule that the law granted parents broad decision-making power over their children, as observed by the Supreme Court in *Parham v. J. R.*³⁵ in 1979:

The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has been recognized that natural bonds of affection lead parents to act in the best interests of their children.³⁶

B. Statutory Exceptions to Parental Consent in Medical Procedures

The recognition of children's rights by the mid-twentieth century did not encompass a minor's decisional rights in relation to general medical procedures. As with many legal concepts, several exceptions developed from the general rule. The four recognized exceptions to parental consent are: (1) emergencies, (2) emancipation, (3) minor treatment statutes, and (4) the mature minor doctrine.³⁷ The earliest exceptions to common law addressed the need of a minor to receive treatment in an emergency and those minors who had been legally emancipated from their parents or guardians.³⁸ The emergency exception reflects a societal notion that it is cruel to allow a minor to sit in

her to notify her parents of the abortion).

³⁴ U.S. CONST. amend. XXVI.

³⁵ 442 U.S. 584, 606, 620-21 (1979) (ruling a Georgia law constitutional that required a "neutral factfinder" to evaluate a child against statutory requirements before her parents could request the child's admission in to a mental health institution).

³⁶ *Id.* at 602.

³⁷ Discrepancies exist among commentators as to whether the mature minor doctrine is an exception to parental consent or a separate legal concept. Compare Allison Mantz, *Do Not Resuscitate Decision-Making: Ohio's Do Not Resuscitate Law Should Be Amended To Include A Mature Minor's Right To Initiate a DNR Order*, 17 J.L. & HEALTH 359, 370 (2003) (defining the mature minor doctrine as an "exception" to the general rule), and Driggs, *supra* note 19, at 690 ("The courts have recognized [the mature minor doctrine as one of] three exceptions to the requirement for parental consent in medical treatment of children . . ."), with Penkower, *supra* note 15, at 1179 (stating that the mature minor doctrine is part of "a gray area into which the common law has attempted to extend the rights of minors regarding their health care."). There appears to be no commentary on this discrepancy or arguments made for one classification over the other. This Note will assume that the mature minor doctrine is an exception to the general rule.

³⁸ Penkower, *supra* note 15, at 1176.

pain because a medical professional, wishing to avoid a lawsuit, refuses to treat the minor without parental consent.³⁹ One commentator has defined “[a]n ‘emergency’ . . . as anything requiring relatively urgent attention or that is causing a child pain or fear.”⁴⁰ The second exception, emancipation, recognizes the legal rights a minor earns once a court has granted her emancipated minor status. If an emancipated minor has the same legal rights as an adult, she is allowed to make her own medical decisions like an adult.⁴¹

The majority of modern exceptions to parental consent for a minor’s treatment are found in state statutes.⁴² In the 1960s, an epidemic of sexually transmitted diseases amongst teenagers led states to pass “‘minor treatment statutes.’”⁴³ These statutes allowed minors, without parental consent, to receive contraceptives and treatments for sexually transmitted diseases.⁴⁴ The concern for public health extended to the creation of minor treatment statutes for alcohol abuse, substance abuse, and psychiatric care.⁴⁵ To generalize, conditions covered by minor treatment statutes “all had a great social stigma associated with them and minors may be reluctant to seek treatment if they must first advise their parents More importantly, these conditions all have implications that extend beyond the individual minor involved.”⁴⁶

³⁹ ANGELA RODDEY HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 126 (2d ed. 1985).

⁴⁰ *Id.* at 125-26.

⁴¹ See Penkower, *supra* note 15, at 1177 (noting that states have different judicial standards in granting emancipation, but generally an emancipated minor may consent to her own medical care); Driggs, *supra* note 19, at 691. See also Oberman, *supra* note 10, at 130 (“The definition of *emancipation* varies from state to state, but it is generally limited to minors who are not living at home, who are not economically dependent on their parents, and whose parents have surrendered parental duties. In the past, this category consisted primarily of married minors and minors in the military service.” (footnote omitted)).

⁴² See Ewald, *supra* note 11, at 701; Oberman, *supra* note 10, at 130; Penkower, *supra* note 15, at 1177.

⁴³ Oberman, *supra* note 10, at 130 (footnote omitted).

⁴⁴ *Id.* at 130-31. Minor treatment statutes should not be thought of as legislative recognition that some minors were mature: “Society’s interest in halting the spread of sexually transmitted diseases was the true motivating force in promulgating these laws, not society’s belief that some minors could be sufficiently mature to make medical decisions for themselves.” Penkower, *supra* note 15, at 1178.

⁴⁵ See statutes cited *supra* note 11.

⁴⁶ Ewald, *supra* note 11, at 701.

II. JUDICIAL STANDARDS OF THE MATURE MINOR DOCTRINE

The mature minor doctrine is the fourth, and most recent, exception to the general rule that minors are incompetent and subject to the decisional control of their parents or guardians.⁴⁷ Its increased development in judicial opinions in the last twenty years or so has allowed "a minor who exhibits the 'maturity' of an adult to make decisions that traditionally have been reserved for persons who have attained the age of majority."⁴⁸ The application of this maxim has seen many different interpretations when applied to life-threatening illnesses, as opposed to illnesses that are not serious.⁴⁹ The result is the lack of a clear standard and reasonable expectations in the way a mature minor case will be decided by the courts.

Case law is the primary place to study the standards of applying the mature minor doctrine. In *Cardwell v. Bechtol*,⁵⁰ the Supreme Court of Tennessee expressly adopted the mature minor doctrine. The court reinstated the trial court judgment that an osteopath had not committed battery in treating a minor, age seventeen and seven months, for back pain without the consent of her parents.⁵¹ Although the facts did not involve a life-threatening illness, the court supplied a comprehensive list of characteristics to take into consideration when determining whether a minor had the capacity to agree to any medical treatment: age, ability, experience, maturity, education, training, and demeanor.⁵² The court indicated that these factors were to be taken in the context of the whole medical situation, including the ability of the minor to understand the treatment, the risks, and the consequences.⁵³

⁴⁷ Mantz, *supra* note 37, at 370.

⁴⁸ Penkower, *supra* note 15, at 1166.

⁴⁹ Two commentators have noted that "[c]ontroversy regarding the 'mature minor' doctrine does not center upon the justification for the rule itself, but upon its application." Schlam & Wood, *supra* note 11, at 162. The authors continue to explain: [t]he 'mature minor' doctrine has been consistently applied . . . in cases in which the minor (1) is near the age of majority, usually fifteen years or older, (2) displays the capacity to understand the nature and risks of the treatment, and (3) where the nature of the treatment is not 'serious.'

Id. at 163.

⁵⁰ 724 S.W.2d 739 (Tenn. 1987).

⁵¹ *Id.* at 742-43.

⁵² *Id.* at 748.

⁵³ *Id.* at 749. The court, similar to courts before it, followed the adoption of the mature minor doctrine with the statement, "[w]e do not, however, alter the general rule requiring parental consent for the medical treatment of minors." *Id.* at 749.

The Rule of Sevens' age presumptions were the final determining factor.⁵⁴

In the case of *In re E.G.*,⁵⁵ the petitioner, E.G., was a seventeen-year-old suffering from leukemia. As a Jehovah's Witness, E.G. refused recommended blood transfusion treatments; without the treatments, E.G. would certainly have died within a month.⁵⁶ Her mother, also a Jehovah's Witness, supported the decision. Because of the treatment refusal, the State filed a petition in juvenile court seeking to take custody of E.G. and perform the blood transfusions.⁵⁷ During the hearings, E.G. testified that she was refusing the treatments because of her own religious convictions and not because she had a determination to die.⁵⁸ Several witness, including a psychiatrist, testified as to the maturity of E.G. and the sincerity of her religious beliefs.⁵⁹ The trial court noted the maturity of E.G. but ruled that the State's interest outweighed her right to refuse treatment. On appeal, the appellate court reversed and ruled that, as a "mature minor," E.G. had a constitutional right to refuse medical treatment.⁶⁰ The State appealed to the Illinois Supreme Court, which upheld the determination that a mature minor had a constitutional right to refuse medical treatment. As with the common law right of an adult to refuse life-sustaining medical treatment,⁶¹ the court noted that a mature minor's right to refuse treatment had to be weighed "against four State interests: (1) the preservation of life; (2) protecting the interests of third parties; (3) [the] prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."⁶² In cases involving minors, protecting the interest of third parties or, more precisely, the interests of the parents was the criteria courts were to give the highest regard.⁶³ Since E.G. and her mother agreed to refuse treatment, this interest was moot. E.G. was allowed to make her own medical decisions concerning the leukemia.

A third influential case in the development of judicial standards for the mature minor doctrine was *In re Long Island Jewish Medical*

⁵⁴ *Id.* at 748. See discussion *supra* p. 186.

⁵⁵ 549 N.E.2d 322 (Ill. 1989).

⁵⁶ Jehovah's Witnesses believe that blood transfusions constitute "eating" blood, an act prohibited by their religion. *Id.* at 323.

⁵⁷ *Id.* at 323-24.

⁵⁸ *Id.* at 324.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ See *In re Estate of Longeway*, 549 N.E.2d 292, 292, 302 (Ill. 1989).

⁶² *In re E.G.*, 549 N.E.2d at 328.

⁶³ See, e.g., *id.* (showing deference to the importance of the decision to the family unit and dynamics).

Center.⁶⁴ In that case, the minor, a month shy of his eighteenth birthday and suffering from a cancer, refused a blood transfusion because he was a Jehovah's Witness; his parents agreed with the refusal. Upon petition by the treating hospital, the court ordered the minor to undergo transfusions after several doctors said they would not treat the minor with chemotherapy unless they also had the power to give him blood transfusions.⁶⁵ Without the chemotherapy, the minor was expected to live up to a month. On appeal, the court said that common law preserved a competent adult's right to refuse medical treatment, but when a patient was a minor, the court had a *parens patriae* power "because parents may throw their own lives away, if they wish, but they cannot make martyrs of their children."⁶⁶ The New York court cited the decisions of *Cardwell* and *In re E.G.* as evidence of a recent trend in the courts to adopt the mature minor doctrine.⁶⁷ But without any rationale, the court ruled the minor's refusal to undergo treatment was not based on a "mature understanding" of his religion or the fatal consequences of his decision; the minor was not a "mature minor" and was ordered to undergo the blood transfusions.⁶⁸

These three cases clearly demonstrate a range in the standards courts are applying to mature minor cases. The *Cardwell* standard is complex; it takes into consideration seven factors of the minor's presence, three factors of the minor's understanding of his illness, and then the final factor of the Rule of Sevens. The balance of all those factors, colored by the personal views and experiences of judges, could produce a wide range of decisions with an infinite variety of rationales. This standard is focused on the child, questioning the capabilities of the child and the interests of the child. The *In re E.G.*

⁶⁴ 557 N.Y.S.2d 239 (N.Y. Sup. Ct. 1990).

⁶⁵ *Id.* at 240-42.

⁶⁶ *Id.* at 243.

⁶⁷ *Id.* The court quoted *In re E.G.*:

If the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent to or *refuse medical treatment*.

Id. The court also quoted *Cardwell v. Bechtol*: "Recognition that minors achieve varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century." *Id.* Despite reiterating the language of two jurisdictions that adopted the mature minor doctrine and using the respective articulated standards to determine the minors in each case were legally allowed to make their own medical decisions, the New York court did not mention the outcomes of *In re E.G.* or *Cardwell* in its opinion.

⁶⁸ *Long Island*, 557 N.Y.S.2d at 243. The court concluded in footnote 15 that the minor would soon be eighteen and "his life will then be in his own hands." *Id.* at 243 n.15.

standard focuses on the state's interest in the minor, with the most important interest being the opinion of the minor's parents on the situation. In comparison with the *Cardwell* standard, the *In re E.G.* standard is parent-focused. With a brief mention of how children mature at different paces,⁶⁹ the *In re E.G.* court makes no mention of how to determine the maturity of a minor. The ability of the *Cardwell* and *In re E.G.* courts to at least make some effort to articulate a standard on which judges can base a decision rationale is highlighted by the *Long Island* court's complete absence of rationale in reaching its decision. It articulates no standard to apply the mature minor doctrine after curiously discussing the standards of *Cardwell* and *In re E.G.* What makes this decision even more perplexing and what is possibly an attempt to side-step the issue,⁷⁰ is that the court rules against a minor weeks away from his eighteenth birthday. The *Long Island* court rules opposite to the two preceding decisions. The facts of this case were highly similar to the facts of *Cardwell*, and yet the former gives no deference to the *Cardwell* court and gives no reason for its lack of deference.⁷¹ These three court decisions leave the debate with three distinct opinions on the mature minor doctrine: *Cardwell* creates a standard so amorphous that it is almost a standard calling for a case-by-case determination; *In re E.G.* creates a standard that is deferential to parental opinion with no focus on the child's maturity; and *Long Island* creates no standard, leaving the impression that a court may determine a mature minor case how it sees fit without explanation.

⁶⁹ *In re E.G.*, 549 N.E.2d at 327. See discussion *supra* note 67 (quoting *Cardwell*).

⁷⁰ The court recommends "that the legislature or the appellate courts take a hard look at the 'mature minor' doctrine and make it either statutory or decisional law in New York State." *Long Island*, 557 N.Y.S.2d at 243. One could argue that the court is refusing to legislate from the bench and by articulating a mature minor standard it would be doing just that. Again, the court's reference to the *Cardwell* and *In re E.G.* decisions is perplexing because it is referring to two courts that did not take overt issue with judicially creating standards for the mature minor doctrine.

⁷¹ Again, an odd occurrence considering that the *Long Island* court discusses both the decisions of *Cardwell* and *In re E.G.*.

III. MEDICAL STANDARDS TO DETERMINE AN ADOLESCENT'S MATURITY AND OPINIONS ON ADOLESCENT'S CAPACITY FOR HEALTH CARE DECISIONS

A. Defining "Adolescence"

As each person is unique in her physical and emotional state, so is the uniqueness of the development of each person into an adult. Many researchers have nonetheless attempted to develop a theory generalizing the development of children. Jean Piaget is argued to be the most influential child development researcher.⁷² He spent years observing children with the end result being the creation of the Piagetian Cognitive Development Theory. The theory posits that there are four basic levels of cognitive development.⁷³ Level Four, the last cognitive development stage, takes place between ages eleven and fifteen. It is at this stage that a child can imagine the past, present, and future conditions of a situation and hypothesize how the situation might occur in different conditions. At this level, children can solve problems by applying theories and engaging in pure thought aside from real-world actions.⁷⁴ "In Piagetian theory, by the age of fifteen, a child's thinking has evolved into a mature state[,] and adult thought exists within the child's repertoire of mental functions."⁷⁵

⁷² See Mlyniec, *supra* note 20, at 1878; Schlam & Wood, *supra* note 11, at 153.

⁷³ Mlyniec, *supra* note 20, at 1878.

Level One . . . occurs from birth to two years old. . . . At the end of this stage, children can mentally plan simple physical tasks using objects in view. . . . Level Two . . . occurs between two and seven years of age. . . . [A]t this level children gain a facility for language and move from simple problem solving . . . to incipient logical thought. Nonetheless, direct perception, rather than logical thought and governing principles, primarily influence this intuitive thinking. Thus, according to Piaget, children under the age of seven cannot engage in truly intellectual activities Level Three . . . occurs between seven and eleven years of age. During this period, children begin to understand causation, gain a more objective view of the universe, . . . attain a better understanding of others' perceptions [, and] begin to understand why physical events occur.

Id. 1879.

⁷⁴ *Id.*

⁷⁵ *Id.*

Although there have been critiques of Piaget's theory,⁷⁶ modern researchers tend not to stray from the basic premises of Piaget's research. In 1989, Dr. Sanford Leikin attempted to align the Piagetian stages with the stages in which a child comprehends medical treatments and has the ability to consent to them.⁷⁷ According to Leikin, there are four concepts a child must grasp before she has the ability to consent⁷⁸ to medical treatment: understanding, reasoning, voluntariness, and comprehension of death. "Understanding" an illness requires a child to comprehend a disease as a process attacking her body. Leikin believes that children under the age of 11, or before Level Four of Piagetian Development, do not understand the process of a disease and rather just see illnesses as something outside their body attacking it.⁷⁹ "Reasoning" means a child must be able to think about the long term effects of her disease and treatment.⁸⁰ She should be capable of abstract thinking in order to synthesize and analyze past, present, and future events.⁸¹ All of this is associated with the beginning of Level Four around age twelve.⁸² The third concept, "voluntariness," tends not to appear in adolescents under the age of fourteen or fifteen.⁸³ At this age range children's decisions appear not to be a mere acquiescence of authority figures' wishes. Rather, children at the end of Level Four have developed and used logical process thinking to understand their illness and possible treatments.⁸⁴ This allows children to reach a conclusion in the same capacity any adult would; hence, the lack of dependency on other adults' opinions.⁸⁵ "Comprehension and moral

⁷⁶ Some fault Piaget for only studying the "average" child and not taking into account a child's unique environmental experiences, interactions with particular persons, and a child's particular genetic structure. *Id.* at 1880. See also William Gardner et al., *Asserting Scientific Authority: Cognitive Development and Adolescent Legal Rights*, 44 AM. PSYCHOLOGIST 895, 898 (1989) (arguing that adolescent development does not occur in stages, but rather occurs at different times across task domains).

⁷⁷ Leikin, *supra* note 5, at 20-21 ("Medical decision making by young people requires the same abilities as those used by adults: understanding the medical information, considering or reasoning about it, and freely choosing from among the options."). See also Nancy M. P. King & Alan W. Cross, *Children as Decision Makers: Guidelines for Pediatricians*, 115 J. PEDIATRICS 10, 12-14 (1989) (discussing four factors physicians should use in determining a child's capacity for informed consent: reasoning, understanding, voluntariness, and the nature of the decision).

⁷⁸ See *infra* notes 104-05.

⁷⁹ Leikin, *supra* note 5, at 20.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.*

views of death” is the last factor in Leikin’s analysis. He states it is unrealistic to expect a very young child to comprehend death because it manifests a great childhood fear: separation from those who protect and comfort.⁸⁶ Young children see death as something that happens to others and not to them.⁸⁷ Again, as with voluntariness, it appears that the concept of death is not fully understood until the age of fourteen or fifteen, when the adolescent has the capability to “[grasp] . . . the possibilities and limitations of one’s self in relation to a finite future”⁸⁸

The limited amount of empirical research on cognitive development and medical decisions supports Piagetian theory that around age fifteen children have the same decision-making capabilities as an adult.⁸⁹ In a well-known 1982 study, two researchers wanted to test the proposition of the late Supreme Court Justice, William O. Douglas that “the moral and intellectual maturity of the 14-year-old approaches that of the adult.”⁹⁰ They hypothesized an empirical comparison of the competency of fourteen-year-olds and adults would support Justice Douglas’ statement. They took a test group of 96 subjects, and divided them into four groups of twenty-four subjects by age: (1) eight and a half to nine and a half, (2) fourteen, (3) eighteen, and (4) twenty-one.⁹¹ The subjects were presented with four hypothetical medical dilemmas and were asked to choose treatment options for each of the illnesses in the situations.⁹² The subjects’ responses to questions were evaluated and scored by a panel of twenty experts on four standards of competency: evidence of choice, reasonable outcome, rational reasons, and understanding. The results indicated that fourteen-year-olds demonstrated a competency equal to that of eighteen and twenty-one-year-olds. The nine-year-olds demonstrated less competency than the

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.* The author cites several examples of adolescents coming to terms with their impending death, such as one sixteen year old with cancer. In declining chemotherapy, the adolescent patient said, “Now it’s not the quantity of years it’s the quality of years.” *Id.* at 21.

⁸⁹ See Kuther, *supra* note 5, at 349-50 (“Research comparing the decision-making capacity of adolescents and adults is rare...many theorists argue that there is little evidence that minors aged 15 and older are less able to provide consent than are adults.” (citation omitted)); Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589, 1589 (1982).

⁹⁰ Weithorn & Campbell, *supra* note 89, at 1589 (quoting *Wisconsin v. Yoder*, 406 U.S. 205, 245 n.3 (1972)).

⁹¹ *Id.* at 1591.

⁹² The four dilemmas were diabetes, epilepsy, depression, and enuresis. *Id.* at 1592.

fourteen-year-olds, but the former group still appeared to be fairly competent in making treatment decisions.⁹³ Another study asked sixty-two adolescents, age ten to twenty, to list the potential benefits and risks of certain medical treatments.⁹⁴ Non-significant trends in responses revealed that the older adolescents (age fourteen and up) were able to list a greater number of benefits and risks of the medical treatments and were able to anticipate the consequences of treatment in more abstract manner.⁹⁵ As one psychologist has noted on developmental research outside the medical treatment context:

Comparisons of adolescent and adult decision-making with regard to risky behaviors (e.g., substance use, alcohol use, unprotected sexual activity) have demonstrated that adolescents and adults are equally able to identify possible consequences of risky behavior. In addition, adolescents and adults assess the consequences similarly; they estimate similar probabilities or likelihoods of consequences.⁹⁶

B. Medical Institutions' Policies Concerning a Minor's Capacity to Consent

In promulgating country-wide medical policy, the American Academy of Pediatrics (AAP)⁹⁷ researches and develops policy for pediatricians to follow in practice. As the primary American medical organization dedicated to children's health, the AAP has published several statements outlining guidelines concerning who should make medical decisions for minors and when minors possess the capacity to make their own medical decisions.

In 1994, the AAP's Committee on Bioethics published *Guidelines on Forgoing Life-Sustaining Medical Treatment (Guidelines)*.⁹⁸ In an overt showing of respect for a minor's wishes, the committee wrote: "Generally, parents give permission for the treatment of children who

⁹³ *Id.* at 1595-96. The authors note, "Our findings support predictions based upon Piagetian concepts of cognitive development." *Id.* at 1595.

⁹⁴ Kuther, *supra* note 5, at 349.

⁹⁵ *Id.*

⁹⁶ *Id.* (citations omitted).

⁹⁷ The AAP was founded in 1930 to promote children's health. As of 2004, the AAP had a membership of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. The AAP publishes the monthly scientific journal *Pediatrics*. See AM. ACAD. OF PEDIATRICS, AAP-AT-A-GLANCE (2004), available at <http://www.aap.org/75/profile/aaprofile-complete.pdf>.

⁹⁸ Comm. on Bioethics, Am. Acad. of Pediatrics, *Guidelines on Forgoing Life-Sustaining Medical Treatment*, 93 PEDIATRICS 532 (1994).

cannot do so themselves. However, the American Academy of Pediatrics emphasizes that physicians and parents should give great weight to clearly expressed views of child patients regarding [life-sustaining medical treatment], *regardless of the legal particulars.*⁹⁹

The committee follows this passage with a definition of competency and guidelines physicians are to use to determine a person's decision-making capacity:

Decision-making capacity and the legal term "competency" refer to the ability of a person to make decisions at particular times under particular circumstances. One formulation of this overall capacity involves three essential elements: (1) the ability to understand and communicate information relevant to a decision; (2) the ability to reason and deliberate concerning the decision; and (3) the ability to apply a set of values to a decision that may involve conflicting elements. Each potential decision maker regarding [life-sustaining medical treatment] should manifest these abilities. However, *children should have the opportunity to participate in decisions about [life-sustaining medical treatment] to whatever extent their abilities allow.*¹⁰⁰

Again, the AAP reasserts a physician's duty to respect the wishes of the minor in regards to treatment. This excerpt suggests that if a minor possesses the same decisional capabilities of an adult, why should the child not be allowed to make a decision like an adult?¹⁰¹ The policy also instructs a physician to make a formal assessment of a patient's capacity to make decisions and to document the assessment.¹⁰²

Following the aforementioned policy statement, the AAP's Committee on Bioethics published *Informed Consent, Parental Permission, and Assent in Pediatric Practice (Informed Consent)*.¹⁰³ This policy statement refers to more general medical procedures; it does

⁹⁹ *Id.* at 532 (citation omitted) (emphasis added).

¹⁰⁰ *Id.* (citation omitted) (emphasis added).

¹⁰¹ This argument is supported by another sentence in the policy statement: "[T]he gravity of decisions about [life-sustaining medical treatment] requires careful, explicit attention to the wishes and feelings of the children, regardless of the legal status of the patients." *Id.* at 535. But all of these passages could also suggest simply that the physicians must listen to the minor patient, but not necessarily completely defer to her wishes.

¹⁰² *Id.*

¹⁰³ Comm. on Bioethics, Am. Acad. of Pediatrics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314 (1995).

not focus on life-sustaining medical treatment. The statement distinguishes informed consent¹⁰⁴ from assent,¹⁰⁵ two separate concepts and each equally important to a minor receiving medical care. Informed consent occurs when the patient has been given all the information on her illness and all possible options in treating her illness before deciding on a course of action.¹⁰⁶ Assent occurs when the patient agrees to a course of action decided on by a third party; the third party has decided the course of action after receiving all the information on the patient's illness and all possible treatment options.¹⁰⁷ "Only patients who have appropriate decisional capacity and legal empowerment can give their informed consent to medical care. In all other situations,

¹⁰⁴ A universal medical concept, "informed consent," calls upon a physician to disclose all information to a patient about her illness and treatments:

Experts on informed consent include at least the following elements in their discussions of the concept:

1. Provision of information: patients should have explanations, in understandable language, of the nature of the ailment or condition; the nature of the proposed diagnostic steps and/or treatment(s) and the probability of their success; the existence and nature of the risks involved; and the existence, potential benefits, and risks of recommended alternative treatments (including the choice of no treatment).
2. Assessment of the patient's understanding of the above information.
3. Assessment, if only tacit, of the capacity of the patient or surrogate to make the necessary decision(s).
4. Assurance, insofar as is possible, that the patient has the freedom to choose among the medical alternatives without coercion or manipulation.

Id. at 314-15.

¹⁰⁵ Assent is the agreement of a patient to a course of action regarding her illness:

Assent should include at least the following elements:

1. Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition.
2. Telling the patient what he or she can expect with tests and treatment(s).
3. Making a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding (including whether there is inappropriate pressure to accept testing or therapy).
4. Soliciting an expression of the patient's willingness to accept the proposed care. Regarding this final point, we note that no one should solicit a patient's views without intending to weigh them seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived.

Id. at 315-16 (emphasis omitted).

¹⁰⁶ *See id.* at 314-16.

¹⁰⁷ *See id.* at 315-16.

parents or other surrogates provide informed permission for diagnosis and treatment of children with the assent of the child whenever appropriate."¹⁰⁸ The second sentence of the quote states that when a child is too young to comprehend her illness and treatment, the parents should make the informed decisions, but the child should express her acceptance (or assent) of the proposed treatment. The former sentence, however, suggests there may be instances when the minor patient may provide informed consent without her parents. The AAP "encourages" physicians to seek consent according to three groupings: (1) informed permission of the parents when the minor is an infant or young child; (2) assent of the patient and informed permission of the parents when the minor is of older school age; and (3) the informed consent of adolescents and young adults.¹⁰⁹ The policy goes a step further to suggest that empirical data, although limited, indicates that adolescents over the age of fourteen "may have as well developed decisional skills as adults for making informed health care decisions."¹¹⁰

Both *Guidelines* and *Informed Consent* instruct physicians to avoid judicial intervention when there are conflicts concerning consent. *Guidelines* states that there is a "presumption against judicial review" and warns that legal adjudication should only be sought when it is required by law or when the parties have been unable to settle a disagreement through other measures.¹¹¹ *Informed Consent* does not take such an ominous tone about legal recourse, but mentions that an adolescent's refusal to consent to medical treatment might be legally and ethically binding upon the physician.¹¹²

One must concede that neither of the AAP's policy statements explicitly state that physicians, upon determining a minor to be competent to make her own medical decisions, should listen to only the patient's wishes and not the parents'. But the guidelines also do not rule out that possibility; to the contrary, the AAP recognizes a person's right to make her own medical decisions regardless of a statutory age limit that takes nothing but a patient's birth date into consideration.¹¹³

¹⁰⁸ *Id.* at 314 (emphasis omitted).

¹⁰⁹ *See id.* at 316-17.

¹¹⁰ *Id.* at 317. *See supra* note 89.

¹¹¹ Comm. on Bioethics, *supra* note 98, at 533. The AAP suggests several avenues for dispute resolution before turning to the court: psychiatrists, family therapists, ethics consultants or an ethics committee, religious advisors, etc. *Id.* at 534.

¹¹² Comm. on Bioethics, *supra* note 103, at 317.

¹¹³ *See* Comm. on Bioethics, *supra* note 1, at 354 (stating that "[t]he informed decision of an adolescent or young adult patient nearing death to refuse further life-sustaining medical treatment ought to be respected . . .").

C. Scholarship from the Medical Community on a Minor's Ability to Consent to Life-Sustaining Treatments

Aside from the American Academy of Pediatrics' policy statements, there is much discussion in the medical community about (1) the role a physician should play in the determining the capacity of a minor to consent to medical treatments and, after a maturity determination is made, (2) whose opinion should be the final authority in guiding medical treatment.

In his proposal, Leikin sets the general tone for determining a child's decision-making capacity: "The persons who know the juvenile best, the parents and the physician, must perform this difficult evaluation. This great responsibility is even more difficult because they must, at a tragic time, make an evaluation of the young person that is free of their own values and interests."¹¹⁴ Leikin says that pediatricians have three roles in dealing with minor patients and life-threatening diseases. The first is to promote the minor's mental and emotional development. The second is to evaluate her level of maturity. The third is for the pediatrician to support the independence of the patient after he has determined her to be capable of consent.¹¹⁵ Putting all these roles into play, the pediatrician should facilitate the self-determination of the adolescent patient. In regards to the patient's right to final say in a medical decision, Leikin proposes the following policy:

[I]f a minor has experienced an illness for some time, understands it and the benefits and burdens of its treatment, has the ability to reason about it, has previously been involved in decision making about it, and has a comprehension of death that recognizes its personal significance and finality, then that person, irrespective of age, is competent to consent to forgoing life-sustaining treatment.¹¹⁶

He clarifies that he does not want to give the impression that a minor deemed mature should be left with no input from her parents or others who care about her.¹¹⁷ The article does not explicitly say that

¹¹⁴ Leikin, *supra* note 5, at 21.

¹¹⁵ *Id.* at 18.

¹¹⁶ *Id.* at 21.

¹¹⁷ *Id.*

Like an adult in a similar situation, the very ill minor needs the caring support and counseling of family members, physicians, and other health care professionals. These relationships contribute greatly to reducing the pa-

physicians should be the primary party to decide if a minor is mature. Leikin opens with the statement that the physician and parents must attempt to be unemotional and ignore their personal interests in determining the maturity of the minor.¹¹⁸ But the author only goes into the role of the physician in the determination of maturity. This could be indirect support by Leikin to the fact that the physician is the most capable of detaching himself emotionally from the patient in order to determine her maturity.

In their article, *Caring for Gravely Ill Children*,¹¹⁹ a group of twelve medical professionals (primarily physicians) create their own policy concerning treatment decisions for children with life-threatening illnesses. The group recognizes how a treatment policy might be viewed differently in application to ill adolescents. In an ideal world, the decision making would involve mutual opinion input, evaluation, and agreement between the patient, physician, and parents.¹²⁰ In recognition that collaboration between the parties will sometimes fail, the article supports physicians following the decisions of the adolescent after the physician has determined the patient to cognitively and psychosocially mature.¹²¹ Morally, physicians cannot accept a parent's decision over a mature adolescent's decision.¹²²

tient's anxiety and insecurity, thereby enhancing reasoned decision making and providing personal meaning to all those involved.

Id.

¹¹⁸ *Id.*

¹¹⁹ Alan R. Fleischman et al., *Caring for Gravely Ill Children*, 94 PEDIATRICS 433 (1994).

¹²⁰ *Id.* at 437.

¹²¹ The authors do not discuss the role of parents in determining a minor's maturity. Rather, the article is explicit of the role the physician plays in determining maturity. It appears the authors are arguing that it is the physician (or other health care providers) alone who have the responsibility of declaring a minor capable or incapable of making their medical decisions. "When the adolescent patient is deemed cognitively and psychosocially mature by the physician . . . ? The health care professional, after careful assessment of the young person's capacity and mental health, should respect the adolescent's position while working with the family to develop a reasonable plan of management." *Id.* at 437.

¹²² "[W]e believe the physician should respect the adolescent's decision, informing the parent that the health care team cannot morally accept surrogate decision-making for a patient who is functionally autonomous." *Id.* at 437.

In 1995, the Midwest Bioethics Center¹²³ published guidelines concerning health care treatment decision making for minors.¹²⁴ The guidelines were written in response to the Patient Self-Determination Act¹²⁵ because the Act does not extend to minors.¹²⁶ The guidelines are based on three proposals. First, the task force proposes that health care providers are ethically obligated to obtain the assent of minor patients “who are capable of participating in treatment decision making but have not yet fully developed decisional capacity.”¹²⁷ Second, the task force proposes the form of “informed parental/guardian permission” to replace parental consent.¹²⁸ Informed parental/guardian permission requires the parent of a minor patient to receive all the information concerning the illness and treatments from the health care provider, as if the parent was the patient.¹²⁹ The parent then provides “informed permission” to the medical care givers; if the child has a developing capacity for decision making, informed permission should be coupled with the assent of the child.¹³⁰ This proposal demonstrates

¹²³ In May 2004, the Midwest Bioethics Center changed its name to the Center for Practical Bioethics. See *Midwest Bioethics Center Changes Name*, KAN. CITY BUS. J., May 24, 2004, available at <http://www.bizjournals.com/kansascity/stories/2004/05/24/daily12.html>. Established in 1984, the Center is a non-profit institution that raises and responds to ethical issues in health care. See Center for Practical Bioethics, About Us, <http://www.practicalbioethics.org/cpb.aspx?pgID=866> (last visited Oct. 31, 2006).

¹²⁴ Midwest Bioethics Center Task Force on Health Care Rights for Minors, *Health Care Treatment Decision-Making Guidelines for Minors*, 11 BIOETHICS FORUM A/1 (1995). The guidelines were drafted by a task force of pediatric health care providers over a three year period. *Id.* at A/2. Note that the guidelines were published in the same time frame (1994-95) the American Academy of Pediatrics published its guidelines on minor’s decision-making capacity in health care treatments. See discussion *supra* pp. 197-200 and accompanying notes.

¹²⁵ See *supra* note 7.

¹²⁶ Midwest Bioethics Task Force, *supra* note 124, at A/1.

¹²⁷ *Id.* The guidelines define an individual with decisional capacity who “has the ability to make a specific decision, i.e., the ability to understand relevant information, to reflect upon it and to communicate the decision (verbally or non-verbally) to providers. The term decisional capacity can also be understood as the ability to participate in an informed consent process.” *Id.* at A/3.

¹²⁸ *Id.* at A/1 (emphasis omitted).

¹²⁹ *Id.* at A/3.

¹³⁰ *Id.* at A/4.

Some minors have a developing capacity for rationality, participation in decision making and autonomy (e.g., elementary school aged children). Their capacity is not so fully developed as that of mature minors. However, since they are not completely lacking in decision making capacity, respect for such minors requires explicit acknowledgment of their role in health care decision making and treatment.

Id. at A/5. In referencing very young children’s decisional capacity, the Task Force

the task force's concern that the concept of parental consent (and parental right of refusal) is incompatible with the ethical obligations and responsibilities of health care providers to their minor patients.¹³¹ The third proposal states that all persons, including minor children, "with decisional capacity have the right to make health care treatment decisions"¹³² The drafters qualify this proposal with the following statement: "[W]e are committed to the pursuit of a *shared* decision-making model which respects the important and distinct roles of children, parents, and providers in health care decisions."¹³³ As such, the task force believes it is the shared responsibility of the minor, the parents, and the medical care providers to assess the minor's decisional capacity.¹³⁴ The task force does not provide a preference for the medical providers' opinion over parental opinion, although, one commentator has noted, "[r]esponsibility for successful implementation of the *Guidelines* will fall on those in the health care profession."¹³⁵ If there is a conflict between any of these parties, conflict resolution might be warranted with legal resolution as a last resort.¹³⁶ But the underlying notion of the third proposal is that if a minor has decision capacity, she should be independent to make her own medical treatment decisions like an adult.

Although the Midwest Bioethical Center's guidelines have found general support from the medical community and reflect the enumerated policy of the AAP and other scholars,¹³⁷ there are detractors who

writes:

When minors lack capacity to make or communicate treatment decisions (e.g., infants, pre-schoolers, and some cognitively impaired children), such decisions are commonly based on what is called a "best interest of the child standard." . . . [P]arents should be allowed to determine which course of treatment is in the best interests of their child. This presumption is subject to challenge in cases where the course of action chosen by the parents is clearly contrary to providers' judgments

Id.

¹³¹ Midwest Bioethics Task Force, *supra* note 124, at A/1 (noting that the laws of most jurisdictions recognize the rights of parents to make health care decisions for their minor children).

¹³² *Id.* at A/2 (emphasis omitted).

¹³³ *Id.*

¹³⁴ *Id.* at A/13. The Task Force gives some broad guidelines in determining decisional capacity, somewhat similar to the standard outlined in the *Cardwell* decision. *Id.*

¹³⁵ James M. Caccamo, *Children, Society, and Health Care Decision Making*, 11 BIOETHICS FORUM 32, 34 (1995).

¹³⁶ Midwest Bioethics Task Force, *supra* note 124, at A/14.

¹³⁷ See generally William G. Bartholome, *Hearing Children's Voices*, 11 BIOETHICS FORUM 3 (1995); Carson Strong, *Respecting the Health Care Decision-Making Capacity of Minors*, 11 BIOETHICS FORUM 7 (1995). But see generally Joel

criticize the concept that once a minor is determined to have "decisional capacity" she should be allowed to make any medical decision. Dr. Lainie Friedman Ross questions the impact such a policy would have on the intimate relationship of a family.¹³⁸ She also sees equating a child's decisional capacity to her right to make a decision as removing long standing societal protections of children: "[t]o empower children with the same rights as adults is to deny them protection they need. It would mean the dissolution of child labor laws, mandatory education, statutory rape laws, and child neglect statutes."¹³⁹ Ross takes great contention with the notion that a "bad" decision by a child must be respected because the child possesses decisional capacity.¹⁴⁰ James Caccamo writes that successful implementation of the guidelines requires extensive education for parents of critically ill children.¹⁴¹ The concepts of minor treatment decisions, from "child assent" to "informed parental/guardian permission," are difficult for parents to grasp;¹⁴² if they cannot grasp them, how are they to participate in decision they technically have a legal right to make?¹⁴³

IV. INCLUSION OF MEDICAL POLICIES AND PROPOSED MEDICAL STANDARDS INTO THE APPLICATION OF THE MATURE MINOR DOCTRINE

As discussed in Part II, there are different judicial opinions as to the most useful standard to apply the mature minor. Yet review of these standards shows that none incorporate any medical concepts on maturity or show a correlation with medical opinions and policies on respecting a minor's right to choose their own path of treatment when ill with a life threatening disease. In order to develop a better judicial

Frader, *Minors and Health Care Decisions: Broadening the Scope*, 11 BIOETHICS FORUM 13 (1995) (arguing the Midwest Bioethical Center's guidelines require further work in certain substantive areas).

¹³⁸ Lainie Friedman Ross, *Arguments Against Health Care Autonomy for Minors*, 11 BIOETHICS FORUM 22, 23 (1995).

¹³⁹ *Id.* at 24-25.

¹⁴⁰ *Id.* at 25.

¹⁴¹ Caccamo, *supra* note 135, at 33 ("This process of [cognitive] development must be explained to parents so they understand that different levels of decision making are expected from a pre-school-aged child compared with a fifteen year old."). See also Davis, *supra* note 4, at 28 ("As with any program in its infancy, we must be vigilant in our efforts to ensure that all persons have the knowledge base to understand the program.").

¹⁴² Caccamo, *supra* note 135, at 33. Hence, why the health care providers will play such an important role in implementing the *Guidelines*; they will have to be part of the education process for parents.

¹⁴³ *Id.*

standard for the mature minor doctrine, the courts should look to the guidelines and opinions of the medical community in ascertaining a minor's maturity. Individual health care providers have scientific knowledge and experience in determining maturity that judges do not possess. As demonstrated by the discussion in Part III, the medical community has extensively debated the subject of maturity, researched the issues surrounding a minor's maturity in relation to making medical treatment decisions, and incorporated ethical considerations. The legal community should reflect on the medical scholarship and recognize that maturity determinations are best left in the hands of science-oriented disciplines. By allowing the treating physician to make the determination of maturity of the minor, a court will be deferring to a well-educated, experienced, and unemotional party. Hopefully, the repetition of physicians' scientific bases for determinations of maturity will establish a more consistent and defined standard of application for the mature minor doctrine.

A. Legal Scholars' Proposals

Legal commentators have criticized the common law standards, or, more appropriately, the lack of standards, for the mature minor doctrine. The criticism has caused some scholars to weigh in with their own proposals to change or improve the standards of the mature minor doctrine. Review of these proposals shows that they are just as lacking as the current judicial standards. Wallace Mlyniec notes that in abortion cases, where the court is determining whether a minor is mature enough to make her own decision on the procedure, trial judges have revealed little information on how they ascertain the child's maturity. This is due in part to confidential proceedings and the fact that few of these cases have reached appellate review.¹⁴⁴ But, from the cases that have received appellate review, it appears that trial judges determine maturity based on their perceptions of a child's demeanor during testimony.¹⁴⁵ Mlyniec concludes:

It seems clear that, despite a legal recognition of the importance and relevance of social maturity and cognitive capacity in many different kinds of cases involving children, trial judges gain very little information about those concepts during a hearing, and spend very little time considering them. Further, when judges determine that a child is mature or intellectually capable of making decisions, the factors considered

¹⁴⁴ Mlyniec, *supra* note 20, at 1889.

¹⁴⁵ *Id.*

in reaching those decisions frequently do not reflect the accumulated research about child development.¹⁴⁶

He blames the courts' ignorance of cognitive development and their lack of analysis into the minor's cognitive abilities on the speed with which cases move through the courts, resulting in this type of scientific evidence not being admitted into the trial record.¹⁴⁷ Mlyniec properly points out that judges must take into consideration the scientific data on maturity and the obtrusive nature of a judge ordering an unwanted medical procedure upon a child. It is a step in the right direction for Mlyniec to argue for judges to include cognitive development theories into their decisional process. But Mlyniec's general conclusion does not pinpoint a solution to any of the legal situations in which a determination of a child's maturity plays an integral role.¹⁴⁸ His conclusion is simply too broad to define any particular standard for a minor in a life-threatening medical situation.

In *Asking Adolescents: Does a Mature Minor Have a Right to Participate in Health Care Decisions?*, Cara Watts analyzes courts' approaches in determining if a minor has the right to make a medical decision without parental consent.¹⁴⁹ She develops a three-part standard for determining whether a minor should have autonomy to make a medical decision: if there is (1) no reason to deny an adult the right to make her own decision in the situation, (2) no reason to treat a minor differently than an adult in the situation, and (3) no state interest in protecting the minor, then the minor should have the same decisional rights as an adult in the situation.¹⁵⁰ To determine if a minor should be treated differently than an adult in the same medical situation, a court would consider a treatment's effectiveness, a minor's chance of survival with or without the treatment, and the emotional and physical effects of the treatment on the minor.¹⁵¹ Watts evaluates her standard to be "fair, systematic, accurate and critical."¹⁵²

¹⁴⁶ *Id.* at 1903-04.

¹⁴⁷ *Id.* at 1891.

¹⁴⁸ Mlyniec discusses determinations of maturity in custody, adoption, abortion, medical, and criminal cases. *See generally id.*

¹⁴⁹ Cara D. Watts, Note, *Asking Adolescents: Does a Mature Minor Have a Right to Participate in Health Care Decisions?*, 16 HASTINGS WOMEN'S L.J. 221, 222-23 (2005).

¹⁵⁰ *Id.* at 240-41. The author clarifies that the courts should only raise the issue of a minor's decisional right in health care issues when "there is a conflict of interest in the triangle between parents, the child and the state that involves intensive medical care to treat an extreme health situation." *Id.* at 241.

¹⁵¹ *Id.* at 243.

¹⁵² *Id.*

Watts develops a defined standard, but she surreptitiously adds “an additional competency element” at the end of her standard and fails to elaborate on it.¹⁵³ The additional competency element appears to be another way of saying that the court must take the maturity of the minor into consideration. Without the competency element, Watts’s approach would fail because the standard could be used to argue that any child, regardless of age, should be allowed to make her own medical decisions. The addition of the competency element rids the standard of that possibility, but it also swallows the remaining three-part test. If she includes no guidelines for determining competency, we are left at the starting point: the judge must determine “maturity” with his own resources. Further, the three parts of the standard fail to establish a unique mature minor standard when tested. There is a general common law right for an adult to make her own medical decisions; an adult would have to be declared incompetent by a court to lose that right. Part one would then allow a child to make her own medical decisions unless a court declared her incompetent, but that is circular reasoning because children are, by law, considered incompetent. Part two states there must be a reason to treat a minor differently than an adult. The clearest reason to treat a minor differently than an adult would be based on maturity level. Part three allows for a state interest to trump a minor’s decisional right. This prong is moot because a state interest, or an accepted public policy argument, can trump any person’s rights, minor or adult. In the end, the “additional competency element” makes Watts’s standard a restatement of any standard calling upon a court to evaluate a minor’s maturity.¹⁵⁴

Along with commentators’ individually created standards, there are calls to institute a bright-line rule as a standard for the mature minor doctrine.¹⁵⁵ The most obvious bright-line rule would be to allow minors to make their own medical decisions starting at a certain age, such as sixteen. A rule like this would not require a health care provider, or the legal system, to become involved in the decisions of minors who are near the age of majority, the age range of most patients in mature minor cases.¹⁵⁶ One proponent of the age sixteen bright-line rule notes that there is nothing “sacred” about age eighteen in our so-

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ See Laurie Badzek & Sherry Kanosky, *Mature Minors and End-of-Life Decision Making: A New Development in Their Legal Right to Participation*, 8 J. NURSING L. 23, 23 (2002); Newman, *supra* note 12; but see Oberman, *supra* note 10, at 133.

¹⁵⁶ Oberman, *supra* note 10, at 133.

ciety,¹⁵⁷ and, since no scientific evidence shows that sixteen-year-olds have less judgment than eighteen-year-olds, the bright-line rule should triumph.¹⁵⁸ The problem with a bright-line rule is that it will disregard questions of maturity completely, and, although maturity-based standards with their many factors are not ideal, neither is a standard that ignores the individual facts of a case.

Although the above recommendations of standards for the mature minor doctrine contribute positively to the debate, they still demonstrate the lack of consensus in the legal community on a uniform standard. They also show the difficulty in articulating a standard that has definite guidelines but also allows a judge some discretion to consider the particular facts of the case.

B. Deferring to the Medical Community to Create an Improved Standard for Application of the Mature Minor Doctrine

A legal standard to determine a “mature minor” has had obvious difficulty in being defined. The difficulty is demonstrated by the courts in such decisions as *Cardwell*, *In re E.G.*, and *Long Island*, as well as by legal scholars who have attempted to craft their own standards. The failure of the legal discipline in defining a standard for maturity is a result that should not be surprising; a determination of maturity is a scientific one, something that takes into consideration biological and social factors and can only be made by a person who has a frame of reference on the variety of capabilities of children at different ages.¹⁵⁹ Health care providers, or, more appropriately, pediatricians, have a better ability to evaluate these factors because of their medical education, training, and experience.

The medical community has researched and debated the issue of maturity, which provides physicians with all the necessary tools to determine the maturity of a minor. First, there is the Piaget Cognitive Development Theory and supporting empirical research that guides medical professionals as to at what age a person should have certain cognitive functions.¹⁶⁰ Second, the AAP has promulgated several policy statements, taking into consideration experiences with parents, minor patients, medical knowledge, and the bioethical responsibilities

¹⁵⁷ Newman, *supra* note 12, at 529 (“[Sixteen] is the usual age for employment, for marriage, and eligibility for the death penalty, and the age to drive a car is often younger.” (footnote omitted)). Also, the legal age to purchase and drink alcohol is twenty-one.

¹⁵⁸ *Id.* at 531.

¹⁵⁹ See Leikin, *supra* note 5, at 18-21.

¹⁶⁰ See discussion *supra* pp. 194-97.

of physicians, that support the notion a doctor is the best suited to make determinations of maturity.¹⁶¹ Lastly, physicians themselves have studied their role in maturity determinations and recognize the important role they can, and should, play in determining the maturity of a minor.¹⁶² Would a judge have access to all the same information on maturity as a physician? The simple answer is no. Society should not even expect a judge to possess all this knowledge.¹⁶³

It may seem worrisome to defer such a determination, which can become legally binding, to someone outside the judiciary or the government. There are constraints to a physician's determination of maturity. For instance, the AAP policies tell physicians to take into consideration the opinions of the minor and her parents;¹⁶⁴ and physicians themselves recognize the importance of these opinions.¹⁶⁵ Medical studies on maturity have all established that a child reaches the apex of cognitive development between fourteen and fifteen;¹⁶⁶ physicians would have a difficult time ignoring so much medical precedent in declaring anyone under the age of thirteen or fourteen mature enough to make her own medical decision. If a physician were to make a clearly erroneous judgment, she would be accountable to peers in her profession.¹⁶⁷

This proposal also does not discount the constraint on physicians' determinations through judicial discretion. Judges (or juries) will still have the ultimate determination if a minor patient should be granted an exception to make her own medical decisions. Just because a health care worker testifies in court that, in her professional opinion, the minor is mature, the judge still can take the other circumstances of the case into consideration before making a final ruling. If a health care worker determines a minor to be mature, and a judge rules not to extend the mature minor exception, the judge should be able to demonstrate, within the individual facts of the case, why he is ruling against

¹⁶¹ See discussion *supra* pp. 197-200.

¹⁶² See discussion *supra* pp. 201-05.

¹⁶³ "To determine decision-making capacity, a judge must have some sense of the general cognitive functioning of children of the same developmental stage as the petitioner, and more importantly, a good sense of the cognitive functioning of the petitioner herself." Mlyniec, *supra* note 20, at 1891.

¹⁶⁴ See generally Comm. on Bioethics, *supra* note 103, at 314; Comm. on Bioethics, *supra* note 8.

¹⁶⁵ See Fleischman et al., *supra* note 119, at 434, 436-37.

¹⁶⁶ See Leikin, *supra* note 5, at 20; Mlyniec, *supra* note 20, at 1879; Weithorn & Campbell, *supra* note 89, at 1589.

¹⁶⁷ Commentary on current health care issues is one of the main missions of such organizations as the Center for Practical Bioethics. See generally Center for Practical Bioethics, *supra* note 123.

the medically-determined mature minor. This proposal respects judicial discretion while allowing the judiciary to respect a field of knowledge and expertise it lacks. By recognizing that the judge still has final determination of outcomes, some of the concerns around allowing a minor to make her own medical decision could be avoided.¹⁶⁸

The proposal to defer maturity determinations to health care workers is not completely novel. The West Virginia Health Care Decisions Act of 2000 statutorily defines a “‘mature minor’ [as] a person less than eighteen years of age who has been determined by a *qualified physician, a qualified psychologist or an advanced nurse practitioner* to have the capacity to make health care decisions.”¹⁶⁹ The statute was the result of *Belcher v. Charleston Area Medical Center*,¹⁷⁰ a case in which the parents and doctor disagreed as to the maturity level of a minor patient (with muscular dystrophy).¹⁷¹ The parents signed a Do Not Resuscitate (DNR) order but instructed the doctor to resuscitate their son if he requested it.¹⁷² The doctor never consulted the patient as to his wishes concerning the DNR order because, in the doctor’s opinion, the minor was not mature enough to participate in the decision.¹⁷³ When the patient went into respiratory failure, the doctor followed the DNR order and the patient died.¹⁷⁴ The parents sued for wrongful death, and a jury found for the treating hospital and doctor.¹⁷⁵ The appellate court reversed and remanded the verdict because the jury had not been instructed to consider the mature minor exception in its deliberations.¹⁷⁶ In its opinion, the appellate court noted the importance of the doctor’s determination of maturity and how that determination will often be second-guessed.¹⁷⁷ The court

¹⁶⁸ Judicial discretion would stop a minor from making a “bad” decision, a concern of Ross’ in allowing a minor to make her own medical decision. Ross, *supra* note 138, at 25.

¹⁶⁹ W. VA. CODE § 16-30-3(o) (LexisNexis Supp. 2006) (emphasis added).

¹⁷⁰ 422 S.E.2d 827 (W. Va. 1992).

¹⁷¹ *Id.* at 829-31. The minor patient was seventeen and eight months old.

¹⁷² *Id.* at 830.

¹⁷³ The doctor contended that he did not involve the patient in the decisions because: “(1) [the patient] was emotionally immature due to his disease; (2) he was on medication which diminished his capacity; (3) involving him in the decision would have increased his anxiety, thus reducing his chances of survival; and (4) [the] parents told [the doctor] that they did not want [the patient] involved.” *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 838 (W. Va. 1992).

¹⁷⁷ *Id.* at 837. The court went further to ensure that the doctor’s determination of maturity was recorded: “[O]nce the doctor has determined that the minor is mature, this determination should be duly noted as part of the patient’s records.” *Id.* at 837

concluded its analysis of the doctrine with the following: "[W]e agree with the observation that 'the answer will be found in *statutory* laws of consent that incorporate an element of the mature minor rule.'"¹⁷⁸

The West Virginia legislature followed the opinion of the appellate court.¹⁷⁹ From this medical malpractice case, the legislature crafted the above statutory definition of a mature minor to give power to the medical professionals in deciding if a minor was mature enough to make health care decisions. This is the only state statute that gives explicit control to the medical community in determining a mature minor.¹⁸⁰ West Virginia has taken the proposal of this Note a step further, from encouraging the judiciary to defer to physicians' maturity determinations, a rule that could exist in the common law, to codifying it in statutory law. Two commentators have predicted the positive effects of the West Virginia statute on the mature minor doctrine:

As health care providers in West Virginia follow the mandates of their new statute[,] they have a unique opportunity to develop guidelines and report baseline data relative to practice patterns, as well as develop standards for determining mature minor status vis-a-vis advanced care planning. The way in which these providers determine and document decision-making capacities of mature minors, and the impact of autonomous health care decisions concerning advance directives and end-of-life care, may be the foundation for initiating new and improved legislation concerning mature minors and their participation in medical decision making.¹⁸¹

n.14.

¹⁷⁸ *Id.* at 837-38 (quoting FAY A. ROZOVSKY, *CONSENT TO TREATMENT* § 5.2.2 (2d ed. 1990)).

¹⁷⁹ The *Belcher* court was very aware of the bounds of its opinion and actively avoided legislating from the bench. The court recognized there was a common law mature minor exception and that the maturity determination was left in the hands of the fact-finders. See *id.* The *Long Island* court was also aware of the necessity of legislative involvement in the mature minor determinations: "It is recommended that the legislature or the appellate courts take a hard look at the 'mature minor' doctrine and make it either statutory or decisional law in New York State." *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (N.Y. Sup. Ct. 1990).

¹⁸⁰ Arkansas has a statute that recognizes the ability of a mature minor to make a medical treatment decision. "[A mature minor is] [a]ny unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures for himself . . ." ARK. CODE ANN. § 20-9-602 (1987). The statute does not include *who* is to determine maturity.

¹⁸¹ Badzek & Kanosky, *supra* note 155, at 28.

This quote demonstrates how, for policies like the West Virginia statute to be most successful and universally implemented, it will be up to the legislatures to enact mature minor statutes and revise them as needed.¹⁸²

CONCLUSION

Health care professionals need to assert their knowledge and experience when confronted with a minor who should, or should not, be allowed to make her own medical treatment decisions.¹⁸³ The knowledge and experience of health care professionals should not be ignored in making life and death decisions for a minor. By incorporating judicial deference to a physician's determinations of a child's maturity in mature minor cases, the common law will start to see the development of a defined standard for the mature minor doctrine based on scientific research and empirical data instead of relying on the standards of judges, which are usually based on personal experience and brief impressions of the minor.¹⁸⁴

With all the commentary on the mature minor doctrine in relation to life-threatening situations, why have the courts, or the more aptly suited legislatures, failed to take significant steps towards defining a uniform mature minor standard? They are the only institutions that can settle the debate and implement changes to the mature minor doctrine. Has all the medical and legal commentary fallen on deaf ears, or is the issue too complex?¹⁸⁵ Maybe the legislatures see more pressing issues in health care. Millions of children have no health insurance and do not receive adequate health care to begin with.¹⁸⁶ Implementing any form of guidelines for the mature minor "may be difficult in a

¹⁸² Commentators to the mature minor doctrine have noted that there is not enough empirical evidence on maturity. See Weithorn & Campbell, *supra* note 89, at 1590. It seems that this lack of data further supports the contention that physicians should be empowered to determine maturity in mature minor cases. If physicians are instilled with this legal capacity, then maybe they will feel a professional need and responsibility to develop empirical studies to further legitimize the hypothesis that by fifteen most adolescents are as mature as an eighteen year old.

¹⁸³ See Fleischman et al., *supra* note 119, at 438 ("We do not minimize the importance of the family's role in supporting the adolescent . . . but the appropriate role of the health care professional caring for an adolescent is to respect the patient's evolving autonomy and foster the young person's role in decision-making.").

¹⁸⁴ "These [appellate] opinions seldom offer more than generalizations about a child's legal competency [A] judge could obtain little of the information needed for [a maturity] evaluation in a span of eighteen minutes [of testimony]." Mlyniec, *supra* note 20, at 1886-87.

¹⁸⁵ See *supra* note 183.

¹⁸⁶ Caccamo, *supra* note 135, at 32.

society burdened with family and societal problems.”¹⁸⁷ Or could it simply be that mature minor cases arise so infrequently that legislatures have failed to notice the problem, or do they believe that the courts should simply determine these cases on a case by case basis?

Regardless of these questions and concerns, until there is a governmental response, there will be no answers, and the standards of the mature minor doctrine will be continuously added to and subtracted from in case law and in the opinions of scholars.

¹⁸⁷ *Id.* at 34.