

2000

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Recommended Citation

Lawrence Schlam and Joseph P. Wood, MD, *Informed Consent to the Medical Treatment of Minors: Law & Practice*, 10 Health Matrix 141 (2000)

Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol10/iss2/3>

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ARTICLES

INFORMED CONSENT TO THE MEDICAL TREATMENT OF MINORS: LAW AND PRACTICE

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I. INTRODUCTION

*Children who are legally too young to give consent to treatment must still be treated as individuals whose rights as members of society are not solely dependent on the legal definition of the day.*¹

NOT THAT LONG AGO, those under twenty-one were thought to be incapable of consenting to medical treatment. Parental approval was necessary or physicians might be liable in damages for non-consensual battery.² This was the case be-

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¹ J.P.H. Shield & J.D. Baum, *Children's Consent to Treatment: Listen to the Children – They Will Have to Live With the Decision*, 308 BRIT. MED. J. 1182, 1183 (1994).

² See *In re Hudson*, 126 P.2d 765, 781 (Wash. 1962) (holding that a court may not subject a child to a surgical operation over the objection of her parents). The common law rule is that minors are forbidden to consent to medical treatment. Still, “[t]he requirement that medical care be provided to a minor only with the consent of the minor’s parent or guardian remains the general rule . . . throughout the United States.” *American Academy of Pediatrics v. Lungren*, 940 P.2d 797, 801 (Cal. 1997)

cause, until the early 1800s, children were considered chattels of their parents, particularly the father.³ Prior to that time, children had no rights and parents reared their children without any governmental restraints;⁴ the duty to support and protect children was a moral duty only.

Not until the advent of the Industrial Revolution, and the urbanization of the United States it brought, was there general rise in benevolence and concern for children. Their increased exposure to urban vices, such as poverty, coupled with public fears of impending truancy and delinquency, led to the increased use of the *parens patrie* doctrine.⁵ Under this doctrine, the state had a right and a duty to override parental autonomy and act as a surrogate parent where necessary to provide protection for the life and general health of a neglected or abused child.⁶ Thus, by the time of the decision in *Wallace v. Labrenz*,⁷ in 1952, it was no longer unusual for a court to order a state-appointed guardian to consent to medical care for children, even if the parents objected.

Today, however, as a result of the "mature minor" doctrine, doctors may now treat children, even in the absence of parental consent or a court order, because it has become reasonable to assume that mature children are capable of providing informed consent pertaining to their own medical treatment.⁸ Minors may

(holding unconstitutional a statute requiring parental consent or judicial authorization for pregnant minors to obtain an abortion).

³ See 1 LEGAL RIGHTS OF CHILDREN 10 (Donald T. Kramer ed., 2d ed. 1994) (describing early American attitudes relating to children).

⁴ See *id.*

⁵ See *id.* at 10-11.

⁶ See Jay M. Zitter, Annotation, *Power of Court or Other Public Agency to Order Medical Treatment Over Parental Religious Objections for Child Whose Life is Not Immediately Endangered*, 21 A.L.R. 5th 248, 256-57 (1994) (providing that "in a proper case, the state may, through a court or otherwise, intervene to insure that a child is given medical treatment necessary for the protection of its life or limb, including treatment for mental or emotional ills, where the custodian of the child has unreasonably refused to allow such treatment").

⁷ 104 N.E.2d 769 (Ill. 1952) (holding that a child whose parents refused to permit a life-saving blood transfusion was a "neglected child").

⁸ See Avron M. Kreichman, *The Adolescent's Right to Psychiatric Care*, in JUVENILE PSYCHIATRY AND THE LAW 381, 385 (Rosner & Schwartz eds., 1989) (discussing "mature minor" doctrine and the capacity to understand the treatment as the primary concern with minor's consent to the proposed treatment). For a more detailed discussion of the mature minor doctrine, see Garry S. Sigman & Carolyn O'Connor, *Exploration for Physicians of the Mature Minor Doctrine*, 119 J. PEDIATRICS 520 (1991).

be recognized as competent based upon a variety of factors, including their age, maturity, intelligence, and the nature and risks of the proposed treatment.⁹ Even if parents ultimately disagree with the treatment given, the doctor is still protected against liability by the doctrine. Still, it is essential that physicians have a clear understanding of (a) how to adequately determine and record indications of the maturity and decision-making competence of minor patients; and (b) how to be assured that one has properly communicated with and obtained knowing and intelligent medical decisions from competent child patients.

Part I of this Article discusses the requirement of informed consent when treating minors, and describes the evolution of the "mature minor" doctrine, an exception to this requirement. Part II examines research on child development and cognition for two reasons: to establish a standard of competence in children, and for insight into how physicians might make more accurate judgments of maturity before treating children in the absence of parental consent.

Part III analyzes significant decisions on the competence of minors to consent to their own medical treatment. It describes the "multi-factor analysis" judges commonly use in resolving those questions. Part IV discusses the continuing problems in applying the "mature minor" doctrine. Part V addresses the statutory exceptions under which minors may consent to treatment notwithstanding the "mature minor" doctrine. Part VI concludes with recommendations for how physicians might better "inform" and receive consent under the "mature minor" doctrine, and thus minimize misunderstanding or exposure to liability.

⁹ Where, for example, a seventeen-year-old girl suffered from back pain and proceeded on her own to an osteopath, and as a result of treatment had to be hospitalized, lost normal bladder control and some sensation in her buttocks and legs, the jury found no liability because she had the maturity, education, experience, ability, and judgment to knowingly consent to treatment. *See* FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* 262-64 (2d ed. 1990).

II. THE INFORMED CONSENT REQUIREMENT AND THE EVOLUTION OF THE "MATURE MINOR" DOCTRINE

*There are better means for protecting parental autonomy than silencing children.*¹⁰

The "autonomy of the individual in medical decision-making" is protected through the requirement of informed consent.¹¹ This ensures a "genuine respect for human dignity"¹² since "every person has the right to determine what is done to his or her own body."¹³ Without patient consent to treatment, doctors may be sued for battery.¹⁴ Consent, however, gives the physician a privilege that protects against liability for this tort

¹⁰ Susan D. Hawkins, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 *FORDHAM L. REV.* 2075, 2115 (1996).

¹¹ Alan Miesel & Mark Kuczewski, *Legal & Ethical Myths About Informed Consent*, 156 *ARCHIVES INTERNAL MED.* 2521, 2521. See also Lawrence O. Gostin, *Informed Consent, Cultural Sensitivity, & Respect for Persons*, 274 *JAMA* 844 (1995) (stating that informed consent is a "universal expression of respect for persons" recognized by The Nuremberg Code, Helsinki IV, and the Council of International Organizations of Medical Sciences).

¹² This right is "broadly perceived to be a morally necessary method of demonstrating genuine respect for human integrity." Gostin, *supra* note 11, at 844.

¹³ Elizabeth Cauffman & Laurence Steinberg, *The Cognitive & Affective Influences on Adolescent Decision-Making*, 68 *TEMP. L. REV.* 1763, 1765 (1995). See also Anthony Szczygiel, *Beyond Informed Consent*, 21 *OHIO N.U. L. REV.* 171, 184 (1994) (recognizing that "courts built the legal doctrine of consent to medical treatment from the ancient notion that one's body should not be touched without one's approval") (citing *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891)). The concept of autonomy is based on "17th century political philosophy" and English common law. In the modern era, even the Nuremberg Trials held that consent was an international requirement for medical treatment.

¹⁴ Judge Benjamin Cardozo said: "Every human being of adult years and sound mind has a right to determine what can be done with his own body; and a surgeon who continues to operate without his patient's consent commits an assault for which he is liable for damages." *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914) (holding that surgery without *proper* consent constitutes the trespassory tort of assault). If there is no consent at all, the tort is battery. See, e.g., *McNeil v. Brewer*, 710 N.E.2d 1285, 1288-89 (Ill. App. Ct. 1999) (finding that an inmate's inclusion in a medical study did not constitute offensive conduct, an element of battery, when no blood was drawn without the inmate's consent). See also *Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972) (discussing the differences between battery and negligence theories of conduct in the context of medical malpractice) (citing Jennifer F. Skeels, Note, In re *E.G.: The Right of Mature Minors in Illinois to Refuse Life-saving Medical Treatment*, 21 *LOY. U. CHI. L.J.* 1199, 1204 (1990)); Hawkins, *supra* note 10, at 2094 (explaining informed consent doctrine at common law).

so long as patients are informed of the nature and consequences of treatment,¹⁵ and give knowing and intelligent consent to the specific procedures the doctor will perform.¹⁶

Doctors, therefore, must provide the patient with a "reasonable amount of information" for the patient to be able to make a decision about the treatment.¹⁷ "Informed consent," a notion which "surfaced, seemingly out of nowhere,"¹⁸ can only follow after a discussion of "the nature of the proposed treatment procedures, possible alternative treatments, and the nature and the degree of the risk and benefits involved in accepting or rejecting treatment."¹⁹ The doctor must communicate this information in

¹⁵ There may be a "dispute regarding the quality and nature of information that must be disclosed as a condition for securing 'informed consent' . . . [but all agree that] no medical care should be provided without first explaining the nature of the treatment and the accompanying risks, at least for adult patients." Andrew Popper, *Averting Malpractice by Information: Informed Consent in the Pediatric Treatment Environment*, 47 DEPAUL L. REV. 819, 820-21 (citations omitted) (citing *inter alia* DAVID W. LOUISELL & HAROLD WILLIAMS, *MEDICAL MALPRACTICE* ¶ 22.01, at 22-4 (1990) (stating that the information should include the diagnosis, the contemplated procedure, the risks, the prospects of success, the prognosis if the procedure is not performed, and alternative methods of treatment). See also *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957) (holding that a duty existed to obtain not only consent but "informed" consent, including consent to such risks as paralysis, by disclosing facts necessary to make an intelligent decision).

¹⁶ However, if a patient gives a doctor consent to operate, for example, on one ear and the doctor decides to operate on the other ear, the doctor is liable for battery. See *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905) (patient consented to an operation on one ear, but during the operation the doctor discovered that the other ear was in worse condition, and operated successfully on that ear).

¹⁷ Miesel & Kuczewski, *supra* note 11, at 2523 (observing that the doctor must give as much information as "measured by customary professional practice"). The question of what information should have been disclosed by a "reasonable health care provider" was traditionally a matter for expert witnesses because this was viewed as a medical question. See Derek Kroft, *Informed Consent: A Comparative Analysis*, 6 J. INT'L L. & PRAC. 457, 461 (1997) (citing William H. Altman et al., *Autonomy, Competence, and Informed Consent in Long Term Care: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1671, 1683 (1992)). Some jurisdictions, however, reject this approach for a patient-oriented approach which shifts the focus to what a reasonable patient would need to know, a standard which does not need expert testimony, easing the patient's burden of proof. See *id.* (citing *Canterbury v. Spence*, 464 F.2d 772 (D.C. 1972), which involved a physician who did not disclose the possible consequence of paralysis).

¹⁸ Miesel & Kuczewski, *supra* note 11, at 2521 (citing JAY KATZ, *THE SILENT WORLD OF PHYSICIAN AND PATIENT* 60 (1984)).

¹⁹ Lynn E. Lebit, Note, *Compelled Medical Procedures Involving Minors and Incompetents and Misapplication of the Substituted Judgment Doctrine*, 7 J. L. & HEALTH 107, 111 (1992-93) (discussing the doctor-patient relationship developed from the doctrine of informed consent and substitute judgment).

a way that the patient can understand.²⁰ This should include a warning of "risks to which a reasonable person in the patient's position would be likely to attach significance."²¹ Consent is considered informed, therefore, if given "knowingly, competently, and voluntarily."²² If a doctor does not provide enough information to properly allow a patient to make an informed decision about treatment, but the patient nevertheless gives consent, the doctor still may be liable for negligent behavior.²³

²⁰ "[I]nformed consent law requires insight into a patient's specific capacity to make decisions regarding health care rather than her overall competency for personal functioning." Kroft, *supra* note 17, at 460.

²¹ *How Far Should GPS Go In Getting Consent?* PULSE, Apr. 25, 1998, at 2. Informed consent also includes the patient's right to refuse treatment. See Miesel & Kuczewski, *supra* note 11, at 2524 (observing that "physicians are obligated to obtain not only informed consent but also informed refusal"). The process of giving the patient information about the treatment, therefore, does not mean that the patient does not have the right to *refuse* treatment. If a patient does not want the information, then the patient must sign a waiver. See *id.* at 2525. See *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) (extending the duty to disclose to include medical alternatives and risks involved with a recommended medical choice).

²² Cauffman & Steinberg, *supra* note 13, at 1765-66 (noting also the use of informed consent doctrine when *Miranda* rights are given). Proper consent can only follow if the patient: a) has decision-making capacity, b) has received adequate information in terms of what a reasonable patient would need to know under similar circumstances to make an intelligent decision, and c) made her decision without fraud, coercion, or duress. See Kroft, *supra* note 17, at 459, 462-63 (citing PAUL S. APPELBAUM, M.D. ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 49 (1987)). The information required includes the medical diagnosis, steps preceding diagnosis, the nature of the procedure, the risks of treatment, the probability of success and the expected benefits, the treatment alternatives, chosen from medically acceptable options, and the risks of informed refusal. See *id.* at 462-63. The nature of the risks to be disclosed varies according to the nature and magnitude of the procedure. See *id.* at 462 (citing PAUL S. APPELBAUM, M.D. ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 49 (1987)). See also *Wenger v. Oregon Urology Clinic*, 796 P.2d 376 (Or. Ct. App. 1990) (finding that defendants failed to inform plaintiff properly of several available treatment alternatives and used a procedure which caused an infection, ultimately leading to the amputation of the plaintiff's penis). Finally, the decision must be requested and made in a non-threatening manner, and the patient must consent to the chosen treatment voluntarily, without force, coercion, fraud, or duress. See Kroft, *supra* note 17, at 463 (citing William H. Altman et al., *Autonomy, Competence, and Informed Consent in Long Term Care: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1671, 1684 (1992)). See also *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974) (discussing numerous poor people who were improperly told that if they did not agree to sterilization, they would lose a portion of their welfare benefits).

²³ See Popper, *supra* note 15, at 821. See generally *Lebit*, *supra* note 19 (discussing informed consent liability). See generally *Hawkins*, *supra* note 10, at 2093-94 (noting requirements imposed on physicians).

"Thus, it does not take a great leap in logic to conclude that the right to be informed about the nature of the medical treatment is fundamental. It is therefore worth inquiring why a right so basic in the United States legal system fades away to nothingness for most people seventeen and under."²⁴ The reason may be that, until the 19th century, children were considered the chattel of their parents;²⁵ parents were required to provide informed consent for any medical treatment the child needed.²⁶ During the industrial revolution, social reformers brought attention to the needs of children, and legislatures began to pass child labor and compulsory education laws.²⁷ Nonetheless, prior to the 1960s, minors were not considered capable of providing informed consent. It was believed they could not make competent decisions.²⁸

Children's rights were strengthened in 1967, when the Supreme Court determined that the Fourteenth Amendment's due process clause also applied to children.²⁹ Children were now considered "'persons' under our Constitution,"³⁰ and were given rights such as freedom of expression. In *Tinker v. Des Moines School District*,³¹ for example, the court said, "Students in school as well as out of school are 'persons' under our Constitu-

²⁴ *Id.* at 821-22 (citation omitted).

²⁵ *See id.* at 830; Hawkins, *supra* note 10, at 2076 (discussing the history of children's rights in the United States); *In re Clark*, 185 N.E.2d 128, 131 (Ohio C.P. Lucas County 1962).

²⁶ Parents were also considered to have a moral duty to protect their children. As a result, the law did not always act in the best interests of the child. For instance, Massachusetts enacted the Stubborn Child Law of 1646 which permitted parents to obtain a state reprimand for children who were stubborn. The parents could even seek capital punishment for poor behavior. *See* LEGAL RIGHTS OF CHILDREN, *supra* note 3, at 10 (citing SHURTLEFF, RECORDS OF THE GOVERNOR AND COMPANY OF THE MASSACHUSETTS BAY IN NEW ENGLAND 1628-86, 101 (1854)).

²⁷ *See* Hawkins, *supra* note 10, at 2076 (discussing the efforts of the industrial era's children's rights movement).

²⁸ *See, e.g.*, Janet E. Ainsworth, *Re-Imagining Childhood and Reconstructing the Legal Order: The Case for Abolishing the Juvenile Court*, 69 N.C. L. REV. 1083, 1095, 1103 (1991) (defending a case for abolition of the juvenile court system based on the changes in society's view of a minor's capabilities and place in society).

²⁹ *See In re Gault*, 387 U.S. 1, 29-31 (1967) (holding that even if a juvenile delinquency hearing does not meet all of the requirements for an adult hearing, children still must have due process and fair treatment, including assistance of counsel, the privilege against self-incrimination, no double jeopardy, and the right to confront their accusers).

³⁰ *Tinker v. Des Moines Ind. Community Sch. Dist.*, 393 U.S. 503, 511 (1969).

³¹ 393 U.S. 503 (1969).

tion. They are possessed of fundamental rights which the state must respect, just as they themselves must respect their obligations to the state."³²

The Twenty-Sixth Amendment changed the voting age from twenty-one years of age to eighteen in 1971, and changes in the age of majority followed in most states.³³ Eighteen-year-olds were now able to make their own health care decisions and provide informed consent to treatment.³⁴ Finally, by 1979, in abortion and contraception cases, the Supreme Court recognized that minors had a right to privacy.³⁵ Nevertheless, the majority of medical treatments performed on minors continue to require parental consent;³⁶ there is not even a requirement that doctors inform children about the treatment they are to receive.³⁷

³² *Id.* at 511.

³³ See, e.g., DAVIS ET AL., CHILDREN IN THE LEGAL SYSTEM: CASES AND MATERIALS 127-29 (2d ed. 1997) (explaining that the age of majority was, to a significant extent, changed to compensate for a situation where, in Vietnam for example, those dying were nineteen years old yet could not vote, and because of youthful service in the civil rights movement).

³⁴ See Kreichman, *supra* note 8, at 382 (noting the age of majority). See also Isabel Traugott & Ann Alpers, *In Their Own Hands: Adolescents Refusal of Medical Treatment*, 151 ARCHIVES PEDIATRICS & ADOLESCENT MED. 922, 924 (1997) (providing that children over 18 are granted the right to give informed consent by statute).

³⁵ See Hawkins, *supra* note 10, at 2097-99. See also *Carey v. Population Servs. Int'l*, 431 U.S. 678, 681-82 (1977) (striking down a New York statute requiring that only minors over 16 could obtain contraception, and then, only through a licensed pharmacist); *Bellotti v. Baird*, 443 U.S. 622 (1979) (striking Massachusetts law requiring parental consent for abortion for unmarried women under 18); *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976) (stating that minors do not need parental consent for abortion during the first trimester). Thus, no parental consent is necessary for minors to receive treatment in these areas, although some states require a judicial bypass. See Maggie O'Shaughnessy, *The Worst of Both Worlds? Parental Involvement Requirements and the Privacy Rights of Mature Minors*, 57 OHIO ST. L.J. 1731, 1740-41 (1966). The judicial bypass allows the courts to determine whether the minor is mature enough to make the decision to have an abortion without parental consent. If the minor is not mature enough, then the court may also allow the abortion if it is in the minor's best interest to do so without parental consent. See *id.* at 1741.

³⁶ See Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS L. REV. 1, 17 (1996) (stating the legal limits on a minor's decision-making rights regarding life-sustaining treatment); see also Traugott & Alpers, *supra* note 33, at 923-24 (providing that it is a matter of clinical practice for physicians to seek parental consent).

³⁷ See Popper, *supra* note 15, at 831-32 (reasoning that the first step towards granting minors rights in medical treatment is to require "informed assent," a middle ground in which the minor would not be the decision-maker, but would still be informed about the treatment).

In one case, a doctor was sued for performing an abortion on a sixteen-year-old girl without her knowledge.³⁸ The court held that the doctor had no duty to even inform her of the procedure because her mother had already given informed consent. The court reasoned that even being told about the abortion could have been "disturbing to her."³⁹

The short of it is that in the United States the question of how to inform children of the nature, risks, and alternatives prior to medical treatment is not yet on center stage for public dialogue. It should be. In an environment where the potential for medical malpractice liability has become a focal point for those bent on tort limitation through tort reform, it is troubling that this same group of tort-sensitive professionals has failed to take into account not only the basic rights dialogue involving children but also the potential liability scenario.⁴⁰

In truth, "few courts recognize that children have interests independent of those of their parents or the state;"⁴¹ the Fourteenth Amendment has been interpreted to protect the "liberty interest[s] [of parents] in the custody and management of their children, [and has given them] a corresponding duty to provide care."⁴² The requirement of parental consent to treatment is also justified because parents are presumed to act in the best interests of the child due to "natural bonds of affection,"⁴³ because of the belief that children are incapable of making medical deci-

³⁸ See *Powers v. Floyd*, 904 S.W.2d 713, 714 (Tex. Ct. App. 1995) (discussing a case where an abortion was performed on a mentally challenged minor with the written consent of her mother, but without any information being given to the patient herself).

³⁹ See *id.* at 718.

⁴⁰ See Popper, *supra* note 15, at 824 (citation omitted).

⁴¹ Hawkins, *supra* note 10, at (citing Hillary Rodham Clinton, *Children Under the Law*, 43 HARV. EDUC. REV. 487, 491-92 (1973); Elizabeth J. Sher, Note, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 168-69 (1983)).

⁴² Traugott & Alpers, *supra* note 34, at 924 (citing *Prince v. Massachusetts*, 321 U.S. 158, 166 (1943)).

⁴³ *Id.*

sions,⁴⁴ because parents usually pay for the cost of the treatments,⁴⁵ and because parents are presumed to “possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions.”⁴⁶ In addition,

[b]eyond the obvious importance of parental or guardianship control, the potential for liability, the need for uniformity in dealing with large number of patients, and the challenges of adult to child communication, lies a deeper resistance to the declaration of the right [of children to consent] – the fear that children, empowered with information and the right to be heard (dispositively), will make problematic, illogical, irrational, decisions.⁴⁷

Therefore, in order to preserve family integrity as well as protect children from themselves, the courts support parental decision-making in matters related to their children’s care.⁴⁸

When children are quite young, of course, it is reasonable that parents would be considered the best decision-makers with regard to their medical treatment.⁴⁹ Support for parental autonomy in this regard is also intuitively understandable when dealing with families in which there would appear to be insignificant likelihood of child abuse. However, as the child grows older and is more capable of making decisions, reconciling parental authority with the child’s best interests becomes more complicated.⁵⁰ Actually, in the 1990s, “with the classic family

⁴⁴ See Rosato, *supra* note 36, at 18. See also ROZOVSKY, *supra* note 9, at 257 (providing background of the traditional view of minor’s incapacity to consent to medical treatment).

⁴⁵ See Rosato, *supra* note 36, at 18 (citing *Lacey v. Laird*, 139 N.E.2d 25, 30 (Ohio, 1956)).

⁴⁶ Hawkins, *supra* note 10, at 2081 (citing *Parham v. J.R.*, 442 U.S. 582, 602 (1979)).

⁴⁷ Popper, *supra* note 15, at 834 (citing Gary B. Melton, *Children’s Consent: A Problem in Law and Social Science*, in CHILDREN’S COMPETENCE TO CONSENT 1, 4-11 (Gary B. Melton et al. eds., 1983)).

⁴⁸ See Gary B. Melton, *Children’s Consent: A Problem in Law and Social Science*, in CHILDREN’S COMPETENCE TO CONSENT 1, 4-11 (Gary B. Melton et al. eds., 1983) (citing *Newmark v. Williams*, 588 A.2d 1108, 1115 (Del. 1991)).

⁴⁹ Indeed, if the doctor believes that the “information would undermine, rather than promote, the goals of informed consent,” by complicating or hindering treatment or causing psychological damage, she can withhold information using the “therapeutic privilege.” Miesel & Kuczewski, *supra* note 11, at 2525.

unit having so often disintegrated[,] the child may have a more stable and balanced viewpoint than either parent."⁵¹

As a result, the "mature minor" doctrine was developed to ensure treatment of minors (1) when parental consent may cause intra-family conflict or be difficult to obtain,⁵² and (2) to protect physicians who treat mature minors. The doctrine permits minor children to seek required medical treatment with confidentiality, and ensures that they receive treatment in situations in which requiring parental consent would prevent them from doing so.⁵³ Legal privileges are extended to minors by allowing minors "who can understand the nature and consequences of the medical treatment offered" the right to consent to or refuse treatment.⁵⁴

⁵⁰ [M]erely because children vary in their developmental capacities does not mean they are any less entitled to understandable information needed to express an opinion on the plan of treatment . . . [Given] the expanding number and variety of exceptions regarding informed consent, the increase in controversial treatment refusals supported by the courts and public opinion, the acceptance in the international community of the right (albeit hollow in most of those countries) to be informed, and the views in the medical community regarding the health value of information, consideration of an expansive assent rule seems only prudent.

Popper, *supra* note 15, at 832 (citations omitted). For a discussion of the capacity of children regarding legal matters absent parental participation, see *Commonwealth v. Fogan*, 296 A.2d 755 (Pa. 1972) (finding that the totality of the circumstances test is appropriate when considering minors' rights with respect to waiver of the right to counsel); *Commonwealth v. Moses*, 287 A.2d 131 (Pa. 1971) (holding that whether a sixteen-year-old intelligently waived his right to counsel is an issue of fact); *Therault v. State*, 223 N.W.2d 850 (Wis. 1974) (holding that the absence of a parent or legal guardian does not render a murder confession given by a juvenile inadmissible per se. *See also In re Green*, 292 S.2d 387, 392 (Pa. 1972) (when the life of the minor is not imperiled, the personal choices of the minor should be central to treatment decisions) (minor was competent because he understood the benefits of treatment, the risks, and the consequences of non-treatment); *Traugott & Alpers*, *supra* note 33, at 924 (concluding that promotion of "the best interests of any patient, child or adult, means merely that the expected benefits of a medical intervention should outweigh the possible harms").

⁵¹ *Shield & Baum*, *supra* note 1, at 1183 (discussing justification for allowing a minor to make his or her own decisions with regard to medical care).

⁵² *See, e.g., DAVIS ET AL.*, *supra* note 33, at 157 (adding that the "mature minor" doctrine extends legal privileges associated with adulthood to adolescents).

⁵³ *Hawkins*, *supra* note 10, at 2124 (discussing protections afforded by common law "mature minor" doctrine).

⁵⁴ *Carolyn O'Connor, Illinois Adolescents' Rights to Confidential Health Care*, 82 ILL. B.J. 24, 26 (1994).

The Illinois Supreme Court, for example, adopted the doctrine in 1989.⁵⁵ Based upon an interpretation of two statutes – the Consent by Minors to Medical Procedures Act⁵⁶ and the Emancipation of Mature Minors Act⁵⁷ – the court determined that “the legislature did not intend that there be an absolute 18-year-old age barrier prohibiting minors from consenting to medical treatment.”⁵⁸ The court also relied on precedent which concluded that “no ‘bright line’ age restriction of 18 is tenable in restricting the rights of mature minors, whether the rights are based on constitutional or other grounds.”⁵⁹ In order to overcome the presumption of immaturity, there must be clear and convincing evidence 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[.]”⁶⁰ However, neither judicial decisions nor statutes provide specific guidance for determining in advance when a minor is “mature.”⁶¹ The standard for maturity is left to the discretion of trial courts because “cases will arise in circumstances so varied, so complex, and so hard to anticipate that no one could write rules that would accurately guide decision-makers to correct results and only to correct results in a sufficiently large number of the cases.”⁶²

⁵⁵ *In re E.G.*, 549 N.E.2d 322. (Ill. 1989) (granting a seventeen-year-old girl the right to refuse a blood transfusion based upon her religious beliefs)

⁵⁶ See 410 ILL. COMP. STAT. ANN. 210/1 (West 1993) (defining minors’ rights with respect to medical procedures).

⁵⁷ See 750 ILL. COMP. STAT. ANN. 30/1 et seq. (West 1999).

⁵⁸ *In re E.G.*, 549 N.E.2d at 326.

⁵⁹ *Id.*

⁶⁰ *Id.* at 327-28. The court also established a “sliding scale analysis” to determine when the state should intervene, should it wish to do so. If the treatment is life-threatening, for example, the state’s interest is higher; but as the risks of treatment decline, and the maturity and the age of the minor increase, the state has less authority to intervene. The rights of the minor also must be balanced against the state’s interests in preserving life, protecting third party interests, preventing suicide, and maintaining the ethical integrity of the medical profession. *See id.*

⁶¹ See Suellen Scarnecchia & Julie Kuncze Field, *Judging Girls: Decision-making in Parental Consent to Abortion Cases*, 3 MICH. J. GENDER & L. 75, 77-80 (1995) (discussing the origins and interpretations of the “maturity” and “best interests” tests).

⁶² *Id.* at 81 (quoting Carl E. Schneider, *Discretion, Rules, and Law: Child Custody and the UMDA’s Best Interest Standard*, 89 MICH. L. REV. 2215, 2243 (1991)).

III. WHO SHOULD BE CONSIDERED MATURE?

[M]aturation is a process that develops at different rates for different individuals; there is no arbitrary boundary between the incompetent child and the competent child or adult.⁶³

Fortunately, there is a wide array of available developmental research helpful in understanding and determining an adolescent's maturity, decision-making abilities and competency. Jean Piaget, the early, influential researcher into children's cognitive development, studied their evolution toward sufficient maturity to make adult-like decisions,⁶⁴ and how and when they achieve that status. Piaget suggested that this development occurs in several stages, based on when children perceive new events and how they place these new events into preexisting patterns of thought.⁶⁵ Piaget found, for example, that children between eleven and fifteen could exercise independent thought, analyze outcomes, and think logically and deductively.⁶⁶

They can engage in pure thought independent of actions they see or perform. They can hypothesize and draw deductions, understand theories, and combine them to solve problems . . . 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.⁶⁷

Another prominent researcher, Lawrence Kohlberg, in a somewhat different approach, determined maturity by focusing on "moral development" because those children who have reached a "higher [stage] of moral development [tend to be those who] are . . . better able to place a moral problem within

⁶³ Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 728 (1993) (citing FRANKLIN E. ZIMRING, *THE CHANGING LEGAL WORLD OF ADOLESCENCE* 103-04 (1982)).

⁶⁴ See Wallace J. Mlyniec, *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 FORDHAM L. REV. 1873, 1878-79 (1996) (citing Jean Piaget, *Psychology and Epistemology* 5-7 (Arnold Rosin trans., 1971)).

⁶⁵ See *id.* (stating Piaget's belief that learning occurs through the possession of stages).

⁶⁶ See *id.* at 1879 (explaining the learning capabilities of children between the ages of 11 and 15).

⁶⁷ *Id.*

the context of the 'bigger picture.'"⁶⁸ Kohlberg concluded that this ability to think morally usually occurs around age thirteen or fourteen.⁶⁹ However, although they studied two different indicia of maturation, both Piaget and Kohlberg concluded that children over thirteen or fourteen are as capable as adults of formal logical thought.

Several studies completed in the 1970s and 1980s agreed. They specifically focused on cognitive development in terms of adolescent competency to make decisions, such as informed consent, and found that "adolescents do not substantially differ from adults in their ability to understand and reason about medical treatment alternatives."⁷⁰ In one 1982 study, the decision-making of different age groups – nine-year-olds, fourteen-year-olds, and twenty-one-year-olds – were tested with regard to a hypothetical illness and proposed medical treatment. Their understanding of facts, treatment outcomes, choices to be made, and decision-making processes were studied. While the nine-year-olds were a bit more conservative because they chose inpatient care more often, the fourteen-year-olds and twenty-one-year-olds achieved the same results.⁷¹

In another study, where children were asked to give health advice to their peers, twelve-year-olds were determined to be as competent as nineteen-year-olds.⁷² Indeed, when videotapes

⁶⁸ Cauffman & Steinberg, *supra* note 13, at 1786.

⁶⁹ See JOHN W. SANTROCK, *ADOLESCENCE* 407 (7th ed., 1998). Kohlberg's research was based on three levels of development. The first level acts in order to avoid punishment or get rewards. Those in the second level try to maintain social order, and have a sense of morality, but are unable to think formal logical thoughts. See also Scarnecchia & Field, *supra* note 61, at 93-97. Young women also make moral decisions differently from men. See *id.* at 97. Women choose what will cause the most good and the least amount of harm. See *id.* (citing Kelly Flood, *Decision for Abortion Is Moral: Women's Choices Often Based on Responsibilities*, LEXINGTON HERALD LEADER, Mar. 15, 1992, Special Section, at 9). Men make moral decisions based on clearly defined ideas of what is right or wrong. See *id.*

⁷⁰ O'Shaughnessy, *supra* note 35, at 1753. One study determined that the ability to focus on relevant information occurs between the ages of ten and thirteen. See *id.* (citing Michael C. Roberts et al., *Children's Perceptions of Medical and Psychological Disorders in Their Peers*, 10 J. CLINICAL CHILD PSYCHOL. 76 (1981)). Thus, children under twelve may use less information than adults in making decisions, but children fifteen or older nevertheless systematically make decisions in the same way as adults.

⁷¹ See Cauffman & Steinberg, *supra* note 13, at 1769 (explaining a study of adolescents' health care decisions and choices).

⁷² *Id.*

were shown to fifteen-year-olds, they were as competent as twenty-one-year-olds in identifying when patients' rights had been violated.⁷³ Thirteen-year-old women have also been found to be as competent in their decision-making as twenty-one-year-old women when faced with an unplanned pregnancy.⁷⁴ This latter study noted that minors could "reason abstractly about hypothetical situations, reason about multiple alternatives and consequences, consider multiple variables, combine variables in more complex ways, and use information systematically."⁷⁵

Thus, in order to be able to give informed consent to medical treatment, minors must be competent to understand the nature, extent, and probable outcome of the treatment.⁷⁶ They must be able to understand the information provided, reach a reasonable outcome, and rationally make and voluntarily reach a decision.⁷⁷ However, it would appear that minors as young as thirteen or fourteen are generally capable of informed consent to treatment.

Critics of these studies, on the other hand, claim they overlook psycho-social factors,⁷⁸ such as peer influence, which can

⁷³ See Cauffman & Steinberg, *supra* note 13, at 1769.

⁷⁴ See *id.* at 1770 (citing Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 LAW & HUM. BEHAV. 129, 134, 135, 140-41 (1992)).

⁷⁵ Mlyniec, *supra* note 64, at 1882 (quoting Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 LAW & HUM. BEHAV. 129, 147-48 (1992)).

⁷⁶ See Rosato, *supra* note 36 at 21, (citing *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337 (Kan. 1970)).

⁷⁷ See generally Joan-Margaret Kun, *Rejecting the Adage "Children Should be Seen and Not Heard"—The Mature Minor Doctrine*, 16 PACE L. REV. 423, 453 (1996) (discussing the rights of minors to refuse life-sustaining treatment) (citing Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 416-21 (1978)). See also Redding, *supra* note 63, at 704-07 (discussing a child's capacity to understand and the ability to consent). Medical professionals also have a similar standard for competency which includes the following: factual understanding of the problem, implications of the treatment and treatment alternatives, rational decision-making, the capability of communicating a choice, reasonableness of choice and general competency. To determine whether a patient has decision-making capacity, the physician determines whether the patient has reasoning ability, understanding, voluntariness, and understands the nature of the decision to be made. See generally Hawkins, *supra* note 10, at 2127-28 (citing Nancy M.P. King & Alan W. Cross, *Children as Decision Makers: Guidelines for Pediatricians*, 115 J. PEDIATRICS 10, 12 (1989)).

⁷⁸ See Rosato, *supra* note 36 (citing Elizabeth S. Scott, *Judgment and Reasoning in Adolescent Decisionmaking*, 37 VILL. L. REV. 1607, 1624 (1992)). See also Cauff-

make a minor act in an immature manner even though she otherwise possesses the required cognitive skills and maturity to give informed consent.⁷⁹ It has also been determined that priorities and attitudes, for purposes relevant to making judgments, differ between adults and children. Most adolescents are more concerned with short-term consequences, whereas adults are concerned with long-term impacts,⁸⁰ and adolescents are more likely to be risk-takers and believe they are invulnerable to harm.⁸¹ "This sense of invulnerability has been cited not only to explain risky behavior, but also as a basis for legal precedents maintaining that minors are incapable of making rational decisions regarding their own well-being, especially regarding issues of health."⁸²

No empirical evidence, however, supports the view that psychosocial factors directly affect individual medical decision-making.⁸³ Indeed, recent cognitive development studies have recognized that children over age fourteen can make mature and intelligent decisions about health care.⁸⁴ The American Academy of Pediatrics' Committee on Bio-ethics has not only supported the finding that children "achieve decisional capacity at [a] much earlier [age] than is recognized legally,"⁸⁵ but based upon what we now understand to be the adolescent's level of maturity and cognitive abilities, it recommends that adolescents should be *more* involved than at present in health care decision-making.⁸⁶

man & Steinberg, *supra* note 13 (citing Elizabeth S. Scott et al., *Evaluating Adolescent Decisionmaking in Legal Contexts*, 19 L. & HUM. BEHAV. 221, 222 (1995)).

⁷⁹ See Cauffman & Steinberg, *supra* note 13, at 1773.

⁸⁰ See *id.* at 1772-73 (determining what factors differentiate adolescent from adult decision-making).

⁸¹ See *id.* at 1767.

⁸² *Id.* (citing Daniel K. Lapsley & Michael N. Murphy, *Another Look at the Theoretical Assumptions of Adolescent Egocentrism*, 5 DEVELOPMENTAL REV. 201, 214 (1985)).

⁸³ See *id.* at 1788 (cautioning reliance on any connections between traits and mature judgment as authoritative, without studies).

⁸⁴ See Jessica Berg, *How Much Input Should a Child Have About His Treatment?* AM. MED. NEWS, June 1, 1998, at 11 (urging physicians to encourage minors to take an interested role as a participant in their own medical care even where the law is not so flexible).

⁸⁵ MIDWEST BIOETHICS CENTER, HEALTH CARE TREATMENT DECISION MAKING GUIDELINES FOR MINORS 3 (1994-95).

⁸⁶ See Committee on Bioethics, American Academy of Pediatrics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314,

IV. THE JUDICIAL VIEW OF MATURITY

When courts have spoken on this subject of children's maturity, it has usually not been in the context of consent to customary and ordinary medical procedures, but in cases asserting privacy or freedom of religion and the constitutional rights of minors. Notwithstanding the psychological studies, the courts in cases raising constitutional claims presume that the state has *parens patriae* authority over a minor until he is proven mature enough and competent to give informed consent.⁸⁷ More problematic is the fact that the Supreme Court has seemed reluctant to provide guidance in determining maturity when minors demand constitutional rights.⁸⁸ In *Bellotti II*,⁸⁹ which raised the question of whether a minor needed parental consent to obtain an abortion, Justice Powell wrote that "[n]ot only is it difficult to define, let alone determine, maturity, but also the fact that a minor may be very much an adult in some respects does not mean that his or her need and opportunity for growth under parental guidance and discipline have ended."⁹⁰

Nevertheless, in *Planned Parenthood of Central Missouri v. Danforth*,⁹¹ the Court held that a minor does not need parental consent if "she is sufficiently mature to understand the procedure and to make an intelligent assessment of her circum-

316-17 (1995) (urging physicians in certain circumstances to encourage and gain participation and assent of minors with respect to their health care). *But cf. supra* note 44 and accompanying text (explaining presumptions about parental authority's benefits). Studies have found that health professionals, who see children most often in medical settings, believe children are capable of making medical decisions at 10.3 years of age. *See* Shield & Baum, *supra* note 1, at 1183 (citing PRISCILLA ALDERSON, CHILDREN'S CONSENT TO SURGERY 9 (1993)). Parents view them as capable at age 13.9 years. *See id.* Children, themselves, only believe they are competent to make health care decisions at age fourteen. *See id.*

⁸⁷ *See In re E.G.*, 549 N.E.2d 322, 327-28 (Ill. 1989) (discussing the necessary balancing between a state's *parens patriae* authority and a minor's competence and maturity).

⁸⁸ *See* Scarnecchia & Field, *supra* note 61, at 79-80.

⁸⁹ *Bellotti v. Baird*, 443 U.S. 622 (1979).

⁹⁰ *See* Scarnecchia & Field, *supra* note 61, at 77-78 (citing *Bellotti v. Baird*, 443 U.S. 622, 643-44 n.23 (1979) [*Bellotti II*] (a state must have a judicial bypass procedure established if it requires parental consent for abortion)). In *Bellotti*, Justice Powell was addressing the age limits established for marriage, in which the risk to the minor's health is low if the minor has to wait to get married, as compared to the urgency to determine whether the minor is mature when the issue of abortion is involved. *See Bellotti*, 443 U.S. at 642.

⁹¹ 428 U.S. 52, 53 (1976).

stances."⁹² Competence must now be determined by trial judges based upon the context or situation.⁹³ Therefore, in applying the "mature minor" doctrine, courts use a "multi-factor analysis" to determine whether minors properly consented to medical treatment.⁹⁴ These factors include age, degree of maturity, the nature of the treatment, whether a parent agrees with the treatment, and whether the benefit is for the minor rather than a third party.⁹⁵

A. Age

*It is easy to tell when and individual is eighteen; it is hard to know when an individual is mature.*⁹⁶

Courts seldom allow minors under the age of sixteen to make decisions regarding their treatment.⁹⁷ Indeed, no court has ever granted a patient younger than fourteen the right to consent.⁹⁸ "Some courts have recognized the 'rule of sevens,' which derives from English common law[,]"⁹⁹ and under which: children under seven have no capacity to consent; children age seven to fourteen are presumed not to have the capacity to con-

⁹² *Planned Parenthood v. Danforth*, 392 F. Supp. 1362, 1376 (1974) (citing *Younts v. St. Francis Hosp. & Sch. Nursing, Inc.*, 469 P.2d 330, 337 (Kan. 1970)).

⁹³ See Rosato, *supra* note 36, at 51-52 (defining the requisite competence for decision-making regarding life-saving treatment); Michael J. Saks, *Social Psychological Perspectives on the Problem of Consent*, in CHILDREN'S COMPETENCE TO CONSENT 41, 50 (Gary B. Melton et al. eds., 1983); Donald N. Bersoff, *Children as Participants in Psychoeducational Assessment*, in CHILDREN'S COMPETENCE TO CONSENT 149, 151, 174 (Gary B. Melton et al. eds., 1983); Loir A. Weithorn, *Involving Children in Decisions Affecting Their Own Welfare: Guidelines for Professionals*, in CHILDREN'S COMPETENCE TO CONSENT 235, 242 (Gary B. Melton et al. eds., 1983). Minors have been determined to be mature enough to make decisions regarding abortion, *Miranda* rights, medical treatments, and political expression. See notes 29-35, 50 and accompanying text.

⁹⁴ *Danforth*, 428 U.S. at 74 (discussing state law requiring parental consent for minors' abortions).

⁹⁵ See O'Connor, *supra* note 54, at 27, 38.

⁹⁶ Willard Gaylin, *The Competence of Children: No Longer All or None*, HASTINGS CENTER REP., Apr. 1982, at 33.

⁹⁷ See Nancy Batterman, *Under Age: A Minor's Right to Consent to Health Care*, 10 *TOURO L. REV.* 637, 672 (1994) (citing Tania E. Wright, *A Minor's Right to Consent to Medical Care*, 25 *HOW. L.J.* 525, 532 (1982)).

⁹⁸ See O'Connor, *supra* note 54, at 27. See, e.g., *Zoski v. Gaines*, 260 N.W. 99, 103 (Mich. 1935). (holding that a nine-year-old was too young to give consent for a tonsillectomy).

⁹⁹ O'Connor, *supra* note 54, at 27.

sent; and children age fourteen and above are presumed to have capacity to consent.¹⁰⁰

Courts have used this rule to support a presumption that a teenager older than fourteen has the capacity to give informed consent to medical treatment. This distinction is based on the recognition that reasoning ability is usually present by this age. Evidence that formal operational thought emerges at approximately age 12 provides some scientific support for this legal rule.¹⁰¹

B. Indicia of Maturity

Courts use various means of determining maturity and thus competence sufficient to give informed consent. There are no specific rules for determining maturity; children may show competence through conduct ranging from testifying for themselves in court to successfully exercising the responsibility for signing checks.¹⁰² The guidelines for maturity emerge on a case-by-case basis.¹⁰³

In one decision, a court determined that a minor was mature enough to consent to treatment where she had good grades, was planning to go to college the next year, and had been given a blank check from her parents to pay for the office visit.¹⁰⁴ Yet in another case, a seventeen-year-old minor was found immature even though she worked twenty-five to thirty hours a week,

¹⁰⁰ See *id.* (citing *Lacey v. Laird*, 139 N.E.2d 25, 33 (Ohio 1956) (discussing the "rule of sevens" with respect to criminal law and finding that criminal immunity ends when a child turns fourteen). See also *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987) (using the "rule of sevens" in the application of a minor's right to consent to medical treatment).

¹⁰¹ *Id.* (citing BARBEL INHELDER & JEAN PIAGET, *THE GROWTH OF LOGICAL THINKING: FROM CHILDHOOD TO ADOLESCENCE* 334-50 (Anne Parsons & Stanley Milgram trans., 1958)).

¹⁰² See *In re E.G.*, 549 N.E.2d 322, 325-27 (Ill. 1989) (recounting a variety of means courts have used to determine maturity of children to consent to health care); *Cardwell*, 724 S.W.2d at 743.

¹⁰³ Some of the court's measurements have included the following: *In re Seiferth*, 127 N.E.2d 820 (N.Y. 1955) (finding that a minor had "convictions of his own"); *Bach v. Long Island Jewish Hosp.*, 267 N.Y.S.2d 289, 291 (N.Y. Sup. Ct. 1966) (holding that a minor had "reached the age of discretion"); and *In re E.G.*, 549 N.E.2d at 327-28 (finding a minor competent to refuse treatment based on her individual circumstances).

¹⁰⁴ See also *Cardwell*, 724 S.W.2d at 743 (giving characteristics that may qualify the plaintiff to consent to treatment). See also note 5 *supra*.

had good grades, was involved in sports, and paid her own car and phone expenses. In the latter case, the minor had become pregnant a second time and was seeking an abortion. The court held that she lacked competency and maturity.¹⁰⁵ Some cases are more clear-cut, such as where a court determined that a child who depends on his parent's advice, has never been away from home, admits he is still a child, and has never dated, was not mature.¹⁰⁶

Minors must show "proof of [their] maturity by clear and convincing evidence."¹⁰⁷ Whether the minor is mature enough to make medical decisions is a question of fact, to be determined by ascertaining whether the child has the ability to understand the risks, consequences, and nature of treatment.¹⁰⁸ This may be assessed by examining: "1) the evidencing of choice, 2) the reasonable outcome of choice, 3) the choice based on rational reasons, 4) the ability to understand the implications of the choice, and 5) the actual understanding of the choice."¹⁰⁹ Some jurisdictions hold that the more serious the decision, the greater the capacity required in the decision-maker.¹¹⁰

C. Balancing Levels of Maturity Against the Nature of Treatment

Courts generally find children competent to consent to or refuse treatment that has little risk, such as for back pain,¹¹¹ tonsillectomies,¹¹² vaccinations,¹¹³ skin grafts,¹¹⁴ and cosmetic sur-

¹⁰⁵ *In re Jane Doe*, 566 N.E.2d 1181, 1184 (Ohio 1990) (stating that a child did not have the requisite maturity to decide to have an abortion). Justice Brown noted in dissent: "If she is not a 'mature minor,' then who is?" *Id.* at 1189.

¹⁰⁶ *In re Long Island Jewish Med. Center*, 147 Misc. 2d 724, 727, 730 (N.Y. Sup. Ct. 1990) (examining whether a patient seven weeks short of his 18th birthday constituted a mature minor). See also *O.G., P.G. & M.G. v. Baum*, 790 S.W.2d 839, 842 (Tex. Ct. App. 1990) highlighting the fact that a minor's testimony was not presented to the trial court as a significant factor in the court's determination of maturity).

¹⁰⁷ *In re E.G.*, 549 N.E.2d at 327.

¹⁰⁸ See *Cardwell*, 724 S.W.2d at 749.

¹⁰⁹ Kroft, *supra* note 17, at 460.

¹¹⁰ See *id.* See also *Zinerman v. Burch*, 494 U.S. 113 (1990) (holding that confinement of a disoriented patient in psychiatric hospital without hearing to determine capacity to consent infringed upon the patient's liberty interests); *Fuller v. Starnes*, 597 S.W.2d 88 (1980) (holding that a physician's duty to disclose risks is measured by the customary practice of physicians in the community in which he practices).

¹¹¹ See *Cardwell*, 724 S.W.2d at 739.

¹¹² See *Bishop v. Shurly*, 211 N.W. 75, 78 (Mich. 1926) (finding a 19-year-old competent consent to local anesthesia prior to his tonsillectomy).

gery.¹¹⁵ However, ethicists agree that the ordinary indicia of competence should be balanced against the risks of treatment;¹¹⁶ as the risk increases, there must be greater evidence of maturity. Therefore, where a "mature minor" seeks major medical intervention,¹¹⁷ or seeks to refuse life-sustaining treatment without prior parental consent, a court order should be sought. The court will require a heightened standard of proof of competence.¹¹⁸ In addition, while children may not need parental consent to donate blood to be used by third parties, they will need parental consent for non-therapeutic treatment that benefits a third party. Thus, minors cannot consent to donating a kidney,¹¹⁹ or to allowing a skin graft which benefits someone other than the minor.¹²⁰ The treatment must benefit the child and not be for the sole benefit of others.¹²¹

¹¹³ See *Gulf & S.I.R. Co. v. Sullivan*, 119 So. 501, 502 (Miss. 1928) (confirming the general rule that a child who is capable of understanding and appreciating the consequences of a medical invasion can consent thereto).

¹¹⁴ See, e.g., *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970) (holding that a seventeen-year-old female was capable of providing consent for a minor surgical procedure entailing a skin graft to repair her finger).

¹¹⁵ See *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956) (discussing parental versus minor consent to plastic surgery); *Johnston v. Wellesley Hosp.* 17 D.L.R.3d 139 (1970) (finding that a twenty-year-old could give consent for a procedure to remove acne scars).

¹¹⁶ O'Connor, *supra* note 54, at 27 (citing William Gaylin, *The Competence of Children: No Longer All or None*, HASTINGS CENTER REP., Apr. 1982, at 33, 35-38).

¹¹⁷ See O'Connor, *supra* note 54, at 38.

¹¹⁸ See *In re E.G.* 549 N.E.2d 322, 327-28 (Ill. 1989); see, e.g., *In re Swan*, 569 A.2d 1202, 1206 (Me. 1990) (respecting a minor's decision not to be kept on life-sustaining equipment because it was shown that the minor expressed these wishes in two previous serious conversations); see also *In re Rosebush*, 491 N.W.2d 633, 639-40 (Mich. Ct. App. 1992) (requiring a best interests standard, rather than a substituted judgment standard in the context of terminating life support for a minor child because the minor was never competent in the first place and, therefore, one cannot determine what choice the child would have made if competent).

¹¹⁹ O'Connor, *supra* note 53, at 38.

¹²⁰ See *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) (holding as improper a lower court's jury instruction which failed to instruct that without parental consent a 15-year-old could not get a skin graft to benefit a third party).

¹²¹ See DAVIS ET AL., *supra* note 33, at 157.

V. THE PRACTICAL APPLICATION OF THE “MATURE MINOR” DOCTRINE

Controversy regarding the “mature minor” doctrine does not center upon the justification for the rule itself, but upon its application.

The law provides little real guidance to the judge and his decision must necessarily reflect personal and societal values and mores whose enforcement upon the minor – particularly when contrary to her own informed and reasonable decision – is fundamentally at odds with privacy interests underlying the constitutional protection afforded to her decision.¹²²

Trial judges exercise discretion in determining when a minor is mature, and do not have to articulate how they ascertained that fact.¹²³ Making matters worse, “[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].”¹²⁴

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,¹²⁵ and thus unfair. Indeed, U.S. Supreme Court Justice Souter has suggested that judges should disqualify themselves where they may not be able to separate their own morals from the choices the teenager must make.¹²⁶

¹²² *Bellotti v. Baird*, 443 U.S. 622, 655-56 (1979) [*Bellotti II*] (Stevens, J., concurring).

¹²³ See Mlyniec, *supra* note 64, at 1889 (discussing ascertainment of maturity in abortion cases).

¹²⁴ Scarnecchia & Field, *supra* note 61, at 76. Recent studies have reinforced this point. When judges and attorneys were asked to identify mature adolescents from a group of 477 teenagers, judges found nine mature children, while the attorneys determined that there were eleven. Only one teenager was chosen more than once, and the judges and attorneys did not choose the same teens. See *id.* at 81 (citing Susan Yates & Anita J. Pliner, *Judging Maturity in the Courts: The Massachusetts Consent Statute*, 78 AM. J. PUB. HEALTH 646, 647 (1988)).

¹²⁵ See Scarnecchia & Field, *supra* note 61, at 77-80.

¹²⁶ See Scarnecchia & Field, *supra* note 61, at 85 (citing John Milne, *Souter Note Helped Sink ‘81 N.H. Bill on Abortion*, BOSTON GLOBE, July 26, 1990, at 1, 3) (referencing a letter written by Justice Souter while serving on the New Hampshire Supreme Court).

The "mature minor" doctrine has been consistently applied, however, 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." Indeed, no court has rejected the doctrine itself since 1941,¹²⁷ and no doctor has been held liable for battery in the past thirty years when treating a patient over age fourteen without parental consent.¹²⁸ Courts will protect physicians in their "non-negligent treatment of . . . mature minor[s] who consent . . . to a procedure after discussion with the physician."¹²⁹

VI. STATUTES MAY ALSO INDEPENDENTLY GRANT CHILDREN THE RIGHT TO CONSENT TO TREATMENT

In most states, the "mature minor" doctrine is a matter of common law. In a few states, such as Arkansas and Mississippi, the doctrine has been adopted by statute, but most legislatures have chosen to not do so because of the "subjective nature" of its application.¹³⁰

In all states, however, there are statutes that give doctors authority to treat minors, regardless of parental consent, to "prevent certain negative consequences resulting from lack of medical care, such as significant harm to the child or to the community."¹³¹ These statutes offer guidelines to the medical community not always apparent in vague judicial rulings.¹³² "Through these exceptions, the states recognize that minors do not have to reach the statutory age of majority to make their

¹²⁷ See O'Connor, *supra* note 54, at 26.

¹²⁸ "As of 1986, there appears not to have been a single reported case where a physician has been held liable for treating a minor without informed consent." Redding, *supra* note 63, at 744.

¹²⁹ O'Connor, *supra* note 54, at 27.

¹³⁰ Danny R. Veilleux, Annotation, *Medical Practitioner's Liability for Treatment Given Child Without Parent's Consent*, 67 A.L.R. 4th 511, 517 (1989).

¹³¹ Rosato, *supra* note 36, at 26 (citing Abigail English, *Adolescent Health Care: Barriers to Access, Consent, Confidentiality and Payment*, 20 CLEARINGHOUSE REV. 481, 484 (1986)).

¹³² See Hawkins, *supra* note 10, at 2101 (noting the important role of legislators and courts in improving minors' rights to participate in health care decisions).

own medical decisions,"¹³³ and more importantly, that many minors would rather not receive *any* medical care than consult their parents about certain forms of treatment.¹³⁴ In addition to existing "mature minor" provisions, there are three general categories of statutory exceptions to the requirement of parental consent: for medical emergencies, certain unique legal or medical status, and specific medical conditions.¹³⁵

A. Emergencies

Physicians need not obtain consent to treat minors during medical emergencies.¹³⁶ A medical emergency exists where (1) the patient is incapacitated to the point that she cannot use her mental facilities to reach an informed choice; (2) the circumstances are life-threatening or serious enough that immediate treatment is required; and (3) it would be medically imprudent to attempt to solicit consent from some other authorized person on behalf of the patient.¹³⁷ In other cases, obtaining parental consent may not be feasible or might be very harmful to the minor, especially if sexual assault or abuse is involved. Therefore, physicians may treat minors if, "in [their] sole opinion, the obtaining of consent is not reasonable."¹³⁸

¹³³ Rosato, *supra* note 36, at 26 (citing *In re E.G.*, 594 N.E.2d 322, 327-28 (Ill. 1989)). These exceptions, however, were not intended to protect the minors' rights to self-determination. *Id.*

¹³⁴ See Batterman, *supra* note 97, at 640 (stating that "[t]he legislature has determined either that the condition is too damaging to society as a whole to remain untreated or that the treatment is harmless enough to the minor to warrant its application without parental consent") (citations omitted).

¹³⁵ Rosato, *supra* note 36, at 25 (discussing exceptions to the parental consent requirement) (citations omitted).

¹³⁶ See 410 ILL. COMP. STAT. ANN. 210/3(a) (West 1997) (mandating specific situations where consent procedures may be lifted when treating minors); Rosato, *supra* note 36, at 19 (citations omitted).

¹³⁷ See Kroft, *supra* note 17, at 465 (analyzing the exception to the requirement of informed consent). See, e.g., *Stafford v. Louisiana State Univ.*, 448 So.2d 852 (La. Ct. App. 1984) (holding that since conservative treatment had been rendered and good faith efforts were made to reach the patient's next of kin, the physicians were justified in proceeding on the basis of a medical emergency). Permission is implied because it is assumed that parents would consent if they knew of the situation. See Kroft, *supra* note 17, at 468 (citing Nancy Batterman, *Under Age: A Minor's Rights to Consent to Health Care*, 10 *TOURO L. REV.* 637 (1994)).

¹³⁸ See 410 ILL. COMP. STAT. ANN. Act 210/0.01 et seq. (West 1997) (mandating situations where a physician may treat a minor without parental consent).

B. Special Status of the Minor

The "emancipated minor" doctrine¹³⁹ gives minors the right to consent to treatment if they are married, pregnant, or are parents to a child and the court has issued an order giving the minor the right to consent.¹⁴⁰ "[T]he legislature has decided that [these circumstances, as well as] joining the armed forces [or] turning eighteen [constitute] an act of physical, psychological or economic separation from one's parents."¹⁴¹ Thus, the doctrine is intended to protect minors who are no longer dependent on their parents, those whose "parents [have] relinquished control over their child's behavior and personal affairs."¹⁴²

However, the courts have emphasized that while minors emancipated under this doctrine are being given control over certain personal rights, they may still be allowed to depend on parents for certain other property rights.¹⁴³ "Medically emancipated" minors, for example, whose situation is discussed in the next section, may still "retain their own wages, sue their parents for injuries that result from parent's negligence, establish their own domicile, and receive public assistance," even though they cannot sign leases, or sell or control property.¹⁴⁴

C. Specific Medical Conditions

Consent by minors to treatment for mental illness, abortion, contraception, sexually transmitted diseases, and drug and alcohol abuse are often treated differently than routine medical matters. A minor can voluntarily admit herself to a mental health center if she is sixteen years or older.¹⁴⁵ In most states, pregnant

¹³⁹ For a discussion of the "emancipated minor" exception, see generally Smith v. Seibly, 431 P.2d 719, 723 (Wash. 1967) (cited in Batterman, *supra* note 97, at 661).

¹⁴⁰ However, if the parents, guardians, or the child object to the classification, the court cannot grant the order. 750 ILL. COMP. STAT. ANN. 30/9 (West 1999).

¹⁴¹ Batterman, *supra* note 97, at 637.

¹⁴² *Id.* (citing JAMES M. MORRISSEY ET AL., CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS: A LEGAL GUIDE 33, 33-35 (1986)).

¹⁴³ *See id.* (discussing minor's emancipation from parental control).

¹⁴⁴ *Id.* at 647-48 (citations omitted).

¹⁴⁵ *See, e.g.,* 405 ILL. COMP. STAT. ANN. 5/3 -502 (West 1997) (mandating voluntary admission for minors 16 years or older to mental health facilities). Minors 16 years of age or older can admit themselves to a mental health facility by filling out an application. However, in the case of community service areas with a participating mental health center, no minor shall be admitted to a state-run hospital without the

minors may seek abortions without parental consent. In states in which parental consent is mandatory, the state must provide an expeditious "judicial bypass" through which minors may prove their maturity to a judge and be granted an absolute right to consent.¹⁴⁶

In twenty-three states, minors can get birth control medication without parental consent.¹⁴⁷ In Illinois, however, a minor can obtain this medication only if married, a parent, or there is parental consent.¹⁴⁸ The minor can also receive birth control medication if a serious health hazard would result if she did not receive treatment, or if a clergy-person or planned parenthood agency referred the minor for treatment.¹⁴⁹

Forty-nine states allow minors who are twelve years old or older to receive treatment for sexually transmitted diseases without parental consent.¹⁵⁰ Some states even allow treatment for any infectious, communicable, or contagious disease.¹⁵¹ Similarly, in order to promote cessation of drug and alcohol abuse, minors who are twelve years old or older can request outpatient counseling without parental consent.¹⁵² Minors can also seek counseling if a family member is a drug or alcohol abuser.¹⁵³

recommendation of a qualified certifier. *See id.* *See also* 405 ILL. COMP. STAT. ANN. 5/3 - 504 (West 1997) (stating that a parent, guardian, or interested person can admit a minor to a private health center without the minor's consent for emergency treatment).

¹⁴⁶ Rosato, *supra* note 36, at 16 (*citing* Bellotti v. Baird, 443 U.S. 622, 647-48 (1979)). *See also* Planned Parenthood v. Casey, 505 U.S. 833, 899-900 (1992) (showing that, ironically, for minors who choose to carry their child to full term, only twenty-seven states give prenatal care and delivery services without parental consent).

¹⁴⁷ *See* Deborah L. Shelton, *Rights of Passage*, AM. MED. NEWS, June 17, 1996, at 13 (discussing whether confidential health services improve care provided to adolescents).

¹⁴⁸ *See* 325 ILL. COMP. STAT. ANN. 10/1 (West 1993) (mandating requirements for minors receiving birth control).

¹⁴⁹ *See id.*

¹⁵⁰ *See* Shelton, *supra* note 147.

¹⁵¹ *See* Rosato, *supra* note 36, at 29-30 n.109 (*citing* Ala. Code § 22-8-6 (West 1994); CAL. FAM. CODE § 6926(a) (West 1994); DEL. CODE ANN. tit. 13 § 710 (1999)).

¹⁵² *See id.* at 31 (*citing* statutes that eliminate the need for parental consent for the treatment of drug or alcohol abuse) (citations omitted).

¹⁵³ *Id.*

D. Confidentiality

Confidentiality is especially important to an adolescent; many teenagers would not get treatment if they knew that their parents would be notified.¹⁵⁴ In most states, statutes require physicians to maintain the confidences of patients or be liable for their negligent or willful failures to do so.¹⁵⁵ A doctor is only permitted to release information to the person who has the ability to consent to treatment.¹⁵⁶ However, in order to balance society's interests and patient's privacy rights, legislatures have adopted exceptions requiring a physician to notify a third party.

Certain infectious diseases must be reported to public officials, and if a minor is diagnosed with HIV in some states, the physician must notify the Department of Health.¹⁵⁷ The Department of Health will then notify the school principal, who must tell the Superintendent, and may tell classroom teachers, school nurses, or others who work with the minor in educational settings.¹⁵⁸ Health care officials must also try to persuade the child to notify his or her parents. If the child does not, the officials must make a "reasonable effort" to notify the parents if they determine that it is in the "best interests" of the child to do so.¹⁵⁹

Physicians who treat victims of child abuse must notify the Department of Children and Family Services (DCFS).¹⁶⁰ If the minor is a victim of crime, the physician must notify the police.¹⁶¹ The physician also has a duty to warn third parties if she knows the minor may pose a threat to them.¹⁶² If the minor is

¹⁵⁴ *Id.*

¹⁵⁵ *See, e.g.*, ILL. COMP. STAT. ANN. 60/45 (West 1998) (mandating strict patient confidentiality for physicians except in certain enumerated situations).

¹⁵⁶ *See* Patricia Booth Levenberg, *Ensuring Confidentiality in Treating Teens*, 39 AM. MED. NEWS, Oct. 7, 1996, at 18 (discussing the practical and legal issues surrounding confidentiality of adolescents' medical treatment).

¹⁵⁷ *See* 410 ILL. COMP. STAT. ANN. 315/2a (West 1997).

¹⁵⁸ *See* 410 ILL. COMP. STAT. ANN. 210/4 (West 1997) (mandating reporting of sexually transmitted diseases).

¹⁵⁹ *Id.*

¹⁵⁹ *See* 410 ILL. COMP. STAT. ANN. 305/9k (West 1997).

¹⁶⁰ *See* 325 ILL. COMP. STAT. ANN. 5/4 (West 1993).

¹⁶¹ *See* 325 ILL. COMP. STAT. ANN. 5/11.1a (West 1999).

¹⁶² *See, e.g.*, *Tarasoff v. Regents of the Univ. of California*, 17 Cal.3d 425 (1976) (holding, in a landmark decision, that a doctor may be liable for breach of duty for failing to warn a third party concerning threats made by his patient).

admitted to a mental hospital, the physician must notify the parents upon admittance.¹⁶³

However, physicians have a choice as to whether parents should be notified regarding venereal diseases.¹⁶⁴ They should make an effort to tell parents only if it will not impair the treatment.¹⁶⁵ On the other hand, physicians who treat minors for drug or alcohol treatment cannot tell the parents unless "necessary to protect the safety of the minor, a family member, or another individual."¹⁶⁶ If necessary, the director of the medical facility will notify the parents, and notify the minor of the notification.

VII. CONCLUSIONS AND RECOMMENDATIONS

*Let us not as a society limit unnecessarily the freedom of our children to develop and exercise their decision-making capabilities, to obtain needed treatment in confidentiality and to refuse treatment when it may be harmful to their personhood and individuality.*¹⁶⁷

Experts on children's development have agreed that their cognitive abilities, and thus their decision-making competence, mature arguably by thirteen, and certainly by age fifteen.¹⁶⁸ Yet regardless of their actual maturity, when minors' medical decisions are challenged in court, there must be "clear and convincing evidence" of their competence to consent.¹⁶⁹ This burden of proof is made more difficult by the fact that judges are not ordinarily familiar with children's cognitive development. Children also suffer the uncertainty that flows from reliance upon judges' unique "moral constitution" for vindication of their right to engage in medical decision-making.¹⁷⁰

¹⁶³ See 405 ILL. COMP. STAT. ANN. 5/3-502 (West 1997) (mandating that any minor may be admitted to a health care facility following the application of a parent).

¹⁶⁴ See 410 ILL. COMP. STAT. ANN. 210/4, 210/5 (West 1997) (providing consent rules for physicians treating minors with venereal diseases or alcohol and drug issues).

¹⁶⁵ See *id.*

¹⁶⁶ 410 ILL. COMP. STAT. ANN. 210/5 (West 1997).

¹⁶⁷ Redding, *supra* note 63, at 751.

¹⁶⁸ See generally *supra* notes 52-61, and accompanying text (explaining legal development of the mature minor doctrine).

¹⁶⁹ *In re E.G.*, 549 N.E.2d 322, 327-28 (Ill. 1989).

¹⁷⁰ See also Scarnecchia & Field, *supra* note 61, at n.102.

Even though the Supreme Court has provided minors certain limited rights to consent to abortions,¹⁷¹ that Court and most legislatures are unwilling to expand children's rights to consent to medical procedures which are less invasive and morally anguishing.¹⁷² Nonetheless, "[i]f a minor has the right to choose to undergo such an invasive procedure as an abortion, then certainly she should have the right to refuse or accept other forms of medical treatment."¹⁷³ This is crucial to children's ability to protect their privacy, bodily integrity, and self-determination.¹⁷⁴ Therefore, children seeking medical treatment should certainly be presumed by physicians and courts to be mature at age fifteen.¹⁷⁵ Legislatures should also consider codifying the "mature minor" doctrine so the common law guidelines would be made clear and physicians would understand their specific authority under this doctrine.¹⁷⁶

In the meantime, doctors should not be apprehensive about treating minors so long as they (1) take reasonable care to determine "maturity," and (2) communicate in an appropriate way¹⁷⁷ before obtaining consent. The physician should (1) in-

¹⁷¹ See *supra* notes 87-89 and accompanying text (explaining the problem with judicial granting of rights to minors independent of parents).

¹⁷² But see Hawkins, *supra* note 10, at 2100 (citing *In re E.G.*, 515 N.E.2d 286, 290 (Ill. App. 1987)) (predicting that the Supreme Court will expand the privacy rights of minors beyond procreation issues). See also Rosato, *supra* note 36, at 16 (citing *Bellotti v. Baird*, 443 U.S. 622, 642 (1979) for the proposition that deference to minor's abortion rights is justified because of the time limit and the irreversibility of the decision).

¹⁷³ Hawkins, *supra* note 10, at 2077. There are those, however, who would return all medical decision-making power to parents regardless of the minor's maturity, status, the nature of the treatment, or the "best interests" of the child. But see Shelton, *supra* note 147, at 13, 15 (discussing Congress' efforts to return all medical decision-making power to the minor's parents).

¹⁷⁴ See generally Hawkins, *supra* note 10, at 2093 (noting the growth in children's constitutional rights); see also Hillary Rodham Clinton, *Children Under the Law*, 43 HARV. EDUC. REV. 487, 509 (1973) (outlining the extension of the Fourteenth Amendment procedural rights to children).

¹⁷⁵ They can often reasonably be found to be competent by physicians after thirteen. See Rosato, *supra* note 36, at 16-17. Minors who go to court to bypass parental consent certainly should be considered mature. But see Cauffman & Steinberg, *supra* note 13, at 1763-65 (discussing the limits of society's recognition of an adolescent's competency); see generally Hawkins, *supra* note 10, at 2100-01 (demonstrating a growing trend by legislatures, courts, and medical professionals of giving minors greater decision-making authority).

¹⁷⁶ See O'Connor, *supra* note 54, at 38.

¹⁷⁷ "The problems associated with doctor to minor communication have not been effectively addressed . . . in the most common interaction, basic pediatric care . . ."

form the child about the medical necessity, the treatment options, and the risks in a comprehensible fashion, and (2) write notes in the minor's file about the discussion.¹⁷⁸ Maturity or competence may then be assessed by examining for evidence: (1) that a choice is being made, (2) that the minor understands that a choice is being made, (3) that the choice is one with a reasonable outcome, (4) that the choice had a rational basis, and (5) that the minor understands the implications of the choice.¹⁷⁹

Physicians, therefore, must always engage in an individualized evaluation of competency through brief, careful conversations. Because minors view risks differently than adults, risks should be discussed in a manner likely to raise concern about those risks in children.¹⁸⁰ Additional time may also have to be taken to explain difficult medical concepts or treatments in terms that minors can understand.¹⁸¹ Children should also be given an adequate amount of time to make a decision and should not feel pressured by the physician to do so.¹⁸²

The doctor, however, is only required to determine whether the child is mature enough to make a decision regarding treatment, not whether she is mature in all aspects of the her life.¹⁸³ If the child is judged to have a mature understanding of treatment, is close to the age of maturity (older than fourteen), and the treatment is not high risk or for another's benefit, parental consent should not be needed.

Popper, *supra* note 15, at 819 n.1. For a reasonable approach, see Appendix A, *infra*, at 173, which provides examples of questions physicians should ask when determining comprehension and maturity.

¹⁷⁸ Physicians should write notes in minors' files about informed consent discussions. See Peter Moore, *When Must Consent be Written?*, PULSE, Aug. 23, 1997, at 64, 65. A written form signed by the minor should be considered, especially if treatment carries the risk of a lawsuit. *Id.* If the minor were to testify, for example, that the only reason she allowed treatment was because it was the only option the doctor discussed, her consent would not be voluntary and informed, even if she were "mature." See Mlyniec, *supra* note 64, at 1907 (citing Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412 (1978)).

¹⁷⁹ See *supra* note 106.

¹⁸⁰ See Mlyniec, *supra* note 64, at 1907 (recommending that the court require an informed consent dialogue to determine whether the child's preference or waiver is valid).

¹⁸¹ See Berg, *supra* note 84.

¹⁸² See Moore, *supra* note 178, at 65.

¹⁸³ See Scarnecchia & Field, *supra* note 61, at 85-86.

Presently, if there is parental consent, there is no need to explain to children what will happen to them.¹⁸⁴ But the public policies that justify the "mature minor" doctrine require a trusting relationship between children and physicians.¹⁸⁵ Trusting relationships do not develop unless children's right to be informed of and participate in treatment decisions that effect them have been respected.¹⁸⁶ However,

[although the] United Nations Convention on the Rights of the Child (Convention) mandates that "due weight" should be given "to the views of the child according to age and maturity" . . . [in practice] "few children are asked if they "agree to having a blood test, or to being given a drug, or to having an operation."¹⁸⁷

Consequently, a foundation for children's trust in treatment must be built when they are young.¹⁸⁸ Children can be informed of treatment choices, and be part of the collective decision-making concerning their medical treatment, as early as age eleven.¹⁸⁹

Even though they may be incapable of making medical treatment decisions, minors should still be included in decision-making and be allowed to voice their concerns because "it is the

¹⁸⁴ See *Powers v. Floyd*, 904 S.W.2d 713, 718 (Tex. Ct. App. 1995) (holding that a doctor who performed an abortion on a minor without the minor's knowledge was not liable because the doctor had parental consent and providing the information to the minor could have been disturbing).

¹⁸⁵ "Aside from [questions of] liability, there is [a] premise that the rate and quality of healing and recovery is higher with informed patients than with those who do not understand the nature of their treatments." Popper, *supra* note 15, at 826 (describing why informed consent may have therapeutic value for children). See generally Bruce J. Winick, *Competency To Consent To Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 46-53 (1991) (advocating the therapeutic value of having patients informed and involved). When a patient has the freedom to choose a course of treatment, the decision becomes internalized, giving rise to enhanced self-motivation and more effective recovery. See *id.* at 48-50.

¹⁸⁶ See Popper, *supra* note 15, at 826.

¹⁸⁷ *Id.* at 822 (citations omitted).

¹⁸⁸ See Levenberg, *supra* note 156, at 18 (discussing physician confidentiality and its role in interactions with adolescent patients).

¹⁸⁹ See *id.* (discussing the establishment of relationships with minors over transition visits where the minors begin taking responsibility for their medical care).

child who must live with the decision.”¹⁹⁰ “[T]he transition from incapacity to capacity does not occur instantaneously upon reaching the age of majority.”¹⁹¹

¹⁹⁰ See Shield & Baum, *supra* note 1, at 1183. If the child is hostile to the treatment, she is less likely to comply with the requirements of treatment, which could result in prolonged illness or injury. See Berg, *supra* note 84.

¹⁹¹ Berg, *supra* note 84.

APPENDIX A**EXAMPLES OF QUESTIONS PHYSICIANS
SHOULD ASK WHEN DETERMINING
COMPREHENSION AND MATURITY**

How old are you?

Have you ever been hospitalized before or sent to the hospital? When? Why were you there? Are you allergic to any medication or have any other medical conditions of which I should be aware?

[Then, after describing the diagnosis, treatment options, and risks . . .]

What treatment do you want? Have you ever had this treatment before?

Tell me, in your own words, how this treatment is performed.

Are you willing to speak to your parents about this treatment? Why do you feel uncomfortable about speaking with them?

What are the worst part (risks) of this treatment? What concerns do you have about the risk? Why are you willing to [accept] the risk in order to have this treatment done?

What are the other possible treatments? What could you do if you did not have this treatment performed?

What questions do you have about the treatment?

How will you feel after the treatment (emotionally, physically, and medically)?

How will you pay for the treatment?

How are you going to get home after the appointment? (If it is not possible for the minor to drive after the operation.)

When are you going to schedule follow-up appointments? How?