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MINORS AND HEALTH CARE: THE AGE OF CONSENT

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The appropriate age for removal of the various legal disabilities of infancy has been the subject of both considerable discussion and substantial legislative action during the past several years. In the United States, a recent federal constitutional amendment has guaranteed the right of suffrage at age 18[1] and some states have followed this federal step by lowering the age of majority in general to coincide with the age for voting.[2] Others have followed a pattern of reconsidering age limitations for certain purposes, such as marriage. Of particularly widespread concern has been the determination of when medical care can be undertaken for a minor with his or her consent rather than that of a parent. The last problem, by no means a new one, increases in importance as children achieve greater independence earlier and as providing medical care for minors becomes a more important goal in today's health care oriented society.

The basic legal problem can be set forth briefly. The law of torts protects us against unauthorized invasions of our bodies. Medical treatment without consent thus becomes a trespass — what some courts have termed a "technical battery".[3] To be valid, any consent must be an "informed" one,[4] and it must be given by a person with the requisite legal capacity. Thus, a physician who proceeds with what he considers to be treatment in conformity with the best interests of his minor patient, at that patient's request and with his agreement, still might be proceeding without legal consent because the minor may lack capacity to consent because of his age. When the particular treatment is a possibly controversial or emotionally charged one, such as fitting an intrauterine device or prescribing birth control pills in order that a sexually

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[1] U.S. Const. amend. XXVI, was declared to have been ratified on July 5, 1971.

[2] In Virginia, for example, the General Assembly in its 1972 session lowered the age of majority to eighteen. Va. Code Ann. § 1-13.42 (Cum. Supp. 1972). One vestige of the earlier law was retained: Although they may be adults who can marry and vote, persons under twenty-one still cannot purchase alcoholic beverages other than beer. Va. Code Ann. § 4-73.2 (Cum. Supp. 1972).

[3] "A surgical operation on the body of a person is a technical battery or trespass, regardless of its result, unless the person or some authorized person consents to it." *Younts* v. *St. Francis Hospital & School of Nursing, Inc.* (1970), 205 Kan. 292, 469 P.2d 330 (Sup. Ct.).

[4] The question of whether consent was "informed" — that is, whether the consenting party actually knew or had been fully apprised of the risks involved in the particular procedure, and understood them, has been discussed elsewhere in this issue. For still further treatment see J. Waltz and F. Inbau, *Medical Jurisprudence* (MacMillan, 1971) at 152; McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment* (1957), 41 Minn. L. Rev. 381; Plante, *An Analysis of Informed Consent* (1968), 36 Fordham L. Rev. 639; Rozovsky, *Consent to Treatment* (1973), 11 Osgoode Hall Law Journal 103. The issue of "informed consent" could be relevant if the minor does not have the actual capacity to understand the explanation. See discussion at text to note 51, *infra*.

active minor can continue to have intercourse without fear of pregnancy, the possible invocation of criminal sanctions for an offense such as contributing to the delinquency of a minor also can be a very real threat.[5]

Two basic situations involving the unemancipated minor and the capacity to consent to medical treatment have long been dealt with in Anglo-American law. The first of these has led to the "emergency" exception, applicable to both adults and minors. When immediate steps are necessary to effect life saving measures or to begin with medication in severe cases and the appropriate person to authorize consent (who might be the injured party) is unavailable or incapable of giving consent, it is generally recognized that the physician can proceed with treatment without fear of liability for battery.[6] Some theorize that the exception is based on an implied consent.[7]

The second case involves the situation in which consent to treatment is arbitrarily withheld by a parent. Such conduct, even though inspired by religious conviction of the parent, can be categorized as "medical neglect" if the courts so wish, and a substitute parent (not infrequently a hospital administrator or public health official) may be appointed guardian for the limited purpose of consenting to medical care. Broad statutory schemes long have invested the courts with considerable latitude in determining the instances in which withholding of consent will be considered "medical neglect".[8] However, courts, until recently, have seemed reluctant to invoke their substitute parental authority except when failure to provide treatment had dire implications such as a threat to the life of the minor involved.[9] This doctrine of judicial abstention seems to be undergoing considerable change; now we find some courts willing to substitute their decisions for those of parents even at times when major surgical procedures are proposed to remedy conditions posing no physical threat to life.[10]

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[5] There also may be more specific prohibitions against such conduct. In New Zealand it is still a criminal offense to sell or otherwise dispose of any contraceptive to one below age 16. *Police Offenses Amendment Act of 1954,* Section 2, in Reprint of New Zealand Statutes, Vol. 12, at 56.

[6] For a general discussion of the emergency doctrine see J. Watlz and F. Inbau, *supra,* note 4 at 169-72. See also Restatement of Torts 2d, § 62; *Wells* v. *McGehee* (1949), 39 So.2d 196 (La. App.).

[7] As one commentator points out, however, it would seem more accurate to say simply that the defendant was privileged. W. Prosser, *Handbook of the Law of Torts* (4th ed. St. Paul: West Pub. Co., 1971 at 103.

[8] See, e.g. *The Child Welfare Act,* R.S.O. 1970, c. 64, s. 20(1)(b)(x).

[9] See, e.g. *In Re Tony Tuttendario* (1912), 21 Pa. Dist. Reps. 561 (court would not override parental refusal to consent to operation to avoid seven year old boy from becoming a cripple); *Matter of Seiferth* (1955), 309 N.Y. 2d 80, 127 N.E.2d 820 (Ct. of App.) (upholding parental refusal to allow operation to correct cleft palate); *In re Hudson* (1942), 13 Wash. 2d 673, 126 P. 2d 765 (Sup. Ct.) (parental refusal to permit amputation of club arm).

[10] The New York Court of Appeals recently affirmed a Family Court order appointing a guardian to consent to a serious (perhaps even life threatening) operation on a fifteen year old boy to partially alleviate a facial deformity which had caused him to remain out of school from age nine. *In re Sampson* (1970), 65 Misc. 2d 658, 317 N.Y.S. 2d 641 (Family Ct.), *aff'd,* 37 App. Div. 2d 668, 323 N.Y.S. 2d 253, *aff'd,* (1972), 328 N.Y.S.2d 686, 29 N.Y.2d 900, 278 N.E.2d 918 (Appeal Ct.). But see, *In re Green* (1972), 292 A.2d 387 (Pa. Sup. Ct.).

In areas outside the emergency sphere and in cases not involving actual witholding of parental consent, many courts and legislatures also have responded to problems created by the parental consent requirement. The pattern of such responses has varied considerably. The present comment will seek to provide a general comparison of them and an evaluation of their principal merits and deficiencies.

The "Mature Minor" Rule: A Creature of Necessity If Not Emergency

Judicial response to the harshness of a requirement of parental consent for all medical care to minors has come largely through development of what is widely labeled the "mature minor" rule. The effect of this rule is to allow a subjective appraisal of at least some cases in which physicians proceed with non-emergency medical care for minors with only the patient's consent. Two recent cases and two older ones provide good illustrations of the circumstances under which judges have been willing to invoke it.

In *Johnston* v. *Wellesley Hospital*,[11] no parental consent had been obtained by a dermatologist for non-emergency treatment of a 20 year old male to remove facial marks caused by acne. The claimant asserted both negligence and invasion of his body without appropriate consent. As to the latter claim, Addy, J., of the Ontario High Court, pointed out that:

> Although the common law imposes very strict limitations on the capacity of persons under 21 years of age to hold, or rather to divest themselves of, property, or to enter into contracts concerning matters other than necessities, it would be ridiculous in this day and age, where the voting age is being reduced generally to 18 years, to state that a person of 20 years of age, who is obviousy intelligent and as fully capable of understanding the possible consequences of a medical or surgical procedure as an adult, would, at law, be incapable of consenting thereto.[12]

In short, the court was willing to look at the capacity of the particular "infant" under the given circumstances, here an elective operation performed on one only months away from majority.

In *Younts* v. *St. Francis Hospital and School of Nursing, Inc.*,[13] the Supreme Court of Kansas was asked to hold that taking a skin graft from the forearm of a 17-year-old girl to repair her injured finger was a battery because the surgeon had not first secured parental consent. The girl's injury had occurred when her hand was caught accidentally in the door of the hospital room in which her mother had been placed following major surgery. The mother, still semi-conscious from a general anaesthetic, was in no condition to consent. The girl's father, from whom the mother was divorced, lived in another city 200 miles away and his address was unknown and not immediately available. The daughter was taken to the hospital's emergency room where a repair operation and skin graft was effected.

Despite what apparently was a successful operation from a medical standpoint, the daughter later sued the hospital alleging that taking a pinch graft from her forearm was tortious because no parental consent had been

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[11] (1970), 17 D.L.R. (3d) 139.

[12] *Id.*, at 144.

[13] *Younts v. St. Francis Hospital & School of Nursing, Inc., Supra,* note 3.

obtained.[14] To some it might seem that the court could have denied recovery under the "emergency" exception. In any event, they elected not to do so, but held that given the particular circumstances this 17 year old "was mature enough to understand the nature and consequences and to knowingly consent to the beneficial surgical procedure made necessary by the accident." The court clearly took into consideration both the non-availability of either parent and the fact that before the skin graft was effected the treating surgeon had discussed the proposed procedure with the girl's regular family physician and had obtained his approval (even though he had no more legal authority to consent for the child than did the surgeon himself).

In dismissing the plaintiff's allegation of battery in the *Younts* case, the Kansas court cited with approval an earlier Ohio decision in which an 18-year-old girl had responded to a telephone directory advertisement which urged readers to reshape their noses through plastic surgery. At an initial interview with an agent of the defendant doctor the plaintiff stated that she had no money, but she was assured that a loan could be obtained for her to finance the cosmetic procedure. A date for the operation then was set and she returned to the doctor's office. The girl's testimony, which made the operation sound somewhat like an encounter with a mad acupuncturist, was met with the doctor's own statement that she had told him that she was 21 years of age and that following the operation she had called at his office on several occasions for follow-up treatment. An intermediate court reversed the judgment of a trial court which had awarded damages for assault and battery. The reversal was upheld on appeal to the Ohio Supreme Court, which affirmed *Per Curiam* but prepared an official syllabus.[15] Two concurring opinions also were written and variously joined in by members of the court, evidencing a split in views on the issue of the age of consent; an opinion joined in by four of the seven members, however, stressed that the trial court had erred "in charging that a minor of 18 could not consent to what the jury from the evidence might have determined was only a *simple operation.*"[16] This view also was translated into the officially prepared syllabus.

A somewhat different problem was presented to the United States Court of Appeals for the District of Columbia in *Bonner* v. *Moran,*[17] the second of our "older" cases. The plaintiff male, at age fifteen, had been hospitalized for some two months and was permanently disfigured through serving as a tissue donor for a severely burned cousin.

The request for the boy's participation as a donor had come from an aunt of both children. At the time of the request, the boy's mother was ill and she was not advised of the proposed medical procedure. After the boy appeared at the hospital for a blood typing procedure he was admitted for the first of a series of operations in which "a tube of flesh was cut and formed

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[14] The daughter also alleged that a nurse employed by the hospital had negligently closed the door on her finger, causing the injury in the first place. This, of course, had nothing to do with the question of consent.

[15] *Lacey* v. *Laird* (1956), 166 Ohio St. 12, 139 N.E.2d 25 (Sup. Ct.). The plaintiff had also alleged malpractice (negligence) but lost on this count in a directed verdict.

[16] (1956), 166 Ohio St. 12 at 26, 139 N.E.2d 25 at 34. [emphasis by the court].

[17] (1941), 126 F. 2d 121 (D.C. Cir.).

from his arm pit to his waist line"[18] and one end of the tube was attached to his cousin. Unfortunately, the procedure turned out to be a failure. The boy brought suit to recover for his disfigurement but the trial court refused to instruct the jury that consent of both the boy and his mother was necessary, instead telling them that "if they believed that [the plaintiff] himself was capable of appreciating and did appreciate the nature and consequences of the operation and actually consented, or by his conduct implicitly consented, their verdict must be for the defendant."[19] The appellate court held this charge to be incorrect and reversed and remanded the case with the opinion that consent of the parent should have been considered necessary. The appeals court specifically noted its concern over the fact that the boy underwent the surgical operation for the benefit of another rather than for his own health needs.[20]

The preceding decisions, along with some half a dozen others,[21] allow us to draw certain inferences about the type of situation in which courts which recognize the "mature minor" rule will be likely to apply it and dispense with the requirement of parental consent. The cases in which the rule has been applied generally have had the following factors in common:

(1) The treatment was undertaken for the benefit of the minor rather than a third party.

(2) The particular minor was near majority (or at least in the range of 15 years of age upward), and was considered to have sufficient mental capacity to understand fully the nature and importance of the medical steps proposed.

(3) The medical procedures could be characterized by the courts as something less than "major" or "serious" in nature.[22]

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[18] *Id.*

[19] *Id.*, at 122.

[20] *Id.*, at 123. Although they acknowledged that the question was not before them, the court pointed out that it was possible that the mother could have ratified the treatment by her conduct after learning of it.

[21] *Gulf & Ship Island R. R.* v. *Sullivan,* (1929), 155 Miss. 1, 119 So. 501 (Sup. C.) (17 year old could consent to smallpox vaccination); *Bishop* v. *Shurly* (1926), 237 Mich. 76, 211 N.W. 75 (Sup. Ct.) (19 year old could modify choice of anaesthetic); *Bakker* v. *Welsh* (1906), 144 Mich. 632, 108 N.W. 94 (Sup. Ct.) (17 year old could consent to surgery under particular circumstances); *Zoski* v. *Gaines* (1935), 271 Mich. 1, 260 N.W. 99 (Sup Ct.) (parental consent necessary for tonsillectomy on 9 year old); *Rishworth* v. *Moss* (1917), 191 S.E. 843 (Tex. Civ. App.) (11 year old needed parental consent for operation to remove adenoids and tonsils). Cf. *Sullivan* v. *Montgomery* (1935), 155 Misc. 448, 279 N.Y.S. 575 (Sup. Ct. N.Y.) (liberal construction of emergency doctrine when patient twenty-one).

[22] This, of course, is a difficult assessment to make, and treatments will vary in potential danger according to the state of medical development. Several early cases involved administration of anaesthetics at a time when the field of anesthesiology was less developed and the possibility of harm was probably substantial. In any event, the fact that the proposed procedure is a form of surgery does not necessarily mean it is "serious" or "major". See e.g., *Lacey* v. *Laird* (1956), 166 Ohio St. 12 at 26, 139 N.E. 2d 25 at 31 (Sup. Ct.) (concurring opinion of Taft, J.).

In a good number of the cases, it also seemed that the situation at least bordered on one in which the emergency doctrine could have been invoked, and it may be of some significance that the allegation of a battery frequently accompanied a specific charge of negligence. As to the latter point, one may question whether suit would have been brought in the first place simply for the "technical" trespass unless a negligence action also were being filed.

A question to which few of the cases address themselves in detail is the amount of damages allowable. In *Lacey* v. *Laird,* however, the court's syllabus stated that the defendant was entitled to an instruction that only nominal damages could be awarded for the "technical" battery.[23] Barring some particularly egregious or wanton conduct which might lead to an award of punitive damages, the monetary exposure for battery rather than negligence may well be small. Nevertheless, just the possibility of a legal action can serve as a serious deterrent against extension of treatment by physicians.[24]

The Work of the Legislatures

To date the legislative approaches aimed toward the problems of consent for medical treatment of unemancipated minors can be placed within one or more distinguishable categories:[25]

(1) Statutes which provide for a hierarchy of persons or agencies from which consent can be obtained in the event of parental absence or unavailability.[26] Included in the order may be adult siblings, grandparents, or persons standing *in loco parentis,* as well as juvenile and family courts. These statutes have the advantage of providing the physician with a "laundry list" which he can safely follow, but usually they have the disadvantage of not allowing him to rely on the assent of a minor who may be as mature and competent as the substitute parents whose consent will be legally effective.

(2) Restatements of the emergency exception with regard to minors.[27]

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[23] *Lacey* v. *Laird* (1956), 166 Ohio St. 12, 139 N.E. 2d 25 at 26 (Sup. Ct.). The Court's syllabus defined "nominal damages" as being "limited to some small or nominal amount in terms of money." Cf. *Natanson* v. *Kline* (1960), 186 Kan. 393, 350 P. 2d 670 (Sup. Ct.) (deals with measure of damages for failure to obtain informed consent), discussed in J. Waltz and F. Inbau, *supra,* note 4 at 168.

[24] Some physicians, for example, have refused to perform vasectomies on consenting adults for fear of later being faced with civil actions by patients who were sterilized effectively.

[25] The categories do not include general provisions lowering the age of majority, or special provisions on emancipation not specifically aimed at the medical consent problem.

[26] See, e.g., Ga. Code Ann., Ch. 88-2904 (1971 Rev.) (Georgia also has a separate provision on venereal disease and a codified emergency expection); Va. Code Ann. § 32-137 (Cum. Supp. 1972).

[27] See, e.g. Mass. Gen. Stat. c. 112, § 12F (Cum. Supp. 1972); Miss. Code Ann. § 7129-83 (1966); N.C. Gen. Stat. §§ 90-21.1 to 90-21.4 (Supp. 1971), discussed in *Note* (1971), 8 Wake Forest L. Rev. 148.

(3) Codification of the judicially developed "mature minor" rule.[28]

(4) Limited emancipation statutes that permit minors to consent to medical care when they have reached a particular age still short of majority, or have married, or have become parents, or have "left home".[29] Reliance on provisions such as the one last enumerated can sometimes be a precarious venture. For example, has a boarding school or college student left home? The effectiveness of such limited emancipation statutes also will vary according to the specific bottom age which is set. In New York's new medical consent statute, for example, the age for medical consent is set at 18 for those who are not either married or parents.[30] England, on the other hand, has set the age of majority at 18, but has provided that minors nevertheless may consent to "surgical, medical or dental treatment" when they have reached only 16 years.[31]

A number of the laws within this category contain fairly broad exculpatory provisions to protect the physician who acts in good faith on the representations of a particular minor that he or she falls within the class of persons eligible to give effective consent.[32]

(5) Provisions for treating or counseling minors for certain specified illnesses, conditions or health purposes. These laws, which usually contain either a very low age for consent or no age floor at all,[33] typically have been extended to include one or more of such matters as venereal disease, drug addiction, or rehabilitation, pregnancy, childbirth, and family planning or birth control.[34] Some also extend to any reportable disease.[35] A question can be raised as to whether treatment for pregnancy or birth control includes the performance of an abortion; some statutes have resolved this by specifically excluding abortion from their purview.[36] However legislation dealing with the

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[28] Miss. Code Ann. § 7129-81 (1966), for example, contains a general listing of who can consent to medical care. Subsection h. includes:

> Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, for himself.

[29] For a general cataloguing of such provisions in the United States as of September 1971, see H. Pilpel, *Minors' Rights to Medical Care* (1972), 36 Albany L. Rev. 462 at 472-87.

[30] N.Y. Public Health Law § 2504 (1) (Cum. Supp. 1972-73).

[31] The Family Law Reform Act 1969 (1969 c. 46), §§ 1, 8.

[32] See, e.g., Ala. Code Ann., Tit. 22, § 104 (21) (2) (Cum. Supp. 1972); N.Y. Public Health Law § 2504 (4) (Cum. Supp. 1972).

[33] The Virginia law, as one illustration, extends to birth control, pregnancy (except abortion), family planning and drug problems. It allows "any minor" to give effective consent within these spheres. Va. Code Ann., Tit. 32, Ch. 8, § 32-137 (Cum. Supp. 1972). The Texas statute dealing with treatment for drug dependency or other drug-related conditions provides that one 13 years or older has the capacity to consent to examination and treatment. Tex. Civ. Stat. § 4447; (Cum. Supp. 1972).

[34] For a list of the various provisions of this type which had been enacted by September 1971, see H. Pilpel, *supra,* note 29. The statutory appendix to that article places particular emphasis on those provisions dealing with pregnancy and birth control.

[35] See, e.g., Ala. Code Ann., Tit. 22, §104 (17) (Cum. Supp. 1972).

[36] See, e.g., Va. Code Ann. §32-137 (6) (Cum. Supp. 1972).

conditions for abortion usually contains specific age limitations and consent requirements.[37]

The statutes in this category clearly indicate a legislative recognition that communications between parent and child, even when there has been no semblance of legal emancipation, often may be strained or nonexistent on some subjects. It is because of the fear that requiring a minor child to go to his parent for consent may frustrate him from seeking medical care related to drug use or early sexual activity that some jurisdictions have dropped all age restrictions in these areas of concern. Some have taken even a further step by forbidding the physician's disclosure to a parent that the consenting minor is receiving treatment unless the minor himself agrees to such disclosure,[38] or at least insulating the physician from any duty to make such a disclosure by giving him discretion in this regard.[39] Another tack is to require disclosure to parents only in cases where their minor child is actually diagnosed as being pregnant or having a venereal disease.[40]

The Alabama statute: One state's comprehensive approach

Among the statutes enacted to deal specifically with medical consent for minors, Chapter 1C of the Alabama Code is probably the most comprehensive in scope. It also ranges across several of the previously enumerated categories. As a general matter, consent to medical treatment can be given by one who is fourteen or older or who "has graduated from high school, or is married, or having been married is divorced, or is pregnant. . . ."[41] Consent can be given for "any legally authorized medical, dental, health or mental health services for himself or herself. . . ."[42] Any minor, with no statutory age floor, can consent to "legally authorized medical, health or mental health services to determine the presence of, or to treat pregnancy, venereal disease, drug dependency, alcohol toxicity or any reportable disease. . . ."[43] The statute grants minor parents authority to consent to health care for their children;[44] it also contains a broad emergency exception permitting treatment of minors of any age without parental consent "when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would

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[37] The Virginia abortion statute provides that if the woman is an infant (below 18 under present law, reduced from 21 when the abortion statute was enacted), permission must be given "by a parent, or if married by her husband, guardian or person standing *in loco parentis* ..." Va. Code Ann. §18.1 - 62.2 (Cum. Supp. 1972).

In New York, a 1972 law sets the age for consent to medical care at 18. The abortion statute sets no minimum age and some hospitals previously had been willing to permit abortions for persons 17 before enactment of the new law. See, H. Pipel, *supra*, note 29 at 469; N.Y. Penal Code § 125.05 (Cum. Supp. 1972).

[38] Conn. Gen. Stat. Ann. § 19-496c (Cum. Supp. 1972).

[39] See, e.g., Cal. Civil Code § 34.6 (Cum. Supp. 1972).

[40] Hawaii Rev. Stat., Tit. 31, § 577A-3 (Cum. Supp. 1972). This applies to minors below age eighteen. The information must be conveyed to the "spouse, parent, custodian or guardian ... even over the express refusal of the minor patient."

[41] Ala. Code Ann., Tit. 22, § 104 (15) (Cum. Supp. 1972).

[42] *Id.*

[43] *Id.*, at § 104 (17) (Cum. Supp. 1972).

[44] *Id.*, at § 104 (16) (Cum. Supp. 1972).

increase the risk to the minor's life, health or mental health";[45] and furthermore exempts a physician from liability based on trespass if he has in good faith acted on consent obtained by a minor who professed to be capable of effectively assenting under the statute.[46] It contains a legal safeguard for the minor who might have a negligence action by stating that if he is not authorized to enter into binding contracts otherwise than by the medical consent chapter he does not by its terms become legally entitled to waive any right or cause of action by virtue of the treatment he has received.[47]

Other illustrations of the new style of comprehensive medical consent statutes are found in provisions recently incorporated in the state codes of Illinois and Maryland.[48]

Legislative and Judicial Approaches: A Brief Appraisal

The approach of the courts thus far has served the fairly narrow purpose of providing an avenue for escape from the harsh results which can flow from any absolute requirement of consent. Much of this judicial action took place before the current round of legislation lowering the age for adulthood generally. To the extent that the mature minor rule might allow a physician to subjectivise broadly about the maturity and capability of minors, there might be potential for further expansion of the doctrine by the courts. Such a possibility seems quite unlikely in practice, however. We cannot overlook the fact that often the circumstances surrounding the medical treatment in past cases where the mature minor rule was invoked did clearly involve extenuating circumstances. In any event, a requirement of subjective appraisal of the capacity of each minor does not make for the degree of legal certainty which physicians desire in order to protect themselves from the possibility of suit for battery. At most, the present judicial approach thus seems likely to continue as an "escape hatch" for the hard case.

The legislative approach has the advantage of allowing for considerable flexibility in dealing with the multiple problems related to minors and medical care. As pointed out in the outline of the various statutory approaches to date, different consent ages can be applied to different treatments. Such distinctions can be based either on the seriousness of the treatment or on the concern for the social and medical problems associated with lack of treatment. A carefully framed statute also can provide greater certainty for the physician as to when he must obtain consent from someone other than the patient. Special provisions excusing him for mistake caused by good faith reliance on the patient's age representations can add a further margin of safety.

Ceding that the legislative approach permits greater flexibility, which seems to be of more concern today than providing a means for resolving the occasional close case, the question becomes one of determining just what makes a fair and effective statute. Perhaps the most important policy interest

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[45] *Id.*, at § 104 (18) (Cum. Supp. 1972).

[46] *Id.*, at § 104 (21) (Cum. Supp. 1972).

[47] *Id.*, at § 104 (22) (Cum. Supp. 1972).

[48] Ill. Rev. Stat. (Smith-Hurd), c. 91, §§ 18, 1-7 (Cum. Supp. 1972); Md. Code Ann. §§ 135, 135 A (Cum. Supp. 1972).

which must be balanced against the goal of assuring timely and effective extension of medical care to minors is the impact which shifting the discretionary power from parent to child (and sometimes very young child) may have on the family unit as a functioning entity. States which have opted for low or no age floors in specific areas such as sex and drug problems must be considered to have decided that in a substantial number of cases the traditional decision making process of the family unit had broken down or was somehow ineffective. Variations in the extent to which such statutes provide for a parental "right to know" may be considered as some measure of the degree of reliance on the family as a resource in dealing with such problems once initial medical help has been obtained.

Some Remaining Problems

Even the most comprehensive of the medical consent statutes enacted to date leave some legal problems unconsidered or unresolved.

Few of the new statutes address themselves in any detail to the respective financial liabilities of parent and minor child. In instances in which the state or some special program will pay, such uncertainty is not a problem.[49] But this is by no means universally the case. Some statutes have made it clear that a minor may not disaffirm contracts for medical care to which he can consent under the statute.[50] However the parent's stated duty to provide necessary care for his minor children usually has not been modified. Under these circumstances, who will pay for medical procedures which are questionably either within the category of necessaries, or of purely cosmetic, elective surgery (eg. a mammoplasty for a sixteen year old girl who wants larger breasts)?

Seemingly the minor can be bound if he had authority to consent, but what about the liability of the non-consenting parent; is it or should it be joint, several, primary or secondary?

If a minor has the power to consent, then must his consent be obtained as well as that of a parent? This is another area where the statutes are all too frequently silent, and where the establishment of a very low age for consent can introduce a new element of uncertainty for the physician.

An even more serious problem is the extent to which the statutes have failed to deal with the requirement of an "informed" consent. Although a detailed discussion of this concept and questions such as whether failure to adequately inform a patient of risks attendant to a particular treatment or operation should be deemed a battery or negligence is beyond the scope of this comment,[51] we must not overlook the serious ramifications which the informed consent requirement can have when the patient is a minor. Let us assume that a legislature has lowered the age of consent for medical treatment to 12. Are we certain that even the majority of 12-year-olds can comprehend

[49] Even in the absence of any form of national health system, this might be the case when venereal disease or family planning is involved.

[50] See Calif. Civ. Code §34.6 (Cum. Supp. 1972); Colo. Rev. Stat. §41-2-13 (Cum. Supp. 1971).

[51] See *supra*, note 4, for a list of authorities dealing with these problems.

and assess the risks involved in most medical treatment? Must there be a special child's version of the explanation of proposed medical procedures and their potential meaning for the patient? Although some consent statutes contain no age floor, surely there must be some level at which the physician should be placed in the position of questioning individual patient competence to consent because of youth. In short, even under the broader of today's statutes some subjective evaluation by the physician probably will be necessary, and some judicial interpretation may be required of statutes in which this was not anticipated. The question ultimately becomes one of how much discretion we wish to posit in the medical profession, and not just with the minor patient. This raises the concern of possible physician overreaching in the extension of unnecessary or undesirable medical services to minors. At the moment this does not seem to be considered a threat, and the principal emphasis is on enabling minors to get to physicians who will be able to treat them without fear of civil liability except in instances of negligence.