Michigan Journal of Gender & Law

Volume 7 | Issue 1

2000

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I would like to express my deep gratitude to the following people who reviewed this article: Janet Kreps, Esq., Professor Angela Holder, Jamie Ann Sabino, Esq., and Professor Walter Wadlington. The article benefited from their collective wisdom and constructive suggestions; I, of course, remain responsible for any errors. The research for this paper was in part funded by grants from the Robert Sterling Clark Foundation and the Lucille and David Packard Foundation. Their support is gratefully acknowledged.

INTRODUCTION

In 1973, the Supreme Court, in the landmark case of *Roe v. Wade*, held that until viability decisional authority regarding the outcome of a pregnancy must vest in the pregnant woman.[1] Relying on a long line of cases recognizing that "zones of privacy ... exist under the Constitution," the Court characterized the abortion decision as one which is private in nature, and located the right to terminate a pregnancy in the "Fourteenth Amendment's concept of personal liberty."[2]

The Court made clear that although fundamental, the right to terminate a pregnancy is not absolute and that states have a compelling interest in protecting the health of the pregnant woman and the potentiality of life. Recognizing that pregnancy is a dynamic process, the Court held that these interests are not compelling from the outset of a pregnancy, but rather increase in substantiality as a pregnancy progresses.[3] Constructing a trimester framework, the Court determined that the state's interest in protecting health does not become compelling until the second trimester, when the abortion procedure becomes potentially more complex, and that its interest in protecting potential life does not become compelling until the third trimester, when, according to the Court, the fetus is capable of life outside of the womb.[4]

In securing this right of choice, the *Roe* Court spoke about all women—it drew no distinctions based on age or capacity. However, shortly after the decision, a number of states, seeking to deny young women *Roe*'s promise of reproductive autonomy, enacted laws requiring minors to either obtain the consent of or give notice to their parents before having an abortion.[5]

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1. Roe v. Wade, 410 U.S. 113, 163 (1973).
2. *Roe*, 410 U.S. at 153.
3. *See Roe*, 410 U.S. at 162.
4. *See Roe*, 410 U.S. at 162–64. This trimester formulation was subsequently scuttled by the Court in Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 872–73 (1992) in favor of a more restrictive "undue burden" standard. Under this standard, a state may regulate abortion from the time of conception forward in order to promote its interest in the potentiality of life, so long as the regulation does not impose an "undue burden" on the abortion right. *Casey*, 505 U.S. at 876–77. For a fuller discussion of *Casey*, see *infra* notes 66, 135–143 and accompanying text; *see also* Janet Benshoof, *The Pennsylvania Abortion Case*, 9 TOURO L. REV. 217 (1993).
5. These states included: Idaho, Illinois, Ohio, Massachusetts, Missouri, Utah, Nevada, and South Carolina. *See* IDAHO CODE 18-609 (1973); ILL. COMP. STAT. Ch. 38 ¶¶ 81-54.4, 81-64.4 (1986); OHIO REV. CODE ANN. § 2919.12.1(B)(1)–(3) (Anderson 1999); MASS. GEN. LAWS ch. 112 § 12P (1990); MO. REV. STAT. 188.028 (Supp. 1982); UTAH CODE ANN. 76-7-304 (1974); NEV. REV. STAT. 442.250

The conflict over mandatory parental involvement has been one of the most contentious issues in the struggle for reproductive rights. Embodying a view of teenage incapacity and dependence, these laws assume that young women will not exercise the right of choice wisely—that they cannot be trusted to decide for themselves that they are not yet ready for the challenges of motherhood.

Soon faced with challenges to these laws,[6] the Supreme Court, in considering the rights of young women, sought to reconcile an historically rooted vision of minors as dependent persons in need of protection with a more contemporary understanding of minors as autonomous individuals with adult-like claims to constitutional recognition.[7] Building upon these twin themes of dependence and autonomy, the Court both recognized and limited the reproductive rights of young women. On the one hand, the Court indicated that like adult women, minors have a constitutionally secured right of choice.[8] On the other hand,

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(1973); S.C. CODE ANN. § 44-41-30 (1973). When originally enacted, the Massachusetts parental consent provision was designated § 12P. In 1977, it was redesignated § 12S, although no substantive changes were made. For the sake of clarity, this article will use the § 12S designation.

In theory, a notice requirement is arguably less intrusive than a consent requirement, as it imposes an informational rather than an authorization qualification on the abortion right. However, from the perspective of a minor whose parents are opposed to abortion, this distinction is meaningless, as once they know about her plan to terminate her pregnancy, they can prevent her from having an abortion, thus making notice the functional equivalent of a denial of consent.

6. The first challenges were to laws from Missouri and Massachusetts. The Court considered the Missouri law in Planned Parenthood of Cent. Missouri v. Danforth, 428 U.S. 52 (1976), discussed *infra* at notes 63–77 and accompanying text. The Massachusetts law was considered by the Court in two stages; initially, the Court remanded the case, so the statute could be construed by the state's highest court. Respectively, these decisions are Bellotti v. Baird, 428 U.S. 132 (1976) (*Bellotti I*), discussed *infra* at notes 78–93 and accompanying text, and Bellotti v. Baird, 443 U.S. 622 (1979) (*Bellotti II*), discussed *infra* at notes 95–120 and accompanying text.

Since these early decisions, the Court has considered the validity of parental involvement laws on many other occasions. *See* Lambert v. Wicklund, 520 U.S. 292 (1997); Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833 (1992); Ohio v. Akron Ctr. for Reproductive Health, 497 U.S. 502 (1990); Hodgson v. Minnesota, 497 U.S. 417 (1990); Planned Parenthood Ass'n of Kan. City, Mo., v. Ashcroft, 462 U.S. 476 (1983); Akron v. Akron Ctr. for Reproductive Health, 462 U.S. 416 (1983); H.L. v. Matheson, 450 U.S. 398 (1981); Zbaraz v. Hartigan, 763 F.2d 1532 (7th Cir. 1985) *aff'd sub nom.* Hartigan v. Zbaraz, 484 U.S. 171 (1987).

7. For a particularly thoughtful article about how this conflicting vision is reflected in Supreme Court decisions concerning the rights of minors, *see* Janet L. Dolgin, *The Fate of Childhood: Legal Models of Children and the Parent-Child Relationship*, 61 ALB. L. REV. 345 (1997).

8. *See Bellotti II*, 443 U.S. at 633. *Danforth* 428 U.S. at 74.

based on concerns about "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing"[9] the Court held that unlike adult women, the decisional autonomy of minors could be limited in favor of third parties.[10]

Both reflecting and accommodating this tension, the Court in its 1979 *Bellotti v. Baird* (*Bellotti II*) decision constructed what, at first glance, might appear to be a reasonable compromise—one that both honors the reproductive autonomy of teens while purportedly protecting them from the consequences of their immaturity.[11] In deference to historic constraints upon the free agency of minors, the Court concluded that states may impose parental involvement requirements on the abortion decision of teens. However, recognizing that for some teens, mandated parental involvement would result in a loss of the right to terminate a pregnancy, the Court held if a state wished to impose a consent requirement, it had to provide minors with an alternative procedure that would allow them to bypass their parents and secure third party permission for an abortion.[12]

However, beneath the surface of what might appear to be a balanced compromise between the recognition of rights and the perceived need for protection lies a legal reality that destabilizes the Court's reasoning and calls into question the integrity of its parental bypass compromise. Myopically focused on constitutional jurisprudence to support its vision of minors as too immature and too subordinate to parental authority to make their own reproductive decisions, the Court

9. *Bellotti II*, 443 U.S. at 634.

10. *See Bellotti II*, 443 U.S. at 633–38. In *Danforth*, the Court, striking down Missouri's spousal consent requirement, unequivocally rejected the imposition of spousal limits on an adult woman's decisional autonomy. 428 U.S. at 70–71. Subsequently in *Casey*, the Court struck down Pennsylvania's spousal notification rule. 505 U.S. at 895. For a brief discussion about the Court's treatment of spousal involvement requirements, see *infra* note 66 and accompanying text.

11. *Bellotti II*, 443 U.S. at 643–44.

12. *See Bellotti II*, 443 U.S. at 643–48. The Court has since held that a state must provide a bypass procedure if it enacts a law requiring that both parents receive notice of their daughter's intent to terminate a pregnancy. Hodgson v. Minnesota, 497 U.S. 415, 427, 450–55 (1990). *But see* Planned Parenthood v. Camblos, 155 F.3d 352, 365–66 (4th Cir. 1998), *cert. denied* 525 U.S. 1140 (1999) in which the court provides a novel re-interpretation of *Hodgson*, claiming that the Court did not strike down the Minnesota notification law because it lacked a bypass provision, but because the notice requirement did not exempt abusive or absent parents, and was thus overly broad. *Camblos*, 525 U.S. 1140 at 365–66. The Court has not directly ruled on the question of whether a bypass is required in the case of a one parent notification law.

ignored the fact that in the area of medical decision-making, particularly with regards to pregnancy and other sensitive issues, minors possess significant self-consent rights. While puzzling in its own right, this omission is particularly baffling in light of the *Roe* Court's characterization of abortion as a medical decision.[13]

By examining the Court's failure to consider the allocation of authority between parents and children in the critical realm of medical decision making, this article exposes the irrationality of the Court's acceptance of limitations on the abortion rights of minors and reveals the pronatalist thrust of the parental involvement decisions.[14] The article begins by looking at how the *Roe* Court characterized abortion as a medical decision, followed by a discussion about the medical decision-making rights of minors. Rooted in this medical paradigm, the article then turns to the parental involvement cases to examine the Court's failure to consider the medical decision-making of minors when evaluating the constitutionality of parental involvement laws as well as its emerging concern for the rights of the unborn.

I. *ROE* AND THE "REASONABLE" PHYSICIAN

Emphasizing the physical and psychological detriments of forcing a woman to carry to term, the *Roe* Court characterized abortion as "inherently, and primarily, a medical decision. . . ."[15] The Court, although locating ultimate decisional authority in the pregnant woman, assumed that a woman's physician would play a central role in the decision-making process.[16]

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13. *Roe*, 410 U.S. at 163. See *infra* notes 15–16, 18, 21 and accompanying text.
14. In particular, in addition to *Danforth* and *Bellotti I* and *II*, this article will focus on *Casey*, 505 U.S. 833 (1992); *Akron* 497 U.S. 502 (1990); and *Matheson*, 450 U.S. 398 (1981). When read as a whole, these decisions reveal the Court's growing acceptance of the anti-abortion thrust of parental involvement laws.
15. *Roe*, 410 U.S. at 166. This article does not endorse the *Roe* Court's medicalized approach to abortion. Rightfully so, *Roe*'s characterization of abortion has been subject to criticism on many grounds, including that it overemphasizes the role of the physician and ignores the dynamic relationship between reproductive control and gender equity. *See, e.g.*, Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261 (1992). However, an understanding of *Roe*'s characterization of abortion as a medical procedure is essential to the central premise of this article—that minor abortion rights cases reflect an anti-abortion animus rather than a concern for the well-being of young women.
16. Some commentators have suggested that the opinion's emphasis on the role of the doctor may reflect the fact that its author, Justice Harry Blackmun, had served as

Both strands of the Court's medicalized thinking are evident in the following central passage, which explains why the Court believes abortion is deserving of constitutional protection:

> The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm *medically diagnosable* even in early pregnancy may be involved. Maternity, or additional offspring may force upon the woman a distressful life and future. *Psychological harm* may be imminent. *Physical and mental health* may be taxed by child care. There is also the distress . . . associated with the unwanted child, and there is the problem of bringing a child into a family already unable, *psychologically* and otherwise to care for it. In other cases, the additional difficulties and continuing stigma of unwanted motherhood may be involved. All these are factors the woman and her *responsible physician* necessarily will consider in consultation.[17]

Focused on the medical attributes of abortion, the Court, at moments, appeared to be more concerned with the rights of physicians to practice medicine free from undue state interference than it was with the rights of women to avoid unwanted maternity. For instance, in its summary, the Court praised the fact that the decision ". . . vindicates the right of the physician to administer medical treatment according to his professional judgment . . ."[18] while neglecting to mention that most critically it vindicates the rights of women to make self-defining decisions about the meaning and place of motherhood in their lives.

Roe's emphasis on the role and rights of physicians is profoundly unsettling as it both diminishes the agency of women and the significance of the non-medical aspects of the abortion decision.[19] There is, however, a positive aspect to this medical paradigm. Given that abortions are routinely performed in medical settings, the Court clearly

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general counsel to the Mayo Clinic prior to his appointment to the Supreme Court. *See* LAURENCE H. TRIBE, ABORTION: THE CLASH OF ABSOLUTES (1990).

17. *Roe*, 410 U.S. at 153 (emphasis added).

18. *Roe*, 410 U.S. 165. There is a large measure of historic irony in the Court's celebration of the rights of physicians in light of the fact that restrictive abortion laws, such as the one invalidated in *Roe*, resulted, in large measure, from a vigorous campaign by nineteenth century physicians to outlaw abortion. For a discussion of this campaign, *see* KRISTEN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 14–39 (1984); JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800–1900, 147–170 (1978).

19. See Siegel, *supra* note 15, for a critical assessment of *Roe*'s medicalization of abortion.

demonstrated its trust in practitioners to perform abortions as they would any other medical procedure. Stating that abuses of discretion should be subject to the "usual remedies"[20] for physician malfeasance, rather than the historical criminal sanctions, the Court implicitly "normalized" the performance of abortions, making them simply one aspect of what a physician might be asked to do in the ordinary course of caring for her patients.[21]

Had the Court, when considering the rights of teens in subsequent abortion cases, continued to characterize abortion as a medical decision, it might have been forced to engage in a very different analysis than it did in light of the considerable medical self-consent rights of teens, particularly regarding sexual matters. As we shall see, however, the Court moved away from this medical paradigm when considering the rights of minors. To understand the significance of this shift, we first consider the medical decision-making rights of teenagers.

II. Teens and the Making of Medical Decisions

Grounded in the common law right of bodily integrity, a physician, other than in an emergency, is required to obtain the consent of his or her patient before providing medical treatment. To be effective, this consent must be informed. Put simply, this means the doctor must provide the patient with sufficient information about risks and alternatives so that he or she can make a meaningful decision about how to proceed.[22]

When the patient is a minor, the long-standing rule is that consent must be provided by a parent.[23] This rule is predicated on a set of mutually reinforcing presumptions about the decisional incapacity of young people and the integrity of the autonomous family. Minors, regardless

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20. *See* Siegel, *supra* note 15 at 166.

21. Tragically, the recent spate of violence against abortion providers may make it increasingly difficult for doctors who perform abortions to consider this service a "routine" aspect of their practice. *See* Deborah A. Ellis & Yolanda S. Wu, *Of Buffer Zones and Broken Bones: Balancing Access to Abortion and Anti-Abortion Protesters' First Amendment Rights in* Schenck v. Pro-Choice Network, 62 Brook. L. Rev. 547, 548 n.4 (1996); Jack Hitt, *Who Will Do Abortions Here?* N.Y. Times, January 18, 1998, (Magazine), at 20.

22. *See* Walter Wadlington, *Medical Decision Making for and by Children: Tensions Between Parent, State, and Child,* 1994 U. Ill. L. Rev. 311, 312 (1994) (hereinafter Wadlington, *Medical Decision Making*).

23. *See* Angela R. Holder, *Disclosure and Consent Problems in Pediatrics,* 16 Law Med. & Health Care 219, 219 (1988) [hereinafter Holder, *Disclosure and Consent*].

of age or maturity, are presumed to lack the capacity to make informed decisions about their own lives.[24] Counterbalancing this "incapacity," parents are presumed to possess the wisdom and maturity their children lack, and significantly, are presumed to ". . . have an identity of interest with their minor children . . ." such that they will be guided by their children's best interest when exercising their decisional authority.[25] Rooted in the prevailing vision of the family as an integrated and harmonious whole, this consent rule assumes that children do not exist apart from their parents.[26]

These interlocking presumptions are, however, challenged by multiple exceptions to the basic rule of parental consent which, when examined in their totality, seriously undercut the rule's primacy. As developed below, in some contexts, the authority of parents is limited without a corresponding increase in the decisional authority of minors; in others, decisional rights are transferred from parents to their children. When examined as a whole, these exceptions clearly unsettle the dominant vision of parents as hegemonic decision makers for their children.

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24. This presumption has been challenged by a growing body of research suggesting that teens, particularly those ages 14 and up, are able to make mature and informed decisions. *See, e.g.*, Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 LAW & HUM. BEHAV. 129 (1992); Catherine C. Lewis, *Minors' Competence to Consent to Abortion*, 42 AM. PSYCHOL. 84 (1987); David G. Sherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 LAW & HUM. BEHAV. 431 (1991); Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1587 (1982). However, other researchers assert that the studies showing that minors are similar to adults in their decision-making abilities have focused too narrowly on cognitive abilities and have ignored the psychosocial factors that may impinge on decisional ability. *See, e.g.*, Elizabeth S. Scott, *Judgment and Reasoning in Adolescent Decision-making* 37 VILLA. L. REV. 1607 (1992); Laurence Steinberg & Elizabeth Cauffman, *Maturity of Judgment in Adolescence: Psychosocial Factors in Adolescent Decision Making* 20 LAW & HUM. BEHAV. 249 (1996).

25. JOSEPHINE GITTLER ET AL., ADOLESCENT HEALTH CARE DECISION MAKING: THE LAW AND PUBLIC POLICY 2, The Carnegie Council On Adolescent Development (Working Paper June, 1990).

26. For an excellent analysis of how this vision is both reinforced and challenged by Supreme Court jurisprudence on the rights of minors, *see generally* Dolgin, *supra* note 7.

A. Exceptions that Limit Parental Decision-Making Authority Without Shifting Decisional Authority to Minors

In this section, the article considers two situations in which parental decisional authority is limited in favor of third parties—the provision of emergency care and cases of medical neglect. Although neither situation involves a shift of authority to minors, they are nonetheless worth considering as they challenge the notion that parents have unbounded authority over the medical care of their children.

1. Medical Emergencies

It is a well-established practice that a physician may treat a minor without parental consent in the case of a medical emergency,[27] and most states now have statutes that specifically authorize such care.[28] Although sometimes explained by reference to the doctrine of implied consent,[29] which assumes that under the circumstances a parent would consent if contacted, the essential policy rationale behind this rule is that doctors must be permitted to provide necessary medical care without fear of liability.[30]

Although clearly not giving teens independent decisional authority,[31] this rule is not without significance in consideration of the status of teens as medical decision makers. First, by privileging the health needs of minors over the decision-making authority of parents, the rule implicitly recognizes that parental authority is not absolute, and

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27. JAMES M. MORRISSEY ET AL., CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS: A LEGAL GUIDE, 50–54 (1986). Most of these statutes define "emergency" in relatively broad terms to include not only life-threatening conditions, but also ". . . those situations where a delay in treatment would increase the risk to the patient's health, or treatment is necessary to alleviate physical pain or discomfort." MORRISSEY ET AL., *supra*, at 53.
28. *See* MORRISSEY ET AL., *supra* note 27, at 50–51.
29. *See* MORRISSEY ET AL., *supra* note 27, at 50–51; Walter Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOODE HALL L.J. 115, 116 (1973) [hereinafter Wadlington, *Minors and Health Care*].
30. *See* MORRISSEY ET AL., *supra* note 27, at 53; 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, 19 (1996).
31. It is, however, possible that the minor could provide the necessary consent based upon his or her status as a mature or emancipated minor. *See* MORRISSEY ET AL., *supra* note 27, at 55. These concepts will be discussed below in the section on status-based consent rights.

that it must yield to other more immediate interests. Second, by its very presence, this exception quietly recognizes that children exist as separate beings in the world, and that parents may not always be present to either prevent injury or tend to urgent needs. Without implying neglect, it embodies an awareness that in the ordinary course of life, parents and children are not inextricably bound together.

2. Medical Neglect

More directly limiting their authority, parents may be deprived of control over their children's medical treatment in situations of medical neglect. Here, a parent who is otherwise providing suitable care for a child is considered not to be providing appropriate medical care, most frequently by refusing to consent to care deemed necessary by the child's physician. This parental inaction may be rooted in religious beliefs, and may include the use of spiritual healing.[32]

Historically, courts were likely to intervene only if the parents' refusal to consent to medical care posed a direct threat to the life of the child.[33] At least in part due to the expansion of child protection reporting laws and the broadening of actionable harms, however, the standard is now somewhat more relaxed.[34] In deciding if intervention is warranted, courts generally balance a number of competing considerations, such as the risk of harm to the child if treatment is withheld; the benefits of treatment; the certainty of results; the express wishes of the child; the religious beliefs of the parent; rights of parental privacy; and the best interests of the child.[35] If a finding of medical neglect is made, the court usually appoints a guardian to act as a substitute decision maker with respect to the treatment in question, without otherwise limiting the rights of the parents.[36]

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32. *See generally* Wadlington, *supra* note 22, at 314–23. Intervention in cases of medical neglect is most commonly premised on a child protection statute. Most statutes now specifically include medical neglect as a category of parental harm that will support intervention into the family. Where it is not specifically included, the statutory definition of neglect is generally broad enough that it can be construed to include the failure to provide medical care. *See* Gittler, *supra* note 25, at 4.

33. *See* Wadlington, *supra* note 22, at 314–23.

34. *See* Wadlington, *supra* note 22, at 314–323 and 331.

35. *See* Wadlington, *supra* note 22, at 331–34; for a discussion of how these factors may be differentially weighted according to the circumstances, *see* Lisa Ann Hawkins, *Living-Will Statutes: A Minor Oversight*, 78 VA. L. REV. 1581, 1605–06 (1992).

36. It is possible that the failure to provide medical care, could, as in other abuse and neglect situations, result in the loss of all parental rights.

As in cases of medical emergencies, this limitation on the consent rights of parents does not shift decisional authority to minors nor does it challenge the presumption about the decisional incapacity of teens. However, by recognizing the possibility of parental neglect, it directly challenges the presumption that parents always make good decisions that promote the well-being of their children. By capturing the very real possibility of divergent interests, and allowing for parental displacement, this exception forces us to recognize that not all families function as integrated and harmonious units in which the basic needs of children are met by their parents.[37]

B. Exceptions That Simultaneously Limit Parental Decision-Making Authority and Shift Decisional Authority to Minors

As developed in the above section, in cases of a medical emergency or medical neglect, the decisional authority of parents is limited in favor of either the physician or the state. The decision is not, however being made by the minor—authority is still located in a third party. In this section, the article examines rules that limit the authority of parents in favor of vesting minors with decisional control over aspects of their own medical care. First the article explores consent rules that recognize the decisional ability of minors based upon their status; the article then explores treatment-based consent rules.

1. Status-Based Consent Rights

a. The Emancipated Minor

A teen who is legally emancipated can consent to his or her own medical care.[38] Under the common law of emancipation, a minor who is "not living at home and is self supporting, is responsible for himself economically and otherwise, and whose parents (voluntarily or

37. Of course, the possibility of intervention also creates the risk of unnecessary intrusion into families based upon arbitrary definitions of good parenting. This tension has been addressed in numerous articles, and is beyond the scope of our discussion. *See, e.g.*, Douglas J. Besharov, *"Doing Something" About Child Abuse: The Need to Narrow the Grounds for State Intervention*, 8 HARV. J.L. & PUB. POL'Y. 539 (1985).

38. GITTLER, ET AL., *supra* note 5, at 5.

involuntarily) have surrendered their parental duties and rights,"[39] may be adjudicated an emancipated minor. This determination extinguishes the reciprocal rights and responsibilities of the parent-child relationship, and vests the child with adult-like rights, including the right to consent to medical treatment.[40] Common law emancipation may also be situationally determined. Minors who are married or in the armed forces are generally considered emancipated without proof of actual independence based on the incompatibility of their life circumstances with parental control.[41]

Developed primarily as a vehicle by which parents could relinquish control over their child,[42] the common law of emancipation, although clearly recognizing that minors may be fully independent of their parents, was not motivated by a vision of minors as persons with claims to self-determination. A number of states have enacted emancipation statutes to respond to the need for a more teen-centered concept of emancipation, and to bring coherence to the common law approach.[43]

Some of these statutes are general and others are limited in their scope. Under a general emancipation statute, a minor petitions the court "to be relieved of the disabilities of minority."[44] In deciding whether to grant the petition, most states consider the "best interest" of the minor, often in combination with other factors such as whether he or she is capable of conducting his or her own affairs[45] and/or is living

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39. ANGELA RODDEY HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 128 (2nd ed. 1985) [hereinafter HOLDER, LEGAL ISSUES]. The author provides an interesting discussion about minors who meet some but not all of the prongs of this definition. HOLDER, LEGAL ISSUES at 129.

40. Depending on the circumstances, a minor may be deemed to be only partially emancipated, and may therefore not be able to assert all of the rights associated with complete emancipation. Regarding the difference between complete and partial emancipation, see Sanford N. Katz et al., *Emancipating Our Children—Coming of Legal Age in America*, 7 FAM.L.Q. 211, 215–19 (1973) [hereinafter Katz, *Emancipating our Children*]. This article also provides a comprehensive analysis of the law of emancipation.

41. *See* Katz, *Emancipating our Children*, *supra* note 40, at 217.

42. *See* Katz, *Emancipating our Children*, *supra* note 40; *see also* H. Jeffrey Gottesfeld, Comment, *The Uncertain Status of the Emancipated Minor: Why We Need a Uniform Statutory Emancipation of Minors Act (USEMA)*, 15 U.S.F. L. REV. 473, 476 (1981).

43. *See* MORRISSEY ET AL., *supra* note 27, at 33; Wadlington, *supra* note 22, at 323; Gottesfeld, *supra* note 42, at 477–79 (which also discusses the "first generation" of emancipation statutes, which, according to the author, were enacted primarily to reconcile the age of emancipation with the legal age of marriage).

44. Katz, *supra* note 40, at 232.

45. *Id.* at 236.

separate and apart from his or her parents.[46] If the petition is granted the minor is afforded the rights and responsibilities of adulthood, including the right of medical self-consent.[47]

In contrast, a limited emancipation statute grants an identified class of minors relief from specific categorical limitations associated with minority without the necessity of a court proceeding. Utilizing this approach, most states have enacted what are commonly referred to as "medical emancipation" laws which give certain categories of minors medical self-consent rights; for instance, most states allow a minor who is married or in the armed forces to consent to his or her own medical care. Minor parents are also considered emancipated in most states and are able to consent to their own as well as to their children's health care.[48] Many states also allow all minors above a certain age to consent to their own care.[49]

The law of emancipation recognizes that minors may be sufficiently independent of their parents, based either on age or on the objective conditions of their lives, to warrant a transfer of decision-making authority.[50] Here, the presumed identity of interests between parent and child disappears; it is no longer assumed that parental decision-making will promote the best interests of the minor. Correspondingly, although doctrinally grounded in notions of independence, rather than competence,[51] emancipation, by freeing minors from the usual age-based constraints, honors the ability of minors to make appropriate life choices. By shifting decisional authority from parents to teens, the law of emancipation directly challenges the

46. *See* Gottesfeld, *supra* note 42, at 487–88.

47. However, some statutes give the court the authority to attach conditions to the grant of emancipation, resulting in partial rather than complete emancipation. *See* Katz, *supra* note 40, at 237.

48. *See* Holder, *Disclosure and Consent*, *supra* note 23, at 220. Consent rules, however, may be different for unmarried fathers. *See* MORRISSEY ET AL., *supra* note 27, at 42–43. Even if a state does not have a statute that expressly gives minor parents the right to consent to the medical treatment of their children, they would have this authority by virtue of their status as parents. *See* MORRISSEY ET AL., *supra* note 27, at 41.

49. *See* Holder, *supra* note 39, at 128. As with most efforts at categorization, the lines between approaches often blur, and it should be noted that age-based consent laws are sometimes characterized as mature minor rather than limited emancipation statutes. This is more likely to be the case if the statute also refers to the capacity of the minor.

50. Of course, it is important to recognize that independence may be a response to parental neglect rather than a self-determined life course. *See* Carol Sanger & Eleanor Willemsen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. MICH. J.L. REFORM 239 (1992).

51. *See* Rosato, *supra* note 30, at 28.

assumptions that parents are always the preferred decision makers and that minors are incapable of meaningful self-definition.

b. The Mature Minor Rule

The mature minor rule is the other important status-based exception to the parental consent requirement. Developed mainly through judicial decisions, this doctrine allows minors who are mature enough to understand the risks and benefits of proposed medical treatment to give consent.[52] Unlike the law of emancipation which is premised on objective manifestations of independence, the mature minor rule directly recognizes that teens may have the cognitive maturity to make informed decisions about their own medical care.

> [T]he legal principle now applied is that if a young person (aged 14 or 15 years or older) understands the nature of proposed treatment and its risks, if the physician believes that the patient can give the same degree of informed consent as an adult patient, and if the treatment does not involve very serious risks, the young person may validly consent to receiving it.[53]

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52. *See* Holder, *Disclosure and Consent*, *supra* note 23, at 221. Developed in the early part of this century, the mature minor rule pre-dates the development of an extensive body of literature on the decision-making capacity of teens. Emerging over the last thirty or so years, this literature supports the idea that teens possess the requisite maturity to make important life decisions. *See supra*, note 24.

53. Angela R. Holder, *Minors' Rights to Consent to Medical Care*, 257 JAMA 3400 (1987) [hereinafter Holder, *Minors' Rights*]. In general, the doctrine is less likely to be utilized if the treatment is highly risky, the underlying condition is very serious, or if the treatment is undertaken for the benefit of a third party rather than the minor, such as in the case of organ donation. *See* Holder, *Minors' Rights*, at 3401; *see also* Wadlington, *Minors and Health Care*, *supra* note 29, at 119.

An important question that may arise is whether a doctor who treats a minor based on his or her consent may disclose information about the treatment to the minor's parents. According to health law expert Angela Holder, the doctor is bound by the usual rules of confidentiality. As she explains:

> [I]t would seem that if the physician does not feel the need to obtain consent of the parents to treat the child, he is by that decision assuring the child that the normal physician-patient relationship that would obtain if he were an adult has begun to apply. . . . By accepting the child as a responsible patient who has the right to consent to treatment, the physician has implicitly accorded that child the normal rights of a patient within the patient-physician relationship.

A few states have codified the mature minor rule. For example, in Arkansas, "(a)ny unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures" may consent to his or her own medical care.[54]

As with emancipation, the mature minor rule, by transferring decisional authority from parents to minors, directly challenges historic understandings of capacity and the location of decision-making authority. Embodying a dynamic vision of youth, this rule recognizes that minority is not an indistinguishable phase stretching from infancy to young adulthood, and that the allocation of authority between parents and children must account for the increasing capacities of children as they move through adolescence.

2. Treatment-Based Exceptions

Over the past few decades, most states, in response to increasingly visible manifestations of teen sexual activity and drug and alcohol use, have enacted a variety of "minor treatment" statutes that give minors the authority to consent to specific kinds of medical care.[55] These statutes embody the recognition that if required to involve their parents to obtain care related to sexual activity or other sensitive matters, minors might delay or avoid seeking needed services. Accordingly, as a policy matter, these laws privilege the health needs of minors over parental claims of decisional authority.[56] They allow minors to consent to pregnancy-related health care, excepting abortion[57] and sterilization; family

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Holder, LEGAL ISSUES, *supra* note 39, at 143.

54. ARK. CODE ANN. § 20-9-602 (Michie 1987).

55. *See generally* MORRISSEY ET AL., *supra* note 27, at 49–86. Some minor treatment statutes establish a threshold age of consent, commonly 12 or 14, ages which are clearly well below the age of majority. For a state by state guide to minor treatment laws, *see* PATRICIA DONOVAN, OUR DAUGHTERS' DECISIONS: THE CONFLICT IN STATE LAW ON ABORTION AND OTHER ISSUES (1992). *See also* MORRISSEY ET AL., *supra* note 27, at 149–250.

56. Although these statutes give minors the right to consent to their own care, some allow, but generally do not require, the physician to notify the parents regarding the course of treatment. *See* MORRISSEY ET AL., *supra* note 27, at 60–61. This, of course, defeats the underlying purpose of the law, as minors may not seek treatment if they know that their parents might find out about it.

57. This exception is, of course, the primary concern of this article. It should be noted that pregnancy-related care may require the making of medical decisions that involve serious health consequences for either the pregnant woman or the child she is carrying. Thus, for example, under these provisions, a teen could consent to surgical

planning services, including contraception; the detection and treatment of sexually-transmitted diseases;[58] and services related to drug and alcohol dependency and abuse.[59] Many states also allow minors to self-consent to mental health services.[60]

Minor treatment statutes are similar to the status-based exceptions in that they transfer decisional authority to teens. However, unlike the status-based exceptions, these statutes appear to be grounded in considerations of expediency[61] rather than in a recognition of teenage maturity or independence. Framed neutrally as public health measures, these laws have attracted little controversy. Yet by recognizing the necessity of giving minors control over sensitive medical decisions, this exception, similar to that for medical neglect, directly recognizes that the interests of parents and children may diverge, and that parental involvement may interfere with the provision of essential medical care. These laws acknowledge the reality of family conflict, and unsettle deeply-held beliefs that parents are always the preferred decision makers for their children.

Interestingly, these laws are generally concerned with activities that are historically more associated with adulthood than childhood. They seem to implicitly recognize that intergenerational conflicts may arise as children reach adolescence and begin to assert their autonomy by engaging in activities that signal their approaching adulthood and separation from their family of birth. By entrusting minors with the authority to manage these sensitive and significant aspects of their lives, these laws, although not directly premised on considerations of maturity or independence, nonetheless acknowledge the ability of minors to respond to the changing realities of their lives at moments in time when their parents may not be able to do so.

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procedures including, for example, fetal surgery to correct impairments or the performance of a cesarean section. *See infra* note 112.

58. Most of these laws were enacted before the AIDS epidemic. For a discussion about the different approaches states are taking with respect to whether minors can self-consent to the testing for and treatment of HIV-infection, *see generally* William Adams, *"But Do You Have To Tell My Parents?" The Dilemma for Minors Seeking HIV-Testing and Treatment*, 27 J. MARSHALL L. REV. 493 (1994).

59. *See* MORRISSEY ET AL., *supra* note 27, at 44–50.

60. *See* MORRISSEY ET AL., *supra* note 27, at 82–85.

61. *See* Wadlington, *supra* note 22, at 323.

III. Abortion and the Parental Involvement Requirement

This article began by looking at how the *Roe* Court characterized abortion as a medical decision to be made within the context of the patient-physician relationship. From there, the article looked generally at medical consent rules for minors, examining parents' lack of hegemonic control over the medical treatment of their children. Cutting deeply into the presumptions that underlie the parental consent requirement, the law clearly acknowledges the decision-making capacity of minors and the reality that parents do not always act in the best interest of their children.

The critical question for consideration is how teen abortion fits into this framework. Does the Court continue to characterize abortion as a medical decision or does abortion take on other meanings? Does the Court locate its analysis of parental involvement laws in the context of medical consent rights for minors or does it draw upon other understandings of teen capacity and parental authority? With these interrelated questions in mind, the article now turns to critical Supreme Court decisions which, when taken as a whole, reveal how the Court's partial, and arguably distorted, construction of reality divests young women of true reproductive choice.[62]

A. Reasoning Within And Outside Of The Medical Paradigm

Three years after *Roe*, the Court faced challenges to parental consent laws from Missouri[63] and Massachusetts.[64] Although the Court did not uphold the constitutionality of either statute, these decisions lay the foundation for its subsequent formulation of the parental "bypass" construct.

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62. Again, cases to be discussed include: Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833 (1992) (*Casey*); Ohio v. Akron Ctr. for Reproductive Health, 497 U.S. 502 (1990) (*Akron*); H.L. v. Matheson, 450 U.S. 398 (1981) (*Matheson*); .Bellotti v. Baird, 443 U.S. 650 (1979) (*Bellotti II*); Bellotti v. Baird, 428 U.S. 132 (1976) (*Bellotti I*); and Missouri v. Danforth, 428 U.S. 52 (1976) (*Danforth*). For citations to the other Supreme Court cases involving minor abortion statutes, *see supra* note 6.

63. *See Danforth*, 428 U.S. 52.

64. *See Bellotti I*, 428 U.S. 132.

1. The *Danforth* Decision—Setting the Stage for the Selective Burdening of the Abortion Right

Following *Roe*, the state of Missouri enacted a law for the "control and regulation of abortions ... during all stages of pregnancy."[65] Among other limitations, this law included both a parental and a spousal consent requirement. Grounded in the reality of family relationships, the *Danforth* Court was quick to invalidate the spousal consent requirement. Recognizing that marital harmony cannot be achieved by legislative fiat, the Court made clear that in the event of a disagreement, the decision must belong to the pregnant woman, as she is the one who "physically bears the child and who is the more directly and immediately affected by the pregnancy. . . ."[66]

Turning next to the parental consent requirement,[67] the *Danforth* Court began from the premise that like adult women, minors have a constitutionally-protected right of choice, stating that "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights."[68]

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65. *Danforth*, 428 U.S. at 56. See *Danforth*, 428 U.S. at 55–57 for the legislative history of this Act.

66. *Danforth*, 428 U.S. at 71. Although our focus is not on spousal involvement requirements, this aspect of the case is worth mentioning as it suggests an approach that the Court could have taken with respect to parental involvement laws.

The Court revisited the issue of mandated spousal involvement in its 1992 *Casey* decision. *See Casey*, 505 U.S. at 887–99. In considering whether women could be required to notify their husbands of their intended abortion, the Court demonstrated notable sensitivity to the "millions of women in this country who are the victims of regular physical and psychological abuse at the hands of their husbands . . . ." *Casey*, 505 U.S. at 893. It recognized that such a requirement would put women at risk of further harm, and was "likely to prevent a significant number of women from obtaining an abortion." *Casey*, 505 U.S. at 893. Chiding those unmindful of the reality of domestic violence, the Court stated, "[w]e must not blind ourselves to the fact that the significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases." *Casey*, 505 U.S. at 894.

Unfortunately, this sensitivity to the dangers of family violence disappeared without a trace when the Court went on to consider and uphold the parental consent provision of Pennsylvania's law. For an analysis of the inconsistencies in the *Casey* Court's approach to spousal and parental involvement requirements, see Leonard Bermen, Planned Parenthood v. Casey: *Supreme Neglect for Unemancipated Minors' Abortion Rights*, 37 How. L.J. 577 (1994).

67. *Danforth*, 428 U.S. at 72.

68. *Danforth*, 428 U.S. at 74. With this statement, the *Danforth* Court simply assumes, without explicitly stating it, that minors have a constitutional right to abortion. As a

Having included minors in the essential *Roe* right, the Court considered whether Missouri had the constitutional authority[69] to make abortion access conditional upon parental permission.

Remaining true to *Roe*'s characterization of abortion as a medical decision, the Court invalidated Missouri's consent requirement because it vested a third party, namely a minor's parents, with " . . . an absolute, and possibly arbitrary, veto over *the decision of the physician and his patient* to terminate the patient's pregnancy."[70] Reinforcing the locus of the decision, the Court emphasized that giving parents the power "to overrule a determination, made by *the physician and his minor patient*, to terminate the patient's pregnancy would neither strengthen the family unit nor enhance parental authority or control."[71]

By continuing to characterize abortion as a medical decision, and by again recognizing that family relationships are not enhanced by mandated disclosure, the Court in *Danforth* appeared poised to extend its thinking about spousal consent requirements to the parent-child arena, and hold that regardless of age, the abortion decision belongs to the pregnant woman. However, this was not to be. Although invalidating Missouri's parental consent law, the Court made clear that in doing so it was not suggesting that all minors can give effective consent to an abortion,[72] thereby signaling that it might accept a less intrusive law that did not vest final decisional authority in parents.

In leaving the door open to a reformulated consent law, the Court failed to consider the fact that at the time of the decision, teens in Missouri were permitted to self-consent to "medical services for pregnancy

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result, the Court did not specifically discuss whether the right of teens is *fundamental*, although given the equation with adult rights, this would be a logical conclusion. *See Roe*, 410 U.S. at 152–53 (discussing fundamental nature of the right of privacy).

69. *Danforth*, 428 U.S. at 74.

70. *Danforth*, 428 U.S. at 74 (emphasis added). Again, the point here is not to endorse the medical model of decision-making, but to highlight the flaws in the Court's reasoning as it fails to adhere to the medical paradigm that it constructed for reasoning about abortion.

71. *Danforth*, 428 U.S. at 75 (emphasis added). Interestingly, although not discussed by the Court, neither would giving parents this power enhance their responsibility, since, as a rule, parents of pregnant teens do not have any legal obligations to their grandchildren, although parents may still have a duty to support their minor daughter despite the fact of her having become a parent. Where support has been continued, it is usually based on a determination that the daughter is not fully emancipated because of continued financial dependence on her parents. *See, e.g.*, In re Marriage of Clay, 670 P.2d 31 (Colo. Ct. App. 1983); Doerrfeld v. Konz, 524 So.2d 1115 (Fla. Dist. Ct. App. 1988); Wulff v. Wulff, 500 N.W.2d 845 (Neb. 1993).

72. *Danforth*, 428 U.S. at 75.

(excluding abortion), venereal disease and drug abuse."[73] Emphasized by the plaintiffs as the appropriate comparative framework, the Court did not seek to understand why Missouri allowed minors to self-consent to other important medical decisions, including those relating to pregnancy, while denying this right to teens seeking to abort.[74]

In failing to take the medical consent rights of teens into account, the Court also failed to confront the fact that, as the ability to make pregnancy-related medical decisions implicitly carries with it the right to decide to become a mother, the Missouri statutory scheme linked decisional authority to the intended pregnancy outcome. Accordingly, young women were deemed capable of embracing but not avoiding motherhood. Had the Court faced the inherent illogic of Missouri's statutory scheme, it might have been forced to wonder whether in subjecting the abortion decision to a parental consent requirement, while granting decisional autonomy to teens carrying to term, Missouri was in fact truly concerned with the welfare of teens and family integrity, as it had claimed to the Court,[75] or if it was instead seeking to limit the abortion rights of teens.[76]

Had the *Danforth* Court considered the incongruity of Missouri's allocation of medical decision-making rights, especially in relationship to pregnancy, it would perhaps have been forced to recognize that this selective burdening of the abortion right was inconsistent with *Roe*'s promise of decisional autonomy. In ignoring its own characterization of abortion as a medical decision, and disregarding comparable decisional rights, the Court left the door open for the acceptance of parental involvement requirements, even as it invalidated Missouri's law.[77]

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73. *Danforth*, 428 U.S. at 73 (referring to MO. REV. STAT. §§ 431.061–431.063 (Supp. 1975)).

74. Plaintiffs also pointed out that "no other Missouri statute specifically requires the additional consent of a minor's parent for medical or surgical treatment . . ." *Danforth*, 428 U.S. at 73.

75. *See Danforth*, 428 U.S. at 72–73.

76. Ironically, had the Court upheld the Missouri statute, this goal might have been subverted as parents, once given control over their daughter's abortion decision, would have the authority to force her to abort as well as to carry to term.

77. This theme will be elaborated in this section. Also, it should be noted that as it is the most direct comparison, the legal status of teens intending to abort will be compared to the legal status of teens intending to carry to term, rather than to those seeking to make other kinds of medical decisions.

2. The *Bellotti I* Decision—Abortion as Different Because It Is Different

As discussed above, the *Danforth* Court, in ignoring plaintiffs' argument that the Missouri consent law should be considered in light of the state's medical consent law, implicitly suggested that it was acceptable for states to differentiate between teens seeking to abort and those making other sensitive medical decisions, most notably related to pregnancy. The Court's failure to reason within this medical paradigm suggests its discomfort with abortion as a pregnancy outcome at least where minors are concerned. This suspicion is strengthened in light of the Court's same-day *Bellotti I* decision.[78]

Unlike the Missouri law in *Danforth*, the Massachusetts consent law gave minors the right to seek judicial permission for an abortion if parental consent were denied. The *Bellotti I* Court concluded that until the meaning of the statute was clear, it could not determine whether, as plaintiffs claimed, the statute unduly burdened the abortion right or "create[d] some unanticipated interference with the *doctor-patient* relationship. . . ."[79] Accordingly, the Court held that the district court should have abstained from hearing the matter until the meaning of the statute was clear, and remanded the case so the statute could be authoritatively construed by the Massachusetts courts.[80]

In remanding the case, the Court indicated that its primary concern was whether the statute vested parents with veto power over their daughter's decision.[81] The Court suggested that constitutional problems

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78. *Bellotti I*, 428 U.S. 132.

79. *Bellotti I*, 428 U.S. at 148.

80. The Court ordered the district court to certify questions to the Supreme Judicial Court (SJC) concerning the meaning of the statute and the "procedure it imposes." *Bellotti I*, 428 U.S. at 151.

Among other considerations, the certified questions addressed the standard that both parents and judges were to use in deciding if an abortion was in a minor's best interest, whether a judge could override the abortion decision of a mature minor, and whether a minor could avoid her parents through application of the state's mature minor rule. The text of these questions can be found at footnote 13 of the *Bellotti II* decision, 443 U.S. at 630–31.

For the SJC's response to the certified questions, *see* Baird v. Attorney General, 360 N.E.2d 288 (Mass. 1977); for the district court's invalidation of the statute based on the SJC's response, *see* Baird v. Bellotti, 450 F. Supp. 997 (Mass. Dist. Ct. 1978). These decisions are discussed in J. Shoshanna Ehrlich, *Journey Through the Courts: Minors, Abortion and the Quest for Reproductive Fairness*, 10 YALE J.L. & FEMINISM 1, 5–8 (1998).

81. *See Bellotti I*, 428 U.S. at 145.

might be avoided if, as urged by the defendants, the statute could be interpreted to avoid giving parents this degree of authority. For example, the statute could require parents to consider only their daughter's best interest when deciding whether to grant consent, or could allow mature minors to avoid their parents altogether under the state's common law mature minor rule.[82] As in *Danforth*, the Court in *Bellotti I* indicated that a law which involved parents, but stopped short of locating final decisional authority in them, might not impermissibly burden the abortion right of minors.[83]

In suggesting that it might uphold the statute if it were construed to resolve the parental veto problem, the Court again failed to account for the fact that, as in Missouri, Massachusetts minors had significant medical consent rights.[84] Once again, despite its continued understanding of abortion as a medical decision, the Court did not locate its reasoning in the realm of medical decision-making rights. In this case, however, although profoundly unsatisfying in its superficiality, the *Bellotti I* Court seemed to feel some obligation to acknowledge this comparative realm.

Having discussed the unresolved constitutional issue as one of burden, the Court, almost as an afterthought, addressed plaintiffs' argument that the law was invalid because it created an "impermissible distinction between the consent procedures applicable to minors in the area of abortion, and the consent required in regard to other medical procedures."[85] As acknowledged by the Court, this issue had "come to the fore" because Massachusetts had enacted a statute "dealing with consent by minors to medical procedures other than abortion and sterilization" during the pendancy of the challenge to its parental consent law.[86]

Prior to the enactment of this new statute, Massachusetts' primary statutory exception to the parental consent requirement had been limited to medical emergencies;[87] this new statute granted minors

82. *See Bellotti I*, 428 U.S. at 144. For an explanation of the mature minor rule, see the section on status-based consent rights above and *infra* note 97.

83. *See Bellotti I*, 428 U.S. at 145–48.

84. *See infra* notes 86–89 and accompanying text.

85. *Bellotti I*, 428 U.S. at 148.

86. *Bellotti I*, 428 U.S. at 148. This statute was enacted after the district court struck down the state's abortion consent law in *Baird v. Bellotti*, 393 F. Supp. 847 (1975). MASS. GEN. LAWS ch. 112, § 12F (1998), *amended by* 1975 Mass. Acts § 564.

87. Prior to the 1975 changes physicians were exempt from liability for failing to obtain parental consent "when delay in treatment will endanger the life, limb or mental well-being of the patient," MASS. GEN. LAWS ch. 112, § 12F (1998). Other statutes also provided limited exceptions to the parental consent requirements. For example,

considerable medical self-consent rights based either upon their status or the type of treatment sought. Accordingly, Massachusetts minors who were married, widowed, divorced, a parent, a member of the armed forces, or living independently, were now considered fully emancipated for the purposes of consenting to their own medical care, excepting abortion and sterilization.[88] Additionally, and again excluding abortion and sterilization, minors who were or believed themselves to be pregnant, as well as those seeking diagnosis or treatment for diseases deemed dangerous to the public health, could now also consent to their own care.[89]

As in *Danforth*, the Court in *Bellotti I* again faced a statutory scheme that clearly differentiated between abortion and other medical procedures. Most notably, as in Missouri, a Massachusetts minor could make the decision to become a mother on her own, and then while pregnant and thereafter, self-consent to her own medical care, while a minor seeking to avoid motherhood could not effectuate this decision without adult approval.[90]

Despite this starkly contrasting treatment of teens based upon their intended pregnancy outcome, the Court claimed, as with burden, that it could not consider the issue of "impermissible distinction" until the statute had been construed by the state courts.[91] However, the Court was not facing subtle distinctions that demanded careful inquiry and exposition. Regardless of whether, for example, the statute would be interpreted to limit parents to consideration of their daughter's best interest or to allow some minors to go directly to court, it was obvious that in allowing motherhood but not its rejection to be a fully autonomous choice, Massachusetts was differentiating between teens intending to abort and those intending to carry to term. Even in the absence of illuminating detail, had the Court wished, it certainly could

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minors over the age of 12 could consent to the diagnosis and treatment of drug dependency, excluding methadone maintenance therapy. MASS. GEN. LAWS ch. 112, § 12E (1998). Massachusetts also recognized the common law mature minor rule. *See infra* note 97.

88. *See* MASS. GEN. LAWS ch. 112, § 12F (1998) (also recognizing the right of minor parents to consent to the medical care of their children). Unless "life or limb" were at risk, minors were assured complete confidentiality. MASS. GEN. LAWS ch. 112, § 12F (1998).

89. *See* MASS. GEN. LAWS ch. 112, § 12F (1998). Although analytically insignificant, it should be noted that I have chosen to characterize pregnancy as a medical condition rather than as a status, because unlike the other emancipatory statuses, it is often both an unintended and temporary event.

90. *See infra* note 113.

91. *See Bellotti I*, 428 U.S. at 148–50.

have invalidated the statute for impermissibly discriminating against a fundamental right.

Implicit in the *Bellotti I* Court's avoidance of this issue is its acceptance of abortion as a stand-alone procedure that can be singled out for more burdensome requirements than other medical choices. That this is the silent but powerful holding of this case is made clear by the Court's explanation of why it could not act without the insight of the state court: "as we hold today in [*Danforth*] not all distinction between abortion and other procedures is forbidden . . . . The *constitutionality of such distinction will depend upon its degree and the justification for it.*"[92] As indicated by this language, the differential treatment itself is no longer the salient constitutional issue; accepted by the Court as a given, the question has been subtly transformed to one of degree and justification.

Disturbingly silent, the Court offered no explanation as to how this differential treatment can be tolerated under *Roe*. It did not attempt to explain why teens who are deemed competent to make their own medical decisions lack decisional capacity with respect to this singular act. Nor did it offer an explanation of why a pregnant teen can choose to become a mother on her own, but cannot decide to avoid motherhood without adult authorization, or why a teen mother is mature enough to take charge of the medical care for herself and her child, but is not mature enough to make her own abortion decision. Certainly, if a teen is too immature to decide whether or not to terminate her pregnancy, one must wonder whether she is ready to assume the responsibilities of motherhood which, by necessity, entail a never-ending array of decisions with life-shaping consequences for both herself and her child.

Perhaps, however, the Court was silent because there is no explanation that would bear constitutional scrutiny. There is simply no rational way to distinguish between the capacity of teens seeking to abort and those seeking to carry to term or make other permitted medical decisions, or to explain how a teen could simultaneously be too immature to choose to terminate a pregnancy, but mature enough to

92. *Bellotti I*, 428 U.S. at 148–50 (emphasis added). The Court's reliance on *Danforth* to justify distinguishing between consent requirements for abortion and other procedures is misplaced. The *Danforth* Court, in upholding record-keeping requirements for abortions that were not imposed on other medical procedures, made clear that this was acceptable only because these requirements did not have a "legally significant impact or consequence on the abortion decision or on the physician-patient relationship." *Danforth*, 428 U.S. at 81. In *Bellotti I*, in contrast, the distinction in consent requirements goes to the heart of both the abortion decision, as minors are not permitted to make this decision on their own, and the physician-patient relationship, as the doctor cannot act based on the consent of his or her patient.

choose motherhood with all of its attendant decisional responsibilities.[93] This lack of a cogent explanation strongly suggests that the only salient difference is the abortion itself.

Commonly regarded as insignificant when compared to the post-remand *Bellotti II* decision, the *Bellotti I* decision is not as innocent and unimportant as it seems. Although it avoids consideration of the merits in a disarmingly circular manner, the decision conveys a powerful message that paves the way for the Court's subsequent acceptance of parental consent laws—abortion is different because it is different and can therefore be treated differently.

B. Bellotti II—*Constitutionalizing the Differential Treatment of Abortion*

Following remand, the Court again considered the constitutionality of the Massachusetts parental consent law, as construed by the Massachusetts Supreme Judicial Court (SJC).[94] According to the SJC, virtually all minors, regardless of maturity or circumstances, were required by the statute to seek parental consent, and were only entitled to seek court authorization if parental permission was requested and denied—there was no direct access to the Court.[95] Significantly, the SJC

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93. The point of this article is not to suggest extending consent or notice requirements, but to highlight the irrationality of the treatment of abortion. Unlike the United States Supreme Court, the Supreme Court of California, in considering California's parental consent law, grasped the inherent irrationality of such a statutory scheme. Striking down the law, the Court stated:

> Defendants' contention that the restrictions imposed by that statute upon a minor's constitutionally protected right of privacy are necessary to protect the physical and emotional health of a pregnant minor is undermined by the circumstance that California law authorizes a minor, without parental consent, to obtain medical care and make other important decisions in analogous contexts that pose at least equal or greater risks to the physical, emotional, and psychological health of a minor and her child as those posed by the decision to terminate pregnancy.

American Academy of Pediatrics v. Lungren, 940 P.2d 797, 826 (Cal. 1997). This is an extremely thorough and well-reasoned decision that should be read by those interested in this subject.

94. *Bellotti II*, 443 U.S. 622.

95. *See* Baird v. Attorney General, 360 N.E.2d 288, 294 (Mass. 1977). The only exceptions are for minors who are married, divorced or widowed minors and whose parents are unavailable. *See Bellotti II*, 443 U.S. at 630–31. A further discussion of the statute, as construed by the SJC, can be found in *Bellotti II* at 630–33 and 644–47.

determined that the state's medical consent law providing status and treatment-based self-consent rights for teens did not apply to abortion,[96] and furthermore, that the state's common law "mature-minor" rule was no longer applicable to abortion, having been legislatively superseded by the parental consent law.[97] Had it ever been unclear, *Bellotti II* made it authoritative—the Massachusetts statutory scheme for medical consent rights discriminated between minors seeking to abort and those seeking to make other sensitive medical decisions, including those involving pregnancy.

In evaluating the Massachusetts statute, the Court blithely obscured this reality. Maintaining that in enacting its parental consent law, Massachusetts was simply seeking "to reconcile the constitutional right of a woman, in consultation with her physician, to choose to terminate her pregnancy . . . with the *special interest* of the State in encouraging an unmarried pregnant minor to seek the advice of her parents in making the important decision whether or not to bear a child,"[98] the Court

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96. *See Baird*, 360 N.E.2d at 298–300, *discussed in Bellotti II*, 443 U.S. at 631. Regarding this statute, *see supra* notes 86–89 and accompanying text.

97. *See Baird*, 360 N.E.2d at 284, *discussed in Bellotti II*, 443 U.S. at 646–47 n.27. As explained by the SJC, this common law rule actually permits doctors to provide medical treatment to teens without parental involvement based on an assessment of "the nature of the operation, its likely benefit, and the capacity of the particular minor to understand fully what the medical procedure involves." *Baird*, 360 N.E.2d at 295. Moreover, "[j]udicial intervention is not required. If judicial approval is obtained, however, the doctor is protected from a subsequent claim that the circumstances did not warrant his reliance on the mature minor rule. . . ." *Baird*, 360 N.E.2d at 295.

98. *See Bellotti II*, 443 U.S. at 639 (internal citations omitted) (emphasis added). Focusing on the rights side of the equation, it appears that the Court is equating the rights of teens with those of adult women, which would mean that teens have a fundamental right to abortion. *See supra*, note 1. However, by then using a "special" as distinct from the usual compelling state interest standard, one must wonder whether in fact the Court is really making this equation.

The Court's benign characterization of why Massachusetts enacted this law obscures the fact that it was sponsored by anti-choice legislators as part of an omnibus anti-abortion legislative package to "provide protection for the life of the unborn child." Otile McManus, *May I, Judge?* BOSTON GLOBE MAGAZINE, June 15, 1986, at 14. This is a very common pattern. According to a 1986 report of the American Civil Liberties Reproductive Freedom Project, all of the post-*Roe* parental involvement laws were initiated by anti-choice groups "which have as their primary goal ending *all* abortions," and many of them were "introduced a part of omnibus anti-abortion statutes designed to restrict or completely prohibit abortions." ACLU REPRODUCTIVE FREEDOM PROJECT, PARENTAL NOTICE LAWS: THEIR CATASTROPHIC IMPACT ON TEENAGERS' RIGHT TO ABORTION 3 (1986) [hereinafter ACLU].

Most major professional, social service and medical groups who work directly with teens are opposed to laws that mandate parental involvement. *See* ACLU, *supra*

failed to acknowledge that this state interest was actualized through a consent requirement only when the decision was *not* to bear a child. Narrowly focused on the decisional vulnerability and incapacity of young women, and the authority of parents over their children,[99] the Court did not consider whether teens intending to abort, like teens intending to carry to term, should be allowed to make their own reproductive decisions.

Although not straying from this dominant vision of teen girls as decisionally impaired, the Court in reviewing the statute did, however, recognize that many parents hold "strong views on the subject of abortion,"[100] and rather than providing their daughter with "mature advice and emotional support,"[101] might seek to prevent her from going to court or obtaining an abortion, thus, effectively exercising ultimate control over her decision.[102]

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at 3 & 30 n.25. For example, in 1992, the Council on Ethical and Judicial Affairs of the American Medical Association issued a report stating that while physicians should encourage pregnant minors to involve their parents, involvement should not be required due both to the risk of abuse and the importance of privacy around health care issues. This Council Report was adopted by the House of Delegates of the AMA in 1992. *See* Council on Ethical and Judicial Affairs, AMA, *Mandatory Parental Consent to Abortion*, 269 JAMA 82 (1993).

99. In identifying these factors as the basis for limiting the rights of young women to make the abortion decision, the Court invoked a number of earlier decisions in which minors were accorded a different constitutional status than adults. Although broadly supporting the proposition that minors can be treated differently than adults, the Court's reliance on these cases is misplaced, as the conflictual configurations in these cases are different from the direct parent-child conflict presented by the parental consent law. *See Bellotti II*, 443 U.S. at 637–39.

For example, the Court relied on several cases to support its position that the rights of minors can be limited in order to enhance parental authority. However, in the cited cases, the salient conflict was between the parent and the state, with no indication of a dispute between the parent and the child; in these cases the Court invoked parental authority to limit the intrusion of the state into an apparently harmonious family, rather than to curtail a child's assertion of rights. *See Bellotti II*, 443 U.S. at 637–39 (*citing* Wisconsin v. Yoder, 406 U.S. 205 (1972) (holding Amish parents have right to educate children beyond the eighth grade at home)); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (holding parents have right to choose to send their children to private rather than public school)). For further discussion, see J. Shoshanna Ehrlich & Jamie Ann Sabino, *A Minor's Right to Abortion—The Unconstitutionality of Parental Participation in Bypass Hearings*, 25 N. ENG. L. REV. 1185, 1189 n.20 (1991).

100. *See Bellotti II*, 443 U.S. at 647.

101. *See Bellotti II*, 443 U.S. at 641.

102. *See Bellotti II*, 443 U.S. at 647.

Attuned to the devastating impact of compelled maternity,[103] the *Bellotti II* Court, relying on *Danforth*, reiterated that the Constitution does not support giving a third party ultimate control over "*the decision of the physician and his patient* to terminate the patient's pregnancy, regardless of the reason for withholding the consent."[104] Accordingly, it invalidated the statute on due process grounds because it "impos[ed] an undue burden upon the exercise by minors of the right to seek an abortion."[105]

Had the Court stopped with striking down the Massachusetts statute, its failure to reason within the broader context of medical decision-making rights, despite its continued reference to abortion as a medical decision, although perhaps depriving the opinion of a contextual richness, would have been understandable, especially since the blatant discrimination between teens intending to abort and those intending to carry to term would have been eliminated.[106] The Court, however, did not stop with invalidating the Massachusetts statute. Having articulated its belief in the necessity of parental guidance as a counterweight to teen decisional incapacity, the Court went on to formulate what, in its view, would constitute a constitutionally-acceptable parental consent law. As set out in the decision, if a state wishes to require a minor to obtain parental permission before having an abortion, "it also must provide an alternative procedure whereby authorization for the abortion can be obtained;"[107] and, to avoid the risk of a parental veto, a minor must be

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103. *See Bellotti II*, 443 U.S. at 642.

104. *See Bellotti II*, 443 U.S. at 643, *quoting Danforth*, 428 U.S at 74 (emphasis added). In quoting *Danforth*, the Court carries forward the characterization of abortion as a medical decision.

105. *See Bellotti II*, 443 U.S. at 647.

106. It is not entirely clear what the rights of teens intending to abort would have been had the Court not gone on to make clear that a modified parental consent law would withstand constitutional scrutiny. At a minimum, these teens would have had self-consent rights under the state's common law mature minor rule; it is also possible that the abortion exception under 12F would have been deemed invalid. *See* discussion, *supra* note 86.

107. *See Bellotti II*, 443 U.S. at 643 (footnote omitted). In his concurring opinion, Justice Stevens maintained that this aspect of the decision was advisory in nature, as the Court was no longer discussing an actual statute. *See Bellotti II*, 443 U.S. at 656 & n.4. (Stevens, J., concurring, joined by Brennan, Marshall, and Blackmun, JJ.). However, the Court has since made clear that *Bellotti II* is not advisory, but establishes the applicable legal standards against which consent laws must be evaluated. *See, e.g.*, Ohio v. Akron Ctr. for Reproductive Health, 497 U.S. 502, 511–14 (1990); Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476, 490 (1983); City of Akron v. Akron Ctr. for Reproductive Health, 462 U.S. 416, 439–40 (1983).

able to seek such permission without parental knowledge or involvement.[108] In short, a minor must be allowed to bypass her parents completely; court access cannot be made contingent upon a prior effort to secure parental permission.

At first glance, the Court appears to have struck a reasonable compromise with this formulation of a model consent law. The construction seems to both respect the reproductive rights of teens while simultaneously preserving the ability of states to protect an historically vulnerable population. Reflecting the transitional nature of the teenage years, young women are regarded both as autonomous rights-bearing individuals with unmediated claims to legal selfhood and as subordinate members of a parent-centered family unit.

However, despite its surface appeal, the reasonableness of this compromise is immediately called into doubt by the Court's selective construction of adolescent reality. Ignoring both the emerging body of social science literature on the decision making capacity of teens and the rights of teens as medical decision makers, the Court's effort at compromise reveals its anti-abortion leanings.

Committed to its vision of teens as lacking the "ability to make fully informed choices that take account of both immediate and long-range consequences,"[109] the Court simply presumed incapacity without considering any of the emerging social science research suggesting that this long-standing assumption is profoundly flawed. For instance, one influential study concluded that

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As the *Bellotti II* Court did, this article will discuss the alternative procedure in terms of a judicial hearing. However, it should be noted that the Court made clear that states are not limited to this option, and that "much can be said for employing procedures and a forum less formal than those associated with a court of general jurisdiction." *Bellotti II*, 443 U.S. at 643 n.27.

108. *See Bellotti II*, 443 U.S. at 647. The Court also set out other requirements for a constitutionally acceptable consent procedure. First, a minor must be given the opportunity to show that she is mature enough to make her own decision, and if not sufficiently mature, that an abortion is in her best interest. *See Bellotti II*, 443 U.S. at 647–48. Second, the hearing and any appeals that follow must be "completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained." *See Bellotti II*, 443 U.S. at 644. Interestingly, in constructing this alternative procedure, the Court failed to consider that it was simply transferring potential veto power from the minor's parents to the alternative decision-maker. This point was not lost on the concurring Justices who characterized this aspect of the Court's opinion as "particularly troubling." *See Bellotti II*, 443 U.S. at 655 (Stevens, J., concurring).

109. *See Bellotti II*, 443 U.S. at 640.

> [i]n general, minors aged 14 were found to demonstrate a level of competency equivalent to that of adults, according to four standards of competency (evidence of choice, reasonable outcome, rational reasons, and understanding), and for four hypothetical dilemmas (diabetes, epilepsy, depression, and enuresis).[110]

Specific to the abortion context, another study concluded:

> . . . the limited evidence available from studies of pregnancy and contraceptive decision making suggests that minors may equal adults in their *competence* to reason about decisions, and that differences between minors and adults in decision-making *performance* may be a result of the circumscribed role of adolescents in the family and society.[111]

Rooted in an historically static vision of teens, the Court clearly felt no obligation to re-examine its assumptions in light of these more contemporary understandings.

Dissociating itself from the realm of medical decision-making rights, the Court ignored the fact that in Massachusetts, as in Missouri, not all teens were regarded as similarly impaired. Disturbingly, the Court failed to consider how a state could entrust minors to make some but not other crucial medical decisions, in effect declaring that teens lack the ability to make an informed decision not to become a mother, while possessing the ability to make an informed choice to become a mother. Moreover, as the decision not to become a mother cannot exist apart from its effectuation through an abortion, this selective burdening means that the reproductive decision making of a young woman seeking to avoid maternity as well the effectuating medical choice are subject to an adult approval requirement. However, a teen wishing to become a mother enjoys full decisional autonomy over both her reproductive choice and its effectuation through pregnancy-related medical care.[112]

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110. Weithorn, *supra* note 24, at 1595.

111. Lewis, *supra* note 24, at 87 (emphasis in original). Even critics of the studies concluding that the decision-making ability of minors parallels that of adults agree that the Court lacked evidence for its belief "that adolescents are incompetent." William Gardner et al., *Asserting Scientific Authority, Cognitive Development and Adolescent Legal Rights*, 44 AM. PSYCHOL. 895, 897 (1989).

112. This care may include the making of medical decisions with profound and lasting consequences for both the young women and the child she is carrying, such as whether to be tested and possibly begin treatment for the AIDS virus, or whether to

Certainly, if a young woman is capable of deciding to become a mother, with all of the responsibility this decision entails, she is similarly capable of deciding not to become a mother. As recognized by the *Bellotti II* Court, the decision to become a mother carries with it profound and lasting consequences as "the fact of having a child brings with it adult legal responsibility, for parenthood, like attainment of the age of majority, is one of the traditional criteria for the termination of the legal disabilities of minority."[113] Given the significance of this decision, one could reasonably conclude that a state would have a particular interest in ensuring that the decision to bring a child into the world is fully informed.

The absurdity of linking decisional capacity to the pregnancy outcome is highlighted by the fact that the same young woman might well make both decisions during her teenage years. Certainly, most women, adult or teen, when facing an unplanned pregnancy consider, at least briefly, the implications of each choice for her life, perhaps moving back and forth between options before settling on a final decision. Assume for the moment that a young woman's initial decision, upon learning she is pregnant, is to carry her pregnancy to term. Not only is she free to make this decision on her own, but through this decision, she acquires complete control over her own medical care both during pregnancy and following the birth of her child. Now assume that part way through the pregnancy, she changes her mind and decides to abort. With this change of mind, her decisional capacity suddenly vanishes. Not only must she secure adult permission to abort, she is divested of her medical decision-making rights.

Now assume that rather than changing her mind, she carries to term and is a mother with full medical decision-making rights for both herself and her child. If she were to become pregnant again, and this time decide to abort, she would suddenly be recast as vulnerable and in

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undergo *in utero* surgery to correct a fetal condition. *See* H.L. v. Matheson, 450 U.S. 398, 445 n.38 (1981).

113. *See Bellotti II*, 443 U.S. at 642. In addition to carrying adult-like responsibilities, becoming a mother as a teenager has profound life consequences and is likely to negatively impact a young woman's future educational and economic opportunities, making it more likely that she will live in poverty. *See* RISKING THE FUTURE: ADOLESCENT SEXUALITY, PREGNANCY, AND CHILDBEARING 126–32 (Cheryl D. Hayes ed., 1986) [hereinafter RISKING THE FUTURE]. *But see* KRISTEN LUKER, DUBIOUS CONCEPTIONS: THE POLITICS OF TEENAGE PREGNANCY (1996), in which the author challenges the assumption that early childbearing causes poverty, arguing that poverty is likely to contribute to the decision to bear a child at an early age, thus inverting the traditional causal assumption.

need of adult guidance to make this decision.[114] Of course, should she again change her mind, her decisional ability would be fully restored. Clearly, decisional capacity is not temporal and contingent, shifting each time a young woman reassesses her pregnancy options. Yet this is the implication of a statutory scheme that entrusts teens with the decision to bear a child but not to abort.

Similarly, it is also hard to make sense out of the contingent nature of the parental role. In its *Bellotti II* decision, the Court alternated between themes of parental authority and parental nurturance and care in order to justify a state-constructed role for parents in the abortion decision of their daughters. Regardless, however, of whether parental consent laws are understood as giving expression to a "tradition of parental authority"[115] or as embodying a nurturing function, it is not clear why a role should be statutorily prescribed only where a young woman decides to terminate a pregnancy. Certainly, if parents have an important role to play in helping their daughter with the abortion decision, it is clear they could also provide valuable support with respect to the decision to become a mother.[116] This is especially true in light of the multiple medical decisions that pregnancy often entails, in contrast to the singular nature of the abortion decision, and the fact that carrying to term is generally riskier for a teenager than having an abortion.[117]

Yet, as with decisional capacity, the Court viewed the desirability of parental involvement through a partial lens. Honored as an inevitable expression of rightful authority and as an essential counterweight to teen immaturity, the Court failed to address the fact that the statutory scheme before it made selective use of parents—vesting them with central importance where a young woman sought to terminate her pregnancy, but casting them aside where the decision was to become a mother. In failing to consider the logic of a statutory scheme that unevenly distributes medical decision-making rights to teens facing "sensitive" decisions, or selectively excludes abortion as an autonomous

114. Although this would be the case under the Massachusetts statutory scheme, in other states, once a mother, she would be able to consent to an abortion herself.

115. *Bellotti II*, 443 U.S. at 638.

116. This discussion is not in any way meant to disparage the crucial support that many parents provide to their daughters who are faced with an unplanned pregnancy. The concern here is with the element of compulsion. In a ideal world, all young women would have parents who would respond to such an event in a loving and constructive way. But unfortunately, as even the Court recognized, the world we live in is far from ideal.

117. *See* ROBERT A. HATCHER ET AL., CONTRACEPTIVE TECHNOLOGY 481–82 (1994); RISKING THE FUTURE, *supra* note 113, at 123–28.

choice for otherwise medically-emancipated minors, the Court quietly, perhaps even surreptitiously sanctioned the selective burdening of medical decision-making rights to disfavor abortion.

Given this differential treatment of abortion, a relatively undiscussed aspect of the Court's decision—its failure to consider the plaintiffs' equal protection claim—assumes a great symbolic importance. Tucked into a footnote, following its exposition of the unduly burdensome nature of the Massachusetts statute, the Court explained that since "... we have concluded that the statute is invalid for other reasons, there is no need to consider this question."[118] At first glance, the Court's decision not to evaluate whether the Massachusetts parental consent law ran afoul of the Equal Protection Clause appears entirely reasonable. It is also consistent with basic jurisprudential principals not to reconsider a statute through different lenses once it has been declared unconstitutional.

Had the Court stopped with the invalidation of the Massachusetts law on due process grounds, its failure to consider the equal protection implications of a statutory scheme that classified minors according to pregnancy outcome would have been entirely understandable. But its avoidance of the issue assumes a different meaning in light of the fact that the Court did not stop, but instead went on to formulate what, in its view, would constitute a constitutionally-acceptable consent law. It is in the shadow of this law that the Court's failure to address equal protection issues assumes profound significance.

In formulating this model consent law, the Court did not stop to reconsider the issue of unlawful classification. Formulated against the backdrop of a statutory scheme vesting minors, most notably those seeking to carry to term, with significant medical decision-making rights, the Court's acceptance of limitations on the rights of teens seeking to abort clearly signals its approval of treating young women differently based on their intended pregnancy outcome. Thus, although claiming not to reach the equal protection issue, the Court, through the back door, seems to have in fact located this discriminatory treatment outside the reach of the Equal Protection Clause.

So considered, the Court's judicial bypass compromise hardly seems to strike a reasonable balance between the reproductive rights of young women and the state's interest in ensuring informed decision-making through adult engagement. Since there is no reasoned way to differentiate between classes of young women based on their intended

118. *See Bellotti II*, 443 U.S. at 650 n.30.

pregnancy outcome, the Court could not have engaged in the kind of analysis demanded by this article. Thus, one must ask whether, in the final analysis, the *Bellotti II* opinion is best understood as an expression of the Court's discomfort with abortion.

That this may be the truest reading of the case is in fact suggested by the text. Having previously clearly characterized abortion as a medical decision to be made by a pregnant woman and her physician, the *Bellotti II* Court introduces a new understanding of abortion. In discussing the desirability of parental consultation, the Court explains that a state may reasonably determine that "as a general proposition, . . . such consultation is *particularly* desirable with respect to the abortion decision—one that for some people raises profound *moral and religious concerns.*"[119] With abortion thus weighted with symbolic meaning, one must ask whether it is because of these "profound moral and religious concerns" that the Court is uneasy about allowing teens to make their own abortion decisions—that these concerns serve to demarcate the boundary between the decision to bear a child and the decision to abort. Read this way, the decision, rather than embodying a concern for minors and the integrity of families, can be understood as signaling a shift in the Court's thinking about abortion.[120] No longer a medical

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119. *See Bellotti II*, 443 U.S. at 640 (emphasis added). Further suggesting that the Court is backing away from its earlier understanding of abortion as a medical decision and its reliance on doctors to provide informed guidance, the Court goes on to question the ability of doctors, notably those at abortion clinics, to provide minors with "adequate counsel and support." *See Bellotti II*, 443 U.S. at 641 (quoting the concurring opinion of Justice Stewart in *Danforth*, 428 U.S. 91). The Court also raises the concern that without the involvement of their parents, minors, unlike adult women, will not be able to "distinguish the competent and ethical from those that are incompetent or unethical." *See Bellotti II*, 443 U.S. at 641 n.21. Consistent with the rest of the opinion, the Court does not consider the fact that minors choosing to continue a pregnancy may be selecting their own doctors. Moreover, it fails to consider the fact that minors who seek and obtain judicial consent for an abortion will also be doing the same. This shift in attitude from *Roe* towards doctors who perform abortions is troubling, and appears to be linked to the Court's apparent uneasiness with abortion, at least where the pregnant woman desirous of making her own decision is a minor.

120. This shift in the Court's thinking about abortion is also evident in the Medicaid funding cases. In these cases, the Court upheld the constitutionality of statutory funding schemes that denied funding for abortions while paying the costs associated with childbirth, maintaining that laws which encourage women to choose childbirth over abortion are "rationally related to the legitimate governmental objective of protecting potential life." Harris v. McRae, 448 U.S. 297, 325 (1980), *referencing* Maher v. Roe, 432 U.S. 464, 478–79 (1977). For a discussion of these cases *see* Carole A. Corns, *The Impact of Public Abortion Funding Decisions on Indigent Women: A Proposal to Reform State Statutory and Constitutional Abortion Funding Provisions*, 24 MICH. J.L. REFORM 371 (1991); Michael J. Perry, *Why the Supreme Court Was*

decision, abortion has been vested with multiple symbolic meanings that a young woman is deemed incapable of deciphering on her own, thus making the abortion decision different from other medical decisions that teens may make on their own. First expressed in *Bellotti II*, this reconceptualized understanding of abortion is thematically repeated in subsequent decisions involving parental involvement laws.

C. Forget Not the Unborn—Parental Involvement Laws as Pronatalist Measures

Since *Bellotti II*, the Court has elaborated on the theme that abortion is fraught with symbolic meaning and potentially grave consequences. Giving concrete expression to the "profound moral and religious concerns"[121] mentioned by the *Bellotti II* Court, several subsequent decisions make clear that parental involvement laws embrace the rights of the unborn.[122] These decisions provide insight into how far the Court has moved away from its original understanding of abortion as "inherently, and primarily, a medical decision."[123] With this reconceptualization of abortion it is finally clear why the Court has accepted the differential treatment of teens based on their intended pregnancy outcome.

Plainly Wrong in the Hyde Amendment Case*: A Brief Comment on* Harris v. McRae, 32 STAN. L. REV. 1113 (1980); Note, *Abortion, Medicaid, and the Constitution*, 54 N.Y.U. L. REV. 120 (1979).

It is interesting to note that this pronatalist language first appears as a justification for curtailing abortion rights in cases involving teens and poor women; it is not until much later that this language makes its way into and influences the Court's generalized reasoning about abortion. *See Roe*, 410 U.S. 113, 151–53 (1973); *infra* notes 138–144 and accompanying text regarding the 1992 *Casey* decision. Certainly, the governmental interest in protecting potential life is no greater when the pregnant woman is either young or a recipient of public assistance. Perhaps the explanation for this early curtailment lies in the fact that teens and poor women both lack a significant political voice and have been portrayed as irresponsible reproducers with less of a claim to self-determination than other women.

121. *Bellotti II*, 443 U.S. at 640.

122. This, of course, is entirely consistent with the objectives of the proponents of parental involvement laws (for a discussion of these objectives, see note 98). These decisions include: Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833 (1992); Ohio v. Akron Ctr. for Reproductive Health, 497 U.S. 502 (1990); and H.L. v. Matheson, 450 U.S. 398 (1981).

123. *See Roe*, 410 U.S. at 166.

Shortly after *Bellotti II*, the Court considered the constitutionality of a Utah parental consent statute. In *H.L. v. Matheson*,[124] the Court ominously characterized abortion as a decision that has "potentially traumatic and permanent consequences."[125] The Court also claimed that the "medical, emotional, and psychological consequences of an abortion are serious and can be lasting,"[126] and are more serious in minors than adults.[127]

Underscoring its message that abortion is fraught with danger, the Court, in response to plaintiff's claim that "the constitutionality of the statute is undermined because Utah allows a pregnant minor to consent to other medical procedures without formal notice to her parents if she carries to term,"[128] declared that the "state's interests in full-term pregnancies are sufficiently different to justify the line drawn by the statutes. If the pregnant girl elects to carry her child to term, the *medical* decisions . . . entail few—perhaps none—of the potentially grave emotional and psychological consequences of the decision to abort."[129] The Court

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124. *Matheson*, 450 U.S. 398. This case is significant because it starkly reveals the Court's thinking about the dangers of abortion. It is less significant as a precedent because the plaintiff apparently lacked standing to challenge the law as applied to minors who were either mature or could show that notification was not in their best interest, since she failed to allege either as a basis for avoiding notification. *See* 450 U.S. at 405–07. *See also* 450 U.S. at 427–28 (Marshall, J., dissenting).

125. *Matheson*, 450 U.S. at 412.

126. *Matheson*, 450 U.S. at 411. *See infra* note 129 regarding Justice Marshall's response to this statement in his dissent.

127. *See Matheson*, 450 U.S. at 411, n.25. According to two experts in the field, the Court, in making these assertions

> used selective vision in its perception of psychological effects of abortion. Contrary to empirical reality, the Court has assumed that adolescents are vulnerable to grave trauma in abortions decisions. . . . At the same time . . . the Court has ignored the possibility of psychological harm as a result of intrusions upon privacy and of decisions to carry a pregnancy to term. . . . In one of the few instances in which any citation of psychological literature was made, the citation was completely irrelevant. In *H.L. v. Matheson* (1981), Chief Justice Burger cited a report of unsystematic psychoanalytic impressions of adolescents who carried their pregnancies to term as foundation for the conclusion that the psychological effects of abortion on minors are "markedly more severe" than the effects on adults.

Gary B. Melton & Nancy Felipe Russo, *Adolescent Abortion: Psychological Perspectives on Public Policy*, 42 AM. PSYCHOL. 70 (1987) (citations omitted).

128. *Matheson*, 450 U.S. at 412.

129. *Matheson*, 450 U.S. at 412–13 (citations omitted). As remarked by Justice Marshall in dissent, this statement is baffling. Certainly, women carrying to term may face decisions with profound "emotional and psychological consequences" such as whether to be tested and possibly treated for the AIDS virus, or to undergo diagnostic tests,

thus acknowledged the ability of a pregnant girl to "elect" to continue her pregnancy. Motherhood is seen as a natural, perhaps inevitable, outcome of pregnancy. Although lacking any reliable support for its claim, the Court depicted abortion as a choice weighted with devastating emotional and psychological consequences.[130]

Having distorted the decisional framework, the Court revealed its identification with a "pro-life" perspective. Unconcerned that "the requirement of notice to parents may inhibit some minors from seeking abortions,"[131] the Court, relying on the Medicaid funding decisions, made clear that laws which "encourag[e] childbirth except in the most urgent circumstances" are "rationally related to the legitimate governmental objective of protecting potential life."[132] Unmasked is the pronatalist function of parental involvement laws; they are not intended to promote competent decision making, they are intended to stop young women from choosing abortion, hence their distinction from other medical consent laws.[133]

The true significance of the "moral and religious concerns" identified initially by the *Bellotti II* Court is thus revealed. No longer simply abstract preoccupations, these concerns serve to animate the interest of

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such as amniocentesis, or to submit to *in utero* surgery to correct fetal anomalies. Although perhaps not routine in nature, these decisions suggest the possible range of difficult choices that pregnant women may face, many of which may involve the balancing of risks to herself and the child she is carrying. *Matheson*, 450 U.S. at 445 n.38.

130. A considerable body of research makes clear that abortion is safer for teens than carrying to term, especially when done early in pregnancy, and that psychological harm is not an associated risk. Still other research documents the profound detriment that having an unwanted child has on the life of both the mother and the child. *See, e.g.*, Interdivisional Committee on Adolescent Abortion, *Adolescent Abortion: Psychological and Legal Issues*, 42 AM. PSYCHOL. 72 (1987); Catherine C. Lewis, *Minors' Competence to Consent to Abortion*, 42 AM. PSYCHOL. 84 (1987); Jeanne Marecek, *Counseling Clients with Problem Pregnancies*, 42 AM. PSYCHOL. 89 (1987); Gary B. Melton & Nancy Felipe Russo, *Adolescent Abortion: Psychological Perspectives on Public Policy*, 42 AM. PSYCHOL. 69 (1987); Gary B. Melton, *Legal Regulation of Adolescent Abortion: Unintended Effects*, 42 AM. PSYCHOL. 79 (1987). Nancy E. Adler et al., *Psychological Factors in Abortion: A Review*, 47 AM. PSYCHOL. 1194 (1992); Marvin Eisen & Gail L. Zellman, *Factors Predicting Pregnancy Resolution Decision Satisfaction of Unmarried Adolescents*, 145 J. OF GENETIC PSYCHOL. 231 (1984); HATCHER, *supra* note 117 at 481–82; RISKING THE FUTURE, *supra* note 117 at 278.

131. *Matheson*, 450 U.S. at 413.

132. *Matheson*, 450 U.S. at 413 (*quoting* Harris v. McRae, 448 U.S. 297, 325 (1980) *and referencing* Maher v. Roe, 432 U.S. 464, 473–74 (1977).

133. It is hard to imagine that the government is really interested in encouraging teens (and poor women) to have babies. The absurdity of this purported rationale only serves to underscore the antipathy toward abortion that animates these decisions.

the state in the potentiality of life. Without so much as a nod to *Roe*, the *Matheson* Court makes clear that the rights of young women can be curtailed in the name of the unborn.

Almost a decade after its decision in *Matheson*, the Court, in *Ohio v. Akron Ctr. for Reproductive Health*,[134] again revealed how far it had moved from its original conception of abortion as primarily a medical decision, at least where the decision-maker is a minor. Casting abortion as a philosophical choice, the Court explained why parental involvement is important:

> We believe . . . that the legislature acted in a rational manner. . . . A free and enlightened society may decide that each of its members should attain a clearer, more tolerant understanding of the profound *philosophical choices* confronted by a woman who is considering whether to seek an abortion. *Her decision will embrace her own destiny and personal dignity, and the origins of the other human life that lie within the embryo.* The State is entitled to assume that, for most of its people, the beginnings of that understanding will be within the family, society's most intimate association.[135]

The message is clear: left to her own devices, a young woman may fail to fully consider the "origins of the human life that lie within the embryo." It is this potential life, rather than what it means to become a

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134. 497 U.S. 502 (1990). The primary issue before the Court was whether the bypass procedure provided for by Ohio law met the requirements of *Bellotti II*. Despite the fact that among other obstacles, minors were faced with a confusing choice of pleading forms and required to provide clear and convincing evidence of maturity or best interest, the Court held that the bypass satisfied *Bellotti II*. 497 U.S. at 515–17.

Another issue was whether the requirement that notice be provided by the physician who is to perform the abortion rather than by another qualified individual was unduly burdensome. In an ironic twist, having previously questioned the ability of doctors to provide minors with proper counsel and support, the Court then lauded the fact that physicians are in the best position to help parents deal with this "problem in a mature and balanced way." 497 U.S. at 519, *supra* note 119. Given these conflicting depictions of physicians, one cannot help but wonder whether the Court is drawing on multiple images of doctors in order to suit its own objectives.

135. *Akron*, 497 U.S. at 520 (emphasis added). On the same day it issued the decision in *Akron*, the Court issued its decision in *Hodgson v. Minnesota*. Here, yet again, the Court upheld a parental notification law, despite the fact that the state allowed pregnant minors to self-consent to all other pregnancy-related medical care. As in *Bellotti II*, the Court noted that an important function of notice was that, among other considerations, it gave parents an opportunity to discuss the "religious or moral implications" of abortion with their daughter. *Hodgson*, 497 U.S. 417, 448 (1990).

mother, that is of primary concern. A teen's own "destiny and personal dignity" does not ensure decisional autonomy as her right to self-determination must be balanced against the interests of potential life—an interest that the state may seek to protect through the intermediary of a young woman's parents. No longer cast as a medical decision, the Court does not even need to feign consideration of the generally biased allocation of medical decision-making rights; only the decision to end a potential life—not the decision to bring one into the world—is imbued with a significance that a teen cannot comprehend on her own.

In the cases discussed so far, the Court, although revealing the pro-natalist function of parental involvement laws, did not seek to reconcile its decisions with *Roe*'s mandate that the interests of the unborn cannot be considered until the third trimester.[136] By characterizing abortion as a philosophical rather than a medical decision and by allowing the rights of the fetus to determine state abortion policy with respect to young women, these decisions erode the meaning of *Roe*. Hiding behind a distorted vision of teen decisional capacity and family intimacy, the Court makes a mockery of *Roe*'s promise that the autonomy of women cannot be compromised in the name of the unborn.

In *Planned Parenthood v. Casey*, the last of the cases under consideration, the Court caught up with itself.[137] Here, in considering the constitutionality of Pennsylvania's Abortion Control Act (ACT),[138] the Court's preoccupation with the rights of the unborn was not limited to its consideration of the parental involvement provision of this Act, but instead infused the entire decision. Although affirming a woman's right to terminate her pregnancy before viability, the Court, claiming that *Roe* undervalued the state's interest in the potentiality of life, abandoned *Roe*'s trimester formula in favor of a more restrictive undue burden test.[139] As explained by the Court:

> We reject the rigid trimester framework of *Roe v. Wade*. To promote the State's profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed

136. *See* Roe v. Wade, 410 U.S. 113, 162–64 (1973). The same is true with respect to the Medicaid funding cases which allow limits on the rights of women in the interest of encouraging childbirth. *See supra* note 120 and accompanying text.

137. *Casey*, 505 U.S. at 869–77.

138. The provisions of this Act included a spousal notification requirement, a parental consent requirement, and an informed consent requirement with a 24-hour waiting period. *See Casey*, 505 U.S at 881, 887, 899.

139. *See Casey*, 505 U.S. at 872–73.

> to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion.[140]

Given this blossoming of support for the rights of the unborn, it should come as no surprise that the Court upheld the provision of the Act requiring minors to obtain the consent of a parent before having an abortion (subject to the availability of an alternative consent mechanism). However, the decision adds a new twist—not only can a state require parental consent, it can demand that this consent be "informed" in accordance with the informed consent provisions of the Act that the Court also upheld.[141] Accordingly, parents are made subject to the same requirements a woman seeking an abortion would face, including the mandatory 24-hour waiting period.[142]

Challenged as unduly intrusive, the Court made clear that informed consent rules "have particular force with respect to minors: the waiting period, for example, may provide the parent or parents of a pregnant young woman with the opportunity to . . . discuss the consequences of her decision in the context of the values and moral or religious principles of their family."[143] However, the requirement that the consent be informed does much more than this. The state is both seeking to persuade minors to act within the existing belief system of their families (as with the "ordinary" parental involvement law), and to impact parental views—to convince parents that childbirth is preferable to abortion, so that they may, in turn, influence their daughter.

By heightening the consent requirement, the state now has a double opportunity to convince young women that "there are philosophic and social arguments of great weight that can be brought to

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140. *Casey*, 505 U.S. at 878.

141. *See Casey*, 505 U.S. at 881–87. In upholding the Act's informed consent provision, the Court overruled two earlier decisions to the extent that they invalidated informed consent requirements. (The earlier decisions are *Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416 (1983) and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986)). *See* 505 U.S. at 881–83.

According to the Act, for consent to be informed, a woman, at least 24 hours before the scheduled abortion, must, in addition to being told about the nature of the procedure and the risks, be told about the availability of state-published materials "describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion." 505 U.S. at 881.

142. *See Casey*, 505 U.S. at 881.

143. *Casey*, 505 U.S. at 899–900.

bear in favor of continuing the pregnancy to full term. . . ."[144] If enfolding teens in the existing value structure of their families is not sufficient to deter abortion, the value structure itself can be challenged through the intermediary of an informed consent requirement. Following *Casey*, not only are minors now selectively burdened when the decision is to abort rather than to carry to term, parents are likewise burdened. Although not required to participate in their daughter's decision to become a mother, parents can be compelled to submit to the state's persuasive apparatus before consenting to her abortion.

CONCLUSION

Having extolled the persuasive function of the heightened consent requirement, the *Casey* Court simply stopped. It did not even seek to justify the parental involvement requirement in terms of its benefit to young women other than that it provides the opportunity to "discuss the consequences of her decision in the context of the *values and moral or religious principles* of their family."[145] *Casey* clearly shows how the Court's growing preoccupation with the rights of the fetus has moved to center stage. Revealed as the animating force behind the Court's support for parental involvement requirements, it is now easier to understand why the Court shifted away from the medical paradigm set out in *Roe*.

Had the Court continued to reason within this medical paradigm, it could not have avoided confronting the reality that teens enjoy considerable autonomy when it comes to their own health care, especially when matters of a "sensitive" nature are at issue. Faced with this reality, the Court would then have been compelled to ask and answer the kinds of questions set out earlier in this article—namely how a state can distinguish between teens based on their intended pregnancy outcome, granting decisional autonomy to those carrying a pregnancy to term while casting those seeking to abort as vulnerable and in need of guidance.

However, with *Bellotti II*, the Court's understanding of abortion shifted. It no longer spoke of abortion as primarily a medical decision, but as one imbued with "profound moral and religious concerns."[146] Whether or not this shift was a deliberate strategy by the Court to avoid

144. *Casey*, 505 U.S. at 872.
145. *Casey*, 505 U.S. at 899–900 (emphasis added).
146. Bellotti v. Baird, 443 U.S. at 622, 640 (1979).

confronting the discriminatory allocation of medical decision-making rights is unclear; nonetheless, the shift in paradigm was, from the Court's perspective, a success. Draped in symbolic meaning, abortion can no longer be compared to other decisions that a teen may be called upon to make, such as whether she is ready to embrace motherhood and the adult responsibilities, including full medical autonomy, that this status entails.

As revealed in *Casey*, the decision to abort is a decision that the state may seek to undo in furtherance of its interest in persuading women to choose motherhood over abortion. As further revealed, parental involvement laws nobly serve this function, thereby enabling the Court to reason about them within a self-contained and created framework that ignores the true status of teens as possessors of meaningful medical decision-making rights.