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## **Under Age: A Minor's Right to Consent to Health Care**

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# TOURO LAW REVIEW

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## UNDER AGE: A MINOR'S RIGHT TO CONSENT TO HEALTH CARE

Nancy Batterman, Esq.\*

### INTRODUCTION

The rights of minors to consent to their own health care is a perennial dilemma facing the medical and legal communities. Several circumstances, at the current time, have exacerbated this dilemma. First, a majority of adolescents engage in sexual activity well before they reach eighteen years of age, the age at which they would be legally entitled, in most jurisdictions, to consent to their own health care. Therefore, it is not surprising that adolescents are contracting the HIV/AIDS infection at an alarming rate<sup>1</sup> and that other sexually transmitted diseases afflict

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The views expressed in this Article are solely those of the author and should not be taken to represent the views of the New York City Law Department or the City of New York.

1. See *Hearings Before the House Appropriations/Labor, Health and Human Services, Education and Related Agencies*, 103rd Cong., 2nd Sess.

a large number of adolescents.<sup>2</sup> Second, and no less significant, is the status of American family life. With divorce and teenage pregnancy rates soaring, a large number of minors spend their childhood in single parent households<sup>3</sup> and, as a consequence, have fewer adults around with whom health care practitioners, practically or effectively, can communicate. Teenage substance abuse and suicide rates are also on the rise in what many view as a response to the larger problems teenagers face today. The incidence of child abuse and incest is yet another disturbing

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(1994) (statement of Dr. Bill Caspe, director of the Bronx Pediatric AIDS Consortium). Dr. Caspe testified that “[a]s of September 1993 . . . over 14,000 young people ages 13 to 24 . . . have been diagnosed with AIDS” and that HIV disease is “the sixth leading cause of death among young people 15 to 24 years old.” *Id.* See also U.S. DEP’T OF HEALTH & HUMAN SERVS. SURVEILLANCE REP. 11 (3d quarter ed. 1993) (revealing that 980 males and 435 females between the ages of 13 and 19 were afflicted with AIDS during the period from January 1, 1993 to September 30, 1993); Carmen Alicia Fernandez, *Venezuela: Adolescent Mothers Increasing Every Year*, INTER. PRESS SERV., Nov. 11, 1993 (“If the present situation continues, in three years we will have 18,000 adolescents infected with AIDS and other sexually transmitted diseases.”); Bette Harrison & Elizabeth Lenhard, *The AIDS Epidemic: Women, Teens Fall as HIV Widens Its Range*, ATLANTA J. & CONST., March 11, 1994, § A, at 6 (explaining that one reason for the increase of AIDS in adolescents stems from their belief that they are “immortal”).

2. See Benjamin R. Barber, *America Skips School: Why We Talk So Much About Education And Do So Little*, HARPER’S MAG., Nov. 1993, at 39 (stating that “2.5 million adolescents annually contract a sexually transmitted disease”); Bryanna LaToof, *Increase in Teen Sex Paced By Rise In Disease*, ST. PETERSBURG TIMES, Feb. 25, 1994, at 1D (“Adolescents experience higher rates of sexually transmitted disease (STD) than any other age group and are the least likely to seek medical treatment.”).

3. See Jerry Adler, *Kids Growing Up Scared*, NEWSWEEK, Jan. 10, 1994, at 43 (“There has been a 200% growth in single-parent household[s], from 4 million to 8 million homes.” (citing BUREAU OF THE CENSUS, U.S. DEP’T OF COMMERCE)); Ronald Brownstein, *Clinton, Bush Step Up Debate on Family Values; Politics: Both Focus on the Issue in Cleveland Speeches*, L.A. TIMES, May 22, 1992, at A22 (stating that there are “a growing number of single parent families - 12% among whites, [and] 45% among blacks”); David Popenoe, *Mixed Blessings*, CURRENT, Feb. 1993, at 36 (stating that the nuclear family has progressively weakened over time due to increases in single-parent families).

factor plaguing American family life which inevitably interferes with parental ability to engage in or advocate on behalf of a minor's health care interests. Given the sensitive nature of these issues, it comes as no surprise that the law has never adequately addressed the question of whether, or when, a minor can consent to his or her own health care. Courts and legislatures alike are as fearful of encroaching upon parental rights<sup>4</sup> as they are of exposing health care workers to increased liability. As a consequence, even when our lawmakers directly confront these issues, the results are mired in vagaries and ambiguities that will be amply illustrated by this article's case study of New York State law.

When legislatures do specifically promulgate minors' health care legislation, it generally falls into one of two categories: a given minor's status authorizes him or her to consent to health care<sup>5</sup> or a particular medical condition triggers the afflicted

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4. See Francis Barry McCarthy, *The Confused Constitutional Status and Meaning of Parental Rights*, 22 GA. L. REV. 975 (1988). Professor McCarthy noted that "there has been a natural tendency among courts and commentators to define the underlying reasons why [parental] rights ought to be respected . . ." *Id.* at 1016. The reason that state legislatures and courts do not encroach upon parental authority is based on two assumptions. First, "parents possess what a child lacks in maturity," and second, parents will act in the best interests of the child. *Id.* at 1019 (citations omitted).

5. See, e.g., CAL. CIV. CODE § 34.6 (West 1982) (allowing a "minor 15 years of age or older who is living separate and apart from his parents or legal guardian, whether with or without the consent of a parent . . . and who is managing his own financial affairs" to consent to medical care); MD. CODE ANN., HEALTH-GEN. § 20-102 (1990 & Supp. 1993) (providing that a minor can consent to medical treatment only if "the minor is married" or "is the parent of a child"); N.C. GEN. STAT. § 90.21.5(b) (1993) ("Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child."); N.Y. PUB. HEALTH LAW § 2504 (McKinney 1993) (providing that "[a]ny person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services"); TEX. FAM. CODE ANN. § 35.03 (West 1986) (providing that minors can consent to medical treatment "if the minor is on active duty with the armed services of the United States" or "is 16 years of age or older and resides separate and apart from his parents").

minor's right to consent to his or her own health care.<sup>6</sup> As implemented by legislatures, these categories are heavily value-laden. For example, in the case of the medical condition trigger category, the legislature has determined either that the condition is too damaging to society as a whole to remain untreated<sup>7</sup> or that the treatment is harmless enough to the minor to warrant its application without parental consent.<sup>8</sup> With respect to the minor's status category, the legislature there has decided that, *inter alia*, getting married, joining the armed services, turning eighteen or having a child, constitutes an act of physical, psychological or economic separation from one's parents. This separation encroaches upon the parents' ability to determine the appropriate health care for such children.<sup>9</sup> As will be further illustrated by the New York State case study, legislatures have embraced a hybridization of both these approaches.<sup>10</sup>

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6. *See, e.g.*, CAL. CIV. CODE § 34.5 (West 1982) (providing that "an unemancipated minor may give consent to the furnishing of hospital, medical and surgical care related to the prevention or treatment of pregnancy, and that consent shall not be subject to disaffirmance because of minority"); GA. CODE ANN. § 37-7-8 (1982) (allowing a minor to consent to treatment for drug abuse "as if the minor had achieved his majority"); LA. REV. STAT. ANN. § 40:1095 (West 1992) (providing that a minor can consent to medical treatment where the minor "believes himself to be afflicted with an illness or disease"); MD. CODE ANN., HEALTH-GEN. § 20-102 (providing that in an emergency situation "[a] minor has the same capacity as an adult to consent to medical treatment").

7. *See, e.g.*, ANGELA R. HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 141-42 (1977). Dr. Holder notes that "[t]he consequences of untreated contagious diseases in general and venereal diseases in particular are so enormous both to the child himself and to society in general that common sense would require a physician to take the view that something has to be done and to do it." *Id.* at 142.

8. In at least one instance, giving certain minors authority to donate blood without parental consent fulfilled a different purpose -- the public's need to increase the blood supply. Bill Jacket to N.Y. PUB. HEALTH LAW § 3123, 1974 N.Y. Laws 64, at 5-7. *See also infra* note 93 and accompanying text.

9. *See* Tania E. Wright, *A Minor's Right to Consent to Medical Care*, 25 HOW. L.J. 525, 529 (1982) (stating that emancipation of a minor is best characterized as the actual "release of the child by his parents and the actual independence . . .").

10. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2504 (waiving parental consent requirement when an emergency exists but allowing a minor to consent where

One of these legislative categories, the minor's status category, is also reflected in two common law doctrines relevant to this area - - the "emancipated minor" and the "mature minor" doctrines. An "emancipated minor" is generally "one who (1) is living separate and apart from parents with or without their consent; (2) is self-supporting, but without regard to the source of income; and (3) is managing his or her own financial affairs."<sup>11</sup> The "mature minor" doctrine authorizes a minor to consent to medical treatment without parental consent if that minor is of sufficient maturity and intelligence to understand and appreciate the benefits and risks of the proposed treatment; in other words, the "developmental maturation of cognition" provides the authority for such minors to consent to their own treatment.<sup>12</sup> Whether these doctrines implicitly or explicitly survive minors' health care legislation is another ambiguity that, as the New York State case study will illustrate, continues to puzzle courts and health practitioners alike.

## A CASE STUDY - - NEW YORK STATE

### *A. Public Health Law section 2504*<sup>13</sup>

The present legislative scheme pertaining to the health care of minors in New York State engenders a tremendous amount of

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he or she is at least 18 years of age and/or married or pregnant); *see also* MD. CODE ANN., HEALTH-GEN. § 20-102(a)-(b) (providing that emancipated minors can consent to their own medical treatment but also allowing unemancipated minors to give consent for emergency treatment).

11. J. MORRISSEY ET AL., *CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS* 34 (1986). The common law "emancipated minor" doctrine discussed herein should not be confused with statutory emancipation provisions that allow minors to attain legal adulthood before reaching the age of majority. C. Sanger & E. Willemsen, *Minor Changes: Emancipating Children in Minor Times*, 25 U. MICH. J.L. REF. 239 (1992).

12. MORRISSEY ET AL., *supra* note 11, at 43.

13. N.Y. PUB. HEALTH LAW § 2504 (McKinney 1993); *see also infra* notes 13-20 and accompanying text.

uncertainty and confusion. The focal point of this confusion, section 2504 of the Public Health Law, was enacted by the State Legislature on February 15, 1972.<sup>14</sup> Section 2504 can be characterized for the most part as a minor's status category piece of legislation. Subsection 1 thereof, for example, states that "[a]ny person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary."<sup>15</sup> Subsection 2 goes on to authorize individuals "who [have] been married or who [have] borne a child [to] give effective consent for medical, dental, health and hospital services for [their] children,"<sup>16</sup> and subsection 3, which was added in 1984,<sup>17</sup> authorizes pregnant individuals to "give effective consent for medical, dental, health and hospital services relating to prenatal care."<sup>18</sup> Only subsection 4 might be seen as falling into the medical condition trigger category, since it waives any requirement for the consent of a parent or legal guardian "when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health."<sup>19</sup> Finally, the statute provides protection for health care workers in stating that persons who act "in good faith based on the representation by a person that he is eligible to consent pursuant to the terms of [section 2504] shall be deemed to have received effective consent."<sup>20</sup>

The road to enactment of section 2504 was rocky, and the provision has left many questions in its path. A predecessor

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14. 1972 N.Y. Laws 769, § 1. This section became effective on June 2, 1972, pursuant to 1972 N.Y. Laws 769, § 2.

15. N.Y. PUB. HEALTH LAW § 2504(1).

16. *Id.* § 2504(2).

17. *See* 1984 N.Y. Laws 976, § 1.

18. N.Y. PUB. HEALTH LAW § 2504(3).

19. *Id.* § 2504(4).

20. *Id.* § 2504(5).

provision, A. 6585,<sup>21</sup> was passed by both houses, but vetoed by Governor Rockefeller in 1971.<sup>22</sup> A. 6585 did not encompass hospital services. It also did not allow minor parents of children to give effective consent for the parents' own medical, dental and health services. Finally, A. 6585 contained a paragraph, that was deleted from the 1972 enactment, which enumerated specific types of treatment for which all minors were authorized to give effective consent:

Any minor may give effective consent for medical and health services to determine the presence of or to treat pregnancy, drug and alcohol abuse, tuberculosis, and other contagious, infectious, or communicable diseases and the consent of no other person shall be necessary.<sup>23</sup>

In his veto message for A. 6585, Governor Rockefeller expressed his concern that the proposed legislation contained "internal inconsistencies and ambiguities[,] and . . . would not sufficiently safeguard the interests of parents and the Community at large in protecting minors from ill-advised medical treatment."<sup>24</sup> One commentator noted at the time that A. 6585 might have been a backwards step for New York in that there were already many instances in which unmarried minors could request and receive medical services and that the statute's own exceptions to this general rule were far more limited and ambiguously worded.<sup>25</sup> For example, municipal hospitals already were performing abortions on minors without parental consent if

21. A. 6585, N.Y. Legis., 194th Sess. (1971). A. 6585 was to amend the New York General Obligations Law rather than the Public Health Law. *Id.*

22. See *Governor's Memoranda on Bills Vetoed*, 1971 N.Y. LEGIS. ANN. 635 [hereinafter *Governor's Memoranda*].

23. A. 6585, *supra* note 21, § 1.

24. See *Governor's Memoranda*, *supra* note 22. The Governor also mentioned that among the groups recommending disapproval of the bill were the State Education Department, the Committee on Health of the Community Service Society, and the Citizens Committee for Children. *Governor's Memoranda*, *supra* note 22.

25. See Harriet F. Pilpel, *Minors' Right to Medical Care*, 36 ALB. L. REV. 462, 469 (1972). Ms. Pilpel wrote her article before the enactment of N.Y. PUB. HEALTH LAW § 2504 and its 1984 amendment.



the patients were at least seventeen years old, married or emancipated, or if seeking parental consent might have endangered their physical and mental health.<sup>26</sup>

*B. The “Emancipated Minor” and “Mature Minor” Doctrines in New York State*

Not everyone was pleased after the New York State Legislature had approved what is today’s section 2504 of the Public Health Law.<sup>27</sup> Letters urging the Governor to veto the measure were

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26. Pilpel, *supra* note 25, at 469-70. Ms. Pilpel also criticized the provision’s emergency exception on the ground that “[m]aking an exception for delay . . . [would] not cover many cases where the problem is not delay but refusal to seek badly needed treatment if parental consent is a requisite.” Pilpel, *supra* note 22, at 470. The same criticism can be directed at today’s emergency exception. *See also* N.Y. PUB. HEALTH LAW § 2504(4).

27. In letters written to Governor Rockefeller, several opponents of the bill asserted that the bill, in practice, made health care unavailable to many minors because it replaced the traditional, less restrictive “mature minor” and “emancipated minor” doctrines with a more restrictive specific age requirement. For example, a memorandum written on behalf of Dr. Alan Miller, Commissioner of the New York Department of Mental Hygiene, recognized that under the existing law at that time, a “responsible doctor” could provide medical services to a “reasonably mature minor” without obtaining parental consent. *See* Memorandum from Department of Mental Hygiene to Michael Whiteman, Counsel to the Governor (May 24, 1972), *in* Bill Jacket to 1972 N.Y. Laws 769. Furthermore, enactment of the bill would “result in the use of stricter legal criteria [than the two doctrines traditionally applied] in judging the conduct of responsible medical professionals and institutions furnishing medical treatment to minors where it appears professionally responsible to do so without parental consent.” *Id.* Dr. Adele Hofmann, writing for the New York Chapter of the Society for Adolescent Medicine, reasoned that “physicians have been free to act on the concept of the mature minor . . . . To now stipulate that an individual must be of a specific age to receive health care on their own consent . . . can only be viewed as restrictive . . . .” Letter from Dr. Adele D. Hofmann to Governor Nelson Rockefeller (May 15, 1972), *in* Bill Jacket to 1972 N.Y. Laws 769. Dr. Hofmann also noted that “there is no recognition that many youths under 18 are living away from home or are otherwise emancipated . . . . To fail to bestow the right of self consent on these youths is to effectively deny them care and penalize them if they try to act responsibly and seek needed medical attention.” *Id.*

written by various parties, but the bill was signed into law. The New York Chapter of the Society for Adolescent Medicine, for example, wrote to the Governor that the bill would “block care from some individuals [already] receiving it, impl[ie]d a restrictiveness to emergency care [then] now existent and totally fail[ed] to meet the needs of certain categories of youths who [had] been persistently denied health services because they [could not] consent on their own.”<sup>28</sup> This concern was also reiterated by the Citizens Union of the City of New York,<sup>29</sup> the Citizens’ Committee for Children of New York, Inc.,<sup>30</sup> the Community Service Society,<sup>31</sup> and Planned Parenthood of New York City, Inc.<sup>32</sup>

These detractors often referred to the bill’s omission of those “emancipated” and “mature” minors who should have been entitled to consent to their own medical treatment.<sup>33</sup> At its inception, the common law “emancipated minor” doctrine

28. Letter from Dr. Adele D. Hofmann to Governor Nelson Rockefeller (May 15, 1972), *in* Bill Jacket to 1972 N.Y. Laws 769, § 1.

29. *See* Letter from Citizens Union of the City of New York to Hon. Michael Whiteman, Counsel to the Governor (May 31, 1972), *in* Bill Jacket to 1972 N.Y. Laws 769, § 1 (expressing concern that “the bill might be held to limit the right to treatment without parental consent . . . whereas many young people not covered by this bill are now being so treated with presumed legality under common law or other authorizations”).

30. *See* Letter from Citizens’ Comm. for Children of N.Y., Inc. to Hon. Nelson Rockefeller (May 10, 1972), *in* Bill Jacket to 1972 N.Y. Laws 769, § 1 (arguing that such a limited bill would delay effective resolution of the consent issue in the future).

31. *See* Letter from Community Service Society to Hon. Michael Whiteman, Secretary to the Governor (May 3, 1972), *in* Bill Jacket to 1972 N.Y. Laws 769, § 1 (urging against the legislation because it “should not establish an arbitrary limitation that would meet the needs of some, but would fail others with precisely the same problems”).

32. *See* Letter from Planned Parenthood of New York City, Inc. to Hon. Nelson Rockefeller (May 19, 1972), *in* Bill Jacket to 1972 N.Y. Laws 769, § 1 (arguing that “legislation establishing 18 as the age at which a young person may consent to medical services would be construed by many as a restriction on the services now being given to those under 18” resulting “in further confusion, cut-backs in accessibility to service and diminution of service now available”).

33. *See supra* notes 28-32 and accompanying text.

referred to a minor whose parents had relinquished their claims on his or her earnings,<sup>34</sup> a concept that ultimately came to mean that parents had relinquished control over their child's behavior and personal affairs.<sup>35</sup> It is therefore not surprising to find this doctrine most often referenced in New York cases involving child support payments.

In *Gittleman v. Gittleman*,<sup>36</sup> for example, a separation agreement called for a reduction in alimony payments when a child either reached the age of eighteen or was "emancipated."<sup>37</sup> The fact that the child had moved from his mother's house to his father's house was deemed insufficient to constitute emancipation.<sup>38</sup> In *Zuckerman v. Zuckerman*,<sup>39</sup> a divorce agreement called for support payments until the "child attained

34. See, e.g., *Wayne County Dep't of Soc. Servs. v. Schultz*, 81 Misc. 2d 603, 604, 366 N.Y.S.2d 845, 847 (Fam. Ct. Wayne County 1975) ("A self supporting child is an emancipated child."); *Harwood v. Harwood*, 182 Misc. 130, 134, 49 N.Y.S.2d 727, 730 (Sup. Ct. New York County 1944) (stating that emancipation "has frequently and more accurately been held to operate merely as a relinquishment to the child of its earnings, free of any of the rights or claims thereto in favor of the parent").

35. MORRISSEY ET AL., *supra* note 11, at 33; see also Lawrence P. Wilkins, *Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors*, 31 ARIZ. ST. L.J. 31, 38-39 (1975).

The concept of emancipation has evolved over the years to enable minors to be the determinative force in their own emancipation at certain times. MORRISSEY ET AL., *supra* note 11, at 33-34. "Parental relinquishment of claims to supervisory and controlling rights may now occur as much by passive default or simple incapacity as by affirmative and deliberate permission. Moreover, the ability of a minor to function as a self-supporting individual need not be demonstrated by traditional employment alone." *Id.* See also Danny R. Veilleux, Annotation, *Medical Practitioner's Liability for Treatment Given Child Without Parent's Consent*, 67 A.L.R.4th 511, § 2[a] (1989). The factors establishing emancipation "vary to some degree[;]" however, the courts generally look at marriage, age, whether the minor lives away from home and if he or she makes independent financial decisions or is financially independent. *Id.* at 518.

36. 81 A.D.2d 632, 438 N.Y.S.2d 130 (2d Dep't 1981).

37. *Id.* at 632, 438 N.Y.S.2d at 131.

38. *Id.* at 633, 438 N.Y.S.2d at 132.

39. 154 A.D.2d 666, 546 N.Y.S.2d 666 (2d Dep't 1989).

21 years of age, died, married, or became emancipated.”<sup>40</sup> The child was deemed to be emancipated when, at seventeen years of age, he entered the United States Military Academy at West Point.<sup>41</sup>

Even outside the health care context, “emancipated minors” have not been authorized to control every aspect of their daily lives.<sup>42</sup> While being allowed, for example, to retain their own wages,<sup>43</sup> sue their parents for injuries that result from the parent’s negligence,<sup>44</sup> establish their own domicile,<sup>45</sup> and receive

40. *Id.* at 666, 546 N.Y.S.2d at 666-67.

41. *Id.* at 668, 546 N.Y.S.2d at 667. It should be noted, however, that in *Staten Island Hosp. v. Porter*, 59 Misc. 2d 389, 298 N.Y.S.2d 598 (N.Y. Civ. Ct. 1969), the court discussed an earlier line of cases involving separation agreements in which induction into the armed services had not, in and of itself, served to emancipate the minor. 59 Misc. 2d at 391, 298 N.Y.S.2d at 599. *See also Harwood*, 182 Misc. at 134, 49 N.Y.S.2d at 730 (holding that the “induction of [a] child into the armed services” does not emancipate the minor). In these particular cases, the agreements themselves obligated fathers, without exception, to pay their wives a stipulated amount during the infant’s minority, and the courts were loathe to unilaterally vary or destroy valid, voluntary contracts. *See also Bates v. Bates*, 62 Misc. 2d 498, 310 N.Y.S.2d 26 (Fam. Ct. Westchester County 1970). In *Bates*, the court held that a child had not been emancipated despite his refusal to attend school and alleged participation in misconduct. *Id.* at 504, 310 N.Y.S.2d at 33. The father had made weekly child support payments and listed the child as a dependent on his federal income tax return. *Id.* at 507, 310 N.Y.S.2d at 35. The court found that the child was entitled to support as it might determine. *Id.*; *see also* N.Y. FAM. CT. ACT § 413 (McKinney 1991) (emancipation of child suspends parent’s support obligation); WILLIAM T. NELSON, *DIVORCE AND ANNULMENT* § 14:80 (2d ed. 1961) (mother cannot compel child support payments where child’s dependency has ceased by emancipation due to marriage or service in the armed forces).

42. *See Rights and Responsibilities of Young People in New York*, 1990 N.Y. STATE BAR ASS’N REPORT 18 [hereinafter NYSBA REPORT].

43. *Id.* at 17; *see also* N.Y. GEN. OBLIG. LAW § 3-109 (McKinney 1989) (stating that payment of wages to minors is valid unless notified in writing that his or her parent or guardian is claiming such wages).

44. *See* NYSBA REPORT, *supra* note 42, at 17.

45. *See* NYSBA REPORT, *supra* note 42, at 17; *see also In re Chrystol B.*, 104 Misc. 2d 888, 891, 429 N.Y.S.2d 358, 360 (Fam. Ct. New York County 1980) (“Although emancipated minors can set up separate domiciles for

public assistance,<sup>46</sup> they have been prohibited from signing their own leases, buying, selling or controlling real property,<sup>47</sup> or obtaining employment certificates.<sup>48</sup> Moreover, in *Moe v. Dinkins*,<sup>49</sup> the United States Court of Appeals for the Second Circuit refused to read an “emancipated minor” exception into the State’s Domestic Relations Law requirement that a person had to be eighteen years old before he or she could marry without parental consent.<sup>50</sup>

There appears to be only one case within New York jurisprudence that has addressed the “emancipated minor” doctrine in the context of health care. In *Bach v. Long Island Jewish Hospital*,<sup>51</sup> a case that significantly preceded the enactment of section 2504, a twenty-one year old woman sought

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themselves, unemancipated minors continue to have their place of domicile, the residence of their parents or guardians.”).

46. See NYSBA REPORT, *supra* note 42, at 17; see also *Tucker v. Toia*, 43 N.Y.2d 1, 9, 371 N.E.2d 449, 452, 400 N.Y.S.2d 728, 731 (1977) (holding unconstitutional a statute denying public assistance to emancipated minors “solely on the ground that they have not obtained a final disposition in a support proceeding . . .”); *Edwards v. Travis*, 57 A.D.2d 687, 393 N.Y.S.2d 830, 831 (3d Dep’t 1977) (“An emancipated minor over 16 years of age may receive public assistance in her own right if she is ‘otherwise eligible.’” (citing N.Y. COMP. CODES R. & REGS. title 18, § 349.5[1] (1976))).

47. See NYSBA REPORT, *supra* note 42, at 18; see also N.Y. DOM. REL. LAW § 80 (McKinney 1988) (providing that “[w]here a minor for whom a general guardian of the property has not been appointed shall acquire real property, the guardianship of his property” belongs either to the parents or closest living relative if there are no parents); N.Y. DOM. REL. LAW § 84 (McKinney 1994) (stating that “[t]he lawful marriage of a person before he or she attains majority terminates a general guardianship with respect to his or her person, but not with respect to his or her property”).

48. See NYSBA REPORT, *supra* note 42, at 18.

49. 635 F.2d 1045 (2d Cir. 1980), *cert. denied sub nom. Coe v. Axelrod*, 459 U.S. 827 (1982).

50. See N.Y. DOM. REL. LAW § 7 (McKinney 1988). When minors do marry without parental consent in New York State, however, the marriages are still valid unless declared void by a court that has explored all of the surrounding facts and circumstances. *Id.*

51. 49 Misc. 2d 207, 267 N.Y.S.2d 289 (Sup. Ct. New York County 1966).

to disaffirm the consent she had given when she was nineteen and one-half years old to a non-emergency surgical operation that resulted in scarring.<sup>52</sup> The woman was characterized by the *Bach* court as “a minor emancipated by marriage” at the time she consented to the procedure.<sup>53</sup>

The *Bach* court cited a number of then-existing statutory provisions, some of which are still operative today.<sup>54</sup> Most of the provisions cited were from the Domestic Relations Law, and stated, among other things, that an eighteen year old woman could marry without parental consent and that, upon her marriage, her guardianship was terminated with respect to her person but not with respect to her property.<sup>55</sup> The *Bach* court also cited what was then the Decedent Estate Law section 15,<sup>56</sup> the Debtor and Creditor Law section 260,<sup>57</sup> and the General Obligations Law section 3-101.<sup>58</sup> From this litany, the *Bach*

52. *Id.* at 208, 267 N.Y.S.2d at 290.

53. *Id.*

54. *Id.* at 208, 267 N.Y.S.2d at 290-91.

55. *Id.* at 208, 267 N.Y.S.2d at 290 (citing DOM. REL. LAW §§ 15, 84).

56. N.Y. DECEDENT EST. LAW § 15 (McKinney Supp. 1966) (providing that any minor attaining the age of eighteen years may make a will disposing of his personal estate).

57. N.Y. DEBT. & CRED. LAW § 260 was repealed in 1964 and infant's contracts are now governed entirely by N.Y. GEN. OBLIG. LAW § 3-101 (McKinney 1989). This section provides, in pertinent part:

A person who has attained the age of eighteen years shall have the power, regardless of his minority to enter into a binding and enforceable contract for a loan or loans with a bank, trust company, private banker, . . . and to take any other action and execute any other document or instrument to the extent necessary or appropriate to effect any such loan, provide security thereof, carry out or modify the terms thereof, and effect any compromise or settlement of any loan or of any claim with respect thereto.

*Id.* at 3-101(4).

58. N.Y. GEN. OBLIG. LAW § 3-101 (a minor is only entitled to disavow contracts under certain conditions). The *Bach* court cited an older special term case, *Cohen v. Delaware, L. & W. R. Co.*, 150 Misc. 450, 454, 269 N.Y.S. 667, 672 (Sup. Ct. New York County 1934), to support the proposition that married minors may exercise custody and control over their children, and that an emancipated minor may establish a domicile apart from the parental abode; however, *Cohen* really only determined the latter principle.

court deduced that the jurisdiction recognized a legal distinction between a minor's personal and property rights.<sup>59</sup> Only the former could be altered without the intervention of a guardian or the court as *parens patriae*. The court thus reasoned that the "[p]laintiff's consent to the surgical procedure involved was an act of volition, and was a personal right which was validly exercised."<sup>60</sup>

The "mature minor" doctrine, which was also cited by the initial critics of section 2504, is of such a subjective nature that it has been even less popular with legislatures than the "emancipated minor" doctrine.<sup>61</sup> A New York court recently touched upon this issue in *In re Long Island Jewish Medical Center*<sup>62</sup> when it had to decide, in its role as *parens patriae*, whether to order unlimited blood transfusions for Phillip Malcolm, a boy seven weeks short of his eighteenth birthday.<sup>63</sup> As Jehovah's Witnesses, the boy and his parents refused to consent to transfusions if they became medically necessary and thereby thwarted the proposed chemotherapy treatment for the boy's cancer.<sup>64</sup> Without such treatment, the boy was certain to die.<sup>65</sup>

59. *Bach*, 49 Misc. 2d at 208, 267 N.Y.S.2d at 290-91

60. *Id.*

61. Veilleux, *supra* note 35, at 517; *see also* J. MORRISSEY ET. AL., *supra* note 11, at 44 (noting that "[o]nly five states have laws specifically permitting mature minors to consent to health care . . . without parental consent").

62. 147 Misc. 2d 724, 557 N.Y.S.2d 239 (Sup. Ct. Queens County 1990).

63. *Id.* at 724-25, 557 N.Y.S.2d at 240.

64. *Id.* at 725, 557 N.Y.S.2d at 240. Two of Malcolm's treating physicians testified at a court hearing that the necessary treatment would be chemotherapy and radiation. *Id.* at 725-26, 557 N.Y.S.2d at 240-41. However, blood transfusions would have to be performed before treatment could be attempted, and further transfusions would be necessary during the chemotherapy treatment. *Id.*

65. *Id.* at 726, 557 N.Y.S.2d at 241. According to Dr. Philip Lanzkowsky, Chief of Pediatric Hematology and Oncology at Long Island Jewish Medical Center, 75% of patients with Malcolm's condition that receive treatment enter remission periods ranging from several months to years, and 25% to 30% of these patients are cured. *Id.*

The Queens County Supreme Court observed that other states had adopted the "mature minor" doctrine,<sup>66</sup> but that, in its view, Phillip Malcolm was not a mature minor: he had never dated a girl or been away from home, he consulted his parents before making decisions, and he self-admittedly considered himself to be a child.<sup>67</sup> The court also noted the many instances in which New York State law permitted minors to consent to health care,<sup>68</sup> but questioned whether the right to consent should be equated with the right to refuse health care.<sup>69</sup> The court then recommended that the legislature or the appellate courts "take a hard look at the 'mature minor' doctrine and make it either statutory or decisional law in New York State[.]" as well as allow for a hearing to be held first to determine whether a minor is or is not mature.<sup>70</sup>

Since the court in *In re Long Island Jewish Medical Center* concluded that Phillip Malcolm was not a mature minor, did it implicitly authenticate the "mature minor" doctrine? Did it then simply call for statutory or appellate confirmation? Given the

66. See *infra* notes 129-163 and accompanying text.

67. *Long Island Jewish*, 147 Misc. 2d at 727, 730, 557 N.Y.S.2d at 242-43.

68. *Id.* at 729-30, 557 N.Y.S.2d at 243; see also N.Y. MENTAL HYG. LAW §§ 9.13 (McKinney 1994) (enabling minors over 16 years of age to receive inpatient treatment upon voluntary application and consent), 21.11 (allowing a minor to voluntarily seek inpatient or outpatient treatment for alcohol or substance abuse without parental consent if a physician believes treatment is necessary and is either unable to obtain parental consent or parental involvement would have a "detrimental effect" on treatment), 33.21 (allowing minors to consent to voluntary mental health services if the minor meets certain enumerated criteria); N.Y. PUB. HEALTH LAW §§ 2305(2) (McKinney 1993) (waiving parental consent requirement for minors under age 21 for treatment of sexually transmitted diseases), 2504(1)-(2) (treating pregnant minors and minor parents as adults with respect to decision making capacity for their child's health care as well as their own).

69. *Long Island Jewish*, 147 Misc. 2d at 729, 557 N.Y.S.2d at 243.

70. *Id.* at 730, 730 n.16, 557 N.Y.S.2d at 243, 243-44 n.16. It was then recommended that the matter should end if the minor is found to be mature, but that the hearing should continue outside the minor's presence if he or she is found to be immature. *Id.* ("It is a terrible psychological shock to a patient to hear for the first time how serious his or her physical condition is and how minimal are the chances of survival.").



extremely difficult position it found itself in, the court may have viewed its rulings with respect both to the boy's maturity and to the "mature minor" doctrine as a means to justify what it considered a noble end - - saving Phillip Malcolm's life. In point of fact, the "mature minor" doctrine is far more likely to be recognized when the proposed treatment is for the minor's own benefit; courts have refused to apply the exception when the treatment is for the benefit of a third party.<sup>71</sup>

In the aftermath of the enactment of section 2504 of the Public Health Law, the relevant question one must ask is whether the common law "emancipated minor" doctrine, apparently supported by *Bach*, and the common law "mature minor" doctrine, implicitly affirmed in *In re Long Island Jewish Medical Center*, survived the statutory codification of consent requirements for the health care of minors. Those parties urging Governor Rockefeller to veto the bill ostensibly answered this question in the negative.<sup>72</sup> Were they right to jump to this conclusion, and does subsequent jurisprudence or the experiences of other jurisdictions shed any light on this topic?

With respect to the "emancipated minor" doctrine, the first possibility to consider is that the legislators assumed that they had taken care of the entire universe of emancipated minors by

71. See Veilleux, *supra* note 35, at 523-24. For example, where a fifteen year old boy consented to an operation to provide his cousin with flesh for a skin graft, the court found that the boy's parents' consent had been necessary. *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941).

Another New York court recently faced the issue of a minor's refusal of treatment in *In re Thomas B.*, 152 Misc. 2d 96, 574 N.Y.S.2d 659 (Fam. Ct. New York County 1991). There, a fifteen year old boy vigorously objected to the use of surgical intervention to perform the biopsy of a tumor. *Id.* at 97, 574 N.Y.S.2d at 660. The family court granted his biological mother's petition for an order requiring the child to undergo the diagnostic surgery, under physical restraint if necessary, because she considered the treatment to be in the child's best interests. *Id.* at 99, 574 N.Y.S.2d at 661. Of special interest is how the court interpreted Public Health Law § 2504 in order to support its holding. *Id.* at 98-99, 574 N.Y.S.2d at 660-61. The court claimed that "[a]n implicit corollary of that provision is that a person under 18 years of age may not give effective consent" and that "it follows logically that such a person may not effectively withhold consent, either." *Id.*

72. See *supra* notes 27-32 and accompanying text.

authorizing married minors, like the plaintiff in *Bach*, to consent to their own medical, dental, health and hospital services.<sup>73</sup> Since *Bach* appears to be the only New York State case considering the “emancipated minor” doctrine in the health care context, this possibility is not entirely remote. On the other hand, the legislators may have also dismissed *Bach*'s utility because the plaintiff herself, not her parents, was seeking to renege a seemingly valid consent she had given to an earlier treatment.<sup>74</sup> Moreover, the only adverse consequence the plaintiff had suffered was scarring,<sup>75</sup> and the *Bach* court may have legitimately been disposed to side with the hospital which had cautiously performed the biopsy.<sup>76</sup>

### C. A Competing Legislative Proposal?

Another piece to the puzzle of the legislators' intent in promulgating Public Health Law section 2504 resides in a bill that remained in committee the same year that the New York Legislature approved the provision. That bill, S. 9464,<sup>77</sup> was introduced by former Senator A. Frederick Meyerson, and provided, *inter alia*, that “[a] person of at least sixteen years of age or an emancipated minor may consent to the provision of health services to himself.”<sup>78</sup> The bill defined emancipated minor, “*without limitation to its meaning at common law,*” as “a minor who is or has been married, is self-supporting, is managing his own financial affairs, or is residing apart from his

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73. See N.Y. PUB. HEALTH LAW § 2504(1) (McKinney 1993) (providing that “[a]ny person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services . . .”).

74. *Bach*, 94 Misc. 2d at 208, 267 N.Y.S.2d at 290.

75. *Id.*

76. Some commentators have also cited *Bach* for the proposition that New York courts support the “mature minor” doctrine. However, since the plaintiff in *Bach* was married and living with her husband, it would be more appropriate to view *Bach* as an “emancipated minor” doctrine case. See NYSBA REPORT, *supra* note 42, at 87 n.3.

77. S. 9464, N.Y. Legis., 195th Sess. (1972).

78. S. 9464, *supra* note 77, § 2432.

parents.”<sup>79</sup> The bill also stated that “[n]othing contained in this article shall be deemed to abrogate or in any way limit the right of a minor to consent to the provision of health services to himself *under common law*.”<sup>80</sup>

Senator Meyerson’s bill included other distinct provisions. For example, one paragraph enumerated specific types of treatment for which persons of any age could provide effective consent under particular circumstances:

A person of any age may consent to the provision to himself of health services relating to the prevention, diagnosis, treatment and prescription for alcohol abuse, drug abuse and pregnancy where, in the judgment of the attending physician for reasons stated in writing, it would be inimical to the person’s mental or physical health to attempt to seek parental consent.<sup>81</sup>

In this respect, Senator Meyerson’s bill shared a similarity with the vetoed A. 6585,<sup>82</sup> although A. 6585 more broadly encompassed tuberculosis and other contagious, infectious, or communicable diseases.<sup>83</sup>

Senator Meyerson’s bill also provided that “[a]ny minor may consent to the provision of health services to himself in an emergency,”<sup>84</sup> thereby alleviating the burden placed on

79. S. 9464, *supra* note 77, § 2434(1) (emphasis added).

80. S. 9464, *supra* note 77, § 2435 (emphasis added).

81. S. 9464, *supra* note 77, § 2433(1); *see also supra* note 21.

82. A. 6585, *supra* note 21.

83. It should be noted that before either A. 6585 or S. 9464 were drafted, New York State already provided statutory authorization for the diagnosis, treatment and prescription of persons under 21 years of age infected with, or exposed to, sexually transmissible diseases without parental consent. *See* N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 1993).

To the extent that A. 6585 encompassed communicable diseases, it may have intended to accomplish the admirable purpose of consolidating in one location all provisions relating to the medical treatment of minors, whether due to their status or due to their particular health needs. Given the plethora of statutes that have been promulgated since § 2504 was enacted in 1972, *see infra* notes 90-101 and accompanying text, the consolidation of all provisions concerning the medical treatment of minors in one location is once again a worthy goal. *See also supra* notes 166-169 and accompanying text.

84. S. 9464, *supra* note 77, § 2432.

physicians, by both A. 6585 and today's section 2504, to determine that given circumstances warrant immediate treatment.<sup>85</sup> Other sections in Senator Meyerson's bill seem to have attempted to ensure that physicians would not be held liable for going forward with treatment of a minor regardless of what analysis they were or were not called upon to make. For example: (a) proposed section 2434 provided that a minor's consent under the article's terms, and accepted in good faith, should be as effective as if the minor had reached his or her majority;<sup>86</sup> (b) a proposed amendment to section 3-101 of the General Obligations Law provided a new subdivision stating that an infant's contract under the article could not be disaffirmed by him on the ground of infancy where the contract was reasonable and provident when made;<sup>87</sup> and (c) a proposed amendment to section 145-a of the Insurance Law provided, *inter alia*, that any minor authorized under the article to consent to the provision of health services would be deemed competent to contract for accident and health insurance upon his own person or upon the person of his wife or children.<sup>88</sup>

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85. However, under § 2433 of Senator Meyerson's bill, physicians still had to make comparable judgments for the treatment of alcohol abuse, drug abuse and pregnancy. S. 9464, *supra* note 77, § 2433. Some of these requirements have since been codified. For example, § 21.11 of the Mental Hygiene Law provides that minors may only be treated without parental consent for alcohol abuse if the requirement of consent would be detrimental to treatment or the parent has refused consent and the doctor believes that the treatment is in the minor's best interests. N.Y. MENTAL HYG. LAW § 21.11 (McKinney 1994).

86. S. 9464, *supra* note 77, § 2434.

87. S. 9464, *supra* note 77, § 2.

88. S. 9464, *supra* note 77, §§ 2, 3. The proposed amendment to § 145-a of the Insurance Law would also have enabled minors consenting to the provision of health services "to exercise and enjoy every right, privilege and benefit to which he may become entitled under such contract and to give a valid discharge for any benefit accruing or money payable thereunder." S. 9464, *supra* note 77, § 3; N.Y. INS. LAW § 145-a (McKinney 1985).

Section 3-101 of the General Obligations Law seems never to have been amended to reflect Senator Meyerson's concerns. Since it was originally enacted in 1963, this section has provided, *inter alia*, that "[a] contract made . . . by a person after he has attained the age of eighteen years, may not

Perhaps Senator Meyerson was just seeking to clarify what section 2504 had left unclear, rather than carving out a materially broader category of minors entitled to consent to their own health care. The proposed General Obligations Law and Insurance Law amendments certainly seemed aimed at clarification. So did the Meyerson bill's explicit definition of "health services" as "professional services provided by duly authorized or licensed persons in the practice of medicine and dentistry."<sup>89</sup> Still, the concerns of section 2504's objectors ring in our ears, and it is hard not to assume that Senator Meyerson's bill sought to address what these objectors considered section 2504's failings.

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be disaffirmed by him on the ground of infancy, where the contract was made in connection with a business in which the infant was engaged and was reasonable and provident when made." N.Y. GEN. OBLIG. LAW § 3-101(2) (McKinney 1989). The statute also authorizes husbands and wives, regardless of their minority, to enter into loan contracts with banks regarding real property they are occupying as a home. *Id.* § 3-101(3) (McKinney 1994). However, no provision blanketly affirms any infant's contract when reasonably and providently made. Part of Senator Meyerson's concern seems to have been addressed through a 1968 amendment to the General Obligations Law providing that "[a]n obligation incurred by a married minor for hospital, medical and surgical treatment and care for such minor or such minor's children shall not be voidable because of minority. For the purpose of this section only, subsequent judgment of divorce or annulment shall not alter the obligation previously incurred." *Id.* § 3-102(1). Obviously, based on its language, this provision does not cover minors who have never married.

With respect to Senator Meyerson's proposed amendment to the Insurance Law, the Insurance Law was recodified in 1984 and the derivation tables thereto indicate that former § 145 is now represented by § 3207(a), a provision that concerns itself solely with life insurance contracts by or for the benefit of minors. N.Y. INS. LAW § 3207(a) (McKinney 1985).

It should also be reiterated at this point that subdivision 5 of today's Public Health Law § 2504 also deems effective consents authorized by the provision that are acted upon in good faith. N.Y. PUB. HEALTH LAW § 2504(5) (McKinney 1993).

89. S. 9464, *supra* note 77, § 2431(1).

*D. Other New York State Statutes Addressing Minors' Health Care*

As noted, section 2504 is not the only provision for the health care of minors that New York State has enacted.<sup>90</sup> The other provisions relate to particular health needs of minors, rather than their individual statuses, and therefore fall into the medical condition trigger category.<sup>91</sup> On May 1, 1970, for example, licensed or staff physicians in hospitals were authorized to treat persons under twenty-one years of age for sexually transmissible diseases without the consent or knowledge of parents or guardians.<sup>92</sup> Although before 1972, people eighteen years of age were authorized to donate blood without obtaining parental consent, minors seventeen years of age or over are now able to donate blood under the same conditions.<sup>93</sup>

Ten years after section 2504 was enacted, the New York State Legislature authorized treatment for alcohol abuse and alcoholism without parental consent for minors of all ages if the requirement of consent would be detrimental to such treatment or the parent had refused to consent to what the physician believed was in the minor's best interests.<sup>94</sup> Minors may also knowingly and

90. See *supra* note 68 for other provisions.

91. See *supra* note 68.

92. See *supra* note 83. This provision was first added by 1970 N.Y. Laws 361. At that time, it provided that "[a] licensed physician may diagnose, treat or prescribe for a case of venereal disease in a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person." *Id.*

93. See N.Y. PUB. HEALTH LAW § 3123 (McKinney 1993) (added by 1968 N.Y. Laws 158 and amended by 1974 N.Y. Laws 64).

94. See 1982 N.Y. Laws 407; N.Y. MENTAL HYG. LAW § 21.11 (McKinney Supp. 1994) ("If . . . consent would have a detrimental effect on the course of treatment of a minor . . . or if a parent or guardian refuses to consent to such treatment and the physician believes that such treatment is necessary for the best interests of the child, such treatment may be provided to the minor . . ."). Although the statute does not explicitly so provide, it can be relied upon as authorizing treatment of minors for other substance abuse problems without obtaining parental consent. There is support for this approach both in the supporting memorandum of Assemblyman Eliot L. Engel, see 1982 N.Y. LEG. ANN. 136, and in the regulations outlining residential

voluntarily consent to certain outpatient mental health care if the same enumerated conditions are met.<sup>95</sup> If a minor is at least sixteen years of age, he or she can voluntarily consent to inpatient mental health treatment.<sup>96</sup>

In 1988, when the New York State Legislature enacted Article 27-F of the Public Health Law<sup>97</sup> concerning HIV and AIDS Related Information, the medical treatment of minors was considered in a slightly different manner. Section 2780(5) defines “capacity to consent” as

“an individual’s ability, determined *without regard to the individual’s age*, to understand and appreciate the nature and consequences of a proposed health care service, treatment or procedure, or of a proposed disclosure of confidential HIV

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chemical dependency programs for youths. *See* N.Y. COMP. CODES R. & REGS. tit. 14, § 1032.4(c) (1991). Nonetheless, it should be noted that a year before § 21.11 was enacted, an earlier version that expressly included treatment for substance dependence without parental consent was recalled by Senator Goodhue at the request of the Governor. Apparently, substance abuse programs across New York State had serious problems with the earlier legislation. *See* Letter from the State Division of Alcoholism and Alcohol Abuse to Hon. John G. McGoldrick (June 17, 1982), *in* Bill Jacket to 1972 N.Y. Laws 407.

95. *See* N.Y. MENTAL HYG. LAW § 33.21(c) (McKinney 1994)

96. *See* N.Y. MENTAL HYG. LAW §§ 9.13(a), 33.21 (McKinney 1988 & Supp. 1994). (“The director of any hospital may receive as a voluntary patient any suitable person in need of care and treatment, who voluntarily makes a written application therefor.”) In actuality, the inpatient branch of these provisions, § 9.13(a), originated in 1972, the very same year that § 2504 was enacted. *See* 1972 N.Y. Laws 251 at § 31.13(a). The outpatient branch, § 33.21 of the Mental Hygiene Law, stems from 1983 N.Y. Laws 790. However, New York State still has no specific provisions governing abortion, contraception, or sterilization, with respect to minors. Many of these issues have been the subject of intense litigation and are moderated by overriding federal constitutional principles and congressional regulation. *See, e.g.*, *Bellotti v. Baird*, 443 U.S. 622 (1979) (stating parental consent requirement does not unconstitutionally burden a minor’s right to seek an abortion if state also provides an alternative procedure whereby authorization for abortion can be obtained); *Carey v. Population Servs. Int’l*, 431 U.S. 678 (1977) (declaring unconstitutional a New York law which prohibited the distribution of contraceptives to minors under 16).

97. *See* N.Y. PUB. HEALTH LAW §§ 2780-2787 (McKinney 1993).

related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.”<sup>98</sup>

Article 27-F then provides, *inter alia*, that “no person shall order the performance of an HIV related test without first receiving the written, informed consent of the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, of a person authorized pursuant to law to consent to health care for such individual.”<sup>99</sup> Hence, provided a minor has the capacity to consent and has provided a written, informed consent,<sup>100</sup> he or she may be tested for HIV infection without the parent’s or guardian’s consent.<sup>101</sup>

What, if anything, do these provisions tell us about the present status of the “emancipated minor” and “mature minor” doctrines in New York State? Most noteworthy, sections 21.11<sup>102</sup> and 33.21<sup>103</sup> of the Mental Hygiene Law, which were both promulgated after section 2504 and deal, respectively, with a minor’s treatment for alcoholism and outpatient mental health care, define “minor” for their individual purposes as “a person under eighteen years of age . . . not includ[ing] a person who is the parent of a child, or has married or is emancipated.”<sup>104</sup> Thus, so-called “emancipated minors” can avail themselves of the designated services without parental consent even if a requirement of consent would not be detrimental to such treatment or a given parent has not refused such consent.

What at first blush appears to be a conscious expansion of the section categories of minors authorized to consent to their own health care, under section 2504, is muddied by the two bills’

98. *Id.* § 2780(5) (emphasis added).

99. *Id.* § 2781(1).

100. *Id.* § 2781(2). Subsection 2 outlines the contents of an informed consent statement, which must include, *inter alia*, an explanation of the test, the procedures to be followed, and the confidentiality protections afforded HIV-related information. *Id.*

101. *Id.* § 2781(1).

102. N.Y. MENTAL HYG. LAW § 21.11 (McKinney 1988 & Supp. 1994).

103. *Id.* § 33.21 (McKinney 1988).

104. *Id.* § 21.11(a); *see also id.* § 33.21(a).



supporting commentaries.<sup>105</sup> In the bill jacket to the alcoholism treatment provision, the State Division of Alcoholism and Alcohol Abuse noted that section 21.11's definition of "minor" was "consistent with section 2504 of the Public Health Law, and confront[ed] the need to deal with 'mature minors' or 'emancipated minors.'"<sup>106</sup> In contrast, the memorandum accompanying the outpatient mental health services provision, a Governor's Program Bill, noted that "Public Health Law section 2504 enables . . . unemancipated individuals under eighteen to consent to such services only upon a physician's determination of an emergency requiring immediate medical attention."<sup>107</sup> Thus, implying that "emancipated minors" could consent to such services under section 2504 even in the absence of an emergency. Additionally, a New York State Bar Association report, filed to support the outpatient mental health provision, included among its list of exceptions to the parental consent requirement the "emancipated minor doctrine," but presumed that courts, not physicians, would first make this determination.<sup>108</sup>

## STATUTES AND JUDICIAL PRECEDENTS IN OTHER JURISDICTIONS

### *A. The "Emancipated Minor" Doctrine*

Other states have similarly enacted a patchwork of legislation addressing health care for minors based upon a minor's status and/or medical condition.<sup>109</sup> Their courts have also been called

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105. See Letter from State Division of Alcoholism and Alcohol Services to Hon. John G. McGoldrick (June 17, 1982), in Bill Jacket to 1982 N.Y. Laws 407; Bill Jacket to 1983 Laws 790, at 10.

106. Letter from State Division of Alcoholism and Alcohol Services to Hon. John G. McGoldrick (June 17, 1982), in Bill Jacket to 1982 N.Y. Laws 407.

107. Bill Jacket to 1983 N.Y. Laws 790, at 10.

108. *Id.* at 17.

109. See, e.g., ILL. ANN. STAT. ch. 410, para. 210 (Smith-Hurd 1993); TENN. CODE ANN. §§ 68-34-104, 68-34-107 (1992), §§ 39-4-202 (1991),

upon to interpret and struggle with legislative intent.<sup>110</sup> One illustrative case involving the state of Washington is *Smith v. Seibly*.<sup>111</sup> As in *Bach*,<sup>112</sup> the plaintiff attempted to retroactively invalidate his and his wife's consent, in this case, to a vasectomy operation after he had reached the age of majority.<sup>113</sup> At the time of consent to the operation, the plaintiff had been a married eighteen year old minor and father who was a high school graduate and head of his own family.<sup>114</sup> He also owned his own home and supported himself financially.<sup>115</sup> The plaintiff sought the operation because he was afflicted with a progressive, incurable disease and wanted to limit the size of his family.<sup>116</sup> The surgeon had appropriately informed the plaintiff about the permanency of the procedure and had given him a chance to think about the operation overnight.<sup>117</sup>

The trial court had instructed the jury that the law in Washington at the time provided that operations could not be performed on minors unless consent was first obtained from the minor's natural guardians or parents, except if the operation was for the benefit of the minor and was done with the purpose of saving the minor's life or limb.<sup>118</sup> The Supreme Court of Washington recognized that emancipation of minors may occur even in the absence of a statute, and that "age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents [we]re all factors to be considered in such a case."<sup>119</sup>

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§§ 63-6-220, 63-6-222, 63-6-223 (1990); WASH. REV. CODE ANN. 70.24.110 (West 1992), §§ 18.71.220 (1989), 26.28.015(5) (1986).

110. See, e.g., *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987); *State v. Koome*, 530 P.2d 260 (Wash. 1975); *Smith v. Seibly*, 431 P.2d 719 (Wash. 1967).

111. 431 P.2d 719 (Wash. 1967)

112. See *supra* notes 51-60 and accompanying text.

113. *Smith*, 431 P.2d at 721.

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.* at 722 n.2.

119. *Id.* at 723.

Therefore, the Supreme Court of Washington determined that the trial court had properly instructed the jury as to the factors to be weighed in determining the plaintiff's capacity to consent to the operation.<sup>120</sup>

In *Smith*, the Supreme Court of Washington was not faced with a statutory scheme nearly as comprehensive as that in place in New York. In fact, most of the Washington statutes addressing aspects of a minor's health care were not enacted until after *Smith* was decided.<sup>121</sup> In 1969, for example, two years after *Smith* was decided, minors fourteen years or older were authorized to consent to the diagnosis and treatment of venereal disease.<sup>122</sup> In 1971, eighteen year olds were expressly authorized "[t]o make decisions in regard to their own body and the body of their lawful issue[,] whether natural born to or adopted by such person[,] to the full extent allowed to any other adult person including but not limited to consent to surgical operations."<sup>123</sup> This was also the same year in which physicians who were acting in good faith and rendering emergency care to any patient regardless of age were immunized from civil liability even where the patient, or someone else legally authorized, had not consented to the treatment.<sup>124</sup>

One wonders, however, whether these later statutes would have made a difference in the *Smith* decision. In 1975, when these statutes already had been codified, the Supreme Court of Washington had the opportunity to address an issue similar to that presented in *Smith*. In *State v. Koome*,<sup>125</sup> the court invalidated a statute requiring an unmarried woman to obtain parental consent prior to obtaining an abortion,<sup>126</sup> noting the statutes that already recognized a minor's competence to consent

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120. *Id.* at 724.

121. *See, e.g.*, WASH. REV. CODE ANN. §§ 70.24.110 (West 1992), 18.71.220 (1989), 26.28.015(5) (1986).

122. *Id.* § 70.24.110 (West 1992).

123. *Id.* § 26.28.015(5) (Supp. 1994).

124. *Id.* § 18.71.220.

125. 530 P.2d 260 (Wash. 1975).

126. *Id.* at 268.

to medical treatment.<sup>127</sup> The court further observed that none of these other provisions either stated or implied that persons under eighteen years of age did *not* have the right or capacity to make decisions regarding medical treatment, except for the abortion statute it was presently reviewing.<sup>128</sup> Interestingly enough, after *Smith* and *Koome*, the Washington State Legislature did not attempt to enact amendments to any of these provisions or to promulgate a more comprehensive statutory scheme.

### B. The "Mature Minor" Doctrine

In *In re E.G.*,<sup>129</sup> the Supreme Court of Illinois addressed the "mature minor" doctrine in a case involving a minor very much like *In re Long Island Jewish Hospital's Phillip Malcolm E.G.*, a seventeen year old female, diagnosed with acute nonlymphatic leukemia, and her mother refused to consent to blood transfusions prescribed to combat E.G.'s condition on the grounds of their religious convictions as Jehovah's Witnesses.<sup>130</sup> Here, however, unlike Phillip Malcolm in *In re Long Island Jewish Hospital*, the court expressly concluded that minors with the requisite degree of maturity do have a limited right to refuse life-sustaining medical treatment.<sup>131</sup>

Illinois, like New York, had certain statutory provisions regarding minors' health care that existed even at the time the *E.G.* decision was rendered.<sup>132</sup> The Illinois Consent by Minors

127. *Id.* at 266; see also *supra* note 121. The *Koome* Court also acknowledged WASH. REV. CODE ANN. § 69.54.060, which was enacted in 1971 and authorized persons fourteen or older to consent to treatment for alcohol and drug abuse and parental notification thereof. *Id.* This provision was repealed in 1989. See 1989 Wash. Laws ch. 270 § 35.

128. *Koome*, 530 P.2d at 266-67.

129. 549 N.E.2d 322 (Ill. 1989).

130. *Id.* at 323.

131. *Id.* at 327-28 ("If the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions . . . then the mature minor doctrine affords her the common law right to consent or to refuse medical treatment.").

132. See, e.g., ILL. ANN. STAT. ch. 750, paras. 30/1-30/11, ch. 410 para. 210/4 (Smith-Hurd 1993).

to Medical Procedures Act<sup>133</sup> granted minors the legal capacity to consent to medical treatment in certain situations, such as if those minors were married, pregnant or were at least twelve years of age and sought treatment for venereal disease, alcoholism or drug addiction.<sup>134</sup> The Illinois Emancipation of Mature Minors Act<sup>135</sup> enabled mature minors, defined as minors between sixteen and eighteen years of age who had “demonstrated the ability and capacity to manage their own affairs and to live wholly or partially independent[ly]” from parents or guardians,<sup>136</sup> to obtain a judicial declaration of emancipation and thereby control his or her own medical treatment decisions.<sup>137</sup>

The Supreme Court of Illinois referred to these two acts, as well as the Illinois Juvenile Court Act<sup>138</sup> and the United States Supreme Court’s abortion decisions,<sup>139</sup> to determine that “mature minors may possess and exercise rights regarding medical care that are rooted in [Illinois’] common law.”<sup>140</sup> The court then outlined the guidelines for trial courts called to apply the “mature minor” doctrine in comparable cases.<sup>141</sup> Unless the legislature

133. *Id.* ch. 410, paras. 210/01-210/5.

134. *Id.* ch. 410, para. 210/4. Physicians and dentists are also authorized to render emergency treatment or first aid to a minor without consent “if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor’s health.” *Id.* at chap. 410, para. 210/3.

135. *Id.* ch. 750, paras. 30/1-30/11.

136. *Id.* ch. 750, para. 30/3-2.

137. *Id.* ch. 750, para 30/9.

138. *Id.* ch. 705, paras. 405/1-1-405/1-16.

139. *See* *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 440 (1983) (holding unconstitutional an ordinance making “blanket determination[s] that *all* minors under the age of fifteen are too immature to make [abortion] decision[s] and that abortions without parental consent may *never* be in the best interests of a minor); *Bellotti v. Baird*, 443 U.S. 622, 643-44 (1979) (concluding that a pregnant minor could not be denied an abortion for lack of parental approval without the opportunity to demonstrate that she is sufficiently mature to make an independent abortion decision or that, despite her immaturity, an abortion would serve her best interest).

140. *In re E.G.*, 549 N.E.2d at 326.

141. *Id.* at 327-38.

provided otherwise, the trial judge would have to determine by clear and convincing evidence that a minor is mature enough to make health care choices.<sup>142</sup> The judge's intervention is premised on Illinois' valuation of the sanctity of life<sup>143</sup> and the state's *parens patriae* power to protect those incapable of protecting themselves.<sup>144</sup>

Once this common law right to consent to, or to refuse, medical treatment is established,<sup>145</sup> it "must be balanced against four State interests: (1) the preservation of life; (2) protecting the interests of third parties; (3) prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."<sup>146</sup> Viewing the second interest as most significant, the Illinois Supreme Court noted that "both E.G. and her mother agreed that E.G. should turn down the blood transfusions" on religious grounds and, therefore, that the trial court had no need to give serious consideration to E.G.'s mother's wishes.<sup>147</sup>

Since E.G. was no longer a minor at the time that the Illinois Supreme Court rendered its decision, it did not bother remanding the case to the trial court to make an "explicit determination of E.G.'s maturity."<sup>148</sup> Certain factors, however, illuminate that E.G., unlike Phillip Malcolm, would have very likely been declared a mature minor. Several witnesses, for example, confirmed E.G.'s maturity at the initial hearings, including a psychiatrist with special expertise in evaluating the maturity and

142. *Id.* at 327.

143. See *In re Estate of Longeway*, 549 N.E.2d 292, 300 (Ill. 1989) (stating judicial scrutiny is appropriate in deciding whether to refuse or withdraw artificial nutrition since a "presumption exists favoring life").

144. *Id.* at 301.

145. *In re E.G.*, 549 N.E.2d at 327. To establish a minor's common law right to consent to or refuse medical treatment, "the trial judge must weigh these two principles [public policy favoring life and *parens patriae*] against the evidence . . . of a minor's maturity." *Id.* If there is "clear and convincing" evidence that the minor is sufficiently mature to "appreciate the consequences of her actions," and "exercise the judgment of an adult," her common law right is established under the mature minor doctrine. *Id.* at 327-28.

146. *Id.* at 328 (citing *Estate of Longeway*, 549 N.E.2d at 299).

147. *Id.* at 328.

148. *Id.*

competency of minors. This psychiatrist confirmed that E.G. had the maturity of an eighteen to twenty-one year old and the competency to make an informed decision to refuse the blood transfusions, even if her choice was fatal.<sup>149</sup> Even when the trial court had initially ruled that E.G. was medically neglected, it described her as a mature seventeen year old who had reached her decision on an independent basis and who was “fully aware that death [was] assured absent treatment.”<sup>150</sup>

Thus, although faced with the potential, if not inevitable, loss of a young life, the Illinois Supreme Court chose to recognize a mature minor’s right to refuse treatment at common law. Did E.G.’s obvious maturity and present age of majority sway the court’s decision? To a certain degree, one might say that it did, but the court still chose to outline a doctrine that could be applied in other distinct cases wherein the minors involved might exhibit very different characteristics.

In *Cardwell v. Bechtol*,<sup>151</sup> a decision cited by the Illinois Supreme Court in *In re E.G.*,<sup>152</sup> the Supreme Court of Tennessee adopted a “mature minor” exception to the common law rule that a physician obtain parental consent before treating a minor, despite the absence of express statutory authority.<sup>153</sup> Moreover, prior to *Cardwell*, Tennessee legislation had existed regarding medical treatment of minors.<sup>154</sup>

149. *Id.* at 323-24.

150. *Id.* at 324.

151. 724 S.W.2d 739 (Tenn. 1987).

152. 549 N.E.2d 322, 327 (Ill. 1989).

153. *Cardwell*, 724 S.W.2d at 748-49 (stating that adopting the mature minor exception to the common law rule is “wholly consistent” with existing statutes and adds to the “growth and development” of the Tennessee common law).

154. *See, e.g.*, TENN. CODE ANN. §§ 63-6-220 (1990) (authorizing physicians to treat juvenile drug abusers with parental consent), 63-6-222 (authorizing physicians to perform emergency medical or surgical treatment on minors despite the absence of parental consent where there was a reasonable good faith determination that delay would result in serious threats to minor’s well being or after reasonable effort has been made to notify parents), 63-6-223 (authorizing physicians to provide medical care to pregnant minors without knowledge or consent of parents).

Sandra Cardwell, a minor five months shy of her eighteenth birthday who suffered from persistent back pain, had decided on her own to visit a blind osteopath who had treated her father in the past.<sup>155</sup> She paid the osteopath's fee with one of her father's blank, signed checks that was given to her when she needed money.<sup>156</sup> Ostensibly, as a result of the osteopath's treatment of Ms. Cardwell, she had to be hospitalized and lost normal bladder control and some sensation in her buttocks and legs.<sup>157</sup> She and her parents instituted an action against the osteopath alleging, among other things, "battery (failure to obtain parental consent), negligent failure to obtain consent, and failure to obtain informed consent."<sup>158</sup>

After reviewing the statutes that the Tennessee Legislature had enacted, the Tennessee Supreme Court found "no intent on the part of the Legislature to establish a comprehensive statutory scheme that would occupy the area of medical treatment of minors"<sup>159</sup> or "abrogate judicial adoption of an exception to the general common law rule requiring parental consent to treat minors."<sup>160</sup> Instead, the court characterized the legislation as "provid[ing] conditional immunities from certain types of liability in specific situations . . . or promot[ing] certain social purposes, such as treatment of drug abuse or venereal disease in minors."<sup>161</sup> Hence, recognition at common law of the "mature minor" doctrine was considered wholly consistent with existing Tennessee statutory and tort law.<sup>162</sup> Furthermore, the jury had

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155. *Cardwell*, 724 S.W.2d at 741.

156. *Id.* at 742.

157. *Id.*

158. *Id.* The suit, which was filed on April 22, 1983, had initially alleged medical malpractice. *Id.*

159. *Id.* at 744.

160. *Id.*

161. *Id.*

162. *Id.* at 748-49. Tennessee courts have recognized that the "rule of reason is one of the bases of the common law . . . but [it] will be modified and extended by analogy, construction and custom so as to embrace new relations springing up from time to time to conform with the change and desire of society." *Powell v. Hartford Accident and Indem. Co.*, 398 S.W.2d 727, 730 (1965).



accurately concluded that Sandra Cardwell had the maturity, education, experience, ability and judgment to knowingly consent to the osteopath's treatment.<sup>163</sup>

## CONCLUSIONS AND RECOMMENDATIONS

The present legislative scheme for the health care of minors in New York State and elsewhere engenders a great deal of confusion. Are physicians simply refusing to treat "emancipated" or "mature" minors without parental consent or are they only doing so when such treatment is clearly for the minor's benefit and would withstand even the most rigorous scrutiny? Anecdotal evidence supports the latter hypothesis, but is it fair to put our health care workers and our children in this precarious position? Furthermore, given mounting malpractice costs and the concomitant transformation of the American family, particularly in the country's urban areas, can we rest comfortably with this arrangement?

Courts and the health care community deserve better guidance from their respective state legislatures. When the New York State Legislature addressed the provision of outpatient mental health

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163. *Id.* at 749. Other courts have also adopted the "emancipated minor" doctrine or the "mature minor" doctrine at common law in the face of silent or less-than-comprehensive legislation. In *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970), the Supreme Court of Kansas determined that a 17 year old minor was of sufficient age and maturity to comprehend the nature and consequences of a "pinch graft" utilized to repair her finger and therefore no parental consent had been required. *Id.* at 338. The Supreme Court of Kansas could have more easily relied upon the emergency exception since the girl's mother was semi-conscious at the time of the injury, and her father lived two hundred miles away. *Id.* at 333. In *Bakker v. Welsh*, 108 N.W. 94 (Mich. 1906), surgeons performed an operation to remove a tumor from a 17 year old boy's ear. *Id.* at 95. The surgeons were found not liable for damages to the boy's father, who had not consented to the operation, because, *inter alia*, the boy was almost grown into manhood, had gone from his farm to a large city, accompanied by an aunt and two sisters, to submit to an examination and receive advice, and ultimately had a fairly minor surgical operation performed. *Id.* at 96. See also Walter Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOODE HALL L.J. 115, 117-20 (1973).

care for minors in 1983,<sup>164</sup> it did so because mental health practitioners and agencies providing such care, even with the benefit of Public Health Law section 2504, had been uncertain about what the parental role should be and if any such role was appropriate in instances such as child abuse or incest.<sup>165</sup> Obviously, under such circumstances, the old adage that parents most accurately perceive their children's health needs falls to pieces and we as a society are forced to consider alternative means to address and treat such children's medical situations.

*What, then, should state legislatures do?*

The piecemeal statutory approach to minors' health care issues existing in most jurisdictions requires a road map to follow and leaves open the possibility of overlooking or ignoring certain key provisions. In New York State, both Senator Meyerson's bill<sup>166</sup> and A. 6585<sup>167</sup> attempted to consolidate such provisions in one location. State legislators in New York and elsewhere should now revisit and complete this task. The emergent statute will most likely authorize all minors to consent to particular medical treatment and some minors to consent to all medical treatment.

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164. See *supra* notes 95, 103-104 and accompanying text; see also Governor's Approval Memorandum to 1983 N.Y. Laws 790, 1983 N.Y. LEG. ANN. 339. "[P]arental consent will generally be required before mental health services on an outpatient basis are provided to a minor." *Id.* However, the Governor noted that "[p]arental consent will not be required . . . in [those] cases where mental health services are necessary to the minor's well-being and where requiring parental consent would be detrimental to the minor." *Id.*

165. See Governor's Approval Message to 1983 N.Y. Laws 790, 1983 N.Y. LEG. ANN. 339.

166. See S. 9464, *supra* note 77. Senator Meyerson's bill states "that persons of at least sixteen years of age and emancipated minors may give effective consent to health care." S. 9464, *supra* note 77; see also *supra* notes 78-88 and accompanying text.

167. See A. 6585, *supra* note 21. A. 6585 sought to amend General Obligations Law § 3-104 so that "[m]edical, dental, and health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay or treatment which would increase the risk to the minor's life or health." A. 6585, *supra* note 21.

Neither approach would be foolproof. For example, the status approach often denies an entire class of fully capable minors the authority to consent by setting arbitrary cut-offs, such as eighteen years of age. On the other hand, the health needs approach cannot keep pace with evolving pathology and treatment methods. Furthermore, it imposes a value judgment as to which ills society can or cannot tolerate going untreated.

Only by combining these approaches can the state legislatures most comprehensively address the needs of minors and build the greatest flexibility into the system. To impose the guidelines courts and health care workers crave, *and* at the same time allow for flexibility, is *not* contradictory and, if anything, most truly acknowledges the world in which we live and work today. Will the parent be unavailable when his or her consent is needed,<sup>168</sup> and will the physician's fear of liability result in very narrow statutory interpretations? A comprehensive statutory scheme may not allay all of parents' and health care workers' worst fears, but it will at least provide "one-stop" shopping and ensure that all available options are examined in a timely fashion.<sup>169</sup>

Since the courts are queasy about coming out and recognizing the "emancipated minor" doctrine in the health care context, state legislatures must take the lead. If a given legislature is reluctant to use the term "emancipated minor" with a corresponding definition, it should at least clarify and broaden the categories of minors viewed as "emancipated." Take for example, the New York State Legislature. Did they intend to include minors who

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168. See Carol Lawson, *Distance Makes the Heart Skip for Commuter Moms*, N.Y. TIMES, Nov. 7, 1991, § C, at 1.

169. In 1973, The Committee on Youth of the American Academy of Pediatrics wrote "A Model Act Providing for Consent of Minors for Health Services" that could be used as a guidepost for states reconsidering their legislation and attempting to design a more comprehensive, localized scheme. Committee on Youth, *A Model Act Providing for Consent of Minors for Health Services*, 51 PEDIATRICS 293 (1973). Certainly, the argument for a uniform law that crosses state lines itself is compelling given our present day mobility and a uniform law's potentially deterrent effect on "forum shopping" on the part of runaway teens.

have married and then divorced or separated?<sup>170</sup> What about those minors who have borne children and then put them up for adoption or in foster care, or the minor father of a child born out of wedlock who has had nothing to do with the support or upbringing of that child?

Minors who are self-supporting, residing apart from parents, or managing their own financial affairs, also deserve to bring the same autonomy to bear on their medical treatment as they do in other areas of their lives. It is a hypocrisy that such individuals are regarded at common law in New York State, for example, as responsible for the payment of their own medical bills,<sup>171</sup> but are not always allowed to authorize the very treatments they are financing.<sup>172</sup>

Categories of emancipation will continue to evolve. In New York, Senator Meyerson's bill recognized this and included a definition of "emancipated minor" "without limitation to its meaning at common law . . . ."<sup>173</sup> Although one might say that such a definition elevates flexibility over certainty, it also invites courts to continually revisit the concept of emancipation and address its evolving circumstances. A new category of "emancipated minors" will invariably percolate through the judicial system for some period of time before it is deemed to be recognized at common law. Legislatures could then reap the

170. See Rhonda Cohn, *Minor's Right to Consent to Medical Care*, MED. TRIAL TECH. Q., 286, 288 (1985) (stating that a majority of the thirty-four states allowing married minors to consent to their own medical care do not take away the minor's emancipated status if divorce or annulment follows).

171. See, e.g., *Cidis v. White*, 71 Misc. 2d 481, 482-83, 336 N.Y.S.2d 362, 363 (Dist. Ct. Nassau County 1972) (holding that parents cannot be held responsible for the payment of their emancipated minor child's optometrist's bills); *Staten Island Hosp. v. Porter*, 59 Misc. 2d 389, 392, 298 N.Y.S.2d 598, 601 (Civ. Ct. Richmond County 1969) (holding that the father of a 19-year-old minor in the military was not responsible for paying the minor's hospital expenses).

172. See, e.g., N.Y. PUB. HEALTH LAW § 2504 (only those persons eighteen years of age or older, married, parents of a child, or pregnant can authorize medical treatments on their own behalf without parental consent).

173. S. 9464, *supra* note 77; see also *supra* notes 78-84 and accompanying text.

benefits of this intensive examination by amending the law and providing express recognition of a new emancipation category. Hence, inclusion of the clause “without limitation to its meaning at common law” would legitimize ongoing analysis of the emancipation concept and encourage a continuing dialogue between the courts and the legislatures.

In many ways, the “mature minor” doctrine expresses the internal components of the concept of emancipation; rather than looking at the external trappings of adulthood, the “mature minor” doctrine enumerates the qualities adults are assumed to bring to the decision-making process. Thus, if a minor is sufficiently mature and intelligent to understand the benefits and risks of a proposed medical treatment, and to make a reasoned decision on the basis of such knowledge, that minor’s decision should be honored regardless of the opinion, or lack thereof, of the minor’s parent or guardian.

As already noted, legislatures around the country have been somewhat reluctant to statutorily authorize mature minors to consent to their own health care given what is perceived as a highly subjective analysis of the “maturity” criteria.<sup>174</sup> In contrast, however, and without much reluctance, courts have continually mulled over these criteria in a host of circumstances, including those involved in *In re Long Island Jewish Medical Center*.<sup>175</sup> Out of these judicial pronouncements, a pattern has emerged. For example, where the treatment is for the minor’s own benefit, the “mature minor” doctrine is far more likely to be recognized than when the treatment will benefit a third party.<sup>176</sup> Moreover, rarely has a minor below sixteen years of age been

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174. See Bruce C. Hafen, *The Constitutional Status of Marriage, Kinship, and Sexual Privacy - Balancing the Individual and Social Interests*, 81 MICH. L. REV. 463, 515-16 (1983) (“Determinations of maturity are hopelessly subjective, which means that a judge — rather than a minor or her parents — is the real decisionmaker.”).

175. 147 Misc. 2d 724, 730, 557 N.Y.S.2d 239, 243 (Sup. Ct. Queens County 1990); see also *supra* notes 62-70 and accompanying text.

176. See Veilleux, *supra* note 35, at 523-24; see also *supra* note 71 and accompanying text.

viewed as sufficiently mature.<sup>177</sup> The nature of the treatment also plays a role in the “maturity” analysis. Where it will not involve a great deal of risk or complications as a consequence, making it easier for a younger person to fully comprehend and appreciate, and where it is deemed “necessary” by health care providers, chances are, once again, that the courts will recognize the “mature minor” doctrine.<sup>178</sup>

Despite the benefits that might accrue from statutorily codifying these maturity benchmarks, courts would continue to be drawn into the process of assessing the maturity of individual minors with or without established legislative criteria. Rather than confining the parameters of a court's queries, a better approach is to allow the courts a certain degree of discretion. Hence, state legislatures should authorize “mature minors” to consent to their own medical treatment after a court holds a hearing to determine, *inter alia*, whether a given minor sufficiently understands the risks and benefits of the proposed treatment. In essence, this is what courts do best, as no other institution is better equipped to weigh the facts of a given situation and arrive at a reasoned decision.

By codifying the “mature minor” doctrine, legislatures would again be harmonizing the law with what is already current practice. For example, this author and other commentators have not yet found any case in New York State where a physician has been held liable for providing treatment to a mature minor without parental consent.<sup>179</sup> Legislatures should also make crystal clear that minors, like adults, must give “informed consent” before the physician is permitted to go forward, regardless of whether they are seeking to consent to their own

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177. See Tania E. Wright, *A Minor's Right to Consent to Medical Care*, 25 How. L.J. 525, 532 (1982) (noting that “the age range of sixteen to eighteen [is] the age range of capacity for fully independent judgment”). *But see* Wisconsin v. Yoder, 406 U.S. 205, 245 n.3 (1972) (Douglas, J., dissenting) (naming fourteen as the age “that the [child's] moral and intellectual maturity . . . approaches that of the adult”).

178. See Wadlington, *supra* note 163, at 119; *see also* Veilleux *supra* note 35, §§ 3, 7.

179. See NYSBA Report, *supra* note 42, at 87.

treatment under the “mature minor” doctrine or because of some other category. In other words, they must understand their condition or problem, the nature and purpose of the proposed treatment, the risks and consequences of the proposed treatment, the probability that the proposed treatment will be successful and the feasible alternative options, including no treatment at all.<sup>180</sup> This, too, is an individual determination with which courts may or may not become involved.

Legislatures also need to revisit, clarify and perhaps expand upon the particular health needs of minors that would warrant their own consent to medical treatment. For example, New York Public Health Law section 2504 authorizes certain minors to consent to “medical, dental, health and hospital services . . .” without defining what these services are.<sup>181</sup> There has been litigation over this very issue involving the condom availability program commenced in New York City’s high schools by the New York City Board of Education as part of its mandated HIV/AIDS education curriculum.<sup>182</sup> The appellate division recently determined that condom availability is a “health service” under section 2504,<sup>183</sup> and therefore, the statute requires either parental consent for participation in the program or an opt-out provision.<sup>184</sup>

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180. *Id.* at 86; *see also* N.Y. PUB. HEALTH LAW §§ 2803-c(3)(a), (e), 2805-d (McKinney 1993); N.Y. COMP. CODES R. & REGS. tit. 10, § 751.9(h) (1985).

181. N.Y. PUB. HEALTH LAW § 2504.

182. *See* Alfonso v. Fernandez, 195 A.D.2d 46, 606 N.Y.S.2d 259 (2d Dep’t 1993).

183. *Id.* at 52, 606 N.Y.S.2d at 263.

184. *Id.* at 53, 606 N.Y.S.2d at 264. The petitioners in *Alfonso* had argued correspondingly that since the condom availability plan was a “health service,” an implicit corollary to § 2504(1) is that persons under eighteen years of age may not give effective consent to such services. *Id.* at 51-52, 606 N.Y.S.2d at 263. Certain *amicus curiae* in the case, led by the New York Civil Liberties Union, had argued that § 2504 was intended to expand, not contract, young persons’ access to medical treatment and that the court should resist petitioners’ attempt to give the provision such a limited interpretation. Brief *Amicus Curiae* for the New York Civil Liberties Union, et al., at 11-16, Alfonso v. Fernandez, 195 A.D.2d 46, 606 N.Y.S.2d 259 (2d Dep’t 1993). The *amicus curiae* also noted that nowhere in § 2504 was there a declaration

The New York City Board of Education's condom availability program was instituted as a means of thwarting the alarming rate in which adolescents are contracting the HIV/AIDS infection.<sup>185</sup> The New York State Legislature's authorization of HIV testing for minors capable of giving informed consent stems from the same social policy concerns.<sup>186</sup> However, whereas physicians are expressly authorized to treat minors for sexually transmitted diseases<sup>187</sup> without parental consent,<sup>188</sup> Article 27-F of the New York Public Health Law contains no such express authorization for HIV/AIDS treatment.<sup>189</sup>

Minors in New York State and elsewhere who seek treatment as a result of testing positive for HIV can probably do so without obtaining parental consent under a variety of creative statutory interpretations.<sup>190</sup> For example, the minor has exhibited, without the benefit of a codified "mature minor" doctrine, the ability to give "informed consent" to his or her testing that can be carried over to his or her treatment. Additional exceptions already

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that persons under eighteen must obtain parental consent. *Id.* at 14. *Contra In re Thomas B*, 152 Misc. 2d 96, 98, 574 N.Y.S.2d 659, 661 (Fam. Ct. Cattaraugus County 1991) ("An implicit corollary of [§ 2504(1)] is that a person under eighteen years of age may not give consent for [medical, dental, health and hospital] services.").

185. *See supra* note 1; *Alfonso*, 195 A.D.2d at 53, 606 N.Y.S.2d at 264.

186. *See supra* note 1.

187. The category of sexually transmitted diseases does statutorily encompass HIV/AIDS. *See* N.Y. PUB. HEALTH LAW § 2311 (directing the Commissioner of Health and Public Health Council to promulgate a list of sexually transmissible diseases); N.Y. COMP. CODES R. & REGS. tit. 10, § 23.1 (1983) (listing sexually transmissible diseases).

188. N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 1993) ("A licensed physician . . . may diagnose [or] treat . . . a person under the age of twenty-one years without the consent or knowledge of the parents . . . where such person is infected with a sexually transmissible disease . . .").

189. However, § 2781(1) does authorize a physician to perform HIV related tests where the physician has received "written, informed consent of the subject of the test who has capacity to consent . . . ." N.Y. PUB. HEALTH LAW § 2781(1).

190. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2504(4) (providing that a physician may authorize treatment of a minor for HIV/AIDS if "in the physician's judgment an emergency exists and the person is in immediate need of medical attention").



codified by section 2504 and other state law provisions in New York and elsewhere, such as the emergency exception, along with strong public policy concerns favoring prompt intervention, can also be viewed as authorizing a physician's treatment of a minor for HIV/AIDS without first obtaining parental consent.<sup>191</sup>

Rather than relying on these elaborate contortions, state legislatures should explicitly authorize HIV/AIDS treatment without parental consent. No disease is more worthy of prompt, uninterrupted treatment, or more likely to fall into the communication gap between parent and child. Although it is unlikely that a parent would deny consent for treatment of this fatal disease, the minor might forego treatment entirely rather than reveal his or her medical condition to a parent.

Similar strained readings of existing statutory constructs come into play in the arena of abortion and contraception. For example, as already noted, New York State does not have a statute which regulates when minors may receive abortions without parental consent. Any State action would be limited by federal constitutional principles and, where federal funding is provided, federal regulations.<sup>192</sup> The same holds true for

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191. See NYSBA Report, *supra* note 42, at 90.

192. In 1975, a proposed amendment to New York Public Health Law § 2504 which would have, subject to the provisions of subdivision one, prohibited abortions for persons under eighteen without first obtaining parental consent, was defeated. See S. 2419-B/A. 3111-B, N.Y. Legis., 198th Sess. (1975). The provision would have authorized physicians to perform such abortions without parental consent if they "reasonably believe[d] that delay caused by [their] diligent attempt to secure such consent [would] result in permanent and serious physical injury of such person." *Id.* Subsequent United States Supreme Court cases have established that parental consent requirements may only be imposed on a minor's right to an abortion if a judicial bypass alternative is also made available. See, e.g., *Bellotti*, 443 U.S. at 643-44 ("[I]f the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it must also provide an alternative procedure whereby authorization for the abortion can be obtained."). Furthermore, where such abortions would be funded pursuant to certain federal programs, no consent requirement may be imposed. See N.Y. SOC. SERV. LAW §§ 350(1)(e) (McKinney 1992) ("[S]o long as federal law and regulations require, family planning services . . . shall be offered and promptly furnished to eligible persons of childbearing age, including children who can be considered sexually

contraception, and it was a New York statute prohibiting the sale or distribution of contraceptives to minors under sixteen years of age that provided the vehicle for the United States Supreme Court to confirm a minor's privacy rights in *Carey v. Population Services International*.<sup>193</sup>

This article does not attempt to address the highly charged issues of abortion and contraception for minors. However, it is important to note some of the ways in which state statutes, like New York's Public Health Law section 2504, have been interpreted to allow provisions of these services to minors who are neither at least eighteen years of age, married, nor parents of children, without parental consent. For example, the performance of an abortion has been viewed as an emergency for which any delay to secure parental consent would pose a grave risk to the minor's life or health.<sup>194</sup> Minors who seek contraceptive devices have also been viewed as "emancipated" to a limited extent, and therefore, authorized to consent to solely sex-related health care.<sup>195</sup>

The danger of these elaborate justifications should be particularly evident to abortions-rights advocates who see the United States Supreme Court chipping away further at the doctrines first enunciated in *Roe v. Wade*.<sup>196</sup> State courts, including those in New York, are increasingly filling the void by interpreting the rights provided by state constitutions in a more

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active . . . ."), 365-a(3)(c) ("[M]edical assistance shall include . . . family planning services and supplies for eligible persons of childbearing age, including children under twenty-one years of age who can be considered sexually active, who desire such services and supplies, in accordance with the requirements of federal law and regulations . . . ."); *see also* N.Y. COMP. CODES & REGS. tit. 18, §§ 463.1, 463.2(b)(1)-(2), 463.6 (1988).

193. 431 U.S. 678 (1977)

194. Harriet F. Pilpel et al., *Sex-Related Health Care for Minors*, N.Y. L.J., February 27-28, 1975, at 1.

195. *Id.*

196. 410 U.S. 113 (1973). *See, e.g.*, *Rust v. Sullivan*, 111 S. Ct. 1759 (1991) (upholding regulations prohibiting grantees under Title X projects from engaging in counseling concerning referrals for and activities advocating abortion as a method of family planning).

expansive manner.<sup>197</sup> Despite its continuing controversy, state legislatures should presently complete the task of codifying where minors stand on these issues in a manner consistent with state constitutional jurisprudence.

In conclusion, the controversy over a minor's right to consent to his or her own health care is bound to continue, but the confusion should not. The time is ripe for state legislatures to reassess and clarify provisions addressing a minor's health care and to provide the necessary guidance to minors, parents, and health care providers.

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197. *See, e.g.*, *Hope v. Perales*, 150 Misc. 2d 985, 991-94, 571 N.Y.S.2d 972, 978 (Sup. Ct. N.Y. County 1991), *aff'd*, 189 A.D.2d 287, 595 N.Y.S.2d 948 (1st Dep't 1993) (holding that based on the New York Constitution discrimination in Medicaid funding between childbirth and abortion was unlawful notwithstanding earlier decisions of the United States Supreme Court which held that the Federal Constitution does not guarantee nondiscriminatory funding). It should be noted that this case has been appealed by the defendants and was argued before the New York Court of Appeals on March 17, 1994. A decision is pending. *See James Dao, Lawyer Takes Abortion-Rights Case to Top Albany Court*, N.Y. L.J., March 18, 1994 at B5.