

MY GOD MY CHOICE: THE MATURE MINOR DOCTRINE AND ADOLESCENT  
REFUSAL OF LIFE-SAVING OR SUSTAINING MEDICAL TREATMENT BASED  
UPON RELIGIOUS BELIEFS

by

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Adults, those over the age of eighteen, are presumed competent and therefore enjoy a certain level of autonomous decision-making free from outside intrusion. Those who have not reached the age of majority, on the other hand, are presumed incompetent, and thus require the aid of parents or guardians to assist in the decision-making process. Recent studies in adolescent development suggest that certain individuals, though not yet eighteen, have the requisite competence to make informed, autonomous medical decisions. In turn, some states have acknowledged the mature minor doctrine, which is based on the seemingly simple principle that minors who demonstrate a sufficient level of maturity ought to have their choices respected independent of third parties.

Though many agree that certain adolescents reason on a level equal to that of young adults, debate surrounds the conclusion that minors should be permitted to consent to or refuse medical treatment especially when the choice has life or death consequences. A further complication exists when the decision is based upon religious beliefs.

To date, the relevant literature focuses on parents' religious beliefs that influence medical decision making for their minor children, and minors' maturity to decide medical care for themselves. Although some courts and scholars have addressed these topics in the same document, little attention has been paid to the unique circumstances involved

when adolescents attempt to refuse life-saving or sustaining medical treatment based upon their expressed religious beliefs. Failing to address the religious maturity of the minors in question creates the possibility that they will be permitted to die for beliefs that are not truly their own.

The thesis of this paper is that under these circumstances practitioners must inquire into the authenticity of the religious beliefs of the adolescents. Because the religious upbringing of children is directed by the beliefs of their parents and ministers it is necessary to ensure that the adolescents have developed their own underlying and enduring aims and values. Thus, these adolescents should have the burden to demonstrate clearly and convincingly that they understand their beliefs, as well as the consequences of the medical decision. Only then can practitioners be sure that the minors, independent of third party influence or coercion, have the ability to make an autonomous decision to die for those beliefs in line with their true sense of well-being.

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## INTRODUCTION

Julie, a seventeen-year-old girl, lies awake in her freshman dorm room grappling with her faith. She spent the day at the hospital with her roommate who was diagnosed with mononucleosis. The roommate was bedridden for several days before she finally decided to go to the emergency room. The physicians decided to keep her overnight for observation, but felt that she would be ready to go home the next day with proper medication.

Julie's family was actively involved in the Christian Scientist faith, and they did not believe in conventional medical treatment. She was brought up to believe that illness is not caused by viruses and bacteria, but rather by not being spiritually whole with God.<sup>1</sup> Despite her traditional beliefs, Julie feared that she would "catch" the disease. She spoke with her parents earlier in the day and they told her that mono is the "kissing disease," and that the roommate's insistence on behaving impurely distanced herself from God resulting in her suffering.

Julie had no trouble reconciling her parents' statements with her roommate's illness. After all, she was always telling Julie about her late night partying and the different boys she had been with. But Julie did not go to parties. She had never "made out" with any boys, nor did she plan to. She thought she felt whole with God.

What troubled Julie was that the physicians at the hospital told her that because of the close proximity in the dorm rooms, she was at risk for having mono, and should be tested. Julie informed them of her religious beliefs, and declined the test. The physician respected her

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<sup>1</sup> Janna C. Merrick, *Spiritual Healing, Sick Kids and the Law: Inequities in the American Healthcare System*, 29 AM. J. L. & MED. 269, 271 (2003).

decision, but told her of the potential dangers of untreated mononucleosis. Julie laid awake in bed, wondering what she would do if she did have mono.

At school she learned of many different religious beliefs to which she had never before been exposed. She questioned whether her beliefs were more or less correct than any of her friends who worshipped in different ways.<sup>2</sup> She wanted to discuss her confusion with her parents, but knew she could not. They were against her going to a secular college and warned her about the dangers of questioning her beliefs. Perhaps these questions would make her unwhole with God and susceptible to mono. She knew she did not want to die, and fell into a restless sleep.

Now imagine Shannon, but instead of lying awake, she is lying in a diabetic coma hours before her death. Shannon is a sixteen-year-old home-schooled member of the Faith Tabernacle religion. Like Julie, her family does not believe in medical treatment. When she began feeling sick a few days earlier, she and her family began praying that she would get better. When Shannon was ten, her nine-year old brother died from complications arising from an ear infection. Her parents prayed continuously, but apparently God's plan was not for her brother to live. Maybe she questioned God's plan for herself, but her parents assured her that with enough prayer she could overcome her illness. She did not.

While Julie's story is a fictional account, Shannon's is not. Following Shannon's death, her parents were tried and convicted of involuntary manslaughter and endangering the welfare of a child. In their defense, they argued that Shannon was a mature minor who made the decision to forego medical treatment on her own.<sup>3</sup>

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<sup>2</sup> See *infra* Part V discussing religious development in minors.

<sup>3</sup> See *infra* Part IV detailing the case of Shannon Nixon.

The so-called mature minor doctrine is based on a seemingly simple principle; that is, minors who demonstrate a sufficient level of maturity ought to have their choices respected independent of third parties. It is well settled that adults, i.e., those over the age of eighteen, are presumed competent and therefore enjoy a certain level of autonomous decision-making free from outside intrusion. Those who have not reached the age of majority, on the other hand, are presumed incompetent, and thus require the aid of parents or guardians to assist in the decision-making process.

Based on recent studies in adolescent development, various scholars have argued that certain individuals, though not yet eighteen, have the requisite competence to make informed, autonomous choices. Thus, the argument goes, their decisions should be respected to the same degree as those who have achieved the arbitrary age of majority.

Though many agree that certain adolescents reason on a level equal to that of young adults, debate surrounds whether these findings support the conclusion that minors should be permitted to consent to or refuse medical treatment especially when the choice has life or death consequences. A further complication exists when the decision is based upon religious beliefs.

To date, the main body of discourse has focused on one of two things: (1) whether parents should be permitted to refuse medical treatment on behalf of their children based upon religious objections, and (2) whether minors should be permitted to prove a sufficient level of maturity to make medical decisions for themselves. Though some courts and scholars have addressed these topics in the same document, little attention has been paid to the unique circumstances involved when both are implicated, as in the cases of Julie and Shannon.<sup>4</sup> Failing

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<sup>4</sup> In all reported cases involving the refusal of medical treatment, the custodial parents shared the same religious beliefs as the minors involved.

to address the religious integrity of the minors in question creates the possibility that they will choose to die for beliefs that are not truly their own.

This paper will attempt to bridge the current divide. Part I will detail the legal and ethical basis for the presumption that those under the age of eighteen are incompetent to make autonomous decisions, particularly medical decisions. Part II will then delineate those circumstances where parental decisional rights concerning their minor children may be limited. Part III explores situations where minors are empowered to make medical decisions. This includes statutory exceptions for certain treatment, the abortion context and the common law mature minor doctrine. Part IV analyzes the pivotal cases involving both religious and medical decision making by adolescents. The cases reach different results regarding the mature minor doctrine in this context leaving the topic ripe for debate. Part V will then outline the special concerns implicated by the religious expression of adolescents and the extent to which this expression deserves respect. It will deal particularly with defining and measuring religious integrity in those situations where adolescents seek to refuse medical treatment based upon religious beliefs.

This paper will conclude that when adolescents attempt to refuse life-saving or sustaining medical treatment based upon religious beliefs, they have the burden to show by clear and convincing evidence that they both understand the medical aspects of the decision and have beliefs that are central to their conception of well-being. Only then can practitioners determine that the minor, independent of undue third party influence or coercion, has the ability to make an autonomous decision to risk dying for those beliefs.

## I. PRESUMPTIONS: MINORS AND MEDICAL DECISION-MAKING

### A. THE COMMON LAW AGE OF MAJORITY AND THE 26<sup>TH</sup> AMENDMENT

In the eyes of the law there is something magical about the stroke of midnight on the eve of one's eighteenth birthday. It is at this point that individuals are considered to become legally recognizable adults<sup>5</sup> with all the rights – except perhaps drinking alcohol – that stem there from. Prior to the passage of the last second of one's seventeenth year, individuals are plagued with the assumption that they lack the “maturity, experience, and capacity for judgment necessary to make life's difficult decisions.”<sup>6</sup>

As early as the signing of the Magna Carta, the common law age of majority was twenty-one.<sup>7</sup> Before this time individuals aged fourteen or fifteen were commonly held to have adult status. For instance, under Roman Law, the test for adulthood was whether male students had “both understanding and judgment as to acts in law;” this ability was presumed to exist by the age of fourteen.<sup>8</sup>

At some point during the ninth and tenth centuries in Northern Europe the age of majority was set at fifteen. Interestingly, this age was tied closely to the ability to bear arms.<sup>9</sup> As armor became increasingly heavy and burdensome in the middle of the thirteenth century, younger combatants were unable to perform with enough skill to be effective. The introduction of

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<sup>5</sup> Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547, 558 (2000) (noting that various rights accrue at different ages, but the age of majority is the baseline at which “presumptive adult legal status is attained”).

<sup>6</sup> *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

<sup>7</sup> T.E. James, *The Age of Majority*, 4 AM. J. LEGAL. HIST. 22, 26 (1960).

<sup>8</sup> *Id.* at 25.

<sup>9</sup> *Id.* at 24-26.

knights on horseback added another element of skill that fifteen-year-olds rarely possessed.<sup>10</sup> During feudal times younger males often became squires with the hope that after sufficient training they would rise to the level of knight after their twenty-first birthday; the age subsequently adopted under the English common law when individuals became free to make decisions without the aid of a guardian.<sup>11</sup>

The English brought this common law age of majority to the colonies where it remained, and after the Revolution, came under the purview of the States. Until the passage of the Twenty-Sixth Amendment States retained the authority to set the ages at which to recognize rights of citizens.<sup>12</sup> Perhaps the right most associated with being an active citizen is the right to vote.<sup>13</sup>

The Twenty-Sixth Amendment to the United States Constitution, passed in 1971, lowered the age at which citizens have the right to vote in federal and state elections from twenty-one to eighteen.<sup>14</sup> This naturally begs the question of why those under twenty-one were ever prevented from voting. Was it really because those incapable of riding a horse into combat wearing full armor are equally incapable of making intelligent political choices?

Although this sounds humorous, it was just the sort of question asked by those challenging the fact that eighteen-year-olds were being sent into Vietnam,<sup>15</sup> yet could not vote on the political decision to go to war in the first place.<sup>16</sup> The argument for setting a threshold age for voting rests on the assumption that “education and an informed understanding of the issues

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<sup>10</sup> *Id.* at 27.

<sup>11</sup> *Id.* at 28-31.

<sup>12</sup> See generally Scott, *supra* note 5 (discussing various state specific laws regarding the ages at which rights accrue to citizens).

<sup>13</sup> *Id.* at 560 (stating that the “right to vote has long been the defining marker of legal adulthood.”)

<sup>14</sup> The Amendment states: “[t]he right of citizens of the United States, who are eighteen years of age or older, to vote shall not be denied or abridged by the United States or by any State on account of age.” U.S. CONST. amend. XXVI, § 1.

<sup>15</sup> There is more than subtle irony in the fact that in over one thousand years of human achievement the age of majority has been adjusted twice for war-motivated reasons absent an intellectual inquiry into the developmental necessity of setting the age as such.

<sup>16</sup> See Scott, *supra* note 5, at 562-64.

are important to political participation in a democracy, and that adults are more likely to meet these criteria than children and adolescents.”<sup>17</sup> At this time, of course, adulthood began at twenty-one.

Those in support of the amendment argued that the common law boundary between adulthood and childhood did not reflect developmental reality. They argued that psychological maturity is achieved by eighteen,<sup>18</sup> such that the presumption of immaturity should not apply to those between eighteen and twenty-one. The Senate committee that ultimately recommended the enactment of the amendment was cognizant of this, but also acknowledged that “legal minors were treated as adults for the purposes of criminal responsibility and punishment in all states, and that many were engaged in adult roles as employees and taxpayers.”<sup>19</sup>

The passage of the Twenty-Sixth Amendment changed the age of majority for most exercisable adult rights from twenty-one to eighteen. Recent scholarship in the healthcare setting, however, has challenged the notion that eighteen is a proper guidepost for determining the onset of adulthood and the concomitant right to make medical decisions.

## B. THE ETHICS OF MEDICAL DECISION-MAKING

In the medical setting there is a clear divide between the medical decision-making capabilities of adults and minors. At the very core of this divide is the presumption that adults are competent to make these decisions while minors are not.<sup>20</sup> Minors are “assumed to lack sufficient cognitive and conative maturity to craft autonomous health care choices, therefore being deemed legally

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<sup>17</sup> *Id.* at 562.

<sup>18</sup> S. REP. NO. 92-26, at 5 (1971).

<sup>19</sup> Scott, *supra* note 5, at 563.

<sup>20</sup> Rhonda Gay Hartman, *Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices*, 8 U. CHI. L. SCH. ROUNDTABLE 87, 88 (2001) [hereinafter Hartman, *Physician Perceptions*].

incapable of giving genuine informed consent to medical treatment.”<sup>21</sup> The United States Supreme Court has held that “most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment.”<sup>22</sup>

To understand why minors cannot be trusted to make health care decisions for themselves, it is necessary to explore the concept of an autonomous medical decision, and what some would argue prevents minors from achieving this ideal.<sup>23</sup> Bioethics discourse,<sup>24</sup> founded in medicine, law, philosophy and religion, asks difficult moral questions and seeks to provide “decision-makers with principles to guide them to answers.”<sup>25</sup> Rather than starting with presumptions regarding age, a bioethical inquiry seeks to justify why minors’ decisions regarding medical care should or should not be respected.

One of the founding principles of civilized society is that individuals acting in a private capacity may not violate the bodily integrity of one another without the other person’s consent.<sup>26</sup> This principle extends to the health care setting where physicians and other practitioners must obtain consent from a patient before performing medical procedures.<sup>27</sup> Justice Cardozo put it

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<sup>21</sup> Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 299 (2003).

<sup>22</sup> *Parham v. J.R.*, 442 U.S. 584, 603 (1979).

<sup>23</sup> Whether adults truly achieve this ideal is a matter beyond the scope of this paper.

<sup>24</sup> See generally, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (5th ed. 2001) (detailing the four major principles in bioethics: autonomy; beneficence; nonmaleficence; and justice).

<sup>25</sup> Jennifer L. Rosato, *Using Bioethics Discourse to Determine when Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 TEMPLE L. REV. 1, 29 (2000) [hereinafter Rosato, *Bioethics Discourse*].

<sup>26</sup> As the Supreme Court of the United States has stated, “no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.” *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891). See also W. PAGE KEETON ET. AL., PROSSER AND KEETON ON THE LAW OF TORTS 39-42 (5th ed. 1984).

<sup>27</sup> See generally RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 114-25 (1986) (detailing the first reported case of a physician being held liable for failure to obtain consent. *Slater v. Baker*, 95 Eng. Rep. 860 (K.B. 1767). The physician performed an unorthodox procedure to correct a broken leg although the patient only consented to standard treatment). *Id.* at 116.

this way, “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”<sup>28</sup> Although consent has been required for centuries, the notion of informed consent has only existed since the mid-twentieth century.<sup>29</sup>

Historically, medical care was delivered with the paternalistic understanding that physicians knew what was best for their patients.<sup>30</sup> Physicians acted in accord with the principle of beneficence<sup>31</sup> by “preventing harm, removing harm, and doing good.”<sup>32</sup> This was best accomplished when patients did what they were told.

From the late 1950s continuing through the early 1970s scholars began to suggest that patients be permitted to play a more active role in their medical care. Jay Katz described the clash of these two approaches as follows:

The conflict created by uncertainties about the extent to which individual and societal well-being is better served by encouraging patients’ self-determination or supporting physicians’ paternalism is the central problem of informed consent. This fundamental conflict [reflects] a thorough-going ambivalence about human beings’ capacities for taking care of themselves and need for caretaking. . . .<sup>33</sup>

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*See, e.g., Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 269 (1989).

<sup>28</sup> *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914).

<sup>29</sup> FADEN & BEAUCHAMP, *supra* note 27, at 125. The authors cite to *Salgo v. Leland Stanford Jr. Univ. Bd. of Tr.*, 317 P.2d 170 (Cal. Ct. App. 1957) as coining the phrase informed consent.

<sup>30</sup> According to the Hippocratic Oath, which medical school students still often recite at graduation, physicians swear to “apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.” *See* Ludwig Edelstein, *The Hippocratic Oath: Text, Translation And Interpretation*, in ANCIENT MEDICINE: SELECTED PAPERS OF LUDWIG EDELSTEIN 6 (Ousei Temkin & C. Lillian Temkin eds., 1967). Certain scholars view this language as “secretive, sexist, paternalistic, and elitist.” JURIT BERGSMAS & DAVID C. THOMASMA, *AUTONOMY AND CLINICAL MEDICINE* 123 (2000).

<sup>31</sup> The principle of beneficence refers to a moral obligation to act for the benefit of others. BEAUCHAMP & CHILDRESS, *supra* note 25, at 260.

<sup>32</sup> EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *THE VIRTUES IN MEDICAL PRACTICE* 53 (1993).

<sup>33</sup> FADEN & BEAUCHAMP, *supra* note 27, at 126-27.

Rather than assuming that physicians know what is best for their patients, the presumption became that “competent individuals are better judges of their own good than are others,”<sup>34</sup> and as such should be permitted to make medical decisions for themselves.<sup>35</sup> The idea that individuals should be respected<sup>36</sup> in their self-determination is encapsulated by the bioethical principle of respect for autonomy.

From the Greek *autos* (self) and *nomos* (rule or law) “personal autonomy has come to refer to personal self-governance; personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice.”<sup>37</sup> That persons are autonomous is rooted in “the liberal Western tradition” that emphasizes the “importance of individual freedom and choice, both for political life and for personal development.”<sup>38</sup> Edmund Pellegrino and David Thomasma refer to a “fundamental and universal moral truth . . . that humans are owed respect for their ability to make reasoned choices that are their own and that others may or may not share.”<sup>39</sup>

Individuals do not develop personal identities in a vacuum, however. Indeed, persons are “socially embedded” and form identities “within the context of social relationships,” and a complex intersection of “social determinants.”<sup>40</sup> It is not necessary that a person make decisions completely free from influence; rather, autonomous individuals act “freely in accordance with a

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<sup>34</sup> ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 29 (1989).

<sup>35</sup> This is an acknowledgment that from the patient’s perspective, health is only one of many values given consideration. *Id.* at 30.

<sup>36</sup> Respect for persons used throughout this article stems from the Kantian categorical imperative: “act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means.” IMMANUEL KANT, *GROUNDING FOR THE METAPHYSICS OF MORALS* 429 (James W. Ellington trans., Hackett Publishing Co. 3d ed. 1981) (1785).

<sup>37</sup> FADEN & BEAUCHAMP, *supra* note 27, at 8.

<sup>38</sup> *Id.* at 7.

<sup>39</sup> PELLEGRINO & THOMASMA, *supra* note 32, at 21.

<sup>40</sup> BEAUCHAMP & CHILDRESS, *supra* note 24, at 61.

self-chosen life plan.”<sup>41</sup> In other words, their decisions are not controlled by third parties, but are governed by a self conception developed over time in relation to cultural and social experiences.<sup>42</sup>

The principle that one deserves respect as an autonomous person is different than whether that person’s decisions should be respected as autonomous. Autonomous individuals can make non-autonomous choices, for instance in the presence of “temporary constraints such as ignorance or coercion.”<sup>43</sup> Informed consent is founded on the idea that if you give competent individuals sufficient information, absent coercion, they will in turn utilize that information to make an autonomous decision “that they believe will best promote their own well-being as they conceive it.”<sup>44</sup> The analytical elements of informed consent are: “(1) disclosure; (2) comprehension; (3) voluntariness; (4) competence;”<sup>45</sup> and (5) some decisional action.<sup>46</sup>

As the doctrine of informed consent became entrenched in the law disproportionate emphasis was placed on disclosure. Physicians were given the duty to provide certain information if they wished to avoid liability for failure to obtain informed consent.<sup>47</sup> Generally speaking, legal disclosure consists of four categories of information: (1) diagnosis, including the medical steps preceding diagnosis; (2) the nature and purpose of the proposed treatment with likelihood of success; (3) the probability and severity of risk associated with the treatment in question; and (4) feasible alternatives – including non treatment – coupled with their risks,

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<sup>41</sup> *Id.* at 58.

<sup>42</sup> Tom Beauchamp and James Childress emphasize that choices must be voluntary, that is, absent controlling influences such as coercion or undue manipulation. *Id.* at 93-95. Certain forms of persuasion are permissible to the extent that they appeal to the individual’s reason. *Id.* at 94.

<sup>43</sup> FADEN & BEAUCHAMP, *supra* note 27, at 8.

<sup>44</sup> BUCHANAN & BROCK, *supra* note 34, at 30.

<sup>45</sup> FADEN & BEAUCHAMP, *supra* note 27, at 274.

<sup>46</sup> There is some debate as to how to label the last element. Ruth Faden and Tom Beauchamp use “consent,” but note that others prefer “decision, shared decisionmaking or collaboration.” *Id.* at 274-75. All would agree that some “action,” be it consent or refusal, is required.

<sup>47</sup> *Id.* at 276.

consequences and probabilities of success.<sup>48</sup> While disclosure is an important element of informed consent, ethically speaking, it is not the most essential.<sup>49</sup>

For instance, although competence is the fourth element listed, it is really the threshold question.<sup>50</sup> After all, if the particular patient is deemed incompetent, it is not necessary to provide him or her with the information; rather, the information must be provided to a proper surrogate decision-maker.<sup>51</sup> What then does it mean to be competent to make medical decisions?

Allen Buchanan and Dan Brock suggest that there are three capacities necessary for decision-making competence: “capacities for communication and understanding of information, capacities for reasoning and deliberation, and capacity to have and apply a set of values.”<sup>52</sup> These capacities are necessary to ensure that the individual’s choice is truly in line with his or her conception of well-being,<sup>53</sup> and thus deserving of respect as autonomous. Persons can be deemed incompetent, and thus have their decisions set aside, where an inquiry indicates that they are “mistaken about what will best satisfy their underlying and enduring aims and values,” and/or they “fail to accept or choose in accord with objective ideals of the person and personal well-being.”<sup>54</sup>

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<sup>48</sup> BARRY R. FURROW ET AL., HEALTH LAW 356-57 (4th ed. 2001).

<sup>49</sup> FADEN & BEAUCHAMP, *supra* note 27, at 276. The authors suggest that there is “nothing about the nature of an informed consent per se that requires disclosure as a necessary condition, and certainly nothing that would *orient its meaning* around disclosure.” *Id.* The authors make a distinction between true informed consent, known as autonomous authorization, and merely effective informed consent that meets legal or institutional guidelines. *Id.* at 280.

<sup>50</sup> *See Id.* at 287 (referring to competence as the “gatekeeping concept”). Only competent persons are capable of autonomous authorization.

<sup>51</sup> *See generally* BUCHANAN & BROCK, *supra* note 34 (discussing both the importance of selecting a proper surrogate and once the surrogate is chosen, how decisions should be made regarding the incompetent individual).

<sup>52</sup> *Id.* at 23-25.

<sup>53</sup> Defining an individual’s conception of well-being, or what is good, is philosophically complex. Buchanan and Brock summarize three theories of well-being: 1) “hedonist theories hold that the only thing that is good for a person is having conscious experiences of a specified, positive sort;” 2) preference or desire satisfaction, which holds that “what is good for persons is for them to have their desires or preferences satisfied to the maximum extent possible over their lifetimes;” and 3) objective list or ideal theory, which denies that “happiness and preference satisfaction are all there is to personal well-being.” BUCHANAN & BROCK, *supra* note 34, at 31-34

<sup>54</sup> *Id.* at 34.

Recall, however, that adults are presumed to have this capacity, and a full blown inquiry into an adult's competence will only be triggered by peculiar circumstances that indicate to a health care professional that the adult's competence should be questioned.<sup>55</sup> In practice, therefore, unless clear and convincing evidence is supplied to the contrary, adults possess "an unqualified liberty interest . . . to [consent to or] refuse any and all medical treatments."<sup>56</sup> Those under the age of eighteen, on the other hand, are presumed to lack capacity sufficient to rise to the level of competence requisite for autonomous authorization.

Returning to the capacities suggested by Buchanan and Brock, there is a real question, and limited empirical data, regarding the ability of minors to understand and communicate about the semantic content of treatment discussions.<sup>57</sup> While it may be unnecessary for patients to truly grasp the technical medical data, it is essential that they understand the "impact that treatment alternatives will have on their lives."<sup>58</sup> Some argue that because minors have limited life experience, their decisions are "not part of a well-conceived life plan."<sup>59</sup>

Importantly, minors "may give inadequate weight to the effects of decisions on their future interests, and also fail to anticipate future changes in their values that may be predictable by others."<sup>60</sup> Minors tend to place greater emphasis on the present effects of a decision than

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<sup>55</sup> Buchanan & Brock suggest that this presumption is supported by the values of individual well-being and self-determination: they state "first, that a person's important interest in making significant decisions about his or her life, specifically about health care, provides strong support for this general presumption and, second, that adults' health care decisions are in the large majority of cases reasonably in accord with their well-being . . ." *Id.* at 22. A patient's refusal of a physician's recommended course of treatment may give rise to an inquiry, but is not itself evidence of incompetence. *Id.* at 58.

<sup>56</sup> Harvey, *supra* note 21, at 303.

<sup>57</sup> *Id.* at 219 (citing Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412 (1978)).

<sup>58</sup> *Id.* at 219.

<sup>59</sup> See LAINIE FRIEDMAN ROSS, CHILDREN, FAMILIES AND HEALTH CARE DECISION-MAKING 61 (1998).

<sup>60</sup> BUCHANAN & BROCK, *supra* note 34, at 221.

long-term consequences,<sup>61</sup> are more susceptible to peer pressure,<sup>62</sup> and studies have shown that minors participate in “unhealthy risk-taking” more often than do adults.<sup>63</sup>

Taken together, these claims lend themselves to the notion that minors need a “protected period in which to develop ‘enabling virtues’ (habits, including the habit of self control), which advance their lifetime autonomy and opportunities.”<sup>64</sup> In other words, time to develop a true conception of well-being that would be reflected in a competent decision deserving respect as autonomous. As Elizabeth Scott has observed, “this account of childhood leads quite naturally to the conclusion that children must be subject to adult authority, and that the deeply ingrained political values of autonomy, responsibility, and liberty simply do not apply to them.”<sup>65</sup>

Because minors cannot consent to treatment themselves, the general rule is that physicians must obtain consent from the minors’ parents before rendering care.<sup>66</sup> In fact, except in medical emergencies, physicians are liable of the tort of battery where they perform medical procedures on minors without first obtaining parental consent.<sup>67</sup> The rationale for requiring parental consent is founded on two deeply rooted principles: (1) that minors need to be protected from the dangers of uninformed, immature decisions; and (2) who better to decide for children than parents who are presumed to act in their best interests.<sup>68</sup>

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<sup>61</sup> Ann Eileen Driggs, Note, *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?*, 11 HEALTH MATRIX 687, 704 (2001).

<sup>62</sup> Jennifer L. Rosato, *The End of Adolescence: Let’s Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decision-Making*, 51 DEPAUL L. REV. 769, 786 (2002) [hereinafter Rosato, *End of Adolescence*].

<sup>63</sup> LYNN E. PONTON, *THE ROMANCE OF RISK: WHY TEENAGERS DO THE THINGS THEY DO* 1 (1997).

<sup>64</sup> ROSS, *supra* note 59, at 61.

<sup>65</sup> Scott, *supra* note 5, at 551. For an in depth analysis of whether this account should apply to adolescent decision-making, see *infra* Part IV.

<sup>66</sup> See, e.g., Rosato, *supra* note 62, at 771. Among the exceptions to this rule are emergency situations where consent is presumed to exist. Driggs, *supra* note 61, at 691.

<sup>67</sup> Scott, *supra* note 5, at 566.

<sup>68</sup> Rosato, *End of Adolescence*, *supra* note 62, at 771-72.

## II. WHY WE ALLOW PARENTS TO DECIDE AND WHEN WE DON'T

Parents have a fundamental right, protected by the Due Process Clause of the Fourteenth Amendment,<sup>69</sup> to raise their children as they see fit.<sup>70</sup> This right, grounded in both law and ethics, extends to inculcating religious values<sup>71</sup> and making medical decisions<sup>72</sup> for their incompetent children. In *Parham v. J.R.* the United States Supreme Court stated that the “law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions. More important, historically it has been recognized that natural bonds of affection lead parents to act in the best interests of their children.”<sup>73</sup>

Buchanan and Brock offer four reasons in support of the position that parents are proper surrogate decision-makers for their children.<sup>74</sup>

1) “Because in most cases parents both care deeply about the welfare of their children and know them and their needs better than others do, they will be more concerned as well as better able than anyone else to ensure that the decisions made will serve their children’s welfare.”

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<sup>69</sup> The Fourteenth Amendment states, in relevant part that “No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.” U.S. CONST. amend. XIV, § 1.

<sup>70</sup> See, e.g., *Meyer v. Nebraska*, 262 U.S. 390, 399-401 (1923); *Troxel v. Granville*, 530 U.S. 57, 65-66 (2000).

<sup>71</sup> See Emily Buss, *What Does Frieda Yoder Believe?*, 2 U. PA. J. CONST. L. 53, 54 (1999) (stating that “controlling religious upbringing is considered one of the core aspects of parenting”).

<sup>72</sup> See, e.g., Rosato, *Bioethics Discourse*, supra note 25 (arguing that although parents should retain their primary decision-making status, the current state of the law should be reconsidered for situations where parents and children have conflicting interests).

<sup>73</sup> 442 U.S. 584, 602 (1979). Under the best interest principle the surrogate chooses “that which will maximally promote the patient’s good;” where this entails trying to “determine the net benefits to the patient of each option.” BUCHANAN & BROCK, supra note 34, at 94. Compare this to the substituted judgment principle whereby the surrogate chooses “as the patient would choose if the patient were competent and aware both of the medical options and of the facts about his or her condition, including the fact that he or she is incompetent.” *Id.*

<sup>74</sup> See also ROSS, supra note 59, at 39-41.

2) “[P]arents must bear the consequences of treatment choices for their dependent children and so should have at least some control of those choices.”

3) Parents have a right, “at least, within limits, to raise their children according to the parents’ own standards and values and to seek to transmit those standards and values to their children.”

4) “[T]he family is a valuable social institution, in particular [in] its role in fostering intimacy . . . The family must have some significant freedom from oversight, control, and intrusion to achieve intimacy. . .”<sup>75</sup>

In addition, Lainie Friedman Ross argues that the intimate family is itself autonomous, and as such, “promotes the interests and goals of both the children and parents.”<sup>76</sup> She suggests that parents are in the best place to understand familial goals, and therefore, should retain final decision-making authority in continual pursuit of those goals.<sup>77</sup>

This being said, parents generally enjoy the right to make decisions on behalf of their children without state interference. The Supreme Court has stated that “it is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.”<sup>78</sup> In fact, intervention is only justifiable where the state demonstrates “a powerful countervailing interest.”<sup>79</sup>

The State of Massachusetts was successful in raising such an interest in the case of *Prince v. Massachusetts*.<sup>80</sup> *Prince* involved the conviction of a nine-year-old girl’s custodial aunt for violation of the Massachusetts child labor laws.<sup>81</sup> The aunt, a member of the Jehovah’s Witness Church, took her niece with her as she traveled throughout her neighborhood

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<sup>75</sup> BUCHANAN & BROCK, *supra* note 34, at 233-34.

<sup>76</sup> ROSS, *supra* note 59, at 62.

<sup>77</sup> *Id.* Ross’s beliefs are supported by work done by Ferdinand Schoeman who stated that “the family is to be thought of as an intimate arrangement with its own goals and purposes.” BUCHANAN & BROCK, *supra* note 34, at 236.

<sup>78</sup> *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (citing *Pierce v. Society of Sisters*, 268 U.S. 510 (1925)). The right was recently reiterated by the Court in *Troxel v. Granville*. 530 U.S. at 57, 65-66 (2000).

<sup>79</sup> *Stanley v. Illinois*, 405 U.S. 645, 651 (1972).

<sup>80</sup> 321 U.S. 158 (1944).

<sup>81</sup> *Id.* at 159-60.

distributing religious materials.<sup>82</sup> By the time the case reached the United States Supreme Court it was uncontested that this activity violated state statute. Rather, the Court granted certiorari to determine whether the statute itself was constitutional as construed and applied in this context.<sup>83</sup> The aunt argued that it violated her First Amendment right to freedom of religion,<sup>84</sup> and her parental rights secured by the Due Process Clause of the Fourteenth Amendment.<sup>85</sup>

The Supreme Court presented the conflict as the “obviously earnest claim for freedom of conscience and religious practice,” coupled with the “parent's claim to authority in her own household and in the rearing of her children,” against the “interests of society to protect the welfare of children, and the state's assertion of authority to that end.”<sup>86</sup> Although the Court acknowledged the strength of the former, it made clear that neither religious nor parental rights are beyond limitation.<sup>87</sup>

The Court concluded that the State, as *parens patriae*,<sup>88</sup> has “wide range of power for limiting parental freedom and authority in things affecting the child's welfare; and that this includes, to some extent, matters of conscience and religious conviction.”<sup>89</sup> After describing the potential dangers of street propagandizing, the Court delivered one of its most oft quoted statements: “Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”<sup>90</sup>

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<sup>82</sup> The two also stood in stationary locations holding up signs offering the material for five cents per copy. *Id.* at 161-62.

<sup>83</sup> Interestingly, both sides agreed that the statute was valid to the extent of secular application. *Id.* at 165.

<sup>84</sup> The aunt relied on what is generally known as the Free Exercise Clause of the First Amendment: “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.” U.S. CONST. amend I.

<sup>85</sup> *Prince v. Massachusetts*, 321 U.S. 158, 164 (1944).

<sup>86</sup> *Id.* at 165.

<sup>87</sup> *Id.* at 166.

<sup>88</sup> Literally meaning “parent of his or her country.” BLACK’S LAW DICTIONARY 511 (7th ed. 1999).

<sup>89</sup> *Prince*, 321 U.S. at 167.

<sup>90</sup> *Id.* at 170.

A seemingly contrary result<sup>91</sup> was reached in the case of *Wisconsin v. Yoder*, where three sets of Amish parents were convicted at trial of violating the State's compulsory education law.<sup>92</sup> The statute in question required children to attend private or public school until the age of sixteen,<sup>93</sup> but the parents acting in accordance with their religious beliefs,<sup>94</sup> withdrew their children after they completed eighth grade.<sup>95</sup> The parents did not challenge the fact that their actions violated the statute; rather, they argued that the statute unconstitutionally infringed upon their First Amendment rights.<sup>96</sup>

The trial and appellate courts agreed that the compulsory education law interfered with the freedom of the parents to act in accordance with their religious beliefs, but concluded that the State's interest in education made enactment of the statute a "reasonable and constitutional" exercise of government power.<sup>97</sup> Wisconsin's Supreme Court, on the other hand, asserted that this interest was not sufficient to override the parents' rights.<sup>98</sup> It therefore reversed the convictions holding that the compulsory education law violated the Free Exercise Clause of the First Amendment.<sup>99</sup> The United States Supreme Court granted certiorari.

The Court began by noting that although the State's interest in universal education is strong,<sup>100</sup> it is not "totally free from a balancing process when it impinges on fundamental rights and interests, such as those specifically protected by the Free Exercise Clause of the First

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<sup>91</sup> The reasoning in the both cases was consistent, but the results varied due in large part to the different evidentiary records presented.

<sup>92</sup> 406 U.S. 205, 207 (1972).

<sup>93</sup> WIS. STAT. § 118.15 (1969).

<sup>94</sup> The parents feared that by sending their children to high school they "would not only expose themselves to the danger of the censure of the church community, but, as found by the county court, also endanger their own salvation and that of their children." *Yoder*, 406 U.S. at 209.

<sup>95</sup> *Id.* at 207.

<sup>96</sup> The parents presented expert evidence regarding the impact compulsory education could have on the "continued survival of Amish community" considering their "fundamental belief that salvation requires life in a church community separate and apart from the world and worldly influence." *Id.* at 210.

<sup>97</sup> *Id.* at 213.

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> *See, e.g., Pierce v. Society of Sisters*, 268 U.S. 510, 534 (1925).

Amendment, and the traditional interest of parents with respect to the religious upbringing of their children.”<sup>101</sup> The Court found that the Amish way of life was protected under the First Amendment because their tradition is “one of deep religious conviction, shared by an organized group, and intimately related to daily living.”<sup>102</sup>

In this case the Court determined that forcing Amish children to attend high school would expose them to “worldly influences in terms of attitudes, goals, and values contrary to beliefs” in contravention of “the basic religious tenets and practice of the Amish faith.”<sup>103</sup> It determined that to do so, especially during the crucial developmental stage of adolescence, would interfere with “the religious development of the Amish child and his integration into the way of life of the Amish faith community.”<sup>104</sup> In finding the Wisconsin statute unconstitutional, the Court concluded that “enforcement of the State's requirement of compulsory formal education after the eighth grade would gravely endanger if not destroy the free exercise of respondents' religious beliefs.”<sup>105</sup>

The majority’s analysis in *Yoder* was framed as a conflict between the Amish parents and the State.<sup>106</sup> The Court specifically noted that it was the parents who were charged under the Wisconsin statute, and therefore it was “their right of free exercise, not that of their children,” at stake.<sup>107</sup> The State did not argue that the parents were preventing their children from attending

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<sup>101</sup> *Wisconsin v. Yoder*, 406 U.S. 205, 214 (1971).

<sup>102</sup> *Id.* at 216.

<sup>103</sup> *Id.* at 218.

<sup>104</sup> *Id.*

<sup>105</sup> *Id.* at 219. The State attempted to argue that while Amish beliefs are unquestionably protected under the First Amendment, religious action or conduct is frequently regulated under the State’s police power. *Id.* at 220. The Court noted, however, that although the parents were charged for the action of removing their children from school, the Amish way of life is inseparable from their beliefs, and thus, still under the purview of the First Amendment. *Id.* at 215-17, 220. Because of the First Amendment protection, the Supreme Court utilized strict scrutiny to conclude that Wisconsin had not presented a sufficiently compelling state interest.

<sup>106</sup> Buss, *supra* note 71, at 56.

<sup>107</sup> *Yoder*, 406 U.S. at 230-31.

high school against the expressed wishes of the children, so the Supreme Court did not address situations involving conflicts between parents and their children.<sup>108</sup>

Although the Court was careful to limit its decision in the education setting to the specific facts before it,<sup>109</sup> the *Yoder* decision is important because it signifies the strength of parents' First Amendment right to foster the religious development of their children. The majority opinion rejected the State's reliance on *Prince* stating that there was no demonstration of "any harm to the physical or mental health of the child or to the public safety, peace, order or welfare."<sup>110</sup>

In the years between *Prince* and *Yoder*, state courts were substantially on their own in determining when to intervene when parents made medical decisions on behalf of their children based upon religious beliefs.<sup>111</sup> Prior to *Prince* courts utilized a "life threatening exception," that typically involved state intervention in situations where medical care would "obviate almost certain death for a minor whose parents refused to consent to a blood transfusion."<sup>112</sup> In cases where the child's life was not in imminent risk, however, courts were hesitant to override parental objections to medical care.<sup>113</sup> Thus, debate surrounded the issue of when children are placed in risk sufficient to rise to the level of *Prince*-like martyrdom.<sup>114</sup>

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<sup>108</sup> *Id.* at 231. In a partial dissent, however, Justice Douglas indicated that the children's rights and interests were at stake, and should have been given more consideration. *Id.* at 241-42 (Douglas, J., dissenting in part). For a detailed discussion of the Douglas dissent see *infra* Part III.

<sup>109</sup> See Walter Wadlington, *Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. L. REV. 311, 320 n.46 (1994).

<sup>110</sup> *Yoder*, 406 U.S. at 230.

<sup>111</sup> Wadlington, *supra* note 109, at 317 (referring to a case in 1968, where in a one sentence opinion citing to *Prince*, the Supreme Court upheld the constitutionality of a Washington State statute authorizing courts to order blood transfusions for minor children over the objection of their parents. *Jehovah's Witness v. King County Hosp. Unit No. 1*, 390 U.S. 598 (1968)).

<sup>112</sup> Wadlington, *supra* note 109, at 315.

<sup>113</sup> *Id.* at 316-18 (detailing two cases at the outer limits of the "life threatening exception." In one case the court declined to order a recommended arm amputation of a young girl over the objection of the mother. The mother did not have a religious objection, but feared the surgery was too risky. *In re Hudson*, 126 P.2d 765 (Wash. 1942). The other case involved a father who refused to consent to a surgery that would have corrected his son's cleft palate and harelip. The court honored the father's objection, which was based on his own philosophical belief in mental healing, as opposed to organized religious beliefs. *In re Seiferth*, 127 N.E.2d 820 (N.Y. 1955)).

<sup>114</sup> Wadlington, *supra* note 109, at 313-14.

In the early 1970s, two cases emerged addressing the varying judicial attitudes about the state's role in protecting children "in situations that might fit within a category soon to be labeled 'medical neglect.'"<sup>115</sup> The first, *In re Sampson*, involved neglect proceedings brought against the mother of a fifteen-year-old boy (Kevin) who suffered from neurofibromatosis.<sup>116</sup> The mother consented to risky surgery aimed at correcting her son's facial deformity, but refused to consent to the administration of any blood transfusions.<sup>117</sup> As members of the Jehovah's Witness faith, they believed that blood transfusions would violate the biblical prohibition against the consumption of blood.<sup>118</sup>

Although the court noted that Kevin's condition posed no immediate threat to his life, nor had it seriously affected his general physical health,<sup>119</sup> it felt that corrective surgery offered him a chance for a "normal, happy existence," that would "unquestionably be impossible if the disfigurement [was] not corrected."<sup>120</sup> In ordering the mother to permit Kevin to undergo the surgery, the court concluded that she was neglectful by virtue of her refusal to give consent for the "the surgical procedures necessary to insure the physical, mental and emotional well-being of

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<sup>115</sup> *Id.* at 319.

<sup>116</sup> 317 N.Y.S.2d 641, 643 (N.Y. Fam. Ct. 1970). The disease, also known as von Recklinghausen's, caused the boy to have "a large fold or flap of an overgrowth of facial tissue which causes the whole cheek, the corner of his mouth and right ear to drop down giving him an appearance which can only be described as grotesque and repulsive." *Id.*

<sup>117</sup> *Id.* The physician planning to perform the procedure testified as to its high degree of risk even if the blood transfusions were authorized. The surgical team refused to operate in the absence of transfusions. *Id.* at 645.

<sup>118</sup> Jehovah's Witnesses point to several biblical passages in support of their belief. See RELIGIOUS TRADITIONS & HEALTH CARE DECISIONS: A QUICK REFERENCE TO FIFTEEN RELIGIOUS TRADITIONS AND THEIR APPLICATION IN HEALTH CARE Jehovah's Witness 1 (Edwin R. Dubose et al. eds. 2001)[hereinafter RELIGIOUS TRADITIONS]. For instance, when the flood subsided Noah was told "[e]very living thing that moves will be yours to eat, no less than the foliage of the plants. I give you everything, with this exception: you must not eat flesh with life, that is to say blood, in it." *Genesis* 9:3-4. Similarly, under the Levitical Laws of Holiness, the Israelites were warned, "If any member of the House of Israel . . . consumes blood of any kind, I shall set my face against that individual who consumes blood and shall outlaw him from his people. For the life of the creature is in the blood . . . for blood is what expiates for a life." *Leviticus* 17:10-11. The Deuteronomic Code further advises, "[t]ake care, however, not to eat the blood, since blood is life, and you must not eat the life with the meat." *Deuteronomy* 12:23. Finally, in the New Testament, a passage states that one of the few burdens placed on the early Christians was to "abstain from food sacrificed to idols, from blood . . ." *Acts* 15:29.

<sup>119</sup> *Id.* at 652.

<sup>120</sup> *Id.* at 657.

her son.”<sup>121</sup> The record did not reveal whether Kevin’s wishes were ascertained, implying the that State’s conclusion about what would serve Kevin’s best interests was controlling.

In the second case, *In re Green*, neglect proceedings were brought against the custodial mother of a fifteen-year-old boy (Ricky) who suffered from paralytic scoliosis.<sup>122</sup> Ricky’s mother consented to risky surgery aimed at correcting his spinal curvature, but as a Jehovah’s Witness, she refused to allow blood transfusions to be administered during the procedure.<sup>123</sup>

According to the Pennsylvania Supreme Court, the question before it was whether “the State [has] an interest of sufficient magnitude to warrant the abridgment of a parent’s right to freely practice his or her religion when those beliefs preclude medical treatment of a son or daughter whose life is not in immediate danger?”<sup>124</sup> The court acknowledged that Ricky’s condition was “unfortunate,” but held that the State does not have a sufficient interest to interfere with a parent’s religious beliefs unless the child’s life is “*immediately imperiled* by his physical condition.”<sup>125</sup>

The court then took an unusual step. Taking a clue from the Douglas dissent in *Yoder* – stating that the rights and interests of children warrant more consideration – it remanded the case for an evidentiary hearing on Ricky’s wishes.<sup>126</sup> The court stated that the record did not even note whether Ricky was a Jehovah’s Witness or planned to become one.<sup>127</sup> On remand, Ricky

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<sup>121</sup> *Id.* at 658-59. In affirming the decision, the New York Court of Appeals noted that its previous holding in *Seiforth* was not intended to limit the power of courts to direct surgery to solely those circumstances involving “risk to the physical health or life of the subject or to the public.” *In re Sampson*, 278 N.E.2d 918 (N.Y. 1972) (per curiam).

<sup>122</sup> 292 A.2d 387, 388 (Pa. 1972). Ricky’s condition involved a 94% curvature of his spine that would ultimately render him bedridden. *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.* at 390.

<sup>125</sup> *Id.* at 392. The court expressly disagreed with the holding in *Sampson* that religious objections to blood transfusions are not a bar where the transfusions are necessary for the success of the required surgery. Specifically, the Pennsylvania court was hesitant to call any surgery “required” where the life of the patient is not at stake. *Id.* at 391-92.

<sup>126</sup> *Id.* at 392.

<sup>127</sup> *Id.*

indicated that he did not wish to submit to the surgery, at least in part, because he had been in and out of the hospital and “no one had told him that ‘it is going to come out right.’”<sup>128</sup> Because Ricky and his mother ended up agreeing that he not undergo surgery, the court never addressed how it would handle a situation where the child disagreed with his or her parents.

Although the courts in *Sampson* and *Green* had similar facts before them, they came to very different results. While *Green* furthered the “life-threatening exception” to parental control, *Sampson* at least implicitly suggested that the child’s quality of life is a relevant consideration, and can give rise to state intervention as an additional exception.

The aforementioned cases indicate the complexity of trying to determine when parents are permitted to make medical decisions for their children, especially when those decisions involve religious beliefs.<sup>129</sup> In general, parents enjoy the right to raise their children as they see fit without undue interference by the state. This includes both fostering religious development and making medical decisions, but does not extend to decisions that put their children’s lives at risk.

For the most part, these cases address conflicts between the rights and preferences of the parents and those of the state, without consideration of the preferences of the children. Where parents are found to make decisions that do not appear to further the well-being of their children by placing their lives at risk, the state intervenes. Further, the cases rest on the assumption that the minors in question are in need of and require protection either from their parents or the state when their rights are at stake. Returning to the ethical discussion from Part I, the presumption is that either the parent or the state is in a better position than the child to promote the child’s well-

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<sup>128</sup> Wadlington, *supra* note 109, at 321 n. 52 (citing *In re Green*, 307 A.2d 279, 280 (Pa. 1973)).

<sup>129</sup> When religious beliefs are involved the parents argue under both the First and Fourteenth Amendments, thus bolstering their claims against state intervention.

being. While this may be true for younger minors, recent scholarship has challenged the notion that older minors, namely adolescents, should be treated identically.

### III. RIGHTS OF MINORS: STATUTORY EXCEPTIONS, ABORTION & THE MATURE MINOR DOCTRINE

Minors do have rights protected by the Constitution. For instance, the Supreme Court has noted that “neither the Fourteenth Amendment nor the Bill of Rights is for adults alone.”<sup>130</sup> Further, although recognizing the importance of the age of majority, the Court has stated that “[c]onstitutional rights do not mature and come into being magically only as one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”<sup>131</sup> It is clear, however, that these rights are much more limited than those of adults.<sup>132</sup> What is less clear is the extent to which minors’ rights, when recognized, are distinguishable from those of their parents.<sup>133</sup> The following discusses those situations where minors are afforded rights independent of their parents.

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<sup>130</sup> *In re Gault*, 387 U.S. 1, 13 (1967).

<sup>131</sup> *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976).

<sup>132</sup> *Bellotti v. Baird*, 443 U.S. 622, 633-35 (1979) (stating that “the constitutional rights of children cannot be equated with those of adults,” because of “the particular vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing”). See also Scott, *supra* note 6, at 552-53 (discussing the ability of states to restrict children’s access to obscene material, censorship in school newspapers, curfew ordinances, and other limitations that would be unconstitutional as applied to adults).

<sup>133</sup> See Buss, *supra* note 71, at 59; Matt Steinberg, Note, *Free Exercise of Religion: The Conflict Between a Parent’s Rights and a Minor Child’s Right in Determining the Religion of the Child*, 34 U. LOUISVILLE J. FAM. L. 219, 219-20 (1995). See also Joel Feinberg, *The Child’s Right to an Open Future*, in WHOSE CHILD? CHILDREN’S RIGHTS, PARENTAL AUTHORITY, AND STATE POWER, 125 (William Aiken & Hugh LaFollette, eds. 1980) (describing four distinguishable rights of children and adults (1) rights children and adults have in common – right to life; (2) rights possessed only by children – such as the right to have food and shelter provided for them; (3) rights only extended to adults – like making most legally binding decisions; and (4) rights in trust, or rights saved for the child until adulthood).

## A. STATUTORY EXCEPTIONS

Statutory exceptions to the general rule that minors cannot make decisions for themselves commonly fall into one of two categories: (1) status exceptions; and (2) treatment exceptions.<sup>134</sup>

Status exceptions serve to emancipate minors for the purpose of medical decision-making. In other words, legal autonomy is extended to certain older minors “based on their individual or social circumstances.”<sup>135</sup> Rhonda Gay Hartman indicates that these circumstances typically include “a minor who is homeless, married or divorced, has borne a child, is pregnant or has been pregnant, has graduated from high school, is living separately and independently, or is a member of the armed forces.”<sup>136</sup>

In some states emancipated minors are extended decision-making capacity beyond the health care setting.<sup>137</sup> In this sense emancipation is designed “to be a way to legitimize a minor’s independence and ability to make decisions before they [reach] age eighteen.”<sup>138</sup> Emancipation statutes provide formal procedures as well as the criteria necessary for a finding of emancipation,<sup>139</sup> but some argue that determinations of emancipation primarily consider “financial independence as a measure of the maturity that an adult possesses to make major life decisions.”<sup>140</sup>

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<sup>134</sup> A few states have also adopted mature minor statutes. *See infra* Part III.C.

<sup>135</sup> Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Decision-Making*, 28 AM. J. L. & MED. 409, 421 (2002) [hereinafter Hartman, *Coming of Age*].

<sup>136</sup> *Id.* at 421-22 (detailing various state emancipation statutes).

<sup>137</sup> *Id.* at 422.

<sup>138</sup> Carol Sanger & Eleanor Willemsen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. MICH. J. L. 239, 259-60 (1992).

<sup>139</sup> Wadlington, *supra* note 109, at 323.

<sup>140</sup> *See* Rosato, *End of Adolescence*, *supra* note 62, at 777.

Importantly, status exceptions have little to do with the actual decision-making capacity of the emancipated minors.<sup>141</sup> For instance, one could argue that adolescents who get married or become pregnant show a level of immaturity in decision making.

Jennifer Rosato suggests that “these exceptions appear to exist because of an ease of application and a need for consistency, rather than a recognition of the minor’s autonomy.”<sup>142</sup>

The second type of statutory exception allows minors to consent to specific types of treatment.<sup>143</sup> Most states permit minors to consent to treatment for venereal diseases – as well as access to contraception, drug or alcohol dependency, mental health problems<sup>144</sup> or sexual abuse<sup>145</sup> without involving their parents.

Like the emancipation statutes, there is no indication that the treatment exceptions are founded on consideration of the minors’ actual decision-making capabilities. Elizabeth Scott contends that “[n]o one argues that minors should be deemed adults because they are particularly mature in making decisions in these treatment contexts. Rather, the focus is on the harm of requiring parental consent.”<sup>146</sup> For example, a young girl may be afraid to tell her mother that she is being sexually abused by her father, and therefore will go untreated. In this sense, the treatment exceptions seem to be an extension of the state’s *parens patriae* authority; however, rather than the state stepping in, it gives decision-making authority directly to minors.

Another policy behind the treatment exceptions stems from public health and safety. Adolescents may be hesitant to inform their parents of their sexual activity or substance abuse problems, and therefore will forego medical treatment. Allowing minors to consent to these

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<sup>141</sup> Hartman, *Coming of Age*, *supra* note 135, at 422.

<sup>142</sup> Rosato, *End of Adolescence*, *supra* note 62, at 777.

<sup>143</sup> *Id.* at 778.

<sup>144</sup> See Hartman, *Coming of Age*, *supra* note 135, at 416-20.

<sup>145</sup> Rosato, *End of Adolescence*, *supra* note 62, at 778.

<sup>146</sup> Scott, *supra* note 5, at 568.

treatments without involving their parents removes a substantial obstacle. As Scott points out, “society also has an interest in reducing the incidence of sexually transmitted diseases, substance abuse, mental illness, and teenage pregnancy. Together, these social benefits largely explain why lawmakers shift the boundary of childhood for the purpose of encouraging treatment of these conditions.”<sup>147</sup>

## B. ABORTION

In the years following *Roe v. Wade*,<sup>148</sup> the Supreme Court was asked to address the extent to which states may regulate adolescent access to abortion.<sup>149</sup> Discussions about adolescent abortion entail a balancing of interests: the adolescent’s right to choose to have an abortion versus the parental right to make important decisions on behalf of their children.<sup>150</sup>

The Supreme Court first addressed this issue in *Planned Parenthood v. Danforth*, where one of the provisions of a Missouri abortion statute required minors to obtain consent from at least one parent before obtaining an abortion.<sup>151</sup> In striking down the provision, the Court determined that the State’s interest in safeguarding the family unit and parental authority is not “sufficient justification” to condition a minor’s abortion on the consent of a parent or person *in loco parentis*.<sup>152</sup> The Court stated that “[a]ny independent interest that parents may have in the termination of their minor daughter’s pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.”<sup>153</sup>

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<sup>147</sup> *Id.* See also Jessica A. Penkower, Comment, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment – Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1177-78 (1996).

<sup>148</sup> 410 U.S. 113 (1979).

<sup>149</sup> Rosato, *Bioethics Discourse*, *supra* note 25, at 16-19; Scott, *supra* note 5, at 569-76.

<sup>150</sup> Whomever is more likely to act in the furtherance of the child’s well-being should trump.

<sup>151</sup> 428 U.S. at 58.

<sup>152</sup> *Id.* at 75.

<sup>153</sup> *Id.*

Three years later the Court heard arguments in the case of *Bellotti v. Baird*, involving a Massachusetts abortion statute that required minors to obtain parental consent for an abortion, or if the parents refused, judicial approval.<sup>154</sup> The Court began by noting that “legal restrictions on minors, especially those supportive of the parental role, may be important to the child’s chances for the full growth and maturity that make eventual participation in a free society meaningful and rewarding.”<sup>155</sup> It went on, however, to state that the “need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, require a State to act with particular sensitivity when it legislates to foster parental involvement in this matter.”<sup>156</sup>

In light of the special nature of pregnancy and abortion decisions, the Court concluded that if states require parental consent as a condition for minors seeking abortions they must also “provide an alternative procedure whereby authorization for the abortion can be obtained.”<sup>157</sup> To this end, the Court held that:

A pregnant minor is entitled to such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents’ wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests.<sup>158</sup>

The Court ultimately struck down the Massachusetts statute finding that the judicial authorization it provided did not meet constitutional standards.<sup>159</sup>

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<sup>154</sup> *Bellotti*, 443 U.S. at 625. The case was initially brought only on behalf of minors “who have adequate capacity to give a valid and informed consent [to abortion], and who do not wish to involve their parents,” but it later included the rights of all pregnant minors. *Id.* at 626-27.

<sup>155</sup> *Id.* at 638-39.

<sup>156</sup> *Id.* at 642. The Court was cognizant of the fact that most limitations on minors’ rights constitute delays, for example the right to drive or vote, whereas the nature of pregnancy precludes delay. *Id.*

<sup>157</sup> *Id.* at 643.

<sup>158</sup> *Id.* at 644. The Court further held that “every minor must have the opportunity – if she so desires – to go directly to a court without first consulting or notifying her parents,” but the court maintains the right to require parental consultation if it determines that it would be in the minor’s best interests. *Id.* at 647.

<sup>159</sup> *Id.* at 645.

During the next two decades the Supreme Court heard a number of cases involving legislation aimed at regulating adolescent abortion. Specifically, the cases dealt with the level of involvement parents should have in their adolescent daughter's decision to have an abortion.<sup>160</sup> Starting with *Bellotti*, however, the Court made clear that adolescent girl's must be given an opportunity, through judicial bypass, to establish that they are "mature and well enough informed to make intelligently the abortion decision on [their] own."<sup>161</sup> Though the Court did not provide an excessive amount of guidance in maturity determinations,<sup>162</sup> the principle was set: pregnant adolescents adjudged to have sufficient maturity must have their decision to have an abortion respected.

The Supreme Court has not extended this opportunity to minors outside the abortion context.<sup>163</sup> Whether minors should be afforded such rights in other situations is the subject of debate involving the Mature Minor Doctrine.

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<sup>160</sup> See *Lambert v. Wicklund*, 520 U.S. 292, 293 (1997) (upholding the constitutionality of a state statute requiring parental notification, but allowing the minor to bypass a parental refusal through judicial procedure); *Planned Parenthood v. Casey*, 505 U.S. 833, 839 (1992) (upholding a statute requiring parental consent, with a provision for judicial bypass); *Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502, 519-20 (1990) (upholding a statute requiring parental consent or notification, with a judicial bypass procedure); *Hodgson v. Minnesota*, 497 U.S. 417, 455 (1990) (upholding a statute requiring notice to both parents, with judicial bypass); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 440-41 (1983) (the Court struck down a city ordinance requiring parental consent without providing an adequate bypass procedure); *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 490-94 (1983) (upholding statute requiring consent from at least one parent, with judicial bypass); *H.L. v. Matheson*, 450 U.S. 398, 409 (1981) (upholding a parental notice requirement as applied to an immature, dependent minor).

<sup>161</sup> *Bellotti v. Baird*, 443 U.S. 622, 647 (1979).

<sup>162</sup> See Scott, *supra* note 5, at 574 (calling Justice Powell's prescription for judicial bypass "vague," which has led to an "indeterminate legal standard"). Scott indicates that in certain jurisdictions judges seem to rubber-stamp petitions of pregnant teens, while courts in others have a standard of maturity that few minors are able to meet. *Id.*

<sup>163</sup> Some commentators argue that the extension of these rights to minors in the abortion context is more about compromise than truly respecting adolescent decision-making ability. See, e.g., *id.* at 575.

### C. THE MATURE MINOR DOCTRINE: RESPECTING THE RIGHTS OF AUTONOMOUS ADOLESCENTS?

The theory behind the mature minor doctrine<sup>164</sup> is simple: if a minor has sufficient competence to make an autonomous decision, that decision should be respected as such.<sup>165</sup> In other words, certain minors are mature enough to know what decisions would be in accord with their conception of well-being, thus obviating protection from either their parents or the State. A few states have enacted statutes giving minors found to have requisite competence<sup>166</sup> the authority to consent to medical treatment,<sup>167</sup> while others give children with sufficient age and competence a stronger voice in custodial disputes.<sup>168</sup> For the most part, however, the mature minor doctrine exists as a creature of common law, the seeds of which were planted in the early 1970s.<sup>169</sup>

Perhaps the first manifestation by the Supreme Court of the importance of inquiring into the wishes of adolescents came in Justice Douglas's partial dissent in *Yoder*.<sup>170</sup> Recall that the majority in *Yoder* considered the issue to involve a conflict between the Amish parents and the

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<sup>164</sup> *But see* Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L. J. 1265, 1311 (2000) [hereinafter Hartman, *Adolescent Autonomy*] (noting that the use of "doctrine" implies a "consensus of judicial decisions," which in this case would be a misnomer because only certain jurisdictions have empowered minors under specific circumstances).

<sup>165</sup> *See id.* Professor Hartman argues that "autonomous decisional ability should be the cornerstone for a coherent legal model governing issues of adolescence". *Id.* at 1270-71.

<sup>166</sup> Other states have created a bright-line rule allowing adolescents to consent to treatment without a competency determination. S.C. CODE ANN. 20-7-280 (Law. Co-op. 2000) (permitting minors sixteen and older to consent to medical treatment); LA. REV. STAT. ANN. 40:1095 (West 2000) (allowing any minor to consent to medical treatment). The Louisiana statute specifically excludes the ability to refuse medical treatment. *See* Hartman, *Adolescent Autonomy*, *supra* note 164, at 1311 (citing OP. LA. ATT'Y GEN. NO. 88-232 (1988)).

<sup>167</sup> *See* Rosato, *End of Adolescence*, *supra* note 62, at 779 n.72 (citing to ARK. CODE ANN. 20-9-602(7) (Michie 2000) (allowing unemancipated minors to consent to medical treatment if they are of sufficient intelligence to understand and appreciate the consequences of their decision); IDAHO CODE 39-4302 (Michie 2000) (stating that any person of competent intelligence to comprehend the nature and the significant risks posed by the medical treatment is competent to consent on his own behalf); NEV. REV. STAT. ANN. 129.030(2) (Michie 2001) (permitting a minor that understands the purpose of the examination and treatment and its probable outcome to consent to the medical treatment, but provider must make efforts to seek minor's consent to communicate with parents in most instances); *cf.* ALASKA STAT. 25.20.025(2) (Michie 2000) (allowing a minor to consent to medical treatment without parental consent where the minor is first counseled before such treatment)).

<sup>168</sup> *See* Hartman, *Adolescent Autonomy*, *supra* note 164, at 1287-90. On a related note, juvenile criminal offenders found to have sufficient capacity are often tried and convicted as adults. *Id.* at 1293-96.

<sup>169</sup> *See* Wadlington, *supra* 109, at 321-22, n.53 (arguing that, at least initially, the "mature minor doctrine was based less on concern about children's rights than on the desire to negate a battery action against medical personnel if an older minor consented in near-emergency situations or when a parent was unavailable").

<sup>170</sup> *Wisconsin v. Yoder*, 406 U.S. 205, 241-49 (1972) (Douglas, J. dissenting in part).

State.<sup>171</sup> Justice Douglas disagreed with this characterization stating that “[w]here the child is mature enough to express potentially conflicting desires, it would be an invasion of the child’s rights to permit such an imposition without canvassing his views.”<sup>172</sup> Importantly, Douglas went on to suggest that if a child disagrees with his or her parents’ decision “and is mature enough to have that desire respected, the State may well be able to override the parents’ religiously motivated objections.”<sup>173</sup>

Though his language was ethically charged, noticeably missing is a standard for determining maturity, or what makes a child’s particular desire deserving of respect.<sup>174</sup> For example, it would be difficult to defend an argument that children are mature simply by virtue of expressing a desire conflicting with their parents. That being said, Douglas at least presented the notion that when children’s rights are potentially abridged, their voices should be heard.<sup>175</sup> In the years following *Yoder*, courts<sup>176</sup> as well as scholars, began to point to the Douglas dissent when “calling for the recognition of children’s rights independent of the rights of their parents.”<sup>177</sup>

Ethically speaking it is not enough to say that children deserve to make decisions on their own; rather, there must be some evidence that they have sufficient competence to make autonomous decisions deserving of respect. The presumption that minors lack this ability has

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<sup>171</sup> See *supra* Part II.

<sup>172</sup> *Yoder*, 406 U.S. at 242.

<sup>173</sup> *Id.*

<sup>174</sup> In a footnote Justice Douglas pointed to the work of child psychologists and sociologists for the proposition that children aged fourteen and older have moral and intellectual maturity approaching that of an adult. *Id.* at 245 n.3.

<sup>175</sup> For a discussion about the difficulty in ascertaining a child’s wishes and beliefs in the religious context, see *infra* Part V.

<sup>176</sup> See the discussion of *In re Green supra* Part II (finding that although the State could not interfere with the parent’s religious decision to refuse consent for a medical procedure, the case should be remanded for a determination of the child’s wishes).

<sup>177</sup> Buss, *supra* note 71, at 53, n.4. For the purpose of this article two rights are of particular importance: the right of children to make medical decisions on their own, and the right to practice religion independent of their parents’ right to free exercise of religion.

already been discussed;<sup>178</sup> whether that presumption applies with equal force to adolescents is another question.<sup>179</sup>

Those who argue in favor of increased adolescent decisional rights point out that “the existing law fails to take into account a developmental perspective that ‘examines the soundness of age-based legal policies in light of scientific research and theory on psychological development.’”<sup>180</sup> Beginning in the late 1970s – notably very soon after the Supreme Court first extended decision-making authority to pregnant teens in the abortion context – several psychological studies were conducted questioning the decision-making capabilities of minors in the medical setting.<sup>181</sup>

Taken together these studies suggest that older adolescents are no less competent to provide consent than adults.<sup>182</sup> Lois Weithorn and Susan Campbell specifically compared the decision-making capabilities of variously aged minors and young adults. They found that minors aged fourteen and older “demonstrate a level of competency equivalent to that of adults.”<sup>183</sup> These results supported earlier work performed by Jean Piaget which suggested that individuals enter the “formal operational stage” during adolescence, and thereafter “possess the cognitive

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<sup>178</sup> See *supra* Part II.

<sup>179</sup> Hartman, *Coming of Age*, *supra* note 135, at 411.

<sup>180</sup> Rosato, *End of Adolescence*, *supra* note 62, at 783 (quoting Laurence Steinberg & Elizabeth Cauffman, *A Developmental Perspective on Serious Juvenile Crime: When Should Juveniles be Treated as Adults?*, 63 *FED. PROBATION* 52, 52 (1999)).

<sup>181</sup> See, e.g., Grisso & Vierling, *supra* note 57; Lois A. Weithorn & Susan B. Cambell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 *CHILD DEV.* 1589 (1982); David G. Scherer & N. Dickon Reppucci, *Adolescents' Capacities to Provide Voluntary Informed Consent*, 12 *LAW & HUM. BEHAV.* 123 (1988); David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 *LAW & HUM. BEHAV.* 431 (1991).

<sup>182</sup> See Hartman, *Physician Perspectives*, *supra* note 20, at 96-98 (discussing relevant studies in adolescent decision-making capacity).

<sup>183</sup> Weithorn & Campbell, *supra* note 181, at 1595. These findings supported earlier studies performed by Jean Piaget.

capability to reason, understand, appreciate, and articulate decisions comparable to young adults.”<sup>184</sup>

Although these studies cast doubt on the appropriateness of applying a presumption of incompetence to all adolescents, there are critics. Some have argued that the findings are limited because the subjects were typically white and middle-class.<sup>185</sup> Others suggest that these studies define competence too narrowly, or fail to consider psychosocial factors that impact adolescents differently than adults.<sup>186</sup> In one of the first studies, Thomas Grisso and Linda Vierling articulated that “it would be inaccurate to conclude that all adolescents are intellectually capable of providing independent consent.”<sup>187</sup> At the very least, these critiques indicate that it would be imprudent to reverse the current practice and adopt a presumption of competence for all adolescents.

The cases that have dealt with the issue of whether to adopt a mature minor exception have called for or applied an individualized assessment of the maturity of the adolescents in question.<sup>188</sup> When reading these cases it is important to remain cognizant of the conflict involved, and whether the minor is truly empowered to decide in accordance with his or her own conception of well-being.

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<sup>184</sup> Hartman, *Adolescent Autonomy*, *supra* note 164, at 1286 (citing to early studies performed by Jean Piaget).

<sup>185</sup> Rosato, *End of Adolescence*, *supra* note 62, at 785, n. 110.

<sup>186</sup> *Id.* at 786.

<sup>187</sup> Grisso & Vierling, *supra* note 57, at 421. The authors also suggest that the same might be true for a random sampling of adult subjects; however, because adults are presumed competent, they are not subject to the same scrutiny.

<sup>188</sup> The cases discussed below generally fall into three categories: (1) those that adopt a mature minor doctrine and apply it to the adolescent in question; (2) those that adopt the doctrine and hold that the minor’s maturity should have been determined; and (3) those that refuse to adopt the mature minor doctrine or hold that it does not apply to the given circumstances.

1. *Cardwell v. Bechtol*<sup>189</sup>

In perhaps the seminal case addressing the mature minor doctrine,<sup>190</sup> the Tennessee Supreme Court considered whether the State should adopt the doctrine as an exception to the rule that physicians must obtain parental consent before treating minors.<sup>191</sup> Without her parents' knowledge, Sandra Cardwell (aged seventeen years, seven months) visited an osteopathic physician who had treated her father in the past.<sup>192</sup> The physician incorrectly concluded that Sandra's back pain was not caused by a herniated disc, and proceeded to treat her through manipulations of the neck, spine and legs.<sup>193</sup>

When Sandra's pain did not subside, and she developed bladder and bowel retention coupled with decreased sensation in her legs and buttocks, she underwent diagnostic testing confirming that she did in fact have a herniated disc. She eventually had surgery performed in an attempt to correct the problem, but almost one year later she still had not regained full bowel control or lower body sensation.<sup>194</sup> Sandra and her parents filed suit against the osteopathic physician for malpractice (the misdiagnosis), battery (failure to obtain parental consent),<sup>195</sup> negligent failure to obtain consent, and failure to obtain informed consent.<sup>196</sup> This implies that the parents disagreed with Sandra's decision to see the osteopath in the first place.

The trial court granted the physician's Motion for Directed Verdict on the malpractice claim because the Cardwells failed to meet their burden of proof. The court also instructed the

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<sup>189</sup> 724 S.W.2d 739 (Tenn. 1987).

<sup>190</sup> Although earlier cases recognized an exception to obtaining parental consent in litigation involving claims of battery, *Cardwell* is one of the most oft-cited cases regarding the mature minor doctrine. See, e.g., *Commonwealth v. Nixon*, 761 A.2d 1151, 1154 (Pa. 2000); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 836 (W.Va. 1992); *In re E.G.*, 549 N.E.2d 322, 327 (Ill. 1989).

<sup>191</sup> *Cardwell*, 724 S.W.2d at 741.

<sup>192</sup> *Id.* at 743.

<sup>193</sup> *Id.* at 741-42.

<sup>194</sup> *Id.* at 742.

<sup>195</sup> See *supra* Part I.

<sup>196</sup> *Cardwell*, 724 S.W.2d at 742.

jury that if it found Sandra to be mature, the physician was not liable for battery or failure to obtain informed consent.<sup>197</sup> The jury returned a general verdict in favor of the physician, but the appellate court reversed holding that neither the Tennessee Legislature nor the State's Supreme Court had adopted the mature minor exception to the parental consent requirement.<sup>198</sup>

The Tennessee Supreme Court permitted an appeal, and used it as an opportunity to formally adopt the mature minor doctrine. In so doing the court noted the State's medical treatment exception statutes,<sup>199</sup> and its treatment of older adolescents in the criminal context.<sup>200</sup> The court was not willing to grant physicians a "general license" to treat any minor without parental consent; rather it held that application of the mature minor doctrine is "dependent on the facts of each case."<sup>201</sup> Specifically, the court stated:

Whether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved. Moreover, the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor's ability to appreciate the risks and consequences are to be considered.<sup>202</sup>

The court concluded that this determination is a question of fact properly left in the hands of the jury. In Sandra's case, the court felt that the jury was justified in concluding that she "had the ability, maturity, experience, education and judgment . . . to consent knowingly to medical treatment."<sup>203</sup> Sandra was thus empowered as a mature minor to consent to treatment regardless of her parents disagreement.

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<sup>197</sup> *Id.*

<sup>198</sup> *Id.*

<sup>199</sup> *See supra* Part III. A. The court concluded that the statutes are not exhaustive, nor do they "abrogate judicial adoption of an exception to the general common law rule." *Cardwell v. Bechtol*, 724 S.W.2d 739, 744 (Tenn. 1987). *But see Commonwealth v. Nixon*, 761 A.2d 1151, 1155 (Pa. 2000) (holding that similar statutes indicate the extent of legislative intent to grant minors the right to consent to or refuse medical treatment).

<sup>200</sup> *Cardwell*, 724 S.W.2d at 745.

<sup>201</sup> *Id.*

<sup>202</sup> *Id.* at 748.

<sup>203</sup> *Id.* at 749. Interestingly, relying on the Rule of Sevens, the court reassigned presumptions regarding the capacity to make medical decisions: those under the age of seven still require parental consent; those aged seven to fourteen

## 2. *Belcher v. Charleston Area Medical Center*<sup>204</sup>

Another early case addressing the mature minor doctrine involved Larry Belcher who was aged seventeen years, eight months, and suffered from muscular dystrophy.<sup>205</sup> After a fit of breathing difficulty Larry's parents took him to the emergency room, where he subsequently suffered breathing failure, was intubated, placed on a respirator, and transferred to the pediatric intensive care unit.<sup>206</sup>

Larry's treating physician asked his parents whether they would want Larry reintubated should he suffer breathing failure again. Although they initially were undecided, they ultimately told the physician that "they did not want Larry reintubated or resuscitated unless Larry requested it."<sup>207</sup> Without consulting Larry, the physician entered a Do Not Resuscitate order into Larry's progress notes.<sup>208</sup> When Larry later suffered another respiratory arrest, he went into cardiac failure and died. His parents filed suit for wrongful death and medical malpractice, but lost at trial.<sup>209</sup> They appealed the issue of whether Larry should have been consulted prior to entering the DNR order, which the West Virginia Supreme Court suggested would require recognition of the "so-called 'mature minor' exception to the common law rule of parental consent."<sup>210</sup>

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are presumed incompetent, but can rebut that presumption; while those aged fourteen to eighteen, like adults, are presumed competent. *Id.*

<sup>204</sup> 422 S.E.2d 827 (W.Va. 1992).

<sup>205</sup> *Id.* at 829.

<sup>206</sup> *Id.* at 830. Testimony during trial indicated that when Larry was later extubated he seemed "anxious and apprehensive," and motioned his head "no" when asked by his treating physician whether he would want to be reintubated. *Id.*

<sup>207</sup> *Id.*

<sup>208</sup> *Id.* The physician claimed that he did not consult Larry because "(1) he was emotionally immature due to his disease; (2) he was on medication which diminished his capacity; (3) involving him in the decision would have increased his anxiety, thus reducing his chances of survival; and (4) Larry's parents told [him] that they did not want Larry involved." *Id.*

<sup>209</sup> *Id.*

<sup>210</sup> *Id.* at 831. Interestingly, the court could have decided the case under a parents' rights approach, because it was Larry's parents' wish that he be consulted that was violated.

Citing to *Cardwell*,<sup>211</sup> the West Virginia Supreme Court adopted the mature minor doctrine under the common law of the State.<sup>212</sup> The court held that

application of the mature minor rule would vary from case to case. The focus would be on the maturity level of the minor at issue, and whether that minor has the capacity to appreciate the nature and risks involved of the procedure to be performed, or the treatment to be administered or withheld.<sup>213</sup>

Like *Cardwell*,<sup>214</sup> the court in *Belcher* considered this determination to be a question of fact; “a matter for the jury to decide, and not for this Court to speculate.”<sup>215</sup> On the other hand, the court concluded that “where there is a conflict between the intentions of one or both parents and the minor, the physician’s good faith assessment of the minor’s maturity level would immunize him or her from liability for the failure to obtain parental consent.”<sup>216</sup> Rather than itself making a determination as to Larry’s maturity, the court remanded the case so that Larry’s maturity could be assessed in light of the court’s adoption of the mature minor doctrine.<sup>217</sup> The court recognized at least the potential for conflict between parents and their children, and empowered mature minors to consent to or refuse medical treatment over their parents’ objection.<sup>218</sup>

The West Virginia court did not draw a distinction between consenting to or refusing medical treatment. In support of this one might argue that once minors are deemed mature they should be afforded rights equal to those of adults; and adults clearly may refuse medical treatment, even where death is the probable result.<sup>219</sup> Many commentators, however, are not

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<sup>211</sup> The West Virginia court listed factors almost identical to those listed in *Cardwell*. See *supra* note 202.

<sup>212</sup> *Id.* at 837. By utilizing the State’s common law, the court obviated the need to discuss whether mature minors have federal constitutional rights to consent to or refuse medical treatment.

<sup>213</sup> *Id.* at 838. Note that *Cardwell* addressed only the right to consent to treatment whereas the court in *Belcher* suggests the right to refuse treatment as well.

<sup>214</sup> The West Virginia court, however, was unwilling to rely on the Rule of Sevens. *Id.* at 837 n.13.

<sup>215</sup> *Id.* at 837. The court acknowledged that initially physicians would be given the difficult task of determining a minor’s maturity, thus necessitating good record keeping. *Id.* at 837 n.14.

<sup>216</sup> *Id.* at 838.

<sup>217</sup> *Id.*

<sup>218</sup> The court admitted, however, that the State’s legislature could prohibit recognition of the mature minor doctrine should it so desire. *Id.*

<sup>219</sup> See, e.g., *Cruzan v. Dir., Mo. Dep’t. of Health*, 497 U.S. 261 (1990).

ready to go this far when it comes to minors refusing life-saving,<sup>220</sup> or life-sustaining<sup>221</sup> medical treatment.<sup>222</sup> Complicating this issue further, is the fact that parents are typically not permitted to make decisions that put their children's lives at risk.<sup>223</sup>

### 3. *In re Swan*<sup>224</sup>

Seventeen-year-old Chad Swan was in an automobile accident that left him in a persistent vegetative state. His body was maintained by life-sustaining treatment involving a gastrostomy tube providing hydration and nutrition.<sup>225</sup> When the tube eventually eroded, the attending physicians recommended that it not be reinserted; Chad's parents agreed.

When *Swan* was decided, the notion of a "right to die," for any individual was relatively new.<sup>226</sup> States typically challenged decisions to remove gastrostomy tubes and the like by raising four State interests: (1) interests in the preservation of human life; (2) prevention of suicide; (3) third party interests; and (4) protecting the integrity of the medical profession.<sup>227</sup> Taking a proactive stance, and fearing civil or criminal liability, the Swans sought declaratory relief from a trial court in Maine.<sup>228</sup> The trial court listened to evidence presented by Chad's

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<sup>220</sup> Life-saving medical treatment refers to life or death curative treatment that promises that the patient's "short- and long-term prognoses are excellent." Harvey, *supra* note 21, at 316. For example treatments that, if given, will restore the patient to a healthy state, but if withheld, will result in certain death – blood transfusions, or insulin treatment for diabetics.

<sup>221</sup> Life-sustaining treatment, on the other hand, generally involves a quality of life inquiry. The patient is likely to succumb to the underlying disease, but with treatment, could expect to live longer than without. *Id.* Many cancer treatments fall into this category, because they may extend life for a few months or years, but often involve physically burdensome side-effects.

<sup>222</sup> Compare Driggs, *supra* note 61 (arguing that adolescents should never be permitted to refuse treatment when death is the probable outcome), and Penkower, *supra* note 147 (arguing that the mature minor doctrine should not be utilized to permit minors to refuse life-saving medical treatment), with Harvey, *supra* note 21 (arguing for a sliding scale of adolescent empowerment depending upon the type of treatment involved). But see Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J. L. MED. & ETHICS 109 (2000).

<sup>223</sup> See *supra* Part II.

<sup>224</sup> 569 A.2d 1202 (Me. 1990).

<sup>225</sup> *Id.* at 1202.

<sup>226</sup> See generally ALAN MEISEL, *THE RIGHT TO DIE* (2d ed. 1995) (providing a comprehensive analysis of the history and development of the right to choose death rather than medical treatment).

<sup>227</sup> See, e.g., Hartman, *Coming of Age*, *supra* note 135, at 441.

<sup>228</sup> *In re Swan*, 569 A.2d at 1203-04.

mother about his prior wishes, and concluded that Chad would not have consented to reinsertion of the tube.<sup>229</sup>

The district attorney, on behalf of the State, challenged the court's ruling raising interests (1), (3) and (4) above. The attorney also argued that any right Chad might have to refuse medical treatment "was significantly reduced because [he] was under the legal age of majority when he expressed those wishes."<sup>230</sup> The Supreme Judicial Court of Maine rejected these arguments finding that Chad's status as a minor was merely a "factor to be considered by the fact finder in assessing the seriousness and deliberateness" of his statements.<sup>231</sup> In making clear that its decision was based on Chad's beliefs – as opposed to the court's or parents' view of what was best for him<sup>232</sup> – the court concluded that Chad's wishes to not be maintained in a persistent vegetative state reflected "well-informed desires as to medical treatment," and should be followed.<sup>233</sup>

Although the court decided the case based upon Chad's previously expressed wishes, the manifested conflict was between the parents and the State. For instance, if the parents had wanted Chad to be maintained by the gastrostomy tube, one has to wonder whether his previously expressed wishes to the contrary would have surfaced. Therefore, it is not clear how empowering *Swan* would be for future cases involving adolescent refusal of life-saving or life-sustaining medical treatment where the child's wishes conflict with the parents'.

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<sup>229</sup> *Id.* at 1205. Chad's mother testified to remembering Chad state "If I can't be myself . . . no way . . . let me go to sleep," when discussing a young boy his grandmother knew who was in a persistent vegetative state. Similarly, after visiting a comatose friend in the hospital, Chad told his brother "I don't ever want to get like that . . . I would want somebody to let me leave – to go in peace." *Id.*

<sup>230</sup> Hartman, *Coming of Age*, *supra* note 135, at 440.

<sup>231</sup> *In re Swan*, 569 A.2d at 1205.

<sup>232</sup> *See Rosato, End of Adolescence*, *supra* note 62, at 781.

<sup>233</sup> *Id.* at 1205-06.

#### 4. *Benny Agrelo and Billy Best*

In the mid 1990s two adolescents gained wide publicity in their attempts to forego medical treatment.<sup>234</sup> Benny was a fifteen-year-old Floridian who had undergone two liver transplants. He took immunosuppressants that caused severely debilitating side effects to prevent his body from rejecting the organs.<sup>235</sup> Benny ultimately decided to stop taking the medication against both his parents' and doctors' wishes. At some point, however, his mother began to support his decision.<sup>236</sup> When the hospital discovered this, they instituted neglect proceedings against his mother.<sup>237</sup> Benny was taken to the hospital where he resisted resuming the immunosuppressants.<sup>238</sup>

A juvenile court judge held separate meetings with Benny, his mother and his health care team. The judge determined that Benny was mature enough to understand what he was doing, and prohibited further interference with his wishes. Benny returned home and died from liver failure a few months later.<sup>239</sup> Unfortunately, because juvenile court records are sealed, it is unclear what factors the judge considered in making the determination.<sup>240</sup> Benny was empowered to make the decision to forego medical treatment, but like Chad, he had agreement from his mother.

Billy Best was a sixteen-year-old resident of Massachusetts suffering from Hodgkin's lymphoma. Two and a half months into a six month chemotherapy regimen, Billy refused further treatment. Fearing that his parents would force him to undergo additional rounds of

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<sup>234</sup> See Harvey, *supra* note 21, at 307.

<sup>235</sup> *Id.* at 307.

<sup>236</sup> Drigg, *supra* note 61, at 687.

<sup>237</sup> See *supra* Part II (discussing conflicts between parents and the State).

<sup>238</sup> Driggs, *supra* note 61, at 688.

<sup>239</sup> *Id.*

<sup>240</sup> Harvey, *supra* note 21, at 307.

chemo, Billy left home and ran to Texas.<sup>241</sup> Although Billy's physicians indicated that the treatment had a ninety percent cure rate, his parents promised not to force him to submit to further treatment.<sup>242</sup> Massachusetts chose not to intervene, and Billy returned home.<sup>243</sup> Rather than continue chemotherapy, Billy began a series of alternative therapies that succeeded in sending his illness into remission.<sup>244</sup> While this was good for Billy, it obviously leaves open the question of whether the State would have intervened had Billy's condition turned grave and his parents continued to uphold his wish to forego traditional medical treatment.

The aforementioned cases suggest that in certain states, depending on the circumstances, the administration of life-saving or sustaining medical treatment to adolescents who do not want that treatment may be foregone where the minor is adjudged mature and the parents agree with the decision. This stands in contrast to the general rule that state governments intervene in these situations under the assumption that parents who place their children's lives at risk are acting contrary to the child's well-being. Further, the cases do not provide guidance as to the level of maturity a child would need to refuse treatment where death is the likely result.

Notably, the religious beliefs of the parents were not a factor in any of the above cases; rather, the decisions were based upon medical information and quality of life determinations. Recall that religion played a major role in many of the earlier cases defining the scope of parental rights and the duty of the state to intervene as *parens patriae*.<sup>245</sup> While parents were permitted to remove their children from formal schooling based upon their religious beliefs, they were not permitted to put their children's lives at risk. Without consulting the children in

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<sup>241</sup> Susan D. Hawkins, Note, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 *FORDHAM L. REV.* 2075, 2075 (1996).

<sup>242</sup> Harvey, *supra* note 21, at 307.

<sup>243</sup> *Id.*

<sup>244</sup> Driggs, *supra* note 61, at 688.

<sup>245</sup> *See supra* Part II.

question, the conflict in each case was between the parents' and state's belief about what would be in the children's best interests.

When the child's life is at stake, the state presumes that his or her well-being is better served by being kept alive than by dying according to the parents' chosen religious beliefs. The following cases involve parents and children attempting to avoid state intervention by arguing that the choice to die is based not upon the parents' beliefs, but upon the children's.

#### IV. THE MATURE MINOR DOCTRINE AND RELIGIOUS REFUSALS IN CASE LAW

An analysis of the following cases is meant to shed light on the inconsistencies in the adoption and application of a state recognized mature minor doctrine, especially when religious beliefs are involved. In practice, the mature minor doctrine should serve to empower adolescent's capable of autonomous decision-making. To that end, the focus in each case should be on whether the child's decision appears to be in line with his or her true conception of well-being, regardless of the parents' beliefs.<sup>246</sup> Each fails in this regard.

##### A. *IN RE E.G.*<sup>247</sup>

Ernestine Gregory was a seventeen and half-year-old female diagnosed in 1987 with acute nonlymphatic leukemia, a malignant disease of the white blood cells.<sup>248</sup> She was admitted to the hospital where physicians told her that the recommended course of treatment involved chemotherapy coupled with blood transfusions.<sup>249</sup> While both Ernestine and her mother agreed to all other forms of treatment, they adamantly opposed any blood transfusions based upon their religious beliefs.<sup>250</sup>

In response to this refusal, attending physicians at the hospital contacted the office of the State's Attorney, which office subsequently filed a petition in the juvenile court seeking a

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<sup>246</sup> To date, no court has permitted a child to choose to refuse medical treatment without parental consent where death is the probable result. As will be shown in Part V *infra*, in the religious context parental consent should not necessarily bolster the child's decision to refuse treatment.

<sup>247</sup> 549 N.E. 2d 322 (Ill. 1989); 515 N.E.2d 286 (Ill. App. Ct. 1988).

<sup>248</sup> *In re E.G.*, 549 N.E.2d at 323.

<sup>249</sup> *In re E.G.*, 515 N.E.2d at 287. Ernestine's treating physician testified that with treatment her survival rate was twenty to twenty-five percent, with a remission rate of eighty percent. *In re E.G.*, 549 N.E.2d at 323.

<sup>250</sup> *In re E.G.*, 515 N.E.2d 286, 287 (Ill. App. Ct. 1988).

finding that Ernestine was medically neglected by her mother.<sup>251</sup> At the time of the initial hearing, Ernestine suffered greatly from depleted platelet counts and had blood that was only transporting oxygen at one-fifth to one-sixth normal capacity.<sup>252</sup> A treating physician testified that Ernestine's condition left her "excessively fatigued and incoherent," and that without transfusion, she "would likely die within a month."<sup>253</sup> The physician also indicated, however, that in his belief "Ernestine was competent to understand the consequences of accepting or rejecting treatment," and he was "impressed with her maturity and the sincerity of her beliefs."<sup>254</sup> At this point the court found probable cause to believe that Ernestine was medically neglected, and "appointed the hospital official temporary custodian with power to consent to all medical treatment."<sup>255</sup>

Roughly six weeks later, the court called the case for reconsideration. Ernestine had been continuously receiving blood transfusions, and was able to testify.<sup>256</sup> Ernestine stated that "she had studied her faith for several years, and that she had been baptized at age 16, which made her an adult in the eyes of her church."<sup>257</sup> She further testified that "the decision to refuse blood transfusions was her own and that she fully understood the nature of her disease and the consequences of her decision. She indicated that her decision was not based on any wish to die, but instead was grounded in her religious convictions."<sup>258</sup>

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<sup>251</sup> *Id.*

<sup>252</sup> *Id.* at 296 (McNamara, J., dissenting).

<sup>253</sup> *In re E.G.*, 549 N.E.2d 322, 323 (Ill. 1989).

<sup>254</sup> *Id.*

<sup>255</sup> *In re E.G.*, 515 N.E.2d at 288.

<sup>256</sup> *In re E.G.*, 549 N.E.2d at 323.

<sup>257</sup> *In re E.G.*, 515 N.E.2d at 288.

<sup>258</sup> *In re E.G.*, 549 N.E.2d at 324. Jehovah's Witnesses believe that death is a deep sleep from which they will be awoken on the day of Armageddon. See RELIGIOUS TRADITIONS, *supra* note 118, at 6. However, if they receive a blood transfusion they can sever their relationship with God, forfeit a chance of eternal life, and become excommunicated from the congregation. *Id.* at 8.

In addition to her own testimony, Ernestine presented several witnesses to substantiate her maturity and decision-making capability. One such witness was a psychiatrist who testified that, in his opinion, “Ernestine had the maturity level of an 18 to 21 year old,” and that she had the “competency to make an informed decision to refuse the blood transfusions, even if the choice was fatal.”<sup>259</sup>

In the end, concluding that it was in her best interests, the trial court ruled that Ernestine was medically neglected, and appointed a guardian to consent to medical treatment.<sup>260</sup> The court went on to state that Ernestine was “‘a mature 17-year-old individual,’ that reached her decision on an independent basis, and that she was ‘fully aware that death [was] assured absent treatment.’”<sup>261</sup> However, the court also expressed concern that “outward appearances and expressed beliefs often do not reflect the individual’s true wishes.”<sup>262</sup> Although heavily considering Ernestine’s and her mother’s wishes – and the religious basis for them – the court felt that the State’s interest in the case was greater.<sup>263</sup>

On appeal Ernestine and her mother argued that the trial court’s order violated Ernestine’s constitutional rights guaranteed under the First and Fourteenth Amendments by infringing on her religious freedom.<sup>264</sup> At the time this case was heard, Illinois case law clearly established that adults have the right to refuse medical treatment for religious reasons under the Constitution.<sup>265</sup> Further, it was apparent that parents are not permitted to make decisions harmful

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<sup>259</sup> *In re E.G.*, 549 N.E.2d at 324. Ironically, the doctor found Ernestine to be mature based upon her responses to questions regarding her future plans; a future that would be precluded by allowing her to refuse the blood transfusions. *In re E.G.*, 515 N.E.2d at 293 (McNamara, J. dissenting).

<sup>260</sup> *In re E.G.*, 549 N.E.2d at 324.

<sup>261</sup> *Id.*

<sup>262</sup> *In re E.G.*, 515 N.E.2d at 293 (McNamara, J. dissenting).

<sup>263</sup> *In re E.G.*, 549 N.E.2d at 324. The court did not identify which particular State interests were greater.

<sup>264</sup> *Id.*

<sup>265</sup> See *In re Estate of Brooks*, 205 N.E.2d 435 (Ill. 1965).

to their children based upon religious beliefs,<sup>266</sup> including refusing blood transfusions.<sup>267</sup> What was unclear, however, was whether a minor has the constitutional right to refuse medical treatment for themselves.

For an answer to this question, the appellate court turned to the United States Supreme Court's decisions in the abortion arena.<sup>268</sup> The appellate court noted that the Supreme Court has yet to extend such rights beyond reproductive matters, but found that "such an extension is inevitable."<sup>269</sup> The court stated that "[g]iven the paramount importance of religious freedom in the history of our nation," it is unlikely that less protection would be afforded to it than the rights at stake in abortion cases.<sup>270</sup>

The appellate court ultimately held that Ernestine was medically neglected; however, by virtue of that neglect, she became partially emancipated.<sup>271</sup> As a partially emancipated mature minor,<sup>272</sup> Ernestine had the right to refuse the blood transfusion regardless of her mother's consent, such that the trial court's order was "an unjustified abridgement of her first amendment rights."<sup>273</sup> The State's petition to the Supreme Court of Illinois was granted.

By the time of the argument in front of the Illinois Supreme Court Ernestine had turned eighteen. The court decided to hear the case, although technically moot, because it presented "an

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<sup>266</sup> *In re E.G.*, 515 N.E.2d at 289 (citing the oft-quoted martyrdom language in *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944)).

<sup>267</sup> *See Wallace v. Labrenz*, 104 N.E.2d 769 (Ill. 1952).

<sup>268</sup> *In re E.G.*, 515 N.E.2d at 290. *See supra* Part IV.

<sup>269</sup> *In re E.G.*, 515 N.E.2d at 290.

<sup>270</sup> *Id.*

<sup>271</sup> The court relied on the Illinois Emancipation of Mature Minors Act that states that minors sixteen years of age or over found to be neglected may be partially or completely emancipated upon a showing of "capacity to manage his own affairs." *Id.*

<sup>272</sup> The appellate court based its determination of Ernestine's maturity on the statements made by the trial court, not a separate inquiry. *Id.* at 293 (McNamara, J. dissenting).

<sup>273</sup> *Id.* at 291.

issue of substantial public interest.”<sup>274</sup> That issue being whether minors have a right to refuse medical treatment.

The Illinois Supreme Court began by acknowledging that the common law age of majority, eighteen, is not “an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood.”<sup>275</sup> It went on to detail statutory exceptions where minors are granted the right to seek medical attention including treatment.<sup>276</sup> The court also noted that the Illinois Criminal Code provides a “sliding scale of maturity” that permits certain minors to be tried and convicted as adults.<sup>277</sup> Finally, like the appellate court, it looked to the abortion arena where the United States Supreme Court has extended protection to minors under the Constitution.<sup>278</sup>

With this backdrop the Illinois Supreme Court determined that if adjudged a mature minor by clear and convincing evidence, Ernestine had the right to control her own health care.<sup>279</sup> The court felt that a trial judge must be employed to make this determination in light of the State interests involved; namely, in the sanctity of life and the State’s duty as *parens patriae* to protect minors.<sup>280</sup> The court created a common law right to consent to or refuse medical treatment for minors “mature enough to appreciate the consequences of [their] actions,” and “mature enough to exercise the judgment of an adult.”<sup>281</sup>

The court concluded, however, that the minor’s right is not absolute, and must be weighed 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

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<sup>274</sup> *In re E.G.*, 549 N.E.2d at 325.

<sup>275</sup> *Id.*

<sup>276</sup> *Id.*

<sup>277</sup> *Id.* at 326.

<sup>278</sup> *Id.*

<sup>279</sup> *Id.* at 327.

<sup>280</sup> *Id.*

<sup>281</sup> *Id.* at 327-28.

profession.”<sup>282</sup> Of these, the court felt that in Ernestine’s case, the interests of third parties was most significant. The court stated that if Ernestine’s mother opposed her refusal of the blood transfusions the court would have given serious consideration to the mother’s wishes.<sup>283</sup> Because the court found that a mature minor “may exercise a common law right to consent to or refuse medical care,” it declined to address whether refusing medical treatment for religious reasons is protected under the First Amendment.<sup>284</sup> By doing so, the court downplayed the relevance of religious beliefs as the basis for Ernestine’s refusal of the blood transfusions.

In sum, the Illinois Supreme Court held that if Ernestine were found to be a mature minor by clear and convincing evidence she would have had the right to control her medical care. Interestingly, because Ernestine was eighteen by the time of this ruling, the court found no point in remanding the case to the trial court for a proper determination of whether she was a mature minor at the time of the initial hearing.<sup>285</sup>

This appears to be very empowering for future cases, but is limited for two reasons. First, Ernestine’s particular circumstance was not considered by the Illinois Supreme Court, so cases with similar facts cannot point to the supreme court’s ruling as dispositive of maturity. Second, even if the supreme court had held Ernestine to be mature, it stated that if her mother had not agreed with her decision, it would “weigh heavily against the minor’s right to refuse.”<sup>286</sup> Thus, even if mature, Ernestine’s decision would not have been respected as autonomous. Paradoxically this suggests that a mature minor is only empowered to refuse life-saving or sustaining medical treatment to the extent that his or her decision coincides with a parent’s belief

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<sup>282</sup> *Id.* at 328.

<sup>283</sup> *Id.*.

<sup>284</sup> *Id.*.

<sup>285</sup> *Id.*. The court also reversed the appellate court’s finding of medical neglect on the part of Ernestine’s mother, because had she been declared a mature minor, no neglect could have been found. *Id.*.

<sup>286</sup> *In re E.G.*, 549 N.E.2d 322, 328 (Ill. 1989).

that alone would be restricted by the State.<sup>287</sup> Compare the analyses used by the Illinois courts to that utilized by a trial court in New York.

*B. IN THE MATTER OF LONG ISLAND JEWISH MEDICAL CENTER*<sup>288</sup>

Philip Malcolm, just seven weeks shy of eighteen, was admitted to the hospital when he presented to the emergency room with dangerously low hemoglobin and hematocrit blood counts. Both he and his parents refused any blood transfusions as members of the Jehovah's Witness faith.<sup>289</sup> The next morning the hospital and physicians petitioned the court for an order authorizing what they called necessary treatment. Philip and his parents were present at the hearing where they learned that Philip had cancer. The physicians recommended a course of chemotherapy coupled with blood transfusions.<sup>290</sup>

At the hearing Philip's step-father testified that he was adamant in his refusal of blood transfusions, and believed Philip would die or be unable to live a normal life regardless of what was done. Philip and his mother also stated that they would not consent to blood transfusions. Noting that the hearing was the first time the family learned of the cancer, the court adjourned until the following day for the family to reconsider its position.<sup>291</sup>

The following day the hospital presented testimony that without a blood transfusion Philip would likely die within the month, and hence there was need for immediate action. Through testimony of the family the court learned that they had joined the Jehovah's Witnesses three years earlier. Philip stated that he lost interest for a while, but began studying his faith

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<sup>287</sup> In the religious context this is problematic. *See infra* Part V.

<sup>288</sup> 557 N.Y.S.2d 239 (N.Y. Sup. Ct. 1990).

<sup>289</sup> *Id.* at 240.

<sup>290</sup> *Id.* at 241. With treatment the cure rate was estimated to be twenty to twenty-five percent, and the likelihood of remission for months or years was seventy-five percent. *Id.*

<sup>291</sup> *Id.*

again about a year prior. He did not know the books of the Bible, but did seem to understand the “basic tenet of the religion’s prohibition regarding blood transfusions.”<sup>292</sup> Philip also stated that he considered himself a child, rather than an adult, and that if the court ordered the transfusion, “it would not be his responsibility or his sin.”<sup>293</sup> Finally, the court noted that Philip always consulted his parents before making a decision, and there was no evidence to suggest that his parents encouraged him to make his *own* decision in this case.<sup>294</sup>

The court ultimately ordered immediate transfusions to stabilize Philip’s condition, but did not order chemotherapy or further transfusions. Philip and his parents appealed the initial order raising this issue: “[d]oes an intelligent, articulate young man, just weeks shy of his 18<sup>th</sup> birthday, have due process right [sic] to demonstrate his capacity to make medical decisions for himself consistent with his values and convictions before he loses the right to control what is done to his body?”<sup>295</sup>

The judge cited to *In re E.G.* and *Belcher* for the proposition that mature minors may refuse medical treatment,<sup>296</sup> but concluded that “[w]hile this court believes there is merit to the ‘mature minor’ doctrine, I find that Philip Malcolm is not a mature minor.”<sup>297</sup> Interestingly, the court noted that it did not appear as though the decision was Philip’s own, such that it was consistent with *his* values and convictions. This implies that the court was not convinced that Philip’s decision to refuse the blood transfusions was based upon religious beliefs in accordance

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<sup>292</sup> Philip believed that if he consented to a blood transfusion he would not have everlasting life. *Id.* at 242.

<sup>293</sup> *Id.*. Certain Jehovah’s Witness congregations believe that if blood transfusions are given without the person’s consent, his or her conscience is clear. See RELIGIOUS TRADITIONS, *supra* note 118, at 3.

<sup>294</sup> *Id.*.

<sup>295</sup> *Id.* at 243.

<sup>296</sup> Unlike the courts in *Belcher* and *In re E.G.*, however, this court made a distinction between the right to consent and the right to refuse medical treatment, but did not decide whether they should be equated. *Id.*.

<sup>297</sup> *Id.*.

with his well-being.<sup>298</sup> As a trial court, however, the New York Supreme Court was hesitant to adopt the mature minor doctrine; rather, it 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.”<sup>299</sup>

The lower courts in Illinois, and the New York trial court, paid some attention to the expressed religious beliefs of the adolescents in question.<sup>300</sup> The appellate court in Illinois was satisfied that Ernestine was mature enough to refuse blood transfusions based upon her religious beliefs where death was the certain result. The trial court in New York, on the other hand, was not convinced of Philip’s maturity to do the same. Not all courts feel that maturity should even be a factor in determining whether minors should be permitted to refuse medical treatment.

### *C. NOVAK V. COBB COUNTY KENNESTONE HOSPITAL AUTHORITY*<sup>301</sup>

Greg Novak was in a serious car accident when he was sixteen-years-old. In the ambulance on the way to the hospital he informed the paramedics that he was a Jehovah’s Witness, and as such, did not want any blood transfusions administered.<sup>302</sup> At the hospital his father consented to a surgery that was performed without blood transfusions.<sup>303</sup> The following day Greg’s treating physicians became concerned when blood tests revealed that his blood was deficient in levels of

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<sup>298</sup> It is only implicit, because there were limited facts before the court, and it did not specify its exact reasoning for finding Philip immature to make the decision.

<sup>299</sup> *Id.*

<sup>300</sup> The Illinois Supreme Court, on the other hand, did not discuss how Ernestine’s religious beliefs would come into play in a maturity determination.

<sup>301</sup> 846 F.Supp. 1559 (N.D. Ga. 1994) *aff’d*, 74 F.3d 1173 (11th Cir. 1996).

<sup>302</sup> *Novak*, 846 F.Supp. at 1563.

<sup>303</sup> Greg’s parents were divorced, and although his mother had custody, she was not available at first to give consent. She took over decision-making authority once she arrived. *Id.*

both hemoglobin and hematocrit. Greg and his mother remained adamant in their refusal of blood transfusions.<sup>304</sup>

Later that day the physicians came to the conclusion that without a blood transfusion Greg's life was in eminent danger. They contacted the hospital's legal team who petitioned for a court appointed guardian *ad litem*.<sup>305</sup> A hearing was held, without Greg's mother, and a guardian was appointed.<sup>306</sup> On his second day in the hospital, Greg's guardian petitioned the Superior Court of Cobb County to allow the hospital to perform the blood transfusions. The judge granted the petition, and Greg was "physically restrained and transfused with three units of packed red blood cells."<sup>307</sup> Roughly six weeks later, Greg was released from the hospital; and after a lengthy recovery period, "resumed normal physical activity for person of his age but [suffered] from a slight limp" resulting from his accident-related injuries.<sup>308</sup>

Greg and his mother filed suit raising a number of claims under federal and state law. Initially, both alleged violations of their First and Fourteen Amendment rights, but the mother later dropped her First Amendment claim.<sup>309</sup> For purposes of this discourse the important allegation was that "as a 'mature minor,' [Greg] was denied his procedural due process rights to refuse medical care under Georgia law."<sup>310</sup> The hospital and physicians, on the other hand, argued that "any constitutional interest in bodily self-determination Gregory Novak may have

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<sup>304</sup> *Id.*

<sup>305</sup> A guardian *ad litem* is appointed by a court to appear in a lawsuit or on behalf of an incompetent or minor party. BLACK'S LAW DICTIONARY 313 (7th ed. 1999).

<sup>306</sup> *Novak v. Cobb County-Kennestone Hosp. Auth.*, 846 F.Supp. 1559, 1564 (N.D. Ga. 1994).

<sup>307</sup> *Id.*

<sup>308</sup> *Id.*

<sup>309</sup> In a footnote the court noted that the Supreme Court's ruling in *Prince* was "dispositive of any deprivation of religious freedom claim" the mother might have had. *Id.* at 1571 n.16.

<sup>310</sup> *Id.* at 1574.

possessed did not include the right to refuse medically necessary treatment and that Georgia law includes no provision for ‘mature minors’ to refuse medical treatment.”<sup>311</sup>

The district court noted that minors do have constitutional rights, but added that Greg and his counsel pointed to no authority for the proposition that a mature minor “has a constitutional right to refuse a blood transfusion pursuant to either the minor’s First or Fourteenth Amendment rights; nor could they.”<sup>312</sup> This is an important distinction. The cases that have adopted the mature minor doctrine have done so under state law, not federal constitutional law. The United States Supreme Court has yet to extend constitutional protection to minors in the medical setting beyond the abortion context.<sup>313</sup> Therefore, Greg was required to show that Georgia state law supported his claim.

In attempt to find support in state law, Greg pointed to statutory exceptions to the general rule that minors cannot consent to medical treatment.<sup>314</sup> The court noted that under Georgia statutory law, only those over the age of eighteen are expressly permitted to refuse medical treatment; such that, although minors are empowered to consent to certain treatments, they are not statutorily permitted to refuse the same.<sup>315</sup> The court concluded that there was no authority to suggest that Georgia recognizes a common law mature minor doctrine.<sup>316</sup> A similar decision was recently reached by the Pennsylvania Supreme Court in a case with unusual facts.

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<sup>311</sup> *Id.*

<sup>312</sup> *Id.* Recall that the appellate court in *In re E.G.* found just that, but the supreme court later mooted that determination by acknowledging a state common law mature minor doctrine.

<sup>313</sup> See *supra* Part III.

<sup>314</sup> *Novak v. Cobb County-Kennestone Hosp. Auth.*, 846 F.Supp. 1559, 1576 (N.D. Ga. 1994); see also *supra* Part III.

<sup>315</sup> *Novak*, 846 F.Supp. at 1576. But see *In re Rena*, 705 N.E.2d 1155, 1157 (Mass. 1999) (In a case with similar facts – Rena, a Jehovah’s Witness, lacerated her spleen in a snowboarding accident potentially requiring blood transfusions, and the trial court gave the hospital permission to administer them should they become necessary – the highest court in Maine stated that the adolescent’s maturity should be determined to ascertain whether she could make an informed choice).

<sup>316</sup> *Id.* The district court’s ruling was affirmed on appeal. *Novak*, 74 F.3d 1173 (11th Cir. 1996). It should be noted, however, that a Georgia state court has yet to make a determination about whether the state actually does acknowledge the mature minor doctrine.

D. *COMMONWEALTH V. NIXON*<sup>317</sup>

In June of 1997 sixteen-year-old Shannon Nixon began feeling ill.<sup>318</sup> As members of the Faith Tabernacle Church, the Nixon's did not believe in traditional medical treatment, choosing instead to address illness through spiritual treatment.<sup>319</sup> They began to pray for Shannon's health, and took her to their Church to be anointed. Initially, Shannon's condition appeared to improve, but it subsequently deteriorated and she slipped into a coma. She died a few hours later from what an autopsy later determined to be diabetes acidosis: a "treatable, though not curable, condition."<sup>320</sup>

Shannon's parents were subsequently tried and convicted of involuntary manslaughter and endangering the welfare of a child; for which they were sentenced to two and a half to five years in prison and a fine of one thousand dollars.<sup>321</sup> They appealed the conviction claiming in relevant part that (1) Shannon had a constitutionally protected privacy right to refuse medical treatment; and (2) Shannon was a mature minor capable of making the decision to refuse treatment herself.<sup>322</sup>

Shannon's parents raised these arguments to suggest that Shannon was mature enough to make a protected decision, therefore abrogating their parental duty.<sup>323</sup> In other words, that Shannon's decision was her own, and that they merely respected that decision because she was mature enough to make it herself. Without any reported analysis, the superior court held that

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<sup>317</sup> 761 A.2d 1151, (Pa. 2000); 718 A.2d 311 (Pa. Super. Ct. 1998).

<sup>318</sup> *Nixon*, 761 A.2d at 1152.

<sup>319</sup> *Id.* Note the contrast between these beliefs and those of Jehovah's Witnesses who will seek medical care except for blood transfusions.

<sup>320</sup> *Id.* The facts are unusual, because in nearly all other reported cases of children dying when their parents refuse to seek medical attention, the children were very young; thus precluding application of the mature minor doctrine. See Merrick, *supra* note 1, at 290-97 (2003) (detailing cases that reached state Supreme Courts. Other than Shannon, the next oldest child that died was eleven).

<sup>321</sup> *Commonwealth v. Nixon*, 718 A.2d 311, 312 (Pa. Super. Ct. 1998).

<sup>322</sup> *Id.* Mr. and Mrs. Nixon also argued that the jury instructions were faulty and that the sentence was excessive. *Id.*

<sup>323</sup> *Id.* at 313.

Shannon, “as a mature minor, had a right to refuse medical treatment pursuant to her constitutional right to privacy.”<sup>324</sup> It went on to state, however, that “this right does not discharge her parents’ duty to override her decision when her life is in immediate danger.”<sup>325</sup>

The court interpreted *In re Green* to suggest that a sixteen-year-old is permitted to refuse a non life-threatening operation for religious beliefs,<sup>326</sup> but said that a different result is warranted where the minor’s life is in danger.<sup>327</sup> The court further considered its earlier decision in *Commonwealth v. Cottam*,<sup>328</sup> where the parents of two malnourished children argued that the fourteen and twelve-year-olds chose not to eat based on their own religious beliefs. The *Cottam* court held that “even if [the children] were considered mature enough to freely exercise their religious beliefs, this does not dispel [defendant’s] duty while the children are in their care, custody and control to provide them with parental care, direction and sustenance.”<sup>329</sup>

Finally, the court recalled its holding in *Commonwealth v. Barnhart*,<sup>330</sup> where it upheld the conviction of parents belonging to the Nixons’ Religion who relied solely on spiritual healing to treat their two-year old son’s cancer.<sup>331</sup> In *Barnhart*, the court held that all parents in Pennsylvania owe a duty of care to their children, “at the very least, to avert the child’s untimely death.”<sup>332</sup> In ruling against the Nixons, the Superior Court held that even though Shannon was a

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<sup>324</sup> *Id.* The Pennsylvania Superior Court, like the Illinois Appellate Court, took it upon itself to extend constitutional rights to minors for medical decision-making beyond the abortion context.

<sup>325</sup> *Id.*

<sup>326</sup> This interpretation is not entirely accurate. See *supra* Part II.

<sup>327</sup> *Commonwealth v. Nixon*, 718 A.2d 311, 313 (Pa. Super. Ct. 1998).

<sup>328</sup> 616 A.2d 988 (Pa. Super. Ct. 1992).

<sup>329</sup> *Nixon*, 718 A.2d at 313 (quoting *Cottam*, 616 A.2d at 1000). Importantly, the *Cottam* court did not make an actual determination as to the ability of fourteen and twelve-year-olds to exercise their religious beliefs; rather it held that children may never exercise religious beliefs where to do so would result in death.

<sup>330</sup> 497 A.2d 616 (Pa. Super. Ct. 1985).

<sup>331</sup> *Nixon*, 718 A.2d at 313.

<sup>332</sup> *Id.* (citing *Barnhart* 497 A.2d at 621). See also *supra* Parts II & III.

mature minor, this did not abrogate their parental duty to seek medical treatment once her condition became life threatening.<sup>333</sup>

The court held that the sentence imposed by the trial court was not excessive despite the fact that it exceeded the sentencing guidelines.<sup>334</sup> Of particular import was the fact that the Nixons were tried six years earlier on the same charges when their nine-year-old son died of complications arising from an ear infection. In that case the Nixons pled no contest and received two years of probation.<sup>335</sup> The Nixons appealed to the Pennsylvania Supreme Court.

The supreme court granted allocatur to consider two issues: (1) whether to adopt a “mature minor doctrine which would be an affirmative defense to the parental duty to provide care to a minor;” and (2) “whether Shannon Nixon had a right to refuse medical care pursuant to her privacy rights under the constitutions of the United States and [Pennsylvania].”<sup>336</sup>

The supreme court reviewed the cases from other jurisdictions that acknowledged the mature minor doctrine,<sup>337</sup> and stated that “without passing judgment upon the wisdom of the mature minor doctrine itself,” the doctrine is inapplicable to the circumstances surrounding the Nixons’ case.<sup>338</sup> In the court’s opinion, the doctrine was inapplicable because “the legislature of [Pennsylvania] has provided a statute which identifies those minors who are deemed sufficiently mature to give consent to medical treatment.”<sup>339</sup>

The court also relied on Pennsylvania’s adoption of the treatment exceptions,<sup>340</sup> to conclude that these statutes when read together suggest that the legislature did not intend “that any minor, upon the slightest showing, has capacity to consent to or to refuse medical treatment in a life and death

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<sup>333</sup> *Id.* at 313.

<sup>334</sup> *Id.*

<sup>335</sup> *Id.* at 315.

<sup>336</sup> *Commonwealth v. Nixon*, 761 A.2d 1151, 1152 (Pa. 2000).

<sup>337</sup> See *infra* Part III and above, discussing the history and development of the mature minor doctrine.

<sup>338</sup> *Nixon*, 761 A.2d at 1154.

<sup>339</sup> *Id.* at 1155. Referring to status exceptions. See *supra* Part III.

<sup>340</sup> *Nixon*, 761 A.2d at 1155.

situation.”<sup>341</sup> Interestingly, the court’s stated holding was that “the maturity of an unemancipated minor is not an affirmative defense to the charges brought against Appellants.”<sup>342</sup>

Recall above where the court initially framed this issue as whether it would adopt a mature minor doctrine which would be an affirmative defense to the parental duty to provide care to a minor. There is an obvious difference, however, between a wholesale refusal to adopt the mature minor doctrine, and simply refusing to allow the mature minor doctrine to be utilized as an affirmative defense after the fact when parents refuse to seek out medical care and a child dies. In a powerful concurrence, Justice Cappy believed the majority opinion to effect the former.<sup>343</sup>

Although agreeing with the ruling in the Nixons’ case, Justice Cappy would have adopted a mature minor doctrine in Pennsylvania. In his opinion, “when it is determined that a minor has the capacity to understand the nature of his or her condition, appreciate the consequences of the choices he or she makes, and reach a decision regarding medical intervention in a responsible fashion, he or she should have the right to consent to or refuse treatment.”<sup>344</sup> Cappy felt that the record fell short of establishing Shannon as a mature minor, but conceivably, she could have been found mature enough to make the decision for herself.<sup>345</sup> Following *Nixon*, like Georgia, Pennsylvania does not acknowledge decision-making authority for mature minors under any

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<sup>341</sup> *Id.* In a footnote the court cited to the superior court’s statement in *Cottam*, that even if a minor were found to be mature enough to freely exercise their religious beliefs, it would not abrogate the parents’ affirmative duty to provide care direction and sustenance. *Id.* at 1155 n.4.

<sup>342</sup> *Id.* Concerning the second issue for which allocatur was granted, the court held that although Shannon had privacy rights protected by both the state and federal constitutions, those rights were overridden by the compelling state interest as *parens patriae* to protect the life of an unemancipated minor. *Id.* at 1156.

<sup>343</sup> *Id.* at 1157 (Cappy, J. concurring). Justice Cappy felt that the majority opinion was “ambiguous,” but after “deliberation” ultimately concluded that “the majority has evaluated the [mature minor] doctrine and determined that it will not be part of our common law under any circumstances.” *Id.*

<sup>344</sup> *Id.* at 1158. The Superior Court, on the other hand, would never allow a minor to refuse medical treatment where death is the probable outcome.

<sup>345</sup> *Id.*

circumstances not previously existing under statutory law. Justice Cappy aligned himself with the cases endorsing the doctrine, and felt that this was the wrong result.

Review of the aforementioned cases reveals several important implications. First, the mature minor doctrine has yet to be fully developed or consistently applied. Some courts have deferred adoption of the doctrine to State Legislature, preferring to stay out of the debate entirely. Other courts have extended decision-making authority to minors for the purpose of consenting to, but not refusing medical treatment. Still others would allow minors adjudged mature to refuse even life-saving medical treatment if they had agreement from their parents.

Second, although all courts willing to entertain the mature minor doctrine speak of the minors' ability to understand their circumstances and appreciate the consequences of their decisions, none provide specific guidelines for measuring the capacity of minors to do so. In addition, the courts do not recognize a significant difference between the refusal of and consent to medical treatment, especially where the consequences are life or death in nature. Ethically speaking, a higher level of competence is required to refuse than consent to such treatment.<sup>346</sup> The cases dealing with the mature minor doctrine in situations involving life or death decisions are deficient in their discussions regarding whether minors are in fact capable of choosing to refuse life-saving or sustaining medical treatment in accordance with *their* underlying and enduring aims and values.

Finally, the cases in this area involving religious determinations by adolescents pay disturbingly little attention to the religious aspect of the decision-making process. While the courts are clear that they will not let parents make the decision to refuse life-saving or sustaining

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<sup>346</sup> BUCHANAN & BROCK, *supra* note 34, at 52 (arguing that “the appropriate level of competence properly required for a particular decision must be adjusted to the consequences of acting on that decision”). This will be discussed further in Part V.

medical treatment on behalf of their children based upon religious beliefs, they do not make a serious attempt to explicate the religious identity of the minors in question.

The goal of the mature minor doctrine is to ascertain those adolescents who have developed underlying and enduring aims and values, and thus, the capability of making decisions that would promote their well-being without the aid of their parents or the State. Under the current framework, it is possible that a minor could be permitted to refuse life-saving or sustaining medical treatment based upon religious beliefs because they understand and appreciate the medical aspects of their situation, yet do not have authentic beliefs that are integral to their lives. This is a dangerous precedent.

For instance, the trial court believed that Ernestine was mature enough to understand the medical nature of her condition, but was concerned that her expressed religious beliefs were not necessarily her own. In extending decisional authority to Ernestine, the majority opinions from the appellate courts in Illinois down played the religious aspect of the decision by emphasizing her maturity with respect to the medical aspects of the decision.<sup>347</sup> Further, Justice Cappy implied in his concurrence that if Shannon had understood the nature of her condition and appreciated the consequences of her decision, she should have been permitted to refuse medical treatment. This ignores the possibility that Shannon may have been impermissibly influenced by her parents and religious community in coming to a refusal decision in contravention of her true sense of well-being. Disregarding the religious aspect of the decision-making process leaves open the possibility that practitioners will allow adolescents to choose to die for their expressed beliefs in a way that fails to protect and promote the adolescents' well-being.

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<sup>347</sup> The trial court in New York indicated the same anxiety when it declared Philip immature, though it did not expressly identify its reasoning for this finding. The court did note that there was no indication that Philip was encouraged to make the decision on his own. *See supra* note 294 and accompanying text.

Another possibility under the current status of the law is that minors with deeply held religious convictions will be prevented from acting according to their beliefs in violation of their autonomy. For instance, it is conceivable that Gregory Novak was deeply committed to his beliefs, so much so, that forcing him to undergo a blood transfusion would compromise his religious integrity. The district court's wholesale rejection of the mature minor doctrine with respect to treatment refusals fails to adequately protect the potential that Gregory's decision was ethically deserving of respect as autonomous.

Acknowledging that the current framework is wanting, but that the mature minor doctrine has merit, this paper now turns to whether the doctrine should be utilized to permit adolescents to refuse life-saving or sustaining medical treatment based upon religious beliefs. In other words, is it possible to measure the religious integrity of adolescents to the point where it is ethically defensible to allow them to die for their expressed beliefs?

## V. RELIGIOUS INTEGRITY AND MEDICAL DECISION-MAKING

Situations involving the refusal of medical treatment based upon religious beliefs are not simply medical in nature, and therefore, addressing the patient's understanding of the medical aspect of the decision alone is insufficient. In fact, in the cases presented in this paper, the decisions to refuse medical treatment were based solely or primarily upon religious beliefs. The parents of Kevin Sampson, Ricky Green, Ernestine Gregory and Philip Malcolm consented to medical procedures aimed at alleviating their children's ailments.<sup>348</sup> These decisions were medical in nature taking into account – assuming informed consent was obtained – diagnoses, risks and the potential for success associated with the procedures, and feasible alternatives.<sup>349</sup>

The parents of Kevin and Ricky were willing to subject their children to risky surgical procedures, though their lives were not at risk from the underlying condition, in the hopes that they would have a better life. The parents of Ernestine and Philip wanted their children to undergo cancer treatments despite the fact that the cure rate was no higher than twenty-five percent. The refusal of these treatments was not based upon relative risk or success; rather the parents refused based upon their religious prohibition on the administration of blood transfusions.

It is well settled that parents may not refuse medical treatment based upon religious beliefs where to do so would put their children's lives at risk; the State as *parens patriae* has the

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<sup>348</sup> Shannon Nixon's parents, on the other hand, refused all medical treatment.

<sup>349</sup> See *supra* Part II.

duty to intervene and order the necessary treatment.<sup>350</sup> Again, this intervention is based upon the presumption that adults may choose to die for their beliefs, but they may not “make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”<sup>351</sup> While the parents may believe that death furthers their own and their children’s well-being more so than would the given medical treatment, the State reserves that determination for the child upon reaching decision-making capacity. In order to avoid this interference, some parents and children have argued that the decisions were made by the children as mature minors; and as such, with the full and legal discretion to decide for themselves.

In theory, the mature minor doctrine requires ascertaining whether adolescents have developed underlying and enduring aims and values, and thus, decision-making capacity or the ability to make autonomous decisions. When adolescents are willing to die for their religious beliefs, an inquiry is required not just into the ability of the minors to appreciate their medical circumstances, but also into their religious integrity. Only then can practitioners be sure that the decisions are the adolescents’ own.

#### A. CONSIDERATION OF ADOLESCENT RELIGIOUS BELIEFS IN THE LAW

The maturity of minors is given relatively little weight in the context of children’s religious rights.<sup>352</sup> Most cases even addressing the religious rights of minors involve situations where the “children’s interests identified match the parents’ interests, or indeed, the parents are the actual motivating force behind the litigation.”<sup>353</sup> The courts deciding these cases frequently do not distinguish between the religious interests of the parents and their children, leading some

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<sup>350</sup> See *supra* Part II.

<sup>351</sup> *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

<sup>352</sup> Note, *Children as Believers: Minors’ Free Exercise Rights and the Psychology of Religious Development*, 115 HARV. L. REV. 2205, 2208 (2002) [hereinafter *Children as Believers*].

<sup>353</sup> Buss, *supra* note 71, at 62.

commentators to believe that the cases are decided solely upon the parents' claims.<sup>354</sup> Where the courts attempt to disaggregate the interests of the parents and children, scant attention is paid to the centrality of the children's religious beliefs to their lives.

It is fitting to return to Justice Douglas's partial dissent in *Yoder*. Indeed, Douglas partially dissented from the majority's opinion because only two of the three children were not consulted regarding their religious views and preference to withdraw from school after the eighth grade.<sup>355</sup> Frieda Yoder, on the other hand, gave testimony that she wanted to withdraw from school. That testimony, in relevant part, is as follows:

Q: [by parents' counsel]: Frieda, I won't ask you many questions, how old are you?

A: 15

Q: Do you believe in the Amish religion?

A: Yes.

Q: Do you want to live according to the way of your people?

A: Yes.

Q: Do you live that way now?

A: Yes.

Q: Would your going to high school be against your religious belief, Frieda?

A: Yes.

That is All.

Q: [by counsel for the State] Defense counsel asked, and I think you said that you wanted to be brought up in the Amish religion, is that right?

A: Yes.

Q: Now Frieda, otherwise you would be able to attend high school physically, if you were free of religion you could attend, you could walk or get there on the bus?

A: Yes

Q: So I take it then, Frieda, the only reason you are not going to school, and did not go to school since last September, is because of your religion?

A: Yes

That is all.<sup>356</sup>

Douglas wrote his dissent because he was concerned that the majority's opinion served to "impose the parents' notions of religious duty upon their children," without discerning the children's actual religious convictions.<sup>357</sup> Apparently, Frieda's testimony was sufficient to dispel his concerns and convince him of the depth of Frieda's beliefs such that she was "mature enough

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<sup>354</sup> *Children as Believers*, *supra* note 352, at 2210 (citing Emily Buss, *The Adolescent's Stake in the Allocation of Educational Control Between Parent and State*, 67 U. CHI. L. REV. 1233, 1240 n.22 (2000)).

<sup>355</sup> *Wisconsin v. Yoder*, 406 U.S. 205, 243 (1972) (Douglas, J. dissenting).

<sup>356</sup> Buss, *supra* note 71, at n.61.

<sup>357</sup> *Yoder*, 406 U.S. at 242.

to have [her] desire respected.”<sup>358</sup> Because Douglas’s dissent was grounded on the fact that the other two children were not consulted, presumably, had they been asked questions similar to Frieda, he would have joined the majority opinion.

For obvious reasons, this inquiry provides little guidance concerning the authenticity of a child’s religious beliefs. It is unclear from a few yes/no questions whether the choice to leave school was formulated by Frieda on her own, without undue influence or pressure from her parents or religious community. The decision to withdraw from school has less severe consequences than a life or death decision to refuse medical treatment, and would require a lesser showing of competency, but Frieda’s limited testimony fails to supply even this. Since *Yoder*, the Supreme Court of the United States has not offered further guidance concerning adolescent religious claims.

In 1993 a district court in Texas decided an interesting case involving Native American students.<sup>359</sup> Although the members of the Tribes in question converted to Christianity years before, certain younger members returned to some of the traditional ways, including wearing their hair long.<sup>360</sup> The school dress code prohibited boys from wearing their hair longer than their shirt collar, and the students were punished for violating it. The students and their parents brought suit raising violations of their First and Fourteenth Amendment rights.<sup>361</sup>

As practicing Christians, the boys’ parents did not require them to wear their hair long, but they did support their desire to do so. The court detailed testimony from two boys in particular who indicated that wearing long hair was part of their Native American heritage, and

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<sup>358</sup> *Id.*

<sup>359</sup> *Alabama & Coushatta Tribes v. Trustees of Big Sandy Indep. Sch. Dist.*, 817 F. Supp. 1319 (E.D. Tx. 1993).

<sup>360</sup> *Id.* at 1325.

<sup>361</sup> *Id.* at 1323.

both participated in ceremonial dances.<sup>362</sup> With this information the court concluded that the boys had sincerely held religious beliefs worthy of protection. The court also found in favor of the parents' claim relating to their right to direct their children's religious training.<sup>363</sup>

The *Big Sandy* court appeared to give great weight to the religious beliefs presented by the boys as evidence of the sincerity of their beliefs. On the other hand, the "court assigned substantial weight to the parents' support of their children's religious practices,"<sup>364</sup> decreasing the authority of the children's independent religious decision.

One of the most oft-cited cases in recent literature<sup>365</sup> on the ability of children to assert independent religious beliefs was decided by the Pennsylvania Superior Court.<sup>366</sup> *Zummo* involved a custody dispute between a Jewish mother and a Roman Catholic father.<sup>367</sup> The mother was awarded primary custody, but the couple went to court regarding a dispute about the father's wish to take the children to Catholic services, and his complaint that taking the children to Jewish Sunday School diminished his visitation time.<sup>368</sup>

The trial court entered an order preventing the father from controlling his children's religious education, holding that the "children had been "assiduously" grounded in the Jewish faith, and the children should be permitted to continue in "their chosen faith."<sup>369</sup> The superior court disagreed with the trial court's finding that the children, then aged three, four and eight,

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<sup>362</sup> *Id.* at 1326.

<sup>363</sup> *Id.* at 1334.

<sup>364</sup> *Children as Believers*, *supra* note 352, at 2214.

<sup>365</sup> See, e.g., Buss, *supra* note 71, at 70-71; Zaven T. Saroyan, *Spiritual Healing and the Free Exercise Clause: An Argument for the Use of Strict Scrutiny*, 12 B.U. PUB. INT. L. J. 363, n.143 (2003).

<sup>366</sup> *Zummo v. Zummo*, 574 A.2d 1130 (Pa. Super. Ct. 1990).

<sup>367</sup> *Id.* at 1141.

<sup>368</sup> *Id.*

<sup>369</sup> *Id.* at 1148.

“chose” Judaism as their faith, and thus “asserted personal religious identities which were entitled to consideration and protection.”<sup>370</sup>

Significantly, the court noted that “parents and religious leaders define a child's religious identity under the rules of the religion they practice,” and “often such rules impose a presumed religious identity upon a child without requiring the child's consent or understanding, on the basis of a parent's religion.”<sup>371</sup> In light of this the court went on to state that “courts only recognize a *legally* cognizable religious identity when such an identity is asserted by the child itself, and then only if the child has reached sufficient maturity and intellectual development to understand the significance of such an assertion.”<sup>372</sup> Although the Pennsylvania court speaks to a notion of religious identity, because the children were so young, it did not specifically address what the children would have had to show to establish independent, cognizable religious rights.<sup>373</sup>

A seemingly contrary result was reached by the Ninth Circuit in *Cheema v. Thompson*.<sup>374</sup> In this case three Khalsa Sikh children and their parents sought a preliminary injunction against the weapons ban utilized by the children's school as applied to their wearing of ceremonial knives called kirpans.<sup>375</sup> One of the central tenets of the Sikh religion is to wear five symbols of the faith at all time.<sup>376</sup> In upholding the district court's grant of the injunction, the circuit court did not clearly disaggregate the religious interests of the parents and children. Without pointing to any specific facts in the record, however, the majority of the court suggested that the children

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<sup>370</sup> *Id.*

<sup>371</sup> *Id.* at 1148-49.

<sup>372</sup> *Id.* at 1149.

<sup>373</sup> The court ultimately held that preventing the father from taking his children to Catholic services would violate his free exercise rights. *Id.* at 1150.

<sup>374</sup> 67 F.3d 883 (9th Cir. 1995).

<sup>375</sup> *Id.* at 884.

<sup>376</sup> *Id.*

had proved that “their insistence on wearing kirpans was animated by a sincere religious belief.”<sup>377</sup>

In a powerful dissent, Judge Wiggins immediately pointed out that the children in question were aged seven, eight and ten-years-old.<sup>378</sup> He expressed concern that although the religion dictates that kirpans may only be used in “self defense and the propagation of justice,” the record indicated that the children had been seen playing with their knives, and in at least one instance a Cheema child threatened to use his knife against another student.<sup>379</sup> Judge Wiggins agreed with the district court’s initial finding that “[n]othing in the present record suggests that the instruction or advisement given to these children prior to their initiation as Khalsa Sikhs, or that their oath of religion, would divest them of the demeanor, maturity and judgment which equate with their childhood.”<sup>380</sup> In other words, substantial evidence weighed against a finding that the children had sincerely held beliefs which they fully understood and could apply to their life-plan.

The limited cases addressing the religious expression of children are as inconsistent and provide as little guidance as those involving the mature minor doctrine. The decisions in the aforementioned cases imply that certain children are capable of establishing their own independent religious identities; and although the courts suggest notions of sincerity and maturity, they do not provide guidance as to accurate measures of the same. That being said, the majority opinion in *Zummo*, and Judge Wiggins’s dissent in *Cheema* at least attempt to establish a conception of religious identity for minors. The opinions point to the intellectual development

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<sup>377</sup> *Id.* at 885.

<sup>378</sup> *Id.* at 886 (Wiggins, J. dissenting).

<sup>379</sup> *Id.* at 890.

<sup>380</sup> *Id.* at 891. The district court first ruled against the injunction but was reversed by the Ninth Circuit.

of the children in question as well as their understanding of how religious beliefs shape various life activities and decisions.

The thesis of this paper is that only adolescents demonstrating authentic, sincerely held religious beliefs that are central to their lives should be permitted to refuse life-saving or sustaining medical treatment based upon those beliefs, thus dying for them. It is necessary to ensure that adolescents are choosing to die for their own values rather than those of third parties. Recall that in Part I of this paper three capacities were listed as necessary for decision-making competence; the third being the capacity to have and apply a set of values.

The set of values in question must be relative to a particular decision, and “at least minimally consistent, stable, and affirmed as his or her own.”<sup>381</sup> When the values are religious in nature, and the particular decision involves a life or death determination, minimal stability of beliefs affirmed as one’s own necessitates a finding of religious integrity. In this way, practitioners can be sure that the adolescent is not mistaken about what will best satisfy his or her underlying aims and values; and therefore, that the decision is in accord with his or her conception of well-being.

## B. RELIGIOUS INTEGRITY

At the outset it should be noted that expressly sincere religious beliefs are not necessarily integral and defining in a person’s life.<sup>382</sup> This is important because the Supreme Court of the United States is largely deferential to the expressed sincerity of an adult’s religious beliefs in its

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<sup>381</sup> BUCHANAN & BROCK, *supra* note 34, at 25.

<sup>382</sup> Gary K. Leak & Stanley B. Fish, *Development and Initial Validation of a Measure of Religious Maturity*, 9 INT’L J. PSYCHOL. RELIG. 83, 85 (1999).

Free Exercise jurisprudence.<sup>383</sup> When an adolescent seeks to die for his or her religious values, the State's duty as *parens patriae* mandates the presentation of more than a mere expression of sincerely held beliefs.

### 1. Characteristics of Religious Integrity

Integrity in personal values refers to “soundness, reliability, wholeness, and integration of moral character;” to “fidelity in adherence to moral norms.”<sup>384</sup> Those with religious integrity have integrated their religious beliefs into a coherent sense of self, and live in a way that is faithful to their deeply held values. In this way, their beliefs become “integral to [their] self-conception or identity.”<sup>385</sup> Conversely, persons without religious integrity demonstrate a “lack of sincerely held, fundamental moral convictions,” and thus act in a way that is inconsistent with firmly held moral convictions.<sup>386</sup>

Individuals often justify actions or refusals to act on the ground that to do otherwise would sacrifice their integrity.<sup>387</sup> In other words, that their underlying and enduring aims and values shape their identity and guide every aspect of their life, such that requiring them to act contrary would be a gross violation of their autonomy. The refusal of medical treatment based upon religious beliefs is akin to an objection based upon the person's conscience.

When individuals refuse to act in a certain prescribed way, they do so under what is commonly referred to as conscientious objection. For instance, physicians may seek to avoid performing controversial procedures such as an abortion or participating in physician assisted suicide when patients so request. Refusing to treat the patient could be viewed as a violation of

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<sup>383</sup> LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 14-12, at 1242 (2d ed. 1988). Simply put, those with sincere religious beliefs know and adhere to the tenets of their faith which guide their lives. Courts are largely deferential to litigants claiming to be religiously motivated. *Id.* at 1243-46.

<sup>384</sup> BEAUCHAMP AND CHILDRESS, *supra* note 24, at 35-36.

<sup>385</sup> Mark R. Wicclair, *Conscientious Objection in Medicine*, 14 *BIOETHICS* 206, 214 (2000).

<sup>386</sup> BEAUCHAMP AND CHILDRESS, *supra* note 24, at 36.

<sup>387</sup> *Id.* at 35.

the physician's duty to act in the patient's expressed best interests, but many ethicists argue that physicians should not be required to act in a way that violates their personal moral integrity.<sup>388</sup>

Mark Wicclair suggests that the moral weight given to the physician's objection is a function of the "centrality of the beliefs upon which they are based to the physician's core ethical values."<sup>389</sup>

Another area where conscientious objection is frequently raised is in reference to military duty. During the draft associated with the Vietnam War many individuals objected to joining the war effort based upon appeals to conscience. The statute authorizing the draft provided an exception for individuals conscientiously opposed to participation in war in any form by reason of religious training and belief.<sup>390</sup> In a series of cases related to conscientious objectors, the Supreme Court of the United States established that decisions based upon conscientious objection "must be sincere and not based on political grounds; nor may [they] be a simple matter of expediency or self-interest."<sup>391</sup> Further, to act "conscientiously is to act in the honest and sincere belief that what one is doing is morally right, even if it is illegal."<sup>392</sup>

The language of the Court's decision in *Welsh* is explicative. Elliot Welsh attempted to conscientiously object to the military draft imposed during the Vietnam War, and was convicted for violating the statute mandating induction into the Armed Forces based upon a finding that his beliefs were not religious in nature.<sup>393</sup> The Supreme Court first made clear that conscientious objection does not apply to "those whose beliefs are not deeply held and those whose objection

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<sup>388</sup> The rights of physicians to refuse to act upon conscientious objection in less controversial areas, such as prescribing birth control or participation in palliative, end-of-life care is less clear. See, e.g., *Id.* at 38; Wicclair, *supra* note 385, at 213-17.

<sup>389</sup> Wicclair, *supra* note 385, at 221.

<sup>390</sup> *Welsh v. United States*, 398 U.S. 333, 335 (1970).

<sup>391</sup> Alfred J. Sciarrino and Kenneth L. Deutsch, *Conscientious Objection to War: Heroes to Human Shields*, 18 B.Y.U.J. PUB. L. 59, 67 (2003).

<sup>392</sup> *Id.* at 75.

<sup>393</sup> *Welsh*, 398 U.S. at 335.

to war does not rest at all upon moral, ethical, or religious principle but instead rests solely upon considerations of policy, pragmatism, or expediency.”<sup>394</sup>

In reversing Welsh’s conviction the Court relied on his testimony that “I believe that human life is valuable in and of itself; in its living; therefore I will not injure or kill another human being. This belief . . . *is essential to every human relation*. I cannot, therefore, conscientiously comply with the Government’s insistence that I assume duties which I feel are immoral and totally repugnant.”<sup>395</sup> The Court was persuaded that Welsh’s convictions “were spurred by deeply held” moral and ethical values to the extent that requiring him to become an instrument of the war would give him “no rest or peace.”<sup>396</sup> In other words, his beliefs were so tied to his sense of well-being that to order him to act contrary would cause “self-betrayal and loss of self-respect,”<sup>397</sup> in clear violation of the his autonomy.

Like conscientious objectors to war, adults objecting to medical treatment based upon their religious convictions do so under the belief that to act otherwise would cause grave harm to their sense of well-being. In choosing to die for their beliefs, these adults are presumed<sup>398</sup> to have religious integrity, marked by a deeply rooted self-conception that is founded in religious values and is so central to the person’s life that it guides daily activities and decision-making.

This is different than a conception of what might be called religious maturity. In the seminal work on religious maturity Gordon Allport suggested that “[s]trenuous thinking [is]

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<sup>394</sup> *Id.* at 342-43. Further, given the presumption that adults generally act in accordance with a well-conceived life plan, the burden is on the government to prove that the beliefs are not sincerely held. *See* Duane Zezula, *Religious Accommodation in the Military*, 1987 ARMY LAW 3, 8 (1987).

<sup>395</sup> *Id.* at 343.

<sup>396</sup> *Id.* at 344.

<sup>397</sup> *Wicclair*, *supra* note 385, at 214.

<sup>398</sup> Unlike military conscientious objection – where an inquiry into the individual’s religious integrity is triggered by the otherwise illegal action of avoiding military service – no inquiry into religious integrity is required when an adult objects to medical treatment based upon religious beliefs. Because adolescents are presumed to lack religious integrity, an inquiry is mandated by the government as *parens patriae*.

demanding of every aspirant seeking religious maturity.”<sup>399</sup> He discovered that those with religious maturity do not accept religion “unreflectively and uncritically;” rather, they arrive at their beliefs through “reflective examination and questioning.”<sup>400</sup> Allport concluded that mature religious beliefs are “well differentiated, comprising many subsidiary attitudes, critically arrived at, and flexibly maintained as the sphere of experience widens.”<sup>401</sup> In turn, those with religious maturity possess “a mature sentiment . . . [representing] a style of existence that the individual has adopted after considerable reflection as a means of relating to himself.”<sup>402</sup>

From a philosophical standpoint, the ideal may be for individuals to achieve Allport’s sense of religious maturity, but it is an impossibly high standard to hold the general populace. Indeed, he pointed to brilliant minds such as Aquinas, Luther and Kirkegaard as the epitome of religious maturity for which people should strive;<sup>403</sup> and in later works he abandoned some of the elements he originally associated with religious maturity.<sup>404</sup> Thus, it presents an unworkable standard with regard to adolescents who object to medical treatment based upon their religious beliefs.

## 2. Adolescent Development and Religious Integrity

Although courts seem loathe to inquire into the religious identities of children and adults, substantial scholarship exists contemplating religious development.<sup>405</sup> Ronald Goldman, taking a clue from Piaget, mapped religious thought development onto three stages, (1) intuitive (pre-

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<sup>399</sup> GORDON W. ALLPORT, *THE INDIVIDUAL AND HIS RELIGION: A PSYCHOLOGICAL INTERPRETATION* 46 (1950).

<sup>400</sup> *Id.* at 59-60.

<sup>401</sup> *Id.* at 63.

<sup>402</sup> *Id.* at 127.

<sup>403</sup> *Id.* at 46.

<sup>404</sup> Leak & Fish, *supra* note 382, at 84.

<sup>405</sup> See, e.g., RONALD GOLDMAN, *RELIGIOUS THINKING FROM CHILDHOOD TO ADOLESCENCE* 51-67 (1964); Elizabeth W. Ozorak, *Social and Cognitive Influences on the Development of Religious Beliefs and Commitment in Adolescence*, 28 J. SCI. STUD. RELIG. 448 (1989); Justin L. Barrett, *Do Children Experience God as Adults Do?*, in *RELIGION IN MIND* 186 (Jensine Andresen ed. 2001).

operational); (2) concrete; and (3) abstract.<sup>406</sup> He found that by age fourteen many adolescents entered the final stage, and were at least capable of more mature, abstract religious thinking.<sup>407</sup> Goldman acknowledged, and later studies supported, that age is not a bright line indicator of religious thought development. For example, recent scholarship suggests that “[b]oth children’s and adults’ god concepts are limited by context demands in their cognitive complexity” such that the “concrete-to-abstract shift may not occur over the course of development but instead may manifest from one situation to another.”<sup>408</sup>

In a 1989 study Elizabeth Ozorak theorized that “[a] model of religious development in adolescence should be grounded in the process of maturation, especially in cognitive changes, but it should also weigh the influences of the parents and their chosen religious organization (if any) against the more diverse influences of peers.”<sup>409</sup> In other words, religious development does not occur in a vacuum; children “actively process the information they receive and draw inferences from it.”<sup>410</sup> The ultimate question, then, is whether adolescents have the ability to express religious identities independent of third parties. In other words, do they have the capability to formulate a deeply rooted self-conception that will promote their well-being based upon their understanding of their religious values?

Robert Coles, a pediatric psychiatrist, performed a study involving the religious experiences of hundreds of children.<sup>411</sup> Coles found that his subjects “revealed an intense

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<sup>406</sup> GOLDMAN, *supra* note 405, at 51-67.

<sup>407</sup> *Id.* at 60-61. *See also* Carol A. Markstrom, *Religious Involvement and Adolescent Psychosocial Development*, 22 J. OF ADOLESCENCE 205, 2 (1999)(discussing the ability of adolescents to consider abstract concepts with the onset of formal operational thought).

<sup>408</sup> Barrett, *supra* note 405, at 187. Justin Barrett found that although they have the capacity to think abstractly, when faced with difficult cognitive pressure, adults revert to simpler more anthropomorphic concepts of religious thought. *Id.* at 186.

<sup>409</sup> Ozorak, *supra* note 405, at 448. Ozorak points out that “Virtually all research has identified parents as the most important source of religious influence.” *Id.* at 449.

<sup>410</sup> *Children as Believers*, *supra* note 352, at 2224.

<sup>411</sup> ROBERT COLES, *THE SPIRITUAL LIFE OF CHILDREN* (1990).

interest in and engagement with traditionally religious questions and concepts,” in a way that made their beliefs central to their lives.<sup>412</sup> Centrality alone, however, is not sufficient. For instance, the Cheema children’s religious beliefs played a central role in their lives, but that does not mean that the children had the cognitive capacity to establish a self identity based upon those beliefs. This requires a greater degree of sophistication than younger children likely possess. On the other hand, the studies reported in Part III of this paper coupled with those involving religious development suggest that that many adolescents have the cognitive capacity to formulate deeply rooted religious identities.

An inquiry into religious integrity must seek to ascertain whether the adolescent’s beliefs are deeply held and tied to his or her sense of well-being. Only then should the adolescent be deemed competent to make decisions based upon those beliefs. The level of inquiry required depends upon the circumstances of the decision in question.

### C. COMPETENCE REQUIRED TO REFUSE LIFE-SAVING OR SUSTAINING MEDICAL TREATMENT BASED UPON RELIGIOUS BELIEFS

Inquiries into religious integrity and medical decision-making competence are not mutually exclusive. In fact, an “adequate standard of competence will focus primarily not on the content of the patient’s decision but on the *process* of the reasoning that leads up to that decision.”<sup>413</sup> Further, “setting the proper level of decision-making competence involves balancing two important values: protecting and promoting the individual’s well-being, and respecting the individual’s self-determination.”<sup>414</sup>

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<sup>412</sup> *Children as Believers*, *supra* note 352, at 2221.

<sup>413</sup> BUCHANAN & BROCK, *supra* note 34, at 50.

<sup>414</sup> *Id.* at 84.

Competent individuals are thought to be capable of making autonomous decisions that will promote their well-being. Thus, allowing them to make their own decisions both respects their autonomy and protects their well-being. Inquiries into competence are triggered by situations where there appears to be a conflict between persons' decisions and their well-being. If individuals are making truly autonomous decisions, then they know what is in their best interests and the decisions should stand.

When practitioners inquire into competence, they run the risk of two errors: (1) that autonomous individuals will be found incompetent, and thus have the principle of respect for autonomy violated when a surrogate decision-maker is appointed; or (2) that incompetent individuals will be permitted to make harmful, non-autonomous decisions that are contrary to their well-being.<sup>415</sup> Because an individual's conception of well-being is tied closely to his or her religious beliefs, part of the competency determination will rest upon the integrity of those beliefs.<sup>416</sup>

This being said, Buchanan and Brock suggest two central questions for a process standard of competence: (1) "how well must the patient understand and reason to be competent?" and (2) "how certain must those persons evaluating competence be about how well the patient has understood and reasoned in coming to a decision?"<sup>417</sup> As the level of competence increases so too does the level of certainty required.<sup>418</sup>

Recall that determining a person's competence is an inquiry into "a particular person's capacity to perform a particular decision-making task at a particular time and under specified

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<sup>415</sup> BUCHANAN & BROCK, *supra* note 34, at 40-41.

<sup>416</sup> A process standard of competence takes reasoning into account during the competency determination. This is different than first evaluating competency and then inquiring into the rationality of the given choice. Charles Culver and Bernard Gert advocate the latter position, whereby a competent person's decision may be overridden if found to be irrational. *Id.* at 65-68. From a legal standpoint this approach is troubling given the great deal of decision-making protection offered to competent individuals. *See supra* Part I.

<sup>417</sup> *Id.* at 51.

<sup>418</sup> *Id.* at 85.

conditions.”<sup>419</sup> For purposes of this paper, the task involves the refusal of medical treatment based upon religious beliefs. Ethically speaking this is important because the competencies required to consent to and refuse medical treatment are not necessarily equivalent.

Buchanan and Brock suggest a sliding scale, and supply this example, “consent to a low-risk life-saving procedure by an otherwise healthy individual should require only a minimal level of competence, but refusal of that same procedure by such an individual should require the highest level of competence.”<sup>420</sup> Put another way, “the greater the risk relative to other alternatives – where risk is a function of the severity of the expected harm and the probability of its occurrence – the greater the level of communication, understanding, and reasoning skills required for competence to make that decision.”<sup>421</sup>

Inherent to any sliding scale approach to competence is the potential for abuse from practitioners. For instance, one evaluating competence could set the standard so high or low that no person or any person – autonomous or not – could meet it. In this way, the practitioner would promote his or her own values, rather than those of the individual in question. Acknowledging that no test of competence is without error, the sliding scale attempts to err (above) on the side that is more ethically defensible.

Those evaluating the competence of individuals in these circumstances are looking for two possible defects that would preclude an autonomous decision: 1) the patient’s lack of understanding of the relevant information, and/or 2) where the choice is not based upon the person’s underlying and enduring aims and values.<sup>422</sup> The latter is implicated more significantly

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<sup>419</sup> *Id.* at 18. *See also supra* Part I.

<sup>420</sup> BUCHANAN & BROCK, *supra* note 34, at 52.

<sup>421</sup> *Id.* at 55. *But see* BEAUCHAMP AND CHILDRESS, *supra* note 24, at 76 (arguing that the level of competency required should increase with complexity, not necessarily risk). For purposes of this paper it will be presumed that decisions regarding life, death, and eternal existence are inherently risky and complex, thus requiring a very high level of competence under either view.

<sup>422</sup> BUCHANAN & BROCK, *supra* note 34, at 56.

when adolescents' refusal decisions are made in relation to religious beliefs. An inquiry into religious integrity would address the issue of whether the adolescent's decision is truly based upon his or her underlying values, and as such supportive of his or her true sense of well-being.

When adolescents choose to die for their religious beliefs rather than accept medical treatment, they are making decisions that their well-being would better be served through death. By definition, death precludes the further "deliberation, choice and action that normal humans possess," that "make it possible for them to form, revise over time, and pursue in action a conception of their own good."<sup>423</sup> In other words, under error (2), if a low standard of religious maturity is required, it is possible that allowing the adolescent to make a non-autonomous decision to die would fail to protect and promote his or her overall, lifetime well-being. The goal is to avoid error where possible, but if an error must be made, this would be a greater harm than failing to respect the adolescents' potential autonomy under error (1); thus justifying a higher level of competence.<sup>424</sup>

The answer to the authors' first question then, is that when adolescents attempt to refuse life-saving or sustaining medical treatment based upon religious beliefs, where death is the expected outcome, a very high level of competence, marked by a showing of religious integrity, is required. Further, given the severity of harm associated with refusing life-saving or sustaining medical treatment, and the high level of competence required to do so, persons evaluating competence should be convinced by a showing of clear and convincing evidence of the adolescent's understanding of the medical aspects of the decision and his or her religious integrity.

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<sup>423</sup> *Id.* at 38.

<sup>424</sup> Note that for adults the paramount principle is respecting autonomy. Thus, the presumption is that violation of the adult's self-determination is potentially more harmful.

D. IMPLICATIONS: UTILIZING THE MATURE MINOR DOCTRINE WHEN  
ADOLESCENTS REFUSE LIFE-SAVING OR SUSTAINING MEDICAL TREATMENT  
BASED UPON RELIGIOUS BELIEFS

To date, the cases that have dealt with the mature minor doctrine are unclear in the extent to which they empower adolescents adjudged mature. Several cases limited the decision-making authority of the adolescents to situations where they had agreement from their parents.<sup>425</sup> In the religious context this is problematic.

Recall that the mature minor doctrine was utilized in the religious based refusal cases in an attempt to avoid state intervention triggered by the parents' refusal of medical treatment on behalf of their children. It is obvious in these cases that the parents both shared, and in fact inculcated these religious beliefs in their children.<sup>426</sup> Therefore, the parents' agreement with their children's decisions should not be taken as dispositive of the children's independent religious identity.

Cases could also arise in which the parents disagree with their child's decision to refuse medical treatment based upon the child's expressed religious beliefs. At most, the parents' agreement or disagreement should be evidence taken into account by the fact finder in determining the adolescent's competence. The principle behind the mature minor doctrine is to ascertain those minors capable of making autonomous decisions on their own, thus obviating the need for protection from either their parents or the State. Requiring parental consent does not further the goal of the mature minor doctrine.

The ultimate question, then, and one that needs further study, is what type of inquiry is required to ascertain the integrity of an adolescent's religious beliefs? While some courts have suggested simply asking the child what he or she thinks, this is insufficient. Indeed, many

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<sup>425</sup> See *supra* Parts III & IV.

<sup>426</sup> See *Ozorak*, *supra* note 405, at 449; *Zummo v. Zummo*, 574 A.2d 1130, 1148-49 (Pa. Super. Ct. 1990).

children are intensely religious,<sup>427</sup> but it does not necessarily follow that the sincerely held beliefs that they express are their own deeply held convictions central to their lives and sense of well-being.<sup>428</sup> An inquiry into integrity should attempt to find actions by the adolescent that are inconsistent with firmly held moral convictions.

For instance in one reported case, an adolescent and his mother attempted to refuse treatment for a sexually transmitted disease based upon their religious belief in faith healing.<sup>429</sup> The court ordered the treatment based on public health concerns, obviating the need to address J.J.'s religious basis for the refusal.<sup>430</sup> If his religious convictions were tested, one has to wonder how central his beliefs were to his self-conception of well-being. Suppose J.J.'s religion prohibited fornication, this would certainly be evidence against a finding that his beliefs were central and guiding in every aspect of his life. One would have to question why certain tenets are worth upholding, but others not.

Unfortunately, as previously mentioned, the Supreme Court is hesitant to inquire into the depth of an adult's religious beliefs.<sup>431</sup> The presumption being, that adults are competent to make decisions, religious or not, in ways that promote their well-being. The opposite presumption applies to minors, such that courts cannot avoid an inquiry into the sincerity and depth of their beliefs, especially when they seek to die for them. By way of guidance, Major Duane Zezula points to legal commentators who suggest that an inquiry into religious sincerity look to "the history of subscription to a given belief or consistent acts according to the conscientiously motivated principles; external indices, such as the [individual's] demeanor or the

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<sup>427</sup> David Elkind, *Religious Development in Adolescence*, 22 J. ADOL. 291, 293 (1999).

<sup>428</sup> Recall that children obtain their initial beliefs from their parents and possibly religious ministers. See Ozorak, *supra* note 405, at 449; *Zummo v. Zummo*, 574 A.2d 1130, 1148-49 (Pa. Super. Ct. 1990).

<sup>429</sup> *In re J.J.*, 582 N.E.2d 1138, 1139 (Ct. App. Ohio 1990).

<sup>430</sup> *Id.* at 1141.

<sup>431</sup> See *supra* note 383 and accompanying text.

consistency of his or her current statements with prior statements and action; and examination of extrinsic evidence, including patterns of inconsistent activities or statements.”<sup>432</sup>

In addition, the courts should require the adolescents in question to explain the relationship between the centrality of their beliefs and their established sense of well-being. When asked about the suffering Ernestine would experience from a blood transfusion a Jehovah’s Witness minister likened it to that of a rape victim: “Forcing anyone to violate his consideration [sic] is the most painful indignity that an individual could have perpetrated against him.”<sup>433</sup> In fact, the minister’s sentiment is a common argument against violating the principle of respect for autonomy.<sup>434</sup> Again, however, it is only a violation if the person’s choice is truly autonomous; that is, based on underlying and enduring aims and values representing a true conception of well-being. It is possible that Ernestine also felt this way, that was not elucidated at trial.

Given the subjective nature of religious integrity, it is likely impossible to know for certain how central a given individual’s religious beliefs are to their identity. However, a psychological inquiry is still an improvement over lawmakers guesses as to expressed religious sincerity,<sup>435</sup> especially where the decision is life or death in nature. When it comes to religious refusals by adolescents, “the value of the inquiry is not that it can simplify the analysis, but rather that it can facilitate a more intelligent consideration of the complexities.”<sup>436</sup> Further research may extinguish these shortcomings.

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<sup>432</sup> Zezula, *supra* note 394, at 8.

<sup>433</sup> *In re E.G.*, 515 N.E.2d 286, 289 (Ill. App. Ct. 1987).

<sup>434</sup> See PELLEGRINO & THOMASMA, *supra* note 32, at 58 (arguing that a person’s spiritual well-being is more important than physical well-being). Where a patient is capable of autonomous decision-making, their decision to further their spiritual well-being should not be taken for granted.

<sup>435</sup> *Children as Believers*, *supra* note 352, at 2221.

<sup>436</sup> Emily Buss, *The Adolescent’s Stake in the Allocation of Educational Control Between Parent and State*, 67 U. CHI. L. REV. 1233, 1257 (2000).

## CONCLUSION

When adolescents refuse life-saving or sustaining medical treatment based upon religious beliefs, they must show by clear and convincing evidence that they both have understanding of the medical aspects of the decisions, and also that the religious beliefs upon which they are refusing the treatment are deeply rooted and central to their existence. This is not to say that adolescents never have religious integrity; rather the concern is that the children are not expressing values associated with their true sense of well-being. When adolescents seek to die for those beliefs, an inquiry must be made to ensure that they are expressing an independent religious identity rather than advancing the interests of parents or ministers.

Recall Julie lying awake in her dorm room grappling with her faith. It is not the result, but the act of this internal, reflective struggle that is important. As she interacts with her beliefs, she will establish their true role in her life, and whether they are so central that she is willing to risk her life for them rather than violate her conscience. In this way she will come to an autonomous realization about her identity and true sense of well-being. If, as Socrates advised, the unexamined life is not worth living, adolescents should be protected from choosing to die based upon beliefs that are not central to their lives or conceptually their own.

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