The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions regarding Life-Sustaining Treatment

Jennifer L. Rosato
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I. INTRODUCTION

"Childhood is the kingdom where nobody dies."
Edna St. Vincent Millay

Unfortunately, Edna St. Vincent Millay was wrong: children do die. They die of the same causes as adults: from accidents, from terminal illnesses, and from AIDS. Children, however, do not have the same rights as adults to make life-sustaining treatment decisions. Adults possess a virtually unlimited


2. For the purpose of this Article, life-sustaining treatment is defined broadly to protect the patient's right to self-determination. Thus, life-sustaining treatment is medical treatment, not including diagnostic procedures, that would prevent the patient's death in the foreseeable future. See THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 4 (1987) [hereinafter "HASTINGS CENTER GUIDELINES"] (defining life-sustaining treatment as "any medical intervention that is administered to a patient in order to forestall the moment of death"); cf. 2 ALAN MEISEL, THE RIGHT TO DIE § 11.9, at 99 (1995) ("life-sustaining treatment is one that will serve only to prolong the process of dying"). Life-sustaining treatment may be provided for illnesses or conditions in which the threat of death is imminent, such as the need for a respirator. Such treatment may also be provided for conditions or illnesses in which death is more remote, such as chemotherapy for cancer or artificial hydration and nutrition. The essence of life-sustaining treatment is that the child is weighing the significance of death because, without the treatment, the child could die. See infra Part II.A. Consequently, treatments for nondeadly, chronic illnesses are not addressed in this Article.

This definition of life-sustaining treatment is broader than the definitions contained in living wills and health care proxy statutes. Generally, these statutes address decisions made when death is imminent. See HAW. REV. STAT. ANN. § 327D-2 (Michie 1992); 755 ILL. COMP. STAT. ANN. 40/10 (West 1995); ME. REV. STAT. ANN. tit. 18A, § 5-501 (West Supp. 1995); MD. CODE ANN., HEALTH-GEN. I § 5-601 (1995); N.J. STAT. ANN. § 26:2H-55 (West 1995); PA. STAT. ANN. tit. 20, § 5402 (West Supp. 1995); UTAH CODE ANN. § 75-2-1103 (Supp. 1995); VA. CODE ANN. § 54.1-2982 (Michie 1994); see also statutes cited infra notes 139-58.

The broader term of right to die—which includes refusal of life-sustaining treatment, physician-assisted suicide, and voluntary active eutha-
right to make such treatment decisions for themselves.\(^4\)

nasia—has been deliberately avoided. See Jean K. Cipriani, Note, The Limits of the Autonomy Principle: Refusal of Life-Sustaining Medical Treatment for Incompetent Persons, 22 Hofstra L. Rev. 703, 705-06 (1994) (explaining that the right to refuse life-sustaining treatment is not the same as the right to die). This Article focuses on a right that is clearly established for adults—the right to refuse life-sustaining treatment—and analyzes to what extent the right extends to children.

Because the minor's right to refuse treatment generally has been thoroughly discussed by other scholars, it will not be addressed in this Article. See generally Nancy Bateman, Under Age: A Minor's Right to Consent to Healthcare, 10 Touro L. Rev. 637 (1994) (examining whether the "mature minor" and "emancipated minor" doctrines have survived recent legislative attempts to permit minors to consent to certain categories of medical procedures); Rhonda Cohn, Minor's Right to Consent to Medical Care, 31 Med. Trial Tech. Q. 286 (1985) (surveying statutes and cases regarding a minor's right to consent to health care services); Erin A. Neely, Medical Decision-making for Children: A Struggle For Autonomy, 49 SMU L. Rev. 133 (1995) (concluding that medical professionals should defer to the wishes of the parents in treatment decisions for terminally ill minors); Walter Wadlington, Medical Decision Making for and by Children: Tensions Between Parent, State and Child, 1994 U. Ill. L. Rev. 311 (discussing the state's role in ensuring that necessary medical care is not withheld from children beyond the neonatal period because of parental refusal to consent); Carol Munson, Comment, Toward a Standard of Informed Consent by the Adolescent in Medical Treatment Decisions, 85 Dick. L. Rev. 431 (1981) (addressing the need for legal requirements mandating informed consent by minors in health care decisions); Jennifer Sheels, Note, In re E.G.: The Right of Mature Minors in Illinois to Refuse Life-Sustaining Medical Treatment, 21 Loy. U. Chi. L.J. 1199 (1990) (examining a case of first impression where a minor, a Jehovah's witness, was permitted to refuse a life-saving blood transfusion).

Finally, life-sustaining treatment involves unique interests; thus, this Article does not address whether its conclusions would apply if the child refused other kinds of treatment. It does not necessarily follow that if a right to refuse life-sustaining treatment is given to children, a fortiori they must be given the right to refuse all treatment. The balance of interests will be significantly different in these cases. The minor patient personally must face the consequences of the decision to refuse life-sustaining treatment; therefore, this decision will profoundly affect how the minor defines her existence. In contrast, the consequences of making other treatment decisions are not as severe. See infra Part II.A.

3. See Wadlington, supra note 2, at 319-26 (examining developments in cases and statutes expanding minors' ability to consent to procedures).

4. See infra notes 36-37 and accompanying text.
whereas minor children ordinarily must rely on their parents to make treatment decisions for them. The state will interfere with the parents’ decision only if the decision would constitute child abuse or neglect.\(^5\)

Thus far, courts and legislatures have been reluctant to recognize a minor’s right to make life-sustaining treatment decisions and, even in those cases recognizing such a right, the right has not been defined as broadly as that of an adult.\(^6\) In addition, most legislatures have excluded minors from statutes providing for living wills and other advance health care directives, regardless of the child’s maturity or the gravity of the child’s illness.\(^7\)

Because of these inadequacies in existing law, it is time to rethink the categorical denial of a minor’s right to receive or refuse life-sustaining treatment. In most circumstances, mature minors should be able to make life-sustaining treatment decisions themselves. Age should not impose an artificial barrier to a minor’s right to self-determination. The recent cases of Benito Agrelo and Billy Best reinforce this conclusion. Although these minors initially were forced to receive life-sustaining treatment, they ultimately were able to exercise their right to self-determination.

Benito (Benny) Agrelo was born with an enlarged liver and spleen. For the first fourteen years of his life, Benny endured two liver transplants and took various antirejection drugs that caused severe side effects.\(^8\) Consequently, when he was four-

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5. See generally James M. Morrissey et al., Consent and Confidentiality in the Health Care of Children and Adolescents 105 (1986) (noting that a child’s decision will only outweigh the parents’ decision if the parents’ decision would detrimentally affect the child’s health); Susan Hawkins, Note, Protecting the Rights and Interests of Competent Minors in Litigated Disputes, 64 Fordham L. Rev. 2075, 2083-84 (1996) (stating that the state may intervene for the protection of minors when parental decisions threaten a child’s health and safety).

6. See cases discussed infra pp. 10-17.

7. See discussion infra pp. 24-27.

8. These side effects included severe migraines, body aches, irritability, ballooning of the face, and hallucinations. See Carol J. Castenada, Ill Teen Rejects Medicine For “Best Months of My Life”, USA Today, June 13, 1994, at 6A (reporting that Benny also was unable to play with his friends, go to school on a normal basis, or read for more than five min-
teen, Benny decided to refuse further medication and his parents acquiesced in Benny's refusal.\(^9\)

The hospital responded by filing a petition pursuant to the state's child neglect statute.\(^{10}\) Purportedly based on this statute, the state forcibly removed Benny from his home. Against his will, Benny was taken to the hospital for treatment to prevent his body's further rejection of the liver.\(^{11}\) After a hearing, the court determined that Benny was mature enough to decide for himself whether to refuse further life-sustaining treatment.\(^{12}\) He died at home a few months later.\(^{13}\)

Billy Best, a sixteen year old with Hodgkin's lymphoma, refused further rounds of chemotherapy prescribed to treat his cancer.\(^{14}\) With this therapy, doctors believed Billy had an eighty percent chance of a full recovery.\(^{15}\) Although Billy's parents agreed that this treatment was necessary,\(^{16}\) Billy did

\(^{9}\) Benny took three months to make this decision. See Judge Allows Teen to Decide Medication Issue, THE COLUMBIAN, June 12, 1994, at A1.


\(^{11}\) See Lassiter & Walsh, supra note 10, at A1. The state now regrets its decision to forcibly remove Benito from his home. See Amy Driscoll, Personal Apology Made, MIAMI HERALD, June 14, 1994, at A1.

\(^{12}\) See Behind a Boy's Decision to Forgo Treatment, N.Y. TIMES, June 13, 1994, at A12.

\(^{13}\) Benito died on August 20, 1994. See Nancy San Martin, Defiant Transplant Patient Dies at Home, SUN-SENTINEL, Aug. 21, 1994, at 1A.

\(^{14}\) See Morose, Boy with Cancer Runs Away: "Medicine is Killing Me Instead of Helping Me," CHI. TRIB., Nov. 4, 1994, at N26 [hereinafter Morose].

\(^{15}\) A senior pediatric oncologist at the Dana-Farber Cancer Institute, Dr. Howard Weinstein, stated that Billy had a "90 percent or better chance of being cured" of his particular form of Hodgkin's disease. See Richard Saltus, Having Someone to Talk to Might Have Helped Billy Best, BOSTON GLOBE, Nov. 14, 1994, at 13.

\(^{16}\) Marjorie Rosen, ROAD WARRIOR; Billy Best, 16, Fled Home to Escape Chemotherapy and Found New Friends and a Fresh Perspective in
not: he believed that these treatments were painful and contrary to his religious faith.\textsuperscript{17} Faced with the likelihood that he would be forced to receive chemotherapy, Billy decided to run away from home.\textsuperscript{18} He returned home only after the doctors and his parents promised him that he would not be required to undergo further chemotherapy.\textsuperscript{19} Despite his refusal to receive treatment, Billy’s lymphoma is in remission due to alternative therapies.

The cases of Benny and Billy\textsuperscript{20} poignantly address when, if ever, a minor should possess the right to make decisions regarding life-sustaining treatment.\textsuperscript{21} The answer to this question may depend on a number of considerations, including the age and maturity of the child, the treatment’s probability of success, the child’s consent to or refusal of treatment, and the parents’ agreement or disagreement with the child’s decision. This Article develops a comprehensive framework that incorporates these relevant considerations.

Although the Article concludes that the right to decide in—


18. He left a note: “The reason I left is because I could not stand going to the hospital every week. I feel like the medicine is killing me instead of helping me. Please have faith in God.” Gloria Negri, Parents Beg Ill Norwell Youth to Call Home, BOSTON GLOBE, Nov. 4, 1994, at 34.


20. See Hawkins, supra note 5, at 2075, 2131; see also Stephen Magagnini, Sick Hmong Teenager Caught in Bitter Cultural Clash, SACRAMENTO BEE, Nov. 12, 1994, at A1 (reporting that a young Hmong woman refused further treatment for ovarian cancer).

21. Because the child’s right of autonomy is only implicated where the child has expressed a treatment preference, this Article is limited to such situations. See Sanford H. Kadish, Letting Patients Die: Legal and Moral Reflections, 80 CAL. L. REV. 857, 876-79 (1992) (arguing that autonomy should be limited to the present situation, not a prewritten directive or substituted judgment). Autonomy involves an exercise of the will. See Cipriani, supra note 2, at 719. Therefore, where there is no exercise of the will, there is no choice to be respected. See Kadish, supra, at 870-71, 879.
cludes both the right to consent to and to refuse treatment,\textsuperscript{22} it will focus on the right to refuse because it is more problematic than the right to consent. If the child is consenting to treatment, a parent or health care provider probably will agree with the child's decision. Furthermore, the state's interest in protecting children's lives will be protected because the reason for the treatment is to improve the child's health. Alternatively, if a child refuses treatment, a parent or health care provider is more likely to disagree with the child's decision. The state's interest also will be disserved because the decision is likely to result in the child's death. Most problematic, however, is when the minor refuses treatment, but the minor's parents consent. The strength of the minor's right to self-determination is truly tested in this situation.

Section II of the Article concludes that minors should be given the right to make decisions regarding life-sustaining treatment despite their legal inability to make more significant decisions for themselves. These treatment decisions are among the most important that any person can make, as they define one's entire life.\textsuperscript{23} Except in narrow circumstances, the existing law does not permit even mature minors to make these vitally important decisions. A review of the relevant common law and statutes illustrates this glaring inadequacy in the existing law.

Section III develops a common law approach for permitting certain minors to make these decisions for themselves. This approach provides guidelines for a trial judge to determine whether a minor should be able to refuse treatment. Although a minor should be able to exercise his right of autonomy in this context, two significant limitations should be imposed. The first limitation is maturity. Only a competent minor should be able to exercise the right of autonomy. Therefore, the judge's initial determination should be whether the minor has demonstrated competence by clear and convincing evidence.\textsuperscript{24} This section reviews existing psychological literature to define the requisite competence, then proposes an operational definition.

\textsuperscript{22} See infra note 123 and accompanying text.

\textsuperscript{23} See discussion infra pp. 9-13.

\textsuperscript{24} See infra Parts III.A, .B.
of competence to guide judges making these decisions. If the minor is mature, then the judge should defer to the minor’s decision unless the second limitation applies.

The second limitation is narrow and is based on the treatment’s probability of success. Life-sustaining treatment should be imposed against the mature minor’s wishes only when the life-sustaining treatment is nonexperimental and has a significant probability of either curing the disease or condition, or alleviating all of the major symptoms of the disease or condition in the foreseeable future. This limitation protects the state’s strong interest in preventing minors from making detrimental decisions and in protecting the state’s symbolic interest in children as hope for the future. The state’s other interests—preventing suicide, protecting the interests of third parties, and upholding the ethical integrity of the medical profession—are not strong enough to circumscribe the minor’s right of self-determination. Moreover, when one parent or guardian agrees with the mature minor’s decision to refuse treatment, state intervention is even less justified. Thus, when a parent or guardian concurs, the decision must be respected unless it is irrational. Section III concludes by applying this comprehensive standard to five exemplary cases.

Finally, Section IV outlines legislative reforms that will also protect the minor’s right to make life-sustaining treatment decisions. Despite the Article’s preference for a common law mature minor doctrine, a state may prefer a legislative approach for a variety of reasons. This section proposes revisions to existing advance health care directive statutes to include minors who have permission from one parent to execute a directive and mature minors who are terminally ill.

Overall, this Article proposes several reforms to assist courts and legislatures determining who should make life-sustaining treatment decisions for minors. Perhaps even more important-

25. See infra Part III.B.
26. See infra Parts III.A, .C.
27. See infra Part III.C.1.
28. See infra Parts III.C.2 to .A.
29. See infra Parts III.A, .D.
30. See infra Part III.D.
31. See infra Part IV.
ly, this Article provides an opportunity to consider how decision-making power should be divided among the child, the parent, and the state.

II. THE NEED TO RECOGNIZE A MINOR'S RIGHT TO MAKE DECISIONS REGARDING LIFE-SUSTAINING TREATMENT

"[I]t seems as if everything I wanted or believed in was just being disregarded."

E.G. (Seventeen Years Old)

Since minors generally do not possess the right to make nonmajor medical treatment decisions for themselves, why should minors be empowered to make decisions regarding life-sustaining treatment? Because life-sustaining treatment decisions are among the most important that any individual can make. As such, the individual patient, rather than the state, should make these decisions. 32 Furthermore, because these decisions are just as important to minors as to adult individuals, at least some minors should be permitted to make these decisions for themselves. After discussing the importance of these decisions to minors, the Article comprehensively reviews existing law to demonstrate the law's failure to recognize the importance of life-sustaining treatment decisions.

A. The Importance of the Right to Decide

The right to refuse treatment is grounded in the common law right of bodily integrity. 33 All individuals, competent and

32. See infra notes 49-51 and accompanying text.
33. See Bonner v. Moran, 126 F.2d 121, 122 (D.C. Cir. 1941) (stating that the "nature of rights of personality is freedom to dispose of one's own person as one pleases"); Miller v. Rhode Island Hosp., 625 A.2d 778, 783 (R.I. 1993) (noting the rule that the patient has the right to be free "from nonconsensual bodily invasion and the liberty to determine one's own destiny in medical matters"); Cross v. Trapp, 294 S.E.2d 446, 450 (W. Va. 1982) (declaring that every adult human being of sound mind has the right to determine what shall be done to his own body); see also Mohr v. Williams, 104 N.W. 12, 14 (Minn. 1905) (asserting that a citizen's right to inviolability of his person forbids a physician from violating the bodily integrity of his patient without permission); In re Ingram, 689 P.2d 1363, 1369 (Wash. 1984) (stating that a "person's right
incompetent, possess a right of bodily integrity. 34

Unlike a child, a competent adult can exercise the right of bodily integrity on her own behalf. Competence is a contextual determination: competent persons possess the capacity to decide whether to consent to or to refuse treatment. 35 Because adults are presumed competent to make such a decision, the state can interfere with an adult's right only when extraordinary circumstances exist. 36 An adult's right is broad: it in-

to self-determination includes the right to choose between alternate treatments as well as the right to refuse life sustaining treatment.

Traditionally, the common law has protected a competent adult's right to decline or accept medical treatment and thus to be free from nonconsensual invasions of his bodily integrity. See Bouvvia v. Superior Court, 225 Cal. Rptr. 297, 301 (Ct. App. 1986) (stating that the right to refuse treatment is basic and fundamental); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977) (announcing that there is a strong interest in being free from a nonconsensual invasion of bodily integrity); see also In re Conroy, 486 A.2d 1209, 1222 (N.J. 1985); cf. In re Storar, 420 N.E.2d 64, 71 (N.Y. 1981) (noting that New York has no statute prohibiting a patient from refusing medical treatment).

Some courts and commentators also have recognized a constitutional right to refuse life-sustaining treatment. See Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996), cert. granted sub nom. Washington v. Gluckberg, No. 96-110, 1996 WL 411590 (U.S., Oct. 1, 1996); Sylvia A. Law, Physician-Assisted Death: An Essay on Constitutional Rights and Remedies, 55 Md. L. Rev. 292 (1996) (concluding that some physician-assisted suicide statutes are unconstitutional because they violate liberty and privacy rights). At least one commentator has concluded that this right extends to minors. See Hawkins, supra note 5, at 2077-78. Because the constitutional right is not as well-established as the common law right, even for adults, its application to minors will not be addressed.

34. See Guardianship of Doe, 583 N.E.2d 1263, 1267 (Mass. 1992) (stating that incompetent individuals have the same rights as competent individuals to refuse treatment); Saikewicz, 370 N.E.2d at 423 (determining that the substantive rights of the incompetent and competent are the same); In re Grant, 747 P.2d 445, 450 (Wash. 1987) (declaring that the right to refuse treatment applies to incompetents even if they are not in a comatose or vegetative state).

35. See infra notes 228-29, 268-69 and accompanying text.

36. See FAY A. ROZOFSKY, CONSENT TO TREATMENT § 7.11, at 441, 450 & 87-89 (1990 & Supp. 1994); 1 MEISEL, supra note 2, § 8:17, at 516-24. For example, some courts have suggested that a competent adult may not be permitted to refuse treatment if it would result in financial and
cludes consenting to and refusing nonmajor and life-sustaining treatment. 37

Although incompetent individuals theoretically possess a right of bodily integrity, their treatment decisions are made by a surrogate. 38 Children are presumed incompetent; therefore, their right of bodily integrity is exercised by the surrogate, 39 ordinarily a parent. 40 The surrogate has the right to decide whether the child should receive life-sustaining treatment, unless one of a few limited exceptions applies. 41

This allocation of power is particularly problematic when the issue is whether the child should be able to make a decision regarding life-sustaining treatment. The child’s right of bodily integrity is essentially an inchoate right until the age of majority, when the right to self-determination is legally recognized. This Article will address whether this right should be recognized earlier.

The decision to consent to or refuse life-sustaining treatment is one of the most fundamental decisions any person can make. 42 According to Professor Ronald Dworkin, this decision

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emotional abandonment of a minor child. See infra notes 309-19 and accompanying text.

37. See Conroy, 486 A.2d at 1222; In re Colyer, 660 P.2d 738, 741 (Wash. 1983); In re L.W., 482 N.W.2d 60, 67-68 (Wis. 1992).

38. See In re L.W., 482 N.W.2d at 68; Degrella v. Elston, 850 S.W.2d 698, 706-09 (Ky. 1993). For a discussion of standards used by surrogates, see infra note 170.

39. See Rosebush v. Oakland County Prosecutor, 491 N.W.2d 633, 636 (Mich. Ct. App. 1992) (stating that “because minors and other incompetent patients lack the legal capacity to make decisions concerning their medical treatment, someone acting as a surrogate must exercise the right to refuse treatment on their behalf”).

40. See id.

41. See DONALD T. KRAMER, LEGAL RIGHTS OF CHILDREN 587-90 (2d ed. 1994); 2 MEISEL, supra note 2, § 15.6, at 283-89, 291-93; see also infra notes 218-23 and accompanying text.

42. See Compassion in Dying, 79 F.3d at 837 (stating that no decision is as painful or important than how and when one’s life should end); Colyer, 660 P.2d at 742; Lynda M. Tarantino, Withdrawal of Life Support: Conflict Among Patient Wishes, Family, Physicians, Courts and Statutes, and the Law, 42 BUFF. L. REV. 623, 629-45 (1994) (discussing how patients’ decisions involves philosophical, religious and moral views; life goals; values about the purpose of life; and attitudes toward sickness, medical procedures, suffering and death); cf. Cruzan v. Director, Missouri
affects the patient's essential personhood: it addresses the fundamental question of whether and when the person should die.

Most importantly, life-sustaining treatment decisions shape the definition of one's entire life. These decisions affect one's

Dep't of Health, 497 U.S. 261, 278 (1990) (recognizing the right to refuse unwanted medical treatment as a constitutionally-protected right).

The fundamental nature of this decision was recently developed by legal philosopher Ronald Dworkin. See generally RONALD DWORKIN, LIFE'S DOMINION (1993). Although most of the book is devoted to a reconstruction of the abortion rights debate, Dworkin also discusses the right to die because, in his view, both decisions involve the sacred value of life. See id. at 27, 217. Professor Dworkin posits that these decisions are religious in nature and thus receive protection under the First Amendment. See id. at 160-61. This Article does not address Professor Dworkin's reading of the First Amendment, a view that has not been adopted by the United States Supreme Court. Rather, Professor Dworkin's argument will be examined to illustrate that decisions involving the right to refuse life-sustaining treatment are extremely important and therefore must be left to the individual. See id. at 216, 239.


43. See DWORKIN, supra note 42, at 209, 213 (describing the decisions whether to consent to or refuse treatment as essential to a person's integrity).

44. See id. at 199, 210-11. Professor Dworkin explains the importance
core values and the way one will live the remainder of one's life.\textsuperscript{45} For example, some think it is better to live regardless of the degree of suffering, while others would rather die than be forced to suffer for the remainder of their lives.\textsuperscript{46} For others still, living a life of dependency would be intolerable,\textsuperscript{47} undermining their core values of independence and autonomy.

Failing to allow the patient to make this decision will cause irreparable harm to personhood; therefore, the law should be more respectful of the right to self-determination.\textsuperscript{48} According to Professor Dworkin, "[m]aking someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."\textsuperscript{49} To the suffering patient, the source of the right should not matter, whether it is the common law or the Constitution.\textsuperscript{50} The violation to the patient's personhood is the same.

The significant effect of these treatment decisions on the patient's personhood also does not change simply because the patient is a child. For example, a child like Benny Agrelo, a chronically-ill child forced to submit to life-sustaining treatment, essentially would be forced to live the remainder of his life with an identity that he has not chosen. Benny's chosen identity is a life without intrusive treatment, a shorter life with less pain. This identity values a certain quality of life and seeks to live each day to the fullest.\textsuperscript{51} If Benny were forced to submit to treatment, he would be reminded constantly that a different identity had been chosen for him, one defined by greater pain and more intrusive medical intervention than

of this decision by using the constructs of "experiential" and "critical" interests. Experiential interests are valuable because a person derives pleasure from them. See \textit{id.} at 201. Critical interests are those interests that are inherently important, such as coherence in the shape and character of one's life. See \textit{id.} at 201-02, 206-08. According to Dworkin, the right to die affects the patient's critical interests. See \textit{id.} at 209-10.

\begin{enumerate}
\item \textit{See id.} at 191, 213.
\item \textit{See id.} at 212-13.
\item \textit{See id.} at 209-10.
\item \textit{See id.} at 213.
\item \textit{See id.} at 217.
\item \textit{See id.} at 213.
\item \textit{See id.} at 209-11.
\item Professor Dworkin bases his right in the Freedom of Religion Clause of the First Amendment. \textit{See id.} at 160-61.
\end{enumerate}
desired. This different identity is one of a person who struggles mightily to the end: but Benny is not a struggler. Forcing Benny to live a life different than the one he has chosen would cause him significant and irreparable harm. Therefore, Benny—not his parents or the state—should decide how his final chapter should be written.

Similarly, the personhood of a minor with a religious objection to treatment would be irreparably harmed by being forced to undergo treatment against the minor’s fundamental religious tenets. For example, a Jehovah’s Witness sincerely believes that receiving blood transfusions will violate a fundamental religious tenet. The minor would then be forced to live a life contrary to the core religious values that define the minor’s emotional, spiritual, and physical existence—aspects of essential personhood. The minor would live only because of a betrayal of religious beliefs, a betrayal that could result in eternal damnation.

The harm to minors forced to submit to life-sustaining treatment is not mitigated simply because they have not reached the age of majority. Children, like adults, possess a valuable right of personhood. A child may never live to adulthood,

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Jehovah’s Witnesses disagree about how much one will be punished, if at all, for receiving a blood transfusion. See, e.g., William Shepard McAninch, A Catalyst for the Evolution of Constitutional Law: Jehovah’s Witnesses in the Supreme Court, 55 U. CIN. L. REV. 997, 1059-60 (1987). While some Jehovah’s Witnesses believe that they will be personally responsible to Jehovah for the consequences of a transfusion regardless of whether they consented, others believe that they are not responsible for transfusions ordered over their objection. See id.; see also Note, Jehovah’s Witnesses and the Refusal of Blood Transfusions: A Balance of Interests, 33 CATH. LAW. 361, 374, 381 n.94 (1990) (“[S]ome Jehovah’s witnesses... believe that receiving blood transfusions under any circumstances will deny them everlasting life, and others believe they are absolved from fault if they are forced to submit.”). Compare In re Osborne, 294 A.2d 372 (D.C. 1972) (stating that a Jehovah’s Witness will be denied everlasting life regardless of who orders transfusion), with United States v. George, 239 F. Supp. 752 (D. Conn. 1965) (noting that patient is not personally responsible if transfusion is ordered over objection).

but the length of a person's life should not affect the value of that person's choice to live in a particular way.

The life-sustaining treatment decision is just as important to a minor as the abortion decision, thus suggesting that minors should receive the same deference given to them in the abortion context. The United States Supreme Court has developed a mature minor doctrine for abortion decisions that is significantly more deferential to minors than the general rule governing the medical treatment decisions of minors. In several cases, the Court has articulated that the minor's constitutional right to privacy is adequately protected if the state provides a process for her to obtain an abortion after demonstrating her maturity to a judge.\textsuperscript{54} The Court concluded that greater deference to the minor in abortion decisions was justified for two reasons. First, the decision must be made within a limited time, and second, the decision, once made, results in irreversibly consequences.\textsuperscript{55}

Based on this reasoning, a mature minor doctrine should be adopted in the life-sustaining treatment context. Similar to the abortion decision, life-sustaining treatment decisions must often be made within a limited time to prevent the deterioration of the minor's health. Furthermore, similar to the abortion decision, the consequences of providing or failing to provide treatment essentially cannot be reversed. If treatment is given against the minor's wishes, the minor's personhood will be harmed, but if treatment is not given, the minor's physical health will deteriorate.\textsuperscript{56} The Article will argue that courts should acknowledge the similarities between the life-sustaining treatment decision and the abortion decision and recognize the minor's right to bodily integrity, based on the common law rather than the constitution.

Having established the importance of the minor's right to make life-sustaining treatment decisions, the next section will

\textsuperscript{54} See, e.g., \textit{Bellotti v. Baird}, 443 U.S. 622, 647-48 (1979); \textit{See also Planned Parenthood v. Casey}, 505 U.S. 833, 899-900 (1992) (noting that even immature minors may be able to show that the abortion is in their best interests).

\textsuperscript{55} \textit{Bellotti}, 443 U.S. at 642.

\textsuperscript{56} \textit{See generally} 2 \textit{Meisel, supra} note 2, \$ 15.3, at 278.
examine how inadequately existing law protects this right. Although a few recent cases have recognized the need to give greater deference to the minor’s decision, these cases fail to develop the comprehensive and coherent framework necessary to adequately protect the right.

B. The Limitations of Existing Law

1. The General Rule: No Right to Decide

Under the current common law and statutes on health care decision making, there is little, if any, precedent recognizing a minor’s right to make life-sustaining treatment decisions. Even advance health care directive statutes fail to include children. This section illuminates the current discord between the importance of the right and its limited recognition. This section further suggests that the most appropriate means for reforming existing law is through the common law.

a. Common Law

As discussed previously, parental consent is required for major and nonmajor treatment of minors unless an exception applies. If proper consent is not given, the treatment

57. In the earlier cases, the age of majority was twenty-one. See Bonner v. Moran, 126 F.2d 121, 122 (D.C. Cir. 1941); Homer H. Clark, Jr., The Law of Domestic Relations in the United States § 9.1, at 530-32 (2d ed. 1987). The age of majority in most jurisdictions is now eighteen. See id.

constitutes a tort and is actionable.\textsuperscript{59} This parental consent requirement appears to have two primary justifications: children are not capable of making medical decisions for themselves,\textsuperscript{60} and parents should not have to pay for unauthorized treatments.\textsuperscript{61}

To ameliorate the inequities of this rule, the courts have developed a few exceptions to the parental consent requirement: emergency, emancipation, and mature minor.\textsuperscript{62} None of these exceptions, except perhaps an expansive reading of the mature minor exception, include a minor's right to make life-sustaining treatment decisions. Consequently, the common law currently fails to recognize the importance of these decisions

for assault and battery for operating on child without parental permission); see also ROZOVSKY, supra note 36, § 5.1, at 258 (defining physician's liability as battery for intentionally touching a minor without parental consent).

\textsuperscript{59} See, e.g., Kozup, 851 F.2d at 439; cf. Cobbs, 502 P.2d at 7 ("where a doctor obtains consent of the patient to perform one type of treatment and subsequently performs a substantially different treatment for which consent was not obtained, there is a clear case of battery"); Tabor v. Scobee, 254 S.W.2d 474, 475 (Ky. Ct. App. 1951) (stating that a surgeon who operates on an adult patient without patient's consent commits assault and battery).

\textsuperscript{60} See ROZOVSKY, supra note 36, § 5.1, at 257; see generally infra pp. 51-63 (discussing children's competence).

\textsuperscript{61} See Lacey v. Laird, 139 N.E.2d 25, 30 (Ohio 1956) (Hart, J., concurring) (stating that the general rule requiring parental consent for a minor's medical treatment is based upon the potential increased cost to support and maintain the child if the treatment causes unfavorable results); cf. Nancy M. King & Alan W. Cross, Children as Decision Makers: Guidelines for Pediatricians, 115 J. PEDIATRICS 10, 16 (1989) (deferring to the decision of the parents because they must bear the cost of the child's treatment). The parental consent requirement also may be based in part on the parents' well-established right to the care, custody, and control of their children. See infra notes 317-19 and accompanying text.

\textsuperscript{62} See Kozup, 851 F.2d at 439 (recognizing medical emergency, mature minor doctrine, inaccessibility of minor's parents and parents' implied consent as exceptions to parental consent); Younts v. Saint Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330, 337 (Kan. 1970) (defining emergency, emancipation of the minor, inaccessibility of parents, and "when a child is close to maturity and knowingly gives an informed consent" as exceptions to parental consent). See generally ROZOVSKY, supra note 36, § 5.2, at 259-67 (explaining the various exceptions to the traditional parental consent requirement).
and the capacity of some minors to make them.

The well-recognized emergency exception to the parental consent requirement allows a health care provider to act prudently in an emergency when the parents cannot be reached. The emergency exception, as currently defined, fails to enable minors to refuse life-sustaining treatment. The exception’s underlying purpose is to reduce the health care provider’s exposure to liability, not to recognize the autonomy of minors. Some courts justify the emergency exception on an implied consent theory, assuming that in an emergency the parents would give their consent to treatment. This assump-

63. See Jackovach v. Yocom, 237 N.W. 444, 449 (Iowa 1931) (arguing that a surgeon has the duty in an emergency to treat without the patient’s consent); Tabor, 254 S.W.2d at 476 (maintaining that a surgeon may operate on a child without parental consent in an emergency); Luka v. Lowrie, 136 N.W. 1106, 1110 (Mich. 1912) (holding that a doctor “had a right to rely upon the information and to act in the emergency upon the theory that to obtain consent was impracticable” when no evidence indicated that parents would have refused treatment); cf. Plutshack v. University of Minn. Hosps., 316 N.W.2d 1, 9 (Minn. 1982) (holding that “exigent circumstance” of suspected meningitis authorized doctor to perform a lumbar puncture without mother’s consent, particularly when the doctor attempted to reach the mother and the grandmother gave consent); see also Consent as a Condition of Right, supra note 58, at 1373 (citing cases supporting the emergency exception to parental consent rule).

64. See Sullivan v. Montgomery, 279 N.Y.S. 575, 576-77 (Sup. Ct. 1935) (finding a twenty year old minor’s consent to anesthesia sufficient in an emergency). The court reasoned that this situation did not require parental consent:

if a physician or surgeon is confronted with an emergency which endangers the life or health of the patient, or that suffering or pain may be alleviated, it is his duty to do that which the occasion demands within the usual and customary practice among physicians and surgeons in the same locality.

Id. at 577.

tion is unjustified in cases involving life-sustaining treatment.

Moreover, the requisite urgency does not exist in the life-sustaining treatment context. To qualify as an emergency, ordinarily there must be insufficient time to contact a parent or guardian.66 A life-sustaining treatment decision, however, usually can be postponed until a parent is reachable. For example, a child in a persistent vegetative state (PVS)67 awaiting the removal of nutrition or hydration will not endure further physical harm during the period of continued life support. Although a terminally or chronically ill child usually has some time restrictions on determining the course of treatment, there is at least enough time to consult the child’s parents. A few emergency cases may exist. For example, if a child refuses a blood transfusion after a serious accident, the failure to provide a transfusion immediately could result in the child’s death. Only in such emergency cases will the lack of time obviate the need for parental consent.

The second common law exception to the parental consent requirement, the minor’s emancipation, also provides weak support for a minor’s right to make life-sustaining treatment decisions. In most cases, the emancipation exception is based on the principle that certain minors are sufficiently independent from their parents that they should no longer be considered dependent children (at least for some purposes).68 The

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66. See ROZOVSKY, supra note 36, § 5.1 at 257 (stating that an emergency exists if it is either impractical to obtain parental consent or if any delay would unduly endanger the minor’s life); cf. Miller v. Rhode Island Hosp., 625 A.2d 778, 784 (R.I. 1993) (citing Canterbury v. Spence, 464 F.2d 772, 780 n.15 (D.C. Cir. 1972) (determining that an emergency exists when “time is too short to accommodate discussion”); KEETON ET AL., supra note 65, § 18, at 117 (noting that delaying treatment in an emergency until consent is obtained would subject patient to risk of serious bodily harm or death).

67. See, e.g., Eichner v. Dillon, 426 N.Y.S.2d 517, 529 (App. Div. 1980) (defining PVS as “a state where the individual is partially responsive . . . but . . . has no significant cognitive functions. . . .”). A respirator may sustain a patient’s life in a PVS despite the loss of cognitive functions. See id.

68. To determine whether a minor is emancipated for purposes of
importance of the treatment decision and the competence of the minor to make this decision are of little relevance to emancipation.

The third exception recognized by some courts is for a mature minor, which is the only common law exception remotely applicable to minors making life-sustaining treatment decisions. This exception allows a minor to consent to treatment without the consent of his parents, if sufficiently competent to make the medical decision.69 The competence determination making health care decisions, courts will consider various factors that indicate whether the minor can function independently as an adult. Such factors include the minor's age, ability to manage financial affairs, whether the minor is living separate and apart from his parents, any minimum age requirements, entry into the armed forces, and marriage. See Mark I. Soler et al., Representing the Child Client ¶ 3.05, at 3-67; see also Ison v. Florida Sanitarium & Benevolent Ass'n, 302 So. 2d 200, 201-02 (Fla. Dist. Ct. App. 1974) (defining minor as "emancipated" when she left parents' home permanently and had become completely self-supporting); Buxton v. Bishop, 37 S.E.2d 755, 757 (Va. 1946) (holding that a father was not liable for his deceased minor son's hospital bill since his son was an emancipated youth who worked away from home and earned his own wages for three years); Smith v. Seibly, 431 P.2d 719, 723 (Wash. 1967) (determining that a minor approaching age of majority possessed various indicia of independence to justify emancipation: he was married, had completed high school, was head of his family, earned a living, and maintained a home); see generally Carol Sanger & Eleanor Willemsen, Minor Changes: Emancipating Children in Modern Times, 25 U. Mich. J.L. Reform 239 (1992) (discussing statutory factors such as age, living apart from one's parents and managing one's financial affairs as satisfactory indicia of independence to justify emancipation of minor).

69. See Younts v. Saint Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330, 337-38 (Kan. 1970) (finding a seventeen year old mature enough to consent to fingertip skin graft); Gulf & S.I.R. Co. v. Sullivan, 119 So. 501, 502 (Miss. 1928) (determining that a seventeen year old was sufficiently intelligent and mature to consent to vaccination). But see Cardwell v. Bechtol, 724 S.W.2d 739, 740 (Tenn. 1987) (asserting that a seventeen year old was not mature enough to consent to an order not to resuscitate). See generally Restatement (Second) of Torts §§ 59, 892A cmts. b-e (1979) (stating that consent of competent minor is sufficient); Keeton et al., supra note 65, at 114 (noting that consent is ineffective if person lacked capacity to consent); Rozovsky, supra note 36, § 5.2.2, at 260-66 (determining whether a minor is mature is a case-by-case judgment); Danny R. Veilleux, Annotation, Medical Practitioner's Liability for Treatment Given Child Without Parent's Consent, 67 A.L.R. 4th 511, 530-
usually requires the court to ascertain whether the minor understands the treatment and its consequences.\textsuperscript{70}

Based on these principles, the mature minor doctrine could be expanded to include a minor’s life-sustaining treatment decisions. There are a number of reasons why this expansion is unlikely.

First, whether the courts were actually applying a mature minor doctrine is unclear. If applying a true mature minor doctrine, the court initially would have determined the minor’s competence. Next, the court would have determined whether any strong countervailing interests justified circumscribing the mature minor’s right to make life-sustaining treatment decisions.\textsuperscript{71} In cases that have recognized the mature minor doctrine, however, the courts appear to have engaged in a more broad-reaching factor analysis. In these cases the child’s maturity was only one of a myriad of factors considered by the court. For example, in Bakker v. Welsh,\textsuperscript{72} the court considered that the child was near the age of majority and mature,\textsuperscript{73} that adult relatives accompanied the child to the doctor,\textsuperscript{74} that the

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34 (1989) (citing cases applying mature minor doctrine); Annotation, Consent as Condition of Right, supra note 58, at 1373 (citing additional cases applying the mature minor doctrine).

\textsuperscript{70} See Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 829 (W. Va. 1992); see also Younts, 469 P.2d at 337 (finding that the sufficiency of the minor’s consent depends upon the minor’s ability to understand the nature of the surgical procedure, the risks involved and the probability of attaining the desired results). The Belcher court recently recognized a common law mature minor exception, following other states that already recognize such exceptions to the parental consent requirement. See id. at 836 (citing Bakker v. Welsh, 108 N.W. 94 (Mich. 1906) and Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987)). The Belcher court stated that to determine the minor’s maturity, a trial court should consider the following: age, ability, experience, education, training, and conduct and demeanor at the time of the incident. See id. at 838. Based on these factors, the court concluded that the doctor erred in failing to obtain the consent of the child prior to performing the procedure. See id.; see also Batterman, supra note 2, at 641.

\textsuperscript{71} Cf. infra notes 176-89 and accompanying text.

\textsuperscript{72} 108 N.W. 94 (Mich. 1906).

\textsuperscript{73} The court noted that he was a “young fellow almost grown into manhood.” Id. at 96.

\textsuperscript{74} Although his aunt and sister escorted him to the doctor’s office the day before the operation, it is unclear who actually consented to the
treatment was nonmajor,"75 and that the child’s father impliedly consented to the treatment.76 Other cases have applied a similar multifactor analysis.77 The reliance on other factors may indicate that the mature minor exception was not created to give the child autonomy, but to absolve the hospital of liability.78 In some cases, the reliance on other factors may reflect the court’s deference to the parent who expressly or impliedly agreed with the minor’s decision, rendering the minor’s view inconsequential.

Second, these cases were not difficult cases to decide in favor of the minor, and therefore do not provide support for a mature minor doctrine that extends to life-sustaining treatment. These cases were not difficult to decide because they involved minors close to the age of majority.79 When minors reach this age,
they are no less mature than adults. Furthermore, any lack of maturity would not really matter because the minors will soon be adults with the legal right to decide for themselves—rightfully or wrongfully.

Furthermore, the cases were not difficult to decide because they involved a minor's consent to treatment rather than refusal of treatment. In these cases, the child or the child's parent sued the health care provider in tort for failing to seek the requisite consent prior to treatment. Thus, the courts were not required to consider the state's fundamental interest in the sanctity of children's lives, which is implicated when treatment is refused.

Finally, the cases were not difficult to decide because they did not involve major treatment. Major treatment may re-

smallpox vaccination); Sullivan v. Montgomery, 279 N.Y.S. 575, 577 (Sup. Ct. 1935) (holding that parental consent was not required when a physician administered an anesthetic to a twenty-year-old minor with a fractured ankle).

Conversely, courts have not applied the mature minor doctrine in cases involving younger children. See Bonner, 126 F.2d at 122-23 (requiring parental consent for a skin grafting operation performed on a fifteen-year-old boy for the benefit of his cousin); Zoski, 260 N.W. at 102-03 (affirming the trial court's finding that an unauthorized tonsillectomy performed on a nine and a half year old constituted an assault); Rogers v. Sells, 61 P.2d 1018, 1021 (Okla. 1936) (affirming the trial court's finding that a surgeon, who amputated a fourteen-year-old boy's leg without parental consent, was guilty of assault and battery); Moss v. Rishworth, 222 S.W. 225, 226-27 (Tex. Comm'n App. 1920, judgm't adopted) (holding a surgeon liable for failing to obtain parental consent prior to performing a tonsillectomy on an eleven-year-old child).

80. See infra note 226 and accompanying text.

81. See supra notes 35-36 and accompanying text.

82. See Younts, 469 P.2d at 332 (failing to obtain parental consent for a surgical procedure on a seventeen year old's finger); Bakker, 108 N.W. at 95 (failing to obtain father's consent to remove tumor from seventeen year old's ear); Cardwell v. Bechtol, 724 S.W.2d 739, 742 (Tenn. 1987) (failing to obtain parents' permission to perform osteopathic manipulations on their seventeen-year-old daughter).

83. See infra Part III.C.1.

84. See Younts, 469 P.2d at 332 (surgical repair of fingertip); Bishop v. Shurly, 211 N.W. 75, 76 (Mich. 1926) (tonsillectomy); Bakker, 108 N.W. at 96 (removal of small tumor on ear); Gulf & S.I.R. Co., 119 So. at 502 (vaccination); Cardwell, 724 S.W.2d at 741-42 (osteopathic manipulation of the neck, spine and legs).
quire a hospital stay or may pose significant risks to the child's health.\textsuperscript{85} Life-sustaining treatment certainly would be considered major. A court may be more reluctant to permit a child to make decisions when major treatment is involved. The court may conclude, for example, that the child does not have the capacity to make complicated decisions, or that the state or the parents have a greater interest in interfering with these decisions.\textsuperscript{86}

For all of these reasons, the existing common law fails to protect a minor's right to consent to or refuse life-sustaining treatment. The existing statutes are similarly inadequate.

b. Statutes

Most of the current statutes do not address a minor's life-sustaining treatment decisions. The statutes generally contain narrow exceptions to the parental consent requirement.\textsuperscript{87} In some states, the common law may broaden the exceptions beyond those contained in the statutes.\textsuperscript{88}

The statutory exceptions can be divided into four general categories similar to the common law exceptions: emergency, status, specific condition, and mature minor.\textsuperscript{89} All states rec-

\textsuperscript{85} See Jan Costello, If I Can Say Yes, Why Can't I Say No?, in CHILD, PARENT AND STATE 490, 493 & n.14 & 22 (1994); see also KEETON ET AL., supra note 65, § 18, at 115 (determining that major operations involve risk of serious injury or death).

\textsuperscript{86} Cf. infra Parts III.B, I.C.


\textsuperscript{88} Cf. Batterman, supra note 2, at 641 (noting that it is ambiguous whether the common law exceptions to the parental consent requirement survive minor health care legislation).

\textsuperscript{89} Other commentators have identified similar categories. See Batterman, supra note 2, at 639-40 (identifying status and condition exceptions); Eric S. Engum, Expanding the Minor's Right to Consent to Non-Emergency Health Care, 3 J. LEGAL MED. 557, 570-79 (1982) (identifying exceptions for emergencies, emancipation, mature minors, physician's discretion, and treatment of specified conditions); Wadlington,
ognize at least one of these exceptions, while most recognize more. Through these exceptions, the states recognize that minors do not have to reach the statutory age of majority to make their own medical decisions. These exceptions, however, were not intended to protect the minors' rights to self-determination. Instead, the exceptions were designed to prevent certain negative consequences resulting from lack of medical care, such as significant harm to the child or to the community. Only one of the exceptions, the mature minor exception, is directly related to the minor's competence to make health care decisions. Even this exception does not extend to life-sustaining treatment.

The first exception, the emergency exception, is essentially a codification of the common law emergency exception discussed in the previous section. As explained above, the emergency exception is too narrow to apply to most life-sustaining treatment decisions faced by minor patients.

The second exception, the status exception, allows minors who enjoy a particular status to make their own medical treatment decisions. Depending on the state, the status exception may include married minors, minors who are parents, or

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90. See In re E.G., 594 N.E.2d 322, 327-28 (Ill. 1989) (stating that a seventeen year old, who was mature enough to appreciate the consequences of her actions, could refuse life-sustaining treatment).

91. See Abigail English, Adolescent Health Care: Barriers to Access, Consent Confidentiality and Payment, 20 CLEARINGHOUSE REV. 481, 484 (1986) (stating that statutes allowing minors to consent to treatment of specified conditions are designed to reduce the severe health damage to the child and the public health hazard created when illnesses are untreated); see also Ewald, supra note 87, at 701 (stating that statutes authorizing minors to consent to treatment of certain illnesses were enacted, in part, to protect societal interests).

92. See infra notes 125-30 and accompanying text.

93. See supra notes 65-67 and accompanying text; see also Harriet F. Pilpel, Minors' Rights to Medical Care, 36 ALB. L. REV. 462, 464 (1972) (listing states that have codified the common law emergency exception).

94. See supra notes 67-69 and accompanying text.

95. See ALA. CODE § 22-8-4 (1994); DEL. CODE. ANN. tit. 13, §
minors who are emancipated. Based on these categories, this exception is too narrow to protect the rights of most minors making life-sustaining treatment decisions.

States may define emancipation in the emancipation statute itself or through case law. Regardless of the source, the


Under a majority of these statutes, it is unclear whether a subsequent divorce extinguishes a minor's right to refuse treatment. Some statutes explicitly or implicitly determine that a divorce does not terminate a minor's right to refuse treatment. See ALA. CODE § 22-8-4 (1990) (stating that a minor who is married or divorced may consent to medical treatment); ME. REV. STAT. ANN. tit. 19 § 903(2) (West 1992) (noting that any minor who is or was married may consent to treatment); MASS. ANN. LAWS ch. 112, § 12F (Law. Co-op. 1991) (stating that any minor who is married, widowed or divorced may consent to treatment); MINN. STAT. ANN. § 144.342 (West 1995) ("Any minor who has been married . . . may give effective consent . . .").

96. Generally, minor parents are given authority to consent to medical treatment only for their children. See DEL. CODE ANN. tit. 13, § 707(a)(1),(4) (1994); GA. CODE ANN. § 31-9-2(a)(2) (1994); MINN. STAT. ANN. § 144.342 (West 1994); R.I. GEN. LAWS § 23-4.6-1 (1989); see also Cohn, supra note 2, at 288 (stating that twenty-two states allow minor parents to consent to treatment).

Some statutes authorize minor parents to consent to treatment for themselves as well as for their children. See ALA. CODE § 22-8-5 (1990); ALASKA STAT. § 25.20.025(a)(3) (Michie 1995); ILL. COMP. STAT. 410/210-1 (West 1994); MD. CODE ANN., HEALTH-GEN. II § 20-102(a)(2) (1994); MASS. GEN. LAWS ANN. ch. 112, § 12F (West 1994).


For illustrative emancipation statutes, see the statutes cited in Engum, supra note 89, at 572; ROZOVSKY, supra note 36, § 5.3.1, at 268-69 (1990 & Supp. 1994).

98. See Engum, supra note 89, at 573 (concluding that mature minor statutes are superior to emancipation statutes because emancipation statutes condition minors' access to treatment on their age or status).

99. See ALASKA STAT. § 25.20.025(a)(1) (Michie 1994) ("[A] minor who is living apart from the minor's parents or legal guardian and who is
definition of emancipation is based on notions of independence, not competence. Factors demonstrating independence include marital status, pregnancy, membership in the armed forces, high school graduation, age, living apart from one's parents, and managing one's own financial affairs. These requirements are narrowly defined and may only protect a managing the minor's own financial affairs, regardless of the source or extent of income, may give consent for medical and dental services for the minor.

100. See Napolitano v. Napolitano, 732 P.2d 245, 246 ( Colo. Ct. App. 1986) (identifying the child's degree of financial independence and maintenance of a residence away from the family home as significant factors indicating emancipation); Jackson v. Jackson, No. 30 50 41 J, 1992 WL 229156, at *2 (Conn. Super. Ct. Aug. 28, 1992) ("[T]he fact that a child has entered into a relation which is inconsistent with the idea of his being in a subordinate situation in his parent's family is sufficient to effect an emancipation.").

101. See Robert Bennett, Allocation of Child Medical Care Decisionmaking Authority: A Suggested Interest Analysis, 62 Va. L. Rev. 285, 290 (1976) (stating that a high degree of independence increases the likelihood of finding emancipation); Engum, supra note 89, at 573 (noting that emancipation statutes allow independent minors to consent to treatment); Wilkins, supra note 89, at 58-59 (asserting that emancipation statutes confer the power to consent to minors who are independent from financial control).

102. See Batterman, supra note 2, at 640 (providing a list of factors that demonstrate a separation from one's parents); Ewald, supra note 87, at 702 (listing relevant factors in determining whether a minor is emancipated); Wadlington, supra note 78, at 121 (stating that emancipation statutes often consider the minor's age, marital status and whether the minor lives at home); Loren Brian Mark, The Competent Child's Preference in Critical Medical Decisions: A Proposal for its Consideration, 11 W. St. U.L. Rev. 25, 44 (1983) (listing factors that allow a minor in California to petition for emancipation).

103. See Mark, supra note 102, at 44 (noting that emancipation statutes have limited application); Wadlington, supra note 78, at 121 (listing factors demonstrating emancipation); see also Engum, supra note 89, at
minor making nonmajor medical decisions. Moreover, the status exception inadequately protects the minor's right to make life-sustaining treatment decisions. It is overinclusive because some immature minors may be permitted to make important health care decisions simply because of their status. On the other hand, the exception is underinclusive because mature minors may be prevented from making important health care decisions simply because they do not fit within the narrow status categories.

The third exception, based on the minor's specific condition or disease, is also underinclusive. The conditions covered by this specific condition are diverse and vary among the states. They include abortion, pregnancy, contraception,

573 (noting that the majority of minors do not meet the statutory requirements of emancipation).

104. See Engum, supra note 89, at 572; see also ROZOVSKY, supra note 36, § 5.3.2, at 269 (1990 & Supp. 1994).

105. See Batterman, supra note 2, at 670.

106. Minors are not always automatically authorized to consent to abortion. The right is often contingent upon other conditions. See KY. REV. ST. ANN. § 311.732 (Michie 1994) (allowing an emancipated minor to consent to an abortion); ME. REV. STAT. ANN. tit. 22, § 1597A (West 1994); MD. CODE ANN., HEALTH-GEN. II § 20-103(c)(2) (1991); MASS. GEN. LAWS ch. 112, § 12S (1991); MISS. CODE ANN. § 41-41-53 (1994) (allowing minor to petition court to waive the consent requirement); MO. REV. STAT. § 188.028 (1995) (allowing an emancipated minor or a minor with court approval to consent to an abortion).

107. See ALA. CODE § 22-8-6 (1990); ALASKA STAT. § 25.20.025(a)(4) (Michie 1995); ARK. CODE ANN. § 20-9-602(4) (Michie 1991); MD. CODE ANN., HEALTH-GEN. II § 20-102(c)(4) (Supp. 1995); MINN. STAT. ANN. § 144.343(1) (West 1989).

Some statutes require the minor to attain a particular age before she can consent to treatment for pregnancy. See DEL. CODE ANN. tit 13, § 708 (1993) (twelve years old). Other statutes limit the minor's right to consent to pregnancy-related treatment. See KY. REV. STAT. ANN. § 214.185 (Michie 1994) (excluding abortion and sterilization).

108. Similar to abortion, minors are not always automatically authorized to receive contraceptives. See COLO. REV. STAT. ANN. § 25-6-102(1) (West 1990); KY. REV. STAT. ANN. § 214.185(1) (Michie 1991); ME. REV. STAT. ANN. tit. 19, § 1902 (West 1992); MD. CODE ANN., HEALTH-GEN. II § 20-102(c)(5) (Supp. 1995); MISS. CODE ANN. § 41-42-7 (1993); TENN. CODE ANN. § 68-34-107 (1995); see also Engum, supra note 89, at 576 nn.64-65 (citing statutes that authorize minors to consent to treatment for the prevention of pregnancy).
venereal disease, alcoholism, drug abuse, psychiatric or mental health care, sexual assault or abuse, and blood


Other states expand the right to other types of communicable diseases. See Ala. Code § 22-8-6 (1994) (authorizing minors to consent to treatment of any reportable disease); Cal. Fam. Code § 6926(a) (West 1994) (allowing any minor twelve years or older to consent to diagnosis and treatment of contagious, communicable or sexually transmitted diseases); Del. Code Ann. tit. 13, § 708 (1994) (authorizing any minor twelve years of age or over to consent to treatment of contagious, infectious, or communicable diseases).


The applicability of such statutes also may be limited by age. See Ariz. Rev. Stat. Ann. § 44-133.01 (West 1994) (twelve years old or older); Del. Code Ann. tit. 16, § 2210(b) (1983) (twelve years old or older); Miss. Code Ann. § 41-41-14 (1993) (fifteen years old or older); Tex. Health & Safety Code Ann. § 462.022(a)(3) (West 1994) (sixteen years old or older).

111. The exception may extend to inpatient and outpatient care. See Colo. Rev Stat. Ann. § 27-10-103(2) (West 1994) (fifteen years old or older); Kan. Stat. Ann. § 59-2905(a) (1994) (fourteen years old or older); Mont. Code Ann. § 53-21-112(1) (1995) (sixteen years old or older). In contrast, the statute also may be limited to outpatient care. See N.Y. Mental Hyg. Law § 33.21(c) (McKinney 1996); Wash. Rev. Code Ann. § 71.34.030 (West 1995) (thirteen years old or older); Wis. Stat. Ann. §
The condition or disease exception does not appear to be motivated by a desire to recognize a minor's right to make certain health care decisions. For many of these conditions, including venereal disease, drug abuse, and mental health problems, the exception exists because requiring parental consent may discourage a minor from seeking treatment. If the minor failed to seek treatment, the minor's health or the welfare of the community could be jeopardized. For example, a minor's failure to obtain pregnancy-related services because of a fear of parental reprisals could detrimentally affect the health of the mother and the unborn child. Additionally, the failure to treat venereal disease could cause the spread of the disease, thus causing harm to the community.

Similar to the other exceptions to the parental consent requirement, the condition exception does little, if anything, to protect a minor's right to consent to or refuse life-sustaining treatment. The plain language of the statutes does not cover life-sustaining treatment at all, unless the particular condition happens to be life threatening. Moreover, reading the excep-

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114. See Ewald, supra note 87, at 701 (stating that minors are reluctant to seek help if they have to tell their parents); Wadlington, supra note 78, at 122 (noting the deterrent effect of the parental consent requirement); Wilkins, supra note 89, at 31-32 (noting that minors with sensitive medical problems related to sex or drugs frequently are deterred from seeking treatment because the physicians will inform their parents).

115. See Costello, supra note 85, at 493 nn.14 & 22; English, supra note 91, at 484; Ewald, supra note 87, at 701.

116. See English, supra note 91, at 484.

117. See id.
tions to extend beyond the delineated conditions would be illogical in light of the plain language of the statutes.\textsuperscript{118}

The statutes also may be limited to consent to treatment. Most of the statutes apply to consent to treatment, but do not refer to refusal of treatment at all.\textsuperscript{119} By specifically including consent and excluding refusal, the legislature may have intended to allow minors only to consent to treatment. This reading would be consistent with the state's interest in protecting children's lives because it would prevent a minor from refusing necessary health care, and thus would prevent self-inflicted harm.\textsuperscript{120}

Such a narrow reading of the statute, however, would be contrary to the widely accepted principle that the right to consent to treatment includes the concomitant right to refuse treatment.\textsuperscript{121} The right to bodily integrity cannot be exercised effectively if a patient can agree to treatment, but cannot prevent imposition of the same treatment.

The minor's right to bodily integrity may be limited further if the exemption includes a parental notification requirement, which permits or requires parental notification when the child seeks treatment for the particular condition.\textsuperscript{122} For some minors, a notice requirement is as significant a barrier to treatment as a parental consent requirement.\textsuperscript{123} A minor who does not wish to reveal the condition may avoid going to the doctor for diagnosis and treatment.\textsuperscript{124} The exception may deter the

\begin{footnotes}
\item 118. See Engum, \textit{supra} note 89, at 580; Wadlington, \textit{supra} note 78, at 123 (noting that it is unlikely that courts will expand the exceptions to cover life-sustaining treatment); Wilkins, \textit{supra} note 89, at 62.
\item 119. See \textit{ALA. CODE} \textsection 22-8-4 (1990).
\item 120. See discussion infra pp. 69-73.
\item 121. See, \textit{e.g.}, 2 \textit{MEISEL}, \textit{supra} note 2, \textsection 3.2, at 83-84.
\item 122. See 410 \textit{ILL. COMP. STAT. ANN.} ch. 210/4 (West 1993 & Supp. 1996) (requiring parental notification after the minor has received three months of treatment for alcohol abuse); \textit{PA. STAT. ANN.} tit. 71, \textsection 1690.112 (West 1990); \textit{VT. STAT. ANN.} tit. 18, \textsection 4226 (1982) (demanding parental notice when the minor's condition requires immediate hospitalization for alcohol, drug or venereal disease).
\item 124. See Cohn, \textit{supra} note 2, at 299; Wadlington, \textit{supra} note 78, at 122.
\end{footnotes}
minor from obtaining needed treatment, thus resulting in the failure to protect the minor's health and the welfare of the community. While deterrence is more likely when the child is afflicted with a stigmatizing disease such as AIDS, it probably occurs less frequently when the child is terminally ill or in a PVS. In these latter cases, the parents probably know about the child's condition.

Only the mature minor exception is based on the capacity of the minor to decide whether to consent to or refuse treatment. Thus, only the mature minor exception is arguably broad enough to encompass decisions by minors to refuse life-sustaining treatment. This exception takes on essentially two different forms. The first form, the "presumed" mature minor, allows a minor to consent to health care at a certain age. Under this form of the exception, minors of that age are deemed mature enough to make medical decisions. For example, Alabama allows a minor who is fourteen years or older to consent to medical care.

The second form, the "true" mature minor, resembles the common law mature minor doctrine. Under this form of the exception, the minor may consent to treatment if the court finds the minor sufficiently mature to understand the nature and the consequences of the proposed treatment. This form acknowledges that minors mature at different times and that only mature minors possess the right to self-determination. This form of the exception may not be broad enough to protect a minor's right to refuse life-sustaining treatment, however, because it does not appear to extend to refusal of treatment.

125. See Ewald, supra note 87, at 704; see also Rozovsky, supra note 36, § 5.3.2, at 269-70.
126. See Ewald, supra note 87, at 703.
128. See supra notes 71-72 and accompanying text.
Therefore, the broadest statutory exceptions fail to protect a minor's right to make decisions regarding life-sustaining treatment, even if the minor is competent. Furthermore, statutes recognizing advance health care directives provide no additional protection for minors.

c. Advance Health Care Directives

Generally, two types of advance health care directives exist: instructional and proxy. 131 The purpose of advance health care directives is to ensure patients that their care will comport with their individual beliefs and values if they become incapable of making health care decisions. Although forty-seven states have enacted instructional directives such as living wills, 132 and forty-nine states have enacted some form of a proxy directive, 133 no state permits minors to execute either type of directive. Except in narrow circumstances, instructional and proxy directives allow only competent adults to make life-sustaining treatment decisions.

Instructional directives allow a competent adult to delineate precisely the types of medical treatment that should be withheld, withdrawn, or continued in the event that the person becomes incompetent. 134 Their use is limited because they ap-

88-232 (opining that the exception to the parental consent requirement does not extend to the minor's refusal of treatment in most instances).

131. Instructional directives allow a patient to maintain control of health care decisions by delineating the desired types of health care, and proxy directives allow an appointed agent to make those decisions. See, e.g., ALAN LIEBERSON, ADVANCE MEDICAL DIRECTIVES § 20:3 (1992).

132. Michigan, New York and Massachusetts have not enacted instructional directives. See 2 MEISEL, supra note 2, § 11.22, at 120.

133. Alabama has enacted only an instructional directive. See id., § 12.4, at 133, § 12.52, at 211-12.

134. For the purpose of advance health care directives, incompetence has been defined as when a person is "incapable of making [his or her] own decisions." Neil F. Splaine, The Incompetent Individual's Right to Refuse Life-Sustaining Medical Treatment: Legislating, Not Litigating, A Profoundly Private Decision, 27 SUFFOLK U. L. REV. 905, 906 n.7 (1993). For example, a person in a persistent vegetative state (PVS), who is unable to communicate the kinds of medical care desired, would be considered incompetent. The precise definition of incompetency varies among jurisdictions.
ply only to specific situations contemplated at the time the document is executed.\textsuperscript{135} Health care proxy documents,\textsuperscript{136} on the other hand, provide more flexibility because an agent is appointed to make medical decisions that are consistent with the patient’s desires, including unanticipated situations.\textsuperscript{137} These directives could enable minors to make one of the most important decisions they could ever make, but currently the directives do not apply to them.

Although almost all states have enacted living will legislation, no statute explicitly affords minors the right to execute a living will unless the minor achieves a certain status, such as emancipation or marriage.\textsuperscript{138} The statutes limit their scope to adults in various ways.

Some statutes explicitly state that the declarant of the living will must be “at least eighteen years of age or obtain the age of majority,”\textsuperscript{139} whereas others indicate that “any competent

\textsuperscript{135} See id.

\textsuperscript{136} For more comprehensive discussions of health care proxy statutes, see BARRY R. FURROW, ET AL., HEALTH LAW § 17-22, at 682-838 (1995); LIEBERSON, supra note 131, § 20, at 361-73; 2 MEISEL, supra note 2, §§ 12.5-12.6, at 134-35, § 12.52, at 211.

\textsuperscript{137} See Robert B. Leflar, Advance Health Care Directives Under Arkansas Law, 1994 ARK. L. NOTES 37, 38. Because living wills are effective for a number of years, a concern has been raised whether a person’s medical treatment decisions made at the time the document was executed are consistent with the person’s views when those decisions are carried out. Health care proxy documents generally do not raise this concern, however, because the agent is expected to know and carry out the patient’s preferred decisions. See Furrow, supra note 136, § 17-22, at 360-61. The patient is able to choose an agent that is “most likely to understand and apply the patient’s values. [I]t does not require a patient to anticipate with any precision the treatment that she may need when competent.” Id. The physician and family members are able then “to participate in discussions about the proposed treatment.” Id.


\textsuperscript{139} See ALASKA STAT. § 18.12.010(a) (Michie 1995); ARK. CODE ANN. §§ 20-17-201(7), -202(a) (Michie 1991); CAL. HEALTH & SAFETY CODE § 71865(a) (West Supp. 1995); COLO. REV. STAT. § 15-18-104(9) (1989); CONN. GEN. STAT. ANN. §§ 19a-576(a), -577(a) (West Supp. 1995); GA.
adult” may execute a living will. Moreover, several statutes express a broad legislative purpose that would seem to include minors, but then limit the right to adults. One state has no


141. See, e.g., Tenn. Code Ann. §§ 32-11-102(a), -104(a) (Supp. 1995). The legislative intent portion of the Living Wills statute provides:

The general assembly declares it to be the law of the state of Tennessee that every person has the fundamental and inherent right to die naturally with as much dignity as circumstances permit and to accept, refuse, withdraw from, or otherwise control decisions relating to the rendering of the person’s own medical care . . . .

§ 32-11-102(a) (emphasis added).

Later in the statute, however, it states that to execute a declaration for a living will the person must be a “competent adult”, thereby excluding minors. § 32-11-104(a).
express or implied age requirement in its statute.\footnote{142}

Some states provide limited grants of authority to minors. For example, a parent or guardian may execute a health care directive on behalf of a terminally ill minor, but the minor retains limited veto power to prevent the execution of the directive against the minor's wishes.\footnote{143} A few states allow minors to execute living wills on their own behalf, but only if they have attained a certain status,\footnote{144} such as emancipation\footnote{145} or marriage.\footnote{146} Therefore, under current law, most mature minors are prevented from executing a legally binding instructional directive.

An unemancipated minor also is not legally permitted to designate a health care proxy.\footnote{147} Almost half of the states explicitly require the person designating the proxy to be eighteen years of age.\footnote{148} Furthermore, many states fail to specify the

\footnote{142. See N.C. GEN. STAT. §§ 90-320 to -323 (1993). Age may still be a limitation because an unemancipated minor generally cannot make health care decisions. See § 32A-31(c). Moreover, under this statute, a custodial parent may not authorize an agent to consent to remove life-sustaining treatment from the minor. See id.}

\footnote{143. See LA. REV. STAT. ANN. § 40:1299.58.6(A)(1)(2), (B)(1) (West 1992); N.M. STAT. ANN. §§ 24-7-4 (A), (B)(1) (Michie 1994).}

\footnote{144. See 755 ILL. COMP. STAT. ANN. 35/3(a) (West 1999); 20 PA. CONS. STAT. ANN. § 5404(a) (West Supp. 1996).}

\footnote{145. See IDAHO CODE §§ 39-4503(2), 4504 (1993); 755 ILL. COMP. STAT. ANN. 35/3(a) (citing to the Emancipation of Mature Minors Act); 20 PA. CONS. STAT. ANN. § 5404(a); UNIF. HEALTH CARE DECISIONS ACT § 2(a), 9 U.L.A. 224 (Supp. 1996).}

\footnote{146. See NEB. REV. STAT. § 20-403(1) (Supp. 1994); 20 PA. CONS. STAT. ANN. § 5404(a); see supra notes 99-107 and accompanying text.}

\footnote{147. See, e.g., Scheb, supra note 138, at 14 (noting that “statutes authorizing durable powers of attorney do not provide any solution for termination of life support where minor children are concerned”).}

precise age necessary to designate a health care proxy, but re-
quire the person to be a competent "adult."\textsuperscript{149} Since the age of 
adulthood in these states is typically eighteen or older,\textsuperscript{150} a 
minor is excluded from designating a health care proxy under 
this legislative model.

Although several states do not appear to limit their proxy 
statutes to adults explicitly,\textsuperscript{151} it is unlikely that the statutes

(West 1996); N.Y. PUB. HEALTH LAW § 2880.1 (McKinney 1993 & Supp. 
1996); N.C. GEN. STAT. § 32A-17 (1984 & Supp. 1994); N.D. CENT. CODE 
§ 23-06.5-17 (Supp. 1994); OHIO REV. CODE ANN. § 1337.11(A) (Anderson 
1993 & Supp. 1995); OKLA. STAT. ANN. tit. 58, § 1071.2, tit. 63, § 3101.4 
(West 1995 & Supp. 1996); OR. REV. STAT. § 127.505 (1990); 20 PA. 
CONS. STAT. ANN. § 5404(a) (Supp. 1995); R.I. GEN. LAWS § 23-4.10-2 
(1989); S.C. CODE ANN. § 44-77-30, § 62-55-504(9) (Supp. 1995); TEX. CIV. 
PRAC. & REM. CODE ANN. § 135.001(1) (West 1996); UTAH CODE ANN. § 
75-2-1106(1) (1993 & Supp. 1995); W. VA. CODE § 16-30A-6(a) (1995); 
WIS. STAT. ANN. § 155.05(1) (West Supp. 1995); see also OHIO REV. CODE 
ANN. § 2133.01 (1994 & Supp. 1995) (eighteen years old or older); NEB. 
REV. STAT. § 30-3402 (Supp. 1994) (nineteen years old or older).

One state appears to have a discrepancy between its health care 
power of attorney statute and its surrogate decision-making act. See W. 
VA. CODE § 16-30A-6(a) (1995). Under West Virginia law, only capable 
adults can execute a medical power of attorney. See id. A mature minor, 
however, may be a surrogate for a patient who has become incapacitated. 
See §16-30B-3(a). These statutes appear inconsistent because they allow 
mature minors to make decisions for others but not for themselves.

149. See ARIZ. REV. STAT. ANN. § 36-3221(A) (1993 & West Supp. 
1995); DEL. CODE ANN. tit. 16, §§ 2502(a), (b), 2503(a) (1993); D.C. CODE 
ANN. § 21-2205(a) (Supp. 1995); FLA. STAT. ANN. §§ 765.101(12), .102, 
.302 (West Supp. 1996); LA. REV. STAT. ANN. § 40:1299.58 (West 1994); 
MASS. ANN. LAWS ch. 201D, § 2 (Law Co-op 1994); ME. REV. STAT. ANN. 
tit. 18A, § 5-802 (West Supp. 1995); MINN. STAT. ANN. § 145B.03 (West 
Supp. 1996); VA. CODE ANN. §§ 54.1-2982 to 2983 (Michie 1994); VT. 

150. See DEL. CODE ANN. tit. 1, § 701 (1993) (stating that the age of 
majority is eighteen years of age); N.H. REV. STAT. ANN. § 21:44 (1988) 
(defining adult as one who is eighteen or older). See generally supra note 
57.

GA. CODE ANN. §§ 31-36-1 to -10 (1991 & Supp. 1995) ("individual," "pa-
ient," or "principal"); 755 ILL. COMP. STAT. ANN. 45/4-1 to 4-12 (Michie 
41-41-159 (1993) ("principal"); S.D. CODIFIED LAWS ANN. § 59-7-2.5 
will permit unemancipated minors to elect a proxy. First, many of the proxy statutes seem to be modeled on a principal-agent relationship, in which the agent can receive only the powers that the principal is able to delegate. If minors cannot make health care decisions for themselves, they probably would lack the authority to delegate any decision-making pow-
er to an agent.

Second, some of these states expressly allow only adults to execute living wills, a limitation that logically would extend to health care proxies. Although in these states living will statutes include an age limitation and proxy statutes do not, it is unlikely that the age limitation only applies to living wills. Rather, the documents under both statutes probably were intended to be executed by competent adults: both involve important health care decisions traditionally reserved for adults. Further, this interpretation is consistent with the presumption that minors are incompetent to make treatment decisions, absent an express directive to the contrary.

A minority of states allow a minor who has achieved a certain status to designate a health care proxy. For example, a minor who is or has been married, who is the parent of a child, who has graduated from high school, or who is emancipated may make this selection. Yet, the status ex-

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152. See GA. CODE ANN. §§31-36-2(a); MISS. CODE ANN. §§41-41-165(1); S.D. CODIFIED LAWS ANN. § 59-7-2.5; TENN. CODE ANN. §§34-6-204(b); WYO. STAT. ANN. § 3-5-201(a)(ii) (Michie Supp. 1995); see also MO. ANN. STAT. §§404.710(1), 404.810 (limiting durable power of attorney for health care decisions).

153. See GA. CODE ANN. §§31-32-1(d), -2(3), -3(a); see also ALASKA STAT. § 18.12.010 (Michie 1995); TENN. CODE ANN. §§32-11-103(1), -104(a) (Supp. 1995).

154. See supra notes 36-41 and accompanying text.


158. See OR. REV. STAT. §§127.505(1), .510(1); see also TEX. CIV. PRAC. & REM. CODE ANN. § 135.001(1) (West 1995) (permitting an emancipated
ception is a narrow one and is not based on the minor’s competence.  

Although the parental consent requirement generally exists in the common law and statutory law, a few courts have deferred to the minor in making life-sustaining treatment decisions. These cases provide the basis for developing a common law mature minor doctrine to protect the minor’s right to refuse life-sustaining treatment.

2. Narrow Exceptions to the General Rule

Although minors, even if mature, generally cannot decide on life-sustaining treatment, a few recent cases have recognized that minors deserve at least some deference in making these decisions. However, a more coherent and comprehensive approach is needed to recognize the right to decide while also considering the minor’s maturity and the countervailing interests of the state.

In In re Chad Eric Swan, the court deferred to a seventeen year old’s life-sustaining treatment preference after a serious auto accident that left the minor in a PVS. Before the accident, the minor had two conversations expressing his intent to refuse life-sustaining treatment. In one conversation with his mother, sixteen-year-old Chad told her the following about a highly publicized case: “[I]f I can’t be myself... no way... let me go to sleep.” The second conversation occurred eight days before the accident. After visiting his brother’s friend, who was lying comatose in the hospital after an accident, Chad told his brother: “I don’t ever want to get

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minor to execute a durable power of attorney); UNIF. HEALTH CARE DECISIONS ACT § 2(b), 9 U.L.A. 224-25 (Supp. 1996). For example, [a] minor who is a resident of [Texas] and is at least seventeen years of age, or is at least sixteen years of age, living separate and apart from his parents, managing conservator, or guardian and is self-supporting and managing his own financial affairs, may petition to have his disabilities of minority removed for limited purposes or for general purposes.

TEX. FAM. CODE ANN. § 31.01 (1986).

159. See supra notes 68, 98-105 and accompanying text.

160. 569 A.2d 1202 (Me. 1990) (per curiam).

161. Id. at 1205.
like that... I would want somebody to let me leave - to go in peace.\textsuperscript{162}

The decision facing the doctors and the court was whether to reinsert a gastrostomy tube that had provided Chad with nutrition and hydration.\textsuperscript{163} His parents, the doctor, the guardian ad litem, the Division of Human Services, and the trial court\textsuperscript{164} all agreed that the tube should not be reinserted.

The trial court deferred to Chad's wishes, even though his maturity could not be evaluated while he was in the persistent vegetative state.\textsuperscript{165} The trial court referred to him as a "normally mature" seventeen year old.\textsuperscript{166} Applying the law applicable to competent adults,\textsuperscript{167} the trial court concluded that Chad had expressed, through clear and convincing evidence, his desire not to be artificially maintained.\textsuperscript{168} The Maine Supreme Court affirmed, concluding that "[b]oth of Chad's expressions were made in the context of serious discussions with family members about people Chad knew, whose plight he understood."\textsuperscript{169}

Notwithstanding the difficulty of determining whether Chad was mature, or whether his statements were made seriously, the Maine Supreme Court concluded that the trial court properly abided by Chad's wishes. The court adopted a standard that protected the minor's right to self-determination. The court made clear that it was relying on Chad's wishes and not on any "substituted judgment." Under the substituted judgment standard, the court is required to predict what the patient would have wanted if competent.\textsuperscript{170} The court noted

\begin{footnotesize}
\begin{enumerate}
\item[162.] \textit{Id.}
\item[163.] \textit{See id.} at 1203-04.
\item[164.] \textit{See id.} at 1204.
\item[165.] \textit{See id.} at 1206.
\item[166.] \textit{See id.} at 1203. The trial court did not appear to individually assess Chad's maturity. \textit{See id.}
\item[167.] The court applied the principle that when an individual has clearly and convincingly expressed his decision not to receive life-sustaining procedures in a persistent vegetative state, the court must effectuate that personal decision. \textit{See id.} at 1206 (citing \textit{In re} Gardner, 534 A.2d 947, 956 (Me. 1987)).
\item[168.] \textit{See id.}
\item[169.] \textit{See id.} at 1205.
\item[170.] Courts have developed two standards to guide surrogate decision
\end{enumerate}
\end{footnotesize}
making: substituted judgment and best interests. See Kevin P. Quinn, Comment, The Best Interest of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking, 76 CAL. L. REV. 897, 911 (1988). Courts apply these standards when rendering decisions regarding an incompetent patient's refusal of life-sustaining medical treatment. See id. Under the substituted judgment standard, the guardian "attempt[s] to reach the decision that the incapacitated person would make if he or she were able to choose." Id. at 911; see generally Jeffrey J. Delaney, Note, Specific Intent, Substituted Judgment and Best Interests: A Nationwide Analysis of an Individual's Right to Die, 11 PACE L. REV. 565 (1991) (suggesting a substituted judgment standard requiring the surrogate decision maker to "don the mental mantle of the incompetent" and to "act upon the same motives and considerations as would have moved [the patient]"). The surrogate attempts to execute the incompetent person's actual interest and preferences by following explicit instructions made by the patient while competent or, absent these instructions, applying the patient's known preferences and values. See Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 432 (Mass. 1977); Quinn, supra, at 911.

In cases where the patient has never been competent or has never indicated his or her preference while competent, most courts will use the best interests test. See Rasmussen v. Fleming, 741 P.2d 674, 688-89 (Ariz. 1987); In re Jobes, 529 A.2d 434, 457-60 (N.J. 1987); Conroy, 486 A.2d at 1232; cf. Rosebush v. Oakland County Prosecutor, 491 N.W.2d 633, 639 (Mich. Ct. App. 1992) (using substituted judgment for mature minors). "This situation arises when the incompetent patient is an infant, an adult who has been incompetent since birth, or an adult who never expressed his wishes while competent." Rebecca L. Rosnack, Comment, Termination of Life-Sustaining Treatment: The Decision-Making Process After Cruzan v. Missouri Department of Health, 43 BAYLOR L. REV. 841, 859 (1991).

Under the best interests test, the surrogate must objectively decide whether refusing life-sustaining medical treatment is in the incompetent patient's best interests. See In re Drabick, 245 Cal. Rptr. 840, 843 (Ct. App. 1988); Barber v. Superior Ct., 195 Cal. Rptr. 484, 493 (Ct. App. 1983); In re Colyer, 660 P.2d 738, 746 (Wash. 1983). For the treatment to be withdrawn, the burdens of continued life must outweigh the benefits. See Barber, 195 Cal. Rptr. at 493. When performing this balancing test, the surrogate considers factors such as the patient's age, level of consciousness, condition, restrictions on physical freedom, the invasiveness of the treatment, the relief from suffering if treatment is discontinued, the length and quality of life should treatment continue, the impact on the patient's loved ones, and the pain (if any) experienced by the patient. See id. at 493; Rasmussen, 741 P.2d at 689; Jobes, 529 A.2d at 456; Conroy, 486 A.2d at 1232, 1249-50; see also Stewart G. Pollack, Life and Death Decisions: Who Makes Them and By What Standards?, 41
that the role of Chad's parents, as guardians, was merely to effectuate their son's wishes.

Most significantly, the Maine Supreme Court followed the legal standard applicable to adults. The court concluded that age would merely be a factor to determine how seriously Chad had considered his decision. If the trial court concluded that the minor had entered into this decision with sufficient seriousness, his wishes would be respected.

The Illinois Supreme Court also deferred to a mature minor's refusal of treatment, but with qualifications. In In re E.G., the court recognized a mature minor's common law right to refuse life-sustaining treatment, as long as the parents' wishes concurred. E.G. was a seventeen-year-old Jehovah's Witness who refused blood transfusions that doctors determined were necessary to treat her leukemia. E.G. refused the blood transfusions because she believed, according to her religion, that receiving blood transfusions would prevent her eternal salvation. E.G.'s mother did not disagree with her daughter's decision. The state filed a neglect petition so that the trial court would order the transfusions. Before rendering its decision, the trial court conducted hearings regarding E.G.'s competence to make this decision. E.G. demonstrated, by clear and convincing evidence, that she was both mature and sincere. Notwithstanding this finding, the trial court concluded that E.G. was a neglected child and appointed a guardian to consent to the transfusions. The Illinois Court of Appeals reversed, basing its decision on E.G.'s constitutional right to refuse treatment because of her religious beliefs.


171. See Conroy, 486 A.2d at 1205 (citing State v. Hussey, 521 A.2d 278, 280 (Me. 1987)). The Hussey court had concluded that all persons fourteen years or older are competent to testify as a witness. The court further indicated that the witness's age is only one factor to consider when determining the minor's competency to testify. See id.


173. See id. at 323.

174. See id.

175. See id.

176. See id. at 324.

177. See id.

178. See id. Although the trial court considered E.G.'s maturity, the
The Illinois Supreme Court agreed that E.G. had a right to refuse life-sustaining treatment, but based its decision on the common law right to refuse medical treatment rather than a constitutional right. After evaluating the relevant statutory, common law, and constitutional law authorities, the court recognized a mature minor doctrine for life-sustaining treatment decisions. The court failed to see a reason why the right to refuse life-sustaining treatment should not be extended to minors, as long as the minor’s ability to appreciate the consequences of the decision was shown by clear and convincing evidence. Because E.G. understood the consequences of her decision, she had the power to exercise her right. The court did require, however, that the trial court weigh this right against the state’s interests: recognizing the sanctity of life, protecting the interests of third parties, preventing suicide, and maintaining the ethical integrity of the medical profession. After balancing these interests, the court concluded that E.G. could not be ordered to undergo treatment.

religion of her and her parents, and her desire to refuse blood transfusions, it concluded that the transfusions were in her best interests. See id. Moreover, it found that the state’s interest was greater than E.G.’s and her mother’s interests in refusing treatment. See id. The court of appeals based its reversal primarily on E.G.’s First Amendment right to refuse blood transfusions. See id. Most notably, the court of appeals concluded that this right extended to mature minors, based on the mature minor doctrine created by the U.S. Supreme Court in the abortion context. See id. (citing Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416 (1983) and Bellotti v. Baird, 443 U.S. 622 (1979)). Although the court of appeals recognized that the Supreme Court had not expanded this mature minor doctrine beyond abortion cases, the Court found this expansion inevitable. See id.

179. See id. at 326-27.
180. See id. at 325-27.
181. See id. at 327-28. But see O.G. v. Baum, 790 S.W.2d 839, 842 (Tex. Ct. App. 1990). In Baum, the trial court prevented a sixteen-year-old Jehovah’s Witness from refusing blood transfusions. The court of appeals determined that the minor’s right to refuse life-sustaining treatment was not violated because the jurisdiction had not adopted a mature minor doctrine and because the minor would only be given necessary blood transfusions. See id. at 842. The court also noted that the minor’s competence was not demonstrated in the trial court. See id.
182. See id. at 328.
183. See id.
Although the court recognized the right of a mature minor to make this fundamental decision, the court significantly deferred to the parental interests. The court suggested that if parent and child disagree on the course of treatment, the trial court should defer to the parent’s wishes. Specifically, the court stated that if E.G.’s mother had disagreed with E.G., the result in the case would have been different, even though E.G. was deemed mature and was only a few months shy of her eighteenth birthday.

Another court recently addressed whether a minor may refuse life-sustaining treatment, but adopted a more conservative approach than the courts in E.G. and Swan. In In re Long Island Jewish Medical Center, the court declined to recognize a mature minor doctrine in a case involving a terminally ill adolescent. The minor, Phillip Malcolm, and his parents refused to consent to transfusions necessary for chemotherapy treatments. Phillip and his parents were Jehovah’s Witnesses, who opposed the transfusions based on their religious beliefs. The court held a hearing in which evidence of the child’s maturity was presented. Phillip, who was almost eighteen, testified about his understanding of his religion. He also testified that he never had been away from home, never dated, and considered himself a child.

The court concluded that Phillip was not sufficiently mature to refuse the necessary transfusions. More significantly, however, the court declined to adopt a mature minor doctrine for life-sustaining treatment decisions. The court approvingly cited cases from other jurisdictions that had adopted a mature minor doctrine, and noted that New York permits minors to consent to certain types of treatment. Nevertheless, the

184. See id.
185. See id.
188. See id. at 243. In the court’s view, Phillip’s refusal to consent to blood transfusions was not based upon a mature understanding of his religious beliefs or the decision’s fatal consequences. See id.
189. See id. (citing In re E.G., 549 N.E.2d at 327-28; Cardwell v. Bechtol, 724 S.W.2d 739, 744-45 (Tenn. 1987)).
190. Among the statutes that grant such permission are: N.Y. MENTAL
court left adoption of the mature minor doctrine to the appellate courts or the legislature.\textsuperscript{191}

Two Ohio courts considered the preferences of minors and concluded that they should be considered factors in the court’s analysis. In the most recent case, \textit{In re Guardianship of Myers},\textsuperscript{192} Carla Myers entered a persistent vegetative state following a car accident. Like Chad Swan, on two separate occasions Carla declared that she did not want to be kept on life support systems.\textsuperscript{193}

The issue before the court was whether a nasogastric tube that was providing her with nutrition and hydration should be removed.\textsuperscript{194} Her parents,\textsuperscript{195} the guardian ad litem appointed by the court, and the court itself all agreed that the tube should be removed.\textsuperscript{196}

\begin{footnotesize}
\textsuperscript{191} HYG. LAW § 9.13 (McKinney 1994) (permitting minors over sixteen to voluntarily consent to inpatient mental health treatment), § 21.11 (enabling minors to voluntarily seek inpatient or outpatient treatment for alcohol or substance abuse without parental involvement if a physician believes that such treatment is necessary), § 33.21 (permitting minors to consent to voluntary mental health services if the minor fulfills certain criteria); N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 1993) (waiving parental consent for persons under twenty-one for treatment of sexually transmitted diseases), § 2504(1)-(3) (authorizing pregnant minors and minor parents to give consent for various services for their children’s health care as well as their own), §§ 2780-2787 (allowing a minor to be tested for HIV infection without the parent’s consent provided that the minor has the capacity to consent and has supplied a written, informed consent); § 3123 (enabling minors seventeen or over to donate blood without obtaining parental consent).

\textsuperscript{192} 610 N.E.2d 663 (Ohio Ct. C.P. 1993).

\textsuperscript{193} See \textit{id.} at 665. Carla’s father and stepmother testified that on two separate occasions prior to the accident, Carla had stated that “she wouldn’t want to go through life like that.” \textit{Id.} Carla made these statements after watching a movie about removing life support systems and after visiting a relative in the hospital who was on life support due to severe brain injury. \textit{See id.}

\textsuperscript{194} \textit{See id.} at 666.

\textsuperscript{195} Initially, Carla’s father wanted the artificial nutrition and hydration to be removed, but her mother wanted the artificial support to continue. \textit{See id.} at 664. Eventually, Carla’s parents and her stepmother agreed that Carla should be removed from the life-sustaining systems. \textit{See id.} at 670-71.

\textsuperscript{196} \textit{See id.} at 671.
\end{footnotesize}
After a lengthy analysis, the court applied the best interests standard and determined that removing the tube was in Carla's best interests. The court adopted the best interests standard instead of the substituted judgment test in part because applying substituted judgment is difficult when the minor has always been incompetent or when the minor's desires are unreasonable or unknown. The court considered Carla's prior statements to be a factor in the best interests inquiry, but did not give them overriding consideration. The court simply stated that "her age and apparent maturity permit this court to give some weight to her prior statements on removal," which evidenced "a displeasure and negative feeling towards their use." The court failed to provide a basis for finding Carla "apparently" mature.

Furthermore, in In re Guardianship of Crum, the court considered the wishes of a minor in a PVS. Dawn Crum was twelve years old when she contracted viral encephalitis, a disease that caused her to enter a PVS. The probate court granted her parents' application to remove Dawn's nutrition and hydration tubes.

Following state law and the United States Supreme Court's decision in Cruzan v. Director, Missouri Department of Health, the court determined that Dawn, even as an in-

197. See id. at 669-70; see also Ann MacLean Massie, Withdrawal of Treatment for Minors in a Persistent Vegetative State, 35 ARIZ. L. REV. 173, 185-86 (1993) (stating that the substituted judgment test should not be used for minor children); 2 MEISEL, supra note 2, § 15.9, at 293-97 (stating that the best interests test is the appropriate standard).

198. See Myers, 610 N.E.2d at 670 (emphasis added).

199. See id. One commentator has concluded that the Myers decision evidenced careful and clear consideration. See Jennifer L. Evans, Are Children Competent to Make Decisions About Their Deaths?, 13 BEHAV. SCI. & L. 27, 38-39 (1995). I must disagree. The court failed to articulate which test should be applied and relied on post hoc evidence of maturity. The decision does not even reveal her age.


201. See id. at 877.

202. See id. at 883.

203. 497 U.S. 261 (1990). Nancy Cruzan sustained severe brain damage in an automobile accident and was in a PVS. After it became apparent that Ms. Cruzan was not improving, her parents asked the hospital to terminate the artificial nutrition and hydration. The hospital employees,
competent person, possessed a right to refuse nutrition and hydration. The court further concluded that none of the state’s purported interests outweighed Dawn’s constitutional right.

The court considered Dawn’s prior statements about lifesustaining treatment, which indicated that “Dawn would not want to be sustained in the manner in which she currently lives.” Although the court considered her preferences, it failed to articulate clearly whether it was following the substituted judgment or best interests test.

The court first applied the substituted judgment test and concluded that Dawn would have wanted the nutrition and hydration withdrawn. In the next paragraph, however, the court applied the qualitatively different best interests test. The court considered a number of factors to determine whether removing the tube was in Dawn’s best interests, including her physical state, her physical deterioration, her lack of cognitive functions, and her physician’s testimony regarding the effect of

however, refused to terminate without a court order.

The United States Supreme Court, in a 5-4 decision, determined that Missouri’s continuation of the life-sustaining treatment did not violate Ms. Cruzan’s fundamental rights. See id. at 285. Although the Court upheld the state’s restrictions on Ms. Cruzan’s ability to refuse life-sustaining treatment, it acknowledged that competent persons “have a constitutionally protected liberty interest in refusing unwanted medical treatment.” Id. at 278. The Court also recognized that this interest could be effectuated on behalf of an incompetent individual through a surrogate. See id. at 279-80.


205. See Crum, 580 N.E.2d at 880.

206. Id. at 882. While living with a foster child with spina bifida, Dawn told some family and friends “that it was unfair for [the foster child] to have to live that type of existence and she would not want to do so.” Id.

207. For a description of these tests, see supra note 170 and accompanying text.

208. See Crum, 580 N.E.2d at 882. The court most likely erroneously applied the substituted judgment test here. The court assumed that a twelve-year-old child like Dawn was not mature. If she was not mature, then she had no judgment for the court to substitute.

209. See id. at 883.
terminating hydration.\textsuperscript{210}

Thus, courts have presented various ways to consider a child's treatment preferences; some courts consider the child's preferences determinative while others do not consider them at all. Although each court addressed the refusal of life-sustaining treatment, in some sense the cases were "easy" because the parents agreed with the child's decision in each case. A comprehensive framework is necessary to deal with even the most difficult cases—where the minor refuses treatment but the minor's parents want treatment to continue. The framework developed in the following section of this Article is designed to address the entire continuum of cases, although the discussion will focus on cases involving minor refusal and parental consent.

This framework, adopted from the approach of the Supreme Court of Illinois in \textit{E.G.}, considers the minor's competence to make life-sustaining treatment decisions, and accommodates the competing state interests. Under this approach, the court first must ascertain the minor's maturity. Then, if the court deems the minor mature, the strength of the countervailing interests should be considered. Unless these interests outweigh the minor's right, the court should defer to the minor's preference.\textsuperscript{211}

III. COMMON LAW RECOGNITION OF THE RIGHT TO DECIDE

"I know the consequences. I know the problems."

Benito (fifteen years old)

A. Defining the Standard

To adequately protect the minor's right to self-determination in the context of life-sustaining treatment, a common law mature minor doctrine should be adopted. This doctrine would permit a judge to uphold the consent or refusal of treatment by a mature minor, even if the minor's parents or health care providers disagree. A judge may apply this doctrine in the adjudi-

\textsuperscript{210} See id.

\textsuperscript{211} See \textit{In re E.G.}, 549 N.E.2d 322, 326-28 (Ill. 1989).
catory phase of an abuse or neglect proceeding based on the denial of medical treatment, or in a declaratory judgment action brought to assess the legality of withdrawing the minor's medical treatment.

The judge's initial and most important determination will be whether the minor demonstrated his maturity by clear and convincing evidence. If the judge determines that the minor is immature, then the minor's parents should make the decision for the minor based on the applicable standard for incompetent persons. If the minor is deemed mature, the minor's decision should prevail, unless outweighed by the state's compelling interest in preserving the sanctity of children's lives. The state's interest should be considered sufficiently compelling only when the treatment is nonexperimental and when a significant probability exists that the condition or disease will be cured or that the major symptoms of the condition will be alleviated in the foreseeable future. If this probability of success standard is not satisfied, the judge, the health care providers, and the parents must defer to the mature minor's treatment preferences. Moreover, even if the treatment has a significant probability of success, a mature minor should be permitted to refuse treatment if one parent agrees with the minor's decision and if the minor's decision is rational.

Such a common law approach would permit flexibility. The judge would consider the child's maturity on a case-by-case basis. Using this method, the over- and underinclusiveness of strict age limitations would be avoided. In addition, the probability of success determination is based on existing medical facts and thus would be well-suited to judicial interpretation. Furthermore, neither of these determinations would be novel for a judge. Judges not only determine the competence of minors and adults in other contexts, but also balance the

212. See, e.g., supra notes 8-13 and accompanying text (focusing on the Benito Agrelo case); E.G., 549 N.E.2d at 323.
213. See, e.g., In re Swan, 569 A.2d 1202, 1203-04 (Me. 1990).
214. This standard is developed in Part III.C.
215. See Batterman, supra note 2, at 659-68.
216. See infra notes 223-26, 268-72 and accompanying text (noting other areas where judges must determine the competence of minors); ROZOVSKY, supra note 36, §§ 1.5-1.6, at 17-24 (addressing the competence
risks and benefits of treatment in child neglect cases.\textsuperscript{217}

B. The Threshold Determination: Competence

Initially, the court must determine whether the minor is competent to make life-sustaining treatment decisions. Only a competent individual should be permitted to exercise the right to self-determination; however, not only adults are competent. The first part of this section defines the requisite competence for life-sustaining treatment decisions, and the second part develops an operational definition of competence to guide the judge’s maturity determination.

1. Defining the Requisite Competence

This section reviews psychological literature that has addressed the level of competence necessary to make life-sustaining treatment decisions. The relevant psychological literature demonstrates that certain minors are competent to make life-sustaining treatment decisions, but no generalizations yet can be made as to a particular age when it develops. Thus, a case-by-case determination of a minor’s competence is necessary.

Although the law presumes that minors are not competent to make decisions for themselves,\textsuperscript{218} recognized exceptions to this general rule exist. For example, courts have found minors competent to make decisions regarding medical treatment,\textsuperscript{219} political expression,\textsuperscript{220} abortion,\textsuperscript{221} and \textit{Miranda} rights.\textsuperscript{222}

\textsuperscript{217} See Newmark v. Williams, 588 A.2d 1108, 1114-20 (Del. 1991) (holding that a child was not neglected when parents refused treatment with only a forty percent chance of success); \textit{In re McCauley}, 565 N.E.2d 411, 413-14 (Mass. 1991) (authorizing the blood transfusion of a eight-year-old child after her parents refused the procedure on religious grounds); \textit{In re Phillip B.}, 156 Cal. Rptr. 48, 51-52 (Ct. App. 1979) (concluding that the postoperative risks of surgery on a Down’s syndrome child were too great to compel surgery).

\textsuperscript{218} See supra note 57-211 and accompanying text.

\textsuperscript{219} See, e.g., Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 835-88 (W. Va. 1992). \textit{See generally KEETON ET AL., supra} note 65, at 115 (noting that a minor must have the ability to weigh risks and benefits, an ability that may depend on whether operation involves a risk of serious injury or death).

\textsuperscript{220} Cf. Tinker v. Des Moines Indep. Community Sch. Dist., 393 U.S.
The courts' definition of competence depends on the context. 223

The most analogous context to life-sustaining treatment in which psychological studies of competence have been conducted is medical decision making by minors. To make a competent medical decision, the patient must possess the ability to exercise informed consent. In other words, the treatment decision must be informed, voluntary, and competent, 224 and the patient must appreciate the nature, extent, and probable consequences of the treatment. Researchers have translated these prerequisites into a set of standards that include the following: whether the patient reaches a reasonable outcome; whether the patient understands the information on which the treatment decision is based; whether the patient engages in a ratio-

503, 512 (1969) (concluding, without conducting a mature minor analysis, that older minors are capable of exercising their First Amendment rights).

221. See infra notes 269-71 and accompanying text.


223. See GARY B. MELTON ET AL., CHILDREN'S COMPETENCE TO CONSENT 50, 151, 174, 242 (1983); see also Lois A. Weithorn, Children's Capacities in Legal Contexts, in CHILDREN, MENTAL HEALTH, AND THE LAW 25-55 (N. Dickon Reppucci et al. eds., 1984); David G. Sherer, The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions, 15 LAW & HUM. BEHAV. 431, 432-33 (1991) (noting that courts have emphasized the social context in which consent occurs to determine the capacity of minors to make medical treatment decisions).

224. See David G. Scherer & N. Dickon Reppucci, Adolescents' Capacities to Provide Voluntary Informed Consent, 12 LAW & HUM. BEHAV. 123, 124 (1988) (stating that informed consent must be informed, competent, and voluntary); John M. Shields & Alf Johnson, Collision Between Law and Ethics: Consent for Treatment with Adolescents, 20 BULL. AM. ACAD. PSYCHIATRY L. 309, 312 (1992) (defining the components of informed consent); see also ABA INST. OF JUDICIAL ADMIN., STANDARDS RELATING TO RIGHTS OF MINORS § 4.6(A), at 67-68 ("A mature minor of sixteen or older who has sufficient capacity to understand the nature and consequences of a proposed medical treatment for his or her benefit may consent to treatment on the same terms and conditions as an adult.").
nal decision-making process; and whether the patient reaches a decision voluntarily.225

Using these criteria, a number of researchers have concluded that minors are competent to make treatment decisions. Specifically, adolescents older than fourteen or fifteen may be sufficiently competent to make their own medical treatment decisions.226

Notwithstanding these conclusions, most scholars have not recommended that courts adopt a bright-line rule permitting minors over a certain age to make treatment decisions for themselves. Some scholars are reluctant because the studies have been limited to hypothetical situations227 and have sampled only white, middle-class research subjects.228

For others, notably Professor Elizabeth Scott, broad recognition of a mature minor doctrine is not warranted because these studies have not explored how adolescent decision making


226. See Ambuel & Rappaport, supra note 225, at 139-45, 147-48 (noting that minors younger than fifteen who considered abortion as an alternative to pregnancy were no less competent than older adolescents); Grisso & Vierling, supra note 225, at 423-24 (concluding that there is little evidence that consent given by a fifteen year old is less competent than consent given by adults); Lois A. Weithorn & Susan B. Campbell, The Competency of Children and Adolescents to Make Informed Treatment Decisions, 53 CHILD DEV. 1591, 1595-96 (1982); see also Redding, supra note 225, at 726-27 (explaining that fifteen year olds are capable of weighing numerous factors to reach a decision); Shields & Johnson, supra note 224, at 321 (agreeing with an Alabama statute that allows any minor fourteen or older to consent to medical treatment).

227. See Gary B. Melton, Children’s Participation in Treatment Planning: Psychological and Legal Issues, 12 PROF. PSYCHOL. 246, 249 (1981); MELTON ET AL., supra note 223, at 169-70, 173; Scott, supra note 225, at 1634 & n.5; Weithorn & Campbell, supra note 226, at 1595.

228. See Weithorn & Campbell, supra note 226, at 1596; see also MELTON ET AL., supra note 223, at 15-16.
differs from adult decision making.\textsuperscript{229} The existing studies are based on an informed consent decision-making model, which requires the patient to appreciate the information disclosed to the patient and to engage in a rational decisionmaking process. This model focuses on the process of decision making rather than on its outcome. Therefore, according to Professor Scott, this model fails to consider the primary differences in judgment between adults and adolescents. Unlike adults, adolescents are more susceptible to peer influence, are more concerned with their personal appearance, are more impulsive, are less risk-averse, and tend to emphasize short-term rather than long-term consequences.\textsuperscript{230} Professor Scott has opined that studies failing to consider these differences in judgment are insufficient to justify giving minors greater autonomy.\textsuperscript{231}

The reticence to adopt a bright-line rule is even more justifiable when determining whether minors are mature enough to make life-sustaining treatment decisions. Although both decisions require the minor to weigh the risks and benefits of treatment, more competence is required for life-sustaining treatment decisions. First, the minor must have a mature understanding of death. Second, the minor must have a heightened understanding of the risks and benefits of treatment. Specifically, the minor must comprehend the severe consequences of refusing treatment and the complexity of the treatment protocol.

a. Acquisition of The Death Concept

The current psychological literature\textsuperscript{232} supports the conclu-

\begin{footnotesize}
229. See Scott, supra note 225, at 1657-60.
230. See id. at 1643-47.
231. See id. at 1635-36. This reservation may be even more justified in the life-sustaining treatment context because the differences between the decision-making ability of an adult and a minor may be more pronounced. See infra pp. 78-82.
232. As of 1992, there were more than fifty studies examining the child’s understanding of death. See Mark W. Speece & Sandor B. Brent, The Acquisition of a Mature Understanding of Three Components of the Concept of Death, 16 DEATH STUD. 211, 211 (1992). This Article’s review of the literature will focus on broad trends revealed by these studies and
\end{footnotesize}
sion that a minor acquires a mature understanding of death before the age of majority. There is considerable disagreement, however, about when the concept of death develops and how noncognitive factors affect its development. Researchers have agreed that the core components of the death concept include irreversibility, nonfunctionality, universality, and causality. Also, many researchers agree that the child progresses through a series of sequential stages in developing a mature concept of death.

Based on a seminal study of the child's understanding of death conducted by Maria Nagy in the late 1940s, a num-

not on the methodology of particular studies.

233. Irreversibility is defined as the concept that a dead body cannot be made alive again. See Eva Essa & Colleen I. Murray, Young Children's Understanding and Experience with Death, YOUNG CHILDREN, May 1994, at 74, 75-76.

234. Nonfunctionality is defined as the concept that after death all life-defining functions cease. See id.

235. Universality is defined as the concept that all living things die. See Speece & Brent, supra note 232, at 211-12; Maria H. Nagy, The Child's View of Death, in THE MEANING OF DEATH 79, 79-98 (Herman Feifel ed., 1959) (implicitly recognizing the core components of the death concept).

236. Causality is defined as the concept that death can be caused by external or internal factors. See Essa & Murray, supra note 233, at 75-76; Alice Lazar & Judith Torney-Purta, The Development of the Subconcepts of Death in Young Children: A Short-Term Longitudinal Study, 62 CHILD DEV. 1321, 1322 (1991). Other researchers have identified different subcomponents of death. See Barbara Kane, Children's Concepts of Death, 134 J. GENETIC PSYCHOL. 141, 144 (1979) (studying ten subcomponents of the death concept); Israel Orbach et al., Sequential Patterns of Five Subcomponents of Human and Animal Death in Children, 26 AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 578, 578-79 (1987) (considering old age as an additional component).


238. See Nagy, supra note 235, at 79. Although Nagy's findings gener-
ber of researchers have recognized three stages of maturation. In the first stage, the child perceives death as a temporary and reversible state; the child thinks that death can be avoided and that the dead can become conscious again. In the second stage, the child's view of death becomes more realistic: the child is able to discuss specific ways that death results. The child has an awareness of death's finality and the various causes of death. The child still sees death as only remotely possible, and not universal. According to Nagy, children in this stage personify death as something akin to a "death-man" or "bogey-man."

In the final stage, the child reflects a mature understanding of death, knowing that death is final and universal, and that bodily functions cease when a person dies. The child also understands the physical deterioration that characterizes death, can name potential causes of death, and recognizes death as a natural process.

Researchers generally agree that the death concept develops progressively and that most adolescents have a mature under-

ally have been supported, they have not been universally accepted. See, e.g., Virginia A. Atwood, Children's Concepts of Death: A Descriptive Study, 14 CHILD STUDY J. 11, 13 (1984) (summarizing criticisms of Nagy's study).

239. See Kane, supra note 236, at 149-50; see also Hostler, supra note 237, at 1-24 (dividing discussion into early childhood, middle childhood, and adolescence); LONETTO, supra note 237, at 31 (dividing study into ages 3-5, 6-8, and 9-12); Hannelore Wass et al., Use of Play for Assessing Children's Death Concepts: A Reexamination, 53 PSYCHOL. REP. 799 (1983) (reaffirming notion that knowledge of death develops in essentially three sequential stages).

Some researchers have found sequential development, but have identified the stages differently from this Article. See LONETTO, supra note 237, at 35-43.


241. See Nagy, supra note 235, at 88-96; see also LONETTO, supra note 237, at 105, 120-21 (studying children's drawings). Other researchers have failed to find personification. See Atwood, supra note 238, at 26-27; Kane, supra note 236, at 151; Koocher, supra note 237, at 373-75; Wass et al., supra note 239, at 151.

242. See Hostler, supra note 237, at 18-23; see also LONETTO, supra note 237, at 129-57; Wass et al., supra note 239, at 150.
standing of death. They have not agreed, however, as to when children acquire the death concept. Some propose that it may be acquired at age seven or before, while others believe the concept does not develop until age ten or later. Thus, the critical period of acquisition appears to be somewhere between the ages of eight and eleven. Certain components of the death concept, such as universality, may


244. See Lonetto, supra note 237, at 42-43. Some researchers have found a partial development of the death concept before age seven. See Mark W. Speece & Sandor B. Brent, Children's Understanding of Death: A Review of Three Components of a Death Concept, 55 CHILD DEV. 1671, 1682-84 (1984) (stating that at least some understanding of the major components of the child's concept of death are achieved by age seven). In contrast, Speece and Brent's later research found that the concepts of death developed at age ten. See supra note 232; see also Israel Ohrbach et al., Children's Perception of Death in Humans and Animals as a Function of Age, Anxiety, and Cognitive Ability, 26 J. CHILD PSYCHOL. PSYCHIATRY & ALLIED PRINCIPLES 453, 454, 460 (1985) (citing cognitive development studies and concluding that children as young as four can comprehend the meaning of death); Caroline Clunies-Ross & Richard Lansdown, Concepts of Death, Illness, and Isolation Found in Children with Leukemia, 14 CHILD CARE, HEALTH & DEV. 373, 375-76 (1988). Full development of the concept at this early age, however, may be inhibited by the child's anxiety surrounding death. See id. at 459, 462; cf. infra note 258 and accompanying text (stating that anxiety surrounding death may affect the acquisition of the death concept).


246. See Kim Townley & Kathy R. Thornburg, Maturation of the Concept of Death in Elementary School Children, 5 EDUC. RES. Q. 17, 22-23 (1980) (finding that the death concept is acquired by age eleven).

247. See Orbach et al., supra note 244, at 454. Researchers differ as to the percentage of children of a certain age that must acquire the concepts to be considered the age of acquisition. See Speece & Brent, supra note 244, at 1677 (determining that fifty percent of children of a certain age group must understand a given component to determine the age of acquisition). This may be one explanation for the differences in results among the studies.
mature earlier than others.248

Disagreement also exists as to whether the acquisition of the death concept is simply part of the minor's general cognitive development or whether it is a more contextual process involving the interaction of a number of factors, thus requiring a more individualized determination. To support the first theory, researchers have determined that the death concept's stages of development correlate with Jean Piaget's stages of cognitive development:249 preoperational,250 concrete operations,251 and formal operations.252 The characteristics of the formal

248. See Atwood, supra note 238, at 27; Lazar & Torney-Purta, supra note 236, at 1322-23, 1330-32; Speece & Brent, supra note 232, at 219, 220-27; see also Essa & Murray, supra note 233, at 75-76.

249. See Kane, supra note 236, at 150-51; Koocher, supra note 237, at 371-75; Hannelore Wass, Concepts of Death: A Developmental Perspective, in CHILDHOOD AND DEATH 11-23 (Hannelore Wass & Charles A. Corr eds., 1984); see also Evans, supra note 199, at 30. General critiques of Piaget's theories are outside the scope of this Article. See Wallace J. Mlyniec, A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose, 64 FORDHAM L. REV. 1873, 1880 (1996) (listing various critiques of Piaget's theories); see also MELTON ET AL., supra note 223, at 174.

250. A preoperational child is characterized by animistic thinking, artificialism, magical thinking, and egocentrism. See Hostler, supra note 237, at 5-6; Wass, supra note 249, at 5-8; see also NEIL A. STILLINGS ET AL., COGNITIVE SCIENCE 108-09 (1987) (stating that preoperational children have difficulty distinguishing between appearance and underlying reality); Mlyniec, supra note 249, at 1879.

251. A child in the concrete operations stage shows increased objectivity and logic and can symbolize and weigh limited consequences. The child also can recognize the reciprocity of height and weight, enabling the child to appreciate those who are different. The child is not yet able to think abstractly, however, and needs the elements of a problem to be physically present to make a decision. See Hostler, supra note 237, at 12-13; Wass et al., supra note 239, at 8-11; see also STILLINGS ET AL., supra note 250, at 109-10 (noting that concrete operational children grasp the idea that appearances can be misleading).

252. In the formal operations stage, where the child's cognitive thinking is considered mature, the child can think abstractly and can weigh a number of alternatives. See Hostler, supra note 237, at 19; Hannelore Wass & Judith M. Stillon, Death in the Lives of Children and Adolescents, in DYING: FACING THE FACTS 201, 203 (Hannelore Wass et al. eds., 2d ed. 1988); see also Mlyniec, supra note 249, at 1879; Robert J. Sternberg, Human Intelligence: The Model is the Message, 23 SCIENCE 1111 (1985).
operations stage, which include the ability to think abstractly and to weigh a number of alternatives at one time, are necessary prerequisites to making life-sustaining treatment decisions.\textsuperscript{253} This final stage is usually reached by age twelve,\textsuperscript{254} suggesting that the death concept would be acquired by that age.

To support the second theory, some researchers have concluded that reaching a particular cognitive level may be insufficient by itself to acquire a mature understanding of death. Acquisition of the death concept may depend on a number of different factors, including cognitive ability, age,\textsuperscript{255} religious beliefs,\textsuperscript{256} and anxiety about death.\textsuperscript{257} A particularly salient factor is the child's prior experience with death, which may accelerate the child's understanding of the concept.\textsuperscript{258}

\begin{enumerate}
\item[253.] See Sanford Leiken, *The Role of Adolescents in Decisions Concerning Their Cancer Therapy*, 71 CANCER 3343 (1988); Wass, *supra* note 249, at 17 (noting that in the formal operations stage, children see death as irreversible, natural, and universal, and view death as an abstract idea); see also Darryl E. Matter & Roxana M. Matter, *Developmental Sequences in Children's Understanding of Death with Implications for Counselors*, 11 ELEMENTARY SCH. GUIDANCE & COUNSELING 112, 113-17 (1982) (identifying a formal operations child as one who can perceive death abstractly); cf. LONETTO, *supra* note 237, at 153-57 (noting the ability of twelve-year-olds to view death abstractly).
\item[255.] See Atwood, *supra* note 238, at 14-15, 25-26; Orbach et al., *supra* note 244, at 456-62.
\item[256.] See Wayne Gartley & Marion Bernasconi, *The Concept of Death in Children*, 110 J. GENETIC PSYCHOL. 71, 71 (1967). But see Townley & Thornburg, *supra* note 246, at 19-23 (stating that religion did not seem to have any effect on development of the death concept).
\item[257.] See Orbach et al., *supra* note 244, at 454, 456-62. Researchers have considered the effect of other factors, including gender, socioeconomic status, media, culture, and death education. See Wass & Stillon, *supra* note 252, at 205-06; Essa & Murray, *supra* note 233; at 76-77; David J. Schonfeld & Murray Kappelman, *The Impact of School-Based Education and the Young Child's Understanding of Death*, 11 DEV. & BEHAV. PEDIATRICS 247, 249-51 (1990).
\item[258.] At least one researcher has eschewed a developmental model for a
child's experience with the deaths of others or with her own terminal or chronic illness may accelerate the understanding of at least some components of the death concept. On the other hand, experience with death may have negative effects or no effect at all.

Thus, the existing psychological studies fail to support the theory that minors of a certain age possess the maturity to make life-sustaining treatment decisions. At most, the studies suggest that many older adolescents possess a mature understanding of the death concept. Without a consensus of when the acquisition of the death concept takes place, adopting a particular age of maturity would be premature. As such, an individualized evaluation of this understanding is necessary.

more experiential model. See Bluebond-Langner, supra note 240, at 47. Dr. Bluebond-Langner proposes that the acquisition of a mature concept of death depends on a number of factors, including the child's experience with his illness, temporal concerns, life circumstances, and self-concept. See id. at 52-53. Maturity is characterized by the increased ability to integrate and synthesize information about death through experience with his illness. See id. at 53-54. For a more expanded version of this thesis, see Myra Bluebond-Langner, The Private Worlds of Dying Children 170 (1978); cf. Susan M. Jay et al., Differences in Death Concepts Between Children with Cancer and Physically Healthy Children, 16 J. CLINICAL PSYCHOL. 301, 301-02 (1987) (reviewing studies suggesting that children with life-threatening illnesses possess an advanced understanding of the death concept).


260. See Jay et al., supra note 258, at 304-05 (recognizing that cancer patients had no advanced death concepts, but that some young patients did who had experienced the loss of a loved one); see also Townley & Thornburg, supra note 246, at 23 (stating that children who experienced the death of a close relative did not have a better understanding of death).

261. A number of commentators have emphasized the individualized nature of this determination. See Hostler, supra note 237, at 11; Wass, supra note 249, at 17; Sigman & O'Connor, supra note 254, at 522-23; see also David W. Adams & Eleanor J. Deveau, Helping Dying Adolescents: Needs and Responses, in ADOLESCENCE AND DEATH 79, 87 (Charles A. Corr & Joan N. McNeil eds., 1986) (stating that the ability of dying adolescents to cope with death is a result of development and age).
b. Other Indicia of Competence

An understanding of the death concept is necessary but not sufficient for a child to be considered competent to make a life-sustaining treatment decision. A greater understanding of the risks and benefits may be required compared to other treatment decisions. For example, the minor should be able to assess the probability of death and its consequences. A terminally ill adolescent should not overvalue the need to play with friends or the desire to avoid the "ugly" side effects of treatment. The adolescent should not ignore the long-term consequences of refusing treatment—death.

Furthermore, the minor should be able to understand the complexity of the treatment protocol offered. The complicated treatment protocols for some terminal or chronic illnesses like AIDS may require the child to possess a greater level

262. Notably, a minor may understand death but may not appreciate its significance. See Corr, supra note 243, at 38-39; see also discussion supra pp. 54-60 (discussing how an adolescent's judgment differs from an adult's).

263. See Adams & Deveau, supra note 261, at 82-83, 88 (stating that dying adolescents are very concerned with their physical appearance); Hostler, supra note 237, at 21 (noting that the dying adolescent may be more concerned with the physical side effects of the disease than with the disease itself).


265. Generally, people with HIV infection are treated with three types of drugs. The drugs used are those that fight the HIV virus such as AZT and protease inhibitors; those that prevent the complications of the HIV infection; and those that relieve unpleasant symptoms of opportunistic infections. See John G. Bartlett & Ann K. Finkbeiner, The Guide to Living with HIV Infection 222 (3d ed. 1996). The prevention and treatment of opportunistic infections requires a complicated trial and error approach to determine the best regimen for a particular patient. See John Gilmore, How to Manage Medications, in The HIV Drug Book 552 (Project Inform et al. eds., 1995).

This task has become even more complicated through the increased use of medications known as antiretrovirals. This class includes AZT (Retrovir, Zidovudine), ddC (Zalcitabine), ddI (Videx), d4t (Staduvine, Zerit), and 3TC (latvimudine). Recently, the FDA approved new types of drugs known as protease inhibitors, which are intended to be used in combination with other drugs such as AZT. See generally David W. Dunlap & Lawrence M. Fisher, Drug Companies Turn Aggressive in Pro-
of competence than the level required for other less major treatment decisions.

Because a minor's competence may depend on a number of factors, some of which are not applicable to other treatment decisions, it is difficult to generalize when minors become mature enough to make life-sustaining treatment decisions. Therefore, an individualized determination of maturity is essential to assess which minors have the requisite competence. Although most older adolescents probably are sufficiently mature, adoption of a bright-line age of maturity should be rejected. The problem with a such a test is that it may be as over and underinclusive as using the age of majority as a guide. The test may be overinclusive because it would include immature minors over the designated age, and may be underinclusive because it would exclude mature minors who were younger than the designated age.

2. Developing an Operational Definition of Competence

Because a certain level of maturity is required to make life-sustaining treatment decisions and maturity does not necessarily develop at a particular age, an operational definition of

noting New Drugs for AIDS, N.Y. TIMES, July 5, 1996 at A1; AIDS Clinical Trials Group, Treatment of Human Immunodeficiency Virus Infection with Saquinavir, Zidovudine, and Zalcitabine, 334 NEW ENG. J. MED. 1101 (1996). This regimen may require patients to take twenty or more medicines a day. See Landmark Studies Change Outlook of AIDS Treatment, N.Y. TIMES, July 13, 1996, at 14. When protease inhibitors are used, underdosing, noncompliance or partial-compliance with dosing requirements may cause resistant strains of HIV to develop. See Food & Drug Admin., The Protease Inhibitors Backgrounder (Center for Disease Control and Prevention Website, September, 1996). Thus, the price of noncompliance is high.

Not all antiretroviral drugs may be used to treat children, see Kathleen Gault Kellings, Providing Primary Care to the HIV-at-Risk and Infected Child, 19 NURSE PRACT. 48, 51 (1994) (noting that not all antiretroviral drugs have been licensed by the FDA for treating children), and thus far no protease inhibitors may be used to treat children, except on an experimental basis. See Carol Ann Campbell, For AIDS Baby, Hope Lives On, THE RECORD, Oct. 13, 1996, at A12. It is probably only a matter of time, however, until more drugs will be approved to combat AIDS in children.

266. See supra note 261.
competence must be developed for judges to assess maturity.

The mature minor doctrine for informed consent provides an appropriate starting point for defining maturity. Determining the ability to exercise informed consent may require an examination of the minor's age, ability, experience, education, training, degree of general maturity and the conduct and demeanor of the minor at the time of the procedure or treatment.\(^ {267} \)

Simply weighing these factors, however, may not be sufficiently rigorous for life-sustaining treatment decisions because a greater level of competence is required.\(^ {268} \)

Another mature minor doctrine that may provide even better guidance is the doctrine developed by state courts to determine if minors are mature enough to exercise the right to have an abortion. This mature minor determination is particularly appropriate because abortion, like life-sustaining treatment, involves a medical procedure of great importance and requires the consideration of a number of competing values.\(^ {269} \)

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\(^ {267} \) See Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 838 (W. Va. 1992); see also Mlyniec, supra note 249, at 1907; cf. Report of the Working Group on Determining the Child's Capacity to Make Decisions, 64 FORDHAM L. REV. 1339, 1343-45 (1996) [hereinafter Working Group Report] (recommending consideration of a number of factors to determine if the child is able to make decisions regarding representation, including the child's ability to express his position and his reasons for it, the child's decision-making process to ensure preference not coerced, and the child's ability to understand consequences of decision).

\(^ {268} \) See supra notes 264-68 and accompanying text; see also Working Group Report, supra note 267, at 1345 (indicating that the decision requires greater scrutiny as consequences of the decision become more severe).

Similar factors are considered by doctors making life-sustaining treatment decisions. See King & Cross, supra note 61, at 12-13 (considering the minor's prior decisions, the minor's ability to consider future consequences, and the minor's past experiences).

\(^ {269} \) See discussion supra pp. 14-16.

Some commentators suggested that a maturity determination is not appropriate in the abortion context, and that it is preferable to rely on more objective factors such as age, existence of a condition, or that the decision should be left to the parent or the state. See Martha L. Minow, The Role of Families in Medical Decisions, 1991 UTAH L. REV. 1, 18-20; Sharon Elizabeth Rush, The Warren and Burger Courts on State, Parent, and Child Conflict Resolution: A Comparative Analysis and Proposed Methodology, 36 HASTINGS L.J. 461, 506-07 (1985); cf. Satsie Vieth, Note,
ing to one court, the maturity sufficient to be permitted to undergo an abortion is "the intellectual capacity, experience, and knowledge necessary to substantially understand the situation at hand and the consequences of the choices that can be made."270 This understanding has been reflected in a number of factors that should be considered by the trial court, such as age, grades, school activities, and employment. More specifically, the trial court considers the care with which the minor considered the risks of the abortion procedure, its potential emotional and physical consequences, and alternatives to abortion. Furthermore, the court determines whether the minor consulted other knowledgeable persons when making the decision, whether any evidence of coercion exists and, if the minor failed to notify her parents, the reasons why the minor did not.271

Similar factors may be used for life-sustaining treatment decisions. Generally, the trial judge should determine whether the minor understands the illness and treatment alternatives, which include the possibility of death. The judge also should assess whether the minor has the capacity for rational decision making and whether the minor has the ability to make and communicate a choice.272 Specifically, the judge should receive evidence on a number of factors, including:


Some commentators have criticized the courts for failing to set forth a clearer definition of a mature minor to reduce the probability of unguided and subjective determinations. See Katherine M. Waters, Note, Judicial Consent to Abort: Assessing a Minor's Maturity, 54 GEO. WASH. L. REV. 90, 98-102 (1985).

-the child's age;
-the child's performance in school, if child is attending;
-the child's understanding of the concept of death;
-the child's scope of experience with death or serious illness, particularly his own;
-the child's understanding and consideration of the risks and benefits of treatment;
-the child's reasons for refusing treatment;
-the child's understanding of the decision and how it impacts the child's family and others;
-how the child reached the decision;
-other major medical and nonmedical decisions that the child has made in the past; and
-the clarity and strength of the child's intent.

The judge then should balance all of these factors to determine

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273. A finding of maturity is more likely if the minor is over the age of sixteen.
274. If the child is not attending school, the judge should ascertain the reasons why and ascertain their relevance to the minor's maturity.
275. See discussion supra pp. 54-60.
276. Consideration of the risks and benefits of treatment includes consideration of alternatives to treatment.
277. The reasons for refusal of treatment may include hurting parents, reducing pain, religious reasons, peer pressure and short-term benefits, such as having hair or being able to engage in certain activities.
278. When exploring the child's method of reaching a decision, the extent of the child's medical and nonmedical knowledge should be taken into consideration. Cf. Sigman & O'Connor, supra note 254, at 271 (considering whether patient asks appropriate health care questions and whether patient communicates effectively).
279. A similar inquiry should be made when the minor's decision is based on religious beliefs. The court should assess the sincerity of the minor's beliefs and ensure, to the extent possible, that the beliefs are her own. See In re E.G., 549 N.E.2d 332, 328 (Ill. 1990) (noting that the trial court considered the "maturity and sincerity" of the minor's religious beliefs); cf. Bonjour v. Bonjour, 592 P.2d 1233, 1240 n.14 (Alaska 1979) (finding it constitutionally permissible to consider the religious needs of a child in a custody proceeding and describing "religious needs" as the expressed preference of a child mature enough to make a choice between a form of religion); Zummo v. Zummo, 574 A.2d 1130, 1149 (Pa. Super. Ct. 1990) (stating that when religion is an issue in custody cases, the court may, using particular ages as a guide, consider "whether a child has sufficient capacity to assert for itself a personal religious identity.").
if the child is mature enough to make the decision. No one factor should be determinative.\footnote{280} Prior to and during this hearing, the judge should acquire relevant information from the child's family, from the child,\footnote{281} and from a guardian ad litem (if appointed).\footnote{282} Since a judge may not be well-trained in making the maturity determination, assistance from experts should be provided.\footnote{283} The delineation of specific factors, the use of experts, and meaningful appellate review can help ensure that the trial judges do not abuse their discretion.\footnote{284}

To ensure that only those minors who are sufficiently mature are permitted to exercise their right of self-determination, the minor should be required to demonstrate maturity by clear and convincing evidence.\footnote{285} This heightened burden of proof is appropriate, first, because the minor is best able to gather

\footnote{280. The judge, orally or in writing, should clearly set forth the factors considered and how they were weighed in the particular case.}

\footnote{281. This aspect of the process should ameliorate the problem of the judge's failure to understand and know about the child. \textit{See} Waters, \textit{supra} note 271, at 98-99.}

\footnote{282. A child should have an appointed attorney in every case involving a minor's right to refuse treatment. In these cases, the lawyer's role should be to represent the child, not to ascertain what is in the child's best interests. \textit{Cf.} \textit{Proposed Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases}, 29 FAM. L.Q. 375, 376 (1995). If the lawyer is asked to act against the child's best interests, a guardian ad litem should be appointed. \textit{Cf. id. at} 377. Because the number of these cases addressing the minor's right to refuse life-sustaining treatment will not be excessive, it will not impose an onerous financial burden on the state to appoint an attorney in these cases.}

\footnote{283. At least one commentator has suggested that experts actually make the maturity decision, not the court. \textit{See id. at} 113; Howard Feldman, \textit{Note, H.L.V. Matheson: Where Does the Court Stand on Abortion and Parental Notification}, 31 AM. U.L. REV. 431, 466-68 (1982). This solution would be adequate only where the parties agree. If a dispute exists, even over a medico-legal issue, the court should resolve it.}

\footnote{284. \textit{See generally} Gilliam v. Foster, 61 F.3d 1070, 1078 n.5 (4th Cir. 1995) (stating that the appellate court shall determine whether the trial court abused its discretion).}

\footnote{285. \textit{See In re E.G.}, 549 N.E.2d 322, 327-28 (Ill. 1989). In general, the burden of proof is designed to inform the fact finder of the degree of confidence necessary to draw the proper conclusion. \textit{See} Santosky v. Kramer, 455 U.S. 745, 755 (1982). Because a high degree of confidence is necessary in this context, it is important for the standard to be higher than a mere preponderance.
evidence regarding her own maturity. Second, imposing this standard of proof would reduce the probability of an erroneous decision, one which has grave consequences. Third, this rigorous standard would help protect countervailing state or parental interests.\footnote{286}{In sum, the proposed standard represents a vast improvement to the existing parental consent rule because it does not presume the minor’s incapacity. Instead, it imposes a surmountable burden on the minor, while affording adequate protections against erroneous decision making.}

If the court determines that the minor is mature, then the court should proceed to the probability of success determination discussed in the next section. If, however, the court finds that the minor is not mature, then the parents or guardians should have the right to consent to or refuse treatment on behalf of the minor based on the jurisdiction’s standards for surrogate decision making.

\textit{C. Determining the Probability of Success to Accommodate the Competing Interests}

An adult, presumed to be competent, has a right to refuse life-sustaining treatment for himself or herself.\footnote{287}{This right is virtually absolute because the state’s countervailing interests—in preserving the sanctity of life, preventing suicide, protecting the rights of third parties, and upholding the ethics of the medical profession—ordinarily are not strong enough to limit that right. These same competing interests may be stronger when weighed against the right of mature minors.} This section analyzes these countervailing interests to determine whether a mature minor should be treated the same as

\footnote{286}{These interests are discussed in detail \textit{infra} Part III.C.}
\footnote{287}{\textit{See supra} notes 37-38 and accompanying text.}
\footnote{288}{549 N.E.2d at 327.}
\footnote{Additionally, the individual health care provider possesses independent interests in preserving the life of the patient and protecting the ethical integrity of the profession. \textit{See} Stamford Hosp. v. Vega, 674 A.2d 821, 831-32 (Conn. 1996). These interests will not be addressed separately, however, because they overlap with the interests of the state.}
\footnote{289}{\textit{See} 549 N.E.2d at 326-28 (holding that mature minors possess the right to consent to or refuse medical care, except when outweighed by countervailing interests).}
an adult in this context, or, if not, to what extent the right should be limited. After thoroughly evaluating each of the state's interests, this Article concludes that only the state's interest in protecting the sanctity of children's lives justifies limiting the mature minor's right. The state's interests in preventing suicide, in protecting the third-party rights of family members, and in upholding the ethics of the medical profession generally are not strong enough to encroach upon this right. Consequently, the mature minor's right to self-determination should be limited only where the life-sustaining treatment is nonexperimental and has a significant probability of either curing the minor or of restoring his health in the foreseeable future.

1. Preserving the Sanctity of Children's Lives

The state has an interest in preserving the sanctity of life, which may be negatively affected when a patient refuses treatment. In cases involving adults, this interest ordinarily does not outweigh the patient's right to self-determination; however, the state's interest is inherently stronger


291. See Norwood Hosp. v. Munoz, 564 N.E.2d 1017, 1022-23 (Mass. 1991) ("[I]n cases where a competent adult refuses medical treatment for herself, the state interest in preserving the patient's life will not override the individual's decision."); In re Fiori, 673 A.2d 905-910 (Pa. 1996) (holding that the state's interest in preserving life does not outweigh the PVS patient's right to self-determination); see also In re Colyer, 660 P.2d 738, 743 (Wash. 1983) ("[T]his interest weakens, however, in situations where continued treatment serves only to prolong a life inflicted with an incurable condition."). One noticeable exception to an adult's right to refuse treatment is when an adult patient is pregnant and the fetus's survival depends on preserving the mother's life. See Raleigh-Fitkin Paul Morgan Mem. Hosp. v. Anderson, 210 A.2d 537, 538 (N.J. 1964) (holding that the state's interest in the welfare of the fetus justified blood transfusions over the objection of the parents, who were Jehovah's Witnesses). Moreover, the adult patient will not be permitted to refuse treatment where
when children’s lives are at stake. In some cases, this interest may be strong enough to circumscribe even a mature minor’s right.

Two aspects of the state’s interest are implicated when a minor refuses treatment: protecting a child’s health and life, and protecting society’s symbolic investment in children. First, the state in its role as parens patriae has a well-established interest in protecting a child’s health and life. This interest fades as the child gains maturity, due to the child’s ability to exercise informed consent. When a minor demonstrates competence, it logically follows that the court should treat the minor as an adult. The state’s paternalism is no longer needed. This result, however, would inadequately protect the state’s interest because the mature minor could still make a harmful decision. For example, the minor may refuse treatment that probably would cure a life-threatening condition. The state has an obligation to protect minors from making such “bad” decisions.

Professor Elizabeth Scott’s scholarship on adolescent decision making lends support to this conclusion. As previously discussed, Professor Scott has opined that the informed consent decision-making model, which focuses on process rather than outcome, does not adequately consider the differences in judgment between adolescents and adults. For example, adolescents focus on short-term consequences and take greater risks than adults. These differences, which are not based on individual idiosyncracies but on the indiscretions of youth, may result in a greater probability of minors mak-


292. See In re E.G., 549 N.E.2d 322, 326-28 (Ill. 1989) (“The parens patriae power fades, however, as the minor gets older and disappears upon her reaching adulthood.”).


294. See supra notes 229-31 and accompanying text.


296. See id. at 1620.
ing harmful decisions. The need for the state to monitor these
decisions is heightened because the minor's decisions are likely
to be different from the decisions the minor would make as an
adult. Moreover, allowing the minor to refuse treatment
now does not allow for later consent—he will not live long
enough.

To prevent these harmful and irreversible decisions, even
minors considered mature under the informed consent deci-
sion-making model should not be treated exactly the same as
adults. A safety net should be created to accommodate the
state's interest in preventing children from dying unneces-
sarily.

Such a safety net also would further the state's interest in
protecting the unrealized potential of children in our society.
One aspect of this "hope" interest is that the state invests
resources and energy into children with the expectation that
they will live to become healthy and productive adults. 298

297. See id. at 1639; see also Robert Kastenbaum, Death in the World
of Adolescence, in ADOLESCENCE AND DEATH 27-28 (Charles A. Corr &

Anecdotal evidence of the indecisiveness of youth is easily found in
the popular press. For example, fifteen-year-old Tim Wolf had been diag-
nosed with leukemia and was told by his doctors that he needed three
years of chemotherapy. With the chemotherapy the doctors predicted a
seventy percent chance of recovery. After one year, Tim decided to stop
receiving the chemotherapy and try an alternative treatment. He was
adamant that he would never go back on chemotherapy and stated that
he understood all of the consequences. Nine months later he went back
to the hospital and started receiving chemotherapy. The chemotherapy
put his cancer into remission and again he stopped the treatment. In the
end, however, he had a full relapse and resorted to chemotherapy and
the more intrusive bone marrow transplant. He died two years after first
declaring that he would never take chemotherapy again. See Dateline
(NBC television broadcast, Jan. 20, 1995).

One of the most well-known examples of this indecisiveness outside
of the medical treatment context is Kimberly Mays, who had been
switched at birth with another baby. She had pleaded with a court to let
her "divorce" her natural parents and remain with Mr. Mays, the person
who had raised her. Six months later, she ran away from the Mays' 
home and moved in with her natural parents. See Twigg Seeks Divorce,
Palm Beach Post, Feb. 19, 1996, at 6A.

298. See, e.g., Prince v. Massachusetts, 321 U.S. 158, 168 (1944) "A
democratic society rests, for its continuance, upon the healthy, well-
When a child dies, the state’s expectation cannot be realized.

Another aspect of the state’s hope interest is more symbolic, but no less important. Children are society’s hope for the future. A child’s death is a more traumatic loss than an adult’s death because, when a child dies, collective hope dies with the child. This symbolic interest is seemingly unrelated to an individual child’s capacity to make life-sustaining treatment decisions.

Therefore, if the state permits a child to refuse treatment, it appears that society is giving up on the child and its hope for the future. Conversely, if the child is forced to receive treatment, the state’s hope interest is furthered because, ideally, the child will live to become a productive adult.

Although the state’s interest in protecting children’s lives is furthered by imposing treatment, this interest should not override a minor’s refusal in all circumstances. The strength of the state’s interest varies with the treatment’s probability of success. Therefore, the state’s interest is only strong enough to justify encroaching on the minor’s right when there is a substantial probability of either curing the child or allowing the child to live free of the major symptoms of the condition or disease. When this standard is met, the state’s interests

rounded growth of young people into full maturity as citizens, with all that implies.

299. See Hawkins, supra note 5, at 2085; see also TED MENTEN, WHERE IS HEAVEN: CHILDREN’S WISDOM ON FACING DEATH 54, 93 (1995) (“[C]hildren are messengers who bring us the truth we have lost sight of as we grow older. ... Children are filled with joy and laughter, and their final gift to us is the gift of life—their life. In facing death, they show us how to live. Children are everything that life has to offer.”). This interest was poignantly articulated by Joan E. Hemenway:

There is no greater affront to our human experience than the critical illness and impending death of a child. Perhaps it is the disarming innocence of a child that so arouses our feelings of helplessness and rage. Perhaps it is the cruelly foreshortened life of a child that so stirs our cries of injustice. Perhaps it is the tenderness of a child that so evokes our feeling of love and sympathy, hurt and honor as death approaches, overtakes, and eventually has its way.

J. Hemenway, Where is God?, in THE CHILD AND DEATH 229 (1978); see also Kastenbaum, supra note 297, at 79.

will be furthered. Otherwise, the mature minor should have the right to refuse or consent to treatment, just as an adult does.

2. Preventing Suicide

The state's second interest is in preventing suicide. In cases involving adults, courts have agreed that a patient seeking to discontinue life-sustaining treatment is not trying to commit suicide. These courts distinguish cases in which the patient engages in active euthanasia to hasten death from cases where the patient simply refuses life-sustaining treatment. When the patient refuses treatment without a desire to die, the state's interest in preventing suicide generally is not implicated.

Similarly, most minor patients refusing life-sustaining treatment do not want to actively end their lives. These patients are trying to let nature take its course for various reasons.

(finding that where minor is terminally ill and his condition is incurable, the decision to refuse treatment overrides any interest of the state in prolonging the child's life); In re L.W., 482 N.W.2d 60, 74 (Wis. 1992) (noting that the state interest weakens as the chance of recovery wanes); cf. Care & Protection of Beth, 587 N.E.2d 1377, 1383 (Mass. 1992) (citing Superintendent of Belchertown State Hosp. v. Saikewicz, 370 N.E.2d 417, 425-26 (Mass. 1977)); In re Colyer, 660 P.2d 738, 743 (Wash. 1983) (determining that the state interest depends on whether treatment offers a possible cure for a patient, rather than merely prolonging an incurable condition).


302. Courts that have evaluated the state's interest in preventing suicide distinguish refusal of treatment from euthanasia because patients who refuse treatment do not wish to die. See Saint Mary's Hosp. v. Ramsey, 465 So. 2d 666, 668 (Fla. 1985); Wons v. Public Health Trust, 500 So. 2d 679, 688 (Fla. Dist. Ct. App. 1987).

303. See In re E.G., 549 N.E.2d 322, 324 (Ill. 1990) (indicating that the minor's decision to refuse transfusions was based on religious convictions
For example, a child in a PVS may desire to live life without suffering a slow deterioration of health,\textsuperscript{304} and a child suffering from a terminal illness or AIDS may seek to live the remainder of his life with less pain and greater dignity.\textsuperscript{305} A child with a religious objection to treatment may seek to live life in accordance with her religious tenets.\textsuperscript{306} In each of these cases, the children do not want to die.

Consequently, the state's interest in preventing suicide is not implicated in these cases, just as it is not implicated when adults refuse treatment. The state's interest in preventing suicide should not outweigh the mature minor's right to self-determination, unless the facts reveal that the minor is actually trying to commit suicide.

3. Protecting the Interests of Third Parties

The state's third interest is protecting the interests of third parties who may be adversely affected by the patient's refusal of treatment. When minors refuse life-sustaining treatment, the third parties most likely affected are immediate family members. The analysis in this section will focus on the parents since they possess the strongest third-party interests. Parents risk losing their child and their ability to control the upbringing of their child. Similar interests have not been considered strong enough to limit an adult's right to refuse treatment, and they also should not be considered strong enough to limit the mature minor's right to refuse treatment.

Although courts have considered the impact of an adult patient's decision on close family members who were dependent on the patient financially or emotionally,\textsuperscript{307} courts have

\textsuperscript{304} See Swan, 569 A.2d at 1205 (Chad Swan).
\textsuperscript{305} See supra notes 8-12 and accompanying text (Benny Agrelo).
\textsuperscript{306} See supra notes 172-85 and accompanying text (E.G.).
not found this interest sufficiently compelling to override the patient’s decision. The only time courts have suggested that a family member’s interest would be strong enough to interfere with a patient’s right is when refusing life-sustaining treatment would result in the abandonment of the patient’s minor children. A number of courts have analyzed this abandonment issue, but no court in recent history has found such abandonment to exist.


308. Courts have reached this conclusion regardless of the complexity of the treatment or the probability of its success. See, e.g., Tune v. Walter Reed Army Med. Hosp., 602 F. Supp. 1452 (D.D.C. 1985) (holding that a seventy-one-year-old competent patient suffering from terminal adenocarcinoma of the pericardium had right to have life support systems removed); Thor v. Superior Court, 855 P.2d 375 (Cal. 1993) (holding that a quadriplegic prisoner could refuse a surgical feeding tube); Wons v. Public Health Trust, 500 So. 2d 679, 685-87 (Fla. Dist. Ct. App. 1987) (permitting a Jehovah’s Witness to refuse a life-saving blood transfusion), aff’d, 541 So. 2d 96 (Fla. 1989); State v. McAfee, 385 S.E.2d 651, 652 (Ga. 1989) (holding that a quadriplegic could terminate the use of a respirator); In re Farrell, 529 A.2d 404, 410 (N.J. 1987) (permitting a patient to refuse a blood transfusion); In re Lydia E. Hall Hosp., 455 N.Y.S.2d 706 (Sup. Ct. 1982) (affording a terminally ill renal disease patient the right to forego dialysis treatment).

309. See In re Osborne, 294 A.2d 372, 375 (D.C. 1972); Browning v. Herbert, 568 So. 2d 4, 14 (Fla. 1990); In re Farrell, 529 A.2d 404, 412 (N.J. 1987); In re Colyer, 660 P.2d 738, 743 (Wash. 1983); see generally 2 MEISEL, supra note 2 § 8.17, at 225 (discussing results of older cases).


At least one court has suggested that the impact of the patient’s decision on the minor child is not relevant to determining whether to permit the refusal of treatment. See Fosmire v. Nicoleau, 551 N.E.2d 77, 82-84 (N.Y. 1990). According to the court, an adult’s common law right to refuse medical treatment had never been conditioned on parental status, and the legislature did not require courts to consider parental status when it codified this common law right. See generally 2 MEISEL, supra note 2, § 8.17, at 519-24 (stating that recent cases discount third-party
Courts have evaluated factors such as the support of family members for the patient's decision, the closeness of the family, and the ability of remaining family members to care for the children. When evaluating these factors, courts have required compelling evidence of the children's abandonment, rejecting the principle that children have the right to be reared by two parents. As long as some means of economic and interests).

The approach of the Fosmire court is strikingly different from that of the court in In re President & Dirs. of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964). The Georgetown College court determined that a patient's request to refuse life-saving treatment should be denied where the patient was the parent of a minor child. See id. First, the court concluded that the patient's decision to refuse treatment constituted a complete abandonment of the patient's minor child. See id. at 1008. Next, the court focused on the patient's duty to the community to raise the child and held that the state, as parens patriae, could guard the state's interest in the youth's well-being by denying the patient's request. See id. Since the Georgetown College decision, however, most courts have rejected this approach in favor of an emotional and financial abandonment analysis. See, e.g., Dubreuil, 629 So. 2d at 825-28. The approach of the Georgetown College court most likely was influenced by the patient's purported incompetence when she refused treatment. See id. at 826-28.

311. See In re Osborne, 294 A.2d 372, 374 (D.C. 1972) (finding no abandonment where patient's wife and family had sufficient financial resources to meet children's material needs and extended family was prepared to help care for children); Dubreuil, 629 So. 2d at 822 (finding no abandonment where, although couple was separated, no evidence existed that natural father, along with others, would not care for children); Saint Mary's Hosp. v. Ramsey, 465 So. 2d 666, 668-69 (Fla. Dist. Ct. App. 1985) (finding no abandonment where minor daughter of a twenty-seven-year-old patient lived with the patient's ex-wife in another state, the patient seldom saw his daughter, the patient had a small annuity in his daughter's name, and the ex-wife and her family would support the child); Munoz, 564 N.E.2d at 1024-25 (finding no abandonment by mother where no evidence existed that the children's father was unwilling to care for them, where the father had financial resources, and where the father's sister and brother-in-law would assist in caring for the children).

312. See Munoz, 564 N.E.2d at 1024 ("In the absence of any compelling evidence that the child will be abandoned, the state's interest does not outweigh the right of a fully competent adult to refuse treatment."); cf. Dubreuil, 629 So. 2d at 827 (explaining that the state's interest would outweigh the mother-patient's decision only where there was clear and convincing evidence that the father would not properly assume responsibility for the child if the mother died).
emotional support exists for the minor children, abandonment does not exist and the parent can choose to die.

For example, in Public Health Trust v. Wons, Mrs. Wons refused treatment for severe uterine bleeding. A hearing before the trial court established that Mrs. Wons's family supported her decision and that, if she were to die, Mr. Wons was willing to care for their children with the help of his mother and brothers. Moreover, the trial court found that a grandmother would continue to watch the children while Mr. Wons was at work, that the children would be reared by a loving family, and that they would not become wards of the state. Based on this evidence, the Supreme Court of Florida chose not to interfere with Mrs. Wons's right to refuse life-sustaining treatment, even though the children would lose their mother.

Considering the traumatic loss that must be shown before interfering with the adult patient's right to self-determination, a parent's loss caused by the death of a mature child should not be considered the equivalent of abandonment. A parent certainly suffers a terrible loss when a child dies and the parent's grief over that loss may continue throughout her life. She may also feel guilty for being unable to prevent her child's death. But those experiences of loss and guilt, as significant as they may be, do not constitute abandonment. The abandonment doctrine, which is based on the parens patriae power,

313. See Public Health Trust v. Wons, 541 So. 2d 96, 97 (Fla. 1989); In re Dubreuil, 629 So. 2d at 825-26; Munoz, 564 N.E.2d at 1025; Fosmire, 551 N.E.2d at 83.

 Courts also appear reluctant to determine the quality of the emotional and economic support provided for the minor children. For instance, one court considered neither the quality of the father's relationship with the child nor his ability to care for the child. Nevertheless, the court found that the child would not be abandoned by the mother's decision to refuse treatment. See In re Dubreuil, 629 So. 2d at 827. The court reasoned that because Florida's domestic relations laws operated to make the father the child's sole legal guardian if the mother died, the father's obligation to provide basic support and care for his child was sufficient to permit the mother to refuse treatment. See id.


315. See Wons, 500 So. 2d at 681, 688.

316. See Public Health Trust, 541 So. 2d at 98.

317. See In re President &Dirs. of Georgetown College, Inc., 331 F.2d
requires the surviving family member to suffer a uniquely severe emotional or financial loss. A parent ordinarily is not emotionally or financially dependent on a child; therefore, the abandonment doctrine is not triggered when a child refuses life-sustaining treatment. If a child's loss of a parent is not sufficient to constitute abandonment, neither is the parent's loss of a child. Thus, the parent's loss and guilt over the child's death, in and of themselves, should not prevent a mature minor from refusing treatment.

Furthermore, the parent's right to control the upbringing of her child should not prevent a mature minor from refusing treatment. Parents possess a well-established right to make decisions for their children, primarily because children lack the requisite capacity and because parents presumably will act in their children's best interests. In the life-sustaining

1000, 1008 (D.C. Cir. 1964) (citing Prince v. Massachusetts, 321 U.S. 158, 166-67 (1944); see also Norwood Hosp. v. Munoz, 564 N.E.2d at 1024 ("The state as parens patriae has an interest in protecting the well-being of children.").

318. This right is based on the constitutional right to privacy. See Wisconsin v. Yoder, 406 U.S. 205, 234-35 (1972) (holding that the First and Fourteenth Amendments prevent the state from compelling parents to send their children to formal high school to age sixteen); Pierce v. Soc'y of Sisters, 268 U.S. 510, 534-35 (1925) (holding that the state cannot interfere with the due process right of parents to educate their children by requiring all children to attend public school); Meyer v. Nebraska, 262 U.S. 390, 399-400 (1923) (holding that the liberty interest guaranteed by the Fourteenth Amendment includes the right to bring up children, which encompasses the right of parents to instruct their children absent some overriding state purpose).


320. See Parham v. J.R., 442 U.S. 584, 604 (1979); see also Bellotti, 443 U.S. at 634, 637-39 (justifying limitations on a minor's rights to permit parents to guide the minor's decision making).

The Parham court determined that a state's voluntary institutionalization procedures for mentally-ill minors were facially constitutional. Specifically, the parents' interest in the upbringing of their children was strong because parents generally act in their children's best interests: "the natural bonds of affection lead parents to act in the best interests of their children." Id. at 602. The Court did recognize that the best interests presumption would not be justified if "experience and reality" demonstrated that the parents did not act in the children's best interests; for example, if parental abuse were likely. Id. In the context of voluntary
treatment context, however, neither of these justifications apply.

First, the proposed framework would only extend decision-making power to mature minors; therefore, the capacity justification does not apply. Second, parents possess inherent conflicts when they make life-sustaining treatment decisions on behalf of their children, which would cause them to consent to treatment even when it is not in the child’s best interests.

Institutionalization, no showing had been made that the parents or institutional actors had acted in bad faith. Id. at 597, 616.

The best interests presumption has been applied beyond this context. See Hawkins, supra note 138, at 1604 (finding that the presumption pervades the law governing medical consent). But see David Rothman & Sheila M. Rothman, The Conflict Over Children’s Rights, HASTINGS CTR. REP., June 1980, at 7, 8-9; cf. Shields & Johnson, supra note 224, at 314.

321. See discussion supra pp. 50-66.

322. See Hawkins, supra note 138, at 1608-09, 1611-12 (stating that the presumption that parents make decisions in the minor’s best interest is less likely when a conflict of interest exists between the parents and the child). This conflict of interest is especially likely in medical decisions involving organ transplants, abortion, and life-sustaining treatment. See generally John F. Kennedy Mem’l Hosp., Inc. v. Bludworth, 432 So. 2d 611, 618 (Fla. Dist. Ct. App. 1983) (discussing inherent conflicts of family members when making life-sustaining treatment decisions); Tarantino, supra note 42, at 643.

Although less likely, inherent conflicts motivated by emotional burdens may cause a parent to refuse treatment when the child consents. Cf. Cruzan v. Director, Missouri Dep’t of Health, 497 U.S. 261, 286 (1990) (“Close family members may have a strong feeling . . . that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading”); Leslie P. Francis, The Roles of the Family in Making Health Care Decisions for Incompetent Patients, 1992 UTAH L. REV. 861, 862 (stating that families often would rather the patient die than experience a daily renewal of grief as a disabled relative struggles for life); Tracy L. Merritt, Equality for the Elderly Incompetent: A Proposal for Dignified Death, 39 STAN. L. REV. 689, 725 (1987) (stating that watching a relative die can be emotionally draining, prompting family members to end life-sustaining measures in order to begin the grief process). The parent also may be conflicted by financial burdens that may tempt them to refuse treatment entirely, or at least eliminate expensive modalities of treatment. See Francis, supra, at 862 (explaining that the continuing need for care of incompetents may drain family finances, often creating a conflict of interest for the family members in the decision-making process); Tarantino,
The conflicts that arise when a child refuses treatment and the child's parents consent to treatment are primarily emotional. For example, parents may consent to treatment against the child's best interests because they fear losing their child, because they feel guilty, or because they fear their own deaths. These inherent conflicts interfere with the parents' ability to act in their child's best interests; therefore, courts should not presume that parents will do so.

The parents' right to make decisions on behalf of their minor children does not justify interfering with a mature minor's right to make life-sustaining treatment decisions. Mature minor patients are better able to act in their own best interests. Moreover, the right to self-determination empowers mature minors to make decisions for themselves even if against

supra note 42, at 643 (noting that without an advance directive, family members traditionally make decisions for incompetent patients, but that family members may experience a conflict of interest due to the emotional and financial burdens of life-sustaining treatment); John A. Powell & Adam S. Cohen, The Right to Die, 10 ISSUES L. & MED. 169, 173 (1994) (discussing that decisions by some family members to terminate life-sustaining treatment may be motivated by more selfish concerns, such as financial burdens).

323. Cf. Martha Minow, Beyond State Intervention in the Family: For Baby Jane Doe, 18 U. MICH. J.L. REFORM 933, 975 (1985) (discussing how parents' selfless love for their child may lead them to choose prolonged medical treatment despite the pain or futility of such measures).

324. See DYING: FACING THE FACTS 216 (Hannelore Wass et al. eds., 1988); cf. ARTHUR S. BERGER & JOYCE BERGER, TO DIE OR NOT TO DIE? 5-6 (1990) (stating that families often support life-sustaining treatment for a family member out of grief or guilt).


326. Moreover, the right to family integrity is not promoted by requiring parents to decide whether a minor should receive life-sustaining treatment because by the time the case reaches the courts, the family's integrity already has been threatened. Generally the right to family integrity is furthered by having parents make these decisions because it strengthens family cohesiveness and communication. Cf. Bellotti v. Baird, 443 U.S. 622 (1979). These goals, however, are not advanced by imposing the parent's will on the child because a conflict already exists between them. Forcing the child to receive treatment probably would only exacerbate the conflict.
their best interests.

For these reasons, the court in *E.G.* incorrectly concluded that *E.G.* would not have been permitted to refuse treatment if her mother disagreed with her decision.\(^{327}\) A parent’s interests are not strong enough to override the minor’s decision. It logically flows that the interests of other family members are not strong enough either.

4. Upholding the Ethical Integrity of the Medical Profession

The state has an interest in upholding the ethical integrity of the medical profession.\(^{328}\) Nevertheless, this interest has been superseded consistently by a competent adult patient’s right to refuse life-sustaining treatment.\(^{329}\) A mature minor’s right to refuse treatment should supersede the state’s interest as well.

When an adult refuses life-sustaining treatment, a health care provider’s primary commitment to heal and maintain life is implicated.\(^{330}\) This commitment, however, is not necessarily violated by an adult patient’s refusal of life-sustaining treatment.\(^{331}\) The health care provider is not required to make ev-

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\(^{327}\) *Accord 2 MEISEL, supra* note 2, § 15.3, at 279.


\(^{330}\) *See AM. MED. ASS’N COUNCIL ON ETHICAL & JUD. AFFMS.*, 2 CODE OF MEDICAL ETHICS REPORTS 51 (1991); AM. MED. ASS’N COUNCIL ON ETHICAL & JUD. AFFMS., CODE OF MEDICAL ETHICS (1996-1997); *see also AM. MED. ASS’N, THE BOARD OF TRUSTEES REPORT 59 (A-96) (1996).* This principle is derived from the Hippocratic Oath, which is reprinted in Dying: Facing the Facts 419 (Hannelore Wass et al. eds., 1988).

Furthermore, when a patient dies, providers sometimes feel that they have failed both publicly and professionally. *See Louise Harmon, Fragments on the Deathwatch*, 77 MINN. L. REV. 1, 118-19 & n.220 (1992); *see also BLUEBOND-LANGER, supra* note 258, at 217-20.

\(^{331}\) The physician’s duty to maintain life must be balanced against the
ery effort to sustain life in every circumstance.\textsuperscript{332} A provider also must respect the patient’s choice and dignity.\textsuperscript{333}

Hence, the ethical integrity of the medical profession is not violated when the provider advises the patient of the risks involved in refusing or withdrawing life-sustaining treatment and allows the patient to make the decision.\textsuperscript{334} This process

duty to relieve suffering. See AM. MED. ASS’N COUNCIL ON ETHICAL & JUD. AFFS., CODE OF MEDICAL ETHICS 39 (1996-1997) ("Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decisionmaking capacity."). Although granting the patient’s wish to discontinue life-sustaining treatment is considered an ethical procedure by the Council, physician-assisted suicide is not. See AM. MED. ASS’N COUNCIL ON ETHICAL & JUD. AFFS., 5 CODE OF MEDICAL ETHICS REPORTS 269 (1994). The American Medical Association recently has adopted a policy that “physician-assisted suicide is fundamentally inconsistent with the physician’s professional role.” AM. MED. ASS’N, THE BOARD OF TRUSTEES REPORT 59 (A-96), app. B (1996) (quoting AMA policy 140.952).


333. See HASTINGS CENTER GUIDELINES, supra note 2, at 20; Pollack, supra note 170, at 516-517 n.53.

334. See, e.g., Thor, 21 Cal. Rptr. 2d at 368; Delio, 516 N.Y.S.2d at 693; see also Conroy, 486 A.2d at 1225; Storar, 420 N.E.2d at 71; Colyer, 660 P.2d at 743-44 (citing Saikewicz, 370 N.E.2d at 417).

Physicians and other health care professionals, however, cannot be compelled to participate in the withholding or withdrawing of life-sustaining treatment. See In re Longeway, 549 N.E.2d 292, 299 (Ill. 1990);
is consistent with the doctrine of informed consent, in which the doctor's role is primarily to advise the patient of the risks and benefits of treatment.\textsuperscript{335}

Recent advancements in medical technology have further weakened the health care provider's obligation to make every effort to prolong life. Although new technologies may prolong life, they also prolong suffering. A balance must be struck between relieving suffering and maintaining life,\textsuperscript{336} therefore, termination of treatment should be permitted when its burdens exceed its benefits.\textsuperscript{337} Consistent with this approach, courts and major medical associations agree that the dying often may need comfort instead of treatment\textsuperscript{338} and that providing such comfort is not unethical.\textsuperscript{339}

\textit{Delio}, 516 N.Y.S.2d at 694; \textit{Brophy}, 497 N.E.2d at 638-39; \textit{Munoz}, 564 N.E.2d at 1023; \textit{see also Hastings Center Guidelines, supra} note 2, at 8.

335. \textit{See Conroy}, 486 A.2d at 1222; \textit{Jones v. United States}, 933 F. Supp. 894, 901 (N.D. Cal. 1996); \textit{Hawkins, supra} note 5, at 2093-94; \textit{see generally Morrissey et al., supra} note 5, at 12-17.


These ethical principles are no different when applied to a mature minor instead of an adult. If a minor has the capacity to make health care decisions, the ethical integrity of the medical profession will not be compromised by deferring to the minor’s life-sustaining treatment decision. If we are to take seriously the notion that the dying, regardless of age, often need comfort rather than treatment, then the ethics of the medical profession should not be violated when a mature minor chooses to refuse treatment.

The patient’s needs depend primarily on medical facts, not whether the patient is a child or an adult. Consequently, the state’s interest in upholding the ethical integrity of the medical profession should not outweigh the mature minor’s right to refuse life-sustaining treatment.

Based on the strength of the countervailing interests discussed above, the minor’s right to self-determination should only be outweighed when the state’s interest in the sanctity of children’s lives is sufficiently strong. The following section demonstrates how a court should strike this balance in a number of exemplary cases.340

D. Application of the Standard to Exemplary Cases

After a court determines that the minor refusing treatment is mature, a limited inquiry should be conducted to determine whether the state’s interests are strong enough to circumscribe the minor’s right to decide. In many cases, the mature minor’s decision should be respected. The state’s interest should, however, override the minor’s refusal when the treatment is a non-experimental life-sustaining treatment that has a significant probability of either curing the condition or disease or alleviating all of the major symptoms of the condition or disease in the foreseeable future.341 This inquiry requires the court to con-

340. Of course, the balance depends on the facts of the particular case.
341. See Joseph Goldstein, Medical Care for the Child at Risk: On State Supervention of Parental Autonomy, 86 YALE L.J. 645 (1977). In this article, Professor Goldstein presented a similar framework to protect
sider carefully the benefits of the treatment based on the best medical evidence then available.

First, the treatment must be nonexperimental to ensure that a medical consensus exists that the proposed treatment is efficacious and safe. 342 Neither the state nor the minor’s parents should be able to force a mature minor to receive unproven or unsafe medical treatment. 343

the decision-making rights of parents from state interference. See id. at 647. Specifically, Professor Goldstein concluded that the state could interfere with the parents’ life-sustaining treatment decisions for their child only if: (1) the agreed-upon medical procedure were nonexperimental; (2) the denial of the treatment would result in the child’s death; and (3) the treatment would provide the child with an opportunity for a life worth living or a relatively healthy growth toward adulthood. See id. at 652-53.

A number of these concepts are incorporated in the probability of success standard are set forth in this Section. Some of the more value-laden aspects of Professor Goldstein’s framework, such as a “life worth living” and “relatively healthy growth toward adulthood” have been avoided. Although the terms “curing” and “alleviating all of the major symptoms” are by no means valueless, they are less subjective than Professor Goldstein’s terms and are more likely to be medically verifiable.

Professor Goldstein and I disagree more fundamentally on how to treat the health care decisions of mature minors. I am comfortable with having the court make a maturity determination, whereas Professor Goldstein is not. See id. at 661-63. He would also allow emancipated minors to make important decisions for themselves, but emancipation should be determined by objective criteria such as age or condition. See id. at 663. This would lead to decisions that are both overinclusive and underinclusive.

342. A comprehensive definition of experimental treatment has not been described in this Article, since the precise definition may depend on the context in which it arises. Experimental treatment would include, for example, drugs not yet approved by the F.D.A., see 21 C.F.R. § 310 (1995), and research involving human subjects, see 45 C.F.R. § 46.101 to .124 (1995). See generally CHILDREN AS RESEARCH SUBJECTS: SCIENCE, ETHICS AND THE LAW 121-23 (Michael Grodin & Leonard Glantz eds. 1994); CHILDREN, ETHICS AND THE LAW (Gerald Koocher & Patricia Keith-Spiegel eds. 1993).

343. Note that diagnostic tests are not included within the term “treatment.” Therefore, In re Thomas B., 574 N.Y.S.2d 659 (Fam. Ct. 1991), was decided properly, but for different reasons than the court articulated. Thomas B., then fifteen years old, refused a biopsy for a tumor because he feared needles following his father’s death. See id. at 660. The court concluded that the biopsy should be ordered primarily because the child
Second, the treatment must be life-sustaining. Life-sustaining treatment decisions define an individual’s personhood; therefore, the minor’s right to self-determination is stronger with these treatment decisions than with nonlife-sustaining treatment decisions.

Third, the treatment must have a significant probability of curing the condition or disease or of alleviating all of its major symptoms in the foreseeable future. This requirement provides a safety net to ensure that the minor does not make a harmful, irreversible decision. If the treatment only prolongs the minor’s life or improves the minor’s health, a safety net is unnecessary. Thus, to override the minor’s decision, the treatment must be capable of saving the minor’s life or restoring the minor’s health to its state prior to the onset of the condition or disease. Finally, the minor’s recovery or the alleviation of symptoms must be expected to occur in the foreseeable future so that the likelihood of success is not remote.

If the parent agrees with the mature minor’s decision, a court should be even more deferential to the decision. Therefore, if the parent and minor agree that treatment should be refused, the decision should be upheld unless it is irrational. The reason is that parental consent makes it less likely that the decision will be a harmful one. If the parent agrees with the minor’s refusal, it probably means that the parent shares her values or at least respects her maturity. It also means that their combined interests become stronger than those of the state, except in the rare circumstance in which no rational reason is offered.

This standard is not proposed simply because minors faced with life-sustaining treatment decisions will eventually die and thus are not worth protecting. Rather, the proposed standard respects the mature minor’s wishes while accommodating the

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was presumed incapable and the state’s interests were paramount. See id. at 660-61.

Instead, the biopsy should have been ordered because the competing interests involved in the decision could not have been weighed effectively without knowing the diagnosis, as well as the proposed treatment, and the minor’s prognosis.

344. See discussion supra pp. 9-16.

345. See discussion supra pp. 9-16.
state's interest when it is sufficiently strong. Similar to the approach adopted in the child neglect context, the strength of the state's interest depends in part on the treatment's probability of success.346 These sick children are given significant autonomy by being allowed to make their own choices when it is important to them to do so, which is much more autonomy than the existing law offers them.347

Because of the indeterminacy of the maturity and probability of success inquiries, both inquiries should be determined on a case-by-case basis. Where possible, these inquiries should be addressed initially by the patient's health care provider348 or by the ethics committee of the hospital.349 Due to the psychomedico-legal nature of the decision to permit a minor to make life-sustaining treatment decisions, judges may not be best-suited to make this determination initially. Only when a conflict cannot be resolved between the minor and the provider/committee or between the minor and the minor's parents should the court resolve the dispute.350

The standard described above is workable and fair. Although

346. See Newmark v. Williams, 588 A.2d 1108, 1119 (Del. 1991) (holding that a state may not force a child to receive treatment when there is only a forty percent chance of survival); Custody of a Minor, 379 N.E.2d 1053, 1066 (Mass. 1978) (determining that a treatment's likely success justifies the state's imposition of treatment); see generally Hawkins, supra note 5, at 2086 (describing how to balance the risks and benefits of treatment).
347. See supra Part II.B.
348. See King & Cross, supra note 61, at 11-12.
349. See Madeleine Maccallum, Legal Aspects of Institutional Ethics Committees, 41 MED. TRIAL TECH. Q. 242 (1995); Symposium, Hospital Ethics Committees and the Law, 50 MD. L. REV. 742 (1991); Andrew L. Merritt, The Tort Liability of Hospital Ethics Committees, 60 S. CAL. L. REV. 1239 (1987); see also Massie, supra note 197, at 214-15.
350. See Lonowski, supra note 272, at 443-50; Rosenbush v. Oakland County Prosecutor, 491 N.W.2d 633, 638-39 (Mich. Ct. App. 1992) (discussing limited judicial involvement); Dale L. Moore, Challenging Parental Decisions to Overtreat Children, 5 HEALTH MATRIX 311, 322 n.41 (1995) (indicating that many conflicts in the treatment context are resolved without the coercive intervention of a court); Sigman & O'Connor, supra note 254, at 525 (stating that it is the court's role to resolve conflicts). But see Alan R. Fleischman et al., Caring for Gravely Ill Children, 94 PEDIATRICS 433-39 (1994) (stating that although courts may be necessary as a last resort, they are not ideal sites for resolving disputes).
marginal cases may be difficult to decide, most decisions should not be exceedingly difficult or time-consuming. Moreover, considering the importance of the decision at issue, the time invested in these cases is justified.

The remainder of this section applies the proposed standard to some representative cases.\footnote{351}

Case 1 Child in a Persistent Vegetative State: A SEVENTEEN YEAR OLD IS IN A CAR ACCIDENT AND IS LEFT IN A PERSISTENT VEGETATIVE STATE (PVS), SUSTAINED ONLY BY A RESPIRATOR AND INTRAVENOUS HYDRATION/NUTRITION. A YEAR BEFORE THE ACCIDENT, THE MINOR MADE STATEMENTS TO FAMILY MEMBERS INDICATING THAT HE NEVER WANTED TO BECOME A "VEGETABLE."\footnote{352}

Under the proposed standard, minors in a PVS would be unable to refuse treatment. A court could not accurately determine the maturity or treatment preferences of the minor, and thus the competence requirement could not be satisfied. Specifically, a court could not effectively determine, in hindsight, whether the child was mature when the treatment preferences were expressed or whether the minor is mature at the time of the court's decision. A court could only presume the child's maturity based on whether he was a "normal" adolescent close to the age of majority,\footnote{353} or would be limited to anecdotal and potentially undependable evidence of maturity. Moreover, without the ability to communicate directly with the minor, a judge would have difficulty determining the seriousness of the minor's prior expressions of intent. What exactly did the child mean when he said he never wanted to be a vegetable? Was the statement made seriously or casually? Considering that these decisions are difficult enough to make for adults in a PVS,\footnote{354} they are impossible to make for children.\footnote{355}

\footnote{351. The study of bioethics often relies on the use of exemplary cases. See John D. Arras, Principles and Particularity: The Role of Cases in Bioethics, 69 Ind. L.J. 983, 992, 1011 (1994); see generally Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics (4th ed. 1989) (providing a large sampling of case studies).}

\footnote{352. See In re Swan, 569 A.2d 1202, 1205 (Me. 1990).}

\footnote{353. See id. at 1206.}

\footnote{354. See Rebecca Dresser, Life, Death and Incompetent Patients: Con-}
Case 2 Child with Terminal Illness: A FOURTEEN YEAR OLD BECOMES TERMINALLY ILL\textsuperscript{356} WITH CANCER AND REFUSES FURTHER CHEMOTHERAPY BECAUSE IT IS PAINFUL AND LIMITS HIS NORMAL ACTIVITIES.\textsuperscript{357}

Under the proposed standard, the result in the paradigm case will depend primarily on the minor's competence and the treatment's probability of success.

A court should use the operational definition of maturity described above and determine if the child possesses the competence to refuse life-sustaining treatment. For example, in the case of fourteen-year-old Benny Agrelo, the trial judge determined that Benny was mature enough to refuse treatment after the judge consulted with three mental health experts and conducted an extensive interview with the child.\textsuperscript{358}

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355. One scholar has created a different framework that also prevents minors in a PVS from making their own decisions. See Massie, supra note 197, at 196, 199-203, 210 (arguing that a parent's decision should govern when made in good faith, on the theory that such a decision ordinarily encompasses any prior views expressed by the minor as well as the minor's best interests).

356. Terminal illness has been defined as an “incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death.” COLO. REV. STAT. ANN. § 15-18-103 (West 1989); see CONN. GEN. STAT. ANN. § 19a-570 (West Supp. 1996) (providing that an incurable or irreversible condition must be in its final stage); 20 PA. CONS. STAT. ANN. § 5403 (West Supp. 1996). Many statutes define terminal condition in such a way that death must be imminent or death would result in a relatively short time. See GA. CODE ANN. § 31-32-2 (Supp. 1995); ME. REV. STAT. ANN. tit. 18A, § 5-801 (West Supp. 1995); UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1(9), 9B U.L.A. 162 (Supp. 1996) (defining terminal condition as “an incurable and irreversible condition that, without the administration of life-sustaining treatment, will result in death within a relatively short time”).

No single definition of terminal illness predominates; therefore, no particular definition will be used in this Article. The facts of each case must be examined to determine incurability, irreversibility, and imminence.


358. See \textit{Judge Allows Teen to Decide Medication Issue}, THE COLUMBI-
Once the judge determines that the minor is mature, the judge may override the minor's refusal only if the treatment is nonexperimental, and would either cure the underlying condition or disease, or alleviate all major symptoms in the foreseeable future. The latter determination will be most problematic for the courts to apply and will depend on the available medical facts. For example, if the terminally ill child has an eighty percent chance of a full recovery, the court should order treatment despite the child’s refusal.\footnote{359}

In other situations, however, the answer is less clear because the probability of recovery or returning to full-functioning is lower. For example, the court in the Agrelo case correctly concurred in Benny’s refusal of antirejection medicines. Even with the medicine, Benny was likely to die or to require a third transplant. Even with a third transplant, his chance of survival was only fifty percent. Benny probably would have needed to continue taking antirejection medicines after the transplant.\footnote{360} Therefore, the treatment had neither a significant probability of saving his life nor of alleviating his major symptoms. The treatments probably would continue to impair Benny’s ability to perform daily activities. Guided by the general principles outlined above, the probability of success determination is made on a case-by-case basis.

The possibility of an unidentified cure sometime in the future fails to satisfy the probability of success requirement. For example, the state in the Agrelo case argued that perhaps a new drug would be released while Benny was still alive that would not cause severe side effects.\footnote{361} Such wishful thinking by the state does not constitute a sufficient probability of preventing Benny from refusing further treatment.\footnote{362} Benny has

\footnote{359} Therefore, a court probably could have ordered treatments over Billy Best’s refusals. According to the prevailing medical evidence, Billy had a ninety percent or better chance of being cured. See Saltus, supra note 15, at 13.

\footnote{360} See supra notes 9-16 and accompanying text.

\footnote{361} See supra note 354.

\footnote{362} The result might be different, however, if Benny were offered a transplant that provided him with a greater than sixty percent chance of restoring liver functions. A significant probability of alleviating all of the major symptoms of the condition or disease in the foreseeable future then
the right to make decisions regarding the quality of his remaining life.

_case 3 Child with Chronic Illness: A SIXTEEN YEAR OLD AFFLICTED WITH JUVENILE DIABETES REFUSES TO TAKE HER DAILY INSULIN INJECTIONS._

As in Case 2, the result in this paradigm case depends on the minor’s maturity and the treatment’s probability of success. The condition here differs from Case 2 because diabetes cannot be cured. If, however, insulin or other treatment modalities can alleviate all the major symptoms of diabetes, the court should order the treatment over the mature minor’s refusal.\(^ {363}\) In these circumstances, the court will need to carefully examine the medical evidence with the guidance of experts.

The reasons for the minor’s refusal are not relevant to the probability of success determination, but may be relevant to the maturity determination.

_case 4 Child with AIDS: A SEVENTEEN YEAR OLD EXHIBITING SYMPTOMS OF AIDS WANTS TO CONTROL ANY FUTURE TREATMENT._\(^ {364}\) The minor fears the side effects of could be satisfied, even if a full recovery were not possible.

363. Intervention cannot be ordered if the major symptoms of the disease or side effects will persist. Consider a child with kidney failure, who is ordered to undergo regular dialysis after a transplant fails. See John E. Schowalter, et al., *The Adolescent Patient’s Decision to Die*, 51 PEDIATRICS 97, 97 (1973). The child suffers severe side effects from the dialysis, including chills, nausea, vomiting, severe headaches, and weakness. See id. at 97. The child should be permitted to refuse the treatment, even if her parents disagree, because the dialysis will neither cure her disease nor restore her health.

364. No “right-to-die” decision involving a minor with AIDS has been published yet. Considering the number of children currently infected with HIV and suffering from AIDS, such a decision is likely soon.

By the end of 1995, 1350 cases of AIDS in children less than thirteen years old had been reported to the Center for Disease Control and Prevention. 7 CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE REP., No. 2, Dec., 1995. A greater number of children are estimated to have AIDS, however, than have been reported. See AIDS KNOWLEDGE BASE § 8.1-1 (Cohen et. al. ed. 1994). It is estimated that there are 15,000 to 20,000 HIV-infected infants and children in the
EXISTING TREATMENTS AND DOES NOT WISH TO RECEIVE ANY EXPERIMENTAL TREATMENTS.

If the minor is mature, he should be permitted to refuse treatment for AIDS. Because existing treatments for AIDS are experimental or do not have a significant probability of success, the state's interests will not be sufficiently strong to override the minor's refusal in this paradigm case.

The progression of HIV is unique and affects how the proposed standard is applied. For many years, a person with HIV may have no symptoms at all. The only reason the person even knows that he has the disease is because he tests HIV-positive. Eventually, however, the person probably will develop symptoms and opportunistic infections that will cause death within a decade. At present, AIDS is an incurable dis-

United States and an estimated 30,000 HIV-infected adolescents. The AIDS SOURCEBOOK 225, 226 (Karen Bellenir & Peter D. Dresser eds., 1995).

Furthermore, the number of HIV-infected children is bound to increase rapidly. Half of all new HIV infections occur among people under the age of twenty-five, and one-quarter of new infections occur among people between the ages of thirteen and twenty-one. See OFFICE OF NATIONAL AIDS POLICY, YOUTH AND AIDS: A REPORT TO THE PRESIDENT (1996); see also Marsha F. Goldsmith, "Invisible" Epidemic Now Becoming Visible as HIV/AIDS Pandemic Reaches Adolescents, 270 JAMA 16, 16 (1993) (stating that the number of AIDS-infected thirteen to twenty-one year olds in the United States rose by 77% in the last two years). Most young adults (those in the 20-24 age category) were infected as teenagers. See The AIDS SOURCEBOOK, supra, at 285.

Younger children usually were infected through perinatal transmission. See 7 HIV/AIDS SURVEILLANCE REPORT No. 2 (1995). Overall, half of the transmission of the virus among children occurs through heterosexual intercourse. See Goldsmith, supra, at 16.

365. See BARTLETT & FINKBEINER, supra note 265, at 10, 12; see also ATTORNEYS MEDICAL ADVISOR § 53:4 (Lee R. Russ et al. eds., 1994). The asymptomatic period, sometimes called the clinical latency period, may last for more than ten years. See infra note 366. The median range for this period is reported to be between eight years and nine and a half years, but is longer for hemophiliacs and shorter for children. See infra note 366.

366. With few exceptions, a person with AIDS is infected with a disease that progresses through a number of stages. See The AIDS SOURCEBOOK, supra note 364, at 187-90; see also The AIDS SOURCEBOOK, supra note 364, at 58-83; ATTORNEYS MEDICAL ADVISOR, supra note 365,
Several treatments, such as AZT, are currently available to HIV-positive individuals to decrease their symptoms and prevent opportunistic infections. If any of these treatments were offered to an HIV-positive minor, he should be per-

§ 53:4. “Transmission” occurs at the time the virus enters the body. See THE AIDS SOURCEBOOK, supra note 364, at 187. “Acute Infection” occurs one to six weeks after exposure, and is evidenced by an abrupt appearance of symptoms that resemble those of mononucleosis. Id. at 188. They are usually resolved within a few weeks. Id. “Seroconversion” is when antibodies may be detected in the body. See BARTLETT & FINKBEINER, supra note 265, at 61.

“Asymptomatic Infection” or “Clinical Latency” is the next stage. Although most people infected with HIV experience a period in which they show no symptoms of illness, the virus is never truly latent. See THE AIDS SOURCEBOOK, supra note 364, at 188. Thus, “asymptomatic” is a misleading term. See id.; see also ATTORNEYS MEDICAL ADVISOR, supra note 365, § 53:4. This stage may include several abnormalities, such as changes in the blood and immune components. See BARTLETT & FINKBEINER, supra note 265, at 62-67; see also ATTORNEYS MEDICAL ADVISOR, supra note 365, § 53:4. The “Symptomatic Period” is the period when the patient ordinarily suffers from opportunistic infections. See BARTLETT & FINKBEINER, supra note 266, at 72-83.

Although the asymptomatic stage could last for eight to ten years, the average time from the development of AIDS to death is eleven to twenty months. See Cheryl Enger et. al., Survival from Early, Intermedi ate and Late Stages of HIV Infection, 275 JAMA 1329 (1993); see also David W. Webber, AIDS AND THE LAW (2d ed. Supp. 1996) (stating that the average time from HIV infection to death is ten years). The time from the development of AIDS to death is shorter for children. See Cohen et al. § 8.1-5. Thus, the overall progression of the disease is faster in children. See THE AIDS SOURCEBOOK, supra note 364, at 227.

The use of protease inhibitors is expected to increase the period for which the patient remains free of the symptoms of AIDS, and increase the life expectancy. See AIDS WEEKLY PLUS (April 29, 1996); Harry Nelson, Is It Gallbladder Disease? Protease Inhibitors Show Promise in HIV Infection, THE LANCET (Feb. 10, 1996). Because the FDA approved the use of protease inhibitors only seven months ago, it is difficult to ascertain at this point how well these combination therapies work.


368. See supra note 265.

369. Pediatric HIV disease presents a unique management problem for
mitted to refuse them even if his parents consent to treatment. The state's interest is unlikely to be strong enough in this paradigm case to circumscribe the mature minor's right. First, the minor should be able to refuse any experimental AIDS treatment that does not have a proven record of success and safety. Second, and more significantly, no existing treatment can satisfy the probability of success standard, discussed above, because there is currently no cure for AIDS. Existing treatments affect only the length and quality of the mature minor's remaining life, and these are decisions that belong to him. This analysis may change, however, if treatments are developed that restore AIDS patients to full functioning or cure the disease. At this time, an HIV-positive minor should be permitted to refuse treatments, even though they might reduce the chances of contracting opportunistic infections or allow the minor to live longer.

Case 5 Child with a Religious Objection: A SIXTEEN-YEAR-OLD JEHOVAH'S WITNESS REFUSES BLOOD TRANSFUSIONS NEEDED FOR LIFE-SAVING SURGERY. SHE SINCERELY BELIEVES THAT SHE WILL BE VIOLATING A FUNDAMENTAL TENET OF HER RELIGION IF SHE RECEIVES THE TRANSFUSIONS.

Although the court in this paradigm case may conclude that the minor is sufficiently mature, the court should order the transfusions: the procedure is nonexperimental and will likely result in the minor's full recovery in the foreseeable future. The minor's ability to refuse other treatment for religious reasons will depend on the minor's maturity and the treatment's probability of success. The court's analysis then

child patients. See Kellings, supra note 265, at 51. "Older preschool and school-age children may begin to question or negatively react to the frequent clinic visits, frequent invasive procedures, and often complicated regimens of medical therapy." Id. at 52.

370. See supra Part III.B (defining competence in this context).

371. For example, Christian Scientists refuse almost all medical treat-
would resemble the analysis under Case 2.

E. Limitations of the Common Law Approach

Even if a common law approach were fair and workable in most cases, one must still question whether legislative solutions would better protect the mature minor's right to self-determination. Regardless of its effectiveness, a legislative approach is necessary in some states because existing statutes abrogate the development of a common law approach. For example, most statutes addressing the medical treatment of minors specifically articulate narrow exceptions to the parental consent rule. A common law mature minor doctrine would effectively add to the exceptions in the statute. Based on this statutory structure, a court may logically conclude that additional exceptions require statutory enactment.

This conclusion is supported by the language of many statutes that create exceptions only for certain conditions or statutes. Any additions would be contrary to the statutes' plain meaning. The legislature could have included any additional exceptions, but it specifically chose not to include a broader mature minor doctrine. Abrogation would be even more likely if any of the common law exceptions were integrated into its medical treatment statutes. For example, incorporation of the common law emergency exception into many of these statutes implies that there is no longer a separate common law exception in those jurisdictions.

Notwithstanding this support for abrogating the common law, some courts have reached the opposite conclusion, holding that existing medical treatment statutes do not prevent the development of common law exceptions. In fact, one court

372. See discussion supra pp. 24-33.
374. See statutes cited supra notes 127-32.
375. Cf. statutes cited supra notes 127-32 (adopting true or presumed mature minor doctrine).
376. See supra notes 95-99, 105-09.
has used these statutes to demonstrate that the legislature intended to create a general mature minor exception to the parental consent requirement. This conclusion seems contrary to the language and structure of the statutes in most states, which set forth precisely when minors can consent to treatment.

The abrogation issue, however, cannot be resolved in the abstract. When considering whether to recognize a common law mature minor doctrine for life-sustaining treatment decisions, each court must determine whether its jurisdiction has abrogated the common law approach. If so, only legislative reform can create a mature minor doctrine.

Even if the jurisdiction permitted a common law approach, it may not be preferable to a legislative approach. One reason is that, even with the assistance of experts, trial judges may lack the experience and training to determine the minor’s maturity. This criticism already has been made about the maturity determination in the abortion context. One study found that most courts in a state have either deemed minors seeking abortions to be mature or have decided that abortion would be in the minors’ best interests. The reasons for this one-sidedness are unclear: perhaps the judges fear making these value-laden decisions, cannot make these decisions effectively, are influenced by their own biases, or are motivated by a combination of these factors.

Concerns about indeterminate judicial decision making may be even more justified when dealing with life-sustaining treatment decisions. The consequences of the life-sustaining treatment decision are more severe than those of an abortion. First, in the abortion context the minor has the child or an abortion, but in the life-sustaining treatment context the minor may live

378. See E.G., 549 N.E.2d at 327.
379. See supra Part II.B.1.b.
380. Such a specific statutory analysis is beyond the scope of this Article.
381. See Minow, supra note 269, at 18 (citing ROBERT H. MNOOKIN, THE INTERESTS OF CHILDREN: ADVOCACY, LAW REFORM AND PUBLIC POLICY, 149, 239 (1985)).
382. See MNOOKIN, supra note 381, at 240; Minow, supra note 269, at 19 & n.78.
or die. Second, the maturity determination for life-sustaining treatment decisions may be more complex and thus more difficult for the court to apply. Finally, biased decision making is just as likely in this context because the judge’s maturity and probability of success determinations may be influenced by the judge’s own conceptions of medicine, ethics, death, children, and religion.

Although this critique highlights the limitations of a case-by-case approach, the alternative solutions are even less desirable. Relying on objective indicia of maturity such as age, or allowing all minors to make life-sustaining treatment decisions would not achieve the overriding purpose that a mature minor doctrine achieves: allowing only competent minors to make these important decisions. Instead, a bright-line approach would intrude on the state’s interest in the sanctity of children’s lives by permitting incompetent minors to make harmful decisions.

Alternatively, leaving these decisions to parents or to the state and thus ignoring the mature minor’s right to make such fundamental decisions would be equally unsatisfactory. The proposed standard respects the minor’s right to self-determination by only involving the state when necessary to preserve its interest. In addition, the proposed safeguards adequately limit the judge’s discretion.

Another reason for criticizing a common law approach is its encouragement of litigation, particularly where the parents’ and child’s desires conflict. Such litigation is necessary, however, because the few cases that reach the courts will require an individualized determination to reach a proper result. More importantly, this approach may empower minors to make decisions that affect their personhood, which is well worth the cost of increased litigation.

Although a common law approach may not lead to a proliferation of cases, a state may still favor a legislative solution. For

384. See discussion supra pp. 65-66.
385. See Mlyniec, supra note 249, at 1905. Any concerns regarding excessive expenditures of judicial resources would be unwarranted. These cases are infrequent and many are resolved outside of the judicial process.
that reason, the following section outlines some legislative solutions that would permit mature minors to make life-sustaining treatment decisions while protecting the state's interests. Some of these solutions, such as recognizing advance health care directives for minors, can also be used to supplement a common law approach.

IV. LEGISLATIVE RECOGNITION OF THE RIGHT TO DECIDE

"I don't ever want to get like that . . . I would want somebody to let me leave—to go in peace."

Chad (sixteen years old)

Although the Article proposes a common law approach, legislation may be an appropriate means to protect the mature minor's right to make life-sustaining treatment decisions. In some jurisdictions, a legislative approach may be preferable to a common law approach. For example, a legislative approach may articulate the public policy of the state more effectively and may limit judicial discretion, which the state may find desirable.

A legislative approach could take the following forms: a statutory exception to the parental consent requirement; an exception to the state's child abuse and neglect statutes; or an expansion of the state's living will and/or health care proxy statutes. Modifying the definition of abuse or neglect for mature minors and enacting amendments to the living will and health care proxy statutes seem the most appropriate ways to ensure that some minors are able to make these important treatment decisions.

A. Exception to Parental Consent Requirement

One possible legislative reform is to add a mature minor exception to the list of exceptions already delineated by statute: emergency, status, or particular conditions/diseases. It would not be an effective means of a legislative reform, however. A mature minor doctrine such as the one developed in this Arti-
cle is not similar to these other exceptions. A mature minor exception would appear to be contrary to the legislature's intent, as it would significantly broaden the scope of the existing exceptions. The existing exceptions are designed to accomplish specific public policy objectives and keep the parental primacy rule intact, whereas a mature minor exception is designed to recognize the minor's right to self-determination.

If a legislature instead were to amend its treatment statutes to encompass a more competence-based approach, it should enact a presumptive or true mature minor doctrine that is sufficiently broad to include life-sustaining treatment decisions. In addition, to fully protect the minor's right to self-determination, a mature minor doctrine should extend explicitly to refusal and consent to treatment.

B. Exception to Abuse/Neglect Statute

Another possible legislative reform is to include a mature minor exception in the existing child abuse and neglect statutes. Most statutes currently consider the failure to provide needed medical care to a minor as neglect or abuse, regardless of the child's maturity. This definition of abuse or neglect could be amended to exclude competent minors making life-sustaining treatment decisions, unless the treatment is nonexperimental and has either a significant probability of curing the disease or condition or alleviating its major symptoms in the foreseeable future.

The realities of legislative reform make the possibilities of enacting such an amendment unlikely. An exception, how-

386. See supra Part III.B.
387. See discussion supra pp. 24-33.
388. See definitions set forth supra notes 127-34.
389. See supra notes 37-38 and accompanying text.
390. See, e.g., Rosato, supra note 371, at 60.
391. This exemption would resemble the exemption in child abuse and neglect statutes for parents who deny medical treatment to their children for religious reasons. See id. at 51-63.
392. It also seems unlikely that the Department of Health and Human Services (HHS) would condition the receipt of federal funds on the existence of the exception. HHS's concern is with protecting children's health, and this exception would effectively provides less protection for children's
ever, might be created without a formal amendment. Courts ordinarily determine whether a child is abused or neglected by balancing the interests of the child, the parent, and the state.\textsuperscript{395} Perhaps courts could recognize the minor's right by giving greater weight to the mature minor's interest.\textsuperscript{394} For example, if the child can demonstrate his competence to make the treatment decision by clear and convincing evidence, the court should accede to the child's wishes, unless the state or parent possesses a stronger countervailing interest. The analysis in each case then would resemble the common law mature minor doctrine set forth in Part III.

Unlike the common law doctrine, however, statutory law would not abrogate this analysis. This analysis would be an interpretation of the state's child abuse and neglect statute,\textsuperscript{396} and its application would depend in part on whether it was consistent with legislative intent.

C. Advance Health Care Directives for Minors

The best statutory protection for the minor's right to self-determination would be to permit certain minors to execute legally enforceable advance health care directives. Many adults make decisions through living wills or health care proxies.\textsuperscript{396} Minors should not be prevented from executing similar directives simply because of their age. The child's right to decide and the state's interest in protecting the child must be balanced.

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health. Furthermore, HHS no longer requires states to have a faith healing exemption. \textit{See id.} at 60. Regardless of the existence of an exemption, HHS requires that alleged neglect/abuse be reported and that necessary treatment be ordered. \textit{See id.} at 63.

\textsuperscript{393} See cases cited supra note 339.

\textsuperscript{394} \textit{See In re Green}, 292 A.2d 387, 392 (Pa. 1972) (deferring to an older minor's preference).

\textsuperscript{395} The likelihood that this interpretation would be adopted would depend on the state of the law in the particular jurisdiction, which is outside the scope of this Article.

\textsuperscript{396} \textit{See} discussion supra pp. 33-39. Although theoretically an advance care directive can effectively communicate the patient's treatment preferences, not many adults actually have executed advance health care directives. \textit{See} David Orentlicher, \textit{The Limits of Legislation}, 53 Md. L. Rev. 1255, 1260, 1270-75 (1994).
This balance could be achieved by codifying the following principles:
(1) any minor should be permitted to execute a legally enforceable living will or health care proxy if a parent or guardian also consents;
(2) a parent may not execute such a document on behalf of the minor child against the minor's wishes;\(^{397}\)
(3) terminally ill mature minors should be permitted to execute living wills or health care proxies without the consent of either parent or the assent of the health care provider.\(^{398}\)

The first recommendation is proper because the state does not have a strong enough interest to prevent the execution of a minor's advance health care directive to which a parent consents. In this situation, the parent's and minor's rights outweigh the state's interests.

The second recommendation helps ensure that the parent and minor agree on whether a directive should be executed.\(^{399}\) It provides limited recognition of the minor's right of autonomy. This procedure will be most effective if health care providers make advance care directive information available to minors and their parents.

The third recommendation recognizes that terminally ill mature minors should be able to exercise their right of autonomy through advance health care directives. Advance health

\(^{397}\) In this circumstance, the minor essentially can veto the parent's decision.

\(^{398}\) See Massie, supra note 355, at 195-97 (stating that mature minors should be permitted to execute advance health care directives in certain circumstances); see also Hawkins, supra note 138, at 1613-14 (proposing an alternative framework). Hawkins's framework has three components: (1) a minor with parental consent can execute a legally binding living will; (2) a mature minor can execute a nonbinding living will; and (3) an emancipated minor should be permitted to execute a binding living will without parental consent. See id. This framework inadequately protects the rights of mature minors, whose preferences deserve greater deference. Moreover, providing greater deference would not reduce parent-child conflict. If such conflict already exists, family integrity has already broken down.

\(^{399}\) Some statutes already include such a minor veto provision. See supra note 143 and accompanying text.
care directives may be the most effective means for minors to exercise their right to self-determination when they become incapable of expressing their treatment preferences, and these means should be made available to them.

Therefore, if the gravely ill minor expresses a desire to execute a living will or health care proxy, and the parents disagree, the health care provider should ascertain the minor's maturity to execute an advance health care directive. If the provider considers the minor sufficiently mature, the minor should be permitted to execute the directive as an adult would. Procedurally, the parent or the child should be permitted to petition the court to determine the child's maturity, if either disagrees with the provider's decision.

The inquiry would be similar to the one set forth in Part IIIB of the Article. The minor is essentially making a treatment decision that will be effectuated in the near future. Therefore, it is important to determine whether the minor possesses the requisite maturity, the maturity to execute an advance health care directive. A probability of success determination is unnecessary because the directive becomes effective only when the patient is gravely ill, when it is unlikely that the proposed treatment would either cure the disease/condition or alleviate its major symptoms. Any decision would relate to the quality of the patient's remaining life and, consequently, the state's interest would not be strong enough to override the minor's right to self-determination.

A case-by-case approach would provide the best accommodation of the competing interests. A bright-line test, such as allowing all minors of a certain age to execute a directive, would not be desirable because of the significant variation with which minors mature. Even using an older age such as sixteen as a cut-off would be potentially over- and underinclusive. Alternatively, categorically denying minors the right to execute a directive would improperly assume the incapacity of all minors and would weaken the mature minors' right to self-determination. Minors who are mature enough to make treatment decisions should be mature enough to choose in advance what treatment they desire or who they want to make these deci-

400. See supra Part III.B.2; cf. 2 MEISEL, supra note 2, § 11.5, at 87.
sions for them. Executing an advance health care directive is simply an alternative way to exercise the right to make decisions regarding life-sustaining treatment.

The most significant shortcoming of the proposals set forth in this Article is that it does not protect the rights of minors who express their preferences and then enter a PVS due to illness or accident. Their rights could be protected if any minor were permitted to execute an advance health care directive, or if trial courts made maturity inquiries for every minor desires a directive. Both solutions are problematic. Briefly stated, the first fails to protect the state’s interest because immature minors would be permitted to refuse treatment, and the second is too cumbersome for the courts to implement.

Currently, the preferences of a minor in a PVS can only be considered by applying the common law. Depending on the jurisdiction, the minor’s statements of preference are considered under either the best interests test or the substituted judgment test, neither of which adequately protects the minor’s right of autonomy.401

Even with this limitation, the proposed reform significantly and appropriately expand the minor’s right beyond existing law.

V. CONCLUSION

This Article has provided some answers to the questions of when a minor should be given the right to make life-sustaining treatment decisions, and of whether this right should be recognized even when health care providers or parents disagree with the decision. There are no easy answers to these questions, just uncomfortable compromises. The search for answers requires a careful examination of difficult issues, such as: Why should we trust these decisions to children when we do not trust them with many other decisions? Why should parents’ decisions regarding their child’s health generally be respected? What stake does the state have in preserving the sanctity of life for mature adolescents whose death seems imminent?

This Article has reached the most delicate of compromises: allow children to exercise their right to self-determination

401. See supra note 170.
when they are sufficiently mature and when the state's interest is not strong enough to circumscribe the minor's right. This approach is better than the current law, which denies that any child can make these decisions, and ignores the harm created when life-sustaining treatment is imposed on children against their wills. The harm inflicted upon children's personhoods is irreparable when they are forced to receive life-sustaining treatment. The reforms proposed in this Article should alleviate this harm significantly.