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Comment

Rejecting the Adage “Children Should Be Seen and Not Heard” — The Mature Minor Doctrine

I. Introduction

In July 1994, fifteen year old Benny Agrelo discussed the debate surrounding his October 1993 decision to stop taking anti-rejection medication and forego a third liver transplant:

[The doctors] don't realize how bad the pain is, of course, they would never realize it, unless they were going through it themselves, but their job is to keep their patients alive for as long as they can. I mean, that's their job. [B]ut they should learn when to step out of the way. When a patient doesn't want treatment [sic].¹

Benny's decision to stop taking the anti-rejection medication was met with state interference.² When an administrator at Pittsburgh Children's Hospital, where Benny had received his two liver transplants, notified the Florida Department of Health and Rehabilitation Services (hereinafter HRS) that Benny was not taking his medication, HRS forcibly removed Benny from his home.³ Once hospitalized, doctors attempted to

1. *ABC News PrimeTime Live: Benny's Choice - Children and the Right to Decide* (ABC television broadcast, July 7, 1994) (hereinafter *PRIMETIME LIVE*). Benny stated that the medication caused him to be “in pain all the time and [that he was] not . . . able to do anything for [himself].” *Id.*

2. *PRIMETIME LIVE*, *supra* note 1.

3. Nancy San Martin, *Defiant Transplant Patient Dies at Home*, *SUN SENTINEL*, Aug. 21, 1994, at 8A, available in *WESTLAW*, *ALLNEWS* Database. Benny stated that when he was carried to the ambulance “[he] was so angry, [he] put [his] elbow through the window without even thinking about it. They had to tie [him] down and it hurt [him].” *PRIME TIME LIVE*, *supra* note 1.

give Benny liver biopsies and medication but Benny "managed to fight them off alone."⁴

Benny's decision to stop taking the anti-rejection medications made national news when Broward County Circuit Court Judge Arthur Birken ruled that Benny could not be forced to take the medications.⁵ Although under Florida law a child has no right to stop taking life-saving medication,⁶ Judge Birken based his controversial ruling on his long visit with Benny which included four hours of testimony from doctors who had treated the boy.⁷ Benny died in his home on August 20, 1994,⁸ two and one-half months after Judge Birken's ruling.⁹ Benny's story fueled the national debate over whether a minor has the right to refuse life-sustaining medical treatment.¹⁰

More recently, Billy Best, a sixteen year old diagnosed with Hodgkin's disease in August 1994,¹¹ ran away from his Massachusetts home on October 26, 1994, after two and one-half months of chemotherapy.¹² Billy left a letter for his parents in which he stated: "[t]he reason I left is because I could not stand going to the hospital every week. I feel like the medicine is kill-

4. PRIME TIME LIVE, *supra* note 1. Benny's mother initially did not support her son's position to stop taking his medication; however, she later "[b]acked his decision after some struggle." *Teen Shunned Medication*, MIAMI HERALD, Aug. 21, 1994, at 1A, available in WESTLAW, ALLNEWS Database.

5. *Florida Teen Who Refused Liver Drug Dies*, PALM BEACH POST, Aug. 21, 1994, at 8A, available in WESTLAW, ALLNEWS Database. Judge Birken has not issued a formal opinion on this controversial ruling because the matter involved a parental neglect action. Telephone interview with Judge Birken's office (Sept. 6, 1994).

6. PRIME TIME LIVE, *supra* note 1.

7. PRIME TIME LIVE, *supra* note 1. Benny indicated that his decision to stop taking anti-rejection medication (eight medications, three times a day), which doctors said would have extended his life, was based on the side effects of the medication which included headaches, fevers and swelling of his arms and legs. PRIME TIME LIVE, *supra* note 1.

8. Amy Driscoll, *Teen Shunned Medication*, MIAMI HERALD, Aug. 21, 1994, at 1A, available in WESTLAW, ALLNEWS Database.

9. Martin, *supra* note 3.

10. Gail B. Slap & Martha M. Jablow, *Debating Rights of Young Patients*, N.Y. TIMES, Nov. 10, 1994, at C1.

11. *Morose, Boy with Cancer Runs Away Medication is Killing Me Instead of Helping Me*, CHI. TRIBUNE, Nov. 4, 1994, News at 26, available in WESTLAW, ALLNEWS Database.

12. Slap & Jablow, *supra* note 10.

ing me instead of helping me”¹³ When Billy was informed that he would require four months of chemotherapy, he sold some of his belongings, and boarded a bus with his skateboard.¹⁴ Billy ended up in Houston, Texas “where he fell in with some skateboarding friends and lived in abandoned buildings. Later, he was taken in by two families.”¹⁵ After seeing his family’s plea for his return on television, Billy returned home on November 21, 1994.¹⁶ At a news conference held after Billy’s return, his father stated that his son’s future treatments would not include chemotherapy.¹⁷

This Comment will address the rights of mature minors to make informed medical decisions regarding their refusal of life-sustaining treatment. Part II details the traditional legal status of minors and explores judicial recognition of the mature minor’s right to consent to medical treatment. This section also provides an overview of court decisions which accepted and rejected the notion of extending the common law right to refuse life-sustaining medical treatment to minors. Part II further explores the recent guidelines set forth by the Midwest Bioethics Committee, which proposed that minors with decisional capacity be afforded the right to refuse medical treatment.¹⁸

13. *Around the Nation - Cancer Patient Runs Away*, WASH. POST, Nov. 4, 1994, at A4, available in WESTLAW, ALLNEWS Database.

14. Christopher B. Daly, *Teenage Cancer Patient Seeks Normalcy - Chemotherapy Will Not be Part of Treatment*, WASH. POST, Nov. 25, 1994, at A3, available in WESTLAW, ALLNEWS Database.

15. *Id.*

16. *Runaway Cancer Patient Goes Home*, CHI. TRIB., Nov. 22, 1994, News at 4, available in WESTLAW, ALLNEWS Database.

17. Christopher B. Daly, *Teenage Cancer Patient Seeks to Return to Normalcy - Chemotherapy Will Not be Part of Treatment*, WASH. POST, Nov. 25, 1994, at A3, available in WESTLAW, ALLNEWS Database. Instead, Billy began taking Essiac, an herbal drink, as an alternative form of treatment for his cancer. Gloria Negri, *Youth Seeks ‘Alternative’ Cure*, BOSTON GLOBE, Feb. 5, 1995, at 22, available in WESTLAW, ALLNEWS Database. In April 1995, the Dana Farber Institute in Boston announced that Billy’s new tests did not reveal any trace of Hodgkin’s disease. Pattie Hainer, *Cancer Runaway Billy Best Doing Well, Living on*, THE PATRIOT LEDGER, May 15, 1995, at 8B, available in WESTLAW, ALLNEWS Database. The following month Billy’s parents stated: “We’re glad now that he ran away. We would never have known about alternative treatments if he hadn’t.” *Id.*

18. MIDWEST BIOETHICS CENTER, HEALTH CARE TREATMENT DECISION MAKING GUIDELINES FOR MINORS (1994-95) (hereinafter MIDWEST BIOETHICS CENTER).

Part III of this Comment examines the current statutory enactments which allow minors to consent to medical treatment under certain circumstances, and sets forth the conflict within New York lower courts over whether or not minors have the right to refuse life-sustaining medical treatment. Additionally, this section focuses on the New York State Task Force on Life and the Law, which recommended that mature minors should play a substantial role in the decision to refuse life-sustaining treatment.¹⁹ It also addresses the Task Force suggestion that bioethics committees assist in resolving conflicts between mature minors and their parents over the minor's decision to forego medical treatment,²⁰ and the resulting proposed legislation to amend the New York Public Health Law.²¹

Part IV of this Comment explores the role the courts and the legislature should play in granting mature minors the right to forego life-sustaining treatment. This section suggests that the New York Legislature should enact a law granting mature minors the right to refuse life-sustaining medical treatment. Part IV also examines how recently proposed legislation balances the minor's interest in refusing treatment, the parental interest in speaking for their children on health care issues, and the state's interest in preserving life. Finally, Part IV concludes that more appropriate safeguards need to be established for assessing the decision-making capacity of minors who desire to refuse life-sustaining treatment.

II. Background

A. *The Legal Status of Children*

Minors have traditionally been characterized as legal incompetents.²² In 1944, the United States Supreme Court in

19. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE, DECIDING FOR PATIENTS WITHOUT CAPACITY 131 (1992) (hereinafter NEW YORK STATE TASK FORCE).

20. *Id.* at 131-32.

21. *Id.* app. A.

22. See *In re Morrissey*, 137 U.S. 157, 159 (1890) ("The age at which an infant shall be competent to do any acts or perform any duties, military or civil, depends wholly upon the legislature.") (citations omitted); *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941) ("There is general recognition of the fact that many persons by reason of their youth are incapable of intelligent decision [sic], as the result of which public policy demands legal protection of their personal as well as their

Prince v. Massachusetts,²³ noted the parental right to speak for minor children, but qualified this right by stating that “[p]arents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”²⁴ The state has the power to act as *parens patriae* in order to protect the safety and welfare of the children within its jurisdiction.²⁵

Thirty-five years after *Prince*, the Supreme Court reaffirmed the parental right to speak for minor children when it stated that parents primarily speak for their minor children in matters concerning medical treatment.²⁶ At the same time, the Court acknowledged that children “[have] a substantial liberty interest in not being confined unnecessarily for medical treatment”²⁷ Although the right of minors to refuse medical treatment has not been addressed by the Supreme Court, it has been addressed by lower courts.²⁸

property rights.”); *In re Alfonso v. Fernandez*, 195 A.D.2d 46, 50-51, 606 N.Y.S.2d 259, 262 (2d Dep’t 1993), (“As legal incompetents, minors could no more consent to medical treatment than they could enter into binding contracts and they continued to be incompetent in many circumstances to give effective consent to health care.”), *appeal dismissed*, 83 N.Y.2d 906, 637 N.E.2d 278, 614 N.Y.S.2d 388 (1994). For a discussion of *Alfonso*, see *infra* note 175. See also DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE LEGAL STATUS OF ADOLESCENTS - 1980 28 (1980)(the disabilities of minors are removed by operation of the law when the minor reaches the age of majority).

23. 321 U.S. 158 (1944).

24. *Id.* at 170.

25. *Id.* at 166. “‘Parens patriae,’ literally ‘parent of the country,’ refers traditionally to role of state as sovereign and guardian of persons under legal disability such as juveniles or the insane.” BLACK’S LAW DICTIONARY 1114 (6th ed. 1990). See *Parham v. JR*, 442 U.S. 584, 603 (1979) (“[A] state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.”) See also *Wisconsin v. Yoder*, 406 U.S. 205, 230 (1972).

26. See *Parham*, 442 U.S. at 602-03. The Court noted that, “[t]he law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions.” *Id.* at 602. The Court further stated “[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments.” *Id.* at 603.

27. *Id.* at 600.

28. See *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *In re Swan*, 569 A.2d 1202 (Me. 1990); *In re Long Island Jewish Medical Ctr.*, 147 Misc.2d 724, 557 N.Y.S.2d 239

B. *The Emergence of the Mature Minor Doctrine*

Adults, unlike minors, have a common law right of self-termination.²⁹ While the United States Supreme Court has never ruled that a competent adult has a constitutional right to refuse medical treatment, the divided Court in *Cruzan v. Director, Missouri Dep't of Health*,³⁰ assumed that the United States Constitution would grant a competent adult the right to refuse life-sustaining treatment.³¹ However, "the *Cruzan* decision gave virtually no intelligible principles to the states for protecting incompetent persons' liberty interest in forgoing life-sustaining procedures."³²

(Sup. Ct. Queens County 1990); *In re Thomas B.*, 152 Misc. 2d 96, 574 N.Y.S.2d 659 (Fam. Ct. Cattaraugus County 1991); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987); *O.G., P.G., and M.G. v. Baum*, 790 S.W.2d 839 (Tex. Ct. App. 1990). For a discussion of *E.G.*, see *infra* notes 61-81 and accompanying text. For a discussion of *Swan*, see *infra* notes 82-102 and accompanying text. For a discussion of *Long Island Jewish Medical Ctr.*, see *infra* notes 181-198 and accompanying text. For a discussion of *Thomas B.*, see *infra* notes 199-205 and accompanying text. For a discussion of *Cardwell*, see *infra* notes 42-60 and accompanying text. For a discussion of *O.G.*, see *infra* notes 114-139 and accompanying text.

29. See *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.").

30. 497 U.S. 261 (1990).

31. *Id.* The Court based this principle on the Fourteenth Amendment, which provides that no State shall "deprive any person of life, liberty, or property, without due process of the law." U.S. CONST. amend. XIV, § 1. The Court further stated that "[t]he principle that a competent person has a [Fourteenth Amendment] constitutionally protected liberty interest in refusing unwanted medical treatment [could] be inferred from [its] prior decisions." *Cruzan*, 497 U.S. at 278.

In *Cruzan*, 30 year old Nancy Cruzan's parents sought to have their daughter's artificial nutrition and hydration systems removed. *Id.* at 267. Nancy had been in a persistent vegetative state for many years as a result of a car accident. *Id.* at 266, n.1. The Court in *Cruzan* held that the state of Missouri had a legitimate interest in protecting human life, and upheld as constitutional Missouri's standard of requiring clear and convincing evidence that, prior to being in a persistent vegetative state, the patient manifested a desire to have life-sustaining artificial feeding and hydration removed. *Id.* at 286-87.

To date, in addition to Missouri, Michigan and New York allow treatment to be withheld only when supported by clear and convincing evidence that a patient, while competent, expressly decided to reject the treatment in the circumstances present. See *In re Martin*, 538 N.W.2d 399 (Mich. 1995); *In re Westchester County Medical Ctr.*, 72 N.Y.2d 517, 531 N.E.2d 609, 534 N.Y.S.2d 889 (1988).

32. Scott Allan Frick, *The Right to Forgo Life-Sustaining Procedures In Florida: Is Florida "Cruzan-Proof"?*, 20 STETSON L. REV. 519, 524 (1991).

Prior to the 1986 holding in *In re D.P.*,³³ no court had examined whether a minor had the right to refuse life-sustaining medical treatment.³⁴ In *In re D.P.*, a fourteen year old cancer patient refused blood transfusions because it was against her religion.³⁵ The minor stated that she would leave the hospital if the court ordered the transfusions.³⁶ The court did not order the transfusions, holding that the girl could not be kept in the hospital against her will.³⁷ Although no state legislature has passed a law giving minors the right to refuse medical treatment, recently, some courts have recognized a common law right of minors both to refuse and to consent to medical treatment.³⁸

In determining whether minors have a common law right to consent to medical treatment, courts have considered whether the minor has the capacity to consent to, and appreciate the nature, risks, and consequences of the medical treatment involved.³⁹ Courts have also attempted to determine whether there was clear and convincing evidence that the comatose minor, prior to treatment, did not want to be maintained by life-sustaining procedures.⁴⁰ Recognition of a mature minor's right to refuse life-sustaining medical treatment developed as a re-

33. William D. Brewster, Note, *In re E.G., a Minor: Death Over Life: A Judicial Trend Continues as the Illinois Supreme Court Grants Minors the Right to Refuse Life-Saving Medical Treatment*, 23 J. MARSHALL L. REV. 771 n.5 (1990) (citing *In re D.P.*, No. 91950 (Santa Clara County Juv. Ct. July 3, 1986)).

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

38. See *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *In re Swan*, 569 A.2d 1202 (Me. 1990); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987). For a discussion of *E.G.*, see *infra* notes 61-81 and accompanying text. For a discussion of *Swan*, see *infra* notes 82-102 and accompanying text. For a discussion of *Cardwell*, see *infra* notes 42-60 and accompanying text. One court has, however, refused to recognize such a common law right. See *O.G., P.G., and M.G. v. Baum*, 790 S.W.2d 839 (Tex. Ct. App. 1990). For a discussion of *O.G.*, see *infra* notes 114-139 and accompanying text.

39. See *Cardwell*, 724 S.W.2d at 749. See also *E.G.*, 549 N.E.2d at 327 (mature minor doctrine affords the minor, whom the trial judge deems is mature enough to appreciate the consequences of his/her actions, the right to consent to or refuse medical treatment). For a discussion of *Cardwell*, see *infra* notes 42-60 and accompanying text. For a discussion of *E.G.*, see *infra* notes 61-81 and accompanying text.

40. See *Swan*, 569 A.2d at 1206. For a discussion of *Swan*, see *infra* notes 82-102 and accompanying text.

sult of the Illinois Supreme Court's expansion of the statutory right to consent to medical treatment.⁴¹

1. *Capacity to Consent to Medical Treatment*

In 1987, the Tennessee Supreme Court in *Cardwell v. Bechtol*,⁴² a case of first impression in Tennessee,⁴³ recognized a mature minor exception to the common law rule that requires a physician to obtain consent from parents before the physician treats a minor.⁴⁴ In *Cardwell*, a minor and her parents brought an action against an osteopath,⁴⁵ alleging malpractice, battery, negligent failure to obtain consent, and failure to obtain informed consent, because the doctor treated Sandra (who was five months away from her eighteenth birthday) without parental consent.⁴⁶ On appeal, the Tennessee Supreme Court acknowledged that for well over a century the common law recognized "that minors achieve varying degrees of maturity and responsibility (capacity)."⁴⁷ However, the court noted that there was no existing case law which dealt directly with the mature minor exception.⁴⁸ The court looked to decisions in other jurisdictions⁴⁹ which had held that capacity existed when the

41. See *E.G.*, 549 N.E.2d at 322.

42. 724 S.W.2d 739 (Tenn. 1987).

43. *Id.* at 741.

44. *Id.* at 745.

45. An osteopath is a doctor who practices a therapeutic system based upon the "manipulation of the muscles and bones to promote structural integrity." *RANDOM HOUSE UNABRIDGED DICTIONARY* 1371 (2d ed. 1993).

46. *Cardwell*, 724 S.W.2d at 742. The trial court granted the defendant's motion for directed verdict on the malpractice issue and sent the remaining issues to the jury with the instruction that a mature minor did not require parental consent prior to medical treatment. *Id.* A general verdict was returned for the defendant. *Id.*

On appeal, the Tennessee Court of Appeals affirmed the malpractice verdict of the circuit court but reversed on the battery issue because neither the Tennessee Legislature nor the Tennessee Supreme Court had adopted the mature minor exception. *Id.* The court directed a verdict on the battery issue and remanded the case for a new trial solely on the issue of damages. *Id.*

47. *Cardwell*, 724 S.W.2d at 744-45 (citing *The Queen v. Smith*, 1 Cox C.C. 260 (1845), 42 Am. Jur. 2d, *Infants* §§ 9, 45, 142 (1969)).

48. *Cardwell*, 724 S.W.2d at 747.

49. *Id.* at 746-47.

minor had an average person's ability to understand and weigh the risks and benefits of his or her decision.⁵⁰

The Tennessee Supreme Court noted that, while the Tennessee Legislature had not enacted the mature minor exception to the requirement that parental consent is necessary for the treatment of minors, it had enacted statutes which "recognize[d] the varying degrees of responsibility and maturity of minors [fourteen] years and older."⁵¹ The court examined the common law rule of capacity, known as "The Rule of Sevens," which presumes differing levels of capacity depending on whether the individual is less than seven years old, between the ages of seven and fourteen, or older than fourteen years.⁵² Under the Rule, children under the age of seven lack capacity.⁵³ However, a rebuttable presumption of lack of capacity exists for children between the ages of seven and fourteen, and, furthermore, a rebuttable presumption of capacity exists for children between the ages of fourteen and twenty-one.⁵⁴

The court also found that the mature minor exception was consistent with tort law,⁵⁵ criminal law⁵⁶ in Tennessee and other jurisdictions, and other legal authorities.⁵⁷ The court, by

50. *Id.* at 746 (citing W. PAGE KEETON ET. AL., PROSSER AND KEETON ON THE LAW OF TORTS § 18, at 115 (5th ed. 1984) (hereinafter PROSSER & KEETON)).

51. *Id.* at 745. The court took notice of the fact that Tennessee had lowered the age of majority from 21 years to 18 years because the conditions that made 21 the age of majority had eroded with time and "maturity is now reached at earlier stages of growth than at the time that the common law recognized the age of majority at 21 years." *Id.* (the court relied on TENN. CODE ANN. § 1-3-105(1) (1994)). See TENN. CODE ANN. § 55-50-311 (1993) (a minor may obtain a learner's permit to drive at age 15); TENN. CODE ANN. § 55-50-312(e) (a minor may obtain a special restricted license between the ages of 14 and 16).

52. *Cardwell*, 724 S.W.2d at 745.

53. *Id.*

54. *Id.* (construing *State v. Fears*, 659 S.W.2d 370 (Tenn. Crim. App. 1983)).

55. *Id.* at 748 (construing *Walker v. Hamby*, 503 S.W.2d 118 (Tenn. 1973); *Bailey v. Williams*, 346 S.W.2d 285 (Tenn. Ct. App. 1960), *cert. denied* (1961)).

56. *Cardwell*, 724 S.W.2d at 748. A minor may be tried as an adult in criminal cases if "the child was sixteen years of age or more at the time of the alleged conduct, or the child was more than fourteen years of age if such child was charged with [certain violent crimes]." *Id.* (the court relied on TENN. CODE ANN. § 37-1-134(a) (1991); *Colley v. State*, 169 S.W.2d 848 (Tenn.), *cert. denied*, 320 U.S. 766 (1943); *Juvenile Court of Shelby Co. v. State ex rel. Humphrey*, 201 S.W. 771 (Tenn. 1918)).

57. The court cited the relative capacity of minors to consent. *Cardwell*, 724 S.W.2d at 746 (citing PROSSER AND KEETON § 18, at 115 (5th ed. 1984)) ("A minor acquires capacity to consent to different kinds of invasions and conduct at different

noting that it did not find any indication in the Tennessee statutes that the legislature intended to occupy the entire area of medical treatment for minors, recognized the mature minor exception to the requirement of parental consent.⁵⁸ The jury's verdict that Sandra did have the capacity to consent and did effectively consent to the osteopath's treatment was affirmed.⁵⁹ The court, however, cautioned that the "[a]doption of the mature minor exception to the common law rule [was] by no means a general license to treat minors without parental consent and [the exception's] application [was] dependent on the facts of each case."⁶⁰

2. Capacity to Refuse Life-Sustaining Medical Treatment

Just two years after *Cardwell*, the Illinois Supreme Court in *In re E.G.*,⁶¹ a case of first impression, recognized the common law right of minors to refuse medical treatment.⁶² E.G., a seventeen year old girl with leukemia, needed life-sustaining blood transfusions to treat the disease.⁶³ Both the minor and her mother were Jehovah's Witnesses, and withheld consent to the blood transfusion due to their religious beliefs.⁶⁴

The trial court found E.G. to be a "mature [seventeen] year old individual,"⁶⁵ yet held that the state's interest was greater

stages in his development. Capacity exists when the minor has the ability of the average person to understand and weigh the risks and benefits"); RESTATEMENT (SECOND) OF TORTS § 892A cmt. b. (1979) ("[i]f the person consenting is a child . . . , the consent may still be effective if he is capable of appreciating the nature, extent and probable consequences of the conduct consented to, although the consent of a parent, guardian or other person responsible is not obtained or is expressly refused.")).

58. *Cardwell*, 724 S.W.2d at 744. The court stated: "We do not think that the conclusion that these statutes are intended to abrogate judicial adoption of an exception to the general common law rule requiring parental consent to treat minors can be supported by the express terms of any of these provisions." *Id.*

59. *Id.* at 756.

60. *Id.* at 745.

61. 549 N.E.2d 322, 328 (Ill. 1989).

62. *Id.*

63. *Id.* at 323.

64. *Id.* Jehovah's Witnesses refuse blood transfusions because they believe the Bible prohibits "eating blood." John C. Ford, *Refusal of Blood Transfusions By Jehovah's Witnesses*, 10 CATH. LAW. 212 (1964). Receiving a blood transfusion is deemed to be violative of *Leviticus* 3:17 which states: "By a perpetual law for your generation, and all your habitations, neither blood nor fat shall you eat at all." *Id.*

65. *E.G.*, 549 N.E.2d at 324.

than the interests of E.G. and her mother.⁶⁶ A guardian was appointed to consent to the blood transfusions on E.G.'s behalf.⁶⁷ The minor was then compelled to accept the court-ordered transfusions.⁶⁸ On appeal, the appellate court affirmed in part and modified in part, and held that E.G. should be "partially emancipated," and had a constitutional right to accept or refuse medical treatment based on her religious beliefs.⁶⁹

The Illinois Supreme Court granted the state's petition for leave to appeal even though E.G. had since reached the age of majority, stating that the issue presented was not moot because it was of "substantial public interest."⁷⁰ The court stated that the age of majority "is not an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood."⁷¹ The court held that mature minors have a common law right to refuse medical treatment.⁷² In reaching this conclusion, the court relied on both statutes and case law in Illinois, and in other jurisdictions, that recognized the right of minors to consent to medical treat-

66. *In re E.G.*, 515 N.E.2d 286, 288 (Ill. App. Ct. 1987). The trial court noted that E.G. was just six months from the age of majority, and found her to be mature and to have independently made the decision to refuse the blood transfusion. *Id.*

67. *Id.* at 288.

68. *Id.* at 291 (McNamara, P.J., dissenting).

69. *Id.* at 291. The appellate court held that the trial court's order "was an unjustified abridgement of her First Amendment rights" and vacated the trial court's order. *Id.* The First Amendment states in relevant part that "Congress shall make no law . . . prohibiting the free exercise [of religion]." U.S. CONST. amend. I. The court further stated that because the trial court found E.G. "had made a mature independent decision to follow her religious beliefs, such finding obviate[d] any state interest in protecting immature minors." *E.G.*, 515 N.E.2d at 290.

70. *E.G.*, 549 N.E.2d at 325. Considerations in determining the existence of a substantial public interest for mootness purposes include "the public or private nature of the question presented, the desirability of an authoritative determination for the future guidance of public officers, and the likelihood of future recurrence of the question." *Id.* (citing *Wallace v. Labrenz*, 104 N.E.2d 769 (Ill. 1952))(finding the issue on appeal was not moot because of "substantial public interest," even though the minor had received a blood transfusion), *cert. denied*, 344 U.S. 824 (1952)).

71. *Id.*

72. *Id.* at 327-28. In finding this common law right, the court did not address the constitutional issue of whether the First Amendment's free exercise clause entitles a mature minor to decline medical care. *Id.* (citing *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989); *In re Application of Rosewell*, 454 N.E.2d 997 (Ill. 1983) ("Constitutional questions should not be considered if a court can decide a case on other grounds.")). See *supra* note 69 for the partial text of the First Amendment.

ment,⁷³ be declared emancipated,⁷⁴ and be treated as adults under other certain circumstances.⁷⁵ In addition to noting the statutory exceptions to the requirement of parental consent found in Illinois, the court relied on the Tennessee Supreme Court's decision in *Cardwell v. Bechtol*.⁷⁶

The court further concluded that, absent legislative mandate, a trial judge should determine "whether a minor is mature enough to make health care choices on her own."⁷⁷ In doing so, the trial judge must weigh Illinois' public policy valuing the sanctity of life and its *parens patriae* power to protect those who are not competent to protect themselves against the evidence presented of the minor's maturity.⁷⁸ If clear and convincing evidence is presented "that the minor is mature enough to appreciate the consequences of [his or] her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords [the minor] the common law

73. *Id.* at 326 (citing ILL. REV. STAT. ch. 111, paras. 4501-05 (1987) (The Consent by Minors to Medical Operations Act) (current version at ILL. ANN. STAT. ch. 410, paras. 210/0.01-210/5 (Smith-Hurd 1993)) (granting minors legal capacity to consent to medical treatment under specific situations).

74. *E.G.*, 549 N.E.2d at 325 (citing ILL. REV. STAT. ch. 40, paras. 2201-11 (1987) (the Emancipation of Mature Minors Act) (current version at ILL. ANN. STAT. ch. 750, paras. 30/1-30/11 (Smith-Hurd 1993) (allowing minors who are at least 16 years old to be declared emancipated)). The court stated that "when read together in a complementary fashion, [the Consent by Minors to Medical Operations Act and the Emancipation of Mature Minors Act] indicate that the legislature did not intend that there be an absolute 18-year-old age barrier prohibiting minors from consenting to medical treatment." *Id.* at 325-26.

75. *Id.* at 325 (citing ILL. REV. STAT., ch. 111, para. 4504 (1987) (current version at ILL. STAT. ANN. ch. 410, para. 210/4 (Smith-Hurd 1993) (enables minors 12 years and older to seek medical attention for venereal diseases or alcohol or drug treatment); ILL. REV. STAT., ch. 111, para. 4501 (1987) (current version at ILL. STAT. ANN. ch. 410, para. 210/1 (Smith-Hurd 1993) (enables married or pregnant minors under the age of 18 to validly consent to medical treatment))).

Additionally, the court looked to the Illinois Criminal Code which states that juveniles may be prosecuted as adults if the trier of fact finds that the juvenile was mature enough to have formulated the requisite mental state. *Id.* (citing ILL. REV. STAT. ch. 32, para. 805-4 (1987) (The Juvenile Court Act)).

Finally, the court recognized that the United States Supreme Court had adopted the mature minor doctrine in abortion cases allowing women under the age of 18 to have an abortion without first obtaining parental consent. *Id.* at 326.

76. *Id.* at 326-27 (citing *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987)). For a discussion of *Cardwell*, see *supra* notes 42-60.

77. *E.g.*, 549 N.E.2d at 327.

78. *Id.*

right to consent to or refuse medical treatment.”⁷⁹ The common law right is not, however, absolute, as it must be weighed against the following “four State interests: (1) the preservation of life; (2) protecting the interests of third parties; (3) prevention of suicide; and (4) maintaining the ethical integrity of the medical profession.”⁸⁰ The court further noted that protecting the interests of third parties (i.e., parents, guardians, adult siblings, and other relatives) was the most important interest to be balanced against this common law right.⁸¹

The following year, the Maine Supreme Judicial Court in *In re Swan*,⁸² recognized that a minor’s clear and convincing decision not to be maintained by life-sustaining procedures must be respected.⁸³ In *Swan*, Chad, a minor nine months shy of his eighteenth birthday, had been in an automobile accident, which left him in a persistent vegetative state.⁸⁴ His parents, along with his older brother, petitioned the court for a declaratory judgment that the family and others would not be civilly or criminally liable for their participation in removing the feeding tubes.⁸⁵ The family’s affidavits stated that, prior to the accident, Chad told them “that he [did not] want to be kept alive by artificial means should [an] injury render him incapable of existing otherwise.”⁸⁶

The Maine Superior Court had appointed a guardian ad litem for Chad, and held an emergency hearing, after Chad’s body rejected the gastronomy tube, in which the court issued a temporary order directing hydration and medication, but not

79. *Id.* at 327-28.

80. *Id.* at 328 (citing *Longeway*, 549 N.E.2d at 299 (quoting Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977)).

81. *E.G.*, 549 N.E.2d at 328. The court stated that “[i]f a parent or guardian opposes an unemancipated mature minor’s refusal to consent to treatment for a life-threatening health problem, this opposition would weigh heavily against the minor’s right to refuse.” *Id.* The court hypothesized that if E.G.’s mother had not assented to her daughter’s decision to refuse the transfusions, “then the court would have given serious consideration to her mother’s desires.” *Id.* For a discussion of *E.G.*, see Brewster, *supra* note 33.

82. 569 A.2d 1202 (Me. 1990) (per curiam).

83. *Id.* at 1203.

84. *Id.*

85. *Id.* at 1203-04.

86. *Id.* at 1204.

nutrition.⁸⁷ Eleven days later, the court entered an order allowing the hydration to be removed if Chad's guardians and attending physician agreed.⁸⁸ The court stayed its order and ordered that pending the appeal Chad continue to receive hydration and medication.⁸⁹ Chad's family appealed the decision.⁹⁰ On appeal, the Maine Supreme Judicial Court ruled that Chad's desires not to be artificially maintained had been established by clear and convincing evidence.⁹¹ This clear and convincing evidence included evidence that Chad had expressed his desires on two different occasions in the context of serious discussions about people Chad knew who were in persistent vegetative states.⁹² This finding enabled the court to hold that the minor's statements were controlling.⁹³ The Maine Supreme Judicial Court then ordered that Chad's parents, his natural and legal guardians, be allowed to determine whether or not to reinsert the tube.⁹⁴

The Maine Supreme Judicial Court decision meant that Chad, although a minor, would have his desire not to be kept alive honored.⁹⁵ In reaching its conclusion, the court noted: (1) the evidentiary rule that competent minors could testify as witnesses;⁹⁶ (2) the common law presumption of competency for

87. *Swan*, 569 A.2d at 1204. The court ordered that the least invasive means were to be used. *Id.*

88. *Id.* at 1204.

89. *Id.* The guardian ad litem also "urged the court to stay its order." *Id.* The guardian ad litem also urged that a feeding tube be inserted "to preserve the status quo" until the ultimate merits of the case could be decided." *Id.*

90. *Id.*

91. *Id.* at 1205.

92. *Id.*

93. *Id.* at 1206.

94. *Id.*

95. The appellate decision was compelled by the binding authority of *In re Gardner*, 534 A.2d 947 (Me. 1987), in which the court held that "when an individual has clearly and convincingly in advance of treatment expressed his decision not to be maintained by life-sustaining procedures in a persistent vegetative state, health care professionals must respect that decision." *Id.* at 1204 (citing *Gardner*, 534 A.2d at 953). The court stated that *Gardner* controlled even though Joseph Gardner was about 21 years old when he stated he did not want to be maintained artificially, while Chad was only 16 years old when he first discussed with his mother "what it meant to be a 'vegetable.'" *Id.* at 1205.

96. *Swan*, 569 A.2d at 1205 (citing *State v. Hussey*, 521 A.2d 278, 280 (Me. 1987) (the minority of a witness is not dispositive regarding the minor's competency to testify)).

persons fourteen years and older;⁹⁷ (3) that persons attain capacity at different ages;⁹⁸ and (4) the Illinois Supreme Court's decision in *In re E.G.*⁹⁹ The court concluded that "[t]he fact that Chad made these declarations as to medical treatment before he reached the age of eighteen [was] at most a factor to be considered by the factfinder in assessing the seriousness and deliberativeness with which his declarations were made."¹⁰⁰ The court affirmed the superior court's refusal to order reinsertion of the feeding tube.¹⁰¹ The court granted Chad's parents the right to carry out Chad's medical decision not to be artificially maintained.¹⁰²

In 1992, two years after the *Swan* ruling, the Michigan Court of Appeals in *In re Rosebush*,¹⁰³ set forth guidelines regarding the right to remove life-sustaining treatment.¹⁰⁴ *Rosebush* involved a ten and one-half year old girl who had severed her spinal cord in a traffic accident and remained in a persistent vegetative state.¹⁰⁵ Her parents sought to have her life-support system removed.¹⁰⁶ The circuit court authorized the parents "to make any and all decisions regarding the medical treatment received by their daughter, including but not limited to,

97. *Id.*

98. For a general discussion of a minor's capacity to consent, see PROSSER AND KEETON § 18, at 115 (5th ed. 1984); RESTATEMENT (SECOND) OF TORTS § 892A cmt. b (1979). For a discussion of PROSSER AND KEATON and RESTATEMENT (SECOND) OF TORTS, see *supra* note 57. For example, individuals under the age of 18 could consent to adoption, operate a car, purchase tobacco products, leave school, marry, vote, and purchase and drink alcoholic beverages. *Swan*, 569 A.2d at 1205.

99. *Id.* (citing *In re E.G.*, 549 N.E.2d 322 (Ill. 1989)). See *supra* notes 61-81 and accompanying text.

100. *Swan*, 569 A.2d at 1205.

101. *Id.* at 1206. The court's decision was founded on "[the minor's] own conclusions and not on a theory of substituted judgment." *Id.* The "substituted judgment" standard requires a surrogate to "attempt to reach the decision that the incapacitated person would make if he or she were able to choose." PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 132 (1983). This standard "can be used only if a patient was once capable of developing views relevant to the matter at hand; further, there must be reliable evidence of those views." *Id.* at 133.

102. *Swan*, 569 A.2d at 1206.

103. 491 N.W.2d 633 (Mich. Ct. App. 1992).

104. *Id.* at 639-40.

105. *Id.* at 634-35.

106. *Id.* at 635.

the authority to order the removal of the ventilator that sustained the minor's respiratory functions.'"¹⁰⁷ Her parents authorized the removal of the respirator, and the child died shortly thereafter.¹⁰⁸

The Michigan Court of Appeals held that appellate review was appropriate despite the child's death "because the issues involve[d] questions of public significance that may recur and yet evade review."¹⁰⁹ In affirming the circuit court's decision,¹¹⁰ the Michigan Court of Appeals promulgated guidelines beyond the instant case,¹¹¹ stating that mature minors have a limited right to refuse lifesaving medical treatment.¹¹² The court further stated that the appropriate standard for deciding to terminate life-sustaining treatment of mature minors was the substituted judgement standard.¹¹³

107. *Id.*

108. *Id.*

109. *Rosebush*, 491 N.W.2d at 634 (citing *Highland Recreation Defense Found. v. Natural Resources Comm'n*, 446 N.W.2d 895 (Mich. Ct. App. 1989)). The court also referenced *In re Laurance*, 579 N.E.2d 32, 37 (Ind. 1991) & *In re Hamlin*, 689 P.2d 1372 (Wash. 1984). *Id.* at 634.

110. *Id.* at 641. The court held that Michigan recognized "a right to withhold or withdraw life-sustaining medical treatment as an aspect of the common-law doctrine of informed consent." *Id.* at 635. It therefore found it "unnecessary to decide the validity of the constitutional or statutory basis in Michigan." *Id.* at n.1.

The court stated that "the parents' informed decision [was] backed by uncontroverted medical evidence that their young child [was] terminally ill and that her condition [was] incurable and irreversible, their decision over[rode] any interest of the state in prolonging their child's life through extraordinary measures." *Id.* at 637.

The Michigan Supreme Court in *In re Martin*, 538 N.W.2d 399 (Mich. 1995), affirmed the *Rosebush* Court's reasoning "that a necessary corollary of the common-law right to informed consent is the right not to consent." *Id.* at 405.

111. *Rosebush*, 491 N.W.2d at 641 (Sawyer, J., concurring in part and dissenting in part). Judge Sawyer argued that "the majority's pronouncement of guidelines addressing cases beyond the one at bar [was] dangerously close to a usurpation of powers properly belonging to the Legislature." *Id.*

112. *Id.* at 639-40. The court recognized that "[t]he right to refuse lifesaving medical treatment is not lost because of the incompetence or the youth of the patient." *Id.* at 636 (citing *In re LHR*, 321 S.E.2d 716 (Ga. 1984). The court stated "[t]he advance directive of a mature minor, stating the desire that life-sustaining treatment be refused, should be taken into consideration or enforced when deciding whether to terminate the minor's life-support treatment or refuse medical treatment." *Id.* at 636, n.4. (citing *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *In re Swan*, 569 A.2d 1202 (Me. 1990)).

113. *Rosebush*, 491 N.W.2d at 639. For a discussion of the substituted judgement standard, see *supra* note 101. The court rejected adopting the "best interests" and the "clear and convincing" standards. *Rosebush*, 491 N.W.2d at 639. The

C. *Rejection of the Mature Minor Doctrine*

While there appears to be a trend toward recognizing a common law right of mature minors to refuse medical treatment, not all courts which have confronted this issue have held that such a right exists. The Texas Court of Appeals in *O.G.*, *P.G.*, and *M.G. v. Baum*,¹¹⁴ did not find *In re E.G.*¹¹⁵ persuasive and declined to subscribe to the mature minor doctrine.¹¹⁶ In *O.G.*, doctors advised a sixteen year old minor who was struck by a train that a blood transfusion would be needed during surgery.¹¹⁷ The minor, a Jehovah's Witness,¹¹⁸ withheld consent to a transfusion and signed a form releasing the hospital and the doctor "from all liability or responsibility . . . for following [his] request."¹¹⁹ The boy's parents also refused to consent to a transfusion if it was needed during surgery.¹²⁰ The Harris County Child Protective Services (hereinafter CPS) was appointed the boy's temporary managing conservator.¹²¹

The district court heard testimony from a CPS caseworker and the boy's father that the boy understood his refusal could be fatal.¹²² On appeal, the parents argued that the judge's appointment of a conservator deprived them of their constitu-

court noted that the best interests standard was inappropriate with regard to advance directives of mature minors because it is used "where the patient has never been competent." *Id.* Additionally, the court "summarily reject[ed] [the clear and convincing] standard, because its adoption would always preclude the termination of life-support efforts for minors . . . who have never been legally competent, in direct contradiction of the right to refuse medical treatment." *Id.* at n.7.

Three years after *Rosebush*, the Michigan Supreme Court held that where one "was competent and able to express his wishes and desires," a subjective decision-making standard [which is based on a patient's right to self determination] should be used. *In re Martin*, 538 N.W.2d at 408. The *Martin* Court further stated that it "express[ed] no opinion about the proper decision-making standard for patients who [had] never been competent." *Id.* at 409, n.15. It did, however, state that a more objective test, (which is based on the state's *parens patriae* power), may be "necessary and appropriate" under the circumstances presented in *Rosebush*. *Id.* at 408-09.

114. 790 S.W.2d 839 (Tex. Ct. App. 1990).

115. 549 N.E.2d 322 (Ill. 1989).

116. *O.G.*, 790 S.W.2d at 842.

117. *Id.* at 840.

118. For a discussion of the tenets of this religion, see *supra* note 64.

119. *O.G.*, 790 S.W.2d at 840.

120. *Id.*

121. *Id.*

122. *Id.*

tional right to freely exercise their religion and their authority to refuse a blood transfusion for their son.¹²³

The boy, relying on *In re E.G.*,¹²⁴ maintained that he had a constitutional¹²⁵ and common law right¹²⁶ to refuse the transfusion.¹²⁷ The court, however, distinguished *In re E.G.* from the case at hand thereby reducing its persuasive authority in *O.G.*¹²⁸ The court noted that the Illinois decision addressed only Illinois common law and did not address the First Amendment issue.¹²⁹ Additionally, it did not address federal constitutional law or Texas constitutional and common law.¹³⁰ Lastly, the court stated that Texas had not adopted the mature minor standard.¹³¹

The court then factually distinguished *In re E.G.*¹³² The court noted that E.G.'s doctors and the associate general counsel for the University of Chicago Hospital all testified to E.G.'s maturity.¹³³ In *O.G.*, however, only the minor's father had testified that his son understood that his refusal of a transfusion

123. *O.G.*, 790 S.W.2d at 840. The Texas Court of Appeals, affirming the district court, concluded that the parents' First and Fourteenth Amendment rights did not "include the liberty to expose their child to ill health or death." *Id.* at 840 (citing *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944)). The court further stated that "federal authority has refused to recognize parental constitutional rights to refuse blood transfusions for their minor children when a court appoints a guardian with the authority to consent to a transfusion over the parents' objections." *Id.* at 841 (citing *Staelens v. Yake*, 432 F. Supp. 834, 839 (N.D. Ill. 1977)).

124. 549 N.E.2d 322 (Ill. 1989); *See supra* notes 61-81.

125. The minor stated he had a First Amendment right to freely exercise his religion. *O.G.*, 790 S.W.2d at 841-42. *See supra* note 69 for the partial text of the First Amendment.

126. Mature minors in Illinois had a common law right to refuse medical treatment. *O.G.*, 790 S.W.2d at 842.

127. *Id.*

128. *Id.* For a discussion of *In re E.G.*, 549 N.E.2d 322 (Ill. 1989), *see supra* notes 61-81 and accompanying text.

129. *Id.* *See E.G.*, 549 N.E.2d at 328 (stating that "[b]ecause [the court found] that a mature minor may exercise a common law right to consent to or refuse medical care, [the court] decline[d] to address the [First Amendment free exercise clause] issue.").

130. *O.G.*, 790 S.W.2d at 842.

131. *Id.*

132. *Id.* For a discussion of *In re E.G.*, 549 N.E.2d 322 (Ill. 1989), *see supra* notes 61-81 and accompanying text.

133. *O.G.*, 790 S.W.2d at 842. The court discussed that E.G.'s doctors testified that she was "competent to understand the consequences of accepting or rejecting treatment" and a psychiatrist testified that E.G. had "the maturity level . . . of an 18 to 21 year old and that she [was] competent to make an informed decision to

could be fatal.¹³⁴ Additionally, the court mentioned that, although E.G. had testified before the trial court demonstrating her competence to understand the consequences of refusing treatment,¹³⁵ here, the minor had not testified before the trial court.¹³⁶ The Texas Court of Appeals concluded that, because Texas and federal law were not settled as to whether a sixteen year old had a constitutional right to refuse a blood transfusion, the circuit court did not abuse its discretion in appointing CPS as temporary managing conservator.¹³⁷ The court did not reach the issues of whether a minor has a right under the United States Constitution, the Texas Constitution, or the common law to refuse blood transfusions, because the relators¹³⁸ did not cite any cases holding that such a right existed.¹³⁹

D. *Responses of the Non-Legal Community*

The debate over the right of mature minors to refuse life-supporting treatment continues and has been further fueled by the recent policy statements of the American Academy of Pediatrics¹⁴⁰ and the Midwest Bioethics Center of Kansas City, Missouri¹⁴¹ (hereinafter Center) that "[support] the right of

refuse [a] blood transfusion, even if this choice was fatal." *Id.* (citing *In re E.G.*, 549 N.E.2d 322, 324 (Ill. 1989)).

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. Relator is defined as "[a]n informer. The person upon whose complaint, or at whose instance certain writs are issued . . . , and who is *quasi* the plaintiff in the proceeding. . . . A party in interest who is permitted to institute a proceeding in the name of the People or the Attorney General when the right to sue resides solely in that official." (alteration in original) BLACK'S LAW DICTIONARY 1289 (6th ed. 1990).

139. *O.G.*, 790 S.W.2d at 842.

140. Kathryn Dore Perkins, *Kids Asserting Rights in Health Care. Support Grows for Choice in Treatment*, S.F. EXAMINER, May 1, 1995, at B10 [hereinafter Perkins]. The American Pediatrics Academy (hereinafter Academy), after wrestling with the issue for 10 years, published its statement in February 1995. *Id.* The Academy concluded that "[p]atients generally have a moral and legal right to refuse proposed medical intervention, except when the patient has diminished decision-making capacity." *Id.* Dr. William Bartholome was the "primary author and champion" of the academy's policy and "was the force behind an effort by [the Midwest Bioethics Center of Kansas City, Missouri's] . . . weighty statement . . . supporting children's rights." *Id.*

141. *Id.* The Midwest Bioethics Center explained its statement at a discussion group on May 23, 1995. MIDWEST BIOETHICS CENTER, MAJOR DECISIONS AND

competent youngsters to refuse or consent to life-sustaining treatment.”¹⁴² The Center stated it was “committed to the pursuit of a *shared* decision making model which respects the important and distinct roles of children, parents, and providers in health care decisions.”¹⁴³

The Center’s model was based on the following instrumental assumptions:¹⁴⁴ (1) a person’s age was not necessarily determinative of decision-making capacity;¹⁴⁵ (2) children are not the parents’ property;¹⁴⁶ (3) minors have moral status and legal standing independent of their parents;¹⁴⁷ (4) mature minors should be governed by the ethical and legal presumptions of capacity.¹⁴⁸ In addition, the Center recognized “the developing capacity of minors for rationality, autonomy, and participation in decision-making”¹⁴⁹ and set forth three primary components for its “new model for health care decision making involving minors.”¹⁵⁰ The first component of the Center’s model was “child assent.”¹⁵¹ The Center proposed that health care providers solicit the assent of children “who are capable of participat-

MINORS: HEALTH CARE TREATMENT DECISION MAKING FOR CHILDREN (1995). The Center’s Task Force was comprised of “pediatricians, nurses, social workers, child psychologists, child psychiatrists, chaplains, and patient representatives” along with “clinical ethicists, health care lawyers, risk managers, community representatives and staff from Midwest Bioethics Center.” MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0.

142. Perkins, *supra* note 140. Bartholome provided a general overview of the statements: “[I]f a person is 15, 16, or 17 and knows what is wrong with them and understands the options, risks and benefits of treatment, they would have the same right of refusal an adult would have.” Perkins, *supra* note 140.

143. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0 (emphasis in the original).

144. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 4.0.

145. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 4.2.

146. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 4.5.

147. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 4.6.

148. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 4.12.

149. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0. Minors were assumed to fit into three categories for purposes of the guideline: (1) minors who do not have decision-making capacity (e.g., infants, toddlers, most pre-school aged children); (2) minors who have a developing decision-making capacity (e.g., elementary school aged children); and (3) minors who have decision-making capacity to make most medical care decisions (e.g., mature minors, emancipated minors and most senior high school aged minors). MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0.

150. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0.

151. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0. Child assent is “the free expression of a child’s willingness to undergo a specific health care treatment

ing in the treatment decision-making but have not yet fully developed decisional capacity.”¹⁵² The Center’s second component recognized the ethical obligations of health care providers to minor patients and included the concept of informed parental/guardian permission.¹⁵³ Parental/Guardian permission and the assent of the children must be received in order for health care providers to treat children with developing capacities for decision-making.¹⁵⁴ The final component acknowledged the assumption that “minors achieve decisional capacity at [a] much earlier [age] than is recognized legally.”¹⁵⁵

The determination of the minor’s decisional capacity would be shared by the minor, the parents, and the health care providers.¹⁵⁶ Decisional capacity would be assessed on a case-by-case basis.¹⁵⁷ The minor’s desires with respect to treatment alternatives would not be used as evidence of the minor’s decisional capacity.¹⁵⁸ If, however, the minor wanted to refuse medical treatment, the assessment of the minor’s decisional capacity would “require greater confidence about the minor’s decisional capacity on the part of providers and parents.”¹⁵⁹

The Center developed separate Patient Rights Statements for each of the three categories of minors.¹⁶⁰ The Patient Rights Statement drafted for minors with decisional capacity included the right to refuse medical treatment.¹⁶¹ Minors with decisional

based on the child’s knowledge and understanding.” MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0.

152. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0.

153. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0. Informed parental permission was defined as “a process by which parents/guardians of minors grant or deny permission to the provision of recommended health care interventions for their children or wards.” MIDWEST BIOETHICS CENTER, *supra* note 18, at § 2.13.

154. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 2.13.

155. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 1.0.

156. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 7.4.

157. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 7.4.a.

158. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 7.4.a.

159. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 7.4.e.

160. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 6.0. For a discussion of the three categories of minors, see *supra* note 149.

161. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 6.2.i. The statement delineates the right of minors to “[a]ccept or refuse any procedure, drug or treatment and to be informed of the possible consequences of any such decision.” MIDWEST BIOETHICS CENTER, *supra* note 18, at § 6.2.i.

capacity were "regarded as having the right to refuse treatment, including life-sustaining treatment" ¹⁶²

Parents of said minors were regarded as "'consultants' [whose role should include] assist[ing] the minor to make appropriate decisions by providing information and support" ¹⁶³ The Center set forth a parental statement "to complement the patients' rights statements provided to their child." ¹⁶⁴

Recognizing that disagreements transpire among parents and their children over treatment decisions, the Center included two provisions in the parental statement setting forth mechanisms to resolve the conflict. ¹⁶⁵ Mechanisms to resolve the disagreement ranged from talking to another health care provider, to requesting help from the hospital's ethics committee. ¹⁶⁶ In case the disagreement was not resolved, the parents would have the right to transfer their child to another medical institution, and if the health care providers opposed transfer, the health care institution would provide the parents with notice of a pending legal action and give the parents information to help them obtain legal counsel. ¹⁶⁷

The Center acknowledged that its guidelines would not be accepted into the policies of medical institutions at face value. ¹⁶⁸ Therefore, the Center stated that it hoped the guidelines "help[ed] to identify the issues and [had] provided some thoughtful guidance to those who work with minors." ¹⁶⁹

III. Minors in New York

A. *Current Statutory and Common Law Treatment of Minors*

In New York, competent adults have a common law ¹⁷⁰ and a statutory right to bodily self-determination to accept and to re-

162. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 7.3.a.

163. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 7.3.b.

164. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 6.3.

165. MIDWEST BIOETHICS CENTER, *supra* note 18, at §§ 6.3.i & 6.3.j.

166. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 6.3.i.

167. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 6.3.j.

168. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 8.0.

169. MIDWEST BIOETHICS CENTER, *supra* note 18, at § 8.0.

170. *See In re Storar (In re Eichner)*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (the right to decide about medical treatment includes the right to refuse life-sustaining treatment), *cert. denied*, 454 U.S. 858 (1981); *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92 (1914) ("every human

fuse medical treatment.¹⁷¹ Adults also have a right guaranteed by the New York State Constitution to refuse life-preserving treatment.¹⁷² However, the right to refuse medical treatment is not absolute; certain compelling state interests, such as prevention of suicide or protection of a minor or other dependents, may act as a barrier to granting a competent patient's application to refuse extraordinary treatment.¹⁷³

Minors, on the other hand, are for the most part considered incompetent.¹⁷⁴ As such, parental consent is ordinarily required before the minor can receive health services.¹⁷⁵ The right of

being of adult years and sound mind has the right, at common law, to determine what shall be done with his own body . . . and cannot be subjected to medical treatment without his consent.”).

171. See N.Y. PUB. HEALTH LAW § 2803-c(2) and (3)(e) (McKinney 1993) (providing that “every nursing home and facility providing health related service . . . shall adopt and make public a statement of rights and responsibilities of patients” stating that “[e]very patient shall have the right to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions.”). *Id.* at § 2803-c(3)(e).

172. N.Y. CONST. art. I. See also *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 226, 551 N.E.2d 77, 81, 551 N.Y.S.2d 876, 880 (1990) (The “fundamental common-law right [of a competent adult to refuse life-preserving treatment] is coextensive with the patient’s liberty interest protected by the due process clause of [the New York] State Constitution”) (quoting *Rivers v. Katz*, 67 N.Y.2d 485, 493, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74, 78 (1986)).

173. See *Fosmire*, 75 N.Y.2d at 227, 551 N.E.2d at 81, 551 N.Y.S.2d at 880 (1990) (“The threshold inquiry is whether there is an identifiable State interest in intervening in the patient’s medical choice. The state has a well-recognized interest in protecting and preserving the lives of its citizens.”); *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 486, 455 N.Y.S.2d 706, 711 (Sup. Ct. Nassau County 1982) (directed that life support be removed from a terminally ill 41 year old unmarried and childless man who, prior to becoming comatose, made an informed, rational and knowing decision to forego such treatments).

The decision to refuse essential medical care is not considered a suicidal act nor is it an indication of incompetence. *Fosmire*, 75 N.Y.2d at 227, 551 N.E.2d at 82, 551 N.Y.S.2d at 881 (citing *In re Storar*, 52 N.Y.2d at 377-78 n.6, 420 N.E.2d at 71 n.6, 438 N.Y.S.2d at 273 n.6 (1981)).

174. See *In re Alfonso v. Fernandez*, 195 A.D.2d 46, 606 N.Y.S.2d 259 (2d Dep’t 1993), *appeal dismissed*, 83 N.Y.2d 906, 637 N.E.2d 278, 614 N.Y.S.2d 388 (1994); *Weber v. New York*, 267 A.D. 325, 45 N.Y.S.2d 834 (3d Dep’t 1944); *Locklin v. Fisher*, 264 A.D. 452, 36 N.Y.S.2d 162 (3d Dep’t), *reh’g and appeal denied*, 264 A.D. 961, 37 N.Y.S.2d 486 (1942). For a discussion of *Alfonso*, see *infra* note 175.

175. See *In re Alfonso* 195 A.D.2d 46, 606 N.Y.S.2d 259 (2d Dep’t 1993), *appeal dismissed*, 83 N.Y.2d 906, 637 N.E.2d 278, 614 N.Y.S.2d 388 (1994). “Health services” is not defined in the New York Public Health Law or in the common law. *Id.* at 63, 606 N.Y.S.2d at 270 (Eiber J., dissenting).

parents to speak for their children with regard to medical treatment is not absolute.¹⁷⁶ In addition, several exceptions to the general rule requiring parental consent have been codified in the New York Public Health Law;¹⁷⁷ "[t]he exceptions recognize that sound public policy is served by allowing adolescents younger than [eighteen] to control their own health care under certain circumstances."¹⁷⁸ The New York Court of Appeals has yet to address the issue of allowing mature minors to refuse life-

In *Alfonso*, parents of high school students challenged the New York City Board of Education's decision to include a condom distribution program in its HIV/AIDS education program. *Id.* at 49, 606 N.Y.S.2d at 261. The parents contended that the condom distribution program was violative of § 2504 of the New York Public Health Law. Specifically, they argued that the condom availability program was a "health service," and, therefore, the school required parental consent before providing the program. *Id.* See N.Y. PUB. HEALTH LAW § 2504 (McKinney 1985). The parents also argued that the program violated not only their due process rights to direct the upbringing of their children, but also the right to free exercise of religion under the First Amendment to the United States Constitution and the New York Constitution. *Alfonso*, 195 A.D.2d at 49, 606 N.Y.S.2d at 261. See N.Y. CONST. art. I, § 3, and *supra* note 69 for the partial text of the First Amendment.

The appellate division held that the distribution of condoms was a "health service," and as such required parental consent. *Alfonso*, 195 A.D.2d at 51-52, 606 N.Y.S.2d at 263. The court reasoned that the public health law had codified some, but not all, common law exceptions to the general incapacity of minors rule, and none were applicable in the case at bar. *Id.* at 51, 606 N.Y.S.2d at 262.

176. See *In re Cicero*, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Sup. Ct. Bronx County 1979) (court appointed guardian to consent to surgery for child with spina bifida where the parents refused to consent); *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. Ulster County 1970) *aff'd*, 37 A.D.2d 668, 323 N.Y.S.2d 253 (3d Dep't 1971), *aff'd*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972) (court ordered surgery to correct severe facial deformity of 15 year old boy, and held that mother's objection on religious grounds to blood transfusion, in connection with surgery, constituted neglect).

177. See N.Y. PUB. HEALTH LAW § 2504(1) (McKinney 1985) ("Any person who is 18 years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary."); N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 1985) ("Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care."); N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 1985) (Allowing medical, dental, health and hospital services to be given "when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health."). See also N.Y. PUB. HEALTH LAW § 2980(3) (McKinney 1991) (defining "capacity to make health care decisions" as "the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision").

178. NEW YORK STATE TASK FORCE, *supra* note 19, at 42.

sustaining medical treatment,¹⁷⁹ and the New York Legislature has yet to enact such a law, despite the introduction of such bills during the last several legislative sessions.¹⁸⁰

B. *The Lower New York Courts*

The same year that the Illinois Supreme Court recognized the mature minor doctrine, a New York trial court in *In re Long Island Jewish Medical Center*¹⁸¹ recognized the merit in the "mature minor" doctrine. One month before his eighteenth birthday, Phillip Malcolm, was rushed to the plaintiff hospital's emergency room. Preliminary blood tests indicated his blood was being broken down¹⁸² and that he might need a blood transfusion.¹⁸³ Phillip and his parents withheld their consent to the needed blood transfusions because they were Jehovah's Witnesses.¹⁸⁴

The next morning, the hospital petitioned the court for an order authorizing the medical treatment.¹⁸⁵ During the hearing held that afternoon, the doctors announced that Phillip was suffering from widespread pediatric cancer,¹⁸⁶ and that the recommended course of treatment, chemotherapy, would require that Phillip have transfusions.¹⁸⁷ Phillip and his parents immedi-

179. NEW YORK STATE TASK FORCE, *supra* note 19, at 44. As a result, lower New York courts have not been consistent when addressing the rights of minors to refuse life-sustaining treatment. Compare *In re Long Island Jewish Medical Ctr.*, 147 Misc. 2d 724, 557 N.Y.S.2d 239 (Sup. Ct. Queen's County 1990) (calling for the adoption of the mature minor doctrine) with *In re Thomas B.*, 152 Misc. 2d 96, 574 N.Y.S.2d 659 (Fam. Ct. Cattaraugus County 1991) (implicitly rejecting the mature minor doctrine).

180. See N.Y.A. 6791, 218th Sess. (1995) and N.Y.S. 5020, 218th Sess. (1995). For a discussion of these bills see *infra* notes 231-34.

181. 147 Misc. 2d 724, 557 N.Y.S.2d 239 (Sup. Ct. Queens County 1990).

182. *Id.* at 725, 557 N.Y.S.2d at 240. Phillip's blood count revealed that he was anemic and that his hemoglobin and hematocrit counts were abnormally low. *Id.*

183. *Id.*

184. *Id.* For a discussion of the tenets of this religion, see *supra* note 64.

185. *Long Island Jewish Medical Ctr.*, 147 Misc. 2d at 725, 557 N.Y.S.2d at 240.

186. *Id.* at 725, 557 N.Y.S.2d at 240-41.

187. *Id.* at 725, 557 N.Y.S.2d at 241. A doctor testified that 75% of patients respond to this treatment and go into remission from several months to years. The cure rate among those patients who go into remission was between 25% and 30%. *Id.*

ately refused to consent to the transfusions.¹⁸⁸ Since this was the first time that Phillip and his parents had learned of the diagnosis, the court asked them to reconsider their refusal.¹⁸⁹

The next day, the doctor in charge of Phillip's case testified that, without treatment, Phillip would die a painful death, probably within a month.¹⁹⁰ Again, Phillip's parents refused to consent to the transfusions.¹⁹¹ Phillip testified that he joined the Jehovah's Witnesses in 1987, then lost interest for a while until he returned to the religion in 1989.¹⁹² Phillip stated that although he did not know the books of the Bible, he knew that the religion prohibited blood transfusions.¹⁹³ The court noted that Phillip had never been away from home, never dated a girl, always consulted his parents before making decisions, and when asked whether he considered himself an adult or a child, responded "child."¹⁹⁴ Ultimately, after Phillip's condition worsened, the court ordered an immediate transfusion.¹⁹⁵

The court, noting statutory instances permitting minors to consent to medical treatment,¹⁹⁶ held that Phillip was not a mature minor and "his refusal to consent to blood transfusions

188. *Id.* at 726, 557 N.Y.S.2d at 241.

189. *Id.*

190. *Long Island Jewish Medical Ctr.*, 147 Misc. 2d 724, 726, 557 N.Y.S.2d 239, 240 (Sup. Ct. Queens County 1990).

191. *Id.* at 727, 557 N.Y.S.2d at 241.

192. *Id.*

193. *Id.* The books of the Bible are an important part of the study of Jehovah's Witnesses. *Id.* Phillip believed he would not achieve everlasting life if he consented to the transfusion. *Id.* at 727, 557 N.Y.S.2d at 241-42. He further stated that if the court ordered the transfusions "it would not be his responsibility or sin." *Id.* at 727, 557 N.Y.S.2d at 242.

194. *Id.* at 727, 557 N.Y.S.2d at 241.

195. *Id.* at 728, 557 N.Y.S.2d at 241.

196. *Id.* at 729-30, 557 N.Y.S.2d at 242. See N.Y. MENTAL HYG. LAW § 9.13(a) (McKinney 1988) (permitting minors over the age of 16 to consent to inpatient mental health treatment); N.Y. MENTAL HYG. LAW §§ 33.21(c)-(d) (McKinney 1988) (permitting minors to consent to outpatient mental treatment); N.Y. MENTAL HYG. LAW § 21.11(c) (McKinney 1988) (permitting minors to consent to substance abuse treatment); N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 1985) (permitting minors to consent to treatment for sexually transmitted diseases); N.Y. PUB. HEALTH LAW § 2504(1) (McKinney 1985) (permitting any married person or parent to give effective consent for his or her own medical, dental, health and hospital services); N.Y. PUB. HEALTH LAW § 2504(2) (McKinney 1985) (permitting any parent to give effective consent for his or her child); N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 1985) (permitting any pregnant female to give effective consent relating to prenatal care).

[was] not based upon a mature understanding of his own religious beliefs or of the fatal consequences to himself."¹⁹⁷ Finally, the court "recommended that the Legislature or the appellate courts take a hard look at the 'mature minor' doctrine and make it either statutory or decisional law in New York State."¹⁹⁸

The following year, a New York family court in *In re Thomas B.*¹⁹⁹ judicially overrode the protests of a fifteen year old who refused to undergo a tumor biopsy due to his "strong phobia for needles."²⁰⁰ The boy's mother had petitioned the court for an order requiring her child to submit to the surgery.²⁰¹ The boy's legal guardian expressed Thomas' objections, yet agreed that the surgery was consistent with the minor's best interests.²⁰²

Recognizing the New York State's interest in protecting the health and welfare of children within its jurisdiction,²⁰³ the court declared that a person under the legal age of majority could neither consent to treatment nor withhold consent.²⁰⁴ Although the court expressed its reluctance to summarily disregard Thomas' protests, it nevertheless ordered the hospital to immediately admit, examine, and surgically treat him.²⁰⁵

197. *Long Island Jewish Medical Ctr.*, 147 Misc. 2d at 730, 557 N.Y.S.2d at 243.

198. *Id.* at 730, 557 N.Y.S.2d at 243. The court strongly recommended that if the mature minor doctrine did become law in New York, a hearing should be held to determine first whether the child is mature. *Id.* The court further stated that if the minor was not found to be mature, the hearing should continue without the child present. *Id.* at 730, 557 N.Y.S.2d at 243, n.16.

199. 152 Misc. 2d 96, 574 N.Y.S.2d 659 (Fam. Ct. Cattaraugus County 1991).

200. *Id.* at 97, 574 N.Y.S.2d at 659.

201. *Id.* at 97, 574 N.Y.S.2d at 660.

202. *Id.*

203. *Id.* at 98, 574 N.Y.S.2d at 660. "The State, 'as parens patriae, has a strong interest' in protecting the health and welfare of [a] child (within its jurisdiction)." *Id.* (citing *In re Storar*, 52 N.Y.2d 363, 381, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981)).

204. *Thomas B.*, 152 Misc. 2d at 98-99, 574 N.Y.S.2d at 660-61. See N.Y. PUB. HEALTH LAW § 2504(1) (McKinney 1985). The court concluded that "[a]n implicit corollary of [section 2504(a) of the New York Public Health Law] is that a person under eighteen years of age may not give effective consent . . . it follows logically that such a person may not effectively withhold consent, either." *Thomas B.*, 152 Misc. 2d at 98-99, 574 N.Y.S.2d at 660-61.

205. *Thomas B.*, 152 Misc. 2d at 98-99, 574 N.Y.S.2d at 660-61. The court found that the mother and the Department of Social Services had met their burden of demonstrating that "time [was] of the essence." *Id.* at 99, 574 N.Y.S.2d at 661.

C. *The Governor's Task Force on Life and the Law*

In 1985, New York State Governor Cuomo established a Task Force on Life and the Law (hereinafter Task Force)²⁰⁶ to enhance the public's understanding of issues raised by medical advances, including decisions about life-sustaining treatment, and to recommend legislation or regulation.²⁰⁷ The twenty-five member Task Force included prominent physicians, nurses, attorneys, academics and representatives of religious communities.²⁰⁸

206. NEW YORK STATE TASK FORCE, *supra* note 19, at vii. The Task Force was convened as a result of the former state health commissioner Dr. David Axelrod's extraordinary activism. Jonathan D. Moreno, *Who's to Choose? Surrogate Decisionmaking in New York State*, 23 HASTINGS CTR. REP. 5 (1993).

Even though Governor Cuomo lost his reelection bid in November 1994, the Task Force's funding has been guaranteed through the end of March 1996. Telephone Interview with Carl H. Coleman, Associate Counsel to the New York Task Force on Life and the Law (June 27, 1995).

207. NEW YORK STATE TASK FORCE, *supra* note 19, at vii. For a general summary of the Task Force's proposal on surrogate decision-making, see John J. Regan, *Refusing Life-Sustaining Treatment for Incompetent Patients: New York's Response to Cruzan*, 19 N.Y.U. REV. L. & SOC. CHANGE 341 (1991-1992).

208. NEW YORK STATE TASK FORCE, *supra* note 19, at ii-iii. Task Force members included: Karl Adler, M.D. (Dean, New York Medical College); Rev. Msgr. John A. Alesandro (Chancellor, Roman Catholic Diocese of Rockville Centre); John Arras, Ph.D. (Clinical Associate Professor of Bioethics, Albert Einstein College of Medicine/Montefiore Medical Center); Mario L. Baeza, Esq. (Debevoise & Plimpton); The Right Rev. David Ball (Bishop, Episcopal Diocese of Albany); Rabbi J. David Bleich (Professor of Talmud, Yeshiva University; Professor of Jewish Law and Ethics, Benjamin Cardozo School of Law); Evan Calkins, M.D. (Professor of Medicine at Emeritus, SUNY-Buffalo); Richard J. Concannon, Esq. (Kelley, Drye & Warren); Myron W. Conovitz, M.D. (Attending Physician, North Shore University Hospital; Clinical Associate Professor of Medicine, Cornell University Medical College); Saul J. Farber (Dean and Provost, Chairman, Department of Medicine, New York University School of Medicine); Alan R. Fleischman, M.D. (Director, Division of Neonatology, Albert Einstein College of Medicine/Montefiore Medical Center); Samuel Gorovitz, Ph.D. (Dean, College of Arts and Sciences, Professor of Philosophy, Syracuse University); Jane Greenlaw, J.D., R.N. (Director, Division of the Medical Humanities, University of Rochester School of Medicine and Dentistry); Beatrix A. Hamburg, M.D. (Chairman, Division of Child and Adolescent Psychiatry, Mount Sinai School of Medicine); Denise Hanlon, R.N., M.S. (Clinical Specialist, Rehabilitation and Gerontology); Rev. Donald W. McKinney (First Unitarian Church of Brooklyn, Chairman Emeritus, Choice in Dying); Maria I. New, M.D. (Chief, Department of Pediatrics, New York Hospital-Cornell Medical Center); John J. Regan, J.S.D. (Professor of Law, Hofstra University School of Law); Rabbi A. James Rudin (National Director of Interreligious Affairs, The American Jewish Committee); Rev. Betty Bone Schiess (Episcopal Diocese of Central New York); Barbara Shack (The New York Civil Liberties Union); Rev. Robert S. Smith (Director, Institute for Medicine in Contemporary Society, SUNY Health Science Center

1. *Health Care Decisions of Mature Minors*

In addressing the right of mature minors to refuse life-sustaining treatment, the Task Force recognized the "complex balancing of the developing rights of the minor and parental rights,"²⁰⁹ and society's interest "in promoting the autonomy and well-being of minors."²¹⁰ The Task Force rejected the idea of lowering the age of majority for deciding health care issues, noting that minors are currently accorded the right to decide about medical treatment for certain conditions only.²¹¹ Additionally, it refused to extend to minors the presumption of capacity accorded to adults.²¹² It did, however, recognize that some minors have the maturity and capacity to participate in decisions about their life-sustaining treatment.²¹³ The Task Force recommended that mature minors be accorded a *substantial*, and not an exclusive, role in decisions about life-sustaining

at Stony Brook); and Elizabeth W. Stack (Commissioner, New York State Commission on Quality of Care for the Mentally Disabled). NEW YORK STATE TASK FORCE, *supra* note 19, at ii, iii.

All the members supported the proposed legislation except Rabbi J. David Bleich. NEW YORK STATE TASK FORCE, *supra* note 19, at ix. Rabbi Bleich's Minority Report primarily centered on his belief that "there has been a steady, linear progression in the erosion of the value associated with preservation of human life in the mores of our society." NEW YORK STATE TASK FORCE, *supra* note 19, at 240. Drawing a distinction between a surrogate's role in choosing among alternative therapies (the goal of which is to prolong life) and in withholding potentially life-prolonging treatment (the goal of which is the patient's early demise), Rabbi Bleich concluded that the "decision to die is far too awesome a matter to be delegated to a proxy and certainly far too awesome a matter to be delegated to a self-appointed surrogate." NEW YORK STATE TASK FORCE, *supra* note 19, at 243.

209. NEW YORK STATE TASK FORCE, *supra* note 19, at 129.

210. NEW YORK STATE TASK FORCE, *supra* note 19, at 129.

211. NEW YORK STATE TASK FORCE, *supra* note 19, at 129-30.

212. NEW YORK STATE TASK FORCE, *supra* note 19, at 130. The Task Force found that extending such presumption would be inappropriate because regardless of whether the minor has significant cognitive abilities, the adolescent "may have difficulty in assessing future consequences of [his or her] choices or anticipating changes in [his or her] values or preferences." NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

But see Nancy Batterman, *Under Age: A Minor's Right to Consent to Health Care*, 10 *TOURO L. REV.* 637 (1994). Batterman contends that "[b]y codifying the 'mature minor' doctrine, [the New York legislature] would . . . be harmonizing the law with what is already current practice." *Id.* at 673. She describes § 2504 of the New York Public Health Law as a "piecemeal statutory approach to minors' health care issues." *Id.* at 669. See N.Y. PUB. HEALTH LAW § 2504(1), (3), (4) (McKinney 1985).

213. NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

treatment.²¹⁴ It chose to give mature minors this non-exclusive role even though it recognized that in certain cases it would be "ethically acceptable and appropriate to respect the choice of a capable unemancipated minor."²¹⁵ The Task Force "recommend[ed] that the determination of a minor's capacity to participate in a decision about life-sustaining treatment should be made on a case-by-case basis."²¹⁶

Determinations of capacity would be made by the attending physician, in consultation with the parent(s) or guardian(s).²¹⁷ The physician would assess the minor's maturity, conceptual ability and experience in making important life decisions.²¹⁸ If

214. NEW YORK STATE TASK FORCE, *supra* note 19, at 131.

215. NEW YORK STATE TASK FORCE, *supra* note 19, at 131. For example, the Task Force mentioned that an adolescent dying of AIDS or cancer might be able to accept death more readily than his or her parents, and a course of treatment (i.e., chemotherapy or experimental treatment for AIDS) may only prolong the adolescent's dying. NEW YORK STATE TASK FORCE, *supra* note 19, at 131. The Task Force quickly dismissed a proposal to respect the choice of minors in the above scenario basing its rejection on its belief that "few hospitals would remove treatment in the face of parental opposition and that granting minors the right to decide over the objection of parents [would] also yield poor decisions in some cases." NEW YORK STATE TASK FORCE, *supra* note 19, at 131.

216. NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

217. NEW YORK STATE TASK FORCE, *supra* note 19, at 131. The Task Force believed that parents would be most familiar with their child's emotional and cognitive development. NEW YORK STATE TASK FORCE, *supra* note 19, at 131. Compare the Task Force's proposal that ultimately the attending physician would determine capacity based on observations of the minor and information received by the parents and health care professionals. NEW YORK STATE TASK FORCE, *supra* note 19, at 131 with N.Y. PUB. HEALTH LAW §§ 2963(2), (3)(a) (McKinney 1993) (requiring at least 2 physicians concur in the determination that an adult lacks capacity to make a decision regarding cardiopulmonary resuscitation) and N.Y. PUB. HEALTH LAW § 2983(1)(b) (McKinney Supp. 1995) (requiring for a decision to withdraw or withhold life-sustaining treatment that the attending physician who determines that a patient lacks capacity, for the purpose of empowering a health care agent, because of mental illness to consult with a qualified psychiatrist) and N.Y. PUB. HEALTH LAW § 2983(1)(c) (McKinney 1993) (requiring for a decision to withdraw or withhold life-sustaining treatment that the attending physician who determines that a patient lacks capacity, for the purpose of empowering a health care agent, because of a developmental disability to consult with a specific physician or clinical psychologist).

218. NEW YORK STATE TASK FORCE, *supra* note 19, at 130. See *Parham*, 422 U.S. 584, 608 (1979). The *Parham* Court stated that "[w]hat is best for a child is an individual medical decision that must be left to the judgment of physicians in each case" and that "[t]here is no reason to require a judicial-type hearing in all circumstances." *Id.* The Court further noted that it did "not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from

the attending physician found the minor had decisional capacity, the minor would then be accorded a substantial, although not exclusive, role in decisions to refuse life-sustaining treatment.²¹⁹ Parental consent would be required in order for the minor to forego life-sustaining treatment, unless the minor obtained a court order.²²⁰ Although the Task Force believed that disagreements about life-sustaining treatment between minors with decision-making capacity and their parents would be rare,²²¹ it suggested that if such a conflict arose, a bioethics review committee could play a role in contributing to the resolution.²²²

2. *The Role of Bioethics Review Committees*

The Task Force proposed that state law mandate the creation of bioethics review committees²²³ in each health care facility in the state. These review committees would consider treatment decisions on an individual basis, as opposed to an institutional basis, which would examine whole research programs.²²⁴ Each bioethics review committee would include at least one physician; one registered nurse; one certified social worker or other person with training or expertise in providing psychosocial services to patients; one individual with training or expertise in either bioethics, moral philosophy, or theology; and one lay community member unaffiliated with the facility.²²⁵

The Task Force recommended that the bioethics review committees be available to consult and advise persons who are engaged in conflict regarding the care of patients.²²⁶ These com-

a trained specialist using the traditional tools of medical science to an untrained judge" *Id.* at 609.

219. NEW YORK STATE TASK FORCE, *supra* note 19, at 131.

220. NEW YORK STATE TASK FORCE, *supra* note 19, at 131. Parental consent would not, however, be required if the minor chose to have the treatment. NEW YORK STATE TASK FORCE, *supra* note 19, at 131.

221. NEW YORK STATE TASK FORCE, *supra* note 19, at 131.

222. NEW YORK STATE TASK FORCE, *supra* note 19, at 131-32.

223. NEW YORK STATE TASK FORCE, *supra* note 19, at 137-38. Bioethics is defined as "the study of the ethical problems arising from scientific advances" in the fields of biology and medicine. WEBSTER'S NEW WORLD DICTIONARY 140 (3d ed. 1988). See Barbara C. Thorton et al., *Bioethics Education - Expanding the Circle of Participants*, 23 HASTINGS CENTER REPORT 25 (Jan.-Feb. 1993).

224. NEW YORK STATE TASK FORCE, *supra* note 19, at 138.

225. NEW YORK STATE TASK FORCE, *supra* note 19, at 139.

226. NEW YORK STATE TASK FORCE, *supra* note 19, at 148.

mittees would, through informal mediation, have a role in helping to resolve conflicts between minors who refuse life-sustaining treatment, and their parents.²²⁷

In the event conflicts were not resolved, the Task Force suggested that the committees issue non-binding opinions stating their conclusions.²²⁸ The Task Force believed that the use of non-binding opinions to support the minor's decision to refuse life-sustaining treatment would help convince the parents to consent to the mature minor's decision.²²⁹ "In the unusual event" that the parents continued to insist on treatment despite the minor's decision, the Task Force stated that the committee or health care facility should then refer the matter to the Legal Aid Society, or help the minor obtain other legal counsel so that a court could resolve the ongoing conflict.²³⁰

The Task Force recommendations and proposed legislation led Assemblyman Gottfried to again sponsor and introduce a bill to amend the New York Public Health Law.²³¹ This bill, in addition to the Senate Bill introduced by Senator Hannon,²³² set forth the Task Force recommendations with respect to the determination of a minor's decision-making capacity, and the limited role minors with said capacity would have with regard to

227. NEW YORK STATE TASK FORCE, *supra* note 19, at 132.

228. NEW YORK STATE TASK FORCE, *supra* note 19, at 132.

229. NEW YORK STATE TASK FORCE, *supra* note 19, at 132.

230. NEW YORK STATE TASK FORCE, *supra* note 19, at 132.

231. N.Y.A. 6791, 218th Sess. (1995). Prior to the introduction of this bill, Assemblyman Gottfried, at the request of Governor Cuomo, sponsored and introduced bills to amend the New York Public Health Law which did not pass the Assembly. *See, e.g.*, N.Y.A. 7166-B, N.Y. Legis, 215th Sess. (1993).

232. N.Y.S. 5020, 218th Sess. (1995).

withholding life-sustaining treatment.²³³ Neither bill passed during the first session of the legislature.²³⁴

III. Analysis

The New York Legislature needs to decide the issue of whether mature minors should have the right to refuse life-sustaining treatment. Currently, minors in New York do not have a statutory, a common law, or a recognized constitutional right to participate in decisions regarding refusal of life-sustaining medical treatment. Minors who are deemed mature despite their chronological age should know definitively what weight, if any, will be given to their desire to refuse medical treatment.

It is well established that children's decision-making capacity increases with age,²³⁵ and that the such capacity is best assessed on a case-by-case basis that recognizes individualism.²³⁶ New York law must similarly recognize the progressive capacity of minors and the liberty interest minors have with respect to health care decisions,²³⁷ and grant mature minors the right to refuse medical treatment.

The mature minor exception to the general rule that parents speak for their children with regard to health care decisions is not part of New York's common law.²³⁸ Because "[t]he courts can only decide the cases that actually come before

233. Decision-making capacity is defined as "the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of, and alternatives to, any such proposed health care, and to reach an informed decision." N.Y.A. 6791 § 2995-A(7), 218th Sess. (1995); N.Y.S. 5020 § 2995-A(7), 218th Sess. (1995). In determining whether the minor has decision-making capacity:

[a]n attending physician, in consultation with a minor's parent or guardian shall determine whether a minor has decision-making capacity for a decision to withhold or withdraw life-sustaining treatment. If the minor has such capacity, the parent must consent to withhold or withdraw life-sustaining treatment for decisions pursuant to this section.

N.Y.A. 6791 § 2995-E(2)(A), 218th Sess. (1995); N.Y.S. 5020 § 2995-E(2)(A), 218th Sess. (1995).

234. Search of WESTLAW, NY-BILLTRK Database (July 28, 1995).

235. See PROSSER AND KEETON, *supra* note 57.

236. NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

237. See *supra* note 27 and accompanying text.

238. NEW YORK STATE TASK FORCE, *supra* note 19, at 44.

them,²³⁹ the New York Court of Appeals has not yet addressed the issue of whether mature minors have a common law right to refuse life-sustaining medical treatment. Should the court be faced with the issue, absent prior legislative action, it would have to examine whether the New York Public Health Law exceptions to the general rule of parental consent²⁴⁰ are indicative of the legislature's intent to occupy the entire area of medical treatment for minors.²⁴¹

A. *The Role of the Legislature*

The New York Legislature, and not the judiciary, is the proper body to ultimately establish the mature minor doctrine in New York. The debate over whether the courts or the legislature is the proper body to recognize the mature minor doctrine is evidenced by the strong concurrence and dissents in *Cruzan*,²⁴² and the dissents in *In re E.G.*,²⁴³ and *Rosebush*,²⁴⁴ as

239. Hon. Sol Wachtler, *A Judge's Perspective: The New York Rulings*, LAW, MEDICINE & HEALTH CARE, Spring-Summer 1991 at 60, 62.

240. See *supra* notes 177 and 196.

241. The Tennessee Supreme Court premised its decision in *Cardwell* on the fact that it did not find any indication that the Tennessee Legislature intended to occupy the entire area of medical treatment for minors. *Cardwell*, 724 S.W.2d at 744. For a discussion of *Cardwell*, see *supra* notes 42-60.

242. 497 U.S. 261 (1990). Justice Scalia contended that "the federal courts have no business in this field" and that "it [was] up to the citizens of [the states] to decide, through their elected representatives, whether that wish would be honored." *Id.* at 293 (Scalia, J., concurring). Justice Brennan, along with Justices Marshall and Blackmun, stated: "the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment". *Id.* at 313. (Brennan, J., dissenting).

243. 549 N.E.2d at 329. The dissent argued that the court should not have expanded the common law to enable mature minors to refuse life-sustaining treatment, stating:

Unless the legislature for specific purposes provides for a different age, a minor is one who has not attained legal age. It is not disputed that E.G. has not attained legal age. It is fundamental that where language is clear there is no need to seek to interpret or depart from the plain language and meaning and read into what is clear exceptions or limitations.

Id. at 329 (Ward, J., dissenting).

244. 491 N.W.2d 633 (Mich. Ct. App. 1992). Noting the primary distinction between judicial and legislative acts, Judge Sawyer stated that "[t]he [l]egislature makes the law - - courts apply it The legislature prescribes rules for the future. The judiciary ascertains existing rights." *Id.* at 642 (Sawyer, J., concurring in part and dissenting in part) (quoting *In re Forwarding Co.*, 292 N.W. 678 (Mich.

well as the opinion of New York's second department in *Alfonso*.²⁴⁵ The separation of powers doctrine mandates that the legislatures make the law while the courts interpret the law. The former Chief Judge of New York State, Sol Wachtler, stated that "only the legislature can formulate guidelines and rules and speak to cases which have not yet come into court and eliminate the legal uncertainty which only adds to the cost and anguish of those forced to make these painful medical choices."²⁴⁶ Judge Wachtler called for the creation "of a body of law which anticipates the problems and provides solutions before they arise so that those facing a crisis in the hospital do not also have to face a crisis in the courtroom."²⁴⁷ Current Chief Judge of New York State, Judith Kaye, described the proper role of the legislature and the courts: "Statutes are limits; the court's focus is to implement the will of the legislature, not its own will."²⁴⁸

New York statutory law currently affords minors the right to consent to certain medical treatments such as treatment for venereal disease, inpatient mental health treatment, and substance abuse treatment.²⁴⁹ This statutory right to consent to specified medical treatment must not be equated with the right to refuse life-sustaining treatment.²⁵⁰ While courts in other jurisdictions²⁵¹ have created exceptions to the general rule that parental consent is required to treat or to refuse to treat minors, the New York Court of Appeals is not the appropriate forum in

1940) (citations omitted). Judge Sawyer further stated that judicial power extends only so far as interpreting the legislature's enacted law. *Id.*

245. 195 A.D.2d 46, 606 N.Y.S.2d 259 (2d Dep't 1993). The court concluded that "[i]t is for the Congress or the [New York] Legislature, not the courts - and certainly not the State Commissioner of Education or a Board of Education - to provide the exceptions to the parental consent requirements." *Id.* at 54, 606 N.Y.S.2d at 264.

246. Wachtler, *supra* note 239, at 62. Judge Wachtler noted that the legislature's ability to hold hearings to "fully explore the medical, legal and moral implications of the advances in medical technology" made the legislature the proper body to enact law in this area. Wachtler, *supra* note 239, at 62.

247. Wachtler, *supra* note 239, at 62.

248. Hon. Judith S. Kaye, *The Human Dimension in Appellate Judging: A Brief Reflection on a Timeless Concern*, 73 CORNELL L.REV. 1004, 1015 (July 1988).

249. *See supra* notes 177 and 196.

250. *See supra* note 208.

251. *In re E.G.*, 549 N.E.2d 322, 325 (Ill. 1989); *In re Swan*, 569 A.2d 1202, 1205 (Me. 1990); *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987).

which to expand these limited statutory rights currently accorded minors in New York. The New York Legislature should create a law that reflects the will of the citizens of New York with regard to the rights of mature minors to refuse medical treatment.

B. A Starting Point: The Task Force on Life and the Law

The Task Force proposals²⁵² and the most recent New York Assembly and Senate bills²⁵³ provide a starting point in addressing the right of minors with decision-making capacity to forego life-sustaining treatment. The Midwest Bioethics Committee's guidelines²⁵⁴ provide additional insight into the struggle to find the proper balance between the competing patient, parental and state interests in recognizing the right of mature minors to forego life-sustaining medical treatment.

The Task Force was correct in recommending that the age of majority for deciding about health care should not be lowered,²⁵⁵ and that the determination of a minor's decision-making capacity should be made on a case-by-case basis.²⁵⁶ This recommendation comports with the current statutory rights enabling minors to consent to limited medical treatments.²⁵⁷ If the New York Legislature simply lowered the age of majority for refusing life-sustaining treatment, it would negate New York's recognition of the fact that children acquire different levels of capacity based upon their specific life circumstances.²⁵⁸ The case-by-case approach also comports with the Rule of Sevens' presumption of incapacity for minors of certain ages, and the burdens that must be overcome to rebut that presumption.²⁵⁹

The Task Force did not, however, properly balance the subjective element of self-determination with the objective *parens patriae* element in the decision to withhold life-sustaining medical treatment of minors found to have decision-making capacity.

252. NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

253. N.Y.A. 6791, 218th Sess. (1995); N.Y.S. 5020, 218th Sess. (1995).

254. *See supra* note 18.

255. NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

256. NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

257. *See supra* note 177.

258. *See* PROSSER AND KEETON, § 18 at 115 (5th ed. 1984).

259. *See Cardwell*, 724 S.W.2d at 745.

The Task Force correctly recognized that “[c]hildren should be involved in decisions in a way that respects their developing capacity and maturity.”²⁶⁰ Recognition of the subjective factor of self-determination²⁶¹ enabled the Task Force to give great weight to the decisions of mature minors to refuse life-sustaining medical treatment by according these minors a substantial, non-exclusive role in decisions regarding refusal of life-sustaining treatment.²⁶² Although the Task Force stated that the correct balance should respect the self-determination interest of a mature minor, the parental interest in speaking for their children on health care issues, and the state interest in preserving life, the state’s *parens patriae* interest appears to have been overlooked.

C. *The Role of Health Care Providers and the Courts in Determining Decision-Making Capacity and Balancing Competing Interests*

Although the Task Force gave substantial weight to decisions made by mature minors to refuse medical treatment,²⁶³ its proposals should be re-examined with regard to what entity determines whether or not the minor has the capacity to refuse life-sustaining medical treatment. The Task Force proposed that the treating physician, in conjunction with the parents, would be responsible for assessing the decision-making capacity of minors.²⁶⁴ This proposal should be re-examined in order to arrive at the proper balancing of the state’s interest in preserving life.

Neither the Task Force proposals nor the current legislative bills would allow the courts to make the initial determination of decision-making capacity. Instead, each proposed that a single health care provider make this important threshold determination. This is clearly a dangerous proposition. Current law recognizes that adults are presumed to have capacity to make their own health care decisions, and a finding to the contrary requires an additional health care provider to concur with

260. NEW YORK STATE TASK FORCE, *supra* note 19, at 119.

261. *See supra* note 29.

262. NEW YORK STATE TASK FORCE, *supra* note 19, at 130.

263. *See supra* note 215 and accompanying text.

264. *See supra* text accompanying notes 217-18.

the treating physician's finding.²⁶⁵ The Task Force proposal only requires one physician or health care provider to determine that the minor in question has decision-making capacity. If a single health care provider makes the initial determination of a minor's decision-making capacity, the minor would not be provided an important safeguard which adults are given by law. Requiring that an additional health care provider concur with the treating physician's finding that the minor has decision-making capacity would comport with the Midwest Bioethics Center's desire for greater confidence when determining the minor's decisional capacity.²⁶⁶

The Task Force's erroneous belief that conflict between minors who wished to forego life-sustaining treatment and their parents would be rare appears to have played a significant role in its proposals.²⁶⁷ Benny Agrelo's²⁶⁸ and Billy Best's²⁶⁹ decisions to forego life-sustaining treatment, which directly conflicted with their parents' wishes that they continue treatment, indicate that conflicts between parents and their minor children may be more common. Furthermore, the Task Force failed to set forth appropriate guidelines for bioethics committees to follow in order to resolve such conflicts.²⁷⁰

By requiring only one health care provider opinion, the Task Force failed to provide an appropriate safeguard in the event the treating physician erroneously determined a minor had decision-making capacity. Under the Task Force's formulation, the courts would not have the primary function to determine whether a particular minor has decision-making capacity.²⁷¹ While courts are not necessarily more capable of making such determinations,²⁷² judicial precedent would provide the necessary guidelines which are missing from the Task Force proposal. Additionally, the state's interest in protecting the health and welfare of minors within its jurisdiction is better served by including additional safeguards.

265. N.Y. PUB. HEALTH LAW §§ 2963(2) and (3)(a) (McKinney 1993).

266. MIDWEST BIOETHICS CENTER, *supra* note 19, at § 7.4.

267. NEW YORK STATE TASK FORCE, *supra* note 19, at 131.

268. *See supra* notes 1-10 and accompanying text.

269. *See supra* notes 11-17 and accompanying text.

270. NEW YORK STATE TASK FORCE, *supra* note 19, at 138.

271. NEW YORK STATE TASK FORCE, *supra* note 19, at 132.

272. *See supra* note 218.

The inherent problem with the Task Force's single health care provider determination comes to light under the following scenario. If the treating physician's determination that the minor in question has decision-making capacity is based on the physician's limited exposure to children within that age bracket, there is a strong possibility that this initial determination may be incorrect. Assuming parental consent is not forthcoming, the bioethics review committee would then attempt to resolve the conflict between the minor and the parents. Under this scenario, at no time would New York State's interest in preserving life and protecting minors be balanced into the equation. Additionally, the bioethics review committee would not be in a position to review the treating physician's initial determination of decision-making capacity.

New York State's interest in preserving life and in protecting the health and welfare of minors within its jurisdiction is greatest when a minor desires to refuse life-sustaining treatment, as this decision may ultimately result in the minor's death. Legislation expanding the rights of minors to include the mature minor exception should either give the courts a role in determining decision-making capacity, or include the same safeguards afforded adults who are found to be incapable of making their own health care decisions (the concurrence of two health care providers). Any proposed legislation should set forth more comprehensive guidelines for health care providers to follow in making the threshold determination of capacity and should require that the parental and state interests be properly represented when the mature minor's desire to refuse life-sustaining medical treatment is given substantial weight.

Conclusion

The mature minor doctrine recognizes that certain minors may have the decision-making capacity to refuse life-sustaining medical treatment.²⁷³ New York law currently allows mature minors to consent to limited, specific medical treatments, without prior parental consent.²⁷⁴ The question of whether mature minors should have the right to refuse life-sustaining medical

273. See *Cardwell*, 724 S.W.2d at 744.

274. See *supra* note 177.

treatment poses a different question than the right to consent to medical treatment. The New York State Legislature is the proper body to determine whether its constituency favors expanding the rights of mature minors to include the refusal of life-sustaining medical treatment.

The decision to provide mature minors with this expanded right of self-determination necessarily involves the balancing of competing interests, namely those of the minor, the parents and the state. The minor's decision to refuse life-sustaining medical treatment should only be carried out if, (1) the minor is deemed to have decision-making capacity, and (2) the minor's interest in refusing life-sustaining treatment is greater than (a) the parental interest in their minor child's health care choices, and (b) New York State's interest in preserving life.

Enacting a law which gives mature minors a substantial, although not exclusive, role in medical decisions would recognize that certain minors have the requisite decision-making capacity to play a role in their health care choices. At the same time, any mature minor exception enacted in New York should recognize that minors are presumed incapable of refusing medical treatment, and the presumption could only be overcome if (1) the treating physician and another health care provider or (2) the courts, determined that the minor had decision making capacity.

Much more discussion and debate is needed before the New York Legislature enacts a law recognizing the mature minor doctrine. The struggle to find the most appropriate assessment of decision-making capacity will eventually enable New York State to adopt a law which would abandon the adage: "Children should be seen and not heard."

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