1-1-2005

Asking Adolescents: Does a Mature Minor Have a Right to Participate in Health Care Decisions

Cara D. Watts

Follow this and additional works at: https://repository.uchastings.edu/hwlj

Part of the Law and Gender Commons

Recommended Citation
Available at: https://repository.uchastings.edu/hwlj/vol16/iss2/4

This Note is brought to you for free and open access by the Law Journals at UC Hastings Scholarship Repository. It has been accepted for inclusion in Hastings Women's Law Journal by an authorized editor of UC Hastings Scholarship Repository. For more information, please contact wangangela@uchastings.edu.
Asking Adolescents: Does a Mature Minor Have a Right to Participate in Health Care Decisions?

Cara D. Watts*

After removing a tumor from the soft tissue of his mouth, doctors diagnosed 12-year-old Parker Jensen with an extremely rare and aggressive cancer, Ewing's sarcoma.1 Parker's parents were unsure of the proper course of treatment for their son and wanted to secure a second opinion.2 However, physicians filed for a court order to remove Parker from his family and immediately begin a harsh regimen of forty-nine weeks of chemotherapy.3 As Parker's parents battled the State of Utah amidst a confusing, volatile sea of physicians' diagnoses, recommended therapies, court orders and kidnapping and child neglect charges, Parker's voice was completely drowned out.4 Should Parker be adrift from the proceedings, or should his opinion play a vital role in determining his health care?

I. INTRODUCTION

The family unit, which encompasses a diverse and vast array of human relationships, forms the very core of society. Each small family shoulders the immense responsibility of creating and rearing the next generation and

---

* B.A. 2000, University of Nevada, Las Vegas; J.D. 2005, University of California, Hastings College of the Law. While at Hastings, I participated in the Family Law Concentration and in the Public Interest Clearinghouse program, graduating with a Public Interest Law Certificate. I am very grateful to Professor Lois Weithorn for her guidance, encouragement, and wealth of knowledge on this subject. I would also like to thank the editorial board and staff of the Hastings Women's Law Journal for selecting and editing this Note.


3. Id.

4. Id.
imparting to it both the family's unique values and society's norms and regulations. In order to be successful in this endeavor, courts have recognized that the family must be protected by a broad right of privacy that strictly limits government interference in the intimate workings of a family.5

This right of privacy grants a family wide discretion to make its own decisions and determine its own course of direction.6 It stems from a legal trend known as the "constitutionalization" of the family which began in the 1960's when the United States Supreme Court considered state restrictions on marriage, and access to contraception within marriage, in the landmark cases of Loving v. Virginia, 388 U.S. 1 (1967), and Griswold v. Connecticut, 381 U.S. 479 (1965).7 In these cases, the Court extended the definition of liberties protected by the Fourteenth Amendment to include a right to marry, a right to marital privacy and a "right to establish a home and bring up children."8

Since the advent of these cases, many more state regulations of the family have been subjected to constitutional scrutiny.9 Although the state continues to regulate some of the most fundamental aspects of a family, including marriage, divorce, adoption, foster care and child neglect, many modern family issues implicate constitutional liberties and the right to privacy.10 Often, state regulations conflict with parents' wishes for their children and an impassioned struggle ensues over whether the state or the parent will control such vital aspects of a child's upbringing as education, custody and medical treatment.11 The most intense struggles arise when there is a disagreement between a parent's medical wishes and the state's determination of the best interests of the child.12 Occasionally, parents and

5. Elizabeth J. Sher, Note, Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State, 58 N.Y.U. L. REV. 157, 157 (1983) (explaining that "[j]udicial recognition of privacy interests in recent years has produced a corollary that government intervention into family matters should be severely restricted.").

6. See generally Pierce v. Society of Sisters, 268 U.S. 510 (1925) (holding that a state statute may not require parents to send children to a public, as opposed to private, school); Meyer v. Nebraska, 262 U.S. 390 (1923) (invalidating a law that prohibited teaching German to young students).


8. Id. at 313 (quoting Meyer, 262 U.S. at 399).

9. Id. at 312-13 (documenting that "[o]nly after these cases did a sizeable body of litigation seeking to apply the Fourteenth Amendment to allegedly arbitrary state regulation in the domestic relations sphere begin to accumulate").

10. Sher, supra note 5, at 157.

11. Wadlington, supra note 7, at 311 (stating that "[t]he conflict between parental desire to maintain control over the upbringing of their children and the government's interest in ensuring that various aspects of children's lives are not subject to unfettered discretion and parental whim arises frequently within the context of education, religion, or any other of a broad host of social issues.").

12. Id.
the state disagree about the type, length and necessity of medical treatments for a child. In these cases, who, if anyone, possesses the ultimate right and responsibility to make a child's medical decisions? If a parent refuses medical treatment for a child, the state may intervene and adjudicate the case under child abuse and neglect laws if a court determines the child should receive medical care. A court may, and does, "give legal, and, if necessary, physical custody [of a child] to [a] state agency for as long as necessary to administer the approved medical care."

Currently, there is no national consensus as to how much deference should be given to parental health care decisions. As a result, there are extreme cases of both too much and too little deference accorded to a parent's wishes, while the health and well being of a child hangs in the balance. Many argue that in the fight between parents and the state, a minor possesses an interest in participating in medical decisions that so fundamentally and intrusively affect his or her life.

If a minor voices an opinion in the medical decision-making process, when should that voice be determinative, or at the very least persuasive, in the parent-state conflict? An analysis of a minor's right to participate in health care decisions is necessary given the huge variations from jurisdiction to jurisdiction over the amount, if any, of deference given to a minor to consent to or refuse medical treatment. This Note proposes that a child's interest in determining his or her own health care is an essential factor that must be considered in the struggle between parents and the state.

In the event of a conflict between parents and the state over a minor’s health care, this Note argues that not only does the court have a moral obligation to consider a minor’s decision, but a mature minor has a valid liberty interest under the Due Process Clause of the Fourteenth Amendment of the United States Constitution to participate in health care decisions.

13. Sher, supra note 5, at 157 (arguing that "[u]nlike privacy decisions that a parent makes about his or her own life, parental decisions about medical care for a child concern choices about another's life that can have an irreversible effect on the child's future").
14. Id. at 158.
15. Id.
16. See id. at 159.
17. See generally id. at 163-64 (highlighting the distinctions between various jurisdictions, such as New York and California).
18. See generally Sharon Elizabeth Rush, The Warren and Burger Courts on State, Parent, and Child Conflict Resolution: A Comparative Analysis and Proposed Methodology, 36 Hastings L.J. 461, 495 (1985) (reasoning that "a recognition that [a] child has some rights and a willingness to define those rights are necessary to protect the child from unreasonable state regulations. If children's rights are taken seriously, then a child who suffers from unreasonable state regulation of a fundamental right would be entitled to challenge the state whether or not the parent approved.").
19. See Sher, supra note 5, at 163-64 (pointing out that in cases of conflict over a child’s medical treatment, New York alone has “run the gamut from refusing to intervene unless a life-or-death question was involved to permitting intervention whenever it would have a beneficial effect on the child regardless of the parental objection.”).
After comparing and contrasting different approaches of incorporating a minor’s wishes, this Note proposes that a court should employ a tripartite test to determine when a minor may be instrumental in the health care decision-making process.

A tripartite test is useful and thorough as it considers 1) the treatment’s effectiveness, 2) a child’s chances of survival with or without treatment and 3) the emotional and physical side effects of the treatment on the child. This Note recommends that a fourth prong be added to the tripartite test to allow the court to consider the child’s preference for or against medical care. Under this fourth prong a court should consider a minor’s competence to actually seek or refuse treatment. This test will be applied to three cases involving controversies over a child’s health care to demonstrate possible outcomes in a variety of situations, and to highlight the importance of a minor’s role in medical decisions.

II. PARENTAL AUTONOMY

Parental autonomy embodies the idea that a parent exercises enormous control over a child and is recognized by the state as the primary decision maker in all aspects of a child’s life.20 Traditionally, the jurisprudence of this country has reflected this broad, overreaching view of parental autonomy.21 In Parham v. J.R., the Supreme Court firmly established that “our constitutional system long ago rejected any notion that a child is ‘the mere creature of the State’ and, on the contrary, asserted that parents generally ‘have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations.’”22

Over time, the Supreme Court has articulated several justifications for parental autonomy.23 According to the Court, parental autonomy rests on the presumption that a parent is needed to make most decisions for a child because children simply lack the requisite maturity, experience and capacity to adequately make appropriate decisions.24 The Court favors parental autonomy because of the idea that the “natural bonds of affection” between parent and child will “lead parents to act in the best interests of their children.”25

In essence, the Court has justified granting parents nearly absolute parental autonomy on the assumption that children do not possess the experience and perspective to make informed, critical decisions, nor do they possess the “judgment to recognize and avoid choices that could be
Hand in hand with the idea that children are incompetent to reach a valid decision is the assumption that a parent has the capacity to choose the best course of action and will do so out of a desire to love, protect and nurture a child.\textsuperscript{27}

As such, the Court has gladly given parents the guiding role in a child’s life, and the state continues to use parents to protect children from making bad decisions.\textsuperscript{28} Both the Supreme Court and the state recognize and respect parental autonomy in an effort to reinforce the parental role, and in response to the “peculiar vulnerability of children.”\textsuperscript{29}

In his concurring opinion in \textit{Parham}, Justice Stewart upheld parental autonomy, or a parent’s right to decide, as absolute and as the primary consideration for the judiciary in determining a child’s welfare.\textsuperscript{30} Specifically, Justice Stewart stated that “[f]or centuries it has been a canon of the common law that parents speak for their minor children. So deeply embedded in our traditions is this principle of law that the Constitution itself may compel a state to respect it.”\textsuperscript{31} Historically, “the tradition of legal protection of parental rights has deep . . . roots . . . [and] [b]efore the twentieth century, the combined status of biological parenthood and marriage signified a legal authority of almost limitless scope.”\textsuperscript{32} The Supreme Court has drawn on the common law, and more recently the basic tenets of the Constitution, to formulate the legal idea that a person’s parental rights are unquestioned.\textsuperscript{33} In the last several decades, however, the Court began to chip away at absolute parental autonomy, limiting it in a variety of ways to bring it more in harmony with the interests of minors.\textsuperscript{34}

Although the Supreme Court has continuously recognized a parent’s fundamental right to the care, control and custody of a child, that right has been tempered by the idea that parental autonomy is not without some limitations.\textsuperscript{35} A particularly contentious area of limiting parental autonomy appears in health care decisions. In general, there are no clear and consistent guidelines for the judiciary in deferring to or imposing parental autonomy, and the possibility of a limited exception to parental autonomy in the area of minors’ health care is especially murky.\textsuperscript{36}

\begin{enumerate}
\item[27.] \textit{Id.} at 637-38.
\item[28.] \textit{Id.} at 638.
\item[29.] \textit{Id.} at 634.
\item[30.] 442 U.S. at 621 (Stewart, J., concurring).
\item[31.] \textit{Id.}
\item[33.] \textit{Id.} at 2407.
\item[34.] \textit{See generally} Rush, \textit{supra} note 18.
\item[35.] \textit{Id.} at 463 (explaining that several key decisions gave the parent-child relationship constitutional protection but that “the constitutional right of the parent to control the upbringing of the child is not absolute.”).
\item[36.] \textit{Id.} at 483 (highlighting that “[c]learly missing from the Supreme Court’s
In the context of choosing health care for children, "[c]ourt decisions reflect a variety of approaches to state intervention in parental medical decision making." Jurisdictions vary in the deference, or lack thereof, given to parental autonomy over a child's health care, and "courts have proffered a wide range of often conflicting rationales and less-than-thorough analyses of the relevant interests and elements arguably critical to such a decision." Overall, a fierce and unyielding philosophy of absolute parental autonomy remains closely intertwined with judicial resolutions of the parent-state conflict.

In fact, the only consistent element in the judiciary's balance between parent and state interests in children's health care is the importance each court places on the notion of parental autonomy and its attempt to accommodate or override it. As such, most of the disputes over minors' medical care involve a perceived affront on parental autonomy by state interference. Several cases clearly demonstrate the prominent role parental autonomy plays in medical decision-making for minors.

A. PARENTAL AUTONOMY IN CONFLICT WITH THE STATE AND MINORS

Most recently, the case of Parker Jensen illustrates the heart-breaking struggles between parental autonomy and the state. Facing felony kidnapping charges after fleeing with their son to shield him from court ordered chemotherapy, Parker's parents angrily declared, "[t]hey have taken away our rights as parents. It's our decision as to treatment." Parker's father stated that "[a]ny parent with concern for a child would want to know definitely what he has before doing something as invasive as forty-nine weeks of chemotherapy," and both parents desperately argued that Parker was currently healthy and the chemotherapy could just as easily kill him. After an enraged and sympathetic public rallied to defend the Jensen's decision to seek other medical opinions and explore their options, the Utah court finally dropped the child neglect case and did not enforce

37. Sher, supra note 5, at 159.
38. Id.
40. See generally Sher, supra note 5.
41. Wadlington, supra note 7, at 311 (explaining that the "conflict between parental autonomy and governmental protection of children does not promise to be easily resolved.").
42. Foy, supra note 2, at 8.
43. Id.
44. Id.
45. Foy, supra note 1, at 6.
the chemotherapy order.\textsuperscript{46}

Two cases in the past also illustrate the conflict between parental autonomy, the state and a minor's interests. In the first case, Patricia Hudson was born August 8, 1930, with an abnormal left arm that was much larger and heavier than the right arm and that hung limp.\textsuperscript{47} In fact, the size of the left arm caused a variety of serious health problems, including straining Patricia's heart and causing deformities of Patricia's chest and spine from carrying the enormous weight.\textsuperscript{48} Patricia's adult sister and other siblings sought the court's intervention after their parents refused to allow 12-year-old Patricia to undergo an operation that would remove the arm.\textsuperscript{49} Patricia "had many times expressed the wish for removal of the left arm and frequently wept because of her affliction."\textsuperscript{50} Patricia's mother argued vehemently "that there is neither [a] constitutional nor inherent right in [the] . . . court to subject her minor child, over her objection, to a surgical operation."\textsuperscript{51} Despite her mother's argument, the court ordered Patricia's arm to be amputated.\textsuperscript{52} In this case, how much consideration should the court have given to parental autonomy, and how much consideration should have been given to Patricia's wishes?

In the early 1970s a New York court ordered surgery for 15-year-old Kevin Sampson. Kevin suffered from neurofibromatosis, or "elephant man" disease, which had caused a horrific facial disfigurement consisting of a "bag-like" growth that had caused the right side of his face to be twice the size of the left.\textsuperscript{53} The effects of the disfigurement on Kevin's education and social development were severe.\textsuperscript{54} Kevin left school at a young age to escape the cruel teasing he endured from his classmates, and he was withdrawn and functionally illiterate.\textsuperscript{55}

The court documented evidence that Kevin wanted the surgery.\textsuperscript{56} After considering the gravity of Kevin's deformity and situation, the court ordered the risky procedure, against the wishes of Kevin's mother, in order to promote Kevin's development and increase his chances for a "normal, useful life."\textsuperscript{57} In this context, it is difficult to know how much weight the court gave Kevin's desire for the surgery when making its decision to subject him to an operation that was necessary, but dangerous.

\textsuperscript{47} \textit{In re} Hudson, 126 P.2d 765, 767 (Wash. 1942).
\textsuperscript{48} \textit{Id.} at 768.
\textsuperscript{49} \textit{Id.}
\textsuperscript{50} \textit{Id.}
\textsuperscript{51} \textit{Id.} at 768.
\textsuperscript{52} \textit{Id.}
\textsuperscript{53} Wadlington, \textit{supra} note 7, at 319.
\textsuperscript{54} \textit{Id.}
\textsuperscript{55} \textit{Id.}
\textsuperscript{57} \textit{Id.} at 687.
For many, the idea of parental autonomy is an emotionally entangled issue, particularly with regards to parents’ control over the medical treatments of their children. Often, people vehemently object to minors making decisions beyond the authority and desires of their parents. One newspaper editorial questioned “just how much leeway [can]...a parent give a minor child to make a dumb-deadly decision.”58 The editorial argued that allowing minors to make such a decision is akin to allowing children to play ball in a busy street, to play with matches, or to play with a loaded gun.59

On the other hand, in another letter to an editor of a local newspaper in Florida, a woman commented that “[p]arents, like doctors, and government officials, will from time to time make mistakes, but it is far safer to trust loving parents than unrelated bureaucrats who have frequently proved themselves unable to apply common sense in family situations.”60 The cases of Parker, Patricia and Kevin, as well as these editorials, highlight the constant tension between parental autonomy, state interests and a child’s interests in medical treatment decisions.

Predicting when, and in what situations, the judiciary will defer to parental autonomy is extremely difficult.61 There are, however, a number of exceptions, or limitations, to parental autonomy, both in and out of the health care context, which upon closer examination may reveal a pattern where a minor’s autonomy is given some weight.62 This pattern may prove useful in determining when, as in the above three cases, for example, a minor may choose his or her own health care above and beyond a state’s interests or a parent’s voice.63

B. A CHECKERBOARD OF EXCEPTIONS TO PARENTAL AUTONOMY

Although it may seem that parental autonomy is boundless, exceptions to a parent’s right to decide have hemmed in the reach of parental autonomy in a number of important areas.64 Many scholars argue that an absolute parental autonomy may no longer be appropriate in certain circumstances, as the era in which the concept developed is no longer reflective of the modern society in which it is applied.65 For example, when Blackstone articulated the theory of natural bonds of affection that guide parents in making decisions for their children, the law at that time...
granted the father almost sole parental rights and children were often valued in society as pure economic potential, or as people who would be required to perform housework, farm work or work in the family business, beginning at a very young age.\textsuperscript{66} Certainly, eighteenth century English common law, upon which Blackstone drew heavily, was harsh towards children.\textsuperscript{67} As such, there is a persuasive argument to reshape the view of parental autonomy and its role into a more modern approach in which parental autonomy is limited by exceptions that account for today’s radically different conception of children and the family.\textsuperscript{68}

Shifting the approach to parental autonomy requires creating a new legal framework that analyzes and incorporates children’s, as well as parents’, rights and interests.\textsuperscript{69} The Supreme Court began this gradual change towards valuing a child’s rights and interests in the late 1960s during the Warren Court.\textsuperscript{70} The Warren Court addressed a group of cases that questioned the state’s position on 1) due process in a juvenile delinquency hearing, and 2) a child’s First Amendment right to freedom of expression.\textsuperscript{71} In these cases, the Court established a precedent for respecting children and granted them constitutional protection by “requiring the application of recognized values and standards, regardless of the age of the party involved.”\textsuperscript{72}

More and more, critics reject absolute parental autonomy and embrace instead a “child-centered perspective” that traces its beginnings back to the Warren Court’s ground breaking decisions to recognize a minor’s constitutional right to freedom of expression and due process.\textsuperscript{73} In general, there is an increasing dissatisfaction with the idea of the traditional,  

\textsuperscript{66} Scott & Scott, \textit{supra} note 32, at 2406-07 (explaining that “the combined status of biological parenthood and marriage signified a legal authority of almost limitless scope. . . . Parents, particularly fathers as heads of household, had extensive legal authority over the lives of their children. Parental rights were understood to be grounded in natural law and were not dependent on behavior that promoted the child’s interest.”).

\textsuperscript{67} Id. (highlighting the fact that “[p]arents’ interest under traditional law was property-like in many respects. A parent’s right to the custody of his children so approximated property ownership that it could be transferred by contract, and lost only by abandonment or unfitness.”).

\textsuperscript{68} Wadlington, \textit{supra} note 7, at 332.

\textsuperscript{69} Scott & Scott, \textit{supra} note 32, at 2401.

\textsuperscript{70} See Rush, \textit{supra} note 18.


\textsuperscript{72} Rush, \textit{supra} note 18, at 492.

\textsuperscript{73} Scott & Scott, \textit{supra} note 32, at 2401 (criticizing “the traditional focus on parents’ rights as impeding the goal of promoting children’s welfare” and arguing for “a ‘child-centered perspective,’ in contrast to the current regime under which biological parents continue to have important legal interests in their relationship with their children”) (quoting Barbara Bennett Woodhouse, \textit{Hatching the Egg: A Child-Centered Perspective on Parents’ Rights}, 14 \textit{Cardozo L. Rev.} 1747 (1993)).
supposed "rights" of parents.\textsuperscript{74} Many argue that parental autonomy should no longer be viewed in terms of a "right" that parents possess over their children as it emphasizes a parent's self-interest over the child's interest.\textsuperscript{75} In order to make the transition to a child-centered legal system, some legal scholars suggest transforming parental autonomy into a fiduciary duty rather than an "inherent right derived from [biological] status."\textsuperscript{76}

Several new policies suggest that the legal system is embracing a transformation from an absolute parental right to a system in which a parent is viewed as a fiduciary who guards a child's, as opposed to his or her own, interests.\textsuperscript{77} "Through these developments, lawmakers seem ready to intrude upon parental autonomy to a greater extent than was allowed by traditional law."\textsuperscript{78} Treating parents as "fiduciaries entrusted with their children's welfare" constitutes a flexible approach to parent-child-state conflicts that allows a court to acknowledge children's interests.\textsuperscript{79}

Beyond the fiduciary view of parental autonomy is the argument that children simply do enjoy some constitutional protections that supercede any "right" invested in the parent.\textsuperscript{80} The Supreme Court clearly asserted that "[a] child, merely on account of his minority, is not beyond the protection of the Constitution."\textsuperscript{81} The Court has, then, discovered some exceptions to parental autonomy in the Constitution itself.\textsuperscript{82} In essence, under both a fiduciary view, in which a child's interests are the focal point, and a constitutional analysis, in which constitutional protections are extended to children, the Supreme Court and other courts throughout the country have carved out a number of exceptions to parental autonomy and have recognized a minor's autonomy and "constitutional protection from unreasonable state regulation."\textsuperscript{83}

1. Minors' Inherent Constitutional Rights Limiting State Autonomy

The Supreme Court recognized that a child has a right to due process and procedural safeguards in the juvenile justice system when it decided \textit{In re Gault}.\textsuperscript{84} In this case, a 15-year-old was charged with making obscene
phone calls and sentenced to six years in a state industrial school. The process of the minor’s arrest and conviction was patently unfair and offensive to the protections of the Fourteenth Amendment’s Due Process Clause as the minor’s parents were not informed of the arrest, nor was the minor included in the initial proceedings.

The Court concluded that the juvenile justice system should be saddled with the dual responsibility of protecting a child and upholding his or her due process rights. Although the Court accepted the philosophy that the juvenile justice system should treat a child differently than the harsh adult criminal system would, it did not advocate carrying that differential treatment so far as to erase a minor’s due process rights. Rather, in In re Gault, the Court for the first time recognizes a minor’s autonomy and entitlement to due process and paves the way for due process rights to be extended to children in other contexts.

Additionally, the Court extended the right of freedom of expression to minors. In Tinker, five minors were suspended for wearing black armbands to protest the Vietnam War. The Court held that the students’ expulsion was unconstitutional as it interfered with their right to freedom of speech. The Court recognized a state’s interest in controlling schools, but it would not let that interest trample a student’s right to freedom of speech. The Court found that “students are protected by the Constitution even within the special environment of school.” The due process and freedom of speech rights granted by the Court are not dependent on age or context, but rather represent inherent individual liberties guaranteed to both children and adults under the Constitution. As stated in Parham, “Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”

85. Id.
86. Id.
87. Id (explaining that the juvenile justice system should act not as a prosecutor, but rather as a parent correcting a confused child, and demanding that the system afford each child “certain basic procedural safeguards granted to adults.”).
88. See Gault, 387 U.S. at 33-57.
89. Rush, supra note 18, at 466-67 (demonstrating that “the Court emphasized the importance of due process to ‘individual freedom,’” and highlighting the Court’s recognition that in the juvenile justice system in particular, “when children are afforded due process, the case is often dismissed for lack of proof, and some children who are transferred to the adult system for trial may be harmed by the lack of procedural safeguards.”).
91. Id. at 508.
92. Id. at 514.
93. Rush, supra note 18, at 469.
94. Id.
95. Id.
96. 442 U.S. 584, 627 (1979) (Brennan J., concurring in part and dissenting in part)
These cases demonstrate that children have rights against the state when the child’s and the parents’ interests are aligned. Although the cases do not specifically address the interests of a minor in the face of parental autonomy, they clearly establish that minors possess some constitutional rights that serve to limit state autonomy. It may be logically argued, therefore, that these rights can be applied to the medical decision-making context to allow minors to assert their interests whether they are acting in concert with their parents or not.

2. Exceptions to Parental Autonomy Based on Context

Beyond child abuse and neglect, which constitute the most fundamental grounds for terminating parental autonomy and placing a child under the parens patriae power of the state, the first basic exception to parental autonomy is legal emancipation. The definition of a legally emancipated teenager is one who is “not living at home and is self-supporting, is responsible for himself economically and otherwise, and whose parents (voluntarily or involuntarily) have surrendered their parental duties and rights.” Under common law emancipation, a married minor or a minor in the armed forces is deemed to be emancipated on the grounds that the minor’s life is no longer compatible with parental autonomy.

To become emancipated under a general emancipation statute, a minor petitions a court “to be relieved of the disabilities of minority.” The court will analyze the best interests of the minor and the minor’s competence to assume the responsibilities of normal adult life. If a court grants emancipation, a minor assumes all of the rights and responsibilities associated with adulthood, including the right to consent to or refuse medical care.

Emancipation laws recognize that a minor’s life may be so independent of the parents as to “warrant a transfer of decision-making authority.” Emancipation embodies the idea that a minor may be independent and sufficiently competent to make adequate life decisions apart from the desires or influence of his or her parents. “By shifting decisional authority from parents to minors, the law of emancipation directly challenges the assumptions that parents are always the preferred decision-
makers, and that minors are incapable of meaningful self-definition.'

More closely related to the issue at hand, whether a mature minor may participate in health care decisions, are exceptions to parental autonomy that are directly linked to medical care. First, a physician does not have to seek a parent’s permission before providing emergency medical health care to a minor. The policy behind this exception is complex.

The medical emergency exception operates under an implied consent theory, or the theory that a parent would undoubtedly authorize the treatment if contacted, and under the idea that doctors must be able to administer emergency care without the threat of liability. Lurking within this exception, however, is the notion that parental autonomy is not absolute as the exception places more importance on a minor’s welfare than “the decision-making authority of parents,” thereby recognizing that children are separate human beings that cannot be at all times under the protective wing of their parents’ care and authority.

Second, an exception to parental autonomy exists in the form of medical neglect of a minor. In this exception, a state will intervene in a child’s health care if a parent seems unwilling to provide what the state deems to be appropriate medical care. This exception transfers a parent’s decision-making authority to the state, not to the minor. While the medical neglect exception does not explicitly embrace a mature minor’s right to make health care decisions, it does highlight a reality that parents do not always make the best decisions for their children. Rather, beyond natural bonds of affection and a child’s best interests, a parent may be influenced by a number of factors, including finances or religious beliefs.

In the mental health context, the Supreme Court held that a minor possesses due process rights if a minor is involuntarily committed by his or her parents for mental health treatment in a state institution. In Parham, the Court held that a Georgia statute that allowed a minor to be committed by his parents against his will without a judicial hearing was not

105. Id.
107. Id.
108. Ehrlich, supra note 106, at 73.
109. Id. at 74 (clarifying that “[w]ithout implying neglect, [the medical emergency exception] embodies an awareness that in the ordinary course of life, parents and children are not inextricably bound together.”).
110. Id.
111. Id.
112. Id.
113. Id. at 75 (arguing that “[b]y capturing the very real possibility of divergent interests, and allowing for parental displacement, this exception forces us to recognize that not all families function as integrated and harmonious units in which the basic needs of children are met by their parents.”).
unconstitutional. Although the Court clearly articulated that a child "in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment," it did not determine the extent of that liberty interest or due process right.

This case remains pivotal, however, and key in the analysis of exceptions to parental autonomy, because it acknowledges that minors are guaranteed due process rights and may assert a substantial right of privacy and liberty interest in the health care context against the interests and desires of their parents. The Court here establishes clear precedent that "[t]he child's rights and the nature of the commitment decision are such that parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized." The Court found that a neutral fact-finder was necessary to review the commitment decision, and determined that due process was and may be adequately satisfied by an admitting physician acting as that neutral fact finder.

Several state courts have further defined a child's due process rights. The Supreme Court of California recognized in In re Roger S. the personal liberty interest of a minor and concluded that a parent may not waive a minor's procedural due process rights under either the California or the United States Constitution, which entitle a minor to a determination by a neutral fact-finder of whether 1) the minor is mentally ill, and 2) if not, whether the minor will benefit from state hospitalization. This case reinforces that minors possess viable liberty interests, due process rights and autonomy from a parent who may attempt to override those rights. The California Supreme Court strongly declared that:

[t]he serious consequences attendant upon involuntary commitment of a minor as a mentally ill or disordered person, and the significant potential for error in diagnosis convinces us that a minor who is mature enough to participate intelligently in the decision to independently assert his right to due process in the commitment decision

115. Id. at 616-17.
116. Id. at 600.
117. See id.
118. Id. at 604.
119. Kelli Schmidt, "Who are You to Say What My Best Interest Is?" Minors' Due Process Rights When Admitted by Parents for Inpatient Mental Health Treatment. 71 WASH. L. REV. 1187, 1191-2 (1996) (highlighting that a number of questions were "left unanswered by the Court. The Court did not specify any requirements for review of the initial admission decision nor did it discuss whether Georgia's state hospitals had adequate review procedures. Additionally the Court did not determine what due process protections are necessary... to admit the minor to a private, rather than public, mental health hospital.").
120. 569 P.2d 1286, 1289 (Cal. 1977).
121. Id.
must be permitted to do so.\textsuperscript{122}

\textit{In re Roger S.} sets a precedent for a minor to assert a due process right and liberty interest in situations where a health care decision made by a parent may have grave and drastic consequences to the minor’s present and future life.\textsuperscript{123} In Illinois, an appellate court found that when electroconvulsive therapy is proposed to treat a minor, a minor’s liberty interest in being free from such invasive treatment increases and must be protected by more than the court’s approval of a parent’s consent to the treatment.\textsuperscript{124} This extra protection includes a hearing to establish if the minor is competent to consent to electroconvulsive shock therapy, and if not, the court must determine at the hearing, while ensuring the minor receives due process protections, if the treatment would indeed be in the best interests of the minor.\textsuperscript{125}

This exception directly questions a parent’s authority to authorize radical treatment for a minor, and thereby highlights the underlying principle that a minor’s liberty interest is of greater importance and provides for greater protection when the degree of danger and invasiveness of the proposed treatment increases.\textsuperscript{126} The exceptions in the mental health care context clearly establish that a minor possesses viable due process rights that are at least equal to, if not greater than, a parent’s parental autonomy to involuntarily commit a minor or consent to controversial treatments.\textsuperscript{127}

Perhaps the most significant exception to parental autonomy exists in the right of a mature minor to obtain an abortion without parental consent through a judicial bypass procedure.\textsuperscript{128} The Court in \textit{Bellotti} was unwilling to let a parent exert potentially total control over a minor’s right to make procreative decisions.\textsuperscript{129} After considering the implications of forcing a minor to carry a pregnancy to term and potentially assume the tremendous responsibilities and obligations of motherhood, the Court “reiterated that the Constitution does not support giving a third party ultimate control over ‘the decision of the physician and his patient to terminate the patient’s pregnancy, regardless of the reason for withholding the consent.’”\textsuperscript{130}

The Court struck down the statute ultimately on due process grounds as

\textsuperscript{122} Roger S., 569 P.2d at 1291.
\textsuperscript{123} See \textit{In re Roger S.}, 569 P.2d 1286 (Cal. 1977).
\textsuperscript{125} \textit{Id.}
\textsuperscript{126} \textit{Id.}
\textsuperscript{127} See generally \textit{Id.}
\textsuperscript{128} \textit{Bellotti}, 443 U.S. at 647.
\textsuperscript{129} \textit{Id.}
\textsuperscript{130} Ehrlich, supra note 97, at 85 (citing \textit{Planned Parenthood v. Danforth}, 428 U.S. 52, 74 (1976)).
it imposed an undue burden on a minor's right to seek an abortion.\textsuperscript{131} The Court further provided for a mandatory judicial bypass to be included in those statutes, which require parental consent to allow a mature minor to petition the court for an abortion, without parental knowledge or involvement, and to receive the procedure if the court determines that the minor is mature enough to make an informed decision.\textsuperscript{132} The abortion context opened the window for a minor who may be considered to be mature to make critical medical care decisions without parental interference, reflecting a belief that minors may be recognized at times as "autonomous, rights-bearing individuals with unmediated claims to legal self-hood."\textsuperscript{133}

Other exceptions to parental autonomy exist in the context of a minor's right to seek and consent to health care.\textsuperscript{134} Most states have statutes that allow minors to seek and receive treatment, without their parents' consent, for sexually transmitted diseases and drug and alcohol abuse.\textsuperscript{135} In addition, the statutes also allow minors access to family planning services and contraception, pregnancy related health care and mental health treatment without parental permission.\textsuperscript{136}

In fact, minors have not only a statutory, but also a constitutional right to obtain contraceptives as the Supreme Court extended the right of privacy in procreation to include minors.\textsuperscript{137} A minor may receive these basic health care services without parental permission because it furthers the positive state goals of promoting good public health and protecting a child's welfare by guaranteeing that a child, who otherwise may not ask a parent for treatment, will have unfettered access to necessary medical care.\textsuperscript{138} Also embedded in these statutes and a minor's constitutional right of privacy is the idea that a minor can make sensitive, critical health care decisions without parental involvement.\textsuperscript{139}

Overall, these laws recognize that a parent's wishes and beliefs often conflict with a minor's, and those conflicts can deprive a minor of vital medical assistance if a minor chooses to forego health care to avoid a

\begin{flushright}
\textsuperscript{131} Bellotti, 443 U.S. at 647.
\textsuperscript{132} See id.
\textsuperscript{133} Ehrlich, supra note 97, at 86.
\textsuperscript{134} Id. at 77.
\textsuperscript{135} Id. at 77-8. See also In re E.G., 549 N.E.2d 322 (Ill. 1989); Commonwealth v. Nixon, 761 A.2d 1151 (Pa. 2000).
\textsuperscript{136} Ehrlich, supra note 97, at 78.
\textsuperscript{137} Carey v. Population Serv. Int'l, 431 U.S. 678, 694 (1977) (The Court struck down a ban on selling or distributing contraceptives to children under the age of sixteen, asserting that "[s]ince the state may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptives to minors is a fortiori foreclosed.").
\textsuperscript{138} Carey, 431 U.S. at 694.
\textsuperscript{139} Ehrlich, supra note 97, at 78.
\end{flushright}
potentially devastating clash with his or her parents. In essence, each of these exceptions to parental autonomy, in a variety of different contexts, question the entrenched idea that parents are the best and most appropriate decision makers in every aspect of a child’s life. These exceptions also reflect a recognition of minors as persons who are guaranteed basic constitutional rights and protections, and who may function at times as autonomous decision-makers in society.

C. MATURE MINORS CAN PARTICIPATE IN HEALTH CARE DECISIONS

The exceptions work to both limit parental autonomy and shift decision-making authority to children. The rationales behind each of the exceptions clearly support creating an exception to provide a mature minor a right under the Due Process Clause of the Fourteenth Amendment to participate in health care decisions.

The exceptions to parental autonomy that allow a physician to render emergency medical care without parental consent, and that permit a state to administer medical treatment in the event it determines a parent is not providing a minor with adequate health care, both attest to the fact that parental autonomy must not, and in fact cannot, be absolute. Rather, the exceptions establish that parental autonomy must be sacrificed for more pressing, immediate interests.

The exceptions also recognize that children exist as separate human beings in the world, not as mere appendages to their parents, and as such parents cannot possibly be with their children at every moment to protect them and make important decisions for them. Finally, in the cases of medical neglect, the exception to parental autonomy which allows a state to provide medical care to a child against the wishes of the parents, demonstrates that, despite traditional reasoning, parents, though well intentioned, may not always promote the best interests of their children. In fact, “it [the exception] directly challenges the presumption that parents always make good medical decisions for their children.”

Therefore, when carving out an exception for mature minors to actively participate in medical decision-making, it may be argued that the exception exists because of the recognition that parental autonomy is not absolute and has not always proved to be the best way to promote a child’s health and welfare. These policies clearly create space for a minor’s voice in the

140. Id.
141. Id.
142. Id.
143. See generally id.
144. Ehrlich, supra note 97, at 73.
145. Id.
146. Id.
147. Id. at 74.
148. Id.
health care decision.

Other exceptions that actually grant a minor decision-making authority, such as the emancipated minor exception and the exception giving minors the right to seek and consent to substance abuse, venereal disease treatment, pregnancy health care and mental health care without parental permission, highlight the fact that minors are capable of making valid decisions.149 Most importantly, these exceptions, by allowing minors to make some critical health decisions without parental consent, give credence to the belief that parents and minors at times have opposite interests and wishes. Without an exception to parental autonomy, those differences “can interfere with the provision of essential medical care.”150

As such, it may be argued that an exception that allows mature minors to participate in health care decisions should be created as a mature minor can make independent, appropriate decisions. A precedent also exists, in these exceptions, to give a mature minor the opportunity to participate in critical health care decisions to lessen the impact on the minor of being subjected to the possibly contrary wishes of the parents or the state.

The mature minor doctrine, developed in the abortion context, also creates an important exception to parental autonomy that may be applied to permit a minor to have a recognized voice in health care decisions.151 This rule allows a minor who is mature and has the capacity to seek and consent to an abortion.152 This exception is the first to explicitly recognize that minors often have the ability and competence to make their own medical care decisions.153 The implications for this rule in creating an additional exception for a minor’s voice to be heard in general health care decision-making are vast.154 This exception, although narrowly tailored to the abortion context, recognizes that in very specific medical situations, after thorough judicial deliberation of a minor’s competency, a minor may make a critical health care decision.

The mature minor exception challenges the firmly rooted belief that minors universally lack the capacity to make decisions.155 Under a modern view of the exception, parental autonomy must shrink as a minor grows older to “account for the increasing capacities of children as they move through adolescence,” thereby justifying that many mature minors can, and should, have an active role in their vital health care decisions.

An exception to parental autonomy that would allow a minor to play an essential role in health care decisions not only fits into the policies and

149. Ehrlich, supra note 97, at 76.
150. Id. at 78.
151. Id. at 76.
152. Id.
153. Id.
154. Id.
155. Ehrlich, supra note 97, at 77.
reasoning behind the other exceptions that have already been created, but also is implied under the Due Process Clause of the Fourteenth Amendment, and is a natural extension of other constitutional rights that have been granted to minors. The Supreme Court granted minors basic constitutional protections, which do come into play in creating an exception for a mature minor’s voice in health care decisions.\textsuperscript{156} The liberty interest that protects a minor from being committed or treated involuntarily at a state mental health facility without a hearing by a neutral fact-finder also should exist in the context of health care.\textsuperscript{157}

It may be persuasively argued that a minor has a definite liberty interest to be free from crippling, invasive medical treatment. As some states have recognized, if the invasive nature of a medical treatment increases, such as administering electroconvulsive shock therapy, a minor’s liberty interest and procedural due process rights increase as well, protecting a minor from being forced to submit to a treatment without an opportunity to speak his or her opinion and have it seriously considered.\textsuperscript{158} There is also a strong, viable argument under \textit{In re Gault} and \textit{Parham} that a mature minor has a procedural due process right to assert his or her opinion about a future course of medical treatment.\textsuperscript{159} In the event of a conflict between the minor’s wishes and the parents’ or the state’s, the minor’s opinion should be analyzed and weighed appropriately in the final decision by the court or other neutral fact-finder, such as a hospital board.\textsuperscript{160}

Therefore, there should be a valid exception to parental autonomy for minors in making health care decisions. The only key principle that remains to be discussed is when a minor’s due process right to participate in health care decisions applies, and how a court should factor in that minor’s decision in the event of a parent-child-state conflict over health care.

\textbf{III. A MATURE MINOR’S VOICE}

\textbf{A. WHEN SH OULD IT BE HEARD?}

In those rare cases where the court finds a gravely ill minor embroiled in a conflict with his or her parents or the state, the exception to parental autonomy that allows for a minor’s voice to be heard in the health care context is triggered. The court is then left to determine whether the minor

\begin{itemize}
\item \textsuperscript{157} \textit{Parham}, 442 U.S. at 584.
\item \textsuperscript{158} \textit{See In re Roger S.}, 569 P.2d 1286, 1288 (Cal. 1977); \textit{see also In re A.M.P.}, 708 N.E.2d 1235, 1239 (Ill. App. Ct. 1999).
\item \textsuperscript{159} \textit{Parham}, 442 U.S. at 584; \textit{Gault}, 387 U.S. at 33-57 (both cases recognizing a minor’s autonomy and right to due process protections).
\item \textsuperscript{160} \textit{Parham}, 442 U.S. at 584.
\end{itemize}
is competent to utilize the exception and articulate his or her opinion. There are several different approaches to integrating a minor’s interests into the medical decision-making process. Scholars have proposed three different frameworks, reflected in Supreme Court cases, for incorporating children’s interests into the legal system in general. The first method is the coterminous view, in which a child’s rights are as extensive as an adult’s constitutional rights. Under this perspective, a child is granted the most autonomy and is considered a full-fledged member of society, enjoying the same constitutional privileges and protections as adults. A child under the coterminous view would always be given a voice, and perhaps the determinative voice, in medical decisions.

This approach is not the most ideal, however, as children, especially very young children, cannot realistically make critical decisions, and if “everyone enjoyed the same rights regardless of age . . . children could vote without understanding the process; they could marry without being able to handle the responsibilities of married life; and they could choose not to attend school without fear of reprisal.”

Under a separatist method, the court may invoke children's rights cases to decide parent-child-state conflicts. This method simplifies the court’s job as it does not have to struggle to apply adult legal principles to a child’s situation. Rather, this approach allows for a tremendous flexibility in deciding children’s rights cases as the court may fit the child into other cases that match that particular child’s stage of development. This approach is problematic, however, as it does not lead to developing “consistent judicial standards.” Also, in the context of allowing a mature minor a right to participate in health care decisions, the court may swing wildly in allowing some minors, but not others, a voice because the court may determine that only a handful of minors fit into the required developmental state where a minor’s interests become important.

The integrationist view is the best approach to determining when a mature minor has a right to participate. Under this method, a court would apply basic legal principles to determine whether a minor may speak up in
a parent-child-state conflict. First, the exceptions to parental autonomy establish that there is room for a minor’s opinion to be voiced in the context of medical decision-making. A minor’s interests in participating in his or her health care arise when there is a conflict between the parents and the child, the child and the state, or the parent-child and the state, over a proposed medical treatment that is highly invasive and that carries with it grave consequences if is approved or refused. Just like involuntarily committing a minor to a state mental health institution, as in Parham, or approving electroconvulsive shock therapy for a minor as in In re A.M.P., administering or refusing drastic medical treatment necessarily implicates a minor’s liberty interests and elevates those interests to the same level of importance as parental autonomy or the interests of the state. Therefore, this Note proposes that the court should become involved in a minor’s health care and question the authority of the parents, the state, or both, only when there is a conflict of interest in the triangle between parents, the child and the state that involves intensive medical care to treat an extreme health situation.

After making such a determination, the court would proceed under the integrationist method to “compare the rights of the child to those of an adult in a similar situation.” If the court finds that there is no reason in that situation to deny an adult the right to participate in a health care decision, and further that there is no reason to treat the child differently than an adult in that given situation, as in no special state interests arise in protecting a vulnerable child’s welfare, then that child should be accorded the same right to participate in health care decision-making as would be given to the adult. “Conversely, if evidence shows that in a particular situation the child needs to be treated differently, the state may impose a greater restriction on the child pursuant to its police powers . . . [and] the child’s rights should be modified accordingly.”

This integrationist approach is the most thorough, reasonable and fair as it allows a court to consider a child as an individual who may be entitled to a host of rights, and who is at least entitled to just treatment achieved by applying standard, recognized legal principles to children’s cases. By insisting on applying traditional legal principles, regardless of the minor’s age, the court will achieve consistent, predictable results in children’s rights cases. This approach is also flexible enough to allow the state the

171. Rush, supra note 18, at 487.
174. Rush, supra note 18, at 491.
175. Id.
176. Id.
177. Id. at 492.
178. Id. at 491.
discretion to protect children in the event it is demonstrated that a particular minor does not have the capacity to make an appropriate or informed medical decision. Additionally, and most importantly, this approach requires a court to engage in a deeper analysis of children's rights cases because it does not allow the court to rely "on a vague rationale of parens patriae" to justify imposing a state's or parent's wishes on a child, and "[c]onsequently, the reasoning in opinions that determine the validity of state intervention will be more systematic, accurate, critical, and thorough."  

In the particular context of medical decision-making, the integrationist view should be triggered on a sliding scale approach. Under a sliding scale approach, the state's interest in protecting a child from a potentially foolish medical decision is strongest when the minor is very young, or immature, and therefore unable to make critical decisions. The state's interest "fades, however, as the minor gets older and disappears upon [the minor] reaching adulthood." It is when the state's interest is fading on this sliding scale that the integrationist method should be applied to determine if a minor should be granted a right to participate in health care decisions. Therefore, a minor's voice should be heard when the minor is fast approaching adulthood and where it has been determined by the court, under the integrationist method, that there is no compelling reason to treat a child differently than an adult in that particular situation.

B. THE TRIPARTITE TEST

To determine, under the integrationist approach, whether there is a reason to treat a minor differently than an adult, the court should apply a comprehensive tripartite test. In the past, courts have used a variety of methods to determine if a child should have the same rights as an adult in medical decision-making. Some courts analyze whether there is reason to treat a child differently on an ad hoc, case by case basis which is not ideal as it leads to inconsistent results and ruins the thorough, predictable nature of the integrationist method.

Other courts employ a best interests test to determine if a child should be treated equally or differently from an adult. In the best interests test,
courts often weigh "the gravity, or potential gravity, of the child’s illness, the treating physician’s medical evaluation of the course of care, the risk of the treatment and the child’s expressed preferences." Whereas the best interests test is more thorough and measured than an unstable case-by-case analysis, it still gives the court too much discretion to consider some factors and ignore others, and can lead a court to decide that a child should be treated differently from an adult based on the vague reasoning that it is in the parens patriae power of the state to do so.

The tripartite test, used in some jurisdictions, is useful in determining whether a minor should be able to participate in health care decisions, and it also fits snugly into the integrationist approach. Under the tripartite test, the court considers 1) the treatment’s effectiveness, 2) a child’s chance of survival with or without treatment and 3) the emotional and physical side effects of the treatment on the child. The court should add a fourth element to consider a minor’s competence to actually seek or refuse treatment to further assist in determining whether a child, under the integrationist approach, should be treated the same as an adult and subjected to the same legal principles and rights. This tripartite test, with an additional competency element, seems to be the most useful and appropriate as it is clear, precise, consistent, and fits within the goals of the integrationist method to be fair, systematic, accurate and critical.

C. APPLICATION OF THE INTEGRATIONIST METHOD AND THE TRIPARTITE TEST TO PARKER, PATRICIA AND KEVIN’S SITUATION

1. Parker’s Medical Crisis

To judge whether Parker Jensen has a right to participate in the conflict between his parents and the State of Utah regarding the decision to subject him to forty-nine weeks of chemotherapy, the court would first recognize that the dilemma implicates Parker’s liberty interest to be free from invasive treatment and his right of privacy under the Due Process Clause to make medical decisions.

In Parker’s situation, the court finds one of those unusual cases in which a minor suffers from a life threatening illness, Ewing’s sarcoma, and faces an extreme chemotherapy treatment that his parents do not agree with. Therefore, the court would first find here that the exception to parental autonomy that allows Parker to potentially voice his opinion about the treatment is activated. The conflict in this case, and its drastic life or death implications, raises Parker’s possible voice in the treatment decision.

186. Id.
187. Id. (Most notably, the Supreme Judicial Court of Massachusetts used the tripartite test to determine if the state should interfere when parents refused chemotherapy to treat their child’s leukemia in Custody of a Minor, 379 N.E.2d 1053, 1061-62 (Mass. 1978)).
188. Id.
to the same level of importance as parental autonomy, particularly if Parker favors the treatment against the wishes of his parents. The court is now faced with the decision of whether that exception should be honored in this case.

Any adult in Parker's situation would possess the right to refuse or consent to the chemotherapy. This case just barely triggers the integrationist method to determine whether Parker possesses the same right to determine his medical care as would an adult in his situation. On the sliding scale, 12-year-old Parker is at the fringes of adolescence, and therefore it can be argued that the state's interest in protecting Parker as a very young and vulnerable child has just begun to recede into the background, eliminating the need for an extremely aggressive protective stance on the part of the state. As such, under step three of the integrationist approach, the court must proceed to adjudicate whether there is any reason to treat Parker differently from an adult and deny or limit his participation in the chemotherapy decision. To decide whether he should be treated differently, the court will employ the tripartite test.

Assuming Parker would agree with his parents and refuse the treatment, under the first prong of the tripartite test, the court would find that it seems as though the treatment would be effective in eliminating any chance that the cancer may recur. However, under the second prong, Parker’s chances for survival without the treatment are very good. The chemotherapy may be overly aggressive because Parker has not exhibited any cancer symptoms for over a year, and the original diagnosis of Ewing’s sarcoma, a very rare form of cancer, is in dispute. Additionally, under the third prong, the physical side effects of the chemotherapy will be severe, and Parker will suffer terrible emotional side effects undergoing treatment that his family does not advocate and that may necessitate removing Parker from his home if his parents do not cooperate.

Finally, the court should consider under the fourth element Parker's competency to make such a decision. At this point, the court would analyze Parker's maturity level in light of such competency literature as the MacArthur Treatment Competence Study that defines competency as possessing adequate abilities to 1) articulate a choice, 2) understand relevant information, 3) appreciate the nature of the situation and its consequences, and to 4) manipulate information.

190. See Whalen v. Roe, 429 U.S. 589, 599-600 (1977) (holding that the right of privacy encompasses the right to independently and autonomously make “certain kinds of important decisions”); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977) (reinforcing that a patient may refuse invasive treatment under the right of privacy).


The court may find Parker to be competent, which is difficult, but not impossible, to establish in this case, given Parker’s young age. Even if Parker’s competence is questionable under the fourth element of the tripartite test, the other tripartite factors lean heavily in his favor as his chances of survival without the chemotherapy are very good, and as the physical and emotional effects of the treatment would be devastating. As such, the tripartite test suggests that there is not a persuasive reason to treat Parker differently from a similarly situated adult, but rather Parker should be given the opportunity under the exception to parental autonomy to participate in, if not determine, the decision to consent to or refuse the chemotherapy. The court should respect Parker’s decision, even if he decides not to undergo chemotherapy.

If, however, Parker’s chances of survival were very low without the chemotherapy regimen, as some doctors argue, then the court may find that the tripartite test leads to a greater state interest in protecting Parker from making a hasty decision given that Parker’s capacity and prognosis may be questionable. In that situation, a court may order the chemotherapy over Parker’s and his parents’ wishes.

If Parker were to voice a determinative opinion in this case against the treatment, in agreement with his parents, then allowing his voice to be heard under this decisional analysis would greatly help the court resolve the parent-child-state conflict by tipping the scale in favor of respecting Parker and his parents. Under any variation of the facts, the tripartite test, combined with the integrationist approach, provides clear, consistent guidelines for the court to reach a reasonable, critical decision in this case.

2. Patricia’s Desperate Medical Need

Similar to Parker’s case, the conflict between parent, child and state over amputating Patricia’s enlarged left arm implicates her due process right of privacy to make medical decisions. First, the court would acknowledge that a clear exception to parental autonomy exists in this case as the proposed medical treatment is extremely serious and contentious between Patricia, her parents and the state. Second, the state’s interest in protecting Patricia is just beginning to lessen on the sliding scale as Patricia is fast approaching her early teenage years in which minors are more likely to be recognized as capable decision makers. The court should then apply the integrationist method to determine if Patricia may indeed take advantage of the exception to parental autonomy in this case. The conflict is aggravated here because Patricia, unlike Parker, has repeatedly requested the operation with tears and desperation. Under the integrationist method, an adult in Patricia’s situation would possess the right to undergo

193. See Bellotti, 443 U.S. at 622.
194. In re Hudson, 126 P.2d at 768.
The same tripartite test would be applied in Patricia’s situation as in Parker’s to determine whether Patricia should be treated the same or differently from an adult. Under the tripartite test, the court may find that 1) the amputation would cure the problems that the enlarged arm is causing, such as heart strain, frail health, and deformities of the spine and chest, 2) that Patricia has very good chances of surviving the operation, which is recommended by several physicians and 3) that the emotional and physical side effects of amputating her left arm may be minimal to quite positive as Patricia’s mental attitude and physical health would most likely improve significantly.

Finally, the court would consider Patricia’s competence. If Patricia is found to be competent, then there is no reason under the integrationist method to deny Patricia an adult’s right to consent to the operation, as the procedure would 1) greatly benefit her, 2) both Patricia and her physicians desire it and 3) her chances of survival are extremely good. Even if Patricia is not found to be adequately competent, the other three prongs of the tripartite test present compelling arguments that the surgery is necessary and that the state’s intervention is only minimally necessary since the operation Patricia wants, over the desires of her parents, poses significant benefits, not risks.

If amputating Patricia’s arm turned out to have negative results and pose more of a hardship on Patricia then her original condition did, allowing Patricia to assert her voice in the parent-child-state conflict may actually help her, and other minors like her, to more effectively cope as opposed to other minors who are not involved in the decision-making process and who may feel out of control of their lives as a result.

If the facts were different and Patricia refused the operation, which seems to be clearly beneficial under the tripartite test, the court may step in and intervene in her decision, preventing her from exercising the rights of an adult, as the tripartite test points to the facts that the procedure is desirable, and Patricia may not be mature enough to make an appropriate decision. This would activate the state’s legitimate interest in treating the child differently in this situation.

The court in this case did allow physicians to perform the amputation, but how the court reached its decision remains shrouded in mystery, and it is uncertain whether the court gave any consideration to Patricia’s opinion. Certainly the decision did not establish a workable test that could be followed by other courts. Therefore, the decisional tree utilized in this Note is critical in this case because it allows a court to move away from reaching decisions based on individual, subjective notions of fairness. Rather, a court may now thoroughly analyze the facts of each case and reach a decision based on concrete factors that other courts can apply to reach consistent, reliable decisions in this area of the law.
3. Kevin’s Condition

Kevin’s situation parallels Patricia’s as the surgery to remove Kevin’s facial deformity would have very positive consequences and few side effects. Again, the court would first recognize that there is clearly an exception to parental autonomy here to allow Kevin to participate in the decision-making process as there is an extreme medical situation and an aggressive conflict between Kevin, his parents and the state over how to treat it. Kevin is different from both Parker and Patricia in that, at the age of fifteen, the sliding scale distinctly activates the integrationist method as all of the state’s protective interests are fading as Kevin quickly approaches the age of majority.

Under the integrationist method, an adult would have a due process right to seek and consent to the facial surgery. Therefore, applying the tripartite test to Kevin’s situation to determine if Kevin should be treated the same as an adult, the court would find under the test that 1) the surgery would eliminate most of the deformity, that 2) the surgery would be very effective and 3) the surgery would allow Kevin to develop socially and emotionally before his situation worsens. Also, under the fourth element of the tripartite test, it may be much easier to determine Kevin’s maturity and competency given his greater age.

Since the surgery would create significant improvements to Kevin’s emotional and physical well-being and is recommended by physicians, and since Kevin is most likely competent to make the decision, the court should activate the exception to parental autonomy and grant Kevin the right of an adult to choose to have the facial deformity removed against the express wishes of his parents. Although the surgery may pose some bleeding risks under the second prong of the tripartite test, the benefits of the operation and Kevin’s competency indicate that there is not sufficient reason to treat Kevin differently from an adult and hold the state’s protective powers and parental autonomy as more important over Kevin’s due process liberty interest.

If physicians and Kevin’s parents wanted the surgery, and yet Kevin refused for religious or other reasons, this decisional tree demonstrates the extent of Kevin’s liberty interest to determine his own health care. It may be persuasively argued under this analysis that the exception to parental autonomy would hold and Kevin would be allowed to refuse the treatment. Kevin’s competence and the diminishing state interest in his welfare would arguably outweigh any beneficial effects of the surgery, thereby allowing him to refuse the surgery.

IV. CONCLUSION

Rather than subject mature, capable minors to the whims of parents or the state, this Note argues that there are situations in which a minor has a valid liberty interest under the Due Process Clause of the Fourteenth Amendment to play an active role in deciding his or her medical care. This liberty interest has equal, if not sometimes greater, importance than parental autonomy or a state's interests, and it should be heeded by the courts.

This Note proposes a litmus test for determining when a child can, and should, exercise his or her liberty interest to participate in the medical decision-making process. Over several decades of adjudication, absolute parental autonomy has been whittled down to create exceptions for minors to act autonomously in certain circumstances. These exceptions have created potential space for an exception for minors to make health care decisions.

The general health care exception to parental autonomy applies to situations in which there is a conflict of interest between parents, a seriously ill child and/or the state over a drastic, invasive proposed course of treatment. In these cases, the decisional tree set forth in this Note is triggered to guide the court in analyzing 1) under a sliding scale approach, whether the child is old enough to warrant a consideration of his or her due process liberty interests, and if so, 2) whether there is any reason to deny that child's potential liberty interests. To determine if the child's interest to consent to or refuse treatment should be different from an adult's right to choose, the court considers under a tripartite test 1) the treatment's effectiveness, 2) a child's chance of survival with or without treatment, 3) the emotional and physical side effects of the treatment on the child, and finally the minor's capacity to make appropriate decisions. Under the capacity analysis, the court should resort to adolescent psychological competency literature, such as the MacArthur Treatment Competency Study, to make a determination regarding the minor's maturity. This decisional tree is clear, precise and gives the court a road map for consistently charting when a minor's liberty interest outweighs the notions of parental autonomy and the state's protective parens patriae power.

Unfortunately, parents and the state sometimes clash over the type of health care that may be necessary for a gravely ill child. Too often these disputes become bitter battles that pit parental autonomy against the state's interests, resulting ultimately in unpredictable decisions marked by either deference to, or a complete disregard for, a parent's wishes. Lost in these conflicts is the child's interest in participating in health care decisions that have life or death implications. Ideally, an alternative dispute resolution method, such as mediation, should be employed to foster communication between parents, their children and the state to reach a peaceful decision that respects the different interests involved in a minor's medical care. If
such mediation fails, however, this Note highlights the necessity of recognizing a minor’s interest in participating in the medical decisions and proposes a thorough decisional tree that will assist the courts in determining when it is appropriate to recognize and uphold a minor’s liberty interest under the Fourteenth Amendment to choose a course of treatment.