Family Conflicts: The Role of Religion in Refusing Medical Treatment for Minors

Jennifer E. Chen
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INTRODUCTION

The rebellious teenager is a familiar icon in American culture. In a society that inconsistently treats adolescents as adults in some areas and as children in others, the struggle for independence continues until minors reach the legal age of autonomy at eighteen. Until that age, in many areas of legal significance, the minor is subject to the decisions of his or her parents.

Traditionally, minors are completely subject to their parents’ will when it comes to their own healthcare treatment. Often this does not pose a problem because most parents will make decisions that are in the best interests of their children and consistent with societal values that parents should obtain the best medical treatment available when their child is critically ill. Cases exist, however, where parents have refused medical treatment for their child because of their sincerely held religious beliefs. Based on constitutional rights, parents have a certain degree of leeway to make these treatment refusal decisions, and in no published case to date has a child asserted a treatment preference contrary to that of his or her parents refusing treatment on religious grounds. Thus, courts have yet to deal with the scenario of a disagreement between parents and child over a religious-based decision to refuse medical treatment.

This Note examines the intersection of competing interests and individual rights involved in such decisions. Two possible scenarios are

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1. For example, for certain crimes children can be legally tried as adults. For a history of juvenile justice, see Mark R. Fondacaro et al., Reconceptualizing Due Process in Juvenile Justice: Contributions from Law and Social Science, 57 HASTINGS L.J. 955, 958-67 (2006).

2. See infra Part II.

3. See infra Part II.A.
addressed here. In the first scenario, the parents refuse treatment based on religion, while the child desires to be treated. In the second scenario, the parents seek treatment for their child, but the child asserts a religious right to refuse treatment.

Part I of this Note provides a background on the development of current approaches that courts take when balancing parental rights, state interests, and the minor’s rights. Part II will focus on healthcare decision-making. First, Part II will briefly summarize the statutory exemptions that protect the parents’ right to refuse treatment for their child based on sincere religious beliefs, and then it will examine how various courts interpret and apply the statutes. Next, it will review the mature minor doctrine and arguments for and against allowing adolescents to make their own treatment decisions. Part II will also look at cases where courts granted or refused the adolescent’s right to make his own decision. Part III will look at the free exercise rights of minors, considering both the legal and psychological issues. Part III will briefly summarizing the free exercise rights of adults and then compare them to those of minors. Psychological literature will also provide an understanding of when adolescents are determined to have their own identity and beliefs. Examining these different doctrines together, Part IV argues that parents should not be allowed to refuse treatment based on religious reasons for an adolescent child who desires treatment and also that adolescents should not be granted the right to refuse treatment for religious reasons in life-threatening situations, when the parents are seeking treatment.

I. BALANCING THE INTERESTS OF THE FAMILY AND THE STATE

Over eighty years ago, the Supreme Court established in Meyer v. Nebraska that parents have a constitutional right to control the upbringing of their children. Since then, the Court has upheld this right, by limiting state interference in parental decisions regarding the education, religion, association, and healthcare of their children. Most

4. See Meyer v. Nebraska, 262 U.S. 390, 399 (1923) (holding that the Fourteenth Amendment protections include the right to “establish a home and bring up children”). In Meyer, the Court overturned a state law prohibiting teaching in any language other than English, using substantive due process to find that the statute violated the parents’ rights to make decisions for their children. Id. at 399-401; accord ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 654 (1997) (discussing the Meyer case).

5. See, e.g., Troxel v. Granville, 530 U.S. 57, 67-68 (2000) (holding that statute allowing state judge to determine when visitation by grandparents is appropriate, regardless of what the parent believes is in the child’s best interest, violates the due process clause); Parham v. J.R., 442 U.S. 584, 694 (1979) (explaining that parents must maintain a dominant role in deciding whether children should be committed to mental health facilities); Wisconsin v. Yoder, 406 U.S. 205, 213-14 (1972) (stating that our society places a high value on “parental direction of the religious upbringing and education of their children”); Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (“It is cardinal with us that the custody, care and nurture of the child reside first in the parents.”); Pierce v. Soc’y of Sisters, 268 U.S. 510, 534-535 (1925) (acknowledging that parents have a liberty “to direct the upbringing and
recently, in *Troxel v. Granville*, the Supreme Court upheld the principle that the due process clause of the Fourteenth Amendment "protects the fundamental right of parents to make decisions about the care, custody, and control of their children." Three common presumptions support this longstanding tradition of deference to parental discretion. First, minors are presumed to be immature and inexperienced. Second, adult parents possess the experience and judgment capacity to direct their children. Last, parents generally make decisions that are in the "best interests" of their children. These presumptions, along with the Court's rulings, provide significant legal and social justifications for parental autonomy.

While the Court recognizes the fundamental right of parents to make child-raising decisions, in accordance with modern principles of constitutional law, the Court will apply strict scrutiny—whether the state's action is narrowly tailored to serve a compelling interest—to determine whether the state can intervene in family decisions.

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education of children under their control"); *Meyer*, 262 U.S. at 399-401 (overturning the application of a statute prohibiting the teaching of languages other than English because it infringed on fundamental rights).

6. *Troxel*, 530 U.S. at 66. The *Troxel* court declared the parents' liberty interest in raising their children to be "perhaps the oldest of the fundamental liberty interests recognized by this Court." *Id.* at 65.


8. *Id.*

9. *Id.; see e.g., Parham*, 442 U.S. at 602 ("The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions.").


12. Chemerinsky, *supra* note 4, at 644 (strict scrutiny is defined as whether the state's action is narrowly tailored to serve a compelling interest); *see also* *Troxel*, 530 U.S. at 69-70 (discussing the lower court's error in interfering in the parent's fundamental rights to make decisions for the child because it failed to give proper weight to the parent's determination and lacked a compelling interest to determine that visitation rights of grandparents are in the child's best interests). However, states do not automatically win simply because they can point to a compelling interest. See Wisconsin v. *Yoder*, 406 U.S. 205, 214 (1972). The state must also show that its interest will be adversely affected. *Id.* In the absence of such a showing, the state will not be allowed to impinge on the parents' fundamental rights and interests. *Id.* For example, in *Yoder*, the state's purpose in compulsory education was to prepare children to be productive members of society. *Id.* at 213. However, the Court found convincing evidence to support the Amish claim that forgoing one or two years of school would not impair the child physically or mentally, nor result in the child's inability to mature into a self-supporting individual, nor in any other way materially detract from the welfare of society. *Id.* at 234. Based on this finding, the court deferred to the parents' decision because there was no provable harm to the state's
A. THE FUNDAMENTAL RIGHTS OF PARENTS VS. STATE INTERESTS

Initially, the jurisprudence dealing with protecting minors involved balancing the interests of the parents against those of the state. While the parents' rights stood on Fourteenth Amendment protections, the state's interests originated in the traditional parens patriae authority. Under parens patriae, the state is empowered to act as a guardian for members of society who are unable to protect their own interests, and children naturally fall into this category. Thus, the state's interest in protecting the welfare of children gives the government a reason to intervene in the family. In *Prince v. Massachusetts*, the first major case establishing the balance between government and parental interests, the Court acknowledged the state's interest, saying that because a "democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies," the government can "secure this against impeding restraints and dangers, within a broad range of selection."

In *Prince*, the Supreme Court faced the problem of weighing a parent's free exercise rights as applied to raising a child against the state's interest to protect the welfare of the child. The case dealt with the conviction of an adult for violating child labor laws by allowing a

interest. *Id.* at 236.


15. Weithorn, *supra* note 7, at 1402–03.

16. *Prince*, 321 U.S. at 166. The Court declared that it is in "the interests of society to protect the welfare of children, and the state's assertion of authority to that end." *Id.* The Court justified the authority by reasoning that "[i]t is the interest of youth itself, and of the whole community, that children be both safeguarded from abuses and given opportunities for growth into free and independent well-developed men and citizens." *Id.; accord Lainie Freedman Ross, Children, Families, and Healthcare Decision Making* 135 (1998) ("When parents make decisions which are contrary to their child's basic interests, the state as parens patriae, has the right to intervene."). For a discussion on the state's authority to regulate children and families based on the state's dual parens patriae and police power interests, see Weithorn, *supra* note 7, at 1401–07. See also Susan D. Hawkins, *Note, Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 Fordham L. Rev. 2075, 2084–86 (1996) (discussing the state's role as parens patriae and state interests that support intervention into the parent-child relationship).


18. *Id.* at 166. In *Prince*, the state interest was manifested in a statute that prohibited any girl under the age of eighteen from selling or offering to sell "any newspapers, magazines, periodicals or any other articles of merchandise... in any street or public place." *Id.* at 160–61. Sarah Prince, a guardian to her nine-year-old niece, Betty, was convicted of violating these state labor laws when the two were found preaching and selling religious literature on the sidewalk during the evening. *Id.* at 159–60, 162. Mrs. Prince and Betty claimed that they were exercising their freedom of religion rights under the First Amendment, testifying that they were both ordained ministers "exercising [their] God-given right and [their] constitutional right to preach the gospel." *Id.* at 161–62. However, the Court upheld the statute and Mrs. Prince's conviction, finding that the potential harm from the "crippling effects of child employment" outweighed claims of family privacy and parental autonomy. *Id.* at 168–69.
child to accompany her in the evening while distributing religious literature on the sidewalks.\(^{19}\) Although evidence proved that the child willingly participated in the activity,\(^ {20}\) the Court weighed the competing interests by balancing "[t]he parent's conflict with the state over control of the child."\(^ {21}\) The parent and child were in agreement, and it made sense for the Court to assume that the parent would represent the child's interests.\(^ {22}\) Thirty years later in Wisconsin v. Yoder, the Court took similar steps in a case involving the education of adolescents.\(^ {23}\) In determining whether the state could compel Amish teenagers to attend school beyond the eighth grade, the Court weighed the state interest in mandating continued secondary education against the parents' right to free exercise of religion.\(^ {24}\)

The Court's focus on the fundamental rights of parents reveals its view that children's interests are best protected when represented by their parents' interests. An additional or alternative explanation for the focus on the parents' interests could be that the Court failed to seriously examine the minors' interests because the minors were not parties in the cases.\(^ {25}\) Also, in many cases, the facts illustrated or the court assumed that the parents and minor shared identical interests, so protecting the parents' interests would also protect the minor's interests.\(^ {26}\) However,

\(^{19}\) Id. at 159–60, 162.

\(^{20}\) Id. at 162.

\(^{21}\) Id. at 165.

\(^{22}\) Id. at 162.

\(^{23}\) Wisconsin v. Yoder, 406 U.S. 205, 230–32 (1972). Chief Justice Burger makes it clear that the majority opinion does not consider the potential competing interests of the children. Id.

\(^{24}\) Id. at 213–14.

\(^{25}\) In Prince, the state prosecuted the child's guardian for child labor law violations stemming from an incident where a child distributed religious literature on the street. Thus, the Court focused on the conflicting interests between the free exercise rights of the guardian against the state's interests, rather than directly considering the interests of the child. Prince, 321 U.S. at 159, 166. During a dispute over child visitation rights, the Court focused on a mother's fundamental liberty interests rather than the children's associational rights because the dispute was between the children's grandparents and the mother. Troxel v. Granville, 530 U.S. 57, 67–68 (2000). In overturning the ruling, the Court pointed out the error of the lower court, which "gave no special weight at all to [the mother's] determination of her daughters' best interests." Id. at 69. In determining whether Amish children could stop attending high school early, in violation of the state's compulsory education laws, the court upheld the parents' traditional interests with respect to the religious upbringing of their children because it was the parents who were prosecuted by the state. Yoder, 406 U.S. at 231–32 ("The children are not parties to this litigation."). In another case the Court struck down criminal prosecution under a state law that forbade the instruction of any language other than English prior to eighth grade, finding that this provision infringed on a parent's fundamental right to instruct their children in their native tongue. Meyer v. Nebraska, 262 U.S. 390, 399–401 (1923). The Court also found that legislation that forced children to attend public schools unreasonably interfered with the liberty of parents and guardians to educate their children. Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925).

\(^{26}\) See Prince, 321 U.S. at 162–63. Both the adult and the child had similar interests, arguing that they acted within their free exercise rights when they distributed religious literature on the street. Yoder, 406 U.S. at 230–31 (explaining that the holding deals only with the parents' rights to free exercise and that relevant testimony showed that one child's wishes corresponded with their parents);
the lack of direct consideration for minors' preferences when their interests were at stake implied that a minor had no separate or individual interests apart from those that were inherently protected by his or her parents' interests. Justice Douglas addressed these issues in his dissenting opinion in *Yoder*, arguing that the Court should recognize the child's separate right: "Where the child is mature enough to express potentially conflicting desires, it would be an invasion of the child's rights to permit such an imposition without canvassing his views." In Justice Douglas's view, it did not matter whether the parent and child were in agreement, because reaching a certain point of maturity should trigger the protection of certain rights for the child.

While *Yoder* dealt with religious freedom, the issue in *Troxel* was the right of association, and in his dissent, Justice Stevens expressed a similar view regarding the acknowledgement of children's interests: "[T]o the extent parents and families have fundamental liberty interests in preserving such intimate relationships, so, too, do children have these interests, and so, too, must their interests be balanced in the equation."

Although the Court in *Yoder* hesitated to examine the children's interests, cases after *Yoder* involved children as parties with differing interests from their parents. This opened the door for the Court to move from a dyadic to a triadic balance.

B. TRIADIC BALANCING: RECOGNIZING THE CHILD’S SEPARATE INTERESTS

In the cases above, the Court treated the interests of the parents and children as a unified private interest to be weighed against the government's interest. Presuming that the child lacks maturity and parents act to promote the best interests of the child, it follows that the child's interests are incorporated within the parents' interests. However, as minors mature into adolescence, it becomes less clear that protecting their parents' rights will automatically protect their rights, particularly when a conflict exists between the parents and child.

Seven years after

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*Pierce*, 268 U.S. at 534–35 (focusing on the right of parents to direct the upbringing and education of their children); *Meyer*, 262 U.S. at 400 (framing the issue as a parent's right to engage a teacher to instruct their children without examining the individual child's wishes).


28. Id. ("And, if an Amish child desires to attend high school, and is mature enough to have that desire respected, the State may well be able to override the parents' religiously motivated objections."). While Justice Douglas is not clear on the age or criteria to determine the proper stage of maturity, the adolescents in *Yoder* were ages fourteen and fifteen. Id. at 207.


30. See *supra* Part II.

31. Justice Stevens acknowledged in *Troxel* that children may have interests separate from their parents and that courts should consider these interests. *See supra* note 29 and accompanying text. In the context of parents having educational decisions over adolescent children, Justice Douglas also pointed out the importance of giving the child an opportunity to be heard because her desires may conflict with those of her parents, noting that "[i]t is the future of the student, not the future of the
Yoder, the Supreme Court examined this issue and applied a triadic balancing test to separately examine the interests of the parents, child, and the state.\textsuperscript{32}

In Parham v. J.R., the Supreme Court weighed private interests against the government's interest in the context of parents who sought to place their children in state-administered mental institutions.\textsuperscript{33} One major factor, which distinguished Parham from previous cases like Prince or Yoder, was that some of the actual plaintiffs were minor children.\textsuperscript{34} Because the minors were included as parties, the Parham court had to recognize their separate interests.\textsuperscript{35} Thus, in the balance of private versus government interests, the Court found that "the private interest at stake is a combination of the child's and parents' concerns."\textsuperscript{36} However, while the Court acknowledged the child's rights and interests in not being committed, they found that these rights were "inextricably linked with the parents' interest in and obligation for the welfare and health of the child."\textsuperscript{37} While noting that jurisprudence historically reflected the concepts of a family unit with parents having broad authority over minors, the court also recognized the danger that parents may act against the interests of their children, justifying giving states "constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized."\textsuperscript{38} However, because there was no record or evidence of bad faith by any parents, the Court was not persuaded to transfer decision-making power away from the parents, and despite their examination of the children's contrary interests the Court ultimately deferred to the parents.\textsuperscript{39} While the case resulted in a decision that favored the parents' decisions over those of the child, the Court took the initial step of looking to the child's preferences and including them
separately in the balance.\(^{40}\)

During the same term as *Parham*, the Court decided *Bellotti v. Baird* by using the triadic balance of competing interests between the parents, minors, and the state.\(^{41}\) In *Bellotti*, however, the Court was less willing to defer to the parents when the issue involved the regulation of abortions for minors by requiring parental notice and consent.\(^{42}\) In reviewing the constitutionality of a state statute regulating the access of minors to abortions, the Court separately analyzed the minors' constitutional rights, the state's interests in protecting minors, and the parents' rights to guide their children.\(^{43}\) With respect to a minor's constitutional rights, the Court found that while children are "protected by the same constitutional guarantees against governmental deprivations as are adults, the State is entitled to adjust its legal system to account for children's vulnerability and their needs for 'concern,... sympathy, and... paternal attention.'"\(^{44}\) Recognizing that children still lack the experience and judgment to identify and avoid potentially harmful choices, the Court held that states have an interest in protecting minors and could validly limit the freedom of children to make choices with potentially serious consequences.\(^{45}\) Finally, the Court discussed the parents' right to have a guiding role in the upbringing of their children, where this right would be recognized by "state deference to parental control over children."\(^{46}\) Weighing all this in the balance, the Court determined that a mature minor had the right to make the decision

\(^{40}\) *Id.* at 604.


\(^{42}\) *Id.* at 642 ("The need to preserve the constitutional right and the unique nature of the abortion decision, especially when made by a minor, requires a [s]tate to act with particular sensitivity when it legislates to foster parental involvement in this matter."). The Court further held that a "[s]tate could not lawfully authorize an absolute parental veto over the decision of a minor to terminate her pregnancy." *Id.* at 639 (citing Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976)).

\(^{43}\) *Bellotti*, 443 U.S. at 634-39. While the Court acknowledged the separate rights of minors, it stopped short of granting them the same degree of constitutional rights as adults. *Id.* The Court justified its finding that children's rights are to be less protected from state interference, writing that "three reasons justify[ ] the conclusion that the constitutional rights of children cannot be equated with those of adults: the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing." *Id.* at 634.

\(^{44}\) *Id.* at 635 (citation omitted).

\(^{45}\) *Id.* at 635-36. There are several references in the opinion to previous decisions where the Court upheld statutes that limited a minors' First Amendment rights. See, e.g., Ginsberg v. New York, 390 U.S. 629, 639-40 (1968) (upholding a criminal conviction for selling sexually-oriented magazines to a minor under the age of seventeen, when such a conviction could not have stood had the sale been to an adult); Prince v. Massachusetts, 321 U.S. 158, 159, 171 (1944) (upholding an adult's conviction for violating a child labor statute, when the adult guardian had allowed the minor to distribute religious literature on the street after hours).

\(^{46}\) *Bellotti*, 443 U.S. at 637; accord Pierce v. Soc'y of Sisters, 268 U.S. 510, 535 (1925) ("The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.").
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without parental consent.\textsuperscript{47}

After Parham and Bellotti, it is clear that the Court will consider a minor’s interests separately from his or her parents’ interests when the minor is a party.\textsuperscript{48} When a minor is not a party, the Court may decide to use the triadic balance if there is a compelling right or interest involved.\textsuperscript{49} Comparing these two cases, in Bellotti the Court was willing to give more weight in favor of the minors because there was a substantive constitutional right involved—a decision involving abortion—as opposed to merely a procedural right as in Parham.\textsuperscript{50} Thus, in the case of a conflict over healthcare treatment for a minor, the decision could turn on the strength of the minor’s interest and whether there is an underlying substantive right.

II. MAKING DECISIONS TO REFUSE TREATMENT

In Cruzan v. Director, Missouri Department of Health, the Supreme Court held that a competent individual has the right to refuse life-sustaining medical treatment.\textsuperscript{51} There is much debate over whether a minor counts as a competent individual, especially in this context.\textsuperscript{52} Additionally, it is debatable how far this extends to a parent’s right to refuse treatment for their children. The controversy moves beyond life-sustaining treatment and includes treatment of lesser-therapeutic value. Deference to parental decision-making is supported by the constitutional right of privacy in the family, which applies in the area of decision-making for the medical treatment of children.\textsuperscript{53} The presumptions in favor of parents making treatment decisions for their children is based on the same reasoning that parents will act in the best interests of their children.\textsuperscript{54} However, as in the cases previously discussed, the state

\textsuperscript{47.} Bellotti, 443 U.S. at 647. The result of balancing these interests was the court’s creation of an intermediate step for the minor to gain autonomy over her abortion decision. Id. The court provided that every minor should have an opportunity to go directly to court, without first consulting or notifying her parents, where she had a chance to persuade the court that she is mature and well enough informed to make intelligently the abortion decision on her own. Id. If the court were convinced then it would authorize her to act without parental notice or consent. Id.

\textsuperscript{48.} See Bellotti, 443 U.S. at 647; Parham v. J.R., 442 U.S. 584, 600 (1979).


\textsuperscript{50.} Compare Bellotti, 443 U.S. at 642, with Parham, 442 U.S. at 600.


\textsuperscript{52.} See generally Larry Cunningham, A Question of Capacity: Towards a Comprehensive and Consistent Vision of Children and Their Status Under the Law, 10 U.C. DAVIS J. JUV. L. & POL’Y 275 (2006) (discussing how the law measures the competence of minors).


\textsuperscript{54.} See Derish & Heuvel, supra note 53, at 112; Kimberly M. Mutcherson, Whose Body Is It Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents, 14 CORNELL J.L. & PUB. POL’Y 251, 259 (2005) (*For the most part... parents and caretakers are the only parties legally allowed to provide consent to healthcare for a person under the age of eighteen... [S]tate laws rest on a presumption that minors are incompetent and lack the ability to make cogent, mature, and
maintains an interest in protecting the welfare of children and can intervene under its parens patriae authority.\textsuperscript{55}

Normally, when the state finds that parents have endangered their child by failing to obtain necessary medical treatment, the state can intervene to find the parent negligent and/or pursue criminal charges.\textsuperscript{56} The court can then appoint a guardian who will ensure that the child receives necessary treatment.\textsuperscript{57} However, when parents refuse treatment for their child based on religious beliefs, there is a collision between the parents' constitutional rights of privacy and free exercise of religion and the state's interest in protecting the child.\textsuperscript{58} Many states have created a compromise by exempting parents in these situations from being found in neglect, while also providing an opening for state intervention.\textsuperscript{59}

A. RELIGIOUS EXEMPTION STATUTES AND PARENTAL REFUSAL OF TREATMENT

When Congress first addressed the issue of religious-based refusal of medical treatment, it created a compromise by enacting provisions that acknowledged both parental rights and state interests. This resulted in many states enacting laws that protect the parents' religious freedom, but allowed intervention under the parens patriae power to protect children when necessary.

In 1974, Congress enacted the Child Abuse Prevention and Treatment Act ("CAPTA"), which created the Department of Health, Education and Welfare (HEW)\textsuperscript{60} to provide federal guidance to the states for the regulation of child welfare.\textsuperscript{61} The initial version of HEW's regulations defined "negligent treatment" of children as the "failure to provide adequate food, clothing, or shelter," and included an exception for parents who did not provide medical treatment based on religious binding decisions about their own well being."); Hawkins, supra note 16, at 2075 ("In the United States, minors are generally considered legally incompetent to consent to or refuse most forms of medical treatment. Parents generally have the sole authority to decide whether their children will receive such treatment, and a physician may not treat a minor without the consent of the minor's parent or guardian." (citations omitted)).

\textsuperscript{55} See discussion supra Part II.B.

\textsuperscript{56} See Weithorn, supra note 7, at 1323–26 (providing an overview of the child welfare system); see also People v. Ripperger, 283 Cal. Rptr. 111, 122–23 (Ct. App. 1991) (holding that the failure to provide medical care constitutes a misdemeanor).

\textsuperscript{57} Weithorn, supra note 7, at 1323–26.

\textsuperscript{58} See, e.g., Lundman v. McKown, 530 N.W.2d 807, 818–19 (Minn. Ct. App. 1995) (discussing the balancing of a private actor's free-exercise interests against the state's compelling interest to protect the welfare of children).

\textsuperscript{59} See infra Part II.A.

\textsuperscript{60} Now called the Department of Health and Human Services. See U.S. Dep't of Health & Human Servs., History of HHS, http://answers.hhs.gov/ (select "About HHS" category; then follow "History of HHS" hyperlink) (last visited Jan. 4, 2007).

beliefs. The exception recognized the parents' free exercise rights, but also gave weight to the state's interests by providing that "such an exception shall not preclude a court from ordering that medical services be provided to the child when his health requires it." Although the provision allowing courts to order treatment would seem to make the parental exception practically moot, HEW encouraged states to adopt the exception by initially conditioning funding for state child services programs on the state's enactment of the statutory exemptions. This gave states a great financial incentive to avoid a finding of negligence for parents who refused medical treatment for their children because of a legitimate practice of religious beliefs. In effect, parents would not be penalized for withholding medical treatment, but the government could step in to override a parent's decision. This compromise appeared to weigh heavily in favor of state interests, but cases show that the courts mainly allowed state intervention when treatment could prevent life-threatening conditions or stop the spread of disease.

In 1983, the federal government softened its support for the parental right of refusal by taking a more neutral stance on religious exemptions. It no longer required states to recognize a religious exception in order to be eligible for a federal grant, leaving states free to choose whether or not to recognize religious exemptions. HEW also expanded the definition of "negligent treatment" to include the failure to provide medical care, but left the exemptions in the regulations essentially the

62. 45 C.F.R. § 1340.1-2 (1974) ("A parent or guardian legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian."); accord H.R. Rep. No. 93-685, at 2767 (1973), reprinted in 1974 U.S.C.C.A.N. 2763, 2767 ("First, the Committee recognized that 'negligent treatment' is difficult to define, but it is not the intent of the Committee that a parent or guardian legitimately practicing his religious beliefs who thereby does not provide specific medical treatment for a child is for that reason alone considered to be a negligent parent. To clarify further, no parent or guardian who in good faith is providing to a child treatment solely by spiritual means—such as prayer—according to the tenets and practices of a recognized church through a duly accredited practitioner shall for that reason alone be considered to have neglected the child.").


64. This condition was removed in 1983 by the federal government. See infra note 66.

65. Newmark v. Williams, 588 A.2d 1108, 1119-21 (Del. 1991) (holding that parents were not in neglect for refusing treatment for a child diagnosed with an advanced stage of deadly cancer and potential success of treatment was only 40%); In re J.J., 582 N.E.2d 1138, 1141 (Ohio Ct. App. 1990) ("[T]he state may compel a juvenile...to submit to medical treatment for a contagious and potentially life-threatening disease.").

66. 45 C.F.R. § 1340.2(d)(3)(ii) (1983) ("Nothing in this Part should be construed as requiring or prohibiting a finding of negligent treatment or maltreatment when a parent practicing his or her religious beliefs does not, for that reason alone, provide medical treatment for a child; provided, however, that if such a finding is prohibited, the prohibition shall not limit the administrative or judicial authority of the State to insure that medical services are provided to the child when his health requires it." (emphasis added)).
same. Although states were no longer required to provide exemptions, many that had already enacted such statutes left them in place. As a result, the jurisprudence in this area of parental refusal of treatment for minors varies from state to state.

The variations of these religious exceptions resulted in a number of inconsistencies. Despite the exemptions for civil liability, some states still find parents criminally liable for the death of their minor child in situations where they fail to provide medical treatment and rely solely on spiritual healing. Zaven T. Saroyan argues that these prosecutions are a violation of the Supreme Court’s decision that courts should not judge the correctness of a faith or a religion, because a criminal charge is an implicit ruling on the correctness (or incorrectness) of a religion since parents and doctors would not be prosecuted for manslaughter if a child died in a hospital. On the other hand are arguments that the religious exemptions are unconstitutional violations of the Equal Protection Clause or the Establishment Clause.

67. See id. § 1340.2 (1983).

69. Congress has essentially left this up to the states. See 42 U.S.C.A. § 5106(b) (West 2006) (“Except with respect to the withholding of medically indicated treatments from disabled infants with life threatening conditions, case by case determinations concerning the exercise of the authority of this subsection shall be within the sole discretion of the State.”).

70. See, e.g., Walker v. Superior Court, 765 P.2d 852, 870 (Cal. 1988) (upholding the conviction of the parent of a girl who died from meningitis even though they were exercising legitimate and sincere Christian Scientist beliefs); People v. Pierson, 68 N.E. 243, 246-47 (N.Y. 1903) (finding a parent belonging to the Christian Catholic Church of Chicago guilty for infant daughter’s death from pneumonia); Commonwealth v. Barnhart, 497 A.2d 616, 624-25 (Pa. Super. Ct. 1985) (finding members of Faith Tabernacle Church liable for the death of their son from a tumor).

71. Zaven T. Saroyan, Spiritual Healing and the Free Exercise Clause: An Argument for the Use of Strict Scrutiny, 12 B.U. PUB. INT. L.J. 363, 365-66 (2003). Saroyan uses an illustration of two children with meningitis who both die. Id. One child was treated solely through spiritual healing and the other with conventional medicine. Id. at 366. According to Saroyan, in many states, the parents who relied on spiritual healing would be prosecuted for manslaughter whereas the doctor of the other child would be free from criminal charges. Id. Saroyan argues that when the state charges only one party, despite identical results, then “the state is implicitly asserting that one method is correct, and one is not.” Id.; accord United States v. Ballard, 322 U.S. 78, 85-88 (1944) (explaining that the truth or falsity of religious beliefs is not for the courts to judge because an attempt at such a determination is a “forbidden domain” based on the First Amendment).

72. Rita Swan, On Statutes Depriving a Class of Children of Rights to Medical Care: Can this Discrimination Be Litigated?, 2 QUINNIPIAC HEALTH L.J. 73, 92 (1998). Swan argues that religious exemptions create two classes of citizenship: (1) children who have access to medical care, and (2)
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In non-criminal cases where parents assert the right of refusal, the decision seems to turn on a number of factors relating to the strength of the state’s interest which includes the danger to the child, the potential success of the treatment being refused, and the danger to others in the case of communicable diseases. For example, in *Newmark v. Williams*, three-year-old Colin Newmark was diagnosed with an advanced stage of deadly cancer, but his parents, who were Christian Scientists, rejected medical treatment that was proposed for the child. The state petitioned for custody of the child, but the court upheld the parents’ decision. The court determined that the child was not neglected by his parents’ refusal of treatment because the invasive chemotherapy had only a 40% chance of success and there was a very real risk that the treatment itself might cause the child to die. The court concluded there was insufficient justification to allow the state to intervene at the expense of the parents’ autonomy. Thus the religious issues were not as relevant because the court looked at other factors such as the risk of treatment against the chance of success. These other elements tipped the scales in favor of the parents’ decision to refuse treatment, making it unnecessary for the court to fully examine the issues related to religious freedom.

In *Newmark*, if the potential physical consequences from the medical treatment had not been so drastic and Colin’s chances of survival had been higher, the court might have reached a different decision. Under those circumstances the parents’ religious interests could have played a bigger role in the court’s decision. However, even if the parents are protected by a religious exemption and the court considers their free exercise rights, it does not necessarily result in a decision favorable to the parents. In *In re D.L.E.*, the Colorado Supreme Court held that a statutory religious exemption did not preclude a finding of dependency and neglect when a minor was suffering from a life-threatening medical condition due to a failure to comply with a program of medical treatment. The statute in question provided that “no child who in good faith is under treatment solely by spiritual means through prayer in children in “faith-healing sects” who have no access to treatment unless a state agency becomes aware of their needs. *Id.* at 95.


74. 588 A.2d 1108, 1109 (Del. 1991).

75. *Id.* at 1119–21.

76. *Id.*

77. *Id.* at 1118.

78. *Id.* The court also looked at other factors, but focused on the low probability of success. *Id.* at 1114, 1117–19.

accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to have been neglected.”

D.L.E., a minor who suffered epileptic seizures due to brain damage at birth, put his life in imminent danger by refusing to take his prescribed medicine—a decision his mother supported. The state brought an action to declare the child dependent and neglected. The court held that the exemption statute did not confer a defense to a finding of dependency and neglect, by interpreting the phrase “for that reason alone” to mean that other reasons, such as whether the child’s life was in imminent danger, would justify a finding of dependency. Thus, the language of the statute allowed the Colorado Supreme Court to find in favor of the state’s interest to protect the child’s welfare.

Imminent danger is not necessarily the threshold that triggers state intervention. The state can also have a compelling interest when there is a potentially life-threatening disease, particularly when that condition is contagious and therefore likely to affect the welfare of others. In the case of an adolescent and his mother who were in agreement in refusing treatment based on religious grounds for the boy’s gonorrhea, the court found that the state’s interests were strong enough to violate the juvenile’s religious beliefs due to the nature of the contagious and potentially life-threatening disease.

With the exception of this last case, the courts in these treatment-refusal cases did not examine the interests of the minor because they were either too young or else in agreement with their parents’ decisions. The court in In re J.J. however, framed the issue as a question of whether a juvenile had the right to refuse treatment. In its opinion, the court made it clear that the state would not have been able to compel an adult in the same situation to undergo medical treatment. The following section examines the extent of adolescent rights in healthcare decision-making.

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80. Id. at 272 (quoting Colo. Rev. Stat. § 19-1-114 (1973)). The Colorado statute provided:

No child who in lieu of medical treatment is under treatment solely by spiritual means through prayer in accordance with a recognized method of religious healing shall, for that reason alone, be considered to have been neglected or dependent within the purview of this article. However, the religious rights of a parent, guardian, or legal custodian shall not limit the access of a child to medical care in a life-threatening situation or when the condition will result in serious disability.


82. Id.

83. Id. at 274–75.


85. Id. at 1139–40.
B. ADOLESCENT RIGHTS—THE MATURE MINOR

In general, parents and caretakers are the only parties who can legally provide consent to healthcare for persons under the age of eighteen. However, there are a number of areas where the law provides exceptions allowing minors to seek healthcare with the same or almost the same autonomy as adults: 1) pregnancy and abortion decisions, 2) treatment for certain diseases such as STDs and drug or alcohol dependency, 3) the common law doctrine of the mature minor, and 4) emancipated minors.

With respect to reproductive rights, the Supreme Court has created an exception to allow mature minors to make their own abortion decisions without needing parental consent. The Supreme Court first recognized abortion as a constitutional right in Roe v. Wade and held that the government could not prohibit abortions prior to viability of the fetus. The government can regulate abortions prior to viability as long as it does not place an “undue burden” on the access to abortion. With regard to minors, the Court held in Planned Parenthood of Central Missouri v. Danforth that “[m]inors, as well as adults, are protected by the Constitution and possess constitutional rights.” In Danforth, the Court struck down a law requiring the consent of a parent in order for an unmarried minor to obtain an abortion. The Court examined the competing interests of safeguarding parental authority and the privacy rights of a competent mature minor, concluding that requiring parental consent as an absolute condition to obtaining an abortion was a violation

86. Mutcherson, supra note 54, at 259.
87. Id. at 264. But see Rosato, Adolescent Empowerment, supra note 11, at 773–74. Professor Rosato argues that despite the protection of undue burden, states are still able to limit a girl’s abortion rights significantly without violating the Constitution. Id.
88. Mutcherson, supra note 54, at 269.
89. Id. at 268–69.
90. Id. at 266.
92. 410 U.S. 113, 163–64 (1973). Viability is defined as the point where a fetus is potentially able to live outside its mother’s womb with or without artificial aid. Id. The time could be as early as twenty-four weeks but is usually placed at around twenty-eight weeks. Id. at 160.
93. Planned Parenthood v. Casey, 505 U.S. 833, 876–78 (1992) (defining “undue burden” as “a state regulation [which] has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus”).
94. 428 U.S. at 74 (declaring that “[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority”).
95. Id. at 75. The provision at issue stated that “[n]o abortion shall be performed prior to the end of the first twelve weeks of pregnancy except ... (4) [w]ith the written consent of one parent or person in loco parentis of the woman if the woman is unmarried and under the age of eighteen years, unless the abortion is certified by a licensed physician as necessary in order to preserve the life of the mother.”

Id. at 85 (quoting PA. CONS. STAT. § 3205 (1990)).
of a minor’s rights under Roe. The following year, the Court affirmed that “the right to privacy in connection with decisions affecting procreation extends to minors as well as to adults.” Thus, in a number of states, pregnant adolescents are granted adult status, and their healthcare providers have no legal obligation or right to report the pregnancy to the parents or guardians of the patient. With regard to abortions, some states have enacted parental notification requirements, but the Court has found these valid only when a judicial bypass option exists.

Because abortion is a recognized right, there are constitutional reasons to empower adolescents to make their own decisions in this area. However, public policy rationales also support granting more autonomy to adolescents to make healthcare decisions for other forms of treatment which are personal in nature. For example, in order to encourage adolescents to get treatment for sexually transmitted diseases, minors may consent to treatment without the knowledge or consent of their parents or guardian. This also applies to treatment for drug or alcohol dependency, mental health services, some emergency situations, and in some states, for care related to sexual assault. The justification for these exceptions is based on the assumption that adolescents will be less likely to seek treatment in these areas if they have to first get consent from their parents. Society pays a high cost when minors do not receive treatment for these ailments, and this cost is greater than the loss to parental autonomy.

Applying the triadic balance, the compelling state interests, which are closely related to the minor’s interest, outweigh parental autonomy.

Minors who are not suffering from the aforementioned medical issues can still attain some degree of autonomy under the “mature minor” doctrine. This is a common law exception recognized by some

96. Id. at 75; id. at 90–91 (Stewart & Powell, JJ. concurring).
98. See Mutcherson, supra note 54, at 263–64 n.39.
99. See, e.g., Bellotti v. Baird, 443 U.S. 622, 643 (1979) (“[I]f the State decides to require a pregnant minor to obtain one or both parents’ consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.”).
100. Mutcherson, supra note 54, at 264.
101. Id. at 264–66.
102. See Tomas J. Silber, Ethical Considerations in Caring for Adolescents, 10 PEDIATRIC ANNALS 408, 409 (1981) (“[M]any adolescents who need access to medical care in order to better protect their health would never consult a doctor if they knew he would require parental consent prior to treatment.”). The justification is therefore based more on practical and ethical concerns, rather than in particular beliefs about adolescent capacity for decision-making. Mutcherson, supra note 54, at 269–71.
103. Martin T. Harvey, Adolescent Competency and the Refusal of Medical Treatment, 13 HEALTH MATRIX 297, 300 (2003) (referring to the “utilitarian interest of preventing suicide, curbing illicit drug and alcohol abuse and halting the spread of venereal disease” as justification for adolescent consent to treatment); Rosato, Adolescent Empowerment, supra note 11, at 778.
courts, which allows a minor to consent to his own treatment without having to obtain his or her parents’ consent. The minor must prove he or she is “sufficiently competent to make the medical decision,” which usually requires a court determination of whether the minor understands the treatment and all the consequences.

The last exception grants emancipated minors the ability to make their own treatment decisions. Minors can become emancipated based on their age, through a court order, or other life situation. However, even in this case the minor does not always have the same rights as an adult.

C. INCONSISTENCIES IN THE CURRENT LAW AND PROPOSALS FOR CHANGE

Achieving the proper balance between deference to parents and adolescent autonomy requires delicate fact-based considerations because there are potential dangers on both sides. Requiring only parental consent without input from the minor could allow parents to avoid difficult conversations with their children about their illness to the harm of the child. Some parents may “protect” their child by shielding her from information about the prognosis. They may falsely tell her that she

104. Rosato, Adolescent Empowerment, supra note 11, at 789–90.
105. Id.
106. Minors can seek a court order when living independently from their parents. See, e.g., ALA. CODE §§ 26-13-1, -2, -4, -6 (1992); CAL. FAM. CODE § 7002 (West 2004); 750 ILL. COMP. STAT. ANN. 30/3-1, 3-2, 3-4, 3-5 (West 1999); MINN. STAT. ANN. § 144.341 (West 2005); R.I. GEN. LAWS § 14-1-59.1 (LexisNexis 2002). Minors can also be emancipated based on their status. See, e.g., ALA. CODE § 22-8-4 (LexisNexis 1997) (providing that minor must be fourteen or older and must be a high school graduate, married or pregnant); ALASKA STAT. § 25.20.025 (2004); ARK. CODE ANN. § 20-9-602 (2005); CAL. FAM. CODE §§ 6911, 6922 (providing that minor must be living apart from parents and must manage his or her own financial affairs); FLA. STAT. ANN. §§ 743.064, 743.065 (West 2005); IDAHO CODE §§ 39-4302, 4303 (2002). Minors can consent to medical procedures. See, e.g., ILL. COMP. STAT. ANN. 210/I (West 2005) (providing that minor must be married, a parent themselves, or have parental consent); IND. CODE ANN. § 16-36-1-3(A) (LexisNexis 1993) (providing that minor must be emancipated, married, divorced in the military, authorized by statute, or fourteen or older and living away from parents); KAN. STAT. ANN. § 38-1238 (2000) (requiring minor to be sixteen or older); KY. REV. STAT. ANN. § 214.185 (West 2005); MD. CODE ANN., HEALTH-GEN. § 20-102 (LexisNexis 2005); MISS. CODE ANN. § 41-41-3 (West 1999) (providing that minor must have intelligence to understand procedure and its consequences); MONT. CODE ANN. § 41-1-402 (2005) (providing that minor must be married, pregnant, a high school graduate, emancipated, living apart from parents, or financially self-supporting if the health care is for minor’s child); NEV. REV. STAT. ANN. § 129.030 (LexisNexis 2004) (providing that minor must be living apart from parents for four months, married or been married, a mother, in danger of a serious health hazard, or able to understand the nature, purpose, and need for medical care and voluntarily request the care); N.J. STAT. ANN. § 9:17A-4 (West 2002) (providing that a healthcare provider may inform parents at its discretion); OR. REV. STAT. § 109.640, 650 (2005) (providing that minor must be fifteen or older and the healthcare provider may involve the parents); 28 PA. CONS. STAT. ANN. § 27.97 (West 2003); R.I. GEN. LAWS § 23-4-6-1 (2001) (providing that minor must be sixteen or older, married, or a parent); S.C. CODE ANN. § 20-7-280 (1985); TENN. CODE ANN. § 67-6-229 (2004); VA. CODE ANN. § 54.1-2969(A)-(B) (2005) (requiring a court order to authorize a medical procedure); WYO. STAT. ANN. § 14-1-101(b) (2005) (providing that minor must be legally married, on active duty in the military, treatment need must be urgent, and parents or guardian cannot be located, or minor must be living apart from parents and managing her own affairs).

107. See infra note 111 and accompanying text.
will get better in the belief that this saves the child from unhappiness and the possibility of an inadvertent premature death. This is detrimental because a child is often aware that something is wrong, and deception by caregivers and parents will heighten her sense of alienation, disconnect and powerlessness created by the illness.¹⁰⁸

On the other hand, some states allow young people in crisis moments—pregnancy, drug dependency, sexually transmitted diseases—to access healthcare without parental knowledge, and providers lack clear guidelines about their authority or legal responsibility to involve an adult caretaker.¹⁰⁹ Consequently, helpful parental guidance is unnecessarily lost.¹¹⁰

The law dealing with adolescent decision-making autonomy reflects the confusion and contradictions of the larger society.¹¹¹ Given that adolescence is a state in between childhood and adulthood, the law has struggled to regulate the lives of young people by establishing a test that rejects inflexible presumptions of both childhood dependence and adult independence. Professor Mutcherson noted, “[a]s the culture shifts, lawmakers re-draw the lines of adolescence and respond to debate about the borders of adulthood.”¹¹² Adolescent rights are a “patchwork quilt of rights and limitations” creating incongruous situations where “‘a teenage mother must give consent before her baby may be treated,’” but cannot consent to her own healthcare, or an adolescent boy can be treated for HIV without parental consent, but must get parental consent to set his broken leg.¹¹³

These inconsistencies stem from the current range of rationales used to legally recognize adolescent autonomy while protecting parental rights as well. The effect of expanding adolescent rights is that parental autonomy rights constrict as a result. This may explain why the exceptions for adolescent autonomy have been based on utilitarian reasons rather than any criteria of adolescent capacity.¹¹⁴ In many cases,

¹⁰⁸. See Mutcherson, supra note 54, at 278–79.
¹⁰⁹. Id.
¹¹⁰. Id. at 279–80.
¹¹¹. Id. at 257; see In re Rena, 705 N.E.2d 1155, 1157 n.3 (Mass. App. Ct. 1999). The court recognized that the lack of a bright-line rule results in inconsistencies in how minors are treated under the law. Id. For instance, seventeen-year-olds in criminal proceedings are deemed capable of making all decisions relative to the proceeding. Id. Emancipated minors and minors who are married, divorced or widowed can consent to medical treatment. Id. However, there are no exceptions that allow a minor to purchase alcohol or tobacco, nor allowing them to vote or serve on juries. Id.
¹¹². Mutcherson, supra note 54 at 257.
¹¹³. Id. at 269 (quoting Michelle Oberman, Minor Rights and Wrongs, 24 J.L. MED. & ETHICS 127, 127 (1996)); accord Rosato, Adolescent Empowerment, supra note 11, at 777–78.
¹¹⁴. Andrew Newman, Adolescent Consent to Routine Medical and Surgical Treatment: A Proposal to Simplify the Law of Teenage Medical Decision-Making, 22 J. LEGAL MED. 501, 506 (2001) (stating that maturity operates as a “code word,” allowing minors to consent to their own treatment where society deems it appropriate and denies access if there is the real possibility of long-term
the determination to expand the rights of minors was not based on a belief that adolescents are mature, but rather on a societal determination to prevent unwanted consequences.\textsuperscript{115} The exception for certain conditions or diseases serves public policy because it encourages teens to seek medical treatment without having to speak to their parents. However, it does not provide a basis for adopting a mature minor doctrine that is actually based on maturity.\textsuperscript{116}

In response to this, Susan D. Hawkins argues for a "rebuttable presumption of competence," saying that if the individual making the assessment of competence cannot demonstrate that the minor lacks capacity, then the minor should be able to participate fully in the decision-making process.\textsuperscript{117} This approach would essentially take the \textit{Danforth} decision and shift the burden of proof from the minor to the adult making the challenge. Professor Harvey proposes a "sliding scale" approach where the competency bar for a child should depend on the therapeutic benefit of the treatment being considered.\textsuperscript{118} In Professor Harvey's view, a terminally ill adolescent patient who is refusing a life-prolonging treatment with low therapeutic benefit would have a stronger argument for competency than a high-school football player with a potentially fatal heart valve defect who is refusing a life-saving treatment because the surgery would mean he could never play football again.\textsuperscript{119} Another argument draws a bright-line rule that "minors who are emancipated from their parents and who are thus responsible for themselves and for planning and living their own lives as any normal adult" should have all of the same rights as an adult when it comes to the right to refuse life-saving treatment.\textsuperscript{120}

Research on adolescent decision-making capabilities supports the argument for moving from utilitarian-based reasons to adolescent capacity-based reasons. Professor Hartman defines capacity as an "elusive standard" which includes an individual's ability to "understand information, deliberate rationally about information, and communicate concerns and choices."\textsuperscript{121} Professor Hartman found that studies supported the determination that adolescents have a capacity level compatible with legal recognition for decision-making.\textsuperscript{122}
unplanned pregnancy as well as primary care, adolescents showed a maturity in judgment comparable to young adults in the same situation. However, another layer of complexity is added in the case of treatment refusal based on religious beliefs. Under the triadic balance, the analysis above supports granting more weight to the adolescent’s preferences when she desires treatment against her parents’ religious objections. However, in the situation where a minor is refusing treatment based on religion contrary to the parents’ wishes, courts must weigh the adolescent’s religious beliefs against the various state and parental interests.

III. FREE EXERCISE RIGHTS

The free exercise clause of the Constitution protects an individual’s freedom of religious belief, but the Supreme Court has ruled that the government can place limitations on the practice of those beliefs. In many of the cases examined in this Note, the government has intervened to restrict the religious practices of parents when those actions affected the welfare of their children. In *Prince v. Massachusetts*, the government could not have convicted Mrs. Prince for distributing religious literature on the street if she had been alone, but when her exercise of religious freedom violated child labor laws the state was able to act. Although her niece stated it was her choice and claimed religious freedom, the Court held that “the power of the state to control the conduct of children reaches beyond the scope of its authority over adults, as is true in the case of other freedoms.” The Court justified its dual limitations on both a parent and child’s religious freedoms: “Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”

In many states, children reach “the age of full and legal discretion” at eighteen, and until that age children are not automatically entitled to the same protections as adults. However, many adolescents demonstrate a fair amount of maturity prior to the legal age, creating a justification for recognizing more rights for minors. Determining a requisite level of maturity and measuring individual capacity is undoubtedly difficult, and

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123. Id.
124. See Reynolds v. United States, 98 U.S. 145, 166–67 (1878) (holding that despite their religious beliefs and convictions, defendants were not exempt from being convicted under the state’s criminal anti-polygamy statute).
126. Id.
127. Id.
128. Id.
the inconsistencies in the law reflect this challenge. Sometimes the legal system presents adolescents as especially vulnerable to religious ideas and societal pressures. Other times, courts emphasize the maturity of the adolescents and their ability to resist religious ideas and social pressures. In other contexts, courts do not consider the maturity of the adolescents; the courts either assume that the religious rights of the children are adequately represented in their parents’ rights or frame the adolescent’s rights as a class between the parental rights and government interests.

However, recall that Justice Douglas’s dissent in *Yoder* argued for the recognition of an adolescent’s religious freedom and right to make decisions despite their parents’ religious objections. Recent data seems to support Justice Douglas’s position on giving more weight to an adolescent’s religious choices within the context of decision-making when there is a conflict with the parent. Surveys revealed that a large percentage of American teenagers aged thirteen to seventeen professed a certain amount of religious beliefs. Ninety-seven percent said they believed in God; 80% viewed religion as at least fairly important to them; and 93% reported being affiliated with a religious group or denomination. Additionally, more than half said they regularly engaged in religious practices. But most surprisingly, more than one quarter of the teens considered their spiritual life to be more important to them than it was to their parents, and more than three-quarters said they were confident that they would grow up to be more religious than their parents. Psychological data also support adolescent capacity for religious belief, finding that from the beginning of adolescence children understand the symbolic properties of religious scriptures stories and grasp complex aspects of religious morality. This evidence supports

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130. See, e.g., Bd. of Educ. v. Mergens, 496 U.S. 226, 250 (1990) (“[S]econdary school students are mature enough and are likely to understand that a school does not endorse or support student speech that it merely permits on a nondiscriminatory basis.”).
131. See, e.g., Good News Club v. Milford Central Sch., 533 U.S. 98, 115 (2001) (“[T]o the extent we consider whether the community would feel coercive pressure to engage in the Club’s activities...the relevant community would be the parents, not the elementary school children.”).
133. *Id.* at 242 (Douglas, J., dissenting) (“And if an Amish child desires to attend high school, and is mature enough to have that desire respected, the State may well be able to override the parents’ religiously motivated objections.”).
135. *Id.*
136. *Id.* This included activities such as praying alone, attending church or synagogue, frequently reading scriptures, or being involved with religiously affiliated youth groups. *Id.*
137. *Id.*
138. See Pascal Boyer & Sheila Walker, Intuitive Ontology and Cultural Input in the Acquisition of Religious Concepts, in Imagining the Impossible: Magical, Scientific, and Religious Thinking in Children 141 (Karl S. Rosengren et al. eds., 2000). In their conclusion, Boyer & Walker state that at
protecting an adolescent's free exercise rights to the same extent as an adult's rights. Justice Douglas concluded that "children are 'persons' within the meaning of the Bill of Rights," a statement strongly implying that minors' free exercise rights are coextensive with those of adults.

As with adolescent autonomy in the area of healthcare, many distinct arguments exist in the area of free exercise rights for minors. Professor Emily Buss agrees with expanding the recognition of children's free exercise rights; however, she argues for a certain amount of restraint, asserting that the state will do more harm than good if it plays an active role in eliciting children's religious beliefs. Zaven T. Saroyan argues for the use of strict scrutiny in cases where free exercise rights come up against a child's fundamental rights and the state's interest in protecting the welfare of the child. Strict scrutiny can attain the balance between the two extremes of either a complete ban on state intrusion or else complete state control of the issue.

In summary, the Court has indicated that with respect to religious freedoms, the state has more control over a child's exercise of rights than it does over an adult's. The challenge is to find the balance between the freedoms of parents and children when the exercise of religious beliefs affects the health and welfare of the child.

IV. MERGING THE DOCTRINES

The Supreme Court has not resolved the issue of a three-way competition of interests between parents, children, and the state with respect to religious freedoms. However, after Parham and Bellotti, courts have a model for addressing conflicts within the family through a
balancing of the interests of the state, the parents, and the child. The Bellotti Court recognized that it was in the state’s interest to have a family make these decisions as opposed to resorting to a judicial resolution.\textsuperscript{146} When a court is called upon to make a decision, it should take into account a parent’s natural interest in the welfare of his child—an interest that is stronger in normal family relationships where the child is living with one or both parents.\textsuperscript{147}

Different issues arise in the two scenarios of children disagreeing with their parents over healthcare decisions. In the first scenario, parents refuse treatment for their child based on their own religious beliefs, but the minor himself wishes to obtain medical care. Recall the Newmark case, where three-year-old Colin had been diagnosed with terminal cancer and the available medical treatment had only a 40% chance success rate with potentially deadly side effects.\textsuperscript{148} Due to the low probability of treatment success, the court weighed the separate interests of the state and parents, ultimately upholding the parents’ decision to refuse treatment for their child based on religious beliefs.\textsuperscript{149} The court did not consider the minor’s interests separately in that case since he was only three, but suppose a hypothetical situation where a teenager suffers from the same form of cancer as Colin Newmark with identically bleak treatment prospects. While this teenager’s parents refuse medical treatment for him because of their own religious beliefs, he himself wishes to get treatment for his disease. If this case went to trial, under the Bellotti and Parham framework, the court would need to consider the interests of the teenager in addition to those of the parents and state.

In previous cases when parents used their own religious beliefs as the basis for refusing treatment for a minor, the courts evaluated the danger to the welfare of a minor purely from a medical health perspective.\textsuperscript{150} Based on the arguments in Part III supporting the recognition of a minor’s religious beliefs, courts should also weigh the infringement upon a minor’s free exercise rights. Professor Rhonda Hartman’s findings about adolescent capacity add to the weight that courts should give to the adolescent’s interests.\textsuperscript{151} Under Danforth the Court found that the constitutional right to abortion applied to minors and that the government could not place an absolute bar on a minor’s ability to obtain an abortion by requiring parental consent.\textsuperscript{152} The

\textsuperscript{147} Id.
\textsuperscript{149} Id. at 1119-21.
\textsuperscript{150} See, e.g., id.
\textsuperscript{151} Hartman, supra note 121.
\textsuperscript{152} Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976); accord supra note 94 and accompanying text.
argument follows that allowing a parent’s religious beliefs to dictate an adolescent’s decision about medical treatment violates the minor’s constitutional rights of privacy and religion. Using the triadic balance in this situation, the state’s interest in protecting the welfare of minors and the adolescent’s interests weigh in favor of deferring to the adolescent rather than the parents.

Looking to the hypothetical above, the separate interests can be broken down. The state has an interest in protecting the welfare of the minor. Because the cancer is terminal and the medical treatment itself is not guaranteed to cure but could instead cause death, from a health perspective the state’s interests to protect the minor’s welfare are no stronger whether or not the teenager receives treatment. The parents have a fundamental right to make decisions for their child, so their interests would be protected by the court upholding the treatment refusal. Lastly, the teenager has both an interest to make autonomous healthcare decisions and to have his free exercise rights upheld by not being forced to adhere to a religious standard that is not his own. Weighing this in the balance, it seems that the teenager should be allowed to receive treatment for his cancer regardless of the low probability of success. If the hypothetical were modified so that the medical treatment had a higher probability of success, then the support for allowing the teenager to receive treatment over his parents’ objections increases because the state’s interest in protecting the minor also increases. Thus, in this scenario, the adolescent’s desire to receive treatment should always overcome his or her parents’ objections to treatment based on religious beliefs.

A second scenario may be used to explore a minor’s rights to refuse treatment for herself based on her own religious beliefs. In this case, the treatment preferences from the original scenario are switched. The teenager, suffering from a deadly form of cancer with low probability of treatment success, now wishes to refuse treatment based on her own religious beliefs while her parents wish to obtain medical treatment for her. The issue here is whether the teenager’s free exercise rights should be granted such weight that they overcome both the state’s interest to protect her welfare and her parents’ fundamental rights to make decisions about the family.

Using the triadic balance here, it seems that the adolescent’s interests are potentially much weaker in comparison to the other interests at stake. Although Justice Douglas’s argument in *Yoder* provides a strong argument for granting heavy weight to the adolescent interest, the factual context of his arguments had far less serious ramifications. Justice Douglas discussed the possibility of allowing
adolescents to decide to continue their formal education against their parents' wishes. Here the potential consequences from a decision to refuse healthcare are quite different than the possible harm that could result from a bad educational decision. The gravity of the consequences depends on the seriousness of the illness and the probability of treatment success. Professor Martin Harvey looks at therapeutic benefit as a combination of the seriousness of the illness and the probability of treatment success. He creates a sliding scale in which he proposes that the strength of a minor's right to refuse should depend on the therapeutic benefit of the treatment being considered and the nature of the treatment intervention—life-saving, life-sustaining, or life-prolonging. Professor Harvey argues that adolescents should have no right to refuse treatment that has high therapeutic benefit, but a strong right to refuse treatment with low therapeutic benefit.

In this hypothetical, the teenager is in a situation with a low therapeutic benefit. Despite the deadliness of her cancer, the potential success of the chemotherapy treatment is low, and there is a risk that the treatment itself will have fatal consequences. Her interests are based on autonomy and free exercise, which go directly against her parents' interests in making decisions for their child. Similar to the analysis under the previous hypothetical, the state's interests to protect the welfare of children come out neutral in the triadic balance, but the state interest to protect the minor's autonomy and constitutional rights are much stronger. Under Newmark, parents faced with making the same decision for their child had refused treatment and the decision was upheld by the court. It follows that if the teenager's parents were in agreement with her, then the state would not compel treatment. If she were an adult, again the state would not compel treatment because she would be able to make an autonomous decision. Thus, using the arguments for a mature minor standard and the arguments supporting an adolescent's capacity for religious belief, the teenager's decision should be given more weight than that of her parents.

However, the analysis changes as the therapeutic benefit increases. While free exercise prohibits the government from infringing on an

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154. Harvey, supra note 103, at 316.
155. Id.
156. Id. Harvey creates a table designating three levels of therapeutic benefit: (1) High therapeutic benefit means the treatment is life-saving. Id. The patient's short and long-term prognoses are excellent, with a near-full recovery expected from their illness. Id. (2) Moderate means that the long-term prognosis is problematic, but the treatment will provide the patient with a few additional years of life, although the overall quality of life may have little improvement. Id. (3) Low therapeutic benefit means that both the patient's short- and long-term prognoses are extremely poor. Id.
individual's religious belief, our society places limits on religious practices that are illegal or could cause harm. The greater the therapeutic benefit of medical treatment, the greater the harm that could result from refusing such treatment. Despite the need to protect an individual's free exercise rights, the state's interests to protect the welfare of the minor and others give it the right to limit the individual's actions. For example, in In re J.J., the court ordered treatment for a sexually transmitted disease over the adolescent's refusal based on religion because the state had an interest to prevent further transmissions of the disease.\textsuperscript{159} The treatment in this case had a high therapeutic benefit. In that case, the adolescent's parent was in agreement with him and supported his decision to refuse treatment. If the parent had desired for the minor to receive medical treatment in that situation, the case for compelling treatment would have been even stronger. Although the In re J.J. case was unique in that the state's interest also included a concern to protect the welfare of others,\textsuperscript{160} the analysis would not change very much if this element is removed.

For example, suppose the teenager is suffering from thyroid cancer, which is highly treatable with proven rates of success.\textsuperscript{161} Medical treatment would be life-saving and have a high therapeutic benefit. Unlike a sexually transmitted disease, the consequences of refusing treatment in this situation would only harm the patient since it is a non-communicable disease. This, though, would not weaken the state's interests to such an extent that the balance shifts in favor of the teenager. Looking at the triadic balance, the state still has a compelling interest to protect the welfare of the minor. The parents' interests are the same, and the presumption that they are acting in the best interests of their child would not be in question. While the minor has a free exercise right here, the practice of his beliefs—refusing medical treatment—would have harmful consequences. In such a scenario, the strength of the state and parents' interests should be enough to compel treatment for the child over his religious objections. Using this sliding-scale approach based on therapeutic benefit, the result essentially favors an adolescent's physical life and health over his religious faith.

**Conclusion**

The triadic balancing test for weighing the various interests of parents, children, and the state is readily applicable to situations of conflict over healthcare decision-making. While courts may grant more autonomy to adolescents in the area of medical treatment decisions, it is

\textsuperscript{159} 582 N.E.2d 1138, 1141-42 (Ohio Ct. App. 1990).
\textsuperscript{160} Id. at 1141.
important to use a sliding-scale to determine the appropriate weight of the adolescent’s interests in comparison to those of the parents and the state. When parents refuse treatment for their child based on religious beliefs, the triadic balance almost always results in a favorable decision for the minor. In those cases, the state’s interest will be to protect the welfare of the minor. However, in the case of a minor’s refusal of treatment, courts should carefully look at all the factors to determine the strength of the minor’s interests as compared with those of the state and the parents. As the level of therapeutic benefit increases, so will the weight of the state and parents’ interests in the balance.