

THE MATURE MINOR DOCTRINE: DO ADOLESCENTS HAVE THE RIGHT TO DIE?

Ann Eileen Driggs, R.N.[†]

INTRODUCTION

BENNY AND BILLY COULD HAVE BEEN best friends. They were both teenagers who enjoyed spending time with their friends and simply participating in the everyday activities that most adolescents spend their free time doing. They were both fiercely independent and striving to attain a position of autonomy that could be considered far beyond their biological years. More significantly, they both suffered from potentially life-threatening illnesses and the painful effects, not only of the disease process, but also of the medical care needed to treat their illnesses. Eventually, neither teen wanted to continue the medical treatments when they felt the pain and discomfort had become too severe.

Benny Agrelo had been born with an enlarged, malfunctioning liver and an enlarged spleen. In 1994, when he was fifteen years old, Benny had endured two liver transplants. The first one was done when he was eight years old and for the following five years Benny took a drug called cyclosporin to prevent his body from rejecting the new organ. When the medication no longer worked, doctors performed a second transplant and prescribed an experimental anti-rejection drug that affected his normal activities due to side effects of headaches and irritability. Without this drug, his system would reject the new liver and Benny would ultimately die. Against his parents and doctors' wishes, Benny decreased his dosage and eventually stopped taking the medication altogether. Although Benny's mother initially disagreed with him, she eventually supported his decision. When his doctors discovered this, the hospital filed

[†] J.D. Candidate, Case Western Reserve University School of Law, 2002; B.S., Lake Erie College, 1999, A.A.S., Kent State University, 1984.

a petition under Florida's child neglect statute and social workers removed Benny from his home and took him to the hospital. Benny continued to refuse the medication and fought off the staff when any treatments or tests were attempted. A court hearing was held, and although under Florida law a minor had no right to refuse life-saving medication, Benny was determined to be mature enough to decide for himself and he was returned to his home without the medication where he died a few months later. The judge based this controversial decision on meetings with Benny and his doctors. Benny's case established for the first time, that a mature minor could refuse treatment on his own behalf.¹

Billy Best was a sixteen-year-old with Hodgkin's lymphoma. After just two and a half months of chemotherapy, Billy began refusing his treatments even though doctors predicted an 80 percent chance of recovery. Although Billy's parents agreed that the treatments were necessary, Billy complained that they were painful and he did not think he could face the four more months of treatment that were required. Late in 1994, after writing a letter to his parents, Billy ran away from his home in Massachusetts. He returned home a month later only after his parents promised during a television interview that they would not force him to continue the treatments. Interestingly, Billy's lymphoma is now in remission due to alternative therapies.²

Both the aforementioned cases have at least one significant factor in common. One or both parents of the minor either eventually agreed with the minor's decision to refuse treatment, or eventually acquiesced to his decision. It's ironic that when a minor refuses to take his medicine, kicks and screams about it, complains of the side effects, or runs away from home, he can be found to be mature; whereas if an adult acted in this same manner, he would most certainly be considered immature.

From the day their children first enter the world, parents are usually concerned with caring, nurturing and loving their children. As a result, they strive to protect them from every conceivable harm or chance of harm. Medical and psychological studies have been conducted on the bonding of infants with

¹ Nancy San Martin, *Defiant Transplant Patient Dies at Home*, SUN-SENTINEL (Ft. Lauderdale, Fla.), Aug. 21, 1994, at 1A.

² See Christopher B. Daly, *Teenage Cancer Patient Seeks to Return to Normalcy—Chemotherapy Will Not Be Part of Treatment*, WASH. POST, Nov. 25, 1994, at A3.

their mother shortly after birth and the protective instincts that result. It is difficult to let go of the protective instinct, even when the child has matured and demonstrated the ability to make informed and intelligent decisions on his own.

When a child falls ill, especially with a life-threatening illness, or is severely injured, the parents' protective instincts go into "high gear." Even if the child is capable of taking part in the making of a decision regarding his own care in this type of situation, the typical reaction of parents is to treat him as if he was incompetent and completely neglect the possible opinions of the child. However, making the determination that a minor has the adult capacity exclusively to decide to reject life-sustaining medical treatment under the mature minor doctrine may not be a suitable solution when a minor's wishes conflict with his parents' decision. For my purposes here, life-sustaining treatment means any treatment administered in a serious, acute or terminal illness, or in a life-threatening situation that could occur after a serious accident, such that the treatment necessary would prevent or delay the death of the individual being treated. The treatment can be defined as any medical procedure or treatment administered to the individual at the direction of a health care professional in an attempt to prevent or delay the patient's death.

HISTORICAL PERSPECTIVE

Historically, parents have been afforded the right to make medical care decisions for their minor children because children have traditionally been recognized legally as incompetents lacking the necessary capacity to make valid decisions.³ In her article addressing the issue of children's health care decisions, Jennifer Rosato, Associate Professor of Law at Brooklyn Law School, states, "[t]hree primary justifications support this right: parental decision-making benefits the parents, it benefits society, and it benefits the children themselves."⁴ The parents' fun-

³ See, e.g., *In re Morrissey*, 137 U.S. 157, 159 (1890) (stating the age at which one becomes competent depends on the actions of the legislature); *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941) (recognizing that some persons, because of their youth, are incapable of making intelligent decisions, and public policy demands their legal protection).

⁴ Jennifer L. Rosato, *Using Bioethics Discourse to Determine When Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 TEMP. L. REV. 1, 5 (2000) (citations omitted) (explaining the current doctrine of par-

damental rights to care for, control and make decisions for their children can be limited only by a compelling state interest. The U.S. Supreme Court addressed its reasons for granting parents broad decision-making power in *Parham v. J.R.*⁵ as follows:

The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has been recognized that natural bonds of affection lead parents to act in the best interests of their children.⁶

Although it can be argued that in some circumstances parents do not, in effect, look out for their children's best interests, they are probably in the best position to know and decide for them when they are incapable of doing so themselves. However, the rights of parents are not unrestricted but coexist with society's right to protect children. This leads, of course, to the intervention of the state to protect the child's best interests in instances of child abuse or neglect. The broad language in most of the child abuse or neglect statutes has been extended to apply to state intervention when medical treatment has been denied to a minor.⁷ The parent's denial of medical treatment for their minor child can result in a judicial proceeding for child neglect or abuse. The parent's unwillingness to protect the minor in these situations then results in the state's protection of the child by the ordering of administration of the treatment, a judicial safeguard that should effectively protect the child.

The courts have recognized three exceptions to the requirement for parental consent in medical treatment of children: (1) emergency; (2) emancipation; and (3) mature minor.⁸ The emergency situation permits medical personnel to treat a minor

ent-child decision-making in the health care context and arguing that change is necessary).

⁵ 442 U.S. 584 (1979).

⁶ *Id.* at 602.

⁷ See *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52 (1976) (challenging the constitutionality of Missouri's abortion statutes).

⁸ See *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337 (Kan. 1970) (holding that surgery performed on unconscious 17-year-old's finger without parental consent fell within the mature minor exception).

when the parents or guardian are not available to give consent.⁹ This exception was not established to recognize the minor's autonomy, however, but to protect the physician from liability and has been recognized by some courts on the theory that in an emergency situation, had the parent been available, he or she would have consented.¹⁰ The emancipation exception is based on the principle that minors who are totally independent from their parents should be treated as adults.¹¹ The mature minor exception permits a minor to consent to medical treatment if he is found competent enough to make the decision on his own.¹² In the latter circumstance, the court must be petitioned to determine whether the minor fully comprehends both the treatment and the consequences.¹³

None of the aforementioned exceptions recognizes the minor's right to refuse medical treatment, life-sustaining or otherwise. However, in some cases, such as *Benny Agrelo's*, it appears that some courts, although reluctantly, will allow a minor to refuse life-sustaining treatment with parental consent. There is a profound difference between receiving medical treatment effecting a possible cure and return to a healthy condition and the refusal of medical treatment resulting in probable death. No minor, whether determined to be mature or not, should be given the right to choose death over life.

CONSTITUTIONAL ISSUES

Medical technology has made enormous strides in the past few years. The ability to sustain life for increasingly longer periods of time has resulted in terminally ill, competent adults

⁹ See *Sullivan v. Montgomery*, 279 N.Y.S. 575, 576-77 (Sup. Ct. 1935) (holding that parental consent was not required because the physician has a duty to treat the patient in an emergency when life is in danger).

¹⁰ See *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (holding emergency consent is implied if medical treatment in an emergency involves a child or incompetent).

¹¹ See *Ison v. Florida Sanitarium & Benevolent Ass'n*, 302 So. 2d 200, 201-02 (Fla. Dist. Ct. App. 1974) (defining a minor as being emancipated when she permanently moved away from home and supported herself); see also *Smith v. Seibly*, 431 P.2d 719, 723 (Wash. 1967) (stating that emancipation of minor was justified when he completed school, married, had a family, earned a living, and had his own home).

¹² See generally *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987) (applying the "mature minor" exception to finding 17-year-old individual had capacity to consent).

¹³ See *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 829 (W. Va. 1992) (reversing trial court that refused to instruct jury on mature minor exception in case where physician complied with a "do not resuscitate" order signed by minor).

facing the sometimes complex question of whether to reject or accept continued medical treatment. The Supreme Court in *Cruzan v. Director, Missouri Department of Health*¹⁴ determined that the U.S. Constitution would grant a competent adult the right to refuse life-sustaining medical treatment. The court based the decision on the Fourteenth Amendment that prohibits the state from depriving any person of life, liberty, or property, without due process of the law. The court interpreted the liberty interest to include the right of a competent person to refuse medical treatment.¹⁵ Although Nancy Cruzan was in a persistent vegetative state, the decision to remove medical treatment was partially based on the clear and convincing evidence of her expressed desires prior to this condition. However, the court expressed no principles to be applied for protecting the interests of incompetent persons who wished to refuse the same type of treatment if there was no prior evidence of their desires.¹⁶

The courts first recognized the First Amendment right of individuals whose refusal of medical treatment was based on their religious beliefs in 1965.¹⁷ The Illinois Supreme Court held that an adult Jehovah's Witness had a First Amendment right to exercise religion freely in the context of refusal of medical treatment (blood transfusion).¹⁸ The state supreme court ruled that the state could not interfere with an individual's constitutional right to practice her religion freely.

The Constitution has left the protection of the individual's personal right to privacy to the individual states.¹⁹ An adult's constitutional right to privacy has been recognized by the Supreme Court in protecting the individual autonomy in matters of

¹⁴ 497 U.S. 261 (1990).

¹⁵ See *Cruzan*, 497 U.S. at 278-79.

¹⁶ See *id.* at 286-87.

¹⁷ See *In re Estate of Brooks*, 205 N.E.2d 435 (Ill. 1965). In this case, Bernice Brooks refused blood transfusions because of her religious beliefs. The lower court ordered the transfusions despite her objections. The Illinois Supreme Court heard the case despite its mootness due to the substantial public interest involved. The Court reversed the circuit court's decision stating that it interfered with Mrs. Brooks' basic constitutional right to freely practice her religion.

¹⁸ See *id.* at 442.

¹⁹ See *Katz v. United States*, 389 U.S. 347 (1967). "But the protection of a person's general right to privacy ... is, like the protection of his property and of his very life, left largely to the law of the individual States." *Id.* at 350-51.

family, child-rearing and their education, and procreation.²⁰ The right to privacy is not absolute, however, because the government may intervene if a compelling state interest exists.²¹ Although children also have constitutional rights, they are not equal to those of adults²² because children are vulnerable and usually unable to make mature and reasonable decisions in serious or critical situations.²³ A child's right to privacy is evaluated by applying a less severe standard than that which is applied to adults. The state must show a significant state interest rather than a compelling state interest in order to intervene in the privacy right of a minor.²⁴ The state has an interest in protecting children from harm and parents have an interest in raising and controlling their children. The rights of the parents in this regard are significant to the state, anticipating the future contributions of the minors. "The Supreme Court recognized parental interests in their children under the Due Process Clause of the Fourteenth Amendment, describing those interests as 'the

²⁰ See *Roe v. Wade*, 410 U.S. 113, 152-53 (1973) (citing *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); and *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925)).

²¹ See *id.* at 154, 163. The Roe court held that although the state has an interest in protecting the health of its citizens, it could not interfere with an abortion decision unless it has a compelling interest. It set the "compelling point" in abortions at the end of the first trimester because medical information at that time showed that the mortality rate in first trimester abortions was less than that in normal childbirth.

²² See *Ginsberg v. New York*, 390 U.S. 629, 636-37 (1968) (addressing a minor's accessibility to obscene literature, and noting that, although adults could judge and determine for themselves what to read and see, it was constitutionally permissible for the state to restrict the right of minors to access the same material).

²³ See *Bellotti v. Baird*, 443 U.S. 622 (1979) (declaring state statute unconstitutional in its requirement of parental consent for a minor seeking abortion without an accompanying provision providing an alternative procedure for authorization). As stated by the Court:

The unique role in our society of the family, the institution by which "we inculcate and pass down many of our most cherished values, moral and cultural," requires that constitutional principles be applied with sensitivity and flexibility to the special needs of parents and children. We have recognized three reasons justifying 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 (citation omitted). See also Bruce C. Hafen & Jonathan O. Hafen, *Abandoning Children to Their Autonomy: The United Nations Convention on the Rights of the Child*, 37 HARV. INT'L L.J. 449, 459 (1996).

²⁴ See *City of Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 427-28 (1983) (holding a state cannot interfere with a woman's right to obtain an abortion absent a compelling interest).

liberty of parents and guardians to direct the upbringing and education of children under their control.”²⁵

The constitutional right of a competent adult to refuse treatment in a life-threatening situation was first recognized by the Supreme Court in the *Cruzan* case in 1990.²⁶ Because of a child’s inability to make mature and informed decisions in this type of situation, and because of the role of the parents in the lives of their children, the courts have generally not extended this right to minors.²⁷ It is only in specific situations, such as abortion, dispensing of contraceptives, and mental health, that minors are sometimes permitted to make decisions without parental consent. The rationale for these exceptions was the possible impact on public health if the medical conditions remained untreated and parental consent were to be required.²⁸ None of these exceptions to parental consent involve the possibility that death of the minor will result.

The Supreme Court has found statutes in both Massachusetts and Missouri unconstitutional because they required parental consent for a minor to have an abortion. As a result, women under the age of majority are able to exercise their constitutional privacy rights and undergo an abortion without the prerequisite of parental consent.²⁹ In striking down the Missouri statute, the Supreme Court noted that there is no magic line that defines the attainment of majority for any individual, and minors as well as adults should be protected by the Constitution.³⁰ The Supreme Court held that “the State may not impose a blanket provision...requiring the consent of a parent...as a condition for abortion...the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient....”³¹ In addi-

²⁵ Frances J. Lexcen & N. Dickon Reppucci, Special Collection, *Psychology and the Law: Effects of Psychopathology on Adolescent Medical Decision-Making*, 5 U. CHI. SCH. ROUNDTABLE 63, 69 (1998) (discussing the rights of adolescents and parents in medical decision-making).

²⁶ *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 278 (1990).

²⁷ See *Bellotti*, 443 U.S. at 634.

²⁸ See Lexcen & Reppucci, *supra* note 25, at 70.

²⁹ See *Bellotti v. Baird*, 443 U.S. 622 (1979) (finding Massachusetts statute unconstitutional); *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52, 71 (1976) (finding Missouri statute unconstitutional).

³⁰ See *Planned Parenthood of Cent. Missouri*, 428 U.S. at 74 (discussing a minor’s constitutional rights and protections).

³¹ *Id.*

tion, as the Supreme Court noted in *Bellotti v. Baird*,³² “there can be no doubt that a female’s constitutional right to an abortion in the first trimester does not depend on her calendar age.” The Court struck down the Massachusetts statute requiring parental consent for a minor’s abortion noting that the statute was not enacted to protect the minor, but to recognize the rights of the parents.³³

Confidentiality is a crucial factor in the dispensing of birth control to minors. If this confidentiality were not respected, teenagers would be deterred from seeking contraception with the possible result of an escalating teenage pregnancy rate.³⁴ There is also the health risk of an increase in sexually transmitted diseases, which was actually the motivating factor in the states’ enactment of these laws, and not the maturity of the minor.³⁵ Furthermore, the facts demonstrate that most minors would cease to use contraception, but not cease sexual activity, if it were necessary to involve their parents in the decision.³⁶

Confidentiality is also an issue in the treatment of mental health problems. Some states have recognized the fact that many minors might not seek help with problems such as alcoholism, drug abuse,³⁷ depression, and other psychiatric care³⁸ if parental consent were required. These exceptions to the general rule are considered by some to be an outgrowth of the emergency treatment exception for minors and the states’ role in the

³² *Bellotti*, 443 U.S. at 628 (quoting *Baird v. Bellotti*, 393 F. Supp. 847, 855-56 (D. Mass. 1975)).

³³ *See id.* at 644-50.

³⁴ *See Planned Parenthood Ass’n of Utah v. Matheson*, 582 F. Supp. 1001, 1005-06 (D. Utah 1983) (holding state law unconstitutional in its requirement of parental consent for minor’s appropriation of contraception).

³⁵ *See Cardwell v. Bechtol*, 724 S.W.2d 739, 744 (Tenn. 1984) (holding that mature minor had capacity to consent to a medical procedure based on the common law of the state).

³⁶ *See Planned Parenthood Ass’n of Utah*, 582 F. Supp. at 1009.

³⁷ For statutes allowing minors to obtain treatment for alcohol and substance abuse, see ALA. CODE § 22-8-6 (1997); KAN. STAT. ANN. § 65-2892(a) (1992); MONT. CODE ANN. § 41-1-402 (1991); NEV. REV. STAT. ANN. § 129.050 (Michie 1998).

³⁸ For statutes permitting minors to receive mental health services and psychiatric care without parental consent, see ALA. CODE § 22-8-4 (1997); COLO. REV. STAT. § 27-10-103 (2000); FLA. STAT. ANN. § 394.56(1) (West 1998) (permitting a child twelve years of age and older to volunteer for treatment without parental consent); GA. CODE ANN. § 37-3-20 (1995) (regulating the admission of patients, including minors, for hospitalization).

protection of minors.³⁹ This can be further evidenced by studies indicating that factors such as family stressors and parental psychopathology may play a part in the mental health care decision.⁴⁰ These exceptions are not based on the level of maturity of the minor, but rather are based on the issues of the possible transmission of venereal disease, an increase in teenage pregnancy, and confidentiality.

STATES' APPLICATION OF MATURE MINOR DOCTRINE

State courts have not been consistent in their decisions when a minor rejects life-sustaining treatment, and in most states unemancipated minors are not afforded the right to make their own medical decisions. However, three states have adopted the mature minor exception to consent or refuse specific medical treatment.⁴¹ Also, minors who are fourteen years of age or older in Alabama are permitted to give consent for medical treatment.⁴² However, there are no cases in that state addressing the right of a minor to refuse life-sustaining treatment. When the circumstances involve a life-threatening situation, courts have generally not extended the right to reject life-sustaining treatment to minors and are reluctant to apply the mature minor doctrine. The mature minor doctrine permits a

³⁹ See generally Michelle Oberman, *Turning Girls into Women: Re-Evaluating Modern Statutory Rape Law*, 85 J. CRIM. L. & CRIMINOLOGY 15, 48 (1994) (reconsidering confidentiality issues, as they affect minors, in modern statutory rape laws).

⁴⁰ See Lexcen & Reppucci, *supra* note 25, at 72.

⁴¹ See *In re E.G.*, 549 N.E.2d 322 (Ill. 1989). The court stated that, if the trial judge finds by clear and convincing evidence that the minor is mature enough, the mature minor doctrine affords the minor the common law right to consent to or refuse medical treatment. However, if the parent or guardian opposes the mature minor's refusal of treatment for life-threatening health problems, it would weigh heavily on the minor's right to refuse. See *id.* A "Do Not Resuscitate" order is not valid in West Virginia without the consent of the minor, if the minor is between the ages of sixteen and eighteen, and if the minor has been found to have sufficient maturity in the opinion of the attending physician. If there is a conflict between the wishes of the parent and the wishes of the minor, the decision of the mature minor prevails. See *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827 (W. Va. 1992); see also W. VA. CODE § 16-30C-6 (1998). The mature minor exception to the general rule requiring parental consent for medical treatment of minors is part of the common law in Tennessee, however, its application is a question of fact for a jury to decide whether the minor has the capacity to consent. See *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987).

⁴² See ALA. CODE § 22-8-4 (1997).

minor who exhibits the maturity of an adult to make decisions traditionally reserved for those who have attained the age of majority.⁴³ Adolescent minors are somewhere between childhood and adulthood. The years between approximately fourteen and eighteen have become a veritable never-never land when attempting to evaluate their capacity and competence in the world of informed consent. Legally, children in this age group are considered minors and, traditionally, they are considered legal incompetents.⁴⁴

In a New York State case, the court equated the age at which an individual could consent to medical treatment with the age at which he could make a legal binding contract because, until that age, persons were incompetent.⁴⁵ However, some minors in this age category have been deemed “mature minors” by some courts and have been afforded the right to make decisions regarding their own health care in specific situations. When the specific situation concerns a choice between life and death, allowing “mature minors” to decide on death is not appropriate.

Illinois recognizes the mature minor doctrine, including those circumstances that involve life-threatening illnesses.⁴⁶ In the Illinois case, *In re E.G.*, addressing a minor’s refusal of blood transfusions based on religious beliefs,⁴⁷ the court focused on the state’s interests and found they outweighed those of the minor and ordered the transfusions.⁴⁸ On appeal, the appellate court held that the minor could exercise her First Amendment right to practice her religion and that she was a partially emancipated minor.⁴⁹ In finding that she was partially

⁴³ See Jessica A. Penkower, Comment, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment—Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1166 (1996) (discussing the mature minor doctrine as applied to chronically ill minors).

⁴⁴ See *In re Morrissey*, 137 U.S. 157, 159 (1890) (stating that the age at which minors become competent is within the discretion and determination of the legislature).

⁴⁵ See *In re Alphonso*, 606 N.Y.S.2d 259 (App. Div. 1993).

⁴⁶ See *In re E.G.*, 549 N.E.2d at 327-28 (holding that “[i]f the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions, and ... to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent to or refuse medical treatment”).

⁴⁷ See *id.* (basing decision to refuse transfusion on membership in Jehovah’s witness faith).

⁴⁸ See *id.* at 324 (citing to the trial court’s decision).

⁴⁹ See *id.* (citing to the appellate court’s decision).

emancipated, the court relied on the fact that E.G. was only six months shy of her eighteenth birthday and, in the opinion of the psychiatrist who had evaluated her, she had the maturity level of an eighteen to twenty-one-year-old and the competency to reject the transfusions even if death would result.⁵⁰

Subsequently, the Illinois Supreme Court refused to address the First Amendment right,⁵¹ and instead made its decision by applying three state statutes: (1) The Consent by Minors to Medical Operations Act,⁵² which permits minors to consent to medical treatment in specific situations; (2) The Emancipation of Mature Minors Act,⁵³ which states that a minor who is sixteen years of age or older may be declared emancipated and control his own health decisions; and (3) The Juvenile Court Act of 1987,⁵⁴ which permits juveniles under the age of eighteen to be prosecuted as an adult in criminal court in some instances. The court stated that, under common law, a minor who has not as yet attained the age of eighteen may not be precluded from exercising rights normally associated with adulthood if found to be a mature minor,⁵⁵ and affirmed the appellate court's decision that the seventeen-year-old was a mature minor and could exercise her common law right to refuse medical treatment (blood transfusions).⁵⁶ Although E.G. had attained the age of eighteen by the time her case reached the Illinois Supreme Court, the court felt that there was sufficient public interest in the case that an authoritative determination should be made to establish some type of guidance for future cases.⁵⁷

The court in *In re E.G.* was careful to note that the common law right to consent to or refuse medical treatment was not absolute, but rather must be balanced against the state interests of preservation of life, protection of the interests of third parties, prevention of suicide and maintenance of the ethical integrity of

⁵⁰ See *id.* (relying on E.G.'s age and prior testimony from a psychiatric expert who evaluated E.G.'s maturity and competency).

⁵¹ See *id.* at 325-26, 328 (concluding that a mature minor may consent to or refuse medical care).

⁵² 410 ILL. COMP. STAT. 210/1 (West 1997).

⁵³ 750 ILL. COMP. STAT. 30/1-30/11 (West 1999).

⁵⁴ 705 ILL. COMP. STAT. 405/1-1-405/7-1 (West 1999 & Supp. 2000).

⁵⁵ See *In re E.G.*, 549 N.E.2d at 325 (stating that "age is not an impenetrable barrier").

⁵⁶ See *id.* at 328.

⁵⁷ See *id.* at 325 (opining that the issue in the case was one of "substantial public interest," and therefore, permitted a departure from mootness doctrine).

the medical profession.⁵⁸ There must be clear and convincing evidence that the minor fully understands the consequences of his actions, and, in making judgments, he must exhibit the maturity of an adult.⁵⁹ In addition, it is significant in this case that the minor's mother supported her decision to reject the transfusions. The court was careful to note that, had her mother agreed to the transfusions, serious consideration would have been given to the mother's wishes.⁶⁰

In 1990, the Maine court based a decision on prior statements made by a mature minor when it permitted his parents to refuse life saving treatment when the minor was unable to verbalize his own wishes.⁶¹ Seventeen-year-old Chad had been in an automobile accident that left him in a persistent vegetative state.⁶² Based on prior discussions with Chad regarding his wish that he not be kept alive by artificial means, his parents petitioned the court for a judgment that they would not be held liable if they participated in removing Chad's feeding tubes.⁶³ Ultimately, the Maine Supreme Court ruled that Chad's previously voiced preference that he did not wish to be kept alive by artificial means was clear and convincing evidence, and his statements were controlling.⁶⁴ Although Chad made the decisions before he reached the age of maturity, the court based its decision on: (1) the rule that competent minors could testify as witnesses; (2) the common law presumption of competency for persons at least fourteen years old; (3) persons attain capacity at different ages; and (4) the Illinois Supreme Court decision in *In re E.G.*⁶⁵ Although Chad's preference was addressed by the court, the parent's wish to remove the feeding tubes was also given weight in the decision.

⁵⁸ See *id.* at 328 (citing *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989)).

⁵⁹ See *id.* at 327-28 (outlining the balancing test a judge must perform in determining a minor's ability to make a decision to consent to or refuse medical care).

⁶⁰ See *id.* at 328.

⁶¹ See *In re Swan*, 569 A.2d 1202 (Me. 1990) (holding that parents were entitled to withdraw life-sustaining treatment from unemancipated mature minor son, after he had expressly stated that he would not want to live in a persistent vegetative state).

⁶² See *id.* at 1203.

⁶³ See *id.* at 1204, 1206.

⁶⁴ See *id.* at 1206 (relying on precedent established in *In re Gardner*, 54 A.2d 947 (Me. 1987), and mature minor's own professed wishes).

⁶⁵ See *id.* at 1205-06.

Although New York courts seem to value the mature minor concept, they have been reluctant to base any decisions on it. In a 1990 case involving the rejection of blood transfusions by a minor based on religious beliefs, the court simply stated that the minor was not mature⁶⁶ and refused to allow a seventeen-year-old to reject medical treatment, although it did acknowledge the existence of the mature minor doctrine. The judge believed that the minor in this case lacked both a clear understanding of his religious beliefs and the consequences of his actions.⁶⁷ In denying the minor's petition, the court cited the Illinois decision in *In re E.G.* and stated that the evidence of the minor's maturity in this case was not "clear and convincing."⁶⁸

The Georgia courts have not recognized the right of minors to refuse life-saving medical treatment under a mature minor doctrine. In *Novak v. Cobb County-Kennestone Hospital*,⁶⁹ the plaintiffs argued that the Georgia Code⁷⁰ supported the right of the mature minor to refuse blood transfusions because there were exceptions stated in the code for some classifications of minors to so consent or refuse. The Code addresses the adult's power to consent and the right to refuse; however, there are exceptions for married minors, pregnant minors and minors with children.⁷¹ The minor's maturity is not an issue in these instances, but rather they are considered "adults" based on their relative position in society. The court found that the rights were those of an adult, not a minor, mature or otherwise. It further stated that, if a mature minor were to be recognized as an exception, specific provision would have been made a part of the statute.⁷² In its decision, the court cited the fact that the age of majority in Georgia⁷³ is eighteen and that the rights are limited only to those individuals who have attained that age and are then considered adults, or are in a class specifically addressed by the statute. It also noted the lack of the plaintiff to show any

⁶⁶ See *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (Sup. Ct. 1990).

⁶⁷ See *id.*

⁶⁸ *Id.* (citing *In re E.G.*, 549 N.E.2d 322 (Ill. 1989)).

⁶⁹ 849 F. Supp. 1559, 1576 (N.D. Ga. 1994).

⁷⁰ GA. CODE ANN. §§ 39-9-2, 31-9-7 (1996) (discussing persons authorized to consent to medical treatment and to refuse medical treatment, respectively).

⁷¹ See GA. CODE ANN. § 31-9-2(a)(2), (3), & (5) (1996).

⁷² See *Novak*, 849 F. Supp. at 1574-77.

⁷³ See GA. CODE ANN. § 39-9-7(1996).

reported Georgia cases recognizing an exception other than those provided in the statutes.⁷⁴

Also, courts are notoriously inconsistent in the use of a standard of proof that is required for application of the mature minor doctrine. Some courts have relied on the clear and convincing evidence test to prove a minor's maturity.⁷⁵ Courts have also applied the standard of "Rule of Sevens" which is derived from English common law.⁷⁶ This standard is based on the child's reasoning ability, and supports the assumption that a minor older than fourteen has the capacity to give consent for medical treatment.⁷⁷ The rule divides minors into three groups: (1) children under the age of seven have no capacity to formulate criminal intent and cannot be guilty of a crime; (2) children between the ages of seven and fourteen are presumed not to have capacity to form criminal intent; and (3) children older than fourteen are presumed to have that capacity. However, these are presumptions that can be disproved by other evidence.⁷⁸

Although several courts agree with the presumptions used in the Rule of Sevens, they are not consistent in the methods they use to make the determination. The Illinois courts have focused on the minor's ability to understand his or her own actions.⁷⁹ New York has tried to identify whether the minor has reached the age of discretion.⁸⁰ The Pennsylvania court has made the determination based on whether the minor answered questions with no hesitation and appeared to understand the benefits and/or complications of an operation if he agreed or rejected it.⁸¹ In Tennessee, the focus of the court was whether

⁷⁴ See *Novak*, 849 F. Supp. at 1576.

⁷⁵ See, e.g., *In re E.G.*, 549 N.E.2d 322, 327-28 (Ill. 1989) (discussing an unemancipated minor's right to refuse a blood transfusion).

⁷⁶ See *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987) (explaining application of the "Rule of Sevens" to determine capacity).

⁷⁷ See *id.*

⁷⁸ See *Lacey v. Laird*, 139 N.E.2d 25, 33 (Ohio 1956) (stating that a minor who underwent plastic surgery without parental consent had the degree of maturity to understand the procedure and risks).

⁷⁹ See *In re E.G.*, 549 N.E.2d at 327-28.

⁸⁰ See *Bach v. Long Island Jewish Hosp.*, 267 N.Y.S.2d 289, 291 (Sup. Ct. 1966) (reiterating that, upon reaching the age of 18 years, one has reached the age of majority).

⁸¹ See *In re Green*, 307 A.2d 279, 280 (Pa. 1973) (holding that when both the mother and son refused surgery, the state did not have sufficient interest to outweigh their religious beliefs).

the minor had the maturity, experience, education, and judgment to make a decision regarding medical treatment.⁸²

It appears from the cases studied that, even when the courts acknowledge the mature minor doctrine, the decisions are actually based not specifically on the fact that the minor has been determined mature, but on additional criteria as cited in the opinions. The courts will at times allow the rejection of life-sustaining treatment by a minor if at least one parent agrees with the minor's decision, or the minor is within a few months of eighteen years of age, or the minor had expressed his wishes and these wishes were supported by his parents.⁸³ It appears that in most cases, courts defer to the minor's refusal of treatment only if one or both parents agree with that decision. The courts are reluctant to override the parent's decision to treat regardless of the minor's refusal. Some courts struggle with the decision if this is not the case and end up refusing the minor's rejection of the treatment anyway.⁸⁴ It would seem that the parent's mature and thoughtful decision, whatever it might be, made after consultation with physicians and possibly a member of a bioethics committee of the hospital, should be honored without the agony and time consuming process of a court procedure. The parents know the child best and are usually in the optimal position to make a valid informed decision regarding the child's care and treatment.

CHILD COGNITIVE DEVELOPMENT THEORIES

How is it determined that a minor is a "mature minor"? What is a "mature minor"? To determine if a child is "mature", the development of the child must be studied and researched. Child development research has resulted in several differing theories. Which one is to be used when determining the maturity of a child or, more specifically, which one should be deemed most accurate?

⁸² See *Cardwell*, 724 S.W.2d at 748-49.

⁸³ See *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); see also *In re Swan*, 569 A.2d 1202 (Me. 1990).

⁸⁴ See *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239 (Sup. Ct. 1990) (holding that patient who refused to consent to blood transfusion on religious grounds was not a "mature minor" and that the court had authority to act as *parens patriae* to order treatment to save the patient's life).

The most noted researcher in the area of child cognitive development is Jean Piaget.⁸⁵ His theory proposes that there are four stages of development based on knowledge that develops and increases until it has reached that point where it is fully effectual. He theorized that the stages were influenced by self-learning and education.⁸⁶ He proposes that the last stage of development occurs between the ages of eleven and fifteen during which the child engages in independent thought, can draw deductions and understand theories. His theory proposes that by fifteen the child is in a mature state that includes a mature thinking process.⁸⁷ One criticism of Piaget's theory is his neglect of the effect of other people and the environment on the behavior of the child.⁸⁸ In addition, subsequent research has indicated that the Piagetian stages do not include all the abilities of children nor their mastery of all tasks simultaneously within each stage.⁸⁹ Differences in each child's abilities at any given age may occur due to personality, specific demands made upon the child, or their individual conceptual knowledge at the time.⁹⁰ Studies also indicate that children apply a reasoning concept more consistently when it is newly learned rather than when they understand it better, and that the child's functioning within a stage could possibly represent the child's most advanced reasoning, but not his average, normal reasoning ability.⁹¹ Thus, performance at a specific stage does not guarantee that the child can think equally well about all problems encountered, or think at that same level at all times.⁹²

More recently, some researchers in the field of adolescent behavior have concluded that the decision-making process of

⁸⁵ Jean Piaget was a Swiss psychologist who, with his associates, published findings on the development of cognitive processes in children. Published since 1927, it is the largest accumulation of factual and theoretical observations to date. See JOHN L. PHILLIPS, JR., *PIAGET'S THEORY: A PRIMER* 4-9 (1981).

⁸⁶ See R. MURRAY THOMAS, *COMPARING THEORIES OF CHILD DEVELOPMENT* 284-85 (3d ed. 1992) (describing how a child's intellectual development arises from the child's direct participation in events).

⁸⁷ See *id.* at 298-99.

⁸⁸ See *id.* at 316 (noting criticism by B.J. Zimmerman that Piaget placed little emphasis on the effect of social dimensions on a child's environment).

⁸⁹ See Lexcen & Reppucci, *supra* note 25, at 76.

⁹⁰ See Wallace J. Mlyniec, *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 *FORDHAM L. REV.* 1873, 1878-86 (1996) (discussing Piagetian and other child development theories).

⁹¹ See Lexcen & Reppucci, *supra* note 25, at 77.

⁹² See *id.*

fourteen-year-olds is comparable to that of adults.⁹³ These researchers theorize that, the older the adolescent, the more consideration is given to risk and future consequences. They believe that the ability to compare information improves between the ages of ten and thirteen. However, although researchers agree that society and the environment influence the development of the adolescent, they differ as to how much, when it occurs, and to what extent.⁹⁴ Professor Elizabeth Scott states that many studies fail to include: (1) peer influence; (2) tendency to focus on immediate rather than long-term consequences; and (3) an inclination to make risky choices, when evaluating adolescent decision-making capabilities.⁹⁵ Research also seems to indicate that adolescents and adults differ in their perspective of the world.⁹⁶ Adolescents generally place greater importance on short-term consequences while adults focus on long term consequences.⁹⁷ Other research has shown that, when older adolescents consider issues concerning family, education, and careers,

⁹³ See Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1320 (citing a study published by Lois Weithorn and Susan Campbell).

⁹⁴ See, e.g., William Gardner et al., *Asserting Scientific Authority: Cognitive Development and Adolescent Legal Rights*, 44 AM. PSYCHOLOGIST 895, 898 (1989) (theorizing that there are no stages of development, but that skills to perform different tasks develop at different times); see also Urie Bronfenbrenner, *The Ecology of Human Development* 9-10, 16-42 (1979) (theorizing that social and physical settings also affect a child's development); Yoshiaki Nakajima & Miho Hotta, *A Developmental Study of Cognitive Processes in Decision Making: Information Searching as a Function of Task Complexity*, PSYCHOL. REP., Feb. 1989, at 67 (finding that children age fifteen and older used more systematic strategies when making decisions than children under age twelve); Catherine C. Lewis, *How Adolescents Approach Decisions: Changes Over Grades Seven to Twelve and Policy Implications*, 52 CHILD DEV. 538 (1981) (finding that older adolescents considered future risks and consequences more than younger adolescents); Elizabeth Cauffman & Laurence Steinberg, *The Cognitive & Affective Influences on Adolescent Decision-Making*, 68 TEMPLE L. REV. 1763 (1995); Jennifer Soper, Student Article, *Straddling the Line: Adolescent Pregnancy & Questions of Capacity*, 23 LAW & PSYCHOL. REV. 195, 199 n.31 (1999) (citing Gerald P. Koocher & Patricia C. Keith-Spiegel, *CHILDREN, ETHICS & THE LAW* 7 (1990); 1 Donald Kramer, *LEGAL RIGHTS OF CHILDREN* § 14.01 (2d ed. 1994)).

⁹⁵ See Elizabeth S. Scott, *Judgment and Reasoning in Adolescent Decision-making*, 37 VILL. L. REV. 1607, 1643-46 (1992) (comparing adolescent decision-making to adult decision-making and arguing that adolescents deserve more autonomy than they currently possess).

⁹⁶ See Elizabeth S. Scott et al., *Evaluating Adolescent Decision Making in Legal Contexts*, 19 LAW & HUM. BEHAV. 221, 231 (1995) (comparing adolescent and adult attitudes and perceptions of risk).

⁹⁷ See *id.*

they tend to look more towards the future than younger adolescents.⁹⁸ As Cauffman and Steinberg have concluded: “While studies have generally found few cognitive differences between adolescents and adults, this should not be taken as evidence that adolescents are as capable as adults of making consistently mature decisions.”⁹⁹

The ability to make rational decisions and competent judgments is a learned activity that develops over a period of time.¹⁰⁰ The person makes decisions and judgments in different circumstances and eventually acquires the ability to adapt those judgments and decisions to differing circumstances in his life.¹⁰¹ In effect, the ability to make appropriate decisions takes a considerable amount of repetition and practice. Errors in judgment and poor decisions can be made during this learning process. However, although the adolescent may make these errors in judgment, hopefully he learns from them, and eventually improves his performance. Furthermore, the ability to make appropriate and valid decisions may depend on the experiences the adolescent has had and the cognitive maturity he possesses at the time those experiences occur.¹⁰² Because each child matures at a different rate, it is difficult to know at exactly what stage each one has arrived at any given time.

Exposure to stress can also result in ineffective or flawed decision-making. Cauffman and Steinberg discuss “three primary ways in which stress can cause decision-making errors. The first, premature closure, occurs when a decision is reached before all available alternatives have been considered. The second, nonsystematic scanning, refers to the consideration of alternatives in a disorganized, almost ‘panic-like’ fashion. Finally, temporal narrowing may produce faulty decisions because the person acts impulsively and does not give ample time to

⁹⁸ See Jari-Erik Nurmi, *How Do Adolescents See Their Future? A Review of the Development of Future Orientation and Planning*, 11 DEVELOPMENTAL REV. 1, 28 (1991).

⁹⁹ Cauffman & Steinberg, *supra* note 94, at 1788.

¹⁰⁰ See FRANKLIN E. ZIMRING, *THE CHANGING LEGAL WORLD OF ADOLESCENCE* 90-91 (1982) (discussing the fact that young people acquire maturity and judgment over a period of time).

¹⁰¹ See Richard L. Roe, *Valuing Student Speech: The Work of the Schools as Conceptual Development*, 79 CAL. L. REV. 1269, 1293 (1991) (evaluating the learning processes of law students).

¹⁰² See Lita Furby & Ruth Beyth-Marom, *Risk Taking in Adolescence: A Decision-Making Perspective*, 12 DEVELOPMENTAL REV. 1, 29 (1992).

consider alternatives.”¹⁰³ There is no doubt that an adolescent suffering from a serious illness is under severe stress that could compromise rational and effective reasoning and thinking. The resulting decisions made by him could then be, not only irrational, but not in his best interest.

Lynn Ponton, an adolescent psychiatrist at the University of California, has studied adolescent behavior, especially in the area of risk-taking. She has found that adolescents are frequently involved in varying degrees of unhealthy risk-taking.¹⁰⁴ Although most risk-taking during these years is a normal, developmental behavior (positive risk-taking) teaching adolescents how to think, act, and understand consequences of their behavior, it can be potentially dangerous when it has predominantly negative results.¹⁰⁵ During this time, teens want their maturity and independence recognized. However, although they can make independent choices, parents need to set limits and let them know they are not permitted to do everything they want to do in every situation.¹⁰⁶ Risk-taking is the beginning of a life-long process that involves learning to make decisions based on good judgment, but adolescents are not as yet able to fully assess the risks that may be inherent in any given decision. They tend to look at one side of a problem, not the complete picture. As yet, they do not have the wealth of life experiences of an adult to adequately assess the consequences of their actions.¹⁰⁷ Furthermore, many factors such as illness, culture, onset of puberty, peer involvement, and other social factors affect the ability of the adolescent to adequately assess risk.¹⁰⁸

The study of adolescents suffering from chronic illness and the attendant psychosocial effects is a relatively new area of research.¹⁰⁹ Although there is numerous research on normal child development, the particular area of study that investigates how adolescents view the impact of their illness on their family, social and personal well-being, has just recently been ad-

¹⁰³ Cauffman & Steinberg, *supra* note 94, at 1782.

¹⁰⁴ LYNN E. PONTON, *THE ROMANCE OF RISK: WHY TEENAGERS DO THE THINGS THEY DO* 1 (1997).

¹⁰⁵ *See id.* at 6-7.

¹⁰⁶ *See id.* at 13.

¹⁰⁷ *See id.* at 34.

¹⁰⁸ *See id.* at 276-77.

¹⁰⁹ *See* Penkower, *supra* note 43, at 1192-99 (discussing the effects of illness on adolescents).

dressed.¹¹⁰ Research has shown that chronic or serious illness may leave the minor with a feeling of uncertainty about the future and doubt that he will ever be happy.¹¹¹ These adolescents are also more likely to develop major psychosocial problems than those who are healthy.¹¹² Researchers have also found that serious or chronic illness has a potential impact on developmental tasks during adolescence.¹¹³ Risk-taking behavior may increase, self-esteem may be lowered, emotional difficulties may increase, and the sense of personal identity may be compromised.¹¹⁴ It would seem that these factors would then adversely affect the adolescent's decision-making capabilities. It would be difficult, at best, for the adolescent to make a decision that is not distorted by these factors at a time when his health is so compromised.

Development does not seem as simple an evaluation as Piaget once believed. Adolescence is a period of time when minors begin to make new decisions based on their newly developed capabilities, but there is usually the presence of adults to protect them from catastrophe and from suffering the consequences of their possible mistakes in judgment. During this time of "not quite completely autonomous", it would appear, as some argue, that societal influences and life experience should be included with any assessment of adolescent competence.¹¹⁵ Furthermore, an adolescent who is compromised by illness may not be in a condition to make valid decisions regarding his life. The only consistency in any of the theories appears to be that, as a child grows older, he does in fact exhibit an increase in knowledge and the ability to assimilate that knowledge into his life

¹¹⁰ See, e.g., Tracy R. Shaben, *Psychosocial Issues in Kidney-Transplanted Children and Adolescents: Literature Review*, 20 AM. NEPHROLOGY NURSES' ASS'N J. 663 (1993) (reviewing information addressing the psychosocial issues of children and adolescents who have had kidney transplants or who suffer from serious or chronic illness).

¹¹¹ See Penkower, *supra* note 43, at 1192 n.183 (citing Christine Harrison, *Caring for the Chronically Ill Child*, 3 CALYX: ETHICAL ISSUES IN PAEDIATRICS 1, 1 (1993)).

¹¹² See Mario Capelli et al., *Chronic Disease and Its Impact: The Adolescent's Perspective*, 10 J. ADOLESCENT HEALTH CARE 283, 283 (1989).

¹¹³ See S. Sexson & J. Rubenow, *Transplants in Children and Adolescents*, in PSYCHIATRIC ASPECTS OF ORGAN TRANSPLANTATION 33, 35 (John Craven & Gary M. Rodin eds., 1992) (summarizing the potential impact that chronic illness has on developmental tasks during adolescence in Table 4.1).

¹¹⁴ See *id.*

¹¹⁵ See Lexcen & Reppucci, *supra* note 25, at 77.

decisions and judgments. At what exact age that occurs depends on a myriad of external factors in the child's life.

ADOLESCENT PHYSICAL DEVELOPMENT

Not only is cognitive development instrumental in an adolescent's ability to make proper decisions, it has been discovered that the brain in an adolescent is still in the growing and maturing stages, an "adolescent phase" of brain growth.¹¹⁶ Until recently, studies in brain growth involved research in animals.¹¹⁷ Using the technology of magnetic resonance imaging (MRI)¹¹⁸ and positron emission tomography (PET),¹¹⁹ researchers have been able to view the brain in a way that was impossible not so many years ago. By using the MRI scanner, the cortex growth of the brain can be monitored by measuring the thickness of the gray matter forming the outer part of the brain to within a millimeter of accuracy. PET uses radioactive markers to highlight those areas of the brain that are working the hardest. These medical diagnostic techniques have shown that brain growth continues well into adolescence.¹²⁰ In the last few years, neuroscientists discovered that at about the age of eleven the brain begins to undergo reorganization in the area associated with activities such as social behavior and impulse control. Because of this developmental activity or plasticity,¹²¹ the brain is believed to be very vulnerable, especially to traumatic experiences, and unable to handle social pressures and stress in the same manner as the fully developed adult brain.¹²² As a result,

¹¹⁶ See generally Paul M. Thompson et al., *Growth Patterns in the Developing Brain Detected by Using Continuum Mechanical Tensor Maps*, NATURE, Mar. 9, 2000, at 190; Elizabeth R. Sowell et al., *In Vivo Evidence for Post-Adolescent Brain Maturation in Frontal and Striatal Regions*, 2 NATURE NEUROSCIENCE 859 (1999).

¹¹⁷ See generally NEUROBEHAVIORAL PLASTICITY: LEARNING, DEVELOPMENT, AND RESPONSE TO BRAIN INSULTS (Norman E. Spear et al. eds., 1995) (reporting technical innovations and research in behavioral neuroscience); Bryan Kolb & Ian Q. Whishaw, *Brain Plasticity and Behavior*, 49 ANN. REV. PSYCHOL. 43 (1998) (discussing animal research in brain growth and behavior).

¹¹⁸ See Sowell et al., *supra* note 116, at 859.

¹¹⁹ See Kathiann M. Kowalski, *What's Inside the Teenage Brain: How Neurochemistry Affects Thought Processes*, CURRENT HEALTH 2, Nov. 1, 2000, at 12; see also Thompson et al., *supra* note 116, at 192.

¹²⁰ See Sowell et al., *supra* note 116, at 859-60.

¹²¹ See HUGH BROWN, BRAIN & BEHAVIOR: A TEXTBOOK OF PHYSIOLOGICAL PSYCHOLOGY 378 (1976) (defining plasticity as "capable of being molded, reshaped, [or] reformed").

adolescents are more apt to exhibit reckless and impulsive behavior.

Two recent studies have contributed to this theory. One study tracked changes over a number of years in the brains of children.¹²³ The other compared brain maturation in twelve to sixteen year olds with adults in their twenties.¹²⁴ Areas of the brain that control functions such as planning, organization, inhibition, and emotions were found to continue to develop between adolescence and adulthood.¹²⁵

A complex system of neurons in the brain interconnect and are responsible for communicating information to the various areas of the brain.¹²⁶ It was previously believed that most brain growth and increase in the number of these neurons was complete by the age of six.¹²⁷ Scientists believed until recently that, after this age, the number of neurons decreased and there were no new connections formed.¹²⁸ However, recent studies indicate that a significant number of new connections continue to form well into adolescence.¹²⁹ Included in this growth are new connections in the two halves of the brain's cerebrum, areas that are involved with judgment-making and the controlling of emotions.¹³⁰ Because of this continued development and growth during adolescence, teens may rely more on the emotional centers of the brain rather than the areas that will eventually be relied upon as an adult when making judgments.¹³¹ As a result, decisions made during the teen years may be made strictly on an emotional basis rather than a more appropriate judgment basis.¹³²

Until this discovery was made, it had been believed that the unpredictable behavior of children in this age group was solely attributable to the hormonal changes occurring in their bodies.

¹²² See Kowalski, *supra* note 119, at 6; see also Linda Patia Spear, *Neurobehavioral Changes in Adolescence*, CURRENT DIRECTIONS PSYCHOL. SCI., Aug. 2000, at 112.

¹²³ See Thompson et al., *supra* note 116, at 190-91.

¹²⁴ See Sowell et al., *supra* note 116, at 859.

¹²⁵ See *id.* at 860-61.

¹²⁶ See Kowalski, *supra* note 119, at 6.

¹²⁷ See *id.*

¹²⁸ See *id.*

¹²⁹ See Thompson et al., *supra* note 116, at 190-91.

¹³⁰ See Kowalski, *supra* note 119, at 6.

¹³¹ See *id.*

¹³² See *id.*

These hormonal changes during adolescence can cause a swelling of a part of the limbic system, called the amygdala, that is thought to be involved with emotional reactivity and in coordinating response to stress.¹³³ The limbic system consists of parts of the cerebrum, the thalamus, and the hypothalamus and contributes to learning, memory, and emotions. The cerebrum is the brain's thinking and feeling center. Because the limbic system generates feelings and emotions of fear and anger, these emotions may be intensified during this time due to the swelling.¹³⁴ Although the hormonal changes have some bearing on the sometimes erratic and unpredictable behavior of adolescents, this new theory proposes that changes in behavior may also be partially attributable to the new brain growth. This recent discovery adds a whole new dimension to adolescent behavior and the inappropriate choices and decisions that can be made during that time.

To further complicate matters, the use of tobacco, alcohol, and illegal drugs can destroy brain cells and interfere with normal brain development by impairing memory and learning ability.¹³⁵ A study done by the National Institute of Drug Abuse has shown that by their senior year in high school, a significant number of teens have used alcohol and other drugs.¹³⁶ Since many teens are exposed to one or all of these, this further contributes to possible erratic behavior and inappropriate decision-making exhibited by some adolescents.

As yet there is no way to know exactly what the discovery of this teen phase of brain development means, although the patterns of changes observed in the brain between adolescence and adulthood are consistent with cognitive development during this time.¹³⁷ Because there has been a tendency to believe that adolescents' brains are already at the adult stage of development, there has not been much research done in this area.¹³⁸ Teenage behavior has, for the most part, been attributed to

¹³³ See generally Spear, *supra* note 122, at 113.

¹³⁴ See Kowalski, *supra* note 119, at 7, 11.

¹³⁵ See *id.* at 8, 12.

¹³⁶ See Spear, *supra* note 122, at 112 (citing to a 1996 study showing that, by their senior year, approximately 50% of adolescents have used marijuana or hashish, 65% have smoked cigarettes, and 82% have drunk alcohol).

¹³⁷ See Sowell et al., *supra* note 116, at 860.

¹³⁸ See John McCrone, *Rebels With a Cause*, NEW SCIENTIST, Jan. 22, 2000, at 25-26

“surging hormones” and a lack of life experience.¹³⁹ Although they probably play a role, it now appears that this new teenage phase of brain development also has an effect on the how and why adolescents act. Skeptics have taken a cautious view of this new theory, especially because of the lack of research in this area. Although the patterns of changes in the brain between adolescence and adulthood are consistent with cognitive development,¹⁴⁰ it is still necessary to make a definitive causal connection between the evidence of this physical change to observed mental changes.¹⁴¹ Researchers believe that future studies of microscopic brain tissue should also be done to help reinforce these new findings.¹⁴²

Whether this new brain growth actually does have a significant effect on adolescent behavior remains to be seen. As yet, neuroscientists do not know exactly how learning is actually related to brain growth over lifetime. More research is needed in this area. However, the fact that it is even a possibility makes a life or death decision by a teenager that much more dangerous. Factor into this the trauma of a serious illness or accident and/or pain, and an inappropriate emotional response would be difficult to avoid. If the decision is based on emotion instead of good judgment, its validity would most certainly be questionable.

THE JUDICIAL PERSPECTIVE

Juveniles who wish to be adjudged as mature minors eventually find themselves in the repository of the judicial system. Are judges really qualified to make a possibly fatal decision for a minor they don't know, based on subjective data gathered by other professionals? Do judges even want to be in this position? Although judges make numerous decisions that affect the lives of people, adjudging a minor to be a “mature minor” and allowing him to make a decision when that minor rejects life-sustaining treatment, is the only decision they make that may result in the death of that minor. Wallace J. Mlyniec, Professor of Law and Director of the Juvenile Justice Clinic at Georgetown University Law School, has written:

¹³⁹ See *id.* at 22.

¹⁴⁰ See Sowell et al., *supra* note 116, at 860.

¹⁴¹ See McCrone, *supra* note 138, at 27; see also Spear, *supra* note 122, at 114.

¹⁴² See McCrone, *supra* note 138, at 27.

When making decisions concerning a child, judges consider prior events and legal principles in order to make predictions about a child's future....The legal principles judges use to decide cases about children are often vague....[R]esearch concerning child development suggests that concepts like "knowing, intelligent, and voluntary"—while somewhat immutable when applied to the adult reasoning process—is fluid prior to adulthood.¹⁴³

It would, therefore, be difficult for judges to apply these concepts in a uniform manner to cases involving the mature minor doctrine because the stage of development of the child cannot be fully known by the judge.¹⁴⁴ Strong opinions and preferences of the adolescent, in addition to societal effects on this age group, greatly influence the adolescent's decisions. When they voice a preference, they may think they know what they want, but it is difficult to evaluate the rationale for the decision made at that time. They express strong opinions and preferences, but at times do not really know what they want.¹⁴⁵ In custody cases, a juvenile may choose one parent over the other due to material benefits received from the chosen parent; they may choose emancipation to escape from what they perceive as a too controlling environment; they may choose to reject painful medical treatment because they believe life would be easier without it. Adolescents tend to think in terms of immediacy, not the future. Judges are forced to evaluate valid scientific information presented to them about child development, and then render what they believe to be an ethical decision that will govern the life and/or death of the child. In the instance of allowing a minor to reject life-sustaining treatment, judges are in effect, giving a death sentence. If they allow the minor to refuse the treatment in the face of parental opposition, the minor will most assuredly die. It is the only judicial circumstance whereby the judge issues what can amount to a death sentence for an individual that does not constitute punishment for a previously

¹⁴³ Mlyniec, *supra* note 90, at 1873-74.

¹⁴⁴ *See id.* at 1874 (stating that the impact of scientific and societal changes on childhood and adolescence make it difficult for judges to make clear decisions in cases involving minors).

¹⁴⁵ *See id.* (providing examples).

committed action. Is it fair to ask the judge to allow the minor to make this decision to end his life?

The necessity of deciding that a minor is mature places a judge in a most precarious position. Because his decision may result in the death of a child, he is understandably reluctant to permit a minor to reject life-sustaining medical treatment, whether the child's decision is a valid "adult" decision or not. Court hearings can result from circumstances that arise when there is a conflict between the parental decision to administer treatment and the minor's rejection of that treatment. It does not seem reasonable that a judge, although impartial and objective, should make a decision to reject a minor's medical treatment. He does not know the child or the child's behavior and environment intimately enough, even with the assistance of existing but inconsistent expert testimony. He is in fact a stranger to the immediate situation in most instances and, if the case is one of first impression, has little or no case history to evaluate. The responsibility to make the decision should ultimately fall to the parents, but only after consultation with the appropriate health care professionals and possibly ethics committees.

THE NON-LEGAL PERSPECTIVE

The medical community has addressed this issue more than a few times. Both the American Academy of Pediatrics¹⁴⁶ and the Midwest Bioethics Center of Kansas City, Missouri¹⁴⁷ have supported to some degree the right of mature minors, who are deemed to be competent, to consent or reject medical treatment to sustain life.

The American Academy of Pediatrics Committee on Bioethics (AAP) has published position statements recognizing the ability of children with capacity to make medical treatment decisions in life-sustaining situations, and have included guidelines for physicians.¹⁴⁸ Although the AAP's guidelines state that

¹⁴⁶ See Committee on Bioethics, American Academy of Pediatrics, *Guidelines on Forgoing Life-Sustaining Medical Treatment*, 93 PEDIATRICS 532 (1994) (setting guidelines for withholding or terminating life-sustaining treatment for minors).

¹⁴⁷ See Joan-Margaret Kun, Comment, *Rejecting the Adage "Children Should Be Seen and Not Heard"—The Mature Minor Doctrine*, 16 PACE L. REV. 423, 442-44 (1996) (discussing guidelines set by the Midwest Bioethics Center, see Midwest Bioethics Center Task Force on Health Care Rights for Minors, *Health Care Treatment Decision-Making Guidelines for Minors*, BIOETHICS F., Winter 1995).

¹⁴⁸ See Committee on Bioethics, *supra* note 146, at 533-36.

minors possessing decision-making capacity should be informed and permitted to make health care decisions, the AAP does not explain how these guidelines are to be implemented. They define decision-making capacity as: “(1) the ability to understand and communicate information relevant to a decision; (2) the ability to reason and deliberate concerning the decision; and (3) the ability to apply a set of values to a decision that may involve conflicting elements.”¹⁴⁹ There is no discussion as to how these determinations are to be made, who will make the determination, or who will finally decide that the minor’s capacity is sufficiently adequate to reject the treatment.

The Midwest Bioethics Center based its model on the assumptions that age does not necessarily determine decision-making capacity, children are not the property of parents, minors have an independent moral status and legal standing, and mature minors should be governed by a presumption of capacity.¹⁵⁰ It suggested that children should be involved in the decisions regarding their health care and that a minor patient should be included in the informed consent process.¹⁵¹ When a disagreement between parent and child develops, the center suggested that talking to a different health care provider or consulting with a hospital’s ethics committee might assist in resolving the dispute.¹⁵²

Parents of children who do not exhibit decision-making capacity generally make health care decisions concerning treatment of their children. Although the Bioethics Committee of the American Academy of Pediatrics recognized this in its policy statement released in 1994, it stated that weight should be given to a child’s preference when life-sustaining treatment was at issue. It noted three separate elements that should be considered when determining capacity: (1) the ability to understand and communicate information relevant to a decision; (2) the ability to reason and deliberate concerning a decision; and (3) the ability to apply a set of values to a decision that involves a conflict. Furthermore, a presumption in favor of treatment should be made when a medical professional believes that the family’s wishes conflict with the interests of the child.¹⁵³

¹⁴⁹ *Id.* at 532.

¹⁵⁰ See Kun, *supra* note 147, at 442.

¹⁵¹ See *id.*

¹⁵² See *id.* at 442-43.

¹⁵³ See Committee on Bioethics, *supra* note 146, at 533.

A task force composed of 25 health professionals, attorneys, and representatives of academia and religions was established in New York in 1985 by then Governor Cuomo to address the issue of deciding for others in a medical treatment situation.¹⁵⁴ Although the task force suggested that minors participate in life-sustaining treatment decisions, it refused to extend the same presumption of capacity afforded to adults in making the decision independently, noting the difficulty that some adolescents have in assessing the future consequences of an action.¹⁵⁵ The Task Force refused to recommend that the age of majority be lowered in New York for making the decision to reject life-sustaining treatment. However, it did recommend that the minor be accorded a non-exclusive role in the decision making process.¹⁵⁶ It further stated that the attending physician could determine the minor's capacity by assessing his maturity, conceptual ability and his life experience at making decisions. Regardless of the final determination, it recommended that the minor never have an exclusive role in making the decision.¹⁵⁷

CONCLUSION

It appears that every discussion and evaluation made of the mature minor doctrine ultimately returns to "square one"—assessing the capacity and/or competence of the minor. Is the minor competent to make a decision? Does the minor have the capacity to make the decision? How should capacity and competence be evaluated? The difficulty seems to be the manner by which the minor's competence or capacity is assessed. New theories addressing the minor's psychological development are constantly being advanced and research materials in this area are abundant.

The recent discovery of an adolescent phase of brain growth and development in the areas of the brain that are concerned with social judgment and self-control further contribute to the argument that adolescents are unable to make valid, rational decisions, especially during times of stress. Possible drug use can also affect judgments and decisions made during this

¹⁵⁴ See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY 130-31 (1992).

¹⁵⁵ See *id.*, see also Kun, *supra* note 147, at 451-55 (discussing decision and rationale implemented by the Task Force).

¹⁵⁶ See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *supra* note 154.

¹⁵⁷ See *id.*

time. It would be impossible to assess, save a medical diagnostic procedure such as an MRI, at what stage of brain growth an adolescent is at the time a life-sustaining treatment decision must be made. Furthermore, it remains to be determined specifically what the connection is between this growth and the cognitive development of the individual.

Adolescence is a period of not only rapid physical growth but a period of emotional and psychological development that advances at different rates for different individuals. Many adolescents are notoriously rebellious and recalcitrant, attempting to find their own "niche" in the world of adulthood. How can the adolescent's capacity really effectively be evaluated? By rejecting the life-sustaining treatment, is he or she attempting to make a statement simply to authenticate his or her own independence or does the adolescent truly feel that the risk of death is superior to the possibility of living?

Although it is recognized that there is no guarantee that the controlling adult will make the correct decision in the minor's life or death situation, it is more likely than not that this would be the case. It would seem unwise to permit a minor, whether "mature" or not, to make a decision that could ultimately result in his death. There is no "cut and dried" and absolutely fool proof method for making the evaluation of maturity. It is a subjective and arbitrary process depending to a great degree on the perceptions of the evaluator. The current bright-line demarcation of childhood and adulthood, the age of eighteen, may prevent at the very least a judgmental error on the part of the evaluator. By eighteen years of age, most individuals have attained a significant degree of maturity by virtue of the fact that, if nothing else, they have lived long enough. It would seem that even one error in evaluation of a minor as a mature minor, resulting in his death by the rejection of treatment, would be one too many.

Those states that have adopted some form of the mature minor doctrine would be well served to disavow the same in future decided cases involving a minor's rejection of life-sustaining medical treatment for the following reasons:

- (1) The psychological evaluation methods used to assess the minor are inconsistent and depend somewhat on the expertise of the professional chosen;
- (2) The state applications of the mature minor doctrine are necessarily inconsistent as a result of (1);

- (3) The guidelines used to apply the doctrine are vague;
- (4) The recent discovery of an adolescent phase of brain growth may affect the judgment and decision-making process used by teenagers;
- (5) Judges are not equipped to make decisions in such cases; and
- (6) The bright line demarcation of legal age not only has the advantage of being a more objective standard, but is also recognized as the universal legal criteria set for individuals to speak and act responsibly for themselves.