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MEDICAL DECISION MAKING BY AND ON BEHALF OF ADOLESCENTS: RECONSIDERING FIRST PRINCIPLES

B. JESSIE HILL*

I. INTRODUCTION

The school nurse cannot give your teenage daughter an aspirin for her headache without your permission, but that same daughter can get an abortion without even informing you. Or can she? The obligations on medical personnel providing care to adolescents are famously indeterminate.¹ Not only does the United States have a patchwork of differing standards and limits, embodied in statutes,² common-law rules,³ and sometimes even constitutional provisions,⁴ but the imperatives of medical ethics and practice may also conflict with those requirements.⁵ Providers may find themselves caught between their professional obligations to their patients and the obligations that may be imposed, to a more or

* Professor of Law and Director of the Center for Social Justice, Case Western Reserve University School of Law. I would like to thank the *Journal of Health Care Law & Policy*, as well as Professor Leslie Henry and Dean Diane Hoffmann, for inviting me to participate in this symposium. I would also like to thank Professors Max Mehlman and Alex Tsesis for their constructive and insightful feedback and Karelia Rajagopal for her excellent research assistance.

1. See, e.g., B.M. Dickens & R.J. Cook, *Adolescents and Consent to Treatment*, 89 INT'L J. GYNECOLOGY & OBSTETRICS 179, 179–80 (2005) (describing how the legal and ethical duties of health services providers are often unclear with respect to adolescent patients); see also 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, 252 (2005) (“The law’s treatment of minors in the healthcare context has been scattered and contradictory.”).

2. See, e.g., Mutcherson, *supra* note 1, at 265–67 (describing statutory provisions throughout the United States that govern when a minor can independently seek and consent to medical treatment).

3. See, e.g., *id.* at 268 (explaining the common-law mature-minor doctrine, which provides that adolescents demonstrating a certain level of maturity and intelligence can consent to medical treatment without parental consent).

4. See Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L. J. 1265, 1352–54 (2000) (stating that “state high courts have . . . rendered varying decisions under state constitutions” regarding the decisional authority of minors in the area of abortion rights).

5. See, e.g., Mutcherson, *supra* note 1, at 252, 293–94 (suggesting that medical ethics may conflict with the law in situations where “the law support[s] the parents and not the healthcare provider” and in those circumstances, the health care provider violates basic professional obligations by being constrained from offering the highest quality of health care).

less definite degree, by the existing legal regime.⁶ For example, a physician may find that a parent's treatment decision is inappropriate or counter-productive for the patient but may, legally, still have to respect that decision.⁷

Two common-law presumptions have long lurked in the background, and, far from elucidating matters, those presumptions have in fact contributed to the state of confusion. The presumptions are, essentially, default positions against which subsequent legal modifications of minors' and parents' rights and responsibilities must be understood.⁸ The first presumption is that, absent any special rule, children lack the legal authority to consent to medical treatment on their own.⁹ A parallel and corresponding presumption is that parents have a legal entitlement to make medical decisions for their minor children.¹⁰ This Article questions whether those propositions have any force today—if, in fact, they ever did.¹¹ Both as a descriptive matter and as a constitutional matter, these statements are highly questionable, particularly when adolescents are involved.¹²

This Article makes the case that neither presumed truth about the American legal landscape is valid.¹³ It also suggests that the ultimate failure of the law to provide solid and meaningful background presumptions in the domain of minors' medical decision-making rights has done much to aggravate, if not create, the muddle of regulation that confounds health care providers.¹⁴ This Article also demonstrates that this problem is particularly thorny when older minors, who fall into the category of adolescents, are involved.

This Article begins, in Part II, with an overview of the legal landscape pertaining to medical decision making by and on behalf of minors.¹⁵ The emphasis in that Part is on the rules pertaining to children in general and not specifically

6. *See id.* at 294 (arguing that legal principles may inhibit health care providers from carrying out their ethical obligations to their patients); *see also* Rhonda Gay Hartman, *Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices*, 8 U. CHI. L. SCH. ROUNDTABLE 87, 88 (2001) (stating that ethical conflicts resulting from balancing the interests of parents and adolescents are among the many challenges faced by health care providers who have adolescent patients).

7. Mutcherson, *supra* note 1, at 252 (noting that health care providers may be prevented from doing what they believe is best for the patient because it is contrary to the wishes of the adolescent's parents).

8. *See id.* at 259, 261–62 (describing the overarching belief that minors lack the capacity to make their own legal decisions and that parents are better suited to make decisions in the minor's best interests).

9. *See id.* at 259 (asserting that in forty-eight states and the District of Columbia, state health care laws “rest on a presumption that minors are incompetent and lack the ability to make cogent, mature, and binding decisions about their own well being”).

10. *See id.* at 261–62 (describing the “basic premise” of family law that parents must be informed and give consent to medical treatment on behalf of their minor children).

11. *See infra* Part III.

12. *See infra* Parts III–IV.

13. *See infra* Parts III–IV.

14. *See infra* Part II.

15. *See infra* Part II.

adolescents. Part III then questions whether the two presumptions are accurate as a descriptive matter.¹⁶ While the presumptions may correctly describe what actually occurs in the majority of cases, Part III argues that they do not represent true default rules describing the legal requirements that govern in the absence of any specific statutory exception.¹⁷ Especially given the increased autonomy and competency of adolescents both as a factual and legal matter, the purported presumptions cannot be said to represent reality with respect to this particular subset of minors.¹⁸ Part IV discusses the relevant constitutional doctrine, with particular emphasis on minors' constitutional rights to bodily integrity.¹⁹ That Part argues that the constitutional doctrine pertaining to minors' rights to bodily integrity both highlights and founders upon the extreme lack of clarity with respect to the relevant default rules regarding older minors' ability to consent to medical care.²⁰ This Article concludes by suggesting that increased judicial attention directed toward developing the constitutional doctrine surrounding minors' rights to bodily integrity would be highly desirable and beneficial both to health care providers and to minors.²¹

II. OVERVIEW OF STATE LAWS PERTAINING TO THE MEDICAL TREATMENT OF MINORS

To understand the state of medical decision making with respect to minors, it is helpful to first understand the status of medical decision making by adults. First, state law, whether by statute or common law, generally requires informed consent

16. *See infra* Part III.

17. *See infra* Part III.

18. Numerous commentators have discussed both the nature of adolescence and the impact that increasing adolescent decisional capacity should have on the law of adolescent medical decision making. *See, e.g.*, Paul Arshagouni, "But I'm an Adult Now . . . Sort of": *Adolescent Consent in Health Care Decision-Making and the Adolescent Brain*, 9 J. HEALTH CARE L. & POL'Y 315, 359-63 (2006) (making recommendations for revising the legal rules pertaining to adolescent medical decision making); Hartman, *supra* note 4, at 1270-71 ("[A]utonomous decisional ability should be the cornerstone for a coherent legal model governing issues of adolescence."); Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 298 (2003) (outlining an approach based on "a sliding scale conception of adolescent competency pegged to the possibility of therapeutic benefit" (emphasis omitted)). This Article, by contrast, does not undertake to define adolescence or to consider whether the unique nature of adolescence should have legal implications for medical decision making with respect to those minors. Rather, this Article assumes that there is a group of individuals who are legally considered minors but who fall into the category of adolescents and argues that, particularly with respect to those individuals, the background of legal rights and disabilities is less clear than has been commonly stated. *See infra* Parts III-IV. In addition, although some individuals who have reached the age of majority may still be considered to be adolescents, this Article does not address medical decision making by those individuals, because the legal right to make medical decisions is fairly clear with respect to them. *See, e.g.*, *In re Farrell*, 529 A.2d 404, 410-11 (N.J. 1987) (discussing the right of competent adults to refuse medical treatment).

19. *See infra* Part IV.

20. *See infra* Part IV.B.

21. *See infra* Part V.

from a competent adult before a medical procedure may be performed.²² Moreover, adults have a fundamental, though not unlimited, right to make their own decisions about medical treatment.²³ This fundamental right includes a right to refuse treatment—even lifesaving treatment—as well as a right, at least in some contexts, to access medical treatment without excessive interference by the state.²⁴ It is grounded in the substantive due process protection of decisional autonomy and bodily integrity.²⁵ As discussed below, although this doctrine also protects minors’ medical decision-making rights, those protections are subject to additional limitations unique to minors.²⁶

A more extensive and varied set of legal regulations generally governs minors’ access to medical treatment, however.²⁷ It is a commonplace that minors are assumed to be incompetent to give legally effective consent.²⁸ This presumed incapacity is not limited to the health care context, of course. For example, minors

22. See, e.g., GA. CODE ANN. § 31-9-6.1 (2009) (requiring that a doctor obtain informed consent from any patient undergoing any planned surgical procedure); *LaCaze v. Collier*, 434 So. 2d 1039, 1043 (La. 1983) (holding that a physician must obtain the patient’s consent before providing medical treatment). Informed consent requirements may be quite onerous for certain types of procedures. See, e.g., KY. REV. STAT. ANN. § 212.347 (West 2006) (prohibiting a physician from performing a nontherapeutic sterilization until twenty-four hours after the patient has requested such procedure and given written informed consent). Furthermore, various states impose a slew of informed consent requirements specific to abortion, including ultrasound viewing requirements, particularized information about the fetus, and information about alternatives to abortion. See Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 242-54, 261 (2009) (describing abortion-specific informed-consent laws, such as a South Dakota law requiring doctors to inform women that abortion terminates the life of “a whole, separate, unique living human being”).

23. B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 329 (2007).

24. *Cruzan v. Dir., Mo. Dep’t. of Health*, 497 U.S. 261, 278 (1990) (holding that a person has the right to refuse medical treatment under the Due Process Clause of the United States Constitution). Though the right to access treatment is less firmly established, it has been argued that such a right exists and is currently protected by constitutional doctrine. See Hill, *supra* note 23, at 329 (arguing that substantive due process protects the right of individuals to be free from government interference when making medical treatment decisions); see also Abigail R. Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209, 2212 (2011) (“As a handful of scholars have already pointed out, there is support in Supreme Court precedent for this kind of constitutional freedom of health.”); John A. Robertson, *Controversial Medical Treatment and the Right to Health Care*, 36 HASTINGS CENTER REP., Nov.–Dec. 2006, at 15, 15, 19 (2006) (arguing for a negative right to non-interference by the government in medical decision making); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1816 (2007) (asserting that individuals have a right to access medical care needed to protect their health).

25. See Hill, *supra* note 23, at 305.

26. See *infra* notes 78–93 and accompanying text.

27. See Dickens & Cook, *supra* note 1, at 179.

28. See FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE § 5.01[A] (4th ed. 2011); see also Mutcherson, *supra* note 1, at 259.

are also incompetent to form binding contracts.²⁹ Indeed, in some states, the minor's incapacity to provide consent for medical treatment is codified in a statute—either by negative implication, when a statute provides that individuals over a certain age are permitted to consent to treatment,³⁰ or by explicitly granting the power to consent to a minor's care to a parent or other guardian.³¹ Given this state of affairs, it is not surprising that commentators have, by and large, worked from the background presumption that parents do, and minors do not, have the legal authority to consent to a minor's medical treatment.³²

Despite the presumption of minors' inability to consent to medical treatment, the general rule is qualified by numerous exceptions, as commentators readily acknowledge.³³ First, medical emergencies require no consent; indeed, this is true for adults as well as children.³⁴ Additionally, numerous states allow certain classes of minors who are deemed sufficiently adult-like to consent to care as if they were adults.³⁵ This category of exception comprises emancipated-minor rules and mature-minor rules.³⁶ Emancipated minors are those that are found to be independent of their parents—such as minors who are living on their own and

29. See, e.g., *Simmons ex rel. Grenell v. Parkette Nat'l Gymnastic Training Ctr.*, 670 F. Supp. 140, 142 (E.D. Pa. 1987) ("It is hornbook contract law that a minor, with certain exceptions, is not competent to enter into a 'valid' contract."); RESTATEMENT (SECOND) OF CONTRACTS § 14 (1981) (stating that a person may not enter into an enforceable contract "until the beginning of the day before the person's eighteenth birthday").

30. See, e.g., 35 PA. CONS. STAT. ANN. § 10101 (West 2003) ("Any minor who is eighteen years of age or older . . . may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.").

31. See, e.g., MISS. CODE ANN. § 41-41-3 (1972) (listing those persons entitled to consent to treatment for an unemancipated minor, including parents, guardian, custodian, adult sibling or grandparent).

32. See *Little v. Little*, 576 S.W.2d 493, 495 (Tex. Civ. App. 1979) ("The general rule in this State is that a minor cannot consent to medical or surgical treatment."); see also Heather Boonstra & Elizabeth Nash, *Minors and the Right to Consent to Health Care*, GUTTMACHER REP. ON PUB. POL'Y, Aug. 2000, at 4, 4 (stating that states typically prefer a child's health care decision to be handled by parents); Mary Koll, *Growth, Interrupted: Nontherapeutic Growth Attenuation, Parental Medical Decision Making, and the Profoundly Developmentally Disabled Child's Right to Bodily Integrity*, 2010 U. ILL. L. REV. 225, 241 (2010) (supporting the propositions that "[c]hildren are generally considered legally incompetent to consent to their own medical treatment" and that parents can "consent to medical procedures on behalf of their children"); Mutcherson, *supra* note 1, at 263 (noting that in the case of adolescents, all health care decisions must be made with the consent of parents); Alicia Ouellette, *Shaping Parental Authority over Children's Bodies*, 85 IND. L.J. 955, 956 (2010) ("U.S. law allows parents extraordinary power over their children's bodies.").

33. See, e.g., Mutcherson, *supra* note 1, at 263, 269 (describing the exceptions to the general rule that minors lack the capacity to make their own medical decisions).

34. ROZOVSKY, *supra* note 28, § 2.02[B].

35. See, e.g., *Cardwell v. Bechtol*, 724 S.W.2d 739, 746–47 (Tenn. 1987) (adopting the mature-minor doctrine as a question for the trier of fact and noting that other states, such as Kansas and Ohio, have already adopted the mature-minor exception).

36. See Dickens & Cook, *supra* note 1, at 181–82 (explaining the mature-minor doctrine and the emancipated-minor exception); see also ROZOVSKY, *supra* note 28, § 5.01[B][3].

supporting themselves, or minors who are married or in the military.³⁷ The characteristics that make a minor emancipated are fixed by statute in some states, but the common law has also long recognized a more flexible category of emancipated minors, in which a jury or judge is entitled to determine that a minor is emancipated based on a panoply of characteristics that may indicate independence.³⁸ The mature-minor rule is similar to the common-law version of emancipation in that it generally calls for a case-by-case assessment of an individual minor's circumstances.³⁹ The mature-minor rule, however, focuses not on markers of independence but rather on the minor's capacity to give informed consent.⁴⁰ This determination, which is generally considered to be a question of fact for a jury in the tort context, requires an evaluation of a minor's ability to "appreciat[e] the nature, extent, and consequences of the conduct consented to" and to "weigh the risks and benefits."⁴¹ Thus, the determination may depend on factors such as "the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved."⁴²

Finally, all states have statutory exceptions allowing minors to consent to medical treatment for at least some purposes.⁴³ For example, all fifty states and the District of Columbia allow minors to seek testing and treatment for sexually transmitted diseases (STDs) without parental consent.⁴⁴ In addition, many states

37. ROZOVSKY, *supra* note 28, § 5.01[B][4], 5.02[A][1].

38. *See, e.g.*, Smith v. Seibly, 431 P.2d 719, 723 (Wash. 1967) (observing that "emancipation of minors may occur even in the absence of a statute" based on the following factors: "age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents").

39. *See Cardwell*, 724 S.W.2d at 745 (noting that the application of the mature-minor exception is a fact-intensive inquiry).

40. *Id.*; *see also* Younts v. St. Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330, 337 (Kan. 1970) (stating that a minor's ability to give informed consent is gauged by the minor's understanding of the risks and benefits of any given medical procedure).

41. *Cardwell*, 724 S.W.2d at 746 (quoting RESTATEMENT (SECOND) OF TORTS § 892A cmt. B (1979) and W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 18 (5th ed. 1984)).

42. *Id.* at 748. The court in *Cardwell* opined that the mature-minor doctrine should be understood in light of the traditional Rule of Sevens, which states: (1) a child under seven is irrebuttably presumed incapable of informed consent; (2) a child between seven and fourteen is presumed incapable of consent, but the presumption is rebuttable; and (3) a child between fourteen and the age of majority is presumed capable of consent, subject to being rebutted by evidence of incapacity. *Id.* at 749.

43. Boonstra & Nash, *supra* note 32, at 5 (noting that every state at least allows minors to obtain some form of treatment for sexually transmitted diseases absent parental consent).

44. *Id.* Some states include HIV in this category only to allow minors to consent to testing, but not treatment. *See, e.g.*, N.M. STAT. ANN. § 24-2B-3 (2007) (requiring a parent or guardian to provide consent on behalf of a child for all medical decisions, except when the child is seeking an HIV test to be performed on him or herself). Many states also include minimum ages for minors to consent to testing or treatment for STDs, which is usually twelve or fourteen. *See, e.g.*, CAL. FAM. CODE § 6926 (West 2004) (establishing the age of consent at twelve for diagnosis and treatment of infectious diseases); IDAHO CODE ANN. § 39-3801 (2011) (establishing the age of consent at fourteen for diagnosis and treatment of

allow minors to consent on their own to substance abuse treatment,⁴⁵ mental health services (on an outpatient basis),⁴⁶ examination and treatment for sexual assault,⁴⁷ prenatal care,⁴⁸ and contraceptive services.⁴⁹ A complex set of rules, moreover, governs minors' access to abortion.⁵⁰ Many states require parental consent or notification before a minor can receive an abortion,⁵¹ but the Constitution has been interpreted to require that a minor be given the opportunity to bypass that requirement by proving to a judge that she is sufficiently mature and well-informed to make the decision without parental involvement or that the abortion would be in her best interests.⁵² Most, if not all, of these exceptions to the parental consent requirement may be understood as serving the policy goal of not deterring minors from seeking certain kinds of health care.⁵³ The exceptions are apparently motivated by the view that an unacceptably high percentage of minors will decline to seek mental health or reproductive health care if they must involve their parents, and that it is better to encourage the treatment than to serve the parents' interests in being involved in their children's care.⁵⁴

infectious diseases). Unlike in the abortion context, *see infra* notes 50–52, those statutes permit covered minors to access services directly, without any judicial involvement.

45. *See, e.g.*, DEL. CODE ANN. tit. 16, § 2210 (2003) (permitting minors fourteen years of age and over to consent to substance abuse treatment); MASS. GEN. LAWS ANN. ch. 112, § 12E (West 2003) (permitting minors twelve years of age and over to consent to substance abuse treatment); MICH. COMP. LAWS ANN. § 333.6121 (West 2001) (stating that a minor's consent to substance abuse treatment is valid); 71 PA. STAT. ANN. § 1690.112 (West 1990) (permitting minors to consent to substance abuse treatment).

46. *See, e.g.*, MICH. COMP. LAWS ANN. § 330.1707 (West 1999) (permitting a minor, fourteen years of age and over, to consent to mental health treatment).

47. *See, e.g.*, 410 ILL. COMP. STAT. 210/3 (West 2011) (permitting a minor who is a victim of sexual abuse to consent to medical treatment without parental notification).

48. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.9132 (West 2001) (stating a minor's consent to prenatal care is valid and binding); N.D. CENT. CODE § 14-10-19 (2009) (permitting a physician to provide prenatal care to a minor through the first trimester, without parental consent); TENN. CODE ANN. § 63-6-223 (2010) (permitting a physician to provide prenatal care to a minor without parental consent).

49. *See, e.g.*, TENN. CODE ANN. § 68-34-107 (2006) (permitting minors to receive contraception supplies and information without parental consent).

50. *See* Boonstra & Nash, *supra* note 32, at 5–7 (explaining the varying state requirements for minors to gain access to an abortion).

51. *See, e.g.*, ALA. CODE § 26-21-33 (LexisNexis 2009); GA. CODE ANN. § 15-11-112 (2008); IND. CODE ANN. § 16-34-2-4 (LexisNexis 1993). For a list of other states requiring parental consent or notification prior to a minor obtaining an abortion, see Boonstra & Nash, *supra* note 32, at 6–7.

52. *See* Bellotti v. Baird, 443 U.S. 622, 643–44 (1979) (stating that a minor is entitled to show that she is mature and informed enough to make her own decision, or that the abortion is in the minor's best interest); *see, e.g.*, MASS. GEN. LAWS ANN. ch. 112, § 12S (West 2003) (requiring that if a minor's parents or guardian refuse to consent to her having an abortion, the minor may petition a court to authorize the physician to perform the abortion).

53. *See* Boonstra & Nash, *supra* note 32, at 8 (explaining the fear that sexually active minors will not obtain treatment if required to have their parents' consent).

54. *See* Walter Wadlington, *David C. Baum Memorial Lecture: Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. L. REV. 311, 324 (1994) (“These are situations where legislatures feared that minors would be unwilling to seek assistance or consent

This legal landscape appears, at first glance, to be one in which minors are generally incapable of consenting to health care on their own and in which parents are capable of consenting on their behalf, with certain clearly enumerated exceptions.⁵⁵ I will further interrogate this view in Parts III and IV, questioning whether it is truly an accurate description of the background assumptions animating the law of minors' access to medical treatment.⁵⁶ Before moving on to that critique, however, it is important to further refine the picture I have just sketched of the regulations surrounding consent to health care for minors. In particular, it is important to understand what is and is not entailed by the legal authority to consent to medical treatment.

First, the statutory authority to consent to medical treatment does not, in all cases, imply the authority to prevent the treatment by withholding consent.⁵⁷ For example, in Maryland a minor may consent to treatment for drug abuse or alcoholism without parental involvement, but the Maryland Health Code makes it clear that this capacity to consent "does not include the capacity to refuse treatment for drug abuse or alcoholism in an inpatient alcohol or drug treatment program . . . for which a parent or guardian has given consent."⁵⁸ Such statutes therefore function primarily as a way of encouraging treatment for certain conditions, rather than as a means of empowering minors to make treatment decisions.

Minors who are considered mature or emancipated, however, are understood to have the same capacity as adults to make health care decisions.⁵⁹ Therefore, they logically would have the authority to refuse treatment or to seek it, regardless of parental wishes. Nonetheless, this does not appear entirely to be the case.⁶⁰ In *In re*

from their parents. If minors could not personally consent to treatment, they might not obtain medical care – to the detriment of themselves, their families, and society.”). In addition, the statutes in many states concerning minors' access to abortion are motivated, in part, by a desire to respect minors' Fourteenth Amendment right to privacy. See J. Shoshanna Ehrlich & Jamie Ann Sabino, *A Minor's Right to Abortion – The Unconstitutionality of Parental Participation in Bypass Hearings*, 25 NEW ENG. L. REV., 1185, 1198–99 (1991) (discussing the minor's right to privacy in obtaining an abortion without parental consent). Yet, at least one commentator has argued that even the law granting minors' relatively liberal rights to access abortion must be understood as motivated primarily by concerns about the public health problem of teen pregnancy, and not by concerns about minors' rights. MARTIN GUGGENHEIM, WHAT'S WRONG WITH CHILDREN'S RIGHTS 237, 239–40 (2005).

55. See *supra* note 32 and accompanying text.

56. See *infra* Parts III–IV.

57. See Hartman, *supra* note 6, at 94 (explaining that some states allow minors to consent to health care but do not allow minors to refuse it).

58. MD. CODE ANN., HEALTH–GEN. § 20-102(c)(1)–(2), (c-1) (LexisNexis 2009); accord *Dep't of Health and Rehabilitative Servs. v. Straight, Inc.*, 497 So. 2d 692, 693–694 (Fla. Dist. Ct. App. 1986) (holding that parents are permitted to place a child in a drug treatment program without the minor's consent, notwithstanding a state statute that also grants minors the authority to consent to drug treatment).

59. See Dickens & Cook, *supra* note 1, at 181–82; see also ROZOVSKY, *supra* note 28, § 5.01[B][3].

60. See Hartman, *supra* note 6, at 94 (stating that some states “circumscribe adolescent medical decision making to choosing treatment rather than refusing it”). *But see* Lawrence Schlam & Joseph P.

E.G.,⁶¹ for example, the Illinois Supreme Court applied the mature-minor doctrine to allow a seventeen-year-old woman suffering from terminal leukemia to refuse blood transfusions for religious reasons but also held that, despite her maturity, the minor's decision would have to be weighed against the state's interests in "(1) the preservation of life; (2) protecting the interests of third parties; (3) prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."⁶² The court further noted that, had the minor's parent disagreed with her choice, that disagreement would have militated against respecting the minor's decision.⁶³ It is not clear, however, that this approach would be universally applied today.⁶⁴

Likewise, the authority of parents to consent to medical treatment on behalf of their children does not imply an authority to refuse treatment in all circumstances.⁶⁵ Parents are understood to have not only a right, but also a duty to provide health care for their children, which may be codified by statute or evidenced by common law.⁶⁶ Child neglect and abuse laws limit parents' ability to refuse care—and possibly their ability to consent to nontherapeutic care as well, such as plastic surgery or an organ donation to a sibling.⁶⁷ Parents have authority to consent to, or withhold consent for, health care for their children that is routine but not, strictly speaking, medically necessary.⁶⁸ For example, parents can choose either to

Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 151 (2000) (describing mature-minor laws as "allowing minors 'who can understand the nature and consequences of the medical treatment offered,' the right to consent to *or refuse* treatment") (emphasis added).

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

62. *Id.* at 328. The court in *In re E.G.* derived the four state interests from *Superintendent of Belchertown State School v. Saikewicz*, in which the Massachusetts Supreme Judicial Court delineated the factors to be considered in deciding whether a guardian ad litem could refuse chemotherapy for a mentally incompetent adult. 370 N.E.2d 417, 425 (Mass. 1977).

63. *In re E.G.*, 549 N.E.2d at 328.

64. Both *Saikewicz* and *In re E.G.* were decided before the U.S. Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*, in which the Court articulated a substantive due process right for competent adults to refuse even life-saving medical treatment. 497 U.S. 261, 281 (1990).

65. *See* Wadlington, *supra* note 54, at 319–20 (quoting *In re Sampson*, 317 N.Y.S.2d 641, 654 (1970), which states that a court can intervene when there is an emergency and a minor needs medical care, even over the parents' objections).

66. *See id.* at 317–18 (referring to *In re Hudson*, 126 P.2d 765, 783 (Wash. 1942), which argued that "in cases involving child protection, courts may not intervene independent of some clear statutory mechanism authorizing intervention," but doubting the prevalence of such a view and further asserting that "[e]ven if a court holds such a view . . . there is now ample authority for judicial intervention in cases involving medical care for children under child protection, neglect, or abuse statutes").

67. Professor Alicia Ouellette asserts that parents' ability to consent to cosmetic "shaping" and other nonbeneficial surgeries is virtually unlimited; however, it is at least a plausible interpretation of child abuse laws to say that they would forbid such manipulation of children's bodies. *See* Ouellette, *supra* note 32, at 966–67, 971.

68. *See id.* at 966–67 ("The general rule, applicable in almost all situations, is that a parent is free to sort among alternatives and elect the course of treatment based on his or her assessment of the child's best interests.").

withhold or consent to treatment for mild ailments such as antibiotics for respiratory infections, and they may authorize or decline minor surgery such as ear tubes (myringotomy) to prevent recurring ear infections.⁶⁹ But with medical treatment that is required to prevent serious harm to the child, it may be accurate to say that parents both can and must consent on behalf of their children.⁷⁰ Unsurprisingly, of course, the line between these two types of medical care can be blurry.⁷¹

Finally, there are some areas in which neither parents nor children have authority to consent to treatment.⁷² Instead, court authorization is required in particular circumstances where the child is not mature or competent and there is reason to doubt that parents will always act solely in the child's best interests.⁷³ Primarily, the law has removed decision-making power from the reach of both children and parents where sterilization of mentally incompetent children and organ donation are involved.⁷⁴ In the former case, the removal of parental authority is motivated by the concern that parents will act out of fear of having to bear the burden of a child's future unwanted pregnancy, rather than vindicating the child's best interests.⁷⁵ In the latter case, particularly when organ donation to a sibling is at issue, courts may override parental authority when they are concerned that the parents cannot reasonably evaluate the best interests of both children.⁷⁶ Finally, as discussed below, courts may override parents' decision making for an immature minor seeking an abortion if the abortion is determined to be in her best interests.⁷⁷

69. See *In re Hofbauer*, 393 N.E.2d 1009, 1013 (N.Y. 1979) (stating that it is not necessary for parents to get medical treatment for their children every time something is wrong with the child); *Custody of a Minor*, 379 N.E.2d 1053, 1062 (Mass. 1978) (stating that courts are very hesitant to overturn parental objections to medical treatment where the child's life is not in danger).

70. Ouellette, *supra* note 32, at 968 (quoting *Parham v. J.R.*, 442 U.S. 584, 603 (1979)).

71. See 2 DONALD T. KRAMER, *LEGAL RIGHTS OF CHILDREN* § 16:11, at 58–63 (rev. 2d ed. 2005) (asserting that parental medical neglect is not easy to define because not all types of medical care are necessary according to different states and courts). Kramer notes that parents have a duty to provide medical care that is necessary in that it will save the child's life in most instances; however, there are situations where less threatening conditions will be deemed by courts to require parents to provide medical care. *Id.*

72. *Parham*, 442 U.S. at 603.

73. See, e.g., Koll, *supra* note 32, at 246 (noting that courts have authority over parents to decide whether sterilization of mentally incompetent children is appropriate, due to the potential conflict of interest parents may experience).

74. *Id.* at 246–47.

75. *Id.* at 246.

76. *Id.* at 246–47. Compare *Curran v. Bosze*, 566 N.E.2d 1319, 1345 (Ill. 1990) (holding that a father's desire to have his three-year-old twins undergo a bone marrow harvesting procedure on behalf of their half-brother was not in the children's best interests), with *Hart v. Brown*, 289 A.2d 386, 391 (Conn. Super. Ct. 1972) (holding that it would be unjust to deny parents, with honorable intentions, the right to consent to one twin's donating a kidney to the other).

77. See *infra* note 90 and accompanying text.

Moreover, constitutional constraints come into play in various ways.⁷⁸ A number of constitutional provisions may apply to medical decision making for minors, sometimes in ways that conflict.⁷⁹ Perhaps the most commonly cited constitutional right in this context is the right of parents to take care of their children, sometimes referred to as a right to family privacy.⁸⁰ First identified as an aspect of substantive due process in *Meyer v. Nebraska*⁸¹ and *Pierce v. Society of Sisters*,⁸² the contours of this right are not entirely clear, but it is often invoked in order to assert that parents have the authority to make medical decisions on behalf of their children, without undue interference from the state.⁸³ Similarly, the Free Exercise Clause of the First Amendment⁸⁴ may, in some cases, protect parents' rights to refuse medical treatment for their children because of the parents' religious beliefs.⁸⁵ Since free exercise rights and parental rights are often invoked in tandem in medical decision-making cases, it is not always obvious which one is most important to the analysis, or whether they differ in scope.⁸⁶

78. Though this paragraph is intended to refer primarily to federal constitutional constraints, some state constitutions may contain provisions that differ from the federal Constitution and that affect medical decision making. For example, the California Constitution contains explicit protection for the right to privacy, which has been interpreted to grant broader protection than the federal constitution grants to minors seeking reproductive health care services. *See Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 808 (Cal. 1997) (discussing CAL. CONST. art. I, § 1 and its broader protections not afforded by the federal constitution); *In re T.W.*, 551 So. 2d 1186, 1188 & n.1, 1194, 1196 (Fla. 1989) (holding that a Florida state law requiring parental consent for minors seeking abortions violated the Florida Constitution's right to privacy).

79. *See infra* notes 180–85 and accompanying text.

80. *See Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534–35 (1925) (discussing parents' rights to raise their children without state interference).

81. 262 U.S. 390 (1923).

82. 268 U.S. 510 (1925).

83. *Meyer*, 262 U.S. at 399–410; *Pierce*, 268 U.S. at 534–35. *See, e.g.*, *Spiering v. Heineman*, 448 F. Supp. 2d 1129, 1142 (D. Neb. 2006) (rejecting the argument that a newborn metabolic testing law violated parental rights).

84. U.S. CONST. amend. I (“Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . .”).

85. *See, e.g., In re Green*, 292 A.2d 387, 392 (Pa. 1972) (“[A]s between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is not immediately imperiled by his physical condition.”) (emphasis omitted). I have argued elsewhere, however, that cases involving medical decision making on behalf of children do not actually turn in any meaningful way on the free exercise claim and that courts instead usually consider only the medical facts and the best interests of the child. B. Jessie Hill, *Whose Body? Whose Soul? Medical Decision-Making on Behalf of Children and the Free Exercise Clause Before and After Employment Division v. Smith*, 32 CARDOZO L. REV. 1857, 1859 (2011); *cf. Wadlington, supra* note 54, at 326 (stating that less clear-cut cases “have ostensibly been decided not on the parents’ asserted religious objection, but on whether the facts called for intervention in the particular case,” and suggesting “that parental religious objections may be an unstated factor for some courts in resolving especially difficult or ‘long shot’ cases”).

86. *Spiering*, 448 F. Supp. 2d at 1139–40.

As discussed in greater depth in Part IV, minors also possess constitutional rights that weigh against parental rights.⁸⁷ First, minors have a right to access abortion, at least in some circumstances, without parental involvement.⁸⁸ In a series of cases involving state statutes requiring parental consent or notice before a minor obtains an abortion, the Supreme Court outlined the contours of minors' constitutional privacy rights.⁸⁹ Specifically, the Court held that states could not require parental consent for minors seeking abortions unless they also provided a mechanism by which the minor could seek judicial permission to obtain an abortion on her own, upon a showing that she was mature and well-informed enough to consent to the procedure, or that the abortion would be in her best interests.⁹⁰ Though it does not appear that this doctrine has been widely applied in cases outside the reproductive health care context, it nonetheless seems likely that minors possess some sort of right to bodily integrity that may limit the power of the state to restrict their health care choices.⁹¹ Finally, when confinement for treatment is at issue, the Supreme Court has held that minors have a protected liberty interest and a procedural due process right not to be arbitrarily deprived of their liberty.⁹² Though hardly a robust entitlement, this right does minimally ensure that unwilling

87. See *infra* notes 159–79 and accompanying text.

88. See *supra* note 52 and accompanying text.

89. See *Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502 (1990) (upholding a one-parent notification requirement with a judicial bypass option, despite the heightened evidentiary standard imposed on minors seeking the bypass); *Hodgson v. Minnesota*, 497 U.S. 417, 423 (1990) (holding that a statute requiring both parents be notified when a minor attempts to get an abortion was unconstitutional, but upholding the allowance of a judicial bypass for the requirement of parental notice); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983) (upholding a one-parent consent requirement with a judicial bypass option); *H.L. v. Matheson*, 450 U.S. 398 (1981) (upholding a state law requiring notification of parents where possible, as applied to an immature minor); *Akron v. Akron Ctr. For Reprod. Health*, 462 U.S. 416, 441–42 (1983) (striking down a one-parent consent requirement where the state had created no procedures for seeking a judicial bypass); *Bellotti v. Baird*, 443 U.S. 622, 643–44 (1979) (holding that the Massachusetts statute was unconstitutional because a mature and competent minor can make an independent decision regarding abortion, and the statute required parental notification without allowing a minor to seek an independent judicial assessment as to her competency to get an abortion); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (holding that states may not impose a blanket requirement of parental consent for all minors seeking abortions).

90. *Baird*, 443 U.S. at 643–44. In *Hodgson*, a fractured Court struck down a two-parent notification statute without a judicial bypass mechanism, but upheld the same law when the bypass was included. 497 U.S. at 423.

91. See *In re E.G.*, 549 N.E.2d 322, 326 (Ill. 1989) (holding that “mature minors may possess and exercise rights regarding medical care that are rooted in this State’s common law”). Cf. *Dubbs v. Head Start, Inc.*, 336 F.3d 1194, 1203 (10th Cir. 2003) (acknowledging that minors may have a bodily integrity interest, grounded in substantive due process, in avoiding nonconsensual medical examinations, but holding that this issue is “more precisely addressed under the Fourth Amendment”).

92. See, e.g., *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (holding that individuals committed to state institutions have a protected liberty interest under the Due Process Clause of the Fourteenth Amendment that reasonably requires a safe institutional setting, non-excessive use of bodily restraints, and any necessary training to eliminate the need for restraints).

minors will not be committed to an in-patient institution without the approval of a neutral fact finder, even if the parents wish to commit them.⁹³

In summary, the landscape of rules governing minors' access to health care is complex. The mature-minor doctrine, as well as statutes and common-law rules pertaining to the emancipation of older minors, particularly complicates matters when adolescents are involved. Though parents have the right to consent or withhold consent for their children's treatment in many situations, this right is not absolute.⁹⁴ There are limits—albeit not always clear ones—on parents' rights both to require and to withhold particular kinds of care.⁹⁵

III. THE DESCRIPTIVE CASE

Having set forth the basic lay of the land with respect to medical decision making for minors in the preceding Part, this Article now turns to a critique of two often-articulated “background assumptions” regarding minors' ability to consent to health care. Leaving aside normative concerns, Part III questions whether those two assumptions—first, that minors have no legal authority to consent on their own to health care and second, that parents have the legal authority to consent to their

93. *Parham v. J.R.*, 442 U.S. 584, 606 (1979). *Parham* has been widely criticized as insufficiently protective of minors' rights. See, e.g., Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 701–03 (1993) (criticizing *Parham's* assumption that parents and physicians almost always act in their children's best interests with respect to institutionalization); Alexander V. Tsesis, *Protecting Children Against Unnecessary Institutionalization*, 39 S. TEX. L. REV. 995 (1998) (arguing that *Parham* is insufficiently protective of minors' due process rights).

94. See *Hodgson*, 497 U.S. at 471 (asserting that parental authority is not “limitless” and yields if the parental authority threatens harm to the minor).

95. *Id.* In addition, the concept of pediatric *assent* is sometimes applied in a clinical setting to ensure that children who are not yet competent to make their own decisions nonetheless accept the proposed treatment to the extent that they are able to do so. According to the American Academy of Pediatrics (AAP) Committee on Bioethics, assent should be sought from patients under the age of eighteen. The AAP defines assent as:

1. Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition.
2. Telling the patient what he or she can expect with tests and treatment(s).
3. Making a clinical assessment of the patient's understanding of the situation and factors influencing how he or she is responding (including whether there is appropriate pressure to accept testing or therapy).
4. Soliciting an expression of the patient's willingness to accept the proposed care.

Comm. on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 314–15 (1995). The AAP also emphasizes that “[i]n situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived.” *Id.*; see also Amy T. Y. Lai, *To Be or Not To Be My Sister's Keeper?*, 32 J. LEGAL MED. 261, 281–82 (2011). It does not appear that the concept of assent has yet been influential in the legal domain, outside the context of research and testing on minors. See, e.g., LORI B. ANDREWS ET AL., GENETICS: ETHICS, LAW AND POLICY 408–422 (2010) (discussing the law and ethics of genetic testing of children and adolescents).

minor children's health care—are accurate, in purely descriptive terms.⁹⁶ Indeed, this Part contends that these two propositions cannot properly be considered true background presumptions.⁹⁷ Even if they may have been descriptively accurate statements of the default rules at one time, they are no longer entirely true.

To understand the complexity of the two assumptions, it is important to define exactly what is being challenged here. I am willing to accept that the two propositions I have identified are accurate descriptions of what occurs in most—indeed, in the overwhelming majority—of cases. I am also willing to assume that most medical providers take these two propositions as basic guidelines for most run-of-the mill cases.⁹⁸ Indeed, I do not doubt their applicability even when adolescents are involved. I do, however, question whether they may accurately be described as *background assumptions* or *default rules*, particularly with respect to adolescents.

The characterization of these two propositions as not just descriptions of what is normally required or what normally occurs but rather as background assumptions or default rules is significant. To characterize them as such implies that adolescents, even older adolescents, have no right to consent or withhold consent to medical care on their own in the absence of an explicit legal grant of authority. It thus suggests that, absent explicit legal warrant, a medical provider can be held liable for battery for treating an adolescent patient without obtaining parental consent.⁹⁹ Moreover, as discussed in greater depth below, characterizing these propositions as default rules means that constitutional challenges are likely to arise only when the state acts to undermine, rather than enforce, parental control over minors' treatment.¹⁰⁰ As a result, minors' constitutional right to bodily integrity remains under-developed with respect to medical treatment.¹⁰¹

One obvious starting point for the descriptive critique would be to point out that a rule so heavily riddled with exceptions must cease to be considered a valid

96. See *infra* notes 99–129 and accompanying text.

97. See *infra* notes 99–129 and accompanying text.

98. But see Hartman, *supra* note 6, at 111 (reporting that roughly two-thirds of physicians permit adolescent patients to make decisions about their care even when the parent disagrees with the adolescent's choice); see also *id.* at 116–18 (finding significant confusion among physicians about the legal requirements pertaining to consent for treatment of adolescent patients); Ryan E. Lawrence et al., *Adolescents, Contraception and Confidentiality: A National Survey of Obstetrician-Gynecologists*, 84 *CONTRACEPTION* 259, 262 (2011) (finding, based on a “national representative survey,” that ninety-four percent of ob/gyn physicians would likely prescribe birth control pills for a seventeen-year-old college student without informing her parents).

99. See *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 336 (Kan. 1970) (noting that health care providers risk being liable for trespass or battery if they do not obtain consent from patients and/or persons authorized to consent on behalf of incompetent patients for non-emergency surgical procedures).

100. See *infra* Part IV.A.2.

101. See *infra* Part IV.A.2–3.

rule.¹⁰² Yet, the existence of multiple exceptions does not effectively undermine a rule's status as a governing default principle. The Fourth Amendment's warrant requirement,¹⁰³ for example, may be qualified by so many exceptions that it is irrelevant in the vast majority of cases,¹⁰⁴ but no one would take the position that American criminal procedure has no default warrant requirement.¹⁰⁵ In the absence of a particular exception, the requirement must still govern.¹⁰⁶ The same, then, might be said of the two propositions regarding consent for minors' medical treatment.

But not all exceptions are alike. Carefully defined, limited statutory exceptions that permit minors to access certain kinds of treatment—for example, substance abuse counseling or treatment for sexually transmitted infections—do not undermine the generality of the rule and, in fact, reinforce it.¹⁰⁷ As statutory provisions in derogation of the common law, they reinforce the notion that the default rule is still provided by the common law—and that parental consent is required in every case that is not covered explicitly by statute.¹⁰⁸ The mature-minor and common-law emancipation doctrines function differently, however.¹⁰⁹ They hold that certain minors are sufficiently mature or independent to function as adults, and therefore may consent to their own health care, regardless of their

102. *Cf.* FORREST McDONALD, *NOVUS ORDO SECLORUM: THE INTELLECTUAL ORIGINS OF THE CONSTITUTION* 33 (1985) (describing the early American law of trespass as containing “so many exceptions as to be inconsequential,” except in limited circumstances).

103. U.S. CONST. amend. IV.

104. *See, e.g.*, *California v. Acevedo*, 500 U.S. 565, 582 (1991) (Scalia, J., concurring) (contending that “the ‘warrant requirement’ ha[s] become so riddled with exceptions that it [is] basically unrecognizable”).

105. *Id.* at 569 (describing the evolution of the present day warrant requirement).

106. *See id.* at 580 (finding that a warrant is always needed for a search, absent certain exceptions); *cf.* *Illinois v. McArthur*, 531 U.S. 326, 330 (2001) (asserting that seizures are unreasonable unless pursuant to warrant, though there are exceptions for “special law enforcement needs, diminished expectations of privacy, [or] minimal intrusions . . .”).

107. *See supra* notes 44–49 and accompanying text.

108. In addition, as statutes in derogation of the common law, they are to be read narrowly. *See, e.g.*, *Cardwell v. Bechtol*, 724 S.W.2d 739, 744 (Tenn. 1987) (noting that statutes providing exemptions to the common-law rule should be strictly interpreted).

109. To determine whether a minor is emancipated, for the purposes of making health care decisions, courts will consider various factors that indicate whether the minor can function independently as an adult. *See Ison v. Fla. Sanitarium & Benevolent Ass’n*, 302 So. 2d 200, 201–02 (Fla. Dist. Ct. App. 1974) (declaring the minor “emancipated” when she left her parents’ home permanently and “had become completely self-supporting”); *see also Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337–38 (Kan. 1970) (finding a seventeen-year-old mature enough to consent to a fingertip skin graft); *see generally* Carol Sanger & Eleanor Willemsen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. MICH. J.L. REFORM 239 (1992) (discussing statutory factors, such as age, living apart from one’s parents and managing one’s financial affairs, as satisfactory indicia of independence to justify emancipation of minor).

parents' views on the matter.¹¹⁰ Those doctrines are fundamentally inconsistent with a common-law default rule that *every* minor (absent an explicit statutory exception) must have parental consent in order to be treated.

The mature-minor and common-law emancipated-minor doctrines are inconsistent with the default assumption because they conflict directly with it, and they create the possibility of an exception in every case, without limitation.¹¹¹ Because they are common-law creations, the mature-minor and emancipated-minor doctrines need not be read narrowly, and courts are free to adopt them at any time, unless a particular state's legislature or highest court has already rejected the option.¹¹² The very logic of these exceptions—that some minors, despite being below the age of majority, are sufficiently independent or mature to make their own medical decisions—runs directly contrary to the background presumption that adolescents are incapable of consenting on their own, and therefore, require their parents to consent on their behalf.¹¹³

Thus, although one court warned, in adopting the mature-minor doctrine, that the court was not “alter[ing] the general rule requiring parental consent for the medical treatment of minors,” it is difficult to see how this statement can be true.¹¹⁴ By definition, mature-minor and emancipated-minor rules hold that, in any given case, parental consent may not be required before treating a minor, if the minor meets the relevant requirements.¹¹⁵ Indeed, it must be said that, in those jurisdictions that have adopted mature-minor rules, the general rule is in fact that parental consent is required for the medical treatment only of immature minors. Of course, given the highly contextual, fact-specific nature of the mature-minor and emancipated-minor common-law doctrines, providers may be loath to avail themselves of the rule, taking the chance that a jury will find in their favor on the issue of a given minor's maturity.¹¹⁶ But this practicality does not make the mature-

110. See, e.g., *Cardwell*, 724 S.W.2d at 748–49 (finding that if a minor has the capacity to consent to and appreciate the nature, risks and consequences of medical treatment, the minor functions as an adult when making decisions on medical treatment).

111. Some state laws, however, specify a minimum age for a minor to be considered emancipated or mature. See, e.g., ALA. CODE § 26-13-1 (LexisNexis 2009) (stating that minors over eighteen have their “disabilities of nonage” removed under certain circumstances); CAL. FAM. CODE § 7120 (West 2004) (stating that a minor must be at least fourteen years old to petition for a declaration of emancipation).

112. In *Cardwell v. Bechtol*, the Tennessee Supreme Court first adopted the mature-minor exception. 724 S.W.2d 739, 745–46, 749 (1987). While doing so, the court engaged in a lengthy discussion of the common law, noting that “inherent in the jurisprudence of the common law is the power of courts to develop and adapt the principles of its application.” *Id.* at 744.

113. See sources cited *supra* note 32.

114. *Cardwell*, 724 S.W.2d at 749.

115. ROZOVSKY, *supra* note 28, § 5.01[B][3]–[4].

116. See, e.g., ROZOVSKY, *supra* note 28, § 5.01[B][3] (discussing the difficulty for health care providers in applying the mature-minor doctrine, because it forces them to make subjective judgments about the minor's ability to consent to treatment). But, as noted above, many providers treat adolescents without securing parental permission, regardless of their understanding of, or confusion about, the law. See Hartman, *supra* note 6, at 111; Lawrence et al., *supra* note 98, at 262.

or emancipated-minor rule any less of a direct challenge to the presumed background or default rule regarding consent for medical treatment on older minors and adolescents.¹¹⁷

It is ironic, in this regard, that minors perhaps possess their most expansive and well-defined rights to consent to medical treatment in the abortion context.¹¹⁸ Both constitutional law and state statutes set out a detailed set of rules about when and how minors may access abortion without involving their parents.¹¹⁹ This state of affairs came about because states began adopting parental consent requirements for abortion shortly after the Supreme Court's decision in *Roe v. Wade*.¹²⁰ Those statutes were challenged as unconstitutional,¹²¹ and a body of constitutional

117. *Cardwell*, 724 S.W.2d at 748–49. This case highlights how the general rule that minors lack the legal capacity to make informed medical decisions and the mature-minor rule cannot apply to the same situation simultaneously. *Id.* Where one rule is applicable, the other “rule should not apply.” *Id.*

118. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36–2152 (2009 & Supp. 2011) (outlining the judicial procedures for a minor to seek a court order authorizing a physician to perform an abortion without the consent of a parent or guardian). This is true as a matter of legal principle, though not necessarily in reality. *See* Cynthia Dailard & Chinué Turner Richardson, *Teenagers' Access to Confidential Reproductive Health Services*, GUTTMACHER REP. ON PUB. POL'Y, Nov. 2005, at 6, 9 (stating that judicial bypasses provided by state laws, to assist minors in obtaining an abortion without parental consent, can take significant time, thereby delaying the abortion procedure). The judicial bypass requirement is a significant deterrent to minors' access to abortion. *See, e.g.*, *Hodgson v. Minnesota*, 497 U.S. 417, 475–76 (1990) (Marshall, J., concurring in part and dissenting in part) (observing that Minnesota's judicial bypass procedure caused delays for minors that could “significantly increase the health risk to the minor”); Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18 COLUM. J. GENDER & L. 409, 472–73 (2009) (arguing that some state legislatures have implemented judicial bypass options that purport to preserve a minor's right to an abortion, while actually functioning as an additional obstacle to a minor's enjoyment of this right); *see also* Michelle Fine & Sara I. McClelland, *The Politics of Teen Women's Sexuality: Public Policy and the Adolescent Female Body*, 56 EMORY L.J. 993, 1023–24 (2007) (identifying the multiple obstacles young women face when attempting to utilize the judicial bypass option afforded in many states, including differences in accessibility of waivers, the burden of scheduling a hearing, travel costs for the minor, and judges recusing themselves because of moral objections).

119. *Ohio v. Akron Ctr for Reprod. Health*, 497 U.S. 502, 515–19 (1990) (explaining that states can implement procedural requirements before a minor may obtain an abortion). *See, e.g.*, ARIZ. REV. STAT. ANN. § 36–2152 (2009 & Supp. 2011) (outlining the judicial procedures for a minor to seek a court order authorizing a physician to perform an abortion without the consent of a parent or guardian); 13 GA. CODE ANN. §15-11-112(b) (2008) (permitting a minor to petition a court in order to obtain an abortion without parental consent).

120. 410 U.S. 113 (1973); *see* Jon F. Merz et al., *A Review of Abortion Policy: Legality, Medicaid Funding, and Parental Involvement, 1967-1994*, 17 WOMEN'S RTS. L. REP. 1, 9 n.59 (1995) (citing *Analysis: A Review of State Abortion Laws Enacted Since January 1973*, 4 FAM. PLAN./POPULATION REP. 108, 109 (1975)) (asserting that between the *Roe* decision and December 1975, fourteen states passed parental consent laws); *see also* Virginia G. Cartoof, *Massachusetts' Parental Consent Law: Origins, Implementation and Impact 83–84* (Nov. 1984) (unpublished Ph.D. dissertation, Brandeis University) (on file with the Journal of Health Care Law & Policy) (stating that between 1974 and 1982, sixty-six statutes were enacted requiring parental or judicial consent for minors' abortions).

121. ROZOVSKY, *supra* note 28, § 5.03[C][1] (discussing the constitutional challenges that ensued following the enactment of statutes requiring parental consent and the resulting Supreme Court cases such as *Planned Parenthood of Cent. Mo. v. Danforth*, 438 U.S. 52 (1976), *Bellotti v. Baird*, 428 U.S. 132 (1976), and *Bellotti v. Baird*, 443 U.S. 622 (1979)).

doctrine eventually developed to describe the manner in which states could constitutionally regulate minors' access to the procedure.¹²² The irony arises because legislatures' attempts to constrain minors' access to abortion instead resulted, arguably, in greater access to that procedure than to others.

Indeed, one might reasonably ask why those statutes were necessary at all, if the default rule is that physicians must seek parental consent before performing any surgical procedure on a minor.¹²³ If the requirement of parental consent were the default presumption for all medical treatment on minors, there would be no need to legislate that requirement specifically in the abortion context. Nothing in the Supreme Court's *Roe* opinion directly undermined this purported background rule.¹²⁴ Indeed, there is no warrant for automatically assuming that any decision recognizing the constitutional rights of adults would apply in the same way to children.¹²⁵

There are a number of possible explanations. There might have been some doubt about the scope of the *Roe* decision in its application to minors.¹²⁶ Alternatively, the legislation may have been motivated by anti-abortion sentiment and designed both to reinforce the requirement of parental consent and to impose stricter penalties for its violation.¹²⁷ It is also possible that both the mature-minor and emancipated-minor doctrines may have been understood to empower minors

122. *Ohio v. Akron Ctr for Reprod. Health*, 497 U.S. 502, 515–17 (1990) (holding that restrictions on a minor's ability to obtain an abortion, including pleading requirements and a clear and convincing evidence standard to demonstrate that an abortion is in the minor's best interests, do not violate due process); *Bellotti v. Baird*, 443 U.S. 621, 635–48 (1979) (holding that states requiring parental consent prior to an abortion must provide for an alternative court proceeding that bypasses parental consent, whereby the minor has the opportunity to demonstrate to a judge that an abortion is in her best interests); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74–75 (1976) (holding that although a state may implement procedural safeguards when a minor seeks an abortion, it may not "impose a blanket provision . . . requiring the consent of a parent or person *in loco parentis* as a condition for abortion").

123. *See Merz et al.*, *supra* note 120, at 11 ("The fact that numerous states have enacted abortion-specific parental consent laws is curious. At common law, minors were, and are still, generally considered incapable of providing consent to medical care."); *cf. Danforth*, 428 U.S. at 75 (noting that the invalidation of a state statute requiring parental consent for a minor to receive an abortion does not mean that every minor may "give effective consent for termination of her pregnancy").

124. *See, e.g., Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 899 (1992) (discussing the longstanding rule that states may impose parental consent requirements on minors seeking abortions "provided that there is an adequate judicial bypass procedure").

125. *Cf. Crooks v. Kline*, No. 06-3313-RDR, 2007 U.S. Dist. LEXIS 23392, at *17–19 (D. Kan. Mar. 27, 2007) (declining to apply the holding of *Lawrence v. Texas*, 539 U.S. 558 (2003), regarding consensual homosexual sodomy to sex between an adult and a minor, and noting that the decision did not involve minors).

126. *See Roe v. Wade*, 410 U.S. 113, 165 n.67 (1973) (declining to consider the validity of a statute that requires an unmarried minor to obtain parental consent for an abortion).

127. *See Merz et al.*, *supra* note 120, at 12 (noting that abortion-specific consent laws "clarify providers' legal duties, which may have been uncertain under Supreme Court decisions" and "enhance common law adherence by providers by threatening the use of heightened civil and criminal sanctions"); *see also Cartoof*, *supra* note 120, at 94–107 (documenting the powerful anti-abortion sentiment that led to the adoption of Massachusetts' abortion parental consent statute).

seeking abortions; indeed, some state statutes include pregnancy as one of the markers of emancipation, though it is uncommon for state laws to consider pregnancy a sufficient condition for emancipation.¹²⁸ In addition, legislators may have worried that state statutes permitting minors to consent to pregnancy-related care would include a right to seek abortion without parental involvement. Nonetheless, the widespread and immediate adoption of parental consent laws for abortion in the wake of *Roe v. Wade* suggests that the background assumption of adolescents' legal incompetence is not as firm as the language of courts and commentators tends to suggest: there would have been virtually no need for those statutes, after all, if parental consent were already required under the common law.¹²⁹

This Part has thus raised the question whether the two propositions described at the start of this article—that minors are legally incapable of consenting to health care on their own and that parents have legal authority to consent for them—can and should be understood as true background assumptions or legal default rules. Instead, there is reason to doubt that those propositions truly describe the requirements that providers and patients must observe in the absence of any explicit statutory authority to the contrary. The next Part will make the case that the U.S. Constitution, and especially the doctrine that has developed around minors' rights to access abortion, also give reason to question the validity of those two propositions. Part IV also gives greater context to this issue, explaining why it is important to determine whether they are truly default rules, as opposed to mere descriptions of what happens in most cases.

IV. THE CONSTITUTIONAL CASE

This Article has already described some of the constitutional constraints that apply to medical decision making by and on behalf of minors.¹³⁰ The Free Exercise Clause, as well as the requirements of procedural due process, may constrain the

128. See, e.g., 35 PA. CON. STAT. ANN. § 10101 (West 2003) (“Any minor who is eighteen years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.”) (emphasis added). New York’s emancipation law explicitly provides that pregnant minors are emancipated, but only for the purpose of consenting to prenatal care. N.Y. PUB. HEALTH LAW § 2504(1)–(3) (McKinney 2002 & Supp. 2011). See also *Hodgson v. Minnesota*, 497 U.S. 417, 423–24 (1990) (noting that an early version of Minnesota’s Minors’ Consent to Health Services Act allowed minors to consent to medical treatment relating to pregnancy, and that the statute, “unlike others of its age, applied to abortion services”).

129. See Hill, *supra* note 85, at 1873–74 (arguing that the legal backdrop for medical decision-making on behalf of children is not clear and cannot be said to include a true entitlement of parents to withhold or consent to care for their children). *But cf.* J. Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents*, 18 BERKELEY WOMEN’S L.J. 61, 64 (2003) (asserting that the enactment of parental notification laws subsequent to the *Roe v. Wade* decision demonstrated the view of adolescent decisional incapacity).

130. See *supra* notes 78–93 and accompanying text.

state's options in allocating decision-making authority.¹³¹ More interestingly, perhaps, two constitutional rights have the potential to clash directly in this realm: the parents' rights to make decisions about the care and upbringing of their children free from state interference,¹³² and minors' rights to bodily integrity.¹³³ Though parental rights are sometimes cited as support for the proposition that parents can consent to medical treatment for adolescents, who cannot consent on their own, this Part argues that the legal recognition of minors' rights to bodily integrity significantly complicates the situation. In addition, this Part argues that the problem of locating state action, which is inevitably implicated in identifying and vindicating both parental rights and bodily integrity rights under the Constitution, highlights the fact that there is no true legal default rule in these cases.¹³⁴ Because, contrary to the articulations of some courts and commentators, there is no clear, functioning default rule, courts struggle to identify state action and governmental coercion when conducting a constitutional analysis in the context of medical decision making for minors.¹³⁵

A. *Some Constitutional Clarity*

There is much that is indistinct in the constitutional jurisprudence surrounding medical decision-making for older minors, but at least a few propositions are clear. First, parents possess a constitutional right to control their children to some extent and in some contexts.¹³⁶ Though the exact scope and nature of that right are not well established, it is understood to limit the state's involvement in parents' decision making for their children.¹³⁷ Second, children possess a constitutional right to bodily integrity that has some implications for the degree to which parents can be involved in their medical decision making—though, again, the nature and scope of that right are not entirely clear.¹³⁸ Third, the more robust one of these rights is understood to be, the more likely it is to conflict with the other.¹³⁹ The remainder of this subpart is thus devoted to fleshing out the constitutional dimensions of minors'

131. See *supra* notes 78–93 and accompanying text.

132. See *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534–35 (1925) (discussing parents' rights to raise their children without state interference).

133. Cf. Melissa Prober, *Please Don't Tell My Parents: The Validity of School Policies Mandating Parental Notification of a Student's Pregnancy*, 71 BROOK. L. REV. 557, 564–66 (2005) (explaining the constitutional framework for minors' rights to bodily integrity).

134. See *infra* text accompanying notes 180–190.

135. Compare *Alfonso v. Fernandez*, 606 N.Y.S.2d 259, 265 (App. Div. 1993) (holding that a state condom availability program allowing minors to access contraception without parental consent or opt-out was coercive and unconstitutional), with *Planned Parenthood Ass'n of Utah v. Matheson*, 582 F. Supp. 1001, 1009 (D. Utah 1983) (holding that the state cannot impose an absolute parental notification requirement on minors seeking contraceptives).

136. See *infra* Part IV.A.1.

137. See *infra* Part IV.A.1.

138. See *infra* Part IV.A.2.

139. See *infra* Part IV.A.3.

medical decision making and highlighting those areas in which the constitutional entitlements are unclear.¹⁴⁰ The remaining subsections of Part IV will then document the confusion that has resulted from the conflict of vaguely defined constitutional rights in this domain, reflecting on the status of the purported “default rule” regarding parents’ authority to consent or withhold consent for their children’s care.

1. Parental Rights

The Supreme Court’s recognition of parental rights began in a different era, and its indistinctness may, in part, be attributable to those early twentieth-century origins.¹⁴¹ The Supreme Court first identified parents’ right to the custody and control of their children in *Meyer v. Nebraska*, a 1923 case striking down a Nebraska law forbidding the teaching of modern foreign languages in the schools.¹⁴² In that case, the Court also mentioned the constitutional right “to contract, to engage in any of the common occupations of life, to acquire useful knowledge,” and “generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men”—all of which were rights understood to be protected by substantive due process in the *Lochner* era, but which our contemporary constitutional doctrine has long since disowned.¹⁴³ Just two years later, in *Pierce v. Society of Sisters*,¹⁴⁴ the Court again relied, in part, on the constitutional “liberty of parents and guardians to direct the upbringing and education of children under their control” in striking down a state law requiring public school attendance.¹⁴⁵ Yet, it has never been entirely clear exactly what parental rights protect or how robust they really are, despite the strong articulation of parental rights in those two cases. Nor were the scope and meaning of parental rights any clearer after the Supreme Court’s affirmation of the fundamental, constitutional nature of those rights in *Troxel v. Granville*¹⁴⁶ decision, holding that a mother’s parental rights were violated when a state trial court ordered visitation

140. See *infra* Part IV.A.3.

141. See Barbara Bennett Woodhouse, “Who Owns the Child?”: *Meyer and Pierce and the Child as Property*, 33 WM. & MARY L. REV. 995, 1119 (1992) (analyzing the modes of thinking that informed the Supreme Court’s opinions in *Meyer v. Nebraska*, 262 U.S. 390 (1923) and *Pierce v. Soc’y of Sisters*, 268 U.S. 510 (1925)). Both opinions strike us as foreign today, but nonetheless continue to exert some influence on family law. See *id.* at 1117–19 (discussing the contemporary manifestations of the privatizing philosophy of *Meyer* and *Pierce*).

142. See *Meyer v. Nebraska*, 262 U.S. 390, 399–400 (1923) (identifying parents’ right to custody and control of their children).

143. *Id.* at 399.

144. 268 U.S. 510 (1925).

145. *Id.* at 534–35.

146. 530 U.S. 57 (2000).

for a child's grandparents over the mother's objection based solely on a finding that the visitation was in the child's best interests.¹⁴⁷

Parental rights are often invoked to argue that parents should have a right to dictate their children's medical decisions, but those arguments often fail.¹⁴⁸ Parents generally cannot deny medically indicated care to their children—even when the parental rights claim is combined with a claim under the Free Exercise Clause.¹⁴⁹ In addition, while parental rights claims are sometimes discussed in the context of state laws allocating decision-making authority over minors' health care, they rarely seem to make any difference to the outcome.¹⁵⁰ Thus, for example, in *Bellotti v. Baird*,¹⁵¹ a challenge to a Massachusetts statute requiring parental consent for minors seeking abortions as infringing on minors' privacy rights, the Court noted the constitutional status of parental rights but then simply described the parental right as a mere "tradition of parental authority" that is compatible with minors' exercise of individual liberty.¹⁵² Similarly, in challenges to programs and laws allowing minors access to condoms without parental consent, parents have raised

147. *Cf. id.* at 66 (affirming that the Due Process Clause grants parents broad authority to make decisions regarding their children's "care, custody and control"); see also David D. Meyer, *Lochner Redeemed: Family Privacy After Troxel and Carhart*, 48 UCLA L. REV. 1125, 1141 & n.85 (2001) (noting that, in *Troxel*, all but one Justice agreed on the fundamental nature of parental rights). *But see id.* at 1147 (noting that the decision in *Troxel* left legislatures and lower courts with "maddeningly little guidance" as to the meaning and scope of parental rights); Vivian E. Hamilton, *Immature Citizens and the State*, BYU L. REV. 1055, 1085–86 (2010) ("The magnitude and contours of [the right to parent], however—like those of other rights relating to family life—are notoriously indistinct."). Professor Hamilton argues that the Court applies strict scrutiny when a state action threatens to destroy the parent-child relationship altogether, but applies a lower level of scrutiny when the threat is less substantial. *Id.* at 1089–93.

148. See Hill, *supra* note 85, at 1861–64 (demonstrating that courts consistently order medical treatment over parent religious objections); see also *Commonwealth v. Nixon*, 718 A.2d 311, 313 (1998), *abrogated on other grounds by Commonwealth v. Mouzon*, 812 A.2d 617 (2002) (upholding an involuntary manslaughter conviction for parents who denied medical treatment to their child because of their own religious beliefs).

149. Hill, *supra* note 85, at 1864; see also *Commonwealth v. Barnhart*, 497 A.2d 616, 620–22 (1985) (holding that parents had a duty to protect their child from death despite their religious beliefs in spiritual healing).

150. See *Bellotti v. Baird*, 443 U.S. 622, 638–39 (1979) (discussing the right of parents to have control over their children, but ultimately deciding that minors do not need parental consent for an abortion if they obtain approval for the abortion through judicial bypass).

151. 443 U.S. 622 (1979).

152. Specifically, *Baird* stated:

Properly understood, then, the tradition of parental authority is not inconsistent with our tradition of individual liberty; rather, the former is one of the basic presuppositions of the latter. Legal restrictions on minors, especially those supportive of the parental role, may be important to the child's chances for the full growth and maturity that make eventual participation in a free society meaningful and rewarding.

Id. at 638–39.

their parenting rights, among other rights, but have not had much success convincing courts that those rights have been violated.¹⁵³

One might argue that parental rights played a decisive role in *Hodgson v. Minnesota*,¹⁵⁴ in which the Supreme Court partially struck down a law requiring that minors seeking abortions notify two parents of their decision.¹⁵⁵ In that case, Justice Stevens' plurality opinion seemed to find that requiring notice to two parents, rather than just one, unconstitutionally intrudes on the privacy of the family by "intrud[ing] on choices concerning the arrangement of the household."¹⁵⁶ However, the parental rights violation in *Hodgson* was the mandated intra-family communication, and not the actual allocation of decision-making authority; the law required two-parent notice but not consent.¹⁵⁷

Thus, while courts regularly acknowledge the existence of parenting rights, they seem loath to place any analytic weight on them in deciding cases pertaining to medical decision making for children.¹⁵⁸

2. *The Minor's Right to Bodily Integrity*

Though initially articulated as an ancient common-law right, the right to bodily integrity is also a constitutional right with implications that reach many aspects of constitutional doctrine.¹⁵⁹ Perhaps most importantly, the right to bodily

153. See *Parents United for Better Sch., Inc. v. Sch. Dist. of Phila. Bd. of Educ.*, 148 F.3d 260, 277 (3d Cir. 1998) (holding that the Philadelphia School Board did not violate parental rights by creating a voluntary contraceptives distribution program); *Curtis v. Sch. Comm. of Falmouth*, 652 N.E.2d 580, 587 (Mass. 1995) (finding that the school condom-availability program "lacks any degree of coercion or compulsion in violation of the plaintiffs' parental liberties, or their familial privacy"); *Doe v. Irwin*, 615 F.2d 1162, 1168 (6th Cir. 1980) (upholding school's creation of a voluntary birth control clinic); *Decker v. Carroll Acad.*, No. 02A01-9709-CV-00242, 1999 WL 332705, at *13 (Tenn. Ct. App. May 26, 1999) (holding that Tennessee's statute allowing physicians to prescribe contraceptives to minors did not require physicians to notify parents or guardians when their child was prescribed such medications). *But see* *Alfonso v. Fernandez*, 606 N.Y.S.2d 259, 265 (App. Div. 1993) (holding a condom availability program without a parental opt-out procedure unconstitutional as a violation of parental rights).

154. 497 U.S. 417 (1990).

155. *Id.* at 423.

156. *Id.* at 448 (asserting that a one-parent notification requirement would be acceptable). Justice Stevens' opinion was joined on this point by Justice O'Connor, who was the swing vote in the case, and the only Justice to espouse both of the Court's holdings in *Hodgson*: that the statute was unconstitutional insofar as it required two-parent notice without a judicial bypass option but constitutional with such a judicial bypass option. *Id.*

157. *Id.* at 422. The Court's finding that the Minnesota statute was unconstitutional did not hinge on the parent's decision-making authority or lack thereof, but rather on the mandate that a minor notify both parents, which, according to the Court, put an undue burden on the minor's right to an abortion that did not further a legitimate state interest. *Id.* at 448-50.

158. See, e.g., *Hodgson*, 497 U.S. at 423; *Parents United for Better Sch., Inc. v. Sch. Dist. of Phila. Bd. of Educ.*, 148 F.3d 260, 277 (3d Cir. 1998); cf. Meyer, *supra* note 147, at 1190 (stating that involvement in the familial privacy realm requires the Court to make value judgments that it seems unwilling to decisively make).

159. See, e.g., Hill, *supra* note 23, at 304-05 (stating that the notion of bodily integrity is associated with the Fourth, Eighth and Fourteenth Amendments); see also *Foody v. Manchester Mem'l Hosp.*, 482

integrity figures prominently in the line of cases that protect abortion rights.¹⁶⁰ The Supreme Court first made clear in *Planned Parenthood v. Danforth*¹⁶¹ that the state could not give parents an absolute and possibly arbitrary veto over a minor's abortion decision, whether the parents wish to forbid or require the abortion.¹⁶² Instead, the Court explained, "[a]ny independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant."¹⁶³

But can one generalize from the right recognized in the minor abortion cases to a broader constitutional right of at least some minors to make health care decisions in other contexts? The "right of privacy" discussed in *Danforth* and other cases is most strongly associated with the constellation of activities surrounding childbearing, or the decision not to bear children.¹⁶⁴ And indeed, one might point out that pregnant minors are in a unique situation—a uniquely "adult" circumstance, facing a decision with profound long-term effects on the minor's future.¹⁶⁵ Given this fact, as well as the obvious affiliation between cases such as *Danforth* and the adult abortion jurisprudence beginning with *Roe v. Wade*, one might argue that the minor abortion cases are simply *sui generis*.¹⁶⁶

Yet, I would argue, it is difficult to see why or how this right of minors to make health care decisions can be limited to the abortion context. Many minors—such as those with terminal illnesses, or with "adult" problems like substance abuse and sexually transmitted diseases—are indistinguishable from pregnant minors in terms of the seriousness of their situations.¹⁶⁷ Moreover, as the joint opinion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*¹⁶⁸ emphasized:

Roe . . . may be seen not only as an exemplar of *Griswold* liberty but as a rule . . . of personal autonomy and bodily integrity, with

A.2d 713, 717 (Conn. Super. Ct. 1984) (noting that the right to privacy is not only recognized at common law, but also implicitly in numerous constitutional amendments).

160. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 857 (1992); *Roe v. Wade*, 410 U.S. 113, 152-53 (1973).

161. 428 U.S. 52 (1976).

162. *Id.* at 74.

163. *Id.* at 75.

164. *Id.* In *Carey v. Population Services International*, the Supreme Court struck down a ban on distributing contraceptives to anyone under the age of sixteen, thus extending the liberty recognized in *Danforth* to contraception. 431 U.S. 678, 681-82 (1977).

165. *Bellotti v. Baird*, 443 U.S. 622, 642 (1979).

166. These cases tend to refer primarily to one another as precedent. For example, the *Danforth* Court relied primarily on *Roe*, and *Danforth*, in turn, provided important precedent for later cases exploring minors' rights to choose abortion. *Danforth*, 428 U.S. at 75. See, e.g., *Bellotti v. Baird*, 443 U.S. 622, 624 (1979) (referencing *Danforth* and holding a Massachusetts statute, requiring a minor to obtain the consent of both parents in order to get an abortion, unconstitutional).

167. Cf. Prober, *supra* note 133, at 569 (noting that many states grant minors the right to make decisions related to "reproductive health, alcohol and substance abuse, and mental health").

168. 505 U.S. 833 (1992).

doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection.¹⁶⁹

This language makes it possible to infer both that minors, like adult women, have a constitutional right to bodily integrity and that the right is not limited to the right to access abortion and contraception.¹⁷⁰

Indeed, courts and commentators have recognized that minors possess a right to bodily integrity in a variety of contexts.¹⁷¹ There is no reason that this right may not be applied to minors—at least, mature adolescents—who wish to make their own health care decisions.¹⁷² At least one trial court considered the right to be implicated where a sixteen-year-old minor sought to resist her putative father’s request that she undergo a blood test to establish paternity.¹⁷³ Noting that individuals have a right “to be free from unwanted infringements of bodily integrity” and that the minor had “expressed these interests and rights in an effort to resist the removal of her blood for testing,” the court held that the minor’s right trumped the purported father’s more attenuated claim of parental rights.¹⁷⁴ In addition, scholarly commentators have suggested that children’s constitutional right

169. *Id.* at 857. Thus, I have argued elsewhere that one can discern a right to make health care decisions without undue government interference from these and other cases. Hill, *supra* note 23, at 329 (“[T]he Supreme Court has already recognized a substantive-due-process right to make medical treatment choices”); B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 531–37 (2009) (arguing in favor of a “negative right to health”).

170. See Hill, *supra* note 23, at 329.

171. See, e.g., Susan D. Hawkins, Note, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 FORDHAM L. REV. 2075, 2077 (1996); cf. Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424–25 (Mass. 1977) (recognizing that incompetent adults possess a right to bodily integrity). This right is based on both a common law interest in freedom from “nonconsensual invasion of . . . bodily integrity,” and a constitutional right of privacy that “encompasses the right of a patient to preserve his or her right to privacy against unwarranted infringement of bodily integrity in appropriate circumstances.” *Id.* at 424. Most commonly, the right is referenced to support the notion that children have a constitutional right not to be physically or sexually abused by a state actor. See, e.g., Kinman v. Omaha Pub. Sch. Dist., 171 F.3d 607, 611 (8th Cir. 1999) (reversing the lower court’s denial of Kinman’s default judgment, finding that she was deprived of “her constitutionally protected substantive right to be free from such bodily harm and sexual molestation and abuse as secured by the Due Process and/or Equal Protection Clauses of the 14th Amendment to the U.S. Constitution”); Plumeau v. Sch. Dist. No. 40, 130 F.3d 432, 438 (9th Cir. 1997) (finding that there is a right to be free from violations of bodily integrity from state actors, which includes freedom from excessive physical abuse by school employees); Doe v. Rains Cnty. Indep. Sch. Dist., 66 F.3d 1402, 1407 (5th Cir. 1995) (finding a teacher’s sexual abuse of a minor student violated the student’s federal constitutional right to bodily integrity).

172. Anthony W. Austin, *Medical Decisions and Children: How Much Voice Should Children Have in Their Medical Care?*, 49 ARIZ. L. REV. 143, 146–49 (2007) (analyzing the capabilities of minors to make adult-like decisions, including arguing that bodily integrity rights may lead to a minor’s right to make medical decisions).

173. *In re L.*, 632 A.2d 59, 61 (Conn. Super. Ct. 1993).

174. *Id.* at 61 (quoting Foody v. Manchester Mem’l Hosp., 482 A.2d 713 (Conn. Super. Ct. 1984)). In addition, the Illinois Supreme Court cited the abortion cases in holding that the mature-minor doctrine protected a seventeen-year-old’s right to refuse treatment for leukemia. *In re E.G.*, 549 N.E.2d 322, 326 (Ill. 1989).

to bodily integrity may be violated when parents authorize, and physicians perform, invasive surgeries on children that have little or no therapeutic benefit for the child.¹⁷⁵

Indeed, it may be fair to conclude that the minor abortion cases have essentially constitutionalized the mature-minor and best-interests doctrines.¹⁷⁶ In *Bellotti v. Baird*, the Supreme Court held that a minor who wished to avoid parental-consent requirements for abortion must be given the opportunity to bypass the requirement by proving to a judge that either she is mature enough to make the abortion decision on her own, or that the abortion would be in her best interests.¹⁷⁷ These, of course, are the traditional grounds on which state common law and statutory law have permitted the state to withdraw decision-making authority from the parents: if the minor is mature or emancipated, or if the state must do so in order to protect the minor, in the exercise of its *parens patriae* powers.¹⁷⁸ If, as discussed above, minors' bodily integrity rights extend beyond the abortion context, and if the mature-minor doctrine is not just an exception to but rather fundamentally inconsistent with a presumption of parental decision-making authority,¹⁷⁹ it must be true that, to the extent minors possess a constitutional right to bodily integrity, that right overrides the purported common-law default rule of parental decision making for adolescents.

3. *The Conflict*

It should now be clear that parents' rights to make health care decisions for their children are fundamentally in conflict with childrens' rights to bodily integrity, at least where those rights apply—for example, in the case of mature minors.¹⁸⁰ As Professor Anne Dailey has explained:

[A]ny allotment of liberty to the parents necessarily diminishes the liberty of the child; conversely, any enhancement of a child's liberty

175. Koll, *supra* note 32, at 254–61; Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59, 91–93 (2006). Some cases have also recognized minor's "liberty interest" in not being confined for medical treatment without due process. See, e.g., *In re F.C. III.*, 2 A.3d 1201, 1214 (Pa. 2010); *Parham v. J. R.*, 442 U.S. 584, 600 (1979).

176. Cf. Lisa Anne Hawkins, Note, *Living-Will Statutes: A Minor Oversight*, 78 VA. L. REV. 1581, 1602–03 (1992) (arguing that the Supreme Court's minor abortion cases have "essentially constitutionalized the mature minor doctrine" in the abortion context).

177. *Bellotti v. Baird*, 443 U.S. 622, 643–44 (1979).

178. Cf. *In re E.G.*, 549 N.E.2d at 327 (acknowledging the state's *parens patriae* powers to the protect the incompetent).

179. See *supra* Part III.

180. *Bellotti v. Baird*, 443 U.S. at 647–48 (finding that a minor may make a showing before a court that she is a "mature minor" in order to obtain an abortion without parental consent). The constitutionalization of minors' "best interests" may apply to protect immature minors from harmful parental decisions regarding health care, but because the focus of this paper is on adolescents, it is primarily concerned with the bodily integrity rights of "mature minors."

curtails that of the parents. Unlike the right of individual privacy—which entitles the individual to rights against the state and over herself—parental rights entitle parents to rights against the state, but over another person.¹⁸¹

The existence of the bodily integrity right would thus seem to suggest that there cannot be a simple categorical rule allowing parents to consent to medical treatment on behalf of their children.¹⁸² At a minimum, any such rule must be qualified by constitutional constraints, grounded in both the autonomy rights of mature minors (including many adolescents) and the best interests of immature minors.¹⁸³ Although parental rights may ground the stated presumption of exclusive parental authority to consent to children’s health care, there is no obvious reason why that constitutional right should trump the minor’s bodily integrity right.¹⁸⁴ Thus, it is unclear what meaning a presumption of parental rights could possibly have. Certainly, no such presumption can be said to operate in the abortion context in the absence of a parental consent statute. If there are constitutional rules that govern a subject—especially two constitutional rights that, essentially, seem to occupy the field, as in the case of parental rights and minor’s bodily integrity rights—a common-law presumption is incapable of superseding them.¹⁸⁵

B. Constitutional Confusion

In the adolescent medical decision-making context, there are three possible scenarios in which a state regulation could result in a constitutional claim. First, the state could dictate a medical decision—by requiring a particular treatment for a child or forbidding a particular treatment for a child—against the wishes of both the

181. Anne C. Dailey, *Constitutional Privacy and the Just Family*, 67 TUL. L. REV. 955, 986–87 (1993); see also *In re F.C. III*, 2 A.3d 1201, 1210 (2010) (“[T]he constitutional rights of the parent and the child are in tension.”).

182. *But see* Hawkins, *supra* note 171, at 2090 (contending that “[t]o date, no reported cases exist where the minor has resisted the proposed medical treatment consented to by the minor’s parents;” however, “[i]n at least one medical treatment case where the court [took] into account the views of the minor . . . language in the opinion strongly suggested that the court would have deferred to the parents’ wishes” if the parents disagreed with the minor’s decision to refuse treatment) (citing *In re E.G.*, 549 N.E.2d 322 (Ill. 1989)).

183. *Cf.* Bellotti v. Baird, 443 U.S. at 643–44 (holding that all minors must be permitted to seek judicial authorization for an abortion without parental consent).

184. *Cf.* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 75 (1976) (emphasizing that parental authority to consent to a child’s health care is not absolute and did not outweigh the minor’s right to bodily integrity in this case).

185. U.S. CONST. art. VI, cl. 2 (stating that the U.S. Constitution is the supreme law of the land, thus establishing that all rights granted by the Constitution supersede state or common-law rights); *cf.* Meyer, *supra* note 147, at 1179–80 (discussing the “clashing constitutional interests” involving “incommensurable values” in family privacy cases).

parent and the child.¹⁸⁶ Mandatory HPV vaccination would be one such situation.¹⁸⁷ Second, the state could allocate medical decision-making authority to the child—for example, through statutes that allow minors to consent to treatment for sexually transmitted diseases.¹⁸⁸ Finally, the state could allocate decision-making power to the parent, through a statute or common-law rule requiring parental consent.¹⁸⁹

In which of these three scenarios is there state action? In which is a constitutional right implicated—either the right of parents to control their children or the right of minors to control their own bodies? And, perhaps overlapping with the prior two questions, in which has the government acted in a coercive manner—usually a prerequisite to finding a violation of constitutional rights?¹⁹⁰ The existing case law evinces enormous confusion about the constitutional rules and presumptions that apply in precisely these situations. Though this confusion permeates the context of medical decision making for minors, it is particularly acute with respect to older minors who appear to possess constitutional autonomy and privacy rights—which only strengthens the argument that no meaningful default rule operates in adolescent medical decision-making cases. Indeed, a strong, shared understanding of the underlying entitlements would mean that it would appear obvious when the state was acting to take those entitlements away.

1. *State-Dictated Medical Decisions*

The most obvious case for state actions that raise the potential for constitutional claims would be a state law requiring or forbidding a particular medical treatment, despite the wishes of both parent and child.¹⁹¹ The state action

186. *See, e.g.,* *Carey v. Population Servs. Int'l*, 431 U.S. 678, 708 (1977) (Powell, J., concurring) (asserting that a prohibition on parents distributing condoms to children under sixteen violates parental rights).

187. *See* D.C. CODE § 7-1651.04 (2008) (mandating parents to certify that children enrolling in the sixth grade have received the HPV vaccination).

188. *See, e.g.,* ALA. CODE § 22-11A-19 (LexisNexis 2006) (allowing a minor to receive medical treatment for a sexually transmitted decision without parental consent); ALASKA STAT. § 25.20.025(a)(4) (2010) (allowing a minor to receive medical treatment for a sexually transmitted decision without parental consent); CAL. FAM. CODE § 6926 (West 2004 & Supp. 2012) (allowing a minor to receive medical treatment for infectious, contagious, and communicable diseases without parental consent).

189. *See* *Parham v. J. R.*, 442 U.S. 584, 602 (1979) (detailing a parent's medical decision-making authority over that of a minor).

190. Courts have required a showing of coercion to establish a violation of parents' substantive due process or free exercise rights. *See infra* Part IV.B.2. Though cases concerning minors' rights to bodily integrity do not speak in terms of coercion, some showing of a state-imposed burden may well be required. *See* *Maher v. Roe*, 432 U.S. 464, 472-74 (1977) (holding that the Connecticut law placed no obstacles in the pregnant woman's path to an abortion, and that it therefore did not "impinge upon the fundamental right recognized in *Roe*").

191. *See, e.g.,* *Commonwealth v. Nixon*, 718 A.2d 311, 313 (Pa. 1998) (upholding the involuntary manslaughter conviction of parents who did not seek medical treatment for their child based on the child's and their own religious beliefs). For more discussion on state actors imposing medical treatment on individuals, see *Washington v. Glucksberg*, 521 U.S. 702, 727 (1997) (noting that while the

seems apparent in that case, and such a law would have the potential to violate both the parents' rights and the minor's rights.¹⁹² Yet, where very young children are involved, courts regularly substitute their own judgment for those of the parents.¹⁹³ For example, in a recent constitutional challenge to a state's newborn metabolic testing law, the district court described the conflict not as one between the family and the state but as one between "the right of parents to parent and the right of children to safety."¹⁹⁴ Without resolving the constitutional conflict between the child's right to bodily integrity, represented by the concern for the child's best interests, and the parents' rights of control, the court simply upheld the requirement under rational basis review.¹⁹⁵ Even in a case involving an older, mature minor's wish to refuse end-of-life care with her mother's blessing, the court ultimately held that the state could not override the family's wishes only after first weighing the mature minor's rights against the state interests in preserving life, preventing suicide, and protecting the integrity of the medical profession, as well as the interests of the parent.¹⁹⁶

Whatever the rule may be with respect to younger minors, a constitutional claim would almost certainly exist where the state tried to impose its health care choices on a mature minor, against the wishes of both the adolescent and the parent.¹⁹⁷ The state probably could not, for example, forbid all minors from accessing abortion, regardless of parental wishes, any more than it could make

Constitution protects private and autonomous decisions, it does not warrant a sweeping conclusion that all personal decisions would be protected); *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) (rejecting the defendant's argument that his constitutional rights are violated when the state forces him to receive a mandatory vaccination).

192. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684–85 (1977) (striking down a state ban on distributing contraceptives to anyone under the age of sixteen because the right to privacy encompasses a minor's use of contraception); *id.* at 708 (Powell, J., concurring) (arguing that the ban violates parents' rights, because it forbids distribution of condoms by parents to their minor children); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74–75 (1976) (striking down portions of a Missouri law that required parental consent in order for a minor to obtain an abortion because the requirement violates the the minor's right to bodily integrity).

193. *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769, 773–74 (Ill. 1952) (recognizing that the government, acting in *parens patriae*, may override a parent's decision pertaining to a child); Ellen Becker, Note, In *Re Hofbauer: May Parents Choose Unorthodox Medical Care For Their Child?*, 44 ALB. L. REV. 818, 820–21, 838–42 (1980) (explaining that, although parents have a constitutional and common-law right to rear their children, the state may intervene if it perceives a threat to the child's wellbeing).

194. *Spiering v. Heineman*, 448 F. Supp. 2d 1129, 1140 (D. Neb. 2006).

195. *Id.* at 1140–41 (following lower courts in utilizing the rational basis test when reasonable restrictions on legitimate government interests are at stake).

196. *In re E.G.*, 549 N.E.2d 322, 324–28 (Ill. 1989).

197. *Id.* at 326 (stating that the court can "see no reason why this right of dominion over one's own person should not extend to mature minors").

contraception inaccessible.¹⁹⁸ Nonetheless, the constitutional claim does not appear to be a particularly robust one, even in this scenario.

2. *Allocating Decision-Making Authority to the Adolescent or to the Parent*

When the law grants decision-making authority to either the parent or the child, whether by statute or by common law, has the state acted in a way that is sufficient to invoke constitutional protections? In other words, when does a particular allocation of power in this domain constitute state action, and, relatedly, when is that state action of sufficient magnitude to constitute a form of “coercion” or an “obstacle” that potentially infringes the constitutional rights of either the parent or the minor? Courts—and possibly litigants as well—seem to be confused about this issue.

In the abortion context, statutes requiring parental involvement in the minor’s decision are generally challenged on the ground that they infringe on the minor’s rights.¹⁹⁹ If the statute fails to contain certain safeguards, the challenge will be successful. Yet, given the logic, described above, that would extend minors’ rights to other health care decisions, why is it that minors’ rights to bodily integrity are recognized almost exclusively in the context of abortion, and not widely vindicated in other medical treatment contexts?²⁰⁰ The answer, it would seem, is deceptively simple: in the abortion context, minors have succeeded in vindicating their rights to bodily integrity by challenging state laws that require parental consent.²⁰¹ In other cases, implicating minors’ bodily integrity rights, there is rarely a state statute explicitly granting authority to the parents that can be invoked as the basis for state action, as is required in order for a constitutional challenge to proceed.²⁰²

198. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74–75 (1976) (holding that the state may not impose an absolute parental consent requirement on abortion); *Carey v. Population Servs. Int’l*, 431 U.S. 678, 693–94 (1977) (striking down a restriction on minors’ access to contraceptives and citing *Danforth* for the proposition that the state cannot give to a third party a veto power that the state itself does not possess); *id.* at 708 (Powell, J., concurring).

199. *Danforth*, 428 U.S. at 74–75 (holding that a state may require parental notification, but may not condition a minor’s right to abortion on parental consent).

200. See generally Caitlin E. Borgmann, *Abortion, the Undue Burden Standard, and the Evisceration of Women’s Privacy*, 16 WM & MARY J. WOMEN & L. 291, 305–06 (2010) (referencing the court’s tendency to recognize state interests readily in public health and safety matters, making the court quick to infringe on individuals’ medical decision making). Minors’ bodily integrity rights are also recognized in cases of assault or physical abuse by state actors or while the minor is in state custody—presumably because both state action and coercion are obvious in those scenarios. See *supra* note 171. As noted above, at least one court and some commentators have discussed the right in the medical treatment context. See *supra* notes 167–75 and accompanying text.

201. See *Bellotti v. Baird*, 443 U.S. 622, 643 (holding that “[a] pregnant minor is entitled . . . to show . . . that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents’ wishes”).

202. Thus, for example, the abuse of a child by a public school teacher is actionable as a violation of the child’s constitutional right to bodily integrity because the teacher is a state actor. *Doe v. Rains Cnty Indep. Sch. Dist.*, 66 F.3d 1402, 1404–05 (5th Cir. 1995). However, the severe abuse of Joshua

On further reflection, however, this state of affairs is profoundly illogical. If the default rule is that minors need parental consent for medical treatment in any case—and if such a rule would govern in the absence of a state statute—how can the mere existence of the statute create state action where it was missing before? If the common law itself authorizes parents to consent to their adolescents’ medical care in every case unless there is a specific statutory exception, shouldn’t this, too, be sufficient state action to ground a minor’s claim for violation of her right to bodily integrity any time she is subjected to medical treatment against her will? Must the parental right either be authorized by a specific statute, or sought to be vindicated through a judicial proceeding, before state action is sufficiently visible such that the Constitution is implicated?²⁰³

Moreover, it is noteworthy that the minor’s right to seek an abortion appears to be a constitutional right not just against the state, but also, in a sense, against her parents.²⁰⁴ Thus, in *Planned Parenthood v. Danforth*, the Supreme Court stated: “[T]he 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 to terminate the patient’s pregnancy, regardless of the reason for withholding the consent.”²⁰⁵ And after setting out, in almost blueprint fashion, the detailed limitations on state parental involvement requirements for minors seeking abortions, the Supreme Court in *Bellotti v. Baird* commented that “this is the full extent to which parental involvement may be required.”²⁰⁶ Given the supposed widespread presumption of minors’ incapacity to consent to medical care and parents’ legal entitlement to do so on their behalf,²⁰⁷ this is extraordinary language. If parents have authority, as a default rule, to consent or withhold consent to medical care on behalf of their children—arguably grounded in the constitutional right to family privacy or perhaps even natural law—then in what sense can the

DeShaney by his father was not actionable, although the county social services department was aware of the situation and had failed to remove Joshua from the abusive environment, because the legal “default rule” of parental custody is not seen to arise from or depend on state action. *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 191 (1989).

203. *Cf. In re L.*, 632 A.2d 59, 61 (Conn. Super. Ct. 1993) (finding state action where a man requested a sixteen-year-old girl to undergo blood testing for paternity because, “a private party, the movant, seeks to employ the coercive hand of the court”).

204. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (holding “that the State may not impose a blanket provision . . . requiring” parental consent as a condition for a minor’s abortion).

205. *Id.* It is notable, of course, that the state seemingly can and does give the veto right over the minor’s decisions to a judge—by means of the judicial bypass procedure—just not to a minor’s parent. *Bellotti v. Baird*, 443 U.S. 622, 643–44 (1979).

206. *Baird*, 443 U.S. at 648.

207. *See* Ross Povenmire, *Do Parents Have the Legal Authority to Consent to the Surgical Amputation of Normal, Healthy Tissue from Their Infant Children?: The Practice of Circumcision in the United States*, 7 AM. U. J. GENDER SOC. POL’Y & L. 87, 101 (1999) (“Most jurisdictions severely constrain the ability of minors to consent to medical treatment on the premise that minors lack the considered judgment necessary to act in their own best interest.”); *see also* Koll, *supra* note 32, at 241.

state be said to be “giv[ing]” them the authority to “veto” the minor’s reproductive health care decision?²⁰⁸

The problem, perhaps, is not so much that the law presumes a parent’s authority to consent to medical care for his or her child, but rather that the default rules and presumptions are entirely unclear in this area.²⁰⁹ There is no firm or obvious answer to the question of who has the authority to consent to medical treatment on behalf of an older minor or adolescent, in the absence of a state statute on point.²¹⁰ For example, in states that lack abortion parental consent laws, minors are generally assumed to be free to access abortion without parental involvement.²¹¹ At the same time, even in states where parental consent is required for minors seeking abortions, it is unlikely that an unwilling minor could be forced by a parent to submit to the procedure against her wishes.²¹²

The confusion is further demonstrated by the array of opinions in *Hodgson v. Minnesota*, involving a challenge to Minnesota’s two-parent abortion notification law.²¹³ Though the case did not technically involve the constitutionality of an allocation of decision-making authority, as opposed to mere notice, the Justices’ struggle to identify the relevant background assumptions and to apply the relevant constitutional doctrine is evident.²¹⁴ Justice Stevens’s opinion in that case viewed

208. Though philosophical arguments are beyond the scope of this Article, some might argue that natural law, not the state, gives parents authority over their children in this domain. See Woodhouse, *supra* note 141, at 1050 (noting that the rights of parents stem from views grounded partly in natural rights); see also Daniel E. Witte, Note, *People v. Bennett: Analytic Approaches to Recognizing a Fundamental Parental Right Under the Ninth Amendment*, 1996 BYU L. REV. 183, 190 (1996) (recounting that under the English common law, natural rights provided parents the absolute right over their children and the state could only interfere with this right if the parent engaged in wrongdoing).

209. See Povenmire, *supra* note 207, at 105 (noting the “ambiguous constitutional status of parental discretion in medical decision making for minors”).

210. See *id.* (discussing the lack of clarity on the issue of consent for medical treatment on behalf of a minor); see also *supra* note 1 and accompanying text.

211. See Kathryn D. Katz, *The Pregnant Child’s Right to Self-Determination*, 62 ALB. L. REV. 1119, 1126–27 (1999) (explaining that while minors have the same rights as adults under the Constitution, including the right to have an abortion, the Supreme Court has held that such general rights can be limited through state regulation).

212. Mutcherson, *supra* note 1, at 290–91; cf. *In re Smith*, 295 A.2d 238, 246 (Md. App. 1972) (holding that a parent cannot compel her minor daughter to undergo an abortion against her will, but basing this holding on statutory rather than constitutional requirements).

213. 497 U.S. 417 (1990).

214. See *id.* at 434–35, 444–48 (Stevens, J., announcing judgment of the Court) (holding that minor and adult women have a constitutional right to privacy, and that the forty-eight-hour waiting period after parental notification is constitutional but the two-parent notification requirement is unconstitutional); *id.* at 458–60 (O’Connor, J., concurring in part and concurring in judgment) (stating that the two parent notification law is unconstitutional without a judicial bypass, due its infringement of the minor’s privacy rights); *id.* at 462 (Marshall, J., concurring in part and dissenting in part) (positing that the two-parent notification law “usurps a young woman’s control over her own body by giving either a parent or a court the power effectively to veto her decision to have an abortion”); *id.* at 479–80 (Scalia, J., concurring in the judgment and dissenting in part) (noting the highly fractured set of decisions generated by the case and arguing that Constitution’s text provides “no hint” that the various distinctions drawn by the Justices

the two-parent notification requirement as a violation of both the parents' and the child's privacy rights; it was the combination of both interests that was dispositive for him.²¹⁵ For Justice Marshall, on the other hand, the only issue in the case appeared to be the minor's right. Indeed, he argued that "in some instances [the state law] usurps a young woman's control over her own body by giving either a parent or a court the power effectively to veto her decision to have an abortion."²¹⁶ Justice Kennedy's primary concern, by contrast, was with parental rights and prerogatives.²¹⁷ Though he did not view the notification statute itself as violating parental rights, he viewed it as a constitutional attempt by the states to support parents in their exercise of their constitutionally protected authority.²¹⁸ After observing that parents have a constitutionally recognized liberty interest in their relationships with their children, Justice Kennedy explained that "the fact that the Constitution does not protect the parent-child relationship in all circumstances does not mean that the State cannot attempt to foster parental participation where the Constitution does not demand that it do so."²¹⁹ In other words, in Justice Kennedy's view, the state parental notice law was merely a legitimate attempt to shore up the parents' constitutional rights, not an infringement on the child's rights; the state can increase parental power without burdening the minor's right.²²⁰

Each of these differing perspectives demonstrates the extent of uncertainty about the underlying entitlements. The Justices cannot agree among themselves whether a particular allocation of decision-making authority impinges upon the minor's right, the parent's right, both, or neither.²²¹ It is my contention here that this confusion results, in part, from an uncertainty about when and whether the state has acted to change pre-existing prerogatives in the adolescent medical decision-making realm.

"are constitutionally relevant"); *id.* at 482, 500–01 (Kennedy, J., concurring in part and dissenting in part) (stating that the judicial bypass is sufficient to make the law constitutional, in part because the law is aimed at supporting parents' rights and interests with respect to their minor children).

215. *Id.* at 452, 457. Interestingly, Justice Stevens, writing only for himself, also noted that in no "other medical situation in Minnesota or elsewhere . . . [is] the provision of treatment for a child . . . conditioned on notice to, or consent by, both parents rather than just one." *Id.* at 457 (Stevens, J., dissenting in part). Justice Stevens' opinion thus makes explicit the connection between the abortion context and other medical decision-making contexts. *See id.*

216. *Id.* at 462 (Marshall, J., concurring in part and dissenting in part).

217. *Id.* at 480–85 (Kennedy, J., concurring in part and dissenting in part) (focusing on parents' rights over their children under common-law history and precedents).

218. *Id.* at 484 ("A State pursues a legitimate end under the Constitution when it attempts to foster and preserve the parent-child relationship by giving all parents the opportunity to participate in the care and nurture of their children. We have held that parents have a liberty interest, protected by the Constitution, in having a reasonable opportunity to develop close relations with their children.").

219. *Id.*

220. *Id.* at 485–86 (intimating that a parental notification requirement serves both the parents' interests and the minors' interests, because parents are generally protective of their children's welfare).

221. *See supra* notes 213–20.

Moreover, this confusion may even be traced to some of the Court's earliest parental rights decisions, *Pierce* and *Prince v. Massachusetts*.²²² In those cases, the language of parental rights was regularly accompanied by the language of parental duty. The Court in *Pierce* noted that parents had "the right, *coupled with the high duty*" to control their children's destiny.²²³ In *Prince v. Massachusetts*, the Court made the same point, but in negative terms that emphasized the state's lack of authority: "It is cardinal with us that the custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can *neither supply nor hinder*."²²⁴ Although it is commonplace to speak of parents as having both rights and duties with respect to their children, when considered in constitutional terms, this language is somewhat striking. A duty, after all, is the mirror image of a right, implying the existence of a right in another person—here, the child.²²⁵

Similarly, although parents rarely prevail on claims that the Free Exercise Clause entitles them to deny necessary health care to their children,²²⁶ courts almost universally decide those free exercise cases against the parents by finding that the state's interest in the child's wellbeing overcomes the claim, not by determining that governmental coercion is lacking.²²⁷ It seems that neglect and abuse laws are viewed in these cases as statutory exceptions to the background rule of parental authority over minors' health care—suggesting that, in the absence of such coercive laws, parents would be free to withhold consent.²²⁸ Yet, in other cases involving state laws allowing minors to access contraceptives, courts routinely find that there is no governmental coercion sufficient to raise a constitutional issue with respect to the parents' family privacy or free exercise rights.²²⁹ This suggests that, in the

222. 321 U.S. 158 (1944).

223. *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 535 (1925) (emphasis added).

224. *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (emphasis added).

225. Wesley Newcomb Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 YALE L.J. 16, 33 (1913) (concluding that "duty" and "right" are correlative terms). Despite quoting the "duty" language from *Pierce*, the Court did not imply in *Troxel* that parents had any legal duty to provide for their children's best interests with respect to visitation. *Troxel v. Granville*, 530 U.S. 57, 65, 68 (2000) (quoting *Pierce* but not imposing a duty on otherwise fit parents with respect to visitation rights).

226. See Hill, *supra* note 85, at 1859, 1877–88; Wadlington, *supra* note 54, at 325–26 (noting that parents' refusal to seek medical treatment for their children based on religious objections does not make them immune to criminal prosecution).

227. See Wadlington, *supra* note 54, at 326–27 (noting that one court decided against a minor's parents by emphasizing "the gravity of the state's interest in protecting children's health and, indeed, in saving lives").

228. See *id.* at 318 (citing a case brought before the recognition of "medical neglect," where the New York Court of Appeals "refused to authorize a state agency to intervene and overrule a father's refusal to consent to corrective surgery for his fourteen-year-old son's cleft palate and harelip").

229. See *Parents United for Better Sch., Inc. v. School Dist. of Phila. Bd. of Educ.*, 148 F.3d 260, 277 (3d Cir. 1998); *Curtis v. Sch. Comm. of Falmouth*, 652 N.E.2d 580, 584–89 (Mass.1995) (finding that school condom-availability program "lacks any degree of coercion or compulsion in violation of the

absence of the challenged law, parents would have no protected right to prevent their children from accessing contraceptives. In one case, however, the New York Appellate Division did find a public school condom distribution program to be coercive and violative of parental rights, since “parents [were] being compelled by State authority to send their children into an environment where they [were] permitted, even encouraged, to obtain a contraceptive device, which the parents disfavor as a matter of private belief.”²³⁰ The New York court’s language suggests, in contrast to other condom-availability cases, that parents *would* have the right to prevent their children from accessing contraceptives, but for the state’s actions.

There are, of course, valid distinctions among these cases, and a finding of a lack of government coercion is not the same as a finding that state action is missing. But the inconsistency in the case law suggests some confusion about the background presumptions against which the state is legislating, resulting in a measure of uncertainty about when the state can be considered to be coercing parents with respect to their children.²³¹

It seems, then, that a constitutional claim can arise either when the state legislatively limits the parents’ ability to control their children’s health care, *or* when the state grants parents too much authority to control their children’s medical treatment.²³² The first claim sounds in parental rights or free exercise, while the second sounds in the minor’s right to bodily integrity.²³³ While it is not illogical to say both sorts of claims can exist—that the state must negotiate between granting too much or too little control to parents with respect to minors’ health care—the current doctrine raises the question whether there is any functioning default rule that meaningfully sets the standard against which the question of too much or too

plaintiffs’ parental liberties, or their familial privacy”); *Doe v. Irwin*, 615 F.2d 1162, 1168 (6th Cir.1980); *Decker v. Carroll Acad.*, No. 02A01-9709-CV-00242, 1999 WL 332705, at *12 (Tenn. Ct. App. May 26, 1999).

230. *Alfonso v. Fernandez*, 606 N.Y.S.2d 259, 265 (App. Div. 1993). Professor Nomi Stolzenberg has identified a similar difficulty on the part of courts in recognizing coercion of religious parents when they seek to challenge state-mandated exposure of public school children to secular educational materials that conflict with parents’ beliefs. See Nomi Maya Stolzenberg, “*He Drew a Circle that Shut Me Out*”: *Assimilation, Indoctrination, and the Paradox of a Liberal Education*, 106 HARV. L. REV. 581, 599–611 (1993).

231. Compare *Alfonso*, 606 N.Y.S.2d at 265 (holding that the distribution of condoms through a school sponsored program without a parental opt-out was coercive), with *Curtis v. Sch. Comm. of Falmouth*, 652 N.E.2d 580, 587 (Mass. 1995) (finding that the school condom-availability program “lacks any degree of coercion or compulsion in violation of the plaintiffs’ parental liberties, or their familial privacy”).

232. See, e.g., *Alfonso*, 606 N.Y.S.2d at 265 (overturning a state program that limited the parents’ ability to control their children’s access to contraception); *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976) (limiting the parents’ rights where they had been granted too much control over their children’s access to abortion).

233. See, e.g., *Alfonso*, 606 N.Y.S.2d at 265 (finding that the distribution of condoms in school violated parents’ rights to control the upbringing of their children); *Danforth*, 428 U.S. at 74 (acknowledging that minors, like adults, have a right to constitutional privacy protections).

little parental control must be judged. The lack of clarity with respect to the default rules, moreover, has tended to conceal the reality that minors' right to bodily integrity may be implicated by any legal rule that grants nearly plenary authority to parents, because it has tended to obscure the existence of state action in such cases, except in the presence of an explicit statutory enactment granting parental control.²³⁴

V. CONCLUSION

This Article has made the case that the two widely presupposed background assumptions about medical treatment of adolescents—that adolescents, like other minors, are legally incapable of consenting on their own to medical care, and that their parents can consent on their behalf—are not entirely accurate.²³⁵ In addition, this Article has argued that the constitutional backdrop complicates the issue of consent to medical treatment for minors far more than is commonly recognized.²³⁶ The latent unclarity regarding the default rules that actually govern in the absence of an explicit statutory enactment, moreover, has aggravated the uncertainty for health care providers who work with adolescents and has led to under-recognition and under-enforcement of minors' rights to bodily integrity.²³⁷ Indeed, recent studies indicate that many practitioners grant decision-making authority to minors that they perceive as mature, regardless of legal imperatives.²³⁸ Perhaps it is time for the law to catch up with medical practice and articulate a new default rule.

Still, there is no obvious or easy solution to this complex problem. One promising possibility, however, is that courts and litigants might begin to focus more on developing the doctrine pertaining to minors' constitutional right to bodily

234. See, e.g., Povenmire, *supra* note 207, at 105–06 (explaining that because of the uncertainty surrounding the constitutional status of parental discretion, courts have deferred to “parental discretion within a broad spectrum of situations ranging from those which are medically necessary, to those which do not threaten the health of the child”); *supra* note 202 and accompanying text.

235. See *supra* Part III.

236. See *supra* Part IV.

237. See Mutcherson, *supra* note 1, at 293. Mutcherson states:

The complexities of adolescent medicine continue to create dilemmas for healthcare providers. In a 1999 survey conducted by the AAP, 61.4% of responding healthcare providers identified the “availability of clearly defined state statutes on confidentiality, consent and other legal issues” as “*very effective* in reducing potential barriers to providing adolescent health care.” This finding indicates that both healthcare providers and their adolescent patients would benefit from more integrated and consistently articulated legal approach to standards of consent and confidentiality for young people.

Id. (quoting Am. Acad. of Pediatrics, *Periodic #42: Providing Health Care to Adolescents: Pediatricians' Attitudes and Practices*, <http://www.aap.org/research/periodicsurvey/ps42aexs.htm>).

238. Hartman, *supra* note 6, at 111–12 (reporting that roughly two-thirds of physicians permit adolescent patients to make decisions about their care even when the parent disagrees with the adolescent's choice); Lawrence, *supra* note 98, at 262 (finding that almost all ob/gyn physicians would prescribe contraceptives to a seventeen-year-old college freshman without involving the parents).

integrity, outside the contexts of abortion and abuse by state actors. Through case law, courts can thoughtfully and carefully examine the thorny issues pertaining to state action and governmental coercion, with an eye to finding some clear rules. In this way, a more coherent, predictable, and uniform body of law might emerge. At the very least, it is time to question the significance of the often-recited but rarely examined background assumptions regarding consent to medical treatment for adolescents.