

---

## The Right of Minors to Medical Treatment

Rowine Hayes Brown

Richard B. Truitt

Follow this and additional works at: <https://via.library.depaul.edu/law-review>

---

### Recommended Citation

Rowine H. Brown & Richard B. Truitt, *The Right of Minors to Medical Treatment*, 28 DePaul L. Rev. 289 (1979)

Available at: <https://via.library.depaul.edu/law-review/vol28/iss2/3>

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Law Review by an authorized editor of Via Sapientiae. For more information, please contact [digitalservices@depaul.edu](mailto:digitalservices@depaul.edu).

# THE RIGHT OF MINORS TO MEDICAL TREATMENT

Rowine Hayes Brown,\*  
Richard B. Truitt,\*\*

*The ability to freely obtain medical treatment is important to all people. Minors, with some exceptions, may be denied treatment unless their parents consent. The authors examine the scope of this parental consent restriction and discuss statutory and case law which modifies or enhances the minor's right to medical treatment. While there is a discernible trend toward increased recognition of minors' rights in this area, the law has not granted full autonomy to minors. Because of health, social and legal policies, the authors believe that minors should be allowed greater self-determination in matters regarding their health treatment.*

Within recent years society increasingly has become concerned with defining and protecting the fundamental rights of its various members. A basic right which must be secured for all members of a modern society is the right to adequate medical care, a right which is essential to survival. Yet it appears that minors, who comprise a large percentage of the population, presently encounter special difficulties in obtaining necessary medical treatment. Such difficulties have been produced by the confusion attendant to interpreting the various court decisions and statutes which recently have emerged in the area of minors' rights.

This Article will attempt to define the apparent need of minors for increased self-determination in obtaining medical care. To this end, state statutes which grant the rights of minors to treatment for particular medical conditions will be analyzed, and court decisions which have established a trend toward recognizing the minor's right to medical services will be discussed. Specifically, the focus will be on the right to consent to treatment, the area in which most litigation has occurred and most confusion exists.

## GENERAL RULE: CONSENT OF PARENT REQUIRED

An individual's right to prevent unauthorized interference with his physical integrity has been vigorously guarded by the courts.<sup>1</sup> As Justice Cardozo noted over sixty years ago, "every human being of adult years and

---

\* M.D. J.D. Medical Director, Cook County Hospital, Chicago, Ill.; Clinical Professor of Pediatrics, University of Illinois, Abraham Lincoln School of Medicine; Adjunct Professor of Law, Illinois Institute of Technology/Chicago-Kent College of Law; Honorary Degree of Doctor of Science, University of Illinois.

\*\* Senior partner, Truitt, Brown & Truitt, Chicago, Ill.; Miami University of Ohio; J.D., of Illinois Institute of Technology Chicago-Kent College of Law.

The authors wish to thank Nancy Lea Barrett, Steven Bright and Thomas Fahey of DePaul University College of Law for their assistance in the development of this Article.

1. See note 3 *infra*.

sound mind has a right to determine what shall be done with his own body."<sup>2</sup> As a result, the courts consistently have held that a physician's unauthorized treatment of a patient constitutes a battery.<sup>3</sup> When the patient is a minor,<sup>4</sup> the general rule has been that the express or implied consent of the parent or guardian is necessary to authorize medical treatment.<sup>5</sup> The rationale of this consent requirement is that minors lack the sophistication and intelligence to evaluate the consequences of medical treatment, and therefore they cannot give an informed and voluntary consent to the procedure.<sup>6</sup>

Courts, however, have not adhered strictly to the parental consent doctrine and have developed the following exceptions: (1) when an emergency exists; (2) when the child has been emancipated; (3) when the parents are remote, and it is impracticable to obtain timely consent;<sup>7</sup> (4) when the child

---

2. *Schoelndorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

3. *E.g.*, *Oakes v. Gilday*, 351 A.2d 85 (Del. Super. Ct. 1976) (treatment with medication without proper consent constitutes a battery); *Rogers v. Lumberman's Mutual Casualty Co.*, 119 So.2d 649 (La. Ct. of App. 1960) (a battery was committed when during an operation for the removal of an appendix, the physician removed the patient's reproductive organs without her consent and without the presence of an emergency situation); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905) (performance of a surgical operation upon the left ear, when the patient only had consented to surgery on the right ear, constituted a battery).

4. A brief digest of state statutes reveals that forty-three states set the age of majority at eighteen for purposes of consenting to general medical care; the others have established fourteen (Alabama), fifteen (Oregon), sixteen (South Carolina), nineteen (Alaska, Nebraska, Wyoming), and twenty-one (Mississippi, Missouri) as the age of majority for this purpose. FEDERAL REGISTER, Part III, 2101, January 13, 1978.

5. The leading case in the area is *Bonner v. Moran*, 126 F.2d 121, 75 U.S. App. D.C. 156 (D.C. Cir. 1941), in which a physician was sued for performing surgery on a fifteen year old boy without parental knowledge and with only the child's consent. The court held that absent special circumstances (for a listing, see note 8 and accompanying text *infra*) such a procedure constituted a battery regardless of the results. *Id.* at 122-23. *Accord*, *Younts v. St. Francis Hosp. and School of Nursing, Inc.*, 205 Kan. 292, 300-01, 469 P.2d 330, 337 (1970); *Zoski v. Gaines*, 271 Mich. 1, 9, 260 N.W. 99, 102 (1935); *Rogers v. Sells*, 178 Okla. 103, 104-05, 61 P.2d 1018, 1018-20 (1936); *Moss v. Rishworth*, 222 S.W. 225, 226 (Tex. Comm. App. 1920); *Browning v. Hoffman*, 90 W. Va. 568, 579-81, 111 S.E. 492, 496-97 (1922).

6. *Bonner v. Moran*, 126 F.2d 121, 122, 75 U.S. App. D.C. 156, 157 (D.C. Cir. 1941); *Younts v. St. Francis Hosp. and School of Nursing, Inc.*, 205 Kan. 292, 298-301, 469 P.2d 330, 336-37 (1970). *But see* *Lacey v. Laird*, 166 Ohio St. 1219, 139 N.E.2d 25, 30 (1956) (Hart, J., concurring) (the rule is based upon the rights of parents whose liability for support and maintenance of their child may be increased by an unfavorable result from the surgical procedure); *In re Clark*, 21 Ohio Op. 2d 86, 88, 185 N.E.2d 128, 131 (1962) (children are the property of their parents).

7. The remote parent exception will not be discussed further, even though it was listed by the courts denoting the general rule and its exceptions. See note 8 and accompanying text *infra*. The remote parent situation overlaps with the emergency and emancipation exceptions with little case law to distinguish it. See *Younts v. St. Francis Hosp. and School of Nursing, Inc.*, 205 Kan. 292, 469 P.2d 330 (1970) (it was unnecessary to obtain the prior consent of a parent two hundred miles away at an unknown address). The exception could also arise in the treatment of a college student attending school away from home. See A. HOLDER, *MEDICAL MALPRACTICE LAW* 25 (2d. ed. 1978) [hereinafter cited as HOLDER].

is close to majority and can knowingly give an informed consent.<sup>8</sup> For one of these exceptions to become operative, the courts have further required that the treatment be for the benefit of the child.<sup>9</sup> Analysis of the nature and scope of these exceptions is significant, for they represent the primary sources of a minor's right to consent to medical treatment.

## EXCEPTIONS

### *Emergency*

In an emergency medical crisis where delay would produce serious risks for the minor patient, courts have been hesitant to invoke the rule requiring express parental consent.<sup>10</sup> Physicians who have provided necessary medical treatment in these situations have been protected by the courts in lawsuits arising from their actions.<sup>11</sup> Conditions which uniformly would be considered emergencies by a physician are those which would result in severe hemorrhage, respiratory obstruction, or increased intracranial pressure.<sup>12</sup> Courts, however, have expanded upon this list by defining an

---

8. These exceptions to the general rule have been denoted in two cases, *Bonner v. Moran*, 126 F.2d 121, 122-23, 75 U.S. App. D.C. 156, 157-58 (D.C. Cir. 1941), and *Younts v. St. Francis Hosp. and School of Nursing, Inc.*, 205 Kan. 292, 300-02, 469 P.2d 330, 337-38 (1970). See notes 10-36 and accompanying text *infra*.

9. *Bonner v. Moran*, 126 F.2d 121, 123, 75 U.S. App. D.C. 156, 158 (D.C. Cir. 1941); *Younts v. St. Francis Hosp. and School of Nursing, Inc.*, 205 Kan. 292, 300, 469 P.2d 330, 337 (1970). See notes 10-36 and accompanying text *infra*. The *Bonner* court also required that the treatment be performed with the purpose of saving life or limb. 126 F.2d at 123, 75 U.S. App. D.C. at 158. This may be a logical prerequisite for the emergency, but it does not seem essential in the case of the emancipated minor, who is capable of giving consent for general medical treatment. See notes 18-27 and accompanying text *infra*.

10. *E.g.*, *Wells v. McGehee*, 39 So.2d 196 (La. Ct. of App. 1949) (severe fracture of right forearm of a seven year old girl); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912) (mangled and crushed left foot of fifteen year old boy); *Sullivan v. Montgomery*, 155 Misc. 448, 279 N.Y.S. 575 (1935) (fractured ankle). See also STETLER & MORITZ, *DOCTOR AND PATIENT AND THE LAW* 142 (4th ed. 1962).

11. In order to protect the physician, courts will generally conclude that consent is implied from the emergency. *Jackovach v. Yocom*, 212 Iowa 914, 924, 237 N.W. 444, 449 (1931); *Wells v. McGehee*, 39 So.2d 196, 202 (La. Ct. of App. 1949); *Luka v. Lowrie*, 171 Mich. 122, 134, 136 N.W. 1106, 1110 (1912); *Moss v. Richworth*, 222 S.W. 225, 226 (Tex. Comm. App. 1920). Cf. *Bakker v. Welsh*, 144 Mich. 632, 108 N.W. 94 (1906) (consent of father to 17 year old's operation was implied where he had knowledge of surgical preparation and did not object). See HOLDER, *supra* note 7, at 25. See also *Ollet v. Pittsburgh, C., C. & St. L. Ry.*, 201 Pa. 361, 50 A. 1011 (1902) (treatment of 17 year old boy's foot, which was crushed in a railway accident, was proper even though the minor protested that he wished to be treated by his family physician).

The emergency exception has also been adopted by the states through legislation. *E.g.*, ALA. CODE tit. 22, § 22-8-3 (1975); ILL. ANN. STAT. ch. 91, § 18.3 (Smith-Hurd Supp. 1978); PA. STAT. ANN. tit. 35, § 10104 (Purdon 1977). See, *e.g.*, ARK. STAT. ANN. § 82-364 (1976); GA. CODE ANN. § 88-2905 (1971); MISS. CODE ANN. § 41-41-7 (1972).

12. See R. HOEBELMAN, S. BLATMAN, P. BRUNELL, S. FRIDMAN & H. FEIDEL, *PRINCIPLES OF PEDIATRICS*, at 1812, 1936, 1937 (1st ed. 1978).

emergency as a condition which imminently threatens life or limb.<sup>13</sup> Indeed, the treatment of a fracture has been held to give rise to the emergency exception when it was necessary to stop needless pain and suffering.<sup>14</sup>

In a purported emergency it reasonably should appear that under the circumstances it was not feasible for the physician to obtain parental consent. It has been suggested that the physician must attempt to reach the parents before performing an emergency procedure upon a minor.<sup>15</sup> The effort to contact the parent need not be extensive; a phone call will suffice.<sup>16</sup> If a reasonable attempt to locate the parent is unsuccessful, the physician should then proceed with the treatment, for it could be a basis for malpractice liability if treatment were delayed to the detriment of the minor patient.<sup>17</sup>

### *Emancipation*

Parental consent for the medical treatment of a minor child has been deemed unnecessary when the minor patient is emancipated. Emancipation is the legal recognition that a minor is free from the care, custody and control of his parents.<sup>18</sup> In specific instances, courts have treated as emancipated those minors who are either married,<sup>19</sup> away from home with parental

13. *Jackovach v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931) (a bleeding, mangled arm constituted a menace to patient's life). See cases cited note 10 *supra*.

14. *Sullivan v. Montgomery*, 155 Misc. 448, 279 N.Y.S. 575 (1935). Courts generally are not willing to extend the "life or limb" standard too far. For example, in *Tabar v. Scobee*, 254 S.W.2d 474 (Ky. Ct. App. 1951), a physician removed a minor's fallopian tubes without consent during an authorized operation for appendicitis. It was held that an emergency did not exist because death was not likely to ensue immediately had the tubes remained untouched. The *Tabor* court stated that "[a]lthough delay in [the tubes'] removal might have proved harmful, even fatal, there still was time to give the parent and patient the opportunity to weigh the fateful question." *Id.* at 477. *Accord*, *Moss v. Rishworth*, 222 S.W. 225 (Tex. Comm. App. 1920) (removal of a child's tonsils was absolutely necessary but not emergent in the sense that death would have resulted upon the failure to perform the operation).

15. See *Jackovach v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931); *Wells v. McGehee*, 39 So.2d 196 (La. Ct. of App. 1949); *Browning v. Hoffman*, 90 W.Va. 568, 111 S.E. 492 (1922).

16. *Jackovach v. Yocom*, 212 Iowa 914, 923-24, 237 N.W. 444, 449 (1931); *Wells v. McGehee*, 39 So.2d 196, 202 (La. Ct. of App. 1949). See *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912) (an inquiry as to whether the minor's relatives were present in the hospital was sufficient when the physician knew that the parents were not immediately reachable); WALTZ & INBAU, *MEDICAL JURISPRUDENCE* 171 (1st ed. 1971).

17. CHAYET, *LEGAL IMPLICATION OF EMERGENCY CARE* 102 (1st ed. 1969). Obviously, the physician also will be liable if she performs the emergency procedure in a negligent manner resulting in damage to the minor. See, e.g., *Darling v. Charleston Community Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965).

18. E.g., *Vaupel v. Bellach*, 261 Iowa 376, 154 N.W.2d 149 (1967); *Rounds Bros. v. McDaniel*, 133 Ky. 669, 118 S.W. 956 (1909); *Wurth v. Wurth*, 313 S.W.2d 161 (Mo. Ct. of App. 1958). See HOLDER, *supra* note 7, at 24.

19. E.g., *McGregor v. McGregor*, 237 Ga. 57, 58, 226 S.E.2d 591, 592 (1976); *In re Palumbo*, 172 Misc. 55, 56, 14 N.Y.S.2d 329, 330 (1939); *Smith v. Seibly*, 72 Wash.2d 16, 21-22, 431 P.2d 719, 723-24 (1967). See *Bach v. Long Island Jewish Hosp.*, 49 Misc.2d 207, 267 N.Y.S.2d 289 (1966). See also HOLDER, *LEGAL ISSUES IN PEDIATRIC AND ADOLESCENT*

consent,<sup>20</sup> or responsible for their own well-being, economically or otherwise.<sup>21</sup> Some states have enacted statutes which define emancipation and which permit emancipated minors to consent to medical or surgical care without parental approval.<sup>22</sup> Whether the emancipated status has been recognized by the state's case law or its statutes, the result is the same: the child attains adult capacity to contract for medical treatment.<sup>23</sup>

A current area of controversy arising under the emancipation exception involves pregnant minors. Many states consider an unmarried pregnant girl emancipated and permit her to consent to therapy for herself and for the fetus.<sup>24</sup> In several of these states, statutes provide that the minor does not

MEDICINE 139 (1st ed. 1977) (if the marriage is dissolved, the minor remains emancipated unless the basis of the dissolution is an annulment action brought by the parents based upon the minor's lack of capacity to consent).

20. *Tencza v. Aetna Casualty and Surety Co.*, 111 Ariz. 226, 527 P.2d 97 (1974); *In re Marriage of Weisbart*, 564 P.2d 961 (Colo. Ct. of App. 1977).

21. *Carricato v. Carricato*, 384 S.W.2d 85 (Ky. Ct. of App. 1964); *Crosby v. Crosby*, 230 App. Div. 651, 246 N.Y.S. 384 (1930). It has also been held that minors who are in military service are considered emancipated. *Iroquois Iron Co. v. Industrial Comm'n.*, 294 Ill. 106, 109, 128 N.E. 289, 290 (1920); *Swenson v. Swenson*, 241 Mo. App. 21, 25-26, 227 S.W.2d 103, 105-06 (1950); *Fausser v. Fausser*, 50 Misc.2d 601, 602-03, 271 N.Y.S.2d 59, 61 (1966).

22. *E.g.*, ALA. CODE tit. 22, § 8-4 (1975) ("Any minor who is 14 years of age or older, or has graduated from high school, or is married, or . . . divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary."); CAL. CIVIL CODE § 34.6 (West Supp. 1978) (a minor fifteen years of age or older who is living separately from his parents and is managing his own financial affairs may give effective consent to medical treatment); MD. ANN. CODE art. 43, § 135 (Supp. 1978) (a minor who is either married or the parent of a child may give irrevocable consent for any medical treatment); NEV. REV. STAT. § 129.030(1) (Advance Sheets 1977) (minors may give valid consent to health services when he or she is living apart from his or her parents for at least four months, is married or has been married, or is a mother, or has borne a child). *See also* ARIZ. REV. STAT. § 44-132 (1967) and IND. CODE ANN. § 16-8-4-1 (Burns 1973) (a minor who is married or is "emancipated" may consent to medical care. Apparently "emancipated" is to be construed by the courts). Many of these statutes will limit the "emancipated" minor's right to obtain treatment. *E.g.*, CAL. CIVIL CODE § 34.5 (West Supp. 1978) and NEV. REV. STAT. § 129.030(4) (Advance Sheets 1977) (a minor may not obtain a sterilization without parental consent).

23. *See Note, A Minor's Right to Contraceptives*, in PROBLEMS IN LAW AND MEDICINE, 7 U. CAL. D. L. REV. 283 (1974).

24. For a list of these statutes, *see* note 79 *infra*. Furthermore, after the child is born, if it requires medical treatment, many states explicitly permit the minor mother to give effective consent to the procedure. ALA. CODE tit. 22, § 8-5 (1978); ALASKA STAT. § 09.65.100 (a)(3) (Supp. 1978); ARK. STAT. ANN. § 82-363(b) (1976); CONN. GEN. STAT. ANN. § 19-142(a) (West 1977); DEL. CODE tit. 13, § 707 (1974); FLA. STAT. ANN. § 458.215 (2) (West Supp. 1979); GA. CODE ANN. § 88-2904 (b) (Supp. 1978); ILL. ANN. STAT. ch. 91, § 18.2 (Smith-Hurd Supp. 1978); KAN. STAT. ANN. § 38-122 (1973); KY. STAT. ANN. § 214.815 (2) (1977); LA. REV. STAT. ANN. § 40:1293.53 (b) (West 1977); MD. ANN. CODE art. 43, § 135 (a)(1) (Supp. 1978); MASS. GEN. LAWS ANN. ch. 112, § 12F (West Supp. 1979); MINN. STAT. ANN. § 144.342 (Supp. 1979); MO. ANN. STAT. § 431.061 (Vernon Supp. 1979); NEV. REV. STAT. § 129.030 (1978); N.Y. PUB. HEALTH LAW § 2504 (McKinney 1977); OKLA. STAT. ANN. tit. 63, § 2602 (West Supp. 1978); PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977); R.I. GEN. LAWS § 23-51-1 (Supp. 1976); UTAH CODE ANN. § 78-14-5 (4)(a) (1953).

revert to her minority status following the birth.<sup>25</sup> Absent such a statutory provision, however, the common law rule applies, and the young mother will have to obtain parental consent for future medical treatment.<sup>26</sup> Finally, numerous jurisdictions do not consider a pregnant girl to be emancipated and will require parental consent for the medical treatment of both the minor and the fetus.<sup>27</sup>

### *Mature Minors*

The final and perhaps most arbitrary exception to the general rule requiring parental consent is the "mature minor" doctrine. Under this exception, minors are permitted to consent to medical or surgical therapy if it is evident that they are sufficiently mature to understand the nature of the procedure and its consequences. A noted pediatrician<sup>28</sup> has stated that "a 'mature' minor is not easy to define; however, he/she possesses some or all of these attributes: can and does make own decisions on daily affairs, is mobile, independent, and can manage financial affairs; can initiate own appointments, understands risks, benefits, and 'informed consent' (if anyone does!)." <sup>29</sup>

Courts generally have found this exception applicable only if the minor is at least fifteen years old and has intelligence, understanding, and independence of action.<sup>30</sup> In addition, the particular medical treatment to be performed must not be of a serious nature.<sup>31</sup> For example, a seventeen year

25. ALA. CODE tit. 22, § 8-5 (1975); ALASKA STAT. § 09.65.100 (a)(3) (Supp. 1978); KY. STAT. ANN. § 214.815 (2) (1977); MD. ANN. CODE art. 43, § 135 (a)(1) (Supp. 1978); MASS. GEN. LAWS ANN. ch. 112, § 12F (West Supp. 1979); MINN. STAT. ANN. § 144.342 (Supp. 1979); MO. ANN. STAT. § 431.061 (Vernon Supp. 1979); NEV. REV. STAT. § 129.030 (1978); N.Y. PUB. HEALTH LAW § 2504 (McKinney 1977); PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977).

26. Thus, in some states, the young mother will be able to consent to the medical treatment of her child, yet not be able to consent to her own medical care. Such a situation could arise under the Illinois statutory scheme. See ILL. ANN. STAT. ch. 91, § 18.3, ch. 111, §§ 4501-4502 (Smith-Hurd 1978).

27. See note 79 and accompanying text *infra*.

28. Dr. Merrit B. Low, president of the American Academy of Pediatrics, 1975-76. The American Academy of Pediatrics is the official organization of pediatricians.

29. News and Comments, 27 AM. ACAD. OF PEDIATRICS 5 (1976). See also PRINCIPLES OF PEDIATRICS, HEALTH CARE OF THE YOUNG 525 (Hoekelman ed. 1978) [hereinafter cited as HOEKELMAN] (no physician has ever been held liable for damages for treating a minor over the age of fifteen for any purpose when the minor consented).

30. See Chabon, *The Physician and Parental Consent*, 5 J. LEGAL MED. 33 (1977) [hereinafter cited as Chabon]. See notes 32-34 and accompanying text *infra*. See also *Zoski v. Gaines*, 271 Mich. 1, 10, 260 N.W. 99, 103 (1935) (nine year old cannot give valid consent to treatment); *Rishworth v. Moss*, 191 S.W. 843 (Tex. Civ. App. 1917) (parental consent necessary for operation to remove tonsils from an eleven year old child).

31. See Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSCODE HALL L.J. 115, 119 (1973); Wilkins, *Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors*, 1975 ARIZ. ST. L.J. 31, 52 (1975). See notes 32-34 and accompanying text *infra*. Furthermore the treatment must be for the benefit of the minor. See note 9 and accompanying text *supra*.

old boy was held to possess the capacity to consent to a smallpox vaccination since the procedure was simple and the boy could understand its consequences.<sup>32</sup>

In a more recent case, a seventeen year old girl injured her finger while at the hospital where her mother was a patient.<sup>33</sup> The girl was not in shock and the accident was not so severe as to be labeled an emergency. The child consented to a simple operation requiring sutures and a small skin graft. The procedure was performed successfully, yet the girl's mother sued for battery, alleging that the required parental consent had not been obtained. In holding that no cause of action would lie against the surgeon, the court noted that the minor was of sufficient age and maturity to understand the nature and consequences of the procedure and to make an effective consent.<sup>34</sup>

The doctrine of the mature minor also has received the attention of the state legislatures. To date, statutes have been enacted which adopt the rule in two different contexts. In the first type, the statute will explicitly provide that minors possessing sufficient intelligence to understand the consequences of the medical treatment may consent to such treatment.<sup>35</sup> The second type provide that the consent of a minor who professes that his or her consent alone is valid shall be effective if the physician has relied in good faith upon the minor's representation.<sup>36</sup> The overwhelming majority of states, however, do not have "mature minor" legislation and therefore must rely upon judicial promulgation of the doctrine.

---

32. *Gulf-S.I.R. Co. v. Sullivan*, 155 Miss. 1, 10, 119 So. 501, 503 (1928).

33. *Younts v. St. Francis Hosp. and School of Nursing, Inc.*, 205 Kan. 292, 469 P.2d 330 (1970).

34. *Id.* at 301, 469 P.2d at 338. *Accord*, *Bakker v. Welsh*, 144 Mich. 632, 108 N.W. 94 (1906) (nineteen year old could consent to surgery when he had discussed the matter with his father and adult relatives were present); *Lacey v. Laird*, 166 Ohio St. 12, 26, 139 N.E.2d 25, 34 (1956) (Taft, J., concurring) (an eighteen year old is capable of giving consent for simple plastic surgery performed on the nose). *See Baird v. Attorney General*, 360 N.E.2d 288, 293-97 (1977) (mature minor rule will apply in Massachusetts except when the legislature explicitly requires parental involvement) (*see* notes 117-121 and accompanying text *infra*). *See also* *Bishop v. Shurley*, 237 Mich. 76, 211 N.W. 75 (1926) (a nineteen year old who could statutorily contract with a physician could also orally consent to modifications in the treatment procedure); *Bach v. Long Island Jewish Hosp.*, 49 Misc.2d 207, 267 N.Y.S.2d 289 (1966) (there is no reason why a nineteen and one half-year old married girl cannot be said to have reached the age of discretion with regard to consenting to treatment of a skin disorder); *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972) (the wishes of a sixteen year old regarding treatment of poliomyelitis must be considered. This case was remanded to determine the child's wishes. The lower court determined that the child did not wish a transfusion and refused to order one. The Supreme Court of Pennsylvania affirmed. *In re Green*, 452 Pa. 373, 307 A.2d 279 (1973)).

35. ARK. STAT. ANN. § 82-363 (1976); MISS. CODE ANN. § 41-41-3 (h) (1972). *See also* *Chabon*, *supra* note 30, at 36.

36. ALA. CODE tit. 22, § 8-7 (1975); GA. CODE ANN. § 88-2906 (1971); PA. STAT. ANN. tit. 35, § 10105 (Purdon 1977). *See* IDAHO CODE § 39-4302 (1977) (the statute provided that any person of ordinary intelligence and awareness sufficient to comprehend the need, nature and risks of medical treatment is competent to give consent. In addition, the statute states that a



WHEN PARENTS WITHHOLD CONSENT TO MEDICAL  
TREATMENT FOR THEIR MINOR CHILDREN

Parents are typically concerned about the health of their children. They will seek medical care for the child, consent to necessary treatment, and assume financial responsibility for the cost of such treatment. Occasionally, however, the situation will arise where parental consent is required for treatment, and the parents will refuse to give their approval. This situation presents the attending physician with a serious dilemma.

If the physician treats the child under such circumstances, he runs the risk of committing a battery.<sup>37</sup> On the other hand, if treatment is withheld by the physician and the child's health status deteriorates, it is conceivable that grounds for malpractice liability would exist.<sup>38</sup> A final possibility would arise if the child was a "mature minor" under state law<sup>39</sup> and personally consented to the procedure notwithstanding the parental objections. The physician would have to answer for his failure to treat such a minor who enjoys the legal status of an adult for purposes of consenting to medical treatment.

To avoid this dilemma, physicians and hospitals should seek court orders to authorize medical treatment of minors when their parents will not consent and the physician believes treatment is necessary.<sup>40</sup> When a physician is

---

physician may administer health care if the consenting person appears to the physician to possess the requisite intelligence and awareness).

37. See notes 3-5 and accompanying text *supra*.

38. See note 17 and accompanying text *supra*.

39. See text accompanying notes 29-36 *supra*.

40. Social and welfare agencies may initiate court proceedings on behalf of minors who need medical treatment. For example, in *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (1961), a complaint was filed by the county's Child Welfare Department on behalf of an unborn infant whose mother, a Jehovah's Witness, objected to an intrauterine transfusion on religious grounds. Because doctors testified that unless the transfusion was performed the infant would die or be severely damaged "beyond a reasonable doubt," the court declared the infant to be a ward of the court for purposes of obtaining the transfusion. *Id.* at 525, 171 A.2d at 145.

Other concerned parties may petition the courts to aid minors in need of treatment when parental consent is lacking. In one case the sister of a young girl sought a court order to permit surgeons to amputate the child's grossly enlarged and useless arm. *In re Hudson*, 13 Wash. 2d 673, 126 P.2d 765 (1942). See text accompanying notes 48-55 *infra*. Of course, doctors and hospitals do not have precisely the same concerns as do social welfare agencies or close relatives of minors needing medical care. However, to protect themselves from possible liability, physicians should not hesitate to seek judicial intervention in cases involving minor patients whose parents refuse to consent to medical treatment.

The scope of this problem has been recognized in Illinois, as evidenced by recent legislation aimed at encouraging physicians and others to report instances of child abuse or neglect. For example, one provision states that a doctor may take temporary protective custody of a child without the parents' consent, if the doctor reasonably believes the child's life or health is in imminent danger. ILL. REV. STAT. ch. 23, § 2055 (1977). The statute also provides that the physician must notify the parents and the Illinois Department of Children and Family Services. Further custody procedures must then be undertaken in court for purposes of determining the minor's status as a neglected or abused child. *Id.*

uncertain as to the requirement of parental consent, and seeks judicial intervention, he avoids personal liability and at the same time benefits the minor in need of medical treatment.

There are three typical situations in which parents withhold consent to treatment of their minor children: (1) a refusal based on religious grounds, (2) a refusal based on personal bias or fear of risks involved in the treatment, or (3) a refusal to consent to life-sustaining treatment for their deformed or severely brain-damaged children.

The first category involves situations in which religious beliefs have formed the basis of the parents' refusal to consent to medical treatment for their children. Often, this refusal has occurred when the parents are Jehovah's Witnesses and the proposed treatment involves blood transfusions.<sup>41</sup> When courts have attempted to balance the parents' rights to religious freedom against the child's right to receive medical treatment, they generally consider whether transfusions are necessary to save the child's life. If so, the parental objection is almost always overridden.<sup>42</sup> On the other hand, in non-life-threatening situations, such as those involving cosmetic surgery, courts may defer to the parents' religious beliefs.<sup>43</sup>

41. *E.g.*, cases cited in note 42 *infra*.

42. *See, e.g.*, *Jehovah's Witnesses v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968); *Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769, *cert. denied*, 344 U.S. 824 (1952); *Morrison v. State*, 252 S.W.2d 97 (Mo. App. 1952); *State v. Perricine*, 37 N.J. 463, 181 A.2d 751, *cert. denied*, 371 U.S. 890 (1962); *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (1961); *In re Clark*, 185 N.E.2d 128 (Ohio C. Com. Pleas 1962).

In each of the above cases, parents of children needing blood transfusions refused to consent because, as Jehovah's Witnesses, they believed that transfusions were prohibited by their religion. While the parents were sincere in their faith and believed they were acting in their children's best interests, the courts placed the children's right to live above the parents' religious beliefs. In expressing the policy behind judicial intervention under these circumstances, one court stated:

[We] believe that every human being is endowed by God with the inalienable right to live. The fact that the subject is the infant child of a parent who, arbitrarily, puts his own theological belief higher than his duty to preserve the life of his child cannot prevail over the considered judgment of an entire people . . . . Society is not required to stand aside until the child is dead for want of care.

*Morrison v. State*, 252 S.W.2d 97, 101-02 (Mo. App. 1952).

43. For example, a petition was brought by the director of the Pennsylvania State Hospital for Crippled Children, seeking to have a minor declared "neglected" under state law, and thus be given spinal surgery and blood transfusions in an effort to correct severe curvature of the spine. The Supreme Court of Pennsylvania upheld the parents' religious objections to the surgery since the child's life was not in danger and the risks involved in the surgery were high. *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972). The court also remanded the case to procure evidence of the sixteen year old boy's wishes. *Id.* Subsequently, the court affirmed the lower court's determination that since the child did not wish a transfusion, one would not be ordered. *In re Green*, 452 Pa. 373, 307 A.2d 279 (1973). *But cf. In re Sampson*, 29 N.Y.2d 900, 328 N.Y.S.2d 686, 278 N.E.2d 918 (1972) (*per curiam*) (affirmed family court judge's order authorizing cosmetic surgery and transfusions for a minor with grotesque facial lesion, despite parents' religious objection to transfusions); *In re Karwath*, 199 N.W.2d 147 (Iowa 1972) (affirmed juvenile court order requiring non-emergency operations to be performed upon wards of the state, de-

Under the doctrine of *parens patriae*,<sup>44</sup> or by authority of "neglected child" statutes,<sup>45</sup> a court may remove the child from the custody of the parents for purposes of furnishing needed medical treatment. In this situation, the state's interest in protecting its citizens is deemed greater than the first amendment's prohibition against governmental infringement upon religious beliefs. As the United States Supreme Court has recognized, "[t]he right to practice religion freely does not include liberty to expose . . . the child to . . . ill health or death."<sup>46</sup>

A second type of parental objection arises when parents deny their children medical treatment because they fear that the risks involved outweigh the potential benefits, or because they do not believe in the efficacy of medical techniques. As indicated, courts are unlikely to uphold any parental ob-

spite objection of the children's father). See also *In re Hudson*, 13 Wash.2d 673, 126 P.2d 765 (1942) (parent's objection to major surgery on deformed child upheld on non-religious grounds), discussed in text accompanying notes 48-55 *infra*. See generally Annot., 52 A.L.R.3d 1118 (1973).

44. "The doctrine of *parens patriae* expresses the inherent power and authority of the state to provide protection of the person and property of a person non sui juris, and under the doctrine the state has the sovereign power of guardianship over persons of disability." 67A C.J.S. *Parens Patriae*, at 159 (1978).

The United States Supreme Court has made it clear that "neither rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways." *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944).

45. *E.g.*, ARK. STAT. ANN. § 82-364.1 (Supp. 1977); MISS. CODE ANN. § 41-41-9 (1972). See 1978 CAL. LEGIS. SERV. ch. 432, § 8.7 (amending CAL. WELF. INST. CODE § 727) (child must be adjudged a dependent of the court before the court will order treatment); N.Y. JUD. LAW (McKinney Supp. 1978) (a court may order medical treatment performed on any child within its jurisdiction when necessary). An almost identical version of the New York statute was interpreted in *In re Vasko*, 238 App. Div. 128, 263 N.Y.S. 552 (1933), in which parents refused to permit the removal of an eye from their two year old child. The court ordered the needed operation performed stating that "it was the intent of the Legislature to invest the court with wide powers of discretion, to be exercised on the advice of competent medical or surgical authority, uninfluenced by the whims or arbitrary determination of parents or guardians, in advancing the well-being of the child." *Id.* at 130, 263 N.Y.S. at 555. See also NEV. REV. STAT. § 129.040 (1977) (when emergency treatment is necessary, consent may be given by any person in loco parentis to the minor).

Judicial interpretation of dependent or neglected child statutes is generally liberal when the child's life is in danger and parental consent is withheld on religious grounds. Thus, a child may be well-fed and cared for, yet still "neglected" if in need of medical treatment. See, *e.g.*, *People v. Labrenz*, 411 Ill. 618, 624, 104 N.E.2d 769, 773 (1952) (court defined neglect as "the failure to exercise the care that the circumstances justly demand."); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962) (parents' religious-based objection to blood transfusion for child constituted "statutory neglect").

46. *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944). The Court expressed the same sentiment more graphically in *Reynolds v. United States*, 98 U.S. 145, 166 (1878): "[s]uppose one believed that human sacrifices were a necessary part of religious worship, would it seriously be contended that the civil government under which he lived could not interfere to prevent a sacrifice?"

jection when a child's *life* is in imminent danger.<sup>47</sup> Legal and moral problems arise, however, when parents object to medical treatment which is non-essential, yet would greatly improve their childrens' appearance, and by implication, allow them to lead more "normal" lives. Two major cases exemplify the complex issues that courts must resolve when determining whether specific parental objections outweigh the child's right to non-emergency treatment.

The first case, *In re Hudson*,<sup>48</sup> involved an eleven year old girl who was born with a congenital condition of the left arm which had caused the arm to grow to a size almost ten times that of her right arm. Because of her monstrous appearance the child did not attend school and never ventured from home. Eventually, an adult sister complained to the juvenile court that the child needed medical care. The court ordered an examination and doctors recommended that the arm be amputated.<sup>49</sup> The doctors testified at the hearing that the operation would involve a fair degree of risk and that the girl could die. The girl's mother refused to consent to the surgery because of its dangers, despite testimony indicating that the child hated her appearance and wanted the arm removed.<sup>50</sup>

The juvenile court ordered the surgery to be performed, based on a finding that the minor was a "dependent child" within the state's juvenile court law.<sup>51</sup> The Washington Supreme Court reversed.<sup>52</sup> While recognizing that the parents had shirked their duty toward the child, the court could find neither a statutory<sup>53</sup> nor equitable basis<sup>54</sup> for removing the child from her

---

47. See note 42 and accompanying text *supra*.

48. 13 Wash. 2d 673, 126 P.2d 765 (1942).

49. *Id.* at 676, 126 P.2d at 768. The physicians believed removal of the "enormously heavy, useless extremity" was necessary for the girl's general health. As well as destroying her chance for a normal life, the arm was causing a burden on her heart and deforming her chest and spine because of its great weight. *Id.*

50. *Id.*

51. The court said that "[t]he juvenile court law . . . defines a dependent child as any child under the age of eighteen years who is destitute . . . or whose parent does not properly provide for such child. . . . All dependent children are wards of the state and their persons are subject to the custody, care and control of the court." 13 Wash.2d at 680, 126 P.2d at 769. The juvenile court held that the statute was to be liberally construed and that the word "destitute" properly encompassed a child lacking necessary medical or surgical attention. *Id.* at 678, 126 P.2d at 768.

52. *In re Hudson*, 13 Wash.2d 673, 713, 126 P.2d 765, 783 (1942).

53. The court noted that under the state penal statutes a parent who "wilfully omitted" to furnish necessary food, clothing, shelter or medical attention for the child could be found guilty of a gross misdemeanor. The juvenile court law, on the other hand, did not contain a provision concerning the furnishing of necessary medical or surgical care. The court held that parents could not be deprived, even temporarily, of custody of their child "unless they were adjudicated unfit to be parents in a custody hearing." 13 Wash.2d at 712, 126 P.2d at 783.

The mother had employed a "Divine Healer" who had treated the child by prayer alone for four years, and the father was a passive invalid who did not wish to become involved in the controversy. Nevertheless, the court did not find the parents neglectful under the statute or under common law principles, largely because the proposed surgery involved a substantial risk of death and the girl was not otherwise ill-treated by her parents.

54. The court recognized that if parents by neglect are unwilling or unable to care for their

parents' custody to order amputation. The court thus refused to adopt the lower court's construction of the "neglected or dependent child" statute in the absence of further evidence of improper care of the child.<sup>55</sup>

The second major case upholding parents' discretionary objections to medical treatment, *In re Seiferth*,<sup>56</sup> involved a fourteen year old boy with a cleft palate and a harelip, obvious cosmetic and functional deformities. The boy's father believed in mental healing by "letting the forces of the universe work on the body,"<sup>57</sup> and had instilled in the boy a fear of surgery. A county health department official petitioned the New York Children's Court to declare the boy a neglected child and requested a transfer of custody from the parents to the social welfare agency for purposes of consenting to surgery.<sup>58</sup> The New York Court of Appeals agreed with the Children's Court's dismissal of the petition, deferring to the discretion of the trier of fact.<sup>59</sup> The court stated that the boy should make his own decision after a few years, since at the time of the proceedings it did not appear that the boy wished to cooperate with the physicians and speech therapists. Indeed, the boy believed that the surgery would be a "distortion" which would have to be "remedied" before he could go back to the "primary task of healing his body."<sup>60</sup> Therefore, despite the fact that the boy's grotesque appearance could be substantially improved without significant surgical risks, the court refused to force the boy to undergo treatment, in light of his "sincere and frightened antagonism" toward the surgical procedure.<sup>61</sup>

minor children, a court may exercise its equitable jurisdiction to remove the children from the parents' custody and appoint a legal guardian. *Id.* at 698, 126 P.2d at 777. This power did not include, however, removing a child from the custody of parents who were not adjudicated "unfit" and subjecting the child to major surgery over parental objection. 13 Wash.2d at 700, 126 P.2d at 778.

55. See note 51 *supra*. The dissenting opinion stated the parents had violated their parental duty to regard the child's well-being as paramount and such dereliction of duty made them neglectful and unfit as parents. Therefore the child should be considered "destitute." 13 Wash.2d at 722, 126 P.2d at 787 (Simpson, J., dissenting). The dissenting judge felt that the juvenile court had cause to declare Hudson a dependent child, should temporarily deprive the parents of custody, and should enter an order requiring amputation of the child's deformed arm. *Id.* at 733, 126 P.2d at 791-92. Finally, the judge stated that the girl was "entitled to a healthy body, to secure a good education, to take her place in American society. . . . Without an operation all these are denied to her and she is condemned to travel along life's pathway a hopeless cripple. . . ." *Id.*

56. 309 N.Y. 80, 127 N.E.2d 820 (1952).

57. *Id.* at 84, 127 N.E.2d at 822. The father denied that his attitude towards mental healing was a religious conviction, but asserted it was purely his own philosophy.

58. The surgical procedure required for correcting the boy's cleft palate and harelip are usually performed when the patient is quite young. It is not considered emergency surgery, although it is obviously beneficial, cosmetically as well as functionally. The boy's father had stated he would not oppose the operations if his child decided to have them.

59. *In re Seiferth*, 309 N.Y. 80, 85, 127 N.E.2d 820, 823 (1952).

60. *Id.*

61. *Id.* The Children's Court judge had stated that the order for surgery would have been "granted without hesitation if the proceeding had been instituted before [the] child acquired

Both *Hudson* and *Seiferth* reflect judicial hesitation to order non-emergency medical treatment for minors in the face of strong parental opposition or influence. It is true that parental discretion should not be lightly overridden where the treatment involves differences in medical opinions as to the effectiveness of the treatment, or where the proposed treatment is dangerous to the child's life and the child either adopts the parents' views or is too young to decide for himself whether to obtain treatment. On the other hand, when deformities are extreme and corrective surgery would likely enrich the child's life, parental objections should be carefully scrutinized. Ideally, the child should have a decisive voice in determining whether parental objections would be sustained by the courts. Surprisingly, however, few courts appear to be concerned with the child's desires.<sup>62</sup> It may be true that parents' influence over their child's beliefs is so strong that the child would agree with his parents as a matter of course. Nevertheless, a child suffering from a non-fatal condition which could be improved with medical treatment should be given a full explanation of the proposed medical treatment and be allowed to make an informed judgment as to the risks and benefits involved.

The third category of objections includes situations in which parents withhold consent to life-sustaining treatment<sup>63</sup> for their severely deformed or brain-damaged newborn,<sup>64</sup> or an older child who has become incapacitated from accident or disease.<sup>65</sup> This category is distinct in that it involves minors

---

convictions of his own." 309 N.Y. at 86, 127 N.E.2d at 822. The dissenting opinion to the New York Court of Appeals decision stated that the court had a duty to order the surgery and that the court should not foist upon the boy the ultimate decision. *Id.* at 87, 127 N.E.2d at 824. (Fuld, J., dissenting). "Neither by statute nor decision is the child's consent necessary or material, and we should not permit his refusal to agree, or his failure to cooperate, to ruin his life and any chance for a normal existence." *Id.*

62. See *Wisconsin v. Yoder*, 406 U.S. 205, 241-46 (1971) (Douglas, J., dissenting in part). The majority holding in *Yoder* was that compulsory school attendance laws as applied to Amish children after the eighth grade violated the free exercise of religion by the Amish parents. Douglas criticized the Court's analysis because it assumed that the only interests at stake in the case were those of the Amish parents and of the state. Douglas would have remanded to determine whether Amish children wished to continue their public education in spite of their parents' beliefs. Cf. *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972) (court remanded case involving operation for evidence of minor boy's wishes). For a procedural history, see note 43 *supra*.

63. For the purpose of this section, "life-sustaining treatment" refers to measures which prolong life or delay death in situations involving critical injuries or severe birth defects which would either result in eventual death or a lingering vegetative state. A distinction between ordinary and extraordinary treatment has been recognized. See N. ST. JOHN-STEVAS, *EUTHANASIA, IN LIFE, DEATH AND THE LAW* 262, 275-76 (1961). Major religions agree that extra-ordinary measures (such as artificial respirators) need not be applied in hopeless cases. Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1209 (1973).

64. See note 67 *infra*.

65. A child who is in a coma, for example, with little or no chance for survival without the aid of mechanical means may be in a vegetative state. In the widely publicized case, *In re Quinlan*, 137 N.J. Super. 227, 348 A.2d 801 (1975), *modified and rem.*, 70 N.J. 10, 355 A.2d 647

whose condition necessarily excludes them from participating in decisions regarding medical treatment. A primary question which arises under these circumstances is whether a life will be "meaningful and cognitive."<sup>66</sup> Recent emergence of the controversial quality-of-life ethic, which places relative instead of absolute value on life, creates doubts in the minds of some health care workers as to whether some severely damaged children should be permitted to live.<sup>67</sup>

The decision to withhold life-sustaining treatment might be made by the family and the hospital, working as a "team." Physicians, in some cases, might seek intervention from the courts if they do not agree with the parents' decision to withhold treatment, or if they fear liability. It is also possible that a hospital employee, upset by the decision to let the infant die, might report the facts to the "authorities."<sup>68</sup>

The decision to withhold life-sustaining treatment, or "passive euthanasia," poses serious moral and ethical issues.<sup>69</sup> In addition, physicians who withhold medical treatment may encounter difficult legal problems, for omission of treatment could be viewed as malpractice at the minimum, manslaughter

---

(1976), parents of a twenty-one year old comatose girl sought to shut off the respirator which kept their daughter physically alive although her permanently damaged brain was barely functioning and the prognosis for her survival was remote. The New Jersey Supreme Court granted declaratory relief to the girl's father who wished to be appointed her guardian for purposes of deciding whether to disconnect her respirator. The court held that the parents, their choice of physicians, and the hospital's Ethics Board had power to make that determination free of civil or criminal liability, as long as the group concluded that there was "no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state." *Id.* at 55, 355 A.2d at 672.

66. See Nolan-Haley, *Defective Children, Their Parents & the Death Decision*, 4 J. LEG. MED. 9 (Jan. 1976).

67. *Id.* See also Brown & Truitt, *Euthanasia and the Right to Die*, 3 OHIO NORTH. L. REV. 615 (1976). For a comprehensive collection of articles treating the religious, moral, ethical and legal aspects of euthanasia, see DEATH, DYING, AND EUTHANASIA (D. Horan & D. Mott, eds. 1977) [hereinafter cited as DEATH] One section is particularly relevant to this discussion, *Death as a Treatment of Choice?: Involuntary Euthanasia of the Defective Newborn*, in DEATH, *supra* n.67, at 75.

A 1973 report from Yale University Medical School indicated that 43 of the 299 consecutive deaths in their special-care nursery were of infants who were "allowed to die" by the withholding of treatment. The study is reported by Duff & Campbell, *Moral & Ethical Dilemmas in the Special-Care Nursery*, 289 N. ENG. J. MED. 890 (1973). In all of the forty-three deaths, parents and physicians in group decisions concluded that the infants had extremely poor and hopeless prognoses.

68. Brown & Truitt, *Euthanasia and the Right to Die*, 3 OHIO NORTH. L. REV. 615, 631 (1973). There is evidence that euthanasia by omission is widely practiced. See Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1213 n.80 (1973). However, there have not been many prosecutions. See note 70 *infra*. Unless the lay press becomes aware of specific instances of the practice, it is safe to assume that decisions between parents and physicians to withhold life sustaining treatment for defective newborns generally will remain unreported.

69. See R. WEIR, *ETHICAL ISSUES IN DEATH AND DYING* (1977).

or murder in the extreme.<sup>70</sup> Parents who refuse to consent to treatment for their incapacitated minors also might face charges under child neglect statutes or penal provisions.<sup>71</sup> Although public sympathy might well support the euthanasia decision of parents and physicians in extreme "hardship" cases,<sup>72</sup> from a legal standpoint the minor's interests appear to be unprotected.<sup>73</sup> Therefore, in view of the controversial and complex ramifications of legalizing what has been labelled "mercy killing," courts are likely to use caution before ordering or permitting the termination of life-sustaining medical treatment for deformed or brain-damaged infants.<sup>74</sup>

---

70. The legal consequences of euthanasia by omission are unclear. There appear to be no reported cases in which a malpractice claim has been filed against a physician who with the consent of the family, has stopped employing extraordinary means to prolong the life of a terminal patient. Horan, *Euthanasia As Medical Management*, in DEATH, *supra* note 67, at 211. Theoretically, a physician risks civil liability as long as there is a legal duty imposed on him to continue treatment. If the physician fails to exercise ordinary care, he could be liable for damages. *Id.* Of course, assuming the parents of the defective newborn consented to the cessation of extraordinary treatment, it is unlikely that there would be any party to bring suit.

Similarly, it appears that there have been no criminal prosecutions of physicians (or parents) who have withheld medical treatment from a defective infant. *Id.* at 212. See also Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, in DEATH, *supra* note 67, at 139-69. A distinction should be recognized, however, between "passive" euthanasia (withholding extraordinary means of life prolonging treatment) and active "mercy killing." In the latter instance, criminal prosecution is more likely because a deliberate, intentional killing is legally defined as homicide. A "merciful" motive is not generally a defense to the crime. See Horan, *supra* at 208-09. See also *Turner v. State*, 119 Tenn. 663, 108 S.W. 1139 (1908) (the fact that decedent requested accused to kill him did not exculpate the defendant).

71. See Robertson, *Involuntary Euthanasia of Defective Newborns*, in DEATH, *supra* note 67, at 143-50. In typical cases of a social agency or hospital seeking a court order to compel treatment of a minor over parental consent, the child neglect statutes are invoked to aid the injured child, not to prosecute the parents, although different jurisdictions may impose sanctions on the parents. See note 45 *supra*.

72. See Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1214-15 (1973), in which an English case is discussed which illustrates probable public reaction to mercy killing in extreme cases. A man had drowned his six year old son who was described as a "living cabbage." After 600 of the man's neighbors signed a petition for clemency, the judge placed the man on probation. *Id.*, citing to N.Y. Times, Dec. 26, 1971, at 47, col. 7. Note that this case involves "active" euthanasia, arguably more serious than merely ceasing to continue extraordinary, artificial life-prolonging measures.

73. The question is raised as to who protects the minor's right to live. The interests of the parents or physicians of a defective newborn may not coincide with those of the infant, for the assumption that no life is preferable to a severely handicapped or comatose existence is open to debate. The most difficult situations involve infants such as mongoloids, who are severely retarded yet are responsive to love and caring. See Hauerwas, *Selecting Children to Live or Die: An Ethical Analysis . . .*, in DEATH, *supra* note 67, at 228-49; Gustafson, *Mongolism, Parental Desires, and the Right to Life*, in DEATH, *supra* n. 67, at 250-78.

74. See *Maine Medical Center v. Houle*, Civil No. 74-145 (Me. Super. Ct., Feb. 14, 1974), reproduced in R. WEIR, *ETHICAL ISSUES IN DEATH AND DYING* 185 (1977). The court in *Houle* ordered surgery to be performed on a severely deformed infant who could not ingest nourishment without the surgery. The infant almost certainly had suffered brain damage as well, and the parents refused to consent to the surgery. The hospital sought intervention of the court. In authorizing the infant's guardian ad litem to consent to the surgery, the court stated that "at the



MINORS' RIGHTS INVOLVING SPECIFIC  
TYPES OF MEDICAL PROCEDURES

In the preceding discussion comments were made on the current statutory and judicial delineation of the minor's right to consent to medical treatment. This right has been shown to be of limited scope, arising only when there can be found an exception to the general rule requiring parental consent for the treatment of the minor child. We have noted further the dilemma that occurs when parents refuse to consent to such treatment. We now will focus on the right of the minor to consent to certain controversial types of medical care: pregnancy-related treatment, contraception, abortion, sterilization, treatment of venereal disease, and organ donation.

*Pregnancy*

It was projected that in 1978 over one million girls under the age of eighteen would become pregnant—the vast majority of whom would be unmarried.<sup>75</sup> Most pregnant teenagers do not seek a timely diagnosis of their pregnancy and therefore do not receive proper pre-natal care.<sup>76</sup> Indeed, the 1978 statistics predicted that approximately one-third of these "minor" pregnancies would terminate by abortion and one-tenth would result in spontaneous miscarriages.<sup>77</sup> Many girls whose pregnancies are not terminated encounter other problems, such as giving birth to premature infants.<sup>78</sup>

Statutory requirements that the minor receive parental consent for pregnancy-related medical treatment serve to complicate this situation. The problems of delayed detection and treatment arise from the child's hesitance in confronting the dilemma; a parental consent requirement will aggravate this indecisiveness. In recognition of this problem, over one-half of the states have enacted laws which allow pregnant minors to secure pregnancy care by

moment of live birth there does exist a human being entitled to the fullest protection of the law. The most basic right enjoyed by every human being is the right to life itself." *Id.* at 186. See also Chicago Daily Law Bulletin, Feb. 17, 1978, at 1, which reported that a judge in Salem, Massachusetts ordered potentially life-saving surgery for a forty-three day old baby born with severe physical and mental defects, despite the parents' plea that the infant be allowed to die. The judge said that a Massachusetts Supreme Court opinion of Nov. 28, 1977 gave probate courts the right to exercise discretion in the decision of withholding life sustaining equipment.

75. Chicago Sun-Times, March 13, 1978, at 18, col. 1. A substantial proportion of these girls are of junior high-school age. *Id.*

76. Gunby, *Minors Present Major Medical Problems*, 239 J.A.M.A. 1477 (1978) (60% of fifteen year old mothers had no professional care in the first three months of their pregnancy—the period during which the major formation of the fetus occurs). See also Gunby, *The Pregnant Adolescent: A Very Special Problem*, News and Comment of American Academy of Pediatrics (1977); *Special Report—Teenage Pregnancy*, 13 Ill. Comm'n. on Children 8 (1976).

77. Gunby, *Minors Present Major Medical Problems*, 239 J.A.M.A. 1477 (1978).

78. HOEKELMAN, *supra* note 29. See generally J. ZACKLER & W. BRANDSTADT, *THE TEEN-AGE PREGNANT GIRL* (1975).

their own volition.<sup>79</sup> It would be in the best interest of the minor and the fetus if all jurisdictions followed the lead of these progressive states in their attempt to minimize the adverse consequences of teenage pregnancies.

### *Contraception*

The epidemic proportion of teenage pregnancies also has raised the question whether contraceptives should be made available to minors and, if so, whether parental consent should be mandatory.<sup>80</sup> Because of the common law rule which generally requires consent of the parent before a minor is treated for *any* medical condition,<sup>81</sup> physicians may fear tort or even criminal liability for failing to secure parental consent before dispensing contraceptives to minors.<sup>82</sup> The most difficult problem in this area, however, is

79. ALA. CODE tit. 22, § 8-6 (1975); ALASKA STAT. § 09.65.100(a)(4) (Supp. 1978); ARK. STAT. ANN. § 82-363(d) (1976); CAL. CIVIL CODE ANN. § 34.5 (West Supp. 1977); DEL. CODE tit. 13, § 708 (Supp. 1978) (minor must be twelve years of age or over to give effective consent); FLA. STAT. ANN. § 458.215(1) (West Supp. 1979); GA. CODE ANN. § 88-2904(F) (Supp. 1978); HAW. REV. STAT. § 577A-2 (1976); ILL. ANN. STAT. ch. 91, § 18.1 (Smith-Hurd Supp. 1978); KAN. STAT. ANN. § 38-123 (1973) (an unmarried pregnant minor, where no parent is available, may give consent to medical care related to her pregnancy); KY. REV. STAT. ANN. § 214.85(1) (1977); LA. REV. STAT. ANN. § 40:1299.53(e) (West 1977); MD. ANN. CODE art. 43, § 135(a)(2) (Supp. 1978); MASS. GEN. LAWS ANN. ch. 112, § 12F (West Supp. 1979); MINN. STAT. ANN. § 144.343 (Supp. 1979); MISS. CODE ANN. § 41-41-3 (1972); MO. ANN. STAT. § 431.061 (Vernon Supp. 1979); MONT. REV. CODE § 69-6101 (1947); N.J. STAT. ANN. § 9:17A-1 (West 1976); N.M. STAT. ANN. § 24-1-13 (1978); 1977 N.C. ADV. LEGS. SERV. ch. 582, § 2 (amending N.C. GEN. STAT. § 90-21.5); OKLA. STAT. ANN. tit. 63, § 2602 (West 1978); PA. STAT. ANN. 35 § 10103 (Purdon 1977); TEX. FAM. CODE ANN. tit. 2, § 35.03(a)(4) (Vernon 1975); UTAH CODE ANN. § 78-14-5(4)(F) (1953); VA. CODE § 32-137(7) (Supp. 1978). In order to prevent a court from interpreting the statutory right to consent to treatment for pregnancy to include the right to consent to an abortion, Arkansas, Delaware, Florida, Louisiana, Maryland, Massachusetts, Missouri, North Carolina and Virginia have language within the statute that expressly prohibits this from occurring.

Only six jurisdictions permit a pregnant minor to consent to medical treatment beyond that related to the pregnancy itself. ALA. CODE tit. 22, § 8-4 (1975); ILL. ANN. STAT. ch. 91, § 18.1 (Smith-Hurd Supp 1978); MASS. GEN. LAWS ANN. ch. 112, § 12F (West Supp. 1979); MO. ANN. STAT. § 431.061 (Vernon Supp. 1979); MONT. REV. CODE ANN. § 69-6101 (1947); N.J. STAT. ANN. § 9:17A-1 (West 1976).

80. Surveys show that only one in seven adolescents who become pregnant had ever attempted any form of contraception. See Gunby, *Minors Present Major Medical Problems*, 239 J.A.M.A. 1477, 1478 (1978). Studies also show that the lack of contraception does not decrease the sexual activity of adolescents. See Pilpel & Wechsler, *Birth Control, Teen-Agers and the Law: A New Look*, 1971, 3 FAM. PLAN. PERSPECT. 37 (1971). Use of contraceptives is documented as higher among female college students. See Kanter & Zelnick, *Contraception and Pregnancy: Experience of Young Unmarried Women in the United States*, 5 FAM. PLAN. PERSPECT. 21, 34-35 (1973). By 1970 almost one fifth of college and university health services prescribed contraceptives for minors who requested them, in spite of some hesitancy to do so. See Barbato, *Study of Prescription and Dispensing of Contraceptive Medications at Institutions of Higher Education*, 19 J. AM. COLLEGE HEALTH ASS'N 303, 306 (1971).

81. See text accompanying notes 5 & 6 *supra*.

82. See Pilpel, *Laws Relating to Family Planning Services for Girls Under Eighteen*, in THE TEENAGE PREGNANT GIRL 231, 235 (J. Zackler & W. Brandstadt eds. 1975). This fear appears

the possibly conflicting interests of the minor, the parents and the state.<sup>83</sup> Courts and legislatures may have to strike a delicate balance between the religious beliefs and general authority of parents, on the one hand, and the privacy rights asserted by minors, on the other.

Recent United States Supreme Court decisions indicate that a "right to contraception" is emerging as an aspect of personal autonomy or privacy.<sup>84</sup> In 1965, the Supreme Court struck down a statute which made the use of contraceptives a criminal offense, holding that the law was invalid as an invasion of the "right to privacy" of married people.<sup>85</sup> In 1972, the Court expanded this right to unmarried persons by prohibiting unequal statutory treatment of married and unmarried adults.<sup>86</sup>

Of more direct significance to minors is the Supreme Court's recent decision in *Carey v. Population Services International*,<sup>87</sup> in which the Court recognized that "the right to privacy in connection with decisions affecting procreation extends to minors as well as to adults."<sup>88</sup> At issue in *Carey* was a New York statute which provided criminal penalties for anyone convicted of selling or distributing birth control devices to minors under the age of sixteen.<sup>89</sup> The plurality opinion held that neither blanket prohibitions by the state nor absolute parental consent requirements could obstruct minors' access to contraceptives.<sup>90</sup> The Court went on to describe the constitutional

---

to be unfounded, as physicians have not been held liable for prescribing birth control devices to minors without parental consent. *Id.* See also Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy*, 88 HARV. L. REV. 1001 (1975).

83. See generally Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy*, 88 HARV. L. REV. 1001 (1975).

84. See notes 85-88 and accompanying text *infra*.

85. *Griswold v. Connecticut*, 381 U.S. 479 (1965). The court found a constitutional basis for the right of marital privacy in the penumbra or "zones of privacy" in the Bill of Rights. *Id.* at 484. In fact, the Court stated that marital privacy was "older than the Bill of Rights." *Id.* at 486.

86. *Eisenstadt v. Baird*, 405 U.S. 438 (1972). The Court rejected arguments that the Massachusetts criminal statute involved was a deterrent to fornication and a valid health measure. Using an equal protection analysis, the Court refused to differentiate between married and unmarried persons' privacy rights relating to contraception.

87. 431 U.S. 678 (1977).

88. *Id.* at 693, citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 75 (1976).

89. Two other provisions of the statute were held unconstitutional: (1) a prohibition against the distribution of contraceptives by a non-licensed pharmacist to persons over fifteen and (2) a prohibition against advertising or display of contraceptives. *Carey v. Population Serv. Int'l*, 431 U.S. 678, 681 (1978).

90. Six members of the Court agreed that the provision prohibiting distribution of contraceptives to persons over fifteen (except through licensed pharmacists) was an invasion of their right to privacy under the fourteenth amendment due process clause. 431 U.S. at 686-91 (Brennan, Stewart, Marshall, Blackmun, White, and Stevens, J.J.). Four separate concurring opinions and one dissenting opinion were filed along with the opinion of the Court, demonstrating that the justices were not in agreement as to the nature and scope of a minor's right to contraceptives. Two Justices termed as "frivolous" the argument that a minor has the constitutional right to put contraceptives to their intended use, notwithstanding the combined objections of both the parents and the state. *Id.* at 702-03 (White, J., concurring in part and in the result); *Id.* at 713 (Stevens, J., concurring in part and in the result).

standard applicable to state-imposed restrictions as "any significant state interest . . . that is not present in the case of an adult."<sup>91</sup> The Court did not explain which situations might justify state restrictions on the distribution of contraceptives to minors. The Court noted, however, that a narrowly drawn statute might be sustained as long as it did not impose a substantial burden on the minor's privacy right.

As the above cases indicate, the Supreme Court has greatly restricted the scope of permissible state restrictions on the distribution and use of contraceptives. The remaining question concerning minors is whether and to what extent parents may be involved in their children's decision to *obtain* contraceptives. *Carey* makes it clear that minors' privacy rights in this area do not depend on absolute parental consent.<sup>92</sup> The perimeters of this right necessarily will be defined on a case-by-case basis.<sup>93</sup>

In one recent decision, *Doe v. Irwin*,<sup>94</sup> parents of minor children sued for declaratory and injunctive relief to prevent a state-funded family planning center from distributing contraceptives to their children without the parents'

---

To minors, the most important part of the opinion, and the part likely to cause problems of interpretation, is Part IV in which only four Justices joined. 431 U.S. at 691-99 (Brennan, Marshall, Stewart, and Blackmun, J.J.). These Justices were of the opinion that the section of the statute prohibiting distribution of contraceptives to minors under the age of sixteen by nonphysicians was violative of a minor's constitutional rights. They noted that the state's purported policy against promiscuous sexual activity among minors was not sufficient to validate the prohibition, since (1) the right to privacy in relation to procreation decisions extended to minors as well as adults, (2) there was no "significant state interest" to justify the invasion of the minor's rights; (3) a blanket prohibition of the distribution of contraceptives to minors was foreclosed in view of the Court's analogous decisions concerning abortions, in which blanket parental consent requirements were invalidated; (4) there was a lack of evidence that limiting minors' access to contraceptives would in fact discourage sexual activity among the young; and (5) the narrow exception allowing physicians to supply contraceptives to those under 16 did not save the statute because physicians should not have sole authority to decide when and to whom they would furnish contraceptives.

91. *Carey v. Population Serv. Int'l.*, 431 U.S. 678, 694 (1977). The Court reasoned by analogy from its decision in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976). See notes 110-116 and accompanying text *infra*. In *Danforth*, the Court held that the state could not impose a blanket prohibition or blanket requirement of parental consent on the minor's choice to abort. The Court in *Carey* thus reasoned that "the constitutionality of a blanket prohibition of the distribution of contraceptives is a fortiori foreclosed." 431 U.S. at 694.

92. Presumably, physicians or clinics requiring mandatory consent from the parents before dispensing contraceptives would violate the minors' constitutional rights.

93. To date, only one post-*Carey* decision has been found which specifically addresses the parents' interest in participating in the minor's decision to obtain contraceptives. See, *Doe v. Irwin*, 428 F. Supp. 1198 (W.D. Mich. 1977), *vac'd* and *remanded*, 559 F.2d 1219 (6th Cir. 1977), *on remand*, 441 F. Supp. 1247 (W.D. Mich. 1977), discussed in text and notes *infra*. But cf. *M.S. v. Wermers*, 409 F. Supp. 312 (D.S.O. 1976), *rev'd* and *remanded*, 557 F.2d 170 (8th Cir. 1977) (trial court abused discretion in dismissing minor's declaratory action on grounds that minor refused to notify parents of the action, minor's asserted privacy right to obtain contraceptives without parental consent).

94. 441 F. Supp. 1247 (W.D. Mich. 1977).

consent and knowledge. The court ruled in favor of the parents' interest in knowing of their children's attempts to acquire contraceptives.<sup>95</sup> To reach this result, the Court held that the rights asserted by the parents were fundamental and that the defendant's distribution of contraceptives to the minors without first notifying the parents violated their constitutional rights.<sup>96</sup> By focusing on the parents' right to control and care for their children, the Court shifted the emphasis away from the minor's privacy right. The issue then became whether the parental notice and consultation requirement was unduly burdensome on the minor's "fundamental" right to obtain contraceptives, the test required by *Carey*. The Court concluded that its holding "in no way would prevent unemancipated minors from obtaining contraceptives."<sup>97</sup>

If other courts adopt the *Irwin* reasoning, it appears that minors may be hindered in their attempts to obtain and use contraceptives. The requirement of parental notice and consultation probably will have the same effect as the now prohibited absolute parental consent requirement,<sup>98</sup> for it is logical to assume that many minors would be deterred from seeking contraceptives under either circumstance.

The need for clearly drafted legislation concerning minors' access to contraceptives is apparent. Few jurisdictions have laws expressly authorizing the distribution of contraceptives to minors.<sup>99</sup> Some states allow minors to obtain "treatment relating to pregnancy"<sup>100</sup> although it is not clear whether

---

95. *Id.* at 1251. The court stated that "the rights the plaintiffs seek to assert are fundamental rights protected by the first, fifth, ninth, and fourteenth amendments of the United States Constitution." *Id.*

96. The court described three factors which indicated that the parent's rights were "seriously invaded:" 1) that the parent's privacy and religious beliefs were implicated, 2) that minors might "lack the capacity to make decisions in this area," thus requiring parental judgments as to their child's maturity, and 3) that the secrecy with which the minors could obtain contraceptives from the defendant, in effect, deprived the parents of the opportunity to counteract their actions. 441 F. Supp. at 1253.

The court concluded that the parental rights asserted were violated by the defendant center acting "under color of state law." *Id.* Despite the *Carey* decision the court seemed reluctant to concede that any right of minors to birth control medications or devices was of constitutional stature and noted that the Supreme Court Justices were not in agreement on this point. See note 90 *supra*. Even assuming that the right existed, the court went on to say, the "right need not exist to the total exclusion of any rights of the child's parents." 441 F. Supp. at 1254.

97. *Id.* at 1260.

98. See note 91 *supra*.

99. See Note, *A Minor's Right to Contraceptives*, 7 U. CAL. D.L. REV. 270, 280 nn.40-43 (1974) for a listing of twelve jurisdictions which expressly allow minors to obtain contraceptives without parental consent, See, e.g., GA. CODE ANN. § 88-2904 (Supp. 1978); KY. REV. STAT. § 214.185 (1977); TENN. CODE ANN. § 53-4607 (Supp. 1973).

100. See Note, *A Minor's Right to Contraceptives*, 7 U. CAL. D.L. REV. 270, 280 nn.40-43 (1974).

furnishing contraceptives fits into this category.<sup>101</sup> Other jurisdictions provide for family planning programs,<sup>102</sup> which may qualify a minor's right to obtain contraceptives.<sup>103</sup>

In recognition of the health and social problems created by unwanted teenage pregnancies,<sup>104</sup> legislatures should consider granting to minors the explicit capability to obtain birth control information and devices without parental consent. In addition, statutes should provide that minors seeking contraceptives are deemed to have the legal capacity of adults as well as the confidentiality privileges an adult enjoys, at least for the purposes of obtaining contraceptives.<sup>105</sup> The policy underlying such a legislative scheme would be similar to the rationale for encouraging minors to seek treatment for venereal diseases.<sup>106</sup> By providing sexually active minors with incentives to seek and practice birth control, unwanted pregnancies and their attendant problems may decrease.

### *Abortion*

Recent United States Supreme Court holdings have eliminated most limitations on a woman's right to obtain an abortion. This right was established in *Roe v. Wade*,<sup>107</sup> in which the Court held that a state statute prohibiting abortions at all stages of pregnancy was unconstitutional for its invasion of the individual's right to privacy.<sup>108</sup> The decision, however, was explicit in

101. *Id.* The California Supreme Court has indicated that contraceptives would not be considered treatment relating to pregnancy, although abortion would be. *Ballard v. Anderson*, 4 Cal. 3d 873, 882, 95 Cal. Rptr. 1, 7, 484 P.2d 145, 151 (1971).

102. *See, e.g.*, FLA. STAT. ANN. § 381.382 (1973); KAN. REV. STAT. § 23-501 (Supp. 1973); TENN. CODE ANN. § 53-4607 (Supp. 1973); VA. CODE ANN. § 20-14.2 (Supp. 1977).

103. Family planning services may be limited to adults, minors with children and married minors. The Georgia statute is general, and does not mention minors at all. *See* GA. CODE ANN. § 88-2904 (Supp. 1978). *Cf.* FLA. STAT. ANN. § 381.382(5)(a) (1973) (minor may obtain contraceptives without parental consent if in the physician's opinion, the minor will suffer health hazards if the treatment is not provided); ILL. REV. STAT. ch. 91, § 18.7 (1977) (a physician is authorized to provide contraceptives to minors who are referred by another physician, clergyman, or family planning center).

104. It has been noted that:

Teenage motherhood involves a host of problems, including adverse physical and psychological effects upon the minor and her baby, the continuous stigma associated with unwed motherhood, the need to drop out of school with the accompanying impairment of educational opportunities, and other dislocations [including] forced marriages of immature couples and the often acute anxieties involved in deciding whether to secure an abortion.

Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy*, 88 HARV. L. REV. 1001, 1010 (1975) (footnotes omitted).

105. *See* Note, *A Minor's Right to Contraceptives*, 7 U. CAL. D.L. REV. 270, 291-92 (1974).

106. *See* notes 135-139 and accompanying text *infra*.

107. 410 U.S. 113 (1973).

108. *Id.* at 152-55. Although the Constitution does not specifically mention a right to privacy, the Supreme Court has interpreted it as recognizing a right of personal privacy and guarantee-

noting that this right to an abortion was not unqualified; it must be weighed against the state's interest in the pregnancy, an interest which changes according to the various stages of the pregnancy.<sup>109</sup> Thus, the Court recognized that distinct state interests must be considered when evaluating the individual's right to an abortion.

The issue of how the abortion right of an adult would apply to a minor was confronted in *Planned Parenthood of Central Missouri v. Danforth*,<sup>110</sup> in which a state statute requiring parental consent to an abortion performed on a minor during the first twelve weeks of pregnancy was challenged.<sup>111</sup> In concluding that the right of privacy regarding abortion for adults as established in *Roe* extends to minors as well, the Supreme Court ruled that a state may not impose *blanket* provisions requiring parental consent as a condition for an abortion performed on a minor during the first twelve weeks of her pregnancy.<sup>112</sup> Furthermore, *Danforth* held that "the state does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, *veto* over the decision of the physician and his patient to terminate the patient's pregnancy . . ." <sup>113</sup> But it was recognized by the Court that the state does have more authority to regulate children than adults.<sup>114</sup> Indeed, the decision emphasized that although the state statute in question was unconstitutional, this did not mean that every minor, regardless of age or maturity, may give effective consent for termination of her pregnancy.<sup>115</sup> It appears, therefore, that a state could still impose some restrictions on the minor's right to an abortion. *Danforth*, however, does not make clear which restrictions would be permissible.<sup>116</sup>

---

ing protection of certain zones of privacy, *e.g.*, *Terry v. Ohio*, 392 U.S. 1, 8-9 (1968); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942). See notes 84-91 and accompanying text *supra*. In *Roe*, the Court held that this privacy right protects a woman's decision to terminate her pregnancy. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

109. The Court could find no compelling state interest to regulate the decision to abort during the first trimester of pregnancy. *Roe v. Wade*, 410 U.S. 113, 163-65 (1973). However, the Court determined that in promoting its interest in the health of the mother, the state can regulate the abortion decision in the later stages of pregnancy. *Id.* at 162-63. In addition, when the fetus becomes viable, the state's interest in promoting the potentiality of human life was held to be so compelling as to prohibit the abortion. *Id.* at 162-64.

110. 428 U.S. 52 (1976).

111. MO. ANN. STAT. § 188.020(3) (Supp. 1975).

112. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (emphasis added). See *Poe v. Gerstein*, 517 F.2d 787, 789-94 (5th Cir. 1975), *aff'd*, 428 U.S. 901 (1976); *Wolfe v. Schroering*, 541 F.2d 523, 525-26 (6th Cir. 1976); *State v. Koome*, 84 Wash. 2d 901, 530 P.2d 260 (1975).

113. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

114. *Id.* at 74. See *Ginsberg v. New York*, 390 U.S. 629, 638 (1968); *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

115. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 75 (1976).

116. The Court pointed out that the real fault of the Missouri statute was that it required the consent of a person other than the woman and her physician without a sufficient justification for this restriction. *Id.* at 75.

In accord with the notion that a minor's right to an abortion is not entirely absolute is *State v.*

An indication of what may be constitutional in light of *Roe* can be found in the Supreme Court's decision in *Belloti v. Baird*.<sup>117</sup> At issue was a Massachusetts statute which provided that an unmarried minor could obtain an abortion only with the consent of both parents or of a judge acting upon a showing of good cause.<sup>118</sup> The Court construed the statutory language to be subject to the state's judicial interpretation. Accordingly, the case was remanded to the district court with instructions to certify questions to the Massachusetts Supreme Judicial Court.<sup>119</sup>

In remanding the case, the Supreme Court noted that the statute could be read to prefer parental consultation and consent, yet giving to minors the *option* of obtaining a court order for the abortion. Under this construction, a minor who was capable of giving an informed consent to the procedure could readily obtain such an order, while those who would not be considered mature could obtain the court order only upon a showing that the abortion was in their best interests. Thus, the Court felt that the language of the statute could be interpreted in such a way as to circumvent an absolute parental consent requirement. The Court concluded that when interpreted in this manner, the statute was fundamentally different from the unconstitutional statute in *Danforth*, which created an absolute "parental veto" power.<sup>120</sup>

It appears implicit in *Baird* that the minor's right to obtain an abortion can be restricted by a statutory requirement that a court order be obtained for the abortion. The decision also implies that the mature minor doctrine could be applicable to an analysis of this right, for the Court acknowledges the propriety of greater restrictions on the rights of the immature minor.<sup>121</sup> The decision does, however, reinforce the *Danforth* holding that there can be no absolute statutory requirement that the minor obtain parental consent.

When considering the serious mental and physical dangers involved in an abortion, the Supreme Court's possible construction of the statute in *Baird*

---

Koome, 84 Wash.2d 901, 530 P.2d 260 (1975), in which the Washington Supreme Court reversed the conviction of a physician who performed an abortion on a minor without the consent of her parents. Even though the court held that based on *Roe*, the state could not provide parental *veto* power over a child, it did indicate as being permissible less restrictive methods which would insure the adequacy of reflection and consideration in a minor's abortion decision. 84 Wash.2d at 908-10, 530 P.2d at 265-66.

117. 428 U.S. 132 (1976).

118. MASS. GEN. LAWS ANN. ch. 112, § 12P (1974).

119. *Belloti v. Baird*, 428 U.S. 132, 146-47 (1976).

120. *Id.* at 145. See notes 110-116 and accompanying text *supra*.

121. *Id.* at 145. See *Baird v. Belloti*, 450 F. Supp. 997, 1000 (D. Mass. 1978), *prob. juris. noted*, No. 78-329 (U.S. Supreme Court Oct. 30, 1978); Comment, *Minor's Consent to Medical Care: The Constitutional Issue In Oklahoma*, 12 TULSA L.J. 512, 523-25 (1977). See also *Wynn v. Scott*, 448 F. Supp. 997 (N.D. Ill. 1978) (the teaching of *Danforth* and *Belloti* is that the state does in fact have an interest in assuring that the minor's consent to an abortion is intelligently and voluntarily given. This state interest will, therefore, justify a requirement of either parental consent or judicial consent, as long as the judicial proceeding is not burdensome and the inquiry is limited to the ability of the minor to consent and the voluntariness of such consent, or in the case of a minor found wanting in ability to consent, the minor's best interest.).



indicates the proper model to be followed with respect to the minor's right to consent to an abortion. An abortion may leave a lasting emotional scar on a young woman. In addition, the lack of proper medical procedure may cause severe bodily damage or even death. These factors, therefore, provide a basis for requiring some form of adult supervision over a minor's decision to abort. The application of the mature minor rule as noted in *Baird* would provide the necessary input. Through this doctrine, a court will ensure that proper medical facilities are provided to the minor. Furthermore, in order to help prevent any emotional problems, the court may require that the child undergo counseling regarding the impact of an abortion. Moreover, if the court encourages but does not mandate parental involvement in the abortion decision, there will be a promoting of the family unit without forcing the child to seek parental consent, a process which may cause friction in the home. Thus, the *Baird* construction provides the proper degree of freedom with respect to the minor's right to consent to an abortion.

### *Sterilization*

It is obvious that sterilization is a more drastic measure for preventing pregnancy than other means of contraception. If successfully accomplished, surgical sterilization results in permanent loss of the ability to procreate.<sup>122</sup> It follows that a physician who performs a sterilization at the request of a minor<sup>123</sup> would be subjecting herself to liability for violation of the general rule that a minor cannot consent to his or her own medical or surgical care.<sup>124</sup> It also would be unwise to sterilize a normal, nonconsenting child

---

122. With the advent of microscopic surgery, a few reversals are now being reported following both tubal ligations and vasectomies.

123. It would be a rare occurrence for a minor to request a sterilization. However, it has been the experience of the co-author that sexually active girls who have been pregnant several times before majority have requested this procedure at Cook County Hospital.

124. See notes 1-6 and accompanying text *supra*. The exceptions to the general rule which allow a mature or emancipated minor to consent may be applicable to the sterilization procedure, although the extreme consequences of sterilization will cause the court to closely scrutinize the circumstances of the consent. See *Smith v. Seibly*, 72 Wash.2d 16, 431 P.2d 719 (1967) (the court recognized the effective consent of an eighteen year old, married, knowledgeable minor). If an exception was met the sterilization would be valid, for the right of an adult to give voluntary consent to a non-therapeutic sterilization is generally conceded. See, e.g., *Jessin v. County of Shasta*, 274 Cal. App. 2d 737, 79 Cal. Rptr. 359 (1969); *Shateen v. Knight*, 6 Lyc. 19, 11 Pa. D. & C. 2d 41 (1957); OR. REV. STAT. § 435, 305 (1977); VA. CODE § 32-423 (Supp. 1977). See Forbes, *Voluntary Sterilization of Women as a Right*, 18 DEPAUL L. REV. 560 (1969).

Before treating a minor the physician also should be aware of guidelines recently issued by the Department of Health, Education and Welfare which restrict the circumstances under which medical facilities receiving federal funds can allow sterilization operations. These regulations update those of February 6, 1974, which were formulated following disclosures that minor girls were being sterilized without their consent or the consent of their parents. 39 Fed. Reg. No. 76,13873 (1974). According to the new regulations, federal reimbursement is available only for the sterilization of people who are at least twenty-one years old and who are mentally competent. 43 Fed. Reg. No. 217,52146 (1978).

at the request of the child's parents, for this would deprive the child of the right to procreate, a right which appears to have attained constitutionally protected status.<sup>125</sup> If under either of these circumstances a physician is confronted by a request for the sterilization of a minor, she should obtain a court order for the operation rather than proceed *pro se*.<sup>126</sup>

The resolution of this dilemma is less clear when parents seek the sterilization of a mentally retarded child. This is not a frequently litigated issue, and when it does arise in a judicial context the parental consent issue is subordinated to the court's interpretation of its authority to order the sterilization. Accordingly, the resolution of these cases frequently turns on the court's analysis of its subject matter jurisdiction.<sup>127</sup>

Statutes which permit sterilization of the mentally ill are in force in approximately twenty states.<sup>128</sup> While the constitutional validity of these statutes would seem suspect in light of the growing recognition of a constitutional right to procreate,<sup>129</sup> the 1927 decision of *Buck v. Bell*<sup>130</sup> which upheld one such statute is still controlling precedent. Although the number of

---

125. As noted in *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942), "Marriage and procreation are fundamental to the very existence and survival of the race. The power to sterilize . . . may have . . . devastating effects. . . . There is no redemption for the individual whom the law touches. . . . He is forever deprived of a basic liberty." See also, *Griswold v. Connecticut*, 381 U.S. 479, 495 (1965) (Goldberg, J., concurring) ([t]he right to . . . marry and raise a family are of similar order and magnitude as the fundamental rights specifically protected."); *Meyer v. Nebraska*, 262 U.S. 390 (1923) ("[l]iberty . . . denotes . . . the right of the individual to . . . marry, establish a home and bring up children.")

126. See Holder, *Legal Issues in Pediatrics and Adolescent Medicine* 277 (1st ed. 1977).

127. This was the central issue in a recent controversial case, *Stump v. Sparkman*, 435 U.S. 349 (1978). In *Stump*, the Supreme Court overturned a decision of the Seventh Circuit which had denied judicial immunity to a judge who had authorized the sterilization of a fifteen year old allegedly retarded girl upon the petition of her mother. *Sparkman v. McFarlin*, 552 F.2d 172 (7th Cir. 1977), *rev'd sub nom.* *Stump v. Sparkman*, 435 U.S. 349 (1978). In granting judicial immunity, the Supreme Court recognized that the state judge had acted within his jurisdiction in entertaining the petition. In so holding, the court construed broadly a general jurisdictional grant of the Indiana Statutes and noted that the lack of a specific statute permitting sterilization of non-institutionalized retarded persons did not foreclose consideration of the petition. While recognizing the judge's power to entertain the petition, it did not address the merits of his decision to order the sterilization based on his interpretation of the common law. See Note, *A Judge Can Do No Wrong: Immunity is Extended for Lack of Specific Jurisdiction*, 27 DEPAUL L. REV. 1219 (1978).

128. See Comment, *Eugenic Sterilization Statutes: A Constitutional Re-Evaluation*, 14 J. FAM. L. 280, 280 n.1 (1976).

129. See note 127 and accompanying text *supra*.

130. 274 U.S. 200 (1927). Justice Holmes found there to be a reasonable basis for the statutory scheme and tersely noted that "[T]hree generations of imbeciles are enough." *Id.* at 207.

court-ordered eugenic sterilizations performed pursuant to these statutes has steadily decreased,<sup>131</sup> the power of a court to order a sterilization under such statutes has been upheld recently.<sup>132</sup>

Absent statutory authorization, however, courts must consider the common law parent-child relationship when confronted with a parent's petition for the sterilization of a retarded child. The weight of the decisions appears to be that "the common law does not invest parents with such power over their children even though they sincerely believe the child's adulthood would benefit therefrom."<sup>133</sup> There is little case law that has construed this common-law relationship so as to empower a parent to have a retarded child sterilized.<sup>134</sup> Thus, the rights of the mentally retarded minor to not be sterilized apparently will be protected in these common law jurisdictions.

Except in circumstances involving extreme mental retardation, the sterilization of minors should be prohibited. There is no party capable of giving an effective consent to this procedure, for the child is unable to comprehend the implications of a decision to be sterilized, and the parents cannot consent to a procedure which will result in the permanent deprivation of their

---

131. See Comment, *Eugenic Sterilization Statutes: A Constitutional Re-Evaluation*, 14 J. FAM. L. 280, 284 n.18 (1976), in which the author notes a substantial decrease in the number of eugenic sterilizations performed between 1943 (1638) and 1963 (467). The number since has been reduced to approximately 300 eugenic sterilizations per year. *Id.* citing Paul, *State Eugenic Sterilization History: A Brief Overview* in EUGENIC STERILIZATION 25-26 (Robitscher ed. 1973).

132. *In re Moore*, 289 N.C. 95, 221 S.E.2d 307 (1976). The *Moore* court recapitulated the *Buck v. Bell* decision in upholding the North Carolina eugenic sterilization statute, N. C. GEN. STAT. § 35-36 to 50 (1973). The *Moore* decision is noteworthy in that the court considered and rejected every conceivable constitutional argument against state practice of involuntary sterilization.

133. *A.L. v. G.R.H.*, 325 N.E.2d 501, 502 (Ind. App. 1975), *cert. denied* 425 U.S. 936 (1976) (the court denied the petition of the mother of a fifteen year old with an I.Q. of 83). See also *Guardianship of Kemp*, 43 Cal. App. 3d 758, 118 Cal. Rptr. 64 (1974) and *In re M.K.R.*, 515 S.W.2d 467 (Mo. 1974), in which in denying parents' petitions the California and Missouri courts held that statutes making general provision for the welfare of children were insufficient to give the court subject matter jurisdiction; specific legislation providing for sterilization of the retarded was necessary.

134. *Stump v. Sparkman*, 435 U.S. 349 (1978), is a rare exception in that a judge-ordered sterilization pursuant to common law principles was reported and became publicized. See note 127 *supra*. Considering the furor created by the case, it is likely that judges now will construe their jurisdictional grant and their interpretation of the common law parent-child relationship more narrowly when confronted with a parent's petition for the sterilization of his minor child.

The dicta of two cases suggest that a court could find common law authority for ordering the sterilization of a retarded minor at a parent's request. *Wade v. Bethesda Hosp.*, 356 F. Supp. 380, 383 (S.D. Ohio 1973) (in refusing a petition of the state welfare board the court noted it had no consent of the minor's parents); *Holmes v. Powers*, 439 S.W. 2d 579, 580 (Ky. Ct. of App. 1968) (the court refused to order the sterilization of a 35 year-old *at her age*). See generally Comment, *Sterilization, Retardation, and Parental Authority*, 1978 B.Y. L. REV. 380.

child's fundamental right to procreate. Close scrutiny must be given before initiating any treatment of a minor which will have such permanent results.

### *Venereal Disease*

Within the last several years, the incidence of venereal disease among adolescents has reached epidemic proportions.<sup>135</sup> Treatment of this affliction has been a problem, for minors have resisted obtaining parental consent when such consent has been required under local law. Many physicians have recognized this problem and have treated the condition as a medical emergency requiring immediate attention.<sup>136</sup> Indeed, the official position of the American Medical Association is that physicians should not hesitate to treat minors with venereal disease, regardless of the minor's having obtained parental consent.<sup>137</sup>

In recent years, legislators also have recognized the public health hazards associated with venereal disease and the dilemma presented by the parental consent requirement. This has resulted in the enactment of laws which permit adolescents to secure necessary treatment without the permission of their parents,<sup>138</sup> though this freedom has been limited in several states by minimum age requirements.<sup>139</sup>

The primary distinction among these venereal disease statutes rests in whether they require notification of the minor's parents that treatment is necessary or has been given. A few states explicitly prohibit the doctor from notifying the parent of the child's request for treatment.<sup>140</sup> The overwhelming majority of statutes, however, either leaves the decision to the doctor's

---

135. See Center for Disease Control, Morbidity and Mortality Report, 27:533 (Jan. 1979). Between December 31, 1974 and December 30, 1978 there were reported in the United States to the Center for Disease Control 1,015,056 cases of gonorrhea and 21,675 cases of syphilis. The 1977 figures for gonorrhea are 1,000,256, for syphilis 20,567.

136. Holder, *Treating A Minor for Venereal Disease*, 214 J.A.M.A. 1949, 1949 (1970). In addition to authorizing treatment under the emergency exception, treatment for venereal disease should also be available under the emancipation and mature minor exceptions to the general rule requiring parental consent for treatment of minors. *Id.* at 1950. See notes 1-36 and accompanying text *supra*.

137. A.M.A. News, April 17, 1967, at 4.

138. See notes 139-142 *infra*.

139. ALA. CODE 22 § 16-9 (1975) (twelve); CAL. CIVIL CODE ANN. § 34.7 (West Supp. 1978) (twelve); DEL. CODE tit. 13 § 708 (Supp. 1978) (twelve); IDAHO CODE § 39-3801 (1977) (fourteen); ILL. ANN. STAT. ch. 91, §§ 18.4-5 (Smith-Hurd Supp. 1978) (twelve); N.H. REV. STAT. ANN. § 141:11a (1977) (fourteen); N.D. CENT. CODE § 14-10-17 (Supp. 1977) (fourteen); WASH. REV. CODE ANN. § 70.24.110 (1975) (fourteen).

140. CONN. GEN. STAT. ANN. § 19-89a (West 1977); N.Y. PUB. HEALTH LAW § 2305 (2), (McKinney 1977) and § 17 (McKinney Supp. 1978); 1977 N.C. Adv. Legis., Serv. ch. 582, § 2, amending N.C. GEN. STAT. § 90-21.5 (a physician may only notify parents when, in his/her opinion, notification is essential to the life or health of the minor. 1977 N.C. Adv. Legis. Serv. ch. 582 § 1, amending N.C. GEN. STAT. § 90-21.4.

discretion<sup>141</sup> or are silent on the issue.<sup>142</sup> Since these latter types of statutes would discourage the minor from seeking treatment, it would seem that all states should follow those jurisdictions which have prohibited notification of the parents. Only then will the purpose of the statutory scheme be accomplished and the grave personal and societal consequences of non-treatment be minimized.

### *Organ Donation*

The primary concern of this Article has been the right of minors to obtain their own medical care. A related topic involves the minor's rights as a participant in the medical treatment of third parties. Included in this category would be the use of the child as a research subject or donor of blood.<sup>143</sup> The focus of this section, however, will be on the rights of the child as a potential donor in an organ transplant.

When determining whether a minor may consent to medical treatment, courts have looked to whether the child will benefit from the proposed pro-

141. ALA. CODE tit. 22, § 16-9 (1975); DEL. CODE tit. 13, § 708 (Supp. 1978); FLA. STAT. ANN. § 384.061 (West 1973); GA. CODE ANN. §§ 74-104.3 to 4 (1973); HAW. REV. STAT. §§ 577 A-2, -4 (1976); ILL. ANN. STAT. ch. 91, §§ 18.4-5 (Smith-Hurd Supp. 1978); KAN. STAT. ANN. § 65-2892 (1972); LA. REV. STAT. ANN. § 1065.1 (West 1977); ME. REV. STAT. tit. 32, §§ 2595, 3292 (1978) (if hospitalization occurs for more than 16 hours, the hospital shall notify and obtain the consent of the minor's parents); ME. REV. STAT. tit. 22, § 1823 (Supp. 1978); MD. ANN. CODE art. 43, §§ 135(a)(2), (c) (Supp. 1978); MASS. GEN. LAWS ANN. ch. 111, § 117, ch. 112 § 12F (West Supp. 1979); and ch. 112, § 12 (West 1977); MICH. COMP. LAWS ANN. § 329.221 (West 1975); MONT. REV. CODE ANN. §§ 69-6101 to 6102 (1947) (if the minor is found not to be afflicted with venereal disease, then no information may be given to the parents regarding the examination and request for treatment); N.J. STAT. ANN. §§ 9:17A-4 to -5 (West 1976); OR. REV. STAT. §§ 109.610, 650 (1977); TEX. FAM. CODE ANN. tit. 2, § 35.03 (Vernon 1975).

142. ALASKA STAT. § 09.65.100 (Supp. 1978); ARIZ. REV. STAT. § 44-132.01 (Supp. 1978); ARK. STAT. ANN. §§ 82-629 to 630 (1976); CAL. CIVIL CODE ANN. § 34.7 (West Supp. 1978); COLO. REV. STAT. § 25-4-402(4) (1973); IDAHO CODE § 39-3801 (1977); IND. CODE ANN. § 16-8-5-1 (Burns 1973); IOWA CODE ANN. § 140.9 (West Supp. 1978); KY. REV. STAT. ANN. § 214.185 (1977); MINN. STAT. ANN. §§ 144.343, .346 (Supp. 1978) (the physician may inform the parents of treatment given or needed where, in the judgment of the physician, failure to inform the parents would seriously jeopardize the minor's health); MISS. CODE ANN. § 41-41-13 (1972); MO. ANN. STAT. § 431.061 (Vernon Supp. 1979); NEB. REV. STAT. § 71-1121 (1976) (examinations and treatments may be performed without the consent or notification of parents, however, parents are liable for expenses of such treatment to minors under their custody); NEV. REV. STAT. § 129.060 (1977); N.H. REV. STAT. ANN. § 141:11-a (1977); N.M. STAT. ANN. § 24-1-9 (1978); N.D. CENT. CODE § 14-10-17 (Supp. 1977); OHIO REV. CODE ANN. § 3709.241 (Supp. 1978); OKLA. STAT. ANN. tit. 63, § 1-532.1 (West 1973); PA. STAT. ANN. tit. 35, §§ 521.14a, 10103 (Purdon 1977); R.I. GEN. LAWS § 23-11-11 (1968); S.D. COMPILED LAWS ANN. § 34-23-16 (1977); TENN. CODE ANN. § 53-1104 (1977); UTAH CODE ANN. § 26-6-39.1 (1953); VT. STAT. ANN. tit. 18, § 4226 (Supp. 1978) (parents shall be notified by physician if hospitalization is required); VA. CODE § 32-137(b) (Supp. 1978); WASH. REV. CODE ANN. § 70.24.110 (1975); W. VA. CODE § 16-4-10 (1972); WIS. STAT. ANN. § 143.07 (West Supp. 1978); WYO. STAT. ANN. § 35-4-131 (1977).

143. See note 157 *infra*.

cedure.<sup>144</sup> A problem arises with respect to transplants because the donor does not personally require the operation and will not benefit in any physical way. Thus, a dilemma exists as to the minor's legal status as a donor.

The earliest case to address this issue was *Madison v. Harrison*,<sup>145</sup> in which a declaratory judgment was sought so as to permit doctors to perform a renal transplant on nineteen-year-old twins without incurring civil liability. In permitting the operation, the court looked to two factors. First, it determined that the surgery could proceed based on parental consent so long as the donor minor had also been informed of, understood and consented to the transplant.<sup>146</sup> Secondly, the court inquired whether the donor would benefit from the operation. Psychiatric testimony was given that if the transplant were not performed and the sick twin consequently died, a grave emotional impact on the healthy twin would result. The court found that such emotional disturbance could affect the health of the surviving twin and concluded that the operation would, therefore, confer a benefit on both donor and donee.<sup>147</sup> *Madison* thus expanded the "benefit to the minor" rule to include prevention of future harm due to psychological factors.<sup>148</sup>

More recently, the requirements for a minor to be an organ donor were further minimized in *Hart v. Brown*.<sup>149</sup> In *Hart*, physicians had refused to perform a kidney transplant between seven-year old identical twin sisters unless it was declared that the parents had a right to consent to the operation. Upon examining the record and noting that the donor had been informed of the operation and was desirous of donating her kidney, the court permitted the parents to consent to the transplant.<sup>150</sup> In addition, this permission was given only after receiving psychiatric testimony that the donor had a strong identification with her sister, and that the successful result would be beneficial to the donor since she "would be better off in a

---

144. See note 9 and accompanying text *supra*.

145. No. 68651 (Mass. Sup. Jud. Ct. June 12, 1957) published in C. WASMUTH, LAW AND THE SURGICAL TEAM 342 (1969).

146. *Id.*

147. *Id.*

148. See *Foster v. Harrison*, No. 68674 (Mass. Sup. Jud. Ct. November 20, 1957) (fourteen year old twins); *Huskey v. Morrison*, No. 68666 (Mass. Sup. Jud. Ct., August 30, 1957) (fourteen year old twins). But see *In Re Richardson*, 284 So.2d 185 (La. Ct. of App. 1973) (parents of a seventeen year old mentally retarded boy could not authorize the surgical removal and transplantation of one of the boy's kidneys to his thirty-two year old sister because the law must protect a minor's right to be free from bodily intrusion to the extent of loss of an organ, unless such loss would be in the best interests of the child. *Richardson* can be distinguished from other cases in which transplants have been allowed in that the donee suffered from systemic lupus erythematosus, a disease for which there is no known cure. Therefore, it could not be medically proven that the transplant would somehow benefit the minor donor).

149. 29 Conn. Supp. 368, 289 A.2d 386 (1972).

150. *Id.* at 357-78, 289 A.2d at 389-91.

family that was happy than in a family that was distressed . . . ."<sup>151</sup> This expert testimony convinced the court that the transplant would, indeed, benefit the donor.<sup>152</sup>

Analogous to the issue of a minor being a donor in a transplant is the question of when an adult incompetent may donate an organ. In *Strunk v. Strunk*<sup>153</sup> it was requested that a twenty-seven-year-old incompetent, with a mental age of six, be permitted to donate a kidney to his diseased brother. The *Strunk* court agreed to the operation because the donor was greatly dependent upon his normal brother emotionally, and thus would be jeopardized more by his brother's death than by the loss of his own kidney.<sup>154</sup>

The Wisconsin Supreme Court, however, has recently refused to allow the transplant of a kidney from a thirty-nine year old incompetent, with a mental age of twelve, to his sister.<sup>155</sup> The court noted that where the donor does not indicate consent to the procedure and no benefit to the donor is shown, the operation is precluded.<sup>156</sup> Because these cases involve adults with the intelligence of a minor, they should be placed into the same mold as the donor cases discussed earlier. In viewing all of these cases in total it appears that for a minor to be able to donate an organ the following requirements must be met: (1) the minor must indicate consent; (2) the parents must consent; and (3) there must be some degree of psychological benefit to the donor-minor.<sup>157</sup> The authors recognize that the permanency of the loss of

151. *Id.* at 374-75, 289 A.2d at 389. In addition, the psychiatrist stated that the transplant would be a benefit to the donor because it would be a very great loss to the donor if the donee were to die from her illness. *Id.*

152. *Id.* at 378, 289 A.2d at 391. Another factor given by the court in permitting the transplant was that there were negligible risks involved. *Id.* at 373-75, 377, 289 A.2d at 389, 391.

The court also questioned whether it should abandon a child with end stage renal disease to a brief, medically complicated life and eventual death, or should instead permit the parents to take some action based on reason and medical probability of success in order to keep both children alive. The court stated that because the transplant contemplated in this case had progressed to the point of being a medically proven fact of life, it would permit the parents to act. *Id.* at 376, 289 A.2d at 390.

153. 445 S.W.2d 145 (Ky. Ct. of App. 1969).

154. *Id.* at 146-47. The ability for a court to act for an incompetent has been called the "doctrine of substituted judgment." See generally, Robertson, *Organ Donations By Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976).

155. *Lausier v. Pescinski*, 67 Wis.2d 4, 226 N.W.2d 180 (1975).

156. *Id.* at 8-9, 226 N.W.2d at 182. The dissent viewed the majority opinion as being too severe in its requirements for consent and benefit. *Id.* at 9-12, 226 N.W.2d at 182-84 (Day, J., dissenting). With respect to donor consent, medical testimony indicated that the donor in this case could never give direct personal consent because he was insane seven days a week. The dissent, however, felt that consent could be implied from the fact that a competent person would agree to the procedure because of the normal ties of family. *Id.* at 11-12, 226 N.W.2d at 183 (Day, J., dissenting). Benefit to the donor was alleged to be present in that if the incompetent would recover from the mental illness, he would be happy to learn that he helped to save his sister's life. *Id.* at 9-10, 226 N.W.2d at 182. (Day, J., dissenting). The dissent believed that a benefit to a donor could mean more than something that was either financial or physical. *Id.* at 12, 226 N.W.2d at 184 (Day, J., dissenting).

157. Michigan has passed legislation permitting any person fourteen years of age or older to donate a kidney if the court determines that the donor understands the needs and probable

an organ is too serious a matter for a minor to consent to the procedure without parental guidance. Thus, the judicial requirement of parental consent is, indeed, proper in this situation.

#### CONCLUSION

Today's youth has acquired knowledge far exceeding their counterparts of past decades. From their earliest years, today's children are exposed to electronic and printed messages which provide education concerning all aspects of human life. This advanced knowledge, combined with recent moral permissiveness has produced a society whose adolescents challenge traditional stereotypes of childhood. Societal taboos against teenage experimentation with sex and drugs are largely ignored. Minors continue to seek enlargement of their personal rights, both within the family and within the legal system. The minor's right to medical treatment must be re-evaluated in light of this modern reality.

The common law rule that parents must consent to the medical treatment of their children in all cases has become obsolete. The authors propose that modern application of the rule should be limited to those medical procedures which have permanent and irreversible results. In an organ donation, for example, the minor will not be of sufficient maturity to appreciate all of the repercussions of his or her decision, so objective consent is necessary. Although sterilization is of a permanent nature, application of the common law rule would still be inappropriate in light of the constitutional protection of the right to procreate. Thus, neither the child's nor the parents' consent alone should be effective.

Parental consent requirements are inappropriate for all other forms of medical treatment. The authors recognize that abortions constitute a special problem due to the potential physical and psychological damage that may occur, and therefore endorse the idea that a minor alone should only be able to consent to an abortion under the mature minor doctrine as noted in *Baird*.<sup>158</sup> With respect to other forms of medical care, however, the

---

consequences of the gift. MICH. COMP. LAWS ANN. § 701.196 (Supp. 1978).

In addition to donating organs, a minor may wish to be a donor of blood. Many states have enacted statutes which permit minors to donate blood upon reaching a specified age. *E.g.*, DEL. CODE tit. 13, § 709 (1974) (seventeen); ILL. ANN. STAT. ch. 111½, § 600 (Smith-Hurd 1977) (seventeen); KAN. STAT. ANN. § 38-123a (Supp. 1978). In the absence of a specific statute, physicians must be careful that children under the age of majority have the necessary parental consent before blood is donated. *Zaman v. Schulz*, 19 Pa. D. & C. 309 (1933); HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 143 (1st ed. 1977).

Another area of concern regarding minors has been whether or not children should be subjects of research. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research recently has issued recommendations on the question of consent. 43 Fed. Reg. 2083 (1978). It stated that because children seven years of age or older are generally capable of understanding the procedures and purpose of research, their assent should be required in addition to parental permission. *Id.* at 2087. Furthermore, the Commission believed that if a child of any age objects to participation in research, this refusal should be binding. *Id.*

158. See notes 117-121 and accompanying text *supra*.



minor's right to consent should be considered as absolute. In this manner, a child who freely is able to obtain contraceptives or treatment for venereal disease or pregnancy will be preventing more serious health problems. Parental consent or notification requirements serve to complicate these problems, for there is a need for immediate treatment. Moreover, the child will resist seeking the medical attention if she must first confront her parents.

The authors do not wish to minimize the vital interests that parents have in the care and custody of their children. Ideally, the parents' influence in raising their children would result in close communications and a stable parent-child relationship, to obviate the potentially disruptive effect of laws granting minors access to medical treatment. Schools and health agencies should also educate children as to risks and benefits of various methods of health care. In addition, family planning programs should be developed in states which do not have them. As part of a comprehensive program, family planning centers should *encourage*, but not require, parental participation in the minor's decision to obtain treatment. At least the plan should provide adult counseling by such professionals as a clergyman, social worker or physician.

When the interests of the parents conflict with the minor's right to health care, however, in most situations the minor should prevail. The law must keep pace with the emerging demand of minors to obtain greater autonomy. To expand minors' rights to medical treatment is to recognize reality.