The question of whether a competent, terminally ill minor should have the right to refuse life-sustaining medical treatment (LSMT) is perhaps the most intimate, personal, and difficult decision a person could possibly face. While the concepts of physician-assisted suicide and euthanasia are undoubtedly taboo and controversial, especially in the context of minors, they are nevertheless salient public health, legal, and ethical issues that need to be addressed to reconcile the patchwork of legal and medical doctrines that currently define this subject. Recent judicial rulings,[i] legislative developments,[ii] and public policy polls[iii] suggest that the United States is prepared to hold a serious conversation surrounding a patient’s right to refuse LSMT. State legislatures have made significant progress in the Death
with Dignity movement; however, minimal progress, if any, has been made on whether competent, terminally ill minors should also have the right to refuse LSMT.

In response to this topical issue, this Article examines the statutory and constitutional landscape surrounding a minor’s right to refuse LSMT, and promulgates that the best method to address this issue is by creating specialized health care courts. Part I briefly surveys the current statutory regime surrounding physician-assisted suicide. Part II then describes the constitutional parameters the judicial branch has articulated in its attempt to define who has, and under what circumstances, the right to refuse LSMT, as well as discusses how minors fit into the conversation. Finally, Part III recommends that institutional resources would be maximized through the creation of specialized health care courts.

1. State Legislatures Have Embraced the Death with Dignity Movement

Although the Supreme Court held in Washington v. Glucksberg that physician-assisted suicide is not a fundamental right protected under the Due Process Clause, the Court recognized that the decision to allow physician-assisted suicide lies within the constitutional purview of the state. The Court reasoned that decisions surrounding physician-assisted suicide are better suited within the “arena of public debate and legislative action,” and not the judiciary branch. Justice O’Connor articulated that the Court invites states to act as “laborator[ies]” to explore viable options for aid in dying.

In the wake of Glucksberg, Oregon passed the Oregon Death with Dignity Act (DWDA) of 1994, which allows a competent, terminally ill patient to end their life through the voluntary self-administration of legal medications. The Act incorporates various safeguards to ensure that the law is not abused, such as requiring patients to make two oral requests to his or her physician, separated by at least 15 days. Moreover, patients must provide written notice, signed in the presence of two witnesses. Additionally, the prescribing physician must inform the patient of feasible alternatives, including comfort care, hospice care, and pain control. The Act also requires the Oregon Health Authority to collect information about the patients and physicians who participate in the Act, and publish an annual report. Since its enactment, the Oregon DWDA has served as a model law for Washington (2008), Vermont (2013), and California (2015).

In 2009, the Montana Supreme Court legalized physician-assisted suicide when it ruled in Baxter v. Montana, holding that physicians are able to prescribe lethal doses of drugs to competent, terminally ill patients without being subject to Montana’s homicide laws. In making its determination, the Court circumvented constitutional claims, and reasoned that neither legal precedent nor Montana’s statutory schemed deemed physician-assisted suicide against public policy. In doing so, the Court side-stepped constitutional arguments and relied on statutory-based language to make its ruling. In support of its conclusion, the Court articulated that “[t]he patient’s subsequent private decision whether to take the medicine does not breach public peace or endanger others.” To this end, the Court explained
that there was no difference between withdrawing medical treatment and prescribing lethal drugs for the purpose of physician-assisted suicide.[xv]

2. **Common Law Supports the Right to Refuse LSMT**

The Supreme Court has long-recognized parental autonomy as “perhaps the oldest of the fundamental liberty interests.”[xvii] *Meyer v. Nebraska* and *Pierce v. Society of Sisters* firmly established the parental autonomy doctrine—the principle that parents have a constitutional right to raise their children without unreasonable governmental interference.[xvii] This fundamental right was further galvanizied in *Prince v. Massachusetts*, where the Court articulated “that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.”[xviii] Common law has since legitimized a wide-spectrum of parental rights, such as the right to make decisions surrounding the education of a child[xix] and the right to direct the moral and religious training of a child.[xx]

Conversely, the Supreme Court has also afforded minors some of the same constitutional rights that have been bestowed to adults.[xxi] As the Court explained in *In re Gault*, “neither the Fourteenth Amendment nor the Bill of Rights is for adults alone.”[xxii] In the context of medical-decision making, the Supreme Court has ruled in limited circumstances that minors have the constitutional right to make autonomous decisions without parental consent—most notably the right to contraceptives[xxiii] and abortions.[xxiv] More recently, courts have begun to confront the issue of whether competent, terminally ill minors should have the right to refuse LSMT.[xxv] The common law jurisprudence surrounding this issue is premised on the presumption that minors lack the capacity to make informed medical decisions.[xxvii] This area of the law presents fundamental issues that concern informed consent, bodily integrity, and privacy.[xxvii]

**A. Constitutional Background**

Prior to 1986, no court examined the question of whether a minor has the right to refuse LSMT. In the case of *In re D.P.*, the California Superior Court of Santa Clara County held that a 14-year-old cancer patient could not be held in a hospital against her will, and thus was not required to receive blood transfusions.[xxviii] The following year, in *Cardwell v. Bechtol*, the Tennessee Supreme Court addressed the issue of whether a minor can consent to medical treatment.[xxix] In *Cardwell*, a minor and her parents brought suit against an osteopath for medical malpractice on the grounds that the osteopath failed to obtain informed consent for a medical procedure.[xxx] The Court in *Cardwell* “recognize[d] the varying degrees of responsibility and maturity of minors”[xxxii] and ruled that if a minor has the capacity to consent to and appreciate the nature, risk, and consequences of medical treatment, that the minor functions as an adult when making decisions on medical treatment.[xxxii] The Court, however, warned that the “[a]doption of the mature minor exception to the common law rule [was] by no means a general license to treat minors without parental
consent and [the exception’s] application [was] dependent on the facts of each case.” [xxxiii]

The seminal case, *In re E.G.*, was the first to declare that a competent minor has the common law right to refuse LSMT. [xxxiv] In 1989, the Supreme Court of Illinois considered the state’s common law history and statutory scheme, and found that a 17-year-old leukemia patient had the right to refuse LSMT for religious reasons. [xxxv] Ernestine Gregory (E.G.), six months from her eighteenth birthday, refused to receive blood transfusions, asserting that it violated her religious beliefs as a Jehovah’s Witness. [xxxvi] Relying on *Cardwell v. Bechtol* to support its conclusion, the Court articulated that “[a]lthough the age of majority in Illinois is 18, that age is not an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood.” [xxxvii] The court relied heavily on the fact that minors are treated as adults with respect to constitutional law and Illinois’s statutory history. [xxxviii]

In holding that “a mature minor may exercise a common law right to consent to or refuse medical care,” the Illinois court legitimized the mature minor doctrine. [xxxix] The mature minor doctrine was further reaffirmed *In re Swan*, where the Maine Supreme Court ruled that a 17-year-old minor who had suffered life-threatening injuries resulting from an automobile accident had the right to refuse LSMT. [xl] Similar to *In re E.G.*, [xli] the court employed a balancing test to determine that the minor had a right to refuse LSMT, reasoning that the parents had shown clear and convincing evidence that the minor did not “want to be kept alive by artificial means should [an] injury render him incapable of existing otherwise.” [xlii] The same year, in the case of *In re Long Island Jewish Center*, a New York trial court held that a 17-year-old Jehovah’s Witness could not refuse blood transfusions due to lack of maturity. [xlili]

**B. Courts Presume Minors As Legally Incompetent**

Minors are generally presumed legally incompetent, and thus lack the authority to consent to medical treatment. [xliv] Under U.S. common law, parents enjoy a substantive constitutional right to make health care decisions on behalf of their children. [xlv] This is particularly true in the realm of end-of-life care. [xlvi] The notion that minors lack the capacity to make independent decisions concerning medical treatment rests on the presumption that minors lack the maturity and wisdom to make such decisions. [xlvii] In *Prince v. Massachusetts*, the Supreme Court articulated that “[p]arents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.” [xlviii] This parental right, however, is generally assumes that parents will act in the best interest of the minor. [xlix]

As a judicial safeguard, the Supreme Court has also consistently held that under the legal doctrine of *parens patriae*, the state has the power to protect the interest and general welfare of a minor. [li] To this end, parental autonomy must yield to state
intervention when the state believes that the parent is not acting in the best interest of the minor, particularly in the context of medical treatment. This well-established constitutional right takes into account three sets of interests: (1) the “natural rights” of parents; (2) the responsibilities of the state; and (3) the personal needs of the child. Courts must balance these interests to determine when state intervention is appropriate.

The Supreme Court has recognized that “minors achieve varying degrees of maturity and responsibility (capacity).” In the context of physician-assisted suicide, courts have increasingly employed the mature minor doctrine to determine whether certain competent, terminally ill minors have the capacity to make end-of-life decisions. The mature minor doctrine is rooted in the idea that certain minors have the right to “refuse or consent to medical treatment if she possess sufficient maturity to understand and appreciate the benefits and risks of the proposed medical treatment.” The application of the mature minor doctrine is perhaps best exemplified in the context of abortion. In , the Supreme Court answered this question by holding that mature minors may bypass the parental consent requirement by establishing that she is mature and well-informed of the procedure.

While the mature minor doctrine has been employed in cases surrounding contraceptives and abortion, it is a relatively new concept in the context of end-of-life care. Despite its novelty, the mature minor doctrine is a prevailing pattern found in many state jurisdictions. In considering a minor’s capacity to make autonomy medical decisions, courts consider a constellation of cognitive and social factors. Under the mature minor doctrine, courts, along with physicians, conduct subjective evaluations to determine whether minors are capable to give informed consent. There is marked variability in what constitutes maturity. More recently, courts have turned to psychology and neuroscience research regarding adolescent brain development and decision-making to determine whether minors are mature.

Unlike minors, adults are presumed legally competent to make informed medical decisions even if they possess “far from ideal” reasoning ability. Developmental studies in pediatric and health psychology suggest that adolescents, however, are no less competent than adults to make informed medical decisions. In fact, comprehensive studies have reported that adolescents are capable of making independent medical decisions even with parental influence. For instance, in the context of pregnancy decision-making, studies suggest “adolescents aged 14-17 appear to be similar to legal adults in both cognitive competence and volition.” Drawing on these and related studies, another study found that 96 percent of physicians approach medical practice with adolescent patients as if adolescents are capable of making informed decisions.

Conversely, recent research in developmental psychology and neuroscience has shown that adolescents are less capable of mature judgment than adults and more vulnerable to negative influences. Elizabeth Cauffman, a professor of psychology at the University of California, Irvine, is a leader in the study of juvenile
Cauffman’s influential studies show that adolescents have an underdeveloped prefrontal cortex until the age of 25. And in *Miller v. Alabama*, the Supreme Court referenced Cauffman’s research when it declared that mandatory sentences of life without the possibility of parole are unconstitutional for juvenile offenders. [lxix]

**C. Exceptions to Parental Consent**

One of the bedrock tenets of pediatric health and tort law is that parents generally have the right to make medical decisions for their children. Under limited circumstances, state legislatures have created exceptions to parental consent requirements. [lxx] For instance, in medical emergencies, physicians may undertake medical treatment on minors without parental consent. Additionally, emancipated minors may also consent to medical treatment without parental consent. While jurisdictions vary in their definition of emancipation, a widely accepted definition of an emancipated minor is “one whose parents have completely surrendered care, custody, and control of the child, have no involvement in the child’s earnings, and have renounced parental duties.” [lxli] A minor may also be considered emancipated based on status, such as marriage or military service. [lxxii]

States have also codified exceptions through legislation. [lxxiii] Similar to the traditional common law exceptions, state statute exceptions were enacted to address specific diseases, conditions, or treatments. For example, during the 1960s states became concerned about an increase in sexually transmitted diseases (STD) among adolescents, and thus enacted laws to help curb this public health concern. [lxxiv] Over the past 30 years, all 50 states and the District of Columbia have passed laws that expand minors’ right to consent to STD services without parental consent. [lxxv] Moreover, minors may consent to medical care or counseling services related to diagnosis or treatment of drug and/or alcohol abuse without parental consent, if the health facility receives any grant assistance. [lxxvii] Furthermore, minors aged 14 and older may consent to in-patient mental health treatment as long as they knowingly and voluntarily consent. [lxxvii] The logic behind granting minors the right to receive STD, drug/alcohol, and psychiatric medical treatment without parental consent is rooted in the state’s interests to protect the public from health-related incidents. [lxviii]

### 3. Creating Specialized Health Care Courts

The question of whether competent, terminally ill minors should have the right to refuse LSMT raises many legal and ethical issues. In the effort to address this controversial dilemma, this Article argues that the best institutional process to answer this question should rest on specialized health care courts rather than generalist courts. The reliance on generalist courts undermines the Rule of Law, because it leaves questions of life and death to be determined by judges that may be ill equipped to understand, appreciate, and comprehend the nuances and implications of end-of-life care. This section describes the constitutional authority to create specialized courts and the reasons why a specialized health care court is best suited to adjudicate end-of-life cases.
Article III of the U.S. Constitution provides that “the judicial Power of the United States [...] shall be vested in one Supreme Court, and in such inferior courts as the Congress may from time to time ordain and establish.” Following the ratification of the U.S Constitution, Congress created a multitude of federal generalist tribunals (i.e., trial courts, district courts, and appellate courts) to adjudicate a variety of legal disputes. The Supreme Court has since also recognized that “the Constitution [gives] Congress wide discretion to assign the task of adjudication in cases arising under federal law to legislative tribunals.” While the majority of federal courts are considered generalist courts, Congress has used its Article I legislative power to create specialized courts to adjudicate specific areas of the law. For example, Article I, section 8 of the Constitution enables Congress to enact “uniform Laws on the subject of Bankruptcies[.]” The Bankruptcy Reform Act of 1978 established the U.S. Bankruptcy Court, and granted judges authority to handle matters regarding bankruptcies, both individual and corporate. In addition to specialized federal courts, state legislatures have created specialized state courts—most notably in the areas of family law, administrative law, and criminal law.

Specialized courts offer several benefits to the judicial system. First, unlike generalist courts, specialized courts allow judges to become experts in a particular subject matter (e.g. bankruptcy, tax, international trade). This expertise derives not only from their academic, professional, and extralegal training, but also through ongoing experience as specialized judges. The basic tenet behind the expertise-based argument is that judges who specialize in a narrow area of the law are better equipped to resolve complex cases. This complexity may stem from an intricate statutory scheme, or “may involve deeper difficulties in determining how a particular case fits within the doctrinal and policy contours of the applicable body of law.” In theory, a judge that presides over a specialized Tax Court is perhaps more capable of resolving a derivatives-related dispute than a generalist judge that presumably has a basic understanding of tax law. In many instances, generalist courts are ill equipped to resolve multifaceted health care related issues. Second, the creation of specialized courts provides caseload relief for generalist courts burden by pending case backlogs. This, in effect, reduces the number of appeals. Third, proponents of judicial specialization argue that specialized courts create a more efficient-based system. As specialized courts become familiar with the relevant legal and factual framework, the belief is that judges will able to reach decisions more efficiently.

It is evident that specialized courts have the potential to offer advantageous that generalist courts may not; however, there are also shortcomings that emerge from creating specialized courts. For one, specialized judges may be more prone to judicial bias than generalist judges. In other words, judges that specialize in a certain area of the law are likely to rule one way over another merely because of their background. While the same argument can be made for generalist judges, the distinction is that generalist judges face a wider spectrum of cases, and thus unlikely to have a strong opinion for each subject matter. Additionally, specialized courts may stagnate necessary debate on a Supreme Court ruling before hearing
conflicting federal circuit opinions. Another disadvantage may be the loss of a generalist perspective. For instance, specialized judges may have the potential for insularity, and thus lack the ability to gauge changing doctrinal trends.

Conclusion

Despite its miniscule disadvantages, specialized health care courts support the universal tenets of fairness and access to justice. While certain readers may scoff at the relevancy of this issue—unwilling or incapable of understanding how a competent, terminally ill minor would voluntarily consent to end their life—the question of whether a competent, terminally ill minor should have the right to refuse LSMT is germane in both the legal and medical community.

[i] See, e.g., Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987); In re Swan, 569 A.2d 1202 (1990); In re E.G., 133 Ill. 2d 98 (1990); see also In the Matter of Rena, 46 Mass. App. Ct. 335, 337-38 (1999) (suggesting that the trial court should have employed the mature minor doctrine to determine the minor's maturity).

[ii] California (Oct. 5, 2015), Vermont (May 20, 2013), Washington (Nov. 4, 2008), and Oregon (Nov. 8, 1994) legalized physician-assisted suicide through legislation. Montana (Dec. 31, 2009) allows physician-assisted suicide pursuant to Baxter v. Montana, 354 Mont. 234, 269 (2009) (holding that there is “no indication in Montana law that physician aid in dying provided to terminally ill, mentality competent adult patients is against public policy,” and therefore physicians who assist “may be shielded from liability pursuant to the consent statute”).


[vi] Id. at 737 (O'Connor, J., concurring).

[vii] The Act explicitly provides that “[a]n adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.”


[xiv] Id.

[xv] Id. at 1217.


[xviii] See Meyer v. Nebraska, 262 U.S. 390, 402 (1923) (“That the State may do so much, go very far, indeed, in order to improve the quality of its citizens, physically, mentally and morally, is clear; but the individual has certain fundamental rights which must be respected”).


[xxiii] In re Gault, 387 U.S. 1, at 13 (holding that juveniles tried for crimes in delinquency proceedings have the same right to Due Process by the Fourteenth Amendment as adults).


[xxv] Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976) (holding that a state “may not impose a blanket provision . . . requiring the consent of a parent or person in loco parentis as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy”); Hodgson v. Minnesota, 497 U.S. 417 (1990) (holding that minors must be given the option to seek a judicial bypass of parental consent rules); see also
Bellotti v. Baird, 443 U.S. 622 (holding that mature minors must be given permission for an abortion).


[xxx] Bechtol, 724 S.W.2d at 741.

[xxxi] Id. at 744-45.

[xxxii] Id. at 747

[xxxiii] Id. at 745.


[xxxv] Id. at 112-13.

[xxxvi] Id. at 102.

[xxxvii] Id. at 106.

[xxxviii] Id. at 108.

[xxxix] Id. at 109


[xlii] In re Swan, 569 A.2d at 1204.


See, e.g., Troxel, 530 U.S. at 66. (“In light of . . . extensive precedent, it cannot now be doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children”).

See, e.g., Walter J. Wadlington, *Consent to Medical Care for Minors*, in *Children’s Competence to Consent*, ed. Gary B. Melton, Gerald P. Kocher, and Michael J. Saks (New York: Plenum Press, 1983), 59-60. (“Until a child reaches the legal age of majority, is emancipated generally or is specifically empowered by legislative or judicial action to consent to medical treatment, the child’s parent or guardian usually has legal capacity to give or withhold consent to treatment”).


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

Id.

Id.

Id.

Cardwell v. Bechtol, 724 S.W.2d 739, 744-45 (Tenn. 1987).

To determine the requisite maturity and capacity to make medical decisions, certain courts in the past have utilized the Rule of Sevens doctrine: under the age of seven, a presumption of no capacity; from seven until fourteen a rebuttable presumption of no capacity; and from fourteen to twenty-one a rebuttable of capacity.


The issue of physician-assisted suicide has long been analogized to abortion. In *Compassion in Dying v.*
Washington, Judge Reinhardt from the Ninth Circuit explained that even when physician-assisted suicide was prohibited, it was still taking place behind closed doors (similar to abortions).

[lviii] See Bellotti v. Baird, 443 U.S. 622, 643-44 (1979) (stating that a minor is entitled to show that she mature and informed to make her own medical decision, or that the abortion is in the minor’s best interest).

[lix] See, e.g., In re E.G., 133, Ill.2d at 98; Belcher v. Charleston Area Medical Center, 422 S.F.2d 827 (W. Va, 1992).


[lxv] David G. Scherer & Nicholas D. Reppucci, Adolescents’ Capabilities to Provide Voluntary Informed Consent: The Effects of Parental Influence and Medical Dilemmas, 12 Law & Hum. Behav. 123, 135 (reporting that adolescents reserve “the prerogative to make treatment decisions that have consequential bearing on their lives”).


[lxviii] See, e.g., Brief for American Psychological Association et. al. Amici Curiae (“It is increasingly clear that adolescent brains are not yet fully mature in regions and systems related to higher-order executive functions such as impulse control, planning ahead, and risk avoidance”).
Miller v. Alabama, 597 U.S. __ (2012) (noting that the decision “rested not only on common sense—on what ‘any parent knows’—but on science and social science as well”).


*Id.*

*Id.*

Gibbons v. Ogden, 22 U.S. 1, 203 (1824) (opinion of MARSHALL, C. J.); see also Jacobson v. Massachusetts, 197 U.S. 11 (1905) (holding that the state’s interest in preserving public health and safety can trump the individual’s right to bodily integrity).

*See U.S. CONST. art. III, §1.*

*Id.*

*Id.*


U.S. Const. art. I, § 8, cl. 4.

28 U.S.C. §151

Additional examples of specialized state courts include the following: environmental courts, tax courts, workers’ compensation courts, water, courts, land courts, small claims courts, drug courts, and business/commercial courts.

Harold H. Bruff, *Specialized Courts in Administrative Law*, 43 Admin. L. Rev. 329, 331 (1991) (noting that “[a]lthough it would not be efficient for generalized courts to emphasize expensive training in the
background of their judges or staff, the opposite may be true of specialized courts.”).


[lxxxviii] The United States Tax Court is a specialized court established under Article I of the U.S. Constitution. See also 26 U.S.C. § 7441. This court specializes in adjudicating disputes over federal income tax-related issues.

[lxxxix] The current medical liability system (medical malpractice) is one the most cited legal issue affecting health care.

[xc] Rochelle C. Dreyfuss, Specialized Adjudication, 1990 BYU L. Rev. 377 Article 9. 378 (“if, as common experience suggests, experts are better than laymen at dealing with matters in their special areas, the specialized judiciary should handle more efficiently, thereby reducing the number of judge-hours required to decide any given number of cases”).


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