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NOTE

PROTECTING THE RIGHTS AND INTERESTS OF COMPETENT MINORS IN LITIGATED MEDICAL TREATMENT DISPUTES

Susan D. Hawkins

INTRODUCTION

In 1994, Billy Best, a sixteen-year-old cancer patient from Norwell, Massachusetts, ran away to Texas to avoid continuing his chemotherapy treatment, even though his parents had consented to the treatment for him.1 In another highly publicized case, fifteen-year-old Lee Lor fled her home in Fresno County, California after police, paramedics, and social workers “dragged her from her home and forced her to undergo chemotherapy for ovarian cancer.”2 Her parents had refused to consent to the necessary treatment,3 a decision with which Lee agreed, due to “her fears and her Hmong family’s suspicion of Western medicine.”4 These cases are just two examples of situations in which a minor has experienced pressure to undergo medical treatment against the minor’s wishes. Other disputes have also arisen when parents refused to consent to medical treatment for their minor child, despite that the minor herself had expressed a desire to undergo the treatment.5

In the United States, minors are generally considered legally incompetent to consent to or refuse most forms of medical treatment.6 Parents generally have the sole authority to decide whether their children will receive such treatment, and a physician may not treat a minor without the consent of the minor’s parent or guardian.7 Consequently, when the views of the minor and her parents concerning

5. See, e.g., In re Hudson, 126 P.2d 765, 768 (Wash. 1942) (discussing case of 12-year-old girl with a deformed left arm who had “many times expressed the wish for removal of the . . . arm and frequently wept because of her affliction,” but whose mother refused to consent to amputation).
7. See Sigman & O’Connor, supra note 6, at 521. Of course, as an exception to the general rule, physicians are permitted to render medical treatment to a minor without parental consent in an emergency situation. Id.
medical treatment differ, or when the state steps in to compel medical treatment over the parents’ and the child’s religious or other objections, the wishes of the minor receive little or no deference if the case is litigated in court.

Despite this phenomenon, the United States takes pride in its “rights-based” legal culture. The function of the U.S. legal system is “to enable individual litigants to enforce, protect, and preserve their own legal rights.” The ability to exert control in the decision-making process when personal interests are at stake lies at the heart of the American legal system and its commitment to protecting personal legal rights. Adolescents like Billy Best, Lee Lor, and others, however, are routinely excluded from the treatment decision-making process when their health and bodily integrity are at stake.

The extent of children’s legal rights is an issue that has engendered much debate. At one time, children in the United States were regarded simply as the chattel of their parents, or, more accurately, of their fathers. The law relating to children focused not on their rights, but on the rights of adults with respect to their children. Churches and other charitable organizations provided the little protection that was available to minors out of moral obligation. With the advent of industrialization, social reformers, who believed that “children needed to be rescued from the effects of the industrial revolution,” initiated a movement to protect children. These reformers made some advances in the area of children’s rights by advocating the passage of child labor laws, compulsory education laws, and recommending rehabilitation rather than punishment for delinquent children. Since that time, however, the recognition that children have rights equal to those of adults has evolved very gradually. In fact, the recognition of children’s rights under the law truly began as late as the 1960s, when the Supreme Court finally recognized that the Constitution provides clear authority for the protection of children’s rights.

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11. See *Ventrell*, *supra* note 10, at 261.
12. *Id.* at 261–62.
13. *Id.* at 262; see also David J. Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* 205-12 (1980) (discussing the influence of the progressives on the adoption of child welfare measures in the United States, most notably, the creation of juvenile courts).
15. *Ventrell*, *supra* note 10, at 262 (discussing rehabilitation as an alternative to punishment).
16. *Id.* at 264.
The Supreme Court has held that minors are entitled to constitutional protection in a number of circumstances. In addition, the Court has extended to minors the fundamental rights of privacy and bodily integrity in the contraception and abortion contexts. In keeping with this trend of affording children greater protection under the Constitution, a competent minor’s right to make certain medical decisions for herself should receive protection in most instances as well. If a minor has the right to choose to undergo such an invasive procedure as an abortion, then certainly she should have the right to refuse or accept other forms of medical treatment on her own behalf.

Once courts recognize that minors possess rights, the courts must address the related issue of whether minors should have access to counsel to assist in protecting and enforcing their rights. Many members of the legal community agree that children should have some form of independent representation when their interests are at stake; however, they have not reached a consensus as to the proper

17. The Supreme Court has extended due process protections to minors in both criminal and civil contexts. Minors also possess other civil rights and civil liberties guaranteed by the Constitution. See infra notes 107-18 and accompanying text.


19. See, e.g., Bellotti v. Baird, 443 U.S. 622, 651 (1979) (invalidating a Massachusetts statute requiring parental consent or court order before an abortion can be performed on an unmarried woman under the age of 18); 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”). For a full discussion of the facts and the Supreme Court’s reasoning in the contraception and abortion cases involving minors, see infra notes 163-85 and accompanying text.

20. This Note does not argue that minors should have the right to make all medical decisions on their own. For example, a minor should not be able to demand a certain procedure, such as cosmetic surgery, simply because she wants it. Rather, this Note addresses the right of minors to participate in treatment decisions that are medically necessary, either to save or prolong the minor’s life, such as chemotherapy or blood transfusions, or to enhance substantially the minor’s health and well-being.

21. See Bellotti, 443 U.S. at 651; Danforth, 428 U.S. at 74.

22. See, e.g., Institute of Judicial Administration & American Bar Association, Joint Commission on Juvenile Justice Standards, Counsel for Private Parties § 2.3 (1980) [hereinafter IJA-ABA Standards] (recommending the appointment of independent counsel for any juvenile in a delinquency proceeding or in need of supervision proceeding, or for any juvenile who is the subject of proceedings affecting her status or custody); James K. Genden, Separate Legal Representation for Children: Protecting the Rights and Interests of Minors in Judicial Proceedings, 11 Harv. C.R.-C.L. L. Rev. 565, 578-80 (1976) (advocating appointment of independent counsel for the minor, in cases where the state attempts to compel medical treatment over parental objection, when the wishes of the minor are not adequately protected by any existing party); Rodham, supra note 10, at 509 (“Independent counsel for children should not be restricted to children accused of delinquency, but should be required in any case where a child’s interests are being adjudicated.”); Angela D. Lurie, Note, Representing the Child-Client: Kids Are People Too, 11 N.Y.L. Sch. J. Hum. Rts. 205,
role for the child’s attorney. Several theories exist as to what role the attorney for the child should play. This Note argues that the most appropriate role for the competent child’s attorney is that of an advocate, and that, accordingly, a competent minor should have an attorney who serves as the minor’s advocate in medical treatment cases as well. The minor can effectively communicate her views only through an advocate who presents those views to the court.

This Note argues that when a minor is competent, courts must recognize the minor as a party with standing in cases where the parent and the child disagree over medical treatment decisions, as well as in cases where the state has brought an action to compel medical treatment for the minor when the minor’s parents have refused to consent to such treatment on religious or other grounds. Moreover, the competent minor in these proceedings must have access to independent legal counsel whose role is to present the minor’s wishes to the court.

Parts I and II of this Note address the issue of standing in medical treatment cases. Part I discusses the rights and interests of parents and the state, the only two parties who have traditionally enjoyed legal standing in medical treatment cases. Part II argues that courts must recognize that the competent minor, whose health and bodily integrity are at stake, also has standing. Part III examines the role of counsel in proceedings involving children. This part concludes that the most appropriate role for the competent child’s attorney in medical treatment cases is that of an advocate who represents the wishes of the minor, rather than that of a neutral investigator or champion who merely presents evidence of the child’s best interests to the court.

Part IV examines the issues of capacity and competence as they pertain to minors. This part emphasizes the importance of competence in medical treatment cases. Minors must be competent to make medical treatment decisions for themselves and be able to direct their attorneys in those medical treatment cases that are litigated. After examining a number of standards for assessing competence, this part concludes that the most logical standard is a rebuttable presumption of competence. Finally, part V illustrates how the recommended

205 (1993) (noting that commentators suggest that a minor has a constitutional right to counsel in cases in which they have an interest).

Although many commentators maintain that minors must be independently represented in judicial proceedings affecting their interests, there is still much disagreement over this issue. See Howard A. Davidson, Foreword to Ann M. Haralambie, The Child’s Attorney at xi (1993) (remarking that the issue is “far from settled”).

23. See Katherine H. Federle, Looking for Rights in All the Wrong Places: Resolving Custody Disputes in Divorce Proceedings, 15 Cardozo L. Rev. 1523, 1551 (1994); Haralambie, supra note 22, at 3; Wilber, supra note 9, at 353; Lurie, supra note 22, at 203-06; Robyn-Marie Lyon, Comment, Speaking for a Child: The Role of Independent Counsel for Minors, 75 Cal. L. Rev. 681, 681 (1987).

24. See infra part III.B; see also Bruce A. Green & Bernardine Dohn, Foreword: Children and the Ethical Practice of Law, 64 Fordham L. Rev. 1281, 1287-88 (1996) (discussing the various roles assigned to lawyers for children).
model would operate to protect the rights and interests of minors in litigated medical treatment disputes.

I. STANDING IN MEDICAL TREATMENT CASES TRADITIONALLY HAS BEEN RECOGNIZED IN PARENTS AND THE STATE ONLY

Traditionally, in a litigated dispute over the administration of medical treatment to a minor, only the minor's parents and the state have standing. Such cases almost always arise when the parents have refused to consent to necessary medical treatment for their minor child. Typically, a statute provides the procedures by which the state can challenge a parent's refusal of consent to medical treatment for the child on the basis that it constitutes neglect. After the parent has made a decision regarding the type of medical care her child should receive—whether it is an alternative course of treatment or no treatment at all—a state agency may challenge the parent's choice and move to obtain temporary legal custody of the child, allowing an agent of the state to supply the necessary consent for the treatment of the child. The decision whether to award custody of the child to the

25. An exhaustive search of relevant case law reveals no case in which the minor herself was an actual party to the litigation. See generally 2 Thomas A. Jacobs, Children and the Law: Rights & Obligations §§ 10:07-10:08 (1995) (surveying cases where parents have refused to consent to treatment for their minor child and indicating that the dispute is normally between the minor's parents and the state); see also infra notes 88-96 and accompanying text (discussing cases where the state has proceeded against a minor's parents for refusing to consent to necessary medical treatment).

26. See Genden, supra note 22, at 578.

27. See, e.g., Ariz. Rev. Stat. Ann. §§ 8-531 to -546.04 (1989 & Supp. 1995) (setting forth the procedures for terminating the parent-child relationship on ground that the parent has abused, neglected, or abandoned the child, or is otherwise unable to discharge parental responsibilities); Cal. Welf. & Inst. Code §§ 300(b), 305(a) (West Supp. 1996) (defining “dependent child” as one whose parents have willfully or neglectfully failed to provide the minor with adequate medical treatment and providing for any peace officer to take such a minor into temporary custody); Colo. Rev. Stat. §§ 19-10-103, -107 (1986) (defining “neglect” as including parental failure to provide adequate medical care and providing for temporary protective custody for any child believed to be neglected); Del. Code Ann. tit. 16, §§ 901-909 (1983 & Supp. 1994) (defining “child neglect” and providing protective services for neglected children); Fla. Stat. Ann. §§ 39.01, .03 (West 1988 & Supp. 1995) (defining “neglect” as parental failure to provide necessary medical treatment and authorizing a law enforcement officer to take a minor into custody if he has reasonable grounds to believe that the minor has been neglected); Idaho Code §§ 16-1602, -1616 (1979 & Supp. 1995) (defining “neglected child” as one who is without proper medical care and providing for court-appointed medical care when the child's parents refuse or fail to consent); N.Y. Fam. Ct. Act §§ 1012, 1021-1022 (McKinney 1983 & Supp. 1996) (defining “neglected child” as one whose physical, mental, or emotional condition is impaired as a result of parental failure to supply adequate medical care and providing procedures for temporary removal of a child from the home by an agent of an authorized agency, association, society, or institution).

state temporarily, thereby effectively ordering the child to undergo the proposed treatment, is ultimately the province of the judge.\textsuperscript{29} Whether the minor wishes to undergo the treatment is generally not a factor in the court’s decision,\textsuperscript{30} and the minor herself is not a party to the litigation.

A less common scenario arises when the parents have consented to the medical treatment, but the minor does not wish to be treated, as occurred in Billy Best’s case.\textsuperscript{31} No such case appears to have reached the courts.\textsuperscript{32} This absence of litigation is likely due, in part, to the fact that no mechanism exists for the minor to challenge the parent’s consent when the minor does not want the recommended treatment. Even if such a mechanism did exist, courts would likely view the minor as lacking the legal standing to initiate and pursue the case given the general rule that the parents of a minor have the ultimate authority to decide whether their child will receive medical treatment.\textsuperscript{33} This part examines the respective interests of parents and the state in medical treatment cases in an effort to explain why, traditionally, a minor’s parents and the state have been the only parties who have enjoyed standing in such cases.

A. Interests of Parents

In litigated medical treatment disputes, courts consider two parental interests: (1) authority to make decisions concerning their children and (2) freedom of religion. This subpart discusses the nature of these two parental concerns and presents several reasons why courts have both protected and imposed limits on them.

1. Family Privacy and Parental Authority in Decision Making

Courts in the U.S. have long recognized family privacy and parental authority over their children. The Supreme Court has noted that “deeply rooted in our Nation’s history and tradition[] is the belief that the parental role implies a substantial measure of authority over one’s children.”\textsuperscript{34} Decisions of the Supreme Court throughout the

\begin{itemize}
  \item \textsuperscript{29} Id. at 158.
  \item \textsuperscript{30} See Genden, supra note 22, at 578.
  \item \textsuperscript{31} See Knox, supra note 1, at 1.
  \item \textsuperscript{32} See id. at 19 (stating that “the mature minor doctrine has not been tested to support an adolescent’s right to refuse treatment deemed medically necessary”).
  \item \textsuperscript{33} See Feigenbaum, supra note 6, at 852.
  \item \textsuperscript{34} Bellotti v. Baird, 443 U.S. 622, 638 (1979).
\end{itemize}
twentieth century have granted constitutional protection to parents' rights to rear and educate their children.\textsuperscript{35}

Because society values privacy and family integrity, courts accord great deference to parental decisions.\textsuperscript{36} Two presumptions drive such deference to parental authority. First, courts believe that "parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions."\textsuperscript{37} Second, lawmakers presume that the "natural bonds of affection" cause parents to act in their child's best interests.\textsuperscript{38} Courts also recognize that parental autonomy in decision making is an essential element of preserving integrity of the family.\textsuperscript{39} Parental autonomy to care for children free from government interference contributes to the physical and psychological well-being of the child by promoting continuity in the child's life.\textsuperscript{40} Consequently, parents generally have the right to make decisions for their children without state interference,\textsuperscript{41} and, in fact, state intervention in the parent-child relationship is justifiable only when the state can demonstrate "a powerful countervailing interest."\textsuperscript{42} Parental authority in decision making generally includes the

\textsuperscript{35} See Ginsberg v. New York, 390 U.S. 629, 639 (1968) ("[C]onstitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic in the structure of our society."); see also Quillio v. Walcott, 434 U.S. 246, 255 (1978) (stating that "the relationship between parent and child is constitutionally protected"); Wisconsin v. Yoder, 406 U.S. 205, 234 (1972) (holding that state compulsory education law as applied to Amish children violated parents' right to raise their children according to their religious beliefs); Stanley v. Illinois, 405 U.S. 645, 651 (1972) (holding that unwed father's interest in the children he has raised deserves deference and protection); Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925) (holding that state law prohibiting parents from sending their children to private schools interferes unreasonably with their right to choose their child's education); Meyer v. Nebraska, 262 U.S. 390, 400-01 (1923) (holding that state statute criminalizing the teaching of German language to elementary school students violates parents' right to educate their children).

\textsuperscript{36} Sher, supra note 28, at 171. For example, the Supreme Court has articulated that an "important justification for state deference to parental control over children is that '[t]he child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations." Bellotti, 443 U.S. at 637 (quoting Pierce, 268 U.S. at 535).


\textsuperscript{38} Id.; see also Sher, supra note 28, at 171-72 (noting that courts accord great deference to parental decisions on the assumption that parents ordinarily act in their child's best interests).


\textsuperscript{41} Sher, supra note 28, at 171; see, e.g., Prince v. Massachusetts, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.").

\textsuperscript{42} Stanley v. Illinois, 405 U.S. 645, 651 (1972); see also Meyer v. Nebraska, 262 U.S. 390, 399-400 (1923) (stating that the Fourteenth Amendment protects the right
right of parents to make the important decision of whether and when their minor children will receive medical treatment.\textsuperscript{43}

2. Freedom of Religion

Another parental interest often cited in medical treatment cases is the right to free exercise of religion, guaranteed by the First Amendment.\textsuperscript{44} Consideration of parents' religious beliefs in medical treatment cases comes into play when the parents' religion prohibits the use of certain medical procedures, as is the case with Jehovah's Witnesses,\textsuperscript{45} or prohibits resorting to medical treatment at all, as does the Christian Science Church.\textsuperscript{46}

Courts have long recognized parents' rights to provide their children with religious training and to encourage them in the practice of religious beliefs without undue state interference.\textsuperscript{47} While the govern-

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\item \textsuperscript{43} See Feigenbaum, \textit{supra} note 6, at 851 (stating that parents are usually entrusted to make important decisions regarding the health and welfare of their children).
\item \textsuperscript{44} See cases cited \textit{infra} notes 88-90, 93-94 and accompanying text.
\item \textsuperscript{45} While not opposed to medical treatment or surgery per se, Jehovah's Witnesses oppose blood transfusions, which are often a necessary component of medical and surgical procedures. See Mike McKee, \textit{Blood Feud; When Jehovah's Witnesses Refuse Transfusions Based on Their Beliefs, the Legal and Medical Guidelines Are Far from Clear}, The Recorder, Aug. 15, 1995, at *1, available in LEXIS, Nexis Library, Papers File. Witnesses refuse blood transfusions on the ground that such a procedure is akin to eating blood, a practice strictly forbidden in the Bible. Julie A. Koehne, \textit{Witnesses on Trial: Judicial Intrusion upon the Practices of Jehovah's Witness Parents}, 21 Fla. St. U. L. Rev. 205, 207 (1993).
\item \textsuperscript{46} In contrast to Jehovah's Witnesses, Christian Scientists rely on spiritual aid and the healing power of prayer instead of conventional medical treatment. Steven Schneider, \textit{Christian Science and the Law: Room for Compromise?}, 1 Colum. J.L. & Soc. Probs. 81, 81 (1965). "Mary Baker Eddy, the founder of the Christian Science Church, professed a deep belief in spirituality." Newmark v. Williams, 588 A.2d 1108, 1109 n.2 (Del. 1991). She preached that sickness was a manifestation of a diseased mind and claimed that "[m]edicine will not arrive at the Science of treating disease until disease is treated mentally and man is healed morally and physically." \textit{Id.} (quoting Mary Baker Eddy, \textit{Sermon Subject: Christian Healing, in Prose Works Other than Science & Health with Key to the Scriptures 14} (1886)). Thus, Christian Scientists do not treat most sicknesses with medical care; instead, they rely on practitioners who administer spiritual aid. \textit{Id.}
\item \textsuperscript{47} See, e.g., Wisconsin v. Yoder, 406 U.S. 205, 214 (1972) ("[A] State's interest in universal education ... is not totally free from a balancing process when it impinges on fundamental rights and interests, such as ... the traditional interest of parents with respect to the religious upbringing of their children ... "); West Virginia State Bd. of Ed. v. Barnette, 319 U.S. 624, 642 (1943) (holding that to compel Jehovah's Witness children to salute the flag as part of a daily school exercise "transcends constitutional limitations on [local school authorities'] power and invades the sphere of intellect and spirit which it is the purpose of the First Amendment ... to reserve from all official control"); Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925) (finding that Oregon law prohibiting parents from sending their children to parochial school "inter-
ment cannot interfere with religious beliefs, conduct in the pursuit of such beliefs is subject to governmental restraint. Accordingly, in 1944, the Court, in *Prince v. Massachusetts*, sharply curtailed the freedom of parents to make decisions affecting the welfare of their children. In rejecting the appellant's argument that a state statute prohibiting the sale or distribution of literature by minors violated her right to the free exercise of religion, the Court stated: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." Thus, while religious freedom and parental authority are two parental interests that courts accord much respect, "neither right is beyond limitation."

**B. Interests of the State**

In addition to parental interests, the state often has interests at stake in medical treatment cases as well. In any case where the minor, the parent, or both wish to refuse treatment for the minor, the state may have compelling reasons to oppose such a decision. This subpart discusses the relevant interests of the state in medical treatment cases and illustrates those instances when state interests trump the parental concerns discussed above.

1. The State's Role as *Parens Patriae*

Although "the tradition of parental authority is ... one of the basic presuppositions" of individual liberty, the state often has the power to limit parental freedom and authority when parents endanger the

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48. Reynolds v. United States, 98 U.S. 145, 166 (1878). Considering governmental regulation of polygamy, the Court stated: "Laws are made for the government of actions, and while they cannot interfere with mere religious belief and opinions, they may with practices." *Id.*


50. In *Prince*, the Court upheld a Massachusetts child labor statute making it a crime for any adult to provide a minor boy under the age of 12 or a minor girl under the age of 18 with merchandise that the adult knows the minor child intends to sell in the street or in any public place. *Id.* at 160-61, 171. The appellant, a Jehovah's Witness, had been convicted and fined for permitting her ward, a nine-year-old girl, to distribute religious literature in the streets in violation of the statute. *Id.* at 159-60. The Jehovah's Witnesses' practice of permitting children "to preach the gospel ... by public distribution" ... [*is*] in conformity with the scripture: 'A little child shall lead them." *Id.* at 164. Appellant argued, but failed to persuade the court, that the statute was unconstitutional because it interfered with her right to the free exercise of her religious convictions. *Id.* at 159.

51. *Id.* at 170.


The state’s *parens patriae* power permits intervention in private relationships to promote the best interests of a particular individual. The state invokes its *parens patriae* power to protect those members of society who are unable to protect themselves. Children are an obvious category of persons often in need of such protection.

The Supreme Court has recognized that the state can limit parents’ rights when their children’s physical or mental well-being is in jeopardy. For example, the state may restrict parents’ authority over their children by requiring school attendance, regulating or prohibiting child labor, and compelling vaccinations. In general, the state may exercise its *parens patriae* power when parents have failed to provide proper care for their child, or when parental decisions threaten the child’s health and safety. In the event that the minor is placed in danger by a parent who fails to provide proper protection, the state will move to take custody of the minor through court action.

The state may invoke its *parens patriae* power at any time during a person’s minority. This power is strongest, however, when the child is young and immature, and therefore lacks the capacity to make decisions for herself. Thus, “[t]he *parens patriae* authority fades . . . as the minor gets older,” and eventually disappears when the child reaches adulthood.

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62. Sher, *supra* note 28, at 170; *see also* Saratoga County Dep’t of Social Servs. v. Hofbauer, 393 N.E.2d 1009, 1013 (N.Y. 1979) (stating that “the State, as *parens patriae*, may intervene to ensure that a child’s health or welfare is not being seriously jeopardized by a parent’s fault or omission”); *In re Hudson*, 126 P.2d 765, 775 (Wash. 1942) (“[W]here the parents fail to perform their natural duty so to rear and educate the child[,] . . . the state, as *parens patriae* of all children, may assert its power and apply curative measures, so as to prevent injury to the child and to society . . . .”).
64. Scott, *supra* note 52, at 87.
65. *Id.*
67. *Id.*
The state's *parens patriae* power is clearly at issue in cases where parents refuse to consent to necessary medical treatment for their minor child. This power underlies state child abuse and neglect statutes, and authorizes the state to institute dependency proceedings to transfer legal custody of a minor from the parent to the state. As a result of these proceedings, the court may appoint a guardian who has authority to make the treatment decision that best serves the minor's interests. Thus, when the state moves for temporary legal custody of a minor, pursuant to abuse, neglect, and dependency statutes, in order to compel necessary medical treatment, the state relies on its *parens patriae* power.

2. Other State Interests

The state has other interests that support intervention into the parent-child relationship. For instance, the *parens patriae* doctrine is grounded in the belief that the state has a strong interest in preserving human life. Thus, when a parent's affirmative conduct or neglect threatens the life of the child, the state has a duty to intervene. This duty clearly arises when a parent refuses to consent to life-saving medical treatment for her child.

In addition, the state, as guardian of the health and welfare of society at large, has an interest in ensuring the goal of a productive and self-perpetuating society. By taking steps to keep children free from harm, the state enables future adults to contribute to and thrive in society. Protecting the welfare of children also conserves the state's limited resources by preventing children from becoming wards of the state.

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70. Feigenbaum, *supra* note 6, at 858.
72. See E.G., 549 N.E.2d at 327. There, the court stated that “[w]hen a minor's health and life are at stake, this policy [valuing the sanctity of life] becomes a critical consideration. A minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize.” Id.
73. See Belchertown, 370 N.E.2d at 426 (discussing the state’s interest in protecting children from the potentially harmful decisions of their parents).
74. See Prince v. Massachusetts, 321 U.S. 158, 168 (1944) (“A democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies.”).
75. Feigenbaum, *supra* note 6, at 857.
76. Id. at 857 (citing Zablocki v. Redhail, 434 U.S. 374, 394 (1978) (Stewart, J., concurring); see also Marcia Lowry, *Derring-Do in the 1980s: Child Welfare Impact Litigation After the Warren Years*, 20 Fam. L.Q. 255, 257 (1986) (stating that failure of
Finally, the state has an interest in protecting the ethical integrity of the medical profession. As one commentator stated: "The success of the medical profession depends on maintaining the public's confidence that physicians will conduct themselves pursuant to established [ethical] principles." The Hippocratic dictum, "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone," reflects the principle that doctors should strive to enhance their patients' health and well-being, not remain inactive and watch them deteriorate. Thus, when parents refuse to consent to medical treatment for their minor children and the medical profession fails to intervene in contravention of these established ethical principles, society's trust in the medical profession is undermined.

C. Balancing the Interests in Medical Treatment Cases

Thus far, most, if not all, reported medical treatment cases have arisen when parents have refused to consent to treatment for their child, for whatever reason. Even though the child's interests are at stake in medical treatment cases, courts tend to consider only the parents' and the state's interests in the outcome. The interests of the child are deemed secondary, if considered at all.

When presented with a case where parents have refused to consent to medical treatment for their child, courts generally apply a balancing test—"an evaluation of the risk of the procedure compared to its potential success." Courts generally consider two main factors. First, the court considers the effectiveness of the proposed treatment and determines the child's chances of survival with and without it. Second, the court evaluates the nature of the treatment and its effect, physically and emotionally, on the child. The probability of state inter-

77. Belchertown, 370 N.E.2d at 426.
78. Feigenbaum, supra note 6, at 858.
81. Feigenbaum, supra note 6, at 858.
82. See Sher, supra note 28, at 157-58 (stating that "[i]n the typical medical care decisionmaking case, parents have made a good faith decision regarding the type of medical care their child should receive, and a state agency challenges that choice as constituting statutory child neglect"); see also infra notes 84-96, 99 and accompanying text (surveying cases in which the state has sought to compel medical treatment over parental objection).
83. Sher, supra note 28, at 167-73.
85. See, e.g., County of Contra Costa Dep't of Social Servs. v. Ted B., 235 Cal. Rptr. 22, 27 (Ct. App. 1987) ("The state should examine the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm; the evaluation for the treatment by the medical profession; the risks involved in medically
vention on the minor's behalf increases as the risk to the minor grows greater and more imminent.\textsuperscript{86}

Thus, courts uniformly order medical treatment over parental objection when the child's condition is life-threatening,\textsuperscript{87} regardless of the proffered justification for the objection. For example, courts routinely compel treatment for the child when the parental objection is to blood transfusions, based on religious grounds.\textsuperscript{88} In fact, in Jehovah's Witnesses v. King County Hospital Unit No. 1,\textsuperscript{89} the Supreme Court indicated its approval of such action when it upheld the constitutionality of a Washington statute construed to permit judges to authorize a necessary blood transfusion for a minor over a parent's refusal on religious grounds.\textsuperscript{90}

In addition, courts will authorize other types of medical treatment for a minor over the parents' objections when the treatment is "relatively innocuous in comparison to the dangers of withholding medical treatment the child; and the expressed preferences of the child.” (quoting In re Philip B., 156 Cal. Rptr. 48, 51 (Ct. App. 1979), cert. denied, 445 U.S. 949 (1980)); Newark, 588 A.2d at 1117-18 (balancing effectiveness of treatment against nature of treatment in case where Christian Scientist parents refused to consent to chemotherapy for their child with Burkitt's Lymphoma); Custody of a Minor, 379 N.E.2d 1053, 1065-66 (Mass. 1978) (considering effectiveness and adverse effects of chemotherapy in determining whether to order such treatment for three-year-old child).

86. Scott, supra note 52, at 88 ("As the immediacy and magnitude of potential for harm to the child increases, the likelihood for government involvement increases for the child's protection.").

87. Sher, supra note 28, at 162; see also Developments in the Law—Medical Technology and the Law, 103 Harv. L. Rev. 1519, 1596 (1990) [hereinafter Developments—Medical] (stating that "the state may . . . authorize blood transfusions and other lifesaving treatments, and require medical attention to certain less threatening problems in order to avert more severe ailments in the future" (footnotes omitted)).


89. 390 U.S. 598 (1968).

90. Id. at 598. The Court simply affirmed the decision of the Sixth Circuit in a one-sentence opinion, citing Prince v. Massachusetts, 321 U.S. 158 (1944). King County Hosp., 390 U.S. at 598.
care."\(^9\) Finally, if the parent has offered no plausible reason for objecting to the treatment, courts will likewise order treatment.\(^2\)

By contrast, courts have declined to authorize medical care over parental objection where the child does not suffer from a life-threatening, or potentially life-threatening, condition.\(^9\) Similarly, courts are unwilling to compel medical treatment for minors over parents' religious or other objections when the proposed treatment is inherently dangerous and invasive, or involves extreme pain and suffering that overwhelm the benefits of treatment.\(^9\) Courts also tend to uphold

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91. Newmark v. Williams, 588 A.2d 1108, 1117 (Del. 1991); see, e.g., \textit{In re D.L.E.}, 645 P.2d 271, 276 (Colo. 1982) (finding that minor was neglected when mother objected to administration of medication to prevent epileptic seizures).


93. See, e.g., \textit{In re Seiferth}, 127 N.E.2d 820, 822-23 (N.Y. 1955) (refusing to compel surgery on 14-year-old child with cleft palate and hair lip over father's objection to surgery; father preferred "mental healing by letting 'the forces of the universe work on the body' "); \textit{In re Green}, 292 A.2d 387, 392 (Pa. 1972) (refusing to authorize corrective spinal surgery on minor over mother's religious objection to blood transfusion, stating that "as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is not immediately imperiled by his physical condition" (emphasis omitted)). \textit{But see In re Sampson}, 317 N.Y.S.2d 641, 657-59 (Fam. Ct. 1970) (authorizing corrective surgery for minor's facial and neck deformity where mother's religious objection was only to blood transfusion; stating that "mother's religious beliefs" could not "stand in the way of attaining through corrective surgery whatever chance [the child] may have for a normal, happy existence"), aff'd, 323 N.Y.S.2d 253 (App. Div. 1971), aff'd, 278 N.E.2d 918 (N.Y. 1972).

One commentator has characterized \textit{Green} as an important "transitional" case in the history of medical treatment cases. See Walter Wadlington, \textit{Medical Decision Making For and By Children: Tensions Between Parent, State, and Child}, 1994 U. Ill. L. Rev. 311, 321. Even though the child ultimately adhered to his parent's wishes that surgery not be performed, the Pennsylvania Supreme Court remanded the case so that the views of the child whose health was at stake could be heard. \textit{In re Green}, 307 A.2d 279, 280 (Pa. 1973). In this commentator's view, "\textit{Green} may have sowed some seeds for a subsequent movement toward permitting or seeking participation by minor children in decisions affecting their own health." Wadlington, \textit{supra}, at 321. This Note argues that competent minor children must have a voice in such cases affecting their health, and that the most effective way of ensuring that children are heard is to provide them with an independent advocate in the proceedings.

94. See, e.g., \textit{Newmark}, 588 A.2d at 1118 (refusing to compel chemotherapy for child with Burkitt's Lymphoma over Christian Scientist parents' objection because the "proposed medical treatment was highly invasive, painful, involved terrible temporary and potentially permanent side effects, posed an unacceptably low chance of success, and a high risk that the treatment itself would cause his death"); \textit{In re Hudson}, 126 P.2d 765, 768 (Wash. 1942) (refusing to compel amputation of 12-year-old girl's congenitally deformed left arm because mother feared risk of death posed by the surgery); \textit{In re Green} (Wis. Milwaukee County Ct. 1966), \textit{reprinted in Parental Right to Refuse Medical Treatment for Child}, 12 Crime & Delinq. 377, 384-85 (1966) (refusing to find minor a neglected child when the mother, a Jehovah's Witness, failed to give consent to treatment for sickle cell anemia, in part, because she was aware that the proposed procedures were experimental, dangerous, and unlikely to be effective).
parental discretion in medical treatment decisions when the proposed procedure or treatment would provide no clear medical benefit to the child. Finally, courts have declined to order treatment when such treatment is "no more or less likely to benefit the child than the alternative course of action chosen" by the parents.

A more difficult question arises in predicting how courts would treat parental objections to treatment based on fear of the financial or emotional burdens posed by a seriously ill child. At least one commentator argues that courts should not ignore such fears on the part of parents.

95. Developments—Medical, supra note 87, at 1596; Robyn S. Shapiro & Richard Barthel, Infant Care Review Committees: An Effective Approach to the Baby Doe Dilemma?, 37 Hastings L.J. 827, 832 (1986); see, e.g., In re Guardianship of Barry, 445 So. 2d 365, 371 (Fla. Dist. Ct. App. 1984) (upholding parental decision to terminate life-support for terminally ill 10-month-old baby because child had no hope of ever achieving awareness or normal brain functioning); Custody of a Minor, 434 N.E.2d 601, 604, 610 (Mass. 1982) (refusing to order treatment for four-and-a-half-month-old abandoned child suffering from serious congenital heart malformation because patients with such a condition normally die within a year with or without treatment).

96. Developments—Medical, supra note 87, at 1596; see, e.g., Saratoga County Dep't of Social Servs. v. Hofbauer, 393 N.E.2d 1009, 1011, 1014 (N.Y. 1979) (upholding parental decision to treat seven-year-old child with Hodgkins disease with nutritional and metabolic therapy, instead of radiation and chemotherapy); Weber v. Stony Brook Hosp., 467 N.Y.S.2d 685, 686 (App. Div. 1983) (upholding parents' decision to refuse surgery for their infant afflicted with spina bifida, microencephaly, and hydrocephalus, stating that "the parents' choice of a course of conservative treatment, instead of surgery, was well within accepted medical standards and [hence] .. . there was no medical reason to disturb the parents' decision"), aff'd, 456 N.E.2d 1186 (N.Y.), cert. denied, 464 U.S. 1026 (1983). But see Custody of a Minor, 393 N.E.2d 836, 837-38 (Mass. 1979) (affirming lower court finding of neglect when parents refused to consent to continued administration of chemotherapy treatment for their three-year-old child suffering from lymphocytic leukemia, preferring, instead, metabolic therapy).

In the Weber case discussed above, the parents withheld consent for corrective surgery for their infant who was born with multiple congenital defects, choosing instead another acceptable, but more conservative, form of treatment. 467 N.Y.S.2d at 686. Although corrective surgery would have prolonged the child's life, it would not have improved many of her handicaps. Bowen v. American Hosp. Ass'n, 476 U.S. 610, 621 (1986) (summarizing facts from state court proceeding); see also Weber, 467 N.Y.S.2d at 686 (stating that "[c]onsiderations of the risks of the surgical procedure, and its impact upon the patient's overall medical condition, led both doctors to the conclusion that the conservative course of treatment ... was medically appropriate"). The federal government later sued the hospital for discriminatorily withholding medical treatment for a handicapped person in violation of § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. See United States v. University Hosp., 575 F. Supp. 607, 609 (E.D.N.Y. 1983). Ultimately, the Supreme Court held that the hospital had not discriminated against the infant because the lack of parental consent justified the hospital's withholding of treatment. Bowen, 476 U.S. at 622. Although the Court did not expressly uphold the parents' right to choose a reasonable alternative form of medical care for their child, the dicta seemed to indicate the Court's approval of this approach.

97. See Sher, supra note 28, at 190.

98. Id.
Thus, while courts certainly defer to parental decision making in some medical treatment cases out of respect for parental authority and religious beliefs, the right of parents to withhold treatment for their children is far from absolute. When courts overrule parental objections to treatment, however, they usually do so because ordering treatment is in the best interests of the child, not out of deference to the child's wishes.

To date, no reported cases exist where the minor has resisted the proposed medical treatment consented to by the minor's parents. Because courts have, for the most part, accorded little or no weight to the minor's preference in litigated medical treatment disputes, if the parents of Billy Best, the sixteen-year-old Hodgkins disease patient, had taken him to court to force him to undergo further chemotherapy, a judge would likely have ruled in favor of the parents. Legal experts commenting on the case expressed doubt that such a case would ever be litigated, or that anyone would ever compel a minor to undergo treatment that she does not want. In at least one medical treatment case where the court did take into account the views of the minor in reaching its decision, however, language in the opinion strongly suggested that the court would have deferred to the parents' wishes if the parents had not agreed with the minor's decision to refuse treatment.

D. Summary

The premium placed on a parent's right to decide what is best for her minor child has served as justification for subordinating the legal rights of the minor. Deference to parental authority in medical treatment decisions has unquestionably led courts to ignore, or accord less weight to, the wishes of the child, thereby denying the child the

99. See, e.g., Knox, supra note 1, at 1 (stating that legal scholars know of no case in which a U.S. court has ordered chemotherapy to be forced on an adolescent).

100. Id. (postulating a similar factual situation). Billy Best's parents eventually relented, and allowed him to discontinue the therapy. Perkins, supra note 2, at B10. Instead, he began a program of alternative medicine. Id. As of May 1995, Billy Best's cancer was in remission. Id.

101. Knox, supra note 1, at 1, 19 (quoting Leonard Glantz and George Annas, professors of health law at Boston University School of Law).

102. See In re E.G., 549 N.E.2d 322, 328 (Ill. 1989) (“If a parent or guardian opposes an unemancipated mature minor's refusal to consent to treatment for a life-threatening health problem, this opposition would weigh heavily against the minor's right to refuse.”).

103. See Bellotti v. Baird, 443 U.S. 622, 638-39 (1979) (arguing that “[l]egal restrictions on minors, especially those supportive of the parental role, may be important to the child's chances for the full growth and maturity that make eventual participation in a free society meaningful and rewarding”); see also Bruce C. Hafen, Children's Liberation and the New Egalitarianism: Some Reservations About Abandoning Youth to Their "Rights," 1976 B.Y.U. L. Rev. 605, 617 (discussing the "plenary" nature of parental power, which "prevail[s] over the claims of the state, other outsiders, and the children themselves unless there is some compelling justification for interference").
opportunity to make an important choice pertaining to the integrity of her own body. Even in cases where the state’s \textit{parens patriae} power has overridden parental authority, persuading courts to order necessary treatment over parental objection, such decisions have not served to promote a minor’s fundamental right to make medical treatment decisions on her own behalf because courts traditionally balance the interests of the parents against those of the state only. Courts have, to a limited extent, permitted minors to consent to treatment for themselves under mature minor statutes\textsuperscript{4} and in abortion and contraception cases,\textsuperscript{5} but this practice is not widespread in medical treatment cases. Courts must extend the rights of minors even further, by recognizing that they, too, have legal standing to enforce their right to participate in medical treatment decision making.

II. Minors Should Have Standing in Medical Treatment Cases

In the past three decades, a noticeable trend toward greater recognition of children’s rights by federal and state courts has emerged. The Supreme Court has stated that “[a] child, merely on account of his minority, is not beyond the protection of the Constitution.”\textsuperscript{6} The Court has held that minors are entitled to constitutional protection in a number of circumstances. The Fourteenth Amendment’s guarantee against the deprivation of liberty without due process of law is applicable to children in juvenile delinquency proceedings.\textsuperscript{7} Specifically, minors in delinquency proceedings are entitled to adequate notice of charges,\textsuperscript{8} the assistance of counsel,\textsuperscript{9} the privilege against self-incrimination,\textsuperscript{10} and the right to confront their accusers.\textsuperscript{11} Moreover, minors in juvenile delinquency proceedings can be found guilty only upon proof beyond a reasonable doubt.\textsuperscript{12} Finally, the prohibition against double jeopardy also applies to minors.\textsuperscript{13}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{104} See infra notes 343-49 and accompanying text.
\item \textsuperscript{105} See infra notes 163-85 and accompanying text.
\item \textsuperscript{106} \textit{Bellotti}, 443 U.S. at 633.
\item \textsuperscript{107} \textit{In re Gault}, 387 U.S. 1, 27-28 (1967) (stating that, with respect to juvenile court proceedings, “it would be extraordinary if our Constitution did not require the procedural regularity and the exercise of care implied in the phrase ‘due process’ ”).
\item \textsuperscript{108} \textit{Id.} at 35.
\item \textsuperscript{109} \textit{Id.} at 41.
\item \textsuperscript{110} \textit{Id.} at 55.
\item \textsuperscript{111} \textit{Id.} at 57.
\item \textsuperscript{112} \textit{In re Winship}, 397 U.S. 358, 368 (1970).
\item \textsuperscript{113} See \textit{Breed v. Jones}, 421 U.S. 519, 532-33 (1975) (holding that Double Jeopardy Clause prohibits prosecuting juvenile as an adult after a finding in juvenile court that he had violated a criminal statute). Despite the many due process protections enjoyed by minors in the criminal context, the Court has placed limits on the extent of such protection. See, e.g., \textit{McKeiver v. Pennsylvania}, 403 U.S. 528, 545 (1971) (holding that a jury trial in the adjudicative stage of a delinquency proceeding is not constitutionally required).
\end{itemize}
\end{footnotesize}
Minors are entitled to constitutional due process protections in civil contexts as well. For example, children may not be deprived of certain property interests without due process of law.\textsuperscript{114} Other constitutionally protected civil rights and liberties that minors possess include freedom of speech\textsuperscript{115} and equal protection against racial discrimination.\textsuperscript{116} Most recently, the Court has recognized a minor's constitutionally protected right to use contraception\textsuperscript{117} and to have an abortion.\textsuperscript{118} The Court's contraception and abortion decisions have traditionally rested on the notion that privacy is a fundamental right,\textsuperscript{119} and that any infringement is, therefore, subject to strict judicial scrutiny.\textsuperscript{120} The Court has, by implication, extended this fundamental right to minors as well in these limited contexts.\textsuperscript{121}

\begin{footnotes}
\item[114] See Goss v. Lopez, 419 U.S. 565, 574 (1975) (stating that school-age child may not be deprived of property interest in public school education without due process).
\item[115] See Board of Ed. v. Pico, 457 U.S. 853, 871 (1982) (upholding reversal of grant of summary judgment to defendants, stating that removal of books from school library violates students' First Amendment rights if by such removal defendants intended to deny students access to ideas with which defendants disagreed); Tinker v. Des Moines Indep. Community Sch. Dist., 393 U.S. 503, 514 (1969) (upholding high school students' right to wear black arm bands in protest of the Vietnam War). \textit{But see} Hazelwood Sch. Dist. v. Kuhlmeier, 484 U.S. 260, 273 (1988) ("[W]e hold that educators do not offend the First Amendment by exercising editorial control over the style and content of student speech in school-sponsored expressive activities so long as their actions are reasonably related to legitimate pedagogical concerns.").
\item[116] See Brown v. Board of Ed., 347 U.S. 483, 495 (1954). As in the criminal context, the Court has also refused to grant minors civil rights and liberties to an extent equal to that of adults. \textit{See, e.g.}, Veronia Sch. Dist. v. Acton, 115 S. Ct. 2386, 2389, 2396 (1995) (holding that school policy of random urinalysis drug testing of students who participate in the school's athletic programs does not violate students' Fourth Amendment rights).
\item[118] See Bellotti v. Baird, 443 U.S. 622, 651 (1979) (invalidating a Massachusetts statute requiring parental consent or court order before an abortion can be performed on an unmarried woman under the age of 18); 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 \textit{in loco parentis} as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy"); \textit{see also infra} notes 163-85 and accompanying text (discussing the Court's reasoning in extending the rights of contraception and abortion to minors).
\item[119] \textit{See, e.g.}, Roe v. Wade, 410 U.S. 113, 152 (1973) (stating that, despite the absence of explicit mention of privacy in the Constitution, "the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution"); Griswold v. Connecticut, 381 U.S. 479, 484-85 (1965) (stating that an individual's right of privacy is found in the "penumbras" of various Bill of Rights guarantees).
\item[120] \textit{See, e.g.}, \textit{Roe}, 410 U.S. at 155 ("Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest,' . . . narrowly drawn to express only the legitimate state interests at stake." (citations omitted)).
\item[121] Although the Court has extended the right of privacy to competent minors in the contraception and abortion contexts, the Court has refused to recognize that a
\end{footnotes}
A. The Minor Must Have a Voice When a Protected Liberty Interest Is at Stake

The wishes of the minor in medical treatment cases are rarely discussed, primarily because, other than in limited circumstances, few courts recognize that children have interests independent of those of their parents or the state. When facing the possibility of undergoing medical treatment against her wishes, or the possibility of being denied medical treatment that she desires, the minor has fundamental interests at stake. The right of a competent individual to make decisions affecting her own body is grounded in the common law rights of informed consent and bodily integrity, and in the constitutional right of privacy. Given the recent judicial trend towards affording children greater protection under the Constitution, a minor’s right to make medical decisions for herself should receive full protection, and a minor should enjoy standing in contested medical treatment cases to protect her rights of informed consent, bodily integrity and self-determination, and privacy.

1. The Common Law Doctrine of Informed Consent

An individual has the right to make medical decisions on her own behalf pursuant to the common law doctrine of informed consent. Under this doctrine, a patient must receive information about all potential benefits and attendant risks of treatment in order to consent.
effectively to that treatment. If a physician performs the treatment without having first obtained effective consent by the patient, the physician may be liable to the patient for battery at common law. The informed consent doctrine permits the individual to control her own medical decisions and, thus, preserves the rights of bodily integrity and self-determination.

2. The Common Law Rights of Bodily Integrity and Self-Determination

The common law rights of bodily integrity and self-determination also support the contention that every individual has the right to make her own treatment decisions. Courts, without question, recognize the rights of bodily integrity and self-determination in adults. The Supreme Court stated in *Union Pacific Railway Company v. Botsford* that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." In *Botsford*, the Court refused to order the plaintiff, who had been injured while traveling on one of the defendant’s trains, to submit to a surgical examination at the defendant’s behest without her consent. The Court made clear that no court has the power to compel an individual to accept unwanted medical attention. The Supreme Court has reaffirmed its recognition of the right of bodily integrity in more recent opinions. For example, in *Rochin v. California*, the Court held that forced stomach pumping is "offensive to human dignity." Similarly, in *Schmerber v. California*, the Court stated that "[t]he integrity of an individual’s person is a cherished value of our society." Although the Supreme Court has never expressly stated that minors enjoy a protected right of bodily integ-

127. Skeels, supra note 54, at 1204; see also Norman L. Cantor, Conroy, Best Interests, and the Handling of Dying Patients, 37 Rutgers L. Rev. 543, 546 (1985) (stating that "informed consent" entitles a patient “to be informed about and shape the course of his medical treatment”). For a more thorough discussion of the doctrine of informed consent, see infra notes 302-05, 381-89 and accompanying text.
128. Skeels, supra note 54, at 1204.
129. Feigenbaum, supra note 6, at 863.
130. See *Cruzan*, 497 U.S. at 269 (stating that value of bodily integrity is embodied in the doctrine of informed consent, which is required for medical treatment).
131. Cantor, supra note 127, at 546; Skeels, supra note 54, at 1204.
132. 141 U.S. 250 (1891).
133. Id. at 251.
134. Id.
135. Id. at 257.
137. Id. at 174.
139. Id. at 772.
MINORS IN MEDICAL DISPUTES

3. The Constitutional Right of Privacy

The Supreme Court has not explicitly extended the right of bodily integrity to minors. This subpart demonstrates, however, that the Supreme Court has expressly extended privacy rights to minors in the abortion and contraception contexts. The extension of privacy rights in these controversial medical decisions implies a broader conviction that minors have a critical interest in most, if not all, medical decisions that affect them.

Supreme Court precedent in the area of privacy recognizes that all individuals, including minors, have the right to make medical treatment decisions for themselves. In a series of cases involving challenges to state laws outlawing contraception and abortion, the Supreme Court, in striking down these laws, based its decisions on constitutional grounds, holding that such laws infringe the individual's

140. The Supreme Court has, however, strongly hinted that a constitutionally protected right of bodily integrity exists in minors. See Ingraham v. Wright, 430 U.S. 651, 673-74 (1977). In that case, the Court stated: “[W]here school authorities, acting under color of state law, deliberately decide to punish a child for misconduct by restraining the child and inflicting appreciable physical pain, we hold that Fourteenth Amendment liberty interests are implicated.” Id. at 674.

141. For the most part, those federal and state courts that have specifically acknowledged a minor's right of bodily integrity have done so in cases involving sexual abuse of the minor by a state actor. See, e.g., Doe v. Taylor Indep. Sch. Dist., 15 F.3d 443, 450-51 (5th Cir.) (holding that school children have a liberty interest in their bodily integrity that is protected by the Due Process Clause of the Fourteenth Amendment and that such liberty interest is violated when school child is sexually abused by public school employee), cert. denied, 115 S. Ct. 70 (1994); Black v. Indiana Area Sch. Dist., 985 F.2d 707, 709 & n.1 (3d Cir. 1993) (acknowledging that plaintiffs, female school children who were allegedly sexually molested by their school bus driver, have a liberty interest in their bodily integrity that is protected by the Fourteenth Amendment); Stoneking v. Bradford Area Sch. Dist., 882 F.2d 720, 727 (3d Cir. 1989) (stating that “the ‘contours’ of a student's right to bodily integrity[] under the Due Process Clause[ ]... encompass[es] a student's right to be free from sexual assaults by his or her teachers”), cert. denied, 493 U.S. 1044 (1990); John Does 1, 2, 3 & 4 v. Covington County Sch. Bd., 884 F. Supp. 462, 466 (M.D. Ala. 1995) (following Doe v. Taylor and recognizing that school children have a substantive due process claim when they are sexually abused by a public school employee); Wilson v. Webb, 869 F. Supp. 496, 497 (W.D. Ky. 1994) (“Schoolchildren have a liberty interest in their bodily integrity that is protected by the Due Process Clause of the Fourteenth Amendment and physical sexual abuse by a school employee violates that right.”). Two state cases have specifically addressed a minor's right of bodily integrity in the context of a medical procedure. See In re L., 632 A.2d 59, 62 (Conn. Super. Ct. 1993) (denying a putative father's motion to compel a 16-year-old homeless girl to submit to a blood test to establish paternity, holding that in “[b]alancing [the minor's] constitutional right to bodily integrity against the movant's tentative and attenuated status, the former must obviously prevail”); Custody of a Minor, 393 N.E.2d 836, 844 (Mass. 1979) (acknowledging minor's right of bodily integrity in determining whether parents may refuse chemotherapy for their three-year-old child).

142. See infra notes 158-85 and accompanying text.
fundamental right of privacy.\textsuperscript{143} Implicit in all of these cases is the recognition of the common law rights of bodily integrity and personal autonomy.\textsuperscript{144}

While most of the recent Supreme Court precedent in the area of privacy and bodily integrity has involved abortion in particular, the Supreme Court has had the opportunity to revisit the issues of privacy and bodily integrity outside the abortion context. In *Winston v. Lee*,\textsuperscript{145} for example, the Commonwealth of Virginia sought to compel the respondent, who was a suspected armed robber, to undergo a surgical procedure to remove a bullet lodged in his chest.\textsuperscript{146} Although the Court decided the case primarily on Fourth Amendment grounds,\textsuperscript{147} the Court refused to compel the surgery, in part, because it "would be an 'extensive' intrusion on respondent's personal privacy and bodily integrity."\textsuperscript{148} Similarly, in *Cruzan v. Director, Missouri Department of Health*,\textsuperscript{149} the Court stated that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."\textsuperscript{150} This statement is simply a reiteration that the constitutional right of privacy is inherent in medical decision making.\textsuperscript{151}

Several recent decisions of lower federal courts also make clear that no one can be forced to accept medical treatment against her wishes. The Fourth Circuit in *United States v. Charters*\textsuperscript{152} stated:

The right to be free of unwanted physical invasions has been recognized as an integral part of the individual's constitutional freedoms, whether termed a liberty interest protected by the Due Process Clause, or an aspect of the right to privacy contained in the notions

\textsuperscript{143} See, e.g., *Roe v. Wade*, 410 U.S. 113, 153 (1973) (recognizing the right to seek an abortion as inherent in the right of privacy); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (holding that a state statute banning the use of contraceptives intrudes too far into the constitutionally protected zone of privacy).

\textsuperscript{144} Felgenbaum, supra note 6, at 851 & n.64; see, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 849 (1992) ("[T]he Constitution places limits on a State's right to interfere with a person's . . . bodily integrity." (citations omitted)); *Roe*, 410 U.S. at 153 (holding that the right of privacy encompasses a woman's decision whether or not to terminate her pregnancy and citing the "specific and direct harm" to physical health potentially associated with an unwanted pregnancy); *Griswold*, 381 U.S. at 488 (stating that privacy includes the freedom from bodily restraint) (Goldberg, J., concurring).

\textsuperscript{145} 470 U.S. 753 (1985).

\textsuperscript{146} Id. at 755.

\textsuperscript{147} Id.

\textsuperscript{148} Id. at 764 (quoting *Lee v. Winston*, 717 F.2d 888, 900 (4th Cir. 1983), aff'd, 470 U.S. 753 (1985)).

\textsuperscript{149} 497 U.S. 261 (1990).

\textsuperscript{150} Id. at 278 (emphasis added). The Court ultimately refused to allow the parents of a woman in a permanent vegetative state to terminate her life support because the parents had not offered clear and convincing evidence that such action reflected their daughter's wishes. Id. at 285.

\textsuperscript{151} Skeels, supra note 54, at 1228.

\textsuperscript{152} 829 F.2d 479 (4th Cir. 1987), cert. denied, 494 U.S. 1016 (1990).
of personal freedom which underwrote the Bill of Rights. The right to refuse medical treatment has been specifically recognized as a subject of constitutional protection.\textsuperscript{153}

Similarly, in \textit{Canterbury v. Spence},\textsuperscript{154} the D.C. Circuit stated that "[t]he root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."\textsuperscript{155} Finally, the District of Rhode Island stated in \textit{Gray v. Romeo}:\textsuperscript{156}

\begin{quote}
[T]he [Supreme] Court's decisions have repeatedly affirmed the principle of individual self-determination. A person has the right, subject to important state interests, to control fundamental medical decisions that affect his or her own body. This right, whether described as the principle of personal autonomy, the right of self-determination, or the right of privacy, is properly grounded in the liberties protected by the Fourteenth Amendment's due process clause. This right is also grounded in the notion of an individual's dignity and interest in bodily integrity.\textsuperscript{157}
\end{quote}

These decisions make clear that the constitutional right of privacy extends to a host of medical decisions beyond the choice to have an abortion.

That minors also enjoy the fundamental right of privacy is apparent from the Supreme Court's decisions in contraception and abortion cases involving minors.\textsuperscript{158} The Court in \textit{Griswold v. Connecticut}\textsuperscript{159} and \textit{Roe v. Wade}\textsuperscript{160} did not expressly address the issue of a minor's constitutional rights to procure contraception and to choose abortion.\textsuperscript{161} In fact, in \textit{Roe}, the Court "specifically reserved decision on the question whether a requirement for consent . . . by the parents, or a parent, of an unmarried minor, may be constitutionally imposed."\textsuperscript{162} The Court, however, squarely addressed these issues in subsequent cases.

In \textit{Carey v. Population Services International},\textsuperscript{163} the Court invalidated a provision of a New York statute prohibiting the distribution of nonmedical contraceptives to persons sixteen or over except through a licensed pharmacist, and entirely prohibiting their distribution to per-

\begin{itemize}
\item \textsuperscript{153} \textit{Id.} at 491.
\item \textsuperscript{154} 464 F.2d 772 (D.C. Cir.), \textit{cert. denied}, 409 U.S. 1064 (1972).
\item \textsuperscript{155} \textit{Id.} at 780 (quoting Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (1914)).
\item \textsuperscript{156} 697 F. Supp. 580 (D.R.I. 1988).
\item \textsuperscript{157} \textit{Id.} at 585.
\item \textsuperscript{159} 381 U.S. 479 (1965).
\item \textsuperscript{160} 410 U.S. 113 (1973).
\item \textsuperscript{161} \textit{Roe}, 410 U.S. at 165 n.67. Minors are not mentioned at all in \textit{Griswold}.
\item \textsuperscript{162} \textit{Danforth}, 428 U.S. at 69.
\item \textsuperscript{163} 431 U.S. 678 (1977).
\end{itemize}
The Court held that "the right to privacy in connection with decisions affecting procreation extends to minors as well as to adults." The Court reiterated that state restrictions inhibiting privacy rights of minors are valid only if they serve a significant state interest. Thus, because the state of New York failed to demonstrate a significant state interest justifying its blanket prohibition on the distribution of contraceptives to minors, the Court declared this portion of the statute unconstitutional.

In Planned Parenthood v. Danforth and Bellotti v. Baird, the Court struck down state statutes that required unmarried females under the age of eighteen to obtain parental consent before having an abortion. In Danforth, the Supreme Court announced that "the State may not impose a blanket provision, such as . . . requiring the consent of a parent or person in loco parentis as a condition for abortion of an unmarried minor." Despite the Court's historical recognition of the states' broader authority to regulate the activities of children, "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights." In Danforth, the Court found that the state failed to further a significant interest in conditioning an abortion on the minor's ability to obtain parental consent. This restriction, the Court stated, did not advance the state's proffered interest of safeguarding the family unit and parental authority. Most importantly, the Court emphasized that a parent's interest in her minor daughter's

164. Id. at 681-82.
165. Id. at 693.
166. Id. The articulated standard that must be met for the state to abridge a fundamental right of a minor is less stringent than the "compelling state interest" test applied when the state attempts to abridge a fundamental right of an adult. See Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) (stating that abridgement of fundamental right of an adult is subject to strict judicial scrutiny). This difference reflects the concept that the state has greater authority to control the conduct of minors than it does to control the conduct of adults. Prince v. Massachusetts, 321 U.S. 158, 170 (1944).
170. See id. at 625-27, 647, 651 (declaring unconstitutional a Massachusetts statute that required unmarried females under the age of 18 to obtain both parents' consent or the consent of a superior court judge prior to seeking an abortion and holding that the statute "impose[s] an undue burden upon the exercise by minors of the right to seek an abortion"); Danforth, 428 U.S. at 74 (declaring unconstitutional a Missouri statute requiring consent of a parent or guardian as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy).
174. See supra note 166.
175. Danforth, 428 U.S. at 75.
176. Id.
abortion decision does not outweigh the competent, mature minor’s right of privacy. The Court also pointed out that no other Missouri statute specifically required consent of a minor’s parent for medical or surgical treatment, and that a minor may legally consent to services for pregnancy (excluding abortion), venereal disease, and drug abuse. Thus, the Court held that, provided that the unmarried minor is “sufficiently mature to understand the procedure and to make an intelligent assessment of her circumstances[,]... the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the [minor] to terminate [her] pregnancy.”

Similarly, in *Bellotti v. Baird*, even though the Massachusetts abortion statute at issue provided the minor with an option to go to the court if her parents refused to consent, the Court nonetheless objected to the statute because it required the minor to go to her parents before seeking relief from the court. In the Court’s view, a third party should not have the power to veto a minor’s decision to have an abortion if she has demonstrated the maturity and ability to make an intelligent choice on her own. Accordingly, the Court stated:

177. *Id.*
178. *Id.* at 73.
179. *Id.* at 74 (quoting Planned Parenthood v. Danforth, 392 F. Supp. 1362, 1376 (E.D. Mo. 1975) (Webster, J., concurring in part and dissenting in part)).
181. *Id.* at 625.
182. *Id.* at 651.
183. *Id.* at 647. Even though parental consent cannot be required for an unmarried female minor to exercise her right to procure an abortion, in some states, she may still have to resort to the court before her consent is effective. For instance, in *Bellotti*, even though the Supreme Court struck down the Massachusetts provision that required a pregnant minor to seek consent for an abortion from her parents first, the Court upheld the portion that provided for judicial bypass, maintaining that the minor must satisfy the court that she is mature enough to consent to an abortion for herself. *Id.* Since *Bellotti*, the Court has repeatedly upheld the constitutionality of similar judicial bypass provisions in other state abortion statutes. See, e.g., Planned Parenthood v. Casey, 505 U.S. 833, 899 (1992) (upholding constitutionality of Pennsylvania abortion statute requiring unemancipated pregnant minor to obtain consent of at least one parent because statute also contained judicial bypass procedure); Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 507-08, 510-11 (1990) (upholding constitutionality of Ohio abortion statute requiring parental notification within 48 hours of performing the procedure or parental consent because statute also provided for judicial bypass of the notification requirement); Planned Parenthood Ass’n of Kansas City, Inc. v. Ashcroft, 462 U.S. 476, 490-92, 494 (1983) (upholding the constitutionality of a Missouri abortion statute requiring at least one parent’s consent before an unemancipated pregnant minor may undergo an abortion, but also providing for judicial bypass of the parental consent requirement).
We conclude... that under state regulation such as that undertaken by Massachusetts, every minor must have the opportunity—if she so desires—to go directly to a court without first consulting or notifying her parents. If she satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own, the court must authorize her to act without parental consultation or consent. If she fails to satisfy the court that she is competent to make this decision independently, she must be permitted to show that an abortion nevertheless would be in her best interests. If the court is persuaded that it is, the court must authorize the abortion.\footnote{Bellotti, 443 U.S. at 647-48.}

The Court was sensitive to the fact that many young women do not wish to inform their parents of their decision to have an abortion, and that many parents who are informed might do everything in their power to obstruct their child's access to the court.\footnote{Id. at 647.}

While the Supreme Court has not yet broadened the constitutional right of privacy afforded to minors beyond contraception and abortion cases,\footnote{See In re E.G., 549 N.E.2d 322, 324 (Ill. 1989).} one court views such an extension by the Supreme Court as "inevitable."\footnote{In re E.G., 515 N.E.2d 286, 290 (Ill. App. Ct. 1987).} In the meantime, minors are not entirely without the right to make medical treatment decisions on their own behalf. In some states, mature minor statutes automatically give mature adolescents the right to consent to certain medical procedures.\footnote{With mature minor statutes, theoretically, judicial intervention is not necessary because the right to consent flows to the minor directly. See, e.g., Ala. Code § 22-8-4 (1990) (permitting any minor 14 years or older, or a high school graduate, or any married, divorced, or pregnant minor to consent to legally authorized medical treatment); Alaska Stat. § 25.20.025(a)(4) (1995) (allowing minors to consent to diagnosis, prevention or treatment of pregnancy, and to consent to diagnosis or treatment of venereal disease); Ariz. Rev. Stat. Ann. §§ 44-132.01, 44-133.01 (1994) (allowing any minor to consent to treatment for venereal disease and minors over 12 years of age to consent to treatment for drug abuse); Ark. Code Ann. § 20-9-602(7) (Michie 1991) (providing that "[a]ny unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures" may provide the necessary consent); Ill. Comp. Stat. Ann. ch. 410, §§ 210/1, 210/4 (Smith-Hurd 1993 & Supp. 1995) (permitting a minor under 18 who is married or pregnant to validly consent to her own medical treatment and permitting a minor 12 years or older to seek medical attention on her own if she believes she has venereal disease or is an alcoholic or drug addict); La. Rev. Stat. Ann. § 40:1095(A) (West 1992) (providing that consent by "a minor who is or believes himself to be afflicted with an illness or disease, shall be valid and binding as if the minor had achieved his majority"); Nev. Rev. Stat. Ann. § 129.030(2) (Michie 1993) (stating that a minor may consent who "understands the nature and purpose of the proposed examination or treatment and its probable outcome, and voluntarily requests it").} In addition, state courts have, to a limited extent, solicited the minors's views for a full discussion of the mature minor doctrine, see \textit{infra} notes 343-61 and accompanying text.
in litigated medical treatment cases. A few courts, sensitive to the
rights of the minor, have actually deferred to the minor's wishes in
such disputes. Legislatures that permit minors to consent to treat-
ment for themselves and courts that have respected the wishes of the
minor in their decisions have played an invaluable role in establishing
precedent for promoting and protecting the right of a minor to partici-
pate in the medical decision-making process when her health and bod-
ily integrity are at stake. Nonetheless, minors still do not have
independent legal standing in medical treatment cases, and courts and
legislatures that do value the minor's viewpoint in medical decision
making constitute a minority.

B. Other Interests of the Minor

In addition to the fundamental rights of privacy and bodily integ-
ritv, medical treatment cases implicate several other interests of mi-
nors that warrant recognition by courts. For instance, the minor has
an interest in preserving her own life. Thus, in cases where parents
refuse to consent to life-saving treatment, but the child wishes to un-
dergo the treatment, the minor herself should be able to challenge her
parents' decision. Granted, in such cases, some other party, such as
the state, usually has standing under a neglect statute to challenge a
parent's refusal to consent to necessary medical treatment. The
nature of the right to choose medical treatment, however, is so uniquely
personal that the minor herself must have legal standing to challenge
this decision. Additionally, a minor has a right to a "normal" life in
non-life-threatening situations in which parents refuse to consent to

189. See, e.g., In re Green, 292 A.2d 387, 392 (Pa. 1972) (stating that it would be
"anomalous" to ignore the minor's preference and remanding the case for an eviden-
tiary hearing to determine the minor's wishes).

190. See, e.g., E.G., 549 N.E.2d at 323, 328 (upholding the right of a mature 17-year-
old Jehovah's Witness to refuse a blood transfusion on religious grounds). In another
case from June of 1994, a court in Coral Springs, Florida ruled that a 15-year-old liver
transplant patient had the right to refuse to continue taking antirejection medicine
that caused him painful side effects. See Perkins, supra note 2, at B10. Similarly, in
1986, a Santa Clara County court permitted a 14-year-old Jehovah's Witness cancer
patient to refuse a blood transfusion on religious grounds. See Mckee, supra note 45,
at *3-4. But see In re Sampson, 317 N.Y.S.2d 641, 655 (Fam. Ct. 1970) (refusing to
place the burden of deciding whether or not to undergo corrective surgery for a mas-
sive facial deformity on the child himself), aff'd, 323 N.Y.S.2d 253 (App. Div. 1971),
aff'd, 278 N.E.2d 918 (N.Y. 1972). The court, relying on Judge Fuld's dissent in In re
Seiferth, 127 N.E.2d 820, 824 (N.Y. 1955), stated:

This Court cannot evade the responsibility for [making] a decision now by
the simple expedient of foisting upon this boy the responsibility for making a
decision at some later day, which by the time it is made, if at all, will be too
late to undo the irreparable damage he will have suffered in the interim.
Sampson, 317 N.Y.S.2d at 655.


192. See Wilber, supra note 9, at 351 (stating that "[t]he child's position is never
superfluous" and recommending that the court should hear the minor's wishes even if
they conform to the position held by another party).
treatment to correct a disfigurement.\textsuperscript{193} Finally, in cases where the minor herself refuses treatment, regardless of whether her parents agree with her, the minor's right of religious freedom,\textsuperscript{194} and her wish to be free of the extreme pain and discomfort associated with some forms of medical treatment,\textsuperscript{195} are at stake.

III. THE ROLE OF COUNSEL IN PROCEEDINGS INVOLVING CHILDREN

Part II demonstrates that minors have important rights and interests at stake in litigated medical treatment disputes. Courts have recognized in minors both the rights of privacy and of bodily integrity, mainly in the abortion and contraception contexts.\textsuperscript{196} Minors also have the right to consent to certain forms of medical treatment under mature minor statutes.\textsuperscript{197} Furthermore, in a few medical treatment cases, courts have been sympathetic to the wishes of minors.\textsuperscript{198} Finally, minors in medical treatment cases have important interests worthy of protection in addition to the rights of privacy and bodily integrity, such as the right to preserve one's life and the right of religious freedom.\textsuperscript{199} Accordingly, courts must grant the minor standing to protect these important personal rights.

This part argues that giving the minor standing is only a necessary first step. Once the minor becomes a party to a contested medical treatment dispute, she must also have independent representation in the form of an advocate. Currently, most states afford children the right to representation in several noncriminal proceedings in which their important interests are at stake, such as abuse and neglect pro-

\textsuperscript{193} See, e.g., Sampson, 317 N.Y.S.2d at 657 (ordering corrective surgery for minor's deformity of face and neck over mother's objection, in part, because the court was concerned with minor's chances for "a normal, happy existence, without a disfigurement so gross as to overshadow all else in his life").

\textsuperscript{194} In \textit{In re E.G.}, one of the most progressive decisions to date, the Illinois Supreme Court deferred to the wishes of a mature 17-year-old Jehovah's Witness and permitted her to refuse a life-saving blood transfusion. 549 N.E.2d at 327-28. The court decided the case on common law grounds, however, holding that the mature minor doctrine affords a mature minor in Illinois the right to refuse medical treatment, and specifically declined to address the constitutional issue of the minor's right to the free exercise of religion. \textit{Id.}

\textsuperscript{195} See Perkins, supra note 2, at B10 (stating that the reason Billy Best refused further chemotherapy treatment was because "he was sick and exhausted and said the therapy was killing him").

\textsuperscript{196} See supra notes 158-85 and accompanying text.

\textsuperscript{197} See supra note 188 and accompanying text; \textit{infra} notes 343-49 and accompanying text.

\textsuperscript{198} See supra notes 189-90 and accompanying text.

\textsuperscript{199} See supra notes 191-95 and accompanying text.
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ceedings, parental rights termination cases, custody actions, and others. Accordingly, the minor has a right to independent representation in litigated medical treatment disputes as well.

Commentators argue that a minor has a right to counsel in any proceeding in which the minor has an interest. The proper role for the attorney for minors, however, is the subject of intense debate. An


202. See Linda D. Elrod, Summary of the Year in Family Law, 27 Fam. L.Q. 485, 499 (1994) (stating that, in most states, judges have discretion to appoint a guardian ad litem in custody cases); Jan Hoffman, When a Child-Client Disagrees with the Lawyer, N.Y. Times, Aug. 28, 1992, at B6 (stating that 27 states provide for appointment of a lawyer or guardian to represent the rights of a minor in a custody dispute); see, e.g., Alaska Stat. § 25.24.310(a) (1995) (stating that "[i]n an action involving a question of the custody, support, or visitation of a child, the court may . . . appoint an attorney or the office of public advocacy to represent a minor with respect to the custody, support, and visitation of the minor"); N.H. Rev. Stat. Ann. § 458.17-a(I) (1992) ("In all proceedings for divorce, nullity, or legal separation, the court may appoint a guardian ad litem, to represent the interests of the children of the marriage . . ."); Wis. Stat. Ann. § 767.045(1)(a) (West 1993) (stating that the "[t]he court shall appoint a guardian ad litem for a minor child in any action affecting the family" if the court "has reason for special concern as to the welfare of a minor child" or the "legal custody or physical placement of the child is contested").

203. See Genden, supra note 22, at 570-80 (noting that minors have been appointed independent legal counsel in juvenile delinquency proceedings, civil commitment proceedings, custody actions, termination of parental rights actions, adoption hearings, foster care cases, and paternity suits and recommending provision of independent legal counsel for minors in parens patriae actions to compel medical treatment or education).

204. See supra note 22. Other commentators recognize, however, that appointment of counsel for minors threatens to undermine the interests of parents, by infringing on their privacy and autonomy rights. Guggenheim, supra note 8, at 109. This Note does not argue that the other parties involved in the proceeding—the parents and the state—should not have a voice in order that the court hear the minor's views. Rather, the court must hear the minor's views in addition to those of the other parties so that it can reach the best possible outcome.

205. See infra part III.B.
examination of the role of counsel in our legal system in general, and of the variety of roles played by attorneys for minors, reveals that the traditional role of advocate is the only appropriate role in proceedings where a competent minor's important rights are at stake.206 Expression of the minor's wishes through an independent advocate is the only way to ensure that the court will receive full information about the minor's preferences.

A. The Role Played by Counsel When the Client Is an Adult

Individuals in our legal system have certain legal rights that often need enforcement and protection. The role of the attorney in this system is to assist litigants in the enforcement, protection, and preservation of their legal rights.207 Consequently, "An attorney's purpose and professional duty is to represent the interests of a client according to that client's point of view."208 The concepts of client control and decision making constitute "the ideological bases of the adversary system."209 Allowing the client substantial control over decision making in litigation bolsters the legal system's commitment to the vindication of individual legal rights210 and promotes personal autonomy.211

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206. Regardless of the role the attorney for the child plays, serious practical issues arise when a minor secures representation. For instance, who seeks out the child's attorney? Who pays for the child's attorney? The fact that a medical treatment case is a civil proceeding, however, suggests that there is no constitutional right to representation, as is the case in juvenile delinquency proceedings. See In re Gault, 387 U.S. 1, 41 (1967). Yet, state statutes provide for the appointment of attorneys or guardians ad litem for minors in other civil proceedings. See, e.g., Alaska Stat. § 25.24.310(a) (1995) (providing for appointment of guardian ad litem for minor in any action "involving a question of the custody, support, or visitation of a child"); N.H. Rev. Stat. Ann. § 458:17-a(1) (Supp. 1995) (providing for appointment of a guardian ad litem to represent the interests of the children of the marriage in all proceedings for divorce, nullity, or legal separation); N.Y. Fam. Ct. Act § 241 (McKinney Supp. 1996) (providing for appointment of a law guardian for all minors "who are the subject of family court proceedings"); Wis. Stat. Ann. §§ 48.235, 767.045(1)(a) (West 1992 & Supp. 1995) (providing for appointment of guardian ad litem for minors in termination of parental rights proceedings and in any proceeding "affecting the family"). A thorough discussion of the issues concerning how representation for the minor is attained and who pays for such representation extends beyond the scope of this Note.

207. Guggenheim, supra note 8, at 79.

208. Lyon, supra note 23, at 693.


210. Guggenheim, supra note 8, at 80-81.

211. Id. at 81-82. Professor Guggenheim states:

Allowing the client to control the litigation is consonant with our belief that individuals should be allowed to make the important decisions about their lives for themselves, even though the decisions they make may be unreasonable or shortsighted. While an attorney may counsel his client against a particular decision, ultimately he must allow the client to take responsibility for his own fate.

Id. at 82.
The guidelines put forth by the American Bar Association, the organization responsible for shaping the ethical policies to which members of the legal community in the United States are bound to adhere, reflect the values of client control and autonomy in the litigation process. The ABA Model Rules of Professional Conduct ("Model Rules") and Model Code of Professional Responsibility ("Model Code") require that an attorney present the position of the client to the court.\footnote{212} The Model Rules and Model Code also endorse the idea that the client, not the attorney, has the ultimate authority to direct the course of the litigation.\footnote{213} Finally, the Model Rules and Model

\footnote{212. Model Rules of Professional Conduct Preamble (1983) [hereinafter Model Rules] (stating that an attorney, as advocate, "zealously asserts the client's position under the rules of the adversary system"); Model Code of Professional Responsibility EC 7-1 (1981) [hereinafter Model Code] (stating that the lawyer's duty is to "represent his client zealously within the bounds of the law" (footnote omitted)).}

\footnote{All states but California have adopted either the Model Rules or the Model Code. See Thomas D. Morgan & Ronald D. Rotunda, 1996 Selected Standards on Professional Responsibility 133-37 (1996). California has formulated its own ethical standards, which comprise the California Rules of Professional Conduct and the California Business and Professions Code. Id. at 282-344.}

\footnote{The ABA promulgated the Model Code in 1969, subsequently amending it every year between 1974 and 1980. See Charles W. Wolfram, Modern Legal Ethics 56-57 (1986). In 1977, the ABA appointed a committee to revise the Code substantially, addressing problems with the Code's practical applicability. Id. at 60-61. The result became the initial draft of what is now known as the Model Rules. Id. at 61. The ABA adopted the Model Rules in 1983, replacing the Model Code, id. at 62-63; however, many states continue to follow the Model Code rather than the Model Rules. See id.}

\footnote{The Model Rules consist of imperatives, cast in term of "shall" or "shall not," that define the proper conduct for attorneys for purposes of discipline, as well as permissive guidelines, cast in terms of "may," that permit attorneys a degree of discretion in their conduct. See Model Rules, supra, Scope. The Model Code comprises Canons, Ethical Considerations ("ECs"), and Disciplinary Rules ("DRs"). See Model Code, supra, Preliminary Statement. According to the Model Code Preliminary Statement:}

\footnote{The Canons are statements of axiomatic norms, expressing in general terms the standards of professional conduct expected of lawyers in their relationships with the public, with the legal system, and with the legal profession. They embody the general concepts from which the Ethical Considerations and the Disciplinary Rules are derived.}

\footnote{The Ethical Considerations are aspirational in character and represent the objectives toward which every member of the profession should strive. . . .}

\footnote{The Disciplinary Rules . . . are mandatory in character. [They] state the minimum level of conduct below which no lawyer can fall without being subject to disciplinary action.}

\footnote{Attorneys have a strong incentive to abide by the mandates of the Model Rules and the Model Code because violation of an ethical rule exposes an attorney to disciplinary action ranging from reprimand to disbarment. See Wolfram, supra, at 95, 118.}

\footnote{213. Model Rules, supra note 212, Rule 1.2(a) (providing that "[a] lawyer shall abide by a client's decisions concerning the objectives of representation . . . and shall consult with the client as to the means by which they are to be pursued"); Model Code, supra note 212, EC 7-7 ("[T]he authority to make decisions is exclusively that of the client and, if made within the framework of the law, such decisions are binding on his lawyer."). These ethical guidelines appear to apply mainly to decisions affecting the merits of the case or implicating the client's substantive legal rights. See id.}
Code require a lawyer to provide information to the client to keep her fully informed of developments in the case and to present such information in a manner that permits the client to make reasoned, informed decisions.

The ABA ethics rules, which define the "normal client-lawyer relationship," are "based on the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters." Thus, the ethical norms that govern attorneys' conduct clearly reflect a deep respect for the individual's right to make important decisions for herself and to control her own life.

B. The Traditional Roles Attorneys for Children Play

Legal counsel for minors usually falls into two formal categories: guardians ad litem and attorneys. Typically, a guardian ad litem advocates the child's best interests while an attorney advocates the child's expressed wishes. Very few states, however, clearly differentiate between the two. In particular, there is often confusion as to the guardian ad litem's function. Some jurisdictions require the guardian ad litem to advise or make recommendations to the court regarding the child's best interests, rather than to act as an attorney for any

("In certain areas of legal representation not affecting the merits of the cause or substantially prejudicing the rights of a client, a lawyer is entitled to make decisions on his own.")

At least some courts have held that, while the client has broad control over the subject matter of the case, tactics and procedure may be chosen by the attorney without client involvement. Other commentators and courts, however, have asserted that the client has ultimate authority to instruct the attorney on any and all phases of their relationship.

Guggenheim, supra note 8, at 80 n.13.

214. Model Rules, supra note 212, Rule 1.4(a) (stating that "[a] lawyer shall keep a client reasonably informed about the status of a matter and promptly comply with reasonable requests for information"); Model Code, supra note 212, EC 9-2 (requiring a lawyer to "fully and promptly inform his client of material developments in the matters being handled for the client").

215. Model Rules, supra note 212, Rule 1.4(b) (providing that "[a] lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation"); Model Code, supra note 212, EC 7-8 (requiring a lawyer to "exert his best efforts to insure that decisions of his client are made only after the client has been informed of relevant considerations"). The Model Rules and Model Code do recognize, however, that when the client is a minor, fully informing the client of all relevant considerations may not be desirable. See Model Rules, supra note 212, Rule 1.4 cmt. (stating that "fully informing the client according to [the] standard of Rule 1.4 may be impracticable, for example, where the client is a child"); Model Code, supra note 212, EC 7-11 (recognizing that "[t]he responsibilities of a lawyer may vary according to the intelligence, experience, mental condition or age of a client").

218. Id. at 14.
219. Id. at 2.
particular party.\textsuperscript{220} Other jurisdictions treat the guardian \textit{ad litem} as an attorney for a party, with the exception that the guardian determines the position to be advocated before the court rather than the client.\textsuperscript{221} Thus, because there is confusion as to what function an attorney or a guardian \textit{ad litem} for a minor should play, counsel for children generally adopt one of the three traditional functional roles, which include the neutral investigator, the "champion," and the traditional advocate.\textsuperscript{222} An examination of the functional roles played by counsel for minors may prove more useful than labels such as "guardian \textit{ad litem}" and "attorney" in elucidating what it means to represent a child.\textsuperscript{223}

1. Neutral Investigator

One suggested role for the minor’s attorney is that of neutral investigator. The neutral investigator does not advocate a particular position before the court.\textsuperscript{224} Rather, she uncovers the facts and the legal issues involved in the case and then presents them to the court in a neutral manner.\textsuperscript{225} Because litigation is traditionally adversarial in nature, the neutral investigator plays an important part in ensuring that all possible relevant information is brought to the court’s attention in the proceeding, enabling the court to make an accurate assessment of which outcome will best serve the child.\textsuperscript{226} In essence, the neutral investigator “fills the gaps left by other parties.”\textsuperscript{227}

\begin{itemize}
\item \textsuperscript{220} \textit{Id.} at 10.
\item \textsuperscript{221} \textit{Id.} at 10-11.
\item \textsuperscript{222} See Lurie, \textit{supra} note 22, at 207-11. Some state legislatures have fashioned a fourth functional role for the minor’s attorney—that of law guardian. \textit{Id.} at 207-11. The law guardian may perform a dual role: as advocate, she is charged with representing the minor’s wishes; as guardian, she must represent the minor’s best interests. \textit{Id.} at 211; see, e.g., N.Y. Fam. Ct. Act § 241 (McKinney 1983 & Supp. 1996) (establishing a system for appointment of law guardians for minors in family court proceedings who may require the assistance of counsel to help protect their best interests and to help them express their wishes to the court). Critics of the hybrid approach believe that an attorney who serves as both advocate and guardian faces an inherent conflict of interest. Lurie, \textit{supra} note 22, at 229. For example, in \textit{In re Dobson}, the Supreme Court of Vermont stated that “a lawyer attempting to function as both guardian \textit{ad litem} and legal counsel is cast in the quandary of acting as both attorney and client, to the detriment of both capacities and the possible jeopardizing of the infant’s interests.” 212 A.2d 620, 622 (Vt. 1965).
\item \textsuperscript{223} See Haralambie, \textit{supra} note 22, at 2-3.
\item \textsuperscript{224} Guggenheim, \textit{supra} note 8, at 107.
\item \textsuperscript{225} \textit{Id.}; Lyon, \textit{supra} note 23, at 690.
\item \textsuperscript{226} See Guggenheim, \textit{supra} note 8, at 109. For example, according to one state statute, the neutral investigator’s role in a custody proceeding is to “make such investigation as will enable [her] to ascertain all facts and circumstances that will affect the rights and interests of the children and will enable the court to enter just and proper orders and judgment concerning the care, custody and maintenance of the children.” Ky. Rev. Stat. Ann. § 403.090(3) (Michie 1984 & Supp. 1994).
\item \textsuperscript{227} Guggenheim, \textit{supra} note 8, at 107.
\end{itemize}
Despite the allure of the neutral investigator role for the child’s attorney, it poses several problems. The neutral role of fact finder necessarily conflicts with an attorney’s obligation as an advocate to represent her client zealously. Furthermore, because neutral investigators engage in such extensive pretrial discovery, on which courts will likely heavily rely, their efforts threaten to usurp the fact finder’s traditional role in the adversarial process. The neutral investigator may also present to the court findings that are not truly neutral if, for example, her findings reflect her own personal position on the matter. When this occurs, the investigator imposes her own views on the court, contrary to her appointed role. Moreover, if the child has no advocate speaking for her, she has no mechanism by which to challenge the fact finder’s facts. In the words of Professor Guggenheim, “When courts and commentators propose that children be given investigators, they are really proposing a new form of court-ordered discovery; they are not, however, increasing the legal representation of young children by one iota.”

2. “Champion”

The “champion” represents yet another role often played by the minor’s attorney. The champion’s function demands that she argue to the court her own conception of what is in the best interests of the
child. The champion role is most consistent with the traditional conception of the guardian ad litem appointed by the court.

Commentators have also extensively criticized the champion role for the minor’s attorney. First, the assumption that an attorney is more capable of identifying a child’s best interests than the child herself deprives the child of a voice. Second, the champion “contravenes the traditional prohibition against lawyers expressing their personal views to the factfinder.” The adversarial system usually disregards an attorney’s personal views concerning the case. Third, providing the minor client with a champion adds an element of redundancy to the proceeding. Because in many cases involving children the parties can take only a limited number of positions, often the champion adopts a position that another party already advocates, resulting in a duplication of effort. Fourth, the champion often simply relies on the recommendation of the social worker or other professional involved in the case. The judge, in turn, may be tempted to rely disproportionately on the champion’s judgment. Thus, in effect, the champion decides the case, usurping the role of the judge. Finally, critics argue that for every champion who argues a particular position, many others would argue the opposite; consequently, the champion adds a degree of arbitrariness to the process.

3. Advocate

The third possible role for the minor’s attorney is the traditional role of advocate. The function of the advocate is to argue the express wishes of the child. This role for the minor’s attorney comports with that played by attorneys generally in our legal system. Such an approach conforms with the Model Rules and the Model Code, which require that an attorney represent her client’s position zealously.

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234. Guggenheim, supra note 8, at 100; Lyon, supra note 23, at 691.
235. Haralambie, supra note 22, at 26; Wilber, supra note 9, at 356; see also supra note 218 and accompanying text (defining the role of the guardian ad litem).
236. Wilber, supra note 9, at 356.
237. Guggenheim, supra note 8, at 101; Wilber, supra note 9, at 356.
238. Guggenheim, supra note 8, at 102. In fact, the Model Code provides:
The expression by a lawyer of his personal opinion as to the justness of a cause, as to the credibility of a witness, as to the culpability of a civil litigant, or as to the guilt or innocence of an accused is not a proper subject for argument to the trier of fact.
Model Code, supra note 212, EC 7-24; see also Model Rules, supra note 212, Rule 3.4(e) (stating that a lawyer shall not state a personal opinion as to the above-noted subjects).
239. Guggenheim, supra note 8, at 103-04.
240. See Wilber, supra note 9, at 356.
241. Guggenheim, supra note 8, at 106.
242. Id.
243. Id.
244. Lyon, supra note 23, at 692.
245. Model Rules, supra note 212, Preamble; Model Code, supra note 212, EC 7-1.
and that an attorney for a minor, specifically, "shall, as far as reason-
able possibility, maintain a normal client-lawyer relationship with the
client." Several scholars argue that this function is the only legiti-
mate role for the minor's attorney. Courts, too, have expressed
support for this role. Despite the potential challenges this model
poses for the child's attorney, the courts, and the other interested
parties, providing the minor in a medical treatment case with an
attorney who will advocate the child's own expressed desire or opin-
ion is the only workable alternative.

C. The Competent Minor Must Have Access to an Independent
Advocate in Litigated Medical Treatment Disputes

Competent minors in litigated medical treatment disputes have sig-
nificant personal rights and interests at stake, including the rights of
informed consent, bodily integrity, and privacy. Courts in such cases
must recognize that the competent minor has standing to protect these
rights and interests. Additionally, once the court has recognized the
minor as a party with standing, the minor must have access to an at-
torney to represent her interests, and this attorney must fulfill the role
of advocate to represent the position of the minor in the proceeding
effectively. Because competent children have a right to contribute to
medical treatment decisions that concern them, and because courts

246. Model Rules, supra note 212, Rule 1.14(a). No comparable provision in the
Model Code exists specifically advising the lawyer how to handle clients who are mi-
nors. See id. Rule 1.14(a) cmt. Model Code EC 7-11 provides that the "responsibili-
ities of a lawyer may vary according to the intelligence, experience, mental condition
or age of a client," and Model Code EC 7-12 states that "[a]ny mental or physical
condition of a client that renders him incapable of making a considered judgment on
his own behalf casts additional responsibilities upon his lawyer." Model Code, supra
note 212, ECs 7-11 to 7-12.

247. Lyon, supra note 23, at 692; see, e.g., Guggenheim, supra note 8, at 78, 82-93
(assuming that children over the age of seven ought to have the power to direct their
attorneys in delinquency and other types of legal proceedings that affect them); Wal-
lace J. Mlyniec, The Child Advocate in Private Custody Disputes: A Role in Search of
a Standard, 16 J. Fam. L. 1, 15-16 (1977-78) (asserting that attorneys in custody and
visitation disputes should attempt to effectuate the child's wishes and treat their rela-
tionships with child clients from the traditional attorney-client perspective); Wilber,
supra note 9, at 353-54 (stating that the same principles that apply when the client is
an adult should apply when the child is a minor).

248. See, e.g., Veazeys v. Veazey, 560 P.2d 382 (Alaska 1977). In a case involving a
custody proceeding, the court stated:

[W]hen a child needs [an independent representative], he needs an adva-
cate—someone who will plead his cause as forcefully as the attorneys for
each competing [party] plead theirs. The basic premise of the adversary sys-
tem is that the best decision will be reached if each interested person has his
presented by counsel of unquestionably undivided loyalty.

Id. at 390.

249. See infra notes 280, 286-87 and accompanying text.

250. See infra notes 275-76 and accompanying text.

251. See infra notes 291, 293-94 and accompanying text.

252. See infra notes 253-74 and accompanying text.
sometimes take their views into consideration anyway, minors should be able to express those views formally through an advocate.

The advocate role for the child’s attorney, of course, has both benefits and drawbacks. Several arguments support the advocate role for the minor’s attorney. First, this role respects the autonomy of minors and protects their right to make certain decisions for themselves. As shown in part II, a minor clearly has significant interests at stake when others attempt to make medical decisions for her without her agreement. Once the court has recognized that the minor has standing to challenge those decisions, she must have an advocate to assist her in protecting her rights of informed consent, bodily integrity, and privacy. Further, when the attorney advocates the child’s wishes, the minor feels as if she has participated in the decision-making process, empowering the minor and diminishing her sense of alienation.

As one commentator points out: “In the best of circumstances, litigation can be intimidating and confusing to a child. The experience may be worse when the child feels totally powerless and has no meaningful input.” An outcome that is adverse to the minor’s wishes is easier to accept if the minor has a sense that someone has “gone to bat” for her and that the court has heard her views. To deprive minors of a voice in proceedings in which they have an interest is fundamentally unfair, and fairness is essential to raising children who become responsible, self-respecting citizens.

Second, the role of advocate for the minor’s attorney is consistent with the ethical mandates of the Model Rules and the Model Code. This role, moreover, comports with that recommended by the Institute of Judicial Administration and the American Bar Association’s Joint Commission on Juvenile Justice Standards (“IJA-ABA Standards”). The IJA-ABA Standards expressly reject the “best interests” ap-

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253. See Federle, supra note 23, at 1563 (discussing the “empowering effect” of providing independent representation for minors in the form of an advocate in custody proceedings); Haralambie, supra note 22, at 34 (stating that when a child is verbal and mature, the “child has a right to place his or her position before the court for consideration”).

254. Wilber, supra note 9, at 355.

255. Id.

256. Id.

257. Lyon, supra note 23, at 686 (citing Henry H. Foster, Jr., A “Bill of Rights” for Children at xi (1974)). The Bill of Rights for Children states: “The idea of fairness is part of the fabric of the doctrine of justice, and the sense of what's fair and unfair emerges in childhood. . . . [C]hildren must be treated fairly if we want them to mature into responsible adulthood.” Foster, supra, at xi.

258. See supra notes 212-16, 245-46 and accompanying text.

259. The IJA-ABA Standards “are intended to serve as guidelines for action by legislators, judges, administrators, public and private agencies, local civic groups, and others responsible for or concerned with the treatment of youths at local, state, and federal levels.” IJA-ABA Standards, supra note 22, Preface at v. Unlike the Model Rules and Model Code, the IJA-ABA Standards do not have the force of law and, therefore, violation of any Standard will not subject an attorney to disciplinary action.
proach to the representation of children, urging, instead, advocacy of the minor’s expressed preferences.\textsuperscript{260} Excepting only very young children, the IJA-ABA Standards suggest that, in general, determination of the juvenile client’s interests in delinquency proceedings, in need of supervision proceedings, and protective proceedings, remains the responsibility of the client and that the attorney be bound by the client’s determination.\textsuperscript{261}

Third, the advocate role is consistent with the adversarial model of the U.S. legal system.\textsuperscript{262} Under this system, the trier of fact reaches the appropriate decision after hearing all sides of the issue as presented by the parties in interest.\textsuperscript{263} The judge or the jury can reach the optimal outcome in the case only through zealous advocacy on behalf of each party in interest, which presents all the relevant facts and legal issues. Legal proceedings involving minors require such zealous advocacy to an equal degree: “The parents and the state are represented by counsel who vigorously defend their clients’ positions. Failure to advocate the child’s wishes undermines the court’s ability to determine a just result.”\textsuperscript{264} When the child’s position differs from that of her parents, the child requires an independent advocate to inform the court of her position.\textsuperscript{265} Even if some other party presents the same position as the child, the court still must be aware of the child’s express wishes.\textsuperscript{266} Undoubtedly, the other parties—the parents and the state—present the issues from their own perspectives, slanting them to reflect their own interests.\textsuperscript{267} Because neither the parents nor the state will present an unbiased view of the minor’s position,\textsuperscript{268} the minor’s attorney must do that for her.

Finally, parents do not always make the best decisions for their children,\textsuperscript{269} and do not always have their child’s best interests as their exclusive consideration.\textsuperscript{270} For example, when the family views the minor’s need for medical treatment as presenting a great burden to the family, both emotionally and financially, the parents’ decision regarding treatment may not be objective.\textsuperscript{271} Such a situation presents

\begin{itemize}
\item \textsuperscript{260} Haralambie, supra note 22, at 30.
\item \textsuperscript{261} IJA-ABA Standards, supra note 22, § 3.1(b).
\item \textsuperscript{262} Wilber, supra note 9, at 354; Lyon, supra note 23, at 686.
\item \textsuperscript{263} Wilber, supra note 9, at 354; Lyon, supra note 23, at 686.
\item \textsuperscript{264} Wilber, supra note 9, at 355.
\item \textsuperscript{265} Id. at 351.
\item \textsuperscript{266} Id.
\item \textsuperscript{267} Lyon, supra note 23, at 686.
\item \textsuperscript{268} Id.
\item \textsuperscript{269} Abigail L. Kuzma, The Legislative Response to Infant Doe, 59 Ind. L.J. 377, 382 (1984); see also Lyon, supra note 23, at 684-85 (stating that the presumption that parents will make the best decision for their child is rebuttable).
\item \textsuperscript{270} See Nancy J. Moore, Conflicts of Interests in the Representation of Children, 64 Fordham L. Rev. 1819, 1846 (1996) (noting the “inherent conflict” between parents and child in custody, abuse or neglect, and termination of parental rights cases).
\item \textsuperscript{271} Kuzma, supra note 269, at 382.
\end{itemize}
“an obvious conflict of interest” between the parents and the child. \textsuperscript{272} In addition, the parents themselves may disagree over a proposed course of medical treatment for their child. \textsuperscript{273} As a solution to this problem, one commentator argues that if the minor is competent, the minor’s decision regarding the proposed treatment should govern. \textsuperscript{274}

Despite the many good reasons offered in support of the advocate role for the child attorney, other commentators raise countervailing arguments. For example, one commentator argues that retaining independent counsel for the child invariably results in duplication of effort. \textsuperscript{275} Because the positions of the parents and the state are already represented, the advocate for the child does not add another meaningful perspective to the proceeding. \textsuperscript{276} This argument, however, reduces a complex proceeding to only two possible outcomes: the one advocated by the parents and the one advocated by the state. \textsuperscript{277} The child’s position may, in fact, differ from that of both her parents and the state. \textsuperscript{278} Even if the child’s position comports with that of another represented party, the motivation underlying her position may differ substantially. \textsuperscript{279}

An additional problem stems from the minor’s possible lack of competence. A minor’s difficulty in comprehending the significance of certain issues and in communicating her views makes it difficult for her to direct her attorney. \textsuperscript{280} Others argue, however, that the legal community underestimates the ability of many minors to make “considered judgments.” \textsuperscript{281} Some commentators maintain that many

\textsuperscript{272. Id.}
\textsuperscript{273. Feigenbaum, supra note 6, at 868 & n.166; see, e.g., In re Jane Doe, 418 S.E.2d 3, 4 (Ga. 1992) (considering the case of an unconscious 13-year-old child suffering from a neurological degenerative disorder whose parents disagreed over the decision whether to consent to issuance of a “do not resuscitate” order); Curran v. Bosze, 566 N.E.2d 1319, 1321 (Ill. 1990) (confronting the issue of whether two minor twins could be compelled to donate bone marrow for the benefit of their dying half brother where the twins’ father consented to the procedure but their mother did not); Soloveichik v. Soloveichik, No. 89 CH 215 (Ill. Cir. Ct. Jan. 19, 1989) (considering the case of a 12-year-old boy with a brain tumor whose parents could not agree on the appropriate form of therapy), cited in Feigenbaum, supra note 6, at 846-48 & nn.25-41.}
\textsuperscript{274. Feigenbaum, supra note 6, at 871.}
\textsuperscript{275. Wilber, supra note 9, at 350.}
\textsuperscript{276. Id.}
\textsuperscript{277. Id. at 350-51.}
\textsuperscript{278. Genden, supra note 22, at 580.}
\textsuperscript{279. Wilber, supra note 9, at 350-51. For example, the motivation underlying the minor’s position might differ from that of both the state and her parents in a state-initiated proceeding to compel chemotherapy for a minor over parental objection. Clearly, the state wants to compel treatment to save or prolong the minor’s life. The parents might object to treatment for religious reasons. The minor, too, might object to treatment, not on religious grounds, but rather because she does not wish to undergo painful therapy that has potentially devastating side effects.}
\textsuperscript{280. See Guggenheim, supra note 8, at 93-94; Ventrell, supra note 10, at 275-76.}
\textsuperscript{281. Wilber, supra note 9, at 354 (quoting the Model Code, supra note 212, EC 7-12).}
adults possess no greater ability to make rational decisions than do children. In fact, adult litigants often make irrational decisions, a reality that attorneys must cope with on a daily basis, yet this fact does not mean that such clients should lack control over the course of their own litigation. In any event, that the child possesses the requisite competence to consent to treatment on her own behalf, and to direct her attorney if a dispute concerning treatment is litigated, constitutes an essential component of the model presented in this Note and will be discussed in greater detail in the next part. Many, if not most, minors possess the requisite competence for this proposed model to work effectively. The minor who can articulate her views, but who may be reluctant to open up to her attorney because she is distrustful of adults, poses a more serious problem. If the attorney can convince her client to communicate her wishes, the minor will benefit from the assistance of an advocate in court because the distrustful minor may not be likely to express her views freely to her parents, another party to the proceeding, or the court of her own accord.

The attorney for the child may also face a difficult situation when the minor client insists that her attorney advocate a position that is clearly contrary to the minor’s best interests. Ideally, the attorney is ethically bound to follow the client’s directive even if she believes the client’s position to be unwise. As a possible solution to this dilemma, the attorney can assume her role as advisor to persuade the minor client to reconsider her opinion. The attorney can reason with her client, explain why the client proposes a bad decision, and offer better alternatives, without usurping the decision-making function. In at least one jurisdiction, the attorney may seek to withdraw in extreme circumstances when the minor’s position advances a

282. See, e.g., Wilber, supra note 9, at 354 (“Many children, particularly adolescents, are as capable of rational decision making as adult litigants.”); see also Wallace J. Mlyniec, A Judge’s Ethical Dilemma: Assessing a Child’s Capacity to Choose, 64 Fordham L. Rev. 1873, 1881-83 & nn.37-54 (1996) (citing studies demonstrating that adolescent decision making does not differ significantly from adult decision making).
283. Wilber, supra note 9, at 354.
284. See infra part IV.
286. Id. at 278.
287. See Model Code, supra note 212, ECs 7-7 to 7-8 (stating that “the authority to make decisions is exclusively that of the client and . . . such decisions are binding on his lawyer,” and that only in a “non-adjudicatory matter” may an attorney withdraw if the client “insists upon a course of conduct that is contrary to the judgment and advice of the lawyer”); IJA-ABA Standards, supra note 22, § 3.1(b) commentary (“Although counsel may strongly feel that the client’s choice of posture is unwise, . . . the lawyer’s view may not be substituted for that of a client who is capable of considered judgment . . . .”).
288. Ventrell, supra note 10, at 279.
289. Id.
course of action so inappropriate that the attorney cannot, in good conscience, argue it to the court.290

Critics also claim that providing the minor with an advocate infringes on the interests of the other parties to the proceeding. For instance, this arrangement may undermine the parents' authority and autonomy in making decisions concerning their children.291 Nonetheless, "There are better means for protecting parental autonomy than silencing children."292 Likewise, an advocate for a minor may potentially interfere with the state's duty as parens patriae to act as guardian for those members of society who are incapable of caring for themselves.293 Nevertheless, the court must hear the voice of the most interested party in the proceeding—the minor. Including the voice of the minor does not mean excluding those of the other interested parties.

Finally, having an attorney who represents the minor's wishes may potentially harm the integrity and unity of families.294 If the child and the parent, however, desire the same outcome (e.g., no treatment), then the state becomes the party who interferes in the family relationship. In fact, intrusion by the state in any situation may potentially create dissent among family members. Thus, this argument only has validity in cases where the views of the minor and her parents differ.

Although the advocate model poses some serious drawbacks, its benefits outweigh its disadvantages. Most importantly, the advocate model protects a minor's fundamental rights and interests when some other party—either the minor's parents or the state—attempts to exclude the minor from the treatment decision-making process.

IV. COMPETENCE AS A NECESSARY PREREQUISITE

Thus far, this Note demonstrates that courts must afford minors standing in litigated medical treatment disputes to protect their rights of informed consent, bodily integrity, and privacy. In addition, this Note shows that the most effective means by which to protect the minor's rights in court is to provide her with an attorney who functions as her advocate, communicating the minor's views to the court. This model operates effectively only when the minor is competent.295 This

291. Guggenheim, supra note 8, at 77; Wilber, supra note 9, at 351; see also supra part I.A (discussing the parental rights and interests implicated in proceedings involving their children).
292. Wilber, supra note 9, at 352.
294. Wilber, supra note 9, at 355 (stating that "one can convincingly question the wisdom of adversarial dispute resolution in cases involving children or families").
295. This model does not work for incompetent minors primarily because incompetent children are not capable of making decisions for themselves, nor can they communicate their wishes to an attorney. Guggenheim, supra note 8, at 93-94. Several
part demonstrates why competence is essential and will review some of the means by which to assess competence in minors. This part concludes that a rebuttable presumption of competence presents the most logical and efficient means of assessing the competence of minors.

A widely held and firmly rooted principle in the American legal tradition is that capacity constitutes a necessary prerequisite to the assertion of legal rights. This view originated in the theories of the

commentators have offered suggestions as to how to represent incompetent children in proceedings where their interests are affected. In the medical treatment decision-making arena, however, these proposals are inadequate. The IJA-ABA Standards suggest the appointment of a guardian ad litem in addition to an advocate in proceedings involving incompetent minors. IJA-ABA Standards, supra note 22, § 3.1(b)(ii)(c)[2]. According to this approach, the minor's attorney advocates on behalf of her client the views espoused by the guardian. See id. § 3.1(b) commentary. While this approach would permit the minor's attorney to maintain the position of advocate, Lurie, supra note 22, at 234, the minor's rights are not vindicated. Rather, the attorney simply argues to the court some third party's conception of what is best for the minor. The court is, thus, deprived of the benefit of the minor's views in making its ultimate decision concerning whether to order treatment. If someone other than the minor herself is going to make the treatment decision, that person ought to be the minor's parent or guardian, whose views presumably are already represented in the proceeding.

Another possible solution to the problem posed by incompetent children in medical treatment cases is for the attorney to determine the view of her incompetent client through the doctrine of substituted judgment. Wilber, supra note 9, at 359; Lurie, supra note 22, at 234; Lyon, supra note 23, at 702. Using the doctrine of substituted judgment, the attorney attempts to determine what her client's wishes would be were the client capable of comprehending the situation and expressing her views. Id. In formulating the client's position, the attorney may determine the incompetent minor's intent by examining the minor's habits, attachments, values, and personality, asking the minor what treatment outcome she desires now, seeking the opinion of informed individuals (e.g., her parents, her physician, or her psychologist) as to what the minor will desire in the future, or striving to identify what a reasonable, similarly situated child of the client's age would want. Wilber, supra note 9, at 362-63; Lyon, supra note 23, at 703. Some courts and commentators believe that the incompetent person's free choice and dignity are protected through use of the substituted judgment method in medical treatment cases. See, e.g., Scott, supra note 52, at 86 (citing Custody of a Minor, 379 N.E.2d 1053, 1065 (Mass. 1978) and Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431 n.15 (Mass. 1977)). This may be the case with incompetent adults, who may have been capable of expressing their views on the matter at some time in their lives. Very young children, however, have never been competent to express a viewpoint from which the attorney can formulate a position. Haralambie, supra note 22, at 7. Consequently, there is substantial risk that the incompetent minor's attorney will substitute the minor's view with her own judgment. Wilber, supra note 9, at 363; Lyon, supra note 23, at 705. Merely substituting the position of the minor with that of the minor's attorney defeats the purpose of affording the minor standing and independent representation in the first place—to protect the right of the minor herself to participate in making important medical decisions that directly affect her.

296. Katherine H. Federle, On the Road to Reconceiving Rights for Children: A Postfeminist Analysis of the Capacity Principle, 42 DePaul L. Rev. 983, 987 (1993). An important related issue concerns who decides whether the child is competent. In the medical treatment context, three possibilities exist—the minor's physician, the minor's attorney, or the court. Some commentators argue that the minor's attorney should assess competence because she normally has the most contact with the client
seventeenth- and eighteenth-century philosophers who exerted such a strong impact on this nation's Founding Fathers.\textsuperscript{297} Children's rights theorists have since manipulated the focus on capacity in order "to argue both for the liberation and for the greater protection of children."\textsuperscript{298}

Scholars have argued that competency represents the central issue in determining the rights of children under the law, and have suggested that psychological research is necessary to determine the capacity of children to make legal decisions.\textsuperscript{299} On the one hand, opponents of children's rights argue that children should not have legal rights because of their general incapacity to make meaningful and rational choices.\textsuperscript{300} On the other hand, supporters of children's rights counter that "principles of liberty and justice mandate the extension of legal rights to those children with capacity," and that a child's level of competence should only serve to determine the extent of her rights.\textsuperscript{301} Clearly, no discussion of children's rights can ignore the issue of competence.

A. Why Competence Is Essential in Medical Treatment Cases

Assessment of a minor's competence constitutes an essential element in determining whether a child should enjoy standing and independent representation in medical treatment cases for two main

and is therefore in a better position to assess the minor's capabilities. Wilber, \textit{supra} note 9, at 357. Others insist that, for precisely this reason, the attorney cannot make an objective assessment, and maintain that the court should assess the minor's competence after a court hearing. \textit{See} Lyon, \textit{supra} note 23, at 699-701. In litigated medical treatment disputes, the minor's physician has likely already made an independent assessment of the minor's competence to consent to or refuse the proposed treatment. As a third alternative, perhaps the court could rely, at least in part, on the physician's determination of the minor's capacity to consent.

\textsuperscript{297} Federle, \textit{supra} note 296, at 987. For example, philosophers such as Thomas Hobbes, John Locke, and Jean-Jacques Rousseau, who advocated social contract theory, held that "children have no freedom because of their incompetencies and are instead subject to parental authority until they attain capacity." \textit{Id.} Jeremy Bentham and John Stuart Mill stressed the utility principle— that political society revolves around the natural tendency to pursue pleasure and avoid pain. Competency to seek personal happiness represents an integral part of this philosophy. This political philosophy, too, excludes children because they lack the ability to pursue their own happiness. If children cannot achieve their own happiness, "then their liberty can justifiably be curtailed by others until they reach maturity." \textit{Id.} at 995-96.

\textsuperscript{298} \textit{Id.} at 1011.

\textsuperscript{299} \textit{See}, e.g., Gary B. Melton, \textit{Developmental Psychology and the Law: The State of the Art}, 22 J. Fam. L. 445, 450 (1983-84) (arguing that, because children's incompetence has served as a basis for limiting their rights, developmental research will likely prove to be "especially probative evidence in determining the social facts basic to legal policy affecting children").

\textsuperscript{300} \textit{See}, e.g., Goldstein, \textit{supra} note 40, at 645 (arguing that "[t]o be a child is to be at risk, dependent, and without capacity . . . to decide what is 'best' for oneself" (emphasis omitted)); Hafen, \textit{supra} note 103, at 657-58 (asserting that according children rights prematurely will damage individual liberty).

\textsuperscript{301} Federle, \textit{supra} note 296, at 1013.
reasons. First, the minor must be competent to make decisions about her medical treatment for the court to recognize and protect her position regarding the treatment decision. Second, the minor must have the capacity to participate fully in the litigation if the case proceeds to court.

1. Capacity to Make Medical Treatment Decisions

Competence—which is an integral part of being able to make medical treatment decisions—lies at the heart of the doctrine of informed consent. Informed consent is the treatment authorization given by a patient to the physician. The law imposes on physicians a legal duty to provide the patient, prior to treatment, with information about (1) the particular procedures and treatments; (2) the benefits of the proposed treatment; (3) any significant risks associated with such treatment; and (4) feasible alternatives. The physician must convey this information to the patient in a manner that the patient understands and under circumstances that allow the patient to reflect on the proposed treatment and ask follow-up questions. Equally importantly, the physician must communicate to the patient that the patient possesses the right and responsibility to make the final decisions about treatment.

Traditionally, courts have viewed children as lacking the requisite capacity to make decisions for themselves concerning their own medical treatment. As Justice Burger stated in Parham v. J.R., "Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments." Nevertheless, the practice of requiring informed consent from patients stems from a deeply rooted respect for individual autonomy, and thus should apply to child patients as well as adult patients.

Despite the presumption that children lack the capacity to give informed consent, empirical research within the last decade has demonstrated that some children have a much greater capacity to provide informed consent than the legal community has recognized. For example, one study examined the developmental differences between children and adults when making medical and psychiatric treatment

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303. Id.
304. Id.
305. Id.
307. Id. at 603.
309. See Mlyniec, supra note 282, at 1881-83 & nn.37-54; Redding, supra note 308, at 708.
The researchers found that although significant differences existed between nine-year-old children and adults in decision-making capacity, little or no difference in competence existed between fourteen-year-old adolescents and adults. Another study showed that children as young as ten or eleven appear to have a factual understanding and appreciation of the risks and benefits of psychotherapy. Finally, a third study demonstrated that even children as young as nine years old appear to understand many basic aspects of medical treatment, including differences between various diagnoses and prognoses, as well as treatment risks and benefits. Thus, arguably, a consensus has emerged that "children are capable of quite a lot, if you just let them participate in the decision-making process." In addition to social science research, the medical literature appears to support the practice of obtaining informed consent from minors and inviting their participation in their own health care decisions to the greatest extent possible. Physicians believe that:

Informed consent . . . is more than just a legal obligation, imposed on the physician by society, to give information to patients . . . about their condition and proposed treatment, and to obtain consent before proceeding with treatment. It also has a moral basis fundamental to human relationships: the recognition of individual autonomy, dignity, and the capacity for self-determination.

The medical community remains faithful to the notion that individual autonomy and fairness require that children receive greater opportunity to participate in their own health care decisions when they possess the capacity to do so.

Moreover, physicians and psychologists maintain that many benefits result from allowing children to participate in medical decision making. Recognition of a child's decision-making capacities often results in improved patient care and treatment effectiveness. Participation by children in treatment decisions may also serve to reduce the stress...
of treatment. Additionally, children may have better attitudes about their treatment if they participate in the decision-making process, which, in turn, leads to more successful treatment because children will often be more willing to cooperate. Finally, since minors usually have had limited experience with exercising their rights, permitting minors to exercise their right to make treatment decisions may actually assist them in developing decision-making competence with respect to legal issues and life choices, enabling them gradually to assume adult responsibilities.

Of course, a court should not recognize a child's standing in a medical treatment case if the child, at the outset, lacks the requisite competence to give or refuse informed consent for the proposed treatment. Permitting the child to have independent representation in the proceeding allows her to present her views to the court concerning the particular treatment, thereby giving her the opportunity to protect her interests in the matter. If the child cannot make a mature, reasoned decision whether to accept or refuse the proposed treatment because she cannot understand the nature of the treatment itself, its risks and benefits, and possible alternatives, her participation in the decision-making process is of no value. Social science data indicate, however, that many minors are capable of understanding these aspects of medical treatment, and thus, are competent to make informed treatment decisions. The medical community also appears to agree with the practice of involving minors in treatment decisions, if they possess the requisite capacity. Thus, competency presents the central issue in determining the rights of minors under the law and the competence to give informed consent represents an essential inquiry in determining whether to afford a minor standing in medical treatment cases.

2. Capacity to Participate in the Litigation

The minor's ability to participate fully in the litigation and to guide her attorney reinforces the importance of competence in determining whether a minor should be afforded an independent advocate in a
medical treatment case. First, at a minimum, the child must be capable of communicating her wishes to her attorney. This basic requirement alone, however, does not sufficiently enable the attorney to represent the child effectively. Not only must the child be competent to articulate her desires verbally, but she must be in a position to direct her attorney and the course of the litigation. To do so, the child must understand the consequences of her decision, and the child's attorney must be sure that the child's decision reflects a legitimate opinion and not simply a momentary whim. In the words of one commentator:

Children may fail to comprehend crucial concepts, issues, or the possible consequences of their decisions. They may also fantasize or be prone to indecisive or inconsistent behavior. As a counselor, the attorney must advise and help the child to understand not only what his choices are, but also the potential results of those choices. As an advocate, the attorney must make or obtain some determination as to when a child's utterances could not reasonably be presented to the court as the child's position.

Thus, to justify providing the minor with independent representation, the minor must not only be capable of expressing her viewpoint, she must also be able to understand and accept the long-term consequences of her decision if the court gives weight to her preferences.

Whenever the attorney acts as a traditional advocate for a minor in a case, the representation will likely raise serious issues concerning the minor's ability to participate fully in the litigation. Thus, in addition to demonstrating capacity to give or refuse informed consent about the proposed treatment itself, the minor must also be competent to direct her attorney in the litigation and reach considered judgments about the views she wishes her attorney to present to the court.

325. Competence on the part of the minor likely represents a necessary prerequisite to full participation in any type of proceeding. See Guggenheim, supra note 8, at 92-93. Professor Guggenheim states that "it is the capacity of the client and not the type of proceeding that determines the nature of the attorney-client relationship in the adult context. There is little reason for adopting a different rule where a juvenile client is involved." Id. at 92.
326. See id. at 93.
327. See Annette R. Appell, Decontextualizing the Child Client: The Efficacy of the Attorney-Client Model for Very Young Children, 64 Fordham L. Rev. 1955, 1963 (1996); Guggenheim, supra note 8, at 77 (stating that appointing counsel for young children "creates major difficulties" because they are too young to direct their attorneys); Lyon, supra note 23, at 698.
328. See Lyon, supra note 23, at 695; see also Lurie, supra note 22, at 233 (questioning whether the views of a five-year-old child would be sufficiently mature for an attorney to argue them in court).
329. Lyon, supra note 23, at 695-96 (footnote omitted).
B. How Competence of Minors is Assessed

No single, agreed-upon method of measuring a child's competence exists. In fact, as one group of researchers noted, "The search for a single test of competency is a search for a Holy Grail."330 A thorough examination of all existing measures and theories of competence extends beyond the scope of this Note. Despite disagreement within and among various disciplines, however, several proposed models of defining competence in children have gained acceptance and merit comment. These models fall into three categories: legal standards of competence, psycho-social assessments of competence, and medical community standards of competence.

1. Legal Standards of Competence

Legal standards of competence include chronological age cutoffs and individualized assessments of maturity. Chronological age cutoffs provide a simple and convenient means of classifying which people are entitled to the rights and privileges of society.331 Lawmakers define capacity based on chronological age, and therefore afford rights and privileges based on age as well. For example, state and federal governments set minimum age requirements for drinking, driving, smoking, and voting.332 Chronological age cutoffs, however, constitute a deficient test for several reasons. First, age cutoffs represent an arbitrary means of assessing maturity.333 Second, they do not take into account individual variation. Minors do not magically attain increased powers of judgment and comprehension at a fixed age; rather, individual children develop at varying rates.334 Thus, an immature nineteen-year-old adolescent may vote even if he will not exercise this right wisely, but a seventeen-year-old adolescent who has demonstrated her maturity will be denied this right. Finally, "where the minor stands to lose a fundamental personal right, the convenience of a chronological cutoff comes at too high a cost."335 Despite their flaws, chronological age cutoffs still offer the benefit of a clear and concise standard that is universally applicable.336

Case-by-case assessments of maturity represent another common method of determining competence in the legal community. A minor's maturity may be defined both by statute, through emancipation and mature minor statutes, or by common law, under the mature mi-

331. Mlyniec, supra note 282, at 1876-77; Lyon, supra note 23, at 696.
333. Wilber, supra note 9, at 357.
334. Lyon, supra note 23, at 696.
335. Id. at 697.
336. Id. at 697-98.
The general rule deems minors to be legally incompetent to make medical decisions on their own behalf. The law, however, provides a few narrow exceptions to this rule. For instance, a legally emancipated minor may be entitled to consent to her own medical treatment. An emancipated minor is one whose parents have relinquished all control and authority over her. Many states require a judicial determination of emancipation, and courts will only do so under statutorily prescribed circumstances. Although the statutory definition of emancipation varies from state to state, examples of circumstances that warrant a minor's emancipation include marriage, financial independence, separation from parents, military service, pregnancy, and parenthood.

In addition to legal emancipation, a minor might also be deemed competent enough to consent to medical treatment on her own behalf under a mature minor statute. Mature minor statutes permit minors to consent to treatment for specific medical conditions. Medical "conditions" covered under mature minor statutes often include pregnancy, sexually transmitted diseases, contraception, substance abuse, and mental illness. Mature minor statutes do not necessarily involve a finding of maturity per se; rather, these provisions aim to encourage minors to seek needed medical care, in a confidential manner, that they might not otherwise seek if parental consent were required. Some mature minor statutes impose an age threshold that the minor must reach before she can consent to treatment for herself. Other mature minor statutes are discretionary, and the minor must make an affirmative showing of competence. Still other stat-

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337. See id. at 698.
338. Sigman & O'Connor, supra note 6, at 521.
339. Id.
340. Id.
341. Id.
342. Id.
343. Id.
344. Id.
345. Id.
346. Id.; Wadlington, supra note 93, at 323-24.
347. Sigman & O'Connor, supra note 6, at 521; see, e.g., Ala. Code § 22-8-4 (1990) (permitting any minor over 14 years of age to provide consent to any legally authorized medical, dental, or mental health treatment for herself); Ill. Comp. Stat. Ann. ch. 410, §§ 210/1, 210/4 (Smith-Hurd 1993 & Supp. 1995) (permitting a minor under 18 who is married or pregnant to consent to her own medical treatment and permitting a minor 12 years or older to seek medical attention on her own if she believes she has venereal disease or is an alcoholic or drug addict).
348. Redding, supra note 308, at 715; see, e.g., Ark. Code Ann. § 20-9-602(7) (Michie 1991) (providing that "[a]ny unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures" may provide the necessary consent); Nev. Rev. Stat. Ann. § 129.030(2) (Michie 1993) (stating that a minor "who understands the nature and purpose of the proposed examination or treatment and its probable outcome, and voluntarily requests it" may consent).
utes simply refer to the term “minor” with no mention of an age or maturity requirement.\textsuperscript{349}

Finally, in states without an applicable mature minor statute, the common law mature minor doctrine permits minors to consent to medical treatment for themselves.\textsuperscript{350} Under this doctrine, “minors who are able to understand the nature and consequences of the medical treatment offered are considered mature enough to consent to or refuse the treatment.”\textsuperscript{351} Courts have employed the mature minor doctrine to determine when to defer to a minor’s wishes.\textsuperscript{352} For example, in \emph{Bellotti v. Baird},\textsuperscript{353} the Supreme Court specifically recommended a maturity test to determine the right of a minor to decide to have an abortion without parental consent.\textsuperscript{354} Similarly, the Illinois Supreme Court, in \emph{In re E.G.},\textsuperscript{355} held that the mature minor doctrine affords a minor in Illinois the common law right to consent to or refuse medical treatment if she establishes by clear and convincing evidence that she is “mature enough to appreciate the consequence of her actions” and “mature enough to exercise the judgment of an adult.”\textsuperscript{356} The fact, however, that no court or statute has ever articulated a precise standard for determining whether a minor is mature poses a significant problem with the application of the mature minor doctrine.\textsuperscript{357} In \emph{Bellotti}, the Court stated that the judge’s determination of maturity in the abortion context would be made on a case-by-case basis\textsuperscript{358} and would “reflect personal and societal values and mores.”\textsuperscript{359} Other state and federal case law provides no clear guidance on the matter either, perhaps due to difficulty in interpreting statutory language.\textsuperscript{360} In \emph{In re E.G.}, for example, the Illinois Supreme court did

\textsuperscript{349} See, e.g., Alaska Stat. § 25.20.025(a)(4) (1995) (stating that “a minor may give consent for diagnosis, prevention or treatment of pregnancy, and for diagnosis and treatment of venereal disease”); Ariz. Rev. Stat. Ann. § 44-132.01 (1994) (providing that a “minor who may have contracted a venereal disease may give consent to the furnishing of hospital or medical care related to the diagnosis or treatment of such disease”).

\textsuperscript{350} Sigman & O’Connor, \emph{supra} note 6, at 521.

\textsuperscript{351} Id.

\textsuperscript{352} Lyon, \emph{supra} note 23, at 698.

\textsuperscript{353} 443 U.S. 622 (1979).

\textsuperscript{354} Id. at 647 (stating that if a minor “satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own, the court must authorize her to act without parental consultation or consent”).

\textsuperscript{355} 549 N.E.2d 322 (Ill. 1989).

\textsuperscript{356} Id. at 327-28.

\textsuperscript{357} See Katherine M. Waters, \emph{Note, Judicial Consent to Abort: Assessing a Minor’s Maturity}, 54 Geo. Wash. L. Rev. 90, 110 (1985) (citing a “judicial as well as a legislative failure to delineate specific criteria and approaches for assessing minors’ maturity”). This commentator attributes the lack of a standard for assessing maturity in the abortion context to the requirement that judicial proceedings be kept confidential to protect the anonymity of the minor. \emph{Id.} at 109 n.111.


\textsuperscript{359} \emph{Id.} at 655.

\textsuperscript{360} Waters, \emph{supra} note 357, at 109-12.
not articulate a standard of maturity; rather, it simply affirmed the appellate court's endorsement of the trial court's determination that the minor was mature.\footnote{In re E.G., 549 N.E.2d 322, 324, 327-28 (Ill. 1989).}

Scholars and commentators have attempted to articulate standards to assist in the assessment of maturity, applicable to all decision making by minors, not just to health care decision making. According to one commentator, an appropriate standard for determining the maturity of a minor would be to assess her "ability to know and understand the relevant facts, options, and probable outcomes in a particular decision."\footnote{Lyon, supra note 23, at 698.} The object of this test, analogous to the standard used to determine a testator's competence to make a will, would be to ensure that the minor understands the purpose for which she is making the particular decision, the reasonable options that exist, and the likely consequences of her decision, to herself and to others.\footnote{Id. note 23, at 699.} This approach assesses a minor's maturity on a sliding scale. The minor's competence to make a particular decision will vary according to the minor's age and the complexity of the issue involved;\footnote{Lurie, supra note 22, at 233-34.} the greater the maturity the minor demonstrates, the greater the weight that should be given to the minor's preferences.\footnote{See, e.g., Lyon, supra note 23, at 697 (touting "age-grading" as "useful as a rebuttable presumption to aid courts in making individual determinations of competence").}

Other commentators argue that, because maturity is so closely correlated to age, age-based presumptions offer a very effective means of assessing maturity.\footnote{Wilber, supra note 9, at 357; see, e.g., Guggenheim, supra note 8, at 91 (identifying age seven as the age at which a minor has the capacity to direct her counsel in a delinquency proceeding); Sarah H. Ramsey, Representation of the Child in Protection Proceedings: The Determination of Decision-Making Capacity, 17 Fam. L.Q. 287, 312-15 (1983) (identifying seven years as the age at which most children have the intellectual capacity to make reasoned decisions).} These commentators propose that if a minor is under a specified age, she should be presumed immature and incapable of making reasoned decisions.\footnote{Id. note 9, at 357.} Age-based presumptions resemble chronological age cutoffs, except that they leave room for individual variation by allowing a minor to present evidence of maturity to overcome the presumption of immaturity.\footnote{Wilber, supra note 9, at 357.} Proponents of age-based presumptions, while acknowledging their arbitrariness, praise

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  \item \footnote{In re E.G., 549 N.E.2d 322, 324, 327-28 (Ill. 1989).}
  \item \footnote{Lyon, supra note 23, at 698.}
  \item \footnote{Id. note 23, at 699.}
  \item \footnote{Lurie, supra note 22, at 233-34. A sliding scale of maturity accords with the New York State Bar Association's Law Guardian Representation Standards, which recommend that in the case of a young child, the extent to which the law guardian will advocate the child's wishes in a child protective or termination of parental rights proceeding "depends in large part on the child's age, maturity and capacity." New York State Bar Association, Committee on Juvenile Justice and Child Welfare, Law Guardian Representation Standards 126, 167 (1988).}
  \item \footnote{See, e.g., Lyon, supra note 23, at 697 (touting "age-grading" as "useful as a rebuttable presumption to aid courts in making individual determinations of competence").}
  \item \footnote{Wilber, supra note 9, at 357; see, e.g., Guggenheim, supra note 8, at 91 (identifying age seven as the age at which a minor has the capacity to direct her counsel in a delinquency proceeding); Sarah H. Ramsey, Representation of the Child in Protection Proceedings: The Determination of Decision-Making Capacity, 17 Fam. L.Q. 287, 312-15 (1983) (identifying seven years as the age at which most children have the intellectual capacity to make reasoned decisions).}
  \item \footnote{Wilber, supra note 9, at 357.}
\end{itemize}
them for "introduc[ing] an expedited, objective step in the assessment process." Unless the minor is represented by counsel at the outset, however, she has no means by which to rebut the presumption of incompetence. Thus, in effect, an age-based presumption may not differ significantly from a chronological age cutoff.

2. Psycho-Social Assessments of Competence

Many social science researchers focus on the cognitive abilities of children when assessing their competence. A large body of research stems from Piagetian Cognitive Development theory. Piaget posited that cognitive development occurs along a continuum, with intellectual capacity increasing at four major stages in childhood. According to Piaget, children are essentially incapable of truly intellectual thought before the age of seven. Between ages seven and eleven, children gradually develop the intellectual capacity to understand causation and gain a more objective view of the universe. Between the ages of eleven and fifteen, children's thinking approaches full maturity, and they begin to think and understand like adults. Despite criticism of Piagetian Cognitive Development theory, subsequent research has borne out its validity. Consistent with Piaget's findings, the bulk of this research shows "significant differences between the cognitive abilities of children and adolescents and little or no difference between the cognitive abilities of later adolescents and adults."

369. Id.
370. For a thorough treatment of child development research and theory, see Mlyniec, supra note 282, at 1878-85.
371. Piagetian Cognitive Development theory reflects the work of Jean Piaget, an influential researcher in the area of child development.
372. See Mlyniec, supra note 282, at 1878-79 (citing R. Murray Thomas, Comparing Theories of Child Development 285-99 (3d ed. 1992)). Piaget reported his findings in several books. For convenience, this Note refers to the works of other scholars who have synthesized Piaget's work and presented it in a more concise fashion.
373. Id. at 1879 (citing Thomas, supra note 372, at 290-95).
374. Id. (citing Thomas, supra note 372, at 295-98).
375. Id. (citing Thomas, supra note 372, at 298-99).
376. See id. at 1880 & nn.29-34, 1883 & nn.55-56 (citing several commentators who have criticized Piaget's findings as well as the findings of those studies that have supported Piaget's conclusions).
377. For instance, Weithorn and Campbell found little or no difference between the capacity of 14-year-old adolescents and adults to make medical treatment decisions, but found a marked difference between nine-year-old children and 14-year-old adolescents. Weithorn & Campbell, supra note 310, at 1595-96. Another study examining how people seek information in decision making found no change in the amount of information children examine after the age of 12. Yoshiaki Nakajima & Miho Hotta, A Developmental Study of Cognitive Processes in Decision Making: Information Searching as a Function of Task Complexity, 64 Psychol. Rep. 67, 77 (1989). For other studies confirming Piaget's theories, see Mlyniec, supra note 282, at 1881-83 & nn.38-54.
378. Mlyniec, supra note 282, at 1881.
Other studies emphasize the contextual nature of development. While Piagetian theory may demonstrate that a minor develops full cognitive capacity by late adolescence, other factors exert strong influences during her development that certainly will bear upon her overall level of competence and decision-making capacity.\textsuperscript{379} Equally importantly, learning is a dynamic process that is reinforced by experience. Thus, through the process of trial and error, a minor will make better decisions each time she approaches or confronts a decision-making opportunity.\textsuperscript{380}

3. Medical Community Standards of Competence

Assessment of competence in the medical community can be directly traced to the doctrine of informed consent. Physicians assess a minor's medical treatment decision-making capacity by evaluating her ability to provide or refuse informed consent.\textsuperscript{381} Physicians consider four factors in assessing decision-making capacity: (1) reasoning ability; (2) understanding; (3) voluntariness; and (4) the nature of the decision to be made.\textsuperscript{382} While a patient's reasoning depends on her age, intellectual capacity, and cognitive and emotional functioning, the medical community recommends that physicians and parents also assess the minor's ability to consider future consequences, her history of learning from past mistakes, her tendency toward impulsiveness versus cautious reflection, and her level of comfort with making the treatment decision.\textsuperscript{383} In assessing the minor's understanding, medical experts encourage the physician to consider whether the child has any specific knowledge, information, experience, or misconceptions about the medical problem or the proposed treatment decision.\textsuperscript{384} Understanding also includes the minor's comprehension of the implications of the treatment decision.\textsuperscript{385} The physician can analyze the minor's understanding by asking her how she perceives the matter and by asking more direct questions.\textsuperscript{386} Voluntariness represents the degree to which the patient's decision is free from coercion and manipulation by others.\textsuperscript{387} Because minors are often quite susceptible to influence by

\textsuperscript{379} See id. at 1883-84 & nn.57-70 (noting studies that demonstrate the strong effect of such forces as peer influence, the tendency to focus on immediate consequences, and the inclination to make risky choices on adolescent decision-making capacity).
\textsuperscript{380} See id. at 1884-85 & nn.71-79 (citing studies demonstrating the importance of learning on attaining decision-making competence).
\textsuperscript{381} King & Cross, supra note 302, at 12.
\textsuperscript{382} Id.
\textsuperscript{383} Id. at 12-13.
\textsuperscript{384} Id. at 13; see also Sanford Leikin, The Role of Adolescents in Decisions Concerning Their Cancer Therapy, 71 Cancer 3342, 3344-45 (Supp. 1993) (stressing the importance of knowing what the adolescent understands about the cancer and its treatment outcomes when the adolescent refuses treatment).
\textsuperscript{385} Sigman & O'Connor, supra note 6, at 523.
\textsuperscript{386} King & Cross, supra note 302, at 13.
\textsuperscript{387} Id.
their parents, the physician must attempt to understand the family dynamics to assess the minor's voluntariness. 8

Finally, the gravity of the medical condition and the treatment decision, the immediacy of the need for a decision, and the risk-benefit ratio will also affect the minor's medical decision-making capacity. 389

Another approach suggests that, in addition to assessing cognitive capacity for decision making, the physician examine the minor's set of values concerning treatment, or her "conception of the good." 388 Conception of the good is described as follows:

Possession of a set of values, or a conception of one's good, allows the individual to evaluate the treatment alternatives and their respective components as benefits or harms and to assign them relative weights. The conception of one's good should be sufficiently consistent and stable so that the treatment choice is maintained long enough for the treatment to be completed. It should also encompass the ability to assign appropriate weight to future consequences of present decisions and should reflect the predictable ways that one's values and goals will change over time. 391

A critical factor in assessing a minor's conception of the good is the extent to which her values reflect her future interests. 392 If a minor lacks the ability to anticipate her future, she may give inadequate weight to the effect of a decision on her future interests and be unable to anticipate future changes in her values. 393 The minor's limited experience may contribute to her inability to assess her present values and her future goals. 394 Due to these concerns, physicians frequently hesitate to rely fully on the values of the minor in making a medical treatment decision. 395

Regardless of the standard employed to assess competence, many medical commentators agree that minors under the age of fourteen should not be permitted to consent to or refuse treatment on their own behalf. 396 By contrast, others recommend a case-by-case determination of a minor's capacity to consent and recommend involving

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388. Id.
389. Id. at 14.
390. Leikin, supra note 384, at 3342-43.
391. Id. at 3343.
392. Id.
393. Id.
394. Id.
395. Id.
396. See, e.g., John C. Fletcher et al., Ethical Considerations in Pediatric Oncology, in Principles and Practice of Pediatric Oncology 309, 312 (Philip A. Pizzo & David G. Poplack eds., 1989) (presenting a view that patient assent should not be required of adolescents younger than 14 years of age); Leikin, supra note 384, at 3344 (stating that, with a disease such as cancer, a "paternalistic approach seems logical for the adolescent younger than 14 years"); Sigman & O'Connor, supra note 6, at 522 (stating that "[a] patient should be at least 14 years of age to consent to medical treatment").
her in the decision-making process to a degree commensurate with her current capacity.  

C. Proposed Model: A Rebuttable Presumption of Competence

Whether a minor is deemed competent will necessarily vary according to who is making the assessment, the measure of competence that is employed, and the nature of the decision that the minor must make. Given that many studies show that minors, even quite young children, possess an adult level of competence to make decisions, the most logical approach to assessing competence is a rebuttable presumption of competence. Children's rights advocates support this approach. For example, Hillary Rodham Clinton maintains that the presumption that children are incompetent should be set aside in favor of a presumption that children are capable of exercising rights and assuming responsibilities until proven otherwise. Similarly, Henry Foster, in *A “Bill of Rights” for Children*, proposed that the law grant children individual freedom and autonomy commensurate with their maturity and development, and that the burden should be on the party who wishes to abridge the child’s freedom and autonomy to demonstrate that his position is in the child’s best interests. More recently, the 1995 Fordham Conference on Ethical Issues in the Legal Representation of Children adopted a standard that presumes the minor client’s capacity to make decisions about her legal representation. Undoubtedly, the focus should be placed on the decision-making process rather than on the decision itself. The individual making the assessment of competence should consider the minor’s ability to understand, to reason, and to communicate. And, if that individual cannot demonstrate that the minor lacks capacity, the minor should participate fully in the decision-making process.

398. See Melton, *supra* note 299, at 463 (suggesting that even young children have the capacity to make certain decisions); *see also supra* notes 309-14 and accompanying text (discussing studies disputing the perception that children generally lack the capacity to make decisions).
400. Foster, *supra* note 257, at 73.
403. *Id.* at 309.
V. STANDING AND INDEPENDENT REPRESENTATION OF COMPETENT MINORS IN PRACTICE

As demonstrated, competent minors must have standing and independent representation in litigated medical treatment disputes. This part applies these recommendations to the cases of Billy Best and Lee Lor in an attempt to illustrate how they would work in practice. These cases demonstrate how this model may operate differently depending on which parties differ over the proposed medical treatment decision. In Billy Best's case, the parents' and the child's wishes conflict. By contrast, in Lee Lor's case, both she and her parents oppose treatment, a decision that conflicts with the position of the state.

Assuming that Billy Best, his parents, and his physician could not resolve the issue of further chemotherapy for Billy privately, the dispute might reach a court in one of two ways. Billy's parents could seek a court order requiring Billy to undergo continued treatment against his wishes. Alternatively, Billy could initiate the proceeding, seeking a judicial declaration that his parents cannot force him to accept treatment that he does not want. In either situation, a court would first have to recognize that Billy has standing to challenge the treatment decision his parents have already made on his behalf.

Because Billy is sixteen years old, the judge would likely presume him competent to make the decision to refuse further chemotherapy. Any party opposed to his standing would be required to demonstrate that Billy is incompetent to make the decision to refuse treatment on his own behalf. Such a showing would be difficult to make, given that Billy has already undergone five months of chemotherapy treatment. The court would deem Billy's reason for refusing treatment to be rational, based on an assessment of his quality of life. In the past, chemotherapy made Billy feel even more sick and depressed than did the cancer itself. To Billy, the pain and discomfort of continuing chemotherapy may outweigh its tenuous promise of long-term improvement.

Assuming the case proceeds to court, Billy would appear by independent counsel whose function would be to argue Billy's position to the court. Again, Billy's attorney would learn that Billy is quite capable of communicating his views to her, and that his wishes constitute a mature, considered point of view. Accordingly, Billy's attorney would have no reason to doubt Billy's competence to participate fully in the litigation or the appropriateness of his position. The court would consider Billy's position along with those of his parents and any other parties to the proceeding, and reach what it considers to be a

405. Knox, supra note 1, at 1.
just outcome.\textsuperscript{407} Billy's important personal rights of informed consent, bodily integrity, and privacy would receive protection in the process.

In fifteen-year-old Lee Lor's case, the state would initiate the court proceeding. The state would challenge Lee Lor's parents' refusal to consent to the necessary chemotherapy treatment for ovarian cancer on grounds that such a refusal constitutes statutory child neglect. Normally, only Lee Lor's parents and the state would be formal parties to the proceeding. Under the proposed model, Lee Lor would be a named party as well. Again, the court and her attorney would presume Lee Lor's competence to refuse treatment on her own behalf. Lee Lor's decision reflects her "suspicion of Western medicine"\textsuperscript{408} as well as her wish not to "suffer hair loss, nausea and other side effects of chemotherapy unless doctors could guarantee good results."\textsuperscript{409} Lee Lor's position would be but one among several the court considers, and "[m]erely advocating a position does not guarantee its success."\textsuperscript{410} The judge, as the ultimate decision maker, is bound to make a decision that comports with the child's best interests.\textsuperscript{411} Thus, consideration of Lee Lor's viewpoint along with those of the other parties in interest would not compromise the judge's function.\textsuperscript{412} Rather, including Lee Lor's perspective would serve to protect her right to participate in the treatment decision. Certainly, this scenario presents a preferable outcome to that which did, in fact, occur—removal from her home by force by a team of police, paramedics, and social workers, and imposition of chemotherapy against her will.\textsuperscript{413}

\textbf{Conclusion}

The rights of privacy and bodily integrity are fundamental, and courts accord these rights great respect. True respect for these important personal rights includes the recognition that every competent individual, regardless of age, has a right to participate in the acceptance or refusal of medical treatment. Currently, minors lack legal standing to challenge medical treatment decisions that other parties reach on their behalf. In cases where the state seeks to compel treatment over parental objection, or where the parents make a decision that opposes the minor's wishes, the minor lacks access to an attorney whose role is to present the minor's position regarding treatment to the court. The traditional model thus deprives the most interested party in the proceeding of a voice.

\textsuperscript{407} Wilber, supra note 9, at 354.
\textsuperscript{408} Perkins, supra note 2, at B10.
\textsuperscript{409} Pulaski, supra note 3, at B2.
\textsuperscript{410} Wilber, supra note 9, at 354.
\textsuperscript{411} Id.
\textsuperscript{412} Id.
\textsuperscript{413} Perkins, supra note 2, at B10; Pulaski, supra note 3, at B2.
Courts in litigated medical treatment disputes must recognize that competent minors have rights and interests, apart from those of their parents and the state, that require protection. To make these rights meaningful, the minor in such cases must have independent representation in the form of an advocate who will present to the court the minor's preferred outcome. In following this alternative model, courts and attorneys for minors would play an integral role in protecting the right of minors to participate in the treatment decision-making process and in preserving her fundamental rights of privacy and bodily integrity.