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Do Not Resuscitate Decision-Making: Ohio's Do Not Resuscitate Law Should Be Amended to Include a Mature Minor's Right to Initiate a DNR Order

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DO NOT RESUSCITATE DECISION-MAKING: OHIO’S DO NOT
RESUSCITATE LAW SHOULD BE AMENDED TO INCLUDE A
MATURE MINOR’S RIGHT TO INITIATE A DNR ORDER

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I. INTRODUCTION

*“Constitutional 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.”*¹

Consider the following scenario in light of the ethical and the legal implications that would arise:

A cystic fibrosis patient, nearly 18 years old and unmarried, is brought to the ER in respiratory distress. She’s told the ER nurses and the attending doctor that she wants a Do Not Resuscitate (DNR) order, but her parents are refusing to sign it. Meanwhile, the patient goes into respiratory arrest. What would you do?²

This scenario was printed in a 1993 edition of the nursing magazine, *RN*, along with the responses provided from various nursing professionals. In reply, the majority of nurses expressed that any solution would be problematic based on the ethical and legal issues involved.³ For instance, a Tennessee home health nurse wrote “I would have to assist in the code [to resuscitate], even though it would break my heart,”⁴ and a Pennsylvania rehab nurse commented “I would like to honor the patient’s wishes, but I have no legal basis for doing so.”⁵ The moderator, Amy Haddad, a physician and widely publicized ethicist, noted that although parents have the legal right to make medical decisions for their minor children, minors have rights as well.⁶ Even if there are ethical reasons for not issuing or implementing a DNR, we must remember that parents do not always do what is best for their children, and it is possible that there are other factors that must be taken into consideration.⁷

As reflected by the scenario, as well as the nurses’ responses, matters involving a minor’s capacity to make health care decisions are highly debated. Changes in both the common law and legislation over the years have resulted in minors gaining some degree of autonomy in making their own medical decisions.⁸ According to Professor Angela Holder, “[t]he court and legislatures of this country have not been unmindful of [these] societal changes, and there is a definite trend toward allowing adolescents more freedom to make decisions, and to exercise autonomy and self-determination in

¹*Bellotti v. Baird*, 443 U.S. 622, 634 (1979).

²Amy Haddad, *Ethics in Action; Ethics in Medical Emergencies; Acute Care Decisions*, *RN*, November 1993, at 23.

³*Id.*

⁴*Id.*

⁵*Id.*

⁶Haddad, *supra* note 2.

⁷*Id.* (specifically, other factors include abuse and/or neglect situations).

⁸*See generally* Rhonda Gay Hartman, *Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practice*, 8 U. Chi. L. Sch. Roundtable 87, 88 (2001) (specifically discussing the specific exceptions to the legal presumption of incapacity for adolescents to make medical treatment decisions).

their relationships with healthcare providers.”⁹ Even though these decisions typically involve low-risk medical procedures, as opposed to life-saving or life-sustaining treatment, some states permit minors to make significant medical decisions, including whether to have an abortion without parental consent or notice.¹⁰ Using reasoning similar to the abortion argument, this note will conclude that Ohio’s DNR Order law should be amended to include an exception for unemancipated mature minors who wish to initiate a DNR order when their parents refuse to consent on their behalf.

Part one discusses Ohio’s current DNR law, which does not include an exception for mature minors.¹¹ It explains the medical difference between initiating a valid DNR order and refusing life-sustaining medical treatment. However, the note solely focuses on DNR and how it relates to a minor’s right to initiate his or her own DNR order in light of parental disagreement.

Part two explains the evolution of the minor and healthcare. Specifically, the progression from the early common law assumption that minors lack the capacity to consent, to the present, in which minors are permitted to make some medical treatment decisions without parental consent or knowledge.

Part three examines the development of the mature minor exception, and the effect it has had on minor’s healthcare rights. This section will also discuss three cases that have applied a mature minor exception in determining whether a minor was capable of consenting to some form of medical treatment.¹²

Part four compares West Virginia and New York’s DNR statutes to Ohio’s current law, and ultimately determines that Ohio’s law should be amended to permit mature minor’s to initiate a DNR order with or without parental consent.

Part five will focus specifically on Ohio’s abortion statute, which recognizes a mature minor’s right to have an abortion without parental consent or knowledge.¹³ It will include an overview of Ohio’s abortion law, and an explanation of the judicial bypass proceeding for a mature minor who does not wish to notify her parents. The section will also discuss the mature minor exception as it was applied in the abortion cases of *Bellotti v. Baird*,¹⁴ *Ohio v. Akron Ctr. for Reproductive Health*,¹⁵ *In re Jane*

⁹Angela R. Holder, *Minors’ Rights to Consent to Medical Care*, 257 JAMA 3400, 3402 (1987), quoted in Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 Hastings L.J. 1265, 1308 (2000) (discussing the conflict between legal and social concerns regarding minors and their healthcare rights).

¹⁰See generally Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life Sustaining Treatment?*, 49 Rutgers L. Rev. 1 (1996) (comparing the abortion decision to life-sustaining treatment decisions, which may not be the same argument, but carries similar weight and is based on the same premise).

¹¹See generally OHIO REV. CODE ANN. §§ 2133.21-2133.26 (Anderson 2002).

¹²*Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987), *In re E.G.*, 549 N.E.2d 322 (Ill. 1989), and *Commonwealth v. Nixon*, 761 A.2d 1151 (PA. 2000).

¹³See OHIO REV. CODE ANN. § 2151.85 (Anderson 2002).

¹⁴443 U.S. 622 (1979).

¹⁵497 U.S. 502 (1990).

Doe I,¹⁶ and *In re Jane Doe*.¹⁷ It will conclude that Ohio law should apply the mature minor exception to the area of DNR because it already applies in the significant medical situation of abortion.

All of the above factors lead to the conclusion that Ohio should amend its current law to include an exception for unemancipated mature minors who wish to initiate their own DNR orders. Additionally, the exception should provide a method for resolving disputes when the minor's wishes and the parent's wishes are in conflict. This section will provide a draft for a proposed exception to Ohio's DNR law that will include a provision for mature minors.

II. DO NOT RESUSCITATE: AN OVERVIEW

"[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."¹⁸

A. A Do Not Resuscitate Order: What is it and Why is it Issued?

Cardiopulmonary Resuscitation (CPR) was initially developed to preserve life, restore health, relieve suffering and limit disability of persons who unexpectedly went into cardiac arrest.¹⁹ More specifically, it is an emergency lifesaving procedure that is performed when a person's own breathing or heartbeat have stopped.²⁰ CPR is a combination of rescue breathing, which provides oxygen to the victim's lungs, and chest compressions, which keep oxygenated blood circulating until an effective heartbeat and breathing can be restored.²¹ CPR was not, however, intended to delay the approaching death of terminally ill patients.²² Despite its intended purpose, CPR continues to be classified as an "emergency" procedure for which patients' consent is presumed unless an order is issued to the contrary.²³

Not long after the development of resuscitation techniques in the 1960's, it became clear that a minimal number of patients who were successfully resuscitated survived long enough to be discharged from the hospital.²⁴ Because many resuscitated patients were elderly, terminally ill, or severely and irreversibly demented, resuscitation only prolonged their suffering or sustained patients in a

¹⁶566 N.E.2d 1181 (Ohio 1990).

¹⁷2002 Ohio 3926, 2002 Ohio App. LEXIS 3994 (1st Dist. Ohio Ct. App. 2002).

¹⁸Union P.R. Co. v. Botsford, 141 U.S. 250, 251 (1891).

¹⁹George P. Smith, *Euphemistic Codes and Tell-Tale Hearts: Humane Assistance in End-of-Life Cases*, 10 HEALTH MATRIX 175, 178 (2000).

²⁰See TABER'S CYCLOPEDIA MEDICAL DICTIONARY, *Cardiopulmonary Resuscitation* (2003), available at www.Tabers.com.

²¹*Id.*

²²See Smith, *supra* note 19, at 178.

²³*Id.*

²⁴*Id.* at 176.

permanent vegetative state.²⁵ Resuscitation was determined to not always be in the patient's best interests, and many physicians believed that resuscitating every patient was in violation of the "ethical principle of non-maleficence (not doing harm)."²⁶

DNR orders direct hospital staff not to apply CPR if and when cardiac or respiratory arrest occurs.²⁷ There are two basic responses to patients in cardiopulmonary arrest: code or no code.²⁸ To "code" a patient means to administer CPR, while "no code" implies that aggressive treatment will not be given to the patient in cardiac arrest (typically DNR).²⁹ DNR orders are issued so that the patient can avoid the negative effects of CPR. Even after receiving CPR, only five to ten percent of patients survive and are able to function as they once did.³⁰ Some patients survive but subsequently die before they are released from the hospital.³¹ If a patient survives, he or she may suffer from a collapsed lung or a broken rib.³² More serious side effects of CPR, such as brain damage, may also occur.³³ Finally, even if a patient survives CPR and is not injured, the patient may be left weak and the CPR has prolonged an already uncomfortable dying process.

Historically, hospitals favored administering CPR in an attempt to maintain life.³⁴ However, in the 1960's, the doctrine of informed consent became more widely recognized as it allowed for increased patient autonomy and a decline in unilateral decision making by physicians.³⁵ This increase in autonomy resulted in the appearance of DNR orders, as a vehicle for hospitals to address life saving treatment decisions. These new procedures arose as a result of evolutions in technology and subsequently created a new wave of ethical dilemmas in healthcare.³⁶ It also opened the door to a number of legal issues, including the *right to die*, which has led more patients to become involved in decisions regarding their medical treatment.³⁷ In 1973, The American Hospital Association adopted the *Patients' Bill of Rights*, which

²⁵*Id.*

²⁶*Id.*, quoting Mark H. Ebell, *Practical Guidelines for Do-Not-Resuscitate Orders*, 50 Am. Fam. Physician 1293, 1293 (1994).

²⁷Smith, *supra* note 21, at 177.

²⁸*Id.*

²⁹*Id.*

³⁰Kaiser Permanente, *Medical Procedures That May Prolong Life* (2003), available at <http://www.kaiserpermanente.org/locations/northwest/members/yourhealth/library/death-medical.html#top>.

³¹*Id.*

³²*Id.*

³³*Id.*

³⁴AMERICAN HOSPITAL ASSOCIATION, *EFFECTIVE DNR POLICIES: DEVELOPMENT, REVISION, AND IMPLEMENTATION 1* (1990).

³⁵*Id.* at 2.

³⁶*Id.*

³⁷*Id.*

allowed patients to be apprised of their diagnosis and treatment options, and allowed patients to consent or refuse treatment, to the extent that the law would allow.³⁸ By 1986, most hospitals had implemented DNR orders, and in 1987 New York State became the first state to pass DNR legislation.³⁹

B. Ohio's Current Do Not Resuscitate Law

Ohio's current DNR law does not allow for anyone under the age of eighteen to initiate a DNR order. A DNR order is a "directive issued by a physician that identifies a person and specifies that CPR should not be administered to the person so identified."⁴⁰ CPR is further defined as "cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR."⁴¹ Under Ohio's DNR law, a declarant may issue a declaration ordering the withholding or withdrawal of CPR.⁴² A declarant is considered "any adult who has executed a declaration..."⁴³ An adult is simply defined as "an individual who is eighteen years of age or older."⁴⁴ In order for a physician to withdraw or withhold CPR from a declarant, the declarant must execute a declaration and receive DNR identification.⁴⁵

Additionally, many states have added the right to refuse Life Sustaining Medical Treatment to their current statutes. DNR orders differ from Life Sustaining Medical Treatment ("LSMT") in a very specific, yet also very subtle, manner. LSMT is defined as "any medical procedure, treatment, intervention, or other measure that, when administered to a qualified patient or other patient, will serve principally to prolong the process of dying."⁴⁶ DNR is limited to situations in which CPR is withheld or withdrawn from a person, as opposed to LSMT, which can include a number of procedures used to sustain life functions, such as nutrition or hydration.⁴⁷ DNR policies are not designed to address issues relating to the withdrawal of treatment or withholding of any treatment other than CPR. Furthermore, refusing LSMT may include a DNR order, based on the patient's wishes, but such an

³⁸*Id.*

³⁹ROBERT ZUSSMAN, INTENSIVE CARE 161 (1992).

⁴⁰OHIO REV. CODE ANN. § 2133.21(D) (Anderson 2002).

⁴¹*Id.* at 2133.21(G).

⁴²*Id.* at 2133.21.

⁴³*Id.* at 2133.01(E).

⁴⁴*Id.* at 2133.01(A) (currently there is not a provision in Ohio's law for anyone under the age of eighteen who wishes to consent to a DNR order).

⁴⁵OHIO REV. CODE ANN. § 2133.23 (Anderson 2002).

⁴⁶OHIO REV. CODE ANN. § 2133.01(Q) (Anderson 2002) (Under Ohio law, in order to issue a declaration regarding the withdrawal or continuation of LSMT, the declarant must be an adult of at least eighteen years of age or older. This definition applies to both LSMT, as well as DNR).

⁴⁷*See id.*

inclusion is not necessary.⁴⁸ In analyzing the right of a minor to refuse life-saving medical treatment, one must look specifically at a DNR order, which does not interfere with the patient's medical care in any way other than if the patient goes into cardiac arrest and requires resuscitation.

III. A LOOK AT THE MINOR AND HEALTHCARE: PAST AND PRESENT

*“Remarkably, the legal presumption of decisional incapacity for adolescent patients rests on scant scientific and social evidence. Developmental research suggests that adolescents are decisionally capable, at least beyond the level presently presumed by law.”*⁴⁹

Should parents have the right to insist on life-saving treatment against the wishes of their child?⁵⁰ This situation undeniably occurs, however the circumstances are yet to be tested in court. Currently, Ohio law does not allow a minor to make decisions regarding most of his or her own medical treatment, let alone refuse treatment. A minor is defined as “an infant or person who is under the age of legal competence...[i]n most states, a person is no longer a minor after reaching the age of 18.”⁵¹ Traditionally, common law has presumed that minors are incompetent and therefore not permitted to initiate or consent to any form of medical treatment on their own.⁵² The issue that arises from this presumption is whether a minor should have some degree of autonomy when it comes to making healthcare decisions.

A. A Historical Glance at the Minor's Healthcare Rights

Autonomy is defined as “the expression of informed preferences or consent to whatever we do, or is done to us by others.”⁵³ In medical treatment decisions, autonomy applies to the right of a patient to give or withhold informed consent; specifically, the right of a patient to either consent to treatment or turn down unwanted treatment.⁵⁴ Adults are presumed to be capable of making their own healthcare choices, as self-determining or self-governing beings.⁵⁵ Alternatively, minors are presumed legally incapable, therefore requiring parents to make healthcare decisions for their children.⁵⁶

⁴⁸See generally OHIO REV. CODE ANN. § 2133.03 (Anderson 2002).

⁴⁹Hartman, *supra* note 8, at 89.

⁵⁰See N.S. Morton, *Pediatric Issues*, in ETHICS AND THE LAW IN INTENSIVE CARE 125, 129 (1996).

⁵¹BLACK'S LAW DICTIONARY 997 (6th ed. 1990).

⁵²See Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109, 112 (2000).

⁵³R.S. Downie, *Introduction to Medical Ethics*, in ETHICS AND THE LAW IN INTENSIVE CARE 1, 6 (1996).

⁵⁴*Id.*

⁵⁵See Hartman, *supra* note 9, at 1266.

⁵⁶*Id.*

Based on the historical presumption that minors are legally incapable, a physician is required to obtain consent from the patient's parents or guardians before administering treatment.⁵⁷ By requiring parental consent, the law presumes that parents are acting in the best interests of their children. While this may be the typical case, in some instances, parents may not be acting in their child's best interests.⁵⁸ In a speech given to the Illinois College of Law, Professor Walter Wadlington inquires as to whether it is appropriate to presume that parents are acting in the best interests of their children at a time when the creation of child abuse reporting statutes and minor consent laws are becoming more widespread.⁵⁹

In most cases, parents are not acting maliciously, but are unwilling to let go of their child, even if it would allow the child to end an extremely painful existence. For instance, a child who has lived with AIDS or cancer may be ready and willing to accept death, rather than live life in pain. Because some diseases are diagnosed at an early age, a minor may have the disease long enough to have a heightened awareness of what it means to live with it.⁶⁰ The child can be more prepared to face his or her own death and forego a painful resuscitation, while the parents are unwilling to lose their child. In these instances, a minor may wish to initiate a DNR order if they are ever to go into cardiac arrest, directing attending physicians not to resuscitate.

Also, in issues of neglect or abuse, parents who have not been looking out for their child's best interests while they are alive cannot be trusted to make the right choices when their child wants to die. In the case of neglect or abuse, the state has the right to step in and take custody of the child away from the parents when they are not acting in the best interests of their children.⁶¹ This rationale is known as the doctrine of *parens patriae*, allowing the state to assume the role of "ultimate protector" for all children. Given the state's interest in preserving the best interests of the minor, when making the decision whether to allow a child to die, the state's interests must be considered in the balance.⁶² A minor's interest in autonomy should be weighed by taking into consideration the risk of harm from the minor's own poor

⁵⁷See generally Ann Eileen Driggs, R.N., *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?*, 11 HEALTH MATRIX 687, 689-690 (2001). See also Jessica A. Penkower, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment - Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1174 (1996).

⁵⁸Driggs, *supra* note 57, at 689-690. See also Derish & Vanden Heuvel, *supra* note 54, at 117. (parents may be neglectful, abusive, selfish, uncaring, or similarly detrimental to their child's best interests)

⁵⁹Walter Wadlington, *Medical Decision Making For and By Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. L. REV. 311, 332 (1994).

⁶⁰See Haddad, *supra* note 2, at 23.

⁶¹See Driggs, *supra* note 57, at 689-690. See also Derish & Vanden Heuvel, *supra* note 52, at 117.

⁶²See Derish & Vanden Heuvel, *supra* note 52, at 112-113.

decisions, the interests of the minor's parents, and society's interest in promoting the well-being of all minors.⁶³

The interest of a child's life lies in many hands. In one hand is the minor's interests in ending the painful treatments he or she has been enduring and refusing to endure the suffering caused by the administration of CPR.⁶⁴ On the other hand, is the interests of the minor's parents to preserve the life of their child and the interests of the state to preserve the best interests of every minor.⁶⁵ For this reason, most states do not permit minors to make medical decisions without parental consent notwithstanding a few common law exceptions and recent statutory exemptions.⁶⁶ Common law exceptions have emerged for emergency situations and emancipated minors.⁶⁷ Additionally, some states have enacted statutory exemptions for married minors, mature minors, venereal disease treatment, alcohol abuse treatment and abortion.⁶⁸

B. Exceptions to the Common Law Rule

In the case of an emergency situation, if a minor's condition requires immediate attention because it poses imminent danger to the minor's health, and parental consent is not available, courts typically hold that parental consent is implied by law. Anything requiring immediate attention, or that is causing a child to be in pain or to be fearful, constitutes an emergency.⁶⁹ The emergency exception arose out of the notion that the state's interest in protecting children is diminished when a physician refuses to render care to a minor for fear of being sued by the minor's parents.⁷⁰

The emancipated minor assumes all legal responsibility for himself or herself, and when making healthcare decisions there is no legal duty for a parent to consent. A minor may be emancipated from parental care and control because of status, such as marriage or military service, or a state may provide a statutory procedure for a

⁶³LEGISLATING MEDICAL ETHICS: A STUDY OF THE NEW YORK STATE DO-NOT-RESUSCITATE LAW 129 (Robert Baker et al. eds., 1994).

⁶⁴See generally Derish & Vanden Heuvel, *supra* note 52, at 117 (responding to arguments against a mature minor's right to refuse LSMT, including the state's *parens patriae* duty). See also Penkower, *supra* note 57, at 1165 (balancing of ethical interests involves adolescent's interest in ending treatment and society's interest in preserving life).

⁶⁵*Id.*

⁶⁶See Penkower, *supra* note 57, at 1176-1177 (discussing the "Early Exceptions to the Common Law Rule" of a minor's capacity to consent to medical treatment). See also Driggs, *supra* note 57, at 690-691 (discussing three general exceptions to the parental consent requirement, including: emancipation, emergency, and mature minor. Furthermore, none of the exceptions are recognized in the refusal of treatment). See also Hartman, *supra* note 9, at 1309-1310.

⁶⁷See generally *id.*

⁶⁸*Id.*

⁶⁹See Penkower, *supra* note 57, at 1176-1177.

⁷⁰*Id.* at 1177.

self-supporting minor who wishes to be emancipated.⁷¹ Generally, an emancipated minor's parents have no legal involvement in the child's life, including care, custody and control of their child and the child's earnings.⁷² Emancipation may be expressed or implied.⁷³ If the emancipation is expressed, the parents and minor have voluntarily agreed to the entire surrender of the minor.⁷⁴ If the emancipation is implied, the parents and the minor conduct themselves as if the minor is emancipated.⁷⁵ Implied emancipation may be complete, which involves the complete surrender of care, or it may be partial, which only frees the minor from a part of the period of minority or a part of the parents' rights.⁷⁶ Additionally, if a minor is not formally emancipated, but is married or, in some instances, has a child, the minor may be deemed emancipated and therefore permitted to make his or her own medical decisions.⁷⁷

Married minors may make decisions regarding their own health care, as well as the health care of their minor children. In Ohio, minors may marry at sixteen if female and eighteen if male.⁷⁸ If a minor is married, emancipated, or in an emergency situation, consent will not be needed from a parent or guardian for a physician to perform a medical procedure. However, in the case of an emergency situation in which a minor requires CPR, a physician is required to resuscitate, even if it is against the patient's wishes.

If a minor does not fall within one of the above exceptions, but is deemed sufficiently mature, the mature minor exception will allow a minor to receive some medical treatment without parental consent.⁷⁹ Minors have also been given additional statutory rights to refuse or receive some medical treatment.⁸⁰ These statutory exemptions may or may not require a finding of maturity for the physician to treat the patient.

Most states currently allow minors to make some medical treatment decisions. Such treatment decisions include care for venereal diseases, contraception, blood donation, drug and alcohol abuse treatment, and abortion.⁸¹ Generally, the medical procedures listed, except for abortion, do not require a physician to find that the minor is mature in order to treat him or her without receiving parental consent.

⁷¹Robert L. Stenger, *Exclusive or Concurrent Competence to Make Medical Decisions for Adolescents in the United States and United Kingdom*, 14 J.L. & HEALTH 209, 211 (2000).

⁷²See Penkower, *supra* note 57, at 1177.

⁷³See BLACK'S LAW DICTIONARY 521 (6th ed. 1990).

⁷⁴*Id.*

⁷⁵*Id.*

⁷⁶*Id.*

⁷⁷See Penkower, *supra* note 57, at 1177.

⁷⁸OHIO REV. CODE ANN. § 3101.01 (Anderson 2002).

⁷⁹See generally Hartman, *supra* note 9, at 1309-1310.

⁸⁰See *id.*

⁸¹*Id.*

These exemptions were created based on the need for minors to be permitted to confidentially seek some of their own medical treatments; and the determination that the minor's interests in having confidential medical treatment outweigh the parent's interest in their child's healthcare.⁸²

C. Ohio's Statutory Exceptions

Ohio currently has laws that allow minors, without a finding of maturity, to make their own medical treatment decisions without parental consent. Ohio minors may receive venereal disease treatment and drug and alcohol abuse treatment, without parental consent and without the requirement that the physician make a finding of maturity.⁸³ These exemptions arose from the need to allow minors to seek treatment without fear of their parent's disapproval and to protect abuse victims.⁸⁴

An Ohio minor may give consent for the diagnosis or treatment of any venereal disease by a licensed physician without additional consent by a parent or guardian.⁸⁵ These laws arose from the increase in sexually transmitted diseases among minors and the fear that minors would not seek treatment if they were required to obtain consent from their parents.⁸⁶ In this instance, Ohio recognized the need for minors to be permitted to receive treatment without the knowledge or consent of their parents or guardians. Furthermore, the attending physician may treat minors without determining if they are mature enough to consent to the treatment.

Similarly, in Ohio, a minor may give consent to a physician for the diagnosis or treatment of any condition that is reasonably believable to be caused by the abuse of drugs, beer, or intoxicating liquor.⁸⁷ A physician may render medical or surgical services to a minor giving consent for an alcohol or drug-related condition and will not be subject to criminal or civil liability.⁸⁸ In drug and alcohol abuse treatment, Ohio again recognizes the need for a minor to be permitted to confidentially seek treatment, without obtaining consent from a parent or guardian. Under these circumstances the physician may perform surgical services without seeking consent by the minor's parents.

⁸²Alan R. Fleischman, *Caring for Gravely Ill Children*, PEDIATRICS, October 1994, at 433-439 (discussing the "special considerations" that should be given to adolescent patients, including the request for confidentiality during treatment).

⁸³See OHIO REV. CODE ANN. § 3709.241 (Anderson 2002). See also OHIO REV. CODE ANN. § 3719.012 (Anderson 2002).

⁸⁴See Hartman, *supra* note 9, at 1309-1310.

⁸⁵See OHIO REV. CODE ANN. § 3709.241 (Anderson 2002).

⁸⁶See Penkower, *supra* note 57, at 1178.

⁸⁷See OHIO REV. CODE ANN. § 3719.012 (Anderson 2002).

⁸⁸*Id.*

IV. THE EVOLUTION OF THE MATURE MINOR EXCEPTION

*“For the protection of the individual and the protection of society, the mature minor doctrine is set into practice.”*⁸⁹

A. *The Mature Minor Exception Defined*

In response to the obvious necessity for exceptions to the common law parental consent rule, courts began allowing exceptions permitting minors to make some of their own medical treatment decisions.⁹⁰ The mature minor doctrine is an exception to the premise that minors are generally incompetent.⁹¹ It allows a minor who “exhibits the maturity of an adult to make decisions traditionally reserved for those who have attained the age of majority.”⁹² In cases involving a terminally ill minor, the minor typically exhibits a much higher degree of competence and an increased ability to make informed medical decisions regarding his or her own treatment.⁹³ This increased decision making ability is a result of the minor experiencing the illness for some time, understanding the illness and the prognosis, and being involved in the decision making process.⁹⁴

The mature minor exception provides that a physician will not be held liable for battery or malpractice, if the physician treats a consenting minor of sufficient maturity without the parent's consent.⁹⁵ Under this doctrine, physicians are not liable for unconsented touching when the minor has given permission for treatment under these limited circumstances. They are liable only if they exceed the boundaries.⁹⁶ Without the mature minor exception, physicians must obtain parental consent prior to treating a minor, or be subject to an assault and battery or malpractice action.⁹⁷ In order for the exception to apply, the physician must first make a determination regarding the minor's capacity and maturity to make such decisions.⁹⁸ The physician is the most capable to determine the minor patient's maturity, including the patient's understanding of the disease, the treatment options, and the suffering that would be endured.⁹⁹ Some of the factors to be weighed in determining the maturity of a minor

⁸⁹RICHARD HEDGES, CONTEMPORARY LEGAL ISSUES, BIOETHICS, HEALTHCARE, AND THE LAW: A DICTIONARY 144 (1999) (defining mature minor in both the medical and legal contexts).

⁹⁰H. NEIL WIGDER, *Minor Refusing Treatment*, in STANDARDS OF CARE IN EMERGENCY MEDICINE: A PRACTICAL GUIDE TO EMERGENCY PROCEDURES AND LEGAL LIABILITY 24 (1994).

⁹¹*Id.*

⁹²Penkower, *supra* note 57, at 1166.

⁹³Fleischman, *supra* note 82.

⁹⁴*See* Derish & Vanden Heuvel, *supra* note 52, at 113.

⁹⁵Hedges, *supra* note 89.

⁹⁶*Id.*

⁹⁷*Id.*

⁹⁸Fleischman, *supra* note 82.

⁹⁹*See generally* Derish & Vanden Heuvel, *supra* note 52, at 118-119.

include: the minor's age; ability; experience; education; training; degree of maturity or judgment obtained by the minor; conduct and demeanor of the minor; the nature of the treatment and its risks or probable consequences; and the minor's ability to appreciate the risks and consequences.¹⁰⁰

Based on the special physician-patient relationship, the opinion of the attending physician as to his patient's competence should be considered in the highest regard.¹⁰¹ If the physician feels as if his patient is competent and "mature" enough to consent to the treatment, and the patient does in fact consent, the physician should be permitted to treat his or her patient as the patient wishes.¹⁰² To date, the Supreme Court has not made a determination as to whether there is a constitutionally based right for minors to refuse medical treatment. Even though the Supreme Court has not made a ruling, many states have recognized that minors are competent enough to make decisions regarding medical treatment.¹⁰³

B. Cases Involving a Mature Minor's Right to Initiate or Refuse Medical Treatment

One of the earliest cases to consider this issue is *Cardwell v. Bechtol*,¹⁰⁴ in which the Supreme Court of Tennessee held a defendant physician not liable for providing medical care to a seventeen-year-old without parental consent.¹⁰⁵ The Court based its holding on the fact that the patient was sufficiently mature to make a decision regarding her medical treatment. The defendant physician testified that the patient appeared to be a mature young woman, and that her demeanor led him to think that she was of age, therefore no parental consent was sought.¹⁰⁶ The Court found that the plaintiff "had the ability, maturity, experience, education and judgment at her 17 years, 7 months of age to consent knowingly to medical treatment."¹⁰⁷

Another case which addresses a patient's maturity level in connection with her right to refuse medical treatment is *In re E.G.*¹⁰⁸ In this case, a seventeen-year-old refused a blood transfusion based on her beliefs as a Jehovah's Witness.¹⁰⁹ The Illinois Supreme Court held that courts must balance the state's interest in the sanctity of life and the state's *parens patriae* power to protect those incompetent to protect themselves, with the minor's maturity.¹¹⁰ The Court found that if the

¹⁰⁰*Cardwell*, 724 S.W.2d at 748.

¹⁰¹Fleischman, *supra* note 82.

¹⁰²*Id.*

¹⁰³*See* Rosato, *supra* note 10, 10-16.

¹⁰⁴724 S.W.2d 739 (Tenn. 1987).

¹⁰⁵*Cardwell*, 724 S.W.2d at 748.

¹⁰⁶*Id.* at 743.

¹⁰⁷*Id.* at 749.

¹⁰⁸549 N.E.2d 322 (Ill. 1989).

¹⁰⁹*Id.* at 323.

¹¹⁰*Id.* at 327-328. (*parens patriae* allows the state to assume the role of "ultimate protector" to all children)

evidence is clear and convincing that the minor patient is sufficiently mature to appreciate the consequences of her actions, and that she is mature enough to exercise the judgment of an adult, then the mature minor doctrine allows her the common law right to consent to or refuse medical treatment.¹¹¹ However, in its opinion, the Court stated that the parent's consent was a significant factor in its decision:

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. In this case, for example, had E.G. refused the transfusions *against* the wishes of her mother, then the court would have given serious consideration to her mother's desires.¹¹²

The last case to be discussed regarding the application of the mature minor exception is *Commonwealth v. Nixon*.¹¹³ The Supreme Court of Pennsylvania held that the maturity of an unemancipated minor is not a sufficient affirmative defense.¹¹⁴ As such, the minor patient's parents were convicted of involuntary manslaughter and child endangerment, after they refused to seek medical treatment for their daughter.¹¹⁵ The Court ruled against the mature minor exception defense in this case, but Justice Cappy, in his concurrence, recognized the need to allow some minors to consent or refuse medical treatment:¹¹⁶

[i]n the same way, I believe that when it is demonstrated that a minor has the capacity to understand the nature of his or her condition, appreciate the consequences of the choices he or she makes, and reach a decision regarding medical intervention in a responsible fashion, he or she should have the right to consent to or refuse treatment. I would, therefore, adopt the mature minor doctrine.¹¹⁷

C. The Medical Perspective

Even though legal opinions seem varied, medical professionals tend to agree that minor patients, specifically those who have dealt with terminal illnesses, may have the competence and maturity to make their own decisions. For example, the American Nurses' Association's Code of Ethics states that minors have rights to "determine what will be done with his or her person...and to accept, refuse, or

¹¹¹*Id.*

¹¹²*Id.* at 328.

¹¹³761 A.2d at 1151 (Pa. 2000).

¹¹⁴761 A.2d at 1152.

¹¹⁵*Id.*

¹¹⁶*Id.* at 1157.

¹¹⁷*Id.* at 1158.

terminate treatment.”¹¹⁸ Further, the Code states that nurses must respect these rights to “the fullest degree permissible under the law.”¹¹⁹

Additionally, the American Academy of Pediatrics’ Committee on Bioethics’ guidelines state that minors possessing “decision-making” capacity should be informed and permitted to make health care decisions.¹²⁰ Decision-making capacity is further defined as the ability to understand and communicate information relevant to a decision, the ability to reason and deliberate concerning the decision, and the ability to apply a set of values to a decision that may involve conflicting elements.¹²¹ These medical opinions seem to be based primarily on the premise that minors who have dealt with terminal illness are sufficiently capable to make their own medical treatment decisions. As stated by the American Academy of Pediatrics, in an article in *Pediatrics*,¹²² adolescents, specifically those with a terminal illness, may have an increased decision-making capacity.¹²³ If there is a disagreement in the course of treatment between the patient and parent, the physician, after a careful review of the patient’s mental abilities, should ideally respect the patient’s decision.¹²⁴

The concept of the ‘mature minor,’ which recognizes that some adolescents possess sufficient autonomy to be allowed to consent to or refuse care without parental involvement and regardless of parental objection, is receiving increasing recognition. We believe that this trend, which supports the involvement and autonomy of the adolescent patient, is important, and should be expanded to include all capable adolescents.¹²⁵

V. NEW YORK AND WEST VIRGINIA: RECOGNITION OF A MATURE MINOR’S RIGHTS IN DO NOT RESUSCITATE LAW

*“[I]n some cases, it will be ethically acceptable and appropriate to respect the choice of a capable, unemancipated minor to withhold or to stop life-saving or life-sustaining treatment, even in the face of parental objections.”*¹²⁶

The idea of a mature minor’s capability to consent to his or her own DNR order is statutorily recognized in both New York and West Virginia.¹²⁷ Both states extended

¹¹⁸Haddad, *supra* note 2 (quoting American Nurses’ Association). CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS (1985).

¹¹⁹*Id.*

¹²⁰Driggs, *supra* note 57, at 713-714 (noting Committee on Bioethics, American Academy of Pediatrics, *Guidelines on Foregoing Life-Sustaining Medical Treatment*, 93 *Pediatrics* 532 (1994)).

¹²¹*Id.*

¹²²Fleischman, *supra* note 82.

¹²³*Id.*

¹²⁴*Id.*

¹²⁵*Id.*

¹²⁶Legislating Medical Ethics, *supra* note 63, at 131.

their DNR laws to include the rights of the mature minor.¹²⁸ Ideally, more states may begin to follow the lead of New York and West Virginia and recognize the importance of the mature minor exception and the autonomy of the capable minor patient.

A. *West Virginia's DNR Law*

West Virginia currently recognizes that some minors possess the capacity and maturity to consent to end-of-life treatment decisions. In the issuance of a DNR order, West Virginia's law provides that a parent may refuse CPR on behalf of his or her minor child, provided that a second physician who has examined the child concurs with the opinion of the attending physician.¹²⁹ Furthermore, a minor, between the ages of 16 and 18, who is, in the opinion of the attending physician, sufficiently mature enough to understand the nature and effect of a DNR order, must be included in the decision to refuse CPR in order for the DNR order to be valid.¹³⁰ In the event of a conflict between the wishes of the parents or guardians and the wishes of the mature minor, the wishes of the mature minor shall prevail.¹³¹ The law does not specify that a minor patient's decision will not prevail if the minor is seeking the initiation of a DNR order and his or her parents are refusing to consent, resulting in the assumption that it may be left to judicial interpretation if the situation arises.

This statutory exception was applied in the West Virginia Supreme Court's decision in *Belcher v. Charleston Area Medical Center*.¹³² In this case, the defendant physician did not obtain consent from decedent, a seventeen-year-old, before issuing a DNR order.¹³³ The Court held that there is no "hard and fast" rule providing a particular age to deem a "mature minor."¹³⁴ The Court applied the rule in *Cardwell* and held that:¹³⁵

Whether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved. Moreover, the totality of the circumstances, the nature of the treatment and its risks

¹²⁷See NY. Pub Health Law § 2967 (Consol. 2002). See also W.VA. CODE ANN. § 16-30C-6 (Michie 2002).

¹²⁸*Id.*

¹²⁹W.VA. CODE ANN. § 16-30C-6 (Michie 2002).

¹³⁰*Id.*

¹³¹*Id.*

¹³²422 S.E.2d 827 (WV 1992).

¹³³*Id.* at 830.

¹³⁴*Id.* at 837.

¹³⁵*Id.* at 837.

or probable consequences, and the minor's ability to appreciate the risks and consequences are to be considered.¹³⁶

In making its decision, the Court found that it was likely that a minor, who has dealt with a serious illness, was capable of making his or her own medical treatment decisions.¹³⁷ "It is difficult to imagine that a young person who is under the age of majority, yet, who has undergone medical treatment for a permanent or recurring illness over the course of a long period of time, may not be capable of taking part in decisions concerning that treatment"¹³⁸

However, the Court was cautious not to set a definite rule in the application of the mature minor doctrine. It stated that application of the mature minor rule would vary from case to case, with the focus being on the maturity level of the minor at issue, and whether that minor has the capacity to appreciate the nature and risks involved in the procedure to be performed or the treatment to be withheld.¹³⁹ Furthermore, the Court noted that where there is a conflict between the patient and the parents, the physician must make a good faith assessment of the minor's maturity level.¹⁴⁰ After making this assessment, if the physician deems the minor to be sufficiently mature, the physician is protected from liability for failure to obtain parental consent.¹⁴¹ In the most difficult of cases where the patient and the parents do not agree, if the minor is deemed mature, the physician may resolve the conflict on his or her own.¹⁴²

B. New York's DNR Law

While it has not been tested in court as to whether a minor may initiate a DNR order when the parents refuse to consent, New York State has also implemented a DNR law that requires the mature minor to refuse CPR before the order can be validated.¹⁴³ In the case of conflict between the parents and patient's wishes, there is a mediation program in place to resolve disputes.¹⁴⁴

In New York State, if a DNR order is requested and the minor patient has the capacity to consent, the physician must obtain the consent of the patient before issuing the order.¹⁴⁵ The attending physician must first determine whether the patient is capable of making life-ending treatment decisions. In the case of a conflict between the parent(s) and the patient, the physician may refer the matter to the

¹³⁶See *Cardwell*, 724 S.W.2d at 109.

¹³⁷See *Belcher*, 422 S.E.2d at 836.

¹³⁸*Id.*

¹³⁹*Belcher*, 422 S.E.2d at 838.

¹⁴⁰*Id.*

¹⁴¹*Id.*

¹⁴²*Id.*

¹⁴³See N.Y. PUB. HEALTH LAW § 2967 (Consol. 2002).

¹⁴⁴See N.Y. PUB. HEALTH LAW § 2972 (Consol. 2002).

¹⁴⁵See N.Y. PUB. HEALTH LAW § 2967.

dispute mediation system.¹⁴⁶ Each hospital is statutorily required to implement a dispute mediation program for the purposes of remedying disputes involving DNR orders. Once a dispute is submitted to the dispute mediation board, a DNR order cannot be issued until the mediation is settled, or if an order has already been issued, it shall be revoked.¹⁴⁷ Parties interested in participating in mediation are also entitled to judicial review, if they are unhappy with the outcome of the mediation.¹⁴⁸

If either party is unhappy with the decision of the mediation board, the patient or parent may seek a judicial review of the determination.¹⁴⁹ Further, a parent may bypass mediation and seek judicial review if he or she can show by clear and convincing evidence that the DNR order is not in the minor patient's best interests.¹⁵⁰ If the parent seeks judicial review through these means, the court may issue a temporary restraining order, enjoining the order not to resuscitate until the completion of the proceedings.¹⁵¹ Each decision would be made on a case-by-case basis, with an analysis of the maturity, conceptual ability, and experience in making important life decisions.¹⁵²

West Virginia and New York have implemented statutes that recognize the mature minor DNR decision-making. As time goes on, more states may begin to follow in their footsteps and implement their own statutory exceptions to DNR law. However, many states, including Ohio, have already implemented laws permitting mature minors to make abortion decisions without parental notification or consent. In doing so, these states are acknowledging the need for minors to be permitted to make their own decisions regarding medical treatment.

VI. THE MATURE MINOR DOCTRINE AS APPLIED TO THE ABORTION DECISION

*"The United States Supreme Court has developed a mature minor doctrine for abortion decisions that is significantly more deferential to minors than the general rule governing the medical treatment decisions of minors."*¹⁵³

Most states require parental consent for a minor who wishes to have an abortion. However, states that have a parental consent requirement for abortion are required by the United States Supreme Court to include a judicial bypass clause for the law to be held constitutional.¹⁵⁴ The bypass clause give directives for an unemancipated minor, after a finding of sufficient maturity, to seek an abortion without parental consent or notice.¹⁵⁵ Judicial bypass clauses recognize that many minors are

¹⁴⁶See N.Y. PUB. HEALTH LAW § 2972.

¹⁴⁷*Id.*

¹⁴⁸See N.Y. PUB. HEALTH LAW § 2973 (Consol. 2002).

¹⁴⁹*Id.*

¹⁵⁰*Id.*

¹⁵¹See N.Y. PUB. HEALTH LAW § 2973 (Consol. 2002).

¹⁵²*Id.*

¹⁵³Rosato, *supra* note 10, at 16.

¹⁵⁴See *id.*

¹⁵⁵See *id.*

competent enough to make decisions regarding invasive procedures such as abortions.¹⁵⁶ They also allow for situations in which a parent or guardian may not be acting in a minor's best interest.¹⁵⁷

A. Ohio's Abortion Law

Ohio law permits an unmarried minor to seek an abortion without notice to parent, guardian or custodian.¹⁵⁸ The statute specifically allows a pregnant, unmarried and unemancipated woman, under the age of eighteen, to seek an abortion without the notification of her parents, if she can prove that she is either sufficiently mature, or that she is the victim of abuse.¹⁵⁹

In order to seek an abortion without parental notification, the complainant must file a complaint in the juvenile court of her county, bordering counties or counties where an abortion clinic is located.¹⁶⁰ The complaint must allege that the complainant is sufficiently mature and well enough informed to intelligently decide whether to have an abortion without the notification of her parents, guardian, or custodian.¹⁶¹ Alternatively, if she is not sufficiently mature, the complainant must show that one or both of her parents, her guardian, or her custodian was engaged in a pattern of physical, sexual, or emotional abuse against her, or that the notification of her parents, guardian, or custodian otherwise is not in her best interest.¹⁶² Once the petition is brought before the court, the court must find by clear and convincing evidence that the complainant is sufficiently mature and well informed to decide intelligently whether to have an abortion.¹⁶³ Recognizing the minor's right to bodily integrity, the judicial bypass procedure was a result of the Supreme Court's decision in *Bellotti v. Baird*.

B. Court Decisions on the Mature Minor's Right to Consent to an Abortion

In *Bellotti v. Baird*, the Supreme Court weighed a woman's right to choose to seek an abortion against the state's right to encourage an unmarried pregnant minor to seek consent and advice from her parents.¹⁶⁴ A Massachusetts statute required parental consent for an unmarried minor to obtain an abortion except in an emergency situation. This statute was declared unconstitutional by the District Court, and the Supreme Court subsequently affirmed. The Supreme Court held that in the abortion context it is unconstitutional to require a minor to seek permission of

¹⁵⁶*See id.*

¹⁵⁷*See id.*

¹⁵⁸*See* OHIO REV. CODE ANN. § 2151.85 (Anderson 2002).

¹⁵⁹*Id.*

¹⁶⁰*Id.*

¹⁶¹*Id.* at § 2151.85(A)(4)(a).

¹⁶²*Id.* at § 2151.85(A)(4)(b).

¹⁶³*Id.* at § 2151.85(C)(1).

¹⁶⁴*Bellotti*, 443 U.S. at 639.

her parents or guardians, or to be required to notify her parents or guardians.¹⁶⁵ Furthermore, a state's abortion statute must have a judicial bypass clause to allow a minor to seek an abortion without notification of her parents.¹⁶⁶ In seeking the abortion, the minor must show the court that she is sufficiently mature and well enough informed to make the decision on her own.¹⁶⁷ If the court does not deem her sufficiently competent to make the decision independently, she must show that an abortion would be in her best interests.¹⁶⁸ Following the decision in *Bellotti*, the Ohio Supreme Court reviewed Ohio's abortion statute, in order to determine whether it survived constitutional scrutiny.

Ohio v. Akron Ctr. For Reproductive Health examined House Bill 319, and determined that it was constitutional.¹⁶⁹ The Supreme Court held Ohio's statute to be constitutional because it provides a method for an unmarried, unemancipated pregnant minor to have an abortion without parental notice, if she follows the judicial bypass procedure.¹⁷⁰ Additionally, the Court found that H.B. 319 met the following four criteria, as established in *Bellotti*.¹⁷¹ First, the minor must be permitted to show that she is sufficiently mature and well enough informed to make the abortion decision regardless of her parent's wishes.¹⁷² Second, if the minor is not able to show sufficient maturity, she must be permitted to show that the abortion is in her best interests.¹⁷³ Third, there must be anonymity; and four, there must be a judicial bypass procedure that will ensure the minor an expedited opportunity to obtain the abortion.¹⁷⁴ "We have, however, squarely held that a requirement of pre-abortion parental notice in all cases involving pregnant minors is unconstitutional. Although it need not take the form of a judicial bypass, the State must provide an adequate mechanism for cases in which the minor is mature or notice would not be in her best interests."¹⁷⁵ Expanding on the judicial bypass requirement, Moyer's dissenting opinion in *In re Jane Doe 1* urged the adoption of a maturity test mirroring that in *Cardwell*, in order to ensure that the minor is sufficiently mature enough to make the decision regarding an abortion.¹⁷⁶

The Supreme Court of Ohio, in *In re Jane Doe 1*, held that the trial court did not abuse its discretion in finding that the appellant was not sufficiently mature to make

¹⁶⁵*Id.* at 653.

¹⁶⁶*Id.* at 647.

¹⁶⁷*Id.*

¹⁶⁸*Id.* at 647-648.

¹⁶⁹*Akron Ctr. for Reproductive Health*, 497 U.S. at 506-07.

¹⁷⁰*Id.* at 507-508.

¹⁷¹*Id.* at 511.

¹⁷²*Id.*

¹⁷³*Id.*

¹⁷⁴*Id.* at 512-13.

¹⁷⁵*Id.* at 522 (J. Stevens, concurring in judgment).

¹⁷⁶*See In Re Jane Doe 1*, 566 N.E.2d at 1185 (J. Moyer, dissenting in judgement).

a judgment regarding an abortion.¹⁷⁷ Further, the Court held that she was unable to prove by clear and convincing evidence that her father was engaged in a pattern of abuse.¹⁷⁸ The appellant provided evidence that she was a senior in school, maintained a 3.0 grade point average, had plans to attend college, was employed, and was responsible for obtaining her own medical care.¹⁷⁹ However, based on the testimony, the Court did not find sufficient maturity. The Court also refused to adopt guidelines to assist trial courts in defining “sufficiently mature.” However, Chief Justice Moyer, in dissent, urged that the court adopt the following factors to guide trial court’s in finding whether or not a minor is sufficiently mature: age, overall intelligence, emotional stability, credibility and demeanor as a witness, ability to accept responsibility, ability to assess the future impact of her present choices, ability to understand the medical consequences of abortion and apply that understanding to her decision, and any undue influence by another on the minor’s decision.¹⁸⁰

Finally, the Plaintiff in *In re Jane Doe*, appealed the Hamilton County Juvenile Court’s denial of her application to have an abortion without parental notification.¹⁸¹ The Court of Appeals found that Jane Doe clearly and convincingly presented evidence that she was sufficiently mature and well enough informed to decide intelligently whether to have an abortion without notification of her parents.¹⁸² In making this determination, the Court looked at Jane Doe’s relationship with her family and her desire to protect it from potential conflict; her academic standing in her high-school class; her active participation and leadership role in school extracurricular activities; her acceptance to college as a scholarship student; her consideration of adoption or foster care as alternatives; and, her introspection related to the consequences of her decision.¹⁸³ The court stated that it could not “conceive of a case stronger than the present one. If permission is not granted in this case, it will never be. The law must be followed whether or not it fits our personal preferences. To refuse to grant permission in this case would be to render R.C. 2151.85 meaningless.”¹⁸⁴

From the decisions in the above cases, Ohio courts recognize the need for mature minors to make their own decisions regarding high-risk procedures, such as abortion,

¹⁷⁷*Id.* at 1182.

¹⁷⁸*Id.* at 1184.

¹⁷⁹*Id.* at 1181.

¹⁸⁰*Id.* at 1185-86. (J. Moyer, dissenting in judgment. Justice Brown, in his dissent, also identifies factors relative to determining a minors maturity. He states the determination of whether a minor is “mature should be made based on how she has conducted her entire life, and not just on the events which have brought her into court. While maturity cannot be determined by resort to a simple, bright line test, it is possible to identify certain factors which are indicia of maturity and which may be used to focus the inquiry.”).

¹⁸¹See *In re Jane Doe*, No. C-020443, 2002 Ohio App. LEXIS 3994 (1st Dist. Ohio Ct. App. July 10, 2002).

¹⁸²*Id.* at *5.

¹⁸³*Id.*

¹⁸⁴*Id.* at *4-5.

and therefore should permit mature minors to determine whether or not to initiate a DNR order if they so choose.

VII. PROPOSED AMENDMENT TO OHIO'S DO NOT RESUSCITATE LAW

*"The best statutory protection for the minor's right to self-determination would be to permit certain minors to execute legally enforceable advance health care directives."*¹⁸⁵

"Whether an adolescent should be able to direct that a DNR order be placed in his medical chart and honored presents a legal dilemma...Not surprisingly, allowing an adolescent patient to initiate a DNR order merits special consideration."¹⁸⁶ An analysis of the legal and ethical implications that arise results in the conclusion that Ohio should amend its DNR statute to include a mature minor exception. This exception would allow unemancipated minors the right to initiate a DNR order without parental consent. In doing so, Ohio would recognize the need for minors to be permitted to exercise some degree of autonomy in making their own medical decisions. Cases must be taken on an individual basis, and each minor's decision-making capacity and maturity should be assessed before a physician issues a DNR order. In the worst-case scenario, if one or both parents do not agree with the minor's decision, the minor patient's wishes must be taken into consideration, and weighed against the parent's interests in keeping their child alive.¹⁸⁷

Ohio currently permits minors, regardless of a finding of maturity, to lawfully consent to and receive some medical treatments. These decisions typically involve low to moderately invasive, but highly important, medical procedures, including treatment for venereal diseases, drug and alcohol abuse treatment, and contraception decisions.¹⁸⁸ More importantly, Ohio currently recognizes a mature minor exception to the parental consent requirement in abortion cases.¹⁸⁹ This exception recognizes that many minors are competent enough to make important and invasive medical decisions. Furthermore, other jurisdictions have recognized the mature minor exception specifically for DNR order decisions.¹⁹⁰

The West Virginia Statute requires an unemancipated mature minor be involved in the decision whether to initiate a DNR order on his or her behalf.¹⁹¹ In the case of a conflict between a minor patient and the parent(s), the physician may make an independent determination as to the maturity of the minor.¹⁹² New York has also adopted a statutory exception to its DNR law, which requires a mature minor to

¹⁸⁵Rosato, *supra* note 10, at 99.

¹⁸⁶Hartman, *supra* note 9, at 1328.

¹⁸⁷*See generally* Penkower, *supra* note 57, at 1165.

¹⁸⁸*See* OHIO REV. CODE ANN. §§ 3709.241, 3719.012.

¹⁸⁹*See* OHIO REV. CODE ANN. § 2151.85.

¹⁹⁰*See* N.Y. PUB. HEALTH LAW § 2967; *See also* W.VA. CODE ANN. § 16-30C-6.

¹⁹¹*Id.* at § 16-30c-6(d) (minors are only included in the decision if they are between 16 and 18 years of age).

¹⁹²*Id.*

consent to the DNR order before a physician can issue it.¹⁹³ However, New York has also created a mediation dispute provision, requiring hospitals to provide dispute resolution if there is a conflict between the minor patient's wishes and the parent(s) wishes.¹⁹⁴ If the mediation is not successful, the parties may then seek judicial review.¹⁹⁵

Obviously, courts and legislatures are accepting the responsibility of determining whether a minor is sufficiently mature to make some of their own medical treatment decisions. Other jurisdictions recognize the need for mature minors to be involved in the decision regarding a DNR order, and Ohio currently recognizes the need in abortion decisions. The question then arises as to why Ohio has not yet recognized that a necessity exists for permitting a mature minor the right to initiate a DNR order.

An amendment to Ohio's DNR law will include unmarried, unemancipated minors, without an age restriction. Prior to the age of legal majority, no precise age or maturity level can be designated at which all minors should be permitted to make their own health care decisions. Restricting a minor's ability to initiate a DNR order based on age could possibly permit minors who are of age, but not yet sufficiently mature, to initiate a DNR order, while prohibiting minors who are not yet of age, but sufficiently mature, from initiating a DNR order.

A determination of maturity would be made by the attending physician's independent review.¹⁹⁶ In order to make this determination, the physician must first discuss with the patient the meaning of issuing a DNR order and in what situations it would be applied.¹⁹⁷ The physician must also discuss the patient's illness in great detail, and the treatment options that would be available.¹⁹⁸ Further, the physician would need to explain to the patient what his or her chances of surviving cardiac arrest, should it occur, and the quality of life the patient could expect following cardiac arrest and successful resuscitation.¹⁹⁹ Finally, the physician must discuss the patient's possibilities for a cure, even if they are minimal.²⁰⁰ Once the physician and patient have discussed all alternatives and treatment options, if the physician deems the minor to be mature, the physician should be permitted to initiate a DNR order for the minor patient. If the parent and the patient are in agreement, a valid DNR order will be added to the patient's file for reference if the patient is ever in cardiac arrest.

If a situation arises in which the parent and patient do not concur, the physician will be responsible for referring the dispute to an approved mediation program in a

¹⁹³See N.Y. PUB. HEALTH LAW § 2967.

¹⁹⁴*Id.* at § 2972.

¹⁹⁵*Id.* at § 2973.

¹⁹⁶See generally Derish & Vanden Heuvel, *supra* note 52, at 118. (authors discuss a proposed solution which would allow a minor to make decisions regarding his or her own healthcare, specifically regarding advance directives and life-sustaining medical treatment).

¹⁹⁷*Id.*

¹⁹⁸*Id.*

¹⁹⁹*Id.*

²⁰⁰*Id.*

timely manner, in which a determination will be made as to the minor's maturity.²⁰¹ The form and guidelines of the mediation program will also be statutorily set, but will be left to each hospital to implement.²⁰² The mediation program will be available in order to lessen the burden on the court systems, and to avoid lawsuits against the hospital, should disputes arise.

In order for the patient or parent to petition the court, the parties must first attempt to mediate the dispute using the hospital's mediation procedure.²⁰³ If mediation is not effective, either party may seek a judicial bypass through the court system, allowing a judge to determine whether the DNR order should be validated.²⁰⁴ In making a decision, the Court will look at the totality of the circumstances, and make a determination based on the minor's age, ability, experience, education, training, degree of maturity or judgment obtained by the minor, conduct and demeanor of the minor at the time of the incident involved, the nature of the treatment and its risks or probable consequences, and the minor's ability to appreciate the risks and consequences.²⁰⁵ Once the court determines whether the minor is sufficiently mature, the court will issue an order directing the hospital to either validate or invalidate the DNR order, regardless of whether there is parental consent. If the judge does not find the minor to be sufficiently mature to initiate an order, and the parents refuse to consent, the DNR order will be held invalid. This statute will allow minor patients the autonomy they deserve, as well as protect physicians from liability in the event a parent consents, but the minor patient not.

Based on West Virginia, New York, and Ohio's current DNR laws, the framework for the amended statute would be as follows:

§ 2133.27 DECISION MAKING ON BEHALF OF A MINOR PATIENT;
A MINOR DEEMED SUFFICIENTLY MATURE TO INITIATE A DNR ORDER;
MEDIATION AND JUDICIAL BYPASS PROCEEDINGS

1. A parent or legal guardian may consent to a do-not-resuscitate order on behalf of his or her minor child, provided that the attending physician makes a determination as to the medical condition of the minor, and a second physician concurs with the diagnosis.
2. If a minor patient is deemed sufficiently mature and capable of understanding the nature and effect of a do not resuscitate order, and the minor patient wishes to initiate a DNR order, the minor may be permitted to initiate the order on his or her own behalf.
3. In the event of a conflict between the wishes of the parents or legal guardian and the wishes of the minor patient, the attending physician

²⁰¹See generally N.Y. PUB. HEALTH LAW § 2972.

²⁰²See N.Y. PUB. HEALTH LAW § 2972.

²⁰³*Id.*

²⁰⁴See N.Y. PUB. HEALTH LAW § 2973.

²⁰⁵See *Cardwell*, 724 S.W.2d at 748. See also *In re Jane Doe 1*, 566 N.E.2d at 1185-86. (using criteria from both cases, these factors will allow an Ohio Court to make a determination).

will be required to refer the matter to the hospital's dispute mediation program for a determination as to the minor patient's maturity.

4. Upon resolution of the mediation, the mediation board shall issue a legally binding decision, instructing the hospital to either issue a valid do not resuscitate order or to revoke the do not resuscitate order.
5. If the dispute can not be resolved through mediation, either party may seek a timely judicial bypass proceeding, in which a judicial officer will review the facts, the recommendation of the mediation board, and the maturity of the minor patient, and make a determination as to whether a do not resuscitate order will be validated or revoked.

VIII. CONCLUSION

*"It is not too much to ask for a multi-faceted response from courts, Congress, and state legislatures to a newly recognized ethical dilemma in medicine. Nor is it unrealistic."*²⁰⁶

Unless we can differentiate degrees of dignity that should be accorded to adults and minors, DNR orders may allow minor patients a viable means for respecting their personal wishes.²⁰⁷ DNR orders should be available to all competent and capable patients, whether they are adults or minors.²⁰⁸ This idea is based on the fact that terminally ill minors are capable of making mature decisions involving their medical treatment, including initiating DNR orders. Commentators Robert Weir and Charles Peters best state this notion:

[Minors] have had, at the very least, multiple opportunities to think about the inescapable suffering that characterizes their lives, the features of life that make it worth continuing, the benefits and burdens that accompany medical treatment, and the prospect of death. At least some of these adolescents want to give voice to their values, provide directions for parents, physicians, and nurses regarding end-of-life care, and be assured that their wishes and preferences will be respected and carried out should their medical conditions deteriorate to the point that they will no longer be able to communicate their deeply felt views.²⁰⁹

The mature minor exception evolved as it became more evident that minors have healthcare rights, just as any adult does. The common law presumption that minors are incapable of making their own decisions regarding medical treatment is slowly fading, and exceptions to this rule have been emerging. Even though the medical and legal worlds have not yet made a steadfast rule regarding minors and medical treatment decisions, minors are gaining more rights with time. In the future, more courts and legislatures will recognize the need for minors to be legally recognized as

²⁰⁶Derish & Vanden Heuvel, *supra* note 52, at 119.

²⁰⁷Hartman, *supra* note 9, at 1330 (citing Robert F. Weir and Charles Peters, *Affirming the Decisions Adolescents Make About Life and Death*, 27 HASTINGS CENTER REP. 29, 34 (1997)).

²⁰⁸Robert F. Weir and Charles Peters, *Affirming the Decisions Adolescents Make About Life and Death*, 27 HASTINGS CENTER REP. 29, 34 (1997).

²⁰⁹*Id.*

competent enough to make decisions regarding their own personal medical treatment. This need to be recognized should also be extended to include a right to initiate a DNR order if the minor is deemed significantly mature.

Combining the material discussed and referring back to the ethical scenario discussed in the introduction results in one question: what should be done? To recall, the scenario involved a seventeen-year-old, cystic fibrosis patient who wished to initiate a DNR order but her parents were refusing to consent on her behalf. Perhaps more information should be included, in order to make an informed decision. Assuming there was an attached medical definition of cystic fibrosis, which stated that cystic fibrosis is a disease with a poor prognosis.²¹⁰ The disease attacks the endocrine glands of infants, children, adolescents and young adults, resulting in pancreatic insufficiency, chronic pulmonary disease, and in some cases, cirrhosis of the liver.²¹¹ Knowing that this patient has suffered her entire life with this disease, and that she is aware of the medical treatment options available, all of which are extremely painful and none of which offer a guaranteed cure. Furthermore, the patient understands the risks involved in resuscitation and the pain that is involved. Should she now be permitted to initiate a DNR order? What if the patient is an honor student, involved in school leadership activities, and planned on attending college on a full academic scholarship? Would she be deemed sufficiently mature and then be permitted to initiate a DNR order on her own behalf?

Under the proposed exception to Ohio's current DNR law, all of these factors would be examined in order to determine, on a case-by-case basis, whether a minor is sufficiently mature to make his or her own decision regarding a DNR order. Looking at the original facts, it is apparent that more information would be needed to make an informed decision. However, unless the law in Ohio is amended to allow this young woman autonomy in making her decision, she may be forced to suffer for as long as she remains alive, or until her parents determine for her what is in her best interests.

ALLISON MANTZ

²¹⁰TABER'S CYCLOPEDIA MEDICAL DICTIONARY, *Cystic Fibrosis* (2003), available at www.tabers.com

²¹¹*Id.*