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## Exclusive or Concurrent Competence to Make Medical Decisions for Adolescents in the United States and United Kingdom

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EXCLUSIVE OR CONCURRENT COMPETENCE TO MAKE  
MEDICAL DECISIONS FOR ADOLESCENTS IN THE UNITED  
STATES AND UNITED KINGDOM

ROBERT L. STENGER<sup>1</sup>

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I. COMPETENCY TO MAKE MEDICAL DECISIONS

Making decisions about receiving or refusing medical diagnosis and treatment continues to challenge health care providers, legislators, lawyers and judges, ethicists, patients, and families. For the past half century the focus has been on informed consent as a necessary condition for diagnosis and treatment.<sup>2</sup> The Supreme Court of the United States has recognized “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. . . .”<sup>3</sup> The assertion that a competent person has a “constitutional right” to accept or refuse medical treatment requires an analysis of how competence is defined and who determines whether someone is competent. Competency determinations are particularly difficult for “minors, who are sufficiently mature that it is implausible to exclude them from the decision-making process altogether, but whose competence to make certain important decisions is questionable.”<sup>4</sup>

It is helpful to avoid assuming a dichotomy between the globally competent (who can always make any decision) and the non-competent (who can make none). There are times when a court is called upon to determine global competence; it does so in

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<sup>2</sup>Cf. Beauchamp and Childress, *PRINCIPLES OF BIOMEDICAL ETHICS*, 142 (4th ed., New York, 1994). “Since the Nuremberg trials, which presented horrifying accounts of medical experimentation in concentration camps, the issue of consent has been at the forefront of biomedical ethics.” The beginning of the Nuremberg Code provides: “1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have the legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.” Annas and Grodin, eds., *THE NAZI DOCTORS AND THE NUREMBERG CODE*, 1992, at 2.

<sup>3</sup>*Cruzan v. Director, Missouri Department of Health*, 110 S. Ct. 2841, 2851 (1990).

<sup>4</sup>Buchanan & Brock, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING*, 215 (1989).

actions for guardianship of the person.<sup>5</sup> Precisely because such proceedings can legally result in the loss of significant personal rights and freedoms, such decisions are predicated upon heightened protections for the individual, including psychological examinations by experts, interdisciplinary recommendations, hearings with heightened burdens of proof, and the appointment of counsel.<sup>6</sup> Ordinarily competence is understood as decision-making capacity which is decision-relative, not global. "A competence determination, then, is a determination of a particular person's capacity to perform a particular decision-making task at a particular time and under specified conditions."<sup>7</sup>

Because the law requires informed consent before any medical diagnosis or treatment, there must be some initial determination that the person providing consent is capable of doing so, i.e. is competent.<sup>8</sup> Similarly, ethical norms and standards of professional conduct require that health professionals receive consent from patients before treatment. A health care provider who acts without adequate informed consent, except in narrowly defined emergency situations, runs the risk of criminal prosecution, civil liability and/or professional discipline.

One who is determining competence should be aware that the law presumes global competence for all adults.<sup>9</sup> Those who have not reached the age of majority or adulthood, which at common law was twenty one and now generally is eighteen, were called "infants", later "children" or "minors."<sup>10</sup> It should be obvious that arrival at some defined age of majority, the birthday when a child who lacked almost all legal powers and liberties immediately possesses all of them, is inconsistent with our experience and understanding of the processes of education and maturation. On the other hand, the efficient functioning of society requires some general line of

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<sup>5</sup>*Id.* at 22.

<sup>6</sup>"Procedural due process must be provided when: (a) there is a deprivation of life, liberty or property; and (b) potential factual issues exist concerning a particular individual or group." ERWIN CHEREMINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES, 449 (1997).

<sup>7</sup>Buchanan & Brock, *supra* note 4, at 18.

<sup>8</sup>Before the turn of the century, this Court observed 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." *Union Pacific R.Co. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891). This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, provided the classical statement of this doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914); *Cruzan*, 110 S. Ct. 2841 at 2847. Thus, the requirement of informed consent rests both upon the constitutional doctrine of protected liberty interests and the common law tort doctrine of battery (nonconsensual touching). *Id.*

<sup>9</sup>Buchanan & Broch, *supra* note 4, at 21.

<sup>10</sup>Homer Clark, Jr., *THE LAW OF DOMESTIC RELATIONS IN THE UNITED STATES*, 309 (2d ed., 1988).

demarcation when those in the process of growing up are legally recognized as adults who both demand and are given responsibility for their own actions and decisions.

Medical decision-making is one area where drawing and applying a single defining line between childhood and adulthood has proven difficult. Each society determines how it will allocate decision-making authority with respect to children. This article will address how such allocations have been developed in the United States and the United Kingdom. An analysis of the capacity of an adolescent to make decisions remains incomplete without some consideration of the role of parent(s) and of the government. It is precisely here that recent developments in the United Kingdom may provide helpful guidance in the United States.

## II. MEDICAL DECISIONS FOR MINORS IN THE UNITED STATES

The general state of the law with respect to medical decisions by minors is not complicated in theory:

As a general rule, informed parental consent is both a necessary and sufficient condition for the medical treatment of minors. Some standard common law and statutory limitations and exceptions to the general parental consent requirement . . . relate to mandatory immunization and screening procedures (applicable to all children), the neglect limitation (where a court may override a parental decision for an individual child), the emergency treatment of children (where no parental consent is required if the parent is unavailable), and various exceptions that allow minors themselves to consent to treatment.<sup>11</sup>

Some general limitations and exceptions apply both to adults and to children: public health considerations could provide a sufficiently important or even compelling governmental interest to justify mandatory quarantines or immunizations and individuals who cannot provide informed consent can be treated if their caregivers fail to provide necessary medical treatment and life or health are at serious risk. Underlying these exceptional situations is the presumption that a reasonable person who understood the situation would consent to treatment. Application of the rules to specific cases will involve determinations which may be challenged: Was the situation really an emergency? Was the treatment provided really necessary? Was the patient really the subject of medical neglect?

More difficult questions arise concerning the exceptions which allow minors themselves to consent. A minor may be emancipated from parental care and control because of status, such as marriage or military service; some jurisdictions additionally provide a statutory emancipation procedure available to minors who are self-supporting and living independently of parents.<sup>12</sup> Those who deal with

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<sup>11</sup>Robert H. Mnookin & D. Kelly Weisberg, *CHILD, FAMILY AND STATE*, 533 (3d ed., 1995).

<sup>12</sup>Cf. 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, 20-21 (1996); Nancy Batterman, *Under Age: A Minor's Right to Consent to Health Care* 10 *TOURO L. REV.* 637, 645-650 (1994); Walter Waddlington, *Medical Decision Making For and By Children: Tensions Between Parent, State and Child* *U. ILL. L. REV.* 311, 323-324 (1994). Even when a minor appears to have achieved a status which includes emancipation, questions remain

emancipated minors may continue to have concerns, e.g. are contracts emancipated minors sign enforceable against them? Who is responsible for payments? In jurisdictions and within cultural traditions with no or rather low ages for marrying, health care providers may question consents to treatment and wonder whether the consent will hold up if challenged.

In addition to emancipation by status or age, statutes in each state provide a variety of age-specific powers and disabilities: e.g. no persons under 21 may enter licensed premises to purchase alcoholic beverages although those who are at least 18 may stock malt beverages;<sup>13</sup> minors under 14 shall not work at gainful occupations, but minors at age 11 may work as caddies at golf courses;<sup>14</sup> consent to adoption is required of minors who are 12 and over,<sup>15</sup> while minors 14 and older may nominate their own guardians;<sup>16</sup> with respect to crimes involving sexual actions, a person under 16 is deemed incapable of consent (statutory rape).<sup>17</sup> Such age-specific statutes stand in marked contrast with statutes which have generally been adopted for specified medical decisions:

(1) Any physician upon consultation by a minor as a patient with the consent of such minor may make a diagnostic examination for venereal disease, pregnancy, alcohol or other drug abuse or addiction and may advise, prescribe for and treat such minor regarding venereal disease, alcohol or other drug abuse or addiction, contraception, pregnancy or childbirth, all without the consent or notification to the parent. . . . Treatment under this section does not include inducing of an abortion or performance of a sterilizing operation.

(2) Any physician may provide outpatient mental health counseling to any child age 16 or older upon consent of such child without the consent of a parent. . . .

(3) (A)ny emancipated minor or any minor who has contracted a lawful marriage or borne a child may give consent to the furnishing of hospital, medical, dental or surgical care to his or her child or himself or herself and such consent shall not be subject to disaffirmance because of minority.<sup>18</sup>

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whether the minor is emancipated for all purposes and whether emancipation ceases when the marriage or military service ends.

<sup>13</sup>KY. REV. STAT. ANN. §§ 244.085, 244.087 (Michie 1984).

<sup>14</sup>KY. REV. STAT. ANN. §§ 339.220, 339.225 (Michie 1984).

<sup>15</sup>KY. REV. STAT. ANN. § 199.500(3) (Michie 1984).

<sup>16</sup>KY. REV. STAT. ANN. § 387.050 (Michie 1984).

<sup>17</sup>KY. REV. STAT. ANN. § 510.020(3)(a) (Michie 1984).

<sup>18</sup>The Kentucky statute follows in many ways the Model Statute: Juvenile Justice Standards—Standards Relating to Rights of Minors, of the Institute of Judicial Administration and the American Bar Association. Exceptions to parental consent include treatment of chemical dependency, venereal disease, contraception and pregnancy. *Id.* § 4-2.B. The mature minor doctrine is also recognized: “A minor of [16] or older who has sufficient

Such statutes are justified both by public health concerns (diagnosis and treatment should be encouraged and readily available for people with sexually transmitted diseases or substance abuse and for preventing teenage pregnancies and minors would be deterred from seeking medical attention if their parents were to be informed) and risk-benefit analysis (the patient does not face serious risks and choice of treatment does not involve complex alternatives). At the same time, however, such statutory emancipation for medical decisions is inconsistent with the requirement of voluntary informed consent. It creates a statutory reversal of the usual presumption that a minor is incompetent to make legally binding decisions. Policy justifications for the statute are unrelated to the elements of informed decision-making. For example, an unmarried mother of any age would be empowered to make medical decisions concerning her child, including the complex decisions facing parents of at-risk neonates.

The statute does include protection for the provider of health care who relies in good faith on the minor's assertion of age. Two deterrents may affect the minor's receiving care: the provider may inform the parent or legal guardian if this is judged beneficial to the minor and parents who do not consent are not financially liable for the treatment provided.<sup>19</sup> Thus, the minor has the burden of showing why informing parents would not be beneficial and of providing some source of payment.

Alongside statutory exceptions to parental consent requirements, a common law doctrine of mature minors has been created by the courts. Its origins and rationale are discussed at length in *Cardwell v. Bechtol*.<sup>20</sup> The Court noted that "recognition that minors achieve varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century."<sup>21</sup> At common law recognition of the gradually increasing capacity of minors was called the Rule of Sevens: under the age of seven, a presumption of no capacity; from seven until fourteen a rebuttable presumption of no capacity; and from fourteen to twenty-one a rebuttable presumption of capacity.<sup>22</sup> The Court drew the definition of capacity from the Restatement: "If the person consenting is a child . . . the consent may still be effective if he is capable of appreciating the nature, extent and probable consequences of the conduct consented to."<sup>23</sup>

The mature minor rule is not a general presumption based upon an event such as arriving at a particular birthday or marrying or parenting a child. Rather, the conclusion that an adolescent is a mature minor depends upon the minor's ability "to

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capacity to understand the nature and consequences of a proposed medical treatment for his or her benefit may consent to that treatment on the same terms and conditions as an adult." *Id.* § 4.6.A.). However, a minor "of any age" may consent to medical services, treatment or therapy relating to alcohol or drug abuse and to medical services, therapy or counseling for treatment of venereal disease, family planning, contraception, birth control (other than sterilization), and pregnancy, including abortion. *Id.* §§ 4.7.A., 4.8.A. MNOOKIN & WEISBERG, *supra* note 11, at 542-45.

<sup>19</sup>KY. REV. STAT. ANN. § 214.185(5),(3),(7).

<sup>20</sup>*Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987).

<sup>21</sup>*Id.* at 744-745.

<sup>22</sup>*Id.* at 745.

<sup>23</sup>*Id.* at 746. Citing, RESTATEMENT (SECOND) OF TORTS § 892A cmt. B (1979).

appreciate his own conduct and the consequences of the conduct of others.”<sup>24</sup> Here the plaintiff was seventeen years and seven months, a senior in high school planning to attend college, recognized as someone who acted older than her age, who visited a licensed osteopath for back pain and, when the treatment did not succeed, sued with her parents for battery (nonconsensual touching). The Court found that she was a mature minor whose consent, manifested by visiting the osteopath, was sufficient.<sup>25</sup>

In support of its decision, the Tennessee Court cited *Younts v. St. Francis Hospital and School of Nursing, Inc.*, where Kansas had recognized a mature minor exception applied to a seventeen year old, intelligent and capable for her age with respect to treatment of an injured finger.<sup>26</sup> *Cardwell* was followed by Illinois in the case of a 17-year old woman with leukemia who, along with her mother, refused consent to a blood transfusion because of her religious beliefs.<sup>27</sup> The Illinois Court, while concluding that “a mature minor may exercise a common law right to consent to or refuse medical care,” added several procedural restrictions. First, it determined that the presence of a judge was appropriate both because the state’s public policy which values the sanctity of life is a critical consideration when a minor’s health and life are at stake and because the state’s *parens patriae* role is specially involved when there is a life-threatening situation. Second, the judge “must weigh these two principles against the evidence he receives of a minor’s maturity” [and] “[if] the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions and that the minor is mature enough to exercise the judgment of an adult,” then, third, the judge must balance the mature minor’s right to consent or refuse consent “against four State interests: (1) the preservation of life; (2) protecting the interests of third parties; (3) prevention of suicide; and 4) maintaining the ethical integrity of the medical profession”<sup>28</sup> Here the most significant state interest was protection of the interests of parents, guardians, siblings and adult

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<sup>24</sup>*Id.* at 747.

<sup>25</sup>*Id.* at 741, 743.

<sup>26</sup>469 P.2d 330, 338 (Kan. 1970). The Tennessee Court also cited a *per curiam* Ohio decision in which the mature minor exception was discussed only in a concurring opinion. *Lacy v. Laird*, 139 N.E.2d 25, 34 (Ohio 1956).

<sup>27</sup>*In re E.G.*, 549 N.E.2d 322 (Ill. 1989). When the patient and her mother refused to consent to a blood transfusion, attending physicians who considered the transfusion to be necessary contacted the office of the State’s Attorney, which sought a finding that the patient was medically neglected and the appointment of a temporary guardian who would consent to the transfusion. The court, even though it found the patient to be a mature minor who had arrived at her decision independently, yet found her to be medically neglected; a guardian was appointed and transfusions were received. The Court of Appeals in a split decision reversed the guardianship for the minor who was seventeen and a half, mature, and able to refuse transfusions independently. *In the Interest of E.G.*, 515 N.E.2d 286 (Ill. App. 1 Dist., 1987). The rule is called the Illinois Rule: a child under 7 is conclusively presumed to be incapable of contributory negligence as a matter of law; children 7 to 14 are presumed to be incapable of negligence, however, this presumption is rebuttable, and children over the age of 14 are presumptively capable of negligence and the burden shifts to the minor to prove lack of capacity. Donald J. Gee & Charlotte Peoples Hodges, *The Liability of Children*, TRIAL, May, 1999, 52 (citing *Chicago City Railway Co. v. Tuohy*, 63 N.E. 997 (Ill., 1902).

<sup>28</sup>*In re E.G.*, 549 N.E.2d at 327-328.

relatives and the Court suggested that the minor's decision in this case would be upheld because her mother agreed with her; had the mother opposed her daughter's decision, "this opposition would weigh heavily against the minor's right to refuse."<sup>29</sup>

Maine utilized similar reasoning in recognizing the wishes of a seventeen and a half year old normally mature high school senior not to be maintained with artificial nutrition and hydration after he suffered permanent and totally disabling head injuries in an automobile accident and was in a persistent vegetative state.<sup>30</sup> The court had found "by clear and convincing evidence that Chad made a pre-accident decision with regard to his medical treatment," his parents who had been appointed co-guardians concurred in that decision, and the only opposition came from the District Attorney.<sup>31</sup>

On the other hand, Texas refused to allow a sixteen year old male Jehovah's Witness, whose parents joined his request, to refuse a blood transfusion which surgeons determined to be necessary in their attempt to save an arm severely injured when the young man was struck by a train.<sup>32</sup> So also, New York refused to accept a fifteen year old young man's refusal of diagnostic surgery after a tumor was discovered; his mother wanted the surgery but the young man had a "strong phobia for needles."<sup>33</sup> In a much more debatable decision, a New York court refused to accept the refusal of a blood transfusion by a male Jehovah's Witness who was just seven weeks short of his eighteenth birthday and whose parents agreed with his decision.<sup>34</sup> There was evidence from medical experts that without treatment, he would die within a month, during which he would suffer great pain, while the recommended treatment, including blood transfusion, offered a seventy-five percent possibility of remission for months or years and a twenty-five to thirty percent possibility of cure. The court noted that the family had joined the Jehovah's Witnesses only in 1987, Philip had returned to religious study only the previous year, Philip testified that if he consented to a transfusion he would not have everlasting life but if the court ordered a transfusion, he would have no sin, and although he was a senior in high school, he had never been away from home or dated a girl, and when asked if he considered himself an adult or a child, he replied "child."<sup>35</sup>

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<sup>29</sup>*Id.* at 328.

<sup>30</sup>*In re Chad Eric Swan*, 569 A.2d 1202 (Me. 1990).

<sup>31</sup>*Id.* at 1206.

<sup>32</sup>*O.G. v. Baum*, 790 S.W.2d 839 (Tex. App. 1990). The court noted that Texas had never adopted the mature minor doctrine and that the only evidence that the patient understood that denying a transfusion would be fatal came from the testimony of his father. *Id.*, at 842.

<sup>33</sup>*In the Matter of Thomas B.*, 574 N.Y.S.2d 659 (N.Y. Fam. Ct. 1991).

<sup>34</sup>*In the Matter of the Application of Long Island Jewish Medical Center*, 557 N.Y.S.2d 239 (N.Y. Sup. Ct. 1990).

<sup>35</sup>*Id.* at 242. A factually similar case arose in West Virginia in *Belcher v. Charleston Area Medical Center*, 422 S.E.2d 827 (W. Va. 1992). In *Belcher* the patient who was seventeen years and eight months and had muscular dystrophy died when he was not resuscitated after suffering a second respiratory arrest. *Id.* The physician who signed the DNR [Do Not Resuscitate] testified that the parents had consented to the DNR order and that the patient could not consent because his disease made him emotionally immature, medication lessened his capacity, involving him would have increased his anxiety and lessened his chances of



The common law doctrine that a mature minor can consent to medical treatment has in some places received qualified acceptance. Some jurisdictions in adopting the rule also require heightened scrutiny in the determination of maturity when the minor is refusing treatment which would preserve life and/or when the parent(s) or guardian do not agree with the minor's refusal.<sup>36</sup>

The Supreme Court of the United States has repeatedly discussed the mature minor doctrine with respect to the specific issue of a minor's decision to terminate a pregnancy. Three years after the Court's decision in *Roe v. Wade*<sup>37</sup> that the state could not always prevent a pregnant woman from choosing to terminate her pregnancy, the Court was faced with challenges to a statute which required, *inter alia*, that during the first twelve weeks of pregnancy an unmarried woman under eighteen required the written consent of a parent before a physician could perform an abortion (except for emergencies when abortion may be necessary to save the mother's life).<sup>38</sup> While supporters of the statute argued that Missouri provided a number of limitations upon minors (e.g. sales of firearms, cigarettes, alcohol and certain types of literature to minors, appointment of guardians ad litem, and parental consent for medical treatment), opponents pointed out that minors could consent to medical services for pregnancy and venereal disease and a minor married with parental permission could consent to abortion. Justice Blackmun for the plurality held that "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of a physician and his patient

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survival, and the parents said they didn't want their son involved. *Id.*, at 830. After the trial court returned a verdict in favor of the hospital and the doctor, the Supreme Court reversed the verdict with respect to the doctor and remanded for a determination of the patient's maturity after the Court had adopted the mature minor exception to the medical consent law. The Court held:

A physician has no legal right to perform a procedure upon, or administer or withhold treatment from a . . . child without the consent of the child's parents or guardian, unless the child is a mature minor, in which case the child's consent would be required. Whether a child is a mature minor is a question of fact. Whether the child has the capacity to consent depends upon the age, ability, experience, education, training and degree of maturity or judgment obtained by the child, as well as upon the conduct and demeanor of the child at the time of the procedure or treatment. The factual determination would also involve whether the minor has the capacity to appreciate the nature, risks and consequences of the medical procedure to be performed, or the treatment to be administered or withheld. Where there is a conflict between the intentions of one or both parents and the minor, the physician's good faith assessment of the minor's maturity level would immunize him or her from liability for the failure to obtain parental consent. *Id.*, at 838.

<sup>36</sup>549 N.E.2d 322, 327-328 (Ill. 1989). *Cf. In re E.G.*, "If the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent." 574 N.Y.S.2d at 661. In the Matter of Thomas B., "The Court further finds that the mother and the Department of Social Services have amply met their burden of demonstrating that 'time is of the essence' with respect to medical treatment for the respondent and that the protests of the respondent must be judicially overruled."

<sup>37</sup>410 U.S. 113 (1973).

<sup>38</sup>*Planned Parenthood of Central Missouri v. Danforth*, 420 U. S. 52 (1976).

to terminate the patient's pregnancy."<sup>39</sup> While recognizing the State's interest in safeguarding the family unit and upholding parental authority, he noted that the family was already fractured by the pregnancy and the minor's decision not to inform her parents, and he concluded that "any independent interest [of] the parent" is "no more weighty than the right of privacy of the competent minor mature enough to become pregnant."<sup>40</sup>

Three years later the Court developed the judicial bypass procedure: if the State chooses to require parental consent for an unmarried minor's abortion, it must also provide an alternative procedure in which the minor can receive authorization for an abortion if she can show "(1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents wishes or (2) that even if she is not able to make this decision independently, the desired abortion is in her best interests."<sup>41</sup> Justice Powell for the plurality, while recognizing the legitimacy of the State's concern for the vulnerability of minors and its power to limit minors' ability to make important decisions with potentially serious consequences and its recognition of the guiding role of parents, also noted the potentially severe problems which pregnancy posed for a pregnant minor: "considering her probable education, employment skills, financial resources, and emotional maturity, unwanted motherhood may be exceptionally burdensome for a minor."<sup>42</sup> The decision did not develop the description of the mature minor beyond the almost tautological mature enough and well enough informed to make her abortion decision.

Two cases which came before the Court in 1983 provided an opportunity for further exploration of the notion of a mature minor. In *Planned Parenthood Association of Kansas City v. Ashcroft*, the Court upheld a Missouri statute which forbade abortions upon pregnant women under age eighteen without the consent of the woman and one parent or the consent of an emancipated minor or a minor who was found by a court to possess the power to self-consent or a court which found that abortion was in her best interests.<sup>43</sup> There was no discussion of the factors which the statute outlined for the determination of maturity: her age, that she was fully informed of the risks and consequences of abortion, that she is of sound mind and has sufficient intellectual capacity to consent to abortion, and that the court

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<sup>39</sup>*Id.* at 74.

<sup>40</sup>*Id.* at 75. The Court would soon abandon the connection between becoming pregnant and maturity. Justice Stevens in dissent challenged the plurality's assumption that capacity to conceive a child and judgment of a physician are the only constitutionally permissible determinants for whether she can make the abortion decision and thought that states should be able to choose other criteria, such as chronological age. *Id.*, at 104-105. Justice Stewart, with whom Justice Powell concurred, proposed that the absolute limitation on the minor could be avoided if there were a provision for prompt judicial determination that the minor is mature enough to consent to the abortion or that abortion is in her best interests. *Id.*, at 90.

<sup>41</sup>*Bellotti v. Baird*, 443 U.S. 622 (1979).

<sup>42</sup>*Id.* at 642.

<sup>43</sup>462 U.S. 476 (1983), citing MO. REV. STAT. § 188.028. (1982)

determining maturity hear evidence relating to her emotional development, maturity, intellect and understanding.<sup>44</sup>

In *City of Akron v. Akron Center for Reproductive Health* the challenged city ordinance provided that physicians shall not perform abortions upon unmarried women under age eighteen without first having given at least twentyfour hours actual notice to one of her parents or upon minors under age fifteen without written consent of the minor and one parent or a court order.<sup>45</sup> The majority struck down the consent provision because there was no alternative whereby the minor could demonstrate that she was mature enough to make the abortion decision herself. "Akron may not make a blanket determination that all minors under the age of fifteen are too immature to make this decision."<sup>46</sup> Thus, the mature minor doctrine in the context of abortion would apply even to one less than fifteen who could convince the judge of her maturity.

Related to the issue of parental consent to abortion of an unmarried minor is that of notice to parents. Chief Justice Burger upheld a Utah statute requiring notice, if possible, to the parents where the petitioner was an unmarried fifteen year old who lived with her parents and was dependent upon them for support and who made no claim that she was mature.<sup>47</sup> With respect to maturity, he stated that "there is no logical relationship between the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion."<sup>48</sup> Justice Marshall in commenting upon the Utah court's claim that parents after notice could provide the physician with significant medical information about the minor stated "it seems doubtful that a minor mature enough to become pregnant and to seek medical advice on her own initiative would be unable or unwilling to provide her physician with information crucial to the abortion decision."<sup>49</sup>

The constitutionality of notice provisions with judicial bypass was upheld in two cases in 1990. In *Ohio v. Akron Center for Reproductive Health* the Court upheld an Ohio statute requiring that a physician before performing an abortion on an unmarried and unemancipated woman under eighteen provide actual notice to one parent or that the minor satisfy a court by clear and convincing evidence that she has the maturity and information to make an intelligent decision or that one parent has engaged in a pattern of physical, sexual or emotional abuse against her.<sup>50</sup> The majority found that the statute was constitutional for it followed the criteria for judicial bypass established in the parental consent statutes; the three dissenters thought that the bypass procedures were complex and burdensome to the minor and unsubstantiated by legitimate state interests.

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<sup>44</sup>*Id.*; MO. REV. STAT. § 188.028 2(1),(3).

<sup>45</sup>462 U.S. 416 (1983); *See* Akron Ordinance No. 160-1978 (Akron Codified Ordinances, ch. 1870.05 (A) notice and (B) consent.)

<sup>46</sup>*Id.* at 440.

<sup>47</sup>*H.L. v. Matheson*, 101 S. Ct. 1164 (1981); UTAH CODE ANN. § 76-7-304 (1974).

<sup>48</sup>*Id.* at 1170.

<sup>49</sup>*Id.* at 1189, Marshall, dissent.

<sup>50</sup>497 U.S. 502 (1990); *See* OHIO REV. CODE ANN. § 2919.12(B).

In an opinion delivered on the same day, a sharply divided Court struck down a Minnesota requirement that both parents be notified of the abortion of an unemancipated minor (with no exception for a divorced parent, a noncustodial parent, or a father never married to the minor's mother) but allowed the two-parent notice requirement if accompanied by a judicial bypass provision.<sup>51</sup> The analysis of legitimate state interests ranged from a recognition that there was no legitimate interest in notifying both parents (for in ideal families one parent would notify the other while in dysfunctional families two-parent notice requirements could be harmful to the minor) to a recognition of the importance of the involvement of both parents in the care and nurture of children to promote their best interests.<sup>52</sup> In its most recent decision, the Court in a *per curiam* opinion clarified a misunderstanding by holding that a determination that parental notification was not in an unemancipated minor's best interests was equivalent to a determination that abortion without parental notification was in her best interests.<sup>53</sup>

While upholding the validity of parental consent requirements for abortions on unmarried minors so long as there was a bypass procedure whereby the minor could establish that she was mature or that abortion was in her best interest, the Court did not define maturity. The suits, which were facial challenges to statutes, did not require discussion of the statute as applied. Justice Marshall noted that a challenged statute "gives no guidance on how a judge is to determine whether a minor is sufficiently 'mature' and 'capable' to make the decision on her own" or "whether an abortion without parental notification would serve an immature minor's 'best interests'."<sup>54</sup> He opined that only the judge's personal opposition to abortion would justify his requiring an immature minor to continue a pregnancy against her will.<sup>55</sup> The way in which judges faced the challenge of determining maturity and best interests is perhaps reflected in the statistics quoted by Justice Stevens: of 3,573 bypass petitions filed in Minnesota, 6 were withdrawn before decision, 9 were denied, and 3,558 were granted.<sup>56</sup>

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<sup>51</sup>Hodgson v. Minnesota, 497 U.S. 417 (1990); See MINN. STAT. § 144.343(2)-(7), 1988. No notice was required if the physician certified that the abortion was necessary to prevent the woman's death and there was no time to provide notice or if persons entitled to notice had consented or if the minor declared she was a victim of sexual or physical abuse or neglect and such had been reported to the appropriate authorities.

<sup>52</sup>The former position was articulated by Justice Stevens (joined by Justices Brennan, Marshall, Blackmun and O'Connor) while the latter was written by Justice Kennedy (joined by Chief Justice Rehnquist and Justices White and Scalia). Justice O'Connor was the swing vote; she agreed that the two-parent notice was often unworkable but found it acceptable if there was a judicial bypass provision whereby a minor could avoid notifying one or both parents.

<sup>53</sup>Lambert v. Wicklund, 520 U.S. 292 (1997).

<sup>54</sup>Marshall, concurring in part and dissenting in part, *Hodgson*, 497 U.S. 417, 474.

<sup>55</sup>*Id.* 474. He quoted Justice Stevens who had suggested that because the best interests standard offered so little guidance to the judge, "his decision must necessarily reflect personal and societal values and mores" which he would impose upon the minor. 443 U.S. 622 (1977).

<sup>56</sup>*Hodgson*, at 436.

State courts faced application of the bypass requirement to individual cases. In Massachusetts appellate courts determined that after a finding that a minor was mature, a judge could not condition her decision upon hearing from her parents and their counsel<sup>57</sup> or upon her having an abortion in a hospital because she was sixteen weeks pregnant.<sup>58</sup> Similarly, once the court determined that a pregnant fourteen year old was not sufficiently mature to make a decision but that abortion would be in her best interests (by objective criteria: her lack of significant life experiences, her lack of understanding of the responsibilities of motherhood, the likelihood that the pregnancy might be further along than she thought), it could not then require her to consult at least one parent (because she had a loving and supporting family).<sup>59</sup>

In Florida a petition for waiver of parental consent was deemed granted because the appellate court did not render a final decision within the required 48 hours, even though the trial court had found that a sixteen year old high school junior was not sufficiently mature (for she had only talked to a girlfriend and a counselor whom she could not name and who had not discussed with her the medical risks of abortion and alternatives to abortion).<sup>60</sup>

A Tennessee court found that there was valid consent by a minor one month short of her sixteenth birthday (who during an abortion suffered a perforated uterus) for the state follows the Rule of Sevens which provides that there is a rebuttable presumption of capacity in minors between fourteen and twenty-one and the minor and her mother failed to rebut that presumption.<sup>61</sup>

Courts in Alabama have devoted the most effort to defining the maturity necessary for waiver of parental consent. In the first case under Alabama's waiver statute, a judge turned down the petition of a minor who was within a month of her eighteenth birthday, lived by herself and held down a full-time job, had considered the alternatives of keeping the baby versus adoption, but chose not to talk to her mother, with whom she was on good terms, because her stepfather had a history of abusive tendencies; the Court of Appeals found the denial to be a misapplication of the law to undisputed facts.<sup>62</sup> At the other end of the age spectrum, the trial and appellate courts found that a minor less than thirteen who was fourteen to sixteen weeks pregnant was not sufficiently mature nor well enough informed to make a decision.<sup>63</sup>

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<sup>57</sup>In the Matter of Moe, 498 N.E.2d 1358 (Mass. App. Ct. 1986).

<sup>58</sup>In the Matter of Mary Moe, 517 N.E.2d 170 (Mass. App. Ct. 1987).

<sup>59</sup>In the Matter of Mary Moe, 423 N.E.2d 1038 (Mass. App. Ct. 1981).

<sup>60</sup>*In re J.V.*, 548 So.2d 749, (Fla. App. Ct. 1989).

<sup>61</sup>*Roddy v. Volunteer Medical Clinic, Inc.*, 926 S.W.2d 572, (Tenn. App. Ct. 1996). The Court of Appeals noted that Tennessee had adopted the Rule of Sevens in the landmark case of *Cardwell v. Bechtol*, *supra*, note 13.

<sup>62</sup>In the Matter of Anonymous, 515 So.2d 1254, 1255 (Ala. Civ. App., 1987).

<sup>63</sup>In the Matter of Anonymous, 531 So.2d 895 Ala. Civ. App., 1988); *Ex parte Anonymous*, 531 So.2d 901 (Ala. 1988). This case exemplifies the difficulties which can arise during judicial determinations of petitions for waivers of parental consent. The minor was not yet thirteen and was in the legal and physical custody of the Alabama Department of Human Resources, which could not legally consent to an abortion because restrictions on federal Medicaid funding prohibited governmental funding of abortion. *Id.* at 905. Because there was

Trial courts began to add to the minor's burden of proving maturity the necessity of proving that waiver of parental consent was in her best interests. In the case of a seventeen year old who lived at home, had good grades and had sought counsel of married sisters about abortion, the judge thought her fears that her parents might disown her and cast her out were speculative and she should talk to them.<sup>64</sup> The Supreme Court held that the minor showed understanding and sophistication for she consulted not only her family and the presumed father but also pro-life organizations about alternatives to abortion.<sup>65</sup> The Court concluded: "[h]er voluntary decision to resort to the judicial procedure, specifically requesting the advice of legal counsel, may, of itself, indicate maturity."<sup>66</sup> Thereafter, when a trial judge found that a sixteen year old with good grades who intended to go to college, discussed the risks of abortion procedures, and feared violence from her father if she told him or her mother, had not presented sufficient evidence of her father's potential violence,<sup>67</sup> the Court of Appeals reversed, for after finding that the minor was mature, she could make the decision.<sup>68</sup>

The appellate courts reversed denials of waivers to sixteen or seventeen year old petitioners who had sought advice from counselors or agency personnel.<sup>69</sup> It also

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no one who could legally consent to the minor's abortion, the Court of Appeals found the Alabama judicial bypass unconstitutional. *Id.*, at 907. By the time the Supreme Court heard the minor's appeal from a denial of the waiver, which the minor had applied for on May 16th, it was June 21st; the minor was then 17-19 weeks pregnant and the Supreme Court held that an abortion was in her best interest while three dissenters argued that there was not yet sufficient medical testimony and the case should proceed on remand. *Id.* at 906-907.

<sup>64</sup>In *Parte Anonymous*, 595 So. 2d 497, 498-499 (Ala. 1992).

<sup>65</sup>*Id.* at 499.

<sup>66</sup>*Id.*

<sup>67</sup>In *the Matter of Anonymous*, 618 So. 2d 717, 718 (Ala. Civ. App. 1993).

<sup>68</sup>On the same date as this opinion, however, a different panel upheld over a strong dissent (and with one judge concurring only in the result) denial of waiver to a sixteen year old eleventh grader who had sought advice from a clinic because she did not want to tell her parents because she was embarrassed; the Court of Appeals found adequate support for the judge's finding that discussion with her parents would be in her best interests. 618 So. 2d 718, 719 (Ala. Civ. App. 1993). The Supreme Court reversed by noting that a waiver of consent is not contingent upon the minor's proving what her parents' reaction to her abortion would be; the focus is upon the minor's maturity. *Ex Parte Anonymous*, 618 So. 2d 722, 724-725 (Ala. 1993). It is erroneous to place undue weight upon a minor's responsibility to consult a parent, or to require of a minor the same indicia of maturity as would be found in an adult, or to superimpose on the minor the judge's moral convictions about what she should do. *Id.*

<sup>69</sup>In *the Matter of Anonymous*, 628 So. 2d 854 (Ala. Civ. App. 1993); In *the Matter of Anonymous*, 650 So. 2d 923 (Ala. Civ. App., 1994); In *the Matter of Anonymous*, 655 So. 2d 1052 (Ala. Civ. App. 1995); In *the Matter of Anonymous*, 660 So. 2d 1022 (Ala. Civ. App. 1995); *Ex Parte Anonymous*, 664 So. 2d 882 (Ala. Civ. App. 1995); In *the Matter of Anonymous*, 684 So. 2d 1337 (1996) (where the Appeals Court criticized the judge's finding "[t]hat petitioner's action in becoming pregnant in light of sex education in the schools and the extreme amount of publicity about teen pregnancy is indicative that she has not acted in a mature and well informed manner"). The only exception was *In re Anonymous*, 650 So. 2d 919, 921 (Ala. Civ. App. 1994); where a divided Court of Appeals affirmed denying a waiver to a minor who was just one month beyond her sixteenth birthday and did not present evidence

reversed denial to a fourteen year old petitioner who had consulted a physician, was well informed, and whose mother was willing to take her for an abortion but would not consent because of religious beliefs.<sup>70</sup> The differing viewpoints of judges appear dramatically in a recent case in which a trial judge denied waiver of parental consent to a petitioner who was almost eighteen.<sup>71</sup> Petitioner was a high school senior receiving B's and C's who planned to attend college to study nursing, had dated the alleged father (an older man) for over six months, had visited three clinics (including one out-of-state) and an attorney to discuss procedures, and did not wish to talk to her mother who had become "very emotional" over her sixteen year-old sister's pregnancy.<sup>72</sup> The Appeals Court found "that the trial court misapplied the law to the facts of this case," where "[t]he evidence overwhelmingly supports the issuance of the waiver of parental consent."<sup>73</sup>

Judges in Nebraska, whose law requires proof by clear and convincing evidence that the minor is mature and capable of providing informed consent, concluded that a pregnant minor of thirteen did not have appreciation and understanding of the relative gravity and possible detrimental impact of each available option as well as realistic perception and assessment of possible short term and long term consequences of each of those options," nor the ability to "weigh alternatives independently and realistically."<sup>74</sup> Similarly, a minor of fifteen who had "some appreciation and understanding" yet failed to show that she "was fully informed or fully considered the relative gravity and possible detrimental impact of the abortion option."<sup>75</sup> It is unclear whether an older minor would have met the standards.

The Supreme Court of Texas has recently struggled with petitions to bypass parental notification statutes by one adolescent who was sixteen and three who were seventeen.<sup>76</sup> In each case the trial court had denied the petition, the court of appeals had affirmed, and the Texas Supreme Court reversed and remanded. The Texas Supreme Court in the first case articulated the burden to be met by petitioner. She had to prove by preponderance of the evidence that she was mature, which would require her to make three showings:

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that she had consulted any adult except her eighteen year old boyfriend. The dissenting judge found that she understood abortion and its risks and consequences even though she had not consulted adults. *Id.* at 922.

<sup>70</sup>In the Matter of Anonymous, 678 So. 2d 783, 784 (Ala. Civ. App. 1996).

<sup>71</sup>In the Matter of Anonymous, 718 So.2d 64 (Ala. Civ. App. 1998).

<sup>72</sup>*Id.* at 64-65.

<sup>73</sup>*Id.* at 64.

<sup>74</sup>In re Petition of Anonymous 1, 558 N.W.2d 784, 787 (Neb. 1997). The Court *cited* HB v Wilkinson, 639 F. Supp. 952 (D. Utah 1986), for the proposition that minors lack experience, perspective and judgment when they are "wholly dependent and have never lived away from home or had any significant employment experience." *Id.* at 954.

<sup>75</sup>In re Petition of Anonymous 2, 570 N.W.2d 836, 838-839 (Neb. 1997).

<sup>76</sup>In re Jane Doe, 19 S.W.3d 249 (Tex. 2000); In re Jane Doe 2, 19 S.W.3d 278 (Tex. 2000); In re Jane Doe 1, 19 S.W.3d 300 (Tex. 2000); In re Jane Doe 3, 19 S.W.3d 300 (Tex. 2000); In re Jane Doe 4, 19 S.W.3d 322 (Tex. 2000); In re Jane Doe 4, 19 S.W.3d 337 (Tex. 2000); and In re Doe, 19 S.W.3d 346 (Tex. 2000).

(1) “that she has obtained information from a health-care provider about the health risks associated with an abortion” and that she understands those risks (at her particular stage of pregnancy); (2) “that she understands the alternatives to abortion and their implications . . . and “has given thoughtful consideration to her alternatives”; and (3) “that she is aware of the emotional and psychological aspects of undergoing an abortion, which can be significant for . . . some women” and “that she has considered how this decision might affect her family relations.”<sup>77</sup>

While she need not seek information from professional counselors, she must show she used reliable and informed sources.<sup>78</sup> To show that she was sufficiently well informed, the minor had to show that she not only had information, but understood and could deal responsibly with the nature and risks of the abortion procedure, the alternatives to abortion, and the physical, emotional and social consequences of abortion or bringing the pregnancy to term.<sup>79</sup>

When the criteria were applied, the Court ruled that only one of the minors could not receive an abortion without parental notification.<sup>80</sup> She had spoken to a doctor but could not explain to the judge why her medical condition would require a different type of abortion and how the risks would be different. Nor could she show that bypassing parental notification would be in her best interests, which involved consideration of (1) her emotional or physical needs, (2) the possibility of emotional or physical danger to her, (3) the stability of her home and whether notification would cause serious and lasting harm to the family structure, and (4) the relationship between the minor and her parents and the effect of notification on that relationship.<sup>81</sup> The minor was seventeen, a senior in high school who lived at home, and her sister had been kicked out of the house by her parents for becoming pregnant; while the minor feared the same fate, she also said she knew her parents loved her and would be there for her.<sup>82</sup>

The struggles of the justices to interpret properly the Parental Notification Statute, to carry out their limited appellate role in reviewing factual determinations by one who had questioned the minor, and to reconcile their own views of abortion for a pregnant minor without notification to parents are evident in the twenty-four opinions covering one hundred forty five pages in the seven cases. There is a lack of congruity between the general and abstract character of the definitions and factors to be considered and their application to the minor’s actual situation.

Three states have recently considered the constitutionality of judicial bypass statutes under their state constitutions and state rights of privacy. Florida’s adding a right of privacy “for every person” to its constitution [“Every natural person has the right to be let alone and free from governmental intrusion into his private life.”] meant that the State had to provide a compelling (and not simply a significant) state

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<sup>77</sup>*In re Jane Doe*, 19 S.W.3d 249 at 256-257

<sup>78</sup>*Id.*

<sup>79</sup>*Id.* at 257.

<sup>80</sup>*In re Jane Doe 4*, 19 S.W.3d at 338.

<sup>81</sup>*In re Jane Doe 2*, 19 S.W.3d at 282.

<sup>82</sup>*In re Jane Doe 4*, 19 S.W.3d at 340.



interest to justify intrusion into a minor's decision about her own body. The state's interests in protecting immature minors and fostering family integrity were not compelling for the state allowed pregnant minors to make all medical decisions concerning themselves and their child except abortion, including the decision to terminate life-support for a neonate.<sup>83</sup>

California's explicit right of privacy in its Constitution requires that the State provide compelling reasons for infringing upon a minor's abortion decision; even though the California Supreme Court found that the State's interests in the minor's health and in fostering parent-child relationships are compelling, it also found that the judicial bypass statute did not further those interests but would likely be detrimental to maternal health and family relationships.<sup>84</sup>

Massachusetts, on the other hand, upheld a requirement that a minor receive consent of a parent or a court, but struck down a requirement that a minor obtain consent of both parents.<sup>85</sup> The Court found that the bypass provision was based upon the state's interest in assuring that a minor's decision was truly free and informed. Because a minor is different from an adult in maturity, judgment and experience, it was appropriate for the state to insure some adult presence in the minor's decision-making process. "The fact that virtually every minor who seeks judicial approval of her decision to have an abortion obtains that approval does not mean that judicial bypass of parental consent is unnecessary or irrational."<sup>86</sup> The minor's knowledge of the existence of the bypass procedure may induce her to consult her parents.

Courts in the United States have been recognizing the competence of minors who show the requisite maturity to make medical decisions. In practice, however, the minors whose consent has been upheld have generally been close in age to 18 and their parent(s) concurred in the decisions. Some exception was made with respect to the abortion decision because of constitutional considerations, but even here there has been a growing recognition of parental notification. In sum, the situation remains one where parents make decisions, including medical decisions, for their

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<sup>83</sup>In re T.W., 551 So.2d 1186, (Fla. 1980).

<sup>84</sup>American Academy of Pediatrics v. Lungren, 66 Cal.Rptr. 201, (Cal. 1997). The difficulty of the decision can be seen in its procedural history: the Legislature adopted the judicial bypass in 1987; in November 1987 plaintiffs obtained a preliminary injunction based upon the right of privacy; the Court of Appeal upheld the injunction in October, 1989; in October and November, 1991, 25 persons testified in person and 6 by deposition at the trial, after which the court concluded that state interests in the health of minors and parent-child relationships were compelling but the bypass procedure did not further them, thus the bypass is unconstitutional; the Court of Appeal affirmed and permanently enjoined the statute; the Supreme Court reversed 4-3 on April 4, 1996. 51 Cal.Rptr.2d 201, (Cal. 1996). That decision was vacated and the Supreme Court, again by 4-3 vote, concluded that the statute did not further the compelling state interests in maternal health and family integrity. 66 Cal.Rptr.2d 210, (Cal. 1997).

<sup>85</sup>Planned Parenthood League of Massachusetts, Inc., v. Attorney General, 677 N.E.2d 101, (1997).

<sup>86</sup>*Id.*, at 106. Jamie Ann Sabino, a Massachusetts attorney and cochair of the Judicial Consent for Minors Lawyer Referral Panel, had testified in the California bypass case that "Massachusetts courts had ruled on approximately 9000 bypass petitions, of which all but 13 were granted. All 13 denials were appealed and only 1 was affirmed." 51 Cal.Rptr.2d 201, at 228 n.12.

minor children except when the minors can prove their maturity or fit within a statutory exception to parental consent.

### III. MEDICAL DECISIONS FOR MINORS IN THE UNITED KINGDOM

By the Family Law Reform Act 1969 the age of majority (“full age”) is reached at eighteen rather than twenty-one. [Section 1 (1)] By the same act, consent for medical decisions may be given by those who are sixteen:

(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment, it shall not be necessary to obtain any consent for it from his parent or guardian.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

This provision includes two striking differences from typical statutes in the United States. First, a sixteen year old is authorized to make all medical decisions and not only those relating to substance abuse (drugs or alcohol) or sex (venereal disease, contraception and abortion). Second, the competence of the minor to consent does not diminish the competence of the parent(s) or guardian to consent.

The competence of minors less than sixteen to make medical decisions was recognized in the case of *Gillick v. West Norfolk and Wisbech Area Health Authority and Another*.<sup>87</sup> Victoria Gillick, the mother of five daughters, challenged a memorandum of guidance from the Department of Health and Social Security which would allow the provision of family planning services to those under sixteen without parental consent.<sup>88</sup> Lord Fraser found no statutory or caselaw authority which compelled him to conclude that a girl under the age of 16 lacked the legal capacity to consent to contraceptive advice, examination and treatment, provided that she had

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<sup>87</sup>[1985] 3 All E.R. 402 (AL 1995).

<sup>88</sup>*Id.* at 405-06. “The Department would therefore hope that in any case where a doctor or other professional worker is approached by a person under the age of 16 for advice in these matters, the doctor or other professional will always seek to persuade the child to involve the parent or guardian (or other person *in loco parentis*) at the earliest stage of consultation, and will proceed from the assumption that it would be most unusual to provide advice about contraception without parental consent. It is, however, widely accepted that consultation between doctors and patients are confidential. . . . To abandon this principle for children under 16 might cause some not to seek professional advice at all. They could then be exposed to the immediate risks of pregnancy and of sexually-transmitted diseases, as well as other long-term physical, psychological and emotional consequences which are equally a threat to stable family life. This would apply particularly to young people whose parents are, for example, unconcerned, entirely unresponsive, or grossly disturbed. . . . The Department realizes that in such exceptional cases the nature of any counselling must be a matter for the doctor or other professional worker concerned and that the decision whether or not to prescribe contraception must be for the clinical judgment of a doctor.

sufficient understanding and intelligence to know what they involve.<sup>89</sup> Lord Scarman agreed and sought a principle from caselaw for deciding the relationship between parental custody and control and a minor's right to make his or her own decision. The principle he found was that "parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child."<sup>90</sup> Lord Scarman quoted with approval the words of Lord Denning: "The legal right of a parent to custody of a child ends at the 18th birthday; and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice"<sup>91</sup>

Lord Brandon in dissent agreed with the Court of Appeal that the issue should be decided under the Sexual Offenses Act 1956 which provided that it is a felony for a man to have intercourse with a girl under the age of 13 and an offense if she is not under the age of 13 but is under the age of 16. He concluded that because the intercourse is criminalized and against public policy, advising about contraception or prescribing contraceptives would promote, encourage and facilitate a crime.<sup>92</sup> Lord Templeman based his dissent upon his conclusion that "the decision to authorize and accept medical examination and treatment for contraception is a decision which a girl under sixteen is not competent to make" and that a doctor could do so without parental consent only under court order or in an emergency or in the exceptional circumstance that a parent had abandoned or forfeited by abuse the right to be consulted.<sup>93</sup>

Lord Bridge fully agreed with Lord Fraser and Lord Scarman because public policy called for protecting young girls from the untoward consequences of intercourse, foremost among which was the risk of pregnancy, and prescribing contraception was the only effective means of avoiding a wholly undesirable pregnancy.<sup>94</sup>

While the decision provided a name ("Gillick-competency") to the competence of a minor less than 16 to provide consent for medical treatment, it did not provide answers to questions which arose. Was the doctor authorized to treat a Gillick-competent patient without parental involvement if the doctor determined it was in the

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<sup>89</sup>*Id.* at 407-09. The physician must have discretion to act in accordance with his view of the girl's best interests; he must be satisfied that the girl will understand the advice, that she cannot be persuaded to inform her parents, that she is likely to begin or continue sexual intercourse without contraceptive treatment, that her best interests require him to give her contraceptive advice or treatment, and that unless she receives such advice or treatment, her physical or mental health are likely to suffer. *Id.* at 410.

<sup>90</sup>*Id.* at 420. "The principle is that parental right or power of control of the person and property of his child exists primarily to enable the parent to discharge his duty of maintenance, protection and education until he reaches such an age as to be able to look after himself and make his own decisions." *Id.* at 421.

<sup>91</sup>*Id.* at 422 (quoting *Hewer v Bryant* [1970] QB 357, 369. Lord Fraser had also quoted these words of Lord Denning. *Id.* at 412.)

<sup>92</sup>*Id.* at 429.

<sup>93</sup>*Id.* at 434-35.

<sup>94</sup>*Id.* at 427.

patient's best interests or was the doctor to determine whether the patient was Gillick-competent (a "mature minor") and follow the minor's decisions, including a decision not to involve the parent(s).<sup>95</sup> While the various speeches contained descriptions of Gillick-competence, there was no precise definition whereby a health professional could determine whether any particular minor was Gillick-competent. Such concerns would be worked out in subsequent cases.

The scope of the consent to medical treatment provided by a Gillick-competent minor was the issue *In Re R (A Minor)(Wardship: Consent to Treatment)*.<sup>96</sup> The action was brought by the local authority to use compulsory antipsychotic medication on a young woman who was fifteen years and ten months old and a ward of the court. Between March and September she had been in voluntary care, in a foster home, in a children's home, under an interim care order, the subject of emergency psychiatric assessment, and finally a ward of the court. She had been suicidal and had become violent when restored to her parents. An issue arose under *Gillick*, because the consultant child psychiatrist found "she is of sufficient maturity and understanding to comprehend the treatment being recommended and is currently rational," yet the unit demanded a free hand to administer medication against her

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<sup>95</sup>P.N. Parkinson, *The Gillick Case—Just What Has It Decided?*, FAMILY LAW 11, 12-13 (1986). He noted the difficulty of the case (five of nine judges sided with Mrs. Gillick: three judges of the Court of Appeal and two Justices of Appeal) and that only Lord Scarman, of the three judges in the majority, adopted a pure "mature minor" position. G.L. Peiris, on the other hand, focusing on the increasing availability of contraception, the changed status of women, the growing independence of teenagers, and the attenuated relationships of many adolescents with their parents, found that even Lord Scarman's position was too narrow. G.L. Peiris, *The Gillick Case: Parental Authority, Teenage Independence and Public Policy*, CURRENT LEGAL PROBLEMS 93, 114 (1987). Perhaps the tension is captured in the contrasting views of Lord Scarman:

Much has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to [contraceptive] treatment. It is not enough that she understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate.

and Lord Templeman:

Any decision on the part of a girl to practise sex and contraception requires not only knowledge of the facts of life and of the dangers of pregnancy and disease, but also an understanding of the emotional and other consequences to her family, her male partner and to herself. I doubt whether a girl under the age of sixteen (16) is capable of a balanced judgment to embark on frequent, regular or casual sexual intercourse fortified by the illusion that medical science can protect her in mind and body and ignoring the danger of leaping from childhood to adulthood without the difficult formative transitional experiences of adolescence. There are many things which a girl under sixteen needs to practise but sex is not one of them.

*Gillick*, at 253-254, 265.

<sup>96</sup>[1992] Fam. 11 (CA 1991).

wishes and the local authority concluded it could not consent to medication against her will.<sup>97</sup>

Lord Donaldson, MR, after reviewing the law that a doctor who treats a patient without consent of someone authorized to give consent is liable for trespass and criminal assault, except in cases of emergency, noted that

consent by itself creates no obligation to treat. It is merely a key which unlocks a door. Furthermore, whilst in the case of an adult of full capacity there will usually only be one keyholder, namely the patient, in the ordinary family unit where a young child is the patient there will be two keyholders, namely the parents, with a several as well as a joint right to turn the key and unlock the door.<sup>98</sup>

He then employed the keyholder analogy to explain the statement of Lord Scarman in *Gillick* that “as a matter of law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.”<sup>99</sup> Lord Donaldson argued that the words could not mean that if a child were *Gillick*-competent, the parents ceased to have an independent right to consent, for that would put the doctor in a dilemma whenever the child refused treatment to which the parent consented; the doctor would have to act without knowing whether adequate consent had been given. Rather, in that situation there were several keyholders: the legal parents and the competent child, any of whom could provide legal consent. In cases of conflict between parent and child, parental consent enables treatment to be provided but does not mandate treatment. The failure of a competent child to consent is “a very important factor” which the doctor must consider in deciding whether to act upon the consent provided by one or both parents.<sup>100</sup>

Finally, because the court’s wardship jurisdiction derives from the Crown’s power to protect its subjects and is not derived from parental rights, the court can act without and even against the decisions of the parents and the competent minor. Lord Staughton, while wondering whether a wardship judge should have greater power than a natural parent (because the state must have good reason to exercise power to control the decisions of a competent person, adult or minor, concerning their own well-being), recognized that the force of precedent supported the power of the Crown as national parent.<sup>101</sup> He thereby avoided discussing any disagreement between parent and child.

Lord Farquharson addressed directly the decision of the psychiatrist that the patient was rational and capable of making medical decisions. He concluded that the *Gillick*-test should include not only the mental state and capacity at a particular time

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<sup>97</sup>*Id.* at 19-21. This case differed from *Gillick*, where the children were not wards of the court, and where the denial of consent came from the mother without the knowledge or involvement of the children.

<sup>98</sup>*Id.* at 22.

<sup>99</sup>*Gillick*, at 423.

<sup>100</sup>*In Re R*, at 25.

<sup>101</sup>*Id.* at 28. Lord Donaldson had referred to the “judicial reasonable parent.” *Id.* at 25.

but the entire medical history. In this case there was a fifteen year old with a mental illness which affected her decision-making from day to day. The psychiatrist had admitted that the patient's understanding was neither permanent or even long-term.<sup>102</sup> Lord Donaldson also discussed *Gillick*-competency but instead of focussing on the presence or absence of mental illness, he distinguished Lord Scarman's statement that the child must have sufficient understanding and intelligence to understand fully what is proposed.<sup>103</sup> Noting that a maturing child gradually acquires the capacity to consent to more serious medical treatments, he described this as a progression and not something which fluctuates day to day. It includes "not merely an ability to understand the nature of the proposed treatment—in this case compulsory medication—but a full understanding and appreciation of the consequences both of the treatment, in terms of intended and possible side effects, and, equally important, the anticipated consequences of failure to treat."<sup>104</sup>

Commentators quickly and generally took issue with the reasoning, but not the result, of *Re R*. S.M. Cretney thought that Lord Donaldson's views were inconsistent with the views of Lord Scarman in *Gillick* and with the policy of the Children Act 1989 which embodied the mature minor's right to decide.<sup>105</sup> There was concern about the power of a parent and doctor to override the refusal of treatment by a *Gillick*-competent child whose case might be appealed to a court less sympathetic to the rights of minors.<sup>106</sup> Andrew Bainham noted that while a limited view of state

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<sup>102</sup>*Id.* at 31.

<sup>103</sup>*Gillick*, at 423.

<sup>104</sup>In *re R*, at 26. Lord Donaldson summarized his conclusion as follows:

1. No doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision whether to treat is dependent upon an exercise of his own professional judgement, subject only to the threshold requirement that, save in exceptional cases usually of emergency, he has the consent of someone who has authority to give that consent. In forming that judgement, views and wishes of the child are a factor whose importance increases with the increase in the child's intelligence and understanding.

2. There can be concurrent powers to consent. If more than one body or person has a power to consent, only a failure to, or refusal of, consent by all having that power will create a veto.

3. A *Gillick*-competent child or one over the age of sixteen will have a power to consent, but this will be concurrent with that of a parent or guardian.

4. *Gillick*-competence is a developmental concept and will not be lost or acquired on a day-to-day or week-to-week basis. In the case of a mental disability, that disability must also be taken into account, particularly where it is fluctuating in its effect.

5. The court, in the exercise of its wardship or statutory jurisdiction, has power to override the decisions of a *Gillick*-competent child as much as those of parents or guardians.

6. Waite J was right to hold that R was not *Gillick*-competent and, even if R had been, was right to consent to her undergoing treatment which might involve compulsory medication.

*Id.*, 26-27.

<sup>105</sup>*Family Law*, ALL E R ANNUAL REVIEW, 176, 178-179 (1991).

<sup>106</sup>Phil Fennell, et al., *Medical Law*, ALL E R ANNUAL REVIEW, 230, 235 (1991). They also noted that while Lord Donaldson's view was in the minority on overriding a capable

paternalism would protect children only against decisions which would inhibit their healthy development, a more extensive paternalism could be justified from the Children Act 1989. However, one could wonder whether some adults would also fail the "full understanding" test proposed by Lord Donaldson and whether the analysis was not result-oriented (as the adult who disagrees with the minor's decision deems him or her incompetent).<sup>107</sup> Gillian Douglas also wondered whether *Re R* would not undermine the rights of minors which had been recognized in *Gillick*, including "that most dangerous but most precious of rights: the right to make [one's] own mistakes."<sup>108</sup>

Other applications of the concept of *Gillick*-competence included abortion, mental illness and refusal of treatment for religious reasons. *In re B (Wardship:Abortion)*, on application of a local authority, a judge authorized an abortion for a ward who was age twelve years and nine months and almost 18 weeks pregnant.<sup>109</sup> The judge had the consent of the minor, of her grandparents (who had raised her since she was 18 months old), and of the putative father; the only one refusing consent was the minor's mother, who remained in frequent contact with her.<sup>110</sup> The judge heard the views of obstetricians and psychiatrists and concluded that this young woman should not be forced to continue a pregnancy against her expressed wishes.<sup>111</sup>

*In re K, W and H (Minors)(Medical Treatment)* involved three youths who were highly disturbed and in treatments offered to adolescents who had proved unmanageable by other means.<sup>112</sup> Two of these were 15 and being treated with the consent and cooperation of one or both parents; the other was 14 and in care of the local authority.<sup>113</sup> The judge determined that none of these were *Gillick*-competent and even if the minor could consent and refused to do so, *Re R* had held that someone with parental rights could do so and had done so here.<sup>114</sup>

The court faced a more difficult decision in *South Glamorgan County Council v W and B* where both the minor and her father objected to the proposed treatment.<sup>115</sup>

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refusal, as a senior and highly respected member of the judiciary his views would carry great weight. *Id.*

<sup>107</sup>*The Judge and the Competent Minor*, 108 THE LAW QUARTERLY REVIEW 1992, 194, 196. He concluded with the hope that the judiciary might inject detachment and objectivity into assessments of a minor's competence to decide.

<sup>108</sup>Gillian Douglas, *The Retreat from Gillick*, 55 MOD. L. REV. 1992, 569, 573, quoting J. Eekelaar, *The Emergence of Children's Rights*, 1986 OXFORD J. L. S., 161, 182. Rosy Thornton also regarded *In re R* as a step back from *Gillick*. Rosy Thornton, *Multiple Keyholders—Wardship and Consent to Medical Treatment*, 1992 CAMBRIDGE L.J. 34, 37 (1992).

<sup>109</sup>2 Fam. 426 (FD 1991).

<sup>110</sup>*Id.* at 430.

<sup>111</sup>*Id.* at 431.

<sup>112</sup>1 Fam. 854 (FD 1993).

<sup>113</sup>*Id.* at 856-857.

<sup>114</sup>*Id.* at 859.

<sup>115</sup>1 Fam. 574 (FD 1993).

The young woman was just past her fifteenth birthday; her parents were divorced and she and her older brothers were in the custody of their father.<sup>116</sup> Both older brothers had been hospitalized for mental disorders.<sup>117</sup> When she was eleven, the girl began remaining home from school.<sup>118</sup> She became a recluse in the front room of their home and dominated the others in the household with her demands.<sup>119</sup> Several evaluations found her lucid, alert, without thought disorders, coherent, but uncooperative, verbally abusive and obsessive about cleanliness.<sup>120</sup> She was not suitable for an order under the Mental Health Act 1983.<sup>121</sup> Her condition was brought to the attention of the local authority, which sought to compel assessment and treatment.<sup>122</sup> The young woman refused and her father argued that the finding that she was “not *Gillick*-incompetent” and the Children Act 1989 s.38(6)<sup>123</sup> had the effect of taking away the court’s inherent jurisdiction. The judge concluded that a court could not be deprived of its inherent jurisdiction and the court would exercise the power it had in a case like this in the best interests of the minor, for her views, which were given “the fullest consideration” by the court, could not override the evidence of psychiatrists and experienced social workers who argued that she must be admitted for assessment and treatment without delay.<sup>124</sup>

Other cases in which the patient was under sixteen involved blood transfusions for those who as Jehovah’s Witnesses are religiously opposed. In *Re E (A Minor)(Wardship: Medical Treatment)* the young man, who would have turned sixteen on December 6th, 1990, was found to have leukemia on September 8, 1990.<sup>125</sup> Standard treatment called for administration of drugs which would attack the leukemia and the bone marrow; blood transfusions are a necessary part of the therapy. In the two weeks after diagnosis, his hemoglobin and white cell count deteriorated.<sup>126</sup> The patient and his family opposed blood transfusion for religious reasons; the hospital authority sought leave of the court to treat the boy. The judge,

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<sup>116</sup>*Id.* at 577.

<sup>117</sup>*Id.*

<sup>118</sup>*Id.*

<sup>119</sup>*Id.* at 578-579.

<sup>120</sup>1 Fam. at 579.

<sup>121</sup>*Id.* at 580.

<sup>122</sup>*Id.* at 582.

<sup>123</sup>CHILDREN ACT OF 1989 § 38(6): “Where the court makes an interim order or interim supervision order, it may give such directions, if any, as it considers appropriate with regard to medical or psychiatric examination or other assessment of the child, but, if the child is of sufficient understanding to make an informed decision, he may refuse to submit to the examination or other assessment.”

<sup>124</sup>*South Glamorgan County Council*, at 585. The judge agreed with the guardian who pointed out that the young girl had had twenty-two previous court appearances and this should not go on any longer. *Id.*

<sup>125</sup>1 Fam. 386 (FD 1993).

<sup>126</sup>*Id.* at 388.



who called this “an excruciatingly difficult case,” quoted Lord Donaldson in *Gillick* and concluded:

He is a boy of sufficient intelligence to be able to take decisions about his own well-being, but . . . there is a range of decisions of which some are outside his ability fully to grasp their implications. Impressed as I am by his obvious intelligence, by his calm discussion of the implications, by his assertion that he would refuse well knowing that he may die as a result, in my judgement [he] does not have a full understanding of the whole implication of what the refusal of that treatment involves.<sup>127</sup>

The judge recognized not only the distinction between knowing the fact of death and fully appreciating the process of death, but also the absence of freedom in a teenager (“teenagers often express views with vehemence and conviction--all the vehemence and conviction of youth”) as applied to a boy of fifteen “conditioned by the very powerful expressions of faith to which all members of the creed adhere.”<sup>128</sup> The wardship was confirmed; and treatment, which had a high probability of success and low risk of further injuring the patient, was authorized. He concluded with the famous statement of Oliver Wendell Holmes: “Parents may be free to become martyrs themselves, but it does not follow that they are free in identical circumstances to make martyrs of their children.”<sup>129</sup>

*In Re S (A Minor) (Medical Treatment)* the patient, who was fifteen and one half, suffered from beta minor thalassaemia major, and received treatments, including blood transfusions, every four weeks.<sup>130</sup> When the girl was almost eleven, her mother became a Jehovah’s Witness and within two years the group’s hospital liaison committee became involved.<sup>131</sup> In May the patient refused her regular blood transfusion and when she was not available for the June transfusion, the local authority asked the court to exercise its inherent authority and order the transfusion.<sup>132</sup> The judge found that even though she was of an age to have a right to decide whether to have the treatment or not, she was also less mature than many girls her age, had had a sheltered upbringing, and did not understand the full implications

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<sup>127</sup>*Id.* at 391. In particular, the judge found that the minor did not understand that he would become increasingly breathless and he did not sufficiently appreciate the pain and fear he would experience and the distress he would suffer as a son watching his family’s distress. In short, the patient had some concept of the fact that he would die but no realisation of the full implications of the process of dying.

<sup>128</sup>*Id.*

<sup>129</sup>*Id.* at 394, quoting *Prince v Massachusetts*, 321 U.S. 158 (1944). It was reported in *In Re S (A Minor)(Medical Treatment)*, [1994] 2 FLR 1065, that the patient in *Re E* had in fact exercised his power to decide to forego treatment several years later and had died. 1075.

<sup>130</sup>2 Fam. 1065.

<sup>131</sup>*Id.* at 1066-67.

<sup>132</sup>*Id.* at 1067.

of her decision (thinking, for example, that there might be a miracle and not understanding that failure to have transfusions will certainly result in her death).<sup>133</sup>

The case of *Re L (Medical Treatment: Gillick Competency)* was easier because the patient, a fourteen-year old Jehovah's Witness, due to the serious burns she had received, could not be told how severe her injuries were nor of the horrible death which would ensue if she did not have treatments (which included blood transfusions).<sup>134</sup> Sir Stephen Brown found that she lacked *Gillick*-competency because although she was sincere in her religious beliefs, she was only fourteen, and had limited experience of life. He concluded that she could not be told that, without treatment, gangrene would set in and produce a very distressing period, while probability of successful treatment was high.<sup>135</sup>

In these cases discussing *Gillick*-competence the judges concluded that while the minor less than sixteen showed some evidence of maturity and understanding, yet for the particular decision under scrutiny, there was not sufficient understanding to permit the minor to refuse treatment that offered high probability of success and low risk. If there was also a history of mental illness, the variation between periods of competence and periods of illness would preclude a finding of competence. Where religious beliefs were the basis for rejecting treatment, there was concern whether the minor grasped the full implications of rejecting treatment as well as concern about freedom of choice in the context of religious training and persuasion.

In addition to defining and applying the common law notion of "the *Gillick*-competent" minor, courts wrestled with the scope of the Family Law Reform Act 1969. Section 8(1) of that act provided that "the consent of a minor who has attained the age of sixteen years to any surgical, medical, or dental treatment which, in the absence of consent would constitute a trespass to his person, shall be as effective as if he were of full age." Did these words mean that after the age of sixteen the minor's consent alone was necessary? If so, then what meaning should be given to Section 8(3) "Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted?" Courts had utilized § 8(3) in the cases mentioned above to support medical decisions by mature minors who were not sixteen, whose common law right to consent was not negated by the statute which recognized that a sixteen-year-old had capacity to consent.

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<sup>133</sup>*Id.* at 1074. The court employed the distinction from *Re E*: "an understanding that she will die is not enough. For her decision to carry weight she should have a greater understanding of the manner of the death and pain and the distress." *Id.*, 1076.

<sup>134</sup>2 Fam. 810 (FD 1998).

<sup>135</sup>*Id.* at 813. Charlotte McCafferty questioned the judge's conclusion that the young woman lacked *Gillick*-competence because the details which it would be necessary for her to know if she were to provide informed consent were withheld from her on the basis that she was not able to bear the additional pain of knowledge about the details of dying. But would an adult not have been given such information? A minor cannot be competent to refuse treatment if minority is itself a justification for denying the information necessary to make a decision. *Won't Consent? Can't Consent? Refusal of Medical Treatment*, FAMILY LAW 336, 338 (May 1999).

Lord Donaldson MR in *In re W (Medical Treatment: Court's Jurisdiction)* determined the meaning of the statute.<sup>136</sup> The court faced the issue whether it had any jurisdiction to make orders concerning medical treatment that conflicted with the expressed wishes of a sixteen-year-old. He admitted that his decision in *Re R* had occasioned critical academic commentary, that some of his remarks were not necessary to the decision, and he offered to begin afresh.<sup>137</sup>

He explained that the issue in *Gillick* had not been whether the child under sixteen could refuse to consent to medical treatment but whether the mother (parent) could veto the child's consent. The House of Lords held that "at common law a child of sufficient intelligence and understanding (the 'Gillick-competent' child) could consent to treatment, notwithstanding the absence of parents' consent and even an express prohibition by parents."<sup>138</sup> Lord Donaldson interpreted the language of Lord Scarman in *Gillick* to mean that the parents lost their exclusive right to consent at that point, for the minor could also provide effective consent when the child reached sixteen. All agreed that the court could provide consent and override the decision of the minor or the parents. Consent served two purposes: the clinical purpose was to elicit the patient's cooperation in the treatment (for the patient's faith or confidence in the efficacy of the treatment would contribute to its success); the legal purpose was to provide those involved in treatment with a defense to criminal assault or civil trespass to the person. The statute provides that a minor who is sixteen or seventeen is presumed competent to consent, while *Gillick* established that a minor not yet sixteen could be mature enough to provide effective consent. But the competence of the minor at sixteen to consent did not abrogate the parents' competence to consent. Lord Donaldson then changed analogies, from the keyholder analogy of *Re R* (for a key can both unlock and lock) to a flak jacket, which provides legal defense to doctors whether it is acquired from a minor of sixteen or seventeen, a *Gillick*-competent minor not yet sixteen, or a parent of a minor not yet eighteen. "Anyone who gives [the doctor] a flak jacket (that is, consent) may take it back, but the doctor needs one and so long as he continues to have one he has the legal right to proceed."<sup>139</sup>

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<sup>136</sup>1Fam. 64 (FD 1993). The case involved a young woman of sixteen who suffered from anorexia nervosa. When the girl was five, her father died of a brain tumor; when she was eight, her mother died of cancer; her aunt (testamentary guardian) could not care for her and she was placed with foster parents, where she was bullied by an older child and had to be moved. When she was twelve her new foster mother developed breast cancer and when she was fourteen her grandfather, to whom she was very attached, died. A few months after his death she was diagnosed with anorexia nervosa, which is an illness one of whose clinical manifestations is a desire not to be cured. She was treated by doctors and psychologists and at times was institutionalized. When she turned sixteen, the local authority, fearful that she would not consent to necessary treatment, made application for the court to exercise its inherent jurisdiction.

<sup>137</sup>*Id.* at 75.

<sup>138</sup>*Id.*

<sup>139</sup>*Id.* at 78. FAMILY LAW REFORM ACT 1969 § 8(1) provides that minors at sixteen can consent to surgical, medical or dental treatment; § 8(2) extends treatment to include diagnosis and procedures ancillary to treatment (including administration of an anesthetic). Thus, the minor of sixteen or seventeen may not consent to what is not treatment: blood or organ donation.

The flak jacket analogy speaks only to the legal purpose of consent. The clinical purpose, which is also a matter of medical ethics, requires the doctor to act in the best interests of the patient, which includes ascertaining and honoring the patient's wishes. If the patient's (or parents') wishes appear contrary to the patient's best interests, the court can still invoke its inherent jurisdiction to act in the minor's best interests. Applying his analysis to this patient, Lord Donaldson doubted that she was competent to make a medical decision although the patient may have sufficient intelligence and understanding to appreciate the treatment and the consequences of refusing it, the very nature of anorexia nervosa is to destroy the patient's ability to make an informed choice or to incline her to choose only that treatment which is likely to be ineffective.<sup>140</sup> The inherent powers of the court extend beyond the powers of a parent and are theoretically limitless; the court can override the minor's refusal to consent not by ordering the doctors to provide treatment but "by authorizing the doctors to treat the minor in accordance with their clinical judgment."<sup>141</sup> He recognized that adolescence is a time of progressive transition from childhood to adulthood with the acquisition of experience and understanding. Minors of sixteen and seventeen should be accorded as much decision-making power as they can prudently manage. While they should not be sheltered from all risks, they must avoid "taking risks which, if they eventuate, may have irreparable consequences or which are disproportionate to the benefits which could accrue from taking them."<sup>142</sup>

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<sup>140</sup>*Id.* at 81. The trial judge had found that the patient had sufficient understanding to make an informed decision. Lord Justice Balcombe accepted that finding, which was fully supported by psychiatric evidence. Lord Justice Nolan noted without comment the finding of competence at trial.

<sup>141</sup>*Id.*

<sup>142</sup>*Id.* at 82. Here the risk of refusing treatment was weight loss to the point of serious jeopardy to the patient's fertility and health. As he had elsewhere, Lord Donaldson summarized his conclusions:

1. No question of a minor consenting to or refusing medical treatment arises unless and until a medical or dental practitioner advises such treatment and is willing to undertake it.

2. Regardless of whether the minor or anyone else with authority to do so consents to the treatment, that practitioner will be liable to the minor in negligence if he fails to advise with reasonable skill and care and to have due regard to the best interests of the patient.

3. This appeal . . . concerned with the treatment of anorexia nervosa . . . the disease itself creates a wish not to be cured. . . . Treatment has to be directed at this state of mind as much as to restoring body weight.

4. Section 8 of Family Law Reform Act 1969 gives minors who have attained the age of sixteen a right to consent to surgical, medical or dental treatment. Such a consent cannot be overridden by those with parental responsibility for the minor. It can, however, be overridden by the court. . . .

5. A minor of any age who is "Gillick-competent" in the context of particular treatment has a right to consent to that treatment which again cannot be overridden by those with parental responsibility, but can be overridden by the court. . . .

6. No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in

Lord Justice Balcombe concurred, basing his analysis on the text of Family Reform Act 1969 § 8(1) and (3) which did not authorize minors of sixteen or seventeen to refuse medical treatment and did not eliminate parents' rights to consent. He acknowledged the power of the court to provide for the best interests of the minor, objectively considered, especially when the minor attempts to refuse treatment in circumstances that will probably lead to death or severe permanent injury. In making a determination, however, a judge "should approach the exercise of the discretion with a predilection to give effect to the child's wishes on the basis that prima facie that will be in his or her best interests."<sup>143</sup>

Commentators were divided about the arguments offered in *Re W*. Some found that while the Family Law Reform Act 1969 [s.8(1)] and *Gillick* acknowledged the maturity and independence of minors concerning what was done to their bodies, the opinions in *Re W* undermined such control and thus were regrettable.<sup>144</sup> Others found in the decision a balanced and necessary statement of the court's role in protecting minors while also giving due respect and efficacy to their decisions regarding medical treatment.<sup>145</sup>

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deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.

7. The effect of consent to treatment by the minor or someone else with authority to give it is limited to protecting the medical or dental practitioner from claims for damages for trespass to the person.

*Id.* at 83-84.

<sup>143</sup>*Id.* at 88. Lord Justice Nolan also concurred. He would have the court consider the minor's wishes while recognizing the obligation of the court to protect the minor's best interests. "In general terms, however, the present state of the law is that an individual who has reached the age of eighteen is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to that age." *Id.* at 94.

<sup>144</sup>Rosy Thornton, *Minors and Medical Treatment—Who Decides?* CAMBRIDGE L.J. 34, 36 (1993). Hazel Houghton-James, *The Child's Right to Die*, FAMILY LAW 550. She concluded: "Does this restrictive interpretation indicate the death-knell of one of the key aspects of the Children Act 1989?" *Id.* at 554. John Eekelaar, *White Coats or Flak Jackets? Doctors, Children and the Courts—Again*, 109 LAW QUARTERLY REVIEW, 182: "Lord Donaldson seems to be reluctant to accept that the law should protect minors, even if competent, in the same manner [as adults]. Rather, his primary concern is to fashion the law so as to minimise the risk of legal action against doctors." *Id.* at 185. Michael A. Jones, *Tort*, 47 CURRENT LEGAL PROBLEMS 207, 1994, found Lord Donaldson's argument that a minor could not veto medical treatment (for a flak jacket could be provided by consent of the parent(s)) while no one else could consent if an adult vetoed treatment repugnant, for it ignored the high regard the law rightly places upon an individual's claim to bodily integrity. *Id.* at 211-212.

<sup>145</sup>Nigel Lowe & Satvinder Juss, *Medical Treatment—Pragmatism and the Search for Principle*, 56 THE MODERN LAW REVIEW 865 (1993). "*Re W* is a pragmatic remedies approach well-suited to the common law tradition. It takes a case-by-case approach to individual problems without showing an excessive desire to formulate legal principles. *Gillick*, however, was a rights-based approach where the court advocated a view of rights that was broad and general in terms." *Id.* at 870. Phil Fennell, et al., *Medical Law: Treatment of Refusing Minors*, ALL E R ANNUAL REVIEW 291 (1992). They acknowledged that some statements in the opinion might suggest that when providing refusing patients under eighteen with treatment upon the consent of their parent(s) and without court involvement, in practice and in accord with professional ethics, the doctor treating a minor whose competence may be in question or

Two cases following *Re W* involved medical treatment of sixteen-and seventeen-year-old minors. In *Re C* (Detention: Medical Treatment) a sixteen-year-old was being treated for anorexia nervosa with her consent and the consent of her parents and the local authority.<sup>146</sup> The local authority had invoked the inherent jurisdiction of the court when the doctor and private hospital refused to provide further treatment without a court order. The local authority had not instituted care proceedings because it was attempting to provide a supportive environment for relationships between the young woman, her parents and medical providers. The family history included involvement with social services for fifteen years; none of the five children lived at home except the sixteen year old. There was evidence that she had been sexually abused by a brother, that she was very self-conscious concerning her weight, and that she had experienced eating disorders for several years. When she began to lose significant amounts of weight, she was hospitalized but repeatedly absconded from the hospital and was difficult to deal with. The local authority began the current action when the doctor said that if she continued treatment, she would regain adequate weight in a few months, but if she stopped eating, as she might, she would risk collapse and sudden death within three to seven days. The issue presented was whether the court could order detention of the sixteen year old for purposes of medical treatment even without her consent.<sup>147</sup>

The judge determined, following *Re W*, that the court under its *parens patriae* jurisdiction had the authority to order her detention at the clinic, the use of reasonable force to detain her there, and the use of reasonable force to administer the refeeding program, which the judge found to be necessary and in the patient's best interests. It was objected that because there was no care order, (thus, the local authority did not share parental responsibility), and the clinic was not a party, there were no checks on the power given to the hospital and doctors. The parents may not have adequate understanding of the nature and risks of treatment, the child may have limited understanding, and the court would be involved only if someone brought the matter before it. Childrens Act 1989 § 25 providing for secure accommodation includes several protections for the minor; that provision did not apply here for the minor was detained for the purposes of medical treatment and not simply to restrict her liberty.<sup>148</sup> The judge responded by carefully tailoring an order providing that (1) the parents would return the minor to the clinic after any approved leave or if she absconded from the clinic and returned home; (2) the order (of March 5th) would expire no later than April 18th; (3) the doctors would file reports about treatment by March 19th; (4) the clinics would formulate treatment plans (for in-patient, discharge, and out-patient) with the minor and her parents (in writing, if possible),

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with a decision which involved death or permanent injury should seek direction from the court. *Id.* at 294-295.

<sup>146</sup>2 Fam. 180 (FD 1997).

<sup>147</sup>*Id.* at 184-187.

<sup>148</sup>The judge was not sure that a place intended for one purpose but to which access was restricted could be a secure accommodation under Children Act 1989 s 25. But even if it could be covered under Section 25 or the Mental Health Act 1983, the court could not order the local authority to exercise its statutory powers. Thus, he would make an order imposing equivalent constraints. Gillian Douglas, *Medical Treatment: Re C (Detention: Medical Treatment)*, FAMILY LAW 474, 475 (1997).

(5) the minor and her parents would be involved in discussions of her returning home; and (6) all names would be deleted to protect privacy.<sup>149</sup>

With respect to the minor's consent, the judge recognized that he must have regard to her wishes and feelings but could override them if what she wanted would not be in her best interests. He drew a test for analyzing the decision-making process from *Re C (Refusal of Treatment)*: three stages comprise the decision-making process: (i) comprehending and retaining treatment information; (ii) believing it; and (iii) weighing it in the balance to arrive at a choice.<sup>150</sup> He found that the sixteen year old failed part (iii), for although she did receive and understand information about the amount of food to maintain weight, she could not use that information to balance risks and needs, for like others with anorexia nervosa, she will distort the information to suit her immediate purposes. "The immediate gratification involved in being able to override the pangs of hunger, and to feel in control, is such that worries about the effects on the body, and eventually threats to life itself, are ignored."<sup>151</sup> The conclusion was that the minor did not have power to consent to or refuse treatment.

A similar conclusion was reached in *A Metropolitan Borough Council v DB*,<sup>152</sup> where a local authority sought an order to retain in the hospital for medical treatment a seventeen year old with a crack cocaine addiction who had delivered a child two days previously.<sup>153</sup> The judge found that she had some understanding but was simple; she grasped something about what was given her and why, but she did not fully comprehend this nor was she capable of a risk/benefit analysis. Thus, she was far from competent to make a medical decision. Under Lord Donaldson's analysis in *In re R*, the requirement of her consent to necessary medical treatment in the face of a life-threatening condition or serious danger to her health carries very little weight. Also, both her mother and the local authority have parental responsibility for her and they agree to her detention and treatment.<sup>154</sup>

In a 1999 decision the judge faced the issue whether to order a heart transplant for a young woman who was fifteen and one-half and suffered heart failure, whose physicians predicted death within the next few days without a transplant, and who refused to consent because she did not want to take medication for the rest of her life

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<sup>149</sup>*Id.* 199-201.

<sup>150</sup>1 Fam. 31, 33 (FD 1994).

<sup>151</sup>*Re C (Detention)* at 196.

<sup>152</sup>1 Fam. 767 (FD 1997).

<sup>153</sup>*Id.* The minor had had no prenatal medical attention because of her fears of doctors, medical intervention and needles. She had been admitted to the hospital because of eclamptic fits brought on by extremely high blood pressure. When her waters broke, against the advice of doctors and with the risk of infection, she voluntarily discharged herself from the hospital. After that the local authority brought action for an order to retain her in the hospital and to deliver the baby by Caesarean section. The baby was immediately placed under an emergency protection order. After the birth, she again wished to discharge herself voluntarily from the hospital. Upon advice of doctors, the local authority sought an order to retain her in the hospital for seven days for treatment of her high blood pressure and the possible complications of Caesarean section (bleeding, infection, and thrombosis).

<sup>154</sup>*Id.* at 777. Here the judge found that the maternity ward was a secure accommodation for the patient was being retained there expressly in order to restrict her liberty to leave.

or live with someone else's heart.<sup>155</sup> While recognizing that "M is an intelligent fifteen-year old girl whose wishes should carry considerable weight," nonetheless he concluded that he had to order "what was best for M" which was to "authorize the giving of treatment according to Mr. D's [the consultant cardiothoracic surgeon] clinical judgment."<sup>156</sup>

The law in the United Kingdom with respect to medical decisions by adolescents is now a carefully balanced structure. Sixteen and seventeen year-olds, by statute, and mature minors less than sixteen ("Gillick-competent" minors), by caselaw, can consent to medical treatment. Their parent(s) and legal guardian(s) and the court can also consent to treatment. Parental consent can override a minor's refusal of treatment. Refusal of medical treatment by the minor or the parent is subject to review by a court, which will decide in accord with the minor's best interests. The best interests will most often be the recommendations of the attending physicians, especially when the recommended treatment is deemed necessary in a life-threatening situation or is likely to produce beneficial results with low risk.

#### IV. CONCLUSION

A perusal of statutory and caselaw attempts in the United States and the United Kingdom to respond to the challenges of medical decisions for maturing adolescents is instructive. On both sides of the Atlantic legislators and judges have recognized that adolescence involves a process of increasing independence in decision-making. The young person who lives in tightly regimented and over-protective structures grows older but is less likely to grow up. At the same time, young persons often believe that their abilities to make decisions rest on more solid foundations than really exist. Parents recognize their dual responsibilities of educating their children for adulthood by incrementally allowing them to make decisions and take responsibility for their consequences while simultaneously attempting to insulate them as far as possible from facing decisions which exceed their understanding and experience.

Medical decisions represent a continuum ranging from rather routine and low risk treatments for the scrapes and bruises of daily living to the life-and-death decisions of foregoing chemotherapy, kidney dialysis, or immunosuppressant drugs. In addition, the context for the medical decision is different for an adult who has

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<sup>155</sup>*Re M (Medical Treatment: Consent)*, 2 Fam. 1097 (FD 1999). Because of the urgent time pressures, the judge sought a local solicitor who acted for the Official Solicitor in representing the minor. The young woman expressed ambivalence: "I am only fifteen and don't want to take tablets for the rest of my life . . . It's hard to take it all in. . . . Death is final. I don't want to die but I would rather die than have the transplant and have someone else's heart. I would be different from anybody else—being dead would not make me different from anybody else." *Id.* at 1100.

<sup>156</sup>*Id.* at 1100. Gillian Douglas noted that the judge did override the minor's refusal even though his decision would require anti-rejection drugs for the rest of her life. Gillian Douglas, *Re M (Medical Treatment: Consent)*, FAMILY LAW 753 (1999). Andrew Downie expressed concern about the discretion which the judge had under the court's inherent jurisdiction to place the judge's view of the minor's welfare over that of the minor who refused treatment and to formulate an order which allowed physicians to act according to their own medical judgments. Andrew Downie, *Consent to Medical Treatment - Whose View of Welfare?* FAMILY LAW 818, 819 (1999).



already experienced the possibilities of learning, choosing a career, experiencing life in many ways and for many years, sharing these experiences with significant others, perhaps being a parent, and receiving recognition for one's accomplishments, than for the adolescent who has only just begun to live independently.

The United Kingdom has since the Family Law Reform Act 1969 Section 8(1) established the competence of any person sixteen years of age or older to consent to medical treatment. In the United States a few states do likewise. While such a "birthday rule" is simple to apply and protects health care providers who act with the consent of sixteen and seventeen year old patients, it does not address the maturity of an individual who for other purposes remains a minor, with all the legal protections thereof.

While the United Kingdom allows all who are sixteen or over to consent to medical treatment, most states in the United States allow minors or minors of some specified age to make only those medical decisions involving pregnancy, contraception, venereal disease, drug and alcohol abuse, and perhaps mental health. Separate constitutional caselaw provides access to abortion for mature minors. While public policy reasons such as public health (preventing the spread of communicable diseases, preventing teenage pregnancy) and privacy (unwillingness of minors to share information about sexual activity or substance use and abuse with their parents) support such laws, once again the law is unrelated to the maturity of the minor.

In both countries minors' medical decisions can be reviewed by a judge. If the judge determines that the minor's decision is not in the minor's best interests, the decision can be modified or even reversed. Courts in both countries recognize the inherent jurisdiction of a court to exercise its *parens patriae* authority: it is the duty and responsibility of a judge to ensure so far as possible the protection of those who cannot provide for themselves because of age or disability.

In the area of medical decisions, the health care provider is, in practice, the one who evaluates the competence of a patient to make a medical decision. Statutes provide presumptions which may be rebutted in individual cases upon a showing that this person does not possess the presumed competence. There remain the challenges of defining competence and of defining and interrelating the roles of the adolescent, the parent(s) and the court.

In the United Kingdom, Lord Donaldson provided guidance in addressing these challenges by distinguishing between consenting to medical treatment and refusing treatment and among medical decisions of differing severity. The statute and, by implication, a finding that a minor less than sixteen is "*Gillick*-competent," allow adolescents to consent to medical treatments. The person who has not reached eighteen, the age of legal majority, is not competent to refuse medical treatment. That will be especially true where the treatment refused is considered by the attending physicians to be necessary for life or health. The seriousness of the decision affects the evaluation of the decision-maker's competence: the very fact that a minor is refusing treatment judged necessary for life or health raises questions about competence. Judges have concluded that a minor refusing medically necessary treatment may not fully understand the finality of death or fully appreciate the pain which will accompany the chosen non-treatment.

In addition, Lord Donaldson recognized the competence of the sixteen-year old or the "*Gillick*-competent" minor less than sixteen to consent without denying the parents' competence to consent. The flak jacket which consent provides to the

practitioner may be provided by the minor or by the parent or by the court. The law recognizes the continuing role and responsibility of the parents to provide for their child's best interests by making for the child decisions to refuse medical treatment and with the child decisions to consent to medical treatment.

Legislators and judges in the United States should consider the benefits of distinguishing between consenting to and refusing medical treatment and of allowing both parents and mature minors to consent to medical treatment. This approach would relate the seriousness of the medical decision to evaluations about competence and it would not create an adversarial divide between parent and child whereby only the parent or only the child can decide.

They should also consider the desirability of expanding competence to consent beyond matters relating to pregnancy, contraception, venereal disease, substance or alcohol abuse, and mental health. Statutes allowing minors always to provide consent destroy the necessary connection between the seriousness of the decision and the ability of the decision-maker to make it and produce anomalous results such as a minor parent's being able to make decisions for a son or daughter that she could not make for herself.

Judges in the United States in the context of determining whether a pregnant minor is mature and judges in the United Kingdom in the context of determining the competency of a "Gillick-competent" minor have recognized the importance psychologically and therapeutically of including in the decision-making process the wishes of the minor. Judges in the United States have weighed whether denying parents involvement in or knowledge of the decision concerning abortion was in the minor's best interests. Such considerations should be generalized to all medical decisions. The court cannot act as final arbiter of the best interests of the minor without determining what level of involvement, if any, is appropriate in the context of a particular family situation.

Finally, legislators and judges must determine how far society is ready to go in recognizing the competence of minors to make medical decisions. In the United States, with its wider access to abortions, there will be more decisions concerning the termination of pregnancies. Continuing developments in medical technologies and treatments will expand the number of situations in which serious decisions will have to be made. Such decisions will include continuing or resuming therapies for cancer or other life-threatening conditions and about including minors in research. In an increasingly pluralistic society legislators and judges will have to determine when minors should be allowed to make medical decisions which may have harmful consequences and which may be "wrong" in the view of some observers.