

The Legal Authority of Mature Minors to Consent to General Medical Treatment

abstract

The nature and scope of mature adolescents' legal authority to consent to general medical treatment without parental involvement is often misrepresented by commentators. This state of affairs is further complicated by the law itself, which has developed a broad "mature minor exception" to the general requirement of parental consent in abortion cases and which has additionally carved out numerous specific status-based and condition-based exceptions to that requirement. In these circumstances, it is not always a simple matter for physicians and other medical professionals who treat adolescents to ascertain the applicable law. In this article, we discuss the underlying differences between medical ethics and law, which have caused some of the confusion in this area, and we set out the most current legal rules governing adolescent decision-making authority in general medical settings. A comprehensive analysis of both statutory and common law demonstrates that in such settings, parental consent continues to be required by most jurisdictions, even when the minor can be considered cognitively "mature." *Pediatrics* 2013;131:786–793

AUTHORS: Doriane Lambelet Coleman, JD,^{a,b} and Philip M. Rosoff, MD, MA^{b,c}

^a*School of Law, Duke University, Durham, North Carolina; and*
^b*Trent Center for Bioethics, Humanities & History of Medicine, and*
^c*Departments of Pediatrics and Medicine, Duke University Medical Center, Durham, North Carolina*

KEY WORDS

mature minor, adolescents, decision-making

Professor Coleman and Dr Rosoff both devised the study and participated in writing of the manuscript; and Professor Coleman was responsible for the legal research and was primarily responsible for drafting the legal analysis.

www.pediatrics.org/cgi/doi/10.1542/peds.2012-2470

doi:10.1542/peds.2012-2470

Accepted for publication Dec 19, 2012

Address correspondence to: Professor Doriane Lambelet Coleman, School of Law, Duke University, Durham, NC 27710.
E-mail: dlc@law.duke.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2013 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: *The authors have indicated they have no financial relationships relevant to this article to disclose.*

FUNDING: No external funding.

Adolescents present particular challenges to pediatricians and other health workers involved in their care. Not only are their medical needs unique to their stages of rapid physical development, but their evolving neuropsychological maturity also poses a moving target for evaluation of their ability to engage in, and supervise, their own health care. One especially vexing problem in these circumstances is establishing if and when adolescents acquire the legal capacity to consent or not to diagnostics and treatment in general medical settings; this problem is particularly knotty where the law appears to be inconsistent with established ethical norms. It arises when parents or guardians are unavailable at the time medical decisions are being considered, when adolescents disagree with their parents or their doctors about the course of their treatment, or more simply when adolescents express an independent view about that treatment. It is well understood in the medical community that adolescents' aptitude to make rational, responsible decisions changes over time and that older teenagers and young adults have substantially similar cognitive capacities.¹⁻³ These neurobiological facts, together with an increasingly prevalent ethical sense that especially older adolescents deserve to be treated as autonomous medical decision-makers, have caused some medical professionals to believe that children after ages 12 or 13 who appear to be mature have or ought to have the right to consent or to withhold consent to general medical treatment. This ethically derived right is often described in the medical literature as the "mature minor rule" or the "mature minor doctrine."⁴⁻⁷

Several commentators have suggested that the law generally recognizes this mature minor rule; that is, based either on a mistaken conflation of ethics and law or else on a misunderstanding of

the law's details, they have implied that applicable legal rules either mirror progressive medical ethics in this context, or are at least trending in that direction.^{4,8,9,10,11} They are wrong. In fact, less than one-fifth of the states (8) have a broad mature minor exception to the standard requirement of parental consent. The remainder have no exception at all (34), have significantly narrower or conditioned versions (6), or permit minors of any age to consent to treatment in all or specific circumstances (3). Where it exists, this exception is either statutory and thus most generally applicable or common-law based and thus applicable only on analogous facts.

To clarify these circumstances, in this article, we describe the nature and extent of the law's mature minor exception to the requirement of parental consent and provide accurate, up-to-date, state-by-state guidance on adolescents' decisional authority in general medical settings. Specifically, Part I provides the legal context in which the issue of a mature minor exception is to be correctly understood and analyzes the points of disjunction between the medical and legal communities' approaches to the capacity of adolescents to consent to general medical treatment. Part II provides a detailed accounting of the states that do and do not have some version of a mature minor exception and explains the important points of law associated with the various rules at issue. For the states that do have the exception in some form, it also summarizes the exception's scope and requirements and provides citations to the applicable law. The review concludes with legal advice for medical professionals who care for adolescents and other cognitively mature minors.

Because this review is only concerned with adolescents' consent authority in general medical settings, it does not

discuss the consent issues that arise in the abortion context, which is governed by a combination of federal constitutional law and state common and statutory law that is not applicable in other medical settings. Relatedly, the review is not concerned with other well-understood exceptions to the requirement of parental consent, including emergencies; a minor's status as emancipated, married, pregnant, enlisted, or incarcerated; and a minor's ability regardless of maturity to access treatment of contraceptives, mental illness, sexually transmitted diseases, or substance abuse. These instances, which may have complicated lay observers' ability to discern the applicable law, are particularly well described in other publications.^{9,11}

I. UNDERSTANDING THE LEGAL CONTEXT AND THE RESULTING DISJUNCTION BETWEEN LAW AND MEDICINE CONCERNING THE TREATMENT OF MATURE MINORS

To the extent that there is confusion about the nature and extent of the mature minor exception, it appears to be related to a few fundamental mistakes about the law. It is thus useful as a threshold matter to make clear the following.

First, although one state's law may sometimes be influential as another state is considering its lawmaking options, state law is only formally applicable in the state at issue. What this means is that one cannot assume from a judicial decision or statutory allowance in one state that a different state's law is the same.¹² For example, a case out of Illinois that articulates a persuasive rationale for adopting a mature minor exception or a statute in Arkansas providing that minors have consent authority as long as they can meet the informed consent standard says nothing about the existence or terms of the mature minor exception in other states.

Second, the applicability of a state's law to a particular context often depends on whether that law is statutory (enacted by the legislature) or judge-made (common law). The former is limited only by its terms and its compatibility with the Constitution and thus has the broadest potential applicability. The latter is limited by its terms, its compatibility with the Constitution, and the facts of the case in which the law was developed, and thus it may have much more restricted applicability.¹²⁻¹⁴ For instance, a case adopting the mature minor exception in the context of a 17-year-old Jehovah's Witness who seeks to decline a blood transfusion may not be dispositive of a subsequent case involving a 15-year-old, an adolescent who is not religiously motivated, or an adolescent who seeks to accept (rather than to decline) treatment. In contrast, a statute that allows any minor to give lawful consent to medical treatment if she can meet the informed consent standard will apply most broadly to that category of adolescents unless there is a constitutional or other (eg, financial) impediment to that result.

More generally, it appears that much of the disjunction between the medical and legal communities' views of older adolescents' cognitive capacity and corresponding autonomy stems from these communities' different foundational principles and objectives. Although law is often based in or at least compatible with ethical norms, this is not always the case. Children's law, which is applicable to individuals from birth to the age of majority, is particularly riddled with important points of diversion. Mainly this is because its constitutional bases are longstanding and strong and thus, unlike medicine and medical ethics, have not evolved much over time. Members of the medical community who are interested in the rights of mature and maturing minors may thus gain useful insight by noting 2 of these points of diversion.

The most important of these is probably that the medical community appears largely to assume a neurobiological and developmental approach to adolescent autonomy, whereas the law's approach is primarily grounded in political theory and attendant constitutional doctrine. That is, some health care workers may assume that an adolescent's ability to make a health care choice depends or should depend on cognitive capacity and social maturity and that as these aptitudes increase, so too does (or should) decisional autonomy; given that medicine is fundamentally about the scientific facts, that medical ethics are centrally concerned with the exercise of personal autonomy conditioned only on factual capacity, and that the legal informed consent standard applicable to adults is based primarily on capacity, this assumption makes perfect sense. It is flawed from the law's perspective, however, because it fails to account for one of the most important aspects of American political theory: the fact that individual rights, including parents' rights, belong almost exclusively to adults. Indeed, children have been described as "the Achilles Heel of liberalism" precisely because their constitutional status is mostly not as bearers of individual rights.¹⁵

Thus, although the law considers children's (including adolescents') cognitive capacity and social maturity for some specific, limited purposes (most notably, responsibility for torts and crimes and the abortion decision), generally it does not. Rather, the law generally emphasizes and reemphasizes parents' decision-making rights and the "fundamental" role these occupy in our constitutional order.^{7,16} In the realm of medical care, the still-controlling US Supreme Court case on point is *Parham v. J.R.*, involving an unsuccessful challenge to a state's scheme permitting parents to commit even their unwilling children under age

18 to state mental institutions. In that case, the Court explained that its

jurisprudence historically has reflected Western Civilization concepts of the family as a unit with broad parental authority over minor children. . . . this includes a "high duty" to recognize symptoms of illness and to seek and follow medical advice. The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children. . . . The same characterization can be made for a tonsillectomy, appendectomy or other medical procedure. Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments. . . . The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority to decide what is best for the child.¹⁷

Notably, this view of the parental role (and of children's relative incapacity) is not just a matter of political theory or federal constitutional doctrine. As this excerpt from a recent Alabama Supreme Court decision involving a 17-year-old girl illustrates, it is also constituted and upheld by popular consensus on the ground:

In such matters as deciding on the need for surgical or hospital treatment, the wishes of young children are not consulted, nor their consent asked when they are old enough to give expression thereto. The will of the parents is controlling, except in those extreme instances where the state takes over to rescue the child from parental neglect or to save its life. Similarly, the right to grant or refuse a medical examination of a child belongs not to the child, but to the parents.¹⁸

Given the court's fealty to the political propositions that grounded its decision, it was irrelevant that the child at issue was on the cusp of the age of majority and otherwise a world away from biological infancy both cognitively and socially.

Faalty to these same propositions by citizens across the political spectrum also explains major policy decisions, such as why the United States has not implemented the United Nations Convention on the Rights of the Child with its requirement that both parents and the state recognize the child's "evolving capacities" and grant them decision-making rights (including medical decision-making rights) accordingly; and it explains relatively minor, related policy decisions such as why most states do not have a mature minor exception to the requirement of parental consent in general medical settings.^{18–21} Given this context, it is not surprising that most, if not all, statutes permitting minors to consent to general medical treatment were motivated not by a respect for the autonomy of mature adolescents but rather by a desire to limit the liability of health workers who care for minors in circumstances in which their parents are either unavailable or unwilling themselves to consent on their children's behalf. Lobbying to limit the liability of doctors who properly care for children is much more likely to be popular and successful than lobbying to limit the rights of parents.

The second point of diversion about objectives is closely related. The law is keenly interested in, but not exclusively guided by, facts. The most widely known instance of this diversion is probably the different ways the disciplines (science and medicine on one hand and law on the other) approach determinations of causation. For science and medicine, causation is established only if a high threshold of proof is met. For law, causation is established with this same high threshold if the matter is criminal, but if the case is civil, a 51% likelihood will do because the objective is compensation and because society is said to be willing to bear a 49% error rate if the penalty involves money (as opposed to liberty).^{22,23} Another commonly known

instance of this diversion, especially popular in the current period, is the fact that the law embraces the legal fiction of free will even as neuroscience lays the lie to that notion, because it is concerned with deterrence and retribution in addition to culpability.²⁴ The same paradigm obtains as we consider the different ways the disciplines approach mature and maturing minors; that is, the law embraces the legal fiction that childhood is, for most purposes, a monolithic category of individuals aged 0 to 18, all of whom lack legal if not cognitive capacity, because its focus tends to be on the protection of parents' rights.²⁵ Children's best interests are not erased in this equation, of course; but the strong legal presumption is that for the duration of the child's minority, parents are the proper proxy decision-makers with respect to these interests.

II. THE MATURE MINOR EXCEPTION: A STATE-BY-STATE ACCOUNTING AND EXPLANATION

A. States That Permit Minors to Consent to General Medical Treatment

As shown in Table 1, 14 states permit mature minors to consent to general medical treatment either in all or a range of restricted circumstances, and 3 states allow minors regardless of their age or maturity to consent to treatment in either all or limited circumstances.

We hesitate to generalize from these details because generalization is likely responsible, at least in part, for some of the confusion about the applicability and scope of the states' laws on the subject of minors' consent authority. Indeed, the only accurate generalization is probably that there is no such thing as "the" mature minor exception to the general requirement of parental consent, at least to the extent that this language tends to suggest a broadly applicable legal rule. A better way to

think of this area of the law is as a set of jurisdiction-specific exceptions to this general requirement.

There are, however, a few detectable patterns among the jurisdictions with exceptions. The first is to permit all adolescents above a certain age to consent to general medical treatment without regard to maturity otherwise; depending on the jurisdiction this age is 14, 15, 16, 18, or being a high school graduate. The second is to permit either all minors, all minors above a certain age (16), or all minors who are mature and capable of informed consent to consent to general medical treatment, but only if their parents are unavailable or unwilling themselves to provide consent. The third is to permit all minors who are mature and/or capable of informed consent to consent to general medical treatment.

In addition to these patterns, 3 points of law and associated caveats are mostly relevant across jurisdictions, with exceptions.

First, some states with mature minor legislation distinguish between evaluations of maturity and evaluations of the capacity to give informed consent. The 2 concepts are clearly related but also distinct (at least in the law). For example, a minor may have the cognitive capacity to understand the risks and benefits of particular treatment and the necessary will to decide voluntarily to accept or forgo the intervention, but he or she may not otherwise present as mature based on the indicia of maturity typically expected by the courts. Where the state requires that both be established, this minor would not have legal consent authority. Although the adolescent reproductive autonomy cases are not otherwise on point, because they are the only established context in which courts routinely engage the analysis of adolescent maturity, the indicia they have established for this purpose (including age, level of

education, grades in school, work or other extracurricular activities, disciplinary issues, and future plans) are useful also to judges seeking to establish maturity in other medical settings.^{26–30} Notably, age is not the predictable, developmentally based criterion in the law that it is in medicine; rather, likely because of abortion politics, 17-year-olds are often adjudicated “immature” by the courts (along with 14-year-olds) even when they are doing well in school, working part-time, and thinking about their futures.³⁰

Second, many states with mature minor legislation have parallel legislation that absolves parents of financial responsibility for medical care that is provided without their consent, that is, when the only consent provided is by their child.¹¹ (The 2 predominant rationales for parents’ constitutional decision-making rights are that parents are most likely among the potential proxies to make decisions in children’s best interests and that they deserve these rights as a *quid pro quo* for taking on the responsibilities, including the financial responsibilities, of childrearing. In this *quid pro quo* context, if the decision-making right is taken away, the corollary is that responsibility for the decision is also taken away.)¹⁶ In effect, in these states, the mature minor exception ensures that physicians and any health care facility in which the service is provided will not be liable for failure to obtain parental consent, but it does not provide the basis for recovery of fees and costs from the parents. Where this condition exists, unless there is evidence that the parents would not provide effective alternative care, it is prudent to assume that the legislature has also abrogated the common law doctrine that parents are responsible for their children’s medical necessities.

Third, although it is unlikely in the ordinary course of a medical practice (where malpractice is not an issue) that

TABLE 1 Provision for Minors’ Consent Authority by State

State	Provision for Minors’ Consent Authority and References
Alabama	By statute, Alabama provides that minors aged ≥ 14 have consent authority. No separate evaluation of maturity is required to trigger the exception. Al. Stat. Ann. 22-8-4
Alaska	By statute, Alaska provides that minors regardless of age are able lawfully to consent to medical treatment when their parent is either unavailable or unwilling to consent. Ak. Stat. Ann. 25.20.025
Arkansas	By statute, Arkansas provides that minors who are capable of meeting the informed consent standard have consent authority. No particular age or separate evaluation of maturity is required to trigger the exception. Ar. Stat. Ann. 20-9-602(7)
Delaware	By statute, Delaware provides that minors regardless of age are able lawfully to consent to medical treatment where reasonable efforts have been made first to obtain parental consent. De. Stat. Ann. 707(b)(5)
Idaho	By statute, Idaho provides that minors who are capable of meeting the informed consent standard have consent authority. No particular age or separate evaluation of maturity is required to trigger the exception. Id. Stat. Ann. 39-4503
Illinois	By judicial decision, Illinois provides that a mature minor who is capable of meeting the informed consent standard has consent authority both to accept and to refuse treatment. Case-by-case evaluations of maturity are required as a threshold matter. In cases of conflict, the courts require “clear and convincing evidence” of maturity. However, because of the state’s interests in life and relevant third parties, even a mature minor’s informed and voluntary decision to refuse treatment against the wishes of her parent(s) may be ignored. <i>In re E.G.</i> , 549 N.E.2d 322 (1989)
Kansas	By statute, Kansas provides that minors aged ≥ 16 have consent authority but only in circumstances where no parent is immediately available. Kansas Statutes 38-123b. Additionally, Kansas by judicial decision provides that a mature minor who is capable of meeting the informed consent standard has consent authority. Case-by-case evaluations of maturity are required as a threshold matter. <i>Younts v. St. Francis Hospital and School of Nursing, Inc.</i> 469 P.2d 330 (1970). The decision in <i>Younts</i> has been affirmed on multiple occasions by the state’s attorney general. Opinions Nos. 2003-35; 1992-71; 1991-49
Louisiana	By statute and opinion of the state’s attorney general, Louisiana allows any minor to consent to any treatment she or he believes to be necessary. La. Stat. Ann. 40:1095; 76 Op. Att’y Gen. 454 (Mar. 30, 1976)
Maine	By judicial decision, Maine provides that a mature minor’s preaccident statements indicating a wish never to be kept in a persistent vegetative state may be determinative of the decision whether to withdraw life support. <i>In re Chad Eric Swan</i> , 569 A.2d 1202 (1990). A subsequent decision emphasized the “exceptional circumstances” to which this very limited exception applies. <i>Connolly v. Board of Social Work Licensure</i> , 791 A.2d 125 (2002)
Massachusetts	By judicial decision, Massachusetts provides that a mature minor who is capable of meeting the informed consent standard has consent authority, but only in circumstances where the minor’s “best interests . . . will be served by not notifying his or her parents of intended medical treatment.” <i>Baird v. Attorney General</i> , 360 N.E.2d 288 (1977). Mature minors close to the age of majority who are religiously motivated may also have the right to refuse medical treatment. <i>In re Rena</i> , 705 N.E.2d 1155 (1999)

TABLE 1 Continued

State	Provision for Minors' Consent Authority and References
Montana	By statute, Montana provides that minors who have graduated from high school have consent authority. Mont. Stat. Ann. 41-1-402
Nevada	By statute, Nevada provides that minors who are capable of meeting the informed consent standard have consent authority but only in circumstances in which the health care worker believes that she or he is "in danger of suffering a serious health hazard if health care services are not provided." Nev. Stat. Ann. 129.030
Oregon	By statute, Oregon provides that minors aged ≥ 15 have consent authority. Or. Stat. Ann. 109.640. This statute may not apply to protect the right of mature minors to refuse treatment. <i>In re Connor</i> ; 140 P.3d 1167 (2006)
Pennsylvania	By statute, Pennsylvania provides that minors aged ≥ 18 and high school graduates have consent authority. 35 Pa. Cons. Stat. Ann. 10101
S. Carolina	By statute, South Carolina provides that minors aged ≥ 16 can consent to all medical treatment except "operations." SC Stat. Ann. 65-3-340. A different state statute provides that a licensed health worker may provide any necessary medical treatment to any child (regardless of age) without consent. SC Stat. Ann. 63-5-530. This provision, which appears to be a version of the traditional emergency exception, also distinguishes "operations."
Tennessee	By judicial decision, Tennessee provides that mature minors who are capable of meeting the informed consent standard have consent authority. Applying tort law's traditional rule of sevens, the state's courts further presume that minors aged 7 to 13 are not mature and that minors aged 14 to 18 are. Both presumptions are rebuttable. <i>Cardwell v. Bechtol</i> , 724 S.W.2d 739 (1987). The decision in <i>Cardwell</i> was affirmed by the state's attorney general in 2003. Tenn. Op. Att'y Gen. No. 03-087
W. Virginia	By judicial decision, West Virginia provides that mature minors who are capable of meeting the informed consent standard have consent authority. <i>Belcher v. Charleston Area Medical Center</i> ; 422 S.E.2d 827 (1992). <i>Belcher</i> cites Tennessee's decision in <i>Cardwell</i> , but rejects <i>Cardwell</i> 's reliance on the rule of sevens.

parents will have the initiative, energy, or funds necessary to seek to enforce their rights through the courts, it is important to note that bypassing parents' decision-making authority can be risky as a constitutional matter.^{16,31,32} This is true whether that authority is circumvented by action in the absence of or consistent with state law; in the hierarchy of American law, federal constitutional law is supreme. This does not mean that medical professionals should never feel comfortable treating adolescents in the absence of their parents; rather, it simply means that before they do, they should ensure that the state law pursuant to

which they proceed is one that, like the condition- and status-based exceptions, meets the requisite constitutional standard.

B. Jurisdictions That Require Parental Consent for General Medical Treatment

Thirty-four jurisdictions have no mature minor exception applicable in the general medical setting. That is, in these jurisdictions, unless a different and specific exception applies (eg, for abortions; for emergencies; minor's status as emancipated, married, or enlisted; for treatment of diseases and conditions affecting the public health) parental

consent remains the legal requirement regardless of the age or maturity of the adolescent at issue. They include Arizona, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming. Importantly, the fact that these jurisdictions do not have a generally applicable mature minor exception is not an indication of a "gray area" in the law. (It has been suggested, for example, that the mature minor rule might still exist in states that have not yet opined on the matter one way or the other.^{11,33}) The reason this and the other status- and condition-based exceptions are called "exceptions" is that there is a long-standing, comprehensive web of law that clearly establishes the default requirement of parental consent. This web of law includes federal constitutional law, state common law of contracts, and state common law of torts. As we explained in Part I, federal constitutional law has established parents' rights as "fundamental", among the most important of our individual rights; this requires the state to demonstrate a "compelling interest" if it wishes to violate them.^{7,31} It also specifically provides that medical decision-making is among the rights "fit" parents have as against their children,¹⁷ and establishes abortion as an exception to this rule in certain circumstances.³⁴ ("Fitness" is a term of art in the law; fit parents are parents who have not been legally determined to be abusive or neglectful or to have abandoned their children.) State contracts law typically does not permit individuals under the age of majority validly to contract for goods or services with the exception of necessities, and it absolves parents of

financial responsibility for their children's void or voidable contracts unless, again, these are for necessities. Importantly, purveyors of goods or services are generally not entitled to compensation from parents for necessities supplied to children in contravention of the formers' wishes unless they are unwilling or unable to provide these themselves.¹⁶ Finally, state tort law describes battery as, among other things, a medical touching that is not preceded by lawful consent. This same law typically denies children authority to provide lawful consent to medical touching.⁵⁵

It is also imprudent to assume that a state without a mature minor exception can be convinced to develop one because it already has other condition- or status-specific exceptions to the default requirement of parental consent on its books. The typical statutory exceptions for minors based on their status as married, emancipated, or enlisted, and for minors based on their need for treatment of sexually transmitted diseases, substance abuse, and mental illness, are justified by separate, specific concerns including significant public health considerations, all of which likely meet the Constitution's "compelling state interest" test. Although there is a substantial interest in progressive quarters in ensuring that all mature minors have access to general health care unrestrained by parental involvement, this interest is not constitutionally analogous. Indeed, in this period in particular, the politics in most states are anything but progressive; because of this, exceptions that benefit mature minors and take

away parental rights are more likely to be taken off the books than added on.

CONCLUSIONS

Pediatricians and other medical professionals who care for adolescents should ensure that they are familiar with and proceeding according to their particular state's laws concerning minors' consent authority. Most states do not permit even mature minors to consent to general medical care; parental consent therefore remains the default requirement in most jurisdictions. Those states that do have a mature minor exception may provide for broad consent authority, but they are likely to condition that authority on a number of grounds including, among others, age and parental availability. Additional features of the law may also be significant. For example, depending on the state, proceeding on the basis of a mature minor's lawful consent may absolve parents of responsibility for the associated medical bills.

To protect against liability in states with mature minor exceptions that require a finding of maturity, medical providers who treat adolescents on a regular basis should consider developing protocols to ensure (1) that maturity and the capacity to meet informed consent requirements are established in individual cases and (2) that appropriate records concerning maturity, the consent process, and parental availability are kept as evidence in the event of litigation. Because maturity and the capacity to meet the informed consent standard are distinct legal questions, the protocol should cover both inquiries. Although not directly applicable,

the courts' evaluations of maturity in the abortion and judicial bypass setting are helpful in detailing the aspects of development and experience that are likely to be relevant in this related context. These cases suggest that the maturity test should address aspects of the child's development and experience including age, level of education, success in school, engagement in work or other extracurricular activities, disciplinary issues, and future plans.

Finally, it should be emphasized that although the law mostly continues to require parental consent in general medical settings, this does not mean there is no role for adolescents' voices in medical decision-making or for related medical ethics norms that respect the adolescent as the patient. Indeed, it is likely that in the modern context, these voices and norms largely influence (if not actually dictate) most parents' best interests determinations. To the extent this is right, the law's requirement that the consent form be signed by a parent is mostly a formalism. Even parents who refuse to be team players in this respect, however, cannot cause a physician to act against his or her ethics. For example, although the law may permit a parent to ignore a mature adolescent's voice and even physically force treatment on an unwilling adolescent, it does not require the child's physician to partner in either effort. Ethics is thus continually operating in the interstices of the law.

ACKNOWLEDGMENTS

We thank Don Beskind, Abigail English, Kelly Leong, and Elizabeth Scott.

REFERENCES

1. Steinberg L, Cauffman E, Woolard J, Graham S, Banich M. Are adolescents less mature than adults?: minors' access to abortion, the juvenile death penalty, and the alleged APA "flip-flop". *Am Psychol.* 2009;64(7):583–594
2. Steinberg L. Should the science of adolescent brain development inform public policy? *Am Psychol.* 2009;64(8):739–750

3. Albert D, Steinberg L. Judgment and decision making in adolescence. *J Res Adolesc*. 2011;21(1):211–224
4. Hickey K. Minors' rights in medical decision making. *JONAS Healthc Law Ethics Regula*. 2007;9(3):100–104; quiz 105–106
5. Holder AR. *Legal Issues in Pediatrics and Adolescent Medicine*. 2nd ed. New Haven, CT: Yale University Press; 1985
6. Silber TJ. Adolescent brain development and the mature minor doctrine. *Adolesc Med State Art Rev*. 2011;22(2):207–212, viii
7. Will JF. My God my choice: the mature minor doctrine and adolescent refusal of life-saving or sustaining medical treatment based upon religious beliefs. *J Contemp Health Law Policy*. 2006;22(2):233–300
8. Arshagouni P. "But I'm an adult now. . . sort of". Adolescent consent in health care decision-making and the adolescent brain. *J Health Care Law Policy*. 2006;9:315–364
9. Campbell AT, English A. Law, ethics, and clinical discretion: recurring and emerging issues in adolescent health care. *Adolesc Med State Art Rev*. 2011;22(2):321–334, xi
10. Talati ED, Lang CW, Ross LF. Reactions of pediatricians to refusals of medical treatment for minors. *J Adolesc Health*. 2010;47(2):126–132
11. English A. *State Minor Consent Laws: A Summary*. 3rd ed. Chapel Hill, NC: Center for Adolescent Health & The Law; 2010
12. Newman RK Jr. *Legal Reasoning and Legal Writing: Structure, Strategy, and Style*. 5th ed. New York: Aspen Publishers; 2005
13. Burnham W. *Introduction to the Law and Legal System of the United States*. 3rd ed. St. Paul, MN: West Group; 2002
14. Llewellyn KN. *The Bramble Bush: On Our Law and Its Study*. Dobbs Ferry, NY: Oceana Publications; 1960
15. Coleman DL. Storming the castle to save the children: the ironic costs of a child welfare exception to the Fourth Amendment. *William Mary Law Rev*. 2005;412:414–540
16. Davis SM, Scott ES, Wadlington W, Whitebread CH. *Children in the Legal System: Cases and Materials*. 4th ed. New York, NY: Foundation Press; 2009
17. *Parham v. J.R.*, 422 U.S. 584 (U.S. Supreme Court 1979)
18. *R.J.D. v. Vaughan Clinic*, 572 So.2d 1225, 1227–1228 (Ala. 1990)
19. Ross LF. *Children: Families and Health Care Decision Making*. Oxford, UK: Oxford University Press; 2004
20. Woodhouse BB. From property to personhood: a child-centered perspective on parents' rights. *Georgetown J Fighting Poverty*. 1998;5:313–320
21. United Nations. *Convention on the Rights of the Child*. New York, NY: United Nations; 1990
22. Barnes DW. Too many probabilities: statistical evidence of tort causation. *Law Contemp Probl*. 2001;64:191–212
23. *Tatman v. Provincial Homes*, 382 P. 2d 573 (Arizona 1963)
24. Farahany NA. A neurological foundation for freedom. *Stanford Technol Law Rev*. 2012;4:11–25
25. Scott ES. The legal construction of adolescence. *Hofstra Law Rev*. 2000;29:547–598
26. *In re E.G.*, 549 N.E. 2d 322 (Ill. 1989)
27. *Cardwell v. Bechtol*, 724 S.W. 2d 739 (Tenn. 1987)
28. *Baird v. Attorney General*, 360 N.E. 2d 288 (Mass. 1977)
29. *Younts v. St. Francis Hospital and School of Nursing* 469 P.2d 330 (Kan. 1970)
30. *In re Jane Doe*, 566 N.E.2d 1181 (Ohio 1991)
31. *Troxel v. Granville*, 530 U.S. 57 (U.S. Supreme Court 2000)
32. Chemerinsky E. *Constitutional Law: Principles and Policies*. 2nd ed. New York, NY: Aspen Law & Business; 2002
33. Penkower JA. The potential right of chronically ill adolescents to refuse life-saving medical treatment—fatal misuse of mature minor doctrine. *De Paul Law Rev*. 1996;45(4):1165–1216
34. *Bellotti v. Baird*, 443 U.S. 622 (U.S. Supreme Court 1979)
35. Dobbs D. *The Law of Torts* (Hornbook Series). Eagan, MN: West Group; 2000