

MEDICAL DECISIONS AND CHILDREN: HOW MUCH VOICE SHOULD CHILDREN HAVE IN THEIR MEDICAL CARE?

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With infants and very young children there is no question that they lack competence for all health care decisionmaking; perhaps, there might be no controversy as well that an exceptionally mature 17-year-old is competent to consent to a relatively simple and straightforward medical treatment imposing no significant risks. But adolescents and pre-adolescents constitute one of the largest and most important classes of patients of questionable or borderline competence for the health care decisions they commonly face.¹

INTRODUCTION

Imagine a situation involving a young child, perhaps twelve years old, who has been diagnosed with inoperable cancer and is given three years to live.² There is a slight chance that with drastic, extraordinary medical care the child would survive to the age of twenty or even twenty-one. However, the treatment proposed is painful and risky with no guarantee of success. In fact, it might make the child's quality of life worse for her remaining years. If the treatment is refused, however, she will die. What should the parents do? Who decides what treatment is performed and what treatment is not performed? Is the child competent to decide on her own? If not, then what legal standard should be used to determine what is in her best interests?

This Note will attempt to answer those questions and will examine the role a child should have in determining the course of her medical treatment,

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1. Dan W. Brock, *Children's Competence for Health Care Decisionmaking*, in CHILDREN AND HEALTH CARE: MORAL AND SOCIAL ISSUES 181, 183 (Loretta Kopelman & John C. Moskop eds., 1989).

2. Terminal and life-threatening cancer is a common situation involving refusal of medical care. See, e.g., *Suenram v. Soc'y Valley Hosp.*, 383 A.2d 143 (N.J. 1977).

especially with respect to extraordinary care and life-sustaining treatment. Section I of this Note examines whether any patient has the right to refuse treatment. The right to refuse medical treatment necessitates examination of statutory provisions that affect medical treatment decisions by children. These provisions include living wills,³ powers of attorney,⁴ and advanced directives.⁵ Language in these provisions often refers only to adults,⁶ which raises the question whether these statutes apply to children. If such statutes do apply to children, then the role a child should have in filling out an advanced directive or power of attorney must be determined.

Section II examines whether children are competent to make life and death decisions regarding their medical care. If children are competent, at what age do their choices regarding medical decisions become binding and determinative? This issue is perhaps the most important and most difficult to answer.⁷

Next, Section III seeks to determine the appropriate decisionmaking standard for incompetent children. States use three different standards to determine what an incompetent patient would have wanted: (1) the subjective standard, which requires clear evidence of a directive from the patient;⁸ (2) the substituted-judgment standard, where the decisionmaker determines what the patient would have decided if he or she were competent;⁹ and (3) the best-interests standard, where a decisionmaker considers the patient's wishes before making a final determination of what is best for the patient.¹⁰

Finally, Section IV addresses what can be done to ensure that those children who are legally competent have a voice when making decisions regarding medical treatment. The conclusion is that competent children should have significant power in making routine medical decisions; however, for extraordinary care or life-sustaining decisions, the child's wishes should only be a factor in the final decision.

The best-interests standard,¹¹ while problematic, provides the best solution for making medical decisions for an incompetent child. A modified version of the best-interests standard would most accurately represent the child's wishes. For children, the adult version of the best-interests standard should be modified to include an objective and independent decisionmaker who resolves disputes between patients and physicians regarding life-sustaining and extraordinary care decisions.

3. ARIZ. REV. STAT. § 36-3261 (2006).

4. ARIZ. REV. STAT. § 36-3221 (2006).

5. ARIZ. REV. STAT. §§ 36-3291 to -97 (2006).

6. See ARIZ. REV. STAT. § 36-3221.

7. See Brock, *supra* note 1, at 184.

8. See *In re Conroy*, 486 A.2d 1209, 1229-33 (N.J. 1985).

9. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 431 (Mass. 1977).

10. See *Rasmussen v. Fleming*, 741 P.2d 674, 689 (Ariz. 1987).

11. *Id.*

I. A PATIENT'S RIGHT TO REFUSE TREATMENT

A patient's right to refuse medical treatment in spite of the fact that such a refusal will lead to his or her death raises serious medical, legal, and ethical dilemmas for courts.¹² It is important to note that the right to refuse medical treatment applies to both mentally competent and incompetent individuals.¹³ Numerous courts, when faced with this dilemma, have accepted the notion that all patients can refuse life-sustaining medical treatment.¹⁴ While the United States Supreme Court has not definitively ruled on whether the "right to die" exists, it implicitly concluded that refusal of life-sustaining medical treatment is within the patient's discretion.¹⁵

A. Right to Privacy as a Justification for the Right to Refuse Medical Treatment

The constitutional right to privacy is the primary justification courts use in finding patients have a right to refuse treatment.¹⁶ According to the Arizona Supreme Court, "the right to privacy is broad enough to grant an individual the right to chart his or her own medical treatment plan."¹⁷

The constitutional right of privacy, while not explicit in the Constitution, arises out of other guarantees in the Bill of Rights.¹⁸ The United States Supreme Court determined the right to privacy is part of a penumbra of rights that arise out

12. Thor v. Superior Court, 855 P.2d 375, 380 (Cal. 1993).

13. See Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 270 (1990); ARIZ. REV. STAT. §§ 36-3221, 36-3231, 36-3261 (2006).

14. See, e.g., Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300-01 (Ct. App. 1986); Bartling v. Superior Court, 209 Cal. Rptr. 220, 224 (Ct. App. 1984); *In re Osborne*, 294 A.2d 372, 374 (D.C. 1972); Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Estate of Brooks*, 205 N.E.2d 435, 442 (Ill. 1965); Lane v. Candura, 376 N.E.2d 1232, 1236 (Mass. App. Ct. 1978); Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 627 (Mass. 1986); *In re Requena*, 517 A.2d 869, 870 (N.J. Super. Ct. App. Div. 1986), *aff'd*, 517 A.2d 886 (N.J. Super. Ct. App. Div. 1986); *In re Quackenbush*, 383 A.2d 785, 789-90 (N.J. Super. 1978).

15. In *Cruzan*, the United States Supreme Court upheld the Missouri Supreme Court's balancing of a patient's right to refuse treatment and the state's strong interest in preserving life. 497 U.S. at 286-87, 292. The Court also assumed "for purposes of this case" that competent persons have a constitutionally protected right to refuse life sustaining medical procedures. *Id.* at 279.

16. See Rasmussen v. Fleming, 741 P.2d 674, 681-82 (Ariz. 1987); *Bartling*, 209 Cal. Rptr. at 220; Satz, 362 So. 2d at 162; Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977); Leach v. Akron Gen. Med. Ctr., 426 N.E.2d 809, 813 (Ohio Misc. 1980), *superseded on other grounds by statute*, OHIO REV. CODE ANN. § 2111.50(C) (2006), *as recognized in In re Guardianship of Myers*, 610 N.E.2d 663 (Ohio Com. Pl. 1993); *In re Welfare of Colyer*, 660 P.2d 738, 741 (Wash. 1983), *overruled on other grounds by In re Guardianship of Hamlin*, 689 P.2d 1372, 1376 (Wash. 1984).

17. *Rasmussen*, 741 P.2d at 682.

18. See *Eisenstadt v. Baird*, 405 U.S. 438, 454 (1972); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969).

of and give life to specific guarantees in the Bill of Rights.”¹⁹ Specifically, the Court found the penumbra of rights, which includes the right of privacy, are necessary to ensure that the Third Amendment’s prohibition against the quartering of soldiers, the Fourth Amendment’s right to be secure in one’s person, the Fifth Amendment’s right against self-incrimination, and the Ninth Amendment’s guarantee that the states will retain all rights not enumerated in the Constitution are fully realized by constituents.²⁰

Federal and state courts have utilized the right of privacy to guarantee patients’ rights. According to the United States Supreme Court, the right to privacy protects a woman’s right to have an abortion²¹ and a married couple’s right to use birth control pills.²² Further, the Supreme Court of Arizona determined that “[t]he right to refuse medical treatment is a personal right sufficiently ‘fundamental’ or ‘implicit in the concept of ordered liberty’ to fall within the constitutionally protected zone of privacy contemplated by the [United States] Supreme Court.”²³

A patient’s right of privacy is not unlimited and may be trumped by legitimate state interests. Applying the right to privacy in a refusal of treatment situation, the Supreme Court of New Jersey stated that the right to privacy is not absolute but must be weighed against the state’s interests.²⁴ State interests include preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties.²⁵ The New Jersey court also stated that the state’s interest “weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims.”²⁶

The right to privacy also protects an incompetent patient’s right to refuse medical treatment. The Supreme Court of New Jersey stated that the right to refuse treatment is not lost merely because a patient is incapable of competently expressing his wishes.²⁷ The court held that an incompetent patient maintains the right to refuse medical treatment, albeit through a surrogate decisionmaker.²⁸

B. Common Law Doctrine of Informed Consent as the Justification for the Right to Refuse Medical Treatment

Other courts, applying a common law approach, have determined that the right to bodily integrity or autonomy guarantees patients the right to refuse medical

19. *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (“The foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance.”).

20. *Id.* at 484–85.

21. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

22. *Griswold*, 381 U.S. at 484–86.

23. *Rasmussen v. Fleming*, 741 P.2d 674, 682 (Ariz. 1987).

24. *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976), *abrogated by In re Conroy*, 486 A.2d 1209 (N.J. 1985).

25. *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985).

26. *Quinlan*, 355 A.2d at 663–64.

27. *Conroy*, 486 A.2d at 1229.

28. *Id.*

treatment.²⁹ The United States Supreme Court departed from its previous privacy-based jurisprudence and utilized this alternative approach to conclude that the right to refuse treatment is guaranteed by the common law protection from “unwanted touching.”³⁰ The Supreme Court stated that “no 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.”³¹

The common law approach led to the development of the informed consent doctrine for medical treatment procedures.³² Justice Cardozo stated that “[e]very 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.”³³ According to the Supreme Court, the logical opposite and corollary of the right to consent to treatment is the right to refuse treatment.³⁴ The Court also implicitly stated that a right to refuse treatment is captured in the Fourteenth Amendment, which states that no State shall “deprive any person of life, liberty, or property, without due process of law.”³⁵

Additionally, a minority of courts use a mixed approach in which they rely upon both constitutional and common law concepts as justification for the patient’s right to refuse medical treatment.³⁶

C. Statutory Responses to the Right to Refuse Treatment

In response to these court decisions affirming the right of patients to refuse treatment, states have enacted statutes that establish guidelines and procedures for a competent patient’s decision to refuse life-sustaining medical treatment. These statutes allow adults³⁷ to create living wills³⁸ and health care

29. See *Thor v. Superior Court*, 855 P.2d 375, 381 (Cal. 1993); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 301 (Ct. App. 1986); *In re Gardner*, 534 A.2d 947, 951 (Me. 1987); *In re Jobes*, 529 A.2d 434, 453–54 (N.J. 1987).

30. *Vacco v. Quill*, 521 U.S. 793, 807 (1997). While the United States Supreme Court’s decisions regarding privacy are instrumental and form the basis for state court decisions, the Court itself has not relied upon the right to privacy in its refusal of medical treatment decisions. See *id.*

31. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990) (quoting *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

32. *Schloendorff v. Soc’y of N.Y. Hosps.*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957) *and superseded by statute*, 1975 N.Y. Laws ch. 109 § 1.

33. *Id.*

34. *Cruzan*, 497 U.S. at 270.

35. *Id.* at 278. See *Jacobson v. Massachusetts*, 197 U.S. 11, 24–30 (1905) (holding that a patient’s liberty interest in refusing treatment can outweigh the State’s interests).

36. *McConnell v. Beverly Enters.–Conn., Inc.*, 553 A.2d 596, 600–01 (1989); *In re C.A.*, 603 N.E.2d 1171, 1177 (Ill. App. Ct. 1992); *In re Lawrance*, 579 N.E.2d 32, 38–39 (Ind. 1991).

37. ARIZ. REV. STAT. § 36-3261 (2005) (“An *adult* may prepare a written statement known as a living will” (emphasis added)).

powers of attorney,³⁹ and to choose surrogate decisionmakers.⁴⁰ These statutes are designed to work together to allow individuals to control end-of-life decisions even if they become incompetent.⁴¹

Living wills are completed before a patient undergoes treatment and allow a patient to set out her preferences regarding life-sustaining treatments and other procedures in specific circumstances.⁴² A living will requires that an adult specify what medical care, if any, should be performed if a specific medical situation occurs.⁴³ This document also serves to protect doctors from civil and criminal liability for decisions and treatments based upon a living will.⁴⁴

In *Wright v. Johns Hopkins Health Systems Corp.*, the plaintiffs sought damages from their son's doctors for failing to abide by his living will.⁴⁵ The son's living will stated that if death was imminent and two physicians had certified his condition as terminal, no life-sustaining methods were to be used.⁴⁶ The doctors, however, performed CPR and intubated the son after they found him with no pulse.⁴⁷ The court held that the son's living will was not applicable because the doctors failed to certify the son's condition as terminal, and, as a result, the doctors were not liable for damages.⁴⁸

A health care power of attorney is similar to a living will and can be used in conjunction with a living will.⁴⁹ A health care power of attorney allows an adult patient to give another adult the power to make decisions regarding the patient's medical treatments if the patient becomes incompetent.⁵⁰ This document also allows the writer to state specifically in which medical situations the designated person will have the power to make decisions for the patient.⁵¹ Thus, when an

38. *See id.*

39. *See, e.g.*, ARIZ. REV. STAT. § 36-3221 (2005).

40. *See, e.g.*, ARIZ. REV. STAT. § 36-3231 (2005).

41. *E.g.*, ARIZ. REV. STAT. § 36-3261.

42. *E.g., id.*

43. *E.g., id.*

44. *E.g., id.*

45. 728 A.2d 166, 173 (Md. 1999), *superseded by statute*, 2002 Md. Laws 152.

46. *Id.* at 174. The son's living will stated,

If at any time I should have any incurable injury, disease or illness certified to be a terminal condition by two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, and the physicians have determined that my death is imminent and will occur whether or not life-sustaining procedures are utilized and where the application of such procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, and the performance of any medical procedure that is necessary to provide comfort, care or alleviate pain.

Id. at 172 n.9.

47. *Id.* at 171.

48. *Id.* at 175.

49. *E.g.*, ARIZ. REV. STAT. § 36-3221 (2005).

50. *E.g., id.*

51. *E.g.*, ARIZ. REV. STAT. § 36-3223 (2005).

adult combines a living will and a health care power of attorney, she is able to make a very detailed plan for what should happen if she becomes incompetent.

Surrogate decisionmaking is distinct from the two planning devices discussed above. Surrogate decisionmaking statutes identify the appropriate decisionmaker if the patient becomes incompetent before making a living will or a health care power of attorney.⁵² This method is designed to assist health care providers in locating a person with authority to make medical care decisions for the patient.⁵³ Statutes vary, but most create a hierarchy of surrogate decisionmakers and set out limitations on those individuals' authority.⁵⁴ Arizona's hierarchy places the patient's spouse first, followed, respectively, by the patient's adult child, parents, domestic partner, sibling, and close friend. An example of a limitation on authority is that in Arizona, surrogate decisionmakers that are not created by a power of attorney or living will cannot order the removal of food or hydration.⁵⁵

The next section will evaluate children's competence to make medical decisions. The level of a child's competence plays a role in the amount of power she is given over the course of her treatment. Competency also influences the structure of the tests a court should administer to determine the course of medical treatment for incompetent children. It will also influence whether living wills and health care power of attorney statutes are interpreted in a way that gives children equal protection.

II. COMPETENCY OF CHILDREN AS DECISIONMAKERS

Whether a child can act as a decisionmaker depends on that child's level of competency.⁵⁶ If a child can demonstrate the same level of competency as an adult, then it logically follows that the child should play a significant role in determining the course of her medical treatment. However, as will be discussed below, due to societal concerns and the gravity of some medical decisions, children should not be given unbridled control over their medical treatment decisions.

Competency decisions, regardless of age, pit three very important values against each other. On one side is a patient's right to self-determination. Then there is the state's duty to protect and promote the safety and health of individuals.⁵⁷ Additionally, parents and their own interests and biases add a unique third dynamic to decisions regarding children's decisionmaking authority.⁵⁸ The interests of parents, while not an explicit factor in competence decisions, play a role in deciding how much power, if any, a child should have to make medical

52. *E.g.*, ARIZ. REV. STAT. § 36-3231 (2005).

53. *E.g., id.*

54. *E.g., id.*

55. ARIZ. REV. STAT. § 36-3231(D).

56. *See Brock, supra* note 1, at 199.

57. *Id.*

58. *Id.*

treatment decisions.⁵⁹ Courts are hesitant to give a minor child the power to refuse lifesaving treatment, especially when the parents want the treatment performed.⁶⁰

A. Competence Standards Generally

While there is no generally accepted definition of competency, courts assess competence by the presence or absence of certain abilities.⁶¹ The first consideration is whether the person has the ability to communicate choices.⁶² In order for others to understand a person's wishes, that person must be able to communicate his choices. For example, a person who is incapable of speech and movement would be unable to express her desire to keep life-sustaining medical procedures in place or to ask for their removal.

Second, jurisdictions examine whether the patient understands her current situation, the available treatment options, and the consequences of those available options.⁶³ Without such understanding, a person is not capable of making competent decisions. A patient, for example, is unable to make a competent decision about accepting or rejecting medical treatment to repair a hole in her heart if she does not understand the nature of her condition or the potential consequences of either surgically repairing the heart or doing nothing.

Third, to determine competency, courts look to whether an individual is capable of understanding relevant information when making a decision.⁶⁴ This requirement goes hand in hand with the previous factor. Persons that cannot understand the relevant information required to make a medical treatment decision cannot make an informed decision. For example, a patient cannot make an informed, competent decision with respect to cancer treatment options if she cannot understand what chemotherapy is and what side effects it will cause.

Finally, in assessing a patient's competency, courts consider the person's ability to manipulate information rationally.⁶⁵ If the patient with the hole in her

59. *Id.*

60. See John Hodgson, *Rights of the Terminally Ill Patient*, 5 ANNALS HEALTH L. 169, 173 (1996).

61. "The search for a single test of competence is a search for the Holy Grail." Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 293 (1977).

62. See MO. REV. STAT. § 404.805.1(2) (2006); OR. REV. STAT. § 127.505(13) (2006) ("Incapable means that, in the opinion of the court, in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal's attending physician, a principal lacks the ability to make and communicate health care decisions.").

63. N.H. REV. STAT. § 137-J:1 (IV) (2005) ("Capacity to make health care decisions means the ability to understand and appreciate the nature and consequences of a health care decision . . .").

64. N.C. GEN. STAT. §32A-15(b) (West 2005) ("The purpose of this Article is to establish an additional, nonexclusive method for an individual to exercise his or her right . . . when the individual lacks sufficient understanding . . .").

65. S.C. CODE § 44-66-20(6) (2005) ("'Unable to consent' means unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that

heart is unable to rationally manipulate and consider the information about potential side effects, future complications, and chances of survival, any decision she makes will not be a competent decision.

A person can be competent for some decisions and incompetent for other decisions.⁶⁶ Some states take the approach that incompetence in one regard does not render that person incompetent with respect to all situations and decisions.⁶⁷ This type of distinction can play an important role regarding children.⁶⁸ For example, if a child is competent to make a decision outside of the medical treatment field, that does not mean that she is per se competent to make a decision regarding refusal of medical treatment.⁶⁹ Similarly, the child may be competent to make a decision regarding ordinary medical care while at the same time incompetent to make decisions regarding life-sustaining medical treatment.⁷⁰

B. Competence Development in Children

To be competent, a child must understand the nature and consequences of her decisions.⁷¹ With regard to medical treatment decisions, it must be determined "whether it is possible to put information relevant to [the] patient's treatment decisions in terms that children can understand."⁷² What is important is a child's ability to understand the impact of alternate treatment plans on her life, rather than her ability to understand complex medical procedures and data.⁷³

When denying children the power to make medical decisions, the courts have used two main justifications.⁷⁴ The first justification is that children are not capable of making important life decisions.⁷⁵ The United States Supreme Court in *Carey v. Population Services, International*, stated that "[t]he law has generally

decision in an unambiguous manner."). It is important to note that in South Carolina this definition does not apply to minors. S.C. CODE § 44-66-20(6). "This definition does not include minors, and this chapter does not affect the delivery of health care to minors unless they are married or have been determined judicially to be emancipated." *Id.*

66. See, e.g., 755 ILL. COMP. STAT. § 5/11a-12(c) (West 2005); SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 340-41 (3d ed. 1985) (stating that the line between competency and incompetency is blurred and a patient may be competent for some decisions but not others).

67. See N.Y. PUB. HEALTH LAW § 2963(5) (McKinney 2005) ("A determination that a patient lacks capacity to make a decision regarding an order not to resuscitate pursuant to this section shall not be construed as a finding that the patient lacks capacity for any other purpose."); 755 ILL. COMP. STAT. § 5/11a-12(c) (allowing for a limited guardian if a person is adjudged to lack some but not all competence).

68. See Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 697 (1993).

69. Redding, *supra* note 68, at 697.

70. *Id.*

71. Brock, *supra* note 1, at 184.

72. *Id.* at 186.

73. *Id.*

74. Redding, *supra* note 68, at 697.

75. *Id.*

regarded minors as having a lesser capability for making important decisions.”⁷⁶ Upholding a New York law, the Court held that only a “significant state interest” and not a “compelling state interest” was required to ban the sale of contraceptives to minors.⁷⁷ The Court reasoned that the less stringent standard was justified because of the “States’ greater latitude to regulate the conduct of children” and because minors are traditionally treated as having a lesser capability to make important decisions.⁷⁸

Second, the courts assume that parents, after being informed by the physicians, will make decisions in the best interests of the child.⁷⁹ For example, the Supreme Court held that “[m]ost children, even in adolescence, simply are not able to make sound judgments . . . including their need for medical care or treatment. Parents can and must make those judgments.”⁸⁰ However, as the next section demonstrates, the assumptions courts rely on in finding children incompetent to make medical treatment decisions are easily refuted by widely recognized developmental psychology studies.

1. Children’s Ability to Act as Competent Decisionmakers

Modern developmental psychologists have strong evidence that children after the age of fourteen develop adult-like competence. Children “are a varied population, not only in terms of age, but also with relative amounts of maturity.”⁸¹ There is, however, no one theory of competence.⁸² Most of the major theories are complimentary and differ only in minor ways.⁸³ This section will first review several of the more prominent theories of psychological development in children, and then it will examine limitations on childhood competency.

Psychologists Thomas Grisso and Linda Vierling have stated that “neither statutes nor case law provide [sic] clear guidelines for judging the competence of a minor to provide meaningful consent.”⁸⁴ According to the authors, in order for a child to give consent she must have “sufficient intelligence to understand and appreciate the consequences of her decision.”⁸⁵ They go on to suggest, using a

76. *Carey v. Population Servs. Int’l*, 431 U.S. 678, 693 n.15 (1977) (allowing minors access to contraceptives).

77. *Id.* at 693.

78. *Id.*

79. Redding, *supra* note 68, at 697.

80. *Parham v. J.R.*, 442 U.S. 584, 603 (1979).

81. Andrew Newman, *Adolescent Consent to Routine Medical and Surgical Treatment*, 22 J. LEGAL MED. 501, 503 (2001).

82. Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 293 (1977).

83. Most psychologists agree that a child or adult needs to be able to understand the information provided, reach a reasonable outcome, and rationally and voluntarily make a decision. See Paul S. Appelbaum & Thomas Grisso, *Assessing Patients’ Capacities to Consent to Treatment*, 319 NEW ENG. J. MED. 1635 (1988); Brock, *supra* note 1, at 186; 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, 52 (1996).

84. Thomas Grisso & Linda Vierling, *Minors’ Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 416 (1978).

85. *Id.* (internal citations omitted).

competence/informed consent model, that scientific evidence supports the proposition that adolescents over the age of fifteen are as competent as adults to make medical treatment decisions.⁸⁶ Based on this evidence, the authors analyze and define the concepts of knowing consent, intelligent consent and voluntary consent.⁸⁷ The development of these capacities allows a child to communicate her preferences and understand the consequences of those choices.⁸⁸

Under Grisso and Vierling's theory, the most serious impediments to a child's competence come from her inability to reason and deliberate.⁸⁹ Rational decisionmaking can be defined as "the ability to reach conclusions that are logically consistent with the starting premises."⁹⁰ A child must be able to perform several different tasks and mental processes to perform rational decisionmaking.⁹¹ For example, a child must be able to sustain her "attention to the task" at hand.⁹² In addition, the child must have the "ability to delay response in the process of reflecting on the issues," and the "ability to think in a sufficiently differentiated manner."⁹³ These abilities enable a child "to weigh more than one treatment alternative and set of risks simultaneously," and "to abstract or hypothesize as [to] yet nonexistent risks and alternatives."⁹⁴ A child with these abilities is capable of employing inductive and deductive forms of reasoning.⁹⁵ The level of reasoning and deliberation a child can reach should play a vital role in determining how much control she should have over the course of her medical treatment.⁹⁶

Another prominent theory, put forth by C.E. Lewis, focuses on a child's perception of who is in control of decisions.⁹⁷ Lewis's study examined the child's perception of where the ability and power to make decisions resides.⁹⁸ The study conducted by Lewis removed adult figures from the decision of when to visit medical professionals.⁹⁹ This forced the children to adopt a locus of control that was internal to the child and not a "but *you* were supposed to tell me what to do" reaction.¹⁰⁰ By forcing children to make decisions about seeking treatment Lewis was able to examine a child's ability to make the most basic of decisions: Do I

86. *Id.* at 423. The authors warn, however, that the entire field needs to be researched more from a clinical setting. *Id.* at 424.

87. *Id.* at 416–23.

88. *Id.* Capacity groups are composed of similar skills and abilities that usually develop together. *Id.* at 416.

89. Brock, *supra* note 1, at 186–87.

90. Appelbaum & Grisso, *supra* note 83, at 1636.

91. *Id.*

92. Grisso & Vierling, *supra* note 84, at 418.

93. *Id.*

94. *Id.*

95. *Id.*

96. *See* Redding, *supra* note 68, at 697.

97. Charles E. Lewis, *Decision Making Related to Health: When Could/Should Children Act Responsibly?*, in CHILDREN'S COMPETENCE TO CONSENT 75, 78 (Gary B. Melton et al. eds., 1983).

98. *Id.* at 77–79.

99. *Id.*

100. *Id.*

need care?¹⁰¹ This study was designed to challenge the classical notion that only a parent knows when the child needs medical attention.¹⁰²

When children are placed in control of their decisions concerning medical treatment, Lewis noticed a rate of visitation to medical professionals similar to adult patients.¹⁰³ The use of services by children ages five to twelve years old closely mimicked the same rates as that of adults age thirty-five to fifty-four.¹⁰⁴

Lewis saw this role-taking as important to developmental theory for competency determinations.¹⁰⁵ This showed that children can look at a situation and evaluate a very complex decision: Is this something I can take care of on my own or do I need professional help?¹⁰⁶ According to the study, children as young as five years old are capable of making such a decision in a way that is similar to that of adults.¹⁰⁷

Jean Piaget suggests that the psychological development of children occurs in stages.¹⁰⁸ The most important stage in the evolution of a child's ability to reason is the formal operations stage.¹⁰⁹ This stage, which usually occurs around the ages of eleven to thirteen, involves the development of several crucial abilities to a child's decisionmaking processes.¹¹⁰ According to Piaget's theory, by age fifteen a child is capable of thinking in a mature and adult fashion.¹¹¹ Children in the formal operations stage are able to "perform inductive and deductive operations . . . or hypothetical reasoning at a level of verbal abstraction that would be represented by many consent situations involving treatment alternatives and risks."¹¹² In addition, this stage sees the development of capacities necessary for a child to understand the causation of disease and illness.¹¹³ During this

101. *Id.* at 76–78.

102. *Id.* at 76.

103. *Id.* at 79.

104. *Id.*

105. *Id.* at 80.

106. *Id.*

107. *Id.* at 79.

108. See Wallace J. Mlyniec, *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 *FORDHAM L. REV.* 1873, 1878–79 (1996) (stating Piaget's beliefs that learning occurs in stages).

109. JEAN PIAGET, *THE CHILD'S CONCEPTION OF THE WORLD* (1972); JEAN PIAGET, *THE MORAL JUDGMENT OF THE CHILD* (Marjorie Gabain trans., 2d ed., Free Press 1965); JEAN PIAGET & B. INHELDER, *THE PSYCHOLOGY OF THE CHILD* (Helen Weaver trans., 2d ed., Basic Books 2000) (1969).

110. JEAN PIAGET, *THE CHILD'S CONCEPTION OF THE WORLD* 30–35 (1972); JEAN PIAGET, *THE MORAL JUDGMENT OF THE CHILD* 56–70 (1965); PIAGET & INHELDER, *supra* note 109, at 14–24.

111. Mlyniec, *supra* note 108, at 1879.

112. Grisso & Vierling, *supra* note 84, at 419.

113. The understanding of disease follows a developmental pattern. Sanford L. Leiken, *Minor's Assent or Dissent to Medical Treatment*, 102 *J. PEDIATRICS* 169, 171–72 (1983). Children around the age of five see disease and its cause as magical. *Id.* at 179–80. At age twelve or thirteen, most children begin to understand the workings of disease and the human body's response to it. *Id.* at 180–81.

developmental stage the child becomes more flexible in her thinking.¹¹⁴ This flexibility allows her to attend to multiple aspects of one problem at the same time, as would be necessary when weighing alternative treatments and results.¹¹⁵ Finally, a child's ability to use novel data and logic greatly increases during Piaget's formal operations stage.¹¹⁶

Another developmental psychologist, Lawrence Kohlberg, takes a slightly different approach from the theories above and suggests that maturity should be determined by measuring moral development.¹¹⁷ Kohlberg theorizes that children who have reached "a higher stage of moral development are . . . better able to place a moral problem within the context of the bigger picture."¹¹⁸ With maturity comes a higher level of "moral development."¹¹⁹ Kohlberg, coming to the same conclusion as Piaget, determined that children over the age of thirteen or fourteen are as competent as adults.¹²⁰

2. Limitations to a Child's Competency

Despite the psychological evidence supporting the competency of children, there are still some limitations to children's competence. Developmental psychologists and courts have warned that a child's current values might not represent and reflect her future interests.¹²¹ A child's difficulty in anticipating her future leads to two problems.¹²² First, she may give inadequate weight in her evaluations to the effects of her decisions.¹²³ Secondly, she may not be able to foresee changes to her values, changes that adults should be able to predict.¹²⁴

In order to make a decision relating to future interests, a child must have a set of values that supplies the standards by which she evaluates treatment alternatives, analyzes and understands their various features, and assigns relative

114. PIAGET & INHELDER, *supra* note 109, at 15.

115. Brock, *supra* note 1, at 187.

116. *Id.*

117. Lawrence Kohlberg, *Moral Stages and Moralization: The Cognitive-Developmental Approach*, in MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH, AND SOCIAL ISSUES 31, 52–53 (Thomas Lickona ed., 1976) (advancing a "cognitive-developmental theory of moralization, based on studies of moral stages"); *see also* Elizabeth Cauffman & Laurence Steinberg, *The Cognitive and Affective Influences on Adolescent Decision-Making*, 68 TEMP. L. REV. 1763, 1786 (1995).

118. Kohlberg, *supra* note 117, at 31–32.

119. Cauffman & Steinberg, *supra* note 117, at 1786; Kohlberg, *supra* note 117, at 52–53.

120. Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 154 (2000).

121. Michael A. Grodin & Joel J. Alpert, *Informed Consent and Pediatric Care*, in CHILDREN'S COMPETENCE TO CONSENT 93–96 (Gary B. Melton et al. eds., 1983); *In re E.G.*, 549 N.E.2d 322, 327 (Ill. 1989) ("When a minor's health and life are at stake, [the sanctity of life] becomes a critical consideration. A minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize."); *see* Allen E. Buchanan & Dan W. Brock, *Deciding for Others: Competency*, 64 Milbank Quarterly 67–80 (1986).

122. Grodin & Alpert, *supra* note 121.

123. *Id.*

124. *Id.*

weights of importance to those features.¹²⁵ However, research shows that adolescents are often more concerned with short term results, whereas an adult in the same situation focuses on the long term impacts.¹²⁶ Appreciation of the personal implications of a decision requires not only adult-like cognitive skills but adequate emotional maturity as well.¹²⁷

Psychologists also fear that parents, the state, and others will not be able to separate their own wishes, values, and beliefs from the determination of a child's competence.¹²⁸ Martin Harvey points to the hypothetical where a seventeen-year-old football player refuses life-saving heart surgery because it would forever prevent him from playing football.¹²⁹ As psychologists correctly point out, most people would find this appalling and would insist that the doctors refuse to follow the minor's decision.¹³⁰ We, as a society, are simply unable to accept the seventeen-year-old's view that a life without high school football is not a life worth living.¹³¹ But in our free and liberal society who is to say which value is the correct one?¹³²

Psychologists also warn that the theories of minor competence overlook psycho-social factors.¹³³ A minor may be competent but may act in an immature way and nonetheless make questionable decisions due to the burdens of peer pressure.¹³⁴ A great example of this is the story of Billy Best, a sixteen-year-old undergoing chemotherapy for cancer.¹³⁵ The chemotherapy was working but left Billy nauseated, aching, bald, and fatigued.¹³⁶ These treatments and side-effects isolated Billy from his classmates and friends.¹³⁷ Billy even tried to hide his illness from his classmates and friends to avoid being seen as vulnerable.¹³⁸ Rather than

125. *Id.*

126. Cauffman & Steinberg, *supra* note 117, at 1786.

127. Paul S. Appelbaum & Loren H. Roth, *Competency to Consent to Research: A Psychiatric Overview*, 39 ARCHIVES GEN. PSYCHIATRY 951 (1982).

128. See Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 303-08 (2003).

129. *Id.* at 310.

130. *Id.*

131. *Id.*

132. *Id.*

133. See Cauffman & Steinberg, *supra* note 117, at 1785-86; Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS L. REV. 1 (1996); Elizabeth S. Scott, *Judgment and Reasoning in Adolescent Decisionmaking*, 37 VILL. L. REV. 1607, 1624 (1992). Supporters of minor decisionmaking are quick to point out that "[n]o empirical evidence . . . supports the view that psychosocial factors directly affect individual medical decision-making." Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 156 (2000); see also Cauffman & Steinberg, *supra* note 117, at 1788.

134. Cauffman & Steinberg, *supra* note 117, at 1767; Mike Dorning, *Teen's Flight from Cancer Drugs Stirs Rights Debate*, CHI. TRIB., Nov. 13, 1994, at C1.

135. Dorning, *supra* note 134.

136. *Id.*

137. *Id.*

138. *Id.*

continue the treatment, Billy ran away from home, effectively refusing his treatment.¹³⁹

3. *Parents' Wishes Are Not Always in the Best Interests of the Child*

Courts often leave matters of children's competence untouched because of the presumption that a child's interests will be best protected by his parents.¹⁴⁰ The presumption that parents always act in the best interests of their child is deeply rooted in Western civilization.¹⁴¹ The presumption, however, is not always correct. For example, in the mental health arena, parents are often incapable of separating their problems from those of their children: A parent may blame her child for her (the parent's) own mental health issues.¹⁴² One psychologist explored the use of a different baseline assumption: "I shall assume that the values, needs, desires, and so-called best interests of parents and their children are not necessarily congruent. In fact, I expect that the best interests of parents and their children will often be different or even contradictory."¹⁴³ Courts have taken measures to limit this tension by developing various doctrines, such as the doctrine of *parens patriae*.

a. Conflicts Between Parents' and Children's Interests

It is difficult to separate a child's honest desires from those that merely reflect the wishes of the child's parents.¹⁴⁴ The family-systems theory posits that a child's problems and values cannot be separated from those of the family in any sort of meaningful way.¹⁴⁵ In those situations, a parent may in fact be blaming the child for the parent's own emotional problems.¹⁴⁶ For example, a mentally ill parent may have her child committed by a physician when the parent is merely depressed and needs to relieve stress from an active child.¹⁴⁷ Thus, when a parent

139. *Id.*

140. Redding, *supra* note 68, at 697; *see also* R.D. LAING, *THE POLITICS OF THE FAMILY AND OTHER ESSAYS* 33 (1971). Modern law concerning children's competence is based upon common lore, traditional assumptions about children's abilities, and idealistic views about the role of parents in making decisions for their children.

141. LAING, *supra* note 140, at 33; Redding, *supra* note 68, at 697.

142. Redding, *supra* note 68, at 697. A seven-year-old girl was hospitalized in a psychiatric ward against the advice of psychiatrists because her parents did not approve of her older boyfriend. LAING, *supra* note 140, at 33 (citing Holly Metz, *Branding Juveniles Against Their Will*, *STUDENT LAWYER*, Feb. 1992, at 21–22).

143. Gerald P. Koocher, *Competence to Consent*, in *CHILDREN'S COMPETENCE TO CONSENT* 111, 112 (Gary S. Melton et al. eds., 1983); BRAKEL ET AL., *supra* note 66, at 454–56.

144. "A child is always vulnerable to parental pressure. . . ." Rosalind Ekman Ladd, *The Child as Living Donor: Parental Consent and Child Assent*, 13 *CAMBRIDGE Q. HEALTHCARE ETHICS* 143–48 (2004).

145. LYNN HOFFMAN, *FOUNDATIONS OF FAMILY THERAPY* 45 (1981); Patricia Minuchin, *Families and Individual Development: Provocations from the Field of Family Therapy*, 56 *CHILD DEV.* 289, 291 (1985).

146. Redding, *supra* note 71, at 700.

147. *Id.* at 701.

cannot separate out his own issues from those of his child, he may insist on a course of treatment for the child that is not required and possibly even harmful.¹⁴⁸

This tension between parent and child places doctors and clinicians in awkward and difficult positions when addressing treatment options for the child. When a child or any patient is admitted for medical care, the clinician has an ethical duty to address the patient's best interests.¹⁴⁹ However, doctors often must take into account the wishes of the parents, even if they are not congruent with the needs of the child, because parents pay the bills and are often vocal in the care of their children.¹⁵⁰

b. Legal Responses to the Conflict Between Parents' and Children's Interests

In response to the recognized conflict between parental interests and the interests of the child, courts have tried to ease the tension in several ways. First, the state can exercise a power known as *parens patriae*.¹⁵¹

This power allows the state to "care for infants within its jurisdiction and to protect them from neglect, abuse, and fraud."¹⁵² When applying this power, courts have stated that parents do not have "complete control, free of all state authority."¹⁵³ Under this power, courts are allowed to consent to treatment for children when the parents are unavailable or unwilling to do so.¹⁵⁴

One common situation in which a court invokes *parens patriae* involves blood transfusions, where parents refuse blood transfusions that would save the life of their child, often on religious grounds.¹⁵⁵ In one such case, the Arizona Court of Appeals disagreed with the parents and stated that every child deserves a home with a parent or guardian that will provide medical attention for her.¹⁵⁶ The court also held that while religious beliefs may be protected, religious practices are not, and it is the court's responsibility to ensure that children receive the medical treatment they require.¹⁵⁷

148. *Id.* at 700.

149. See Matthew L. Howard, *Physician–Patient Relationship*, in LEGAL MEDICINE 235, 236 (S. Sandy Sanbar et al. eds., 5th ed. 2001).

150. See Redding, *supra* note 71, at 702 (stating that mental health physicians are often forced to take into account the parents' wishes even though they are not helpful in treatment).

151. *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769, 773 (Ill. 1952).

152. *Id.*

153. *E.g.*, *In re Appeal in Cochise County Juvenile Action No. 5666-J (Cochise County)*, 650 P.2d 467, 471 (Ariz. Ct. App. 1981), *vacated by Cochise County Juvenile Action No. 5666-J*, 650 P.2d 459 (Ariz. 1982).

154. *In re Comm'r of Soc. Servs. v. Bette D.*, 339 N.Y.S. 2d 89, 91 (N.Y. Fam. Ct. 1972).

155. See, *e.g.*, *Harley v. Oliver*, 404 F. Supp. 450, 455 (W.D. Ark., 1975); *Jehovah's Witnesses v. King County Hosp.*, 278 F. Supp. 488, 491 (W.D. Wash., 1967), *aff'd*, 390 U.S. 598 (1968); *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769, 771 (Ill. 1952); *Muhlenberg Hosp. v. Patterson*, 320 A.2d 518, 519 (N.J. Super. Ct. Law Div. 1974).

156. *Cochise County*, 650 P.2d at 469.

157. *Id.*

Courts have also adopted the "mature minor" doctrine to guarantee that minor children receive the medical treatment they require.¹⁵⁸ This doctrine allows minor children "who can understand the nature and consequences of the medical treatment [being] offered" the legal power to consent or refuse treatment in situations in which parental consent would be difficult to obtain or would cause family conflict.¹⁵⁹ It also serves to protect the physicians that treat those minors.¹⁶⁰ Courts that apply and accept this doctrine have stated that there is no bright line concerning the rights of minors.¹⁶¹ One court determined that when a "minor is mature enough to appreciate the consequences of her actions, and [when] the minor is mature enough to exercise the judgment of an adult," that minor can make decisions regarding her medical treatment.¹⁶²

The doctrine of parental support for minors' health care decisions is another attempt by courts to limit the tension between parents and children.¹⁶³ Under this doctrine, consent by a minor is a necessary, but not determinative, factor in the decisionmaking process.¹⁶⁴ Parents have the ability to limit short term decisions of their children in order to promote "lifetime autonomy."¹⁶⁵ In addition, the more a decision will impact a minor's survival the more the parents must support that decision.¹⁶⁶ The parental support doctrine, however, does nothing to address the idea that a fully competent individual should have power over her medical decisions.¹⁶⁷ In addition, the problem of conflicting interests between the parent and the child is once again a factor.¹⁶⁸

III. JUDICIAL DECISIONMAKING TESTS: ARE THEY ADEQUATE?

Because of the evolving nature of a child's competence, current judicial tests for determining the proper medical treatment for an incompetent individual are insufficient. The problem for children is that the courts presume children to be incompetent.¹⁶⁹ "For children, because of the law's presumption of incompetence, the question is how good their decisionmaking abilities and performance must be on a particular decision to overcome or rebut the presumption of their incompetence and for them to be found competent to decide for themselves."¹⁷⁰

158. See SAMUEL M. DAVIS ET AL., *CHILDREN IN THE LEGAL SYSTEM* 158–61 (3d ed. 2004).

159. Carolyn O'Connor, *Illinois Adolescents' Rights to Confidential Health Care*, 82 ILL. B.J. 24, 26 (1994).

160. DAVIS, *supra* note 159.

161. *In re E.G.*, 549 N.E.2d 322, 326 (1989).

162. *Id.*

163. Harvey, *supra* note 131, at 310–12.

164. *Id.*

165. *Id.* (quoting LAINIE FRIEDMAN ROSS, *CHILDREN, FAMILIES AND HEALTH CARE DECISION-MAKING* 61 (1998)).

166. *Id.*

167. *Id.*

168. *Id.*; Ladd, *supra* note 144, at 144.

169. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 693 n.15 (1977).

170. *Id.* at 693 n.15; Brock, *supra* note 1, at 190. The presumption of incompetence has served as "a paradigm for the manner in which the legal system deals with children." Gerald P. Koocher, *Children Under Law: The Paradigm of Consent*, in

The court tests discussed in this section presuppose that a person is fully competent or incompetent to make her own decisions. Developmental psychology evidence, however, suggests that children are not either wholly competent or wholly incompetent but are actually somewhere in between.¹⁷¹ The current all-or-nothing standard which determines the threshold separating the competent from the incompetent is simply not able to capture the evolving nature of a child's competency.¹⁷²

Currently, courts use several different tests to determine the appropriate course of action for an incompetent individual, whether adult or child. The actual type of test used varies by state but falls into one of three categories: the subjective standard,¹⁷³ the substituted-judgment standard,¹⁷⁴ and the best-interests standard.¹⁷⁵

A. Decisionmaking Tests

1. Subjective Standard

The subjective standard is the strictest test for determining what course of medical treatment should be followed. It requires clear evidence of a directive from the patient.¹⁷⁶ This standard requires more than casual statements by the patient about treatment preferences.¹⁷⁷ The wishes of the patient must be specific and not too far removed in time from the onset of the patient's condition.¹⁷⁸ The subjective standard is so strict that courts have rejected attempts to remove life-sustaining treatment where a patient expressed that she did not want to be a burden on her family,¹⁷⁹ that she did not want to live in a vegetative state,¹⁸⁰ and that she did not want to lose her dignity.¹⁸¹

The United States Supreme Court applied the subjective standard in *Cruzan v. Director, Missouri Department of Health*.¹⁸² In *Cruzan*, the Court determined that a test requiring clear and convincing evidence to prove a patient's intent regarding medical decisions was not unconstitutional.¹⁸³ The patient had suffered a serious car accident and was in a persistent vegetative state.¹⁸⁴ The

REFORMING THE LAW: THE IMPACT OF CHILD DEVELOPMENT RESEARCH 3, 6 (Gary B. Melton ed., 1987).

171. See Brock, *supra* note 1, at 190.

172. See *id.*

173. See *In re Conroy*, 486 A.2d 1209, 1229–33 (N.J. 1985).

174. See *Barber v. Superior Court*, 195 Cal. Rptr. 484, 493 (Ct. App. 1983).

175. See *Rasmussen v. Fleming*, 741 P.2d 674, 689 (Ariz. 1987).

176. See *In re Conroy*, 486 A.2d at 1229–33.

177. *In re Westchester County Med. Ctr. ex rel. O'Connor (O'Connor)*, 531 N.E.2d 607, 614–15 (N.Y. 1988) (holding that statements by the patient that she did not want to be a burden and did not want to be kept alive by artificial means were not clear and convincing evidence of her wishes).

178. *Id.*

179. *O'Connor*, 531 N.E.2d at 614–15.

180. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 285 (1990).

181. *O'Connor*, 531 N.E.2d at 614–15.

182. *Cruzan*, 497 U.S. at 280.

183. *Id.*

184. *Id.* at 265–66.

patient's parents sought to end the life-sustaining treatment, arguing that in conversations with her roommate, the patient had expressed her wish to not be kept on life support.¹⁸⁵ The Court concluded that the Missouri Supreme Court did not act unconstitutionally when it refused to allow the patient's parents to terminate their daughter's life-sustaining medical treatment despite her expressed desire to not be kept alive in a brain dead, comatose state.¹⁸⁶ The Court found that the patient's conversations and other actions did not deal with the removal of nutrition and hydration and, therefore, were not clear and convincing evidence of the patient's intent.¹⁸⁷

This standard presents problems when applied to children. Clear directives are difficult enough to come by for adults. It is highly unlikely that a child who is incompetent to make medical decisions will provide clear directives for specific medical situations.¹⁸⁸ In fact, if the child is not competent to make the decision in the first place, it is probable that the child does not understand the nature of medical procedures.¹⁸⁹ Hence, it is impossible for the child to provide clear directives for specific situations.¹⁹⁰ Because of the child's inability to provide such clear directives, the court would be forced to deny the refusal of medical treatment, or the court would have to turn to the parents and the resulting problems that that situation presents.¹⁹¹ In light of these problems, it is safe to say this standard provides the least protection for a child's autonomy and self determination.¹⁹²

2. Substituted-Judgment Standard

The substituted-judgment standard is the most common test courts use to determine an incompetent patient's wishes.¹⁹³ Courts, when applying this test, search for what the patient would have decided under the circumstances had she been competent.¹⁹⁴ The most important factor to the court's determination is the

185. *Id.* at 267–68.

186. *Id.* at 285.

187. *Id.*

188. *See In re C.A.*, 603 N.E.2d 1171, 1180 (Ill. App. Ct. 1992).

189. *See id.* at 1181.

190. *See id.* at 1180–81.

191. *See In re Rosebush*, 491 N.W.2d 633, 639–40 (Mich. Ct. App. 1992).

192. *See In re C.A.*, 603 N.E.2d at 1180; *Rosebush*, 491 N.W.2d at 639.

193. *See Barber v. Superior Court*, 195 Cal. Rptr. 484, 493 (Ct. App. 1983); *Footy v. Manchester Mem'l Hosp.*, 482 A.2d 713, 720–21 (Conn. Super. Ct. 1984); *In re A.C.*, 573 A.2d 1235, 1247 (D.C. 1990); *In re Guardianship of Browning*, 568 So. 2d 4, 16 (Fla. 1990); *Morgan v. Olds*, 417 N.W.2d 232, 236 (Iowa Ct. App. 1987); *In re P.V.W.*, 424 So. 2d 1015, 1020 (La. 1982); *Mack v. Mack*, 618 A.2d 744, 757–58 (Md. 1993); *Guardianship of Jane Doe*, 583 N.E.2d 1263, 1267–68 (Mass. 1992); *In re Rosebush*, 491 N.W.2d at 639; *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976), *abrogated by In re Conroy*, 486 A.2d 1209 (N.J. 1985); *In re Guardianship of L.W.*, 482 N.W.2d 60, 75–76 (Wis. 1992).

194. *See In re A.C.*, 573 A.2d 1235, 1247 (D.C. 1990); *DeGrella v. Elston*, 858 S.W.2d 698, 709 (Ky. 1993); *Mack*, 618 A.2d at 757–58.

patient's wishes.¹⁹⁵ Unlike the subjective standard, courts have allowed these wishes to be inferred from circumstantial evidence.¹⁹⁶ In fact, recently made general statements have been found sufficient to represent a patient's wishes regarding life-sustaining medical treatment.¹⁹⁷ In addition to the patient's wishes, judges consider the patient's age,¹⁹⁸ the probable side effects of treatment,¹⁹⁹ the likelihood that the treatment will cause suffering,²⁰⁰ the patient's reaction to the medical treatment of others,²⁰¹ the patient's religious beliefs,²⁰² and the patient's prognosis with and without the treatment.²⁰³

DeGrella v. Elston provides an example of how a court has applied the substituted-judgment standard.²⁰⁴ In this case, the patient's mother sought to remove her daughter's feeding tube after tests showed that the patient had suffered severe mental trauma that could not be remedied by ongoing medical treatment.²⁰⁵ The court determined that the mother had proved, by clear and convincing evidence, that her daughter would have wanted the feeding tube removed based on the medical facts, the patient's prognosis, and the patient's statements to the effect that she did not want to be kept alive through artificial means.²⁰⁶

Most cases, regardless of the judicial standard applied, involve patients who were competent at one time but are now no longer able to make informed decisions.²⁰⁷ It is difficult, if not impossible, for courts to apply the substituted-judgment standard if the patient has never been competent.²⁰⁸ In those situations,

195. See *A.C.*, 573 A.2d at 1247; *DeGrella*, 858 S.W.2d at 709 (“[S]tatements of choice made before [patient] became incompetent, while not dispositive of the question at hand, are competent evidence upon which a surrogate decision-maker could exercise substitute judgment in the circumstances presented.”); *Mack*, 618 A.2d at 757–58.

196. See *A.C.*, 573 A.2d at 1247 (stating that a court must “determine the patient’s wishes by any means available”); *DeGrella*, 858 S.W.2d at 709; *Mack*, 618 A.2d at 758.

197. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 285–87 (1990) (upholding the Missouri Supreme Court’s ruling that Cruzan’s statement that she would not want to live life as a “vegetable” was not sufficient to represent her wishes).

198. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 422 (Mass. 1977).

199. *Id.*; *Mack*, 618 A.2d at 758.

200. *Superintendent of Belchertown State Sch.*, 370 N.E.2d 417, 422.

201. *McConnell v. Beverly Enters.—Conn., Inc.*, 553 A.2d 596, 605 (Conn. 1989); *In re Estate of Greenspan*, 558 N.E.2d 1194, 1198 (Ill. 1990); *In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985).

202. *In re Guardianship of Browning*, 543 So. 2d 258, 262 (Fla. Dist. App. Ct. 1989); *DeGrella v. Elston*, 858 S.W.2d 698, 709 (Ky. 1993); *Care & Protection of Beth*, 587 N.E.2d 1377, 1381 (Mass. 1992); *In re Quinlan*, 355 A.2d 647, 658 (N.J. 1976), *abrogated by In re Conroy*, 486 A.2d 1209 (N.J. 1985).

203. *Browning*, 543 So. 2d at 272; *Mack*, 618 A.2d at 758; *Care & Protection of Beth*, 587 N.E.2d at 1381.

204. 858 S.W.2d at 700–02.

205. *Id.*

206. *Id.* at 702–03, 710.

207. See, e.g., *In re A.C.*, 573 A.2d 1235, 1238 (D.C. 1990).

208. E.g. *In re Rosebush*, 491 N.W.2d 633, 639 (Mich. Ct. App. 1992); see also John Hodgson, *Comparative Health Law: Rights of the Terminally Ill Patient*, 5 ANNALS HEALTH L. 169, 170 (1996).

courts are forced to determine wishes that were never stated by the patient and could not have been stated because of the patient's incompetency.²⁰⁹

This problem is particularly acute when the test is applied to children, especially incompetent children. In fact, one court stated that the "substituted judgment test . . . is of limited relevance in the case of infants or immature minors."²¹⁰ Incompetent children, almost by default, do not have stated wishes that can be followed by courts.²¹¹ It is therefore impossible for a court to determine what the wishes of the child would be had the child been able to make the decision.²¹² In essence, the court would be guessing at the child's wishes without any foundation. This standard, therefore, does very little to protect the child's rights and interests.

3. Best-Interests Standard

The third standard that courts apply when attempting to decide what course of medical treatment should be followed is the best-interests standard. This test is most useful when patients have not expressed or were unable to express a view on whether they would want to undergo life-sustaining medical treatment.²¹³ Under this standard, the views of the patient are one factor in a multifaceted balancing test, and in applying this test, the patient's wishes are not determinative.²¹⁴ Instead, the decisionmaker balances the benefits of treatment against its burdens.²¹⁵ The test is a mixed subjective and objective test that takes into consideration objective medical data and the perceived subjective wishes of the patient.²¹⁶ Specifically, judges consider whether the continued treatment would relieve suffering or would improve the patient's condition.²¹⁷ Any benefits are then

209. See *Rosebush*, 491 N.W.2d at 639; *In re Jobes*, 529 A.2d 434, 447 (N.J. 1987); *In re Storar*, 420 N.E. 2d 64, 73 (N.Y. 1981); *In re Guardianship of Myers*, 610 N.E.2d 663, 669–70 (Ohio Ct. Com. Pl. 1993). When the patient has never been competent, courts turn to one of the other tests, subjective or best interests, to determine the patient's desires and preferences regarding medical treatment. See, e.g., *Rasmussen v. Fleming*, 741 P.2d 674, 688–89 (Ariz. 1987) (applying a best-interests standard).

210. *Div. of Family Servs. v. Carroll*, 846 A.2d 256, 271 (Del. Fam. Ct. 2000).

211. *Rosebush*, 491 N.W.2d at 639–40.

212. "[T]he application of substituted judgement necessitates that the patient had been competent at one time and had in some manner expressed her preferences or values concerning life-sustaining treatment." *In re K.I.*, 735 A.2d 448, 465 (D.C. 1999) (quoting Karen H. Rothenberg, *Foregoing Life-Sustaining Treatment: What Are the Legal Limits in an Aging Society?*, 33 ST. LOUIS U. L.J. 575, 586 (1989)).

213. See *Rasmussen*, 741 P.2d at 689; *Conservatorship of Drabick*, 245 Cal. Rptr. 840, 854–55 (Ct. App. 1988); *In re Conservatorship of Torres*, 357 N.W.2d 332, 338 (Minn. 1984); *In re Conroy*, 486 A.2d 1209, 1229–32 (N.J. 1985); *In re Guardianship of Grant*, 747 P.2d 445, 455–56 (Wash. 1987).

214. See *Rasmussen*, 741 P.2d at 689–90 (applying best-interests standard in absence of patient's express wishes).

215. See *id.* at 689.

216. See *id.*

217. *In re Conroy*, 486 A.2d at 1231; *In re Guardianship of L.W.*, 482 N.W.2d 60, 63 n.4 (N.J. 1985).

weighed against the subjective costs of continued treatment which include continued pain,²¹⁸ indignity,²¹⁹ and a diminished quality of life.²²⁰

Rasmussen v. Fleming is a good example of the application of the best-interests standard.²²¹ There, the guardian ad litem for the patient argued that the public fiduciary must agree to remove the “do not resuscitate” and “do not hospitalize orders” before he could be appointed as guardian over the patient.²²² The court held that a guardian has the right to exercise the patient’s refusal of medical care in the best interests of the patient.²²³ The court stated that often the best interests of the patient involve the refusal of medical care.²²⁴

The problem with the best-interests standard is that it is inherently vague and unpredictable in its application.²²⁵ Considering the values and options involved, it is reasonable that different people would view the best interests of the child differently.²²⁶ This often leads to harsh and serious disagreements about what is in the best interests of the patient.²²⁷ In turn, the disagreement turns not into a decision of what the best interests of the patient are, but who the decisionmaker is, because the decisionmaker will implement what she feels is in the best interests of the patient.²²⁸ Therefore, the best-interest standard still leaves much of a patient’s interests and rights unprotected.

Despite its shortcomings, the best-interests standard presents the best option for protecting the rights of incompetent children. Courts have stated that when dealing with a minor who has never been competent, the best-interests standard is the only reasonable option.²²⁹ “The best interests standard . . . allows a guardian or court to objectively weigh the benefits and burdens of a proposed course of action to determine ‘how a reasonable person in the patient’s circumstances would promote her well being.’”²³⁰ This standard, as discussed in

218. *In re Conroy*, 486 A.2d at 1231.

219. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Ct. App. 1986); *Torres*, 357 N.W.2d at 340; *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990).

220. *Conroy*, 486 A.2d at 1231; *McKay*, 801 P.2d at 624. Some courts however are wary of this factor, considering it a prelude to euthanasia. *See Mack v. Mack*, 618 A.2d 744, 759 (Md. 1993).

221. 741 P.2d at 688.

222. *Id.* at 679.

223. *Id.* at 688–89.

224. *Id.* (“[T]he right to consent to or approve the delivery of medical care must necessarily include the right to consent to or approve the delivery of *no* medical care. To hold otherwise would . . . ignore the fact that oftentimes a patient’s interests are best served when medical treatment is withheld or withdrawn.”).

225. *Ladd*, *supra* note 144, at 144.

226. *Id.*

227. *Id.*

228. *Id.*

229. *Div. of Family Servs. v. Carroll*, 846 A.2d 256, 272 (Del. Fam. Ct. 2000).

230. *In re K.L.*, 735 A.2d 448, 465 (D.C. 1999) (quoting Karen H. Rothenberg, *Foregoing Life-Sustaining Treatment: What Are the Legal Limits in an Aging Society?*, 33 ST. LOUIS U. L.J. 575, 586 (1989)).

Section IV of this Note, is the only practical way to determine the proper medical treatment for incompetent children.²³¹

B. Burden of Proof

Courts require clear and convincing proof when determining whether an incompetent patient wishes to terminate life-sustaining medical treatment.²³² This burden of proof is often described as “proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented.”²³³

The United States Supreme Court decision in *Cruzan* explicitly held that a standard of clear and convincing evidence is not unconstitutional.²³⁴ However, the Court acknowledged that different courts have different standards of clear and convincing evidence.²³⁵ State courts have, under their respective tests, required different things. For example, the subjective standard requires proof of the patient's previously expressed directives.²³⁶ The substituted-judgment standard, on the other hand, requires proof of what the patient's wishes would be.²³⁷ Alternatively, the best-interests standard requires proof of what is in the best interests of the patient.²³⁸

The standard varies greatly by court and is very fact intensive. For example, one court applying the substituted-judgment standard held that the burden was not met even though the patient's daughters testified that patient had told them that she did not want to be kept alive on machines.²³⁹ The patient also stated that “she would never want to lose her dignity before she passed away, that nature should be permitted to take its course, [and] that it is ‘monstrous’ to use life-support machinery.”²⁴⁰ The court further stated that such statements were statements “older people frequently, almost invariably make.”²⁴¹

IV. RECOMMENDATION AND CONCLUSION

In *Cruzan*, the United States Supreme Court acknowledged the right of a person to refuse medical treatment.²⁴² That right may be exercised by incompetent

231. *Infra* Part IV.C.

232. *See, e.g.*, *Rasmussen v. Fleming*, 741 P.2d 674, 688 (Ariz. 1987).

233. *In re Westchester County Med. Ctr. ex rel. O'Connor*, 531 N.E.2d 607, 613 (N.Y. 1988).

234. 497 U.S. 261, 284 (1990).

235. *Id.*

236. *See, e.g.*, *Cruzan v. Harmon*, 760 S.W.2d 408, 415 (Mo. 1988), *aff'd*, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

237. *See, e.g.*, *DeGrella v. Elston*, 858 S.W.2d 698, 709 (Ky. 1993).

238. *See, e.g.*, *In re C.A.*, 603 N.E.2d 1171, 1180 (Ill. App. Ct. 1992).

239. *In re Westchester County Med. Ctr. ex rel. O'Connor*, 531 N.E.2d 607, 614–15 (N.Y. 1988).

240. *Id.*

241. *Id.*

242. In *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 279 (1990), the Court assumed such a right exists, and it does not later repudiate that assumption.

and competent individuals alike.²⁴³ To protect the right to refuse treatment, states have enacted statutes that enable individuals to plan ahead and make serious medical decisions in advance.²⁴⁴ In addition, special decisionmaking tests have been developed that allow courts and guardians to exercise the right to refuse medical treatment on behalf of an incompetent individual.²⁴⁵

Children present a special problem because they are in a state of constant physical and emotional growth. Their competence and mental abilities are constantly evolving and improving. Therefore, any competence and decisionmaking standard must reflect the developing nature of children.

Merely seeking a child's informed consent at the beginning of rehabilitation treatment has been shown to greatly improve the treatment's effectiveness.²⁴⁶ In fact, seeking informed consent from children may even improve competence because children often lack opportunities to exercise their rights.²⁴⁷ Allowing children to exercise legal rights may help them to develop decisionmaking competencies relating to legal issues and life choices, and gradually to assume adult-like responsibilities.²⁴⁸

A. When Children Are Competent Decisionmakers

Based on the developmental psychology evidence cited above in Section III, there is a strong argument that children around the age of fourteen are competent to be involved in decisions regarding their medical treatment.²⁴⁹ According to clinical psychological research, children around the age of fourteen are capable of levels of competence similar to that of adults.²⁵⁰ In fact,

243. *E.g.*, *In re Conroy*, 486 A.2d 1209, 1229 (N.J. 1985).

244. *E.g.*, ARIZ. REV. STAT. §§ 36-3221 to -3261 (2006).

245. *Eichner ex rel. Fox v. Dillon*, 426 N.Y.S.2d 517, 547 (App. Div. 1980) (subjective standard); *Barber v. Superior Court*, 195 Cal. Rptr. 484, 493 (Ct. App. 1983) (substituted-judgment standard); *Rasmussen v. Fleming*, 741 P.2d 674, 689 (Ariz. 1987) (best-interests standard).

246. *See Rochelle T. Bastein & Howard S. Adelman, Noncompulsory Versus Legally Mandated Placement, Perceived Choice, and Response to Treatment Among Adolescents*, 52 J. CONSULTING & CLINICAL PSYCHOL. 171, 178 (1984).

247. *See Sigmund E. Dragastin, Epilogue to ADOLESCENCES AND THE LIFE CYCLE: PSYCHOLOGICAL CHANGE AND SOCIAL CONTENT* 291, 296 (Sigmund E. Dragastin & Glen H. Elder, Jr. eds., 1975).

248. Redding, *supra* note 68, at 709 (citing PRESIDENT'S COMM'N ON MENTAL HEALTH, REPORT TO THE PRESIDENT FROM THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 638 (1978) (report of the Task Panel on Mental Health)).

249. *See Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337-38 (Kan. 1970) (holding that a seventeen-year-old consenting to surgery was mature enough to withstand a challenge); 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, 21-24, 53 (1996).

250. "[C]hildren as young as about twelve appear to have a factual understanding and appreciation for the risks and benefits of psychotherapy . . . nine-year-olds appear to understand many basic aspects of treatment, including differences between various diagnoses and prognoses, and treatment risks and benefits. Twelve-year-olds are able to define accurately many basic legal concepts." Redding, *supra* note 68, at 708.

psychologists have concluded that “adolescents do not substantially differ from adults in their ability to understand and reason about medical treatment alternatives.”²⁵¹ In addition, research shows that minors can “reason abstractly about hypothetical situations, reason about multiple alternatives and consequences, consider multiple variables, combine variables in more complex ways, and use information systematically.”²⁵²

B. Decisionmaking Process for Competent Children

While fourteen-year-olds may in fact have the power to reason and make rational decisions, the inability of children to predict their future interests and fully evaluate the effects of their decisions suggests that children should not be given complete control over their medical decisions.²⁵³ A balance must be found between the right of a competent child to chart her medical treatment and society's desire to promote and protect the welfare of children.

I believe that this balance can be found by allowing a competent child the full control to make decisions regarding treatments that are not life-sustaining or extraordinary.²⁵⁴ For example, a competent child with a sprained ankle could decide whether to place it in a full cast or a walking boot, or instead to use physical therapy. When decisions regarding life-sustaining or extraordinary treatment must be made, a child's desires should play a significant role in the decisionmaking process but should not be determinative. Decisions of this nature should never be made without outside opinions or viewpoints. For this reason, life-sustaining treatment decisions should involve not only the wishes of the child but also the parents of the child and the child's physician.

251. Maggie O'Shaughnessy, *The Worst of Both Worlds?: Parental Involvement Requirements and the Privacy Rights of Mature Minors*, 57 OHIO ST. L.J. 1731, 1753 (1966).

252. Mlyniec, *supra* note 108, at 1882 (quoting Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 LAW & HUM. BEHAV. 129, 147-48 (1992)).

253. Grodin & Alpert, *supra* note 121.

254. Life sustaining treatment is defined as that which serves only to prolong life and does not heal or cure the patient. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 3 (1983). Included among this grouping of treatments are ventilators and respirators, kidney dialysis, and transfusions. *See, e.g.*, *Severns v. Wilmington Med. Ctr., Inc.*, 421 A.2d 1334, 1344 (Del. 1980) (respirator); *In re R.H.*, 622 N.E.2d 1071, 1074 (Mass. App. Ct. 1993) (kidney dialysis); *In re E.G.*, 549 N.E.2d 322, 327 (Ill. 1989) (transfusions). It is important to note that there is a difference between ordinary and extraordinary care. *See Foody v. Manchester Mem'l Hosp.*, 482 A.2d 713, 719 (Conn. Spec. Ct. 1984). Courts base this decision on medical ethics that require physicians to perform ordinary care but allow a doctor to cease extraordinary treatment at the request of the patient. *Id.* Ordinary care is defined as treatments that “offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.” *Id.* (citation omitted). Extraordinary care, on the other hand is defined as “all medicines, treatments, and operations which cannot be obtained or used without excessive expense, pain or other inconvenience, or if used, would not offer a reasonable hope of benefit.” *Id.* (citation omitted).

The child's physician should be involved in the decisionmaking process as an outside observer. The physician's role is vital because parents are, understandably, very emotional when their child is facing serious medical decisions.²⁵⁵ This emotional state may prevent a parent from correctly assessing what is in the child's best interests and acting in a rational manner.²⁵⁶ Therefore, crucial decisions, such as those regarding life sustaining or extraordinary care, must be viewed with a certain suspicion. The physician serves as a counter-balance to the potential irrationality of the child's parents.

Under this division of decisionmaking power, a child should be allowed to make an advanced directive that incorporates a living will and health care power of attorney. The advanced directive would spell out exactly what the child wants done in specific situations. It would also specify who would be authorized to make decisions regarding medical treatment for the child should she become incapacitated.²⁵⁷ Ideally, the form would be notarized or authenticated in some manner to ensure authenticity. This would potentially prevent any difficult situations involving a difference of opinion between the child, the parents, and the doctor.

Two options are available if the child, the parents, and the doctor are unable to agree on a single course of action with regard to life sustaining or extraordinary care. The first option calls for a vote—with each actor (parent, child, doctor) having one vote—where the majority's course of action will be implemented. This would be the preferred option because it would prevent possible hard feelings resulting from a court's or uninvolved third party's intrusion. In addition, any decision would either be in accordance with medical advice (parents and doctor, child and doctor) or would require the consent of the entire family to go against medical advice (parents and child).

Second, hospitals could create an arbitration committee that would be available to resolve conflicts involving life-sustaining or extraordinary treatments. The committee would seek to determine the best interests of child and then order that medical care be given or withheld as appropriate. This option could also serve as a backup to the first option if no course of medical treatment commands a majority of the votes.

These options allows competent children to participate in making decisions regarding the course of their medical treatment while, at the same time, protecting the child from potentially unwise, life-threatening decisions. Thus, the child is able to exercise her right to participate in making decisions about the course of her medical treatment, but the parents and the doctor ensure that the child is protected from her own potentially harmful, irrational decisions.

255. See Ladd, *supra* note 144, at 144.

256. *Id.*

257. Normally the decision makers will be the parents but in non-nuclear families this could prevent disputes between step-parents, extended family members, etc., all of whom, in their own minds, would be acting in the child's best interests.

C. Decisionmaking for Incompetent Children

The best-interests standard, as discussed above, provides the best option for incompetent children.²⁵⁸ The test, however, must be fine tuned for application to children. Most notably, the test needs to be formulated in a way that addresses the parent's wishes and concerns while, at the same time, focusing on the child's best interests.

A court could incorporate the evolving standard of competency by first looking to whether the treatment is ordinary or extraordinary. If the decision involves only ordinary care then the court would need to determine whether the child is competent to make the decision. If so, then the child makes the decision and nothing further happens.²⁵⁹ If the child is incompetent, then the decision is left to the parents.

However, if the situation involves life-sustaining treatment or extraordinary care, the court would need to evaluate the child's competence. Absolute certainty of the child's best interests would not be needed. In fact, according to the Supreme Court, clear and convincing evidence is constitutionally sufficient and I see no reason why it would be inappropriate here.²⁶⁰ Requiring an elevated standard would create enormous burdens that either side would be hard pressed to satisfy. Should the court determine the child is incompetent, the court would then need to determine the best interests of the child. In making this decision, the court should be wary of parents' stated preferences because of the inherent potential of irrational and emotionally-based decisions.

While this approach does interfere with the rights of parents to make decisions regarding their children, decisions of this magnitude deserve to have a second opinion. Refusal of care decisions are crucial decisions, and it is important that the wishes and interests of the child be protected. In addition, this system would not completely abrogate a parent's rights to make other medical decisions free of medical interference. A parent would still be free to make decisions for his incompetent child that do not involve life-sustaining treatment or extraordinary care.

Thus, the focus would remain on the best interests of the child. In addition, the parents' rights would be protected, but when decisions regarding life or death situations went against medical advice, the parents' decisions would be balanced with the best interests of the child by an outside decisionmaker. Importantly, society's interest in ensuring that children receive medical treatment and are not inappropriately denied medical care would also be satisfied.

258. See *supra* Part III.A.3; *In re Rosebush*, 491 N.W.2d 633, 639–40 (Mich. Ct. App. 1992).

259. Realistically, it is unlikely a case like this would reach a court. However, should a routine medical decision require a court's intervention, the child's wishes should be controlling.

260. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 285 (1990)