The Role of Minors in Health Care Decision Making: Current Legal Issues

by David J. Waxse

Legal guidelines have not kept pace with the ethical principles which serve as a basis for the MBC Guidelines *document. Constitutional and statutory laws affecting children do not prohibit informed decision making and consent on the part of the minor provided the parent or guardian is also a part of this process.*

A question often asked during the development of the *Health Care Treatment Decision-Making Guidelines For Minors* was, "What is the law in this particular area?" The project task force determined that the proposed guidelines would be created based on ethical principles rather than on the legal standards. The purpose of this paper is to examine the law relating to minors generally, and in Kansas and Missouri specifically, to consider the possible legal ramifications on the use of guidelines.

Before examining the legal issues, it is helpful to review the ethical principles upon which the guidelines are based.

Guideline Principles

A basic principle of bioethics is that an individual has an absolute right to participate in the decision-making process concerning his/her own medical treatment. As the field of bioethics evolves, one of the critical areas that the public as well as health care providers must recognize as a part of that principle is the ability of a minor (a person under the age of eighteen for most purposes) to participate actively in the decision-making process concerning his/her own medical treatment. In most circumstances, it is logical to allow all individuals with the ability to make an informed decision to participate in that decision-making process.

In general, however, the law both limits the rights of minors and affords them special protection. In most instances, minors are not allowed to speak for themselves; rather the law gives their parents or guardians the decision-making responsibility and authority to consent, regardless of the minor's own decision-making capacity.

This paper discusses the evolution of the legal principles concerning a child's legal status and argues that in a health care setting, minors should be treated according to capacity and not age.

Origins of a Child's Legal Status

The United States Constitution is the obvious starting point of any discussion of the legal framework within which the members of society must function. Regrettably, the Constitution does not even mention children. It was not until the late 1960s and the historic United States Supreme Court decision in *Inre Gault* that the Supreme Court even considered a child a "person" within the meaning of the Fourteenth Amendment and the Bill of Rights. While Supreme Court cases decided in the early twentieth century seemed to protect children, when examined in depth it is apparent that the Supreme Court in reality refused to give children legal rights independent of their parents. Instead, the Court focused its opinions on the vindication of the parents' rights rather than identifying children as members of society who deserved distinct protection under the

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Constitution.

With the 1967 decision in *In re Gault*, the Supreme Court made it clear that children possessed constitutional rights. Justice Abe Fortas, writing for the majority, stated, "... neither the Fourteenth Amendment nor the Bill of Rights is for adults alone." The Supreme Court, however, has refused to provide children the full gamut of constitutional rights afforded adults. Nevertheless, over the years since the Gault decision, the Supreme Court has decided numerous cases further establishing and defining a child's specific rights under the Constitution. The Supreme Court's decisions in these cases have helped form the legal parameters which support the premise that health care providers should allow children who are capable of participating in treatment decisions the opportunity to do so.

Generally, these Constitutional cases have developed three common themes: within certain limitations a child has the right to due process, the right to privacy, and the right to equal protection. Due process or the lack thereof is primarily concerned with ideas of notice and fair play (that is, the opportunity to be heard before a neutral decision maker). The Supreme Court's ruling in *Gault* was the Court's first decision acknowledging a child's constitutional right to due process. While most of the Court's due process cases, including *Gault*, have involved a child's right to due process in the context of a Juvenile Court, the same elements of notice and informed decision making are at the crux of a child's participation in his/her own health care decision making.

A child's right to privacy has evolved primarily in the context of procreation and a minor's access to abortions or the use of contraceptives. In the first of these cases, *Planned Parenthood of Central Missouri v. Danforth*, the Supreme Court struck down as unconstitutional a Missouri statute requiring parental consent before a minor could obtain an abortion. The Court found that the Missouri statute imposed the possibility of "an absolute, and possibly arbitrary, veto [by a third party] over the decision of the physician and his patient to terminate the patient's pregnancy." Subsequent Supreme Court cases have addressed the constitutionality of state statutes requiring notice or parental consultation before the minor may consent to an abortion or statutes which unduly restrict a minor's access to contraceptives. Generally, the Court has found unconstitutional any attempts the state may take to substantially limit the minor's options in procreation decisions.

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Last, and perhaps most important, is a child's right to equal protection. The Constitution mandates that every person, regardless of group or class affiliation, be treated as equal under the law. The concept of equal protection requires that individuals be treated according to their individual characteristics and not solely according to their membership in a group. Our history is replete with Supreme Court decisions which have attempted to eliminate society's emphasis on group characteristics, most notably with respect to women and minorities. Only within the last twenty years has the Court begun to recognize that children also are entitled to equal protection based on their individual characteristics and not limited by their membership in a group of "minors."

Despite the Supreme Court's extension of constitutional protection to minors, the classification of an individual as a minor continues to be controlled primarily at the state level. A majority of states have enacted legislation which statutorily

defines an individual as a "minor" based solely on chronological age. This broad categorization is at the root of the legal problems affecting a minor's role in his/her own health care decisions and remains the primary legal barrier limiting a minor's consent and participation in treatment decisions.

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Kansas and Missouri Statutory Provisions

Kansas and Missouri are among the many states which define the "period of minority" (Kansas) or an "infant" (Missouri) as any person under the age of eighteen. In both Kansas and Missouri, an individual under eighteen years of age generally does not have the capacity to consent. Practically speaking, minors are given no capacity to enter into contracts, own property, sue, or be sued. Thus, as far as state law is concerned, all persons under the age of eighteen are accorded the same treatment no matter what individual characteristics he/she may possess. As with any set of rules, however, there are always exceptions. Generally, exceptions to the rule of consent fall into the broad categories of marriage, emancipation, contracts, and medical emergencies and/or treatments.

In terms of marriage, the general rule is that persons must be eighteen in order to marry. However, both Kansas and Missouri allow persons younger than eighteen to marry provided the parents have consented. In addition, Kansas recognizes common law marriages which simply require an agreement between two people that they are married and are holding themselves out as being married. The marriage is legal provided the man has attained the age of fourteen and the woman is twelve. Once "minors" under the age of eighteen have married, both Kansas and Missouri confer the status of "adult" or "majority" on the parties, which then gives the "minor" the right to consent.

Another method of conferring "majority" status on minors, and thus the ability to consent, is through a court process known as "emancipation." The court determines that the child should be given the status of majority. Kansas has enacted specific legislation conferring such authority on the district courts. Missouri has not enacted a statutory provision similar to that of Kansas but follows a common law principle of emancipation.

In terms of medical issues, Kansas and Missouri again tie a person's ability to consent to age with the legal threshold at eighteen. If a person is under that age, the statutes provide the parents or guardians with the authority to consent for the minor. As with the general consent statutes, state legislatures also allow for exceptions in the medical area. In Kansas, a minor sixteen years of age or over may consent to any medical treatment provided no parent or guardian is immediately available to provide such consent. Kansas recognizes that a sixteen-year-old person has different characteristics and abilities than the total population of "minors." Kansas also provides a special exception for unmarried pregnant minors to consent to medical care without parental consent, if a parent or guardian is not available to give such consent. Both statutes further provide that the minor's consent is binding. This language is necessary because of the requirement that a person must be eighteen before entering into a legally binding contract. Kansas also allows a person over seventeen to donate blood without parental consent.

Missouri's medical consent statute is similar to Kansas' but does not provide the exception for a sixteen-year-old minor whose parents are not

available to give consent. With some exceptions, Missouri requires parental consent for any medical treatment to a person under the age of eighteen. A minor may consent to his/her own medical treatment in the case of pregnancy, venereal disease, and drug or substance abuse, but not abortions. If the minor is lawfully married or has a child, Missouri considers that minor to be an adult for the purpose of medical treatment for the minor, the minor's spouse, and their child. Missouri also allows a person seventeen or older to donate blood without parental consent.

Both Kansas and Missouri have enacted special statutes addressing abortions performed on minors. The Kansas statute provides a minor more rights than does the Missouri statute although both provide mechanisms for court approval. Although the Kansas statute does not require parental consent, it does require the person who is to perform the abortion to give prior notice to the minor's parent or guardian. The minor may object to giving such notice; however, the minor must petition the court for waiver of the notice requirement. Before a person may perform an abortion on a minor in Missouri, the law requires informed written consent of the minor and one parent or guardian. Absent this consent, the minor may petition the court for self-consent, emancipation, or court consent to have the abortion.

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Another major area of medical exceptions concerns emergency medical treatment. These statutes are commonly referred to as "good samaritan" laws. Generally, both Kansas and Missouri allow a health care provider to render emergency care to a minor at the scene of the accident without obtaining the consent of the parent or guardian. If the care is rendered in good faith and without compensation, the health care provider will not be liable for civil damages other than those damages caused by gross negligence or by willful or wanton acts or omissions.

The good samaritan laws protect the health care provider in an emergency situation from liability arising from rendering aid without consent. These statutes create what is oftentimes referred to as "implied consent," thus limiting the caregiver's liability except in instances of gross negligence or the like.

Advance Directives

An advance directive refers to an individual's attempt to direct his/her health care wishes prior to that individual's loss of decisional capacity. Written advance directives may take the form of living wills, health care treatment directives, or durable powers of attorney for health care. Most states have enacted legislation making advance directives legally binding. The critical feature of these laws, however, is that only adults are legally authorized to issue advance directives. Once again, children, because of their "pigeon hole" as minors, are prevented from entering into legally recognized advance directives regardless of their individual decisional capacity.

Despite the fact that a minor's advance directive is not legally binding, health care providers should allow the use of advance directives by all persons if the person had decisional capacity at the time the advance directive was created. This is supported by the ethical principle of autonomy which is the foundation for the patient's right of self-determination. Important aspects of autonomy include: the concept of informed consent; the presumption that patients have the capacity to make decisions; the presumption that patients have a right to delegate decision-making authority; the patient's right to be adequately informed;

and, the right to authorize or refuse any medical treatment. This ethical principle applies to all persons without regard to the legal standard that might be in effect.

Even though there currently are no statutory exceptions or case law to support a health care provider's use of the advance directive created by a minor with decisional capacity, there are no criminal prohibitions against such use. The legal issue remaining is an analysis of any potential civil liability if a minor's advance directive is followed. Assuming the minor had sufficient capacity to create it, it is unlikely that a minor who later regained capacity would have a successful claim against the health care provider. The key concept here is to know and understand the decisional capacity of the minor at the time the advance directive was created. The idea is to move from the automatic consent/capacity at age eighteen to an individualistic approach to consent.

Conclusion

The bioethics principles advanced by the MBC *Guidelines* require health care providers to include minors in the decision making about their own medical treatment. The law has not yet aided health care providers in doing so primarily because persons are characterized as minors based solely on their chronological age and the lack of legal capacity which results from that categorization. On the other hand, the law also does not prohibit such informed decision making and consent on the part of the minor provided the parent or guardian is also a part of this process. In certain areas, the minor may make medical decisions on his/her own without the parent's consent. Granted, not all situations will be conducive to this approach of informed decision making. It is also inevitable that conflicts will arise between the health care provider, the minor, and the parent or guardian. If all parties are kept informed from the beginning and disputes are dealt with as they arise, the chances of having to resort to the legal system or other mechanisms of conflict resolution will be mitigated. Hopefully at some point in the near future, the law will catch up with current ethical principles and make it clear that there are no legal problems in allowing complete use of the *Health Care Treatment Decision Making Guidelines For Minors.*

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