

Comment, **To Vax or Not to Vax: How the COVID-19 Pandemic Is Compelling a Reconsideration of Minors' Rights**

I. Introduction

In 2000, a mother asked the U.S. Supreme Court to declare a Washington statute unconstitutional because, in granting other people such as grandparents the right to petition for visitation, it interfered with her rights as a parent to rear and make decisions for her children.¹ The majority opinion in *Troxel v. Granville* declared: “the liberty interest at issue in this case—the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by this Court.”² Along with this liberty interest, *Troxel* stands for the presumption that fit parents act in the best interest of their children.³

It is this liberty interest and presumption that forms the basis for the rights of parent to make decisions for their children in regards to healthcare and custody, among other areas. But the COVID-19 pandemic is challenging how courts evaluate parents' rights to make decisions when what the parents want for their children is in conflict with what the children want for themselves. As Justice Stevens noted in his dissent in *Troxel*, “The presumption that parental decisions generally serve the best interests of their children is sound, and clearly in the normal case the parent's interest is paramount. But even a fit parent is capable of treating a child like a mere possession.”⁴

As many teenagers do, Elizabeth, a high-school senior, is keeping a big secret from her parents, though this secret may carry greater consequences than do many teenagers' secrets: she

¹ See generally *Troxel v. Granville*, 530 U.S. 57 (2000).

² *Id.* at 65.

³ *Id.* at 68.

⁴ *Id.* at 86 (Stevens, J., dissenting).

has received the COVID-19 vaccination.⁵ Her divorced parents share decision-making authority over her healthcare.⁶ Her mother is in favor of the vaccine, while her father is strongly opposed and has threatened to sue her mother if Elizabeth is vaccinated.⁷ She keeps the secret from both parents to provide her mother plausible deniability.⁸

Isabella, a 17-year-old in Florida, wants to receive the vaccine because her friends are vaccinated, and she wants to spend time with them unmasked.⁹ Her mother opposes the vaccine, and when Isabella tries to assert her own bodily autonomy, her mother responds with “It’s my body until you’re 18.”¹⁰

Marina, a 15-year-old in Florida, has been excluded by her friends because her mother opposes her receiving the vaccine and has shut down discussion about it.¹¹ Her friends threw a party and invited her, asking if she was vaccinated against COVID-19.¹² When she responded in the negative, she was uninvited from the party.¹³

The COVID-19 pandemic is largely a pandemic of the unvaccinated, and vaccination rates are low, mostly among the younger generation.¹⁴ To address the desires of unvaccinated teenagers to be vaccinated against their parents’ wishes, Kelly Danielpour founded VaxTeen, which helps teenagers learn about their options and their rights.¹⁵ One 16-year-old girl who wanted to be vaccinated reached out to Danielpour, expressing that “I feel like my health and my concerns are just being completely disregarded.”¹⁶

⁵ Jan Hoffman, *As Parents Forbid Covid Shots, Defiant Teenagers Seek Ways to Get Them*, N.Y. TIMES (Sept. 30, 2021), <https://www.nytimes.com/2021/06/26/health/covid-vaccine-teens-consent.html>.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ Katie Reilly, *When Parents Said No to Their Kids Being Vaccinated, This Teenager Created VaxTeen. It’s Now More Crucial Than Ever*, TIME (July 22, 2021, 5:10 PM), <https://time.com/6082966/vaxteen-covid-19/>.

¹⁵ *Id.*

¹⁶ *Id.*

Generally, parents or guardians have primary legal authority to make health care decisions for their children, including decisions regarding vaccinations.¹⁷ As of 2021, about one-third of U.S. states have statutes or case law that establishes the “mature minor doctrine,” a legal framework allowing teenagers themselves in certain circumstances to make particular healthcare decisions in the absence of parental consent.¹⁸

The mature minor doctrine, though historically limited to decisions about healthcare, has the potential to play a role in all circumstances where decisions are being made that will affect the life of a minor. This comment will proceed in three parts. Part II will review the mature minor doctrine and the circumstances that allow minors to make their own decisions without parental consent. Part III will look more closely at minors’ rights in healthcare decision-making—a major arena in which the mature minor doctrine comes into play. Part IV will look at the role a child’s preference plays in custody determinations and to what extent the mature minor doctrine should be influential in this realm.

II. The Mature Minor Doctrine

While adults of sound mind enjoy the presumption that they are capable of consenting to and making decisions regarding their own healthcare, such a presumption is not applied to minors.¹⁹ This is because, under the principles of informed consent, minors are assumed to lack the cognitive maturity to make autonomous healthcare decisions, and therefore are denied the legal capacity to give genuine informed consent to treatment.²⁰ Thus, in line with the rights of fit parents affirmed in *Troxel*, courts tend to defer to parental judgments regarding non-emer-

¹⁷ Brian Dean Abramson, *Do US Teens Have the Right to be Vaccinated Against Their Parents’ Will? It Depends on Where They Live*, CONVERSATION (Aug. 31, 2021, 8:28 AM), <https://theconversation.com/do-us-teens-have-the-right-to-be-vaccinated-against-their-parents-will-it-depends-on-where-they-live-166147>.

¹⁸ *Id.*

¹⁹ Allison G. Morrow, *Will Your Religion Allow You . . . To Live? The Mature Minor Doctrine, Religious Exemptions, and a Look into Louisiana Law*, 41 S.U. L. REV. 259, 272 (2014).

²⁰ *Id.*

gency medical decisions for their children.²¹ To consent to medical treatment, a patient must be competent, and minor patients are deemed incompetent simply because of their age.²² Courts justify narrowing minors' rights on the assumptions that minors do not have the capacity to care for themselves and that they lack the appropriate perspective to recognize and avoid detrimental choices.²³

One exception to this is the mature minor doctrine, which allows minors who can demonstrate an understanding of the nature and consequence of the treatment to be considered sufficiently mature to give or refuse consent.²⁴ The premise is straightforward: if a minor is sufficiently competent to make an informed decision, parents, healthcare providers, and courts should respect that decision.²⁵ The application of the doctrine is not dependent on the age of the minor, but rather is a question of fact that must be determined on a case-by-case basis.²⁶ A court will generally consider the minor's ability to appreciate the nature and consequences of the procedure, as well as their ability to weigh risks and benefits.²⁷ While age may be a factor in the minor's abilities, a court may also consider factors like education and experience.²⁸

A. *Adoption Through Statute and Common Law*

Most states have yet to adopt the mature minor doctrine.²⁹ In the few states that have adopted it, its application varies.³⁰ Legislatures have been reluctant to adopt the doctrine because of

²¹ Emily Ikuta, Note, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDISC. L.J. 179, 182 (2016).

²² *Id.* at 188.

²³ *Id.*

²⁴ *Id.* at 182.

²⁵ Morrow, *supra* note 19, at 273.

²⁶ *Id.*

²⁷ B. Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL'Y 37, 42 (2012).

²⁸ *Id.*

²⁹ Ikuta, *supra* note 21, at 200.

³⁰ *Id.*

what is perceived as highly subjective criteria for determining maturity.³¹ In contrast, courts have repeatedly turned to and applied these criteria in a myriad of circumstances.³² Of significance was the decision by the Supreme Court of Tennessee in *Cardwell v. Bechtol*, holding that a minor did have the capacity to consent to medical procedures, but whether a minor has the capacity to consent and appreciate the nature, risks, and consequences of the procedure is a question of fact for the jury.³³ The court also adopted a rule of capacity: children under age seven are denied capacity, children age seven to fourteen are rebuttably presumed to not have capacity, and individuals age fourteen to twenty-one are rebuttably presumed to have capacity.³⁴ Following Tennessee, the high courts of Illinois³⁵ and West Virginia³⁶ have held that their common law recognizes an exception to parental consent for mature minors. Kansas,³⁷ Maine,³⁸ and Massachusetts³⁹ have likewise weighed a minor's maturity for purposes of making healthcare decisions.

Several other states have adopted mature minor statutes. Some states permit minors to consent to certain procedures based on maturity,⁴⁰ while other states allow minors to consent based on age⁴¹ or whether parents are available to consent.⁴² States that allow consent based on age may allow consent regardless of the maturity of the minor, and states that consider the

³¹ *Id.*

³² *Id.*

³³ See generally *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987).

³⁴ *Id.* at 745.

³⁵ See *In re E.G.*, 549 N.E.2d 322, 326 (Ill. 1989).

³⁶ See *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837 (W. Va. 1992).

³⁷ See *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 338 (Kan. 1970).

³⁸ See *In re Swan*, 569 A.2d 1202, 1205-06 (Me. 1990).

³⁹ See *Baird v. Att'y Gen.*, 360 N.E.2d 288, 296 (Mass. 1977). See Ikuta, *supra* note 21, at 200-02, for a review of the cases cited in notes 33-39 and the statutes cited in notes 40-42 and the application of the mature minor doctrine.

⁴⁰ See, e.g., ARK. CODE ANN. § 20-9-602(7) (2022); IDAHO CODE § 39-4503 (2022); NEV. REV. STAT. ANN. § 129.030(3) (LexisNexis 2021).

⁴¹ See, e.g., ALA. CODE § 22-8-4 (LexisNexis 2022); KAN. STAT. ANN. § 38-123b (2022).

⁴² See, e.g., ALASKA STAT. § 25.20.025(a)(2) (2022); DEL. CODE ANN. tit. 13, § 707(b)(5) (2022).

availability of parents may allow mature and capable minors to consent only if their parents are unavailable or unwilling to consent.⁴³

B. *Assessing a Minor's Maturity*

As they are called upon to apply the mature minor doctrine, courts require wide discretion in assessing each minor's maturity.⁴⁴ However, there is no agreed-upon definition of maturity or competency.⁴⁵ Some commentators are concerned that giving courts such wide discretion will lead to inconsistent results, making application of the doctrine unpredictable.⁴⁶ But there are a few common factors that courts have used in assessing a minor's maturity and capacity to consent: (1) the treatment benefits the minor, not a third party; (2) the minor's age; (3) the minor has the capacity to understand the nature and importance of the proposed treatment; and (4) the procedure is not a major medical procedure.⁴⁷ The fourth factor recognizes that there are some medical procedures that carry such a high risk that the minor needs protection in the form of a parent's decision.⁴⁸ When the procedure involves lower risk to the minor, judges may be less concerned with allowing a minor to receive treatment against their parents' wishes.⁴⁹ Even the same type of procedure can carry different levels of risk that may lead a court to different conclusions in requiring parental consent. For example, in *Younts v. St. Francis Hospital and School of Nursing*, the seventeen-year-old girl in question was judged to be mature enough to consent to a skin graft to restore a fingertip.⁵⁰ In contrast, in *Bonner v. Moran*, the court concluded that a fifteen-year-old was unable to consent to being a donor in a skin graft because he was unable to understand the complicated nature and technique of the proce-

⁴³ Ikuta, *supra* note 21, at 201-02.

⁴⁴ *Id.* at 205.

⁴⁵ Richard E. Redding, *Children's Competence to Provide Informed Consent For Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 709 (1993).

⁴⁶ Ikuta, *supra* note 21, at 206.

⁴⁷ *Id.* at 207.

⁴⁸ *Id.* at 208.

⁴⁹ *Id.*

⁵⁰ *See generally Younts*, 469 P.2d 330.

dure.⁵¹ In addition to the factors listed above, a court might consider a minor's understanding of alternative treatments, the ability to make and communicate a choice, the reasonableness of the choice, or a general showing of adult problem-solving capabilities.⁵²

C. A Doctrine Based on Research

Courts typically rely on two general reasons to deny a child's ability to consent: first, a child is perceived and presumed incompetent to consent, and second, parents are presumed to act in the best interests of their child.⁵³ However, empirical research indicates that children are much more competent to make decisions than the law recognizes, if they can just participate in the deliberative process.⁵⁴ It appears that adolescents can be capable of adult-like cognition, including displaying "a factual understanding and appreciation for the risks and benefits" of treatment.⁵⁵ More specifically, between the ages of fifteen and seventeen years, adolescents develop a strong metacognitive understanding, which includes a "knowledge of [their] own qualities, characteristics, and limitations with regard to decision-making."⁵⁶ In addition to cognitive abilities, a child's competence appears to be related to life experience: a child who has personal experience with an illness may display greater understanding than a child of the same age who lacks such experience.⁵⁷ For example, a child with a chronic disorder that they have learned to live with will likely display greater competence in making related decisions than a child of the same age who is hospitalized for an acute illness.⁵⁸

⁵¹ *Bonner v. Moran*, 126 F.2d 121, 123 (D.C. Cir. 1941). See Ikuta, *supra* note 21, at 208-09, for more elaboration on *Younts* and *Bonner*.

⁵² Redding, *supra* note 45, at 710.

⁵³ *Id.* at 697.

⁵⁴ *Id.* at 708.

⁵⁵ *Id.*

⁵⁶ Irma M. Hein, Pieter W. Troost, Alice Broersma, Martine C de Vries, Joost G. Daams & Ramon J. L. Lindauer, *Why Is It Hard to Make Progress in Assessing Children's Decision-Making Competence?*, 16 BMC MED. ETHICS 1, 3 (2015).

⁵⁷ *Id.*

⁵⁸ Pierre-Andre Michaud, Robert Wm Lum, Lazare Benaroyo, Jean Zermattern & Valentina Baltag, *Assessing an Adolescent's Capacity for Autono-*

While many brain functions do not fully develop until a person is in their mid-twenties, a person's ability to reason and consider different choices matures during the teenage years.⁵⁹ Adolescents are able to discuss unpleasant issues, recognize violations of confidentiality, and understand when a treatment is ineffective.⁶⁰ Some children as young as nine years old can understand differences between different diagnoses and prognoses, as well as risks and benefits of treatment options.⁶¹ Children as young as six years old may even be able to perceive procedural injustice, indicating that simply allowing young patients to participate in decisions may enhance their perception that they were treated fairly.⁶² Allowing them to participate may also improve treatment by increasing their cooperativeness.⁶³

Additional studies show that adolescents can be exceptionally thoughtful about healthcare decisions.⁶⁴ Researchers have distinguished between "hot" and "cold" cognition, where cold cognition refers to deliberation in the absence of high levels of emotion.⁶⁵ This typically occurs in a healthcare setting where the minor has access to an adult consultant and there is an absence of time pressure.⁶⁶ During "cold cognition," minors generally have access to their more developed logical reasoning abilities.⁶⁷ Adolescents display a high level of thoughtful and mature perceptions about what factors influence their decisions in seeking medical care, which include the interpersonal style of the healthcare provider: such as whether that provider is skilled in adolescent care, competent, compassionate, unpretentious, nonjudgmental, willing to respect confidentiality, and someone

mous Decision-Making in Clinical Care, 57 J. ADOLESCENT HEALTH 361, 363 (2015).

⁵⁹ Lois A. Weithorn & Dorit Rubinstein Reiss, *Providing Adolescents with Independent and Confidential Access to Childhood Vaccines: A Proposal to Lower the Age of Consent*, 52 CONN. L. REV. 771, 840 (2020).

⁶⁰ Redding, *supra* note 45, at 708.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1318 (2000).

⁶⁵ Weithorn & Reiss, *supra* note 59, at 840.

⁶⁶ *Id.* at 841.

⁶⁷ *Id.* at 840.

who is clear as a communicator, candid, sensitive to individual needs, and promotes equal treatment.⁶⁸ It is becoming clear that adolescents desire to exercise their decision-making abilities and be responsible for those decisions.⁶⁹ There is also evidence that older adolescents are comparable to young adults in some circumstances of medical decision-making and should not be excluded on the presumption that they lack the requisite capacity.⁷⁰

III. Making Decisions in Healthcare

As shown in the previous section, the mature minor doctrine is based on the minor's ability to make certain healthcare decisions. In addition to a finding of maturity, the doctrine is usually only applicable when the minor is seeking a certain procedure. However, social customs have seen significant change in recent decades, providing teenagers with much more independence in all areas of life.⁷¹ This means that adolescents are involved in more adult-like behaviors than they will discuss with their healthcare providers.⁷² But the obligations that medical providers have to adolescents can be difficult to articulate, as the United States has a patchwork of standards and limitations that may leave the provider caught between obligations to their patients and obligation to the law.⁷³ This section will discuss the rights of mature minors to make healthcare decisions regarding vaccination, blood transfusions, mental health care, and gender-affirming healthcare.⁷⁴

⁶⁸ Hartman, *supra* note 64, at 1318.

⁶⁹ *Id.* at 1319.

⁷⁰ *Id.* at 1319-20.

⁷¹ *Id.* at 1308.

⁷² *See id.*

⁷³ Hill, *supra* note 27, at 37-38.

⁷⁴ Other healthcare issues that minors may face include those related to abortion and sexual health. Decisions regarding abortion are based on constitutional rights rather than the mature minor doctrine and are thus beyond the scope of this paper. *See e.g.* Bellotti v. Baird, 443 U.S. 622 (1979). All fifty states and the District of Columbia allow minors to seek testing and treatment for sexually transmitted diseases, and many states allow minors to receive contraceptive services without parental consent. Hill, *supra* note 27, at 42-43.

A. *Vaccinations*

The principle that certain minors may be vaccinated without parental consent is consistent with the medical profession's recommendations.⁷⁵ In 2013, the Society for Adolescent Health and Medicine spoke out in favor of policies that provide opportunities for minors to be vaccinated when parents are physically absent.⁷⁶ There is no federal mandate for access to vaccinations by minors without parental consent, and this results in a patchwork of policies across the states—with some requiring parental consent in all cases, and others allowing minors in certain circumstances to give consent.⁷⁷ And while a minority of states have adopted some form of the mature minor doctrine, even fewer states have statutes specific to a minor's right to receive vaccines.⁷⁸

Attempts to expand the availability of vaccines to minors have faced intense opposition from members of the anti-vaccination community, and this opposition has increased due to COVID-19 vaccination hesitancy.⁷⁹ The CDC recently identified vaccine hesitancy as one of the top threats to global health.⁸⁰ Researchers have repeatedly shown a strong relationship between parents refusing to immunize and higher rates of vaccine-preventable infection.⁸¹ Despite this hesitancy, there is a global consensus among experts that vaccines are safe and effective, and while nothing can be 100% safe or 100% effective, the benefits of vaccines are substantial and the risks are low.⁸²

Research shows variability in parental opposition to vaccines, generally divisible into two categories: vaccine-hesitant parents and vaccine-rejector parents.⁸³ A vaccine-hesitant parent is more open to persuasion if their child wishes to be vaccinated, while a vaccine-rejector typically repels any attempts at persua-

⁷⁵ Abramson, *supra* note 17.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ Lauren V. Engle, *Faith by Choice: An Argument for Expanding Mature Minor Provisions in North Carolina*, 20 *FIRST AMEND. L. REV.* 143, 146 (2022).

⁸¹ Weithorn & Reiss, *supra* note 59, at 773.

⁸² *Id.* at 780.

⁸³ *Id.* at 786.

sion.⁸⁴ Researchers have found that parents who strongly hesitate to vaccinate their children are more likely to value purity, which places an emphasis on avoiding putting anything unnatural into the body, and thus they might be open to messages promoting vaccines that are in line with that value.⁸⁵ In cases where minors desire vaccination but have vaccine-resistant parents, the parental consent requirement and a knowledge of their parents' views on vaccines can serve as a deterrent from the minor involving parents and receiving care.⁸⁶

In addition to protecting the vaccinated individual, when enough people are vaccinated, the entire community is protected, even many unvaccinated individuals through the herd immunity effect.⁸⁷ Conversely, when parents choose not to vaccinate their child, they are putting their own child and others at risk of serious harm from infectious diseases.⁸⁸ While deference to parental healthcare choices for their children is the default in the American legal system, when those choices endanger their children's welfare or the public's health, intervention may be necessary to serve the state's *parens patriae* interests, to protect the individual child, and in the police power, to protect the larger community.⁸⁹

The child who wishes to be vaccinated over their parents' objections also has their own interest: that of avoiding illness, disability, or death, which may outweigh the parents' interests in circumstances when a medical intervention—such as a vaccine—comes with high benefits and low risks and the parents are exercising their decision-making authority based on misinformation.⁹⁰ However, while there may be a right for children to not be negligently infected by others, there is no recognized affirmative right to vaccination.⁹¹ Sadly, what results is children contracting easily preventable diseases, sometimes resulting in disability or death, because of a parent's religious or philosophical objection

⁸⁴ *Id.*

⁸⁵ *Id.* at 788.

⁸⁶ *Id.* at 828.

⁸⁷ *Id.* at 781.

⁸⁸ *Id.* at 781-82.

⁸⁹ *Id.* at 801-02.

⁹⁰ *Id.* at 831-32.

⁹¹ Elias Feldman, *Vaccination and the Child's Right to an Open Future*, 25 LEWIS & CLARK L. REV. 209, 211 (2021).

to a highly effective, highly recommended medical intervention.⁹²

B. *Chemotherapy, Blood Transfusions, and the Right to Refuse Care*

Decisions regarding certain medical treatments often involve not just the right to consent, but the right to refuse treatment, as well as the added complexity of asserting religious liberty and potential child neglect or other criminal charges.⁹³ Many states provide exemptions for such charges to parents who seek religious healing for their children rather than modern medicine.⁹⁴ Proponents of such exemptions point to the substantive due process rights of parents in the care, custody, and control of their children, as well as the privacy right to raise children in accordance with religious beliefs.⁹⁵

However, the question here is whether minors can refuse medical care when the parents have refused but the state orders the treatment to proceed. While there is a recognized right to make decisions regarding one's own body, such a right does not equally apply to minors.⁹⁶ Refusing medical care is often based on religious beliefs, which may be protected under the Free Exercise Clause of the First Amendment.⁹⁷ When a minor asserts religious beliefs as a basis for refusing care, a court is not just assessing the minor's capacity to understand but also the integrity of the religious beliefs.⁹⁸ As will be shown in the following cases, states differ in their opinions and willingness to adopt a mature minor doctrine in relation to the right to refuse care.

In *Commonwealth v. Nixon*, the parents of a sixteen-year-old girl, Shannon, were convicted of involuntary manslaughter and of endangering the welfare of a child after Shannon died from diabetic acidosis, a treatable condition.⁹⁹ When Shannon

⁹² *Id.* at 211.

⁹³ *See, e.g.,* *Commonwealth v. Nixon*, 761 A.2d 1151, 1152 (Pa. 2000).

⁹⁴ Shaakirrah R Sanders, *Religious Healing Exemptions and the Jurisprudential Gap Between Substantive Due Process and Free Exercise Rights*, 8 U.C. IRVINE L. REV. 633, 634 (2018).

⁹⁵ *Id.* at 652.

⁹⁶ Morrow, *supra* note 19, at 272.

⁹⁷ *Id.* at 266.

⁹⁸ Engle, *supra* note 80, at 160.

⁹⁹ *Nixon*, 761 A.2d at 1152.

fell ill, her parents prayed for their daughter's health and took her to their place of worship where she participated in a religious healing ritual.¹⁰⁰ She soon fell into a coma and died a few hours later.¹⁰¹

The offense of child endangerment involved violating a duty of care, protection, or support.¹⁰² The parents asked the court to adopt the mature minor doctrine and allow them to assert that doctrine as an affirmative defense.¹⁰³ The parents argued that Shannon was mature enough to make her own decisions regarding religion and healthcare, and so they—the parents—ought to be excused from their statutory duty of care, protection, and support in this instance.¹⁰⁴ However, the court noted that the statute placed an affirmative duty on the parents and guardians of children.¹⁰⁵ In doing so, the legislature was acting in its role as *parens patriae* to care for those who are legally incapacitated.¹⁰⁶

While the court agreed that the right to control one's healthcare and refuse life-sustaining treatment should extend to mature minors, it declined to adopt a common law mature minor doctrine.¹⁰⁷ Instead, it noted that the legislature had already provided statutes that identify those minors who are deemed mature enough to consent to medical treatment, as well as specific situations in which any minor may consent to medical treatment.¹⁰⁸ While these statutes create specific exceptions to the general rule of a minor's incapacity to consent, the statutes do not show any legislative intent that any minor, upon a showing of maturity, has capacity to consent to or refuse healthcare in a life or death situation.¹⁰⁹ Thus, the court affirmed the parents' convictions.¹¹⁰

In *In re Cassandra C.*, medical providers reported Cassandra, a seventeen-year-old girl, and her mother to the Department of Children and Families after they both refused chemotherapy

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.* at 1152-53.

¹⁰³ *Id.* at 1153.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 1154-56.

¹⁰⁸ *Id.* at 1155.

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 1156.

treatments for Cassandra, who had been diagnosed with Hodgkin's lymphoma.¹¹¹ In neglect proceedings, and on appeal, the mother asked the court to recognize and adopt a common-law mature minor doctrine.¹¹² As in *Commonwealth v. Nixon*, the court here noted that such a doctrine already existed by statute, but that it was limited to a certain category of mature minors: only emancipated minors could consent to medical treatment without parental consent.¹¹³ Additionally, there are specific, limited circumstances where minors may make medical decisions for themselves.¹¹⁴ Thus, the general rule is that minors are presumed to be incompetent to make medical decisions.¹¹⁵

Because Cassandra was presumed to be incompetent to make decisions regarding chemotherapy treatment since she was a minor and not emancipated, the burden was on her mother to show that Cassandra was mature.¹¹⁶ Not only was no such evidence produced, the department provided ample evidence that Cassandra was not a mature minor: her proneness to engage in compulsive and risky actions, being unable or unwilling to speak her true mind to authority figures, and being reluctant to hold opinions differing from her mother's.¹¹⁷ Concluding that Cassandra was not a mature minor, the court then declined to consider whether to adopt the mature minor doctrine, since it would not have applied in this case.¹¹⁸

In *In re E.G.*, a seventeen-year-old girl and her mother both refused to consent to blood transfusions on religious grounds.¹¹⁹ As a result, the state filed a child neglect petition against the mother.¹²⁰ At the initial hearing, E.G.'s doctor testified that he discussed the proposed course of treatment with her and that she was competent to understand the consequences of accepting or rejecting treatment.¹²¹ He was likewise impressed with her ma-

¹¹¹ *In re Cassandra C.*, 112 A.3d 158, 159 (Conn. 2015).

¹¹² *Id.*

¹¹³ *Id.* at 169.

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 169-70.

¹¹⁶ *Id.* at 171.

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 172-73.

¹¹⁹ *In re E.G.*, 549 N.E.2d 322, 323 (Ill. 1989).

¹²⁰ *Id.*

¹²¹ *Id.*

turity and the sincerity of her religious convictions.¹²² The court appointed a temporary guardian for E.G., who consented to transfusions on E.G.'s behalf.¹²³ Following these transfusions, further hearings were held, during which E.G. testified that the decision to refuse transfusions was her own and that she fully understood the nature and consequences of her decision.¹²⁴ She was upset by the court's decision and felt as if everything she wanted and believed in was disregarded.¹²⁵ In its final decision to appoint a guardian to consent to medical treatment for E.G., the trial court noted that it considered E.G.'s maturity and religious convictions, and gave great weight to her wishes, but felt that the state's interest in protecting her from medical neglect was greater than her interest in refusing treatment.¹²⁶

In considering E.G.'s appeal, the Supreme Court of Illinois noted that while the age of majority in the state was eighteen years, age is not an impenetrable barrier that precludes minors from possessing and exercising certain rights normally associated with adulthood, and that a number of exceptions exist in their jurisdiction and others which treat minors as adults under specific circumstances.¹²⁷ Noting the circumstances under which minors in Illinois have a statutory right to consent to treatment, the court concluded that the legislature did not intend that eighteen years of age should be an absolute barrier prohibiting minors from consenting to medical treatment.¹²⁸

The court found no reason that the right of dominion over one's own person should not extend to mature minors.¹²⁹ In determining whether a minor is mature enough to make their own healthcare decisions, the intervention of a judge is appropriate for two reasons: (1) Illinois public policy values the sanctity of life, and minors should be protected from foolish decisions; and (2), the state has *parens patriae* authority to protect the incompetent.¹³⁰ The judge must weigh the evidence of the minor's matur-

¹²² *Id.*

¹²³ *Id.* at 324.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.* at 325.

¹²⁸ *Id.* at 325-26.

¹²⁹ *Id.* at 326.

¹³⁰ *Id.* at 327.

ity against these two principles, and if there is clear and convincing evidence that the minor is mature enough to appreciate the consequences of their choices, that minor has the common law right to consent to or refuse medical treatment.¹³¹ That E.G.'s mother agreed with her refusal of care worked to E.G.'s benefit; had E.G. and her mother been in conflict, the court would have to give serious consideration to her mother's desire, which would have weighed heavily against E.G.'s right of refusal.¹³² *Cassandra C.* and *E.G.* stand in powerful juxtaposition to one another: two seventeen-year-old girls, both refusing life-saving care, and both having parents that agreed with their refusals. Yet, because they lived in different states with different approaches to a minor's medical decision-making authority, their cases had opposite outcomes.

C. *Mental Health Care*

In addition to a child's presumed incompetence, a court may also defer to a parent's decisions regarding mental health care because they assume that parents, after consulting with the medical provider, will make decisions that are in their child's best interest.¹³³ While judges make this assumption, medical providers are cautious, if not cynical, about the parent's decision-making role.¹³⁴ This is explained by family-systems theory, which posits that a child's problems cannot be truly separated from a family's dysfunction.¹³⁵ A child's emotional disturbances are often viewed as symptoms of a wider dysfunctional, disturbed family system.¹³⁶ Often, parents will exaggerate their child's behaviors or defiance.¹³⁷ However, a child's behavior may not be caused by any underlying mental illness, but rather may reflect a home environment that does not adequately provide for the child's needs.¹³⁸ In

¹³¹ *Id.* at 327-28.

¹³² *Id.* at 328.

¹³³ Redding, *supra* note 45, at 697.

¹³⁴ *Id.* at 698.

¹³⁵ *Id.* at 699.

¹³⁶ *Id.*

¹³⁷ *Id.* at 700.

¹³⁸ *Id.*

the extreme version of these cases, parents may institutionalize their child simply to relieve stress in the home.¹³⁹

States with a mature minor doctrine can adjudicate the maturity of the minor in question, and maturity is more likely to be found when the minor is near majority and where the court feels that allowing the child to decide is in the child's best interest.¹⁴⁰ Applying the mature minor doctrine is important because minors tend to prioritize confidentiality and the desire to obtain care without parental knowledge, or they may not receive care at all for fear of their parents being notified.¹⁴¹ In a dysfunctional family, obtaining mental health care may be highly stigmatized, especially if it is related to substance abuse, which may cause the minor child to not approach their parents for help.¹⁴² This may lead to the minors not receiving the treatment they need and desire if they cannot consent to it themselves. Regardless of whether the minor is found to be mature, physicians who are aware of a minor patient's need for mental health care should ensure that the patient is involved in decision-making and encourage parental involvement if there is reason to believe that the parents will be helpful and understanding.¹⁴³ Involving parents in their child's mental health care may be an avenue by which the larger dysfunction within the family unit is revealed and addressed.

D. Gender-Affirming Healthcare

The fight for gender-affirming healthcare for transgender individuals, especially minors, is being fought in state legislatures across the country. In the first month of 2023, more than one hundred bills were introduced in twenty-two states that targeted the LGBTQ+ community, with the majority of those bills focused on transgender youth.¹⁴⁴ Many legislatures have also

¹³⁹ *Id.* at 701.

¹⁴⁰ *Id.* at 712.

¹⁴¹ Katherine Slisz, *Protecting Minors with Substance Use Disorders: A Closer Look at the Relationship of Confidentiality with Treatment Options*, 8 IND. J.L. & SOC. EQUALITY 401, 406 (2020).

¹⁴² *Id.* at 411.

¹⁴³ *Id.* at 412-13.

¹⁴⁴ Jo Yurcaba, *With over 100 Anti-LGBTQ Bills Before State Legislatures In 2023 So Far, Activists Say They're 'Fired Up'*, NBC NEWS (Jan. 14, 2023),

sought to include criminal charges for medical professionals who provide gender-affirming care to minors.¹⁴⁵ This is all in spite of the country's key medical organizations – American Medical Association, the American Academy of Pediatrics, and the American Psychological Association – supporting gender-affirming healthcare for minors.¹⁴⁶

Advocates and doctors have contended that state legislators who seek to ban gender-affirming care for minors mischaracterize what gender-affirming care is.¹⁴⁷ Before puberty, a transgender child might socially transition—as there is nothing medically that can or should be done at this stage—which would include changing their name, pronouns, and clothing.¹⁴⁸ However, going through puberty as the gender they were assigned at birth can have a negative effect on a transgender youth, so the onset of puberty is when medical interventions can begin.¹⁴⁹

Gender-affirming care is often put into three categories: reversible (counseling or hormone blockers), semi-reversible (hormone replacement therapy), and irreversible (surgery).¹⁵⁰ It is the opinion of most professionals that irreversible treatments should not be available to a transgender person until they have reached the age of majority and have lived continuously for twelve months in the gender role consistent with their gender identity; thus, for transgender minors, irreversible treatments are not even a consideration.¹⁵¹ Prescribing hormone blockers can be an effective treatment at the onset of puberty because they pause the progression of puberty for the duration of the treatment; the effects are fully reversible – if the child stops taking the hor-

<https://www.nbcnews.com/nbc-out/out-politics-and-policy/100-anti-lgbtq-bills-state-legislatures-2023-far-activists-say-fired-rcna65349>.

¹⁴⁵ F. Lee Francis, *Who Decides: What the Constitution Says About Parental Authority and the Rights of Minor Children to Seek Gender Transition Treatment*, 46 S. ILL. U. L.J. 535, 561-62 (2022).

¹⁴⁶ Yurcaba, *supra* note 144.

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ Anne C. Dailey & Laura A. Rosenbury, *The New Parental Rights*, 71 DUKE L.J. 75, 135 (2021).

¹⁵¹ *Id.* at 135-36.

mones, the body will resume going through puberty.¹⁵² During this time, the child, the child's doctor, the child's counselor, and the family can explore and consider the best course of action and to what extent the child wants to transition as they continue into adulthood.¹⁵³

Even if a transgender minor's parents are not openly hostile, they may not fully accept their child and their child's wishes to transition, which can create a barrier to the child obtaining parental consent for gender-affirming care.¹⁵⁴ While the mature minor doctrine is not yet widely adopted and applied throughout the United States, it remains the best option—in states that have not yet banned gender-affirming care for minors¹⁵⁵—by which transgender adolescents can receive gender-affirming healthcare when their parents are unwilling to provide consent.¹⁵⁶ For these youth, simply delaying the onset of puberty through hormonal interventions is emerging as a best practice; gender dysphoria is minimized and a final decision can be made at a later date, when the individual is no longer a minor.¹⁵⁷

Courts should allow minors to receive gender-affirming care without the consent of the parents if it can be shown that either the minor consulted with their physician or the treatment would be in their best interest.¹⁵⁸ The medical guidelines for transgender care require hormone blockers be prescribed only after consultation with a physician, and the treatment will nearly always be in the child's best interest because of its reversibility and both the benefits of easing gender dysphoria and the negative

¹⁵² Federica Vergani, Comment, *Why Transgender Children Should Have the Right to Block Their Own Puberty with Court Authorization*, 13 FLA. INT'L U. L. REV. 904, 908 (2019).

¹⁵³ *Id.*

¹⁵⁴ Dailey & Rosenbury, *supra* note 150, at 137.

¹⁵⁵ Alabama, Arkansas, Florida, Tennessee, and Utah all have in place some form of restrictions on gender-affirming care for minors. Alabama's and Arkansas' bans are currently on hold while they are being challenged in court. See Barbara Barrett, *Republicans Have Filed Dozens of Bills to Disrupt Transgender Youth Health Care*, PEW TRUSTS (Feb. 9, 2023), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2023/02/09/republicans-have-filed-dozens-of-bills-to-disrupt-transgender-youth-health-care>.

¹⁵⁶ Ikuta, *supra* note 21, at 182.

¹⁵⁷ *Id.* at 181.

¹⁵⁸ Vergani, *supra* note 152, at 905.

consequences of delaying transition.¹⁵⁹ Even if a minor may not be mature enough to make medical decisions on their own in other contexts, authorizing gender-affirming care aligns with the state's role as *parens patriae*, as it steps in to protect the mental and physical well-being of the child when the parents' attempts to deny care are antithetical to the child's best interests.¹⁶⁰

Transgender youth face a variety of health and social challenges.¹⁶¹ A 2011 study of adolescents admitted to a gender identity clinic showed that most did not have a comorbid psychiatric disorder, suggesting that many of the difficulties they face are a result of external conflicts rather than internal pathology.¹⁶² Perhaps most significant is the rejection, neglect, and abuse transgender youth endure at home, sometimes to the point of finding themselves without a home.¹⁶³ It is also family rejection—not gender variance or social pressure to conform to gender stereotypes—that has been linked to higher rates of depression and suicide attempts among transgender youth.¹⁶⁴ When transgender youth are raised by parents who reject their identity and experience, they are presented with a legal barrier, lack of parental consent, to receiving gender-affirming, if not life-saving, healthcare.¹⁶⁵ Parents enjoy a rebuttable presumption that they are acting in the best interests of their children.¹⁶⁶ Thus, in rebutting that presumption, attorneys and advocates for the child should educate the courts on the urgency and reversibility of treatments, which should temper any concerns judges may have in allowing transgender adolescents to make their own transition-related healthcare decisions.¹⁶⁷

¹⁵⁹ *Id.*

¹⁶⁰ *Id.* at 927.

¹⁶¹ Ikuta, *supra* note 21, at 186.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.* at 187.

¹⁶⁵ *See id.* at 188.

¹⁶⁶ *Id.*

¹⁶⁷ *See id.* at 182-83. Gender affirming healthcare for minors is a new and emerging field, and the details of the research are beyond the scope of this paper. Practitioners should apprise themselves of opportunities to receive education on this issue in order to effectively advocate for the best interests of the children that they represent.

IV. Custody

Family court judges frequently face one of the most formidable tasks known to the judiciary: deciding on a child's future contact with their parents.¹⁶⁸ Child custody orders—unlike divorce decrees, property settlements, or support awards—determine the relationships between children and their caregivers, setting the course of entire lives.¹⁶⁹ While almost all states provide that their courts may consider a child's preference in deciding custody, there is great variety in the discretion granted to trial judges, particularly with respect to the weight given to the child's preference.¹⁷⁰ Some states require judges to consider the child's preference if that child is of a certain age, while other states allow the preference of older minors to prevail.¹⁷¹ While a child's preference is acknowledged as an important factor, most states have determined that it is only one factor among several to be considered, though it may be the most indispensable.¹⁷² This section will take a closer look at the variety of ways in which courts consider the child's preference in custody determinations.

Courts are generally in agreement that a child's preference should play *some* role in custody decisions, although some judges will not listen to the preferences of young children, feeling that they are too immature to express such a preference.¹⁷³ However, these judges fail to recognize that even young children can provide valuable insights into their relationships with each parent that can aid judges in making their determinations.¹⁷⁴ These children can express rational thoughts about how close they are to each parent, the stability from day to day, and how engaged each parent is in the child's life.¹⁷⁵

¹⁶⁸ Barbara A. Atwood, *The Child's Voice in Custody Litigation: An Empirical Survey and Suggestions for Reform*, 45 ARIZ. L. REV. 629, 629 (2003).

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* at 630.

¹⁷¹ Sarah J. Baldwin, *Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?*, 46 SUFFOLK U. L. REV. 503, 514-15 (2013).

¹⁷² Hartman, *supra* note 64, at 1288.

¹⁷³ Baldwin, *supra* note 171, at 515.

¹⁷⁴ *Id.* at 515.

¹⁷⁵ Atwood, *supra* note 168, at 655.

The social science research discussing adolescent preferences provides support for the practice to carefully consider and weigh the child's preference.¹⁷⁶ Specifically, there is data that supports the involvement of children as young as nine years old in the decision-making process and to give considerable, if not controlling, weight to the preferences of children fourteen years and older.¹⁷⁷ Overall, the research suggests that there is value in allowing young children to express their preference to the decision-maker and that children of at least pre-adolescent age can more likely state reliable preferences.¹⁷⁸ It should be noted that the research supports the proposition that giving children of any age the decision-making power may not be in their best interest.¹⁷⁹ And while a child may not have a right to decide, the research does support a child's interest in being heard in custody proceedings.¹⁸⁰

Among the states, a review of the case law is helpful in understanding the wide range in how a child's preference is considered in custody disputes. In *Berndt v. Berndt*, the Nebraska Supreme Court addressed the role of a child's preference in custody modifications.¹⁸¹ Nebraska's standard for modification is a showing of a material change of circumstances affecting the best interests of the child.¹⁸² The Berndts' eleven-year-old daughter testified at trial that she preferred an alternating weekly parenting schedule and indicated that the time she spent with her mother was not enough.¹⁸³ She also stated that equal time with each parent would be good for her and that it was important to her because she loved each parent equally and enjoyed being around them.¹⁸⁴ While the child's preferences are not controlling in custody determinations, if a child is of sufficient age and has expressed an intelligent preference, that child's preference is entitled to consideration.¹⁸⁵ The court noted that in cases where the

¹⁷⁶ Hartman, *supra* note 64, at 1290.

¹⁷⁷ *Id.* at 1290-91.

¹⁷⁸ Atwood, *supra* note 168, at 658.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *See generally* *Berndt v. Berndt*, 904 N.W.2d 24 (Neb. Ct. App. 2017).

¹⁸² *Id.* at 29.

¹⁸³ *Id.* at 30.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

child's preference was given significant consideration, the child was usually ten years old.¹⁸⁶ In the Berndts' case, the child's change in preference was one factor among several that resulted in a material change in circumstances that justified a modification of custody, allowing the daughter to spend more time with her mother.¹⁸⁷

In *Brown v. Brown*, the South Carolina Court of Appeals had to address the role of a child's preference in an initial custody determination.¹⁸⁸ The mother contended that the trial court had erred in failing to consider the preferences of the children.¹⁸⁹ The appellate court noted that, in determining the best interests of the child, the trial court must consider the child's reasonable preferences for custody, but the court should also place weight upon that preference based upon the age, experience, maturity, judgment, and ability to express a preference.¹⁹⁰ Little weight should be given to the child's preference if influenced by the permissive attitude of the preferred parent.¹⁹¹ In affirming the trial court's order that custody be given to the father, the court finally noted that the child's preference is merely a factor in the analysis and is not determinative.¹⁹² Together, *Brown* and *Berndt* illustrate that a child's preference may not be determinative in the initial custody arrangement, but if that child's preference changes, that alone can be sufficient grounds to, at a minimum, petition the court for a custody modification.

V. Conclusion

The COVID-19 pandemic has brought to the forefront concerns of inconsistencies between the rights and interests of parents to make decisions for their children and the rights and interests of children to exercise autonomy. As demonstrated by courts' treatment of minors' wishes regarding COVID-19 and other vaccinations, blood transfusions, mental health treatment, and custody orders, the desires and concerns of minor children

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* at 30-31.

¹⁸⁸ *See generally* *Brown v. Brown*, 606 S.E.2d 785 (S.C. Ct. App. 2004).

¹⁸⁹ *Id.* at 789.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.* at 791.

are often unheard. While a minority of states have adopted the mature minor doctrine, many teenagers across the country, with their own desires, dreams, and futures, are left at the whim of parents, who, while not unfit, may not always be acting in their children's best interests. As the country moves forward and beyond this pandemic, it is time for these children's voices to be heard and for legislatures and courts to establish protections for minors who can assert their own preferences and interests.

Jarom Petersen