

The Mature Minor Doctrine: Can Minors Unilaterally Refuse Medical Treatment?

Michael Hayes*

I. INTRODUCTION

In 1960, the Journal of the American Medical Association published an article describing a surprisingly simple and remarkably effective life-saving technique.¹ The technique, now known as cardiopulmonary resuscitation (CPR), enabled medical professionals to “restor[e] spontaneous circulation” to patients suffering from cardiac arrest.² Once administration of CPR became standard procedure, however, medical professionals recognized that it may not always be in a patient’s interest to attempt resuscitation.³ Rather, resuscitating a terminal patient already near death may cause the patient to endure a painful last few days of life. Recognizing this, doctors and nurses looked for a way to curb the unnecessary “suffering inflicted on many terminally ill patients by repeated resuscitation attempts that only prolonged death.”⁴

Hospital staffs adopted “procedures to delay or deny resuscitation attempts in situations in which they believed CPR would not be beneficial.”⁵ Doctors designated certain patients for “less-than-full” resuscitation attempts; word of mouth or symbols on a patient’s chart

* J.D. Candidate, 2019, University of Kansas School of Law; Ph.D. Candidate, University of Kansas Department of Philosophy; B.A. University of Dallas. I would like to thank Mathew Petersen, Haley Claxton, Nick Snow, Nancy Musick and the University of Kansas Law Review staff for their thoughtful comments and careful review of this Note. Special thanks to my wife Erin and her unfailing patience.

1. W. B. Kouwenhoven, James R. Jude & G. Guy Knickerbocker, *Closed-Chest Cardiac Massage*, 173 JAMA 1064 (1960); *See also* Joan White, *Closed-Chest Cardiac Massage*, 61 AM. J. NURSING 57, 57 (1961) (noting that “[a]nyone can learn the new lifesaving measure”).

2. Jeffrey P. Burns & Robert D. Truog, *The DNR Order After 40 Years*, 375 NEW ENG. J. MED. 504, 504 (2016).

3. *See id.* at 505 (“Today, the decision about whether to attempt resuscitation is just one of many salient decisions that physicians are encouraged to discuss with patients and their surrogates with regard to desired end-of-life care.”).

4. *Id.* at 504.

5. *Id.* at 504–05.

would indicate the level of treatment recommended.⁶ As noted by Jeffrey Burns and Robert Truog:

Many physicians became increasingly concerned that the absence of an established policy and a procedure for transparent decision making about resuscitation prevented them from obtaining adequate informed consent from the patient or the patient's family—and meant that hospitals and clinicians were failing to provide and document a sufficient rationale and accept accountability for what did or did not transpire.⁷

In short, medical professionals often chose, on their own initiative, which patients' lives were worth saving. The American Medical Association, attempting to combat this morally, legally, and ethically dubious practice, recommended that physicians indicate orders not to resuscitate on their order sheets and in a patient's progress notes.⁸ Medical professionals were encouraged to discuss resuscitation decisions with patients and their families in advance.⁹ Thus, a physician's "do not resuscitate order," adopted by hospitals and recognized in most states, is an attempt to ensure that the patient—or the patient's caregivers—can decide for themselves whether resuscitation should be attempted.

Yet not all patients can make these decisions. Few states recognize a minor's right to refuse medical treatment. And recent Kansas legislation on do not resuscitate orders (DNRs) for minors seems to ignore the fact that minors—especially those who understand the nature and consequences of a DNR or similar physician's order—may disagree with their parents about what, if any, medical care they should receive.¹⁰ This recent legislation, known as "Simon's Law," presents a bigger question: whether a minor has the right—under either the U.S. Constitution or Kansas law—to unilaterally refuse resuscitation and medical treatment.

Scholars have argued that minors—at least those of a sufficient level of maturity—should have the freedom to refuse medical treatment against the wishes of their parents.¹¹ A cursory glance at Supreme Court precedent

6. *Id.* at 505.

7. *Id.*

8. *Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 227 SUPPLEMENT TO JAMA 837, 864 (1974).

9. Burns & Truog, *supra* note 2, at 505.

10. See S.B. 85, 87th Leg., Reg. Sess. (Kan. 2017).

11. See, e.g., Melinda T. Derish & Kathleen Vanden Huevel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109 (2000); 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); Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based*

and Kansas common law might lead one to conclude that a minor's right to refuse treatment is protected by the U.S. Constitution and state law. Such a conclusion, however, is mistaken. Rather, granting a minor the right to refuse medical treatment, against the wishes of the parents, would undermine the moral order and authority of the family.¹² Parents' natural (i.e. pre-political) duty to make decisions for the good of the family is protected by the U.S. Constitution, and when properly understood, there is no reason that a minor's interest in refusing medical treatment should outweigh this duty.¹³ Moreover, advocates for minors' right to refuse treatment often neglect the important difference between *consenting* to an arguably beneficial procedure and *refusing to consent* to such a procedure.¹⁴ This Note therefore argues that a minor's ability to refuse medical treatment is protected by neither the U.S. Constitution nor Kansas law, and that protecting a minor's ability to refuse treatment is contrary to sound public policy upholding traditional parental rights and duties.

In Part II of this Note, I will primarily examine the legal basis upon which advocates for minors' right to refuse treatment build their arguments. As both the U.S. Constitution and Kansas law provide a plausible (but ultimately insufficient) basis for this right, I will examine these two sources insofar as they can be used to advance a minor's interest in refusing treatment. In Part III, I will then show why the argument in favor of a minor's right to refuse medical treatment is flawed. As it turns out, advocates for a minor's right to refuse treatment misconstrue the nature of parental rights and they interpret constitutional and state case law far more liberally than is warranted given the actual considerations involved. In addition, much of the empirical data about adolescent psychology relied upon in favor of a minor's right to refuse treatment is far from compelling (as the Supreme Court itself implied in *Roper v. Simmons* (2005)).¹⁵ My conclusion, therefore, is that there need be no right for "mature minors" to refuse medical treatment against the wishes

Upon Religious Beliefs, 22 J. CONTEMP. HEALTH L. & POL'Y 233, 236 (2006) ("The so-called mature minor doctrine is based on a seemingly simple principle: minors who demonstrate a sufficient level of maturity ought to have their choices respected independent of third parties.").

12. See *infra* Part III.B.

13. See, e.g., *Wisconsin v. Yoder*, 406 U.S. 205, 233 (1972) (upholding parents' right to inculcate "moral standards, religious beliefs, and elements of good citizenship"); *Pierce v. Society of Sisters of the Holy Names of Jesus and Mary*, 268 U.S. 510, 535 (1925) (holding that "the child is not the mere creature of the State"); *Meyer v. Nebraska*, 262 U.S. 390, 400 (1923) ("[I]t is the natural duty of the parent to give his children education suitable to their station in life.").

14. For an example of this argument in case law, see *In re E.G.*, 549 N.E.2d 322 (Ill. 1989).

15. See *infra* note 94.

of the parents, and that the current arguments made in favor of such a right are misguided.

II. BACKGROUND

The legal argument in favor of a mature minor's right to refuse medical treatment is ultimately grounded on two bodies of law: (1) law that establishes an adult's protected interest in *refusing* medical treatment, and (2) law that establishes a mature minor's right (in certain circumstances) to *consent* to medical treatment.¹⁶ A minor's right to refuse medical treatment does not obviously follow from these two established bodies of law. But scholars argue that a natural and logical expansion of these principles yield the conclusion that mature minors, at least in certain circumstances, have or should have a protected interest in refusing medical treatment. In this section, I will present the constitutional and common-law basis for this line of reasoning. Despite its initial plausibility, this line of reasoning is ultimately flawed, as it fails to recognize natural parental rights, undeveloped adolescent moral character, unclear empirical data, and other important considerations.

In Part II.A of this Note, I will explain the general right of adults to refuse medical treatment. Next, in Part II.B.1, I will explain the right of minors to consent to medical treatment under the Constitution. In Parts II.B.2-3, I will then examine the ways in which states, particularly Kansas, permit minors to consent to their own healthcare decisions. Finally, in Part II.C, I will provide a brief explanation of Simon's Law, which places the decision to refuse the resuscitation of a minor solely in the hands of the parents.

A. *The Right to Refuse Medical Treatment*

The justification behind legally permitting and regulating DNR orders is simple: people have autonomy over their bodies, and may therefore

16. Presumably minors do have the right to consent to life-saving medical treatment even if the parents would have it otherwise. After all, (1) life is clearly an intelligible, substantive good, whereas continued illness and ultimate death is not, and (2) minors have the right to consent to abortion and birth control over parental objection, and abortion and birth control—whatever their moral status—are far less important than the life itself which continued medical treatment would further. If minors can consent to morally contested medical treatment (e.g. abortion and birth control) against their parents' wishes, then it stands to reason that minors can consent to less controversial procedures which preserve life itself. When this line of reasoning is combined with the common-law "mature minor exception," see *infra*, Part II.B.2, it appears that a minor's right to consent to medical treatment against parental wishes is on surer footing than the right to refuse treatment.

choose whether to allow a physician to work on them.¹⁷ At common law, merely touching another without consent or legal justification is a battery.¹⁸ As Judge Cardozo explained: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”¹⁹ No doctor—absent special circumstances—can treat a patient without informed consent. Doing so would violate the “sacred [and] . . . carefully guarded” right to the “possession and control of his own person.”²⁰

Thus, the doctrine of informed consent lies behind any right to refuse treatment.²¹ Without informed consent, no medical treatment is permitted. Decades before the widespread use of DNR orders, the Kansas Supreme Court recognized the right to forgo medical treatment—even life-saving medical treatment. It noted, in passing:

Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.²²

A doctor therefore cannot unilaterally decide to treat a patient without thereby violating the patient’s right to self-determination and control over his body.²³

This right, within the past few decades, has been protected by statute in most jurisdictions.²⁴ In Kansas, for example, the Natural Death Act

17. GERMAIN GRISEZ & JOSEPH M. BOYLE, JR., *LIFE AND DEATH WITH LIBERTY AND JUSTICE: A CONTRIBUTION TO THE EUTHANASIA DEBATE*, 87–88 (1979).

18. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990) (citing W. KEETON ET. AL, *PROSSER AND KEETON ON LAW OF TORTS* § 9, at 39–42 (5th ed. 1984)).

19. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated by* *Bing v. Thunig*, 143 N.E.2d 3 (1957), *superseded by statute*, N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2012), *as recognized in* *Starozytnyk v. Reich*, 871 A.2d 733 (2005).

20. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

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

22. *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960).

23. There are exceptions in emergency situations. However, the legal justification for this is telling, as it treats the incapacitated patient as giving implied consent, thereby rendering treatment consistent with the general rule. *See, e.g.*, Cecil Casterline, Comment, *Informed Consent: Malpractice*, 18 BAYLOR L. REV. 137, 138 (1966) (noting that “in emergency situations, where consent is implied, the duty to make disclosures [to the patient about risks of treatment] never arises”).

24. *Living Wills*, 0160 Surveys 4 (Thompson Reuters 2017).

protects an adult's "fundamental right to control the decisions relating to the rendering of [his or her] own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition."²⁵ Yet, in most states, this right is statutorily protected only for adults; generally speaking, unemancipated minors do not have a statutory right to refuse medical treatment.²⁶

In addition to the various statutory protections created by state legislatures, an adult has a constitutionally-protected liberty interest in refusing unwanted medical treatment. The Supreme Court, in *Cruzan v. Director of Missouri Department of Health*, held that the Due Process Clause protects a patient's "right not to consent, that is, to refuse treatment."²⁷ Like all liberty interests, however, the scope of constitutional protection depends on the nature and extent of other counterbalancing state interests.²⁸ In *Cruzan*, the Court held that one's liberty interest in refusing medical treatment must be weighed against a state's interest in "the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession"²⁹ At the same time, the Court noted that

[o]n balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient's competency to make a rational and considered choice.³⁰

States may impose limitations on the right to refuse medical treatment, it seems, primarily to protect third-parties and those not competent to make rational decisions.³¹

Because unemancipated minors remain in the custody of their parents or guardians (i.e. third parties), and because minors are generally recognized to have less capacity for rational decision making than adults,

25. Natural Death Act, KAN. STAT. ANN. §§ 65-28,101–28,120 (2002 & Supp. 2017).

26. See KAN. STAT. ANN. § 65-28,103 (2002) (granting right to refuse medical treatment to "[a]ny adult").

27. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 270 (1990).

28. *Id.* at 279.

29. *Id.* at 271.

30. *Id.* at 273 (quoting *In re Conroy*, 486 A.2d 1209, 1225 (N.J. 1985)).

31. See, e.g., *id.* at 284 (upholding Missouri's requirement that "clear and convincing" evidence be shown of an incapacitated adult's desire to withhold medical treatment).

a state would presumably have a stronger interest in limiting a minor's right to refuse medical treatment. This interest is arguably strengthened by the heightened danger of teenage suicide. Yet the Court has, in a few instances, held that constitutional protection of liberty interests does not depend on the age of those seeking its protection.³² Additionally, scholars have, for the past few decades, argued that the right of a "mature minor"—a minor whose decision-making capacity is not in serious question—to refuse medical treatment outweighs the interests of third parties, and as such should be afforded the same rights and protections as adults who refuse medical treatment.³³ These arguments for a minor's ability to refuse resuscitation and medical treatment are presented in the following sections.

B. A Minor's Right to Consent to Medical Treatment

Many states, including Kansas, have both statutory and common-law exceptions to the general rule that minors cannot consent to medical treatment.³⁴ Likewise, the Constitution protects a minor's interest in consenting to certain kinds of medical treatment.³⁵ Scholars have argued that, because both state and constitutional law protect a minor's ability to consent to medical treatment (at least in some circumstances), state and constitutional law also protect—or ought to protect—a minor's ability to *refuse* medical treatment.³⁶ As one scholar notes: "Clearly, there is an intimate relationship between *consenting* . . . and *refusing to consent* to treatment. Courts and commentators generally agree that if the patient's right to 'informed consent' is to have any meaning, it must encompass the right to *refuse* to consent."³⁷ But this argument is not obviously sound; rather, the persuasiveness of the argument depends on the rationale behind the state and constitutional protections, which I will expound upon below. Ultimately, this argument fails to fully recognize the difference between

32. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

33. *See, e.g.*, Derish & Vanden Huevel, *supra* note 11; Rosato, *supra* note 11; Will, *supra* note 11, at 236 ("The so-called mature minor doctrine is based on a seemingly simple principle: minors who demonstrate a sufficient level of maturity ought to have their choices respected independent of third parties.").

34. *See* KAN. STAT. ANN. § 65-6705 (Supp. 2017); *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337 (Kan. 1970).

35. *See generally Danforth*, 428 U.S. 52 (protecting minors' interests in abortion).

36. *See, e.g.*, Will, *supra* note 11, at 236 (adding a first-amendment religious freedom argument).

37. Alexander M. Capron, *TREATISE ON HEALTH CARE LAW* § 18.01[1][b] (2017) (emphasis added).

minor and adult decision-making, including the decision to refuse medical treatment.

1. The Constitution and a Minor's Interest in Consenting to Medical Treatment

According to *Cruzan*, every "competent person" has a constitutionally protected liberty interest in refusing unwanted medical treatment.³⁸ If a minor is found to be a competent person, then it seems to follow that his or her interests would enjoy the same protections. Advocates for a minor's right to refuse medical treatment put great weight on the fact that the Constitution protects a minor's interest in unilaterally consenting to medical treatment.³⁹ The protection of a minor's ability to consent, it might be argued, supports the protection of a minor's ability to refuse to consent.

In *Planned Parenthood of Central Missouri v. Danforth*, for example, the Supreme Court examined the constitutionality of a law requiring unmarried minors to obtain parental consent before obtaining an abortion.⁴⁰ After noting that women have a constitutionally-protected liberty interest in terminating a pregnancy, the Court held that a protected liberty interest "do[es] not mature and come into being magically only when one attains the state-defined age of majority."⁴¹ Whether one is of majority or minority age status does not impact whether, for example, a state can give third parties "an absolute, and possibly arbitrary, veto over the decision of the physician and his patient."⁴²

At the same time, however, the Court recognized that "the State has somewhat broader authority to regulate the activities of children than of adults."⁴³ While the State does have the right to act for the sake of minors who cannot act for themselves and who lack adequate caretakers under the doctrine of *parens patriae*, the people charged by both nature and the law with the welfare of minors are the minors' parents.⁴⁴

38. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

39. See Jennifer Fouts Skeels, Note, *In re E.G.: The Right of Mature Minors in Illinois to Refuse Lifesaving Medical Treatment*, 21 LOY. U. CHI. L.J. 1199, 1210-11 (1990) (analyzing federal constitutional law and Illinois case law).

40. See generally *Danforth*, 428 U.S. 52 (1976); see also *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (examining the constitutionality of a law requiring two-parent notice before a minor obtains an abortion).

41. *Danforth*, 428 U.S. at 74.

42. *Id.*

43. *Id.*

44. See *Parham v. J.R.*, 442 U.S. 584, 602-603 (1979) (holding that "[o]ur jurisprudence

This involves a recognition that children ought to have their welfare looked after, often in ways that may curtail their freedom. While the parents have the natural obligation to protect the welfare of their children, the State may also exercise its *parens patriae* right to act on behalf of children who cannot act for themselves.

In effect, the Court must weigh the minor's liberty interest against "[t]hree separate but related interests—the interest in the welfare of the . . . minor, the interest of the parents, and the interest of the family unit."⁴⁵ The State has an interest in the welfare of the minor, because a minor's "immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely."⁴⁶ This becomes an especially pressing concern with respect to refusing medical treatment, as there is a very fine line between refusing medical treatment and suicide—a line arguably more difficult to recognize and properly respond to for minors than for adults.⁴⁷ And since the avoidance of suicide is one of the factors in *Cruzan* that weighs against one's interest in refusing medical treatment, great caution should be exercised when advocating for a minor's right to refuse medical treatment.⁴⁸ It should also be noted that the State has an interest in the parents, who in turn have an interest in making "choices concerning the arrangement of the household," and who generally make decisions that are in their children's best interests.⁴⁹ Finally, the State has

historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children," and that a "state is not without constitutional control over parental discretion dealing with children when their physical or mental health is jeopardized"); see also *P.W. v. Kan. Dep't of Soc. & Rehab. Servs.*, 877 P.2d 430, 435–36 (Kan. 1994) (explaining the scope of Kansas' *parens patriae* doctrine).

45. *Hodgson*, 497 U.S. at 444; see also *Danforth*, 428 U.S. at 75 (weighing a state's interest in "the safeguarding of the family unit and of parental authority" against a minor's liberty interest in terminating a pregnancy).

46. *Hodgson*, 497 U.S. at 444 (citations omitted).

47. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 294–99 (1990) (Scalia, J., concurring) ("It is not surprising . . . that the early cases considering the claimed right to refuse medical treatment dismissed as specious the nice distinction between 'passively submitting to death and actively seeking it. The distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug.'" (quoting *John F. Kennedy Mem'l Hosp. v. Heston*, 279 A.2d 670, 672–73 (N.J. 1971))).

48. *Id.* at 279 (majority opinion) (holding that the state's interest in preventing suicide must be weighed against a patient's interest in refusing treatment).

49. *Hodgson*, 497 U.S. at 447; see also *Parham*, 442 U.S. at 602 ("The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has been recognized that natural bonds of affection lead parents to act in the best interest of their children." (citations omitted)); see also Will, *supra* note 11, at 236 (citing ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 29 (1989) (giving four reasons why parents are the proper surrogate decision makers for their children)).

an interest in the family unit, which provides the primary locus of care, nurture, responsibilities, and moral formation within society.⁵⁰ Such considerations, then, must be weighed against the Supreme Court's dictum that a protected liberty interest "do[es] not mature and come into being magically when one attains the state-defined age of majority."⁵¹ However, as will be seen below, the considerations against a minor's interest in refusing medical treatment prevail.

2. Kansas Common Law Mature Minor Exceptions

Many states recognize a common-law "mature minor" exception, which permits minors to consent to medical treatment without their parent's permission.⁵² In one of the paradigm cases, *Younts v. St. Francis Hospital and School of Nursing, Inc.*, a seventeen-year-old girl severely injured her hand while visiting her mother in the hospital.⁵³ Doctors rushed her into surgery without obtaining her mother's consent to operate.⁵⁴ The mother argued that an unauthorized operation of this sort is a "technical battery or trespass, regardless of the result," because a minor is incapable of giving informed consent.⁵⁵ As such, the mother argued the surgeon was liable for damages.⁵⁶

The Kansas Supreme Court, however, found that in some circumstances, a minor may consent to medical treatment. A minor's ability to consent to medical treatment, the Court argued, depends on his or her "ability to understand and comprehend the nature of the surgical procedure, the risks involved, and the probability of attaining the desired results in the light of the circumstances which attend."⁵⁷ Ultimately, the Court held that a minor *could* consent to a beneficial surgical procedure if she understands the nature and consequences of the procedure.⁵⁸ In applying this rule, the Court found that the daughter was "of sufficient age

50. See *Stanley v. Illinois*, 405 U.S. 645, 651 (1972) (noting that the integrity of the family unit "found protection in the Due Process Clause of the Fourteenth Amendment, . . . the Equal Protection Clause of the Fourteenth Amendment, . . . and the Ninth Amendment") (citations omitted).

51. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

52. Jessica A. Penkower, Comment, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment—The Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1180–81 (1996).

53. 469 P.2d 330, 332 (Kan. 1970).

54. *Id.*

55. *Id.* at 336.

56. *Id.*

57. *Id.* at 337.

58. *Id.* at 338.

and mature” enough to understand the nature and consequences of the operation, and that the operation was “the approved surgical treatment and in the best interests of the patient.”⁵⁹ Furthermore, the Court noted, the daughter’s physical condition demanded immediate medical attention, which would only have been delayed by seeking consent—thus, it was in the daughter’s best interests that the operation occur before obtaining parental consent.⁶⁰

Other jurisdictions have similar common-law rules. The Supreme Court of Tennessee, for example, approvingly cited *Younts* while recognizing a “mature minor” exception in *Cardwell v. Bechtol*.⁶¹ A minor could consent to medical treatment, the Court held, if the minor had “the capacity to consent to and appreciate the nature, the risks, and the consequences of the medical treatment involved.”⁶² Similarly, West Virginia has recognized that “minors who are mature may be involved in the medical decisions that affect their livelihood” and that “[w]hether the child has the capacity to consent depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the child, as well as upon the conduct and demeanor of the child at the time of the procedure or treatment.”⁶³ Age, in such states, is therefore not the determining factor in whether a minor can consent to treatment.

It is especially important to recognize, however, that the common-law mature minor exception was not created to advance the autonomy of minors. It was primarily created to protect the interests of physicians, permitting them to avoid battery and malpractice charges when treating minors without their parents’ permission. The exception emerged out of a judgment that doctors should not be liable for attending to the real and pressing needs of patients simply because there was neither time nor opportunity to obtain parental consent; it was more important that a minor patient be treated to avoid further damage than the doctor strictly adhere to the technicalities of tort law. This history should not be lost on those debating whether the common-law mature minor exception gives minors any right of autonomy respecting their medical decision-making.

3. Kansas Statutory Mature Minor Exceptions

In addition to the common-law “mature minor exception,” most states

59. *Id.*

60. *Id.*

61. 724 S.W.2d 739, 746–47 (1987) (citing *id.*).

62. *Id.* at 749.

63. *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 835, 838 (W. Va. 1992) (holding that a mature seventeen-year old’s consent is required for a DNR order).

have laws that permit mature minors to consent to certain kinds of medical treatment, typically relating to sexual health and pregnancy. For example, in Kansas, a minor can unilaterally consent to an abortion, without the typically-required parental notice, if a court “finds by a preponderance of the evidence that either: (1) The minor is mature and well-informed enough to make the abortion decision on her own; or (2) notification of a [parent or guardian] would not be in the best interest of the minor.”⁶⁴ The definition of “mature,” within this context, is not always perfectly clear.⁶⁵ Nevertheless, Kansas courts have determined that minors need not be “extraordinarily mature” for their age, nor need they be married or “freed from the care, custody and control of their parents.”⁶⁶ Rather, all that is required is that the minor “have the intellectual capacity, experience, and knowledge necessary to substantially understand the situation at hand and the consequences of the choices that can be made.”⁶⁷ Furthermore, because “every human act and decision can be fraught with long- and short-term consequences which no person can completely appreciate,” a minor may be mature even if his or her decisions are “made despite imperfect knowledge and understanding.”⁶⁸

The import of such statutory mature minor exceptions cuts two ways. On one hand, the existence of such statutory mature minor exceptions suggests an acknowledgement that many people under the age of majority have the intellectual capacity to consent to medical treatment. That minors often have the capacity to consent to medical treatment is a central premise for many arguments in favor of a mature minor’s ability to refuse medical treatment.⁶⁹ This may influence whether courts may recognize a mature

64. KAN. STAT. ANN. § 65-6705 (Supp. 2017). The statute tracks the language of *Bellotti v. Baird*, in which the Court held that a minor’s interest in an abortion outweighed a State’s interest in a notice requirement when “(1) . . . she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents’ wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests.” 443 U.S. 622, 643–44 (1979).

65. See Ann Eileen Driggs, Note, *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?*, 11 HEALTH MATRIX 687, 694 (2001) (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 424 U.S. 52, 74) (noting that precise definition and consistent application are hard to come by within the “mature minor” context).

66. *In re Doe*, 866 P.2d 1069, 1074 (Kan. Ct. App. 1994).

67. *Id.*

68. *Id.*

69. See, e.g., Lisa Anne Hawkins, Note, *Living-Will Statutes: A Minor Oversight*, 78 VA. L. REV. 1581, 1588 (1992); Joan-Margaret Kun, Comment, *Rejecting the Adage “Children Should Be Seen and Not Heard”—The Mature Minor Doctrine*, 16 PACE L. REV. 423, 441–44 (1996); Allison Mantz, Note, *Do Not Resuscitate Decision-Making: Ohio’s Do Not Resuscitate Law Should Be Amended to Include a Mature Minor’s Right to Initiate a DNR Order*, 17 J.L. & HEALTH 359, 366 (2003).

minor's right to refuse medical treatment, even absent a statutory mature minor exception. On the other hand, however, state legislatures often do not create these statutory mature minor exceptions to refusal of consent laws. These lawmakers obviously know how to create statutory mature minor exceptions and they know how to create laws protecting the right to refuse medical treatment, yet they choose not to create mature minor exceptions on their refusal of consent laws.⁷⁰ Simon's Law, passed by the Kansas legislature in 2017, presents an illustrative example.

C. *Simon's Law*

Simon Crosier was born on September 7, 2010. Shortly after he was born, Simon was diagnosed with Trisomy 18, a rare genetic condition characterized by the presence of an extra chromosome 18.⁷¹ Infants like Simon have a mortality risk over 100 times greater than children without birth defects—only 5% to 10% of trisomy-18 live births make it to their first birthday.⁷² The children that do survive to enjoy childhood, however, may reach a 6–8 month developmental level—they can generally smile and recognize family members, often crawl, feed themselves, follow simple commands, understand cause and effect, and sometimes even use a walker.⁷³ This was the Crosiers' short-lived hope: Simon died three months later.⁷⁴

After Simon died, his mother, noticed that his doctor had put a DNR order on his medical records shortly after Simon was diagnosed.⁷⁵ Neither Mrs. Crosier nor her husband had consented to the DNR order. The Crosiers were previously unaware that, pursuant to the hospital's "futility policy," medical professionals would not intervene in the event of a cardiac arrest in trisomy-18 patients.⁷⁶ The hospital effectively decided to

70. See KAN. STAT. ANN. § 65-6705(b) (Supp. 2017) (permitting minors to object to and bypass a parental consent requirement for abortion); S.B. 85, 87th Leg., Reg. Sess. (Kan. 2017).

71. Jennifer Brinker, 'Simon's Law' Considers Parent's Role in Health-Care Decisions, ST. LOUIS REVIEW (Jan. 28, 2015), <http://stlouisreview.com/article/2015-01-28/simons-law-considers>.

72. Anna Cereda & John C Carey, *The Trisomy 18 Syndrome*, 7 ORPHANET J. OF RARE DISEASES 1, 5 (2012), available at <https://ojrd.biomedcentral.com/articles/10.1186/1750-1172-7-81>.

73. *Id.* at 6.

74. *Simon Dominic Crosier Obituary*, ST. LOUIS POST-DISPATCH (Dec. 5, 2010), <https://www.legacy.com/obituaries/stltoday/obituary.aspx?n=simon-dominic-crosier&pid=146919141>.

75. Brinker, *supra* note 71.

76. *Id.*; see also Cereda & Carey, *supra* note 72, at 5 ("[H]istorically there has been a consensus among care providers that trisomy 18 be considered a condition for which non-intervention in the newborn was indicated.") Cereda and Carey also note that surveys show that many physicians would still intervene for the parents' sake. *Id.*

provide “less than full” medical attention to a patient without consent—precisely what DNR statutes and policies were intended to prevent. In response to the Crosiers’ story, the Kansas legislature passed “Simon’s Law,” which mandates transparency of hospital futility policies and ensures that medical professionals cannot unilaterally refuse life-saving care for minor patients.⁷⁷

While Simon’s Law clearly protects the interests of parents like the Crosiers, it also protects the interests of children like Simon who, with adequate medical care and a little luck, could defy the odds and live relatively long, happy lives. But by placing the decision about whether to refuse medical care solely in the hands of the minor’s parents, states like Kansas appear to prevent minors of sufficient maturity from deciding for themselves whether to refuse medical treatment.

It is worth noting that Simon’s Law includes an exception for *emancipated* minors—i.e. parental consent is not required for DNR orders if the child is married or otherwise removed from the parents’ custody—but does not include a general exception for mature minors.⁷⁸ And as Kansas courts remind us, emancipated minors and “mature minors,” for the purpose of the mature minor exception, are two different things.⁷⁹

Even where Simon’s Law establishes procedures for resolving disputes about whether to refuse medical treatment, the law does not require that the minor’s desires or opinions be taken into consideration.⁸⁰

77. See S.B. 85, 87th Leg., Reg. Sess. (Kan. 2017).

78. The relevant portions of Simon’s Law are as follows:

(b) A do-not-resuscitate order or similar physician’s order shall not be instituted, either orally or in writing, unless at least one parent or legal guardian of a patient or resident who is an unemancipated minor or prospective patient or resident who is an unemancipated minor has first been informed of the physician’s intent to institute such an order and a reasonable attempt has been made to inform the other parent if the other parent is reasonably available and has custodial or visitation rights. . . .

(c) Either parent of an unemancipated minor or the unemancipated minor’s guardian may refuse consent for a do-not-resuscitate order or similar physician’s order for the unemancipated minor, either in writing or orally. Any such refusal of consent must be contemporaneously recorded in the patient’s medical record. No do-not-resuscitate order or similar physician’s order shall be instituted either orally or in writing if there has been such a refusal of consent except in accordance with a court order issued pursuant to subsection (d) [providing procedures for resolving disagreements between parents and between parents/medical professionals]. . . .

(f) Upon the request of a patient or resident or a prospective patient or resident, a healthcare facility, nursing home or physician shall disclose in writing any policies relating to a patient or a resident or the services a patient or resident may receive involving resuscitation or life-sustaining measures, including any policies related to treatments deemed non-beneficial, ineffective, futile or inappropriate, within the healthcare facility or agency.

Kan. S.B. 85, § 1(b)-(c), (f).

79. See *In re Doe*, 866 P.2d 1069, 1074 (Kan. Ct. App. 1994).

80. See Kan. S.B. 85.

It is safe to assume that adults—whether parents, physicians, or judges—usually have the minor’s best interests in mind when determining the level of care the minor should receive. Yet this does not mean that a minor’s preferences are always upheld, nor does it mean that a minor can unilaterally refuse medical treatment (including resuscitation). And whether the Constitution recognizes a minor’s liberty interest in refusing medical treatment, or whether Kansas law authorizes a mature minor exception is the focus of this Note. Ultimately, however, neither the Constitution nor Kansas common law require a mature minor’s refusal of medical treatment to be respected above a parent’s wishes.

III. ANALYSIS

In this section, I argue that unemancipated minors have neither a constitutionally protected liberty interest nor a Kansas common-law right to (unilaterally) refuse unwanted medical treatment. Proponents of applying a mature minor exception to the refusal of medical treatment often incorporate the following syllogism:

1. If an unemancipated minor is capable of mature decision-making, then he should be able to unilaterally refuse medical treatment.
2. Some minors are capable of mature decision-making.
3. Therefore, those minors should be able to unilaterally refuse medical treatment.⁸¹

There is good reason to question—or at least to prudently refrain from adopting—premises (1) and (2). Despite legal scholars’ citations to psychological studies, it is unclear whether (2) is supported by the empirical data. At the same time, there is little support provided for (1) besides appeals to the value of autonomy—and the (intrinsic) value of autonomy is an open ethical and political question, even within a liberal

81. See, e.g., Will, *supra* note 11, at 259 (“[I]f a minor has sufficient competence to make an autonomous decision, that decision should be respected as such.”); Kun, *supra* note 69, at 442 (citing the Midwest Bioethics Center guidelines stating that “(1) a person’s age was not necessarily determinative of decision-making capacity; (2) children are not the parents’ property; (3) minors have moral status and legal standing independent of their parents’ (4) mature minors should be governed by the ethical and legal presumptions of capacity.”); Penkower, *supra* note 52, at 1204 (“The logical justification for employing the mature minor doctrine would seem to be judicial recognition that it is possible for some adolescents to attain the faculty for adult-like decision-making . . . [and] ought to enjoy the same substantive rights that an adult enjoys while engaging in adult-like activity.”); but see Neil C. Manson, *Transitional Paternalism: How Shared Normative Powers Give Rise to the Asymmetry of Adolescent Consent and Refusal*, 29 *BIOETHICS* 66 (2015) (arguing for shared decision-making procedures because of adolescents’ developing, but not fully developed, competence).

democratic society.⁸² This section will examine the merits of these premises, concluding that prudence should caution us against treating a minor's decisions with the same deference as an adult's. As such, there is good reason to reject both the major and minor premises of the above syllogism—at least insofar as the law is concerned. Empirical data about minors' decision-making, as well as social and moral considerations surrounding parental and family rights, ultimately tell against a mature minor's freedom—under either the Constitution or under state law—to refuse medical treatment. Once we see a clearer picture of the empirical data, as well as a clearer picture of the relationship between parent and child, it becomes clear that neither the Constitution nor Kansas law support a minor's right to refuse medical treatment.

A. Do Minors Have the Same Decision-Making Abilities as Adults?

The mature minor doctrine depends on whether the decisions of minors and the decisions of adults are similar enough that they should be given equal deference under the law. Recall *Cruzan*, in which the Court held that every competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.⁸³ The argument is that at least *some* minors are “competent,” insofar as they have the same decision-making capacities as adults. Therefore, proponents argue, mature minors should be able to unilaterally refuse medical treatment as well.⁸⁴

Whether minors have “mature” decision-making capacities is an empirical question. Scholars regularly look to psychological research to justify claims about the cognitive capacities of minors. As Melinda T. Derish and Kathleen Vanden Huevel argue:

In the last twenty years . . . studies have indicated that “adolescents, with some exceptions, are capable of making major health decisions and giving informed consent.” In light of this knowledge, it has become increasingly difficult for physicians, lawyers and judges to sustain the position that a minor's actual decision making capacity is legally irrelevant, simply because her consent is not legally effective.⁸⁵

82. See ROBERT P. GEORGE, MAKING MEN MORAL: CIVIL LIBERTIES AND PUBLIC MORALITY 173–82 (Oxford University Press 1993) (arguing, *contra* Joseph Raz, that autonomy has no intrinsic value, and only appears to be valuable insofar as one's autonomy is used to pursue some intelligible good).

83. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

84. Michael Branch, Note, *A Competent, Terminally Ill Minor's Right to Refuse Life-Sustaining Medical Treatment*, 32 OKLA. CITY U. L. REV. 481, 494–95 (2007).

85. Derish & Vanden Huevel, *supra* note 11, at 113 (citations omitted).

These studies include findings that “the decision-making process of fourteen-year-olds is comparable to that of adults.”⁸⁶

But the studies cited in support of the proposition that minors are capable of mature decision-making actually prove far less than their proponents suggest. Thomas Grisso and Linda Vierling, for example, argue that their research shows “no psychological grounds for maintaining the general legal assumption that minors at age 15 and above cannot provide competent consent.”⁸⁷ It is not all that surprising that a study which examines only a few simple variables—e.g. whether minors (1) understand the meaning of words and sentences, (2) have cognitive processes that involve rationality and reflection, (3) recognize consequences of decisions, and (4) desire to make decisions independently—will turn up “no psychological grounds” for treating decisions of fifteen-year-olds and twenty-year-olds differently.⁸⁸ But equivalence of maturity does not follow from such limited findings.

The fact that adolescents understand causality, have theoretical knowledge, and desire independence, while relevant, does not by itself determine whether adolescents make decisions as well as adults do. It is one thing to select the most reasonable medical treatment for a hypothetical patient when you are provided with relevant information.⁸⁹ It

86. Driggs, *supra* note 65, at 703–04 (citation omitted); *see also* Hawkins, *supra* note 69, at 1588 (“Literature on cognitive development supports this view and indicates that minors are capable of exercising sound judgment about medical care earlier than the law generally presumes.” (citations omitted)). The studies themselves do not warrant such a bold conclusion. For example, the study by Lois A. Weithorn and Susan B. Campbell cited by Hawkins recognized differences between the “reasonableness” of fourteen-year-olds’ decisions and those of eighteen- and twenty-one-year-olds. Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 *CHILD DEV.* 1589, 1594–96 (1982). Moreover, Weithorn and Campbell note that even the 9-year olds in their study “tended to express clear and sensible treatment preferences similar to those of adults,” which seems to negate the significance of the similarities they found between the decisions of fourteen-year-olds and those of adults. *Id.* at 1596.

87. Thomas Grisso & Linda Vierling, *Minors’ Consent to Treatment: A Developmental Perspective*, 9 *PROF. PSYCHOL.* 412, 424 (1978).

88. *Id.*; *see also* Brian C. Partridge, *The Mature Minor: Some Critical Psychological Reflections on the Empirical Bases*, 38 *J. OF MED. & PHIL.* 283, 288 (2013); Driggs, *supra* note 65, at 714 (2001) (citation omitted) (noting that the American Academy of Pediatrics also looks at only a few simple factors for competency, including “(1) the ability to understand and communicate information relevant to a decision; (2) the ability to reason and deliberate concerning the decision; and (3) the ability to apply a set of values to a decision that may involve conflicting elements”). The problem with this approach is obvious. The Grisso and Vierling study probably *also* turned up “no . . . grounds” for believing that fifteen-year-olds make more dangerous decisions or act more imprudently than do adults. A study’s inability to generate evidence for X (especially due to its limited scope) is *not* grounds for believing ~X (much less for creating a legal presumption of ~X). Grisso & Vierling, *supra* note 87, at 424.

89. *See generally* Grisso & Vierling, *supra* note 87 (examining adolescents’ ability to select medical treatments for hypothetical patients).

is another thing to make a decision about one's own life and death in one of the most emotionally unstable, physically demanding, and psychologically trying times in one's life.⁹⁰ The studies cited fail to address the fact that most patients making a decision about refusing medical treatment are in a unique situation:

Research has shown that chronic or serious illness may leave the minor with a feeling of uncertainty about the future and doubt that he will ever be happy. These adolescents are also more likely to develop major psychosocial problems than those who are healthy. Researchers have also found that serious or chronic illness has a potential impact on developmental tasks during adolescence. Risk-taking behavior may increase, self-esteem may be lowered, emotional difficulties may increase, and the sense of personal identity may be compromised.⁹¹

In short, even if many minors can make reasonable hypothetical medical decisions about other people, as some psychological studies suggest, when such minors are healthy and in a controlled environment, it would be quite a leap to assume that they could similarly make mature decisions in situations that count. Even if we take the data produced by the studies cited in support of the mature minor doctrine at face value, it would still be an unwarranted move to conclude—as often happens in the literature—“mature minor patients are better able to act in their own interests” than their parents.⁹² More importantly, the emotional difficulties, self-esteem issues, and general uncertainty that come with life-threatening disease—which are heightened during adolescence⁹³—should make us especially wary about the dangers of suicide. It is well-documented that suicide is a pressing danger for adolescents, who, for various reasons, are more likely to consider ending their lives than adults.⁹⁴ This suggests that adults and minors make decisions differently, and that minors are more prone to make decisions that would lead to premature death.

Of course, adults faced with a decision to continue or forgo medical treatment face many of the same challenges as do similarly-situated adolescents. And so, the real question, for present purposes, is not whether

90. Penkower, *supra* note 81, at 1192–203 (surveying research on chronically ill adolescents, cataloging the unique physical, social, psychological, and developmental challenges they face).

91. Driggs, *supra* note 65, at 707 (citations omitted).

92. Rosato, *supra* note 11, at 79.

93. See Penkower, *supra* note 81, at 1192–1203.

94. See *Suicide: Facts at a Glance*, CENTERS FOR DISEASE CONTROL (2015), <https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf>; see also Centers for Disease Control and Prevention, *Youth Risk Behavior Surveillance—United States 2013*, 63 SURVEILLANCE SUMMARIES 4 (June 13, 2014), <https://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>.

adults and minors have similar cognitive capacities (though that question is important and arguably tells against the rights of minors to refuse treatment).⁹⁵ Rather, the real question is whether the law should treat the decisions of adults and minors as equivalent. After all, it is not obvious that minors can be trusted to use their cognitive capacities in the way that we expect virtuous and competent adults to do.⁹⁶ A brief look at the risk-taking behavior of adolescents as compared to adults suggests that, as a general rule, they cannot.⁹⁷ One can grant the premise that many minors have the same cognitive capacities and use the same cognitive processes as do adults and still deny that minors are (as a rule) competent decision makers.⁹⁸ The studies cited above do not take into account psychological, physiological, or emotional maturity; they fail to account for the virtues of patience, prudence, courage, and obedience, nor do they account for mental, emotional, and social stability—all of which seem immediately relevant to the question at hand. Thus, even if the purported results from the oft-cited studies are true, it does not follow that minors will tend to exercise their decision-making faculties in a manner equivalent to adults.

Additionally, psychological evidence may count *against* the mature minor doctrine. For instance, the Supreme Court in *Roper v. Simmons* found the empirical evidence against adolescents' maturity and adult-like agency too compelling to permit the exercise of the death penalty on minors.⁹⁹ As Mark J. Cherry notes, "the Court concluded that the

95. See Jan Brogan, *Teen's Brains Make Them More Vulnerable to Suicide*, THE BOSTON GLOBE (March 10, 2014), <https://www.bostonglobe.com/lifestyle/health-wellness/2014/03/09/brain-development-makes-teens-more-vulnerable-suicide-and-mood-disorders/tGBStHOnjqAyanfCe7rbsK/story.html>.

96. Whether one subscribes to a view of substantive morality which treats such traits as virtues or not is irrelevant; I will refer to "virtues" throughout this piece to indicate stable character traits that enable people to consistently make prudent and moral decisions, especially in difficult and novel situations.

97. See, e.g., Driggs, *supra* note 65, at 706–07 (citations omitted); see also Centers for Disease Control and Prevention, *Youth Risk Behavior Surveillance*, *supra* note 94. The risk-taking behaviors studied by the CDC include "1) behaviors that contribute to unintentional injuries and violence; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection; 5) unhealthy dietary behaviors; and 6) physical inactivity." *Id.* at 2. Concrete examples of risk-taking behaviors include not wearing a seat belt, riding with a driver who had been drinking, driving after drinking, texting while driving, fighting, carrying weapons near schools; the study also examined frequency of suicides, suicidal thoughts, and sexual violence among teenagers. *Id.* at 5–12.

98. Here the term "competent" is used in a normative, legal sense.

99. *Roper v. Simmons*, 543 U.S. 551, 568 (2005) (holding the death penalty unconstitutional for crimes committed by minors). Justice Kennedy, writing the majority, cites Jeffrey Arnett, *Reckless Behavior in Adolescence: A Developmental Perspective*, 12 DEVELOPMENTAL REVIEW 4, 339 (1992). The opinion adopted Arnett's findings that, due to a variety of factors, minors are more likely to be influenced by outside pressure and are less likely to have a well-formed character. *Roper*, 543 U.S. at

overwhelming weight of the psychological and neurophysiological data regarding brain maturation supports the conclusion that adolescents are qualitatively different types of agents than adult persons.”¹⁰⁰ Even if the basic structures of rationality are in place, the brain may nevertheless still be developing, even after the age of eighteen.¹⁰¹ Likewise, the fact that fifteen-year-olds may have similar cognitive processes and desires for independent action does not preclude the fact that they “(1) lack maturity and possess an immature sense of responsibility; (2) ‘are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure,’; and (3) do not yet possess a fully formed personal character.”¹⁰² This re-emphasizes the point that, regardless of what adolescents may possess in terms of cognitive capacities, they may still lack in experience, perspective, and virtue. And of course, this is perfectly consistent with the empirical findings that adolescents are more prone to imprudent and reckless behavior than adults.¹⁰³

There may nevertheless be some “mature minors” out there, whose decision-making capacity—i.e. the understanding, cognitive capacity, experience, perspective, and virtue—is equivalent to that of an average and reasonable adult. But their undisputed existence does not require legislatures and courts to carve out exceptions to their laws, thereby permitting their decisions to override those of their parents. Rather, a state’s determination that a parent’s decision is always required when available, over and above the decision of someone under the age of eighteen, is perfectly reasonable. After all, the natural rights and obligations of parents to ensure the well-being and moral formation of their children (see *infra* Part III.B) do not magically disappear once their children become virtuous and good decision-makers. A state must nevertheless determine at which point it will defer to the decisions of an individual over his or her parents. It typically does this (for efficiency’s sake, no doubt) by designating a particular age considered appropriate within the community, but if a state wishes to diverge from the traditional rule, engage in case-by-case analyses, and create mature minor exceptions,

569–70 (citing also Laurence Steinberg & Elizabeth S. Scott, *Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty*, 58 AM. PSYCHOLOGIST 1009, 2014 (2003); ERIK ERIKSON, *IDENTITY: YOUTH AND CRISIS* (W. W. Norton & Co. 1968)).

100. Mark J. Cherry, *Ignoring the Data and Endangering Children: Why the Mature Minor Standard for Medical Decision Making Must Be Abandoned*, 38 J. MED. & PHIL. 315, 316 (2013).

101. *Id.* at 320.

102. *Id.* at 323 (citations omitted).

103. *Supra* note 97.

it may choose to do so.¹⁰⁴ But the decision to refrain from engaging in some philosophical and psychological guesswork from the bench is not contrary—as some scholars suggest—to “a quarter century of mounting scientific and developmental research.”¹⁰⁵ Nor would it be an unjust affront to the rights of minors to do so. The mounting scientific and developmental research—at least in the eyes of the Supreme Court—suggests that, because of their developmental, intellectual, and moral differences, the law should *not* treat minors and adults equivalently.¹⁰⁶ As such, the argument for mature minors’ ability to refuse treatment is more difficult to justify.

B. Should Decisions of “Mature Minors” Be Treated the Same as Decisions of Adults?

Scholars arguing in favor of permitting “mature minors” to unilaterally refuse medical treatment often assume that, if a minor is deemed “mature,” then his or her decision should be given the same amount of deference as an adult’s decision.¹⁰⁷ In many cases, it seems as if this premise is based on the assumption that a parent is simply a

104. One potential problem is that the standards used in case-by-case evaluations are often ambiguous. In Kansas, for example, a minor simply needs to “[be] close to maturity and knowingly give[] an informed consent.” *Younts v. St. Francis Hosp. & Sch. of Nursing*, 469 P.2d 330, 337 (Kan. 1970). In addition, Kansas also seems to require that the treatment be in the “best interests of the patient.” *Id.* at 338. The problem in the context of refusing medical treatment is that whether medical treatment can or should be refused in a given case is an important moral question; by applying the “best interests of the patient standard,” the court simply replaces the parents’ answer to this moral question with its own. I find this imposition of values to be problematic, but such impositions are not uncommon in American jurisprudence. See *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976).

Ambiguity can be found in other states’ standards as well. In Tennessee, the minor must have “the capacity to consent to and appreciate the nature, the risks, and the consequences of the medical treatment involved.” *Cardwell v. Bechtol*, 724 S.W.2d 739, 749 (1987). This seems even more ambiguous than the standard used in Kansas; after all, an adolescent may have the *capacity* to consent to and appreciate the nature, the risks, and the consequences without actually appreciating the nature, risks, and consequences of the procedure and thereby actually giving informed consent.

105. Rhonda Gay Hartman, Comment, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1267–68 (2000).

106. See, e.g., *Roper v. Simmons*, 543 U.S. 551 (2005).

107. See e.g., Hawkins, *supra* note 69, at 1588 (“When the presumption of incompetence breaks down, due to the maturity or independence of the minor, autonomy restrictions become harder to justify.”). I take this as suggesting that the *only* or at least *primary* rationale for parental consent requirements is the cognitive incompetence of minors; as if parental consent is simply a form of surrogate decision-making. See also Derish & Vanden Huevel, *supra* note 11, at 113; Kun, *supra* note 69, at 444 (citation omitted) (analyzing an alternate model where parents “were regarded as ‘consultants’ [whose role should include] assist[ing] the minor to make appropriate decisions by providing information and support.”).

surrogate decisionmaker because minors are deemed “incompetent”—as if this provides the only basis for treating a parents’ decision as binding on the minor. But a minor’s decision-making incompetence is not the only basis for prioritizing parents’ decisions over those of their minor children. Rather, parents have a pre-political authority over their minor children which authorizes them to make decisions on their behalf, regardless of the child’s cognitive capacities.¹⁰⁸

Melissa Moschella describes this pre-political moral parental authority as follows:

[T]he nuclear family—parents and their children—is a community that is sovereign within its own proper sphere, with reference to the particular common good that defines it. . . . [P]arental authority entitles parents to the moral space that they need to make decisions on behalf of the family community, particularly the members of that community who do not yet have sufficient maturity to be able to direct themselves toward their own fulfillment.¹⁰⁹

This understanding of parental authority is often lost in the literature. Parents are not simply surrogate decision-makers for incompetent children. Rather, the family is a sovereign unit with the parents as its governing authority.¹¹⁰ The good of each family member is inherently tied up in the common good of the family; a decision affecting the family will affect its members, and vice-versa. It is the parents, not simply members capable of adult decision-making, who are charged with safeguarding and advancing the common good of all and the personal good of each. The state chooses to protect the natural authority of parents over their children until a specified time (usually until the children are eighteen) and it generally only interferes with this authority when it is being abused, neglected, or endangers members of the family or larger society.¹¹¹

108. Melissa Moschella, *Natural Law, Parental Rights and Education Policy*, 59 AM. J. JURIS. 197, 211–12 (2014); see also Catechism of the Catholic Church ¶¶ 2211, 2221, www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a4.htm (last visited Apr. 9, 2018) (providing a specific, but commonly held, articulation of this view).

109. Moschella, *supra* note 108, at 212–13.

110. For a fuller articulation of this position, see Robert John Araujo, S.J., *Natural Law and the Rights of the Family*, 1 INT’L J. JURIS. FAM. 197, 200–02 (2010).

111. See, e.g., *Wisconsin v. Yoder*, 406 U.S. 205, 232–33 (1972) (holding that certain compulsory education requirements “interferes with the liberty of parents and guardians to direct the upbringing and education of children under their control”); *Prince v. Massachusetts*, 321 U.S. 158, 166–67 (1944) (holding that a state’s interest in the safety and welfare of children protected by child labor laws overrides the contrary interest of parents).

Of course, the exact age of majority is largely arbitrary—there is nothing magical about the age eighteen. But a state must decide at which point it will respect its citizens’ decisions (for good or ill); a perfectly reasonable and simple way to do this is to decide on an age that is in keeping with the

This parental authority is a liberty interest protected by the Constitution.¹¹² Even if a minor child is competent to make important decisions, the parents retain parental authority.¹¹³ The Supreme Court has recognized that parental authority is not merely limited to that of a surrogate decision-maker for incompetent children; rather, they have found that “the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.”¹¹⁴ The parents’ authority is a moral authority—they are charged with the pursuit of the common good of the family as they teach, by example, those in their charge to make competent, rational, and virtuous decisions. The fact that one of their children has reached a certain level of cognitive development does not abrogate this authority.

Of course, parents do not always act in the best interests of their children. And the state has the right to exercise its authority as *parens patriae* when parents fail to virtuously exercise their authority.¹¹⁵ This is the exception, not the rule; as the Supreme Court reasoned in *Parham*:

Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. . . . The law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children.¹¹⁶

The Court concluded that Supreme Court precedent “permit[s] the parents to retain a substantial, if not the dominant, role” in decisions regarding their children’s psychological and social health and well-being.¹¹⁷

The issue, then, is not primarily one of competence, but of authority—namely, whether the parental authority should continue to be recognized when parents and their children disagree about whether the child should

social and cultural expectations of its citizens.

112. See, e.g., *Yoder*, 406 U.S. at 233.

113. See *Morrissey v. Perry*, 137 U.S. 157, 159 (1890) (holding both that parents have the right to veto a minor’s decision to join the military and that mature minors have the capacity to legally bind themselves to military service).

114. *Prince*, 321 U.S. at 166 (noting also the *parens patriae* rights of the State for public policy reasons).

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

116. *Id.* at 602 (citations omitted).

117. *Id.* at 604.

accept or refuse medical treatment.¹¹⁸ When a mature minor's decision is given priority over that of the parent, a breakdown of moral authority occurs. If a court, for example, determines that a minor is competent to refuse medical treatment against the wishes of her parents, the state has effectively usurped authority of the parents—something it is generally only permitted to do in cases of abuse, neglect, or substantive and compelling public policy.¹¹⁹

Alternatively, some argue that the government routinely overrides this natural authority, thereby suggesting that parental authority counts for little in contemporary American jurisprudence. For example, in *Danforth* and in similar cases that followed, the Court permitted minors to bypass parental authority in order to exercise certain liberty interests.¹²⁰ But it does not follow that the Constitution always permits minors to exercise their liberty interests, regardless of how much deference a state gives to the parents' natural authority. After all, *Danforth* and its progeny are often interpreted *not* as the Court's affirmation of a minor's ability to act autonomously, without state or parental restraints, but rather as exercises of paternalism by the Court.¹²¹ Under this interpretation, the question before the Court was not whether the good of a minor's autonomy overrides the good of parental authority, but rather whether the "good of reproductive health care unquestionably overrides the good of parental authority when the two come into apparent conflict."¹²² As Barina and Bishop put it:

[T]he real dilemma is not about adolescents' ability to consent, because contraception is perceived as beneficial and good regardless of consenting ability. The real conflict is between state interests in public health and parental authority. Under the guise of the adult-like developmental stage of adolescence, health outcomes have clearly been prioritized above parental authority and the primacy of the family structure without significant attention to what maturity is or if adolescents actually possess it.¹²³

118. See Tania E. Wright, Comment, *A Minor's Right to Consent to Medical Care*, 25 HOW. L.J. 525, 536 (1982) (noting that "[t]he legitimacy and nature of [parents'] substantive interest[s] in their children] has produced much debate and confusion").

119. See *Parham*, 442 U.S. at 603–04.

120. See *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976); see also *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (examining the constitutionality of a law requiring two-parent notice before a minor obtains an abortion).

121. See, e.g., Rachele Barina & Jeffrey P. Bishop, *Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor*, 38 J. MED. & PHIL. 300, 306–07 (2013).

122. *Id.* at 306.

123. *Id.* at 307.

This is, to be sure, a contentious interpretation. Yet it cannot be doubted that in the cases where the Court or the legislature has overridden parental authority, there were other broad, public policy considerations beyond simply a minor's ability to act autonomously.¹²⁴ After all, many such cases require a court to determine that bypassing parental authority is in the interest of the child—courts often weigh the risk of disease, teenage pregnancies, domestic abuse, and ostracization from family or community life against parental authority.¹²⁵ Such considerations are meant to justify bypassing parental authority, which implies that without such considerations in play, there is no reason that parental authority should be bypassed.¹²⁶ When examining the ability of minors to refuse medical treatment, these considerations rarely, if ever, are present.

The central premise underlying much argument for the right of “mature minors” to refuse medical treatment, therefore, is largely unsupported. Even if minors could exercise the same decision-making capacities as could adults, it does not follow that the law ought to give their decisions the same weight. After all, unemancipated minors are, by definition, under the care and custody of those with moral authority to make decisions on their behalf for their good and the good of the family; these decisions are supposed to help guide the minor to develop the virtue, character, and practical reason that he may currently lack. This lack of practical reason, broadly construed, is reflected by minors' tendency to engage in riskier behaviors—and the proximity to suicide in refusal-of-treatment cases should not be ignored. Permitting a minor's autonomous decision to override this parental authority effectively undercuts its entire purpose and function. With this in mind, a mature minor's right to refuse medical treatment becomes much more difficult to justify.

124. See, e.g., *Danforth*, 428 U.S. at 72 (permitting judicial bypass in cases where abortion is purportedly in the minor's interest); *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944) (enforcing child labor laws, noting that the material well-being of children may override parents' religious beliefs); *but see Wisconsin v. Yoder*, 406 U.S. 205, 241–43 (Douglas, J., dissenting) (stating that the adolescents' religious interests ought to be considered in addition to parental and state interests).

125. See *In re Doe*, 866 P.2d 1069, 1074–75 (Kan. Ct. App. 1994) (noting that the risk of physical abuse is not the only factor for the court to consider in such cases).

126. It should also be remembered that the “judicial bypass” of parental authority in such cases (at least in cases where the minor is not at risk of physical harm through domestic or partner abuse) is rather controversial. After all, the judgment that sexual freedom, sexual health, unwanted pregnancies, and other unintended consequences of sexual behavior better promote the well-being of a minor than, say, moral and religious rectitude requiring avoiding abortion and contraception is a *moral* judgment traditionally suited for parental, not judicial, authority. For a court to say that obtaining certain material goods and services (e.g. abortion and contraception) is more important than religious and moral rectitude, at least in the parents' reasoned judgment, ought to concern supporters of both traditional values and parental authority.

C. *Does a Minor Have a Constitutionally-Protected Interest in Refusing Medical Treatment?*

The constitutional argument for a mature minor's right to refuse medical treatment is as follows. An adult has a protected liberty interest in refusing unwanted medical treatment. A minor has the same liberty interests as adults, so long as the minor's interest outweighs the State's interest in protecting the minor, her parents, and her family. A minor's interest in obtaining morally controversial medical treatment (e.g. abortion) outweighs the State's interest in protecting the minor, her parents, and her family. Therefore, insofar as refusing medical treatment is analogous to obtaining medical treatment—even that as divisive as an abortion—a minor has a constitutionally-protected liberty interest in refusing medical treatment.¹²⁷

Even if this argument is successful, it does not follow that minors will actually have the unilateral right to refuse medical treatment, regardless of the interests of their parents and the state. After all, one's liberty interest in any case must be balanced against the state's interest in preserving life, preventing suicide, protecting third-party rights, and upholding the integrity of the medical profession.¹²⁸ The preservation of life, prevention of suicide, and the integrity of the medical profession, it seems, are all called into question—at least to some degree—by the empirical evidence that impressed the Court in *Roper*.¹²⁹ After all, if minors are *not* often capable of making prudent and virtuous decisions, there is less reason to believe that their refusal of medical treatment would be easily distinguishable from suicide.

It is no consolation to say that only “mature” minors will be exercising their decision-making in the refusal of treatment. In addition to the rather murky standards used to determine a minor's maturity,¹³⁰ the evidence of a minor's maturity will likely come from periods in the minor's life that are not as emotionally, physically, socially, and morally challenging as

127. See Wright, *supra* note 118, at 540 (arguing for general rights of minors to consent to medical care).

128. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 271 (1990).

129. *Roper v. Simmons*, 543 U.S. 551, 569 (2005).

130. See Penkower, *supra* note 81, at 1175; *see also supra* note 104. Whether a doctor or a judge would determine a minor's maturity would depend on whether the mature minor exception is framed as judicial bypass—i.e. permitting a minor to seek a judge's determination that she can consent to or refuse medical treatment independent of her parents' wishes (as in the abortion context)—or as a physician's defense against tort actions filed based on inadequate consent (as in the Kansas common-law context).

when faced with, say, a life-threatening disease.¹³¹ Deeming a minor mature because of his decision-making and reasoning in more stable environments may not inspire great confidence in his ability to exercise prudence and virtue in considerably more difficult situations. When this is combined with the well-documented observation that minors are more prone to suicide, suicidal thoughts, anxiety, and risk-taking behavior,¹³² one can see how *Cruzan*'s application to minors may be markedly different from its application to adults.

More important for this Note, however, is the impact that a mature minor's right to refuse medical treatment would have on third-parties—specifically, the parents. The Court in *Cruzan* noted that a liberty interest will be afforded less protection if its exercise would infringe on the rights of third parties.¹³³ Parents have a pre-political, constitutionally-protected right to exercise their moral authority over their children and make legally binding decisions concerning the children's and the family's welfare.¹³⁴ As such, a minor's right to unilaterally refuse medical treatment would subvert this moral authority; it would undercut the principle that parents' decisions are the sources of moral formation and for the good of the minor and the family as a whole.

While this consideration was not weighed heavily in *Danforth* and its progeny, *Danforth* involved situations in which (1) a minor's access to a (purported) substantive and public good was at issue, (2) negative effects of seeking parental consent were possible and/or likely, and (3) bypassing parental authority was thought to be in the minor's best interest.¹³⁵ None of these factors are present in the case of a minor's ability to unilaterally refuse medical treatment. Autonomy is not a substantive good, as it is merely the power to direct oneself to what one takes to be good; neither is a minor's exercise of autonomy a public good any more than the minor's obedience to parental authority (unless, of course, that authority is being abused or the child is being neglected). Except in clear cases of abuse or neglect, or a failure to act in good faith, it is not clear how a judge might determine whether life or unwanted medical treatment is in the best interests of the minor. After all, it is far from clear in *any* case whether death is in one's interest. Whether death can be in someone's interest

131. See *id.* at 1192–1203.

132. Centers for Disease Control and Prevention, *Youth Risk Behavior Surveillance—United States 2013*, 63 SURVEILLANCE SUMMARIES 4 (June 13, 2014), <https://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>.

133. *Cruzan*, 497 U.S. at 273.

134. See *supra* Part III.B.

135. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 72–75 (1976).

depends on the nature and content of human well-being, which is ultimately a moral or religious question. Because this ultimately would be a question about substantive values, and the exercise of the minor's autonomy would not further other public health interests (as it arguably does in abortion and contraception cases), a judge has no reason to replace the parents' determination of what the child ought to do with his own.¹³⁶ Moreover, the usurpation of parental authority in such a case would neither promote life nor prevent suicide, which the state has an interest in doing. The Court suggests this much in *Hodgson v. Minnesota*—that a minor's liberty interest must be weighed against the state's interest in the minor's welfare, "the interest of the parents, and the interest of the family unit."¹³⁷ It is only when countervailing public policy and public health interests—as in *Danforth*—that the states' interests might be overridden.

The conclusion, therefore, is that there is no reason to think that a minor's interest in refusing medical treatment is constitutionally protected; its protection would require an infringement on the rights of third parties—i.e. parents—and would, at least arguably, counteract the state's interest in the preservation of life and the prevention of suicide to a much greater extent than it did in *Cruzan*.

D. Does Kansas Law Protect the Mature Minor's Refusal of Medical Treatment?

Recall that Kansas law permits adults to refuse medical treatment, and that it allows minors to unilaterally consent to medical treatment.¹³⁸ However, Kansas law does not and should not permit a minor to refuse medical treatment against the parents' wishes because the refusal of medical treatment is not obviously beneficial for the minor, and because permitting a minor to do so would depart from the purposes and policy justifications of Kansas' present mature minor exceptions.

Even if we credit the minor with an ability to understand and comprehend the consequences of both treatment and its refusal, it does not follow that Kansas law permits minors to refuse medical treatment (absent at least one parent's approval).¹³⁹ After all, in *Younts*—as well as most of the common-law mature minor cases—the minor consented to a *beneficial*

136. This is not to say that a minor's access to contraception and abortion are, in fact, substantive goods worthy of overriding a parent's moral judgment. I take the opposite to be true, but a full discussion of that argument is beyond the scope of this Note.

137. 497 U.S. 417, 444 (1990).

138. See *supra* Part II.C.

139. Cf. Grisso & Vierling, *supra* note 87.

medical procedure.¹⁴⁰ In addition, in *Younts* and other cases, the minor required immediate medical attention to prevent her condition from worsening.¹⁴¹ These factors are not present in the case of a minor's refusal of medical treatment. It is certainly not clear that the *refusal* of a potentially beneficial medical procedure requires the same amount of deference as *consent* to a potentially beneficial procedure.¹⁴² Furthermore, the decision to refuse medical treatment is hardly time-sensitive in the same way that consenting to a medical treatment may be.

More importantly, however, we should be aware of the mature minor exception's "mission creep."¹⁴³ The exception, as it originated, was typically used as a physician's defense against malpractice and battery claims; a doctor was permitted to escape liability for his treatment of a minor without parental permission if the minor understood the nature and consequences of the procedure.¹⁴⁴ As discussed above, the exception was also invoked when the traditional requirement of parental consent might interfere with public health goals or the material well-being of the minor.¹⁴⁵ Not until the past few decades has a minor's autonomy—apart from unreasonable physician liability, public health goals, or the minor's material well-being—been considered as an important goal furthered by the mature minor exception.¹⁴⁶ This recent trend does not reflect the purpose of the mature minor exception as it has been recognized in Kansas.

The common-law mature minor doctrine, as it exists in Kansas, certainly does not require a minor's unilateral decision to refuse medical treatment to be respected. Because the minor's decision to refuse treatment does not protect doctors, and because it furthers neither the health of the minor nor the community, it is easily distinguishable from *Younts* and similar cases. There is no reason to suppose that the mature minor exception applies to a minor's refusal of medical treatment. Furthermore, the Kansas legislature has clearly expressed its intent to uphold parental authority when it comes to the refusal of medical treatment for minors.¹⁴⁷ It permitted an exception only to emancipated minors—that is, those who are legally *outside* of the immediate scope of parental

140. *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 335–37 (Kan. 1970).

141. *Id.*

142. See Manson, *supra* note 81.

143. Barina & Bishop, *supra* note 121, at 311.

144. *Id.* at 303.

145. *Id.* at 305–06.

146. *Id.* at 311.

147. See S.B. 85, 87th Leg., Reg. Sess. (Kan. 2017).

authority.¹⁴⁸ Additionally, it is clear that Kansas legislators know how to create a mature minor exception, as they have done so in other situations.¹⁴⁹ Furthermore, when it comes to disputes about refusing or consenting to medical treatment, Kansas lawmakers tend to express a preference for continued life and treatment rather than its refusal.¹⁵⁰ Therefore, it seems that recognizing a mature minor's ability to refuse medical treatment would be both an unwarranted expansion of current Kansas law, *and* it would do so contrary to the express intent of the Kansas legislature.

IV. CONCLUSION

Simon's Law places decisions about refusing medical treatment and resuscitation solely within the hands of the parents. The law arose out of a fear that medical professionals might make decisions that violate the parents' right to make decisions for the good of their family and their children.¹⁵¹ But the law also precludes minors from unilaterally deciding whether to refuse treatment and resuscitation. Scholars have argued that such preclusion is unjustified—that it is an arbitrary affront to a mature person's autonomy which ought not to exist.¹⁵² But this position only makes sense if the minor in question is as competent a decision-maker as are adults *and* that parents *only* make decisions for their children because the children are incompetent. The purpose of this Note is to show that these assumptions are unwarranted.

There is no reason to think that either the Constitution or Kansas law *does* or *should* protect the right of a minor to refuse medical treatment against the wishes of her parents. I am not, however, suggesting that a state cannot exercise its *parens patriae* right to protect children from abuse and neglect, and such cases of abuse and neglect may become apparent in disputes about medical care. Parents have the inherent moral authority to make decisions for the good of their children and the family; it is only

148. *Id.*

149. KAN. STAT. ANN. § 65-6705(b) (Supp. 2017) (permitting minors to object to and bypass a parental consent requirement for abortion).

150. *See, e.g.*, KAN. STAT. ANN. § 65-28,106 (2002) (noting that a patient's present desire to undergo treatment always supersedes the effects of a declaration directing the withholding of medical treatment); *see also* KAN. STAT. ANN. § 65-28,102(e), 103 (2002) (requiring a patient to have an incurable injury, disease, or illness from which there is no recovery, certified by two physicians, before authorizing a declaration directing the withholding of treatment); KAN. STAT. ANN. § 65-28,109 (2002) (ensuring that the law does not condone the deliberate ending of life).

151. Brinker, *supra* note 71.

152. *See, e.g.*, Derish & Vanden Huevel, *supra* note 11; Rosato, *supra* note 11; Will, *supra* note 11, at 236.

when they fail in their duties that the state may exercise its *parens patriae* rights. And minors within the care of their parents are bound by the just exercise of the parents' moral authority, even when they disagree or would act otherwise. This moral authority is more than a mere decision-making surrogacy for incompetent children; it is supposed to guide and shape minors into virtuous and prudent citizens and human beings. It would be unwise to usurp this authority simply because a minor with adult-like cognitive capacities disagrees with her parents' decision.