FAITH BY CHOICE: AN ARGUMENT FOR EXPANDING MATURE MINOR PROVISIONS IN NORTH CAROLINA

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ABSTRACT

In response to the public health crisis created by Covid-19, North Carolina granted certain "mature minors" the right to consent to vaccination over the objections of their parents. But these same minors are still barred from making independent healthcare decisions in other contexts. As studies continue to reveal the potential for minors to fully participate in their own healthcare, the legal system must decide how much "personal liberty" to grant minors. Although the law in North Carolina has yet to answer that question, SL 2021-110 indicates a higher degree of trust which could open the way for more consistent legal treatment of minor rights. The proposal in this note provides a legislative option which would secure the personal integrity of capable minors while still providing a legal outlet for parents to retain their constitutional control over their children.

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INTRODUCTION

In the eyes of the law, a child transforms into a fully functioning adult at the stroke of midnight on their eighteenth birthday.[1] Until this moment, the law assumes an individual lacks the "maturity, experience, and capacity for judgment required for making life's difficult decisions."[2] This divide is even more pronounced in the medical setting, where minors are "assumed to lack sufficient cognitive and conative maturity to craft autonomous health care choices" and therefore, are incapable of giving legally binding consent.[3] Although the Supreme Court has declared that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone,"[4] the constitutional rights of minors are clearly much more limited than those of adults.[5] This legal ambiguity has led state courts to widely disparate results regarding a minor's right to choose their own medical treatment.[6]

Questions about the medical decisional capacity of minors are further complicated by differing religious beliefs. Religious exceptions to certain medical procedures are frequently upheld under the free exercise clause of the First Amendment.[7] But in cases involving minors, courts generally conflate the religious beliefs of parents with those of their minor children.[8] Failing to address either the personal maturity or religious integrity of

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[1] Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547, 557–58 (2000) (noting that various rights accrue at different ages, but the age of majority is the baseline at which "presumptive adult legal status is attained").
[2] Parham v. J. R., 442 U.S. 584, 602 (1979).
[3] Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 299 (2003); *see also Parham*, 442 U.S. at 603.
[4] *In re* Gault, 387 U.S. 1, 13 (1967).
[5] *See, e.g.*, Bellotti v. Baird, 443 U.S. 622, 649 (1979) (restricting access to abortions for minors); Brown v. Bd. of Educ., 347 U.S. 483, 495 (1954); *In re* Gault, 387 U.S. at 33–55.
[6] *See, e.g.*, Novak v. Cobb Cnty. Kennestone Hosp. Auth., 849 F. Supp. 1559 (N.D. Ga. 1994).
[7] U.S. CONST. amend. I.; *see e.g.*, Pub. Health Trust v. Wons, 541 So. 2d 96, 97 (Fla. 1989); St. Mary's Hosp. v. Ramsey, 465 So. 2d 666, 669 (Fla. Dist. Ct. App. 1985); *In re* Brown, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997).
[8] *See, e.g.*, Prince v. Massachusetts, 321 U.S. 158 (1944); Wisconsin v. Yoder, 406 U.S. 205 (1972); W. Va. State Bd. of Educ. v. Barnette, 319 U.S. 624 (1943); *In re* Sampson, 278 N.E.2d 918 (N.Y. 1972). *But see In re* Green, 307 A.2d 279, 280 (Pa. 1973) (finding that the case should be remanded for a determination of the child's wishes); Wisconsin v. Yoder, 406 U.S. 205, 241–42 (Douglas, J., dissenting) (indicating that when children's rights and interests were at stake, they should be given more consideration).

individual minors creates the possibility that children may "die for beliefs that are not truly their own."[9]

The potential social costs of equating the beliefs of minors and their parents have become more pronounced in the age of Covid-19. In 2019, before the outbreak of the pandemic, the CDC named "vaccine hesitancy" among its top global health threats and indicated an additional 1.5 million lives could be saved if vaccination rates improved.[10] The lifesaving potential of vaccines has only increased with the onset of Covid-19. In response, many states, including North Carolina have passed laws allowing mature minors to override the objections of parents to receive the Covid-19 vaccine.[11] These laws indicate that North Carolina may be more amenable to granting minors greater autonomy in other healthcare decisions as well.

This note will argue that the passage of North Carolina SL 2021-110 demonstrates a greater openness to recognizing the medical rights of minors. As such, it should be used to further the statutory and common law provisions for minors in the medial setting. Part I will examine the legal background which historically gives parents the right to determine the medical treatment of their children. It will also provide a brief overview of the caselaw surrounding religious exemptions to medical treatments. Part II provides a survey of the legal doctrine of the "mature minor." Part III examines the mature minor exception in connection with medical treatment decisions based on religious beliefs. Parts IV and V turn to the Covid-19 minor vaccination statute in North Carolina and argue for an extension of minor rights based on maturity beyond the context of "communicable diseases" like Covid-19. Part V concludes with a brief restatement of the suggested solution and an acknowledgement of future issues.

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[9] Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs*, 22 J. CONTEMP. HEALTH L. & POL'Y, 233, 237 (2006).

[10] Brett Molina, *People Choosing Not to Vaccinate Now a Global Health Threat, Says the WHO*, USA TODAY (Jan. 17, 2019, 3:08 PM), https://www.usatoday.com/story/news/health/2019/01/17/not-vaccinating-children-global-health-threat-says-who/2601140002/.

[11] *See* N.C. GEN. STAT. § 90-21.5 (2021).

I. LEGAL BACKGROUND

A. Common Law Informed Consent Doctrine

One of the hallmarks of civilized society is the idea that private individuals may not violate each other's bodily integrity without valid consent.[12] In the health care setting, this principle requires practitioners to obtain a patient's "informed consent" before performing medical procedures.[13] If a physician administers treatment without first obtaining effective consent, that physician may be liable to the patient for battery.[14] To obtain legally binding informed consent, a physician must disclose material information regarding: "(1) the nature of the procedure, (2) the risks and benefits and the procedure, (3) reasonable alternatives, [and] (4) risks and benefits of alternatives."[15]

The physician must also assess the patient's understanding of each disclosure to determine whether they have decision-making capacity.[16] Capacity for healthcare is generally expressed in terms of four criteria: "(a) Understanding, (b) Appreciation, (c) Reasoning, and (d) Expression of a Choice."[17] A patient demonstrates understanding and appreciation when they clearly comprehend the information disclosed by their physician and can apply this information to their own situation.[18] A patient meets "reasoning" criteria if their "decisions reflect the presence of a reasoning process."[19] The fourth criteria is more complex.

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[12] *See* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.").

[13] *See* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (1914) (stating for the first time that a physician could be held liable for not getting a patient's "informed consent").

[14] *See id.*

[15] Parth Shah et al., *Informed Consent*, STATPEARLS, Jun. 14, 2021, at 1, https://www.ncbi.nlm.nih.gov/books/NBK430827/.

[16] *Id.*

[17] Barton W. Palmer, & Alexandrea L. Harmell, *Assessment of Healthcare Decision-making Capacity*, 31 ARCHIVES OF CLINICAL NEUROPSYCHOLOGY 530, 531 (2016) (citation omitted).

[18] *Id.* ("'Understanding' refers to the ability of the individual to comprehend the information being disclosed in regard to his/her condition as well as the nature and potential risks and benefits of the proposed treatment and alternatives (including no treatment). . . . The 'Appreciation' component of decision-making capacity involves the ability to apply the relevant information to one's self and own situation.").

[19] *Id.* (describing the reasoning component as the "ability to engage in consequential and comparative reasoning and to manipulate information rationally.").

Generally, a patient must be able to communicate a decision to the physician to meet the "expression of choice" requirement.[20] But some courts require physicians to go a step further and look for evidence that the patient's choice is "clear and consistent."[21] This capacity requirement is founded on the idea that "competent individuals are better judges of their own good than are others."[22] As Justice Cardozo famously stated, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[23]

But as Justice Cardozo noted, only adults can give legally binding informed consent.[24] The law presumes that all adults have medical decision-making capacity, and only inquiries into individual competency in specific circumstances.[25] For patients under the age of seventeen, however, physicians must obtain "informed permission" from the patient's parents before administering treatment.[26] The rationale for requiring parental consent is rooted in two ideas about childhood development: "(1) that minors need to be protected from the dangers of uninformed, immature decisions; and (2) who better to decide for children than parents who are presumed to act in their best interests."[27]

B. Family Privacy and Parental Decision-Making Authority

Almost one hundred years ago, the Supreme Court established in *Meyer v. Nebraska*[28] that parents have a fundamental

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[20] *Id.*

[21] *Id.* ("[Some patients] are able to speak but seem unable to choose—to make up their mind. Thus patients might be considered unable to Express a Choice if, during several consecutive days, they are so ambivalent that they can neither commit to a choice nor assign the decision to someone else. In other cases, patients may vacillate between consent and refusal for medical procedures, thereby producing a clinical stalemate." (quoting THOMAS GRISSO & PAUL .S. APPELBAUM, ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS 36 (1998)).

[22] ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 29 (1990).

[23] Schloendorff v. Soc'y of New York Hosp., 105 N.E. 92, 93 (1914).

[24] *See id.*

[25] *See id.*; *see also* Shah et al., *supra* note 15, at 2.

[26] Shah et al., *supra* note 15, at 2.

[27] Will, *supra* note 9, at 246. *See e.g.*, Parham v. J. R., 442 U.S. 584, 602 (1979) ("The law's concept of the family rests on the presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions.").

[28] 262 U.S. 390 (1923).

right to make child-rearing decisions.[29] According to the Court, the Fourteenth Amendment guarantees parents the right to "establish a home and bring up children[.]"[30] Since then, the Court has limited state interference in parental decisions related to the association, religion, education, and healthcare of their children.[31] But these parental rights are not all inclusive. The Court carved out a thin exception in *Prince v. Massachusetts*,[32] where a nine-year-old girl was caught selling religious literature in violation of a state child labor law.[33] There, the Court weighed the conflicting interests of the free exercise rights of the girl's guardian with the state's interest in preventing "the crippling effects of child employment[.]"[34] Although the girl's aunt stood as her representative in this case, the Court nonetheless limited the extent of any guardian's control, noting that: "Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."[35] Thus, state protection for parental rights ends where parents attempt to force martyr-like choices on to their children—especially in cases where a child's life is imminently at risk.[36] Where the risk to a child's life is more remote, the Court will limit parental power "if it appears that parental decisions will

[29] *See id.* at 403 (overturning a state law which prohibited teaching in any other language than English on substantive due process grounds).
[30] *Id.* at 399.
[31] *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205, 205–13 (1972) (holding that society highly values "parental direction of the religious upbringing and education of their children"); Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925) (stating that parents have the liberty "to direct the upbringing and education of children under their control"); Prince v. Massachusetts, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents[.]"); Troxel v. Granville, 530 U.S. 57, 67–68 (holding it unconstitutional for a state judge to determine the appropriateness of grandparent visitation over the objections of parents).
[32] Prince v. Massachusetts, 321 U.S. 158 (1944).
[33] *See id.* at 162.
[34] *Id.* at 168–69. ("[T]he state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare; and that this includes, to some extent, matters of conscience and religious conviction.").
[35] *Id.* at 170.
[36] *Id.* at 158; *see e.g.*, *In re* Hudson, 126 P.2d 765 (Wash. 1942); *In re* Seiferth, 127 N.E.2d 820 (N.Y. 1955).

jeopardize the health or safety of the child, or have a potential for significant social burdens."[37]

Thirty years after the *Prince* decision, the Court again considered the tension between the free exercise rights of parents and the state's concern for the well-being of minors.[38] In *Wisconsin v. Yoder*,[39] the Court considered whether the state had the power to compel Amish teenagers to continue attending school after eighth grade.[40] Similar to the Court's approach in *Prince*, the majority only examined the free exercise interests of the parents.[41] The Court ultimately upheld the parent's traditional interest in controlling the religious upbringing of their children.[42] This focus on the fundamental rights of parents indicates the Court's consistent belief that the interests of children are protected best when represented by their parents.[43]

Neglecting to directly consider the preferences of minors also implies that a minor has no separate interests apart from those of their parents. Justice Douglas addressed this issue in his dissent, arguing that "where a child is mature enough to express potentially conflicting desires, it would be an invasion of the child's rights to permit such an imposition without canvassing his views."[44] In Justice Douglas' view, agreement between parents and children was an irrelevant question.[45] Instead, Douglas insisted the Court should look first to maturity, arguing that a child who has reached a certain level of maturity should receive constitutional protections regardless of their parents' wishes.[46] In doing so, he reminded the Court that it had "held over and over again" that minors are entitled to the same constitutional protections as adults, including free exercise

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[37] Wisconsin v. Yoder, 406 U.S. 205, 234 (1972).
[38] *Id.* at 205 (deciding whether the state's interest in compelling continued secondary education outweighed the parents' free exercise rights).
[39] *Id.*
[40] *Id.*
[41] *Id.* at 213–14.
[42] *Id.* at 231–32.
[43] *See* Jennifer E. Chen, *Family Conflicts: The Role of Religion in Refusing Medical Treatment for Minors*, 58 HASTINGS L.J. 643, 645 (2007); *see also Yoder*, 406 U.S. at 231–32 (indicating that the Court only considered parental free exercise rights because "[t]he children are not parties to this litigation.").
[44] *Yoder*, 406 U.S. at 241–42 (Douglas, J., dissenting).
[45] *Id.*
[46] *Id.* ("And, if an Amish child desires to attend high school, and is mature enough to have that desire respected, the State may well be able to override the parents' religiously motivated objections.").

rights.[47] Although the majority in *Yoder* was unwilling to examine the individual interests of children, Douglas' dissent opened the door for minors with differing interests from their parents to be fully heard in subsequent cases.

C. Parental Authority in Medical Decision Making

In the years following *Prince* and *Yoder*, state courts struggled to discern when the state could override the medical decisions of parents. The Supreme Court offered some guidance by illustrating the limits of parental rights of control in *Parham v. J.R.*[48] In that case, two minor plaintiffs were committed by their parents to state-administered mental institutions.[49] Unlike *Yoder*, some of the plaintiffs in this class action lawsuit were minors, so the *Parham* court had to consider their separate interests.[50] Thus, the Court had to balance the interests of the state and the private interests of both parents and their children.[51] Although precedent indicated parents have broad authority over minors, the Court also acknowledged the potential for parents to act against the interests of their children.[52] This possibility justified giving states "constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized."[53] In this case however, there was no evidence of bad faith by the parents, so there was no need for state interference.[54] Nevertheless, the Court recognized the due process rights of minors under the Fourteenth Amendment, insisting that before a minor can be committed, they must receive "an adequate, independent diagnosis of [their] emotional condition and need

[47] *Id.* at 243; *see also In re* Gault, 387 U.S. 1, 13 (1967) ("[N]either the Fourteenth Amendment nor the Bill of Rights is for adults alone.").
[48] 442 U.S. 584 (1979).
[49] *Id.* at 590–91.
[50] *Id.* at 600.
[51] *Id.* ("[T]he private interest at stake is a combination of the child's and parents' concerns.").
[52] *Id.* at 602–03.
[53] *Id.* at 603.
[54] *Id.* at 603–04 (holding that complaints over a hospital commitment decision are not enough to limit parental authority to determine what is best for their child). Although the Court did not want to impose "unnecessary procedural obstacles that may discourage the mentally ill or their families from seeking needed psychiatric assistance," a parent's decision to institutionalize their child presents enough risk that a procedural inquiry by a "neutral factfinder to determine whether a state's statutory requirements for admission [were] satisfied" was necessary. *Id.* at 605–06. This way, the Court could effectively balance all three interests (state, parent, child) by placing control of the hospitalization decision in the hands of both parents and the hospital admission staff. *Id.* at 605–07.

for confinement under the [medical standards for admission]."[55] Although the Court ultimately favored the parents' preferences, their separate consideration of the child's interest was an important first step in recognizing the independent constitutional rights of children.

In the 1970s, two key cases arose which illustrate the different judicial perspectives on the state's role in protecting children.[56] The first case, *In re Sampson*,[57] involved a mother who gave consent for her son to undergo a risky surgical procedure to correct her son's facial deformity.[58] Her son's condition did not pose an immediate threat to his life, but the corrective surgery could give him the chance for a "normal, happy existence."[59] Although the mother consented to the surgery, she refused to allow her son to receive a blood transfusion.[60] Her beliefs as a Jehovah's Witness would not allow her to consent to the transmission, as it would violate the biblical provision against "consumption of blood."[61] In considering this case, the court did not inquire into the son's wishes.[62] Instead, the court considered whether a mother's refusal to give consent for "surgical procedures necessary to insure the physical, mental and emotional well-being of her son" constituted neglect and thus warranted state intervention.[63] Thus, New York and several other states decided that a state may only override parental rights where parents are neglectful.[64] Under this approach, the State's conclusions about a minor's best interests would be controlling.[65]

Other states adopted an alternate approach which considered the interests of individual minors.[66] The second case, *In re*

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[55] *Id.* at 606 ("The standard for admission is 'whether or not hospitalization is the more appropriate treatment' for the child.").
[56] *See In re* Sampson, 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970); *In re* Green, 307 A.2d 279 (Pa. 1973).
[57] 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970).
[58] *Id.* at 645.
[59] *Id.* at 655.
[60] *Id.* at 645.
[61] *Id.* at 646; *see also* PARK RIDGE CTR. FOR THE STUDY OF HEALTH, FAITH, AND ETHICS, THE JEHOVAH'S WITNESS TRADITION: RELIGIOUS BELIEFS AND HEALTH CARE DECISIONS 1, 2 (Edwin R. Dubose & M. James Penton eds., rev. ed. 2002).
[62] *See In re* Sampson, 317 N.Y.S.2d at 656 ("They are not interested or concerned with whether he does or does not want the essential operation.").
[63] *Id.* at 658–59.
[64] *Id.*
[65] Because the court made no effort to ascertain Kevin's interests in this case, they strongly implied that the State's ideas about a child's best interests were determinative. *Id.*
[66] *See In re* Green, 307 A.2d 279, 280 (Pa. 1973).

Green,[67] illustrates this general approach.[68] *Green* involved claims of neglect brought against the custodial mother of a boy named Ricky who suffered from paralytic scoliosis.[69] Like the mother in *Sampson*, this mother also consented to a risky surgery which would correct her son's spinal deformity.[70] This mother also refused to allow blood transfusions.[71] The court considered whether its interests in protecting minors warranted "the abridgement of a parent's right to freely practice his or her religion when those beliefs preclude medical treatment of a son or daughter whose life is not in immediate danger."[72] In this case, Ricky's condition was not life threatening, so the court ultimately concluded the State had no right to interfere.[73] Significantly, the court took the unusual step of remanding the case for an evidentiary hearing of Ricky's wishes.[74] Although this case limited state interference to "life threatening" circumstances, it nonetheless reflects a clear concern for the wishes of involved minors.[75]

The above cases demonstrate the difficulty of determining the medical rights of parents over their children, especially where religious beliefs are involved. Generally, parents enjoy a broad right to raise their children as they wish, including a right to foster religious beliefs and make medical decisions. But this right clearly ends where religious preferences would put their children at risk. As such, *Sampson* and *Green* illustrate two key issues which divide courts in similar cases: (1) what level of risk warrants state interference and (2) whether the preferences of minors are relevant considerations.[76] Most courts side with the

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[67] 307 A.2d 279 (Pa. 1973).
[68] *Id.*
[69] *Id.* Ricky had a 94% curvature of his spine which would eventually render him bedridden. *Id.*
[70] *Id.*; *see also In re* Sampson, 317 N.Y.S.2d at 645.
[71] *In re* Green, 292 A.2d 387, 388 (Pa. 1972).
[72] *Id.* at 390.
[73] *Id.* at 392. The court directly disagreed with the holding in *In re Sampson.* The court in *In re Green* was hesitant to call any surgery "required" where the life of the patient is not at stake. *Id.* at 391–92.
[74] *Id.* at 392. The court noted that the record didn't indicate whether Ricky was a Jehovah's Witness or ever planned on becoming one. *Id.* On remand, Ricky revealed that he did not even want the surgery for fear that it may not "come out right." *In re* Green, 307 A.2d 279, 280 (Pa. 1973).
[75] The court held that the State does not have a sufficient interest to interfere with a parent's religious beliefs unless the child's life is "immediately imperiled by his physical condition*." In re Green*, 292 A.2d at 392.
[76] The *In re Sampson* court stated that it was not necessary that "a child's life be in danger" for a court to decide that state intervention was necessary, and it implied

reasoning in *Sampson* and only address the conflict between parents and the state.[77] But this approach fails to recognize the growing body of scholarship which demonstrates the cognitive abilities of certain minors.

II. THE MATURE MINOR EXCEPTION

As previously stated, the Supreme Court recognizes the constitutional rights of minors to a certain extent, as "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."[78] But the rights of minors are much more limited than those of adults.[79] This is because of the inherent assumptions that minors are (1) a particularly vulnerable group and (2) unable to make critical decisions in an informed, mature manner.[80] Altogether, these background ideas make it unlikely that the preferences of minors will carry legal weight independent of their parents. This section will address those situations where minors enjoy rights independent of their parents.

A. Statutory Exemptions

There are three main categories of statutory exceptions to the general rule that a minor cannot make medical decisions for themselves: (1) status exceptions, (2) treatment exceptions and (3) mature minor exceptions. Status exceptions extend decision making authority to certain minors based on certain social or individual circumstances.[81] These circumstances include

that the quality of a child's life was a relevant consideration. *In re* Sampson, 317 N.Y.S.2d 641, 669 (N.Y. Fam. Ct. 1970). But that court did not consider Kevin's preferences and assumed that State intervention would be in his best interest. *See In re Sampson*, 317 N.Y.S.2d at 659–60. In contrast, the court in *In re Green* clearly limited state interference to life threatening situations but took measures to ascertain Ricky's wishes. 307 A.2d at 280.

[77] *See, e.g.*, *In re* Athena Y., 161 N.Y.S.3d 335 (N.Y. App. Div. 2021); *In re* Faridah W., 579 N.Y.S.2d 377 (N.Y. App. Div. 1992).

[78] *In re* Gault, 387 U.S. 1, 13 (1967).

[79] *See* Bellotti v. Baird, 443 U.S. 622, 633–35 (1979).

[80] *Id.* at 634.

[81] Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Decision-Making*, 28 AM. J. L. & MED. 409, 421 (2002).

marriage,[82] homelessness,[83] pregnancy,[84] emancipation,[85] high school graduation,[86] and membership in the armed forces.[87] Treatment exceptions similarly extend autonomy to minors who are considering certain types of treatment.[88] Most states allow minors to consent to treatment for substance abuse, venereal diseases, pregnancy, and mental health problems.[89] These statutes are based on policy concerns for public health and safety, as adolescents who are afraid to inform their parents of their problems may forgo medical treatment entirely.[90]

Although founded on public policy and consistency concerns, neither status exceptions nor treatment exceptions assess the actual decision-making capacity of individual minors. Only mature minor exceptions take this consideration into account.[91] The idea behind the exception is relatively simple: if a minor demonstrates sufficient capacity to make an autonomous decision, that decision will be respected.[92] Although some states have statutorily codified this doctrine, most only

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[82] *See, e.g.*, ME. REV. STAT. ANN. tit. 22, § 1503 (West 2019); MD. CODE ANN., HEALTH-GEN. § 20-102(1) (West 2019); MASS. GEN. LAWS. ch. 112, § 12F (2022); MONT. CODE ANN. § 41-1-402(1)(a) (2021); 23 R.I. GEN. LAWS § 23-4.6-1 (2022).
[83] *See, e.g.*, ARIZ. REV. STAT. ANN. § 44-132(a) (2021).
[84] *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 20-102(c)(4) (West 2021); MONT. CODE ANN. § 41-1-402(1)(c) (2021); N.C. GEN. STAT. § 90-21.5 (2021).
[85] *See, e.g.*, N.C. GEN. STAT. § 90-21.5(b) (2021); ME. REV. STAT. ANN. tit. 22, § 1503 (West 2019) (sixty-day period attached to living separately and independently); MINN. STAT. ANN. § 144.341 (West 2021) (no time period); MONT. CODE ANN. § 41-1-402(1)(b) (2021) (no time period); OKLA. STAT. ANN. tit. 63, § 2602(A)(2) (2021) (no time period).
[86] *See, e.g.*, MONT. CODE ANN. § 41-1-402(1)(A) (2021); 35 PA. STAT. AND CONS. STAT. § 10101 (West 2022).
[87] *See, e.g.*, ME. REV. STAT. ANN. tit. 22, § 1503 (2019); MASS. GEN. LAWS ch. 112, § 12F (2022).
[88] *See* Hartman, *supra* note 81, at 420–21.
[89] *See, e.g.*, N.C. GEN. STAT. § 90-21.5 (2021).
[90] *See* Will, *supra* note 9, at 256.
[91] *See, e.g.*, ARK. CODE ANN. § 20-9-602(7) (2021) ("It is recognized and established that, in addition to other authorized persons, any one (1) of the following persons may consent, either orally or otherwise, to any surgical or medical treatment or procedure not prohibited by law that is suggested, recommended, prescribed, or directed by a licensed physician: . . . (7) Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, for himself or herself . . . .").
[92] *See, e.g.*, ARK. CODE ANN. § 20-9-602(7) (2021) (allowing unemancipated minors to consent to medical treatment if they are of sufficient intelligence to understand and appreciate the consequences of their decision); IDAHO CODE § 39-4302 (2022) (stating that any person of competent intelligence to comprehend the nature and the significant risks posed by the medical treatment is competent to consent on his own behalf); NEV. REV. STAT. § 129.030(2) (2021) (permitting a minor who understands the purpose of the procedure and its likely outcome to consent, but the provider must make efforts to seek minor's consent to communicate with parents in most instances).

recognize it as a branch of common law—which truly began with Douglas' dissent in *Yoder*.[93] Since *Yoder*, courts have primarily recognized rights for mature minors in the context of abortion decisions.

B. Abortion

Following its decision in *Roe v. Wade,*[94] the Supreme Court struggled to articulate the limits of state regulation on adolescent access to abortion procedures. Any discussion about the rights of adolescents to choose to have an abortion necessarily implicates the rights of parents to make medical treatment decisions for their children. The Supreme Court first addressed this issue in *Planned Parenthood v. Danforth*,[95] where two physicians contested a Missouri abortion law requiring minors to obtain parental consent before they could receive an abortion. In striking down the law, the Court declared that "[a]ny independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant."[96] The Supreme Court thus recognized the right of minors to make their own healthcare choices through a judicial bypass system.[97]

In years following *Planned Parenthood*, the Court upheld their grant of self-determination to minors in the context of abortion specifically. Just one year later, they affirmed that the "right to privacy in connection with decisions affecting procreation extends to minors as well as to adults."[98] Although states pushed back by enacting parental notification requirements, the Supreme Court only upheld these statutes where a judicial

[93] *See* Will, *supra* note 9, at 260.
[94] 410 U.S. 113 (1973).
[95] Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 58 (1976).
[96] *Id.* at 75; *see also id.* at 73–74 (quoting Planned Parenthood of Cent. Mo. v. Danforth, 392 F. Supp. 1362, 1376 (E.D. Mo. 1975) (Webster, J., dissenting)) (quoting the dissent of the lower court which argued a minor should be "entitled to the same right of self-determination now explicitly accorded to adult women, provided she is sufficiently mature to understand the procedure and to make an intelligent assessment of her circumstances with the advice of her physician.").
[97] *Id.*
[98] Carey v. Population Servs. Int'l, 431 U.S. 678, 693 (1977).

bypass option was available.[99] In *Bellotti v. Baird*,[100] the Court indicated two ways for minors to bypass parental refusal and obtain authorization for an abortion: (1) if a pregnant minor can show she is "mature enough and well informed to make her abortion decision" or (2) if she cannot make this decision independently, an abortion would be in her "best interests."[101] Although the Court did not provide much guidance in maturity determinations, they set an important precedent: the decisions of pregnant minors with sufficient maturity must be respected.

The Supreme Court has not extended the mature minor exception to adolescents outside of the abortion context. Nevertheless, some states have afforded similar rights to minors in the medical setting.[102]

C. Jurisdictional Approaches: Mature Minors, Medical Consent, & The Right to Die

Of the courts that have addressed the mature minor doctrine, the Tennessee Supreme Court's decision in *Cardwell v. Bechtol*[103] presents the clearest adoption of the exception.[104] In that case, a seventeen-year-old girl—Sandra Cardwell—received treatment

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[99] *See, e.g.*, Bellotti v. Baird, 443 U.S. 622, 643 (1979) ("[I]f the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.").
[100] 443 U.S. 622 (1979).
[101] *Id.* at 643–44. The Court further held that "every minor must have the opportunity—if she so desires—to go directly to a court without first consulting or notifying her parents," but the Court maintained the right to require parental consultation if it determines that it would be in the minor's best interests. *Id.* at 647.
[102] *See, e.g.*, Ala. Code § 22-8-4 (2021) ("Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary."); Ark. Code § 20-9-602(7) (2021) ("It is recognized and established that, in addition to other authorized persons, any one (1) of the following persons may consent, either orally or otherwise, to any surgical or medical treatment or procedure not prohibited by law that is suggested, recommended, prescribed, or directed by a licensed physician: . . . (7) Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, for himself or herself . . . ."); IDAHO CODE § 39-4503 (2022) ("Any person . . . who comprehends the need for, the nature of and the significant risks ordinarily inherent in any contemplated hospital, medical, dental, surgical or other health care, treatment or procedure is competent to consent thereto on his or her own behalf.").
[103] 724 S.W.2d 739 (Tenn. 1987).
[104] *Id.* at 745.

from an osteopathic physician for back pain without her parents' consent.[105] Sandra and her parents later sued the osteopath for battery (failure to obtain informed consent).[106] In its ruling, the Tennessee Supreme Court held that the "mature minor" exception was part of the state's common law tradition[107] and that determinations of minor consent capacity are fact questions for the jury.[108] The court limited its adoption of the exception by the common law Rule of Sevens, which is generally applied in criminal cases.[109] Under this rule, minors under the age of 7 are presumed to lack capacity, minors between 7 and 14 carry a rebuttable presumption of no capacity, and minors between 14 and 21 carry a rebuttable presumption of capacity.[110] In this case, the court held that the jury was justified in concluding that the minor "had the ability, maturity, experience, education and judgment . . . to consent knowingly to medical treatment."[111] Although this course of treatment proved ineffective, Sandra was nonetheless empowered through the mature minor exception to consent to treatment.

Other early cases involving the mature minor doctrine considered issues related to medical decision-making for critical and life-prolonging care.[112] Of courts who have considered this issue, their rulings are clearly informed by judicial perspectives on the rights and responsibilities of individuals in death. Some courts emphasize the individuality of dying and work to respect the decisions of competent individuals.[113] Others focus on the quality of a patient's life and tailor their decisions based on "best interests" determinations.[114] Beyond serving as precedent on

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[105] Although Sandra was unaware of what exact therapy was involved, she generally understood this physician's osteopathic practice because her father had previously been treated by him. *Id.* at 743.

[106] *Id.* at 742.

[107] In support of its decision to adopt the exception, the court relied on caselaw from other jurisdictions, legal commentary, and the requirements for child consent in the Second Restatement of Torts § 892A. *Id.* at 742–49.

[108] *Id.* at 748.

[109] *Id.* at 749.

[110] *Id.*

[111] *Id.* (holding that the jury was justified in finding that a minor who was 17 years and 7 months old, a senior in high school, with good grades, college plans, a drivers' license, and who had responsibly used her father's signed, blank checks since the age of 14 was mature enough to consent to medical treatment).

[112] *See, e.g.*, Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 837 (W. Va. 1992); *In re* Swan, 569 A.2d 1202 (Me. 1990); *In re* Guardianship of Crum, 580 N.E.2d 876 (Ohio Prob. Ct. 1991).

[113] *See, e.g.*, *Belcher*, 422 S.E.2d at 835–36.

[114] *See, e.g.*, *In re Swan*, 569 A.2d at 1205–06; *see also In re Guardianship of Crum*, 580 N.E.2d at 882–83.

which other courts may rely when considering legal autonomy issues, these cases indicate the extent of judicial support for the medical decisions of mature minors.

In its consideration of adolescent decision-making capacity, the Supreme Court of Appeals of West Virginia established a precedent that focuses on the wishes of the individual.[115] In that case, the minor's father consented to a DNR order without any discussion with his son.[116] Like *Cardwell*, the court in *Belcher* adopted the common law mature minor doctrine and considered determinations of maturity to be a question of fact.[117] If there were discrepancies between the wishes of the minor and their parents, the court concluded that the "good faith" decision of the physician should be followed.[118] Interestingly, the court asserted that experience with illness, rather than age, should be the chief consideration in determining maturity, as maturity is linked with confronting the challenge of illness.[119] Thus, the court provided another avenue through which a mature minor may bypass the objections of their parents.[120] Further, throughout its opinion, the *Belcher* court showed a serious concern for the integrity of the decisional process as well as the protection of the preferences of adolescents whose life was at risk.

While the *Belcher* court focused on maturity determinations, other courts are more outcome focused, and emphasize quality of life over maturity in deciding whether minors can refuse life-sustaining treatment.[121] For example, the high courts of both Maine and Ohio recognized a minor's right to refuse life-sustaining medical treatment based on evidence of the minor's previously expressed wishes.[122] In both cases, the court admitted heresay testimony by the minors' parents that

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[115] *See Belcher*, 422 S.E.2d at 835–36.
[116] *Id.* at 829–31.
[117] *Id.* at 837.
[118] The court reasoned that physicians, rather than judges or parents, possess the expertise to assess an adolescent's capacity to "appreciate the nature, risks, and consequences of the medical procedure to be performed, or the treatment to be administered or withheld." *Id.* at 838.
[119] As to this assertion, the court reasoned, "[i]t is difficult to imagine that a young person who is under the age of majority, yet, who has undergone medical treatment for a permanent or recurring illness over the course of a long period of time, may not be capable of taking part in decisions concerning that treatment." *Id.* at 837.
[120] *Id.* at 838.
[121] *See, e.g.*, *In re* Swan, 569 A.2d 1202, 1205–06 (Me. 1990); *see also In re* Guardianship of Crum, 580 N.E.2d 876, 882–83 (Ohio Prob. Ct. 1991).
[122] *See In re Swan*, 569 A.2d at 1205; *see also In re Guardianship of Crum*, 580 N.E.2d at 882.

they did not wish to receive further treatment.[123] Neither court inquired into the maturity or capacity of the minors when they purportedly expressed these wishes.[124] While some commentators cite *Swan* and *Crum* as evidence of an "expanding legal recognition and respect for adolescent autonomous wishes,"[125] the extent to which these wishes were truly autonomous is unclear. Reliance on the testimony of parents whose wishes coincide with the purported expressions of their children leaves potential that the desires of these minors are not heard at all. In some ways, these courts paid lip service to the rights of minors but failed to separate their interests from those of their parents. Further, the courts' neglect to make any maturity inquiry or to provide a standard for future inquires supports the idea that these decisions expand parental rights rather than child rights.

III. MERGING THE DOCTRINES: RELIGIOUS INTEGRITY & MATURE MINORS

Cases involving a minor's refusal of medical treatment due to religious beliefs are not just medical in nature and implicate a host of constitutional questions. As a result, simply assessing a patient's capacity based on their medical understanding is insufficient. Courts must also seriously consider the integrity of a minor's religious beliefs where they form the basis of a medical treatment decision.

Although it is settled law that parents may not refuse medical treatment for their children based on religious beliefs if it would put their children's lives at risk,[126] precedent involving religious refusal of minors themselves is less clear. In theory, the mature minor doctrine should answer this question, as it requires confirmation that an adolescent has "developed underlying and

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[123] In *In re Swan*, the court admitted testimony from Chad's mother that she and Chad had discussed a highly publicized case involving a step-grandson of a close friend of Chad's grandmother. 569 A.2d at 1205. The step-grandson was in a persistent vegetative state. *Id.* When she explained to Chad that such a person required total care, she remembered him saying, "if I can't be myself . . . no way . . . let me go to sleep." *Id.* In *In re Guardianship* of *Crum*, the court highlighted testimony that Dawn had previously commented about a foster child who suffered from spina bifida, saying that it was unfair for him to live like that and that she would not want to live like that. 580 N.E.2d at 882.

[124] *See In re Swan*, 569 A.2d at 1205; *see also In re Guardianship of Crum*, 580 N.E.2d at 882.

[125] *See* Hartman, *supra* note 81, at 441.

[126] *See* Prince v. Massachusetts, 321 U.S. 158, 170 (1944).

enduring aims and values, and thus, decision-making capacity or the ability to make autonomous decisions."[127] In practice however, courts are skeptical of granting minors the same level of religious autonomy as adults. When confronted with medical treatment issues involving religious minors, state courts have adopted inconsistent solutions. Some have skirted the issue of religion altogether,[128] while others limited or expressly denied the religious refusal rights of minors.[129]

The courts in *In re E.G.*[130] and *In re Long Island Jewish Medical Center*[131] both avoided (intentionally or unintentionally) deciding whether the religious beliefs of minors carried legal weight in the medical context.[132] *In re E.G.* involved a minor who refused blood transfusions necessary to sustain her life based on her religious beliefs.[133] The Illinois Supreme Court held that if the minor could prove her maturity by "clear and convincing" evidence, then she had a right to control her own health care.[134] This right included the authority to refuse medical treatment.[135] Because the court based its reasoning on the common law rights of mature minors, it did not address underlying questions about the religious integrity of minors.[136] Similarly, the court in *In re Long Island Jewish Medical Center* did not provide a clear rule.[137] But in that case, this ambiguity was more the result of an immature minor than purposeful vagueness by the court.[138] Nevertheless, that court expressed its support for the mature minor doctrine in other contexts and did not discount a future discussion of religious refusals by mature minors.[139]

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[127] Will, *supra* note 9, at 284.
[128] *See, e.g.*, *In re* E.G., 549 N.E. 2d 322 (Ill. 1989); *see also In re* Long Island Jewish Med. Ctr., 557 N.Y.S.2d 239 (N.Y. Sup. Ct. 1990).
[129] *See, e.g.*, Novak v. Cobb Cnty. Kennestone Hosp. Auth., 849 F. Supp. 1559 (N.D. Ga. 1994); *see also* Commonwealth v. Nixon, 761 A.2d 1151 (Pa. 2000).
[130] 549 N.E.2d 322 (Ill. 1989).
[131] 557 N.Y.S.2d. 239 (N.Y. Sup. Ct. 1990).
[132] 549 N.E.2d at 327–28; 557 N.Y.S.2d at 242.
[133] *In re E.G.*, 549 N.E. 2d at 323.
[134] *Id.* at 326–27.
[135] *Id.*
[136] *Id.* at 328 ("Because we find that a mature minor may exercise a common law right to consent to or refuse medical care, we decline to address the constitutional [religion] issue."). *But see id.* at 328 (holding that if her mother had not agreed with E.G.'s decision, it would "weigh heavily against the minor's right to refuse.").
[137] *In re Long Island Jewish Medical Center*, 557 N.Y.S.2d at 242.
[138] *Id.* at 243.
[139] *Id.* ("While this court believes there is much merit to the 'mature minor' doctrine, I find that Phillip Malcolm is not a mature minor.").

Not all courts are as supportive of the mature minor doctrine. The rulings of state courts in *Novak v. Cobb County Kennestone Hospital Authority*[140] and *Commonwealth v. Nixon*[141] illustrate a lack of trust in the capacity of minors to determine their own medical treatment in emergency situations—especially where religion is involved.[142] In *Novak*, a sixteen-year-old refused blood transfusions after a car accident.[143] Doctors later administered blood transfusions over the objections of both the minor and his parents in order to save his life.[144] Although acknowledging that minors have constitutional rights, the court held that minors do not have the right to refuse medical treatment based on their religious beliefs.[145] The court noted that the United States Supreme Court had only expanded medical decision-making authority to minors in abortion cases.[146] As such, the state court concluded there was no statutory or common law support for granting minors free exercise protections in the medical context.[147]

Similarly, the Pennsylvania Supreme Court in *Nixon* held that minors did not have the authority to refuse life-saving treatment based on their religious convictions.[148] In that case, the minor suddenly fell ill and refused to go to a hospital and chose instead to address her sickness through spiritual treatment.[149] She eventually died, and her parents were convicted of involuntary manslaughter of their child, Shannon.[150] On appeal, they argued that (1) Shannon had a privacy right to refuse medical treatment, and (2) Shannon was a mature minor who may decide to refuse medical treatment herself.[151] According to the court's reading of the states' mature minor statute, the Pennsylvania state legislature did not intend that "any minor, upon the slightest showing, has capacity to consent or to refuse medical treatment

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[140] 849 F. Supp. 1559 (N.D. Ga. 1994).
[141] 761 A.2d 1151 (Pa. 2000).
[142] *See Novak*, 849 F. Supp. at 1559; *see also Nixon*, 761 A.2d at 1151.
[143] *Novak*, 849 F. Supp. at 1563.
[144] *Id.* at 1564.
[145] *Id.* at 1574.
[146] *Id. See* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976).
[147] *Novak*, 849 F. Supp. at 1576.
[148] Commonwealth v. Nixon, 761 A.2d 1151, 1156 (Pa. 2000).
[149] *Id.* at 1152.
[150] Commonwealth v. Nixon, 718 A.2d 311, 312 (Pa. Super. Ct. 1998).
[151] *Nixon*, 761 A.2d at 1152. The court held that although Shannon had privacy rights protected by both the state and federal constitutions, those rights were overridden by the compelling state interest as *parens partriae* to protect the life of an unemancipated minor. *Id.* at 1156.

in a life and death disputation."[152] As such, the court revoked the possibility that the maturity of an unemancipated minor may be brought as an affirmative defense.[153]

IV. NORTH CAROLINA LAW

While many states have extended statutory rights to mature minors, North Carolina has not.[154] Accordingly, North Carolina General Statutes section 90-21.5 provides that:

> (a) Subject to subsection (a1) of this section, any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.
> (b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.[155]

Clearly, North Carolina statutory law only grants minors autonomy according to certain status and age exceptions.[156]

Although the caselaw in the state grants minors more independence—it is not much more. Generally, minors may only receive medical treatment over the objections of their

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[152] *Id.* In a footnote the court cited to the superior court's statement in *Commonwealth v. Cottam*, 616 A.2d 988 (Pa. Super. Ct. 1992), that even if a minor were found to be mature enough to freely exercise their religious beliefs, it would not abrogate the parents' affirmative duty to provide care direction and sustenance. *Id.* at 1155–56 n.4.
[153] *Id.* at 1155.
[154] *See* N.C. GEN. STAT. § 90-21.5 (2021).
[155] *Id.*
[156] *Id.*

parents (religious or otherwise) if the parents have been adjudicated neglectful.[157] As the Supreme Court of North Carolina stated, "absent a finding that parents (i) are unfit or (ii) have neglected the welfare of their children, the constitutionally-protected paramount right of parents to custody, care, and control of their children must prevail."[158] The state gives primacy to parental rights due to the presumption that parents will act in the "best interests" of their children.[159] Where a parent's conduct is inconsistent with their children's "best interests," they lose their "paramount status" and the state may intervene in its role as *parens partriae.*[160] But there is no evidence in North Carolina caselaw of court considerations of individual minor interests or maturity in medical decision-making cases.

With the onset of Covid-19 and the public health concerns it creates, the state legislature amended the North Carolina General Statutes section 90-21.5 to include:

> (a1) Notwithstanding any other provision of law to the contrary, a health care provider shall obtain written consent from a parent or legal guardian prior to administering any vaccine that has been granted emergency use authorization and is not yet fully approved by the United States Food and Drug Administration to an individual under 18 years of age.[161]

This amendment went into effect on August 20, 2021 and barred minors from receiving vaccines granted emergency use authorization by the FDA.[162] Only three days later, the Pfizer-BioNTech Covid-19 vaccine was granted full FDA approval for

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[157] *See In re* Hughes, 119 S.E.2d 189, 191 (N.C. 1961); *In re* Huber, 291 S.E.2d 916 (N.C. Ct. App. 1982), *appeal dismissed and denied,* 294 S.E.2d 223 (N.C. 1982); *In re* Stratton, 571 S.E.2d 234 (N.C. Ct. App. 2002), *writ denied*, 572 S.E.2d 159 (N.C. 2002).

[158] Petersen v. Rogers, 445 S.E.2d 901, 905 (N.C. 1994). In *Peterson*, the reviewing court held that an extensive inquiry into the plaintiff's religious beliefs was unnecessary. *Id.* Such an inquiry would only be necessary where parents are clearly neglectful and thus lose their rights of control over their children. *Id.*

[159] Price v. Howard, 484 S.E.2d 528, 534–35 (N.C. 1997).

[160] *Id.*

[161] N.C. GEN. STAT. § 90-21.5 (2021).

[162] *Id.*

individuals 16 years and older.[163] As previously enacted, North Carolina G.S. 90-21.5 gives minors the legal authority to prevent communicable diseases reportable under G.S.130A-135—which includes Covid-19.[164] As such, adolescents 16 and 17 years of age have the ability to consent to the Covid-19 vaccine, if they show the decisional capacity to do so.[165]

This extension of decision-making authority to minors in the medical setting is unprecedented in North Carolina. While granting greater autonomy to minors may simply be the result of health concerns surrounding Covid-19, it also signals a growing trust in the capacity of certain minors. This movement towards recognizing greater medical rights for minors should not be curtailed to the treatment of "communicable diseases" such as Covid-19. Rather, North Carolina legislators should extend the same level of trust to minors in other treatment contexts.

V. MEDICAL DECISION-MAKING BYPASS RIGHT FOR MATURE MINORS

A. Proposed Solution

In response to the public health crisis created by Covid-19, state legislatures have afforded greater legal deference to the interests of minors in the medical setting. But this deference is limited to vaccinations—creating a legal paradox where minors may individually consent to more experimental treatments like the Pfizer-BioNTech Covid-19 vaccine but are barred from making their own decisions about well-established medical procedures. One way to resolve this inconsistency would be to adopt a more wide-reaching mature minor exception for individuals in the medical context.

A deferential law granting physicians the ability to make legally binding maturity determinations would provide an efficacious solution. This system would allow treatment decisions to be made quickly without requiring a judicial determination of maturity in every case. Deference to the

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[163] Press Release, U.S. Food & Drug Administration (FDA), FDA Approves First Covid-19 Vaccine (Aug. 23, 2021), https://www.fda.gov/news-events/press-announcements/fda-approves-first-covid-19-vaccine.
[164] N.C. GEN. STAT. § 90-21.5 (2021).
[165] *Id.* At this time, written consent from parent or a legal guardian is required for twelve to fifteen-year-old minors to receive Pfizer COVID-19 vaccine because of the emergency use authorization. *Id.*

understanding of attending physicians is important, as research on child psychology varies widely[166] and there is no bright line rule demarcating when a child reaches "maturity."[167] Nevertheless, some minors are demonstrably mature and capable of making serious medical decisions. Therefore, this decision should be delegated to the attending physician, as they have more experience with both (1) medical standards of competency in pediatric patients and (2) the individual patient.

Delegating maturity determinations to physicians would both expedite the opportunity of minors to assert their legal rights and allow for a more developmental approach to informed consent.[168] Such an approach would recognize the unique nature of pediatric practice, which allows for "increasing inclusion" of the minor's opinions over time.[169] The decision-making capacity of minors is dependent on several factors: cognitive ability, moral authority, and maturity of judgment. Studies indicate that children as young as seven years old enter the "concrete operations stage" of development, allowing them "limited logical though processes and the ability to develop a reasoned decision."[170] As such, physicians can received informed assent (if not fully informed consent) from children above the age of seven if they explain the proposed treatment in "developmentally appropriate language."[171] Seriously including minors in discussions about their medical treatment will not only protect their rights, but also foster a sense of autonomy and personal responsibility for health in young individuals.

This deference to physicians should be paired with a judicial bypass system[172] which would expeditiously deal with parents

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[166] Courts considering maturity have come to a wide variety of outcomes. Delegating authority to physicians would place the decision in the hands of more "expert" individuals. *See* Lee v. Weisman, 505 U.S. 577, 636 (1992) (Scalia, J., dissenting) ("[I]nterior decorating is a rock-hard science compared to psychology practiced by amateurs.").

[167] Katz et al., *Informed Consent in Decision-Making in Pediatric Practice*, PEDIATRICS, Aug. 2016, at e9, https://publications.aap.org/pediatrics/article/138/2/e20161485/52519/Informed-Consent-in-Decision-Making-in-Pediatric.

[168] *Id.*

[169] *Id.*

[170] *Id.*

[171] *Id.*

[172] This judicial bypass system would be similar to those in place for minors considering abortion. *See, e.g.*, Bellotti v. Baird, 443 U.S. 622, 643 (1979) ("[I]f the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.").

who wish to dispute a physician's assessment of maturity. This bypass system would allow parents to petition the court for a hearing on the maturity of their minor child. These petitions should be prioritized and heard within seventy-two hours.[173] At the hearing, parents should have the chance to dispute the physician's assessment of their child's maturity. Although judges should consider maturity on a case-by-case basis, a system of presumptions could provide a set of guidelines. For example, a workable system could create a rebuttable presumption of maturity for individuals aged 16-17 and a rebuttable presumption of immaturity for those aged 12-15.[174] Such a system would provide flexibility for minors whose life experiences expedite their development into maturity.[175] It would also require younger minors who are more likely to rely on their socioemotional impulses to demonstrate full reasoning about their decisions.[176]

A doctor's expert opinion would weigh heavily in these bypass hearings but would not be determinative. During the hearing, the judge would also consider a myriad of other factors such as "academic performance, intellectual capacity, participation in extracurricular activities, at school, plans for the future, and the [minor's] ability to handle [their] own finances."[177] Judges would measure these factors against the generally accepted requirements of informed consent for minors.[178]

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[173] This time requirement is based on the 72-hour requirement for judicial hearings on abortion waivers set in Mississippi. MISS. CODE ANN. § 41-41-55(3) (2022). In North Carolina however, this requirement is much more lenient (no more than seven days) N.C. GEN. STAT. § 90-21.8(d) (2021).

[174] For a similar proposal regarding a judicial bypass option for mature minors (not their parents), see Josh Burk, *Mature Minors, Medical Choice, and the Constitutional Right to Martyrdom*, 102 VA. L. REV. 1355 (2016).

[175] "Adolescents or older children who have experienced serious and/or chronic illnesses often have an enhanced capacity for decision-making when weighing the benefits and burdens of continued treatment[.]" Katz et al., *supra* note 167, at e10.

[176] "The implications for decision-making by adolescents in stressful health care environments are that they may rely more on their mature limbic system (socioemotional) rather than on the impulse-controlling, less-developed prefrontal cognitive system." Katz et al., *supra* note 167, at e8.

[177] *See* Burk, *supra* note 174, at 1371.

[178] "The general consensus among scholars and courts finds a minor capable of a mature decision if she is able to fully discuss the medical procedure, understand the risks, and has the ability to make a choice without undue peer or parental pressure." Burk, *supra* note 174, at 1371.

B. Potential Objections

Those who object to this solution will first claim it represents an undue infringement on the constitutional right of parents to direct the upbringing of their children. They may argue that requiring parents to request a judicial hearing to dispute the maturity determination of a physician would place parents at a disadvantage in an area where they traditionally enjoy a high degree of legal deference: family decision-making. However, the traditional rights of parents are not exhaustive; they only allow for the support and preservation of the child's interests.[179] The constitution does not protect a parent's right to express their own choices (religious or otherwise) through their children.[180] As such, any objections based on parental beliefs which conflict with the "best interests" of their children are not protected.

Further, the rights of parents must be balanced against equally embedded ideas of personal liberty and bodily integrity underlying the doctrine of informed consent.[181]

CONCLUSION

As studies continue to reveal the potential for minors to fully participate in their own healthcare, the legal system faces an important question: how much "personal liberty" are we willing to grant minors? Although the law in North Carolina has yet to answer that question, SL 2021-110 indicates a higher degree of trust which could open the way for more consistent legal treatment of minor rights. The proposal in this note provides a legislative option which would secure the personal integrity of capable minors while still providing a legal outlet for parents to retain their constitutional control over their children.

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[179] *See* Prince v. Massachusetts, 321 U.S. 158, 166 (1944).
[180] *See id.*
[181] *See* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) ("[N]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . . .").