Catherine is 15 years old. She began smoking marijuana with her older brother when she was 12, and last week tried cocaine. Scared, she has gone to a clinic. She insists on confidentiality, since she “doesn’t want to get her brother in trouble.”

Joe is 16 years old. His parents are alcoholics who abused him throughout his childhood. He ran away last year, and now has a room over the restaurant where he is a dishwasher. He is taking classes, trying to earn his high school equivalency diploma. He was recently diagnosed with hepatitis and his ability to consent for treatment is a problem, since he is a minor.

These cases seem not to have much in common but at the heart of each is the question of minors and healthcare decision making, and the myriad of ethical issues that that entails. Catherine and Joe are representative of two categories of minors whose needs demand that the system move away from the simple mandate that healthcare decisions be made for minors by their parents or other adult proxies. These issues are framed here from the perspective of the law, since much of the ethical debate involves legislation and policies.

Indeed, a plethora of laws exist across the 50 states and the District of Columbia to address the needs of these minors. A comprehensive presentation of all their variations would fill a book, and healthcare professionals must determine and apply the laws of the state(s) in which they practice. There are some commonalities, however. For example, those who are very young, and whose parents are for some reason not able to decide in their best interest, can be made wards of the state or have guardians appointed. This would have been the approach taken with Joe if he were 12 or 13 years old. Now that he is 16, however, he can seek a court ordered declaration of “emancipation”. Such legal declarations vary from state to state, in design and application, but all seek to offer sufficiently responsible and mature adolescents like Joe a significantly better option than trying to cope with an irreparably dysfunctional family.

A legal pronouncement of emancipation allows an adolescent to exercise, virtually across the board, the rights and privileges of those who have attained the age of majority, including healthcare decision making. (It does not grant a minor the right to vote or purchase alcohol, and in some states other limits are imposed until the age of majority, such as the making of contracts or voluntary sterilization.)

Similarly, circumstances demand that minors in military service be emancipated, and in some states emancipation is automatically achieved through marriage or parenthood. It is important to note that emancipation is granted more on circumstance than on any case-by-case determination of a particular adolescent’s actual decision-making capacity or moral development.

Other laws apply to minors such as Catherine. These (and again, they vary from state to state) allow unemancipated minors to receive treatment for sexually transmitted diseases; for mental health care; and for alcohol and other drug abuse, without parental notification or consent. Contraception and abortion, as well, present issues of consent and confidentiality for other- than-Catholic healthcare providers who offer such services to minors.

Even though all these laws do, in effect, grant minors the right to make at least some healthcare decisions, they do not suggest that these adolescents are somehow intellectually or morally better equipped to make decisions than their counterparts who are not sexually active, pregnant, or using drugs or alcohol. In reality, these laws exist to ensure not only that such minors will get care for themselves, but also to protect society as a whole from the social, economic, and health risks presented if they do not. It is argued that in these cases, entitling minors to give their own consent for confidential care is a public health necessity.

For practical reasons, other laws in this category allow minors to give permission for their children’s and/or spouse’s health care. Even if not emancipated, pregnant teenagers are usually allowed to consent for pregnancy-related care, and often for their health care in general. (State-by-state notations on such laws can be found at: http://www.bostoncoop.net/lcd/mature_minor/mature_minor.html)

Finally, there is a rather amorphous, yet legally recognized construct, referred to as the “Mature Minor” rule or doctrine. It accepts that a physician may choose to proceed, upon the consent of a minor, if that minor (a) is...
Cases in Ethics

Calendar of Events

Conference Calls

Ethics Champions Education Program

ACUTE CARE
Section A
Module 8: Resource Allocation
Monday, 11/3/03
12:00 1:30 pm

Section B
Wednesday, 11/5/03
12:00 1:30 pm

CONTINUING CARE
Module 8: Boundary Issues
Tuesday, 11/4/03
12:00 1:30 pm

BEHAVIORAL HEALTH
Module 8: Boundary Issues
Thursday, 11/6/03
12:00 1:30 pm

Dial in phone number for all conference calls: 610-355-2070, ID 2063

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over a given age (usually between 14 and 16), (b) understands the nature and risks of
the proposed medical treatment, and (c) is
judged capable of giving informed consent.
But other factors must apply as well: The
procedure must be for the good of the
minor (not for some other person, as with
skin grafts or organ donation), and the risk
must be minimal. For example, a minor
might be allowed to give consent for
suturing a cut or treatment for flu—but
certainly not for something such as
chemotherapy or surgery—without his or
her family’s involvement.

Determination of whether a minor is
‘mature’ is initially made by a healthcare
practitioner, and controversy about that
decision arises only if parents later
challenge the treatment given. In the U. S.,
no case has been found in the last several
decades in which a physician was sued
successfully, simply on the basis that the
parent’s consent was not obtained. That is,
for providing a minor with treatment that
was not negligent, and that was within the
parameters outlined here.

Since the ethical principle of
confidentiality is often critical to a minor’s
willingness to seek medical attention, one
practical guideline to consider is that when
a minor has the right to consent, a provider
usually may not disclose medical records
or information about treatment to the
patient’s parents or legal guardians without
the patient’s consent. Still, this is not an
exceptionless norm. Maintaining
confidentiality may not be possible in cases
involving: (1) the mandatory reporting of
suspected child abuse or neglect, (2) threats
by the minor against him- or herself or
others, (3) admission to a mental health
facility, or (4) billing by insurance
companies, which may, in effect, reveal
confidential information to a minor’s
parents. To avoid losing the trust of minor
patients, doctors may wish to discuss the
scope of confidentiality with them before
healthcare services begin.

As mentioned earlier, this e-Case has
discussed ethical issues through a legal
prism. In doing so, it has laid the foundation
for a moral question of great magnitude. It
has prepared us to consider Margaret.

Margaret is 16 years old, and has suffered
from leukemia for five years. She has
undergone both standard and experimental
treatments, all painful and exhausting. Her
prognosis is extremely poor when her
physician suggests yet another research trial.
Her loving parents enthusiastically give their
permission, even though the chances of
success are determined to be no better than
50/50. But Margaret says “No. It’s time to
stop. I am so tired. I can’t do this anymore.”

Margaret’s is arguably the most serious
ethical question of this debate: Should
minors be allowed to refuse life-sustaining
treatment against both medical advice and
the wishes of their parents? The Mature Minor
rule has never been tested in court to
determine the answer. What mechanisms are
in place in your hospital to address this
situation, should it ever arise? Would your
ethics committee defer to prevailing
judgment that Margaret’s parents are the
appropriate decision makers, or would it
consider supporting her against her parents
and her doctor? If the answer to the latter
question is no, why not? If yes, how might
that action be accomplished?

In effect, all these laws and ethical
debates flow from one fundamental question.
That is, should the current overarching U. S.
law that withholds healthcare decision-
making rights based on age be maintained, or
should minors, like adults, be considered
competent to give consent until proven
otherwise?

Educational considerations are
not to be construed as policy
recommendations.