

# CAPACITY AND AUTONOMY: A THOUGHT EXPERIMENT ON MINORS' ACCESS TO ASSISTED REPRODUCTIVE TECHNOLOGY

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## I. INTRODUCTION

Autonomy figures significantly in judicial and political policy debates involving reproductive decision-making. However, medical and legal policy debates focused on reproductive decision-making too often suffer from reductive assumptions captured by our nation's ongoing internal struggle about abortion. In that context, competing interests about access to abortions, the constitutionality of the procedure, questions of personhood, and concerns about where life begins predominate and significantly define how the lay public and legislators speak about reproductive decision-making. Yet this narrow discourse partially engages one subset of the reproductive field and misses many others. Assisted reproduction and the umbrella of technologies cabined within that framework serve as telling examples. Despite the high demand for assisted reproductive technology ("ART") services, this type of reproductive decision-making typically escapes sustained social, legal, and public policy review. To date, there exists only one federal law tied to ART, and its main charge—to require the collection of data on "success rates"—serves as a passive reminder that in 1992 Congress once considered the issue.<sup>1</sup> This project takes up a blind spot in reproductive decision-making; it considers minors' capacity to make informed decisions regarding the use of ART. It also offers a departure from traditional reproductive health framing, and takes an interdisciplinary approach<sup>2</sup> to analyze the legal, medical, and psychological discourses concerning the rights, capability, and capacity of minors to consent to health care and medical procedures.<sup>3</sup> That analysis serves as a backdrop to test a thought experiment on the socio-medical risks and benefits of controlled access to ART for minors.<sup>4</sup>

This Article engages a nuanced, narrow framing of teenage reproduction, avoiding the undeniably compelling, but reductive approach to evaluating reproductive health and autonomy, which casts such discussions along blunt lines: choice is the primary or exclusive concern of women in matters of reproductive health; the legal rights of children deserve recognition and protection; parental rights trump those of their children; and teen pregnancy concerns only the poor or racialized minority communities in the United States. Such reductive framings oversimplify reproductive health care and

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<sup>1</sup> Fertility Clinic Success Rate and Certification Act of 1992, 42 U.S.C. §§ 263a-1–263a-7 (2006).

<sup>2</sup> By interdisciplinary, this Article calls for resisting a purely doctrinal or medical examination of this topic. Rather, we call for a methodology that engages law, medicine, psychology, and culture to fully situate the thought experiment proposed by this article.

<sup>3</sup> By capability we mean an examination of the extent of a minor's abilities. By capacity, we refer to a minor's cognitive and emotional power to fully understand or comprehend. In this context, we treat capacity as a matrix for evaluating minors' wherewithal to understand the burdens, benefits, and nuances of reproductive decision-making.

<sup>4</sup> Purposely, the analysis in this project moves beyond the recurrent refrain that contends that minor consent statutes serve as a means to usurp parental rights. This critique does not take up that important but polarized discourse.

decision-making and create a false debate between children's rights and parental authority or children and society. By taking a prospective approach, we attempt to peek into a realistic future,<sup>5</sup> one where the use of ART by minors is not only contemplated, but also perhaps encouraged by some teens, their families, and physicians.<sup>6</sup> A provocative news release issued by the University of Pittsburgh, portends the inevitable:

One of the nation's first comprehensive programs to help preserve or restore fertility after cancer treatment for not only adults, but also preadolescent girls and boys, has been established by a network of experts in reproductive medicine and cancer at Magee-Womens Research Institute (MWRI), Children's Hospital of Pittsburgh of UPMC, Magee-Womens Hospital of UPMC and the University of Pittsburgh School of Medicine.<sup>7</sup>

Who will benefit or be harmed by that not too distant future?<sup>8</sup>

We rethink the deeply entrenched framings that understand children and reproduction through rigid, inflexible, nonoverlapping lenses: moral poverty, pure autonomy, economic irresponsibility, and government burden.<sup>9</sup> The

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<sup>5</sup> Biotechnological advancements in the past two decades have transformed options for new and prospective parents. Options previously unavailable to their parents now present realistic possibilities for new parents, including umbilical cord cryopreservation, stem cell banking, tissue banking, and other cryopreservation technologies of which some hold significant promise in treating life-threatening issues. See Jenifer Goodwin, *Infant Formula*, SAN DIEGO UNION TRIB., May 30, 2004, at E-1; Viv Groskop, *Babies on Ice*, GUARDIAN, Mar. 4, 2006, at 28; Marilyn Linton, *Banking on Baby*, CALGARY SUN, July 26, 2010, at 41.

<sup>6</sup> *Fertility Preservation Program in Pittsburgh Offers New Options to Even the Youngest Cancer Patients*, TARGETED NEWS SERVICE, Mar. 7, 2011, available at Factiva, Doc. No. TARGNS0020110309e737002cg.

<sup>7</sup> *Id.*

<sup>8</sup> Cryopreservation technologies promise benefits for parents and their children. But these technologies also hold significant promise for private industry, including corporations that advertise, promote, and service cryopreservation products. See *Cryo-Cell Reports Financial Results for Fiscal Year 2010*, INDIA PHARMA NEWS, Mar. 9, 2011, available at Factiva, Doc. No. ATPHAM0020110317e7390005m ("During the third quarter of fiscal year 2010, Cryo-Cell announced that S-Evans Biosciences (SEB), the Company's exclusive Celle(SM) menstrual stem cell technology license partner in China has opened a new state-of-the-art laboratory operation and research & development (R&D) facility located in a Hi-Tech park designated to become an epicenter for stem cell and genomics R&D, cellular therapies and stem cell cryopreservation services. The exclusive Celle(SM) technology license agreement with SEB in China and Thailand is expected to provide Cryo-Cell with future royalty fees from the processing and annual storage of menstrual stem cells. Currently, SEB is conducting three pre-clinical studies for heart disease, type I diabetes and liver disease utilizing menstrual stem cells prepared in SEB and recently reported that the preliminary data are encouraging.").

<sup>9</sup> See, e.g., Stephen J. Caldas, *Teen Pregnancy: Why It Remains a Serious Social, Economic, and Education Problem in the U.S.*, 75 PHI DELTA KAPPAN 402, 403 (1994) (emphasizing the hampered economic well-being of teen mothers and "the intergenerational transfer of poverty" associated with teenage motherhood); Joseph J. Fischel, *Per Se or Power? Age and Sexual Consent*, 22 YALE J.L. & FEMINISM 279, 300-03 (2010) (arguing for reforms in age of consent laws based on sexual autonomy); Jesse R. Merriam, *Why Don't More Public Schools Teach Sex Education?: A Constitutional Explanation and*

project unfolds by first analyzing the dichotomous assumptions: that adolescents lack the cognitive capacity to consent to serious health care decisions, and most especially reproductive health care, and the counterpoint, that teenagers of reproductive “biological age” are necessarily gifted with the best decision-making capacities for their reproductive health matters. The conflict between both views centers on capacity: legal, cognitive, and emotional. The project then considers whether the umbrella of adolescent consent should include ART procedures in certain circumstances.<sup>10</sup>

This Article serves as a vehicle to advance an important conversation evaluating the efficacy of recognizing an adolescent’s capacity to provide informed consent in matters of reproductive health and pregnancy-related intervention. Moving beyond issues of access to hormonal contraception and pregnancy termination, this project centers on the viability of the hypothesis that adolescents possess the capacity to consent to or participate in assisted reproductive services. It offers critical analysis of three situations for which we may wish to evaluate adolescent use of ART: (1) adolescents as cancer survivors or youth facing impending loss of fertility due to other medical conditions or illness, (2) adolescents as altruistic donors for ailing relatives who wish to parent, perhaps analogized to situations of sibling donor status or other familial organ and tissue donation, and (3) adolescents living separately from and financially independent of parents or legal guardians [hereinafter “P&Gs”] in a marriage relationship.

We engage law and medicine to study the nuances of ART as a health care resource for adolescents. Part II briefly takes up the reproductive rights of adolescents within the broader spectrum of minors’ and women’s decision-making authority. It provides a backdrop for understanding the competing decision-making interests between children, parents, and the State. Part III traces the recognition of adolescents as health care consumers, separate from their parents. It engages medical sciences to map the evolutionary staging and development of adolescence. Part IV then studies case law, analyzing the doctrinal underpinnings of adolescent health care decision-making. It considers the case for adolescent capacity by analyzing the tenets of informed consent. Part V examines the case for adolescent utilization of assisted re-

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*Critique*, 13 WM. & MARY J. WOMEN & L. 539, 559 (2007) (“[T]he government acts as a surrogate for parents in educational matters. In this role, the government may exercise discretion to give effect to parental interests.”); Amber Hausenfluck, Comment, *A Pregnant Teenager’s Right to Education in Texas*, 9 SCHOLAR 151, 179–81 (2006) (discussing sex education and abstinence-only frameworks in the context of pregnant teens being treated as social outcasts or failures).

<sup>10</sup> To be clear, the purpose of this project is not to promote adolescent pregnancy or childbearing. To the contrary, a well developed literature and decades of government-sponsored studies paint a compelling portrait of the negative economic, physical, and emotional effects teenage pregnancy presents for young women. Cyclical, intergenerational poverty may result from teenage pregnancy, along with higher incidences of dropout access and poor health outcomes for the babies that result. Such empirical literature disproves any theories that teenage pregnancy should be treated on balance and as an equal to adult pregnancy.

productive technologies. It considers the appropriateness of ART falling within the scope of adolescent reproductive health care decision-making. Taking into account moral, legal, and cognitive capacity considerations, we suggest that in limited, regulated circumstances, use of ART may be appropriate in this population. Part VI concludes the Article.

## II. MINORS' RIGHTS IN CONTEXT

In the United States, minor consent statutes serve as the primary vehicle for granting medical decision-making authority to minors. The content of minor consent statutes varies by state,<sup>11</sup> but they generally permit specific medical treatments and services to minors without notification of or permission from a parent or legal guardian.<sup>12</sup> In most states, these services include reproductive health care, which in the majority of statutes includes care related to the diagnosis and treatment of pregnancy and sexually transmitted infections.<sup>13</sup> Nevertheless, the capacity of minors to consent to their own health care, and particularly to reproductive health care, remains a contested theme among diverse stakeholders concerned with promoting the health and well-being of adolescents. Indeed, these statutes are continually debated on the grounds that they interfere with the rights of P&Gs to determine the destiny of their minor children.<sup>14</sup> Opponents of the statutes characterize

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<sup>11</sup> See, e.g., ARK. CODE ANN. § 20-9-602 (2005) (specifying that any minor may consent to unspecified medical services if married, emancipated, incarcerated, or sufficiently intelligent to understand consequences of consent); CAL. FAM. CODE § 6922 (West 2004) (noting that a minor may consent to unspecified health care if age fifteen years or older and lives apart from parents, and manages her own finances); DEL. CODE ANN. tit. 13, § 707 (2009) (allowing that minors eighteen years or above may consent to unspecified medical services). In each of the foregoing examples, however, special exceptions are provided in the case of reproductive medicine wherein younger minors are able to seek reproductive health care services to treat sexually transmitted diseases or to obtain contraceptives without parental notification. See ARK. CODE ANN. § 20-16-304 (2005) (any minor); CAL. FAM. CODE § 6925 (West 2004) (any minor); DEL. CODE ANN. tit. 13 § 710 (minor age 12).

<sup>12</sup> See, e.g., ARK. CODE ANN. § 20-16-508 (2005) (sexually transmitted diseases); CAL. FAM. CODE § 6925 (West 2004) (pregnancy prevention or treatment); COLO. REV. STAT. § 13-22-102 (2010) (drug addiction or use); VA. CODE ANN. § 54.1-2969(E) (2009) (allowing minors to consent to treatment as an adult for services related to sexually transmitted diseases, birth control, pregnancy, or certain family planning services, substance abuse, and mental illness or emotional disturbance).

<sup>13</sup> See, e.g., ALASKA STAT. § 25.20.025 (2008) (permitting minors to give consent to receive contraceptives and prenatal services); ALA. CODE §§ 22-8-4, 22-8-6 (2006) (permitting minors aged fourteen and older to receive contraceptives and prenatal services without the consent of a parent); VA. CODE ANN. § 54.1-2969(E) (2009) (allowing minors to consent to treatment for sexually transmitted diseases).

<sup>14</sup> See, e.g., Major Charles G. Kels, *Confidentiality and Consent: Why Promising Parental Nondisclosure to Minors in the Military Health System Can Be Risky Proposition*, ARMY LAW., Aug. 2010, at 12, 19 (suggesting that health care providers get caught between respecting adolescents' privacy and facilitating parental support for adolescents); Paul Benjamin Linton, *Long Road to Justice: The Illinois Supreme Court, the Illinois Attorney General, and the Parental Notice of Abortion Act of 1995*, 41 LOY. U. CHI. L.J. 753, 754-60 (2010) (discussing the thirty-five year attempt by the Illinois General As-

them as challenges to parental authority, claiming that the consent statutes move the jurisdiction of parenting away from the family locus, while simultaneously promoting and condoning promiscuous behaviors.<sup>15</sup>

The notion that minors might possess interests apart from their parents, or that these interests may conflict, will not evoke robust contestation or discord in contemporary legal or medical discourse. Cases involving child exploitation or abuse present the most obvious examples where the best interests of children and parents diverge and where the law intervenes on the child's behalf.<sup>16</sup> These types of abuse cases reveal how parental duties to care for their children and parental rights to raise their children might be in conflict: the duty to parent responsibly proscribes parental license to abuse children.<sup>17</sup> Notwithstanding the most vivid illustrations of parent-child conflicts of interest in the abuse and exploitation context, historically, children lacked legal recourse or recognition of their "rights" independent of their parents.<sup>18</sup> Indeed, the language of minors possessing "rights" inscribes a newer legal conceptualization, one that evolved concomitantly with other broader notions of fairness and justice in wholly separate spheres of legal movements: women's rights, civil rights, and social justice.<sup>19</sup>

This section briefly considers children's evolving legal rights and capacity against two important relational models: the parent and society. Understanding this evolution helps contextualize the relatively new concept of "adolescent rights." It also exposes historical fault lines to reveal a broad, deeply entrenched, and inflexible legal conception of parental rights, one

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sembly to enact an enforceable *parental* consent statute requiring parental consent or notice for minors to access an abortion).

<sup>15</sup> See Joseph W. Ozmer II, Note, *Who's Raising the Kids: The Exclusion of Parental Authority in Condom Distribution at Public Schools*, 30 GA. L. REV. 887, 909–11 (1996) (discussing concerns about parental inability to "opt out" of laws allowing condom distribution in public schools); Stephanie A. Zavala, Note, *Defending Parental Involvement and the Presumption of Immaturity in Minors' Decisions to Abort*, 72 S. CAL. L. REV. 1725, 1745–48 (1999) (arguing that parental involvement in minors' abortion decisions is in minors' best interests); see also Nicole Phyllis, *When Sixteen Ain't So Sweet: Rethinking the Regulation of Adolescent Sexuality*, 17 MICH. J. GENDER & L. 271 (2011). Phyllis argues that inconsistencies between age of consent requirements in statutory rape laws, which confer "consent-giving capacity" and enable adolescent sexual maturity, and parental involvement requirements for abortion services, which protect against minor immaturity, encourage impulsive adolescent sexual behaviors. *Id.* at 277–83, 290.

<sup>16</sup> See Darryn Cathryn Beckstrom, *Balancing Civic Values and Parents' Free Exercise Rights*, 45 GONZ. L. REV. 149, 161 (2010) (arguing that the state has expertise in the area of child abuse and should intervene rather than defer to parents when necessary to protect children).

<sup>17</sup> See *id.*

<sup>18</sup> See STEVEN MINTZ, *HUCK'S RAFT: A HISTORY OF AMERICAN CHILDHOOD* 54 (2004) (describing how the Age of Revolution inspired new ideas about children's rights).

<sup>19</sup> *Id.* (noting a 1799 quote by British moralist Hannah More that suggested discourse about both women's and children's rights was an outgrowth of the revolutionary era); see also Barbara Bennett Woodhouse, *The Courage of Innocence: Children as Heroes in the Struggle for Justice*, 2009 U. ILL. L. REV. 1567, 1569 (2009) (noting children's involvement in furthering civil rights, social justice movements, and their own "constitutional and human rights").

that casts children as property and parents as not only protectors but also owners.<sup>20</sup> In this section, we address those thematic inquiries through a process of distillation, where we envision the issues on a spectrum—one that includes as its grounding or starting place, the U.S. regulatory and jurisprudential legacy of consigning women as property generally, and wives more specifically, to their husbands.<sup>21</sup> Through this methodology we offer a grounded and analytically rich synthesis that recognizes girls' legal interests and social statuses as bounded to broader legal conceptions and framing of mothers and wives.

### A. *Children and Mothers as Property*

To understand why children were viewed as the property of their parents requires a broader conception of the rights and duties associated with persons and within families. Under English and colonial American common law, wives became the property of their husbands upon marriage,<sup>22</sup> and like-

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<sup>20</sup> The subordination of women and children dates back to antiquity, where “[p]arents, and especially fathers, made an initial decision whether their offspring would survive at all.” Margaret F. Brinig, *The Effect of Transactions Costs on the Market for Babies*, 18 SETON HALL LEGIS. J. 553, 560–61 (1994). Historically, although both parents held the discretion to abuse a child, since it was fathers who held as property all that was within their land and household, the right to discipline, punish, and even sacrifice children logically fell to them. See Hillary B. Farber, *The Role of the Parent/Guardian in Juvenile Custodial Interrogations: Friend or Foe?*, 41 AM. CRIM. L. REV. 1277, 1279 (2004) (noting that presumptions about parents' inclusion in juvenile custodial interrogations originate “in family law jurisprudence, where it is assumed that minor children are the property of their parents and that parents act in the best interests of their children”); Brian D. Gallagher, *A Brief Legal History of Institutionalized Child Abuse*, 17 B.C. THIRD WORLD L.J. 1, 4–5 (1997) (grounding, in part, a historical analysis of child abuse by fathers in Biblical teachings, including Lot's offer to sacrifice his daughters, Jephthah's offering of his daughter as a “holocaust,” and others).

<sup>21</sup> We do not address children as indentured servants or property of the state, which was common during the antebellum period. Children were involuntarily conscripted from poor houses and off the streets to be shipped to the new colonies in the United States. See MARY ANN MASON, *FROM FATHER'S PROPERTY TO CHILDREN'S RIGHTS: THE HISTORY OF CHILD CUSTODY IN THE UNITED STATES* 2 (1994) (quoting a seventeenth-century colonial law):

[I]f any of them shall be found obstinate to resist or otherwise to disobey such directions as shall be given in this behalf, we do likewise hereby authorize such as shall have the charge of this service to imprison, punish, and dispose of any those children . . . and so ship them out for Virginia with as much expedition as may stand with conveniency.

<sup>22</sup> The vast and elegant literature concerning the lives of women from the late-seventeenth century through the feminist movements that marked the mid-twentieth century reveals strict codes of conduct and social expectations for women that were woven into the law, thereby affecting the legal access and legal standing of women in civil and criminal matters. Legally, women were considered the “property” of their husbands, denied the opportunity to vote, and in some instances, denied the ownership of their property as husbands served as the masters of wives and all things belonging to their wives. See Margaret Valentine Turano, *Jane Austen, Charlotte Brontë, and the Marital Property Law*, 21 HARV. WOMEN'S L.J. 179 (1998) (examining Jane Austen's *EMMA* and

wise, children were recognized as the property of their parents.<sup>23</sup> *Bell v. Bell's Administrator* sets forth the general judicial principles of women and their property status in the United States.<sup>24</sup> The case, brought to determine the ownership of a slave, Linda, and her children, centered on the question of to whose estate—husband or wife—the slave woman and her children belonged. In reaching its decision, the Alabama Supreme Court iterated a general rule of law, “that the wife’s possession of chattels is the husband’s possession, and that the husband’s property in the wife’s chattels springs into existence with the commencement of her possession during the coverture, as if the manucaption had been his instead of hers.”<sup>25</sup> The court’s reliance on Clancy’s treatise *Husband and Wife*, demonstrates that its holding was not an aberration, but consistent with legal norms. Citing Clancy, the court asserted,

as a general rule, the wife cannot possess personal property; that, as far back as English jurisprudence could be traced, marriage conferred on the husband dominion over the possession of the wife; that, in the contemplation of law, the wife is scarcely considered to have a separate existence; that the unity of the persons of husband and wife is the source whence the wife’s disability to possess personal property is derived, and that the husband takes the wife’s chattels, which come into the wife’s possession in her own right, whether it be by gift, or bequest, or in any other way.<sup>26</sup>

This conceptual framing of women and children as the property of male heads of households morphed into an entrenched American jurisprudence in which children could not sue their parents<sup>27</sup> for even the most heinous assaults and women’s rights independent of and against their husbands were conservatively construed, including in matters of sexual independence.<sup>28</sup>

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Charlotte Bronte’s *JANE EYRE* for insights into the social and legal theories underlying coverture).

<sup>23</sup> See, e.g., JOAN PERKINS, *VICTORIAN WOMEN* (1993). Perkins paints a gloomy, but undeniably accurate, portrait of life for women and girls in Victorian-era England. She notes that the majority of English girls were deprived the advantages of formal schooling for most of the nineteenth century. *Id.* at 27. State-supported education did not come into being until the late 1800s, and parents routinely paid for the private schooling of their sons and not their daughters. *Id.* at 27, 31–32. For those working class girls able to access schooling, much of what they were taught had less to do with intellectual matters than preparation for domestic service in the homes of their husbands and fathers. *Id.* at 49.

<sup>24</sup> 36 Ala. 466 (Ala. 1860).

<sup>25</sup> *Id.* at 473.

<sup>26</sup> *Id.* at 473–74 (citing JAMES CLANCY, *A TREATISE OF THE RIGHTS, DUTIES, AND LIABILITIES OF HUSBAND AND WIFE, AT LAW AND IN EQUITY* 1 (1828)).

<sup>27</sup> *Villaret v. Villaret*, 169 F.2d 677, 677–78 (D.C. Cir. 1948) (citation omitted) (“Criticism of the rule has been voiced, . . . however . . . it continues to be the almost unanimous judicial opinion that an unemancipated child may not maintain an action against a parent for a personal tort.”).

<sup>28</sup> That husbands were exempt from prosecution for raping their wives further illustrates the deeply subordinate position of wives. See, e.g., MISS. CODE ANN. § 97-3-99



Furthermore, these issues were relegated to the private, “and therefore beneath the notice of law and politics.”<sup>29</sup>

### 1. *Sexual Property*

The concept of women as sexual property conveyed via their social status and conduct, such as contractual terms of their marriages, captures important aspects of our approach to this research and the thought experiment presented herein. First, at a methodological level, understanding young women’s sexual autonomy and capacity necessitates a broader inquiry into the legal statuses of women along similar and divergent spectrums. This approach calls for looking within the explicit bounds of the law to understand how law functions to protect the rights of these groups or to undermine their security. Second, and equally important, we recognize the importance of utilizing the tools of social science to study the impact of formal law and specifically grappling with exogenous rules to understand how social behaviors are shaped according to cultural expectations. To this end, it is insufficient to ponder the capacity and autonomy of female minors in isolation of valuable qualitative empirical sources, including case law, biographies, narratives, and other means of excavating truth. Thus, for scholars to understand the concept and status of children as property—as a bridge to frame enlightening discussions on children’s welfare, interests, and rights—it requires us to be cognizant and deeply discerning about the roles of power, social license, institutional organizations, and culture within American statutory regulations and jurisprudence.

The place where we begin is women’s and girls’ sexual independence as it helps to explain how women’s sexuality became the domain of men’s concern and control. The historical account that men were bread winners and protectors of women and therefore entitled to their wives and daughters’ vir-

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(2010) (“A person is not guilty of any offense under Sections 97-3-95 through 97-3-103 if the alleged victim is that person’s legal spouse and at the time of the alleged offense such person and the alleged victim are not separated and living apart . . .”). In *Davis v. Mississippi*, a husband challenged his conviction of aiding and abetting in the gruesome rape of his wife. 611 So. 2d 906 (Miss. 1992). His defense, that he could not be prosecuted (and therefore convicted) if he raped his wife, was supported by the majority: “Davis is, of course, correct that if he had himself solely perpetrated this atrocity, then under Miss. Code Ann. § 97-3-99 he was immune from prosecution.” *Id.* at 912.

<sup>29</sup> Sally F. Goldfarb, *Violence Against Women and the Persistence of Privacy*, 61 OHIO ST. L.J. 1, 5 (2000). Privacy provides an important lens through which to evaluate the evolution of state protection of women’s interests. Judicial deference to husbands was often justified on the basis that family matters deserve the protection of privacy, and therefore the state abjured intervention except in limited cases. *Id.* at 20–21. More recently, courts and scholars have taken to “privacy” as a means to exalt the independence and rights of women independent of their spouses and the State. These competing notions—within the feminist contexts—are not fully resolved in the literature. Indeed, an argument can be made that privacy is an evolving standard of justice, and that less State intervention is an important liberty interest. Of course, it must be recognized that such arguments were typically used to silence the interests of women within the broader domestic context.

tue (and thus legally privileged to control their sex), is an incomplete and unacceptable explanation for a gender power hierarchy that endured for centuries. In her elegant analysis of domestic violence and rape exemption statutes, Sally Goldfarb offers a nuanced alternative answer: the deeply entrenched “ideology of nonintervention in the family” permitted violence against women and girls through “[d]octrines like interspousal tort immunity, parental tort immunity, and the marital rape exemption in criminal law . . . .”<sup>30</sup> As a result, women were left with “little or no recourse” against incest, marital rape, and domestic battery committed by their “protectors.”<sup>31</sup>

The origins of wives’ sexual subordination<sup>32</sup> to husbands likely predate the marital rape canons. Legally, however, it was in Sir Matthew Hale’s acclaimed 1736 treatise, *Historia Placitorum Coronae, History of the Pleas of the Crown*, that a legal shift materialized. Hale proclaimed that a “husband cannot be guilty of rape” because marriage conveys unconditional consent, whereby wives have entered a binding contract and “hath given up [themselves] in this kind unto [their] husband[s], which [they] cannot retract.”<sup>33</sup> No prior English common law articulated this standard, but Hale’s new rule found broad appeal among parliamentarians, and was foundational to jurisprudence on women’s sexual authority in the United States. Nearly every state adopted such a law and North Carolina, in 1993, was the last state to rescind the marital rape exemption.<sup>34</sup>

That American legal jurisprudence, from its earliest origins through the late 1980s, is replete with cases where courts refused to recognize and enforce wives’ sexual independence (or *a right to refuse sex*) against their husbands,<sup>35</sup> provides an important context and historical backdrop for the questions presented in this section and the broader Article. In *State v. Paoella*, a case involving the kidnapping at gunpoint and rape of an estranged wife, a Connecticut court acknowledged that “[c]ertainly there is ample evidence at this point for the court to find that the . . . basic elements of the rape have been proven.”<sup>36</sup> However, the Supreme Court of Connecticut on appeal strictly construed state legislation, to pronounce the following:

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<sup>30</sup> *Id.* at 22.

<sup>31</sup> *Id.*

<sup>32</sup> By extension, women’s reproductive decision-making also became subordinate to the desires of their husbands.

<sup>33</sup> 1 WILLIAM HALE, *THE HISTORY OF THE PLEAS OF THE CROWN* \*629.

<sup>34</sup> See Jill Elaine Hasday, *Contest and Consent: A Legal History of Marital Rape*, 88 CAL. L. REV. 1375, 1381 (2000).

<sup>35</sup> *Connecticut v. Paoella*, 554 A.2d 702 (Conn. 1989) (holding that under Connecticut law, a finding by the trier of fact that the “alleged offender and the victim were married” qualifies as an “acquittal,” exonerating “the alleged offender, regardless of the proof of forcible sexual intercourse”).

<sup>36</sup> *Paoella*, 554 A.2d at 708 (quoting the trial court, which explained, “[t]he basis of the ruling as I indicated is the opinion of the Court that the spousal exemption is valid and the evidence indicates clearly . . . that these parties were still legally married on that day, and it is for that reason I am granting the Judgment of Acquittal as to these two counts”).

General Statutes § 53a-65(2), which defines the sexual intercourse prohibited under §§ 53a-70(a) and 53a-70a(a), excludes married people. Under this statutory scheme, a defendant married to the alleged assault victim cannot be found guilty of violating those sexual assault statutes. A finding of non-culpability based on the “marital exemption” of § 53a-65(2) necessarily depends upon proof of the fact that the victim and the defendant were legally married . . . [A] finding by the trier that the alleged offender and the victim were married exonerates the alleged offender, regardless of the proof of forcible sexual intercourse.<sup>37</sup>

In reviewing dozens of rape cases involving husbands’ sexual assaults against wives for this Article, what becomes clear is that historically, when presented with a compelling case of rape, judges often refused to engage in a robust constitutional law analysis, which might have included an equal protection query.<sup>38</sup> Instead, judges abnegated their authority to exercise discretion, even in cases where evidence of rape was undisputed. As the Colorado Supreme Court explained in 1981, marital exemptions from rape prosecutions promoted legitimate state interests in preserving family relationships and preventing juries from grappling with “intimate sexual feelings, frustrations, [and] habits” of married couples.<sup>39</sup> The court turned on its head what juries have been asked to do since that institution came into existence. Legally, then, it could be argued that U.S. courts were never concerned with women’s capacity or autonomy in evaluating choices with regard to sex, sexuality, and reproduction.<sup>40</sup> Those types of questions were unnecessary to ask and answer, because women’s and girls’ responses were irrelevant, even in the most brutal cases of rape.

In *Commonwealth v. Fogerty*, a case involving the brutal rape of a ten-year-old girl, the Supreme Court of Massachusetts announced that the men who “ravished” the child could not plead exceptions.<sup>41</sup> However, in very telling dicta, the court concluded by reminding the public, “[o]f course, it would always be competent for a party indicted to show, in defence [sic] of a charge of rape alleged to be actually committed by himself, that the woman on whom it was charged to have been committed was his wife.”<sup>42</sup> Similarly in *People v. Henry*, a provocative case where prosecutors alleged the

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<sup>37</sup> *Id.*

<sup>38</sup> Marital sexual assault exemption statutes draw arbitrary and irrational distinctions between actors for committing the same types of acts, in similar ways. Courts have responded, however, that promoting family harmony prevails over consideration of the individual. *See e.g.*, *Colorado v. Brown*, 632 P.2d 1025 (Colo. 1981). In that case, the defendant, convicted of rape, unsuccessfully challenged the District Court judgment and the constitutionality of the marital sexual assault exception judgment by the District Court.

<sup>39</sup> *Id.* at 1027.

<sup>40</sup> *See, e.g.*, *Anonymous*, 89 So. 462, 464 (Ala. 1921).

<sup>41</sup> 74 Mass. 489, 491 (Mass. 1857).

<sup>42</sup> *Id.*

rape of a thirteen-year-old girl by her father, the court noted that it could not be disproved that the girl was not married—to her father or someone else—which would bar the state's prosecution of rape.<sup>43</sup> The court chided the prosecution for not demonstrating that a thirteen-year-old child who lives at home is not married to anyone, including the father.<sup>44</sup> Thus, despite her pregnancy, childbirth, prior testimony, and the father's jailhouse confession to an officer, the case was remanded for a new trial.<sup>45</sup>

This legacy is informative for scholars seriously concerned about the evolution of women's legal autonomy generally, and specifically within the domains of reproductive decision-making. At a pragmatic level, courts historically and consistently participated in relegating wives' sexual independence to the control and province of their husbands.<sup>46</sup> In this way, women lacked meaningful access to courts and, therefore, justice.<sup>47</sup> As Robin West explains, "marital rape exemptions are strikingly easy to trace to misogynist roots, from Hale's infamous argument that a married woman is presumed to consent to all marital sex and, therefore, cannot be raped, to the common law's assumption that marriage results in the unification of husband and wife . . . ."<sup>48</sup>

Both through the legislative process and judicial opinions, law functioned as a tool to relegate women's sexuality to the province and control of their husbands. The "marital exception," for example, shielded husbands from criminal liability for the sexual assaults and rapes inflicted on their

<sup>43</sup> *California v. Henry*, 298 P.2d 80, 84 (Cal. Dist. Ct. App. 1956).

<sup>44</sup> *Id.* at 84–85 ("In the present case, notwithstanding the evidence regarding the same surname, not having been married to defendant, not having been outside the county, and living at defendant's home, a marriage between Vickie and someone other than the defendant might have existed. There was not sufficient proof of the non-marriage of Vickie to establish the nonmarriage element of the corpus delicti, and there was not a proper foundation for receiving the alleged confession in evidence.").

<sup>45</sup> *Id.* at 82–83. The father's written, but later retracted, confession provided a disturbing narrative to the trial:

The first act of sexual intercourse I had with Vickie was in the first part of May, 1953. It was in the morning of a weekday. I don't remember the exact day, but it was in the morning. My wife had gone to work and Vickie got in bed with me. We are a very close family, and the children often got in bed with me. I was fondling her and she asked me what I was doing. Then I asked her didn't she want me to do that. She said she didn't know. Then I went ahead and had an act of sexual intercourse. I don't think that I got more than about one-quarter of an inch of my penis in her that time. The second and third acts were complete, and I experienced an orgasm on all three. It is possible that her child is mine but I'm not sure. Signed, Arvie D. Henry. 3:50, 1/28/54. Newton detectives, Officer Brantley and Hannibal.

*Id.*

<sup>46</sup> Hasday, *supra* note 34, at 1381.

<sup>47</sup> See generally CATHARINE A. MACKINNON, *FEMINISM UNMODIFIED* (1987); CATHARINE A. MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* (1989).

<sup>48</sup> Robin West, *Equality Theory, Marital Rape, and the Promise of the Fourteenth Amendment*, 42 FLA. L. REV. 45, 64–65 (1990).

wives.<sup>49</sup> According to the *American Law Reports 4th Edition* on marital rape, “[u]ntil very recently, the courts were nearly unanimous in their view that a husband could not be convicted of rape, or assault with intent to commit rape, upon his wife as the result of a direct sexual act committed by him upon her person.”<sup>50</sup>

This notion of property ownership was less a legal fiction than a platform by which duties could be understood and imposed on parties responsible for the health and safety of those considered “vulnerable” and “fragile.”<sup>51</sup> For example, Blackstone’s discussion of marriage in the late eighteenth century captured the notion that wives’ identities and legal rights were subsumed within the broader scope of their husbands’ identities.<sup>52</sup> This model, borrowed from coverture laws abroad, functioned to preserve legal and social order, and to promote familial harmony.<sup>53</sup> According to Blackstone:

By marriage, the husband and wife are one person in law: that is, the very being or legal existence of the woman is suspended during the marriage, or at least is incorporated and consolidated into that of the husband: under whose wing, protection, and *cover*, she performs every thing; and is therefore called in our law-[F]rench a *feme-covert* . . . . Upon this principle, of an union of person in husband and wife, depend almost all the legal rights, duties, and disabilities, that either of them acquire by the marriage . . . . For this reason, a man cannot grant any thing [sic] to his wife, or enter into covenant with her: for the grant would be to suppose her separate existence; and to covenant with her would be only to covenant

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<sup>49</sup> *Id.*; see also COLO. REV. STAT. ANN. § 18-3-409 (West 1973) (“(1) The criminal sexual assault offenses of this part 4 shall not apply to acts between persons who are married, either statutorily, putatively, or by common law.”); CONN. GEN. STAT. ANN. § 53a-65(2) (exempting marital rape from prosecution by limiting the definition of “sexual intercourse” to “persons not married to each other”) (West 1958); MISS. CODE ANN. § 97-3-99 (West 1972) (“A person is not guilty of any offense under sections 97-3-95 through 97-3-103 if the alleged victim is that person’s legal spouse and at the time of the alleged offense such person and the alleged victim are not separated and living apart.”); MONT. CODE ANN. § 45-5-503 (1981) (“Sexual intercourse without consent. (1) A person who knowingly has sexual intercourse without consent with a person of the opposite sex *not his spouse* commits the offense of sexual intercourse without consent.”) (emphasis added); OKLA. STAT. tit. 21, § 1111 (1951) (defining rape as “an act of sexual intercourse accomplished with a female, not the wife of the perpetrator . . .”).

<sup>50</sup> Michael G. Walsh, Annotation, *Criminal Responsibility Of Husband For Rape, Or Assault To Commit Rape, On Wife*, 24 A.L.R. 4TH 105, §2(a) (2009).

<sup>51</sup> Striking images of duties reversed in this realm are informative. For example, images of the Victorian nurse as a heroic, powerful, and healthy woman standing in contrast to sickly male patients portrayed a notable gender role reversal in the mid-nineteenth century. See, e.g., CATHERINE JUDD, *BEDSIDE SEDUCTIONS: NURSING AND THE VICTORIAN IMAGINATION, 1830–1880* 6 (1998) (comparing the Victorian nurse to class, gender, and sexuality issues associated with “the fallen woman”).

<sup>52</sup> See 2 WILLIAM BLACKSTONE, *COMMENTARIES* \*442–45 (discussing the “chief legal effects of marriage during coverture”).

<sup>53</sup> See *id.*

with himself: and therefore it is also generally true, that all compacts made between husband and wife, when single, are voided by the intermarriage.<sup>54</sup>

## 2. *Coverture: Duties, Discipline, and Responsibilities*

The coverture model for governing women, however, lacked flexibility in its blunt application. What it provided (or promised) in terms of promoting health and safety for women and children it sometimes lacked in enforcement of good care, commitment to harmonious conduct, and accountability.<sup>55</sup> The judicious writings of Dorothea Dix, a prominent nineteenth-century author, teacher, and activist, detailing her research across the United States of women “turned out” by their husbands and fathers, provide vivid illustrations of the crude conditions under which women barely survived:

It is impossible to enter upon individual histories here, and I think that the plain facts, stating recent outward conditions, are sufficient to show that society at large is unfaithful to its moral and social obligations . . . . I know of sisters and daughters subject to abusive language, to close confinement, and to “floggings with the horse-whip.” . . . I know of many *cast out from dwellings*, to wander forth, and live or die, as the elements, less merciless than man, permit.<sup>56</sup>

Common law duties required husbands to support their wives. Such duties thereby conferred a “right of support” to wives. But, courts made clear that such a right was not absolute.<sup>57</sup> For example, a wife was to be supported at the family home, but if she departed her husband could deny support.<sup>58</sup> That is to say, with the duty to promote and protect came also the *right* to control how a wife would be supported, and the *power* to punish with impunity and without consequence. Coverture-based civil law regimes meant that women could not sue their husbands if abuse occurred. The Supreme Court warned that if Congress had intended to grant women permis-

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<sup>54</sup> *Id.* at \*442.

<sup>55</sup> For example, in the United States, propertied men who were considered mentally ill were given jury trials to preserve and promote due process prior to a civil incarceration. See, e.g., MARK E. NEELY, JR. & R. GERALD MCMURTRY, *THE INSANITY FILE: THE CASE OF MARY TODD LINCOLN* 19 (1993). However, women and girls could be committed to mental health facilities with barely more than a husband or father’s complaint and a third party affirmation. *Id.*

<sup>56</sup> See DOROTHEA L. DIX, *To The Honorable The Legislature of The State of New York, in ON BEHALF OF THE INSANE POOR* 1, 47 (1971).

<sup>57</sup> See *Brindley v. Brindley*, 25 So. 751, 752 (Ala. 1899) (holding that the duty to provide marital support “is not absolute. [The husband] is bound to support her at the common home, and not under another’s roof . . . . Hence, if she abandons her home without cause, the right to support from her husband at once ceases”).

<sup>58</sup> *Id.*

sion to sue their husbands, thereby altering the common law governing husbands and wives, it would have articulated its intent with “irresistible clearness.”<sup>59</sup>

Equally important to this research then, is to advance a more nuanced and illimitable understanding as to why wives, given the prior discussion, might brave public embarrassment and judicial disincentives, risk their safety, and endure possible stigma in order to utilize the judicial process to sue their husbands. For this we turn briefly to representative cases, research, narratives, and case studies. Margaret Turano succinctly articulates how women’s living and social conditions under English common law rule created the impetus for action:

The husband had a right to the couple’s children and could name a person other than his wife as their guardian. If a woman left her husband, even for a good reason, the court could order “their infant child, then at her breast” to be delivered to him. This was true even if he was living in adultery with another woman, unless the wife could show that the husband would “abuse his right” to custody of the infant. If the couple had a minor child who wanted to marry, only the consent of the father was required, not that of the mother. If a deceased father had appointed a guardian other than the mother, that guardian’s consent, and not the mother’s, was required.<sup>60</sup>

Courts answered women by reaffirming a commitment to the English common law tradition, which denied wives the right to sue their husbands for battery, and justified the denial by asserting the state’s interest in promoting marital harmony and emphasizing the joined nature of husbands and wives. As an indivisible unit, courts reasoned, one could not recover against the other. In the United States, courts adopted the language of “gentle restraint” to describe the type of physical punishment husbands could legally inflict on their wives without fear of criminal punishment or civil liability, while women were foreclosed from using the American tort system to seek remedies against their husbands. The North Carolina Supreme Court advised in *North Carolina v. Oliver* that its position had evolved, “[w]e may assume that the old doctrine, that a husband had a right to whip his wife, provided he use a switch no larger than his thumb, is not law in North Carolina.”<sup>61</sup> Yet, in its holding, the North Carolina Supreme Court issued the following response on domestic battery, “if no permanent injury has been inflicted, nor malice, cruelty nor dangerous violence shown by the husband, it is better to draw the curtain, shut out the public gaze, and leave the parties

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<sup>59</sup> *Thompson v. Thompson*, 218 U.S. 611, 618–19 (1910).

<sup>60</sup> Turano, *supra* note 22, at 183.

<sup>61</sup> 70 N.C. 60, 61 (N.C. 1874). Note, however, that North Carolina was the last state to modify its marital rape exemption statute.

to forget and forgive.”<sup>62</sup> A similar posture was adopted by courts throughout the United States, emphasizing the social importance of maintaining “domestic harmony” as a public policy value and goal. Courts in Maine articulated this goal slightly differently under the same general principle. In *Abbott v. Abbott*, the court denied Mrs. Abbott the opportunity to recover for injuries she sustained after a brutal battering by her husband.<sup>63</sup> In that case, the court emphasized that the “husband and wife are one person.”<sup>64</sup>

Interspousal and parental immunity doctrines, which emanated from coverture rules, were justified as furthering individual and broader social goals. Family immunity defenses advanced policy goals associated with the coverture model, in that the U.S. tort doctrine protected husbands and fathers from tort liability and discouraged litigation from wives and children. As a public policy matter, courts deemed it in society’s interest that households reside in harmonious companionship, unimpaired by the tensions that could arise from litigation.

Courts refused to acknowledge that avoiding the marital tensions and disharmony that could possibly result from litigation did not cure physical, emotional, and sexual abuse in the marital homes, or violence inflicted on children. Coverture rules did not ensure the safety, care, and betterment of women and girls. Instead, those most severely abused during the height of coverture became caught in a complex social decline that included homelessness (as a means of escape or abandonment) or forcible incarceration in mental health facilities.

Ralph Reisner and Christopher Slobogin trace this history with notable adroitness and depth. According to the authors, forced incarceration in asylums served as a warning to women, particularly as life in these facilities included floggings, unsanitary conditions, and sexual abuse.<sup>65</sup> Due Process was an illusory concept in mental health asylums. Parents could—and sometimes did—incarcerate their daughters for failure to conform to expected social behavior.<sup>66</sup> On the other hand, adolescents could not refuse submission to corporal punishment or, for that matter, medical interventions and experimentation compelled by parents.<sup>67</sup>

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<sup>62</sup> *Id.* at 61–62.

<sup>63</sup> *Abbott v. Abbott*, 67 Me. 304 (Me. 1877).

<sup>64</sup> *Id.* at 306.

<sup>65</sup> See generally RALPH REISNER & CHRISTOPHER SLOBOGIN, *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 596–604 (2d ed. 1990) (noting the ease with which arbitrary confinement could take place).

<sup>66</sup> Tamara Myers, *The Voluntary Delinquent: Parents, Daughters, and the Montreal Juvenile Delinquents’ Court in 1918*, 80 *CANADIAN HISTORICAL REV.* 242, 242 (1999) (“[H]undreds of delinquent daughters were brought before Montreal’s Juvenile Delinquents’ Court, which opened in 1912. Their ‘crimes’ consisted primarily of defying parental authority over contributions to the family economy and housework, and their seemingly precocious attitude towards sexuality.”).

<sup>67</sup> See PETER DE CRUZ, *COMPARATIVE HEALTHCARE LAW* 117 (2001) (“[H]istorically, children have been regarded as coming within the category of those who are legally incompetent to give consent, being unable, at least in the early years of



The subordination of women and children can be understood in parallel, particularly because children have historically been regarded within the law as the property of their parent(s), and more specifically the possessions of their fathers.<sup>68</sup> Justifications for such treatment of minors mirror defenses of the coverture model for women, including the interests of social order, obedience, and familial harmony.<sup>69</sup> According to a Mississippi Supreme Court decision,

[t]he peace of society, and of the families composing society, and a sound public policy, designed to subserve the repose of families and the best interests of society, forbid to the minor child a right to appear in court in the assertion of a claim to civil redress for personal injuries suffered at the hands of the parent.<sup>70</sup>

*Roller v. Roller* provides a chilling and seminal example of judicial deference to parental authority and the fragile association of parental “rights” or “interests” with that of the (female) child.<sup>71</sup> In that case, the Washington Supreme Court maintained that a fifteen-year-old girl could not pursue a cause of action against her father for rape.<sup>72</sup> The case exposes a deeply entrenched view of parental authority in relation to the child, and remains stunning for two reasons. First, the underlying charge of rape was not in dispute, nor denied by the father.<sup>73</sup> In fact, the court recognized rape as a heinous action, but opined that there would be no principled way to

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their life, to decide on what medical treatment they should have . . . .”); Daphne Blunt Bugental & Joan E. Grusec, *Socialization Processes*, in 3 HANDBOOK OF CHILD PSYCHOLOGY: SOCIAL, EMOTIONAL, AND PERSONALITY DEVELOPMENT 366, 401 (Nancy Eisenberg ed., 6th ed. 2006) (noting the historical importance of corporal punishment of children in America).

<sup>68</sup> MARY ANN MASON, FROM FATHER’S PROPERTY TO CHILDREN’S RIGHTS: THE HISTORY OF CHILD CUSTODY IN THE UNITED STATES (1994).

<sup>69</sup> See *Villaret v. Villaret*, 169 F.2d 677, 677–78 (D.C. Cir. 1948) (citations omitted); MARY ANN MASON, *supra* note 68, at 6 (stating that parental common law rights suggest to some legal historians that that law treated children as property).

<sup>70</sup> *Hewellette v. George*, 9 So. 885, 887 (Miss. 1891) (holding that the doctrine of parental immunity does not apply in automobile accident cases, where a minor is injured as a result of his or her parent’s negligent operation of the motor vehicle), *abrogated by* *GLASKOX ex rel Denton v. Glaskox*, 614 So. 2d 906 (Miss. 1992).

<sup>71</sup> 79 P. 788, 788 (Wa. 1905) (“The rule of law prohibiting suits between parent and child is based upon the interest that society has in preserving harmony in the domestic relations, an interest which has been manifested since the earliest organization of civilized government, an interest inspired by the universally recognized fact that the maintenance of harmonious and proper family relations is conducive to good citizenship, and therefore works to the welfare of the state.”); see also CHILD ABUSE: A GLOBAL VIEW 243–44 (Beth M. Schwartz-Kenney, Michelle McCauley, & Michelle A. Epstein eds., 2001) (describing societal responses to child abuse in the United States in the nineteenth and early-twentieth centuries); Norrie Clevenger, Note, *Statute of Limitations: Childhood Victims of Sexual Abuse Bringing Civil Actions Against Their Perpetrators After Attaining The Age of Majority*, 30 J. FAM. L. 447 (1991) (summarizing recent cases involving childhood incest).

<sup>72</sup> *Roller*, 79 P. at 789.

<sup>73</sup> *Id.* at 788. Her father had already been convicted of rape by the time his daughter brought the tort action. *Id.*

differentiate between rape and “any other tort” in actions by children against their parents.<sup>74</sup> Second, the court was persuaded by the father’s plea, which emphasized the importance of maintaining domestic tranquility and harmony.<sup>75</sup> The court ascribed to the view that familial accord was “conducive to good citizenship” and so “worked to the welfare of the state.”<sup>76</sup>

Based on the forgoing, it becomes clear that the child as a separate entity is not an inherent legal premise.<sup>77</sup> In civil law contexts, courts afforded prophylactic protection of parental interests through the affirmative defense of parental immunity laws.<sup>78</sup> In cases in which children were harmed by their parents, courts endorsed an immunity regime that balanced children’s interests against prevailing social and legal commitments to promote social welfare, preserve familial harmony, and protect disciplinary order in households.<sup>79</sup> Courts’ reluctance to interfere in domestic disputes between children and parents not only captures an important historical note,<sup>80</sup> but places this Article’s thought experiment in context: historically, the notion of children’s rights was more illusory than real, the law generally deferred to parents in matters of domestic dispute, and considerable deference was granted to parents generally, and fathers primarily, in the guidance and rearing of their children.

In a recent article in the *Annals of the American Academy of Political and Social Science*, Professor Elizabeth Bartholet emphasizes that “current law in the United States gives children very little in the way of rights and places overwhelming emphasis on parents’ rights, justifying this often as consistent with children’s best interests.”<sup>81</sup> Bartholet dispels any doubts about the historically marginalized legal status of children in the United States, explaining that “United States law *allows* the state to protect children but does not impose on states a constitutional *duty* to protect children. Under U.S. law, the state’s power to protect children is limited by parents’ constitutional rights to be free from undue state intervention.”<sup>82</sup> Nor does

<sup>74</sup> *Id.* at 789.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> See MASON, *supra* note 69, at 6 (noting history of parental common law rights with respect to their children); see also Michele Goodwin, *A View From the Cradle: Tort Law and the Private Regulation of Assisted Reproduction*, 59 EMORY L.J. 1039, 1076–79 (2010) [hereinafter Goodwin, *A View From the Cradle*] (discussing the intra-familial immunity doctrine with respect to children).

<sup>78</sup> See, e.g., *Villaret v. Villaret*, 169 F.2d 677, 679 (D.C. Cir. 1948) (dismissing a negligence action brought by a child against his mother).

<sup>79</sup> See Goodwin, *A View from the Cradle*, *supra* note 77, at 1076 (“Permitting claims brought by children against their parents would turn social order on its head.”).

<sup>80</sup> See *id.* at 1078–79.

<sup>81</sup> Elizabeth Bartholet, *Ratification by the United States of the Convention on the Rights of the Child: Pros and Cons from a Child’s Rights Perspective*, 633 ANNALS 80, 86 (2011) (noting that by contrast, the “CRC makes it clear that children have *affirmative* rights, not just negative rights to keep the state from interfering in their autonomy”). *Id.* at 85.

<sup>82</sup> *Id.* at 86.

the United States invest children with a constitutionally recognized interest in the State's protection.<sup>83</sup>

The promotion of familial harmony in judicial opinions reflects the use of social and legal values as a means to guide youth toward healthy life trajectories and meaningful participation in society.<sup>84</sup> The conflict, however, is that courts' deference to family and parental authority has not always resulted in meeting the needs and securing the best interests of the child.<sup>85</sup>

### B. *Rethinking Minors' Rights*

Let us now turn to considering the applicability of a rights discourse to children. In Part II.B we turn briefly to the perception of rights. We take up the issue of why moving toward "actual" children's rights might be better achieved by a nuanced framework, rather than blunt rulemaking in Part II.C.

In recent years, scholars have taken up the cause of "children's rights" across a vast spectrum, from the protection against labor exploitation to a broader sphere of rights: the right to refuse psychotropic drugs,<sup>86</sup> to be free from a medically chartered, parent-designed life,<sup>87</sup> to be spared a future of physical disabilities resulting from parental utilization of preimplantation genetic diagnosis,<sup>88</sup> to be "free" from sexual harassment in low-wage employment,<sup>89</sup> to wear controversial clothing,<sup>90</sup> and, in keeping with the publicity-

<sup>83</sup> *Id.*

<sup>84</sup> See *id.*; see also *Roller v. Roller*, 79 P. 788, 788 (Wash. 1905) (arguing that the public policy of family unity justifies parental immunity), *distinguished in part* by *Borst v. Borst*, 251 P.2d 149 (Wash. 1952) (holding that a minor child can sue his parent for a tort resulting in personal injuries, where the father, operating his business vehicle for business purposes ran over his child, on the grounds that at the time he hit his son, the relationship between the two of them was not that of father and child, but of driver and pedestrian).

<sup>85</sup> The conflict between judicial deference to parental rights and children's best interests is routinely evidenced in the context of abuse/neglect and divorce proceedings. See, e.g., Samantha Brennan & Robert Noggle, *The Moral Status of Children: Children's Rights, Parents' Rights, and Family Justice*, 23 SOC. THEOR. & PRAC. 1, 19–20 (1997) (suggesting a conflict between the policy of keeping biological families together and a child's best interests).

<sup>86</sup> See Jennifer Albright, Comment, *Free Your Mind: The Right of Minors in New York to Choose Whether or Not to be Treated with Psychotropic Drugs*, 16 ALB. L.J. SCI. & TECH. 169, 171 (2006) (arguing that more weight should be given to the preference of a child to receive psychotropic drugs).

<sup>87</sup> See George J. Annas, *Human Cloning: A Choice or an Echo?*, 23 U. DAYTON L. REV. 247, 260–63 (1998) (providing arguments against cloning children, in part because the practice does not take into account "any consideration of the child's choice or welfare").

<sup>88</sup> See Karen Schiavone, Comment, *Playing The Odds or Playing God? Limiting Parental Ability to Create Disabled Children Through Preimplantation Genetic Diagnosis*, 73 ALB. L. REV. 283, 284 (2009).

<sup>89</sup> See Jennifer Ann Drobac, *I Can't to I Kant: The Sexual Harassment of Working Adolescents, Competing Theories, and Ethical Dilemmas*, 70 ALB. L. REV. 675 (2007) (formulating a framework to develop legal protections against sexual harassment and abuse against adolescents at work).

prone times, to be free from their parents' attempts at celebrity.<sup>91</sup>

Within contemporary legal discourse, children are generally understood to have some rights in three specific contexts: criminal, welfare, and statutory delegations. On closer examination, these arguments in children's rights scholarship, which appear to articulate minors' "rights," are more appropriately described as *protections against harms* or *negative rights*. With the exception of some historically controversial issues such as minors' access to abortions,<sup>92</sup> or rights associated with criminal prosecution,<sup>93</sup> most children's rights discourse aims to protect children from the negative reaches of others, including their parents, employers, the State, schools, and other institutions traditionally granted authority in children's lives. Susan Bandes tackles an aspect of this question in an important project on negative rights following *DeShaney v. Winnebago Department of Social Services*,<sup>94</sup> a U.S. Supreme Court case distinguishing the State's responsibility in child abuse cases.<sup>95</sup> According to Bandes, "the conventional wisdom distinguishes between negative rights to be free from governmental interference and positive rights to

<sup>90</sup> See Jay Alan Sekulow & Erik M. Zimmerman, *Tinker at Forty: Defending the Right of High School Students to Wear "Controversial" Religious and Pro-Life Clothing*, 58 AM. U. L. REV. 1243, 1245 (2009) (advocating for "broad First Amendment protection for 'controversial' religious and pro-life student expression").

<sup>91</sup> See Dayna B. Royal, *Jon & Kate Plus the State: Why Congress Should Protect Children in Reality Programming*, 43 AKRON L. REV. 435, 439–40 (2010) (articulating a legal regime for regulating the employment of children whose parents involve them in reality television).

<sup>92</sup> See Leonard Berman, Note, *Planned Parenthood v. Casey: Supreme Neglect for Unemancipated Minors' Abortion Rights*, 37 HOW. L.J. 577, 603 (1994) (arguing for a minor's right to abortion and criticizing parental consent statutes); Michael Grimm, Comment, *American Academy of Pediatrics v. Lungren: California's Parental Consent to Abortion Statute and the Right to Privacy*, 25 GOLDEN GATE U. L. REV. 463, 504–05 (1995).

<sup>93</sup> See Emily Buss, *Constitutional Fidelity through Children's Rights*, 2004 SUP. CT. REV. 355, 369 (arguing that procedures "developed to secure meaningful participation and accurate decision-making for adults in criminal court" are a poor "constitutional fit" for children in juvenile court); Sandra M. Ko, Comment, *Why Do They Continue to Get the Worst of Both Worlds? The Case for Providing Louisiana's Juveniles with the Right to a Jury in Delinquency Adjudications*, 12 AM. U. J. GENDER SOC. POL'Y & L. 161, 163 (2004).

<sup>94</sup> 489 U.S. 189 (1989).

<sup>95</sup> Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271, 2274–76 (1990). According to Bandes:

In short, the conventional wisdom rests on the efficacy of the distinction between government action and inaction. Government has no obligation to act, except, in limited circumstances, to ensure that no harm is caused by its previous actions. In order to make the distinction between action and inaction, it becomes crucial to determine what constitutes a governmental act, to distinguish the acts of government from those of private persons, and to delineate the circumstances in which the government has caused harm. Therefore, the distinction between action and inaction reappears in other forms: the public/private distinction; the penalty/subsidy distinction; and the rules of causation. Part II examines the application of the action/inaction distinction in its various forms, and seeks to demonstrate that it is unworkable and misguided.

*Id.* at 2278.

have government do or provide various things.”<sup>96</sup> Bandes critiques the conventional wisdom, describing it in the following terms: “individuals have no right to have government *do* anything at all; it must only refrain from harming or coercing them.”<sup>97</sup>

For example, Justice Rehnquist’s majority opinion in *DeShaney v. Winnebago Department of Social Services* rejected the due process claim brought on behalf of a minor who suffered irreversible brain injury resulting from chronic child abuse, which a local social service agency failed to prevent.<sup>98</sup> The § 1983 lawsuit claimed that the agency’s failure to intervene and protect Joshua DeShaney from his father’s abuse, which it knew about or should have known about, violated the child’s right to liberty without due process of law.<sup>99</sup> The 6–3 majority opinion clarifies the Supreme Court’s conception of affirmative duties, thereby distinguishing positive from negative rights generally, and specifically, in this case, involving minors.<sup>100</sup> Bandes describes the conventional wisdom as resting “on the efficacy of the distinction between government action and inaction.”<sup>101</sup>

This view that the government is not obligated to act in matters of child safety or to intervene between private parties in a non-negligent manner could also be interpreted as the absence of a right to which the State is obligated to respond. Thus, the traditional view conceptualizes government along the following lines: it “has no obligation to act, except, in limited circumstances, to ensure that no harm is caused by its previous actions.”<sup>102</sup> Accordingly, as Rehnquist clarifies in *DeShaney*, the U.S. Supreme Court interprets the substantive component of the Due Process Clause as not “requir[ing] the State to protect the life, liberty, and property of its citizens against invasions by private actors.”<sup>103</sup> Explicitly, then, the Rehnquist majority leaves us to understand that even in cases of child abuse, minors do not have a constitutional right to state protection against their parents. In a footnote, the Court declined to consider whether “child protection statutes gave [the child] an ‘entitlement’ to receive protective services in accordance

<sup>96</sup> *Id.* at 2274.

<sup>97</sup> *Id.*

<sup>98</sup> *DeShaney*, 489 U.S. at 201–03.

<sup>99</sup> *Id.* at 193.

<sup>100</sup> *Id.* at 202 (“A State *may* . . . impose such affirmative duties of care and protection . . . [But because] the State has no constitutional duty to protect [the minor] against his father’s violence, its failure to do so—though calamitous in hindsight—simply does not constitute a violation of the Due Process Clause.”) (emphasis added). Similarly in *Jackson v. Byrne*, the Seventh Circuit refused to recognize the positive right of two children to fire protection in a case where the children died in a conflagration when firefighters located directly across the street from the blaze did not respond. 738 F.2d 1443 (7th Cir. 1984).

<sup>101</sup> Bandes, *supra* note 95, at 2278.

<sup>102</sup> *Id.*

<sup>103</sup> *DeShaney*, 489 U.S. at 195.

with the terms of the statute, an entitlement which would enjoy due process protection . . . .”<sup>104</sup>

An important distinction between *DeShaney* (and similar cases),<sup>105</sup> and minors’ rights to specific reproductive services as articulated in this Article, is the difference between being acted upon—a right of protection to be free from other’s harmful behaviors, including the State—and the *entitlement* or *right* to carry out a specific act or medical decision. *DeShaney* and similar cases focus on the former, while this project considers the latter. Notice, however, that courts are not particularly compelled to assert that an entitlement exists in cases where a perceived “right” to state services, such as social services or police protection, is at stake.<sup>106</sup> Such is the state of the law for both adults and also minors—children possess no greater rights than their parents. Thus, any notion that a developed jurisprudence on children’s rights exists within the American judicial system is misinformed.

The rich scholarly legacy of *DeShaney* focuses primarily on two issues: the nuances of that specific case and deconstructing “negative” rights; neither issue addresses children’s affirmative rights. Noticeably, attention to affirmative rights of minors is left out. Likewise, much of the current “children’s rights” discourse does not address the affirmative acts and interests of minors. We agree with Lee Teitelbaum’s forceful work on this important point: traditional “rights” frameworks do not map easily on the activities and personhood of children.<sup>107</sup>

### 1. *The Criminal Context*

The criminal law context provides a clear example of how traditional “rights” do not easily map onto the lives and realities of children. In a persuasive treatment on children and the criminal law, Emily Buss contends that due process procedures created to protect constitutional interests and secure full, unburdened participation in criminal adjudications for adults are

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<sup>104</sup> *Id.* at 195 n.2.

<sup>105</sup> More recently in *Town of Castle Rock v. Gonzales*, the Supreme Court reversed a Tenth Circuit Court of Appeals decision, which found a property interest in the enforcement of a restraining order in a case where the plaintiff-mother claimed that the city violated the Fourteenth Amendment Due Process Clause when police officers failed to act on repeated reports that the children’s father had kidnapped them, which resulted in the children’s murders. 545 U.S. 748 (2005). According to Justice Scalia, Colorado law did not *require* enforcement of restraining orders; the police had discretion in their enforcement of the statute. *Id.* at 764–66; *see also*, *Sacramento v. Lewis*, 523 U.S. 833 (1998) (holding that a police officer’s reckless conduct during a car chase, which led to the injury of respondent, did not give rise to liability for a due process right to life); *Doe v. Milwaukee*, 903 F.2d 499 (1990) (holding that minors and their guardians do not have a constitutionally protected property interest to have a department of social services investigate claims of child abuse).

<sup>106</sup> *See Gonzales*, 545 U.S. at 764.

<sup>107</sup> *See* Lee E. Teitelbaum, *Children’s Rights and the Problem of Equal Respect*, 2006 UTAH L. REV. 173, 188–91 (2006), *reprinted with permission from* 27 HOFSTRA L. REV. 799 (1999).

actually a “poor fit” for children in criminal proceedings.<sup>108</sup> Buss makes a compelling point: traditional legal regimes designed for adults do not easily “fit” children even with similar interests. Adult-based laws do not always provide the protections or privileges children seek.<sup>109</sup>

Buss’s observation is particularly enlightening because the criminal law context happens to be where children’s rights are most rigorously guarded, protected, and promoted. The criminal law offers a unique, but not universal, lens through which to study “children’s rights,” in part because of what is at stake in those cases. *In re Gault* provides an important example. In that case, the Supreme Court found that under the Fourteenth Amendment to the United States Constitution minors accused of delinquency in criminal proceedings must be afforded similar, and in some cases the same, rights as adults.<sup>110</sup> By this, the majority explained that the Constitution guaranteed procedural due process to juveniles, including the right to counsel,<sup>111</sup> appropriately timed notification of charges,<sup>112</sup> confrontation of witnesses in the absence of a valid confession,<sup>113</sup> and privilege against self-incrimination.<sup>114</sup> Uniquely, then, the rights articulated in *In re Gault* (and similar criminal cases) are not predicated on parental consent, participation or acquiescence, child capacity, or promoting basic child welfare, but on a shifting judiciary possibly responding to exogenous social movements and cultural changes.<sup>115</sup>

In a later case examining the legal interests of minors, Justice Sandra Day O’Connor provided a tailored explication to distinguish why children’s liberty interests arise in criminal law contexts.<sup>116</sup> O’Connor’s concurrence in *Reno v. Flores* is notable for its judicial insights. She distinguishes tough criminal cases from equally grievous civil cases in which minors’ quality of life and even life or death may be implicated, but in which courts do not recognize a liberty interest. She explained that precedent “makes clear that children have a protected liberty interest in ‘freedom from institutional restraints.’”<sup>117</sup> O’Connor acknowledged that, “it may seem odd that institutional placement” even in a relatively open detention center, “where

<sup>108</sup> Buss, *supra* note 93, at 368–69.

<sup>109</sup> *Id.* at 363–64.

<sup>110</sup> 387 U.S. 1, 13 (1967) (“[N]either the Fourteenth Amendment nor the Bill of Rights is for adults alone.”).

<sup>111</sup> *Id.* at 36–37.

<sup>112</sup> *Id.* at 33.

<sup>113</sup> *Id.* at 56.

<sup>114</sup> *Id.* at 55.

<sup>115</sup> In a later education case, *Tinker v. Des Moines Independent Community School District*, the Court achieved a similar tone despite apparent differences between the cases. In *Tinker*, several children were suspended because they wore black armbands to school in protest of the Vietnam War and in violation of school policy. *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503, 504 (1969). In both *Tinker* and *Gault*, the Court emphasized its interest in upholding constitutional principles, including balancing the rights of individuals against state interference. *Id.* at 513–14.

<sup>116</sup> *Reno v. Flores*, 507 U.S. 292, 317–18 (1993) (O’Connor, J., concurring).

<sup>117</sup> *Id.* at 317.

conditions are decent and humane . . . implicates the Due Process Clause.”<sup>118</sup> The answer, she suggested, is quite simple. Childhood is a vulnerable time in the developmental stage, and the risk of erroneous institutionalization could irreparably cause “scars for the rest of their lives.”<sup>119</sup> This interest—to avoid erroneous incarceration—is far more global than to the individual; it implicates strong societal interests.<sup>120</sup>

## 2. Welfare Rights

The evolution of “positive” rights for children can be traced to the judiciary—in part as a response to child abuse and neglect, and as a means to set meaningful legal and social standards in the treatment of children. Thus, children are recognized to have positive welfare rights to those things that are necessary to sustain life in a broad sense.<sup>121</sup> With limited exception, P&Gs are presumed to be responsible for the provision of such rights, including the right to food, shelter, safety, clothing, and education.<sup>122</sup> Courts will also find a due process right against the State in specific circumstances involving child welfare or education.<sup>123</sup> Courts also make clear that children’s welfare rights do not exist in isolation. Indeed, parental duties reside in intimate association and entanglement with the welfare rights of children.<sup>124</sup> But for parental duties, would children’s welfare rights exist? Maybe not. At least one way of viewing children’s welfare rights is that they are not independent of parental responsibilities.

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<sup>118</sup> *Id.* at 318.

<sup>119</sup> *Id.* (noting that our social norm should be children growing up in families rather than “governmental institutions”).

<sup>120</sup> *Id.*; see also *Addington v. Texas*, 441 U.S. 418, 423 (1979) (noting that criminal standards of proof are higher than civil cases because of defendant’s interest in avoiding erroneous judgment); *In re Winship*, 397 U.S. 358, 372 (1970) (Harlan, J., concurring) (emphasizing society’s interest in avoiding erroneous convictions).

<sup>121</sup> Teitelbaum, *supra* note 107, at 178–79.

<sup>122</sup> *Id.*; see also United Nations Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3 (establishing cross-national human rights protections for the well-being of children).

<sup>123</sup> See, e.g., *Jeremy H. by Hunter v. Mount Leb. Sch. Dist.*, 95 F.3d 272, 278 (3d Cir. 1996) (finding that IDEA sets forth a positive right to a “free appropriate public education”); *White v. Rochford*, 592 F.2d 381 (7th Cir. 1979) (police officers violated due process when, after arresting the guardian of three young children, they abandoned the children on a busy stretch of highway at night); *American Civil Liberties Union of Fla., Inc. v. Miami-Dade Cnty. Sch. Bd.*, 439 F. Supp. 2d 1242 (S.D. Fla. 2006) (granting plaintiff’s motion for injunction to prevent the censoring of books on Cuba, finding a positive right for students to receive books and information), *rev’d* 557 F.3d 1177 (11th Cir. 2009).

<sup>124</sup> See Teitelbaum, *supra* note 107, at 178 (suggesting that children’s rights assume parental obligations).



### 3. *Statutory Rights*

Statutory rule making is another domain in which children's interests, privileges, and "rights" are articulated and ensconced within the law. At the federal and state levels, children's rights discourse expands beyond general welfare norms and criminal law protections, granting minors the legal "right" to participate in certain activities, including those that are inherently dangerous, and those that expose adolescents and others to serious risk. In an attempt to properly calibrate minors' capacity in association with the statutory right, legislatures set age limits: twenty-one years for purchasing alcohol; eighteen years for voting or purchasing of tobacco; sixteen years for seeking employment (with exceptions), marriage, or eligibility for the death penalty; and fourteen to sixteen years for obtaining a permit to drive, or accessing reproductive care and certain mental health services without parental consent.<sup>125</sup>

But juvenile statutory rights are not absolute, nor do they function without restrictions by age (to access the right) or parental supervision (to delegate the right).<sup>126</sup> The provision of statutory rights remains predicated on some level of parental or paternalistic oversight. In most instances, parental oversight is not simply expected, but required. Thus, while it could be argued that statutory rights reflect legislatures' recognition of the developing capacities of young people, that reasoning fails to capture important nuances. Legislatures engage in a measure of balancing, using parental oversight, supervision, and support as tipping points in the filtering of rights to minors.<sup>127</sup> In delegating statutory rights, legislatures have done nothing less than preserve and perhaps promote parental veto power. As Teitelbaum notes, "all seventeen-year-olds are not treated equally."<sup>128</sup> Nor are all seventeen-year-olds of equal maturity, experience, and cognitive ability, and that is often why children are treated differently or afforded privileges unequally, even within families, because of demonstrable maturity, capacity, and ability to accept responsibility. As Teitelbaum summarizes:

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<sup>125</sup> *Id.* at 180–81.

<sup>126</sup> Compare COLO. REV. STAT. ANN. § 13-22-101(1)(d) (West 2005) ("[E]very person, otherwise competent, shall be deemed to be of full age at the age of eighteen years or older for the following specific purposes: . . . To make decisions in regard to his own body and the body of his issue . . . to the full extent allowed to any other adult person.") with COLO. REV. STAT. ANN. § 13-22-102 (West 2005) (granting physicians the right to treat minors for "addiction to or use of drugs" without parental consent). Without scientific data and social reports to inform us about the cognitive and social capacities of children, it is possible to overestimate the maturity of children to perform certain tasks without unnecessarily increasing risks to others. On the other hand, it could be that kids are better positioned to handle certain tasks more efficiently and effectively at an earlier age.

<sup>127</sup> Teitelbaum, *supra* note 107, at 182.

<sup>128</sup> *Id.*

Some seventeen-year-olds who wish to marry will be allowed to do so by their parents, others will not. Whether they will be allowed to do so depends entirely on the private views of their parents rather than any public judgment about capacity. There is, moreover, no assurance that parents will act in a consistent fashion regarding that decision or that they will employ any consistent criterion in making that decision. Most particularly, there is no requirement that parental judgments be made solely on the basis of assessments of the child's relative maturity.<sup>129</sup>

To better understand the unequal grant of statutory rights to children, including the potential for inconsistent application, consider that some parents will grant permission for "rights" to be accessed and exercised (such as driving a car, marriage before the age of majority, or working) and others will not. Some rights may filter through the socio-economic status of the child: poverty may render meaningless a "right to drive" if a family cannot afford the luxury of owning an automobile. Or, a "right" to work may be crucial to parents hoping to spread the costs associated with raising children, buying groceries, or paying rent. Metaphorically, statutory rights are railroad tracks without the trains, or doors without locks; unlocking the door aids our perception that a door will open. But, in reality, simply unlocking a door does not guarantee that it will open or that other mechanisms will not block its opening. Full, meaningful access to and participation in the rights are contingent on interaction and association with others; in these examples, parents are the gatekeepers. And as parents' views differ on issues ranging from curfew to premarital sex, from underage drinking to even computer access, assumptions that children have qualitatively equal access to statutory rights is inaccurate.

#### 4. *Minor Consent Statutes and Informed Consent*

Consent statutes mark a fourth domain in which the interests of minors have expanded. These laws relate to children's authority (granted by state-enacted legislation) to consent to medical treatments. Lost from that debate are definitional matters, which we will clear up before proceeding. Minor consent statutes are predicated on the assumption that adolescents possess the capacity to make informed choices about their health care,<sup>130</sup> and therefore have not only the capability, but also the capacity, to provide medical professionals with an *informed* consent.

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<sup>129</sup> *Id.* at 182–83.

<sup>130</sup> See Tara L. Kuther, *Medical Decision-Making and Minors: Issues of Consent and Assent*, 38 *ADOLESCENCE* 343, 344 (2003) [hereinafter Kuther, *Medical Decision-Making and Minors*] ("Informed consent only can be given by those with *legal entitlement and decisional capacity*, otherwise a parent or guardian must provide permission.") (emphasis added).

Our working definition of “informed consent” for this project is borrowed from Thomas Grisso and Linda Vierling. Grisso and Vierling distinguish the right to know about a medical treatment or participate in that treatment from the right of contract or veto power.<sup>131</sup> Informed consent necessitates that an individual give authorization “knowingly, intelligently, and voluntarily.”<sup>132</sup> According to the authors, “*knowing* can be defined operationally as the match between the information given to [a person] and [that person’s] own paraphrase of [the information].”<sup>133</sup> Intelligence, on the other hand, “focuses upon the competence of the [individual] to arrive at the consent decision rationally, not on others’ opinions concerning the advisability of the patient’s decision itself.”<sup>134</sup> Here, the reference is to an individual’s cognitive ability in assimilation, processing, and application of information toward a decision about treatment or care.<sup>135</sup> Grisso and Vierling offer a worthy list of considerations relevant to minors’ capacity to give informed consent:

[O]ne’s attention to the task, ability to delay response in the process of reflecting on the issues, ability to think in a sufficiently differentiated manner (cognitive complexity) to weigh more than one treatment alternative and set of risks simultaneously, ability to abstract or hypothesize as yet nonexistent risks and alternatives, and ability to employ inductive and deductive forms of reasoning.<sup>136</sup>

Informed consent serves as the basis for all medical decision-making, but it is often in contention. For example, some scholars debate whether there can ever be full, informed consent, as risks to medical treatments can never be fully known.<sup>137</sup> We do not take up that question, but rest our definition of informed consent on Grisso and Vierling’s conceptualization as we turn to the matter of minor consent statutes.

Minor consent statutes vary by state, but generally grant legal authority to minors to participate in medical decision-making through the informed consent process.<sup>138</sup> Minor consent statutes authorize minors to consent to

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<sup>131</sup> Thomas Grisso & Linda Vierling, *Minors’ Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 414 (1978).

<sup>132</sup> *Id.* at 415.

<sup>133</sup> *Id.* at 416.

<sup>134</sup> *Id.* at 418.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> See, e.g., William A. Silverman, *The Myth of Informed Consent: In Daily Practice and in Clinical Trials*, 15 J. MED. ETHICS 6 (1989) (pointing out flaws and absence of full information in informed consent processes).

<sup>138</sup> See, e.g., CAL. FAM. CODE § 6925(a) (West 2004) (“A minor may consent to medical care related to the prevention or treatment of pregnancy,” subject to parental consent to obtain an abortion or be sterilized); 57 Op. Cal. Att’y. Gen. 28 (1974) (concluding a minor may obtain an abortion, under statute, “without parental consent as long as the minor has sufficient maturity to give an informed consent”).

medical treatments, and generally fall within two categories. The first type is prophylactic, granting minors—based on status—near absolute authority to consent to a broad range of medical treatments.<sup>139</sup> By example, in California, “minors authorized to give legal consent to medical treatments” under these statutes include:

- a) Married (or divorced) minors (Family Code §§ 7002 and 7050 (e)(1));
- b) Minors on active duty with the U.S. Armed Forces (Family Code §§ 7002 and 7050 (e)(1));
- c) Minors emancipated by a court order (Family Code § 7120); and
- d) Self-sufficient minors (minors fifteen years or older living away from home and managing their own financial affairs (Family Code § 6922)).<sup>140</sup>

Notwithstanding this broad, encompassing rule and the appearance of an absolute right, California law grants physicians authority, “with or without the consent of [a] ‘self-sufficient’ minor,” to “advise the minor’s parent or guardian of the treatment given or needed” if the physician has reason to know the whereabouts of the minor’s parent or guardian.<sup>141</sup> Other states engage similar protocols or constraints.<sup>142</sup> This raises a number of important questions, including whether the scope of a right is diminished by disclosure to a parent or guardian of the use of the right, and whether the ability to meaningfully engage in a right might be compromised by intimate disclosure. Are minors as likely to access the medical treatments enunciated within the scope of medical consent laws if disclosure to parents is likely or certain to occur? How should minors’ privacy interests be balanced against a parental notification regime? What are the values preserved and the risks presented when minors’ medical consent also includes the assent or acknowledgement of parents? The emotional and psychological dilemmas inherent in such scenarios further underscore the need for a sustained review and dialogue about these matters.

The second, and perhaps better known, type of minor consent laws authorizes specific health care decision-making. Expressly, minor consent legislation may grant minors the authority to consent to select narrow medical

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<sup>139</sup> Under this type of consent regime, minors are granted full authority to consent to medical treatments with the exception of those treatments that are highly invasive or pose irreversible risks. See *Minor Consent to Treatment*, CALIFORNIA MEDICAL ASSOCIATION FOUNDATION, [http://www.thecmafoundation.org/projects/HPV/ProviderResources\\_Minor.aspx](http://www.thecmafoundation.org/projects/HPV/ProviderResources_Minor.aspx) (last visited Feb. 26, 2011).

<sup>140</sup> *Id.*

<sup>141</sup> *Id.* The California Medical Association warns, however, that “a physician should be cautious in contact[ing] the minor’s parent or guardian, since disclosure of a minor’s medical information may constitute an unlawful invasion of the minor’s right of privacy.” *Id.*

<sup>142</sup> See, e.g., KAN. STAT. ANN. § 38-123 (West 2007) (“The consent of a parent or guardian of an unmarried pregnant minor shall not be necessary in order to authorize hospital, medical and surgical care related to her pregnancy, where *no parent or guardian is available.*”) (emphasis added).

treatments involving pregnancy, contraception, abortion, contagious diseases, and sexually transmitted diseases.<sup>143</sup> Despite the narrowed authority to consent defined by this category, it attracts the most significant scrutiny, criticism, and controversy. Unlike the broader health care consent statutes like the one in place in California, which give the appearance that minors are the final arbiters of their health, these rules vest minors with full and often exclusive discretion in charting their medical decision-making.<sup>144</sup> In fact, in 1997, the California Supreme Court rejected parental disclosure in cases of abortion, opining that minors' right to privacy, guaranteed by the state constitution, was at stake.<sup>145</sup> California voters, in semblance of agreement with the court, have "rejected two (2) subsequent state propositions that would have required parental notification related to abortion."<sup>146</sup>

Significant difference of opinion remains as to whether either of these types of minor consent statutes explicitly grants rights to children. For example, Michelle Oberman argues that legislators are balancing interests when they enact medical consent statutes.<sup>147</sup> According to Oberman:

Minor treatment statutes reflect public consensus that ensuring minors' access to the given treatment outweighs parental interests in controlling the care a child receives. The focus of such exceptions rests not on an assessment of maturity, but on a calculus that grants minors autonomy only when the treatment is relatively low risk, and when denying access may cause the minor (or the public at large) to suffer permanent harm.<sup>148</sup>

As we interpret Oberman's arguments, they are not about the explicit content of minor consent statutes, which facially express intent to grant minors the ability to respond to important, sensitive medical demands. We do not take up that debate here, although as noted earlier, the quality of a right or unfettered access to a right may be burdened or diminished by intimate public disclosure.<sup>149</sup>

An important factor to consider, and the point that we argue deserves further unpacking and scrutiny, concerns a scholarly failure to acknowledge that competing social interests, and not exclusively minors' interests, may drive the creation of minor consent statutes. The point is a subtle but impor-

<sup>143</sup> See, e.g., *supra* notes 12–13.

<sup>144</sup> Minors would only need to be capable of giving informed consent. See, e.g., *supra* notes 11–13

<sup>145</sup> *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 800 (Cal. 1997).

<sup>146</sup> CALIFORNIA MEDICAL ASSOCIATION FOUNDATION, *supra* note 139.

<sup>147</sup> Michelle Oberman, *Minor Rights and Wrongs*, 24 J.L. MED. & ETHICS 127 (1996).

<sup>148</sup> *Id.* at 131.

<sup>149</sup> The case we build here is not to suggest that some medical disclosures are not in society's interest in some circumstances. Tracking incest or sexual violence against girls may shift the balance between respect for a minor's privacy and the paternalistic, societal goal of eliminating or combating pedophilia, incest, rape, and sexual abuse.

tant one to make. That is to say, legislators respond to the demands of their voting constituents, lobbyists, and sophisticated interest groups that can afford to establish a strong presence near their legislative offices and convey special interests through mechanisms to which even the lay public do not have access. Minors are at times the beneficiaries of broader health, financial, legal, and political interests.

Thus, granting rights to minors might be less about children's interests than about a societal interest in reducing the spread of communicable diseases. In the case of pregnancy and reproductive health care matters, the societal interest might be fidelity to the Constitution and the preservation of its capacity to address *situations* and *status* rather than the individual. In other words, when the California Supreme Court in *American Academy of Pediatrics v. Lungren* refused to establish a parental consent threshold for minors' access to an abortion, its decision was as much about redressing social externalities as it was about protecting minors' intimate interests.<sup>150</sup>

### C. *Whose Right?*

If we look closely, it appears that judicial and legislative efforts to extend the rights or interests of children are not about protecting the rights of children as individuals, but rather are guided by some other set of interests. So what can we glean and learn from judicial and legislative actions to expand the legal interests of minors? First, preserving and promoting family relationships matter to both courts and legislatures. Neither judges nor legislators have an interest in promoting the rights of children above those of their parents, nor placing the interests of children and parents in competition or contention. Second, in matters of criminal law, that which might be confused as a vigorous defense of children's rights could be explained by courts' interest in and fidelity to preserving the integrity of the Constitution. That is, when courts appear to actively advance the rights of minors, including expanding the rights to representation, jury trials, and the like, child advocacy may not be their objective or principal focus. Rather, the courts' primary consideration might be the integrity of the law. Third, statutory privileges granted to children cannot be viewed as "full spectrum" rights as they are often predicated on the consent of parents. As such, informed consent of children may be its own fiction, with consent actually serving the purpose of assent. Fourth, and most ironically, neither courts nor legislatures have seriously taken up measuring capacity as a means to evaluate granting rights and privileges. Finally, glaringly missing from the language and discourse of children's rights, statutory rights appendices, and judicial opinions, is a sustained, thoughtful analysis about capacity and how to mea-

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<sup>150</sup> *Lungren*, 940 P.2d at 832 (Kennard, J., concurring) ("[T]he benevolent appearance of parental involvement laws is deceiving; the laws have serious adverse effects and yield few benefits for children or society.").

sure when children have the maturity to “handle” or assume the risks and duties of rights.

### III. ADOLESCENCE, SEPARATE FROM CHILDHOOD

Symbolic or key socialization characteristics capture the American cultural conception of what it means to be an adolescent: responsiveness to peer attitudes, moodiness, irritability, self-doubt, and perceptions of invincibility.<sup>151</sup> Those sensitive to the needs and demands of youth could dismiss these social observations and attitudes about adolescents as stereotypes and folklore, stressing that they fail to capture the full spectrum of adolescents. Such critiques would be correct. Interestingly however, social and medical descriptions of adolescence map closely with stereotypes about youth; the difference is that scientific literature explains them. This Section briefly explicates the medical contours of adolescence, advancing a key objective in this project, which is to better integrate medicine and law to understand adolescents as a population and to achieve healthier outcomes for youths.

In a collection of writings on adolescence, Jean Piaget identifies four separate and increasingly advanced stages of mental awareness and psychological understanding that youth traverse on their way to heightened insight and judgment.<sup>152</sup> Piaget points out that the period of adolescence includes formal stages of cognitive development. The scale of development begins in early life, and adolescence is marked by the third and fourth stages of cognitive development.<sup>153</sup> The scale of adolescent development is chronicled by years: concrete operational development (seven to eleven years old) and formal, operational development (beginning at age eleven to fifteen years, and continuing into adulthood).<sup>154</sup>

According to Piaget, the progression from concrete operational development to formal operational thought is signaled by an adolescent transition from an inability to solve problems using abstract concepts and a lack of understanding of hypothetical risk, to an ability to process information through a framework of future orientation.<sup>155</sup> The scope of adolescent devel-

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<sup>151</sup> See Linda Patia Spear, *Brain Development and Adolescent Behavior*, in HUMAN BEHAVIOR, LEARNING, AND THE DEVELOPING BRAIN: TYPICAL DEVELOPMENT 362, 362–72 (Donna Coch et al. eds., 2007).

<sup>152</sup> See JEAN PIAGET, *THE MORAL JUDGMENT OF THE CHILD* 16 (Marjorie Gabain trans. 1932) (“From the point of view of the practice or application of rules four successive stages can be distinguished.”).

<sup>153</sup> See *id.* at 32–41.

<sup>154</sup> See JEAN PIAGET & BÄRBEL INHELDER, *THE PSYCHOLOGY OF THE CHILD* 92–151 (Helen Weaver trans., 1972).

<sup>155</sup> See *id.* at 130–51.

opments during this age period also includes recognition of the theoretical and potential impact of behavioral tasks and threats.<sup>156</sup>

The drive to medically understand youth development predates contemporary scholarship. With the publication of *Adolescence: Its Psychology and Its Relation to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education* in 1904,<sup>157</sup> G. Stanley Hall “introduced Americans to the idea that adolescence should be considered a distinct developmental category,” separate from childhood.<sup>158</sup> With this, the twentieth century concept of adolescence was established. To be clear, adolescence was not conceived of as a “vaguely defined time of gradual change.”<sup>159</sup> Rather, it captured a period of dynamic change in a youth’s biological and emotional processes.<sup>160</sup> Major developmental tasks are identified within the period of adolescence, including “achieving independence” from P&Gs, “adopting peer codes and lifestyles, assigning increased importance to body image and acceptance of one’s body,” and “establishing sexual, ego, vocational, and moral identities.”<sup>161</sup>

According to decades of medical studies, the rebellious posture often used to describe adolescence represents a normal sign of adaptive or adapting maturity within the individual, a way of enabling a young person to meet future demands and social challenges.<sup>162</sup> Researchers contend that common threads binding adolescents together also facilitate their description as a separate group, deserving unique appraisal and treatment in both social and legal contexts.<sup>163</sup> This point is particularly salient as it provides added justification for the law’s treatment of youth in special private and public law contexts. The point we make here is that law should be driven by more than a hunch, and when available, medical science should guide legal scholars, legislators, and judges in their understanding of this cohort which may illuminate important values, such as giving greater sufficiency and weight to their decision-making or assessments. Turning to science—and deservedly

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<sup>156</sup> See DON H. HOCKENBURY & SANDRA E. HOCKENBURY, *PSYCHOLOGY* 394 (4th ed. 2006) (“[T]he young person becomes capable of applying logical thinking to hypothetical situations . . .”).

<sup>157</sup> G. STANLEY HALL, *ADOLESCENCE: ITS PSYCHOLOGY AND ITS RELATIONS TO PHYSIOLOGY, ANTHROPOLOGY, SOCIOLOGY, SEX, CRIME, RELIGION AND EDUCATION* 90 (1904).

<sup>158</sup> Adriana Schmidt, *The History of Adolescent Medicine: Three Periods of Awareness and Development During the Twentieth Century*, 82 *MED. & HEALTH, R.I.* 386, 386 (1999).

<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

<sup>161</sup> Mari Radzik et al., *Psychosocial Development in Normal Adolescents*, in *ADOLESCENT HEALTH CARE* 52, 53 (Lawrence Neinstein ed., 4th ed. 2002).

<sup>162</sup> See BENJAMIN B. WOLMAN, *ADOLESCENCE: BIOLOGICAL AND PSYCHOSOCIAL PERSPECTIVES* 49–53, 56–58 (1998) (discussing the meaning behind teenage rebellion).

<sup>163</sup> *Cf. Roper v. Simmons*, 543 U.S. 551, 572–73 (2005) (holding that the Constitution forbids the death penalty for offenders under the age of eighteen: “The differences between juvenile and adult offenders are too marked and well understood to risk allowing a youthful person to receive the death penalty despite insufficient culpability”).



with a keen eye<sup>164</sup>—might also inform us about when judges make poor or less informed decisions.<sup>165</sup>

Researchers illumine several important common experiential values threading the biological and psychological experiences of youths together. These common, generalizable experiences relate to several principal medical concepts.<sup>166</sup> First, adolescence marks a time in which links with traditions are severed, and discontinuity with other generations (older and younger) manifests.<sup>167</sup> Second, during adolescence, peer group relationships assume greater relevance and value; they are prized over all other associations.<sup>168</sup> Third, symbols or hallmarks of the group gain universal acceptance, readily apparent in the language, dress, music, and visual art forms.<sup>169</sup> Fourth, researchers observe a prevalence of attitudes that stress an antipathy between self and adults.<sup>170</sup> Fifth, adolescents develop a critical and questioning posture toward the established social system, including their parents.<sup>171</sup> Mindful of overgeneralizations and the pitfalls of conflation, our intention is not to

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<sup>164</sup> We also acknowledge the ways in which judges and legislators selectively adopt medical science to promote negative social platforms and agendas, such as eugenics, to perpetuate stereotypic and medically unfounded assertions about the intellectual deficiencies of some racial minorities, or grant the unjustified elevation of other racial groups as intellectually and morally superior formal legal weight. It was thought crime could be cured through science: sterilization, lobotomy, or trephined. *See, e.g.*, *Buck v. Bell*, 274 U.S. 200, 207–08 (1926) (holding that state-imposed sterilization of the mentally ill was not unconstitutional); *see also* MARTIN S. PERNICK, *THE BLACK STORK: EUGENICS AND THE DEATH OF “DEFECTIVE” BABIES IN AMERICAN MEDICINE AND MOTION PICTURES SINCE 1915*, 83 (1996) (“In 1908 a Dr. Cronin reportedly cured delinquent New York public school students by removing their adenoids. In 1914 a Philadelphia court ordered a juvenile offender to be trephined to cure his criminal behavior. The following year, a Brooklyn judge, overriding parental opposition, ordered a nine-year-old’s tonsils removed as a cure for truancy.”); HARRIET A. WASHINGTON, *MEDICAL APARTHEID* (2006) (documenting in urgent detail the manner in which scientists, doctors, and government officials have historically colluded in exploiting African Americans as research subjects). Important historical landmines as described above deserve continued attention from scholars, and are addressed in the author’s prior literature. The point to be emphasized here is that medical science can be a useful tool to help us understand youth development, but we encourage mindful, vigorous interrogation of science as should be expected in all intellectual discourses.

<sup>165</sup> *See Skinner v. Oklahoma*, 316 U.S. 535, 545 (1941) (Stone, J., concurring) (“Science has found and the law has recognized that there are certain types of mental deficiency associated with delinquency which are inheritable. But the State does not contend—nor can there be any pretense—that either common knowledge or experience, or scientific investigation, has given assurance that the criminal tendencies of any class of habitual offenders are universally or even generally inheritable.”); Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 *STAN. L. REV.* 773, 773–74 (1988) (concluding that institutionalization has become a more prevalent treatment for vulnerable youths).

<sup>166</sup> *See, e.g.*, Hillary E. Millar, *New Approaches to the Delivery of Health Care to Adolescents*, 256 *SUPPL. ACTA PAEDIATR. SCAND.* 39 (1975).

<sup>167</sup> *Id.* at 40.

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

overstate youth development. Rather, from this starting point, we can advance the central debates in this Article and come to a more informed understanding about youth development and important capacities: moral, social, and intellectual.

To explicate, in the 1950s, J. Roswell Gallagher became the first physician to argue that adolescents have health care needs separate from both adults and children.<sup>172</sup> Gallagher is most noted as the “father” of the patient-physician relationship. He is also known as the key figure in advancing a different conception of youths, one in which adolescents were seen separately from their P&Gs and were considered capable of responding to their individual health care needs.<sup>173</sup> Treating the adolescent patient as an independent decision-maker, however, redefined the relationship between parents, children, and physicians, and promoted what is now standard: evaluating the best interest of the patient.<sup>174</sup> This medical movement was not in isolation, however, as the legal interests of children were evolving within the context of the law.<sup>175</sup>

#### IV. CAPACITY, ACCESS, AND HEALTH CARE DECISION-MAKING

In the first half of this Article, we made the case that in the context of adolescent decision-making, the consideration of their rights deserves a more nuanced treatment in legal scholarship than it enjoys today. Rights in the abstract or rights that are conditioned on others’ assent may undermine the legitimacy and access to those rights legislatively enacted or judicially granted. We noted several distinct categories of “youth rights,” and expressed doubt that what appears to be a right actually functions as a right in many instances involving youth. Equally, the exceptions may not be in explicit service to youths. The driving force behind such rulemaking, we argue, may be steered by two factors: a fidelity to law (i.e. Constitutional guarantees, particularly in the criminal law domain, cannot become hostage to or diluted by racial animus, age discrimination, or other biases that prevent the full power of the law to be realized) and a concern for public health and safety.

We take up the latter of these issues in the second half of this Article to evaluate whether granting minors, in limited access, the “right” to utilize assisted reproductive technologies will cause negative externalities, which should be avoided. Part IV (A) examines minor consent statutes and (B) specifically considers rethinking minors’ capacities.

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<sup>172</sup> HEATHER PRESCOTT, A DOCTOR OF THEIR OWN: THE HISTORY OF ADOLESCENT MEDICINE 73 (1998).

<sup>173</sup> *Id.* at 100.

<sup>174</sup> *Id.*

<sup>175</sup> *Id.* at 156.

*A. Minor Consent Statutes*

The most politically charged health service delivered to adolescents is reproductive health care. Reproductive health care debates often pit private interests against broader social goals in what could be described as misaligned contestation. These issues become heightened in political milieus where politics on abortion become a litmus test for fidelity to political parties in electoral campaigns, a sign of progressive politics or archaic views, and a source of inflamed sensitivity within the broader society. Of course, these associations with abortion are reductive, and yet these are the cultural landmines that guard the gates of a more informed contemporary discourse on the reproductive health of women and adolescents.

In popular culture, political ideology on abortion supposedly tells us something critically important, something more than one's view on an incredibly sensitive, personal topic; instead in our cultural politics it serves as a crystal ball or window to the soul that illuminates moral values about the worthiness of a person.<sup>176</sup> But reproductive health care access and its menu of options are far more complicated and nuanced than that, and issues they raise deserve proper scrutiny untethered from the contentious debates on abortion politics.

The abortion debates are, however, given some discussion here to acknowledge the rocky landscape where reproductive health care is planted, and to further contextualize the milieu in which reproductive health care debates take place. For example, as we put forth this thought experiment about minors' access to ART, it should be acknowledged that some lawmakers fear that increasing access to services as innocuous as reproductive counseling will translate into an increase in sexual activity.<sup>177</sup> Despite such fears, the use of health clinics by adolescents seeking accurate information about pregnancy, contraception, and infection prevention has not been associated with a trend to earlier or increased sexual activity.<sup>178</sup> Nevertheless, from their inception, teen-friendly health clinics attracted strident criticism primarily on the grounds that reproductive health care for minors

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<sup>176</sup> See Elizabeth Reilly, *The "Jurisprudence of Doubt": How the Premises of the Supreme Court's Abortion Jurisprudence Undermine Procreative Liberty*, 14 J.L. & POL. 757, 758–59 (1998) ("The political process cannot provide for constructive confrontation of the issues of procreation and abortion. The failure of politics and public discourse is due in part to unstated negative assumptions about the moral, social and political value of procreative liberty [and] about women and their moral capacity to make decisions . . .").

<sup>177</sup> See CHARLES ZASTROW & KAREN K. KIRST-ASHMAN, *UNDERSTANDING HUMAN BEHAVIOR AND THE SOCIAL ENVIRONMENT* 270–71 (8th ed. 2010) (describing common controversies related to informing adolescents about sex).

<sup>178</sup> See Robert W. Blum & Peggy M. Rinehart, *Reducing the Risk: Connections That Make a Difference in the Lives of Youth*, DIVISION OF GENERAL PEDIATRICS AND ADOLESCENT HEALTH, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF MINNESOTA, 31–34 (1998), [http://www.med.umn.edu/peds/ahm/prod/groups/med/@pub/@med/documents/asset/med\\_21816.pdf](http://www.med.umn.edu/peds/ahm/prod/groups/med/@pub/@med/documents/asset/med_21816.pdf).

interferes with parents' rights.<sup>179</sup> These matters are further complicated by statutory requirements that mandate parental notification from medical providers when teens seek certain types of reproductive health care or counseling.<sup>180</sup>

Currently, minor consent statutes operating in all fifty states grant adolescents the ability to consent to certain medical treatments.<sup>181</sup> Such statutes permit minors<sup>182</sup> to access select health services independent of a parent's consent or knowledge.<sup>183</sup> In addition to medical consent statutes, a few states have passed "mature minor" statutes that allow an unaccompanied adolescent who resides at home to consent to and receive health services upon a medical provider's assessment that the young person demonstrates the appropriate level of emotional and cognitive development to contemplate the risks and benefits of the medical procedure.<sup>184</sup> Services included under the umbrella of minor statutes are not uniform throughout all states, but most cover care for contraception, pregnancy, sexually transmitted infection, sexual assault, chemical dependency, mental health counseling, and medical emergencies.<sup>185</sup> In addition, federal legislation requires that all states providing family planning services via Title X of the Public Health Services Act ensure that reproductive health-related care is available to adolescents on a confidential basis.<sup>186</sup>

As stated earlier, minor consent statutes differ by state and also by scope. In narrow circumstances, for teens of a particular status, rights under the statutes might be expanded. For example, special designation may afford minors the ability to consent to an expanded level of health care. These include emancipated minors, particularly those adolescents serving in the armed forces, minors living away from home and responsibly managing their own finances, and in some states, teens who are married, pregnant, or

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<sup>179</sup> See PRESCOTT, *supra* note 172, at 100.

<sup>180</sup> *E.g.*, MD. CODE ANN., HEALTH-GEN. § 20-103 (LexisNexis 2009) (requiring a physician to notify minor's parent before performing an abortion); *see also* 750 ILL. COMP. STAT. ANN. 70/5 (West 2010) ("Parental consultation is usually in the best interest of the minor and is desirable since the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related."). *See generally* James A. Morone et al., *Back to School: A Health Care Strategy for Youth*, 20 HEALTH AFFAIRS 122 (2001) (outlining debate regarding minors' access to care in the school setting).

<sup>181</sup> Christopher E. Kraus & Joseph L. Rauh, *Consent, Confidentiality, and Privacy in ADOLESCENT MEDICINE* 44, 45 (Gail B. Slap ed., 2008) (highlighting that all fifty states allow persons under eighteen to give informed consent for certain medical decisions); Sarah J. Lerand, *Teach the Teacher: Adolescent Confidentiality and Minor's Consent*, 20 J. PEDIATRICS & ADOLESCENCE GYNECOLOGY 377, 377 (2007).

<sup>182</sup> The definition of minor located in state consent statutes varies from twelve to fourteen years and above. *See, e.g.*, ALA. CODE § 22-11A-19 (2006) (twelve or older); CAL. FAM. CODE § 6922(a)(1) (West 2004) (fifteen or older).

<sup>183</sup> *E.g.*, *supra* notes 12-13; Morone, *supra* note 180.

<sup>184</sup> Lerand, *supra* note 181, at 377.

<sup>185</sup> *Id.*

<sup>186</sup> *Id.*

parents.<sup>187</sup> Across these spectra, in some states, teens are treated as having reached the age of majority (eighteen years) and are therefore granted the authority to consent to all health care services.<sup>188</sup>

### B. Rethinking Minors' Capacity

Statutory regimes provide an important legal framework for understanding the contours of minors' health care rights. How rights become deployed and actualized in society is altogether a different matter. In her treatment of child-capacity norms, Tara Kuther advances an important finding: although the research is rare, empirical evidence indicates that the decision-making capacity of adolescents in certain instances may be similar to that of adults.<sup>189</sup> Indeed, some case law represents the judiciary's push in the same direction when confronted by the tough medical choices that some children must make.

In *Younts v. St. Francis Hospital and School of Nursing*, the Supreme Court of Kansas held that a minor could consent to surgical care for the injuries sustained during a visit with her mother at the hospital.<sup>190</sup> In that case, the court denied the girl and her mother's tort claim against the hospital and found that the plaintiff, who was seventeen years old at the time of the accident, possessed sufficient capacity and maturity to understand the nature and consequences of the surgical procedures required to repair her finger.<sup>191</sup>

Similarly, the Illinois Supreme Court struck down a lower court ruling that required a young Jehovah's Witness to submit to a blood transfusion. In *In re E.G.*, the Illinois high court upheld a girl's refusal to submit to a physician-prescribed blood transfusion to treat acute nonlymphatic leukemia, on the grounds that a forced blood transfusion would violate her religious beliefs.<sup>192</sup> In reaching its holding, the Court acknowledged the State's interest in preserving life and its *parens patriae* authority to intervene in matters of public health and safety.<sup>193</sup> However, the Court affirmed that a mature minor could exercise a right to consent to or refuse care despite the state's interest in the sanctity of life, particularly where she grasped the consequences of accepting or rejecting treatment.<sup>194</sup>

<sup>187</sup> See, e.g., MD. CODE ANN., HEALTH-GEN. § 20-103 (LexisNexis 2019) (creating exception to parental notice requirement if unmarried minor does not live with a parent or guardian and reasonable effort was made to locate parent).

<sup>188</sup> Amer. Acad. of Pediatrics Comm. on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 316 (1995).

<sup>189</sup> Kuther, *Medical Decision-Making and Minors*, *supra* note 130, at 349–50 (citing studies comparing the decision-making competencies of adolescents and adults, specifically with respect to evaluation of risk and consequences).

<sup>190</sup> 469 P.2d 330, 338 (Kan. 1970).

<sup>191</sup> *Id.*

<sup>192</sup> 549 N.E.2d 322, 328 (Ill. 1989).

<sup>193</sup> *Id.* at 327.

<sup>194</sup> *Id.* at 328.

*In re Chad Eric Swan* involved a seventeen-year-old who suffered a head injury that caused him to exist in a persistent vegetative state.<sup>195</sup> The Supreme Court of Maine did not order the reinsertion of a feeding tube after evidence showed that Chad, prior to his injury, had verbally expressed to family and others that he would not want to be kept alive by artificial means.<sup>196</sup> This case, as well as the cases noted above, reflect the courts' efforts to consider the capacity of minors in difficult medical decision-making circumstances.

Despite these and other similar cases, state laws granting minors the authority to consent to medical treatments can best be described as a patchwork system, and courts are inclined to defer such matters to the legislature so long as important constitutional rights are not at stake.<sup>197</sup> Nor is guidance from premier national medical organizations clear on these matters.

The American Medical Association ("AMA") asserts that medical providers have an ethical duty to promote the autonomy of the minor patient. AMA guidance makes clear that, when a minor requests "contraceptive services, pregnancy-related care . . . or treatment for sexually transmitted disease, drug and alcohol abuse or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient."<sup>198</sup> And in instances where confidentiality is breached, AMA guidance provides that the reasons for the breach must be made known to the minor patient prior to outside disclosure.<sup>199</sup> As an organization, the AMA advocates for wider adoption and recognition of these approaches, also asserting a boldly affirmative stance on the importance of minors providing informed consent for medical, psychiatric, and surgical care.<sup>200</sup> In recognizing the importance of confidential care as requisite for improving the health of adolescents, the AMA works to guard against allowing parental consent or notification to become a barrier to the provision of health services.<sup>201</sup>

By contrast, the American Academy of Pediatrics ("AAP") takes a decidedly more conservative and formalist approach to adolescent decision-

<sup>195</sup> 569 A.2d 1202, 1203 (Me. 1990).

<sup>196</sup> *Id.* at 1205.

<sup>197</sup> *Cf.* Kuther, *Medical Decision-Making and Minors*, *supra* note 130, at 344–46 (revealing the complexity of informed consent in the context of pediatrics and suggesting that state legislation has become the primary vehicle for providing guidance in this area).

<sup>198</sup> AMERICAN MEDICAL ASSOCIATION, H-60.964 CONFIDENTIAL CARE FOR MINORS, [http://www.ama-assn.org/ama1/pub/upload/mm/388/alc\\_adolhealthcare.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/388/alc_adolhealthcare.pdf) (last visited Nov. 13, 2010) (providing guidelines for physicians in the confidential care of minors).

<sup>199</sup> *Id.* Breach of confidentiality is medically appropriate in cases in which abuse/neglect of a patient is discovered, or in cases in which the patient presents a danger to self or others (i.e., suicidal or homicidal threat); *cf.* Committee on Bioethics, *Informed Consent*, *supra* note 188, at 315.

<sup>200</sup> AMERICAN MEDICAL ASSOCIATION, H-60.965 CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS, [http://www.ama-assn.org/resources/doc/alcohol/alc\\_adolhealthcare.pdf](http://www.ama-assn.org/resources/doc/alcohol/alc_adolhealthcare.pdf) (last visited Nov. 13, 2010).

<sup>201</sup> AMERICAN MEDICAL ASSOCIATION, H-60.965 CONFIDENTIAL CARE FOR MINORS, [http://www.ama-assn.org/ama1/pub/upload/mm/388/alc\\_adolhealthcare.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/388/alc_adolhealthcare.pdf) (last visited Nov. 13, 2010).

making than the AMA.<sup>202</sup> The AAP supports strong parental involvement in adolescent health care decision-making. In its policy statement on informed consent, the AAP's Committee on Bioethics maintains that "[o]nly patients who have appropriate decisional capacity and legal empowerment can give their informed consent to medical care."<sup>203</sup> For all other patients, "parents or other surrogates provide informed permission for diagnosis and treatment of children with the assent of the child whenever appropriate."<sup>204</sup>

The AAP's approach is not surprising, particularly if parents, rather than their children, are understood to be the consumers of pediatric medical services, even where they are not the patients. Parents are long-term, loyal consumers of pediatric services, generally establishing relationships at the birth of their child(ren) and continuing the relationship through adolescence. Indeed, the AAP reinforces the importance of parental involvement and consent even in clinical examples where the Academy directs physicians to obtain informed consent from an adolescent patient and concedes there is no additional requirement to obtain parental permission.<sup>205</sup> Such cases include:

- (1) performance of a pelvic examination in a 16-year-old, (2) diagnostic evaluation of recurrent headache in an 18-year-old, (3) request for oral contraceptives for fertility control in a 17-year-old, (4) proposed long-term oral antibiotics administration for severe acne in a 15-year-old, and (5) surgical intervention for a bone tumor in a 19-year-old.<sup>206</sup>

The debate within the medical community regarding how best to interpret the law regarding a minor's capacity and ability to consent in medical cases is captured by the vastly different perspectives of the AMA and AAP on this point. However, the problem is cyclical; physicians rely on legal signals from courts and judges on these matters, and judges and legislators look to the medical profession for empirical guidance.<sup>207</sup> In neither of these realms are clear, consistent signals sent. Even if the law permits minors to access particular health care options without parental notification or consent, those options will appear more illusory than real if medical services legal rules are ignored or subordinate to medical custom. In cases where parents

<sup>202</sup> See Comm. on Bioethics, *Informed Consent*, *supra* note 188.

<sup>203</sup> *Id.* at 314.

<sup>204</sup> *Id.*

<sup>205</sup> *Id.* at 317 (encouraging doctors to obtain informed consent from adolescent patients who have "decision-making capacity and the legal authority" to make medical decisions and asserts no additional parental permission is required in those circumstances).

<sup>206</sup> *Id.*

<sup>207</sup> Compare *Roper v. Simmons*, 543 U.S. 551, 573–74 (2005) (relying on data from the American Psychiatric Association in discussion about whether a juvenile offender exhibits mere "transient immaturity" or "irreparable corruption") with Kuther, *Medical Decision-Making and Minors*, *supra* note 130, at 344–46 (suggesting that health care providers look to state legislatures for guidance regarding minors' capacity to give informed consent).

and children might conflict on the best course of treatment for the child, traditionally the weight of determination has been granted to a minor's parent or legal guardian.<sup>208</sup> Thus, despite the existence of statutory medical consent statutes in each state, and a smattering of cases that grant judicial weight and authority to minors' autonomous, health care decision-making, U.S. legal custom remains predicated on the assumption that minors lack the capacity to make autonomous decisions about medical treatment and intervention.<sup>209</sup> This is largely justified, according to some scholars, by judges' and legislators' fidelity to the best interest of the child standard.<sup>210</sup>

However, as Kuther argues, best interest standards are frequently vulnerable to subjective interpretations.<sup>211</sup> This may be especially true during the period of adolescence, where increasing self-interest and independence is common.<sup>212</sup> Further, as some scholars note, in the context of reproductive health care, strict adherence to an age of majority standard is arbitrary and problematic, precisely because it fails to take into account experience, maturity, and life circumstance.<sup>213</sup> Thus, locating a balance between parental autonomy, child capacity, and protecting the public health proves challenging in the context of providing health services and intervention.<sup>214</sup>

#### V. MINORS' ACCESS TO ART: A THOUGHT EXPERIMENT

Assisted reproductive technology is a multi-billion-dollar revenue generating industry.<sup>215</sup> The demands and conflicts in the field outpace the creation of laws to handle its thorniest aspects. Indeed, there is only one federal

<sup>208</sup> See, e.g., 750 ILL. COMP. STAT. ANN. 70/5 (West 2010) (asserting that parental consultation provides the wisdom that "immature minors often lack" when it comes to abortion).

<sup>209</sup> Sari Keanne Kives & Deborah Robertson, *Adolescent Consent in Reproductive and Sexual Health Decision-Making: Should There Be an Arbitrary Age of Consent or Should It Be Based on 'Evolving Capacities of the Child'?*, 21 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 47, 49–50 (2008). Resonant with this assumption is the premise that parents and guardians are "entitled to provide permission because they have legal responsibility and, in the absence of abuse or neglect, are [presumed] to act in the best interests of the child." Kuther, *Medical Decision-Making and Minors*, *supra* note 130, at 344.

<sup>210</sup> See, e.g., Mary Ann McCabe, *Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations*, 21 J. PEDIATRIC PSYCHOL. 505, 507 (1996) ("[W]hen children were given protection by the Constitution, parents still maintained a right for family autonomy. The prevailing spirit . . . is that parents are the most motivated and capable people to act in their children's best interests . . .").

<sup>211</sup> Tara L. Kuther, *Competency to Provide Informed Consent in Older Adulthood*, 20 GERONTOLOGY & GERIATRICS EDUC. 15, 18–19 (1999) (suggesting that those in the legal system may evaluate competence based on values instead of functional ability).

<sup>212</sup> Radzik, *supra* note 161, at 53.

<sup>213</sup> See Kives & Robertson, *supra* note 209, at 49.

<sup>214</sup> Kuther, *Medical Decision-Making and Minors*, *supra* note 130, at 353 (noting that physicians are given a tremendous amount of responsibility to determine whether a minor is capable of providing consent).

<sup>215</sup> Connie Cho, *Regulating Assisted Reproductive Technology*, 7 YALE J. MED. & L. 40, 41 (2010).



law, the Fertility Clinic Success Rate and Certification Act (“FCSCA”),<sup>216</sup> which governs this institution, and the FCSCA is most concerned with ART “success rates.”<sup>217</sup> Most of the current discussion surrounding the use of assisted reproductive technology references adult women who have delayed childbearing and are experiencing ovarian dysfunction due to the cumulative environmental exposure that comes with age.<sup>218</sup> However, the causes of infertility are multiple; some are endogenous and detected during adolescence, and some are a resulting side effect of life-saving treatment administered during adolescence.<sup>219</sup>

In Part V, we turn to teen reproduction. Subpart A briefly addresses foundational issues, including our shared views regarding the urgency of developing effective, efficient frameworks to address the pitfalls of teen pregnancy. Ironically, youth represent a category of biologically capable females least likely to require or seek assisted reproductive technologies; fertility declines as women age.<sup>220</sup> Teens and women in their early twenties represent the most fertile cohort of women.<sup>221</sup> However, those most inclined to utilize ART are professional, middle-class, middle-aged women.<sup>222</sup> Perhaps because of this visible demand cohort for ART services, the scholarly literature in this domain ignores why and if younger women may be drawn to the technology. Subpart B takes up that question.

#### A. *Traditional Teen Pregnancy*

Adolescent pregnancy and assisted reproduction represent two controversial and usually non-overlapping points of medical, legal, and social interest. Thus far, most academic medical literature addressing reproductive health care in the context of adolescence operates from a disease-prevention framework. In the U.S., much attention is given to reviewing age-appropri-

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<sup>216</sup> Fertility Clinic Success Rate and Certification Act of 1992, 42 U.S.C. §§ 263a-1–263a-7 (2006). Except the FCSCA, Congress has been virtually silent on assisted reproductive technology. Judith F. Daar, *Assisted Reproductive Technologies and the Pregnancy Process: Developing an Equality Model to Protect Reproductive Liberties*, 25 AM. J.L. MED. 455, 464 (1999) (“[T]he U.S. is a virtually regulatory-free environment when it comes to reproductive technologies . . .”).

<sup>217</sup> See, e.g., 42 U.S.C. § 263a-1 (2006).

<sup>218</sup> See generally Maurizio Macaluso et al., *A Public Health Focus on Infertility Prevention, Detection, and Management*, 93 FERTILITY & STERILITY 16.e1, 16.e2–16.e4 (2010) (discussing prevalence, causes, and treatments for infertility).

<sup>219</sup> See, e.g., Stacy Nicholson & Julianne Byrne, *Fertility and Pregnancy After Treatment for Cancer During Childhood or Adolescence*, 71 CANCER 3392, 3393 (1993) (noting decreased fertility rates for male survivors of adolescent cancer).

<sup>220</sup> See GERARD S. LETTERIE, *SURGERY, ASSISTED REPRODUCTIVE TECHNOLOGY AND INFERTILITY* 31–36 (2d ed. 2005).

<sup>221</sup> See *id.*

<sup>222</sup> Cf. Vaclav Inslar & Bruno Lunenfeld, *Efficient Classification of Infertility*, in *THE ART & SCIENCE OF ASSISTED REPRODUCTIVE TECHNIQUES (ART)* 15, 16 (Gautam N. Allahbadia & Rita Basuray Das eds., 2003) (noting the trend for women to delay pregnancy to pursue their careers and that the percentage of IVF patients over forty “increases constantly”).

ate, practical aspects of harm reduction for the prevention of pregnancy and transmission of sexually transmitted infections.<sup>223</sup> A review of the most recent statistics regarding adolescent reproductive health provides validation for this focus of concern.

Rates for unintended pregnancy, birth, sexually transmitted infection, and pregnancy termination for U.S. teens are higher than in any other western industrialized nation.<sup>224</sup> And, despite steady declines in U.S. teen pregnancy and birth rates over the last three decades, declines halted from 2005 to 2007 and small, unanticipated increases in the rates were noted.<sup>225</sup> These data reaffirm the political and social urgency to address teen pregnancy in the United States, particularly in light of unsettling empirical data on the quality of life for teen mothers and their children.

From a macro perspective, unintended adolescent pregnancy and childbearing results in substantial social and economic costs to society,<sup>226</sup> including: (1) more than 9 billion dollars annually in tax money devoted to health care and foster care for babies born to teen moms,<sup>227</sup> (2) increased incarceration and detainment of children of teen parents,<sup>228</sup> (3) lost tax income due to lower educational attainment of adolescent mothers,<sup>229</sup> (4) lost tax revenue due to greater likelihood of high school dropout for children born to teen moms,<sup>230</sup> (5) higher unemployment rates of children born to teen moms,<sup>231</sup> and (6) secondary effects stemming from repetition of a cycle of

<sup>223</sup> See, e.g., Salaam Semaan & Mary Leinhos, *The Ethics of Public Health Practice for the Prevention and Control of STDs*, in *BEHAVIORAL INTERVENTIONS FOR PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES* 517 (Sevgi O. Aral & John M. Douglas, eds., 2007) (discussing ethical concerns regarding STD prevention).

<sup>224</sup> H. HUNTER HANDSFIELD, *COLOR ATLAS & SYNOPSIS OF SEXUALLY TRANSMITTED DISEASES* 2 (2d ed. 2001); Susheela Singh & Jacqueline E. Darroch, *Adolescent Pregnancy And Childbearing: Levels And Trends In Developed Countries*, 32 *FAM. PLAN. PERSP.* 14, 20–22 (2000).

<sup>225</sup> GUTTMACHER INSTITUTE, *U.S. TEENAGE PREGNANCIES, BIRTHS AND ABORTIONS* 4 (2010), <http://www.guttmacher.org/pubs/USTPtrends.pdf>. More recently, teen pregnancy and birth rates appear to be trending downward again. In 2008, 435,000 live births occurred to mothers aged fifteen to nineteen, a rate of 41.5 per 1000 females in this age category. THE NATIONAL CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY, *FAST FACTS: TEEN CHILDBEARING IN THE UNITED STATES, FINAL 2008 BIRTH DATA* 2 (2010), [http://www.thenationalcampaign.org/resources/pdf/FastFacts\\_TeenChildbearing\\_Final2008BirthData.pdf](http://www.thenationalcampaign.org/resources/pdf/FastFacts_TeenChildbearing_Final2008BirthData.pdf).

<sup>226</sup> The measured impact of unplanned pregnancy and childbirth on teens and their offspring remains even when taking into account factors that predispose an adolescent to become pregnant, such as being raised in poverty, having parents with low educational attainment, growing up in a single-parent household, and having a poor connection to and performance in school. Singh & Darroch, *supra* note 224, at 22.

<sup>227</sup> Saul D. Hoffman, *By the Numbers: The Public Costs of Teen Childbearing*, THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY 2 (Oct. 2006), [http://www.thenationalcampaign.org/resources/pubs/BTN\\_Full.pdf](http://www.thenationalcampaign.org/resources/pubs/BTN_Full.pdf).

<sup>228</sup> *Id.* at 16.

<sup>229</sup> *Id.* at 3.

<sup>230</sup> SAUL D. HOFFMAN & REBECCA A. MAYNARD, *KIDS HAVING KIDS: ECONOMIC COSTS & SOCIAL CONSEQUENCES OF TEEN PREGNANCY* 328 (2008).

<sup>231</sup> *Id.* at 328–30.

teenage parenting.<sup>232</sup> These sobering statistics provide justification for a critical and sustained focus on teen pregnancy prevention, especially among U.S. adolescents.

*B. ART Use in the Adolescent Context: The Science of Reproduction*

This project puts forth a challenge tailored to adolescent rights, interests, and privileges. We asked whether adolescents enjoy “rights” in the same manner of adults, generally free from the burdens of third-party consent and absent public disclosures if they exercise their rights. These particular questions help to drill down beneath the generic language of rights to study the substance of a right or when rights possess real meaning. Our answers, revealed in earlier sections of the Article, suggest that the notion of children’s rights might be more illusory than real in most contexts and there are reasonable justifications for this. Reproduction, however, offers a unique lens through which to think about adolescent rights, particularly because of the context in which the point is studied. In instances where teens make reproductive health care decisions—even though there may be a societal interest in that teen being an informed, independent decision-maker—the authority to make those types of medical decisions is generally permissible.

Who benefits from, and who might be harmed, by adolescent access to ART? There are three relevant medical scenarios for which the right to consent might be evaluated and addressed herein: (1) adolescents suffering from cancer who will require surgery, chemotherapy, and/or radiation therapy, rendering them sterile during the process of treatment, or youth facing impending loss of fertility due to other medical conditions or illness; (2) adolescents as gamete donors for ailing relatives who wish to parent; and (3) minors living separately and financially solvent from P&Gs in a marriage relationship.

*1. Contextual Relevance for Minors’ Access: Threatened Sterility During Adolescence*

It is estimated that one in every 1,000 adults is a survivor of childhood cancer.<sup>233</sup> According to Lauren Neergaard, a health care reporter for the Associated Press, “about 10 percent of the 1.5 million people diagnosed with cancer [in 2010] were younger than 45, more than 15,000 of them under 20.”<sup>234</sup> While the harmful reproductive effects of toxic exposures from can-

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<sup>232</sup> *Id.* at 17.

<sup>233</sup> Jaime M. Knopman et al., *Surviving Childhood and Reproductive-Age Malignancy: Effects on Fertility and Future Parenthood*, 11 LANCET ONCOLOGY 490, 490 (2010).

<sup>234</sup> Luran Neergaard, *Doctors Aim To Save Fertility Of Kids With Cancer*, ASSOCIATED PRESS, Mar. 10, 2011, <http://www.live5news.com/story/14202412/doctors-aim-to-save-fertility-of-kids-with-cancer>.

cer treatments may be lower in younger children, overall, it is estimated that the probability of having a child after surviving cancer as a child, adolescent, or young adult is reduced by approximately one-half.<sup>235</sup> According to Dr. Teresa Woodruff of Northwestern University's Oncofertility Consortium, for girls the problem is compounded by "the prospect of menopause in their 20s or 30s."<sup>236</sup>

For some parents, saving their child's life through cancer treatments comes at a very difficult cost: their child's fertility. In an effort to spare their children from the high probability of infertility due to radiation exposure, a group of parents have enrolled their children and even babies in a research trial to store stem cells that for boys will, they hope, produce sperm. For girls, a similar experiment, banking ovarian tissues, might lead to future reproductive possibilities.<sup>237</sup>

Despite personal concerns about risk of cancer in offspring,<sup>238</sup> among cancer survivors, there is preference for opportunity for genetically linked procreation.<sup>239</sup> Not unsurprisingly, Dr. Kim Nagel and colleagues assert that "[a]n important quality of life issue among the increasing number of cancer survivors is the ability to one day have their own family."<sup>240</sup> In addition to cancer and cancer treatment, multiple other medical conditions during adolescence threaten fertility, including ovarian or testicular torsion in an adolescent with a solitary ovary or testis, and genetic conditions such as Turner's syndrome, resulting in impending premature ovarian failure in females.<sup>241</sup>

<sup>235</sup> Knopman et al., *supra* note 233, at 492–93. Because oocytes are arrested in a primordial stage and spermatogenesis is limited prior to puberty, sensitivity to toxic exposures—such as that of cancer chemotherapy and radiation—may be lessened in the pre-adolescent stage of development. *Id.* at 490–91.

<sup>236</sup> Neergaard, *supra* note 234.

<sup>237</sup> *Id.*

<sup>238</sup> Knopman et al., *supra* note 233, at 493–94. Among those experiencing remission or cure of their cancer, fertility preservation techniques and/or subsequent pregnancy resulting from ART has not been found to increase the risk of recurrent cancer, and, outside of heritable genetic syndromes, cancer in the resulting offspring. *Id.* at 494–95; *see also* Mary E. Fallat & John Hutter, *Preservation of Fertility in Pediatric and Adolescent Patients with Cancer*, 121 *PEDIATRICS* e1461, e1466 (2008) (finding no increased risk of recurrent malignancy in relationship to ART procedures for cancer survivors).

<sup>239</sup> *See* Leslie R. Schover et al., *Having Children After Cancer: A Pilot Survey of Survivors' Attitudes and Experiences*, 86 *CANCER* 697, 702 (1999) ("Despite concerns about health risks to offspring, few [cancer patients planning to have children] were ready to consider parenting a nonbiologic child as an alternative.").

<sup>240</sup> Kim Nagel et al., *Collaborative Multidisciplinary Approach to Fertility Issues Among Adolescent and Young Adult Cancer Patients*, 15 *INT'L J. NURSING. PRAC.* 311, 315 (2009). Perhaps reassuringly, for the emerging practice models addressing infertility treatment for minors, conversations centered on adolescent reproductive technology for the cancer survivor call for shared work among multidisciplinary teams of oncologists, nurses in both specialties of oncology and infertility, social workers, reproductive endocrinology and infertility specialists, andrologists, and embryologists. *Id.* at 312. This is unlike the predominant descriptions of business models used when referring to adult focused reproductive technologies. *See* Thomas H. Murphy, *Money Back Guaranties for IVF: An Ethical Critique*, 25 *J.L. MED. & ETHICS* 292 (1997).

<sup>241</sup> Adam Balen & Adam Glaser, *Health Conditions and Treatments Affecting Fertility in Childhood and Teenage Years*, in *SEXUALITY AND FERTILITY ISSUES IN ILL HEALTH*

The use of ART in these settings of threatened sterility might facilitate the potential of genetic procreation in the future.

Options for ART,<sup>242</sup> which might prove relevant for this population, include semen, sperm, and oocyte cryopreservation, hormonal supplement during toxic medical treatment, and ovarian tissue banking.<sup>243</sup> For males, “[d]epending on the number and quality of cryopreserved sperm, [future] conception can be attempted by thawing the sample and using it for intrauterine insemination (IUI). Alternatively, with compromised seminal quality . . . more advanced techniques such as *in vitro* fertilization (IVF) with or without intracytoplasmic sperm injection” may be attempted.<sup>244</sup>

In the context of cancer treatment, research has shown that adolescents (and P&Gs) are interested in exploring options to preserve fertility.<sup>245</sup> In one study focusing on adolescent females (those receiving cancer therapy and those who had completed a course of therapy) and their P&Gs, Karen Burns and others found that adolescents and their parents were interested in participation in research procedures for preservation of fertility.<sup>246</sup> The same study revealed that both young and older adolescents (ten to fourteen years versus fifteen to twenty-one years) had prior knowledge of infertility, spent time thinking about the future, and were engaged enough to contemplate decisions that would have important impact on their adulthood.<sup>247</sup>

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AND DISABILITY: FROM EARLY ADOLESCENCE TO ADULTHOOD 67 (Rachel Balen & Marilyn Crawshaw eds., 2006) (discussing health conditions leading to infertility in adolescents); Elizabeth Loughlin, *Infertility: An Unspoken Presence in the Live of Teens and Young Women with Turner Syndrome*, in *SEXUALITY AND FERTILITY ISSUES IN ILL HEALTH AND DISABILITY: FROM EARLY ADOLESCENCE TO ADULTHOOD* 159, 160 (Rachel Balen & Marilyn Crawshaw eds., 2006).

<sup>242</sup> There are risks associated with the use of ART, such as harm from ovarian stimulation or injury to organs during gamete retrieval. However, in the adolescent population, there are fewer congenital anomalies resulting from offspring produced by the eggs preserved from younger women as compared to what the CDC reports for women accessing ART after reaching the threshold of advanced maternal age (thirty-five years or older). See, e.g., Centers for Disease Control, 2006 Assisted Reproductive Technology (ART) Report: Section 5—ART Trends, 1996–2006 (2009), <http://www.cdc.gov/ART/ART2006/section5.htm>; Cheryl Wetzstein, *American Women Giving Birth Later; College, Careers Defer Motherhood*, WASH. TIMES, Dec. 12, 2002, at PA08 (reporting that in the last three decades, from 1970 to 2000, the average age for American women to have their first birth has increased from twenty-two to twenty-five); Johannes L.H. Evers, *Female Subfertility*, 360 LANCET 151 (2002) (noting that the two main factors that determine subfertility is the duration of childlessness and the age of the woman).

<sup>243</sup> Karen C. Burns, Christian Boudreau & Julie A. Panepinto, *Attitudes Regarding Fertility Preservation in Female Adolescent Cancer Patients*, 28 J. PEDIATRIC HEMATOLOGY & ONCOLOGY 350, 354 (2006); see also Fallat & Hutter, *supra* note 238, at e1462–66 (outlining options for ART procedures for adolescents); Knopman et al., *supra* note 233, at 493–95.

<sup>244</sup> Nagel et al., *supra* note 240, at 313.

<sup>245</sup> Burns et al., *supra* note 243, at 354; see also Knopman et al., *supra* note 233, at 496 (documenting importance assigned to fertility preservation among young cancer survivors).

<sup>246</sup> Burns et al., *supra* note 243, at 354.

<sup>247</sup> *Id.* at 353. Gamete disposition in the event of death or decision not to parent is an important consideration. However, planning ahead of time would facilitate communica-

The challenge for legislators and judges is that biotechnological advancements often outpace the development of legislation, leaving judges and juries ill-equipped to insightfully and appropriately respond to trend-setting technological advancements, which change the culture of medicine and its delivery. These issues are all the more relevant when conflicts of interests may arise between parents and children, doctors and parents, and doctors and adolescent patients. Our goal, as stated *ante* is to illuminate a very likely reproductive future, and contemplate the role of law in that not too distant future by examining the “right” to assisted reproductive technology services for minors through the filters of autonomy and capacity.

## 2. *The Adolescent as a Gamete Donor*

In *Black Markets: the Supply and Demand of Body Parts*, the compelling and distressful narrative of organ donation is laid bare.<sup>248</sup> This story is more than just adults who are struggling to preserve their health. Young people require organs too, and their siblings are more likely to step in as donors than any other group.<sup>249</sup> In adult and adolescent transplants, siblings comprise the largest donor pool in the United States, followed by offspring.<sup>250</sup> The importance of family involvement cannot be understated as currently the demand for organs drastically outpaces supply.

Organ failure and organ transplantation are increasingly important matters for our society. Both at the adult and child levels, siblings occupy the largest population of direct organ donors in the United States.<sup>251</sup> Perhaps the most visible of examples is that of fertile couples who decide to have another child in hopes of providing a genetic match for a child who is suffering from a devastating illness that may be tempered by hematopoietic stem cell therapy, or donation of other human leukocyte antigen-matched tissue.<sup>252</sup> Over the past fifty years, parents have called upon their children to provide organs and other biological tissues to siblings, ranging from kidneys to bone marrow.<sup>253</sup>

The extension of a “right” of donation to include an adolescent’s ability to donate reproductive tissue that also potentiates life would seem plausible.

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tion of disposition wishes, such as donation to other infertile individuals versus gifting to medical research versus simple, regulated disposal of the genetic material.

<sup>248</sup> MICHELE GOODWIN, *BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS* (2006) (providing a contemporary view of human organ and tissue procurement).

<sup>249</sup> *Id.* at 62, 71–72.

<sup>250</sup> *Id.*

<sup>251</sup> See, e.g., *id.* at 82; R. S. Sung et al., *Organ Donation and Utilization in the United States, 1997–2006*, 8 AM. J. TRANSPLANTATION 922, 932 (2008) (living kidney donors).

<sup>252</sup> Am. Acad. of Pediatrics Comm. on Bioethics, *Children as Hematopoietic Stem Cell Donors*, 125 PEDIATRICS 392, 400 (2010).

<sup>253</sup> GOODWIN, *supra* note 248, at 66–71 (discussing *Curran v. Bosze*, an Illinois Supreme Court case involving a father’s demand that his estranged girlfriend surrender their twins for blood tests and possible bone marrow extraction to save the life of his son, their half-brother).

One could envision an older female sibling who is suffering from infertility and desires to have a child that is a genetic relative. In the absence of adult relatives who are available and willing to donate, an adolescent sibling who is able to donate eggs for the process of assisted procreation presents a powerful opportunity. Biologically, what is provided in this context serves a very different purpose than that of a kidney. Yet, the substantive question, easing someone else's pain through altruistic biologic donation, is the same. Both processes involve general anesthesia and present similar risks.

Conceptualizing capacity and autonomy in the reproductive sphere could add benefit to the broader contexts of organ and tissue donation, where children's autonomy is not well defined. Traditionally, courts defer to parents and engage in a weak best interest or substituted judgment inquiry to determine a child's willingness to donate. Neither test advances a focus on capacity, involving maturity, experience, intellectual, and emotional capacity, which are among the factors that we believe relevant to the assignment of adolescent "rights." Historically, courts inquire into whether the child providing the organ or bone marrow would be psychologically benefitted by saving the life of her sibling. We reject that test based on its limited value and the potential for serious externalities to arise. The better option, we believe is to make a dual inquiry into adolescent capacity and autonomy.

### 3. *Adolescents in a Marriage Relationship*

The decision to parent is personal and intimate. Despite current U.S. trends that view marriage as an institution into which individuals enter during later life, there remain some communities for which marriage is sanctioned and encouraged during the teenage years.<sup>254</sup> In these communities, building a family carries as much, if not more interest, than the career one will craft, or the type of post-graduate education one will pursue.<sup>255</sup> For these families, relationships and building families are the priorities of life. For some feminists, adolescent marriage is unthinkable and unsettling. In many ways, the social expectations for women have shifted during the last four to five decades, because it was not that long ago that marriage and family building served as the (perceived) primary contribution of women to society.<sup>256</sup> But with these shifts, there remain strong cultural and community norms in favor of family building, which cannot be fully replaced by what feminism has to offer.

As in the prior examples above, the question posed here is whether adolescent marital use of ART is a category in which the language of adoles-

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<sup>254</sup> See, e.g., Sue Chan, *Teenage Marriage On The Rise*, CBS NEWS (Nov. 8, 2002), <http://www.cbsnews.com/stories/2002/11/08/national/main528755.shtml>.

<sup>255</sup> See, e.g., Timothy Egan, *Utah's Claim to Fame: No. 1 in a Family Way*, N.Y. TIMES, Apr. 23, 1995, at 18.

<sup>256</sup> See SARA M. EVANS, *BORN FOR LIBERTY: A HISTORY OF WOMEN IN AMERICA* 246-47 (1989).

cent rights is appropriate or whether adolescent use of ART can be justified. In the context of marriage, a couple's decision to begin infertility treatment is protected by a right of privacy. Should that also apply to teens? Minor consent statutes do not address this issue, although many provide an age exemption for married minors to access medical and reproductive services. Reconciling statutory provisions for married minors within the broader realm of reproductive medicine and services could bring greater coherence to reproductive policy.

### C. *Why Focusing on Capacity Makes Sense*

Earlier in this Article, we articulated why child-rights are not absolute. Moving the conversation of adolescent rights to measuring capacity would be a far better approach to granting rights both generally and in the specific area of ART usage. In the realm of ART, shifting the focus to capacity might open the door for some adolescent users and close the door for some others. Why might society desire to shift from arbitrary age rules associated with adolescent rights to a more substantive model? This subsection offers a few thoughts. First, we should want adolescents to demonstrate appropriate ability to reason abstractly and to consider the future. Second, adolescents should understand cause-and-effect relationships. Third, adolescents should have the capacity to weigh risks and benefits of treatment versus no treatment.<sup>257</sup>

What does a focus on capacity achieve? The focus on capacity offers relief from the very important reality that contributed to the crafting of minor consent statutes; for many reasons, there are conditions for which a minor may not be able to engage P&Gs in decision-making, and penalizing the adolescent for this may not only compromise health, but also bring about other social harms.

In considering the case for minors' access to ART, it is necessary to advance the debate about teenage sex and reproduction beyond traditional notions of adolescent behavior and reproduction. Traditionally, the public conceives of teenage reproduction as something that affects young, vulnerable persons who naively engage in "adult" sexual behavior, somewhat if not fully unaware of the life consequences of their actions.<sup>258</sup> Routinely, teen pregnancy and sex are painted as "low-income" or racialized, focusing on racial minorities.<sup>259</sup> Through this lens, teen sex could be likened to the pull

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<sup>257</sup> See Kuther, *Medical Decision-Making and Minors*, *supra* note 130, at 353–55 (suggesting that physicians should be attentive and respectful of minors' wishes in evolving legal and ethical arenas).

<sup>258</sup> See 750 ILL. COMP. STAT. ANN. 70/5 (West 2010) ("[I]mmature minors often lack the ability to make fully informed choices that consider both the immediate and long-range consequences [of abortion].").

<sup>259</sup> See, e.g., June Carbone, *Age Matters: Class, Family Formation, and Inequality*, 48 SANTA CLARA L. REV. 901, 944 n.193 (2008) (contrasting the "overall" unintended pregnancy rate with statistics for poor black and Latina women specifically).



of a roulette wheel—a high risk, low intelligence activity, with generally little benefit other than thrill seeking or a death wish.

We take a different approach to analyze the appropriateness of teenage access to ART, and rights more generally. As a medical and social matter, ART does not involve sex, and therefore neatly bypasses some of the concerns about teen reproduction, which are located in the sexual act.

For us, the more salient points in evaluating teen capacity include the measurement of adolescent capacity, and the use of adolescent capacity as a vehicle to inform the courts. By focusing on these points, a different role for capacity is defined, one which does not perpetuate conceptions of powerlessness,<sup>260</sup> nor simply rely on the importance of context and intimacy in relationships.<sup>261</sup> Instead, we suggest that adolescent rights might better be based on capacity. This should include establishing requisite knowledge, reasoning capability, and future orientation as a means to safely access a right to consent to assisted reproduction, which is a unique and specialized intervention. By arguing for measuring capacity as the most effective gateway to adolescents' rights to ART, we urge a more nuanced definition of the best interest standard.

Focusing specifically on adolescents' capacity for general health care decision-making, Dan Brock distinguishes between three broad categories: "(1) capacities for communication and understanding of information; (2) capacities for reasoning and deliberation; [and] (3) capacity to have and apply a set of values for conception of the good."<sup>262</sup> Extending these guiding principles and the framework for informed consent set forth by Grisso and Vierling to the landscape for ART, we shape a few clear ideas about what minors' capacity might look like in this context. These ideas include: (1) an understanding of the nature of the condition necessitating usage of ART (i.e., reasonable understanding of germane medical terminology); (2) consideration and understanding of the consequences of ART and the responsibility for creating the potential for human life versus the consequences of no treatment and alternative options for parenting that do not involve manipulation of genetic material (i.e., adoption); (3) demonstration of a firm grasp of personal goals and values, including future interests, thus revealing the ability to envision oneself in the future; (4) an understanding of the risks and benefits of ART intervention versus no intervention (e.g., in the case of a married couple, greater risk of preterm birth given teenage pregnancy and the additional risk of preterm birth associated with ART); and (5) arrival at a deci-

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<sup>260</sup> Katherine Hunt Federle, *Looking Ahead: An Empowerment Perspective on the Rights of Children*, 68 TEMP. L. REV. 1585, 1585 (1995) (framing children's rights in terms of powerlessness vis-à-vis adults).

<sup>261</sup> Ferdinand Schoeman, *Childhood Competence and Autonomy*, 12 J. LEGAL STUD. 267, 287 (1983) (suggesting that the state should not intrude "into the autonomy and privacy of relationship" in the absence of an immediate visible danger).

<sup>262</sup> Dan W. Brock, *Children's Competence for Health Care Decisionmaking*, in CHILDREN AND HEALTH CARE 181, 184 (Loretta M. Kopelman & John C. Moskop eds., 1989).

sion without the experience or perception of undue influence from external sources.

## VI. CONCLUSION

Whether minors should have access to ART services pushes the envelope of children's rights and how we perceive who should have primary or exclusive access to the technology. Bounded in those spheres are fixed, but perhaps inaccurate, notions about adolescents, adults, sex, and assisted reproduction. Unlike a project focusing on teen access to abortion or even contraception, this project makes a query about access to technology. Indeed, this is a project that has little to do with sex, as ART allows for postponed child rearing, and is facilitated without sexual intercourse.

The question of adolescent access to ART, nonetheless, may strike the inattentive reader as controversial scholarship or over-imaginative, impractical, dangerous work. On both points, this Article pushes back, urging a more engaged inquiry generally about the nature of child-rights, and more specifically, interrogates what we predict will be reasonable adolescent inquiries about the use of ART.

There is sufficient theoretical and empirical evidence to support an argument for a minors' ability to make informed health care decisions. Furthermore, given advances in medical therapies, and expanding familial and social roles for adolescents, granting minors' access to ART is not irrelevant. As such, we considered three categories of health need or concern in which minors' capacity should be evaluated to determine whether they could have a "right of access" to ART. For example, (1) adolescents as cancer survivors or youths facing impending loss of fertility due to other medical conditions or illness; (2) adolescents as altruistic donors for ailing relatives who wish to parent; and (3) adolescents living separately and financially solvent from P&Gs in a marriage relationship. Rather than flat denial of these reproductive services to adolescents in those categories, we argue for greater nuanced and substantive inquiry.