ADOLESCENT DECISION-MAKING IN HEALTH CARE: IS IT TIME FOR NEW YORK STATE TO ADOPT A MATURE MINOR STATUTE?

Sarah C. Reckess, J.D.[*]

TABLE OF CONTENTS

I. INTRODUCTION

The judge looked down from the bench as I read the stipulation on the record. It was my first custody hearing, and this negotiation between warring parents had been truly laborious. The judge interrupted me to ask if we had consulted the sixteen-year-old child, who would be subject to the alternating holiday schedule and fifty-fifty custody arrangements. The judge explained that he didn't like to issue orders that the parents would try to enforce and the child would refuse. "Have you ever tried to make a sixteen-year-old do something they don't want to do?" he asked.

Although parents, the state, and the courts may try to compel adolescents to acquiesce to our decisions, many of us acknowledge

[*] Assistant Professor, Center for Bioethics and Humanities, State University of New York Upstate Medical University.

how difficult, and often futile, it is without their participation and consent. This is particularly true when an adolescent disagrees with their parents about medical treatment plans. Adolescents have a growing sense of autonomy over themselves as decision-makers and their maturing bodies, which happens to be at odds with New York State's public health law designating only parents or guardians as decision-makers for medical and dental treatment for anyone under age eighteen.[1] Similarly, New York State's common law only recognizes parents (or the state if the parents are unavailable or incapable) as the decision-makers capable of providing informed consent.[2] When parents make health care decisions that are at odds with the adolescent patient's own wishes, physicians and health care teams are often caught in the middle. It is a growing practice of pediatricians and other medical professionals to involve adolescents fully in medical decision-making if they are mature and can understand the risks and benefits of a medical treatment.[3] Even among very young patients, many pediatricians engage in a shared decision-making model, which treats pediatric patients as an involved and interested party to their medical care and emphasizes that physicians must provide developmentally appropriate information, answer children's questions fully, and learn the values and resources of the family prior to the family making major medical decisions. Additionally, physicians have little appetite for strapping down adult-sized adolescent patients who refuse medical treatment and forcing them to submit to chemotherapy, blood transfusions, or MRIs after their parents have provided consent to treatment. Physicians are equally concerned about parents who refuse accepted, standard medical treatments such as vaccinations or antibiotics when their adolescent children request low-risk, high-benefit treatments.[4]

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[1] N.Y. PUB. HEALTH LAW § 2504 (Consol. 2023). There are exceptions to the requirement that only parents or guardians may provide consent for minors to receive medical or dental treatment, some of which are explored below. Importantly, in the event of an emergency where delay in medical treatment due to lack of parental consent would cause irreparable harm to a patient, physicians may provide treatment.

[2] *See In re* Athena Y., 161 N.Y.S.3d 335 (App. Div. 2021). *See also* Alfonso v. Fernandez, 606 N.Y.S.2d 259 (App. Div. 1993).

[3] This argument first gained traction in the late 1970s and early 1980s. *See* Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PRO. PSYCH. 412 (1978). *See also* Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982).

[4] Larissa Morgan, Jason L. Schwartz & Dominic A. Sisti, *COVID-19*

New York State case law provides little support for adolescent autonomy in medical decision-making,[5] which pits the pediatric standard for adolescent patient care against New York State law. Mature minor statutes can cover the gap between case law and pediatric practice by allowing children who are mature, cognitively aware, and able to understand the consequences of their medical decisions to exert independence from their parents and consent or refuse medical treatment.[6] Is it time for the New York State Legislature to pass a mature minor statute that supports medical decision-making for New York's adolescents?

II. HISTORY OF MATURE MINOR CASES AND STATUTES IN THE UNITED STATES

Mature minor laws exist in a handful of U.S. states with varying degrees of eligibility, event triggers, and age determinations.[7] Some states, like Oregon and Arkansas, have mature minor statutes that were passed by the legislature while other states, like Illinois and Massachusetts, have judicial decisions that have recognized the mature minor doctrine as a common law right.[8] The Supreme Court of Illinois, in their 1989 decision *In re E.G.*, wrote:

If the evidence is clear and convincing that the minor is mature

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Vaccination of Minors Without Parental Consent: Respecting Emerging Autonomy and Advancing Public Health, 175 JAMA PEDIATRICS 995 (2021) (arguing that children and adolescents can reasonably understand high-benefit and low-risk health care interventions like the COVID-19 vaccine and should be allowed to consent to vaccination to slow community spread).

[5] *See, e.g.*, *In re* Thomas B., 574 N.Y.S.2d 659, 660–61 (Fam. Ct. 1991).

[6] Doriane Lambelet Coleman & Philip M. Rosoff, *Adolescent Medical Decisionmaking Rights: Reconciling Medicine and Law*, 47 AM. J.L. & MED. 386, 397 (2021) (detailing the extent of adolescent decision-making in the United States through state statute and case law).

[7] By my count, these include Alabama, Alaska, Arkansas, Delaware, Idaho, Illinois, Kansas, Louisiana, Maine, Massachusetts, Montana, Nevada, Oregon, Pennsylvania, South Carolina, Tennessee, and West Virginia. Some of these states passed statutes while others have judicial decisions. Three states (Alaska, Delaware, and Kansas) are not true mature minor statutes because the laws are only triggered when a parent is unavailable or unwilling to provide consent. Other states have emergency treatment statutes which allow physicians to treat a child experiencing a medical emergency without parental consent, but for this article these emergency provisions are not considered mature minor statutes. In Montana, the mature minor statue only covers minors who have graduated from high school. In Nevada, the statute is only triggered by a "serious health hazard." Doriane Lambelet Coleman & Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 PEDIATRICS 786, 790–91 (2013).

[8] *Id.*

> enough to appreciate the consequences of her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature minor doctrine affords her the common law right to consent to or refuse medical treatment.[9]

Other jurisdictions provide medical decision-making carve-outs for minors to access health care treatment that impacts public health (such as confidential HIV testing) or where minors are making medical decisions with lifetime consequences (such as accessing prenatal care).[10]

Policymakers in the 1960s recognized that minors had separate, and sometimes divergent, views of medical treatment from their parents.[11] Youth could be incentivized to seek medical treatment, particularly preventative care, if their health care decisions were kept confidential from their parents.[12] Over the years, these treatment access carve-out rules for minors have expanded in many U.S. states to include accessing inpatient or outpatient substance use disorder treatment, mental health treatment, HIV testing, treatment for sexually transmitted infections, and reproductive health care, including prenatal care, abortions, and contraception.[13] These treatment exceptions, when compared state-by-state, are a jumble of rules that can require *both* parent and minor consent, *only* minor consent, or *either* parent *or* minor consent.[14]

In New York, *either* a parent *or* a minor can consent to substance use disorder treatment and mental health treatment.[15] What

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[9] *In re* E.G., 549 N.E.2d 322, 327–28 (Ill. 1989) (holding that mature minors had the right to make medical decisions and that the mature minor doctrine was supported by Illinois common law).

[10] *See* Coleman & Rosoff, *supra* note 6, at 394–95.

[11] MaryLouise E. Kerwin, Kimberly C. Kirby, Dominic Speziali, Morgan Duggan, Cynthia Mellitz, Brian Versek & Ashley McNamara, *What Can Parents Do? A Review of State Laws Regarding Decision Making for Adolescent Drug Abuse and Mental Health Treatment*, 24 J. CHILD & ADOLESCENT SUBSTANCE ABUSE 166, 167 (2015).

[12] *See id.*

[13] *See id. See also* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 73–74 (1976), (a landmark decision finding that people under age eighteen had the constitutional right to abortion that superseded the interests of the state or the parent. The Court found that parental consent requirements were unconstitutional and that children were entitled to the same constitutional rights as adults, although the state has a more compelling reason to regulate children's behavior than the same behavior exhibited by adults). *See generally* James Shortall, Hodgson v. Minnesota*: Balancing the Competing Interests of the State, Parents and Minor—A Missed Opportunity?*, 69 DENV. U. L. REV. 539 (1992).

[14] Kerwin et al., *supra* note 11, at 168.

[15] N.Y. MENTAL HYG. LAW §§ 22.11(c), 33.21(e)(2) (Consol. 2025).

would happen if a New York parent sought substance use disorder treatment for their adolescent and the adolescent refused? The answer is unclear. There seems to be little the parent could do to compel treatment, as well as a consensus within the substance use disorder treatment community that forced treatment would ultimately fail.[16] A mature minor statute in New York State would provide guidance should a parent try to compel substance use disorder treatment through the courts.

Those states that have passed broad mature minor statutes, such as Arkansas, allow children to make medical decisions without their parents' consent based on the child's age, maturity, and/or their decisional capacity.[17] Statutes that list an age when a child becomes a mature minor (usually twelve or fourteen) appear to be as arbitrary as the rule determining that children become adults the day they turn eighteen. Some statutes require a hearing to determine if the adolescent is both the minimum age and mature enough to make medical decisions.[18] These broad mature minor statutes provide guidance to the courts, allowing a judge to determine if a child is mature enough to make a significant medical decision and whether that child understands the consequences of the decision, including in cases of accessing or stopping life-saving treatments.[19] The statutes protect the child's right to bodily autonomy when the state, physicians, or parents are focused on treatment options that the child does not wish to pursue.[20] These actors must listen to and consider the child's wishes and explore why the conflict exists in the treatment plan.

Mature minor statutes also provide parents with legal protection when they decline treatment for a child due to religious objections. The mature minor doctrine holds adults accountable for pushing medical treatment plans that can have lifelong physical and emotional impact on young people without accounting for the child's or family's needs, values, or beliefs. These laws also protect parents from charges of medical neglect if they follow their child's direction to stop treatment only to lose custody to the state, wherein the treatment is continued against the child and parents'

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16 *See* Kerwin et al., *supra* note 11, at 173.

17 *See* Coleman & Rosoff, *supra* note 6, at 397–98 (listing states with mature minor statutes and delineating which states consider capacity, maturity, age, or school enrollment as conditions for mature minor status); ARK. CODE ANN. § 20-9-602(7) (2020).

18 *See* Coleman & Rosoff, *supra* note 6, at 397–401.

19 *Id.*

20 *Id.*

wishes. This scenario led to the passage of "Abraham's Law" in 2007 in Virginia, which permits youth fourteen years old and older the right to make their own treatment decisions in life-threatening conditions if the parents are in agreement.[21] States have invoked their right to assume the role of medical decision-maker through the *parens patriae* power, wherein the state can force children to accept medical treatment when parents fail to seek treatment for religious or personal reasons (even if the child agrees to forgo treatment for the same reasons).[22] The broader mature minor statutes, which focus on the child's maturity and decisional capacity, allow the courts to hold a hearing and determine whether the child's wishes have been considered in this clash between the state, physicians, and parents. Courts, then, become the avenue through which the child's personal autonomy is considered for the first time, and we finally ask the questions, "Has the child been consulted? Are they mature enough to consider the consequences of this medical decision?"

III. PEDIATRIC STANDARD OF CARE

The pediatric practice of incorporating adolescent patients as medical decision-makers is at odds with New York State common law. Clinical standards in pediatric care emphasize that the child, not the parent, is the patient, and although parents are responsible for making treatment decisions, those decisions must be made with the child's best interests and medical needs in mind.[23] For example, a parent's request for a medically non-indicated appendectomy would be dismissed outright as not being in the child's best interests.

The U.S. Supreme Court found that parents retain a plenary

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[21] *See* VA. CODE ANN. § 63.2-100 (2007). *See generally* Mark R. Mercurio, Commentary, *An Adolescent's Refusal of Medical Treatment: Implications of the Abraham Cheerix Case*, 120 PEDIATRICS 1357, 1357–58 (2007) (summarizing the implications for pediatricians of "Abraham's Law," the Virginia mature minor law named after a fifteen-year-old with Hodgkin lymphoma who was forced to submit to radiation therapy despite his and his parents' refusal because they wished to try alternative treatments).

[22] The *parens patriae* doctrine gives the state the power to act as protector for a dependent child or incompetent adult. It is also the doctrine that allows the state to sue on behalf of a citizen who is unable to care for or protect themselves. *Parens Patriae*, BLACK'S LAW DICTIONARY 1144 (8th ed. 2004). *See also* George B. Curtis, *The Checkered Career of Parens Patriae: The State as Parent or Tyrant*, 25 DEPAUL L. REV. 895, 895, 899 (1976).

[23] *See* Aviva L. Katz & Sally A. Webb, *Informed Consent in Decision-Making in Pediatric Practice*, 138 PEDIATRICS e1, e5 (2016).

power to make medical decisions for their minor child because parents are presumed to act in their child's best interests and to understand the complexity of the child's health history, home life, and support structure.[24] Parental consent for medical decisions, though, is not absolute.[25] As a child matures, the parents' role providing consent by proxy becomes more ethically fraught. The American Academy of Pediatrics provided guidance to pediatricians on this issue in 1995, exploring ways to increase the pediatric patient's role in medical decision-making as the adolescent matures: "As children develop, they should gradually become the primary guardians of personal health and the primary partners in medical decision-making, assuming responsibility from their parents."[26] The entrenched parental power to make medical decisions reduces the child's moral standing and can lead to conflict between physician, parent, and patient.[27] As a last resort, the American Academy of Pediatrics recommends that physicians seek assistance from the courts.[28]

Among the issues of parental consent by proxy are that parents and children may not share the same treatment goals or values and that "the pediatrician's responsibilities to his or her patient exist independent of parental desires or proxy consent."[29] Others have cautioned that medicine must acknowledge the pediatric patient as "an individual in their own right" regardless of "[w]hether the medical issue is big and important or small and relatively insignificant."[30] Arguably, a pediatrician wishes to support their pediatric patients as they develop their sense of autonomy as medical decision-makers and to "generally advocate for the adolescent's wishes if they reflect an ethically acceptable treatment option."[31] Particularly in cases where a child has a lifelong medical condition or chronic illness, physicians may

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

[25] *See id.* at 603 ("Nonetheless, we have recognized that a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.").

[26] Comm. on Bioethics, Am. Acad. of Pediatrics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 316 (1995).

[27] *Id.*

[28] *Id.* at 314.

[29] *Id.* at 315.

[30] Coleman & Rosoff, *supra* note 6, at 421–22.

[31] Katz & Webb, *supra* note 23, at e11.

support the child's growth as a medical decision-maker at an early age due to the child's familiarity with their own bodies, treatments, and goals of care.[32] Empowering children who have lifelong illnesses or conditions to make informed decisions is appropriate for development into adulthood.

Parental consent by proxy, then, is at odds with an adolescent patient's personal goals for themselves and undermines their development into medical decision-makers. Waiting until age eighteen to give young adults the right to make medical decisions fails to prepare them to assume responsibility for their health care decisions, leading to a seventeen-year-old having no personal autonomy over their health care and the day that they turn eighteen, having matured to the point of understanding the complexity of health care treatment. For a health care team providing medical care to an adolescent as they mature, especially an adolescent with a chronic condition or terminal illness, modeling medical decision-making and involving the child in health care decisions is imperative to guiding them to become a good medical decision-maker as an adult.

Beyond teaching adolescents to become medical decision-makers, physicians must incorporate the medical standards of patient autonomy and informed consent for patients who are legally deemed incompetent.[33] The American Academy of Pediatrics' Committee on Bioethics recommends that pediatric patients be as involved in their treatment plans as developmentally appropriate, regardless of age.[34] The informed consent doctrine strives to involve patients fully in medical decision-making by providing accurate and timely information that gives patients the ability to make choices that reflect personal goals, lifestyle, resources, values, and beliefs.[35] Ultimately, the patient must accept the consequences of their treatment decisions, and the physician will have to respect those decisions.[36] As informed consent relates to children, physicians and parents should consider the opinions of the patient and "[the] cognitive abilities, maturity of judgment, and the respect owed to a moral

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[32] Nancy E. Walker & Theresa Doyon, '*Fairness and Reasonableness of the Child's Decision:' A Proposed Legal Standard for Children's Participation in Medical Decision Making*, 19 BEHAV. SCI. & L. 611, 623 (2001).

[33] Katz & Webb, *supra* note 23, at e1.

[34] Comm. on Bioethics, *supra* note 26, at 315.

[35] *Id.* at 314–15.

[36] *Id.*

agent, which may not all proceed to maturation along the same timeline."[37]

The American Academy of Pediatrics provided further guidance on informed consent in 2016, recommending that the opinions of pediatric patients who refuse a course of treatment should be respected if the refusal is for a nonurgent, non-life-threatening issue.[38] Physicians are advised to seek to understand the patient's refusal while providing education, answering questions to correct misconceptions, and helping the patient understand treatment benefits and risks.[39] If physicians have done their due diligence providing informed consent, then a mature adolescent's refusal should be respected.

This guidance is at odds with New York State common law, which consistently recognizes that parents are the medical decision-makers for minor children, and if the parents are unavailable or incapable, then the state must intervene. The case of *In re Thomas B.* is telling; the mother of a fifteen-year-old with mediastinal tumors petitioned the court to compel her adolescent son to submit to diagnostic surgery after he refused, and the court reaffirmed its role in compelling treatment for a child's immediate medical needs.[40] The court did not apply a mature minor analysis or hold a hearing to let the fifteen-year-old speak to his refusal decision, although it did acknowledge its reluctance to disregard a fifteen-year-old's treatment refusal.[41] Instead, the court looked at the emergency nature of the medical diagnosis and found it imperative that the adolescent respondent submit to the diagnostic surgery.[42] If a court hearing had applied a mature minor doctrine to the facts of the case, it may have found similarly and directed treatment over objection. The court noted that the respondent had a fear of needles and thus did not display an appropriate understanding of the life-threatening risk of the tumor nor of the importance of diagnostic testing to determine the best course of treatment.[43] However, the impact of the ruling on the child is chilling: the court not only ordered the child to "cooperate fully"

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37 Katz & Webb, *supra* note 23, at e7.

38 *Id.* at e11.

39 *Id.*

40 *See In re* Thomas B., 574 N.Y.S.2d 659, 660–61 (Fam. Ct. 1991) (finding that the state has "parens patriae" authority to direct medical intervention that will benefit a child over the child's explicit refusal).

41 *See id.* at 660.

42 *Id.* at 660–61.

43 *See id.* at 660.

with the surgery but also directed the Sheriff's Department to "take all necessary steps to enforce the order, including but not limited to transporting the respondent to the hospital, restraining him, if necessary, and supervising the respondent while he is in the hospital."[44]

The brutality of this decision, with law enforcement physically transporting and restraining an adolescent against his wishes, begs the question of whether the adolescent and his family would be better served by a hearing to determine his maturity, which would allow the adolescent to speak on the record, testify to his maturity, and articulate further his reasons for not wanting to submit to the diagnostic surgery.[45] The court may have ruled in the same way after a hearing and compelled treatment given the seriousness of the medical issue, but the adolescent would have been treated respectfully as an autonomous patient making a consequential decision. Although there is no way to follow the adolescent's progress or to know if serious and continued medical interventions were needed after the diagnostic surgery, it is horrifying to imagine the Sheriff's Department being continuously dispatched to transport and restrain an adolescent for a lengthy series of treatments as well as the moral distress experienced by the medical team if the child needed to be restrained for any subsequent treatments.

The American Academy of Pediatrics warns against the actions taken in *Thomas B.*, stating that "parents and physicians should not exclude children and adolescents from decision-making without persuasive reasons."[46]

Additionally, physicians should always seek the child's assent, which means communicating developmentally appropriate information about the clinical treatment and goals for care and asking for the pediatric patient's willingness to accept care and the treatment plan.[47] The U.S. Department of Health and Human

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[44] *Id.* at 661.

[45] *See id.* at 659–61 (notably, the respondent's father died of lung cancer in January 1991, four months before the child's own diagnosis of having an anterior (frontal) mediastinal tumor. Mediastinal tumors develop near the lungs and can be either malignant or non-malignant). *See also* Cleveland Clinic, *Mediastinal Tumor*, https://my.clevelandclinic.org/health/diseases/13792-mediastinal-tumor [https://perma.cc/YJL4-9884] (last visited July 24, 2023).

[46] *See* Comm. on Bioethics, *supra* note 26, at 314.

[47] *Id.* at 315–16. *See generally* Jonathan M. Marron, Elaine C. Meyer & Kerri O. Kennedy, *The Complicated Legacy of Cassandra Callender: Ethics, Decision-Making, and the Role of Adolescents*, 175 JAMA PEDIATRICS 343, 343–44 (2021) (detailing the Connecticut case of Cassandra Callender, a seventeen-year-old

Services' Office for Human Research Protections requires researchers performing pediatric research to obtain assent from their patients in addition to consent from the parents or guardians.[48] Including children in medical decision-making, whether through assent or consent, reinforces the moral authority children possess over their bodies and their health care.[49] In certain situations, the American Academy of Pediatrics advises pediatricians to seek full consent from adolescents when prescribing contraceptives, prescribing acne treatments that will require adolescents to regularly take medication, ordering diagnostic tests for headache management, and performing pelvic exams, rather than allowing a parent to make unilateral decisions.[50] These treatments, though minor, are invasive, and most children are able to comprehend why they are necessary and the potential risks and benefits of the decision.

Physicians must consider pediatric patients' treatment needs in the context of their status as moral beings, the accepted standard of medical care, and the parents' responsibility to make medical decisions that support the best interests of the child.[51] The process for juggling these competing interests is the practice of shared medical decision-making, wherein physicians provide both parent and child with informed consent at multiple points along the way, and physicians, parents, and pediatric patients consider the long-term treatment goals of health care (rather than short-term events) and practice constant communication between all the parties.[52] Additionally, the American Academy of Pediatrics recognizes that framing medical decision-making as a parental right ignores a child's autonomy, and instead it is a parent's responsibility to make medical decisions that support the child's

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patient with Hodgkin lymphoma who refused further chemotherapy treatment, and the inadequacy of informed consent about the benefits and risks of cancer treatment as experienced by adolescent cancer patients).

[48] *Research with Children FAQs*, U.S. DEP'T OF HEALTH AND HUM. SERVS., https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/children-research/index.html#:~:text=What%20is%20child%20assent%2C%20and,agreement%2C%20be%20construed%20as%20assent [https://perma.cc/7D64-Q7HR] (last visited July 27, 2023).

[49] *See* Katz & Webb, *supra* note 23, at e7–8 ("Assent from children even as young as [seven] years for medical interventions may help them become more involved in their medical care and can foster moral growth and development of autonomy in young patients.").

[50] Comm. on Bioethics, *supra* note 26, at 316–17.

[51] *See* Katz & Webb, *supra* note 23, at e5.

[52] *See id.* at e4.

best interests and preserve the family unit.[53]

The trend toward incorporating adolescents' consent in health care decisions is supported by adolescent cognitive development research that began in the 1970s and continues in adolescent neurodevelopment today. Research published in the 1980s found that when adolescents fifteen years old and older were provided with medical information as well as the benefits and risks of the decision, they made legal and medical decisions that were comparable to the decisions made by adults.[54] A growing body of research shows that minors have the cognitive ability to understand diagnostic and treatment options in the same way as adults and to choose alternatives with the same consideration for benefit and risk.[55] Additionally, there is evidence that involving minors in medical decision-making improves health outcomes[56] and improves cooperation with treatment plans.[57] Research has also found that adolescent patients who were provided informed consent had improved psychological and physical recovery from surgery compared to their peers who were not involved in treatment decisions.[58]

Much has been written about current neuroscience research documenting how adolescent brains continue to develop well past eighteen years of age and into adulthood, but brain development and the maturation of adolescents are fluid and do not follow a prescriptive timeline.[59] Arguably, each child should be assessed independently for their maturity and cognitive ability to make medical decisions rather than developing a bright-line mature minor rule that simply moves the age of consent from eighteen to a younger age such as fourteen.[60]

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[53] *See id.* at e5.

[54] Laurence Steinberg, *Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?*, 38 J. MED. & PHIL. 256, 258 (2013) (these empirical studies informed the U.S. Supreme Court's decision in Hodgson v. Minnesota, 497 U.S. 417 (1990), which found adolescents had the right to access abortion without parental consent).

[55] Nichole M. Stettner, Ella N. Lavelle & Patrick Cafferty, *Who Decides? Consent for Healthcare Decisions of Minors in the United States*, 35 CURRENT OP. PEDIATRICS 275, 276–77 (2023) (comparing research literature on the cognitive ability of older minors to consent to medical treatment and research in clinical trials against survey results showing U.S. youth are willing to receive the COVID-19 vaccine but their parents report vaccine hesitancy).

[56] *Id.*

[57] Walker & Doyon, *supra* note 32, at 616.

[58] *Id.*

[59] Steinberg, *supra* note 54, at 265.

[60] *Id.* Note that behavioral research has generally found adolescents fourteen

Lastly, the medical community is aware of the trauma caused by forced medical interventions on patients, including pediatric patients whose parents have given consent. A 2021 commentary published in the American Medical Association's Journal of Ethics cautions physicians that the "potential long-term harm to a patient who is traumatized during a forcibly performed intervention and potential long-term consequences to a patient's trust in clinicians must be seriously considered" before performing even life-saving treatments.[61] This warning, although generalized to all patients, is important to consider when the patient is under the age of eighteen and the parent and health care team are pushing a treatment the adolescent does not want. The adolescent's future relationship with the health care system, including the ability to engage in self-advocacy and give informed consent, is very much at stake.

IV. NEW YORK CASE LAW CONSIDERING MATURE MINORS

Although New York does not have a mature minor statute or a common law history recognizing the rights of adolescents in medical decision-making, the issue has been considered by the courts. In a 1990 case before the Queens County Supreme Court, the court considered the maturity of a seventeen-year-old Jehovah's Witness who refused the blood transfusion recommended by his treatment team.[62] The physicians argued that without a blood transfusion, the patient was certain to die, and the hospital sought a court order to compel the blood transfusion against the wishes of the patient and his parents.[63] The court noted that a mature minor statute would be helpful in guiding the court's decision in medical decision-making cases, but that it was loathe to create a mature minor doctrine without the express support of the legislature or the Appellate Division.[64] The court specifically requested that any mature minor statute include

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and younger to be less competent than those fifteen and older, but that bright line rules do not allow for individual variability. Children with chronic or terminal illnesses often have been participants in complex medical decision-making from a young age.

[61] Robert L. Trestman & Kishore Nagaraja, *How Should Clinicians Execute Critical Force Interventions with Compassion, Not Just Harm Minimization, as a Clinical and Ethical Goal?*, 23 AMA J. ETHICS 292, 292 (2021).

[62] *In re* Long Island Jewish Med. Ctr., 557 N.Y.S.2d 239 (Sup. Ct. 1990).

[63] *Id.* at 240–41.

[64] *Id.* at 243.

language granting courts the authority to hold a hearing to determine the maturity of the minor.[65]

Despite a mature minor doctrine being inapplicable in New York, the court in *Long Island Jewish Medical Center* applied the facts of the case as though one existed.[66] The court ruled the adolescent could not refuse medical treatment because he was too immature in his religious reasoning skills and knowledge of his religion's tenets, emphasizing he did not understand the fatal risk to his life if he refused the blood transfusion.[67] Additionally, although the adolescent was two months from his eighteenth birthday, the court cited as evidence of his immaturity that he still considered himself a child, that he asked his parents for their approval for most decisions, and that he had "never dated a girl."[68] The court agreed with the hospital that the adolescent should be forced to receive the blood transfusion against his and his parents' wishes but noted, "[i]n a few weeks he will become an adult; and, of course, his life will then be in his own hands."[69]

Twenty-five years later, few published cases have come before the New York courts to further test adolescent medical decision-making, and when they do, the courts continue to note the lack of a mature minor doctrine.[70] When the opportunity to apply a mature minor doctrine has arisen, the courts have punted the issue to the legislature, stating that they have already defined eighteen as the age of majority to consent and the court does not wish to intrude on the legislature's role.[71] Simultaneously, the legislature has continued to carve out exceptions to the rule that allow some minors to make their own medical decisions.[72] If adolescents in cases before the court are not eligible for those carve-outs, which include married minors, parenting minors, and economically self-sufficient minors, then those adolescents have no ability to participate in their own medical decision-making.

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[65] *Id.* at 243 n.16.

[66] *Id.* at 242.

[67] *Id.* at 243.

[68] *Id.* at 242–43.

[69] *Id.* at 243 n.15.

[70] *Id.* at 243 n.16; *see also In re* Athena Y., 161 N.Y.S.3d 335, 337–38 (App. Div. 2021).

[71] *See Athena Y.*, 161 N.Y.S.3d at 337–38; N.Y. PUB. HEALTH LAW § 2504(1) (Consol. 2023).

[72] *See, e.g.*, PUB. HEALTH § 2504(1) (listing minors who are parents, married, or homeless as emancipated and having the right to consent to medical treatment). *See also* Zuckerman v. Zuckerman, 546 N.Y.S.2d 666, 667–68 (App. Div. 1989) (explaining that minors in the military are deemed emancipated).

V. WHY NOW?

New York legislators have continued to expand minors' rights to consent to medical treatment in piecemeal fashion. State law currently allows people under eighteen years of age to access prenatal care,[73] mental health treatment,[74] substance use disorder evaluation and treatment,[75] diagnosis and treatment of sexually transmitted infections,[76] and HIV testing[77] without parental consent. Additionally, anyone who parents a child[78] or is pregnant,[79] regardless of their own status as a minor, may make medical decisions affecting the health of their children. As recently as 2022, the New York Legislature expanded minors' rights again when it passed Senate Bill 8937, allowing homeless and runaway youth to consent to medical, dental, and hospital treatment without parental permission.[80] Advocates for the bill argued that adult homeless and respite service staff were not allowed to give medical consent by proxy for homeless and runaway youth despite being the parental figure in that child's life, and thus New York should recognize homeless and runaway youth as independent, or mature, minors.[81] Homeless youth advocates note that the law only applies to youth who meet the state's defined category of homeless or runaway; thus, those who live in rural areas that lack state-certified shelters or programs for runaway youth are unable to consent to their own medical treatment.[82]

Thirty-five U.S. states and Washington, D.C., have laws allowing emancipated youth, including youth who are homeless

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[73] PUB. HEALTH § 2504(3).

[74] N.Y. MENTAL HYG. LAW § 33.21(c) (Consol. 2023).

[75] *Id.* § 22.11(c).

[76] PUB. HEALTH § 2305(2).

[77] *Id.* § 2781(1).

[78] *Id.* § 2504(1).

[79] *Id.* § 2504(3).

[80] Adilia Watson, *New York's Runaway and Homeless Minors Can Now Consent to Their Own Health Care*, THE IMPRINT (Apr. 13, 2023, 11:00 PM), https://imprintnews.org/top-stories/new-yorks-runaway-and-homeless-minors-can-now-consent-to-their-own-health-care/240258 [https://perma.cc/V86D-4TAH]. N.Y. Senate Bill 8937 amended Public Health Law section 2504 to include runaway and homeless youth as primary decision-makers in their health care treatment. *See id.*

[81] N.Y. C.L. UNION, 2021 – 2022 LEGISLATIVE MEMORANDUM: ENABLING HOMELESS AND RUNAWAY YOUTH TO CONSENT TO MEDICAL, DENTAL, HEALTH AND HOSPITAL SERVICES A.9604 (GOTTFRIED) / S.8937 (BRISPORT) 1–2, https://assets.nyclu.org/field_documents/220503-legislativememo-hryconsent.pdf [https://perma.cc/8VH5-FL63].

[82] Watson, *supra* note 80.

and unaccompanied by a guardian, to consent to routine medical care.[83] Some states additionally allow homeless youth to access treatment for infectious diseases.[84] The legislation varies by jurisdiction and may include an age limit, such as in Utah (fifteen years of age) or Florida (sixteen years of age).[85] In passing Senate Bill 8937, New York did not assign an arbitrary age to the legislation, allowing homeless or runaway youth of any age to access medical treatment.[86] This recent legislation in New York State enables homeless and runaway youth to seek diagnosis and treatment of viral and bacterial infections, and access annual and routine health maintenance, including vaccinations, without parental permission.

New York has continued to expand medical treatment exceptions to allow minors to access health care without parental consent.[87] However, without a mature minor law to support this public policy, having exceptions apply to certain patients and not others puts physicians and treatment providers in a difficult place. The physician may believe an adolescent is too immature to make medical decisions, particularly if the physician believes that rehabilitation and follow-up care will be delayed or difficult to complete without the consent and participation of a parent or guardian. The adolescent may be statutorily free to make medical decisions, such as when accessing substance use disorder treatment, but the treatment team may understand that the minor is not mature enough to understand their treatment plan or the

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[83] *State Laws on Minor Consent for Routine Medical Care*, SCHOOLHOUSE CONNECTION (June 5, 2023), https://schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-medical-care [https://perma.cc/FG6E-U3WT].

[84] *Id.*

[85] *Id.*

[86] N.Y. PUB. HEALTH LAW § 2504(1) (Consol. 2023).

[87] In the New York 2021–2022 Legislative Session, A9963 was introduced to allow minors to consent to medical care. Assemb. B. 9963, 2021-2022 Leg. (N.Y. 2022). The bill, which never progressed out of committee, broadens consent for medical and dental treatment to anyone, regardless of age, who can understand the foreseeable risks and benefits and does not require parental or physician consent. *Id.* It does not provide minors with the right to refuse treatment. *Id.* There is no mechanism in the bill for determining whether a minor meets the threshold of someone who understands foreseeable risks and benefits, and there is no role for the judiciary as a safeguard. *Id.* The bill specifically provides:

> Any person, including a minor, who comprehends the need for, the nature of, and the reasonably foreseeable risks and benefits involved in any contemplated medical, dental, health, or hospital service, as well as any alternatives thereto, may give effective consent thereto for themself, and the consent of no other person shall be necessary.

Id.

steps needed to stay sober. Likewise, a physician may believe an adolescent is mature enough to consent to routine health care, such as completing a COVID-19 vaccine series, but the child is unable to consent because the vaccine is not listed as one of the exceptions. A mature minor statute would allow health care teams to support minors who display a certain maturity and knowledge of the benefits and risks of the health care treatment and also to refrain from providing medical care if they believe the child is not mature enough to understand the consequences and long-term risks of the procedure. The recent changes to Public Health Law section 2504 presume that all homeless and runaway youth are mature enough to make medical decisions on their own behalf, but there are no safety mechanisms to protect a child such as requiring a court hearing or insisting a physician screen a child for maturity.

Additionally, the medical profession continues to advocate for pediatric patients to assume a more active role in medical decision-making and underscores that pediatricians must promote patient autonomy and meet the requirements of informed consent.[88] Unfortunately, this mandate means that pediatricians are out of step with New York State law.[89] Bringing law and medicine together on this issue is imperative as it is a matter of applied justice when the law creates carve-outs for some minors but not others. A runaway youth who seeks a strep throat test at an emergency department should be able to consent to a course of treatment that includes antibiotics as most adolescents can understand the risks of not completing the antibiotic regimen as well as the side effects they may experience. But shouldn't that same standard be applied to an adolescent whose family refuses to seek medical treatment for their sore throat because the family distrusts doctors?

The courts have made it clear that they do not wish to step in

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[88] *See, e.g.*, Sinead O'Brien, *Minors and Refusal of Medical Treatment: A Critique of the Law Regarding the Current Lack of Meaningful Consent with Regards to Minors and Recommendations for Future Change*, 7 CLINICAL ETHICS 67, 71 (2012); Sara Taub, *Learning to Decide: Involving Children in their Health Care Decisions*, 5 AMA J. ETHICS 336, 336–37 (2003); Sanford L. Leikin, *Minors' Assent or Dissent to Medical Treatment*, 102 J. PEDIATRICS 169, 176 (1983).

[89] It is not uncommon for medical practitioners and bioethicists to cite the United Nations Convention on the Rights of the Child as source material for why pediatricians should seek assent or consent from pediatric patients. The Convention on the Rights of the Child is neither legally-binding nor has it been ratified by the United States. Taub, *supra* note 88, at 336; Erin E. Kilmer, *A Child's Right to Consent to Medical Treatment*, 25 N.Y. STATE BAR ASS'N HEALTH L.J. 45, 46–48 (2020).

and legislate this issue, and they have continued to read the New York State Legislature's silence as the policy, leading to decisions that severely restrict an adolescent's personal autonomy and medical decision-making until the day they reach eighteen years of age. Most recently, the Appellate Division, Third Department, reaffirmed its reluctance to legislate from the bench when it stated, "courts generally should not intrude on the other two branches of government by expanding the rights of minors to make decisions in categories not included in those statutes or regulations."[90] The 2021 case shows the court's reluctance to expand the right of mature minors to consent to routine medical treatment (a COVID-19 vaccination) absent express authorization from the legislature.[91] The court overturned a Rensselaer County Family Court ruling that permitted two minor children, who were in foster care, to access a COVID-19 vaccine despite the children's consent and evidence that the attorney for the children, the Department of Social Services, and the children's incarcerated father all supported the children's decision.[92] The mother, who did not have physical custody of the children, refused to consent to the vaccinations.[93] The court found that because New York State law does not include COVID-19 vaccinations as one of the medical treatments that adolescents can access without parental consent,[94] and because there was current legislation pending in New York State to allow minors fourteen years and older to access vaccinations without parental consent, the court did not have the authority to add new vaccines to the list of medical treatments that do not require parental consent.[95] Reviewing New York Social Services Law, the court noted that "nothing in the regulation authorizes the local social services agency . . . to provide

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[90] *In re* Athena Y., 161 N.Y.S.3d 335, 338 (App. Div. 2021).

[91] *Id.* at 337.

[92] *Id.* at 337, 342.

[93] *Id.* at 337. The court reaffirmed previous case law wherein parents retain legal custodial rights, including the right to consent to medical treatment, even when the children are removed from their physical custody due to abuse or neglect. *Id.*

[94] *Id.* at 338. The court noted that "the state does not have a general policy of allowing children ages [twelve] and older to consent to medical decisions, but has instead carved out specific situations where parental consent is not required for minors, such as in emergency situations and for family planning and reproductive services." *Id.* (citations omitted).

[95] *Id.* Although Senate Bill S3041 did not pass in the 2021–2022 legislative assembly, it was reintroduced in 2023 as N.Y. Senate Bill 6103 and would allow children ages fourteen and older to consent to required or recommended vaccines without parental consent. S.B. S6103, 2023-2024 Leg., Reg. Sess. (N.Y. 2023).

immunizations over a parent's objection."[96] The state's Office of Children and Family Services directs local agencies to seek court approval for medical treatment when a parent objects, which brought the case to Rensselaer County Family Court.[97] The Appellate Division explored the court's historic role in weighing a parent's objections to medical treatment against the potential benefits that the children would receive and determined that the Rensselaer County Family Court must hold a hearing for the sake of due process.[98] The hearing would determine whether the thirteen- and fifteen-year-old minors could comprehend the COVID-19 vaccine's risks and benefits and if they had "the capacity to consent"; the court could then decide if the local social services agency could authorize the vaccine.[99] This ruling effectively instructs the Rensselaer County Family Court to apply a mature minor doctrine without the doctrine being in place.

Access to immunizations is one of the areas of medical decision-making and informed consent that would be best served by a mature minor statute. In the United States, fifty-eight percent of youth ages twelve to seventeen completed the two-dose COVID-19 vaccination series while seventy-six percent of youth between the ages of fourteen to twenty-four reported they were willing to receive a COVID-19 vaccine.[100] This discrepancy between young people's willingness to receive a vaccine and actual completion of the COVID-19 two-dose series may be due in part to parental vaccine hesitancy; a recent study found one-third of parents of teenagers reported pediatric vaccine hesitancy.[101]

New York State allows young people to access Human Papillomavirus ("HPV") vaccines without parental consent, which indicates that the legislature supports adolescents' ability to access preventative treatment on their own, especially when the vaccine is preventing the spread of a virus with global public health implications.[102] Rather than the New York State

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[96] *Athena Y.*, 161 N.Y.S.3d at 338 (citing N.Y. COMP. CODES R. & REGS. tit. 18, § 441.22(d) (2021)).

[97] *Id.* at 339.

[98] *Id.* at 340–41.

[99] *Id.* Notably, the court quoted a 1979 New York Court of Appeals opinion twice in the decision, cautioning the family court to refrain from "'assum[ing] the role of a surrogate parent.'" *Id.* (quoting *In re* Hofbauer, 393 N.E.2d 1009, 1014 (1979)).

[100] Stettner et al., *supra* note 55, at 275, 278.

[101] *Id.* at 278.

[102] The Human Papillomavirus ("HPV") vaccine is a two-dose shot given during adolescence prior to becoming sexually active. The vaccine prevents

Legislature continuing to identify piecemeal health care rights and public health emergency exceptions for mature minors, the legislature should consider a mature minor statute which would provide open access to adolescents seeking or refusing treatment with the added protection of the courts being able to determine whether the child is mature enough to make medical decisions.

VI. HOW THE FAMILY HEALTH CARE DECISIONS ACT CAN HELP

New York State's Family Health Care Decisions Act ("FHCDA") is landmark legislation passed in 2010 that codifies surrogate medical decision-making for patients who lack capacity, allowing surrogates and physicians to make important health care decisions when a patient cannot provide informed consent.[103] Section 2994-e of the FHCDA acknowledges that parents have the authority to withhold or withdraw life-sustaining treatment for their children.[104] However, the Act also notes that parents are required to make decisions in the best interests of the child and adds that they should consider "the minor's wishes as appropriate under the circumstances."[105] In terms of withholding or withdrawing life-sustaining treatment, the Act directs physicians, in consultation with the parents, to determine the minor's decision-making capacity prior to withholding medical treatment; if the patient has capacity, the parent may not withdraw life-sustaining treatment without the minor's consent.[106] The Act specifically notes the importance of mature minors being involved in life-and-death medical decision-making and does not allow a parent to stop medical treatment if the child is deemed mature and wishes to

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cancer and genital warts, and the U.S. Centers for Disease Control and Prevention reports an eighty-eight percent drop in infections caused by HPV since 2006. *Human Papillomavirus: HPV Vaccine*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/hpv/parents/vaccine-for-hpv.html [https://perma.cc/2QV7-AA62] (last visited July 13, 2023).

103 N.Y. PUB. HEALTH LAW § 2994-b (Consol. 2025).

104 *Id.* § 2994-e.

105 *Id.* § 2994-e(2)(a). Interestingly, the statute specifically provides instructions on how physicians and hospital ethics review committees should consider the request by an emancipated minor with decision-making capacity to stop life-sustaining treatment; if the request "accords with the standards for surrogate decisions for adults," the mature minor's request should be respected as long as the ethics review committee agrees. *See id.* § 2994-e(3)(a). The FHCDA also mandates that parents be provided notice of an emancipated minor's intent "[i]f the hospital can with reasonable efforts ascertain the identity of the parents" and obtain their contact information. *Id.* § 2994-e(3)(b).

106 *Id.* § 2994-e(2)(b).

continue treatment.

The Act specifically instructs physicians to consider emancipated minors (who are themselves parents, or those over fifteen years old who are living on their own) as having medical decision-making capacity.[107] If the minor is emancipated, the physician is instructed to allow the minor patient to make their own decisions about life-sustaining treatment.[108] The language of the FHCDA explicitly gives adolescents the right, if mature enough, to make their own refusal decisions for life-saving treatment as long as a physician agrees. The FHCDA legislation identifies a fifteen-year-old as potentially mature enough to stop life-sustaining medical treatment, suggesting that their wishes at the end of life should be respected, but the state does not consider the same child mature enough to take an antibiotic for strep throat.[109]

This language in the FHCDA provides model language for a mature minor statute. It divides medical care into two categories: routine and major. If an adult patient without a surrogate decision-maker lacks capacity and needs routine care, the FHCDA does not require specific consent from patients. Routine care includes treatments, services, or procedures to diagnose or treat physical or mental conditions, including prescribing medication, taking blood draws, or providing dental care that requires local anesthesia. The Act enables physicians to provide routine medical care if an adult patient lacks decision-making capacity.[110] When major medical care is necessary, the FHCDA requires two physician consent, which means that two physicians must independently determine that the adult lacks capacity and major medical care is the best treatment option for the patient.[111]

The New York State Legislature could apply the FHCDA framework used for surrogate decision-making to minor patients seeking medical care. For example, if a minor seeks routine medical treatment from a physician and the parent refuses or is unable to provide consent, the physician could determine that the minor is mature and has the capacity to understand the benefits and risks of treatment.[112] If the minor seeks major medical care,

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[107] *Id.*
[108] *Id.* § 2994-e(3)(a).
[109] *Id.*
[110] *Id.* § 2994-g(3)(b).
[111] *Id.* § 2994-g(4)(b)(ii).
[112] *See, e.g.*, *id.* § 2994-e(2)(b), (3) (providing processes for a physician working

the statute could require two physician consent, wherein two physicians would independently evaluate the child's decision-making capacity and agree on the best course of treatment. If there is a challenge or conflict as to the maturity of the adolescent, a hearing in New York State court would be the next step wherein a judge would determine the child's maturity and review their understanding of informed consent.

Additionally, the statute could provide guidance to the judicial system for inevitable conflicts that arise. Among those guidelines could be a consideration of the rationality of the treatment decision as understood by the multiple parties involved: physician(s), parent(s), and child. Thus, if the treatment option would extend a child's life by nine to twelve months but render them unable to talk, walk, or return to school, the court could weigh the child's decision to forgo continued medical treatment in favor of a quicker death but a better quality of life against the parent's decision to give the child the longest time left to be together. In application, the court could weigh the child's ability to (1) list possible outcomes for both treatments; (2) weigh the alternatives appropriately; and (3) understand the risks and benefits of both treatments.[113] Then the court could also balance the interests of the parents and physicians in a similar manner and issue a decision based on knowing that the adolescent's choice was rational, mature, and informed.

VII. CONCLUSION

A mature minor statute that allows adolescents to participate fully in their medical decision-making has the potential to provide clarity for health care teams and the courts and to support the personal autonomy and decision-making skills of adolescents. Pediatricians across the United States, with support from the American Academy of Pediatrics, seek "assent" for medical intervention from their pediatric patients, and many pediatricians, in practice, are requiring informed consent from mature minors or adolescents. In order to create harmony between pediatric practice and New York State law, a mature minor statute would support minor patients and provide clear guidance to courts about how and when children may exert autonomy over their own bodies. A

with a mature or emancipated minor who is seeking to continue or stop life-sustaining treatment, despite a parent's decision or lack thereof).

[113] Walker & Doyon, *supra* note 32, at 631.

mature minor statute would reduce the hodge-podge of public health laws that carve out exceptions for New York's minors to access health care and instead create a standard of care that recognizes that children do not suddenly become adults capable of important medical decision-making on the day they turn eighteen.