



The Rights of Minors Regarding Their Own Health Care

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I. Rights of Parents

Traditionally, the law has recognized the fundamental right of parents to make decisions regarding the care of their children.¹ This right is based on the premise that children generally lack the maturity and experience necessary to make reasonable, informed decisions regarding their own care, and that parents presumably act in the best interests of their children.²

II. Limitations on Rights of Parents

- A. *Parens Patriae*—Under the common law duty of *parens patriae*, which translates to “parent of the country,” the state may, and in some cases must, act as guardian of those who are under a legal disability to act on their own behalf, including children.³ This intervention may involve the appointment of a guardian for the child and/or prosecuting parents for neglecting their child’s health.
1. Parent Denies Treatment for Minor Based on Religious Beliefs—In these cases, courts tend not to be sympathetic to the parents,⁴ unless it is a case in which the parent has acquiesced in the decision of mature minor.⁵

¹ See *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (citing *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Prince v. Massachusetts*, 321 U.S. 158 (1944)).

² See *Parham v. J.R.*, 442 U.S. 584, 602 (1979). According to the court, “most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments.” *Id.* at 603.

³ See *West Virginia v. Chas. Pfizer & Co.*, 440 F.2d 1079, 1089 (2d Cir. 1971); *Troxel*, 530 U.S. at 88 (“...a parent’s interests in a child must be balanced against the State’s long-recognized interests as *parens patriae*...”).

⁴ See, e.g., *State v. Norman*, 808 P.2d 1159 (Wash. Ct. App. 1991) (parent was guilty of manslaughter for refusing to seek treatment for 10-year-old child with severe medical condition based on religious belief); *Schmidt v. Mutual Hosp. Svcs., Inc.*, 832 N.E.2d 977 (Ind. Ct. App. 2005) (adults may refuse treatment for themselves based on religious beliefs, but a parent’s desire to deny treatment to a child based on same beliefs is secondary to state’s interest in protecting the welfare of the child). *But see Diana H. v. Rubin*, 171 P.3d 200 (Ariz. Ct. App. 2007) (state not justified in intervening when parent refuses immunizations for child based on religious beliefs).

⁵ See, e.g., *In re E.G.*, 549 N.E.2d 322 (Ill. 1989).



2. Parent Denies Treatment for Other Reasons—In other instances, a decision at odds with a health care provider’s recommendation is based on the parent’s determination that a different course is in the child’s best interest, particularly if the child is dealing with a life-threatening condition. Outcomes in those cases will vary depending on state law and the circumstances of each situation.⁶

B. Minor’s Capacity to Make Decisions

1. Emancipated Minors—It is generally understood that emancipated minors, i.e., those who are free of parental control,⁷ have the right to consent to their own medical care.⁸ This is also usually true for minors who are pregnant or are parents.⁹
2. Mature Minors—A mature minor is someone younger than the legal age of majority who is deemed to have achieved a certain level of maturity and intelligence that makes it possible for the minor to make reasonable, informed decisions, including consent for health care.¹⁰ Yet even mature minors may not have autonomy with regard to their own health care. Those determinations depend on the minor’s circumstances and the laws of the state in which the minor resides.

⁶ In *H.C.A., Inc. v. Miller ex rel Miller*, 36 S.W.3d 187 (Tex. Ct. App. 2000), *aff’d*, 118 S.W.3d 758 (Tex. 2003), the Texas Court of Appeals held that a hospital was not liable for resuscitating a premature infant without consent from the parents because the parents’ statutory right to withhold treatment was limited to circumstances in which the child’s illness was “certifiably terminal.” See also *In re Nikolas E.*, 720 A.2d 562 (Me. 1998) (mother’s decision to delay child’s treatment for HIV with HAART did not constitute neglect because treatment was considered experimental and mother’s decision was well reasoned). But see *A.D.H. v. State Dep’t of Human Resources*, 640 So.2d 969 (Ala. Civ. App. 1994) (court ordered mother to submit child for HIV treatment because mother was incapable of making rational decision regarding child’s best interests).

⁷ Emancipated status generally depends on the facts in a given situation, including whether the minor is married, living apart from parents, and self-supportive. The rules vary by state. See web site of the Empire State Coalition of Youth and Family Services (visited Feb. 27, 2008) <<http://www.empirestatecoalition.org/emanc.html>> (New York); web site of the Juvenile Law Center (visited Feb. 27, 2008) <<http://www.jlc.org/index.php/factsheets/emancipation>> (Pennsylvania).

⁸ See, e.g., CAL. FAM. CODE § 7050(e)(1); CONN. GEN. STAT. § 46b-150d.

⁹ See, e.g., ALA. CODE § 25.20.025; 410 ILL. COMP. STAT. 210/1; MASS. GEN. LAWS ch. 112, § 12F; MINN. STAT. §§ 144.342, 343; N.Y. PUB. HEALTH LAW § 2504.

¹⁰ See *In Re Conner*, 140 P.3d 1167 (Or. Ct. App. 2006) (adopting a mature minor exception would require the judge to determine if a minor demonstrates the requisite capacity and maturity to make decisions for her/himself). See also *Hodgson v. Minnesota*, 497 U.S. 417 (1990); *H.L. v. Matheson*, 450 U.S. 398 (1981). For examples of the mature minor doctrine as a defense, see *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987) (practitioner not guilty of battery on a minor for treatment without parental consent when minor was mature enough to consent to treatment) and *Commonwealth v. Nixon*, 761 A.2d 1151 (Pa. 2000) (parents may not claim that minor child was mature enough to make her own decisions as a defense to neglect charges after denying her health care for life-threatening illness).

3. Right to Refuse Treatment—In *In re E.G.*,¹¹ the Illinois Supreme Court, invoking the mature minor doctrine, found that a 17-year-old girl could refuse medical treatment based on her own religious beliefs. In another case, the Virginia legislature passed a law that requires mature minors who are at least 14 years old to have a say in their own medical care, including the right to refuse treatment.¹² However, the right to refuse treatment, like the right to consent to treatment, will be based on a determination of the minor’s capacity to make health care decisions.
- C. Privacy—In *Planned Parenthood of Central Missouri v. Danforth*, the court concluded that, “[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”¹³ In these cases, arguments supporting autonomy for minors regarding their health care are often based in privacy theory. In *American Academy of Pediatrics v. Lungren*,¹⁴ the California Supreme Court held that the state statute requiring a pregnant minor to obtain parental consent before having an abortion violated the plaintiff’s constitutionally protected right to privacy in procreative matters.

III. Rights of Minors Related to STI/HIV Testing and Treatment

- A. STI Testing and Treatment—In all 50 states and the District of Columbia, minors may consent to testing and treatment for sexually transmitted infections (STIs) without parental consent.¹⁵
- B. HIV Testing—A majority of states allow minors to consent for HIV testing.¹⁶ Whether or not the right to consent includes a corresponding right to refuse HIV testing when requested by a parent or guardian is less clear.
- C. HIV Treatment—Having the capacity to consent to testing for HIV, or testing and treatment for STIs, does not necessarily mean that a minor has the capacity to consent to HIV treatment. Unlike treatments for most STIs, treatments for HIV are long-term and come with a host of unpleasant side effects, which makes a requirement for parental consent

¹¹ 549 N.E.2d 322 (Ill. 1989). There must be clear and convincing evidence that the minor is mature enough to understand the consequences of her actions. *Id.* at 327-28.

¹² *Assembly Gives 14-Year-Olds a Say on Key Medical Care*, WASH. POST, Feb. 24, 2007, at B5. See VA. CODE ANN. § 63.2-100. For an example of what might happen when a minor is not granted a right to refuse treatment, see Gail B. Slap & Martha M. Jablow, *Debating Rights of Young Patients*, N.Y. TIMES, Nov. 10, 1994, at C1.

¹³ 428 U.S. 52, 74 (1976). See also *Bellotti v. Baird*, 443 U.S. 622 (1979); *Planned Parenthood Ass’n v. Ashcroft*, 462 U.S. 476 (1983); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

¹⁴ 940 P.2d 797 (Cal. 1997).

¹⁵ *Minors’ Access to STI Services*, STATE POLICIES IN BRIEF (Guttmacher Institute, New York, N.Y.), Mar. 1, 2008, at 1.

¹⁶ *Id.*



more likely. Most states that categorize HIV as an STI allow minors to consent to HIV treatment.¹⁷ In other states, the rules will vary.¹⁸

- D. Right to Know—In order for minors to be involved in their own HIV care, they must first know that they have HIV. The AAP recommends that children be told about their condition in a manner that is “geared to a child’s level of cognitive development and psychosocial maturity.”¹⁹ The AAP has also stated that physicians have an ethical obligation to inform adolescents about their HIV status, even against the parents’ wishes, in order to ensure that adolescents participate in their own care and understand how to reduce the risk of transmission to others.²⁰

IV. Confidentiality & Privacy

- A. HIV Testing Statutes—If a state has an HIV confidentiality statute, the requirements of that statute will generally apply to minors just as they apply to adults, at least in terms of disclosure to anyone other than a parent or guardian.²¹ In many states,²² however, when a minor provides consent for STI/HIV testing or treatment, the treating physician has the option of notifying the minor’s parents if the physician determines that doing so would be in the minor’s best interests. In Iowa, if a minor tests positive for HIV, the parent or guardian *must* be notified.²³ However, in Washington state, if a minor is tested for HIV, regardless of the result, the information *must not* be disclosed to the parent or anyone else.²⁴
- B. HIPAA²⁵—The HIPAA privacy rule requires that a minor’s health information not be released to anyone, including a parent or guardian, if the minor has the legal authority to consent to the related health services without parental consent or if the parent or guardian has assented to an agreement of confidentiality between the minor and health care provider.²⁶ The exception to

¹⁷ Wing Wah Ho et al., *Complexities in HIV Consent in Adolescents*, 44 *CLINICAL PEDIATRICS* 473, 476. See, e.g., CAL. FAM. CODE § 6926(a).

¹⁸ In Connecticut, for example, the law requires parental consent for HIV treatment, unless the physician determines that treatment would be denied, or the minor would not access treatment if consent is sought, and the minor requests that the parents not be notified. See CONN. GEN. STAT. § 19a-592.

¹⁹ See American Academy of Pediatrics Committee on Pediatric AIDS, *Disclosure of Illness Status to Children and Adolescents with HIV Infection*, 103 *PEDIATRICS* 164 (1999, *aff’d*, 2005).

²⁰ *Id.* at 165.

²¹ This is not true in Illinois where, if a minor tests positive for HIV, the state is required to notify the principal of the school at which the minor is enrolled. See 410 ILL. COMP. STAT. § 315/2a.

²² As of March 1, 2008, there were 18. *Minors’ Access to STI Services*, *supra* note 18, at 2.

²³ IOWA CODE § 141A.7.

²⁴ WASH. REV. CODE § 70.24.105(2)(a), (b).

²⁵ The Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

²⁶ 45 C.F.R. § 164.502(g)(3)(i)(A)-(C)



this rule, however, is that state law takes precedence if state law, including case law, specifically permits or requires a health care provider to disclose information about a minor to the parent or guardian.²⁷ Fortunately, the same holds true if state law prohibits a provider from disclosing the information.²⁸ If state law is silent on the issue, the health care provider may, based on professional judgment, determine whether or not to disclose the information.²⁹

C. Payment

1. Private Insurance—In many instances, if a minor is granted the legal authority to consent to testing or treatment for HIV or an STI, the law absolves the parent of responsibility for payment related to the testing or treatment.³⁰ This does not, however, necessarily mean that the parent’s insurance will not be billed, especially if the testing or treatment is provided by a private physician. In those instances, an inadvertent breach of confidentiality might occur when the parent receives a notification of benefits from the insurer. HIPAA allows a patient to request confidential communications, but the physician would likely have to advocate on behalf of the minor, and the insurer does not have to agree.³¹
2. Public Insurance—Medicaid guarantees confidential access to family planning services for minors.
3. Title X—Protection of minors’ confidentiality is guaranteed though if the minor receives services from a Title X funded organization, where services must be provided according to a fee scale that is based on only the minor’s income.³²

²⁷ § 164.502(g)(3)(ii)(A).

²⁸ § 164.502(g)(3)(ii)(B).

²⁹ § 164.502(g)(3)(ii)(C).

³⁰ *See, e.g.*, OHIO REV. CODE ANN. §§ 3701.242, 3709.241.

³¹ *See* 45 C.F.R. § 164.522.

³² *Reducing Teenage Pregnancy*, FACT SHEET (Planned Parenthood Federation of America, Inc., New York, N.Y.), Mar. 2000, at 4.