A Child's Right to Consent to Medical Treatment

By Erin E. Kilmer

I. Introduction

Under New York state law,[1] a minor child[2] is not generally able[3] to consent to "medical, dental, health or hospital services."[4] In not allowing children under the age of 18 to consent to medical treatment, New York state law is not in line with the United Nations (UN) recommendations in the Convention on the Rights of the Child. The Convention on the Rights of the Child outlines that children are holders of rights and that they must be respected "in a manner consistent with the evolving capacities of the child."[5] While this does not mean that all children should have an independent right to direct their health care, it does mean that the "evolving capacities" of children should be taken into account when considering whether a child has the ability to consent to health care.

However, New York state is not bound to comply with the Convention on the Rights of the Child as the United States is the only country that has not ratified or accessioned the Convention.[6] That being said, there is no reason for New York to not work to comply with the Convention. Since 2016, New York has presented itself as a progressive state, working against what it sees as federal failures. If New York wishes to be progressive, one step it needs to take is modifying its laws to be in line with the Convention on the Rights of the Child. This article looks at one specific aspect of New York law, the ability of children to consent to medical treatment, and suggests how New York law may be modified through the mature minor doctrine to comply with the Convention on the Rights of the Child.

II. The UN Convention on the Rights of the Child

The UN Convention on the Rights of the Child entered into force on September 2, 1990,[7] and today it is lauded as the "most widely and rapidly ratified human rights treaty in history."[8] It recognizes children's human rights and establishes international law that requires all States Parties[9] to ensure that all children have the ability to achieve their rights in an accessible and active manner.[10] Its articles are interdependent and indivisible, and they outline the responsibilities that the States Parties have to protect children because "by reason of [their] physical and mental immaturity, [they] need[] special safeguards and care, including appropriate legal protection, before as well as after birth."[11]

The Convention includes 54 articles that specify certain rights that States Parties must guarantee to all children.[12] Although none of these articles specifically articulates that children must be given the right to control their own health decisions, the Convention does clearly articulate that children have the right to access to health care,[13] and that children have "evolving capacities"[14] which must be given due weight based on the maturity of the child.[15] As supplements to the Convention, the Committee on the Rights of the Child has also issued a number of General Comments, more specifically explaining how the general rights in the Convention can be guaranteed by Member States. General Comment Number 4 articulates that children must be informed about their health and given the opportunity to provide an opinion about the options.[16]

A. The United States

Although the United States has not ratified the Convention, the United States signed the Convention and, consequently, it may not work against it.[17] It is not uncommon for the United States to be one of few countries to not ratify an international convention. The United States has a long history of not ratifying international conventions, including the Convention on the Elimination of All Forms of Discrimination Against Women[18] and the International Covenant on Economic, Social and Cultural Rights.[19] The discussion in the United States surrounding ratification of the Convention on the Rights of the Child often concerns the worry in the United States that the Convention threatens the rights of parents.[20] While it does not seem that the United States will ratify the Convention in the near future,[21] because the document is so well observed and accepted, it is worth looking to as a starting point for reforming children's rights.

B. A Child's Capacity

Although the Convention on the Rights of the Child does not specifically address a child's ability to consent to medical treatment, it does contain a number of provisions that are relevant in considering how much control a child should have over their[22] own medical treatment.[23] Because all of the articles in the Convention are interdependent and indivisible, the best interests standard outlined in Article 3 ("[i]n all actions concerning children, . . . the best interests of the child shall be a primary consideration") applies to all other considerations under the Convention.[24] This not only applies to all other articles in the Convention, but can also be viewed independently as a standard that requires all medical treatment to be in the child's best interest as far as health is considered. However, in all cases, the idea of a child's best interest goes further than health considerations. It may also be in the child's best interest to be heard, to feel respected, and to "have a say" in their own medical choices.

One of the few articles in the Convention to explicitly address children's health is Article 24. Article 24 states that children have a right "to the enjoyment of the highest attainable standard of health," and that States Parties must take actions to make this happen, particularly to guarantee "that

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no child is deprived of his or her right of access to . . . health care services."[25] This includes specifically "that all segments of society . . . are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition."[26]

In addition to the best interest standard outlined in Article 3, there are a number of articles that are relevant in determining how far children should be allowed to direct their own medical treatment decisions. Articles 5 and 12 of the Convention both specifically recognize that children have "evolving capacities" and that these capacities need to be respected.[27] Article 5 further acknowledges that parents have their own rights in regards to how their children are brought up. It states: "States Parties shall respect the responsibilities, rights and duties of parents . . . to provide, in a manner consistent with the evolving capacity of the child, appropriate direction and guidance."[28] Article 5 shows a strong respect for parental rights, but it tempers this with respect for the child to be able to also direct their upbringing.

Following this, Article 12 requires that "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child" and that those views are to be given "due weight in accordance with the age and maturity of the child."[29] The idea discussed in Article 5 about evolving capacities is again mentioned in Article 12. Because children's capacities are ever evolving, and because children mature at different rates, it is important that both age and maturity be taken into account when considering how much weight to accord any individual child's ideas.

In addition to respecting the rights of children to express their own ideas, Articles 16 and 17 are also applicable to children's health care decisions. Article 16 protects children from unlawful invasions of their privacy,[30] and Article 17 requires States Parties to encourage the dissemination of appropriate information through mass media.[31] The protection of children's privacy would include that of their health care matters, and required dissemination in the media would include information about health care that is appropriate for children, including about medical treatments and their ability to consent or withhold treatment, and sexual health, particularly pregnancy and sexually transmitted infections.

Although the Convention does not specifically discuss a child's ability to consent to treatment, the Committee on the Rights of the Child addressed it explicitly in General Comment Number 4.[32] In this General Comment, the Committee went to great lengths to more specifically outline some of the specifics that the Convention requires. The Committee expands on Article 16, specifically requiring adolescents to be provided "with access to sexual and reproductive information, including on . . . contraceptives, . . . and the prevention and treatment of sexually transmitted diseases."[33] It also expands on Article 17, explicitly requiring States Parties to create laws that allow for children to receive confidential advice about their treatment so that they may give informed consent.[34]

In addition to expanding on some of the less specific articles, the Committee also touched on the idea of children's consent to medical treatment. The Committee wrote that "[b]efore parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight."[35] This means that any child, with any level of maturity, should be given the opportunity to express their view and that view should be considered with an appropriate amount of weight based on the child's maturity and age. However, the paragraph continues on that "if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the 'best interest of the child.'"[36] Therefore, it is the Convention's view that before the age of 18, it is highly possible that a given child will be able to consent for themself, and that therefore, the child's maturity level should be considered when determining whether they may make the determination themself.

III. A Discussion on Capacity

Unfortunately, in many clinical and legal discussions about consenting to or refusing treatment, the words "capacity" and "competence" are often conflated.[37] However, it is important for this article to make a distinction. Capacity refers to a clinical judgment about an individual's ability to understand their situation and make educated treatment decisions.[38] On the other hand, competence refers to a legal determination about whether an individual legally has the ability to make treatment decisions.[39] I am arguing that children today are determined to not be competent to make medical decisions because the laws do not allow them to consent, but that there are children who do in fact have the capacity to understand their situations and make educated treatment decisions.

In the clinical context (and most other contexts), an adult "is presumed to be competent unless demonstrated to be otherwise."[40] In order for a judiciary to find that an adult is incompetent, there must be "clear and convincing evidence" showing such.[41] This high standard (although lower than the "beyond a reasonable doubt" standard used in criminal convictions) is important because an individual's right to make their own medical decisions is an important right.[42] Determinations of capacity are task-specific.[43] This means that in determining capacity, a physician must look to what decision the patient is making and determine whether the patient has capacity to make that specific decision.[44] When an adult is found to be competent to make medical decisions, they may consent to or refuse any medical treatment.[45] This rests on the idea that individuals who are competent have "a constitutionally protected liberty interest in refusing unwanted medical treatment."[46]

When dealing with children, however, a child's capacity is traditionally never considered. Instead, the child is automatically deemed incompetent, and their parent has the right and responsibility to make medical decisions for the child.[47] This "rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment re-

quired for making life's difficult decisions."[48] A child's parents are presumed to be in the best position to make a decision that is in the best interest of the child. However, this automatic determination of incompetence prevents children who have capacity from being allowed to make their own health care decisions. Because some children have this capacity while others do not, when there is a conflict, health care providers should perform an inquiry into the individual child's actual capacity.

There is already precedent that a parent's right and responsibility to make medical decisions for their child is not boundless. Previous cases have determined that a parent's right to control their child's upbringing is not absolute because the state also has an interest in protecting the children within its borders.[49] In the context of a religious freedom case in 1944, the United States Supreme Court held that "[p]arents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children."[50] This case, *Prince v. Massachusetts*, has been cited a number of times in cases where a parent was refusing lifesaving treatment for their child and a court overruled the parent's decision. Because of this, a child's parents do not have an absolute right to refuse medical treatment; for all minors, the state has an interest in protecting them.[51]

These relationships between the child, the parent, and the state are reflected in the American Medical Association's (AMA's) Code of Medical Ethics. Opinion 2.2.1 of Pediatric Decision Making states that decisions should be based on the child's best interest, but that when it is unclear "whether a specific intervention promotes the patient's best interests," the "decisions of the patient and the parents/guardian" should be respected.[52] The AMA also recommends that the medical condition, its implications and the treatment plan should be explained to minor patients capable of assent.[53]

However, in 2016, the American Academy of Pediatrics (AAP) released a revised statement on informed consent regarding the treatment of minors.[54] Rather than only focusing on assent, this revised statement emphasizes "that patients should participate in decision-making commensurate with their development" and that assent should be obtained whenever possible.[55] Additionally, the AAP recommends that "[d]issent by the pediatric patient should carry considerable weight when the proposed intervention is not essential and/or can be deferred without substantial risk."[56]

Both the AMA's and the AAP's ethical opinions extol the idea that a minor patient's assent should be obtained prior to any treatment.[57] They both recognize the need for the patient to be informed about their medical prognosis and the course of treatment that is to be performed.[58] However, both also recognize that it is the minor patient's parents or guardians who get to make the medical decisions, unless the decisions the parents make are not in the best interests of the child.[59] This conflict is particularly highlighted by the fact that both groups recommend turning to the courts to resolve disagreements.[60] Although this option is seen as the "last resort," the mention of courts nevertheless recognizes that within these constructs, there is potential room for conflict, and sometimes it will be necessary for the courts to decide what is ultimately in the best interest of the child.[61]

Although children generally lack some of the "maturity, experience, and capacity for judgment required for making life's difficult decisions,"[62] this does not mean that a child's autonomy should be disregarded entirely. Beauchamp and Childress define personal autonomy as "at a minimum, self-rule that is free from both controlling interference by others and from certain limitations." They compare an autonomous individual who "acts freely in accordance with a self-chosen plan," and a person of diminished autonomy who is either "controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans."[63] Beauchamp and Childress discuss two conditions that are required for autonomy, "liberty (independence from controlling influences) and agency (capacity for intentional action)."[64] The amount of autonomy a child can exhibit is dependent on these two conditions.

As mentioned, New York state law does not currently recognize that a child has the amount of liberty necessary to exercise autonomy. While there are recommendations that assent be obtained,[65] a child's liberty is controlled by their parents'—and potentially even the state's—decisions about best interests.[66] However, even if a mature minor standard were introduced, it is important to recognize that a child will likely not have complete independence from controlling influences.[67] Children are likely to be influenced by their parents' opinions, even if the children are allowed to make their own decisions.[68] Because of this, it is important that those individuals responsible for making capacity determinations consider how much influence a child's parents are having on them.[69] This influence is not unique to children; it can be a problem with all individuals who are dependent on a caregiver.[70] Even adult individuals who are dependent on other people to take care of them are likely to be swayed by the opinions of those caregivers for fear of negative reactions from the caretakers.[71] Because of this, there are already techniques in the medical and psychology fields that physicians and psychologists can use to determine if an individual has enough liberty to have the capacity necessary to make medical decisions.[72]

When it comes to the capacity of a child, the question of agency is arguably more important than the question of liberty. Many of the barriers to a child's liberty come from state or socially imposed constraints on children's liberty. Agency, on the other hand—the measure of an individual's "capacity for intentional action"[73]—is less constrained by actions of others, and more dependent on an individual child's ability. Jurisprudence regarding children's rights in the United States has centered predominantly on children's agency, or lack of, to justify granting children a more limited scope of rights than adults.[74] Choice theory is based on the idea that children lack the capacity to make autonomous decisions and are therefore unable to exercise the same rights as adults.[75]

While choice theory may give reason to deprive children of rights, it rests on a flawed premise that until individuals reach the age of majority they are completely unable to make

autonomous decisions.[76] In *Parham v. J.R.*, the Supreme Court asserted that "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions."[77] That same year, the Supreme Court also found that children under the age of majority lack the "experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them."[78] However, the Supreme Court has also found that children need to be "given opportunities for growth into free and independent well-developed men and citizens."[79] Similarly, researchers have found that children's capacity for autonomous thought is developed through learning over time.[80] Because of this, it is important that children be given opportunities to develop this capacity, and to recognize that some children, before the age of majority, will be able to make autonomous, rational decisions.[81]

As early as 1989 the *Journal of Pediatrics* was arguing that "the child's concerns are central"[82] and that "the physician is obligated to determine the maturity level in the seriously ill juvenile and to facilitate the patient's self-determination."[83] This idea aligns with the experiences of many physicians who have found that some children do have "the capacity to understand the consequences of a choice and the ability to assess his or her best interests."[84] Because it is possible for some children to have the capacity necessary to understand their medical situation and the choices available as treatment, physicians should be allowed to make the inquiry into whether an individual child had the capacity required to make their own medical decisions.

Although a physician should be the first person making a capacity inquiry when a conflict arises, the physician may not be able to be the final arbiter of who makes the final decision when there are so many individuals with interests and opinions involved. Because of this, the AMA and the AAP both recognize that the parties may need to turn to the courts to make the final determination.[85] When a court is tasked with making this determination, it should consider a mature minor standard.

IV. Minor Consent Laws in the United States

While a mature minor standard has been contemplated in a number of cases in the United States, most commonly it is used in the context of obtaining an abortion.[86] The Supreme Court of the United States has heard a number of cases regarding the mature minor standard in the context of abortion, finding state laws unequivocally requiring parental consent for a minor to obtain an abortion to be unconstitutional.[87] However, while the Supreme Court of the United States has not applied the mature minor standard in health care outside of the context of abortion, a small number of states have.[88]

In re E.G.[89] from the Illinois Supreme Court is one of the most often cited state decisions in support of a mature minor standard. E.G. was a 17-year-old Jehovah's Witness who refused to consent to a blood transfusion.[90] Her decision was supported by her mother who was also a Jehovah's Witness.[91] An appellate court found that E.G. was a mature minor and therefore was able to refuse a blood transfusion; however, the court upheld a finding of neglect against her mother for refusing the transfusion on E.G.'s behalf.[92] The Illinois Supreme Court upheld the determination that E.G., being a mature minor, was competent to refuse the transfusion, and reversed the finding of neglect against E.G.'s mother.[93] The Illinois Supreme Court cited a number of the mature minor abortion cases in the Supreme Court and held that while an extension of the mature minor doctrine might not be "inevitable,"[94] there is "no 'bright line' age restriction of 18 [that] is tenable in restricting the rights of mature minors."[95]

The state of Arkansas is one of the few states that statutorily allows mature minors to consent to or refuse medical treatment.[96] Arkansas' consent statute states that "[a]ny unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, for himself or herself"[97] is free to consent, "either orally or otherwise, to any surgical or medical treatment or procedure."[98] This allows for any minor to show that they have the capacity to understand their medical situation and treatment options, and to consent to or refuse treatment as they wish.

V. New York Minor Consent Laws

A. Statutory Law

Generally, a minor does not have the ability to consent to medical treatment in New York state—only the minor's parent or guardian may do that.[99] However, for various public policy reasons, New York has written a number of exceptions to this into the law.[100]

One of the largest exceptions to minor consent laws deals with a minor's sexual health. A minor who is pregnant may give consent to medical services related to their prenatal care,[101] and anyone who is the parent of a child or has married is allowed to consent to their own medical treatment.[102] Similarly, a minor parent is allowed to consent to medical treatment for their child.[103] These laws mean that a minor who is pregnant may consent to medical treatment insofar as it has to do with their pregnancy, and once that minor gives birth (assuming they maintain parental rights) they may consent to any medical treatment for themself and their child.

New York Public Health Laws also allow a physician to diagnose, treat, or prescribe for a minor, without the consent or knowledge of the minor's parents, if the minor has been exposed to a sexually transmitted infection.[104] Further, New York Public Health Laws provide that any individual who wishes to be tested for human immunodeficiency virus (HIV) needs only to have the capacity to consent.[105] This is further defined to be "determined without regard to the individual's age," considering only the individual's capacity.[106]

New York Mental Hygiene Laws additionally allow mental health providers to provide outpatient mental health services and access to psychotropic medications to minors without parental consent in a limited number of circumstances.[107] A mental health practitioner may provide mental health

services to a minor who knowingly and voluntarily seeks them, as long as the services are necessary for the minor's wellbeing and if the parent is not reasonably available, if requiring such involvement would have a detrimental effect on the treatment, or if the parent has refused to consent and the treatment is in the minor's best interests.[108] The requirements to administer psychotropic medications to a minor in a hospital, in a non-emergency situation, are similar.[109]

B. Case Law

All of the cases in New York concerning the ability of minor to consent to treatment, the issue in the case arose because either the child, the parent, or the hospital wanted to refuse treatment, and one or both of the other parties wanted the treatment to occur.

In *In re Long Island Jewish Medical Center*,[110] a 17-year-old cancer patient, Phillip Malcolm, and his parents wished to refuse blood transfusions due to their religious beliefs.[111] In response, the hospital petitioned for a court order authorizing them to treat Malcolm with a blood transfusion.[112] The hospital wished to treat Malcolm with a blood transfusion because without it, he would likely die within a month, during which time he would be in pain.[113] The court authorized a blood transfusion, and that decision was later upheld in the same court.[114] In determining whether Malcolm should be allowed to refuse to consent to the blood transfusion, the court discussed the "mature minor" doctrine as a common law right in some states that allows a minor who is mature enough to consent to or refuse treatment.[115] The court discussed the doctrine's use in a number of other states, but it found that Malcolm, seven weeks shy of his 18th birthday, was not a mature minor.[116] The mature minor doctrine has not again been addressed by a New York court.

In most of the other New York cases, the conflict is similar to *Long Island Jewish Medical Center* where the parents and the child's wishes align but are in conflict with a medical provider.[117] However, in *In re Thomas B.*,[118] the parents' and the child's wishes were in conflict.[119] Thomas B. was a 15-year-old boy with cancer.[120] He was scheduled to undergo surgery for a biopsy, but he refused, against his mother's and the hospital's advice.[121] Although the court discussed that it was "reluctant to summarily and precipitately disregard the emphatic protests of the 15-year-old respondent,"[122] it determined that under Public Health Law, Thomas did not have the authority to give consent for treatment because he was only 15, and therefore he was not able to effectively refuse treatment.[123]

VI. Conclusion

Based on the Convention of the Rights of the Child, New York needs to modify its consent statute so that children's opinions about their health care are respected. One way of doing this would be to institute a "mature minor" standard. A few states have done so in a statutory manner, and a number more that have done so through the courts. However, New York has done neither.[124] A mature minor standard, particularly if it was not one created through the courts, would allow medical providers to look at the best interests of the child and determine if the child has the capacity to consent to treatment. The way that it stands today, a child could have the capacity to consent to treatment because they are able to give, and are actively giving, informed consent; however, that child, because they are not 18, is not competent to consent.

Endnotes

1. This article will deal primarily with New York state law. For information about other states' laws, *see* National District Attorneys Association, Minor Consent to Medical Treatment Laws (2013), https://www.ndaa.org/pdf/Minor%20Consent%20to%20Medical%20Treatment%20(2).pdf.
2. "Minor" is defined under New York Domestic Relations Law and General Obligations Law as someone under the age of 18. *See* N.Y. Domestic Relations Law § 2 (DRL); N.Y. General Obligations Law § 1-202 (GOL). This is the same age used in the Public Health Law.
3. The Public Health Law does build in a number of exceptions that allow minors to consent to specific treatments and under specific circumstances. *See infra* for a discussion on the exceptions.
4. N.Y. Public Health Law § 2504(1) (PHL).
5. Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3, art. 5.
6. *See* United Nations Treaty Collection, Status of Treaties, Convention on the Rights of the Child (Apr. 4, 2018, 5:01 AM), https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-11&chapter=4&lang=en [hereinafter Status of Convention on the Rights of the Child].
7. Convention on the Rights of the Child, *supra* note 5.
8. *Convention on the Rights of the Child: Frequently Asked Questions*, UNICEF (Nov. 30, 2005) https://www.unicef.org/crc/index_30229.html. As mentioned at fn 19, the United States is the only country to not have ratified or acceded the Convention.
9. "A 'State Party' to a treaty is a country that has ratified or acceded to that particular treaty, and is therefore legally bound by the provisions in the instrument." Introduction to the Convention on the Rights of the Child, UNICEF 2.
10. *See Convention on the Rights of the Child: Frequently Asked Questions*, *supra* note 8.
11. Convention on the Rights of the Child, *supra* note 5.
12. *Id.*
13. *See id.*, art. 24.
14. *Id.*, art. 5.
15. *See id.*, art. 12.
16. *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, UN Committee on the Rights of the Child, (Jul. 1, 2003), CRC/GC/2003/4, https://www.unicef-irc.org/portfolios/general_comments/GC4_en.doc.html [hereinafter *General Comment No. 4*]. The Committee on the Rights of the Child is composed of 18 independent experts who monitor implementation of the Convention by States Parties.
17. *See* Status of Convention on the Rights of the Child, *supra* note 6.
18. United Nations Treaty Collection, Status of Treaties, Convention on the Elimination of All Forms of Discrimination Against Women (Apr. 6, 2018, 5:01 AM), https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-8&chapter=4&lang=en (ratified by 189 countries with the United States signing but not ratifying).
19. United Nations Treaty Collection, Status of Treaties, International Covenant on Economic, Social and Cultural Rights (Apr. 6, 2018, 5:01 AM), https://treaties.un.org/Pages/

ViewDetails.aspx?src=IND&mtdsg_no =IV-3&chapter=4&clang=_en (ratified by 166 countries with the United States signing but not ratifying).

20. *See, e.g.*, Richard G. Wilkins, Adam Becker, Jeremy Harris & Donlu Thayer, *Why the United States Should Not Ratify the Convention on the Rights of the Child*, 22 St. Louis U. Pub. L. Rev. 411 (2003); Susan Kilbourne, *The Wayward Americans—Why the USA Has Not Ratified the UN Convention on the Rights of the Child*, 10 Child & Fam. L.Q. 243, 245 (1998); Soo Jee Lee, Note, *A Child's Voice vs. A Parent's Control: Resolving a Tension Between the Convention on the Rights of the Child and U.S. Law*, 177 Colum. L. Rev. 687, 690 (2017); Michael J. McMillin, Note, *The Road to Implementing the UNCRC: Maintaining Parental Authority in the Religious Education of Children*, 35 Okla. City U.L. Rev. 853, 862 (2010).

21. *See, e.g.*, Draft, *Executive Order—Moratorium on New Treaties*, https://apps.washingtonpost.com/g/documents/world/read-the-trump-administrations-draft-of-the-executive-order-on-treaties/2307/ (last visited Dec. 7, 2018) ("[T]he U.N. Convention on the Rights of the Child has been interpreted to prohibit spanking. Whether one agrees or disagrees with these outcomes as a substantive policy matter, these are not appropriate matters for international treaties. To the contrary, these types of treaties are emblematic of a larger problem, whereby these treaties are used to force countries to adhere to often radical domestic agendas that could not, themselves, otherwise be enacted in accordance with a country's domestic laws.").

22. "They," "them," and "theirs" are used in this paper as gender neutral, singular pronouns. *See* Lauren Easton, *Making a Case for a Singular "They,"* Associated Press, (Mar. 24, 2017) https://blog.ap.org/products-and-services/making-a-case-for-a-singular-they.

23. *See generally* Convention on the Rights of the Child, *supra* note 5.

24. *Id.*, art. 3.

25. *Id.*, art. 24.

26. *Id.*

27. *Id.* arts. 5, 12.

28. *Id.*, art. 5.

29. *Id.*, art. 12.

30. *Id.*, art. 16.

31. *Id.*, art. 17.

32. *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, UN Committee on the Rights of the Child, (Jul. 1, 2003), CRC/GC/2003/4, https://www.unicef-irc.org/portfolios/general_comments/GC4_en.doc.html [hereinafter *General Comment No. 4*]. The Committee on the Rights of the Child is composed of 18 independent experts who monitor implementation of the Convention by States Parties.

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

37. *See* Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 New Eng. J. Med. 1834, 1834 (2007).

38. *See id.*

39. *See id.*

40. Raphael J. Leo, *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, 1 Primary Care Companion J. Clinical Psychiatry 131, 131 (1999).

41. *See id.*

42. *See id.* For more information about an individual's right to make their own medical decisions and the concept of respect for autonomy in medical ethics, *see generally* Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics 99–148 (6th ed. 2009).

43. *See* Leo, *supra* note 40, at 131.

44. *See id.*

45. *See, e.g.*, *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 277 (1990).

46. *See id.*

47. *See Parham v. J.R.*, 442 U.S. 548, 602 (1979) ("[P]arents generally 'have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations.'") (quoting *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925)) (second alteration in original).

48. *Parham*, 442 U.S. at 602.

49. *See, e.g.*, *PJ v. Wagner*, 603 F.3d 1182, 1197–98 (10th Cir. 2010) (citing *Prince v. Massachusetts*, 321 U.S. 158 (1944)); *In re Willmann*, 493 N.E.2d 1380, 1388–89 (Ct. App. Ohio 1986) (citing *Prince*, 321 U.S. 158).

50. *Prince*, 321 U.S. at 170.

51. *See PJ*, 603 F.3d at 1197–98 (citing *Prince*, 321 U.S. 158).

52. *See Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, American Medical Association https://www.ama-assn.org/delivering-care/pediatric-decision-making (last visited Dec. 7, 2018).

53. *See id.*

54. Committee on Bioethics, Policy Statement, *Informed Consent in Decision-Making in Pediatric Practice* 138 Pediatrics 1 (2016).

55. *See id.* at 1.

56. *See id.* at 4.

57. *See id.* at 2; *Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, *supra* note 52.

58. *See* Committee on Bioethics, Policy Statement, *supra* note 54, at 2; *Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, *supra* note 52.

59. *See* Committee on Bioethics, Policy Statement, *supra* note 54, at 2; *Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, *supra* note 52.

60. *See* Committee on Bioethics, Policy Statement, *supra* note 54, at 2; *Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, *supra* note 52.

61. *See* Committee on Bioethics, Policy Statement, *supra* note 54, at 4; *Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, *supra* note 52.

62. *Parham v. J.R.*, 442 U.S. 548, 602 (1979).

63. Beauchamp & Childress, *supra* note 42, at 99.

64. *Id.* at 100.

65. *See* Committee on Bioethics, Policy Statement, *supra* note 54, at 4; *Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, *supra* note 52.

66. *See PJ v. Wagner*, 603 F.3d 1182, 1197–98 (10th Cir. 2010) (citing *Prince v. Massachusetts*, 321 U.S. 158 (1944)).

67. This was one of the biggest concerns in the Cassandra C. case. *See In re Cassandra C.*, 112 A.3d 158 (Conn. 2015). Cassandra C. was a 17-year-old girl who was diagnosed with Hodgkin's lymphoma. *See id.* at 159. A neglect petition was filed against her mother after her mother refused to consent to chemotherapy because Cassandra did not want it. *See id.* at 160. A judge was requested to consider whether Cassandra was a mature minor and could therefore make her own medical decisions. *See id.* at 171. However, the judge determined that because she "was very emotionally dependent on her mother, and was heavily influenced by her mother's distrust of physicians and other persons in positions of authority," she was not a mature minor and "was not competent to make her own medical decisions." *See id.* at 171–72.

68. *See Cassandra C.*, 112 A.3d 158.

69. *Id.*

70. *See* J. David Velleman, Against the Right to Die, 17 J. MED. & PHIL. 665, 675 (1992).
71. *See id.*
72. *See, e.g.*, *id.*
73. BEAUCHAMP & CHILDRESS, *supra* note 42, at 100.
74. *See* Anne C. Dailey, *Children's Constitutional Rights*, 95 MINN. L. REV. 2099, 2106 (2011).
75. *See id.*
76. *See id.* at 2109
77. *Parham v. J.R.*, 442 U.S. 584, 603 (1979) (holding that a minor could be involuntarily committed to a mental institution by their parents).
78. *Bellotti v. Baird*, 443 U.S. 622 (1979) (holding that a mature minor could consent to an abortion and that a requirement of parental notification all cases of abortions was unconstitutional).
79. *Prince v. Massachusetts*, 321, U.S. 158, 165 (1944) (allowing the state to prevent child labor, even when such labor was a child practicing religion).
80. *See* Dailey, *supra* note 74, at 2113; R. F. Weir & C. Peters, *Affirming the Decisions Adolescents Make About Life and Death*, 27 HASTINGS CENTER REPORT 29, 31 (1997).
81. *See* Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life Sustaining Treatment?*, 49 RUTGERS L. REV. 1, 33 (1996).
82. N.M.P. King & A.W. Cross, *Children as Decision Makers: Guidelines for Pediatricians*, 115 J. PEDIATRICS 10, 14 (1989).
83. S. Leiken, *A Proposal Concerning Decisions to Forgo Life-Sustaining Treatment for Young People*, 115 J. PEDIATRICS 17, 18 (1989).
84. A.R. Fleischman, et al., *Caring for Gravely Ill Children*, 94 PEDIATRICS, 433, 434 (1994).
85. *See* Committee on Bioethics, Policy Statement, *supra* note 54, at 2; *Pediatric Decision Making: Code of Medical Ethics Opinion 2.2.1*, *supra* note 52.
86. *See, e.g.*, *In re Anonymous*, 905 So. 2d 845, 852 (Ala. 2005); *State v. Planned Parenthood*, 35 P.3d 30, 41 (Alaska 2001); *Am. Acad. Of Pediatrics v. Van De Kamp*, 214 Cal. App. 3d 831, 839–40 (Ct. App. Cal. 1989).
87. *See, e.g.*, *City of Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416, 439 (1983) ("[T]he State may not impose a blanket provision . . . requiring the consent of a parent or person in loco parentis as a condition for abortion of an unmarried minor.") (omission in original) (quoting *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976)); *Bellotti v. Baird*, 443 U.S. 622, 648 (1979) ("If, all things considered, the court determines that an abortion is in the minor's best interests, she is entitled to court authorization without any parental involvement.").
88. *See infra.* There are approximately 10 states that allow a mature minor to consent to or refuse medical treatment. *See* ALA. CODE § 22-8-4 (2018); ALASKA STAT. § 25-20-025 (2018); ARK. CODE ANN. § 20-9-602(7) (2018); IDAHO CODE § 39-4503 (2018); *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *Younts v. St. Francis Hospital and School of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970); LA. STAT. ANN. § 40:1095 (2018); *Baird v. Attorney General*, 360 N.E.2d 288 (Mass. 1977); *In re Rena*, 705 N.E.2d 1155 (Mass. 1999); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987); *Belcher v. Charleston Area Medical Center*, 422 S.E.2d 827 (W. Va. 1992).
89. 549 N.E.2d 322.
90. *Id.* at 323.
91. *Id.*
92. *Id.*
93. *Id.* at 327–28 ("If the evidence is clear and convincing that the minor is mature 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.").
94. *Id.* at 326 (quoting the Appellate Court).
95. *Id.*
96. ARK. CODE ANN. § 20-9-602(7) (2018).
97. *Id.*.
98. *Id.* at § 20-9-602.
99. N.Y. PHL § 2504.
100. *See infra*.
101. *Id.* at § 2504(2).
102. *Id.* at § 2504(1).
103. *Id.* at § 2504(2).
104. *See id.* at § 2305(2). Relevantly, there is no case law regarding what sort of evidence it is necessary for a physician to have to determine that a minor has been exposed to a sexually transmitted infection.
105. *See id.* at § 2781(1).
106. *Id.* at § 2708(5).
107. N.Y. Mental Hygiene Law § 33.21(c) (MHL).
108. *Id.*
109. *Id.* at § 33.21(e).
110. 147 Misc. 2d 724, 557 N.Y.S.2d 239 (Sup. Ct., Queens Co. 1990).
111. *Id.* at 724.
112. *Id.* at 725.
113. *Id.* at 726.
114. *Id.* at 728.
115. *Id.* at 729.
116. *Id.* at 720.
117. *See, e.g.*, *Matter of Sombrotto v. Christiana W*, 50 A.D.3d 63, 852 N.Y.S.2d 57 (1st Dep't. 2008); *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. Ulster Co. 1970).
118. 152 Misc. 2d 96, 574 N.Y.S.2d 659 (Fam. Ct. Cattaraugus Co. 1991).
119. *Id.* at 97.
120. *Id.*
121. *Id.*
122. *Id.* at 98.
123. *Id.* at 99.
124. It should be noted that in every New York legislative session since 1993, a bill has been introduced that would include a mature minor clause. *See, e.g.*, A.05637, 240th N.Y. Leg. Sess. § 1. It defines "mature minor" as "a person under the age of eighteen who is unemancipated . . . and who is able to make an informed, reasoned and considered judgement in connection with a decision whether or not to proceed with the abortion." *Id.* Notably, this bill would reduce children's rights to direct their own medical treatments by removing the exception that allows a pregnant individual to consent to medical treatments regarding the pregnancy and instead require a court order to allow an abortion without parental consent, but only if a court determines that the individual requesting an abortion is a "mature minor."