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To be able to readily obtain medical and psychiatric treatment when needed is important to everyone. However, minors, with certain exceptions, may be denied such treatment unless they are able to obtain parental consent. In recent years, minor children have gained some degree of legal recognition as active participants in the medical treatment process; however the appropriate extent of their participation has not yet been fully delineated and the legal standards governing their participation remain in flux.

Generally, the legal principles governing the relationship between the physician and the patient are found in an analysis of the tort of battery, the willful touching of another without consent. 6A C.J.S. Assault & Battery. § 7B (1975). Courts have consistently held that a doctor's unauthorized treatment of a patient constitutes a battery. *Oakes v. Gilday*, 351 A.2d 85 (Del. Super. Ct. 1976).

In tort law, a defense to an action of battery is that the alleged injured party consented to, or participated in, the acts causing the injury. *Seigel v. Long*, 169 Ala. 79, 53 S. 753 (1910). This consent may be either express or implied. *O'Brien v. Cunard* S.S. Co., 154 Mass. 272, 28, 266 (1891). The general rule has been that when the patient is a minor, the express or implied consent of a parent or a guardian is necessary for the authorization of medical or psychiatric treatment.

In *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941), a physician was sued for performing surgery on a fifteen year old boy without his parent's knowledge and with only the child's consent. Based on the common law rule, the court held that absent special circumstances (exceptions provided by statute), such a procedure constituted a battery, regardless of the results of the surgery.

It was thought that children lacked the capacity to provide consent for purposes of avoiding a battery. Courts held that until children reached majority, usually at the age of 21, only a parent or a legal guardian could give effective consent to medical treatment. The law assumed that minors were not wise or mature enough to determine their medical needs and a parent was often vested with control over the child. *Younts v. St. Francis Hosp. and School of Nursing, Inc.* 205 Kan. 292, 469 P.2d 330 (1970).

The requirement of parental consent was partially based on the notion that the right of parents to control their minor child constituted a property right. The parental consent requirement was also supported by the belief that it promoted family harmony, discipline and authority. *Commonwealth v. Brasher*, 359 Mass. 550, 270 N.E.2d 389 (1971).

As can be imagined, the requirement of parental consent in accordance with the common law rule had the potential of harsh results. For example, minors who were economically independent of their parents might be subject to the requirement of obtaining parental consent before obtaining medical or psychiatric treatment, even though they were functioning as adults in society. Perhaps more importantly, a minor could have been faced with the possibility of increased injury in the event that prompt medical care was needed and the parents could not be found to consent to the treatment. *Roe v. Doe*, 29 N.Y.2d 188, 272 N.E.2d 567, 324 N.Y.S.2d 71 (1971).

Because of the potential for such unfortunate results, certain exceptions began to emerge. One such exception is that of "emergency," where delay in providing prompt care could be critical. *Bonner*, 126 F.2d at 122. Thus, courts have been reluctant to apply the rule requiring express parental consent in emergency medical situations. Medical personnel who have provided the necessary medical treatment during emergency situations have been protected by the courts from lawsuits arising from such treatment. *Wells v. McGehee*, 39 So.2d 196 (1949); *Sullivan v. Montgomery*, 155 Misc. 448, 279 N.Y.S. 575 (1935).

It should be pointed out that the consent of a minor in an emergency situation was of no importance to the primary decision to provide medical treatment. The courts have generally concluded that consent is implied from the emergency itself. *Ollet v. Pittsburgh C. C. & St.L. Ry.*, 201 Pa. 361, 50 A. 1101 (1902).

Emergency conditions include those which would result in severe hemorrhage, respiratory obstruction, increased intracranial pressure, or any other condition which poses an immediate threat to life or to limb. *Jackovach v. Yocum*, 212 Iowa 914, 237 N.W. 444 (1931).

Another exception to the parental consent requirement is that of emancipation. This is the legal recognition that a minor is free from the care, custody, and control of his parents. Courts have considered a minor to be emancipated when he/she is married, is in the military, or is economically independent. *McGregor v. McGregor*, 237 Ga. 57, 226 S.E.2d 591 (1979).

Still another exception is that of the "mature minor," defined as one who is sufficiently intelligent and mature to understand the nature and consequences of the medical treatment being sought. *Zoski v. Gaines*, 271 Mich. 1, 260 N.W. 99 (1935). However, courts have set up some general parameters. The mature minor exception is generally applicable only if the minor is at least fifteen years old and has intelligence, understanding, and independence of action. In addition, the medical treatment being sought must not be of a serious nature. *Younts*, 205 Kan. 292, 469 P.2d 330 (1970).

The Child's Interests

Primarily, the equal protection and

due process guarantees of the Fourteenth Amendment have provided the basis for the expanded recognition of the capacity of minors to consent to medical and psychiatric treatment. Supreme Court decisions on the issues of pregnancy and abortion have served as the main vehicles for the expansion of these rights. In *Roe v. Wade,* 410 U.S. 113 (1973), the Court invalidated a Texas criminal abortion statute and held that it was violative of due process. The Court also established that there is a fundamental privacy right of a woman to decide with her physician whether to terminate her pregnancy.

In *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976), the Court found that the parental consent provision was an unconstitutional delegation to a third person of a veto power over the minor's decision to abort. The Court affirmed that a minor does have the capacity to provide consent in matters pertaining to medical care. This case is of primary significance because the minor's right of privacy in these matters is given express recognition. The *Danforth* case is also significant because the Court opted to rule in favor of the minor over the state's arguments that discipline and the state's interest in promoting family unity and harmony outweighed the minor's privacy right to obtain medical care.

With respect to psychiatric care, the minor's consent capacity has also been expanded. In the leading case of *Parham v. J.L.,* 442 U.S. 584 (1979), a Georgia statute provided that a minor could be signed into a hospital by a parent or a guardian "if found to show evidence of mental illness and to be suitable for treatment." The only discharge mechanism, in addition to that provided by the hospital before the minor reached eighteen years of age, was by the application of the parent or the guardian.

Two minors filed suit alleging that they and others similarly situated had been deprived of their liberty without due process by the Georgia statute. The Supreme Court held that the children had been institutionalized without a hearing or other procedural safeguards, and that they had not been afforded a hearing to determine an appropriate time for discharge. The Court also held that the minors had been hospitalized without initial or periodic consideration of placement in the least restrictive environment necessary for treatment. The Court felt that the case essentially involved a balancing of three competing interests: the child's liberty interest, the parents' interest in the welfare and the health of the child; and the state's significant interest in properly utilizing its mental health facilities.

In the leading Maryland case, *Johnson v. Solomon,* 484 F. Supp. 278 (4th Cir. 1979), the standards set forth by the Maryland statute regarding the civil commitment of minors to mental institutions were held to be impermissibly vague and unconstitutional as violative of due process and equal protection since they did not require a finding that a juvenile is dangerous to himself and others and did not guarantee that the commitment would bear a rational relationship to the underlying *parens patriae* principle justifying the loss of liberty. The Federal District Court of Maryland held that the state had to establish new procedures for the civil commitment of minors to mental institutions and also held that the least restrictive alternative must be explored before a Maryland juvenile court can civilly commit a minor to a mental institution. *Id.* at 313.

The Parents' Interests

Because children were historically presumed to be incapable of making reasonable decisions regarding their own medical treatment, consent of the parents has been the legal substitute for the minors' consent. The rationale is that children were protected against the possibility of their own improvident decisions or unscrupulous medical care. Also, the doctor was relieved from liability for treatment without consent. *Bonner v. Moran,* 126 F.2d 121 (S.C. Cir. 1941).

In *Craig v. State,* 220 Md. 590 (1959), 155 A.2d 684, the Court of Appeals of Maryland affirmed the involuntary manslaughter conviction of parents who failed to supply medical care for their child who had a fatal illness. The parents had claimed that their religion prevented them from providing the required medical care. The Court held that the parents are required to obey the mandate of statutes wherein they are charged with the care and welfare of their minor children by providing medical care when necessary. *Id.*. at 600, 155 A.2d at 691.

In *Matter of Smith,* 16 Md. App. 209, 295 A.2d 238 (1972), a sixteen year old unmarried, pregnant female who was found by the circuit court (Juvenile) to be a "Child in Need of Supervision" (CINS), was placed in the custody of her mother, and was ordered to submit to an abortion despite her wishes to bring the pregnancy to term. The appellate court overruled the juvenile court and held that irrespective of the mother's wishes, the girl could not be compelled to submit

to abortion procedures.

In re Phillip B, 442 U.S. 584 (1979), the United States Supreme Court affirmed the common law doctrine permitting parents to refuse non-emergency medical treatment for their unemancipated children. A California Superior Court had dismissed the petition of the state's juvenile probation division to have a twelve-year-old boy suffering from Down's Syndrome declared a dependent of the state so that he could receive cardiac surgery over the objection of his parents. Although the prognosis for the boy was poor without the surgery, the Court sided with the parents and based its decision on the parental consent theory.

The State's Interest

The State acts on behalf of the child under the doctrine of *parens patriae.* Under this doctrine, the State may intervene within the family unit in order to protect the child's interests. This doctrine originated with the Courts of Chancery in England, due to a desire to protect the property and morals of children whose parents were considered unfit. The doctrine was enlarged to allow the State to overrule parental objections to medical treatment by relying on the old English doctrine that medical care is one of the necessities of life, and parents must provide it for their minor children. *Eyre v. Countess of Shaftsbury,* 24 Eng. Rep. 659 (Ch. 1722).

The state, through the use of its authority as *parens patriae* and the police power, has to be considered as an active participant in the balancing of interests. Under the police power, states have imposed mandatory vaccination programs for minors. *Zucht v. King* 1260 U.S. 174 (1922). The United States Supreme Court has held that this type of exercise by the state constitutes a "reasonable and proper exercise of police power." *Jacobson v. Massachusetts,* 197 U.S. 11 (1905). Newborn testing and screening (the administration of eyedrops within an hour or two of birth), and the floridation of public water supplies to prevent tooth decay in children, exemplify how states have used their police power to insure that medical treatment is provided to minors. *Kaul v. Chehalis,* 45 Wash.2d 616, 277 P.2d 352 (1954).

In the State of Maryland, the Legislature has enacted statutes providing that minors can obtain medical treatment independently. Where a minor is married, pregnant or has a venereal disease, he/she may consent to medical or surgical care MD. ANN. CODE art. 43, §135 (a) (1980 rep. vol.). Maryland juvenile courts may order that a child be studied or examined by a physician, psychiatrist, or psychologist after a petition has been filed in juvenile court. MD. ANN. CODE, Courts and Judicial Proceedings, §3-818 (b) (1980 rep. vol.). After adjudication of a petition, the juvenile court may also order that the child be committed to the custody of the Department of Health and Mental Hygiene for care and treatment. *Id.,* §3-820(e), (f), (g) (1980 rep. vol.). Further, the juvenile court may order that emergency, dental, or surgical treatment be provided to a child suffering from some condition or illness, §3-822 (1980 rep. vol.). In addition, a child may refuse to participate in or submit to an abortion. MD. ANN. CODE art. 43, §138 (a) (1980 rep. vol.); *Matter of Smith,* 16 Md. Appl. 209, 295 A.2d 238 (1976).

Conclusion

The right of privacy requires that a minor child who is intelligent and mature enough to consent should not be treated differently than adults with respect to medical and psychiatric care. This represents a departure from the harsh common law rule of strict parental consent.

Courts still must balance the three competing interests of the child, the state, and the parents. While the state may create procedures to insure that the minor is competent to consent, it cannot delegate to third parties, such as parents, the absolute power to veto an informed consent decision by a "mature minor." The era of absolute parental control over the power of the minor to seek medical and psychiatric care is coming to an end. It must be noted, however, that the children who are not "mature" minors and who do not fall under one of the state or court-provided exceptions will probably find their parents' consent substituted for that of their own.