TOPIC 2

MEDICAL DECISIONS AFFECTING REPRODUCTIVE HEALTH

§ 19.02. Consent by Minor to Reproductive Health Treatment

(a) A mature minor is authorized to provide legally sufficient consent to medical treatment affecting reproductive health, including treatment concerning pregnancy, childbirth, and the prevention or termination of pregnancy, without notification of the minor's parent.

(b) Unless otherwise directed by law, a mature minor is a minor capable of giving informed consent to the proposed medical treatment.

(c) A minor who is not mature is permitted to undergo abortion without the consent or notification of the minor's parent if termination of the pregnancy without such consent or notification is in the minor's best interest.

(d) Parental consent to reproductive health treatment without the voluntary agreement of the minor ordinarily is invalid.

a. Constitutional background and rationale. Under this Section, a mature minor is authorized to give legally sufficient consent to reproductive health treatments. This Section follows constitutional law recognizing that the decision to obtain contraceptive treatment and the decision to continue or terminate a pregnancy implicate interests not present in other medical decisions. Under the Supreme Court's constitutional doctrine of reproductive privacy, the state has limited authority to burden the decision of an individual, including a mature minor, seeking to prevent or terminate pregnancy. These decisions implicate not only healthcare, but also the individual's interest in controlling reproduction and in preserving privacy when making choices about intimate, deeply personal matters. Under constitutional doctrine, mature minors as well as adults have an interest in reproductive privacy. For this reason, reproductive health decisions represent a category of medical treatment decisions that receives special protection for minors. See Comment *b,* describing reproductive health treatments under this Section to include treatment to prevent, terminate, and manage pregnancy and childbirth.

The minor's authority to make reproductive health decisions is also based on the state's interest in minors' health and in the health of children born to minors. Preventing unwanted pregnancy, promoting prenatal health, and treating sexually transmitted diseases (another

reproductive health treatment under this Section) further the welfare of the minor and of society. Authorizing the mature minor to make these decisions without involving parents removes obstacles to treatment. Similarly, it is in the state's interest that the mature minor who decides to proceed with the pregnancy obtain prenatal and maternity care; under this Section, she is authorized to consent to treatment without involving a parent.

Although reproductive health decisions can be understood, to an extent, as a special category of medical decisions subject to the mature minor rule, some reproductive health treatments, such as abortion and caesarian sections cannot be classified as "routine" under § 19.01. Under this Section, the legal rationale for recognizing the right of a mature minor to make a reproductive health decision has a somewhat different emphasis than the rationale of the general mature minor rule. The mature minor rule of § 19.01 recognizes the emerging personhood of the mature minor and his or her interest in making medical decisions, but the primary rationale for the general rule is to facilitate routine, beneficial medical treatment for the minor by removing obstacles created by requiring parental consent. The rule adopted in this Section is also justified on the ground that it facilitates beneficial reproductive health treatment sought by the minor. Avoiding the health risks of unwanted pregnancy and childbirth usually promotes the minor's health and welfare, as does facilitating prenatal and maternity treatment for the minor who plans to bring the pregnancy to term. But a key rationale for this Section's rule is to protect the right of the individual minor to control reproductive decisions, a right grounded in constitutional jurisprudence. This right includes protection against involuntary reproductive health treatment. Under Subsection (d), unless the minor faces a substantial risk to her life or health, her agreement is a necessary condition for treatment. See Comment *e*.

A minor's interest in controlling reproduction is similar to that of an adult. In deciding that an adult woman has a constitutionally protected right to choose abortion, the Supreme Court emphasized the substantial burdens created by an unwanted pregnancy. These burdens include physical and psychological costs associated with the pregnancy and with the birth of an unwanted child. Roe v. Wade, 410 U.S. 113 (1973). The burdens of unwelcome pregnancy are often even more onerous for a minor than for an adult. Pregnancy and childbirth carry greater health risks for a minor, who also may be less capable than an adult of dealing with the psychological burdens and responsibilities of pregnancy and parenthood. Further, the disruption of the minor's education and

life generally is likely to be substantial. Thus the minor who desires to avoid or terminate a pregnancy has an interest in reproductive choice that is as great as that of an adult.

Many features of reproductive health treatments distinguish these medical decisions from other medical contexts and support the rationale for the rule adopted in this Section. First, as indicated, the Supreme Court has established that the right of reproductive privacy enjoys constitutional protection as a liberty interest protected by the Due Process Clause of the Fourteenth Amendment; this sets reproductive health decisions apart from other medical decisions. Moreover, the urgency of pregnant minor's situation signifies that her ability to exercise the right to control reproduction cannot be postponed until she attains legal adulthood, in contrast to other rights, such as the right to marry and the right to vote. Further, all reproductive health decisions under this Section inherently implicate adult concerns; if the minor becomes pregnant and carries the fetus to term, she will undergo childbirth, and bear the legal responsibilities of a parent, either to care for her child or place the child for adoption. This decision will necessarily have a substantial impact on her future life. Decisions relating to the control and management of pregnancy, including decisions about childbirth, are reproductive health decisions under this Section.

The distinctive features of medical decisions implicating reproductive health justify this Section's special protection of the minor's authority to make these decisions independently. Ordinarily, of course, parents have broad authority to make medical decisions for their minor children, and it is assumed that the interests of parents are aligned with those of their children. The rule adopted in this Section does not represent a rejection of the assumption that parents generally aim to promote their children's best interest, according to the parents' values and beliefs. Instead, the rule recognizes that reproductive health decisions, and particularly decisions about terminating and managing pregnancy and childbirth, are adult choices that can involve personal moral values in ways which are less likely to arise in other medical decisionmaking contexts. Unlike many medical decisions, the decision of whether or not to terminate pregnancy can implicate a contested moral choice, with no clearly superior medical outcome. The pregnant minor has the most important stake in the outcome. A minor who does not want to carry the pregnancy to term has made a deeply personal decision on the basis of her values and goals for herself as an individual. This Section holds that in the usual case, that choice should be respected, and that the minor's values and preferences should be determinative, rather than those of the parent.

Constitutional doctrine regarding reproductive rights has focused primarily on the minor's right to terminate her pregnancy. In a series of opinions, the Supreme Court has recognized that the state cannot unduly burden the decision by a mature pregnant minor to obtain an abortion by involving her parents. In Bellotti v. Baird, the Court held that the state cannot require parental consent to abortion by a minor who is "mature and well enough informed" to make her own abortion decision. Bellotti v. Baird, 443 U.S. 622 (1979). Under this Section, a minor determined by the court to be capable of giving informed consent to the medical abortion procedure has a right to terminate her pregnancy without the consent of a parent.

Under this Section, the court will not authorize notification of a parent against the minor's wishes when a mature minor obtains an abortion. The Supreme Court upheld a statute authorizing physician notification of parents when a minor seeks abortion, but the Court specifically declined to hold that parental notification was constitutional in cases involving mature minors. H.L. v. Matheson, 450 U.S. 398 (1981). In light of *Bellotti* and other Supreme Court opinions involving minors' abortion rights, it is clear that notification is prohibited if the minor is mature. In many families, of course, parents are aware of the minor's pregnancy and provide support to their pregnant child. But the mature minor decides whether to inform her parents.

This Section also authorizes the court to determine that an immature pregnant minor can obtain an abortion without parental consent or involvement. Subsection (c) follows the Supreme Court's prescribed response if a minor is not competent to give informed consent to the abortion procedure: The court will authorize the procedure without involving the minor's parent if termination of the pregnancy without parental involvement is deemed to be in the best interest of the minor. Bellotti v. Baird, 443 U.S. 622 (1979).

Bellotti indicates that the state can establish a judicial by-pass proceeding in which it is determined whether the minor seeking to terminate her pregnancy without involving a parent is mature enough to make her own decision, and, if she is not, whether abortion without parental involvement is in her best interest. A majority of states, by statute, have established judicial by-pass proceedings in which courts make these decisions. This Section applies to any decision made by a court in such a proceeding, as well as to any other judicial decision dealing with the authority of minors to make reproductive health decisions.

b. What are reproductive health treatments? Under this Section, a mature minor has the authority to consent to a reproductive health treatment without involving a parent. For purposes of

this Section, reproductive health treatments include treatments associated with prevention, control, and management of pregnancy—including contraceptive treatment, treatment to terminate pregnancy, and treatment associated with pregnancy management and childbirth. Treatment for sexually transmitted diseases is also reproductive health treatment under this Section. Statutes in many states authorize minors to consent to specific reproductive health treatments that have a public health dimension, including contraception and treatment for sexually transmitted diseases. See Statutory Note.

Some decisions affecting reproductive health are not so defined for purposes of this Section. Sterilization, gender confirmation surgery, puberty postponement drugs, surgery on reproductive organs, ova donation, and breast enhancement or reduction surgery do not constitute reproductive health treatment under this Section. Sterilization permanently ends reproductive capacity and only a mature adult can consent to this procedure. Statutes in many states set a minimum age for sterilization that is beyond the age of majority. Sexual alignment surgery and puberty postponement treatment involves a complex set of medical and personal decisions; ordinarily the minor and his or her parents make these decisions together. Ova donation benefits a third party with no health benefit to the minor; on this basis it is beyond the scope of this Section. A minor is not authorized to consent to breast enhancement surgery, a cosmetic procedure that carries substantial risks. Breast reduction surgery is seldom performed on a minor and is only for medical purposes. Consent to this procedure is not within the scope of this Section.

c. Informed consent and reproductive health decisions. Under this Section, a mature minor is authorized to make independent reproductive health decisions. As § 19.01, Comment *c*, explains, a mature minor is a minor who is capable of providing informed consent to the proposed medical procedure. Informed consent involves two dimensions. First, the healthcare provider must disclose all information that a reasonable person would find material to the decision. This information includes the purpose of the procedure, its health risks and benefits, alternatives available to the patient (including the alternative of receiving no treatment), and the risks and benefits of those alternatives. Second, the patient must be capable of understanding the information provided as it applies to his or her health situation, and of making a rational decision to undergo the procedure. A minor is competent to make an informed abortion decision, for example, if she understands that the procedure will terminate the pregnancy, that it carries particular medical risks, and that the alternative is to continue the pregnancy, which also carries enumerated health risks. The precise

procedure and attendant risks may depend on the duration of the pregnancy. The minor's reproductive health decision must also be voluntary, and not made in response to undue influence by another person. See Comment *f*.

Illustrations:

1. Maria, age 15, recently learned that she was pregnant and decides to terminate the pregnancy. Maria goes to a family planning clinic with her friend, Angela. Dr. Gulati explains to Maria that she is seven weeks pregnant and that the abortion procedure would involve ingestion of an oral medication that would be followed by discomfort and cramping. Dr. Gulati explains that the procedure carries a small risk of infection and bleeding. She also describes symptoms, including pain and excessive bleeding, that would indicate that she should call the clinic. The clinic counselor also explains to Maria that she could proceed with the pregnancy and give birth to the baby, and that she could then place the baby for adoption if that were her decision. In response to questions, Maria indicates that she understands the information communicated by Dr. Gulati and the counselor and that she is firmly committed to her decision to have the abortion. Maria is competent to make an informed medical decision and is authorized to consent to the abortion procedure without involving her parents.

2. Elena, age 17, discovered that she was pregnant and is considering whether to have an abortion or continue the pregnancy to term. Elena is a devout Catholic, has serious reservations about abortion, and is leaning toward having the baby and placing it for adoption. But Elena's boyfriend, Andy, insists adamantly that she have an abortion. They argue about the decision, and Andy tells Elena that he would break off the relationship if she didn't have an abortion. Elena is very dependent on Andy, who is her first boyfriend. She is also very anxious about revealing the pregnancy to her parents. Elena reluctantly agrees to undergo an abortion. When she arrives at the clinic, Elena is sobbing and says she isn't sure she can go through with the procedure. Andy says that if she has the baby, she will never see him again. Elena tells the physician that her only choice is to have the abortion because she can't live without Andy. Although Elena understands the material medical information about the abortion procedure and is otherwise competent, her decision is not voluntary and thus her consent is invalid.

Research studies indicate that by mid-adolescence, a typical minor is comparable to an adult in his or her competence to make medical decisions. See § 19.01, Comment *c* and Reporters' Note thereto. Studies have found that by age 14, minors are capable of adult-like comprehension of medical conditions and treatment options based on information disclosed in the research setting; by comparison, younger minors demonstrate poorer comprehension. The methodology of this laboratory research replicates the treatment setting in which the provider discloses material information about the patient's condition and treatment options. Studies that have focused specifically on decisionmaking about abortion have found similarly that mid-adolescents comprehend the medical information and make decisions as competently as adults. This research is consistent with studies of decisionmaking competence in other domains. For example, research on adjudicative competence has found that decisionmaking competence increases through early adolescence and plateaus at adult levels in mid-adolescence. See §15.30 Comment *b* and Reporters' Note thereto.

The studies indicating that adolescents are capable of making competent reproductive health decisions are supported by general research on cognitive development in childhood and adolescence. During late childhood and early adolescence, individuals improve in their information-processing, memory, and comprehension of words and concepts. The ability to engage in hypothetical thinking also matures during early adolescence, such that by mid-adolescence an individual is capable of considering and weighing alternative hypothetical outcomes not in present reality. Developmental scientists concur that most individuals attain maturity in cognitive development (the ability to process information, use working memory, and reason hypothetically) by mid-adolescence. These are the capacities deployed in making medical decisions, including those involving reproductive health.

That is not to say that minors are fully mature by age 14 or 15. While individuals attain *cognitive* maturity by mid-adolescence, emotional and psychosocial development continues into late adolescence and early adulthood. Adolescent brain research indicates that the brain's executive functions continue to mature into the early twenties. Thus in settings of emotional arousal, especially in the presence of peers, adolescent decisionmaking can reflect poor impulse control, sensation-seeking, and susceptibility to peer influence. On this basis, courts have found juvenile offenders to be less culpable than their adult counterparts. But a medical decision, including the decision to terminate a pregnancy, differs from a decision to engage in criminal activity because

the minor making a medical decision has the opportunity to deliberate over a period of time; the decision is unlikely to represent an impulsive momentary response. Moreover, the medical setting is conducive to rational choice. Medical personnel will explain the medical procedure to the minor and can assure that she is able to comprehend the decision and its consequences.

This Section adopts the same standard for determining whether a minor is capable of making an independent reproductive health decision, including the decision to terminate a pregnancy, as is applied to other medical decisions by a mature minor under § 19.01. This standard focuses on the individual's ability to understand material information about the treatment options disclosed by the healthcare provider and to make a decision on the basis of that information. This is the dominant standard applied to a patient's ability to give valid consent to medical treatment.

The determination of whether a minor making a reproductive health decision, including a decision to terminate pregnancy, satisfies the informed consent standard does not involve an inquiry into aspects of maturity other than those directly implicated in making the medical decision. Although some courts evaluating the minor's right to make an independent abortion decision have allowed questions about her general maturity, such an inquiry is not appropriate for a minor any more than it would be appropriate for an adult. A broad inquiry into maturity creates a substantial burden on the minor's interest in reproductive privacy.

Illustration:

3. Annabella, age 16, became pregnant by her boyfriend, and she wants to obtain an abortion. Annabella has never had a part-time job and she does very little to help around the house. She also is somewhat irresponsible about completing homework assignments and often loses books, papers, and other possessions. The physician at the family planning clinic speaks with Annabella for some time about the abortion procedure. She demonstrates that she fully understands the procedure and its risks and benefits, as well as the risks and benefits of carrying the pregnancy to term. Annabella expresses a firm desire to have the abortion, commenting that she can't imagine going through childbirth and being responsible for a baby. Annabella is competent to consent independently to the abortion procedure without involving her parents. The fact that she may be somewhat immature in other areas is irrelevant.

c. The presumption of maturity. Under this Section, a minor is functionally presumed to be mature for the purpose of consenting to reproductive health treatments. This presumption is supported by statutory and case law and by judicial practice in many states. Under statutes in most states, a minor is deemed an adult for the purpose of consenting to prenatal treatment and to treatment and procedures associated with childbirth, as well as contraceptive services and treatment for sexually transmitted diseases. Further, a minority of states do not distinguish between minors and adults for the purpose of consenting to abortion. Moreover, empirical studies have found that judges in some jurisdictions routinely find minors to be mature in judicial by-pass hearings. Although informed consent is a prerequisite for medical treatment, an adult does not bear the burden of demonstrating that he or she is capable of making an informed decision. Under this Section, the minor also does not bear the burden of demonstrating that she is competent to consent to reproductive health treatment.

The presumption in this Section that the minor is sufficiently mature to consent to reproductive health treatment is justified by the importance to the individual minor of controlling reproduction. A minor, like an adult has an essential interest in avoiding an unwanted pregnancy and, if the minor is pregnant, of controlling the decision to terminate the pregnancy or bring it to term. Probably no medical decision implicates an individual's personal values and goals more deeply than a decision about whether to terminate pregnancy. The presumption of maturity assures that the minor's interest in making this decision independently receives legal deference unless she is clearly unable to give valid consent. As discussed in Comment *d*, even a minor who is unable to make an informed medical decision has a deeply personal interest in this decision that should be given substantial weight.

d. The best interest inquiry and the immature minor. A very young pregnant minor who wants to terminate the pregnancy may be too immature to give informed consent to abortion. Under those circumstances, the Supreme Court has offered courts a means by which an immature minor who does not want to involve her parents can obtain an abortion. The Court directed that the court considering this question to inquire into whether it is in the immature minor's best interest to proceed with abortion without parental involvement. This decision will focus on the minor's health and welfare; it is not based on the decisionmaker's or the parents' religious or moral views regarding abortion.

The court's best interest inquiry follows a determination that the minor is not sufficiently mature to give informed consent to the abortion procedure. But under this Section, the immature minor's preference will be given substantial weight even though she is not capable of making an informed medical decision. The immature minor's desire to avoid an unwanted pregnancy represents a deeply personal individual choice in the same way as does the decision of a mature minor or an adult. Therefore, respect for the immature minor's decision is usually justified as long as she understands that the consequence of the procedure is the termination of her pregnancy, and this outcome represents her clear choice.

The importance of respecting the immature minor's choice to end her pregnancy is reinforced in light of the greater cost of an unwanted pregnancy for a younger minor than for older pregnant minors or adults. The immature minor's best interest will seldom be served by bringing the pregnancy to term and becoming a parent. Pregnancy and childbirth pose greater health risks for a minor (particularly a younger minor) than does first-trimester abortion. Moreover, the psychological harms associated with unwanted pregnancy are likely to be substantial for a younger minor. Finally, a minor too immature to make the abortion decision is almost certainly incapable of assuming the responsibilities of parenthood, and the stresses associated with adoption placement are likely to weigh more heavily on an immature minor. The fact that the minor who is subject to the best interest inquiry has been identified as immature militates in favor of facilitating termination of the pregnancy without requiring parental consent or notification.

Some courts in evaluating whether access to abortion is in the immature minor's best interest have focused on whether the minor's parents are likely to harm her, banish her from the family, or otherwise respond with hostility when they learn about the pregnancy. This Section does not focus the inquiry in the usual case on the predicted parental response. If an immature minor is ambivalent about terminating the pregnancy, or has serious moral or religious reservations about the procedure, an inquiry into the parents' response and the likelihood that they will support their child may be appropriate. But the immature minor's voluntary decision to terminate the pregnancy together with clear opposition to involving her parents indicates that termination is in her best interest and that parents should not be consulted.

e. Treatment over the objection of the minor ordinarily prohibited. If a parent or guardian seeks abortion for a pregnant minor over the minor's objection, the procedure will not be performed. The parent cannot give valid consent to abortion for a mature minor, and an immature

minor must agree to the procedure, even though she is not competent to make an independent decision. Abortion cannot proceed over the minor's objection even if the objection is based on immature reasons or unrealistic expectations. Even if the minor's parent will bear financial responsibility for the child's upbringing, the parent has no authority to consent over the minor's objection to abortion. To perform an abortion against the will of the individual is a serious intrusion into bodily integrity and reproductive privacy. Abortion will be ordered over the objection of a minor only if continuation of the pregnancy represents a substantial threat of serious harm to the minor. Similarly, if a minor objects to a medical procedure or treatment other than abortion, the procedure will be performed over her objection only if the failure to treat creates a serious risk of substantial harm to the minor; even a mature minor does not have the authority to refuse treatment under these circumstances. See § 19.01, Comment *e* and Reporters Note thereto.

Illustration:

4. The parents of 16-year-old Maya have recently learned that she is pregnant. Maya's boyfriend, Ben, recently broke off the relationship due to the pregnancy and has strongly urged Maya to have an abortion. Maya's parents also strongly support abortion. They believe that having a child will derail Maya's education; also in the jurisdiction in which the family lives, parents are responsible for providing financial support for the child of the parents' minor child. Maya refuses to have an abortion. She is distraught about the breakup of her relationship with Ben and believes that he will resume their relationship if they have a child. Maya's parents have no authority to consent to Maya's abortion over Maya's objection, regardless of her reason.

REPORTERS' NOTE

Comment a. Background and rationale. The Supreme Court first recognized a constitutionally protected zone of reproductive privacy for adults in Griswold v. Connecticut, 381 U.S. 479 (1965). Invalidating a state statute that prohibited the use of contraceptives, the court found that the law intruded in marital intimacy, contravening "a right of privacy older than the Bill of Rights." 381 U.S. at 486. A few years later in Eisenstadt v. Baird, 405 U.S. 438 (1972), the Court extended the right to reproductive privacy beyond marriage, striking down a Massachusetts statute that allowed married couples, but not single persons, to obtain contraceptives. In *Eisenstadt*, the Court stated "[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." 405 U.S. at 453. The

constitutional protections afforded to reproductive privacy were found to include the right to obtain an abortion in Roe v. Wade, 410 U.S. 113 (1973) (right to terminate pregnancy inheres in liberty and personal autonomy). *Roe* emphasized the burden on the pregnant woman of continuing an unwanted pregnancy, and of forcing upon her a "distressful life and future. Psychological harm may be imminent . . . the distress, for all concerned, associated with the unwanted child." Id. at 153. See also Planned Parenthood of Southeast Pennsylvania v. Casey, 505 U.S. 833, 860 (1992) (reaffirming *Roe* and observing "[t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment").

The Supreme Court has extended the right of reproductive privacy to minors. In Planned Parenthood of Cent. Missouri v. Danforth, 428 U.S. 52 (1976), the Court struck down a state law that gave parents a veto over a minor's decision to obtain an abortion, holding that "[a]ny independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." 428 U.S. at 72. Several years later, the Court indicated that a state statute requiring parental consent to a minor's abortion must provide a minor with the ability to obtain an abortion if she can show that she is "mature enough and well informed" to make the decision, or that the abortion would be in her best interests. Bellotti v. Baird, 443 U.S. 622 (1979). While the Court recognized that the right to privacy as applied to minors may be restricted on the basis of children's vulnerability and incompetence to make decisions, as well as parents' important interest in raising their children, it held that a mature minor nevertheless has a right of reproductive privacy analogous to that of an adult. Id. at 633, 642 (citing to Roe v. Wade and discussing the "potentially severe detriment[s]" facing women who are pregnant, which exist regardless of minority status).

In *Bellotti*, the Court endorsed the statutory framework under which the minor in a hearing could seek to avoid parental consent by demonstrating her maturity or best interest. Bellotti v. Baird, 443 U.S. 622, 643 (1979) ("[I]f the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained."). Many states, by statutes have subsequently established "by-pass" hearings predicating minors' access to abortion on their demonstration of maturity or best interest in such a hearing. See statutes described below. Comment *b* deals with the standard for evaluating a minor's maturity and Comment *d* deals with the best interest inquiry. See also City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416 (1983) (striking down state law that prevented a physician from performing an abortion on minors younger than 15 years of age unless parents consented); Carey v. Population Services, 431 U.S. 678 (1977) (striking down New York law that prohibited distribution of contraceptives to anyone under the age of 16).

Bellotti recognized the right of a mature minor to make an independent abortion decision, but also concluded that an immature minor's rights could be restricted to a greater extent than those of an adult. The Court pointed to three differences between minors and adults that justify differential treatment. The Court noted that children are particularly vulnerable, and the legal system should account for "their needs for concern, sympathy, and paternal attention." Bellotti v.

Baird, 443 U.S. 622, 635 (1979) (quoting McKeiver v. Pennsylvania, 403 U.S. 528 (1971)). Second, the Court noted that children have an "inability to make critical decisions in an informed, mature manner" as they "lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them." Id.. Lastly, the Court reasoned, "the guiding role of parents in the upbringing of their children justifies limitations on the freedoms of minors." Id. at 637. The Court recognized that parents take the lead in inculcating children with moral and social values, and that "legal restrictions on minors, especially those supportive of the parent role" help to further this process of growth. Id. at 638.

Because of the differences between adults and minors, the Court found that a minor could be required to demonstrate her maturity and, for the immature minor, parental consent could be required, but only if parental involvement is determined to be in the minor's best interest. Id. at 643.

The constitutional protections surrounding abortion reflect the reality that the decision of whether to terminate a pregnancy is of "deep, personal character . . . [i]t was this dimension of personal liberty that *Roe* sought to protect." Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 853 (1992). An important theme in the jurisprudence of abortion is that unwanted pregnancy and childrearing are onerous burdens. See Roe v. Wade, 410 U.S. 113, 153 (1973) ("There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it."). The Supreme Court has recognized that the burden of unwanted pregnancy is particularly difficult for a minor to bear, as minors are presumed to lack the self-sufficiency of an adult. See, e.g., Bellotti v. Baird, 443 U.S. 622, 642 (1979) ("[C]onsidering her probable education, employment skills, financial resources, and emotional maturity, unwanted motherhood may be exceptionally burdensome for a minor").

A large body of research supports the concern that unwanted pregnancy imposes a substantial burden on a minor, and the broader conclusion that a minor's health and welfare is seldom promoted by unwanted pregnancy. Of most immediate importance, scientific research shows that pregnancy and childbirth carry greater health risks for a minor, who also may be less capable than an adult of dealing with the psychological risks and with the responsibilities of parenthood. See Jane E. Dopkins Broecker, *Pregnancy in Adolescence*, Global Library of Women's Medicine (Feb. 2009) (finding that medical risks known to be associated with teen pregnancy include higher rates of pregnancy-induced hypertension (preeclampsia and eclampsia), low-birth-weight infants, and higher rates of neonatal or infant death than comparable rates for adults). This study also found that teenage mothers are more likely than adult counterparts to live in poverty, receive public assistance, and have long periods of welfare dependency. See Dawn Kingston, Maureen Heaman, Deshayne Fell & Beverley Chalmers, *Comparison of Adolescent, Young Adult, and Adult Women's Maternity Experiences and Practices*, 129 PEDIATRICS (May 2012) (studying 6,000 pregnant adolescents, found that girls ranging from 15 to 19 experienced postpartum depression at a rate that was twice as high as women aged 25 and older). See also Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18

COLUM. J. GENDER & L. 409 (2009) ("The medical consequences of delay are more serious in the case of teenagers, who already tend to acknowledge and confirm their pregnancies later than adults").

Beyond the health risks, researchers and scholars have pointed to substantial evidence of the psychological, educational, and economic costs, confirming that pregnancy poses a particularly heavy burden on minors and ultimately on society. See, e.g., SAUL D. HOFFMAN & REBECCA A. MAYNARD, KIDS HAVING KIDS: ECONOMIC COSTS & SOCIAL CONSEQUENCES OF TEEN PREGNANCY (2008) (arguing that unintended pregnancy and birth among minors increases the likelihood of dropping out of high school); Kate Perper, Kristen Peterson & Jennifer Manlove, *Diploma Attainment Among Teen Mothers*, CHILD TRENDS: FACT SHEET (Jan. 2010) (findings show that "slightly more than one-half of young women who had been teen mothers received a high school diploma by the age of 22, compared with 89% of young women who had not given birth during their teen years"), http://www.childtrends.org/wp-content/uploads/2010/01/child_trends-2010_01_22_FS_diplomaattainment.pdf; National Campaign to Prevent Teen and Unplanned Pregnancy, *Counting It Up: The Public Costs of Teen Childbearing 2013* (2013) (arguing that teen childbearing costs taxpayers up to $9.4 billion annually, with most costs associated with increased costs for healthcare, foster care, incarceration, and lost tax revenue). See also Nancy Felipe Russo & Henry P. David, *When Pregnancies Are Unwanted*, TRANSNATIONAL FAMILY RESEARCH INSTITUTE (Mar. 5, 2012) (arguing that unintended childbearing can exact a great health, social, and psychological cost on the mother), http://www.prochoiceforum.org.uk/psy_ocr2.php. Charles H. Wright, *Teenage Pregnancy, A National Disaster: A Significant Factor in Black Teenage Unemployment*, 70 J. NAT'L MED. ASS'N 685 (1978) (arguing that teenage pregnancy exacts a social, emotional, and psychological toll on mothers, and also contributes greatly to the underdevelopment of marketable labor skills).

These costs fall on the unwanted children as well. Children of unmarried teenage mothers have significant disadvantages as compared to other children. Disadvantages include low birth weight, complications of the mother's pregnancy and delivery, and health problems associated with poor perinatal outcomes; higher risk of perinatal death; lower IQ and academic achievement in childhood, including a higher risk of repeating a grade; higher risk of social and emotional problems; a higher risk of having a fatal accident before age one; and finally, a greater probability of teenage parenthood. RISKING THE FUTURE: ADOLESCENT SEXUALITY, PREGNANCY, AND CHILDBEARING, VOLUME II: WORKING PAPERS AND STATISTICAL APPENDICES 174 (Sandra L. Hofferth & Cheryl D. Hayes eds., 1987) (analyzing why children of teen parents are at greater risk than children of older parents for a host of health, social, and economic problems); see also SAUL D. HOFFMAN & REBECCA MAYNARD, KIDS HAVING KIDS: ECONOMIC COSTS AND SOCIAL CONSEQUENCES OF TEEN PREGNANCY (2d ed. 2008) (detailing micro and macro consequences of teenage childbirth); Stefanie Mollborn & Jeff A. Dennis, *Explaining the Early Development and Health of Teen Mothers' Children*, 27 SOCIOL FORUM 1010 (Dec. 2012) (finding, in part, that having a teenage mother predicted compromised development across several areas by age 4½); Henry P. David, *Born Unwanted: Long-Term Developmental Effects Of Denied Abortion*, 48 J. OF

SOCIAL ISSUES 163 (1992) (in study of 220 children born in Prague from 1961-1963, finding that "unwantedness in early pregnancy has a detrimental effect on children's psychosocial development").

States have adopted several approaches in regulating minors' access to abortion. Twelve states explicitly or implicitly do not distinguish between adults and minors seeking abortion, effectively adopting a presumption that a minor is competent to make this medical decision. These state laws are discussed in detail in the Reporters' Note to Comment *c*. See Guttmacher Institute, *Parental Involvement in Minors' Abortions* (May 1, 2017), https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions; see also Reporters' Note to Comment *c*, (discussing states that have a default informed consent standard due to having no parental-regulation statutes).

Other states adopt the framework proposed in *Bellotti* requiring a by-pass hearing in which it is determined whether the minor is a mature minor or, if not, whether abortion without parental consent is in her best interest. See discussion of by-pass hearings below. See, e.g., ALA. CODE§ 26-21-4; ARIZ. REV. STAT. ANN. § 36-2152; ARK. CODE ANN. § 20-16-809 (West 2016); IDAHO CODE ANN. § 18-609A (West 2007); IND. CODE ANN. § 16-34-2-4 (West 2011); KAN. STAT. ANN. § 65-6705 (West 2014); KY. REV. STAT. ANN. § 311.732 (West 2005); LA. STAT. ANN. § 40:1061.14; MASS. GEN. LAWS ANN. ch. 112, § 12S (West 1980); MICH. COMP. LAWS ANN. § 722.904 (West 2014); MISS. CODE ANN. § 41-41-55; MO. ANN. STAT. § 188.028 (West 1986); NEB. REV. ST. § 71-6902; N.C. GEN. STAT. ANN. § 90-21.8; N.D. CENT. CODE ANN. § 14-02.1-03.1 (West); 18 PA. STAT. AND CONS. STAT. ANN. § 3206 (West 2016); TENN. CODE ANN. § 37-10-303 (West); WIS. STAT. ANN. § 48.375 (West 2011).

A third category of states require parental notification before a minor can terminate her pregnancy, but parental consent is not required. The Supreme Court has upheld statutes that require parental notification of a minor's abortion on the ground that this requirement gives neither parents nor judges a veto over a minor's abortion decision. See H. L. v. Matheson, 450 U.S. 398 (1981) (upholding a Utah state law requiring physicians to notify, if possible, the parents of a child upon whom an abortion is to be performed); Hodgson v. Minnesota, 497 U.S. 417 (1990) (holding that the two parent notification requirement in Section 2 of the statute was unconstitutional, but was remedied by another section providing a judicial by-pass procedure). Although the Court has not held explicitly that a mature minor is exempt from parental notification, statutes requiring notification provide a procedure for the minor to demonstrate maturity and avoid parental notification. See, e.g., OHIO REV. CODE ANN. § 2151.85 (West 2012) (providing judicial by-pass if minor can demonstrate that she is mature); COLO. REV. STAT. ANN. § 12-37.5-108 (West) (same); 24 DEL. C. § 1783 (same); FLA. STAT. ANN. § 390.01114 (same); GA. CODE ANN. § 15-11-682 (West) (same); W. VA. CODE, § 16-2F-3 (same); N.H. REV. STAT. § 132:34 (2012) (same); 750 ILL. COMP. STAT. 70/25 (1995) (same); IOWA CODE ANN. § 135L.3 (West 1996) (same); MINN. STAT. ANN. § 144.343 (West 1971) (same); S.D. CODIFIED LAWS § 34-23A-7 (1973) (same).

In recent years, courts have been hostile to parental notification statutes. The Alaska Supreme Court struck down a 2010 parental notification statute on equal protection and privacy

grounds, even though the statute provided an exception to the notice requirement for mature minors and minors demonstrating parental abuse. Planned Parenthood of the Great Nw. v. State, 375 P.3d 1122 (Alaska 2016). In 2017, a federal District Court in Kentucky struck down a 2014 amendment to its judicial by-pass statute requiring parental notification of even a mature minor unless the court found the notification to be against the minor's interest. Planned Parenthood of Indiana & Kentucky, Inc. v. Comm'r, Indiana State Dep't of Health, 258 F. Supp. 3d 929 (S.D. Ind. 2017). The court acknowledged that, in holding notification to a mature minor's parent unconstitutional, it was answering the question not answered in H. L. v. Matheson. See also Reprod. Health Servs. v. Marshall, 268 F. Supp. 3d 1261 (M.D. Ala. 2017) (finding unconstitutional statute providing that notice be provided to parent aware that minor child was seeking judicial by-pass of parental consent, and also providing that parent be allowed to participate in proceeding).

Parental notification requirements are deemed less intrusive than parental consent requirements because the parent cannot prohibit the abortion. Nonetheless, critics have argued that parental notification constitutes a substantial deterrent for many minors. See, e.g., Theodore Joyce, Robert Kaestner & Silvie Colman, *Changes in Abortions and Births and the Texas Parental Notification Law*, 354 NEW ENGLAND J. MEDICINE 1031 (2006) (finding that parental notification laws "compel a small proportion of minors to continue unwanted pregnancies"); Robert L. Ohsfeldt & Stephan F. Gohmann, *Do Parental Involvement Laws Reduce Adolescent Abortion Rates?*, 12 CONTEMP. ECON. POL'Y 65 (1994) (concluding that parental involvement laws are associated with about an 18% reduction in the adolescent abortion rate); Scott K. Henshaw, *Parental Involvement in Minors' Abortion Decisions*, 214 FAM. PLAN. PERSP. 196 (1992) (finding that one-third of teenagers who did not tell their parents about their decision to seek an abortion had experienced violence in their family, or feared that violence would occur or that they would be forced to leave home).

This Section describes the standard to be applied by a court in a bypass proceeding or in any proceeding in which the competence of the minor to make the abortion decision is questioned. This Section guides the judge in a by-pass proceeding to consider only the ability of the minor to give informed consent to the medical procedure and not to evaluate her maturity more generally. In a state that does not require a hearing before a minor seeks an abortion, the physician will proceed with the abortion unless confronted with substantial questions about the minor's competence to consent. See Comment *c* and Reporters' Note thereto. In such a jurisdiction, this Section directs the court to evaluate whether the minor is capable of consenting to the abortion procedure without consent or notification of parents, applying the presumption of maturity described in Comment *c*. Under both approaches, if a minor is competent to give informed consent to the procedure, her independent consent is valid. If the minor is not competent to make the medical decision, the court will determine whether abortion is in her best interest.

Scholars have criticized the requirement that a minor be required to demonstrate maturity in a by-pass hearing. For example, Elizabeth Scott points to the lack of any evidence that the by-pass proceeding promotes the interest of the teen; it typically only leads to delays and later-term abortions. Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547

(2000). Carol Sanger argues that by-pass hearings, although they are civil proceedings, are punitive, and damage the dignity of teenage women. This is borne out in part by the fact that almost all petitions for judicial by-pass are approved: the punishment is in the process of seeking a by-pass. CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA (2017); Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18 COLUM. J. GENDER & L. 409 (2009); see also Rachel Rebouché, *Parental Involvement Laws and New Governance*, 34 HARV. J. L. & GENDER 175 (2011) (explaining that most minors cannot consult their parents for logistical and personal reasons, and by-pass procedures do not function as a workable alternative); B. Jessie Hill, *Constituting Children's Bodily Integrity*, 64 DUKE L.J. 1295 (2015) (suggesting that by-pass procedures undermine a child's right to bodily integrity, as much of the abortion decision is delegated to parents or judges); Satsie Veith, *The Judicial Bypass Procedure and Adolescents' Abortion Rights: The Fallacy of the "Maturity" Standard*, 23 HOFSTRA L. REV. 453 (1994) (arguing in part that judicial bypass procedures, while ostensibly trying to protect minors, actually victimize them as the procedure is a "rubber-stamp" that only serves to place political burdens in the way of minors). Substantial evidence supports Veith's point that the by-pass procedure is a "rubber-stamp," in that the minor's petition is almost always approved. This evidence is discussed in the Reporter's Note to Comment *c*.

b. What are reproductive health treatments? Minors are not allowed to consent to sterilization in any state; nor can parents consent to the sterilization of a minor. An exception in some states applies to children with severe intellectual disabilities. Parents can petition a court to authorize sterilization based on a determination that it is necessary to preserve the minor's life, or physical or mental health. See e.g., In the Matter of A.W., 637 P.2d 366 (Colo. 1981); Wentzel v. Montgomery General Hosp., Inc., 447 A.2d 1244 (1982). See also W. Va. Code Ann. § 16-11-1 (West 1974); N.C. Gen. Stat. Ann. § 90-272 (1971).

The minimum age for sterilization paid for under federal programs is 21. The Department of Health and Human Services (DHHS) sets age 21 as the minimum age at which they will pay for the elective sterilization of mentally competent individuals under federal programs. See e.g. 42 CFR § 441.253 (Among other requirements individuals must be at least 21 to be electively sterilized through Medicaid); 42 CFR § 50.203 (2012) (Individuals must be at least 21 to be electively sterilized through the Federal Assisted Family Project); Indian Health Service, *Chapter 13 - Maternal And Child Health Part 3*, Indian Health Manual, https://www.ihs.gov/IHM/pc/part-3/p3c13/#3-13.12F5 (Sterilization services available only in compliance with DHHS guidelines).

Transgender minors are not authorized to consent to treatment associated with gender confirmation. Though American courts have not considered the issue, some scholars have argued that the mature minor doctrine should apply to transgender minors seeking medical transition in the absence of parental consent, particularly those who are seeking nonsurgical puberty postponement treatment or hormone therapy. Delaying puberty postponement treatment or transitional hormone therapy can lead to extreme distress, depression, anxiety, and suicidal thoughts. Thus, scholars have argued that under the same rationales by which courts have granted

mature minors the right to access the reproductive health treatments discussed in this Section, mature minors should also have the right even in the absence of parental consent to access puberty postponement treatment, hormone therapy, and perhaps even gender confirmation surgery where an appropriate healthcare provider has determined that it is in the best interest of the mature minor. See Amanda Kennedy, *Because We Say So: The Unfortunate Denial of Rights to Transgender Minors Regarding Transition,* 19 HASTINGS WOMEN'S L.J. 281, 293 (2008) (arguing, et alia, that minors should be able to access transition-related healthcare without parental consent where he or she has been judicially determined to be a mature minor and where a clinician has determined that receiving the care is in the best interest of the minor); Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE 361, 363 (2007) (arguing that "mature minors" should be able to consent to transition-related healthcare without parental or state—in the case of children in foster-care—consent where the *Bellotti II* factors have been met); Emily Ikuta*, Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDISC. L.J. 179, 228 (2016) (Arguing that "[t]hrough the mature minor doctrine, adolescents who prove themselves mature and capable of informed consent should have the right to access puberty-suppressing treatment independent of their parents' wishes."); Maureen Carroll, *Transgender Youth, Adolescent Decisionmaking, and Roper v. Simmons,* 56 UCLA L. REV. 725, 753 (2009) (Arguing that the Supreme Court's view of and description of adolescence underlying its decision in Roper v. Simmons*,* "supports a presumption in favor of allowing transgender youth to obtain hormones without parental consent.").

A Canadian court authorized a 14 year old to consent to transition-related hormone therapy over his father's objection. See https://nationalpost.com/news/canada/transgender-teen-can-proceed-with-hormone-treatment-despite-fathers-objections-b-c-court-rules.

Comment c. Informed consent and reproductive health decisions. In *Bellotti*, the Supreme Court held that a pregnant minor "is entitled in a [bypass] proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests." Bellotti v. Baird, 443 U.S. 622, 643-644 (1979). The Court framed the maturity inquiry as "satisfy[ing] the court that she is competent to make this decision independently." Id. at 647. The Court noted that maturity entails "the minor [being] capable of making . . . an informed and reasonable decision to have an abortion." Id. at 650.

Under this Section, the standard applied to evaluate whether the minor is mature enough to make an independent abortion decision is the informed consent standard applied to medical decisions generally for adults and mature minors. See § 19.01. This standard, limiting the inquiry into the minor's maturity to the question of whether she is competent to make the medical abortion decision, is applied by states that do not distinguish between minor and adult patients seeking abortion. This represents the law in 12 states. These laws, in both statutory and judicial form, are

discussed in detail in the Reporters' Note to Comment *d*, The presumption of maturity. As Comment *d* and the Reporters' Notes thereto explain, in these states, minor and adult patients alike are presumed to be competent to consent to the medical procedure. See, e.g., CONN. GEN. STAT. ANN. § 19a-601 (1990) (providing that a doctor should counsel a minor seeking an abortion on various risks and alternatives, but that the decision whether to inform her family rests with the minor). In states with no statute regulating minors' access to abortion, a minor has the same right of access to abortion as an adult; thus, the informed consent standard applies by implication.

The informed consent standard is also applied in a judicial by-pass proceeding to determine whether a minor is a mature minor who has the right to consent to abortion without requiring either consent or notice by parents. The language of *Bellotti*, above, supports the application of the informed consent standard by judges in a judicial by-pass proceeding. Indirect evidence supports that courts apply this standard and that they presume that most minors are competent to consent. Although few appellate opinions explicitly discuss the standard, courts in judicial bypass proceedings overwhelmingly authorize minors to consent to abortion without involving their parents. This evidence is discussed in the Reporters' Note to Comment *d*.

A few states allow a broader inquiry into the minor's "experience, perspective and judgment" by courts evaluating whether the minor has the right to make an independent decision. See, e.g., R.B. ex rel. V.D. v. State, 790 So. 2d 830, 833 (Miss. 2001) ("[M]inors often lack the *experience, perspective, and judgment* to recognize and avoid choices that could be detrimental to them."); Ex parte Anonymous, 92 So. 3d 68 (Ala. 2012) (Parker, J., concurring) ("Acknowledging that potential 'lack of experience, perspective, and judgment' on the part of minors, the Alabama legislature enacted the Parental Consent Act"); Petition of Anonymous, 558 N.W.2d 784 (Neb. 1997) (adopting the view that "maturity may be measured by examining the minor's experience, perspective, and judgment."); H---- B---- v. Wilkinson, 639 F. Supp. 952, 954 (D. Utah 1986) ("maturity . . . calls for experience, perspective and judgment."). Several state statutes also call for judges to evaluate the experience, perspective, and judgment of the minor in determining maturity. ARK. CODE ANN. § 20-16-809 (West 2016); KAN. STAT. ANN. § 65-6705 (West 1992); OKLA. STAT. ANN. tit. 63, § 1-740.3 (West 2005).

Statutes in a few states direct courts to consider the emotional development, maturity, intellect, and understanding of the minor as to the nature, possible consequences, and alternatives to the abortion. See, e.g., KY. REV. STAT. ANN. § 311.732 (West 2005); 18 PA. STAT. AND CONS. STAT. ANN. § 3206 (West 1992); S.C. CODE ANN. § 44-41-32 (1990); WIS. STAT. ANN. § 48.375 (West 2011). Some states specifically permit a broad and expansive look into maturity, directing courts to factor in a juvenile's socioeconomic position, education level, emotional stability, intelligence, and credibility. See, e.g., FLA. STAT. ANN. § 390.01114 ("in making a maturity determination a judge may consider factors such as overall intelligence, emotional development and stability, credibility and demeanor, ability to explain the medical risks of an abortion, and ability to accept responsibility"); ARIZ. REV. STAT. ANN. § 36-2152 ("a court may consider minor's age, experience working and living outside of the home, personal finances, the minor's conduct since learning of her pregnancy and her intellectual ability"); TEX. FAM. CODE ANN.

§ 33.003 (West) (stating that a court may consider minor's age, life experiences (including managing personal finances), reasons why the minor is seeking an abortion, and steps taken by the minor to explore her other options and require the minor to be evaluated by a mental health counselor).

This Section applies the conventional informed consent standard restricting courts from basing the judgment about whether the minor is "mature enough and well enough informed to make her [own] abortion decision," on factors that extend beyond whether the minor is capable of consenting to abortion. *Bellotti* at 643. A broader inquiry seriously intrudes into the minor's privacy and imposes serious psychological costs on her in a difficult time. Under a general maturity standard, the court has very broad discretion to probe into intimate personal matters that extend well beyond the minor's ability to make the abortion decision. The broad standard allows the judge's view of abortion and of the minor's sexual activity itself to influence the judgment about the minor's maturity, and to base the decision on factors that would hold for most minors, such as lack of financial independence.

These concerns are supported by a review of judicial opinions that have adopted a broad discretionary standard. See, e.g., In re A.W., 826 So. 2d 1280, 1282 (Miss. 2002) (finding that the minor was immature because the minor "was simply afraid of the responsibility of motherhood."); In re Jane Doe, 19 S.W.3d 346, 358 (Tex. 2000) (rejecting petition for bypass, despite minor having researched the procedure and consulted with counselors, because she did not understand the "intrinsic benefit" of having a child); In re Jane Doe 1, 566 N.E.2d 1181, 1184 (Ohio 1991) (finding immaturity because minor had previously had an abortion and was pregnant again); In re Anonymous, 684 So. 2d 1337, 1338 (Ala. Civ. App. 1996) (finding a minor immature in part because the minor had sex despite the high school teaching sex education); Ex parte Anonymous, 803 So. 2d 542, 544-545 (Ala. 2001) (affirming trial court decision that minor was immature, despite her ability to describe the procedure and any potential complications); H---- B---- v. Wilkinson, 639 F. Supp. 952, 954 (D. Utah 1986) (finding minor immature because she was not financially independent, had not lived away from home, and appeared to find the hearing stressful); Petition of Anonymous 1, 558 N.W.2d 784, 788 (Neb. 1997) (affirming that minor was immature based on never having handled personal finances or held a long-term job).

Scholars have harshly criticized by-pass proceedings for probing sensitive and private matters that go well beyond the minor's ability to make an independent abortion decision. See Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18 COLUM. J. GENDER & L. 409 (2009) (arguing that bypass proceedings humiliate women because the topics discussed are often of the most private nature, especially from a teenager's vantage point). Moreover, some judges emphasize the importance of the minor showing remorse for her pregnancy. Id. at 409 ("Bypass hearings are supposed to be about a minor's maturity . . . [y]et advocates who represent minors are often aware that some judges want to hear some indication that she is sorry").

The informed consent standard has two components. First, the physician must disclose material information about the procedure that the patient is considering, including the purpose,

potential risks and benefits, and alternatives. See, e.g., Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891) ("[A] physician has a legal duty to disclose to the patient all medical information that a reasonably prudent patient would find material before deciding whether to undergo a medical procedure"); Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir. 1972) (informed consent includes allowing "the patient to chart his course understandably."). See also N.Y. PUB. HEALTH L. § 2805-d (McKinney) (Lack of informed consent is defined as "failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits . . . in a manner permitting the patient to make a knowledgeable evaluation."); WASH. REV. CODE ANN. § 7.70.050 (West 2011) (material facts include alternatives, risks, and benefits).

Second, the patient must be capable of understanding the disclosed information and of making a decision on the basis of that information. See discussion of informed consent in § 19.01, Comment *a.* See also Loren Roth & Alan Meisel, *Test of Competency to Consent to Treatment*, 139 AM. J. PSYCHIATRY 279 (1977) (stating that the ability to understand the risks, benefits, and alternatives to treatment is most consistent with the law of informed consent); Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEW ENGLAND J. MED. 1834, 1840 (2007) (concluding that "to the extent that the patient . . . can clearly communicate her decisions, understands the information about her condition, appreciates the consequences of her choices . . . and can weigh the relative risks and benefits of the options, she should be considered competent"). See also various state laws defining informed consent in this fashion, VT. STAT. ANN. tit. 12, § 1909 (West 2009) (defining informed consent as a "knowledgeable evaluation"); COLO. REV. STAT. ANN. § 26-3.1-101(1) (West 1995) (defining capacity, or lack thereof, as showing a "sufficient understanding or capacity to make or communicate responsible decisions."); ALA. CODE § 26-2a-20(8) (1992).

A third component of valid consent to abortion is that the decision must be voluntary. This requirement holds for other medical decisions as well, as indicated in disputes over patients' refusal to consent to treatment. In abortion cases, the issue can arise when the minor's parent or the putative father of the child urge abortion against the wishes of the pregnant minor. In this situation, abortion should not proceed.

State courts have adopted a similar approach to informed consent for general medical decisions. See, e.g., Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987) (adopting mature minor exception and stating that "[c]apacity exists when the minor has the ability of the average person to understand and weigh the risks and benefits" of the medical procedure); Younts v. St. Francis Hospital and School of Nursing, 469 P.2d 330, 333 (Kan. 1970) (holding that 17-year-old girl could give consent to surgery without parental consent, was mature enough to understand the nature and consequences, and to knowingly consent). See § 19.01 for further discussion.

The minor seeking abortion must understand material information about the procedure she is considering. Information about different types of abortion procedures are relatively straightforward and the risks are low. The procedure itself can take a medical or surgical form. Medical abortions are typically administered via a tablet inserted either orally, vaginally, or

intravenously and are recommended when the individual is within the 50th day of conception. See F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 364, 368 (24th ed. 2014). A medical abortion typically involves no anesthesia, a very low incidence of serious bleeding (.1%), a low infection rate, and a failure rate of two to five percent. Id. at 365. Surgical abortions usually involve dilatation and curettage, vacuum aspiration, or a manual aspiration approach. Id. at 364. Surgical abortions have a success rate of 99 percent. Id. Only .1 percent of surgical abortions incur severe bleeding, the procedure has a low infection rate, and a failure rate of one percent. See F. GARY CUNNINGHAM ET AL., id. at 365. Surgical abortions involve anesthesia which has attendant risks. Overall, the mortality rate for elective abortions is one per 1,000,000 procedures, and the mortality rate for early abortions is even lower. Id. at 370.

The health risks of pregnancy and childbirth are more substantial for minors than the risks of terminating the pregnancy. See Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215 (Feb. 2012) (concluding that "[l]egal induced abortion is markedly safer than childbirth. The risk of death associated with childbirth is approximately 14 times higher than that with abortion. Similarly, the overall morbidity associated with childbirth exceeds that with abortion"). Further, the mortality rate for teenage births is higher than the mortality rate for adults. See Jane E. Dopkins Broecker, *Pregnancy in Adolescence*, Global Library of Women's Medicine (Feb. 2009) (finding greater health and mortality risks for adolescents than adults); Deanne Lachner, *Teen Mothers & Infant Mortality*, LIVESTRONG (Sept. 7, 2010) (citing research showing babies born to teen mothers under 15 suffered an infant mortality rate of 16.4 deaths per 1000 live births compared with a 6.8 mortality rate per 1000 births for mothers of all ages), http://www.livestrong.com/article/233972-teen-mothers-infant-mortality/.

There is no evidence of serious psychological disorders subsequent to abortion, see CUNNINGHAM, ET AL., supra, at 370, and conflicting data on whether future pregnancies are affected by an induced abortion. See id. Some studies show that adverse pregnancy outcomes are more common in women who have had an induced abortion—specifically, a 1.5x increased incidence of preterm (22 to 32 week) birth. Id.

Both developmental research on adolescents' cognitive maturation and research evaluating competence to make medical decisions confirm that by mid-adolescence, most minors are competent to understand the relevant medical information and to consent independently to abortion.

Cognitive brain development attains adult levels of maturity by mid-adolescence. Abilities implicated in rational decisionmaking, such as information processing, working memory, verbal ability, logical reasoning, and the capacity for hypothetical thinking develop through childhood and early adolescence. By age 14 or 15, an adolescent is comparable to an adult in his or her capacity to deploy these capacities in making decisions. See ROBERT SIEGLER, CHILDREN'S THINKING (4th ed. 2004); JOHN FLAVELL, PATRICIA MILLER & SCOTT MILLER, COGNITIVE DEVELOPMENT (4th ed. 2001); LAURENCE STEINBERG, ADOLESCENCE 57 (10th ed. 2013) (offering a comprehensive analysis of cognitive and brain development in adolescence); Thomas Grisso,

Laurence Steinberg, Jennifer Woolard, Elizabeth Cauffman, Elizabeth Scott, Sandra Graham, Fran Lexcen, N. Dickon Reppucci & Robert Schwartz, *Juveniles' Competence to Stand Trial: A Comparison of Adolescents' and Adults' Capacities as Trial Defendants*, 27 L. AND HUM. BEHAV. 333 (2003) (showing that studies on adjudicative competence support scientific findings that basic cognitive abilities, such as memory and logical reasoning, do not appreciably mature after age 16). At this age, most adolescents are capable of engaging in formal reasoning. See, e.g., Shawn L. Ward & Willis Overton, *Semantic Familiarity, Relevance, and the Development of Deductive Reasoning*, 26 DEVELOPMENTAL PSYCHOL. 488, 492 (1990) (reporting results of study indicating that only 16% of sixth-grade subjects but 80% of 12th-grade subjects could be classified as formal reasoners).

Researchers have studied the capacity of minors to make medical decisions specifically, with many studies finding that by mid-adolescence, individuals can make competent decisions. See, e.g., Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412 (1978) (concluding that research evidence provides no psychological grounds for maintaining the general legal assumption that minors at age 15 and above cannot provide informed consent to treatment); Lois Weithorn & Susan Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982) (testing 96 subjects and finding, in part, that 14-year-olds exhibited no difference in competency (assessed against four legal standards) when compared with adults). See further discussion in § 19.01, Comment *b* and the Reporters' Note thereto. Some studies have focused specifically on the decision of whether or not to carry a child to term. See, e.g., Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 L. AND HUM. BEHAV. 129 (1992) (in a survey of 75 women considering abortion, aged 13-21, a series of cognitive exams showed that the women above 15 years of age were as competent as adults); Catherine C. Lewis, *Minors' Competence to Consent to Abortion,* 42 AM. PSYCHOL. 84 (1987) (arguing that psychological research provided no basis to restrict minors' decisionmaking on the ground of competence alone); Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions*, 50 AM. J. ORTHOPSYCHIATRY 446 (1980) (showing in a comparison of 16 pregnant adolescents and 26 pregnant adults that minors and adults registered similar responses—asking the same questions, having similar concerns, understanding similar consequences, and listing similar factors as bearing on the decision).

Some judges (most famously, Justice Scalia in Roper v. Simmons, 543 U.S. 551) have questioned how this research can be reconciled with claims that adolescent offenders, due to their immaturity, are less culpable than their adult counterparts. 543 U.S. at 617 (2005) (Scalia, J., dissenting) ("We need not look far to find studies contradicting the Court's conclusions. As petitioner points out, the American Psychological Association (APA), which claims in this case that scientific evidence shows persons under 18 lack the ability to take moral responsibility for their decisions, has previously taken precisely the opposite position before this very Court. In its brief in *Hodgson v. Minnesota* . . . the APA found a 'rich body of research' showing that juveniles are mature enough to decide whether to obtain an abortion without parental involvement."). The

difference in maturity in the two contexts reflects different rates of development of different brain structures and functions. Studies have shown that adolescents attain cognitive maturity (implicated in medical decisionmaking) earlier than emotional or social maturity (implicated in decisions about involvement in criminal activity). Under conditions of emotional arousal and in the presence of peers, adolescents make more impulsive and short-sighted decisions than do adults. But when these conditions are not present, adolescent decisionmaking approximates that of adults. See, e.g., Laurence Steinberg, *Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?*, 38 J. MED PHILOS. 256 (2013) (arguing that adolescents aged 15 and older are as mature as adults under conditions that typically characterize medical decisionmaking—when emotional arousal and peer influence is minimized); Laurence Steinberg et al., *Are Adolescents Less Mature Than Adults?*, 64 AM. PSYCHOL. 583, 591-592 (2009) (reporting studies finding that, by age 15, adolescents were similar to adults in cognitive capacity to make decisions involving deliberation and consultation with experts including medical decisions, legal decisions, and research participation decisions).

Comment c. The presumption of maturity. This Section follows the approach of states that subject reproductive health decisions of minors to the same legal requirements as similar decisions by adults. Informed consent is required for every medical procedure, including abortion and other reproductive health decisions. But the burden is not on the patient to demonstrate competence to make the decision. Unless the physician observes evidence of impairment or lack of comprehension in discussing the procedure with the minor patient, he or she is justified in presuming that the minor comprehends the material information to the extent that this presumption would be appropriate with an adult patient. Under this Section, a court evaluating the minor's competence to consent applies the same presumption.

For medical decisions generally, the presumption favoring the competence of the patient to make the decision is seldom challenged. See § 19.01, Comment *a*. The vast majority of claims based on lack of informed consent involve allegations that the provider failed to disclose material information. Cases challenging the competence of the patient to make an informed medical decision almost all involve intellectually handicapped individuals who refuse to consent to life-saving or -sustaining treatment. Id. See also Robert D. Orr, *Competence, Capacity, and Surrogate Decision-Making*, The Center for Bioethics & Hum. Dignity (Mar. 9, 2004) ("Competence is presumed unless a court has determined that an individual is incompetent"), https://cbhd.org/content/competence-capacity-and-surrogate-decision-making; Raphael J. Leo, *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, 1 PRIM. CARE COMPANION J. CLIN. PSYCHIATRY 131 (1999) ("individuals who are in persistent vegetative states, severely demented, severely mentally retarded, or actively psychotic would be considered incompetent generally"); Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW ENGLAND. J. MED. 1635, 1635-1636 (1988) (stating that "only patients with impairment that places them at the very bottom of the performance curve should be considered to be incompetent"); Zinermon v. Burch, 494 U.S. 113 (1990) (stating, as part of an overall evaluation of a § 1983 claim, that "[i]t is hardly unforeseeable

that a person requesting treatment for mental illness might be incapable of informed consent"); James W. Ellis, *Decisions by and for People with Mental Retardation: Balancing Considerations of Autonomy and Protection*, 37 VILL. L. REV. 1779, 1802 (1992) (arguing that mentally impaired individuals should be evaluated for competency in a fact-specific manner, but acknowledging that some mentally impaired individuals cannot be deemed competent); Marshall B. Kapp, *Treatment of Incompetent Patients*, JAMA (May 18, 1984) (in 18 studied cases of physician–patient conflict on course of treatment, 15 patients who were treated despite refusal were later deemed incompetent); Lawrence Markson et al., *Physician Assessment of Patient Competence*, 42 J. AM. GERIATRIC SOC'Y. 1074 (1994) (in study of 2,100 doctors, 92% deemed patient competent or would consult psychiatrist to verify; only 17% reported that they would ever go to court to determine competence).

Several states either explicitly authorize minors to consent to abortion independently or do not distinguish between minors and adults seeking abortion. These states thus effectively have adopted a presumption that minor patients are competent to make the medical decision and to consent to abortion. See, e.g., CONN. GEN. STAT. ANN. § 19a-601 (1990) (providing that a doctor should counsel a minor seeking an abortion on various risks and alternatives, but that the decision whether to inform her family rests with the minor); ME. REV. STAT. tit. 22, § 1597-A (West 2016) (providing a doctor may perform an abortion on a minor if the minor provides informed consent). Some states have no specific provision regulating or restricting abortion decisions by minors. In these states, the minor's decision is subject to the medical standard for informed consent. See, e.g., N.Y. PUB. HEALTH LAW § 2504 (McKinney 2005) (providing that "[a]ny person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care."); VT. STAT. ANN. tit. 12, § 1909 (West) (detailing informed consent for medical decisions as requiring disclosure of alternatives, risk, and benefits, permitting a knowledgeable evaluation by patient); WASH. REV. CODE ANN. § 9.02.100 (West 2016) (stating every woman has the fundamental right to choose or refuse an abortion); WASH. REV. CODE ANN. § 7.70.050 (West 2011) (setting out informed consent standard, emphasizing disclosure of material facts, including likely outcomes, alternatives, and risks); OR. REV. STAT. ANN. § 677.097 (West 2014) (detailing informed consent standard, emphasizing the disclosure of alternative treatment and risks).

See also discussion of various laws authorizing minors to consent to abortion in ACLU of Hawaii, Youth Rights (June 2015) ("A minor of any age may consent to have an abortion – your parents/guardians do not need to be notified or give consent."), http://acluhi.org/youthrights/#consent; Elizabeth Hovde, *Underage Abortions: Parental Notification Makes Sense for Families*, OREGON LIVE (Nov. 3, 2012) ("Neither Oregon nor Washington has a consent or notification law for minors' abortions"), http://www.oregonlive.com/hovde/index.ssf/2012/11/underage_abortions_parental_no.html.; Vermont Network Against Domestic and Sexual Violence (2013) ("In Vermont, there are no laws that specifically address the issue of parental consent for teens receiving the following services."), http://www.vtnetwork.org/wp-content/uploads/2-13-Parental-Consent-and-Confidentiality-with-SANE-3.pdf.

In several states, federal courts and state supreme courts have enjoined statutes requiring parental consent or notice on state constitutional grounds, thereby allowing minors to consent to abortion without parental involvement. In California, for example, the state Supreme Court ruled the parental consent statute unconstitutional under the California constitution in 1997. See Am. Acad. of Pediatrics v. Lungren, 940 P.2d 797, 830 (Cal. 1997) (enjoining California parental consent law, leaving no consent or notice laws in place). The court acknowledged that parents are entitled to certain rights over their children, but found that the parental consent statute infringed on the minor's privacy right protected by the state constitution. Id. at 815. The court observed the importance of the abortion decision, and recognized a minor's capacity to make such a decision. Id. The legislature has not enacted a new statute. The Supreme Court of New Jersey also invalidated a state parental notification statute, finding that the law acted as an effective bar to "a minor's exercise of her constitutional right to make her own reproductive decisions." Planned Parenthood of Cent. New Jersey v. Farmer, 762 A.2d 620, 634 (N.J. 2000). The court found that "most minors 14 to 17 years of age are as competent as adults . . . to provide consent to abortion. . . ." Id. at 636. As a result of these decisions, minors are presumed competent and are subject to the generally applied informed consent standard in California and New Jersey. See discussion in Minors' Access to Confidential Reproductive Healthcare, New Jersey, ACLU (Apr. 2008) ("A minor who understands the risks, benefits, and proposed alternatives to certain health services outlined in this card may give informed consent . . . [a] minor in New Jersey may obtain an abortion without mandated parental consent or notification."), https://www.aclu-nj.org/files/9413/1540/4576/2008minorsrights.pdf.

See also Planned Parenthood of The Great Northwest v. State, 375 P.3d 1122, 1145 (Alaska 2016) (enjoining Alaska's parental notification statute on the basis that it violates the state's guaranty of equal protection; no replacement statute adopted); Planned Parenthood of Montana v. State, 342 P.3d 684 (Mont. 2015) (reversing and remanding to the district court, which had granted summary judgment to plaintiffs challenging a 2011 parental notification law and a 2013 parental consent law. The district court had applied collateral estoppel in favor of the plaintiffs on the basis that they had successfully received a judgment, in 1999, enjoining a 1995 parental notification law); Glick v. McKay, 937 F.2d 434 (9th Cir. 1991) (enjoining Nevada's parental notification law; no replacement parental involvement law adopted). See also N.M. A.G. Op. No. 90-19 (N.M.A.G.), 1990 WL 509590 (publishing official opinion of New Mexico Attorney General that New Mexico's parental consent law, which prohibits juvenile abortions unless the juvenile receives parental consent, was unconstitutional and thus unenforceable).

Courts in malpractice suits sometimes have applied a presumption of competence in minors seeking abortion, despite the lack of a formal presumption under state law. See Roddy v. Volunteer Med. Clinic, Inc., 926 S.W.2d 572, 576 (Tenn. Ct. App. 1996) (upholding dismissal of malpractice suit, as plaintiffs had failed to rebut presumption of capacity for 16-year-old minor seeking an abortion, and citing to The Queen v. Smith, 1 Cox C.C. 260 (1845) for proposition that "minors achiev[ing] varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century.").

In states that require a formal determination of maturity when a pregnant minor seeks abortion in a by-pass hearing, no presumption of maturity is explicitly applied. But it appears that in many jurisdictions, judges in these hearings implicitly apply a presumption of competence. Judges in many states almost always conclude the minor is mature enough to make the abortion decision without parental involvement. See, e.g., Hodgson v. Minnesota, 497 U.S. 417, 436 (1990) ("during the period for which statistics have been compiled, 3,573 bypass petitions were filed in Minnesota courts. Six petitions were withdrawn before decision. Nine petitions were denied and 3,558 were granted."). Carol Sanger found that judges seldom rejected a minor's petition. See CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA 157 n.19 (2017); Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18 COLUM. J. GENDER & L. 409, 437 n.111 (2009) (finding that "[o]ut of 15,000 cases in Massachusetts heard by the year 2000, only 13 were denied and 11 of those were reversed on appeal"). Sanger also described another report: "Planned Parenthood reports that during 2007, in six of its regional offices (the Rocky Mountains, Southeast Virginia, Bucks County and Central Pennsylvania, and Mid and South Michigan), out of 150 bypass petitions sought, none were denied." Id.

Many states presume that minors are competent to make reproductive and other healthcare decisions under minor consent statutes that authorize minors to consent to treatments that implicate public health concerns. Under the Virginia statute, for example, "A minor *is deemed an adult* for the purpose of consenting to medical or health services" to treat sexually transmitted diseases, substance abuse, pregnancy-related conditions, and mental illness (outpatient services). See Va. Code Ann. § 54.1-2969 (West 2008). The statute also authorizes minors to consent to contraceptive treatment. Minor consent statutes have been adopted in a large majority of states: treatment for STDs (50 states); treatment for substance abuse (49 states); pregnancy-related treatment and contraceptive services (39 states). These statutes are collected in a Statutory Note following the Reporters' Notes for § 19.01.

Comment d. The best interest inquiry and the immature minor. If a court in a judicial by-pass proceeding finds the minor to lack the maturity to make an independent decision about abortion, the court must determine whether abortion without parental involvement is in the minor's best interest. See Bellotti v. Baird, 443 U.S. 622, 644 (1979) ("A pregnant minor is entitled in such a proceeding to show . . . that even if she is not able to make this decision independently, the desired abortion would be in her best interests.").

The Supreme Court has not held expressly that a by-pass proceeding is required under a parental notification statute to determine whether notice to the parents of an immature minor is in her best interest. However, most notification statutes require a judicial by-pass hearing on the question of whether allowing the immature minor access to abortion without notifying parents would be in the minor's best interest. See, e.g., OHIO REV. CODE ANN. § 2151.85 (West 2012) (providing judicial bypass if minor can demonstrate that it would be in her best interests); COLO. REV. STAT. ANN. § 12-37.5-108 (West 1998) (same); 24 DEL. C. § 1784 (1995) (same); FLA. STAT. ANN. § 390.01114 (2011) (same); GA. CODE ANN. § 15-11-684 (West 2014) (same); N.H. REV.

STAT. § 132:34 (2012) (same); 750 ILL. COMP. STAT. 70/25 (1995) (same); IOWA CODE ANN. § 135L.3 (West 1996) (same); MINN. STAT. ANN. § 144.343 (West 1971) (same); S.D. CODIFIED LAWS § 34-23A-7 (1973) (same).

The Court in *Bellotti* stated clearly that the inquiry should focus on whether abortion is in the immature minor's best interest. See above. This Section follows *Bellotti* in limiting the inquiry to that question, allowing the court to consider whether any alternative outcome would better serve the minor's interest. Many courts adopting this approach appear to assume that carrying the pregnancy to term is highly unlikely to be in the best interest of a minor found too immature to make an independent abortion decision; greater maturity would be required for outcomes other than the termination of the pregnancy (such as undergoing childbirth and raising the child, marrying the father, or placing the child for adoption). One study found that Massachusetts judges ordered abortion in almost all cases of minors found to be immature. ROBERT H. MNOOKIN, IN THE INTEREST OF CHILDREN: ADVOCACY, LAW REFORM, AND PUBLIC POLICY 239 (1985) (discussing *Bellotti* and noting that of 1,300 women who sought abortions in Massachusetts, none were refused). In one instance described by Mnookin, a judge found a woman to be both immature, and that the abortion would not be in her best interest; nonetheless, "[the judge] invited the teenager simply to ask some other Superior Court judge for another opinion. She did, and consent was granted by the other judge." Id. Mnookin observed, "many judges see the process as a sham." Id. Mnookin also noted that "if the judge decides that the young woman before him is not mature, on what basis (other than moral revulsion to abortion) could he possibly decide that it is not in the best interests of an immature minor. . . [i]n terms of the responsibilities of motherhood, how could the judge determine that it is in the interest of a minor to give birth to a child if she is too immature even to decide to have an abortion?" Id. at 263.

In Ex Parte Anonymous, the Alabama Supreme Court held that the burden of proof for the maturity and best interests inquiries lies with the minor. A dissenting justice, crediting Mnookin's argument, wrote that "[c]ommon sense . . . militates against a presumption that maintaining a pregnancy to term and bearing a baby are in the best interest of a minor." Ex parte Anonymous, 889 So. 2d 525, 527 (Ala. 2003) (Johnstone, J., dissenting). See Reporters' Note to Comment *a*, for a discussion of the burdens and health risks that teenage pregnancy carries for the mother. As discussed in the Reporters' Note to Comment *c*, courts seldom reject minors' abortion petitions. This suggests that courts usually hold that abortion without involving parents is in the petitioning immature minor's best interest.

The conclusion that younger minors are more likely than older minors to suffer harmful consequences of bringing the pregnancy to term is supported by research as well as by common sense. Leo Morris, Charles Warren & Sevgi Aral, *Measuring Adolescent Sexual Behaviors and Related Health Outcomes*, 108 Pub. Health Reports 31 (1993) (finding that maternal death rate for teenagers younger than 15 is 2.5 times greater than the death rate for mothers ages 20-24). Teenagers generally experience higher physical and psychological risks than do adults in pregnancy and childbirth. See studies described in the Reporters' Note to Comment *a*. The risks for younger and more immature minors is likely far greater. See, e.g., Guttmacher Institute, *Sex*

and America's Teenagers (1994) (finding that the younger the mother is, the less likely they are to receive prenatal care during the first trimester of pregnancy); Kristen A. Moore, David E. Myers, Donna R. Morrison et al., *Age at First Childbirth and Later Poverty*, 3 J. RESEARCH ADOLESCENTS 393 (1993) (finding that age at first birth is positively correlated with likelihood of subsequent poverty for the mother). Further, as Mnookin observed on the basis of interviews of judges, immature teens are far less likely than adult women to function adequately as parents. Janet Reis, *A Comparison of Young Teenage, Older Teenage, and Adult Mothers on Determinants of Parenting*, 123 J. PSYCHOLOGY 141 (1989) (showing that young teen mothers differed from the older mothers in terms of knowledge of child development, punitive attitudes toward childrearing, and level of depression); Peggy L. Parks & Edward K. Arndt, *Differences Between Adolescent and Adult Mothers of Infants*, 11 J. ADOLESCENT HEALTH CARE 248 (1990) (concluding, inter alia, that adolescents (particularly younger minors) perceived that care-giving had less influence on infant outcome, and they provided a lower quality of stimulation in the home environment than did adults).

Some courts do not consider whether abortion is in the immature minor's interest, as directed by the Supreme Court in *Bellotti*; instead these courts focus on whether harmful consequences are likely to follow from notifying parents. A court adopting this approach may evaluate the minor's fear of retribution, looking at prior parental conduct. See, e.g., State v. Planned Parenthood of Alaska, 35 P.3d 30, 51 (Alaska 2001) ("[e]xamples such as physical, sexual, or emotional abuse are given as instances where parental consent is not in the minor's best interest). Some courts credit this factor when it is particularized, but not when it is simply a "generalized" fear. See, e.g., In re E.H., 524 S.E.2d 2, 4 (Ga. Ct. App. 1999) ("the juvenile court found that the reason she did not want to tell her parents did not stem from any fear that they would abuse or harm her if they found out about the pregnancy, but rather that she simply did not want to tell them."); In re Doe, 166 P.3d 293, 296 (Colo. App. 2007) (fear that her mother would "disapprove" of the abortion was inadequate on its own to satisfy the best interest prong). For courts determining that the minor's fear is too generalized to satisfy the best interests inquiry, see In re T.P., 475 N.E.2d 312, 315 (Ind. 1985) ("The only testimony indicating potential adverse effects on T.P. and her family was T.P.'s appraisal that a second episode of pregnancy would be upsetting to her parents"); In re Anonymous 2, 570 N.W.2d 836, 840 (Neb. 1997) ("While [minor] expresses concern that the knowledge of her pregnancy would upset her mother, [minor] has failed to [show] . . . how her mother's alleged inability "to handle it" would affect [minor's] welfare").

Loss of parental financial support or ejection from the home is another factor that courts take into consideration. Usually, such circumstances warrant finding that an abortion without involving parents would be in the child's best interest. See, e.g., In re Doe 10, 78 S.W.3d 338, 342 (Tex. 2002) ("a minor's well-being would be 'adversely affected if her parents withdrew support and severed all contact with her'"); In re Doe, 932 So. 2d 278, 286 (Fla. Dist. Ct. App. 2005) (stating that because notification would possibly lead to her ejection from her home this "would support a finding that notifying Doe's parents of her decision was not in her best interest"); In re Petition of Doe for Waiver of Notice, 866 P.2d 1069 (Kan. 1994) (reversing district court and

finding abortion would be in minor's best interest in part because of testimony that parents would kick child out of house and remove financial support); In re Complaint of Doe, 615 N.E.2d 1142, 1143 (1992) (per curiam) (reversing district court, and granting by-pass, based in part on mother's testimony that she would eject minor from house without financial support).

The Texas Supreme Court offered guidelines focusing on the impact on the minor of notifying parents. In re Doe 2, 19 S.W.3d 278 (Tex. 2000). The court determined that judges should look at "(1) the minor's emotional or physical needs; (2) the possibility of emotional or physical danger to the minor; (3) the stability of the minor's home and whether notification would cause serious and lasting harm to the family structure, and (4) the relationship between the parent and the minor and the effect of notification on that relationship." 19 S.W.3d at 282. In In re Doe 4, the Texas Supreme Court applied these factors to find that the minor's alleged health issues meant that "her physical needs and the potential physical dangers may weigh in favor of involving her parents in her decision," while the fact that her parents kicked her sister out of the house years earlier upon learning she was pregnant supported bypass of notification. In re Doe 4, 19 S.W.3d 337, 340 (Tex. 2000). As of January 1, 2016, the Texas legislature amended the statute to list more general criteria. TEX. FAM. CODE ANN. § 33.003 (West 2016). Courts may look at "(1) the minor's reasons for not wanting to notify and obtain consent from a parent, managing conservator, or guardian; (2) whether notification or the attempt to obtain consent may lead to physical or sexual abuse; (3) whether the pregnancy was the result of sexual abuse by a parent, managing conservator, or guardian; and (4) any history of physical or sexual abuse from a parent, managing conservator, or guardian." Id. See also Petition of Doe, 866 P.2d 1069, 1075 (Kan. Ct. App. 1994) ("primary consideration [should be given] to the physical, mental, or emotional conditions and needs of the child . . . [p]hysical abuse is only one factor").

Under this Section, inquiry into the harmful consequences of involving parents is not deemed appropriate. As *Bellotti* directs, the court will limit its inquiry to whether termination of the minor's pregnancy is in her best interest. Studies (discussed below) show that the parents of most younger minors are aware of their children's pregnancies and presumably consent to abortion along with the minor. Thus few younger minors, who are more likely to be immature than older minors, petition in by-pass proceedings. By petitioning the court, the immature minor has strongly indicated that she wants to proceed with the abortion and does not want to inform her parents about the pregnancy. A court undertaking an inquiry into whether informing parents of the pregnancy will likely have harmful consequences likely does not consider that the minor whose petition is rejected may decline to inform her parents. Instead the minor, who has emphatically expressed her desire to end the pregnancy, might choose another course that could be harmful to her welfare, such as continuing the pregnancy until it is too late for termination, running away, or seeking illegal abortion. Further, unless the court concludes that the minor's interest is furthered by continuing the pregnancy, respecting her desire not to do so is consistent with constitutional values that support reproductive rights jurisprudence for both minors and adults.

Research shows that parents of pregnant teenagers usually know about the minors' pregnancy. A study that surveyed over 1,500 minors seeking an abortion found that 61 percent

said their parents *knew* that they were receiving an abortion. Stanley Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions*, 214 FAM. PLAN. PERSP. 196 (1992); Aida Torres et al., *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 FAM. PLAN. PERSP. 284 (1980) (survey of 1,170 minors found that 55% of parents knew they were having an abortion, and that the younger the minor, the more likely her parents were to know). In this same study, 24 percent reported that parents who found out about the abortion through a secondary source resorted to violence or forced the juvenile to have the abortion. Id. Other studies have reached similar conclusions. See, e.g., Robert W. Blum et al., *Factors Associated with the Use of Court Bypass by Minors to Obtain Abortions*, 22 FAM. PLAN. PERSP. 158, 159 (1990) (noting that 57% of the minors seeking abortions in a state with a parental involvement law did not seek judicial bypass, strongly inferring that they notified a parent); J. Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision Without Involving Their Parents*, 18 BERKELEY WOMEN'S L.J. 61 (2003) (citing to previous studies, and stating "the majority of teens, both in states with and without parental involvement laws, discuss their abortion plans with a parent . . .").

Comment e. Treatment over the objection of the minor ordinarily prohibited. Research indicates that the abortion decision is often initiated by the parents and not by the minor. Further, some parents coerce their daughters to terminate their pregnancies, overriding the minor's desire to continue the pregnancy. See, e.g., Stanley Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions*, 214 FAM. PLAN. PERSP. 196 (1992) (finding that 18% of minors were coerced by parents to have abortions); Peter Barglow & Susan Weinstein, *Therapeutic Abortion During Adolescence: Psychiatric Observations*, 2 J. OF YOUTH & ADOLESCENCE 33 (1973) (finding in part that minors differ from adults in that the abortion decision is often encouraged by parents, and that minors sometimes abort due to pressure from parents); Ellen W. Freeman, Karl Rickels & Steven J. Sondheimer, *Influence of Maternal Attitudes on Urban, Black Teens' Decisions About Abortion v. Delivering*, 30 J. OF REPROD. MED. 731 (Oct. 1985) (finding that 81% of pregnant minors chose the pregnancy outcome that their parents supported; 18% stated the pregnancy decision was made by their mother); Raye H. Rosen, *Adolescent Pregnancy Decision-Making: Are Parents Important?*, 15 ADOLESCENCE 43 (1980) (finding, in a study of 423 pregnant teenagers, that parental influence was important in pregnancy decisionmaking); Aubrey Spriggs Madkour, Yiqiong Xie & Emily W. Harville, *The Association Between Prepregnancy Parental Support and Control and Adolescent Girls' Pregnancy Resolution Decisions*, 53 J. ADOLESCENT HEALTH 413 (Sept. 2013) (finding that parental interaction with pregnant child affected decision, although more involvement was correlated with less likelihood of an abortion).

Parents urging a daughter to have an abortion likely often act in their daughter's interest, but may also be motivated by a desire to avoid responsibility for the resulting child. In many states, a minor's parent has financial responsibility for the minor's child. See, e.g., ARIZ. REV. STAT. ANN. § 25-810 (West 2005) (stating parents may be joined in an action against putative mother or father); IDAHO CODE § 32-706(4) (West 2008) (stating court may order parent of minor parent to provide financial support); 305 ILL. CODE § 5/10-10 (stating child can bring action against parents for

financial support); MD. CODE ANN. FAM. § 5-203(c) (West) (stating parents of minor parent are jointly and severally responsible for child support of grandchild); MO. REV. STAT. § 454.400(2)(16) (2014) (stating court can enforce orders against parent of minor child for child support); N.H. REV. STAT. ANN. § 167:3-a (West 2017) (stating can receive support from parents of minor parent if parents have enough weekly income); N.C. GEN. STAT. § 50-13.4 (West 2015) (stating grandparents share liability for care of child with minor parent); OHIO REV. CODE ANN. § 3109.19(B)(1) (2000) (stating can force parents of minor parent to provide support for child under certain circumstances); R.I. GEN. LAWS § 15-5-16.2(g) (West 2011) (stating can order parent of minor parent to reimburse state for care of child); S.C. CODE ANN. § 20-7-936 (2008) (same); S.D. CODIFIED LAWS § 25-5-18.2 (1995) (stating parents of minor parent can be required to support child); WIS. STAT. § 49.90(1)(a)(2) (West 2008) (stating parents of minor parents must support child unless unable to do so); WYO. STAT. ANN. § 42-2-103(e) (West 2017) (stating can enforce child support requirements on parents of minor child).

Consent to an abortion, like any medical decision must be voluntary. Parents typically have authority to consent to general medical decisions for minors. But agreement by the minor is usually required, unless she is not competent to participate in the decision or her refusal creates substantial risk of serious harm to her health or life. See § 19.01, Comments *d* and *e* and the Reporters' Notes thereto. In the case of abortion, a parent will sometimes consent to abortion with the assent of a younger minor incapable of making her own decision. But parental consent to abortion over the objection of the minor patient is not valid, and the abortion will not be performed. Cases occasionally arise in which the parents attempt to force their minor child to have an abortion over her objections. See In re Mary P., 111 Misc. 2d 532, 444 N.Y.S.2d 545 (Fam. Ct. Queens Co. 1981); see also In re Smith, 295 A.2d 238, 245 (Md. Ct. Spec. App. 1972) (deciding on statutory grounds that a parent having the "custody of a minor daughter who has attained the age of 16 years" may not "compel that child over the child's opposition to submit herself to procedures which may lead to an abortion"). In *Mary P.*, the mother tried to have her daughter declared a person in need of supervision because the minor refused to have an abortion. The court instead issued an order of protection for the daughter, directing the mother not to interfere with her daughter's decision. The court observed that "Mary has made her choice and it is, indeed, her choice to make. In deciding to give birth, she has exercised a personal liberty guaranteed to her by the fourteenth amendment. Her decision now requires parental forbearance." Id. at 548. See also *Pregnant Texas Teen Files Suit Against Parents in Abortion Feud*, U.S. NEWS (Feb. 13, 2013) (Sixteen-year-old teenager filed suit to enjoin parents from physically and verbally coercing her to have abortion), https://usnews.newsvine.com/_news/2013/02/13/16949097-pregnant-texas-teen-files-suit-against-parents-in-abortion-feud. The court granted an injunction in the case as part of a mutual agreement between the parties. *Girl Wins Lawsuit Against Parents Who Were Trying To Force Her To Get Abortion*, CBS (Feb. 19, 2013), http://houston.cbslocal.com/2013/02/19/girl-wins-lawsuit-against-parents-who-were-trying-to-force-her-to-get-abortion/.

The public health literature indicates that the problem of coerced abortion by parents or others arises more often than case law indicates. See, e.g., Lauren Ralph, Heather Gould, Anne

Baker & Diana Greene Foster, *The Role of Parents and Partners in Minors' Decisions to Have an Abortion and Anticipated Coping After Abortion*, 54 J. OF ADOLESCENT HEALTH 428 (2014) (roughly one in ten aborting minors did so because of pressure from someone else). For example, one study suggests that 14 percent of minors don't consult their parents about their pregnancies, out of concern that the parent will insist that they have abortions. Stanley Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions*, 214 FAM. PLAN. PERSPECT. 196 (1992); see also ALISSA C. PERRUCCI, DECISION ASSESSMENT & COUNSELING IN ABORTION CARE: PHILOSOPHY AND PRACTICE 160 (2012) (discussing the interplay between parents and pregnant teens as an instance of a potentially coercive environment where parental involvement can dictate the minor's decisionmaking). Fear of parental coercive involvement in minors' abortion decisions was corroborated in a study of 30 minors seeking abortion in Illinois. Erin K. Kavanaugh et al., *Abortion-Seeking Minors' Views on the Illinois Parental Notification Law: A Qualitative Study*, 44 PERSPECT. ON SEXUAL & REPROD. HEALTH 159 (2012).

STATUTORY NOTE

Statutes in 50 states and the District of Columbia expressly authorize minors to consent to STD or venereal disease treatment. Code of Ala. § 22-8-6; Alaska Stat. § 25.20.025; A.R.S. § 44-132.01; A.C.A. § 20-16-508; Cal. Fam. Code § 6926; C.R.S. § 25-4-1402; Conn. Gen. Stat. § 19a-216; Del. Code Ann. tit. 13, §§ 707, 710; D.C. Mun. Regs. tit. 22, § 600.7; Fla. Stat. § 384.30; O.C.G.A. § 31-17-7; HRS §§ 577A-1, 577A-2; Idaho Code §§ 39-601, 39-602, 39-3801; 410 ILCS 210/4; Ind. Code § 16-36-1-3; Iowa Code §§ 139A.35, 141A.7; K.S.A. § 65-2892; Ky. Rev. Stat. Ann. § 214.185; La. Rev. Stat. Ann. § 40:1065.1; Me. Rev. Stat. Ann. tit. 22, § 1823; Md. Code Ann., Health-Gen. § 20-102; ALM GL ch. 111, § 6, 112, § 12F; Mich. Comp. Laws Ann. § 333.5127; Minn. Stat. § 144.343(3); Miss. Code Ann. § 41-41-13; Mo. Rev. Stat. § 431.061(4); Mont. Code Ann. §§ 41-1-402, 50-18-101; R.R.S. Neb. §§ 42-105, 43-2101; Nev. Rev. Stat. §§ 129.060, 441A.310; N.H. Rev. Stat. Ann. § 141-C:18; N.J. Stat. § 9:17A-4; N.M. Stat. Ann. §§ 24-1-9, 24-1-9.3; N.Y. Pub. Health Law § 2305; N.C. Gen. Stat. § 90-21.5; N.D. Cent. Code § 14-10-17; Ohio Rev. Code Ann. § 3709.241; Okla. Stat. Ann. tit. 63, §§ 1-532.1, 2601, 2602; Or. Rev. Stat. § 109.610; 35 Pa. Cons. Stat. Ann. §§ 521.14a, 10103; R.I. Gen. Laws § 23-11-11; S.C. Code Ann. §§ 63-5-340, 63-5-350; S.D. Codified Laws §§ 34-23-16, 34-23-17; Tenn. Code Ann. § 68-10-104; 25 Tex. Admin. Code § 97.3; Tex. Fam. Code Ann. § 32.003; Utah Code Ann. § 26-6-18; Vt. Stat. Ann. tit. 18, § 4226; Va. Code Ann. § 54.1-2969(E); Wash. Rev. Code §§ 70.24.017, 70.24.110; W. Va. Code § 16-4-10; Wis. Stat. Ann. § 252.11; Wyo. Stat. Ann. § 35-4-131.

Statutes in 38 states and the District of Columbia expressly authorize minors to consent to contraceptive or pregnancy-related care. See, e.g., Code of Ala. § 22-8-4; Code of Ala. § 22-8-6; Alaska Stat. § 25.20.025; A.C.A. § 20-16-304; A.C.A. § 20-9-602(4); Cal. Fam. Code § 6925; C.R.S. § 13-22-105; Del. Code Ann. tit. 13, § 710; D.C. Mun. Regs. tit. 22, §§ 600.7, 600.8, 603.1; Fla. Stat. § 381.0051; Fla. Stat. § 743.065; O.C.G.A. §§ 31-9-2, 31-9-5, 49-7-3; HRS §§ 577A-1, 577A-2; Idaho Code § 18-603; Idaho Code § 39-4504; 325 ILCS 10/1; 410 ILCS 210/1; Iowa

Code § 141A.7; K.S.A. § 38-123b; Ky. Rev. Stat. Ann. §§ 212.345, 214.185; La. Rev. Stat. Ann. § 40:1095; Me. Rev. Stat. Ann. tit. 22, § 1908; Md. Code Ann., Health-Gen. § 20-102; ALM GL ch. 111, § 124E; ALM GL ch. 112, § 12F; Mich. Comp. Laws Ann. § 333.9132; Minn. Stat. § 144.343(1); Miss. Code Ann. § 41-42-7; Miss. Code Ann. § 41-41-3; Mo. Rev. Stat. § 431.061(4); Mont. Code Ann. § 41-1-402; Nev. Rev. Stat. § 129.030; N.J. Stat. § 9:17A-1; N.M. Stat. Ann. § 24-8-5; N.M. Stat. Ann. §§ 24-1-13, 24-1-13.1; N.Y. Pub. Health Law §§ 2504, 2515; N.C. Gen. Stat. §§ 90-21.5, 90-21.5(a), 90-271, 90-272; Okla. Stat. Ann. tit. 63, §§ 2601, 2602; Or. Rev. Stat. § 109.640; 35 Pa. Cons. Stat. Ann. §§ 10101, 10103; S.C. Code Ann. § 20-7-290; S.C. Code Ann. §§ 63-5-340, 63-5-350; Tenn. Code Ann. § 68-34-107; Tenn. Code Ann. § 63-6-223; 25 Tex. Admin. Code § 56.13; Tex. Fam. Code Ann. § 32.003; Utah Code Ann. § 78B-3-406(6); Va. Code Ann. § 54.1-2969(E); Wash. Rev. Code § 9.02.100; Wyo. Stat. Ann. § 42-5-101.

Statutes in 34 states and the District of Columbia allow pregnant minors to consent to their own healthcare. Generally, these statutes state that a pregnant minor may consent to healthcare treatment in relation to her pregnancy. Code of Ala. § 22-8-4; Alaska Stat. § 25.20.025; A.C.A. § 20-9-602(4); Cal. Fam. Code § 6925; C.R.S. §§ 13-22-103.5, 13-22-105; Del. Code Ann. tit. 13, § 710; D.C. Mun. Regs. tit. 22, §§ 600.7, 600.8, 603.2; Fla. Stat. § 743.065; O.C.G.A. §§ 31-9-2, 31-9-5, 49-7-3; HRS §§ 577A-1, 577A-2; Idaho Code § 39-4504; 410 ILCS 210/1; K.S.A. § 38-123; Ky. Rev. Stat. Ann. § 214.185; La. Rev. Stat. Ann. § 40:1095; Md. Code Ann., Health-Gen. § 20-102; ALM GL ch. 112, § 12F; Mich. Comp. Laws Ann. § 333.9132; Minn. Stat. § 144.343(3); Miss. Code Ann. § 41-41-3; Mo. Rev. Stat. § 431.061(4); Mont. Code Ann. § 41-1-402; Nev. Rev. Stat. § 129.030; N.J. Stat. § 9:17A-1; N.M. Stat. Ann. §§ 24-1-13, 24-1-13.1; N.Y. Pub. Health Law § 2504; N.C. Gen. Stat. § 90-21.5; Okla. Stat. An. Tit. 63, §§ 2601, 2602; Or. Rev. Stat. § 109.640; 35 Pa. Cons. Stat. Ann. § 10101; S.C. Code Ann. §§ 63-5-340, 63-5-350; Tenn. Code Ann. §§ 63-6-223, 68-34-107; Tex. Fam. Code Ann. § 32.003; Utah Code Ann. § 78B-3-406(6); Va. Code Ann. § 54.1-2969(E), (G).