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"There is a certain right by which we many deprive a man of life, but none by which we may deprive him of death; this is mere cruelty." — Friedrich Nietzsche (1876)

I. INTRODUCTION

In the United States, a person is deemed a minor until they reach the age of eighteen.[1] Throughout those eighteen years, a minor has certain limitations based on the theory that they are not yet functioning adults and, therefore, require additional protection during their vulnerable state. The idea is that minors do not possess the mental capacity that comes with adulthood.[2] In theory, this bright-line age requirement of eighteen benefits minors in the United States, but it creates the risk of infringing upon the minors' inherent rights as citizens. This age requirement has the potential to prevent minors from dying with dignity. In the United States, assisted suicide by a physician (hereinafter referred to as "medically assisted dying") is allowable by statute in nine states and the District of Columbia.[3] Within those states, a terminal patient must be eighteen years of age or above to request this service. Thus, those suffering from a terminal illness that fall under the age of eighteen are forbidden to request medically assisted dying.

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1. Jeffrey F. Ghent, Annotation, *Statutory Change of Age of Majority as Affecting Pre-Existing Status or Rights*, 75 A.L.R.3d 228, § 2(a) (1977).

2. Parham v. J. R., 442 U.S. 584, 602 (1979).

3. *See* WASH. REV. CODE ANN. § 70.245.901 (West 2009); VT. STAT. ANN. tit. 18, § 5281 (West 2013); MONT. CODE ANN. § 50-9-101 (West 2015); CAL. HEALTH & SAFETY CODE § 443.2 (West 2016); OR. REV. STAT. ANN. § 127.800 (West 2016); D.C. CODE ANN. § 7-661.02 (West 2017); COLO. REV. STAT. ANN. § 25-48-101 (West 2016); H.B. 2739, 29th Leg., Reg. Sess. (Haw. 2018); ME. REV. STAT. ANN. TIT. 22, § 2140 (2019); N.J. STAT. § 26:2H-5.33 (2019).

The data below provides that the bright-line age requirement of eighteen in the select and ever-growing number of states that allow for the practice in the United States is inherently unfair to all minors that possess the sufficient mental capacity to understand the ramifications of requesting medically assisted dying. The rigidity of this age requirement denies mentally competent minors the same access to death with dignity that others with equal competence may request. Ultimately, several alternative suggestions will be proposed in an effort to promote autonomy relating to medically assisted dying. These proposals are aimed to act as safeguards put in place to prevent the possibility of minor abuse.

In order to ensure justice and to avoid depriving any person of what should be their fundamental right to bodily integrity, the United States, specifically the states within it that allow for the practice, should reduce or eliminate entirely the age necessary to receive medically assisted dying. In this Comment, the practice of medically assisted dying will first be defined. While medically assisted dying is similar to euthanasia in that each practice fosters death with dignity, there are distinct differences worth noting. The requirements necessary to successfully request medically assisted dying will also be analyzed. Then, the concept of medically assisted dying will be examined in multiple countries and compared to the policy set forth by the United States. European countries, specifically Belgium and the Netherlands, each have a unique view on medically assisted dying as it relates to minors.

First, as explained in Part I of this Comment, the states that have legalized medically assisted dying should eliminate the age requirement to request the practice all together. Instead of relying on the bright-line age requirement of eighteen, medically assisted dying should be allowed on a more case-by-case basis. Specifically, the individual's mental capacity should be assessed to determine whether he or she is competent to make medical decisions. Secondly, while eliminating the requirement altogether may seem daunting, at the least, a presumption that those under eighteen are mentally competent that is rebuttable eases uncertainty with regards to specific cases. Finally, as a precaution against the potential of taking advantage of minors without adequate capacity, both attending and consulting physicians and at least one counselor should assess the patient's mental capacity before the request is granted.

Part II of this Comment will provide a background of medically assisted dying in both the United States and select European countries. On a global scale, the public's opinion of medically assisted dying boils down to the standard debate between pro-life and pro-choice advocates.[4] Part III

4. Kam C. Wong, *Whose Life is it Anyway?*, 5 CARDOZO PUB. L. POL'Y & ETHICS J. 233, 234 (2006).

will argue that the states in the United States that allow medically assisted dying should eliminate the current age requirement of eighteen in favor of a rebuttable presumption of competence. Part IV will sum up the given data and analysis provided. By explaining the positive effects that will follow from reducing the age necessity to a number lower than eighteen, it shall be evident that in order to protect what should be the fundamental rights and dignity of minors with a terminal diagnosis, the states that allow for medically assisted suicide should lower or abolish the bright-line age requirement.

II. MEDICALLY ASSISTED DYING IN THE U.S. AND ABROAD

The concept of death is an uncomfortable one in societies worldwide.[5] While it is inevitable that all humans will die, the common outlook is to prolong the inevitable for as long as possible. This driving force is often referred to as the will to live or the primal desire to survive.[6] Death is not typically willingly sought out. At some level, death is always considered "bad."[7] Because mortals on the whole tend to place intrinsic value on life, the perception of suicide, or taking one's own life before their natural course of death, is generally a negative one.[8] There are, however, certain instances where a shortening of life is considered humane.[9] Some deaths are "less bad" than others.[10] Some take comfort in the idea of knowing exactly when they are going to die. Others appreciate a certain method of death and may even seek death willingly. The theory behind medically assisted dying falls under this category.

Physician-assisted death involves two practices of dying: medically assisted dying and physician-administered euthanasia.[11] Medically assisted dying transpires when a physician writes a prescription for a lethal dose of medication with the knowledge that the terminal patient intends to end their life by using it.[12] Upon the diagnosis of a terminal illness, the will to live

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5. Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 DENV. U.L. REV. 175, 176 (1993).

6. Marvin Lim, *A New Approach to the Ethics of Life: The "Will to Live" In Lieu of Inherent Dignity or Autonomy-Based Approaches*, 24 S. CAL. INTERDIS. L.J. 27, 38 (2015).

7. Margaret A. Somerville, *The Lyrics of Euthanasia*, 9 J. CONTEMP. HEALTH L. & POL'Y 1, 2 (1993).

8. Annette E. Clark, *Autonomy and Death*, 71 TUL. L. REV. 45, 52 (1996).

9. *Id.* at 46.

10. Somerville, *supra* note 7, at 2.

11. Alyssa Thurston, *Physician-Assisted Death: A Selected Annotated Bibliography*, 111 LAW LIBR. J. 31, 32 (2019).

12. Clark, *supra* note 8, at 46.

is often stricken from the patient for various reasons, at times leading to a request for medically assisted dying. Physicians take a passive role in assisting the patient's suicide by providing the patient with the means to end their own life. Euthanasia, on the other hand, is the act of a physician actively administering the lethal drug to the patient.[13] The etymological origin of the word euthanasia is "good death."[14] Here, it is the physician who ultimately invokes the patient's death. While no state in the United States currently allows for the practice of euthanasia, per the trend throughout the past few decades, states are gradually legalizing the practice of medically assisted dying.

The age at which a terminally ill patient may request medically assisted dying varies significantly worldwide. While some governments, such as certain states within the United States, have set age requirements, other countries, including Belgium and the Netherlands, approve medically assisted dying on a more case-by-case basis. Instead of a bright-line age requirement, these countries' physicians look to the mental capacity of the individual patient while weighing other factors, such as the pain and suffering of the patient. Determining the level of capacity of the patient is a vital aspect of medically assisted dying. Without the requisite ability to understand the complexity encompassing the choice to die with dignity, the patient may not be capable of making an informed decision that is ethically deserving of respect. That capacity is pivotal.

So, at precisely what age does this mental understanding of the totality of death come to fruition? The states in the United States that allow for the practice, through statutes regarding medically assisted dying, have held that this capacity does not exist in patients under the age of eighteen. European countries, however, hold differently. For the purposes of this Comment, the requirements to receive medically assisted dying in those select states in the United States, the Netherlands, and Belgium shall be examined and compared. The concept of medical decision-making will also be analyzed in an effort to establish what age is suitable to make competent medical decisions.

A. Medically-Assisted Dying in the United States

The states that allow for the practice have very rigid requirements when it comes to medically-assisted dying, which is not surprising, given the semi-recent approval of the practice. While the practice of euthanasia is currently illegal in all states, since 1997, nine states—Oregon, Washington, Montana, Maine, New Jersey, Vermont, California, Colorado,

13. Somerville, *supra* note 7, at 2.
14. *Id*.

and Hawaii—and the District of Columbia have legalized medically assisted dying.[15] Within these states, the patient has numerous requirements that must be met before the request for medically assisted dying is granted. The patient must have less than a six-month prognosis, meaning he or she must have been diagnosed with a terminal disease.[16] The majority of Americans that request medically assisted dying (75%) do so following a cancer diagnosis.[17]

In addition to having a terminal diagnosis, the patient is also barred from requesting medically assisted dying until the age of eighteen, with no exceptions.[18] There is no requirement that the patient must suffer from significant and unbearable pain following the terminal diagnosis.[19] In the United States, specifically those states that have legalized medically assisted dying, significant emphasis is placed on the age of the patient, specifically whether he or she has undergone that eighteenth birthday that transforms a child into an adult in the eyes of the law, and the amount of time that the patient has left to live.[20] What those states do not give substantial weight to is the extent of the individual's lack of enjoyment and distress, as well as pain and suffering during their final months. Access to medically assisted dying is geared towards older patients, rather than the youth. Surprisingly, in addition to white persons, men, and the religiously unaffiliated, studies show that younger persons are more likely to favor medically assisted dying in the states that have allowed the practice.[21]

The legality of medically assisted dying remains a controversial topic today.[22] Allowing this practice in a given state conflicts with the history of ethical and moral ramifications regarding the perception of voluntary death. For example, the United States at one time viewed suicide as a felony.[23] The American colonies looked to English common law when

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15. Ezekiel J. Emanuel, et al., *Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe*, JAMA 79, 80 (2016), http://jamanetwork.com; *see also* Neelam Chhikara, *Extending the Practice of Physician-Assisted Suicide to Competent Minors*, 55 FAM. CT. REV. 430, 431 (2017); 2017 Hi. HB 2739 (2018); *Death with Dignity Acts*, DeathWithDignity.Org, https://www.deathwithdignity.org/learn/death-with-dignity-acts/.

16. Emanuel, *supra* note 15.

17. *Id.* at 83.

18. *Id.*

19. *Id.* at 80.

20. Ghent, *supra* note 1.

21. Emanuel, *supra* note 15, at 81.

22. Jonathan R. MacBride, *A Death Without Dignity: How the Lower Courts have Refused to Recognize that the Right of Privacy and the Fourteenth Amendment Liberty Interest Protect an Individual's Choice of Physician-Assisted Suicide*, 68 TEMP. L. REV. 755 (1995).

23. *Id.* at 758.

enacting sanctions against suicide.[24] While suicide has now been decriminalized throughout the United States, a select few states have elected to criminalize medically assisted dying.[25] In these states, the concept of assisting the suicide of another is frowned upon so much so that it is considered a criminal act. In fact, under the Model Penal Code § 210.5, a person is considered guilty of a second degree felony if he or she purposely aids another to commit suicide.[26] In a recent Massachusetts case, then-teenager Michelle Carter was charged with involuntary manslaughter after encouraging her boyfriend to commit suicide through a series of text messages and phone calls.[27] Though she was not physically present with her boyfriend, Carter instructed him to "get back in the car," thus encouraging her boyfriend to follow through with his suicide.[28] On August 3, 2017, she was sentenced to two and a half years in the Bristol County House of Correction after the trial judge described her conduct as "reckless."[29] The fact that Carter was not physically present at the scene of her boyfriend's death was deemed immaterial.[30] Select states, including Massachusetts, reject the idea of a person aiding another in their choice to die.

Despite the mixed views on both euthanasia and medically assisted dying, the Oregon Death with Dignity Act was passed on November 8, 1997.[31] Under this Act, competent adults that are diagnosed as terminally ill by both an attending and consulting physician are permitted to request lethal medication.[32] In recent years, there has been a dramatic shift in public opinion regarding medically assisted dying.[33] A number of national and state polls conducted since 2012 show a strong support for the legalization of the practice among a majority of Americans.[34] In addition to the seven states and District of Colombia that have legalized medically assisted dying, almost two dozen states considered pertinent legislation in 2018.[35]

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24. *Id.* at 759.

25. *Id.*

26. MODEL PENAL CODE § 210.5(2) (AM. LAW INST. 2007).

27. Katharine Q. Seelye, et al, *Guilty Verdict for Young Woman Who Urged Friend to Kill Himself*, N.Y. TIMES (June 16, 2017), https://nyti.ms/2sxI1XR.

28. *Id.*

29. Emily Shapiro, et al., *Michelle Carter sentenced to 2.5 years for texting suicide case*, ABC NEWS (Aug. 3, 2017, 4:20 PM), https://abcnews.go.com/US/michelle-carter-set-sentenced-texting-suicide-case/story?id=48947807.

30. *Id.*

31. Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800-.897 (1997).

32. MacBride, *supra* note 22, at 766.

33. Thurston, *supra* note 11, at 32.

34. *Id*.

35. *Id*.

One of the essential functions of the process of medically assisted dying is to provide a dignified death to a terminally ill patient. Another is to allow a terminally ill patient to escape from the torture of severe pain, emotional distress, and lack of life enjoyment leading up to the patient's death. In an attempt to reject this concern, adversaries of medically assisted dying have been quick to point out that "the potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts."[36] Further, opponents suggest that administering heavy sedation or copious amounts of anesthesia may not be necessary for most terminally ill patients.[37] The opponents concede, however, that the severe pain of patients does sometimes require the use of extensive sedation to produce a sleep-like state throughout the last weeks or days of the dying process.[38]

B. Medically-Assisted Dying Worldwide

The perception of medically-assisted dying by the United States is drastically different than that of certain European countries. Internationally, multiple countries have legalized or are contemplating legalizing medically assisted dying.[39] Two countries in particular, the Netherlands and Belgium, embrace more of an accepting view of the practice.

In the Netherlands, a country that has already legalized euthanasia, the age to receive medically assisted dying is also a set, bright-line requirement; however, the age is significantly lower than the requirement in the states of the United States that have legalized the practice. In order to request medically assisted dying, a Dutch patient must be twelve years of age or older.[40] Under Article Two of the Termination of Life on Request and Assisted Suicide Act passed in 2002, Dutch physicians must comply with certain requirements when involved in medically assisted suicide.[41] The physician must be satisfied that the patient's suffering is lasting and unbearable, the patient's request is voluntary, and there is no other solution

36. Richard E. Coleson, *The Glucksberg & Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide*, 13 ISSUES L. & MED. 3, 9 (1997) (citing AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996)).

37. *Id.*

38. *Id.*

39. Thurston, *supra* note 11, at 32.

40. Emanuel, *supra* note 15, at 80.

41. Sydni Katz, *A Minor's Right to Die with Dignity: The Ultimate Act of Love, Compassion, Mercy, and Civil Liberty*, 48 CAL. W. INT'L L.J. 220, 222 (2018).

that is reasonable.[42] In addition, the physician must fully inform the patient of all options, consult at least one other physician, and assist in the suicide with due care.[43]

Physicians in the Netherlands are also legally certified to end the life of severely-malformed newborns.[44] Dutch patients who seek medically assisted dying are not required to be terminally ill, but must possess "unbearable physical or mental suffering" without the prospect of recovery.[45] In the Netherlands, in order to request medically assisted dying, the focus of the physician is not whether the patient is an adult in the eyes of the law, but rather, the extent of suffering that the patient must endure.

In Belgium, on the other hand, there is no a bright-line age requirement to request medically assisted dying.[46] In 2013, the Belgian Senate passed an amendment that provided terminally ill children with the opportunity to choose medically assisted dying.[47] Belgian Senator Jean-Jacques De Gucht stated that "[t]here is no age for suffering and, next to that, it's very important that [Belgium has] a legal framework for the doctors who are confronted with this demand today."[48] The 2013 amendment mandates that, as long as the minor possesses a "capacity for discernment," he or she is permitted to die with dignity.[49]

With the enactment of this Act, Belgium, a country that has already legalized euthanasia, became the first nation to remove all age restrictions for medically assisted dying. Without a set age that provides when a person is competent, what exactly constitutes this mental capacity? In order to successfully request medically assisted dying, the minor must be in a "medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident."[50] As recent as 2016, a Belgian minor that was seventeen years of age received medically assisted dying.[51] The Act contains several protections regarding an adolescent's right to die: there must be capacity for discernment and consciousness at the time of the

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42. *Id*.

43. *Id*.

44. Emanuel, *supra* note 15, at 80. ("In 2007 the Dutch government made it possible for a physician to end the life of severely malformed newborns without being prosecuted if due care criteria are met.").

45. *Id.*

46. *Id.*

47. Browne Lewis, *A Deliberate Departure: Making Physician-Assisted Suicide Comfortable for Vulnerable Patients*, 70 ARK. L. REV. 1, 48 (2017).

48. *Belgian Senate Votes to Extend Euthanasia to Children*, BBC (Dec. 13, 2013, 11:49 AM), https://perma.cc/B9X4-F8HL.

49. Lewis, *supra* note 47, at 48.

50. *Id.*

51. *Id.*

decision-making, the request must be voluntary and repeated, and the minor must have "constant and unbearable physical or mental suffering" resulting from a serious illness or injury that cannot be cured.[52] Furthermore, the attending physician must consult with a child psychiatrist or psychologist who then examines the minor before certifying that he or she possesses the capacity for discernment.[53] If the minor is not emancipated, he or she must obtain consent from both parents.[54]

III. A LOOK INTO WHAT CONSTITUTES MENTAL CAPACITY

Why are the states that have legalized medically assisted dying in the United States unwilling to extend the practice to minors? If the Netherlands allows for a person as young as twelve to request the practice and Belgium has no age requirement at all, why are patients in America forbidden to make this choice until they reach eighteen? The country's legal framework postulates that all persons under the age of eighteen are not competent to make life-altering choices.[55] Minors in the United States are prohibited to take part in many day-to-day acts, including buying or selling real property, and even entering into contracts.[56] Unsurprisingly, a minor's access to medicine is also highly regulated. The reasoning behind denying minors the ability to make their own medical decisions may be summed up into two assumptions: (1) minors do not have the capacity to make sound medical decisions, and (2) parents inevitably act in the best interests of their children.[57]

This reasoning is overly-broad and fails to consider the many competent minors and subpar parents in the United States. A seventeen-year-old child who has been battling cancer for many years could arguably have a higher mental capacity than an average adult who has never been diagnosed with an illness. Further, that seventeen-year old most likely has a better grasp on the finality of death than the healthy adult.[58] Imagine that the seventeen-year old receives a prognosis stating that she has only four months to live. Throughout that time, she suffers unbearable pain both daily and nightly. She cannot travel, attend school, or play the sports that she loves. Her condition weakens every day and she must watch as her family attempts to come to terms with her prognosis. Because she falls just under the rigid age requirement of eighteen, she must continue to suffer

52. Katz, *supra* note 41, at 242.
53. *Id*.
54. *Id*.
55. Lewis, *supra* note 47, at 49.
56. *Id.*
57. *Id.*
58. *Id.*

throughout the duration of her life, even if she would desire that her death come more quickly, less painfully, and with more dignity. It seems almost cruel to fail to recognize a right to die with dignity.

Unbearable pain and suffering is not the only reason to desire medically assisted dying—in fact, it is not even the most common reason. The majority of terminally ill patients choose to request medically assisted dying because their illnesses prevent them from participating in the activities that they enjoy.[59] Other reasons include losing their independence and their dignity.[60] A terminally ill minor may be faced with other factors aside from the illness itself that may contribute to the child's pain. It may be extremely distressing for a minor to witness his or her parents undergo the trauma of watching their child suffer from the illness. The minor could also be aware that his or her illness is tremendously financially burdensome for their parents. The physical pain that comes from the terminal illness may not be the only suffering that a minor undergoes. Despite the many reasons that a minor may choose to die with dignity, the option is unavailable to even the most competent children.

On the matter of minors' competence in dealing with medical decisions, the United States Supreme Court has held that "most children, even in adolescence, simply are not able to make sound judgments . . . including their need for medical care or treatment. Parents can and must make those judgments."[61] This reasoning is reflected in the statutory age requirement necessary to request medically assisted dying. The Court assumes that every adolescent is mentally unable to make sound judgments until the age of eighteen.

A. Minors' Capacity from a Psychological Standpoint

There are multiple well-known psychological studies that suggest that the Supreme Court's finding that a minor is incapable of making comprehensive decisions is incorrect. Beginning in the 1970s, multiple scientific studies were conducted in order to ascertain the medical decision-making capabilities of adolescents of multiple ages.[62] Ironically, these studies began *after* the Supreme Court extended the decision-making ability

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59. *Id*.

60. *Id.*

61. Anthony W. Austin, *Medical Decisions and Children: How Much Voice Should Children Have in Their Medical Care?*, 49 ARIZ. L. REV. 143, 152 (2007); *see* Parham v. J.R., 442 U.S. 584, 606 (1979).

62. Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs*, 22 J. CONT. HEALTH L. & POL'Y 233, 261 (2006).

to pregnant teens in regard to abortion.[63] The result of the studies comprehensively revealed that minors in a certain age range as low as thirteen are just as competent as adults in the medical decision-making context.[64]

One renowned scientific study performed by psychologists Thomas Grisso and Linda Vierling suggests that adolescents above the age of fifteen possess the same competence as adults in terms of making medical decisions.[65] The psychologists go on to state that "neither statutes nor case law provide clear guidelines for judging the competence of a minor to provide meaningful consent."[66]

In another study, C.E. Lewis found that when a child is placed in control of their own medical decisions, children from five to twelve years of age act extremely similar to adults ages thirty-five to fifty-four.[67] The study removed adults from the decision of when to visit the doctor and, therefore, essentially forced children to make decisions about seeking medical treatment.[68] The purpose was to challenge the stereotype that a parent knows when a child needs medical attention.[69] According to the study, Lewis found that children as young as five are capable of decision-making in a way that is similar to adults.[70]

Psychologists Lois Weithorn and Susan Campbell compared the ability of variously aged minors to make decisions.[71] The result of this study aligns similarly with the other psychologists' findings.[72] Weithorn and Campbell found that minors who are fourteen and older possess the same level of competency as adults.[73]

An earlier theory by Jean Piaget suggests that the development of mental capacity occurs in stages.[74] In the formal operations stage, which typically occurs during the ages of eleven to thirteen, a child develops

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63. *Id*.

64. *Id.*

65. *Id.* (citing Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 416 (1978)).

66. Austin, *supra* note 61, at 153.

67. *Id.* at 154 (citing Charles E. Lewis, DECISION MAKING RELATED TO HEALTH: WHEN COULD/SHOULD CHILDREN ACT RESPONSIBLY?, CHILDREN'S COMPETENCE TO CONSENT 75, 78 (Gary B. Melton et al. eds., 1983)).

68. Austin, *supra* note 61, at 153.

69. *Id.* at 154.

70. *Id.*

71. Will, *supra* note 62, at 261.

72. *Id*. at 262.

73. *Id.*

74. Austin, *supra* note 61, at 154 (citing Jean Piaget, THE CHILD'S CONCEPTION OF THE WORLD (1972)).

crucial decision-making abilities.[75] By the time a child has reached the age of fifteen, according to Piaget, he or she is able to "perform inductive and deductive operations . . . or hypothetical reasoning at a level of verbal abstraction that would be represented by many consent situations involving treatment alternatives and risks."[76] In other words, a child at the age of fifteen is essentially capable of reasoning in an adult way.[77] At this age, a child's thinking becomes more dimensional, and they are better able to link actions with consequences.[78]

Other developmental psychologists, such as Lawrence Kohlberg, agree that children above the age of thirteen or fourteen are as mentally-capable as adults in terms of decision making.[79] The key similarity between these psychological theories is that each notion deems ages thirteen to fifteen as ages where a minor possesses sufficient mental capacity to make decisions. During this age range, a minor has the ability to make the same sound judgments as an adult would and should, therefore, be able to request medically assisted dying as an adult would. With the current age requirement of eighteen in the states that have legalized medically assisted dying in the United States, minors in the age range of thirteen to eighteen are unable to make their own medical decisions, though they may be competent enough to do so. Essentially, these competent minors are stuck waiting until the day that they turn eighteen, and the United States finally awards them with the recognition of being mentally capable of medical decision-making.

Of course, there are those that criticize the studies on the decision-making abilities of minors.[80] While these studies support the presumption that all adolescents are competent to make decisions, opponents have argued that the findings of the psychologists are limited.[81] Specifically, critics maintained that the subjects of the studies were typically white and middle-class.[82] Other challengers argue that the studies defined competence too narrowly or did not account for specific factors that are unique to minors.[83] These opponents assumed that the studies propose that

75. *Id.*
76. *Id.*
77. *Id.*
78. *Id.* at 155.
79. *Id.* (citing Lawrence Kohlberg, MORAL STAGES AND MORALIZATION: THE COGNITIVE-DEVELOPMENTAL APPROACH, IN MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH, AND SOCIAL ISSUES 31, 52-53 (Thomas Lickona ed., 1976)).
80. Will, *supra* note 62, at 262.
81. *Id*.
82. *Id*.
83. *Id*.

every adolescent is competent.[84] On the contrary, psychologists Thomas Grisso and Linda Vierling stated in one of their first studies that "it would be inaccurate to conclude that all adolescents are intellectually capable of providing independent consent."[85] While it should not be presumed that every minor is competent, the studies provide that certain minors have the capacity to make competent decisions at a younger age than eighteen.

B. Minors in a Constitutional Context

Under the Due Process Clause of the Fourteenth Amendment,[86] parents have the fundamental right to raise their children as they deem fit.[87] In the United States, it is also assumed that parents inherently have the best interests in mind concerning their children.[88] This presumption, however, does not necessarily serve the best interests of children. Parents too often blame their child for the child's own mental health issues.[89] There is a potential that a parent may have a conflicting opinion than that of the child, ultimately resulting in a harmful effect on the child. Simply put, a parent and a child may disagree on the child's medical decisions. The child's illness could be so distressing that it causes the parent to make harmful medical decisions on the child's behalf.

One psychologist aptly admitted "that the values, needs, desires, and so-called best interests of parents and their children are not necessarily congruent."[90] The psychologist further went on to state that, "In fact, I expect that the best interests of parents and their children will often be different or even contradictory."[91] A parent does not truly know the internal state of the child, including the physical and mental pain that the child undergoes. No one but the child fully knows the extent of the child's own suffering. While parents may on the whole desire what they believe is best for the child, ultimately the individual themselves possess the knowledge of what is actually suitable in terms of decision-making. While it may be appropriate to act on the behalf of a young child, once the child is capable of making their own decisions it becomes blatantly unethical to deny the minor involvement in decisions concerning their own health. The act of

84. *Id*.

85. *Id.* (citing Grisso & Vierling, *supra* note 65, at 421).

86. *See* U.S. CONST. amend. XIV, § 1.

87. Will, *supra* note 62, at 246.

88. Parham, 442 U.S. at 602 ("The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions.").

89. Austin, *supra* note 61, at 157.

90. *Id*.

91. *Id.*

making medical decisions for a child should, therefore, be left to the child as long as they are competent enough to make those decisions.[92]

While parents possess the right to raise their children how they see fit, minors also have constitutional rights. In *In re Gault*,[93] the Supreme Court held that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."[94] The Court noted the importance of a bright-line age of majority; however, it found in *Planned Parenthood v. Danforth*[95] that "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority."[96] Minors are, indeed, protected under the Fourteenth Amendment.

The Supreme Court reasoned in *Roper v. Simmons* that an established age of majority of eighteen exists to protect the young for three reasons.[97] First, juveniles have a lack of maturity and an underdeveloped sense of responsibility.[98] Second, those under eighteen are more susceptible to negative influences and peer pressure.[99] Lastly, juveniles' characters are not as well developed as those of adults.[100] Based on these reasons, the Court found that the Eighth Amendment forbids the imposition of the death penalty on offenders under the age of eighteen.[101] This reasoning applies to the criminal context in which a juvenile offender has no choice in their death. In terms of death with dignity, these minors have done no wrong and seek only to have control over their own medical decision-making.

It is not a far-fetched notion in the United States that minors be allowed to make their own medical decisions. In fact, courts and lawmakers have created multiple exceptions to parents' seemingly exclusive control over a child. One exception that a state may exercise is referred to *parens patriae*.[102] Under this doctrine, courts are able to consent to medical treatment for children when the parents are unavailable or unwilling to do so.[103] The purpose of this power is to protect children from potential abuse,

92. Kimberly M. Mutcherson, *Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents*, 14 CORNELL J. L. & PUB. POL'Y 251, 281 (2005).

93. In re Gault, 387 U.S. 1, 13 (1967).

94. Will, *supra* note 62, at 254.

95. Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976).

96. Will, *supra* note 62, at 254.

97. Roper v. Simmons, 543 U.S. 551, 568-69 (2005).

98. *Id.* at 569.

99. *Id*.

100. *Id*. at 570.

101. *Id*. at 578.

102. Austin, *supra* note 61, at 158.

103. *Id.*

neglect, and fraud.[104] A common example of this power exercised in daily life is when a court overrides a parent's refusal based on religious grounds to allow their child to receive a blood transfusion.[105] The judiciary has acknowledged that in circumstances such as that, the parent does not have the child's best interest in mind regarding medical treatment.[106]

Another example where courts have limited parental control in a child's medical treatment is referred to as the mature minor doctrine.[107] One of its purposes is to guarantee that children receive the required medical treatment by granting minors that can "understand the nature and consequences of the medical treatment [being] offered" the power to consent or refuse medical treatment.[108] The doctrine is aimed towards instances where obtaining parental consent would be difficult or would result in a conflict in the family.[109] The mature minor doctrine was developed in direct response to the glaring problem that results from too much parental control in a child's medical decisions. It is designed to enable mature adolescents capable of independent decision-making and functions as a tool of empowerment to minors.[110] The doctrine is a common law rule that allows minors in certain jurisdictions to consent to or refuse a specific medical treatment without parental consent, if they can establish that they can understand the risks, consequences, and the nature of treatment.[111] Under the mature minor doctrine, a minor has the capacity if he or she has an intelligent appreciation of the fundamental connection between choices and their likely consequences, an evaluative capability of understanding the weight of the risks and benefits associated with choices, and a self-determining capacity to decide or to decline to make a choice, all while not being swayed by compulsion.[112]

In *Cardell v. Bechtol*, the Supreme Court of Tennessee found that a seventeen-year old qualified for the mature minor exception by first applying a rule of capacity discernment referred to as the Rule of Sevens.[113] This rule mandates that those under the age of seven have no capacity, those between seven and fourteen have a rebuttable presumption of no capacity,

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104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.* at 159 (citing Samuel M. Davis et al., CHILDREN IN THE LEGAL SYSTEM, 158-61 (3d ed. 2004).

108. Austin, *supra* note 61, at 159.

109. *Id.*

110. Will, *supra* note 62, at 270.

111. Katz, *supra* note 41, at 236.

112. *Id*.

113. Cardwell v. Bechtol, 724 S.W.2d 739 (1987). In this case, the minor was deemed to have the capacity to consent to treatment of her back pain by the defendant and because she gave her effective informed consent, no battery occurred.

and those between fourteen and twenty-one have a rebuttable presumption of capacity.[114] Since the minor had been seventeen for seven months, the court then examined the minor through testimony and found her to be intelligent enough to make her own medical decisions.[115]

The general mature minor doctrine exists to allow for a competent minor to give legally valid consent for or against medical treatment.[116] In situations where parental consent is difficult to obtain or where a parent would presumptively consent, adolescents may give valid consent.[117] In addition to the general mature minor doctrine, there are other statutes where minors are considered "adults" for the purpose of consenting to a specific kind of medical treatment.[118] These statutes range from treatment for substance abuse and mental health problems to birth control, pregnancy, and treatment for sexually transmitted diseases.[119]

The right to bodily integrity is a deep-rooted constitutional right.[120] Like adults, minors have inherent rights to bodily integrity. In the case of a minor becoming pregnant, the Supreme Court held in *Planned Parenthood v. Danforth* that parents do not have an absolute right to deny a minor from procuring an abortion or to require that she obtain one.[121] The decision to obtain an abortion is life-altering and will undoubtedly have a significant effect on a minor's future. One could even refer to it as an "adult" decision.[122]

It makes sense that there is an exception to the general requirement for parental consent where a minor may decide to have an abortion without the consent of her parents. Would medically assisted dying also not be the very definition of a life-altering decision? A minor has complete control over her body in terms of pregnancy but cannot choose to end her own life even if she should wish to. A terminal illness is comparable to pregnancy in terms of seriousness. If anything, it is certainly an "adult" concept. If minors can rebut the presumption of incompetence when they are pregnant, it is only logical that they should be permitted to do the same when facing their own death.

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114. *Id.* at 745.

115. *Id.* at 755.

116. Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547, 567 (2000).

117. *Id.*

118. *Id*.

119. *Id*. at 568.

120. Symposium, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL'Y 37, 59 (2012).

121. *Id.* at 60. *See* Planned Parenthood v. Danforth, 428 U.S. 52 (1976).

122. Symposium, *supra* note 120, at 61.

C. Further Blurred Lines of Majority

Minors in the United States have crossed into the realm of adulthood at different ages depending on the purpose.[123] For example, under contract law, a minor may disaffirm a contract based on the reasoning that the minor may not make fully formed decisions when entering into the contract.[124] For other purposes—such as voting, military service, domicile, drinking, and driving—adolescents are considered legal children until a specific age converts them into an adult with an accompanying status.[125] On one end of the spectrum, a child as young as ten that is charged with murder, aggravated assault, or kidnapping may be tried as an adult in some states, due to the seriousness of these offenses.[126] On the other end, young adults may not drink alcohol or run for Congress.[127] Clearly, the line between minority and adulthood is not a fixed one and should therefore be rebuttable.

Statutes that allow minors to give consent are a bit of a paradox.[128] The focus of these statutes does not give great weight to the fact that a minor may be more mature in making medical decisions.[129] It is already assumed that a minor is principally mature in the context of consenting to their own medical decisions.[130] Rather, the statutes provide protection from the potential harm of obtaining parental consent.[131] A minor may lack incentives to get treatment for fear of an angry response from their parents.[132] An unplanned pregnancy or the child's drug use may cause the parents to become upset.[133] Allowing for minors to give lawful consent in regard to their own medical treatment encourages minors to seek medical care that may be vital to their health.[134]

Other social benefits include lower rates of adolescent drug abuse, pregnancy, mental illness, and sexually transmitted diseases.[135] The beneficial nature of these minor consent statutes evince why lawmakers have altered this rigid boundary of minority to promote medical treatment

123. Scott, *supra* note 116, at 558.
124. *Id*. at 557.
125. *Id*. at 556.
126. *Id.* at 557-58.
127. *Id.* at 558.
128. *Id*. at 568.
129. *Id*.
130. *Id*.
131. *Id*.
132. *Id*.
133. *Id*.
134. *Id*.
135. *Id*.

in adolescents.[136] When this stiff line is shifted, an important policy objective is being served.[137] Lawmakers and courts have lowered this bright-line age of majority in circumstances where life-altering medical decisions are on the line, for example, pregnancy. These bodies should recognize that, when it comes to medically assisted dying, a competent minor also deserves that leeway to make the most important decision when facing a terminal illness: whether to die with dignity.

D. Looking to Death with Dignity Statutes

According to the 2017 Data Summary for the Oregon Death with Dignity Act of 1997, the number of Death with Dignity Act prescription recipients and deaths have steadily increased since 1998.[138] One can infer that this rise in demand for medically assisted dying indicates that the practice is becoming more acceptable. With the increase in recipients, the logical next step should be that more states will legalize medically assisted dying. In response to the increase in the practice of medically assisted dying, another step should be eliminating the age requirement altogether and relying on the rebuttable presumption of capacity.

By abolishing the age requirement necessary to request medically assisted dying, the practice in the states that have legalized it would become similar to the practice in Belgium, where terminally ill patients are granted medically assisted dying if they are deemed to have the mental capacity for discernment. While it may seem like a more challenging task than assigning a set age requirement, identifying mental capacity has proven to be a successful method in Belgium. As a result of amendments to Belgium's 2002 euthanasia law, a minor may receive medically assisted dying under strict conditions.[139] The child must be terminally ill and deemed by teams of doctors, psychologists, and other care-givers to be suffering beyond medical aid.[140] The minor must also demonstrate their full ability to understand their choice.[141] The final decision is then made with approval of the parents.[142] The states that allow for medically assisted

136. *Id*.

137. *Id.* at 576.

138. *Oregon Death with Dignity Act 2017 Data Summary*, Oregon Health Authority, Public Health Division, http://www.healthoregon.org/dwd.

139. Charlotte McDonald-Gibson, *Belgium Extends Euthanasia Law to Kids*, TIME (Feb. 13, 2014), http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/.

140. *Id.*

141. *Id.*

142. *Id.*

dying in the United States would not be crossing into any uncharted waters by altering the current age requirement.

The Oregon Death with Dignity Act[143] contains multiple safeguards to protect the interests of the patients requesting medically assisted suicide. The Act requires an attending physician to determine whether the patient is mentally capable and a consulting physician to confirm this finding.[144] In addition, the Act contains a counseling referral clause.[145] In the case where an attending or consulting physician determines that a patient may be suffering from depression or a psychological or psychiatric disorder which would impair the patient's judgment, the physician shall refer them to counseling.[146] The patient may not receive the death-inducing medication without the counselor pronouncing that he or she is not suffering from one of the above disorders.[147]

In addition to these mandatory steps, the attending physician also has several other duties. The physician must also inform the patient of the patient's medical diagnosis, the risks and likely results connected with ingesting the lethal medication, and practicable alternatives.[148] There must be a request made to the patient, but not a requirement, that the patient inform his or her closest living relative of the request for medically assisted dying.[149] Finally, the attending physician must give the patient the prospect to withdraw his or her request at any time and advise that the lethal medication must be taken by the patient without aid from any other party.[150]

Determining the mental capacity of children may be found by mirroring this counseling referral clause. If a child is terminally ill and requests medically assisted dying, an unsure physician could refer the child to counseling if they had any doubts about the judgment or mental capacity of that child. The counselor, whether it be a psychologist, psychiatrist, or other qualified individual, would determine whether the child possesses the mental capacity to understand the ramifications of his or her actions. With the verification of the counselor, the minor could then request medically assisted dying. Between the attending physician, consulting physician, and counselor, there would certainly be safeguards in place to ensure that a minor possesses the requisite mental capacity to fully understand the

143. Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800-.897 (1997).
144. *Id.* §§ 127.815-.820.
145. *Id.* § 127.825.
146. *Id.*
147. *Id.*
148. *Id.* § 127.815.
149. *Id.* §§ 127.815-.845.
150. *Id.*

decision in front of them.[151] Similar to Belgium, the minor must demonstrate their ability to understand the concept of death and receive parental consent.

As unfortunate as it is, children suffer from terminal illnesses. Pain does not discriminate by age. Children also undergo unbearable pain. It is not pleasant to imagine any child choosing death. But it is no one's choice but the child's. As hard as it is to accept, the patient has already been given a date of death. Because all patients requesting medically assisted dying have already been diagnosed as terminal, death is inevitable. The choice is merely about the timing and manner of death, rather than death itself. In other words, the practice of medically assisted dying is not simply causing the death of a child, but taking that inevitable looming death and humanely controlling the time and place that it occurs.

It is inherently unfair to deprive those under the age of eighteen suffering from a debilitating terminal illness of what should be their right to decide whether to live or die. As with adults, terminally ill children should also be allowed to die with dignity. Every person has a right to their own bodily integrity and the refusal to extend that right to minors that have the same capacity as adults constitutes discrimination against those who wish to seek medically assisted dying because of their medical condition. In order to preserve that fundamental principle of individual autonomy that exists in minors as well as adults, states that allow medically assisted dying should amend current legislation to extend medically assisted dying to minors who have rebutted the presumption of incompetence.[152]

A child being forced to endure an oncoming and inevitable death promotes unimaginable mental trauma including regret about having to die, guilt, depression, and feelings of terror of the unknown. If our society is truly as concerned about the welfare of minors as our current laws purport to be, then the United States should desire to protect its minors from such emotional traumas. Medically assisted dying diminishes the uncertainty of an imminent natural death and could even bring a certain sense of well-deserved peace to the patient.

IV. CONCLUSION

The steadily growing number of states within the United States that have legalized medically assisted dying should follow the lead of Belgium and the Netherlands. To ensure that every citizen is properly cared for, these states should eliminate or lower the requirement for a terminally ill patient to be eighteen years of age or older in order to request medically

151. *Id.*
152. Katz, *supra* note 41, at 222.

assisted dying. When minors turn eighteen, competence to understand the repercussions of decision-making is not automatically bestowed. That mental capacity to make decisions varies given a person's history and experience. Instead of limiting the practice only to adults, children should also be able to seek the practice of medically assisted dying. After their attending and consulting physicians and/or counselor verifies whether the child possesses the mental capacity to understand the situation in its entirety, the child should have the right to die with dignity if they wish.

Parents are not a fail-proof safeguard when it comes to the best interests of their children. While in theory every parent strives to make the best decisions on behalf of their children, in reality a parent may not always decide the choice that the child needs the most. The existence of the mature minor doctrine proves that parental consent is not always necessary when it comes to medical decision-making. In fact, the doctrine evinces that at times the competent minor is the best actor to make his or her own decisions regarding medical treatment. No one knows a minor's individual pain or thought process better than the minor themselves. It follows that the minor themselves should be then able to make those important medical decisions without parental consent. A paramount medical decision of great importance is the decision of a terminally ill patient in deciding whether to request medically assisted dying. If a minor is terminally ill, they deserve all of the medical options that adults in their situation possess. A terminally ill minor at least deserves the choice to request medically assisted dying.

If the idea of eliminating any age requirement appears to some as too radical, then an alternative is, at the least, to lower the age at which a child has to be to request medically assisted dying. The consensus of the psychological studies noted above indicates that a child may be as mentally capable of decision-making as an adult when he or she reaches the age of thirteen to fifteen. By extending the practice to minors who have rebutted the presumption of incompetence, those children who do indeed possess the capacity to make sound medical decisions would no longer be forbidden from the option of death with dignity. The ultimate goal of medically-assisted dying is to provide relief to those suffering from terminal illness, unbearable pain, and loss of dignity. The practice fosters a dignified death to those that desire it. Medically assisted dying is a means to free patients from the chains of their ill bodies. Children, too, deserve the option to escape pain and suffering.