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Terminally Ill Minors and the Right to Refuse Life-Sustaining  
Medical Treatment: How Specialized Health Care Courts Restore  
the Rule of Law

# **Terminally Ill Minors and the Right to Refuse Life-Sustaining Medical Treatment: How Specialized Health Care Courts Restore the Rule of Law**

## EXECUTIVE SUMMARY

The question of whether a competent, terminally ill minor should have the right to refuse life-sustaining medical treatment (LSMT) is perhaps the most intimate, personal, and difficult decision a person could possibly face. While the concepts of physician-assisted suicide and euthanasia are undoubtedly taboo and controversial, especially in the context of minors, they are nevertheless salient public health, legal, and ethical issues that need to be addressed to reconcile the patchwork of legal and medical doctrines that currently define this subject. Recent judicial rulings,<sup>1</sup> legislative developments,<sup>2</sup> and public policy polls<sup>3</sup> suggest that the United States is prepared to hold a serious conversation surrounding a patient's right to refuse LSMT. State legislatures have made significant progress in the Death with Dignity movement; however, minimal progress, if any, has been made on whether competent, terminally ill minors should also have the right to physician-assisted suicide.

Perhaps equally important is the question of who has the power to make these decisions. Given the seriousness of this topic, it is important to create a fair and just adjudicative process. At present, generalist courts generally have the constitutional authority to determine whether a minor has the right to refuse LSMT, subject to statutory restrictions. While generalist judges are capable of

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<sup>1</sup> See, e.g., *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn.1987); *In re Swan*, 569 A.2d 1202 (1990); *In re E.G.*, 133 Ill. 2d 98 (1990); see also *In the Matter of Rena*, 46 Mass. App. Ct. 335, 337-38 (1999) (suggesting that the trial court should have employed the mature minor doctrine to determine the minor's maturity).

<sup>2</sup> California (Oct. 5, 2015), Vermont (May 20, 2013), Washington (Nov. 4, 2008), and Oregon (Nov. 8, 1994) legalized physician-assisted suicide through legislation. Montana (Dec. 31, 2009) allows physician-assisted suicide pursuant to *Baxter v. Montana*, 354 Mont. 234, 269 (2009) (holding that there is "no indication in Montana law that physician aid in dying provided to terminally ill, mentality competent adult patients is against public policy," and therefore physicians who assist "may be shielded from liability pursuant to the consent statute").

<sup>3</sup> Andrew Dugan, *In U.S., Support Up for Doctor Assisted Suicide*, GALLUP, May 27, 2015, <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx> (last visited Nov. 30, 2015) (reporting that 68% of Americans support euthanasia. This is a 20-point increase from two years ago).

presiding over a wide-spectrum of cases and subject matters, the stakes concerning end-of-life care are too high to deprive litigants from accessing specialized health care courts. Requiring litigants to present an end-of-life case before a generalist judge undermines the Rule of Law because it fails to provide litigants with a fair tribunal—a tribunal with competent and efficient judges that understand the intricacies and complexities of physician-assisted suicide.

While certain readers may scoff at the relevancy of this issue—unwilling or incapable of understanding how a competent, terminally ill minor would voluntarily consent to end their life—the question of whether a competent, terminally ill minor should have the right to refuse LSMT is germane in both the legal and medical community. In response to this topical issue, this Paper examines the statutory and constitutional landscape surrounding a minor’s right to refuse LSMT, and promulgates that the best method to address this issue is by creating specialized health care courts. Correspondingly, this Paper contends that the Rule of Law is undermined when generalist judges have the power to adjudicate cases surrounding end-of-life care. Part I surveys the current statutory regime surrounding physician-assisted suicide. Part II then describes the constitutional parameters the judicial branch has articulated in its attempt to define who has, and under what circumstances, the right to refuse LSMT, as well as discusses how minors fit into the conversation. Finally, Part III recommends that institutional resources would be maximized through the creation of specialized health care courts.

## INTRODUCTION

Imagine you are a 15-year-old adolescent, born with an enlarged liver and suffering from acute-on chronic liver failure. Shortly after undergoing your second liver transplant, your body starts to reject the new liver. The pain in your upper abdomen, persistent nausea, and skin of jaundice become all too familiar symptoms. Your physician cautions you that the odds of surviving another liver transplant are less than 50 percent. You and your family decide the best solution is to administer anti-rejection drugs<sup>4</sup> to prolong your treatment, but these drugs cause painful side effects, including fierce headaches, tremors, and intense irritability.

Following months of treatment, your overall condition worsens and your liver starts to fail. Your death is imminent. After much deliberation with your family, you decide that you want to stop taking drugs and live your remaining life without going through the agonizing side effects. Despite your wishes, the Department of Health denies your request and orders you to take the anti-rejection drugs. You remain adamant in your decision and refuse to oblige to their demands. In response, the Department of Health storms your home, forcibly removes you from your room, and admits you to the hospital for treatment. Once there, physicians attempt to run tests and provide treatment, but you manage to fight them off. In the end, a judge rules that the Department of Health cannot force you to take drugs. You pass away two-months later in your home. While the circumstances of this hypothetical may seem attenuated and unrealistic, it is the story of Benny Agrelo, a 15-year-adolescent from Florida who was diagnosed with an enlarged liver.<sup>5</sup>

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<sup>4</sup> Anti-rejection drugs (or immunosuppressant drugs) are used to prevent the body from rejecting a transplant organ.

<sup>5</sup> *Behind a Boy's Decision to Forgo Treatment*, N.Y. TIMES, <http://www.nytimes.com/1994/06/13/us/behind-a-boy-s-decision-to-forgo-treatment.html> (last visited Sept. 30, 2015).

and medical community. Should you have been able to choose how to die? Is this a dignified way of dying? Who makes the final decision? A physician? A judge? What type of judge? How does the Rule of Law<sup>6</sup> support or suppress your right? These are the types of questions being asked in hospital wards and pediatric intensive care units across the country—questions of life and death.

Recent judicial rulings,<sup>7</sup> legislative developments,<sup>8</sup> and public policy polls<sup>9</sup> suggest that the United States is prepared to hold a serious conversation surrounding a patient’s right to refuse life-sustaining medical treatment (LSMT).<sup>10</sup> Most recently, California, often looked to as a policy trendsetter, became the fifth state to legalize physician-assisted suicide.<sup>11</sup> Furthermore, lobbying efforts to expand this right to other states continues to gain momentum.<sup>12</sup> In response to this topical issue, this Paper examines the statutory and constitutional landscape surrounding a minor’s right to refuse LSMT, and promulgates that the best method to address this issue is by creating specialized health care courts. Correspondingly, this Paper contends that the Rule of Law is undermined when

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<sup>6</sup> The Rule of Law is comprised of five elements: (1) Fair laws; (2) Fair enforcement; (3) Fair courts; (4) Access; and (5) Everyone is subject to the law.

<sup>7</sup> See, e.g., *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn.1987); *In re Swan*, 569 A.2d 1202 (1990); *In re E.G.*, 133 Ill. 2d 98 (1990); see also *In the Matter of Rena*, 46 Mass. App. Ct. 335, 337-38 (1999) (suggesting that the trial court should have employed the mature minor doctrine to determine the minor’s maturity).

<sup>8</sup> California (Oct. 5, 2015), Vermont (May 20, 2013), Washington (Nov. 4, 2008), and Oregon (Nov. 8, 1994) legalized physician-assisted suicide through legislation. Montana (Dec. 31, 2009) allows physician-assisted suicide pursuant to *Baxter v. Montana*, 354 Mont. 234, 269 (2009) (holding that there is “no indication in Montana law that physician aid in dying provided to terminally ill, mentality competent adult patients is against public policy,” and therefore physicians who assist “may be shielded from liability pursuant to the consent statute”).

<sup>9</sup> Andrew Dugan, *In U.S., Support Up for Doctor Assisted Suicide*, GALLUP, May 27, 2015, <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx> (last visited Nov. 30, 2015) (reporting that 68% of Americans support euthanasia. This is a 20-point increase from two years ago).

<sup>10</sup> The terms “physician-assisted suicide” and “euthanasia” are often confused and used interchangeably in the media. Given the seriousness and sensitivity of this topic, it is imperative that I provide a brief distinction to orient the reader. Physician-assisted suicide is when someone, generally a physician, provides a patient with the information, guidance, and means to take his or her own life. For example, the most common form of physician-assisted suicide is when a physician provides a patient with a lethal dose of medication to hasten their death. By contrast, euthanasia can take several forms, but the most common forms are active euthanasia and passive euthanasia. Active euthanasia is when a physician takes specific steps to cause the death of a patient, such as injecting them with a lethal dose of drugs. Passive euthanasia, however, is the act of withholding or withdrawing life-sustaining medical treatment to hasten a patient’s death. This Paper will primarily focus on physician-assisted suicide and passive euthanasia.

<sup>11</sup> Patrick McGreevy, *After Struggling, Jerry Brown Makes Assisted Suicide Legal in California*, L.A. TIMES, <http://www.latimes.com/local/political/la-me-pc-gov-brown-end-of-life-bill-20151005-story.html> (last visited Dec. 1, 2015).

<sup>12</sup> For a comprehensive discussion of state legislative action surrounding physician-assisted suicide, see *In Your State, COMPASSION AND CHOICES*, <https://www.compassionandchoices.org/what-you-can-do/in-your-state/> (last visited Jan. 4, 2016).

generalist judges have the power to adjudicate cases surrounding end-of-life care. Part I surveys the current statutory regime surrounding physician-assisted suicide. Part II then describes the constitutional parameters the judicial branch has articulated in its attempt to define who has, and under what circumstances, the right to refuse LSMT, as well as discusses how minors fit into the conversation. Finally, Part III recommends that institutional resources would be maximized through the creation of specialized health care courts.

## I. STATE LEGISLATURES HAVE EMBRACED THE DEATH WITH DIGNITY MOVEMENT

Advancements in life sustaining medical technologies, such as mechanical ventilation, blood transfusion, and dialysis, have redefined the traditional ethical and legal paradigms surrounding physician-assisted suicide.<sup>13</sup> While these technological innovations in the health care industry have enabled physicians to cure diseases that were once fatal or painful, the proliferation of medical technologies have also given physicians the “power to sustain the lives (or, some would say, prolong death) of patients whose physical and mental capabilities cannot be restored, whose degenerating conditions cannot be reversed, and whose pain cannot be eliminated.”<sup>14</sup> In most cases, prolonging life is the preeminent goal for both the patient and the physician.<sup>15</sup> However, this goal rests on the presumption that the prolongation of life is generally the right decision.<sup>16</sup> To the

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<sup>13</sup> A mechanical ventilator is a machine that helps patients breathe when he or she is recovering from surgery or critical illness. The main risk is infection because artificial airways may facilitate germs to enter the lung. Blood transfusion is a common, yet life-saving procedure in which blood is given to a patient to replace blood lost. Dialysis is a filtering process that removes waste and excess water from the blood, and is used primarily as an artificial replacement for lost kidney function.

<sup>14</sup> Claire Andre & Manuel Velasquez, *Assisted Suicide: A Right or a Wrong?*, Santa Clara University, Markula Center for Applied Ethics, <http://www.scu.edu/ethics/publications/iie/v1n1/suicide.html> (last visited Dec. 5, 2015).

<sup>15</sup> See, e.g., Sidney H. Wanzer, M.D., et al., *The Physician’s Responsibility to Hopelessly Ill Patients*, 310 *NEW ENG. MED.* 955, 956 (1984) (noting that a “physician’s schooling, residency training, and professional oath emphasize positive actions to sustain and prolong life”).

<sup>16</sup> See Sharon Kirkey, *Sometimes There Is No Cure; Doctors, Machines and Technology Can Keep Us Alive, But Why?*, *NATIONAL POST*, <http://news.nationalpost.com/news/canada/sometimes-there-is-no-cure-doctors-machines-and-technology-can-keep-us-alive-but-why> (last visited Dec. 5, 2015); see also David Crippen, *Medical Treatment for the Terminally Ill; The ‘Risk of Unacceptable Badness,’* *CRITICAL CARE* 9: 317-318 (2005) (noting that “[a]n unintended side effect of modern technological advances has been the plausibility of maintaining moribund patients in a state of suspended animation for prolonged and sometimes indefinite periods”).

contrary, the prolongation of life may serve to the detriment of the patient.<sup>17</sup> For example, certain terminally, ill patients may experience severe and debilitating side effects from medications that make it unbearable to live.<sup>18</sup> Unsurprisingly, laws have failed to keep pace at the speed by which medical technologies have developed.<sup>19</sup> In the effort to close this gap, state legislatures nationwide have increasingly proposed bills and initiatives to address the issue of physician-assisted suicide.<sup>20</sup>

#### *A. Nationwide Trend to Legalize Physician-Assisted Suicide*

Although the Supreme Court held in *Washington v. Glucksberg* that physician-assisted suicide is not a fundamental right protected under the Due Process Clause, the Court recognized that the decision to allow physician-assisted suicide lies within the constitutional purview of the state.<sup>21</sup> The Court reasoned that decisions surrounding physician-assisted suicide are better suited within the “arena of public debate and legislative action,” and not the judiciary branch.<sup>22</sup> Justice O’Connor articulated that the Court invites states to act as “laborator[ies]” to explore viable options for aid in dying.<sup>23</sup> In the wake of *Glucksberg*, Oregon passed the Oregon Death with Dignity Act (DWDA), which allows a competent, terminally ill patient to end their life through the voluntary self-

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<sup>17</sup> See, e.g., Superintendent of Belchertown State Sch. et al v. Joseph Saikewicz, 370 N.E.2d 417 (Mass. 1977) (citing In re Quinlan, 355 A.2d 647 (N.J. 1976) and Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891)) (articulating that the “[p]revailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances”).

<sup>18</sup> See, e.g., Stefan C. Weiss, Linda L. Emanuel, Diane L. Fairclough, and Ezekiel J. Emanuel, *Understanding the Experience of Pain in Terminally Ill Patients*, THE LANCET, v. 357 April 28, 2001 (finding that 50 percent of terminally ill patients experience moderate to severe pain).

<sup>19</sup> Glenn W. Peterson, *Balancing the Right to Die with Competing Interests: A Socio Legal Enigma*, 13 PEPPERDINE L. REV. 109, 110 (1985).

<sup>20</sup> At present, 23 states have pending bills. See *Attempts to Legalize Euthanasia/Assisted Suicide in the United States*, PATIENTS RIGHT COUNCIL, <http://www.patientsrightscouncil.org/site/failed-attempts-usa/> (last visited Dec. 2, 2015).

<sup>21</sup> *Washington v. Glucksberg*, 521 U.S. 702, 704 (1997) (holding that “Washington’s prohibition against ‘caus[ing]’ or ‘aid[ing]’ a suicide does not violate the Due Process Clause); see also *Vacco v. Quill*, 521 U.S. 793, 809 (1997) (holding that a New York statute prohibiting physician-assisted suicide was not unconstitutional because it did not violate the Equal Protection Clause of the Fourteenth Amendment).

<sup>22</sup> *Glucksberg*, 521 U.S. at 720.

<sup>23</sup> *Id.* at 737 (O’Connor, J., concurring) (noting that “[t]here is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State’s interests in protecting those who might seek to end life mistakenly or under pressure”).

administration of legal medications.<sup>24</sup> The Act incorporates various safeguards to ensure that the law is not abused, such as requiring patients to make two oral requests to his or her physician, separated by at least 15 days.<sup>25</sup> Moreover, patients must provide written notice, signed in the presence of two witnesses.<sup>26</sup> Additionally, the prescribing physician must inform the patient of feasible alternatives, including comfort care, hospice care, and pain control.<sup>27</sup> The Act also requires the Oregon Health Authority to collect information about the patients and physicians who participate in the Act, and publish an annual report.<sup>28</sup> Since its enactment, the Oregon DWDA has served as a model law for Washington, Vermont, and California.

In 2009, the Montana Supreme Court legalized physician-assisted suicide when it ruled in *Baxter v. Montana*, holding that physicians are able to prescribe lethal doses of drugs to competent, terminally ill patients without being subject to Montana's homicide laws.<sup>29</sup> In making its determination, the Court circumvented constitutional claims, and reasoned that neither legal precedent nor Montana's statutory scheme deemed physician-assisted suicide against public policy.<sup>30</sup> In doing so, the Court side-stepped constitutional arguments and relied on statutory-based language to make its ruling. In support of its conclusion, the Court articulated that "[t]he patient's subsequent private decision whether to take the medicine does not breach public peace or endanger

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<sup>24</sup> The Act explicitly provides that "[a]n adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner."

<sup>25</sup> OR. REV. STAT. ANN. §§ 127.840-50 (West 2013).

<sup>26</sup> OR. REV. STAT. ANN. §§ 127.815-20 (West 2013).

<sup>27</sup> OR. REV. STAT. ANN. § 127.825 (West 2013).

<sup>28</sup> OR. REV. STAT. ANN. § 127.855 (West 2013).

<sup>29</sup> See *Baxter v. State of Montana*, ACLU, <http://aclumontana.org/baxter-v-state-of-montana/> (last visited Dec. 18, 2015).

<sup>30</sup> *Id.*



others.”<sup>31</sup> To this end, the Court explained that there was no difference between withdrawing medical treatment and prescribing lethal drugs for the purpose of physician-assisted suicide.<sup>32</sup>

### *B. Minors’ Right to Refuse LSMT*

While state legislatures across the country have been busy voting on physician-assisted suicide initiatives, little attention, if any, has been paid to whether this right should be extended to minors. This is perhaps unsurprising considering the notable pushback physician-assisted suicide has received for adults. However, there have been instances in U.S. history where state legislators have proposed measures to allow children to end their lives.

On October 22, 1975, Wisconsin State Rep. Lloyd Barbee introduced A.B 1207, which would have made an exception in the state’s homicide law for killing upon request, and it would have abolished the crime of assisting suicide.<sup>33</sup> The measure went a step further and explicitly stated that children between the ages of 7 and 18 had to notify their parents or guardians prior to requesting to end their life, but “permission from such parents or guardian [would] not be a condition precedent to making a valid request to die.”<sup>34</sup> The statutory language under A.B. 1207 was no doubt ahead of its time, even for today’s standards. The bill failed to make it out of the Wisconsin Assembly’s judiciary committee.<sup>35</sup> It was not until 1997 that another bill would advocate for minors to have the right to physician assisted suicide.<sup>36</sup> Under the Illinois Dignity in Dying Act, the bill would have let physicians provide qualified adults and “emancipated minors” the means to end their life.<sup>37</sup> Similarly, the Illinois Dignity in Drying Act failed to make it out of committee.<sup>38</sup>

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<sup>31</sup> *Id.* at. 1217.

<sup>32</sup> See MONT. CODE ANN. § 50-9-503 (indicating that withdrawing or withholding medical treatment does not go against public policy).

<sup>33</sup> Rep. Barbee served in the Wisconsin legislature from 1965 to 1977.

<sup>34</sup> *Assisted Suicide: Not for Adults Only?*, PATIENTS RIGHTS COUNCIL, <http://www.patientsrightscouncil.org/site/not-for-adults-only/> (last visited Jan. 4, 2016).

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

It is safe to say that the death-with-dignity movement for minors in the U.S. is moot and on the back burners of physician assisted suicide advocates. Nonetheless, this movement has gained international traction in recent years. In 2002, the Netherlands<sup>39</sup> made headlines when it passed the Termination of Life on Request (Review Procedures) Act, becoming the first country in the world to legalize euthanasia.<sup>40</sup> Under the law, minors over the age of 12 suffering from a terminal illness with no prospect of improvement may seek euthanasia as an end-of-care option.<sup>41</sup> Minors must receive parental consent and satisfy a series of other conditions.<sup>42</sup> Since 2002, only five minors have been euthanized, one was 12 years old, while the other four were either 16 or 17.<sup>43</sup>

## II. COMMON LAW SUPPORTS THE RIGHT TO REFUSE LSMT

The Supreme Court has long-recognized parental autonomy as “perhaps the oldest of the fundamental liberty interests.”<sup>44</sup> *Meyer v. Nebraska* and *Pierce v. Society of Sisters* firmly established the parental autonomy doctrine—the principle that parents have a constitutional right to raise their children without unreasonable governmental interference.<sup>45</sup> This fundamental right was further galvanized in *Prince v. Massachusetts*, where the Court articulated “that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include

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<sup>38</sup> *Id.*

<sup>39</sup> In 2014, Belgium followed suit and became the first country to legalize euthanasia for terminally, ill minors without age restrictions.

<sup>40</sup> In 2010, the Committee received 3,136 cases for review, a 19% increase from the previous year. Of the total number of cases, the Committee approved 2,667 and found 9 cases in which the physician had not acted in accordance with the law. Of those approved, only 182 cases involved physician-assisted suicide and 44 involved a combination of euthanasia and PAS (the remaining cases were strictly euthanasia).

<sup>41</sup> Justin Huggler, *Give Children Under 12 the Right to Die, Say Dutch Pediatricians*, THE TELEGRAPH, <http://www.telegraph.co.uk/news/worldnews/europe/netherlands/11686716/Give-children-under-12-the-right-to-die-say-Dutch-paediatricians.html> (last visited Dec. 5, 2015).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *See, e.g.*, *Troxel v. Granville*, 536 U.S. 57, 58 (2000) (holding that a Washington statute violated the right of parents, under the Due Process Clause, to make decisions concerning the care, custody and control of their children).

<sup>45</sup> *See Meyer v. Nebraska*, 262 U.S. 390, 402 (1923) (“That the State may do so much, go very far, indeed, in order to improve the quality of its citizens, physically, mentally and morally, is clear; but the individual has certain fundamental rights which must be respected”); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (explaining that “[t]he child is not the mere creature of the State; those who nurture him and direct his destiny have the right”).

preparation for obligations the state can neither supply nor hinder.”<sup>46</sup> Common law has since legitimized a wide-spectrum of parental rights, such as the right to make decisions surrounding the education of a child<sup>47</sup> and the right to direct the moral and religious training of a child.<sup>48</sup>

Conversely, the Supreme Court has also afforded minors some of the same constitutional rights that have been bestowed to adults.<sup>49</sup> As the Court explained in *In re Gault*, “neither the Fourteenth Amendment nor the Bill of Rights is for adults alone.”<sup>50</sup> In the context of medical-decision making, the Supreme Court has ruled in limited circumstances that minors have the constitutional right to make autonomous decisions without parental consent—most notably the right to contraceptives<sup>51</sup> and abortions.<sup>52</sup> More recently, courts have begun to confront the issue of whether competent, terminally ill minors should have the right to refuse LSMT.<sup>53</sup> The common law jurisprudence surrounding this issue is premised on the presumption that minors lack the capacity to

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<sup>46</sup> *Prince v. Massachusetts*, 321 U.S. 158 (1944).

<sup>47</sup> *Wisconsin v. Yoder*, 406 U.S. 205, 213-215 (1972) (holding that parents have an interest in a child’s education).

<sup>48</sup> *Prince v. Massachusetts*, 321 U.S. at 165.

<sup>49</sup> *See, e.g.*, *Tinker v. Des Moines Independent Community School District*, 393 U.S. 503 (1969) (freedom of expression), *Carey v. Population Services International*, 431 U.S. 678 (1977) (right of privacy); *New Jersey v. T.L.O.*, 469 U.S. 325 (1985) (freedom from unreasonable searches and seizures); *Goss v. Lopez*, 419 U.S. 565 (1975) (right of education), and *In re Gault*, 387 U.S. 1 (1967) (procedural process).

<sup>50</sup> *In re Gault*, 387 U.S. 1, at 13 (holding that juveniles tried for crimes in delinquency proceedings have the same right to Due Process by the Fourteenth Amendment as adults).

<sup>51</sup> *Carey v. Population Servs. Int’l*, 431 U.S. 678, 681-82 (1977) (striking down a New York statute that prohibited the distribution of nonmedical contraceptives to persons age 16 or over except through a licensed pharmacist).

<sup>52</sup> *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976) (holding that a state “may not impose a blanket provision . . . requiring the consent of a parent or person in loco parentis as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy”); *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (holding that minors must be given the option to seek a judicial bypass of parental consent rules); *see also Bellotti v. Baird*, 443 U.S. 622 (holding that mature minors must be given permission for an abortion).

<sup>53</sup> *See, e.g.*, Katherine A. Wingfield & Carl S. Hacker, *Physician-Assisted Suicide: An Assessment and Comparison of statutory approaches among the states*, 32 SETON HALL LEGIS. J. 13 (2007) (comparing physician-assisted suicide laws in all fifty states).

make informed medical decisions.<sup>54</sup> This area of the law presents fundamental issues that concern informed consent, bodily integrity, and privacy.<sup>55</sup>

### *A. Constitutional Background*

Prior to 1986, no court examined the question of whether a minor has the right to refuse LSMT. In the case of *In re D.P.*, the California Superior Court of Santa Clara County held that a 14-year old cancer patient could not be held in a hospital against her will, and thus was not required to receive blood transfusions.<sup>56</sup> The following year, in *Cardwell v. Bechtol*, the Tennessee Supreme Court addressed the issue of whether a minor can consent to medical treatment.<sup>57</sup> In *Cardwell*, a minor and her parents brought suit against an osteopath for medical malpractice on the grounds that the osteopath failed to obtain informed consent for a medical procedure.<sup>58</sup> The Court in *Cardwell* “recognize[d] the varying degrees of responsibility and maturity of minors”<sup>59</sup> and ruled that if a minor has the capacity to consent to and appreciate the nature, risk, and consequences of medical treatment, that the minor functions as an adult when making decisions on medical treatment.<sup>60</sup> The Court, however, warned that the “[a]doption of the mature minor exception to the common law rule [was] by no means a general license to treat minors without parental consent and [the exception’s]

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<sup>54</sup> See, e.g., 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, 265-67 (2005) (explaining that in forty-eight states and the District of Columbia, states health care laws “rest on a presumption that minors are incompetent and lack the ability to make cogent, mature, and binding decision about their own wellbeing”).

<sup>55</sup> See, e.g., Jessica Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 HEALTH CARE L. & POL’Y 37 (2012) (describing the relevant social and legal issues concerning minors and medical decision-making rights).

<sup>56</sup> *In re D.P.* (Cal. Super. Ct. Santa Clara County, July 1986).

<sup>57</sup> *Cardwell v. Bechtol*, 724 S.W.2d 739 (1987); *Contra R.J.D. v. Vaughan Clinic*, 572 So.2d 1225, 1227-28 (Ala. 1990) (“In such matters as deciding on the need for surgical or hospital treatment, the wishes of young children are not consulted, nor their consent asked when they are old enough to give expression thereto. The will of the parents is controlling, except in those extreme instances where the state takes over to rescue the child from parental neglect or to save its life. Similarly, the right to grant or refuse a medical examination of a child belongs not to the child, but to the parents”).

<sup>58</sup> *Bechtol*, 724 S.W.2d at 741.

<sup>59</sup> *Id.* at 744-45.

<sup>60</sup> *Id.* at 747

application [was] dependent on the facts of each case.”<sup>61</sup>

The seminal case, *In re E.G.*, was the first to declare that a competent minor has the common law right to refuse LSMT.<sup>62</sup> In 1989, the Supreme Court of Illinois considered the state’s common law history and statutory scheme, and found that a 17-year-old leukemia patient had the right to refuse LSMT for religious reasons.<sup>63</sup> Ernestine Gregory (E.G.), six months from her eighteenth birthday, refused to receive blood transfusions, asserting that it violated her religious beliefs as a Jehovah’s Witness.<sup>64</sup> Relying on *Cardwell v. Bechtol* to support its conclusion, the Court articulated that “[a]lthough the age of majority in Illinois is 18, that age is not an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood.”<sup>65</sup> The court relied heavily on the fact that minors are treated as adults with respect to constitutional law and Illinois’s statutory history.<sup>66</sup> The court articulated that the criminal justice system already treats certain minors as adults, stating that:

“[T]o be convicted of many of the offenses in the Criminal Code, a trier of fact would have to find that a minor had a certain mental state at the time the alleged crime was committed. Implied in finding this mental state would be an acknowledgement that a minor was mature enough to have formulated this *mens rea*. Consequently, the Juvenile Court Act presupposes a ‘sliding scale of maturity’ in which young minors can be deemed mature enough to possess certain mental states and be tried and convicted as adults . . . When a minor is mature enough to have the capacity to formulate criminal intent, both the common law and our Juvenile Court

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<sup>61</sup> *Id.* at 745.

<sup>62</sup> *In re E.G.*, 133, Ill.2d 98, 101-02 (1989). This case was decided before the Supreme Court’s groundbreaking decision in *Cruzan v. Director, Missouri Department of Health*, where the Court recognized for the first time that a competent person has a constitutionally protected state interest under the due process clause of the fourteenth Amendment in refusing unwanted medical treatment that must be balanced against the state’s interest in preserving life

<sup>63</sup> *Id.* at 112-13.

<sup>64</sup> *Id.* at 102.

<sup>65</sup> *Id.* at 106.

<sup>66</sup> *Id.* at 108. E.G. based her challenge in both her common law right to bodily integrity and right to religious freedom under the First Amendment; however, the Illinois Supreme Court found that the common law right was adequate to allow her to refuse care and declined to reach the constitutional question.

Act treat the minor as an adult.”<sup>67</sup>

In holding that “a mature minor may exercise a common law right to consent to or refuse medical care,” the Illinois court legitimized the mature minor doctrine.<sup>68</sup> The mature minor doctrine was further reaffirmed *In re Swan*, where the Maine Supreme Court ruled that a 17-year-old minor who had suffered life-threatening injuries resulting from an automobile accident had the right to refuse LSMT.<sup>69</sup> Similar to *In re E.G.*,<sup>70</sup> the court employed a balancing test to determine that the minor had a right to refuse LSMT, reasoning that the parents had shown clear and convincing evidence that the minor did not “want to be kept alive by artificial means should [an] injury render him incapable of existing otherwise.”<sup>71</sup> The same year, in the case of *In re Long Island Jewish Center*, a New York trial court held that a 17-year-old Jehovah’s Witness could not refuse blood transfusions due to lack of maturity.<sup>72</sup>

### *B. Courts Presume Minors Are Legally Incompetent*

Minors are generally presumed legally incompetent, and thus lack the authority to consent to medical treatment.<sup>73</sup> Under U.S. common law, parents enjoy a substantive constitutional right to make health care decisions on behalf of their children.<sup>74</sup> This is particularly true in the realm of end-

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<sup>67</sup> *Id.* at 107.

<sup>68</sup> *Id.* at 109 (stating that the court can “see no reason why this right of dominion over one’s own person should not extend to mature minors”).

<sup>69</sup> *In re Swan*, 569 A.2d 1202 (1990).

<sup>70</sup> *See, e.g.*, *Cruzan v. Director Missouri Dept. of Health*, 497 U.S. 261 (1990); *Washington v. Glucksberg*, 521 U.S. 702, 728, n.20 (1997); *Vacco v. Quill*, 521 U.S. 793, 808-09 (1997); *Thor v. Superior Court*, 855 P.2d 375, 383 (Cal. 1993) (reaffirming that “the right to be free from nonconsensual invasions of bodily integrity is not absolute. Four state interests generally identify the countervailing considerations in determining the scope of patient autonomy. . . .”).

<sup>71</sup> *In re Swan*, 569 A.2d at 1204.

<sup>72</sup> *In re Long Island Jewish Medical Center*, 557 N.Y.S.2d 239, 243 (N.Y. Sup. Ct. 1990).

<sup>73</sup> *See, e.g.*, Mary Koll, *Growth, Interrupted: Nontherapeutic Growth Attenuation, Parental Medical Decision Making, and the Profoundly Developmental Disabled Child’s Right to Bodily Integrity*, 2010 U. ILL. L. REV. 225, 241 (2010) (explaining that “[c]hildren are generally considered legally incompetent to consent to their own medical treatment”).

<sup>74</sup> *See, e.g.*, *Troxel*, 530 U.S. at 66. (“In light of . . . extensive precedent, it cannot now be doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children”).

of-life care.<sup>75</sup> The notion that minors lack the capacity to make independent decisions concerning medical treatment rests on the presumption that minors lack the maturity and wisdom to make such decisions.<sup>76</sup> In *Prince v. Massachusetts*, the Supreme Court articulated that “[p]arents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”<sup>77</sup> This parental right, however, is premised on the presumption that parents will act in the best interest of the minor.<sup>78</sup>

As a judicial safeguard, the Supreme Court has also consistently held that under the legal doctrine of *parens patriae*, the state has the power to protect the interest and general welfare of a minor.<sup>79</sup> To this end, parental autonomy must yield to state intervention when the state believes that the parent is not acting in the best interest of the minor, particularly in the context of medical treatment.<sup>80</sup> This well-established constitutional right takes into account three sets of interests: (1) the “natural rights” of parents; (2) the responsibilities of the state; and (3) the personal needs of the child.<sup>81</sup> Courts must balance these interests to determine when state intervention is appropriate.<sup>82</sup>

The Supreme Court has recognized that “minors achieve varying degrees of maturity and responsibility (capacity).”<sup>83</sup> In the context of physician-assisted suicide, courts have increasingly

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<sup>75</sup> See, e.g., Walter J. Wadlington, Consent to Medical Care for Minors, in *Children’s Competence to Consent*, ed. Gary B. Melton, Gerald P. Kocher, and Michael J. Saks (New York: Plenum Press, 1983), 59-60. (“Until a child reaches the legal age of majority, is emancipated generally or is specifically empowered by legislative or judicial action to consent to medical treatment, the child’s parent or guardian usually has legal capacity to give or withhold consent to treatment”).

<sup>76</sup> See *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (noting that “[t]he law’s concept of family rest on a presumption that parents possess what a child lacks in maturity, experience and capacity for judgment require for making life’s difficult decisions”).

<sup>77</sup> *Prince*, 321 U.S. at 170.

<sup>78</sup> See generally *Stanley v. Illinois*, 405 U.S. 645, 651 (1972); *Yoder*, 406 U.S. at 232; *Quilloin v. Walcott*, 434 U.S. 246, 255(1978); *Santosky v. Kramer*, 455 U.S. 745, 753 (1982); *Parham v. J.R.*, 442 U.S. at 602; *Glucksberg*, 521 U.S. at 730, and *Troxel*, 530 U.S. at 66.

<sup>79</sup> *In re E.G.*, 549 N.E.2d at 327 (acknowledging the state’s *parens patriae* powers to protect the incompetent).

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Cardwell v. Bechtol*, 724 S.W.2d 739, 744-45 (Tenn. 1987).

employed the mature minor doctrine to determine whether certain competent, terminally ill minors have the capacity to make end-of-life decisions.<sup>84</sup> The mature-minor doctrine is rooted in the idea that certain minors have the right to “refuse or consent to medical treatment if she possess sufficient maturity to understand and appreciate the benefits and risks of the proposed medical treatment.”<sup>85</sup> The application of the mature-minor doctrine is perhaps best exemplified in the context of abortion.<sup>86</sup> In *Bellotti*, the Supreme Court answered this question by holding that mature minors may bypass the parental consent requirement by establishing that she is mature and well-informed of the procedure.<sup>87</sup>

While the mature-minor doctrine has been employed in cases surrounding contraceptives and abortion, it is a relatively new concept in the context of end-of-life care. Despite its novelty, the mature-minor doctrine is a prevailing pattern found in many state jurisdictions.<sup>88</sup> In considering a minor’s capacity to make autonomy medical decisions, courts consider a constellation of cognitive and social factors. Under the mature-minor doctrine, courts, along with physicians, conduct subjective evaluations to determine whether minors are capable to give informed consent.<sup>89</sup> There is marked variability in what constitutes maturity.<sup>90</sup> More recently, courts have turned to

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<sup>84</sup> To determine the requisite maturity and capacity to make medical decisions, certain courts in the past have utilized the Rule of Sevens doctrine: under the age of seven, a presumption of no capacity; from seven until fourteen a rebuttable presumption of no capacity; and from fourteen to twenty-one a rebuttable of capacity.

<sup>85</sup> Melinda T. Derish & Kathleen V. Heuvel. *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J. L. MED. ETHICS, 28 109, 124 (2000).

<sup>86</sup> The issue of physician-assisted suicide has long been analogized to abortion. In *Compassion in Dying v. Washington*, Judge Reinhardt from the Ninth Circuit explained that even when physician-assisted suicide was prohibited, it was still taking place behind closed doors (similar to abortions).

<sup>87</sup> See *Bellotti v. Baird*, 443 U.S. 622, 643-44 (1979) (stating that a minor is entitled to show that she mature and informed to make her own medical decision, or that the abortion is in the minor’s best interest).

<sup>88</sup> See, e.g., *In re E.G.*, 133, Ill.2d at 98; *Belcher v. Charleston Area Medical Center*, 422 S.F.2d 827 (W. Va, 1992).

<sup>89</sup> See McCabe, M.A. (1996). *Involving Children in Medical Decision Making: Developmental and Clinical Considerations*. J. OF PEDIATRIC PSYCHOL., 21, 505-16, 507 (“The ‘best’ medical decision for a given patient is based on factual, technical information and the interpretation of this information within the context of purely subjective factors and values”).

<sup>90</sup> See American Academy of Pediatrics Committee on Bioethics, “Guidelines on Foregoing Life-Sustaining Medical Treatment,” J. OF PEDIATRICS 93 532-36 (1994) (setting guidelines for withholding or terminating life-sustaining treatment for minors); See also Joan-Margaret Kun, Comment, *Rejecting the Adage “Children Should Be Seen and Not Hear” –The Mature Minor Doctrine*, 16 PACE L. REV. 423, 442-44 (1996) (discussing guidelines set by the Midwest



psychology and neuroscience research regarding adolescent brain development and decision-making to determine whether minors are mature.<sup>91</sup>

Unlike minors, adults are presumed legally competent to make informed medical decisions even if they possess “far from ideal” reasoning ability.<sup>92</sup> Developmental studies in pediatric and health psychology suggest that adolescents, however, are no less competent than adults to make informed medical decisions.<sup>93</sup> In fact, comprehensive studies have reported that adolescents are capable of making independent medical decisions even with parental influence.<sup>94</sup> For instance, in the context of pregnancy decision-making, studies suggest “adolescents aged 14-17 appear to be similar to legal adults in both cognitive competence and volition.”<sup>95</sup> Drawing on these and related studies, another study found that 96 percent of physicians approach medical practice with adolescent patients as if adolescents are capable of making informed decisions.<sup>96</sup>

Conversely, recent research in developmental psychology and neuroscience has shown that adolescents are less capable of mature judgment than adults and more vulnerable to negative influences.<sup>97</sup> Elizabeth Cauffman, a professor of psychology at the University of California, Irvine, is a leader in the study of juvenile delinquents. Cauffman’s influential studies show that adolescents

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Bioethics Center Task Force on Health Care Rights for Minors, *Health Care Treatment Decision-Making Guidelines for Minors*, Bioethics F., Winter 1995).

<sup>91</sup> See, e.g., Laurence Steinberg, *Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?*, J. MED. PHILOS. 38(3): 256-67 (2013) (providing that the Supreme Court has drawn on the science of brain development to answer questions surrounding the mature minor doctrine).

<sup>92</sup> Gary B. Melton, *Parents and Children: Legal Reform to Facilitate Children’s Participation*, 54 AM PSYCHOL 935, 937 (1999).

<sup>93</sup> See Thomas Grisso & Linda Vierling, *Minors’ Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 423 (1978) (“[T]here is little evidence that minors of age 15 and above as a group are any less competent to provide consent than are adults”).

<sup>94</sup> David G. Scherer & Nicholas D. Reppucci, *Adolescents’ Capabilities to Provide Voluntary Informed Consent: The Effects of Parental Influence and Medical Dilemmas*, 12 LAW & HUM. BEHAV. 123, 135 (reporting that adolescents reserve “the prerogative to make treatment decisions that have consequential bearing on their lives”).

<sup>95</sup> Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents’ Psychological and Legal Competence to Consent to Abortion*, 16 LAW & HUM. BEHAV. 129, 148 (1993) (noting that adolescents “remain competent decision makers when facing an emotionally challenging real world decision),

<sup>96</sup> Hartman, Rhonda Gay, *Adolescent Decisional Autonomy for Medical Care: Physician Perception and Practices*, *The University of Chicago Law Roundtable* (2001).

<sup>97</sup> See, e.g., Brief for American Psychological Association et. al. *Amici Curiae* (“It is increasingly clear that adolescent brains are not yet fully mature in regions and systems related to higher-order executive functions such as impulse control, planning ahead, and risk avoidance”).

have an underdeveloped prefrontal cortex until the age of 25. And in *Miller v. Alabama*, the Supreme Court referenced Cauffman’s research when it declared that mandatory sentences of life without the possibility of parole are unconstitutional for juvenile offenders.<sup>98</sup>

### *C. Exceptions to Parental Consent*

One of the bedrock tenets of pediatric health and tort law is that parents generally have the right to make medical decisions for their children. Under limited circumstances, state legislatures have created exceptions to parental consent requirements.<sup>99</sup> For instance, in medical emergencies, physicians may undertake medical treatment on minors without parental consent. Additionally, emancipated minors may also consent to medical treatment without parental consent. While jurisdictions vary in their definition of emancipation, a widely accepted definition of an emancipated minor is “one whose parents have completely surrendered care, custody, and control of the child, have no involvement in the child’s earnings, and have renounced parental duties.”<sup>100</sup> A minor may also be considered emancipated based on status, such as marriage or military service.<sup>101</sup>

States have also codified exceptions through legislation.<sup>102</sup> Similar to the traditional common law exceptions, state statute exceptions were enacted to address specific diseases, conditions, or treatments. For example, during the 1960s states became concerned about an increase in sexually transmitted diseases (STD) among adolescents, and thus enacted laws to help curb this

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<sup>98</sup> *Miller v. Alabama*, 597 U.S. \_\_ (2012) (noting that the decision “rested not only on common sense—on what ‘any parent knows’—but on science and social science as well”).

<sup>99</sup> See, e.g., Rhonda G. Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J. L. AND MED. 409, 416-22 (2002) (reviewing states statutes on minors medical decision-making).

<sup>100</sup> Elizabeth J. Sher, *Choosing for Children: Adjudicating Medical Care Disputes between Parents and the State*, 58 N.Y.U.L REV. 157, 158 n.5 (1953).

<sup>101</sup> *Emancipation of Minors*, LEGAL INFORMATION INSTITUTE, [https://www.law.cornell.edu/wex/emancipation\\_of\\_minors](https://www.law.cornell.edu/wex/emancipation_of_minors) (last revisited Dec. 4, 2015).

<sup>102</sup> See generally Jenifer L. Rosato, *The Ultimate Test of Autonomy Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS LAW REVIEW 49:1-103, 25 (1996).

public health concern.<sup>103</sup> Over the past 30 years, all 50 states and the District of Columbia have passed laws that expand minors’ right to consent to STD services without parental consent.<sup>104</sup> Moreover, minors may consent to medical care or counseling services related to diagnosis or treatment of drug and/or alcohol abuse without parental consent, if the health facility receives any grant assistance.<sup>105</sup> Furthermore, minors aged 14 and older may consent to in-patient mental health treatment as long as they knowingly and voluntarily consent.<sup>106</sup> The logic behind granting minors the right to receive STD, drug/alcohol, and psychiatric medical treatment without parental consent is rooted in the state’s interests to protect the public from health-related incidents,<sup>107</sup> and not on the belief that minors have the mental capacity to make medical decisions for themselves.<sup>108</sup>

### III. CREATING SPECIALIZED HEALTH CARE COURTS

The question of whether competent, terminally ill minors should have the right to refuse LSMT raises many legal and ethical issues. In the effort to address this controversial dilemma, this Paper argues that the best institutional process to answer this question should rest on specialized health care courts rather than generalist courts. The reliance on generalist courts undermines the Rule of Law, because it leaves questions of life and death to be determined by judges that may be ill equipped to understand, appreciate, and comprehend the nuisances and implications of end-of-

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<sup>103</sup> Parental Notification Requirements Applicable to Projects for Family Services, 48 Fed. Reg., 3600, 3614 [Title X] (1983).

<sup>104</sup> Heather Boonstra & Elizabeth Nash, Minors and the Right to Consent to Health Care, The Guttmacher Report on Public Policy (2000).

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Gibbons v. Ogden*, 22 U.S. 1, 203 (1824) (opinion of MARSHALL, C. J.) (noting that police powers “form a portion of that immense mass of legislation which embraces everything within the territory of the state, not surrendered to the general government; all of which can advantageously be exercised by the states themselves. Inspection laws, quarantine laws, health laws of every description . . . are component parts of this mass.”); *see also* *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (holding that the state’s interest in preserving public health and safety can trump the individual’s right to bodily integrity).

<sup>108</sup> In addition to public health and medical exceptions, state legislatures have historically treated minors as adults in the criminal justice system. For example, thousands of minors have been sentenced as adults and sent to adult prisons. Perhaps even more staggering is that at least 3000 minors have been sentenced to life imprisonment without the possibility of parole—some as young as 13 years of age.

life care. This section describes the constitutional authority to create specialized courts, the pros and cons of developing specialized courts, and the reasons why a specialized health care court is best suited to adjudicate end-of-life cases.

Article III of the U.S. Constitution provides that “the judicial Power of the United States [] shall be vested in one Supreme Court, and in such inferior courts as the Congress may from time to time ordain and establish.”<sup>109</sup> Following the ratification of the U.S Constitution, Congress created a multitude of federal generalist tribunals (i.e., trial courts, district courts, and appellate courts) to adjudicate a variety of legal disputes.<sup>110</sup> The Supreme Court has since also recognized that “the Constitution [gives] Congress wide discretion to assign the task of adjudication in cases arising under federal law to legislative tribunals.”<sup>111</sup> While the majority of federal courts are considered generalist courts, Congress has used its Article I legislative power to create specialized courts to adjudicate specific areas of the law. For example, Article I, section 8 of the Constitution enables Congress to enact “uniform Laws on the subject of Bankruptcies[.]”<sup>112</sup> The Bankruptcy Reform Act of 1978 established the U.S. Bankruptcy Court, and granted judges authority to handle matters regarding bankruptcies, both individual and corporate.<sup>113</sup> Additionally, in 1969, Congress created the U.S. Tax Court to relieve generalist courts from the burden of time-consuming, tax-related cases.<sup>114</sup> In addition to specialized federal courts, state legislatures have created specialized state

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<sup>109</sup> See U.S. CONST. art. III, §1.

<sup>110</sup> *Id.* (The Judges ... shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office”).

<sup>111</sup> *Freytag v. Commissioner*, 501 U.S. 868, 889 (1991); see also *American Insurance Co. v. Canter*, 1 Pet. 511, 546 (1828) (Marshall, C.J.) (“These Courts, then, are not constitutional Courts . . . They are legislative Courts, created in virtue of the general right of sovereignty which exists in the government, or in virtue of that clause which enables Congress to make all needful rules and regulations, respecting the territory belonging to the United States”).

<sup>112</sup> U.S. CONST. art. I, § 8, cl. 4.

<sup>113</sup> 28 U.S.C. §151 (providing bankruptcy judges in each district shall constitute bankruptcy court).

<sup>114</sup> Markus B. Zimmer, *Overview of Specialized Courts*, INTL. J. CT. ADMIN., <http://www.iaca.ws/files/LWB-SpecializedCourts.pdf> (last visited Jan. 6, 2016).

courts—most notably in the areas of family law, administrative law, and criminal law.<sup>115</sup>

Specialized courts offer several benefits to the judicial system. First, unlike generalist courts, specialized courts allow judges to become experts in a particular subject matter (e.g. bankruptcy, tax, international trade). This expertise derives not only from their academic, professional, and extralegal training, but also through on-going experience as specialized judges.<sup>116</sup> The basic tenet behind the expertise-based argument is that judges who specialize in a narrow area of the law are better equipped to resolve complex cases.<sup>117</sup> This complexity may stem from an intricate statutory scheme, or “may involve deeper difficulties in determining how a particular case fits within the doctrinal and policy contours of the applicable body of law.”<sup>118</sup> In theory, a judge that presides over a specialized Tax Court<sup>119</sup> is perhaps more capable of resolving a derivatives-related dispute than a generalist judge that presumably has a basic understanding of tax law. In many instances, generalist courts are ill equipped to resolve multifaceted health care related issues.<sup>120</sup> Second, the creation of specialized courts provides caseload relief for generalist courts burden by pending case backlogs. This, in effect, reduces the number of appeals. Third, proponents of judicial specialization argue that specialized courts create a more efficient-based system. As specialized courts become familiar with the relevant legal and factual framework, the belief is that judges will able to reach decisions more efficiently.<sup>121</sup>

It is evident that specialized courts have the potential to offer advantageous that generalist

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<sup>115</sup> Additional examples of specialized state courts include the following: environmental courts, tax courts, workers’ compensation courts, water, courts, land courts, small claims courts, drug courts, and business/commercial courts.

<sup>116</sup> Harold H. Bruff, *Specialized Courts in Administrative Law*, 43 ADMIN. L. REV. 329, 331 (1991) (noting that “[a]lthough it would not be efficient for generalized courts to emphasize expensive training in the background of their judges or staff, the opposite may be true of specialized courts.”).

<sup>117</sup> See, e.g., Lawrence Baum, *Probing the Effects of Judicial Specialization*, 58 DUKE L.J. 1667, 1676 (2009); Edward K. Cheng, *The Myth of the Generalist Judge*, 61 STAN L. REV. 519 (2008).

<sup>118</sup> Chad M. Oldfather, *Judging, Expertise, and the Rule of Law*, 89 WASH. U.L. REV. 847, 854 (2012).

<sup>119</sup> The United States Tax Court is a specialized court established under Article I of the U.S. Constitution. See also 26 U.S.C. § 7441. This court specializes in adjudicating disputes over federal income tax-related issues.

<sup>120</sup> The current medical liability system (medical malpractice) is one the most cited legal issue affecting health care.

<sup>121</sup> Rochelle C. Dreyfuss, *Specialized Adjudication*, 1990 BYU L. REV. 377 Article 9. 378 (“if, as common experience suggests, experts are better than laymen at dealing with matters in their special areas, the specialized judiciary should handle more efficiently, thereby reducing the number of judge-hours required to decide any given number of cases”).

courts may not; however, there are also shortcomings that emerge from creating specialized courts. For one, specialized judges may be more prone to judicial bias than generalist judges.<sup>122</sup> In other words, judges that specialize in a certain area of the law are likely to rule one way over another merely because of their background. While the same argument can be made for generalist judges, the distinction is that generalist judges face a wider spectrum of cases, and thus unlikely to have a strong opinion for each subject matter. Additionally, specialized courts may stagnate necessary debate on a Supreme Court ruling before hearing conflicting federal circuit opinions.<sup>123</sup> Another disadvantage may be the loss of a generalist perspective. For instance, specialized judges may have the potential for insularity, and thus lack the ability to gauge changing doctrinal trends.<sup>124</sup>

Despite its miniscule disadvantages, specialized health care courts support the universal tenets of fairness and access to justice. Requiring litigants to adjudicate issues of end-of-life care before a generalist court undermines the Rule of Law, because it fails to provide litigants an adequate, fair, and accessible legal forum. The creation of specialized health care courts would therefore restore the Rule of Law and the jurisprudential integrity of the legal system.

## CONCLUSION

The question of whether a competent, terminally ill minor should have the right to refuse LSMT is perhaps the most intimate, personal, and difficult decision a person could possibly face. While the concepts of physician-assisted suicide and euthanasia are undoubtedly taboo and

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<sup>122</sup> See Edmund Ursin, *How Great Judges Think: Judges Richard Posner, Henry Friendly, and Roger Traynor on Judicial Lawmaking*, 57 BUFF. L. REV. 1267, 1282 (2009) (explaining that personal background and professional experience are factors in judicial decision making).

<sup>123</sup> Robert M. Howard & Shenita Brazelton, *Specialization in Judicial Decision Making: Comparing Bankruptcy Panels and Federal District Court Judges*, 22 AM. BANKR. INST. L. REV. 407, 409 (2014) (noting that [a] national appellate tax court, for example, would foreclose any generalist circuit from offering an opinion in that area and stop the Supreme Court from having the benefit of the conflict of ideas and opinions”).

<sup>124</sup> Simon Rifkind, *A Specialized Court for Patent Litigation? The Danger of a Specialized Judiciary*, 37 A.B.A. J. 425, 425 (1951) (“In time such a body of law, secluded from the rest, develops a jargon of its own, thought-patterns that are unique, internal policies which it subserves and which are different from and sometimes at odds with the policies pursued by the general law”).

controversial, especially in the context of minors, they are nevertheless salient public health, legal, and ethical issues that need to be addressed to reconcile the patchwork of legal and medical doctrines that currently define this subject. State legislatures have made significant progress in the Death with Dignity movement; however, minimal progress, if any, has been made on whether competent, terminally ill minors should have the right to physician-assisted suicide.

Equally important is the question of who has the power to make these decisions. Given the seriousness of this topic, it is important to create a fair and just adjudicative process. Requiring litigants to present an end-of-life case before a generalist judge undermines the Rule of Law because it fails to provide litigants with a fair tribunal—a tribunal with competent and efficient judges that understand the intricacies and complexities concerning physician-assisted suicide. While generalist judges are capable of presiding over a wide-spectrum of cases and subject matters, the stakes concerning end-of-life care are too high to deprive litigants from accessing judges who are experts in the field. To this end, the creation of specialized health care courts would serve to restore the Rule of Law in the context of end-of-life care.

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