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Children's Medical Care in California: Conflicts Between Parent, Child, and State

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Children's Medical Care in California: Conflicts Between Parent, Child, and State

I. Introduction

Jessica, twelve years old, suffers from paralytic scoliosis. Due to acute curvature of the spine, Jessica is unable to stand or walk. Doctors recommend spinal surgery to relieve Jessica's bent position and to restore mobility. Jessica's parents, however, oppose the recommended surgery. The parents are Jehovah's Witnesses who believe that the "eating" of blood is explicitly forbidden by the law of God. Without the parents' permission to administer blood, the surgeons refuse to undertake the risk of surgery. An orthopedic specialist is prepared to testify that the surgery results in a complete recovery in ninety percent of the cases. Ten percent of patients show little or no improvement. The specialist further is willing to state that the operation becomes medically less feasible as time passes. There is no evidence that Jessica's life or general health are in danger.

Assuming that the local social services department has petitioned the court to have Jessica declared a dependent child in order that the surgery can be performed, how should this case be decided? Does the basis of the parents' objection make a difference? For example, do their religious beliefs constitute a kind of constitutional trump card which bars fur-

1. Jehovah's Witnesses commonly cite the following Biblical passages to substantiate objections to blood transfusions: Genesis 9:4 ("I give you everything, with this exception: you must not eat flesh with life, that is to say blood, in it."); Leviticus 17:14 ("For the life of all flesh is its blood, and I have said to the sons of Israel: You must not eat the blood of any flesh, for the life of all flesh is in its blood, and anyone who eats it shall be outlawed from his people."); and Acts 15:19-20 ("I rule, then, that instead of making things more difficult for pagans who turn to God, we send them a letter telling them merely to abstain from anything polluted by idols, from fornication, from the meat of strangled animals and from blood.").

2. "Scoliosis may be a chronic and progressive disorder." Mayo Clinic Family Health Book 994 (David E. Larson ed., 1990). "If left unchecked, the vertebrae at the scoliotic curve will rotate, resulting in widely separated ribs on one side of the body and narrow spaces on the other. In severe cases, heart and lung problems may develop over a period of many years." Id.
ther judicial considerations? Should a twelve-year-old child have a voice with regard to the proposed treatment? Does the non-life threatening nature of the treatment favor intervention or not? Should a court consider the rate of success in deciding whether to follow the parents’ decision? What weight, if any, should a court give to the parents’ lack of an alternative treatment proposal? Should the decreasing likelihood of success affect the willingness of a court to intercede?

California does not currently have a consistent body of case law to guide courts in making these decisions. That is not to say that California courts have not addressed any such cases, but rather that the appellate courts have not employed any consistent standard in deciding them.\(^3\) The lone California Supreme Court decision in the area is *Walker v. Superior Court*.\(^4\) There, the court considered whether a mother may be criminally prosecuted for failing to provide medical care for her daughter.\(^5\) The California Supreme Court, however, has yet to address the underlying decisional dilemma of a conflict between parents and the state.

This comment explores the various issues involved in medical decisionmaking for minors. Part II illustrates the confusing and at times conflicting analyses used by various courts to decide these difficult cases.\(^6\) Part III delineates the issue.\(^7\) Part IV identifies the reasons for and against intervention given by the parents, child, and state, and sorts them into a logical pattern.\(^8\) Part V proposes that the legislature adopt a statute providing specific factors that trial courts must consider in deciding these cases.\(^9\)

## II. Background

### A. California Cases

1. In re Phillip B.

In *In re Phillip B.*,\(^10\) the First District Court of Appeals considered the issue of whether parents have the right to re-

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3. See infra part II.A.
6. See infra part II.
7. See infra part III.
8. See infra part IV.
9. See infra part V.
fuse medical care for their child. Phillip was a twelve-year-old boy with Down's Syndrome. He suffered from a congenital heart impairment called a ventricular septal defect, a hole between his right and left ventricles. Because of this hole, Phillip's heart had to work three times harder than normal. When he overexerted, blood traveled the wrong way through the hole, and unoxgenated blood circulated throughout his body. Without corrective surgery, Phillip's lungs would eventually be unable to carry and oxygenate sufficient blood. With continued deterioration, Phillip would suffer from a loss of vitality until he was forced to lead a bed-to-chair existence. Death would eventually result.

Phillip's parents refused to consent to corrective surgery. The primary reason for their decision was the fact that Phillip was mentally disabled. They asserted that since Phillip's life was not, in their estimation, a "life worth living," it should not be extended by the surgery. The surgery involved a comparatively low mortality rate of five to ten percent, as well as the risks of postoperative complications faced by all Down's Syndrome children. The doctors agreed that Phillip would enjoy a significant extension of his life if the corrective surgery was successful. Without surgery, Phillip had a life expectancy of only twenty additional years.

The juvenile probation department brought the matter before the juvenile court, seeking a court order permitting the

11. In re Phillip B., 156 Cal. Rptr. at 49-50.
12. Id. at 50.
13. Id.
14. Id.
15. Id.
16. In re Phillip B., 156 Cal. Rptr. at 50.
17. Id.
18. Id.
19. Id.
21. "The consequences flowing from adoption of this 'quality of life' idea are staggering. In short, it would base the saving of human life on certain mental or physical performance standards." Id. See generally Joseph Goldstein, Medical Care for the Child at Risk: On State Supervention of Parental Autonomy, 86 Yale L.J. 645 (1977).
22. In re Phillip B., 156 Cal. Rptr. at 50.
23. Id.
24. Id.
In holding that there was no substantial evidence to overrule the trial court's decision to dismiss the petition, the appellate court provided several factors to be considered before a state insists on medical treatment rejected by the parents:

The state should examine the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm; the evaluation for the treatment by the medical profession; the risks involved in medically treating the child; and the expressed preferences of the child. Of course, the underlying consideration is the child's welfare and whether his best interests will be served by the medical treatment.

The appellate court, however, did not apply these factors in Phillip B. Rather, it simply affirmed the trial judge's decision. The appellate court explained, "[T]he power of the appellate court begins and ends with a determination as to whether there is any substantial evidence, contradicted or uncontradicted, which will support the conclusion of the trier of fact." Thus, while recognizing the problem, the court avoided providing binding authoritative guidance to the trial courts.

2. In re Eric B.

Eight years after Phillip B., the First Appellate District revisited the issue of court-ordered medical care for minors in In re Eric B. Eric was three years old when his parents noticed a problem with one of his eyes and took him to a physician. The initial diagnosis was glaucoma, but additional testing revealed that Eric had retinal blastoma, or eye cancer. Eric's left eye was surgically removed at the express

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25. Id. at 48.
26. Id.
27. In re Phillip B., 156 Cal. Rptr. at 51.
28. Id. at 52.
29. Id. at 51.
30. 235 Cal. Rptr. 22 (Ct. App. 1987).
31. In re Eric B., 235 Cal. Rptr. at 23.
32. Id.
request and authorization of his parents. Tests conducted after the surgery raised the probability that not all of the cancer had been removed. Chemotherapy and radiation were recommended. Eric's parents opposed the recommended treatment. They preferred to continue Eric's regular visits with a Christian Science practitioner, which had started before the operation.

The social services department filed a petition to have Eric declared a dependent child to allow the treatment to be implemented. The juvenile court "conducted a series of hearings at which it heard evidence regarding the extremely high statistical probability that, without medical treatment, the cancer would reappear and that Eric might possibly die." The juvenile court sustained the petition, and Eric's parents complied with the court-ordered therapy program.

Upon completion of the program, the physician recommended that Eric enter a two year "observation phase." The physician testified that none of the tests conducted during Eric's therapy program had revealed the presence or recurrence of cancer. Nevertheless, he stated, "[W]e feel there is about a 25 percent chance he might have a recurrence and about a five to ten percent chance he might have a

33. Id.
34. Id.
35. Id.
36. In re Eric B., 235 Cal. Rptr. at 23.
37. The Christian Science practitioner's vocation is one to which any committed and qualified Christian Scientist may aspire. The religious training is essentially a self-conducted study, centering on the Bible and the Christian Science textbook, Science and Health with Key to the Scriptures by Mary Baker Eddy. The practitioner must also complete a short course of intensive instruction from any authorized teacher of Christian Science. Robert Peel, The Christian Science Practitioner, in CHRISTIAN SCIENCE: A SOURCEBOOK OF CONTEMPORARY MATERIALS 137, 137-38 (The Christian Science Publishing Society, 1990). [T]he practitioner's diagnosis is neither medical nor psychological, in the accepted sense of that word, but spiritual. The same thing is true of his treatment. Essentially it is prayer, as the word is understood in Christian Science, and such discussion or counseling as he may carry on with the patient is distinctly subservient to his silent prayer, or metaphysical treatment.

Id. at 140.
38. In re Eric B., 235 Cal. Rptr. at 23.
39. Id.
40. Id.
41. Id.
42. Id.
second tumor. . . . So . . . [t]here is maybe a 40 percent chance he would die if there's nothing monitored and nothing done about it." Eric's parents opposed continuing conventional medical remedies.\footnote{Id. at 27.} A referee ordered a continuation of Eric's dependent child status.\footnote{Id. at 24.} The juvenile court rejected the parents' motion for reconsideration, and the parents appealed.\footnote{Id.}

The appellate court upheld the referee's order to continue Eric's dependency status.\footnote{In re Eric B., 235 Cal. Rptr. at 27.} The court found "substantial evidence supporting the referee's finding that Eric's best interests would not be served by exposing him to [the] possible peril [of a recurrence of cancer]."\footnote{Id.} Again, the substantial evidence rule\footnote{Witkin states the rule in a discussion of the sufficiency of evidence: \textit{Where the evidence is in conflict, the appellate court will not disturb the verdict of the jury or the findings of the trial court.} The presumption being in favor of the judgment . . . the court must consider the evidence in the light most favorable to the prevailing party, giving him the benefit of every reasonable inference, and resolving conflicts in support of the judgment.\textsuperscript{9} \textsc{Witkin}, \textit{Appeal} § 278 (3d ed. 1985) (citation omitted).} allowed the court to avoid setting guidelines for the use of trial courts.

3. In re Petra B.

The Fourth Appellate District also addressed the issue of court-ordered medical care for minors in \textit{In re Petra B.}\footnote{265 Cal. Rptr. 342 (Ct. App. 1989).} Petra was accidentally burned on her face, neck, and upper chest.\footnote{In re Petra B., 265 Cal. Rptr. at 343.} The burns covered four percent of her body.\footnote{Id.} Petra's parents chose to treat her with wheat germ oil, golden-seal, comfrey, myrrh, and cold water.\footnote{Id.} Petra's mother believed that "'God created the herbs for our use, and that he created our body [sic] to repair themselves.'"\footnote{Id.} The parents
did not take Petra to the hospital because they did not believe Petra's condition was serious.\textsuperscript{56}

Eight days after the initial injury, the parents were contacted by a social worker, and Petra was taken to a medical center for an examination.\textsuperscript{57} The doctor found that the majority of Petra's wounds had "'no significant budding or evidence of healing.'"\textsuperscript{58} He also found that Petra had an infection that was unlikely to improve without intervention.\textsuperscript{59} Since the wounds were too deep to heal, skin grafts were performed for coverage and to prevent infection.\textsuperscript{60} The doctor suggested that revision surgery for cosmetic reasons might be advisable in the future.\textsuperscript{61}

The department of social services filed a petition to have Petra declared a dependent child because her parents were failing to provide adequate medical care.\textsuperscript{62} The juvenile court upheld the petition.\textsuperscript{63} The court declared Petra a dependent child, placed her with the parents, and ordered the parents to participate in a maintenance plan to become "'more acquainted with first-aid issues and medical care issues.'"\textsuperscript{64} Petra's parents appealed.\textsuperscript{65}

The appellate court upheld the juvenile court's decision to intervene.\textsuperscript{66} The court again relied on the lower court's decision, stating that the evidence "was sufficient to support the trial court's assumption of jurisdiction,"\textsuperscript{67} and that the department of social services' intrusion into the family was

\textsuperscript{56} Id. at 342. Petra's mother explained that her Norwegian childhood influenced their decision:

In my family, we always — we were calm, waited to see — when an accident happened, we would be calm and we would wait around, because to go to a hospital, we would have to make a day's trip with a boat, and it's a big decision. So we usually waited to see of it was necessary, and that's [what] we did in this case, too.

\textit{Id.} at 346.

\textsuperscript{57} There is no indication in the opinion as to how Petra's condition was brought to the attention of the authorities. \textit{In re Petra B.}, 265 Cal. Rptr. at 342.

\textsuperscript{58} Id. at 343.

\textsuperscript{59} Id.

\textsuperscript{60} Id.

\textsuperscript{61} Id.

\textsuperscript{62} \textit{In re Petra B.}, 265 Cal. Rptr. at 343.

\textsuperscript{63} Id. at 344.

\textsuperscript{64} Id.

\textsuperscript{65} Id.

\textsuperscript{66} Id. at 347.

\textsuperscript{67} \textit{In re Petra B.}, 265 Cal. Rptr. at 345.
"amply justified."68 Interestingly, the appellate court suggested that it might have respected the parents' decision if that decision had been based on religious or cultural opposition to conventional medical treatment.69

B. Other States

Due to the relatively small number of judicial decisions on the issue of children's medical care in California, a sampling of cases from other jurisdictions is helpful to further illustrate the intricacies and inconsistencies surrounding medical decisionmaking for minors.

1. Newmark v. Williams

In Newmark v. Williams,70 the Supreme Court of Delaware decided whether to overrule the parents' decision to reject medical treatment for their son.71 Colin Newmark was three years old when he was diagnosed with Burkitt's Lymphoma, an aggressive pediatric cancer.72 The Newmarks were Christian Scientists who reluctantly took their son for a medical examination, reportedly acting out of a concern for their potential criminal liability.73

Colin's doctor recommended treatment with a heavy regimen of chemotherapy.74 The doctor opined that chemotherapy offered a forty percent chance of alleviating Colin's illness.75 She believed that Colin would die within six to eight months without the treatment.76 The Newmarks refused to authorize the chemotherapy, and instead proposed placing their son under the care of a Christian Science practitioner.77

The court briefly considered whether the state's religious exemptions in neglect and endangerment statutes were constitutional.78 Since neither party raised the constitutional is-

68. Id. at 347.
69. Id. at 346.
70. 588 A.2d 1108 (Del. 1990).
71. Newmark, 588 A.2d at 1109-10.
72. Id. at 1111. Colin's doctor testified that Burkitt's Lymphoma cancer cells double more rapidly than any other form of pediatric cancer, which inevitably results in a fast growing tumor. Id. at 1111 n.3.
73. Id. at 1110.
74. Id. at 1111.
75. Id.
76. Newmark, 588 A.2d at 1111.
77. Id.
78. Id. at 1111-13.
sue, however, the court decided to "leave such questions for another day." Thus, the court purportedly based its decision on factors other than religion.

The trial court rejected the Newmarks' proposal to treat Colin by spiritual means. The Delaware Supreme Court criticized the trial court's ad hoc approach and found that the lower court "erred in not explicitly considering the competing interests at stake." The court proposed a balancing test that weighed: (1) the primacy of the familial unit, (2) the special duty of the state to protect the health and safety of children, and (3) the right of children to enjoy a full and healthy life.

Ultimately, the court seemed to base its decision to uphold the Newmarks' refusal of treatment on the improbability of success. The court stated:

No American court, even in the most egregious case, has ever authorized the State to remove a child from the loving, nurturing care of his parents and subject him, over parental objection, to an invasive regimen of treatment which offered, as [Colin's doctor] defined the term, only a forty percent chance of "survival."

Colin died shortly after the court announced its oral decision.

2. In re E.G.

In In re E.G., the Illinois Supreme Court considered whether a minor has a right to refuse medical treatment. The E.G. issue was thus somewhat different from the above cases, where the courts were more concerned with whether a minor's parents could refuse treatment on behalf of their child.

E.G., seventeen years old, contracted leukemia and needed blood transfusions in the treatment of the disease.
E.G. and her mother, both Jehovah's Witnesses, refused to consent to the transfusions on the basis of their religious beliefs. Consequently, the State filed a neglect petition in juvenile court.

The treating doctor testified that E.G. had approximately one-fifth to one-sixth the oxygen-carrying capacity of normal blood, and therefore was excessively fatigued and incoherent. He stated that without blood transfusions, E.G. would likely die within a month. He testified that transfusions, with chemotherapy, result in remission of the disease in about eighty percent of all patients. He cautioned, however, that the survival rate for patients such as E.G. is only twenty to twenty-five percent.

The trial court ruled that E.G. was medically neglected, and appointed a guardian to consent to treatment. The appellate court noted that E.G. was only six months short of her eighteenth birthday. The court declared that she was partially emancipated and thus had the right to refuse transfusions.

The Illinois Supreme Court discussed several specific circumstances where minors are treated as adults. The court concluded that the common law right to consent to or refuse

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89. Id.
90. Id.
91. Id.
92. In re E.G., 549 N.E.2d at 323.
93. Id.
94. Id.
95. Id. at 324.
96. Id.
97. In re E.G., 549 N.E.2d at 324.
98. Id. at 325-27. For example, in Illinois, persons over age 12 may seek medical attention for venereal disease or substance addiction. ILL. ANN. STAT. ch. 410, para. 210/4 (Smith-Hurd 1993). Persons under age 18 who are married or pregnant may consent to medical treatment. ILL. ANN. STAT. ch. 410, para. 210/1 (Smith-Hurd 1993). Persons over age 16 may be declared emancipated. ILL. ANN. STAT. ch. 750, para. 30/1 (Smith-Hurd 1993). Similarly, persons under age 18 may be prosecuted under the Illinois Criminal Code if circumstances dictate. ILL. ANN. STAT. ch. 705, para. 405/5-4 (Smith-Hurd 1993).

medical care should extend to mature minors. The court stated that "the trial judge must determine whether a minor is mature enough to make health care choices on her own." The court, however, failed to delineate precisely how the trial judge is to determine whether a minor is "mature." In In re E.G., the lower court considered evidence regarding E.G.'s maturity that was provided by a psychiatrist who had special expertise in evaluating the maturity and competency of minors.

The court provided two principles for the trial judge to weigh against the evidence he or she receives regarding a minor's maturity. The trial judge must consider: (1) the sanctity of life ("A minor may have a long and fruitful life ahead that an immature, foolish decision could jeopardize.") and (2) the state's "parens patriae power to protect those incompetent to protect themselves.

C. Juvenile Justice Standards

The Juvenile Justice Standards Project is a series of volumes designed to cover the spectrum of problems pertaining to the laws affecting children. The Institute of Judicial Administration (IJA) began the project in 1971 and was joined by the American Bar Association (ABA) in 1973 as co-sponsor. The standards are intended to serve as guidelines for action by legislators, judges, administrators, public and private agencies, local civic groups, and others responsi-

100. Id. at 327.
101. Id. at 324. Based on interviews with E.G. and her family, the psychiatrist determined that E.G. had the maturity level of an 18- to 21-year-old. He further concluded that E.G. had the competency to make an informed decision to refuse the blood transfusions, even if this choice was fatal. Id.
102. Id. at 327.
103. Black's Law Dictionary defines "parens patriae:"
"Parens patriae," literally "parent of the country," refers traditionally to role of state as sovereign and guardian of persons under legal disability, such as juveniles or the insane, and in child custody determinations, when acting on behalf of the state to protect the interests of the child. It is the principle that the state must care for those who cannot take care of themselves, such as minors who lack proper care and custody from their parents.
106. Id. at v-vi.
ble for or concerned with the treatment of children at local, state, and federal levels. 107 National uniformity was a major goal of the project. 108 The summary volume, Standards for Juvenile Justice: A Summary and Analysis, explains, "It clearly is essential to a concept of fairness in juvenile law that an effort be made to remove inconsistencies in a juvenile's rights and liabilities that are caused by the accident of geography." 109

Standards Relating to Abuse and Neglect, which focuses on state intervention on behalf of children, "adopts family autonomy as a standard and strictly limits official intervention in families to cases of specific harm, requiring a clear showing that a child is or may be endangered before coercive action is authorized." 110 The pertinent standard provides:

2.1 Statutory grounds for intervention.

Courts should be authorized to assume jurisdiction in order to condition continued parental custody upon the parents' accepting supervision or to remove a child from his/her home only when a child is endangered in a manner specified in subsections A.-F.:

....

E. a child in need of medical treatment to cure, alleviate, or prevent him/her from suffering serious physical harm which may result in death, disfigurement, or substantial impairment of bodily functions, and his/her parents are unwilling to provide or consent to the medical treatment. 111

The commentary following standard 2.1(E) mandates that courts abstain from intervention unless the possible harm to the child is "very serious." 112 Further, the drafters comment, "[T]he standard does not require the court to abstain until the child is threatened with death. Any injury which may result in disfigurement or substantial impairment of bodily functioning would justify intervention." 113 Family autonomy is strongly supported.

107. Id. at v.
109. Id.
110. Id. at 25.
111. KAUFMAN, supra note 105, at 16-17.
112. Id. at 73.
113. Id.
The Juvenile Justice Standards Project's laudable goal of a national uniform rule is far from being fulfilled. For example, California has not adopted the standard. The vagueness of the terminology, plus the lack of specific procedural mandates, make it highly unlikely that courts of various jurisdictions using these standards will attain the desired uniformity.

III. IDENTIFICATION OF THE PROBLEM

The preceding cases and standards reveal the variety of approaches to medical decisionmaking for children. The inconsistencies between and within states make it almost impossible to predict the outcome of factually similar cases. In California, In re Phillip B., In re Eric B., and In re Petra B. demonstrate that similarly situated children do not receive equal treatment, since the standards for deciding whether to intervene remain undetermined. The one consistency appears to be a deference to the trial court's decision, irrespective of the outcome, as long as an identifiable evidentiary basis exists. Thus, exactly when the state will step in to ensure that a child receives necessary medical care remains unpredictable.

IV. ANALYSIS

Professor Walter Wadlington of the University of Virginia described the conflicting goals of "children's rights" advocates. He explained:

One group of "children's rights" proponents has the goal of increasing autonomy for children in many or all aspects of decision-making. Another group wishing to march under the same banner promotes expanded state involvement to protect children against their parents and themselves, as well as the rest of the world. Yet another group asserts that children's rights should be fungible with family rights, which is often another way of saying that children should have few rights and that the state should protect parental decision-making in all but dire instances.

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114. See supra part II.A.1.
115. See supra part II.A.2.
116. See supra part II.A.3.
Wadlington's comment points out the tension between child, state, and parent in medical decisionmaking for children. His tripartite division corresponds to the competing interests generally recognized by the courts and law review commentators. In *In re E.G.*, for example, the Illinois Supreme Court argued by analogy for the extension of circumstances where minors are treated as adults. In *In re Petra B.*, a California court of appeals affirmed the state's duty to protect children. And, in *In re Phillip B.*, a California appellate court emphasized a preference for parental autonomy. All of these cases are decided under the broad rubric of "children's rights."

A. Parental Interest

Historically, courts have shown great deference to the concept of parental autonomy. Blackstone is cited for the proposition that "natural bonds of affection lead parents to act in the best interests of their children." Modern courts, however, are more willing to question parental motives. Wadlington observed that "[c]iting Blackstone for such a proposition seems anomalous today, considering that in Blackstone's time only the father had parental rights, and children were valued specially for their economic potential."

Nevertheless, parents continue to argue that the state's involvement in medical decisionmaking is an unwarranted governmental intrusion into the family in violation of the family's constitutional right to privacy. The California right to privacy is a fundamental right which is explicitly

119. 549 N.E.2d 322 (Ill. 1989).
120. See supra note 98.
121. 256 Cal. Rptr. 342 (Ct. App. 1989).
122. *In re Petra B.*, 256 Cal. Rptr. at 346.
124. *In re Phillip B.*, 156 Cal. Rptr. at 51.
125. See, e.g., *In re Tony Tuttendario, 21 Pa. D. 561, 563 (1912) ("We have not yet adopted as a public policy the Spartan rule that children belong, not to their parents, but to the state.").
127. Wadlington, supra note 117, at 332.
found in the state constitution. The California Supreme Court, however, has approved the idea that the right of privacy is not absolute. "The general concept of privacy can be viewed as encompassing a broad range of personal action and belief. However, that right, much as any other constitutional right, is not absolute. A court must engage in a balancing of interests rather than a deduction from principle to determine its boundaries." Thus, while parents have a legally protected privacy interest, it is not an unfettered right.

Rather than blindly relying on the presumed parental autonomy right, the California Supreme Court's adoption of a balancing test to determine the parameters of any privacy claim serves to encourage lower courts to weigh and consider all of the reasons offered by the parents for refusing medical care for their children. Similarly, the Juvenile Justice Standards encourage courts to respect the parents' objections. The commentary following standard 2.1(E) states, "[T]he basis of the parents' objection, whether religious or premised on a concern that the operation is too dangerous, should not be ignored by courts in deciding whether intervention is appropriate."

These reasons include the parents' assertion of religious freedom, the parents' choice of alternative treatments, the medically determined risks of treatment, and the parents' desire to avoid pain to the child. An examination of these various objections reveals that they are not of equal merit.

129. The California Constitution provides: "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness and privacy." CAL. CONST. art. I, § 1.
132. See supra part II.C.
133. See supra text accompanying note 111.
134. KAUFMAN, supra note 105, at 74.
135. See infra part IV.A.1.
136. See infra part IV.A.2.
137. See infra part IV.A.3.
138. See infra part IV.A.4.
1. Religious Freedom

In 1944, the U.S. Supreme Court stated in *Prince v. Massachusetts:* \(^{139}\)

The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death. . . . Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full legal discretion when they can make that choice for themselves.\(^{140}\)

This language has often been quoted in judicial opinions and law review articles addressing religious objections to conventional health care for children. Despite its widespread use, however, it has not ended the debate and inquiry surrounding the topic of religious exemptions.

In California, it is still not clear whether religion acts as a trump card, eliminating the consideration of any other potentially relevant factors in parental decisionmaking about children's medical care. In *In re Petra B.*, \(^{141}\) the court suggested that if the parents' objections had been based on religious or cultural grounds, they might have prevailed. The court stated:

Petra's parents did not seek conventional medical treatment not because they had a religious or cultural opposition to conventional medical treatment but because they believed Petra's condition was not serious enough to warrant taking her to a hospital. Their decision not to take Petra to the hospital was based on their medical assessment of Petra's physical condition, not on a religiously or culturally based opposition to hospitalization.\(^{142}\)

This language implies that if the parents had based their decision on religious grounds, the court might well have bowed to their choice despite other factors. Since the parents, and therefore the court, did not rely on a religion-based claim, however, the comment is dictum.

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142. *In re Petra B.*, 265 Cal. Rptr. at 346.
In *In re Eric B.*, the referee stated that he would not allow Eric to be treated exclusively by spiritual means absent a showing that it would be one hundred percent effective. The parents contended, however, that California recognizes "the validity of treatment by spiritual means alone." The parents based their position on Welfare and Institutions Code section 300.5, which provides:

In any case in which a minor is alleged to come within the provisions of Section 300 on the basis that he or she is in need of medical care, the court, in making such finding, shall give consideration to any treatment being provided to the minor by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner thereof. The court noted that "section 300.5 does not specify what conclusion(s) should be drawn from the fact that a minor is receiving 'treatment... by spiritual means' instead of conventional medical treatment." Acknowledging that a court must "give consideration to any treatment being provided to the minor by spiritual means," the court asserted that it remained free to conclude that spiritual treatment alone was not sufficient to arrest a danger which otherwise requires that a minor be declared a dependent of the court in order to receive traditional medical treatment considered more likely to succeed.

California Penal Code section 270 also deals with the subject of religious objections. Section 270 provides in pertinent part:

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143. 235 Cal. Rptr. 22 (Ct. App. 1987).
144. *In re Eric B.*, 235 Cal. Rptr. at 29.
145. *Id.* at 28.
146. Welfare and Institutions Code section 300 provides in pertinent part: Any person under the age of 18 years who comes within any of the following descriptions is within the jurisdiction of the juvenile court which may adjudge such person to be a dependent child of the court: (a) Who is in need of proper and effective parental care or control and has no parent or guardian, or has no parent or guardian willing to exercise or capable of exercising such care or control, or has no parent or guardian actually exercising such care or control.

147. *Id.* § 300.5 (West 1984).
149. CAL. WELF. & INST. CODE § 300.5 (West 1984).
150. *In re Eric B.*, 235 Cal. Rptr. at 28.
If a parent of a minor child willfully omits, without lawful excuse, to furnish necessary clothing, food, shelter or medical attendance, or other remedial care for his or her child, he or she is guilty of a misdemeanor.

If a parent provides a minor with treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, by a duly accredited practitioner thereof, such treatment shall constitute "other remedial care", as used in this section.\(^\text{151}\)

Justice Mosk, concurring in \textit{Walker v. Superior Court},\(^\text{152}\) raised the issue of whether the religious exemption of section 270 is constitutional.\(^\text{153}\) He expressed the view that "the statutory exemption as it now reads plainly violates the establishment clauses."\(^\text{154}\) Mosk explained:

By sparing the favored from criminal liability while condemning others for failure to cloak identical conduct in the mantle of a sanctioned denomination or procedure, the religious exemption of section 270 operate[s] without neutrality "in matters of religious theory, doctrine, and practice," and thus cannot survive in the absence of a compelling state interest in its discriminatory effect.\(^\text{155}\)

Thus, California remains without clear guidance on the ultimate effect of religious objections.

2. Alternative Treatments

In \textit{Custody of a Minor},\(^\text{156}\) the parents of a three-year-old boy suffering from acute lymphocytic leukemia brought a petition for review and redetermination of the child’s needs for care and protection.\(^\text{157}\) In the previous consideration of this same case,\(^\text{158}\) the Supreme Court of Massachusetts had or-

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\(^{151}\) \textit{CAL. PENAL CODE} § 270 (West 1988).
\(^{153}\) \textit{Walker}, 763 P.2d at 874 (Mosk, J., concurring).
\(^{154}\) \textit{Id.} at 873 (Mosk, J., concurring). The California and the United States Constitutions admonish the Legislature "to make no law respecting an establishment of religion." \textit{U.S. CONST. amend. I; CAL. CONST. art. I, § 4}.
\(^{155}\) \textit{Walker}, 763 P.2d at 876.
\(^{156}\) 393 N.E.2d 836 (Mass. 1979) [hereinafter \textit{Custody of a Minor (II)}].
\(^{157}\) \textit{Custody of a Minor (II)}, 393 N.E.2d at 837.
\(^{158}\) \textit{Custody of a Minor}, 379 N.E.2d 1053 (Mass. 1978) [hereinafter \textit{Custody of a Minor (I)}].
dered the parents to resume chemotherapy treatment for their son. The court upheld the trial judge's findings that "there is a substantial chance for a cure and a normal life for the child if he undergoes chemotherapy treatment. The uncontradicted medical testimony supports those conclusions, and no evidence of any alternative treatment consistent with good medical practice was offered." 

In the second proceeding, the parents accepted the necessity of having their child receive chemotherapy treatment, but also sought the right to administer a program of metabolic therapy. The Massachusetts Supreme Court upheld the trial judge's determination that "metabolic therapy was not only medically ineffective but was poisoning the child . . . the treatment was not consistent with good medical practice and, most important, was contrary to the best interests of the child." The court ignored the concept of family autonomy.

In contrast to Minor (II), the New York Court of Appeals in Matter of Hofbauer upheld the parents' decision to treat their son with metabolic therapy. Joseph Hofbauer, seven years old, was diagnosed with Hodgkin's disease. His parents, having "both serious and justifiable concerns about the deleterious effects of radiation treatments and chemotherapy," elected to take their son to a medical clinic in Jamaica, where a course of metabolic therapy was initiated. Joseph's father described his son as "a pioneer whose purpose was to establish the right of parents to make these decisions

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159. Id. at 1067.
160. Id. at 1056.
162. Custody of a Minor (II), 393 N.E.2d at 845.
164. Matter of Hofbauer, 393 N.E.2d at 1015.
165. Id. at 1011. "If Hodgkin's disease is treated early, the rate of cure is high. . . . Depending on the type of Hodgkin's disease you have, radiation therapy has an 80 to 90 percent success rate in such cases." The American Medical Association Family Medical Guide 433 (Charles B. Clayman ed., 3d ed. 1982).
166. Matter of Hofbauer, 393 N.E.2d at 1014.
167. Id. at 1011.
for their children and to keep Governor Carey and his face-
less bureaucrats out of the family."\textsuperscript{168}

The \textit{Hofbauer} court stated:

\[\text{[T]he court's inquiry should be whether the parents, once
having sought accredited medical assistance and having
been made aware of the seriousness of their child's afflic-
tion and the possibility of cure if a certain mode of treat-
ment is undertaken, have provided for their child a treat-
ment which is recommended by their physician and which
has not been totally rejected by all responsible medical
authority.}\textsuperscript{169}

\textit{Minor (II)} and \textit{Matter of Hofbauer}, two seemingly contra-
dictory cases, can be reconciled by the fact that the \textit{Hofbauer}
court was satisfied that the parents had provided substantial
evidence that they had "undertaken reasonable efforts to en-
sure that acceptable medical treatment [was] being provided
to their child."\textsuperscript{170} In \textit{Minor (II)}, however, the court found that
"the evidence was essentially uncontested that metabolic
therapy for [the] child [was] useless and dangerous."\textsuperscript{171} To-
gether, these cases seem to suggest that a parental decision
in favor of a medically unrecognized treatment will be upheld
if the parents can convince the court that the alternative
method is viable and has not been "totally rejected"\textsuperscript{172} by the
medical community.

In California, the \textit{Petra B.} court repudiated the parents'
decision to treat their daughter's burns with wheat germ oil,
goldenseal, comfrey, myrrh, and cold water.\textsuperscript{173} The lower
court had addressed the parents:

\begin{quote}
You certainly have a lifestyle that is unconventional, and
more power to you for that. . . . But the one thing that
disturbs me is the unconventional treatment, and I would
cautions you to not substitute unconventional treatment
with conventional treatment—conventional medical opin-
ion and treatment, when it comes to the care of your
children.\textsuperscript{174}
\end{quote}

\begin{itemize}
\item \textsuperscript{168} Walter H. Waggoner, Boy, 10, in Laetrile Case Dies, N.Y. TIMES, July
\item \textsuperscript{169} \textit{Matter of Hofbauer}, 393 N.E.2d at 1014.
\item \textsuperscript{170} \textit{Id}.
\item \textsuperscript{171} Custody of a Minor (II), 393 N.E.2d 836, 846 (Mass. 1979).
\item \textsuperscript{172} \textit{Matter of Hofbauer}, 393 N.E.2d at 1014.
\item \textsuperscript{173} \textit{In re Petra B.}, 265 Cal. Rptr. 342, 342-43 (Ct. App. 1989).
\item \textsuperscript{174} \textit{Id}. at 344.
\end{itemize}
The lower court admitted that the herbal treatment might have been reasonable if the burns had been mild, but in this case the parents should have recognized that the burns were serious.\textsuperscript{175} Petra B. suggests that California, like Massachusetts\textsuperscript{176} and New York,\textsuperscript{177} is willing to tolerate a parental preference for alternative treatment, provided the treatment offers possible healing. The court will not, however, allow unbridled parental discretion that rests on little or no medical evidence.

3. \textit{Risks of Treatment}

In \textit{Newmark v. Williams},\textsuperscript{178} the court decided that it would be in the child's best interests to permit the parents to retain custody of their son and to make the treatment decisions.\textsuperscript{179} The court was especially persuaded by the low odds of successful treatment.\textsuperscript{180} The court reviewed the medically determined odds in several other cases\textsuperscript{181} and concluded, "[C]ourts have consistently authorized state intervention when parents object to only minimally intrusive treatment which poses little or no risk to a child's health."\textsuperscript{182}

Wadlington questions the utility of the \textit{Newmark} criteria. He writes, "To many, a forty percent chance of survival when the alternative is near-term death is not bad odds. And in some cases, one could equally dramatize both the agonies

\begin{itemize}
\item \textsuperscript{175} Id.
\item \textsuperscript{176} Custody of a Minor (II), 393 N.E.2d 836, 836 (Mass. 1979).
\item \textsuperscript{177} Matter of Hofbauer, 393 N.E.2d at 1009.
\item \textsuperscript{178} 588 A.2d 1108 (Del. 1990).
\item \textsuperscript{179} Newmark, 588 A.2d at 1120-21.
\item \textsuperscript{180} See supra text accompanying note 84.
\item \textsuperscript{181} Newmark, 588 A.2d at 1119-20. See, e.g., \textit{In re Long Island Jewish Medical Ctr.}, 557 N.Y.S.2d 239, 241 (App. Div. 1990) (ruling that the State could intervene and order chemotherapy treatments over a parent's religious objections when the medical care presented a 75\% chance of short-term remission, but only a 25\% to 30\% chance for cure); \textit{In re Willmann}, 493 N.E.2d 1380, 1382, 1388 (Ohio 1986) (awarding custody of a minor suffering from osteogenic sarcoma to the State when his parents consented to chemotherapy, but later refusing to authorize an operation to partially remove his shoulder and entire left arm, where, although amputation is extremely invasive, there was at least a 60\% chance that the child would survive with the operation); \textit{In re Hamilton}, 657 S.W.2d 425, 427, 429 (Tenn. 1983) (awarding custody of a minor suffering from Ewing's Sarcoma to the State after her parents refused to treat the cancer with medical care, where the child had at least an 80\% chance of temporary remission, and a 25\% to 50\% probability for long-term cure).
\item \textsuperscript{182} Newmark, 588 A.2d at 1120.
\end{itemize}
of treatment and nontreatment for a patient."\(^{183}\) The use of odds is inherently unsatisfactory, as the tolerance for risk varies so widely between individuals. The California appellate courts are in agreement with the Newmark court in terms of assessing the risks of treatment. For example, in *In re Eric B.*,\(^ {184}\) while the court ruled that various procedures as part of an "observation phase" could be performed over the parents' objections,\(^ {185}\) the court specifically found that "[t]he risks entailed by the monitoring [were] minimal."\(^ {186}\)

In *In re Phillip B.*,\(^ {187}\) the appellate court took a more conservative view of what constitutes acceptable odds. The court respected the parents' decision to refuse recommended surgery when an expert witness testified that "Phillip's case was more risky than the average."\(^ {188}\) Robert Baines, who filed an *amicus curiae* brief on behalf of Phillip, argued:

> In Phillip's case, it is difficult to see how the risks of surgery justify the court's decision not to intervene. The operation carries a ten percent maximum risk of death, as compared with the 100 percent certainty of a greatly premature death, either from a sudden heart attack at any time or from a more lingering death as the lungs deteriorate.\(^ {189}\)

Nevertheless, in California, the dual questions of who decides what the odds of successful treatment are, and what odds are acceptable to justify state intervention, remain unanswered.

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184. 235 Cal. Rptr. 22 (Ct. App. 1987).
186. *Id.* at 27.
188. *In re Phillip B.*, 156 Cal. Rptr. at 51. The expert provided two reasons that Phillip's case was more risky than the average. "One, [Phillip] has pulmonary vascular changes and statistically this would make the operation more risky in that he would be subject to more complications than if he did not have these changes. Two, children with Down's Syndrome have more problems in the postoperative period." *Id.* It is unclear whether Phillip's mental disability had any part in the court's balancing of the risks of treatment. The attorney for the parents, however, argued that "it is the family which should ultimately decide life and death questions involving minors who will not lead a 'life worth living.'" Baines, *supra* note 20, at 129. *See supra* note 21 and accompanying text.
4. Avoid Pain to Child

In Minor (I), the parents decided to deprive their son of chemotherapy treatment. According to the mother's testimony, the decision to terminate chemotherapy was not based on the parents' view that another medically effective form of treatment could be found. Rather, it reflected the parents' concern about the child's discomfort in chemotherapy, and their pessimism regarding the odds of success. The mother stated, "[W]e would love for [the child] to have a full and long life. But it is more important to us that his life be full instead of long, if that [is] the way it [has] to be." Nonetheless, the Massachusetts Supreme Court affirmed the judge's findings that chemotherapy was in the child's best interest.

In Newmark v. Williams, where the court found that the child's proposed medical treatment "was highly invasive, painful, involved terrible temporary and potentially permanent side effects, posed an unacceptably low chance of success, and a high risk that the treatment itself would cause [the child's] death," the Supreme Court of Delaware respected the parents' decision to reject the proposed medical treatment for their son. The court stated, "The State's authority to intervene ... cannot outweigh the Newmarks' parental prerogative and Colin's inherent right to enjoy at least a modicum of human dignity in the short time that was left to him."

No California case explicitly discusses the parents' desire to avoid pain to the child. In Phillip B., however, the desire to avoid additional pain to Phillip may have been an underlying concern. Throughout the opinion, the court continuously noted that children with Down's Syndrome have more problems in the postoperative period. While the view that parents are best able to decide how much pain their child should be forced to endure seems to be dominant, an equally
powerful argument can be made that parents are too close to their children to weigh appropriately the pain that may result from successful medical treatment.

There is little likelihood that any court could construct a consistent formula that would provide predictable results when weighing the competing factors of the parents' desire to have their child avoid pain, the likelihood of a successful result, and the benefits of a partial recovery. Such a calculus defies judicial, indeed human, construction.

B. State's Interest

In Phillip B., the First District Court of Appeals described the state's interest in medical decisionmaking for children as follows:

The state is the guardian of society's basic values. Under the doctrine of parens patriae, the state has a right, indeed a duty, to protect children. State officials may interfere in family matters to safeguard the child's health, educational development and emotional well-being.

One of the most basic values protected by the state is the sanctity of human life. Where parents fail to provide their children with adequate medical care, the state is justified to intervene. However, since the state should usually defer to the wishes of the parents, it has a serious burden of justification before abridging parental autonomy by substituting its judgment for that of the parents.199

This language was affirmed by the Fourth Appellate District in In re Petra B.200

In issues of child welfare, the standard that courts frequently apply is the best interests of the child.201 Justice Kennard explained, "This 'best interests' standard serves to assure that in the judicial resolution of disputes affecting a child's well-being, protection of the minor child is the foremost consideration."202 While the best interests standard purports to set forth an all-inclusive rule, its very vagueness undercuts its practical utility. Any decision may be justified

199. Id. at 51 (citations omitted).
by labeling the result as being within the broad category of child's best interests.

C. Child's Interest

*In re Sampson*\(^{203}\) is an early New York case in which the court of appeals considered whether to interfere in a mother's decision to refuse corrective surgery on her fifteen-year-old son.\(^{204}\) In its discussion, the court commented that "if this court is to meet its responsibilities to this boy it can[not] shift the responsibility for the ultimate decision onto his shoulders \ldots\."\(^{205}\) Since the *Sampson* decision in 1970, an increasing number of courts have recognized that children do have an interest in choosing health care alternatives independent of their parents or the state.\(^{206}\) But courts have yet to give a definitive answer to the question of when health care decisions affecting minors should be based primarily on the wishes of the minor. For example, should the courts limit such input to children who have reached a minimum age? Should the decision be based on the "mature minor" standard? And, if the mature minor standard is used, how should a court decide whether a child is "mature" enough to reach an informed and responsible decision regarding his or her own medical care? Should the nature of the disease or condition to be treated affect the weight to be given the child's preference?\(^{207}\)

The IJA and ABA suggest that a minimum age of three be established.\(^{208}\) The commentary following Juvenile Justice Standard 2.1(E)\(^{209}\) states, "[T]he court should consider the child's views in all cases except those involving children under age three. If, as may often be the case, the child shares the parents' views of medical treatment, this may lessen the chances of successful treatment and increase the child's emotional trauma."\(^{210}\)

204. *In re Sampson*, 317 N.Y.S.2d at 641.
205. Id. at 657.
207. Neither California courts, nor sister jurisdictions, have addressed these questions.
208. KAUFMAN, supra note 105, at 74.
209. See supra text accompanying note 111.
210. KAUFMAN, supra note 105, at 74.
To contrast, in *Newmark*, the Supreme Court of Delaware seemed to indicate that it would have respected Colin's decision regarding his own treatment if he had been older. The court noted, "Colin, a three year old boy, unfortunately lacked the ability to reach a detached, informed decision regarding his own medical care."\(^{211}\) The court then added in a footnote:

> [I]t is doubtful that even the most precocious three year old could meet the ["mature minor"] standard. Yet, while not dispositive, there was evidence that Colin overheard some hospital discussion about treating him with chemotherapy. His reaction was one of fright that the proposed treatment would "kill" him. Thus, even at his young age, Colin was able to perceive the very real dangers of the treatment.\(^{212}\)

The California appellate courts never mentioned the possibility of Phillip, Eric, or Petra making their own medical care decisions. Phillip, a twelve-year-old boy suffering from Down’s Syndrome,\(^{213}\) attended a school for mentally challenged children.\(^{214}\) His teacher reported that he was making exceptional progress and was working at a very high level for any mentally challenged child.\(^{215}\) Eric was four years old when his parents appealed the referee’s decision,\(^{216}\) and he was six years old at the time of the appellate court’s decision.\(^{217}\) The court never provided any indication of Petra’s age. Although it is not clear whether Phillip\(^{218}\) or Eric possessed the requisite maturity and understanding to make their own health care decisions, they could have provided some indication of their preferred course of treatment. Given California statutes mandating that a child’s preference be

\(^{211}\) Newmark v. Williams, 588 A.2d 1108, 1116 (Del. 1990).

\(^{212}\) Id. at 1117 n.9.

\(^{213}\) In re Phillip B., 156 Cal. Rptr. 48, 50 (Ct. App. 1979), cert. denied, 445 U.S. 949 (1980).

\(^{214}\) Baines, *supra* note 20, at 128.

\(^{215}\) Id. “[Phillip] is classified as a ‘high functioning trainable mentally retarded’ youth. Most likely, Phillip will always have to live in a supervised environment of some sort, and he will probably always work in a sheltered workshop.” Id.

\(^{216}\) In re Eric B., 235 Cal. Rptr. 22, 24 (Ct. App. 1987).

\(^{217}\) Id.

\(^{218}\) While most twelve year olds would be expected to have significant input regarding their own medical treatment, Phillip is a Down’s Syndrome child. See *supra* note 214 and accompanying text.
considered in areas such as custody proceedings, it is inevitable that California courts will eventually have to address this issue.

A review of the California appellate court decisions regarding medical decisionmaking for children demonstrates repeated reliance on the substantial evidence rule. The effect of this reliance has been to avoid determining the weight to be given to specific factors such as a child's preference. Further, even constitutional questions, such as the effect of religion-based decisions, have not been answered by the courts. This judicial history of rule-making-avoidance compels the following proposal.

V. PROPOSAL

California courts have failed to ensure that children receive necessary medical care in a predictable fashion. The problem is due in part to the difficult nature of medical decisionmaking issues. The California approach, however, has also been crippled by the "substantial evidence" standard, whereby appellate courts have avoided the responsibility of providing authoritative guidance to the trial courts. Sister states have been equally ineffective in dealing with the issue of medical decisionmaking for minors. The current state of case law is both confused and conflicting.

Given the lack of judicially created standards, the California legislature is the appropriate body to provide guidance on this issue. The legislature has the power to hold hearings and to invite experts to testify on the topic of health care for minors. The experts should include members of the medical profession, child psychologists, family law specialists, ethicists, and other interested parties. Such hearings would ensure that all of the various factors and issues are considered in a neutral setting.

The goal of such hearings would be a comprehensive statutory scheme. This process has the obvious advantage of a

219. Family Code section 3042 provides: "If a child is of sufficient age and capacity to reason so as to form an intelligent preference as to custody, the court shall consider and give due weight to the wishes of the child in making an order granting or modifying custody." CAL. FAM. CODE § 3042 (West 1994 & Supp. 1995).

220. See supra parts II.A, IV.


222. See supra parts II.B, IV.
well-planned approach, rather than the case-by-case, piece-meal method used by courts, which is limited by the specific facts of a given case. A legislative approach guarantees that consideration be given to the multitude of factors that should guide a judge who examines a request for state intervention.

The legislature should adopt a statute listing specific factors that any trial court making a choice for state intervention must consider. These factors should be organized around the three competing interests: (1) the wishes of the child;\supra IV.C. (2) the best interests of the child;\supra IV.B. and (3) the basis of the parents' objection.\supra IV.A. The actual statutory language and specific factors will be determined by the legislative process. All of the approaches described in this comment, however, should be considered as potential candidates for inclusion.

The following proposed statute provides a framework upon which such legislation could be modeled.

California Minor's Medical Treatment Decisions Act

(a) In any action brought to mandate a course of medical treatment for an unemancipated minor against the will of that minor and/or the minor's parents or guardian, the following factors must be considered by the trial court:

(1) The seriousness of the medical condition sought to be remedied.

(2) The nature of the treatment proposed by the minor, parents, or guardian, weighed against the nature of the treatment proposed by the state. Special consideration should be given in the case of any experimental treatment.

(3) The degree of risk inherent in the treatment proposed by the minor, parents, or guardian, weighed against the degree of risk inherent in the treatment proposed by the state.

(4) The likelihood of success of the treatment proposed by the minor, parents, or guardian, weighed against the likelihood of success of the treatment proposed by the state.

(5) The risk of lack of treatment proposed by the minor, parents, or guardian.

(6) The degree of pain that the child will endure as a result of the treatment proposed by the minor, par-

\supra part IV.C.
\supra part IV.B.
\supra part IV.A.
ents, or guardian, weighed against the degree of pain
that the child will endure as a result of the treatment
proposed by the state.
(7) The basis of parental objections, such as fear, ex-
 pense, religion, or the choice of any alternative
treatment.
(8) The expressed wishes of any child, with increased
consideration based on the child's age and level of
maturity.
(9) Any other factors which affect the decision.
(b) The best interest of the child as determined by the
court should predominate over the choice of the minor,
parents, or guardian, even if religiously based. The court,
however, is to give special consideration to any religious
objection, especially when the child's life is not at risk.
(c) The court is authorized to appoint independent
physicians or other experts to aid any decision under this
Act. To ensure independence, such experts are to be paid
by the state.
(d) Any decision under this Act must be in writing,
with a discussion of the factors listed under subdivision
(a) to facilitate review by the appellate courts.

To be effective, the adopted statute must include a provi-
sion such as that in subdivision (d). It is critical that trial
courts be required to consider each of the factors that are per-
tinent in a particular case. A statement of decision must be
required in order to provide a basis for appellate review. \(^{226}\)
Although the appellate courts would continue to follow the
substantial evidence rule, the review process would be guided
by these factors, rather than the ad hoc approach currently
being employed. The trial courts' work could then more effec-
tively be examined for abuse and for failure to give appropri-
ate weight to those factors relevant in a particular case.

Although some individuals may be fearful of the idea of
handing such a sensitive issue over to politicians, allowing
the California Legislature to resolve such a complex legal
problem is hardly new. The legislature has considerable ex-
perience in dealing with similar issues involving minors. For

of Pelton, 183 Cal. Rptr. 188 (Ct. App. 1982).
example, it has already regulated the areas of adoption,\textsuperscript{227} custody,\textsuperscript{228} and child support.\textsuperscript{229}

Finally, in light of governmental health care reform efforts, the legislature is a natural choice for untangling the issue of medical decisionmaking for minors. As the legislature considers how medical care should be financed and delivered in California, it is appropriate that it also consider the issue of who should be responsible for the costs of court-ordered treatment for minors.

VI. CONCLUSION

While this comment has not provided a specific answer to Jessica's case,\textsuperscript{230} it has provided the means to obtain an answer to her case and the cases of similarly situated children. Through legislative intervention, the goals of a comprehensive statutory scheme resulting in predictable results and a procedural methodology for control of trial court discretion can be achieved.

Felicia C. Strankman

\textsuperscript{227} \textit{Cal. Fam. Code} § 8500 (West 1994).
\textsuperscript{228} \textit{Cal. Fam. Code} § 3000 (West 1994).
\textsuperscript{229} \textit{Cal. Fam. Code} § 3500 (West 1994).
\textsuperscript{230} See supra text accompanying notes 1-2.