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Note

Judicial Limitations on Parental Autonomy in the Medical Treatment of Minors


I. INTRODUCTION

The states have broad authority under the police powers\(^1\) to order medical treatment for minor children when intervention is necessary to protect the general health and welfare of the community. This authority may be exercised even when it impinges on fundamental rights.\(^2\) However, when a lack of medical treatment does not threaten the health and welfare of the general public, the state's power to order medical treatment for a minor over parental objections is less certain.\(^3\)

The scope of parental rights to refuse medical treatment for mi-

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1. Authority for the exercise of state police power is found in U.S. Const. amend. X, which states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

2. The focus of the state's interest in this type of circumstance is on curing or eliminating a specific disease or condition which poses a danger to the community. See, e.g., Wright v. DeWitt School Dist. No. 1, 238 Ark. 906, 385 S.W.2d 644 (1965) (upheld the authority of the state to require smallpox immunizations of all school-age children despite parents' religious objections to medical treatment); Powers v. State Dep't of Social Welfare, 208 Kan. 605, 493 P.2d 590 (1972) (court upheld the requirement of a physical examination before state benefits could be granted under aid to the disabled program, although the examination was contrary to the applicant's religious beliefs); Kraus v. City of Cleveland, 55 Ohio App. 6, 116 N.E.2d 779 (1953) (court held that city could fluoridate its water, although some residents protested this action on the ground that drinking fluoridated water would constitute receiving medical treatment in violation of plaintiffs' religious beliefs); State v. Armstrong, 32 Wash. 2d 860, 239 P.2d 545 (1952) (upheld requirement of chest x-ray for tuberculosis of all students at college, although it was contrary to plaintiff's religious convictions).

3. See notes 12-14 & accompanying text infra.

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nor children, where the refusal only affects the health of the individual child, has been the focus of much discussion and debate. The state's authority to intervene in this area of parental rights has expanded with the advent and utilization of neglect statutes, which often impose an express duty on parents to provide a minimum amount of medical care for their children. Although a state may intervene under the authority of a neglect statute to order medical treatment over parental objections when the treatment is immediately necessary to save the life of the child, the state-imposed limitations on parental autonomy are less clear when the child's life is not immediately threatened, or when the results of the proposed treatment are uncertain.


5. For a good analysis and comparison of state neglect laws, including tables showing which statutes include parental refusal to provide necessary medical care for the child as a ground for state intervention, see Katz, Howe & McGrath, Child Neglect Laws In America (pts. I-IV), 9 Fam. L.Q. 3, 7, 51, 73 (1975) [hereinafter cited as Katz]. For cases in which the court implied a duty on parents to furnish medical care, although the neglect statute did not expressly authorize state intervention for this reason, see Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978), aff'd on rehearing, 393 N.E.2d 836 (Mass. 1979); State v. Perricone, 37 N.J. 463, 181 A.2d 751, cert. denied, 371 U.S. 890 (1962).


7. For cases where courts ordered medical treatment although the child's life was not immediately threatened, see In re Sampson, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. 1970), aff'd, 37 A.D.2d 668, 323 N.Y.S.2d 253 (1971), aff'd, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972); In re Rotkowitz, 175 Misc. 949, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941); In re Vasko, 238 A.D. 128, 263 N.Y.S. 552 (1933). For cases where medical treatment was not ordered under similar circumstances, see In re Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955); In re Green, 448 Pa. 338, 292 A.2d 387 (1972) (remanding to trial court), aff'd trial court decision on remand, 452 Pa. 373, 307 A.2d 279 (1973); In re Hudson, 13 Wash. 673, 126 P.2d 765 (1942).

8. For cases where courts ordered medical treatment although the results of the proposed treatment were highly unpredictable, see In re Sampson, 65 Misc.
The problems of defining the extent of parental duties under these statutes, the scope of parental rights in the decision-making process, and the state's power to intervene in the "best interests of the child" have arisen in a wide variety of factual contexts. Recently, cases have presented questions involving: court ordered continuation of extraordinary means of medical care in order to keep a child alive who had no hope for recovery;\(^9\) conflict between state interests and parental free exercise of religious rights under the first amendment;\(^{10}\) and emergency situations requiring immediate treatment to save the life of a child.\(^{11}\)

Unlike these cases, *Custody of a Minor\(^{12}\)* marks one of the first instances where a court has confronted the issue of whether to order the continuation of chemotherapy treatments for a minor child over parental opposition,\(^{13}\) where the danger of nontreatment was not immediate death\(^{14}\) and the predicted results of the proposed

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\(^11\) One commentator has asserted that a good faith religious belief is no defense to a parent's failure to provide corrective or preventive medical attention to minor children. Baker, *supra* note 4, at 299. However, some courts have held that medical treatment cannot be ordered over parental objections based on religious beliefs. *E.g.*, Craig v. State, 220 Md. 590, 155 A.2d 684 (1959); *In re Seiferth*, 309 N.Y. 80, 127 N.E.2d 820 (1955); *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972) (remanding to trial court), aff'd trial court decision on remand, 452 Pa. 373, 307 A.2d 279 (1973). A recent decision held that one parent's objection to blood transfusions could not be the primary basis for award of the custody of a minor to the other parent in a divorce action. *Osier v. Osier*, 410 A.2d 1027 (Me. 1980).


\(^13\) Although *Custody of a Minor* did not involve a medical emergency, the court pointed out that time of treatment and the continuity of treatment were important factors in determining the child's chances for survival. 379 N.E.2d at

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treatment were far from certain.\footnote{1065. Expert testimony predicted that without treatment the child would probably die in one to six months. \textit{Id.} at 1063.}

The court was faced with two critical issues. The first issue concerned whether the parents could refuse medical treatment when the treatment offered a "substantial chance for cure"\footnote{15. The court found that the child's chances for survival if he continued chemotherapy were "slightly higher than fifty percent." \textit{Id.} at 1057. On rehearing, the court found that his chances for cure if treatment continued were "close to fifty percent." 393 N.E.2d at 840.} of the child's disease. The second issue involved the parents' right to choose between alternative methods of treatment. The \textit{Minor} court upheld the state's authority to order medical treatment despite parental objection where treatment affords the child a substantial chance for cure.\footnote{16. Custody of a Minor, 379 N.E.2d at 1056. \textit{Id.}} The court also upheld the power of the state to intervene in parental choices between alternative treatments where the parental choice is not proven to be a medically effective alternative.\footnote{17. \textit{Id.}}

\section*{II. HISTORICAL RIGHTS OF PARENTS AND MODERN INFRINGEMENT BY THE STATE}

\section*{A. Necessity of Parental Consent}

In tort law, touching a person without his consent constitutes a battery.\footnote{18. Custody of a Minor, 393 N.E.2d at 846.} Therefore, in order to protect himself from potential civil liability, a physician must obtain a patient's consent before treating him. Prior to receiving such consent, the doctor has an affirmative duty to explain to the patient the material facts concerning the treatment, the available alternatives, and the collateral risks. If the patient then gives his competent, voluntary, and understanding consent to proceed, the doctor is protected from potential tort liability for battery which would otherwise arise from medical treatment.\footnote{19. G. ANNAS, \textit{THE RIGHTS OF HOSPITAL PATIENTS} 137 (1975); W. PROSSER, \textit{HANDBOOK OF THE LAW OF TORTS} 34-37 (4th Ed. 1971). \textit{See} Bennett, \textit{supra} note 4, at 286-87; Note, \textit{The Minor's Right to Consent to}}

This requirement of "informed consent," while serving a useful function in the field of adult medical care,\footnote{20. G. ANNAS, \textit{supra} note 19, at 57; Bennett, \textit{supra} note 4, at 286. \textit{Id.}} runs into difficulty when it is applied to pediatric medicine. Under the common law a child is legally incapable of giving his consent to a battery;\footnote{21. An adult patient who is conscious and mentally competent has the legal right to refuse any medical or surgical procedure, even if it is a life-sustaining measure. G. ANNAS, \textit{supra} note 19, at 79, 81. \textit{See} Bennett, \textit{supra} note 4, at 286-87; Note, \textit{The Minor's Right to Consent to}} there-
fore, any touching of a minor by a doctor, even with the minor’s consent, is technically a battery. Parents and guardians have traditionally been accorded the legal capacity to consent to medical treatment for minor children. Therefore, it is only with their approval that medical treatment of a child may be rendered non-tortious.

This traditional notion operates to give parents control over most medical care decisions concerning the treatment of children.

B. State Infringement on Parental Autonomy

State legislatures and courts have carved out exceptions to the rule that parental consent is required before a minor may receive medical treatment. Parental consent is not required if a child is in a life-threatening situation and the parent or guardian cannot be located. Some states also recognize a “mature minor” exception.

Medical Treatment: A Corollary of the Constitutional Right of Privacy, 48 S. CAL. L. REV. 1417 (1975). The Restatement of Torts § 59 (1934) states: “(1) If a person whose interest is invaded is at the time by reason of his youth... incapable of understanding or appreciating the consequences of the invasion, the assent of such a person to the invasion is not effective as a consent thereto.”

23. G. ANNAS, supra note 19, at 137.
24. Baker, supra note 4, at 297; In re Rotkowitz, 175 Misc. 946, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941); W. PROSSER, supra note 19, at 102-03.
25. G. ANNAS, supra note 19, at 137. Bennett, supra note 4, at 286.
26. Bennett, supra note 4, at 286. Not only may the parent exercise the authority to refuse consent to medical treatment, but parental autonomy may also be exercised to consent to non-beneficial medical treatment for one child which will save the life of a sibling. Under these factual circumstances, the potential psychological effect on the non-ill child, resulting from a refusal to allow treatment, is an important consideration in the court decisions. See Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (1972) (court allowed parents to consent to kidney transplant from identical twin to his brother, where transplant was necessary to save the life of the second twin); Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1967) (parents could consent to kidney transplant from incompetent adult to his brother in order to save the brother’s life).
27. HEALTH LAW CENTER, PROBLEMS IN HOSPITAL LAW 82 (2d ed. 1974); G. ANNAS, supra note 19, at 137; Bennett, supra note 4, at 289; Note, supra note 22, at 1419. In Luka v. Lowries, 171 Mich. 122, 136 N.W. 1106 (1912), the doctor amputated a minor’s foot which had been crushed in a train accident without first obtaining parental consent. The court explained the policy of the emergency rule exception in upholding the doctor’s action:

To hold that a surgeon must wait until perhaps he may be able to secure the consent of the parents before giving to the injured one the benefit of his skill and learning, to the end that life may be preserved, would, we believe, result in the loss of many lives which might otherwise be saved.

Id. at 135, 136 N.W. at 1100-11. However, some courts have held that doctors were liable for treating minors without obtaining parental consent. See, e.g.,
to the parental consent rule, which allows an unemancipated minor who is capable of understanding and appreciating the consequences of the proposed medical procedure to consent to the treatment. More commonly recognized is the "emanicipated minor" exception which allows emancipated minors to consent to their own medical care. States have also enacted statutes which expressly emancipate minors in specific areas of health care decision-making, such as prenatal care, venereal disease and drug dependency, due to the recognition that to require parental consent


in these instances would create a risk that the minor might delay or forego medical treatment.\textsuperscript{32}

If the parent can be located and the minor does not fall within the statutory exceptions to the rule, the requirement of informed consent coupled with the concept that a minor does not have the capacity to consent, theoretically grants parents a veto power over whether children will receive medical treatment. However, this veto power is tempered by recognition of a state interest in protecting the welfare of the child which, in certain circumstances, will override parental refusal to provide medical treatment. In these instances the state, under the doctrine of \textit{parens patriae},\textsuperscript{33}

These statutes have also been used to prevent parents from compelling minors to receive medical treatment against their express wishes. \textit{See, e.g.}, \textit{In re Smith}, 16 Md. App. 209, 295 A.2d 238 (1972) (minor had capacity to consent to treatment for her pregnancy under state law and therefore parent could not compel her to submit to an abortion).


\textit{Parenthood Law Center, supra} note 27, at 85.

\textit{Parenthood Law Center} has been defined as "a right of sovereignty [which] imposes a duty on the sovereignty to protect the public interest and to protect such persons with disabilities who have no rightful protector. . . . [I]t extends to the personal liberty of persons who are under a disability whether by reason of infancy, incompetency . . . ." \textit{Note}, \textit{The Right to Die}, 7 Hous. L. Rev. 654, 663 n.63 (1970) (quoting from \textit{Johnson v. State}, 18 N.J. 422, 431, 111 A.2d 1, 5 (1955)). In \textit{State v. Perricone}, 37 N.J. 463, 475, 181 A.2d 751, 758, \textit{cert. denied}, 371 U.S. 890 (1962), the court described the \textit{parens patriae} power of the state to be a sovereign right and duty to care for and to protect a child during his minority from neglect, abuse and fraud.

For a discussion of the state's \textit{parens patriae} authority encompassed in the neglect statutes, see \textit{Areen, supra} note 4, at 893; \textit{Thomas, supra} note 4, at 313-28; \textit{Wald, supra} note 4, at 989-90; \textit{Note, DE PAUL L. REV., supra} note 4, at 344-46; \textit{Note, SYRACUSE L. REV., supra} note 4, at 84-85.
may appoint a guardian ad litem for the child. When the state intervenes in the parental decision-making process in this manner, it acts not as an allocator of the decision-making responsibility, but as the decision-maker itself.

The state’s right to intervene in the decision-making process stems from its police powers. Originally, the state’s authority in this area was enforced through the imposition of criminal sanctions on parents. More recently, the state’s authority to intervene has been expanded and reinforced through the passage and implementation of neglect statutes, which define minimum parental duties and provide for judicial interference with parental autonomy when the parent fails to fulfill these minimum responsibilities. Most of these statutes allow judicial intervention in

34. A “guardian ad litem” is defined as “a guardian appointed by a court of justice to prosecute or defend for an infant in any suit to which he may be a party.” BLACK’S LAW DICTIONARY 834 (rev. 4th ed. 1968).

35. Bennett, supra note 4, at 294-307.

36. Goldstein, supra note 4, at 648.

37. Baker, supra note 4, at 297-98; Paulsen, supra note 4, at 690; Note, Unauthorized Rendition of Lifesaving Medical Treatment, 53 CALIF. L. REV. 860, 876 (1965).

IND. CODE ANN. § 35-46-1-4 (Burns 1979) provides an example of a neglect statute which imposes criminal sanctions on parents who fail to obtain proper medical attention for their child:

(a) person having the care, custody, or control of a dependent who knowingly or intentionally:
(1) Places the dependent in a situation that may endanger his life or health;
(2) Abandons or cruelly confines the dependent;
(3) Deprives the dependent of necessary support; or
(4) Deprives the dependent of education as required by law;
comits neglect of a dependent, a class D felony.

Id.

For examples of convictions of parents under criminal neglect statutes for failing to furnish medical treatment to children, see Eaglen v. State, 249 Ind. 144, 231 N.E.2d 147 (1967); People v. Pierson, 176 N.Y. 201, 68 N.E. 243 (1903); Regina v. Senior, [1899] 1 Q.B. 283. Parents have also been convicted of manslaughter for negligently causing the death of a child by failing to provide medical care. See, e.g., State v. Stehr, 92 Neb. 755, 139 N.W. 676, aff'd on re-hearing, 94 Neb. 151, 142 N.W. 670 (1913). But see Craig v. State, 220 Md. 590, 155 A.2d 684 (1959) (insufficient evidence that gross negligence of the parents was the proximate cause of the child’s death from pneumonia).

38. See HEALTH LAW CENTER, supra note 27, at 85; Robertson, Involuntary Euthanasia of Defective Newborns: A Legal Analysis, 27 STAN. L. REV. 213, 222 (1975). Although common law did not recognize the denial of medical care to children as an act of parental neglect, legislation now enables the judiciary to transfer custody from the parents to a guardian ad litem to allow treatment upon consent of the court-appointed guardian. For a good analysis of state neglect laws, see Katz, supra note 5.

39. Goldstein, supra note 4, at 648-49. The use of minimal standards indicates our society’s strong presumption favoring parental autonomy and family privacy over coercive state intervention. This policy of minimum state intervention
health care decisions by imposing a duty on parents to provide a minimum amount of medical care for minor children. However, the process of defining the extent of this minimal duty and of determining when the state should intervene has proceeded on a case-by-case basis, with conflicting results among the many jurisdictions which have confronted this issue.

Since only minimum standards of parental responsibility are imposed for the medical treatment of minors, the right of state intervention under the neglect statutes generally only arises when the action or inaction of the parent threatens the child's life. Thus, immediacy of the danger to the child's life is a major factor which a court considers in determining whether or not to intervene. However, there are exceptions to this general rule. Other factors, such as risks to the child's health, risks to the child's social or psychological development, the maturity of the child, the child's own desires, and the benefits and risks of treatment, also enter into the decision-making process.

III. FACTS OF MINOR

On August 30, 1977, in Hastings, Nebraska, a twenty-month-old child awoke with a fever of 106°F. His parents brought him to a local physician who referred the family to the University of Nebraska Medical Center in Omaha. Doctors at the Medical Center discovered that the child had acute lymphocytic leukemia, a disease which is fatal if left untreated.

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40. See note 5 supra.
41. One commentator notes: The law of child medical care decisionmaking builds on outmoded constructs and contains elements often at war with one another. A parent has a 'duty' to provide a child with medical care, but is 'free' to withhold consent to it in cases where the care is obviously required. Public intervention is easily accepted in cases where neither contagion nor near universality of the medical problem would seem to require it but quite wrenching in others where the medical justification is much stronger. Confusion abounds about the proper role of parents' religious beliefs, the maturity of the child, the presence of a threat to life and a host of other considerations.

Bennett, supra note 4, at 329.
42. G. ANNAS, supra note 18, at 87; Bennett, supra note 4, at 302; Note, supra note 22, at 1439.
43. See notes 12-14 & accompanying text supra.
44. HEALTH LAW CENTER, supra note 27, at 86.
45. Acute lymphocytic leukemia is considered to be the most common form of childhood leukemia and the most curable. N.Y. Times, Jan. 21, 1979, § 1, at 29, col. 2. This type of leukemia is characterized by excessive numbers of white cells and abnormal cells in the lymph tissue. Symptoms include enlargement
After being admitted to the University Medical Center, the child began a program of intensive chemotherapy, which was to be administered in three phases over a three-year period. This treatment, which included the use of anti-leukemia drugs and cranial radiation, would have given the child a better than fifty percent chance for survival if he had completed this chemotherapy program. On September 30, 1977, the doctors administered a bone marrow test which indicated that the leukemia was in a state of remission.

On October 8, 1977, the family moved to Massachusetts, where the child was placed in the care of the Chief of the Pediatric Hematology Unit at Massachusetts General Hospital. The doctor allowed the parents to supplement chemotherapy treatments with a diet of distilled water, vegetarian foods, and high dosages of vitamins; however, the parents were informed that this diet would not be an effective means of treating the boy's disease. The child received injections at the hospital and the parents were instructed to give the boy a daily oral dosage of an anti-leukemia drug. Although the child developed some side effects from the medication, these problems were corrected by adjusting the dosages of the drugs.

46. 379 N.E.2d at 1057. The first phase of chemotherapy treatment lasts for four weeks and involves the use of a combination of several anti-leukemia drugs, administered orally and by injection, to attack leukemia cells throughout the body. The second phase of treatment involves the use of different drugs administered over a six-week period. At this stage, cranial radiation is also used and another drug is injected directly into the spinal fluid each week. These latter two types of treatment attack leukemia cells which have migrated into the spinal fluid, beyond the reach of the drugs administered intravenously. The third phase of treatment involves a weekly oral dosage of one drug and a monthly injection of another over the remainder of the three year period. Id.

47. Id. Medical studies indicate that approximately 50% of the children who follow this procedure are still alive four years after beginning the treatment. These studies also indicate that the survival rates vary according to the type of leukemia cells found and the age of the child. Id.

48. Id. The parents were, by this time, averse to the use of cranial radiation. Id.

49. Id. at 1058. The court pointed out that, although certain side effects (temporary hair loss, numbness of the fingers and toes, back and joint pain, sleepiness, headache, stiffness of the neck, and irritation of the tissues surrounding the spinal cord) are common when chemotherapy is administered, the only problems present in this case were stomach cramps and constipation. Id. at 1058 n.2. The parents also contended that the treatments produced behavioral changes in the child, but the court did not consider these changes to be linked to the chemotherapy treatments. Id. at 1058. "The Greens contended that chemotherapy had hurt Chad physically and mentally. They cited aftereffects of violence and pain and said that he had become 'terrified' of the treatment." N.Y. Times, Apr. 6, 1978, § 1, at 18, col. 1.
child his daily medication, without informing the child's attending physician. However, they continued to take the child to the hospital for his monthly visits. By the second week of November, the child's leukemia was still in a state of remission and he entered the third phase of treatment.

However, an examination on February 17, 1978, revealed that the child's blood contained four percent leukemia cells. Upon questioning the parents admitted that they had stopped administering the oral medication more than three months before. The doctor failed in his attempts to persuade the parents to resume the child's treatment.

On February 22, 1978, treatment was resumed pursuant to an order of temporary guardianship by the probate court in response to a petition brought by the child's attending physicians. However, the probate court granted the parents' motion to vacate this temporary guardianship order, and the physicians appealed to the superior court.

The superior court ordered a transfer of legal custody of the

50. On November 7, 1977, the parents asked Dr. Truman, the attending physician, not to administer one of the regularly scheduled injections. The parents also inquired as to what the results would be if chemotherapy were terminated. Dr. Truman agreed to substitute an oral drug for the injection, but informed the parents that there was a one hundred percent chance of relapse if chemotherapy was terminated at this time. 379 N.E.2d at 1058.

51. Id.

52. The petition was brought under a statute which provides:

The Boston juvenile court . . . or the juvenile sessions of any district court of the commonwealth . . . upon the petition of any person alleging on behalf of a child under the age of eighteen years within the jurisdiction of said court that said child is without necessary and proper physical . . . care . . . and whose parents or guardian are unwilling, incompetent or unavailable to provide such care, may issue a precept to bring such child before said court, shall issue a notice to the department, and shall issue summons to both parents of the child to show cause why the child should not be committed to the custody of the department or other appropriate order made . . . If, after a recitation under oath by the petitioner of the facts of the condition of the child who is the subject of the petition, the court is satisfied that there is reasonable cause to believe that the child is suffering from serious abuse or neglect, or is in immediate danger of serious abuse or neglect, and that immediate removal of the child is necessary to protect the child from serious abuse or neglect, the court may issue an emergency order transferring custody of a child under this section to the department . . . Said transfer of custody shall be for a period not exceeding seventy-two hours. Upon the entry of the order a date for a hearing on the extension of the order shall be set, which date shall fall within the seventy-two hour period.

53. The parents' motion to vacate the temporary guardianship order was granted on the ground that the probate court lacked subject matter jurisdiction of the issues raised by the parties. 379 N.E.2d at 1059. The supreme judicial court
child from the parents to the Department of Public Welfare on April 18, 1978.\textsuperscript{54} The parents' physical custody of the child was restricted only to the extent necessary to ensure medical supervision in accordance with the court order. On July 10, 1978, the supreme judicial court affirmed this decision.\textsuperscript{55}

The parents began administering metabolic therapy\textsuperscript{56} to their child in April, 1978, without informing the child's attending physician. When, in September, 1978, the doctor learned that the child was receiving this treatment, he expressed concern that this form of therapy could poison the boy.\textsuperscript{57} Although there was no immediate danger of acute poisoning, the parents were informed of the possibility of chronic, long-term poisoning, and were advised to discontinue these treatments.\textsuperscript{58}

A hearing for a review and redetermination of the needs of the child was held in the superior court in January, 1979.\textsuperscript{59} While the parents accepted the necessity of continuing chemotherapy, they noted that the probate court judge was in error in reaching this conclusion.\textsuperscript{379} N.E.2d at 1059 n.3.


\textsuperscript{55} Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978).

\textsuperscript{56} This metabolic therapy included daily administrations of laetrile, vitamins, enzyme enemas, and folic acid. Custody of a Minor, 393 N.E.2d at 840.

\textsuperscript{57} \textit{Id.} Laetrile is a substance derived from the pits of apricots, peaches and bitter almonds. Because the substance contains small amounts of cyanide, the continued long-term use of laetrile can result in chronic cyanide poisoning, resulting in possible damage to the brain, nervous system and body organs. \textit{Id.} at 840-42.


\textsuperscript{59} The right to petition the court for a rehearing and redetermination was exercised under the following statute:

If the court finds the allegations in the petition proved within the meaning of this chapter, it may adjudge that said child is in need of care and protection and may commit the child to the custody of the department until he becomes eighteen years of age or until in the opinion of the department the object of his commitment has been accomplished, whichever occurs first; or make any other appropriate order with reference to the care and custody of the child as may conduce to his best interests, including but not limited to any one or more of the following—

1. It may permit the child to remain with his parents, guardian, or other custodian, subject to conditions and limitations which the
claimed the legal authority to supplement it with a program of metabolic therapy, and also sought an order granting them legal custody of the child.\textsuperscript{60} The court found that metabolic therapy had no curative effect upon the child’s disease, and posed serious risks of harm.\textsuperscript{61} The parents were ordered to discontinue metabolic therapy and were denied legal custody of their son. The parents appealed to the supreme judicial court.\textsuperscript{62}

On January 24, 1979, the family left Massachusetts to evade the superior court’s order to terminate metabolic therapy.\textsuperscript{63} Nevertheless, the supreme judicial court heard the appeal,\textsuperscript{64} and affirmed

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\textbf{MASS. GEN. LAWS ANN. ch. 119, § 26 (West Supp. 1980).}

\textbf{60.} 393 N.E.2d 838-39. At the time of this hearing, the child’s disease had been in remission ever since the court had originally ordered that treatment be resumed. The chemotherapy treatment program was scheduled to last about two more years. \textit{Id.}

\textbf{61.} Laboratory tests confirmed that the child had low-grade cyanide poisoning which was attributed to his daily ingestion of laetrile. \textit{N.Y. Times}, Jan. 21, 1979, § 1, at 29, col. 2.

\textbf{62.} 393 N.E.2d at 837-38.

\textbf{63.} \textit{N.Y. Times}, Jan. 26, 1979, § 1, at 8, col. 2. The parents were found to be in contempt of court as a result of their actions. \textit{N.Y. Times}, Oct. 15, 1979, § 4, at 9, col. 1. The authorities also considered charging the parents with kidnapping, but this idea was subsequently abandoned. \textit{N.Y. Times}, Jan. 31, 1979, § 1, at 8, col. 6.

After leaving Massachusetts, the parents took the child to a clinic in Tijuana, Mexico, where metabolic therapy was continued. \textit{N.Y. Times}, Oct. 15, 1979, § 4, at 9, col. 1. In August of 1979, the parents had announced that the child was cured of the disease. \textit{N.Y. Times}, Aug. 11, 1979, § 1, at 6, col. 6. However, on October 12, 1979, the three-year-old boy died. \textit{N.Y. Times}, Oct. 14, 1979, § 1, at 44, col. 3.

\textbf{64.} One justice dissented from the opinion of the court on the ground that the appeal should have been dismissed because the parents had already left
the decision of the superior court.\textsuperscript{65}

IV. ANALYSIS

A. The Minor Decisions

In the first appeal to the supreme judicial court,\textsuperscript{66} the parents argued that the superior court's decision to remove legal custody of their child in order to continue chemotherapy treatments violated their constitutional right to choose the type of medical treatment appropriate for their child. The supreme judicial court held that this issue was not properly before the court since the parents had not attempted to prove the existence of an alternative medical treatment, and had not asserted a right to choose between beneficial treatments in the trial court.\textsuperscript{67} However, the court did address the issue of whether a state may intervene when parents refuse to administer the only type of treatment which the evidence has shown could save their child's life. The court indicated that although family autonomy is constitutionally protected, it is not absolute. The state may limit parental rights in instances where "parental decisions will jeopardize the health or safety of [their] child."\textsuperscript{68}

The substantive issue before the court was whether the superior court had properly ordered the removal of legal custody from Massachusetts with the child, in violation of the trial court's orders. 393 N.E.2d at 847 (Braucher, J., dissenting).

\textsuperscript{65} 393 N.E.2d at 846. The court found that the child's chances of being completely cured would have been approximately 80% if the parents had not terminated chemotherapy and if the leukemia had remained in remission. However, because the disease had returned in February of 1978, after the parents had stopped administrating the oral medication, the child's chances for cure were close to 50%. \textit{Id.} at 839-40.

\textsuperscript{66} Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978).

\textsuperscript{67} \textit{Id.} at 1056 n.1. The parents also attacked the court's order on the procedural grounds that: (1) the issue of their fitness as parents was res judicata, since it had been previously decided in their favor by the probate court; (2) the superior court lacked subject matter jurisdiction; (3) the parents received inadequate notice of the superior court proceedings; and (4) the trial de novo in the superior court exposed the parents to double jeopardy. \textit{Id.} at 1056. The supreme court judicial court first decided that the probate court had not dismissed the case on the merits but, instead, on the incorrect conclusion that it lacked the jurisdiction to consider the questions raised. Therefore, the supreme judicial court, like the superior court, held that the probate court order should not be given res judicata effect. \textit{Id.} at 1059. The court also found that the superior court had subject matter jurisdiction, and that the notice of the superior court was adequate. \textit{Id.} at 1059-61. Finally, the supreme judicial court held that the trial de novo in the superior court had not unconstitutionally exposed the parents to double jeopardy, since the proceedings were civil rather than criminal in nature. \textit{Id.} at 1061.

\textsuperscript{68} \textit{Id.} at 1056 (quoting Wisconsin v. Yoder, 406 U.S. 205, 234 (1972)).
the parents so that chemotherapy treatments could be continued. The court considered three competing interests: (1) the personal needs of the child; (2) the natural rights of parents; and (3) the responsibilities of the state. It held that the rights of the parents had been properly limited, and that state intervention under the neglect statute was justified in this case because the chemotherapy treatments were necessary to save the child's life. According to expert testimony, the child would die without treatment, and chemotherapy offered him a substantial chance for cure.

Almost a year later, the supreme judicial court was faced with a different issue when it reviewed the decision on the parents' petition for redetermination of the need for state care and protection of their child. The parents had alleged the existence of an alternative or supplemental medical treatment, and had asserted their rights in the superior court to choose between medical alternatives. Thus, the supreme judicial court was confronted with determining the extent of parental rights to choose the type of medical treatment their child should receive.

The superior court had ordered the parents to cease administering the alternative metabolic therapy, and had ordered that chemotherapy treatments were to be continued. The supreme judicial court affirmed this decision because there was no evidence that the parents' proposed alternative treatment had any curative effects on the child's disease. In addition, the court found that the alternative treatment was actually harming the child and that continued chemotherapy treatments offered the child a substantial chance for a cure and a normal life.

### B. The Interests of the Parties

1. **The Child's Interests**

The legal responsibility for decisions concerning the medical care of children is shared by children, parents, and the state. The Minor court emphasized that among these three competing inter-

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69. 379 N.E.2d at 1061-67. For a discussion of these considerations, see text accompanying notes 76-117 infra.
70. For text of the statute, see note 52 supra.
71. 379 N.E.2d at 1063.
72. Id. at 1056. For a discussion of the "substantial chance for cure" test, see § IV-C of the text infra.
73. Custody of a Minor, 393 N.E.2d 836 (Mass. 1979).
74. See generally § IV-D of text infra.
75. 393 N.E.2d at 839-43.
76. Bennett, supra note 4, at 285. The responsibility and interests of physicians in the decision-making process is also recognized. Health Law Center, supra note 27, at 85.
ests, the paramount interest is that of the child. In determining the best interests of the child, the court applied a "substituted judgment" test, which had previously been used to ascertain the interests of an incompetent adult. Under this test the court attempts to identify the actual values and preferences of the person who, due to minority or mental incompetency, is incapable of expressing his own desires. Through the application of the substituted judgment doctrine, the court seeks to recognize the "free choice and moral dignity of the incompetent person . . . ."79

The court found that the substituted judgment doctrine was consistent with the "best interests of the child" test, which is the test most commonly applied in determining whether a state should intervene and the nature of the state intervention under the neglect statutes. The court recognized that the best interests of the child is basically an objective test under which decisions are made "in behalf of" the child. In contrast, the substituted judgment test is an attempt by the court to "don the mantle" of the other person. Nevertheless, the court found that the "criteria to be examined and the basic applicable reasoning are the same," regardless of which test was applied.

The court indicated that the child's interest in favor of continuing chemotherapy was the opportunity for a longer life and a "substantial chance for cure." This interest was particularly acute because the chances for successful treatment were enhanced due to the type of leukemia involved and the age of the child. Another important consideration in determining the best interests of the child was that there was no effective alternative to chemotherapy in the treatment of the child's disease.

The two factors weighing against chemotherapy were the possibility that more serious side effects could develop in the future, and the child's inability to understand the significance of treatment. Although there were minor side effects associated with the proposed treatment, the evidence established that chemother-

77. The court stated that "where a child's well-being is placed in issue, it is not the rights of parents that are chiefly to be considered. The first and paramount duty is to consult the welfare of the child." 393 N.E.2d at 843.
79. 379 N.E.2d at 1065.
82. 379 N.E.2d at 1065.
83. Id.
84. Id. at 1057.
85. Id. at 1066.
apy would not cause permanent physical harm. Therefore, the potential for future adverse effects of chemotherapy was outweighed by the harm which would result from nontreatment of the disease—almost certainly the child's death.

The importance of the inability of an incompetent to understand the significance of undergoing painful chemotherapy was examined in *Superintendent of Belchertown State School v. Saikewicz*. Although *Saikewicz* dealt with an incompetent who was unable to give "informed consent" to the continuance of medical treatment due to mental retardation rather than minority, the decision indicates that inability to understand and cooperate with medical treatment may be an important factor in determining the interests of an incompetent in the continuance of a particular form of medical treatment.

Joseph Saikewicz was a severely retarded, sixty-seven year old man, who was suffering from acute myeloblastic monocytic leukemia. The superintendent of the state school where Saikewicz lived as a ward of the state filed a petition for the appointment of a guardian to make the necessary decisions about his care and treatment. Both the appointed guardian and the attending physicians recommended against further chemotherapy.

The court, while recognizing that most people in similar circumstances would choose to continue treatments, ordered the discontinuance of chemotherapy. A significant factor in this decision was that, although treatment offered Mr. Saikewicz a substantial chance for remission of the disease, his illness was incurable. Therefore, his inability to understand the treatment and the adverse side effects accompanying the chemotherapy outweighed his interest in a brief prolongation of his life.

Like Mr. Saikewicz, the child in *Minor* was unable to understand the significance of the chemotherapy treatments. However, unlike Mr. Saikewicz, the child had a potentially curable disease. The interest in treatment in *Minor* was, therefore, great enough to outweigh the child's interest in being free from the adverse side effects of treatment.

2. The Parents' Interests

Although the court in *Minor* emphasized that the paramount interest in the determination of whether the minor should continue to receive chemotherapy treatments is the welfare of the

86. *Id.* at 1065-66.
88. *Id.* at 754, 370 N.E.2d at 432.
89. 379 N.E.2d at 1066.
the court also considered the parental interests. The court recognized that the parents have an interest in parental autonomy, or the "natural rights" of parents to make decisions touching on the welfare of their minor children.91

The natural rights of parents have been protected by the courts from unwarranted state intervention.92 Parental autonomy has even been upheld in instances where there is a possibility, or even a likelihood, that the parental decision may eventually result in a permanent handicap for the child.93 However, there has also been a recognition that parental rights may be limited by the state where parental decisions may jeopardize the health or safety of the child.94

While the law recognizes the parental interest in autonomy, "[p]arental rights . . . do not clothe parents with life and death authority over their children."95 The nature of the relationship is not an absolute property right of the parent in the child; instead, it

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90. Custody of a Minor, 393 N.E.2d at 843.
92. See, e.g., Wisconsin v. Yoder, 406 U.S. 205 (1972) (the Court held that state interest was insufficient to force Amish parents to send their children to the public schools after the eighth grade); Meyer v. Nebraska, 262 U.S. 390 (1923) (Court held that state law which forbade the teaching of foreign languages to young children was invalid).

In Yoder, the Court stated: "The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition." 406 U.S. at 232.

93. See Wisconsin v. Yoder, 406 U.S. at 241-49 (Douglas, J., dissenting). Douglas argued that the parental decision to terminate the public school education of Amish children after the eighth grade could handicap the children in later life.

For instances where courts refused to intervene in parental decisions not to treat their children, although the children suffered physical and emotional handicaps as a result of nontreatment, see In re Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955); In re Green, 448 Pa. 338, 292 A.2d 387 (1972) (remanding to trial court), affg trial court decision on remand, 452 Pa. 373, 307 A.2d 279 (1973); In re Hudson, 13 Wash. 673, 126 P.2d 765 (1942).

94. See, e.g., Prince v. Massachusetts, 321 U.S. 158 (1944). The Court in Prince upheld a conviction of a parent for violating child labor laws by allowing her children to distribute religious pamphlets on public streets. The Court stated: "Parents 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." Id. at 170.
95. Custody of a Minor, 379 N.E.2d at 1063. However, one author points out that "the requisite of parental consent to medical care for children becomes
is a right in the nature of a trust, which requires the parent to fulfill a duty to care for and protect the child throughout his minority.\textsuperscript{96} If the parent fails in this duty, the state may intervene and terminate parental rights.\textsuperscript{97}

An individual's right to personal privacy encompasses the right to refuse medical treatment.\textsuperscript{98} Therefore, the courts have generally upheld the right of adults to refuse medical treatment, even when the treatment is necessary to sustain life,\textsuperscript{99} as long as the adult is found competent.\textsuperscript{100} However, if the adult is legally incapable of refusing medical treatment due to unconsciousness or mental incompetency, the courts are unwilling to allow others to meaningless if refusal to consent automatically triggers state inquiry or a finding of neglect.” Goldstein, \textit{supra} note 4, at 651.

\textsuperscript{96} Custody of a Minor, 393 N.E.2d at 843. One commentator notes that problems may result from the notion that parents are the trustees of their children. Wald, \textit{supra} note 4, at 991-93. Blackstone commented:

The duty of parents to provide for the \textit{maintenance} of their children, is a principle of natural law; an obligation... laid on them not only by nature herself, but by their own proper act, in bringing them into the world for they would be in the highest manner injurious to their issue, if they only gave their children life that they might afterwards see them perish. By begetting them, therefore, they have entered into a voluntary obligation to endeavor, as far as in them lies, that the life which they have bestowed shall be supported and preserved. And thus the children will have the perfect \textit{right} of receiving maintenance from the parents.

\textsuperscript{97} Custody of a Minor, 393 N.E.2d at 843.

\textsuperscript{98} Cantor, \textit{A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life}, 26 Rutgers L. Rev. 228, 239-42 (1973). \textit{See also In re Quinlan}, 70 N.J. at 38-42, 355 A.2d at 662-64.

\textsuperscript{99} \textit{See} Note, \textit{supra} note 33, at 662-67. In the following cases, the right of an adult to refuse a blood transfusion on religious principles was upheld: Holmes v. Silver Cross Hosp., 340 F. Supp. 125 (N.D. Ill. 1972); \textit{In re Osborne}, 294 A.2d 372 (D.C. Ct. App. 1972); \textit{In re Estate of Brooks}, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962). \textit{Contra, In re President & Directors of Georgetown College}, 331 F.2d 1000 (D.C. Cir.), \textit{cert. denied}, 377 U.S. 978 (1964); Powell v. Columbian Presbyterian Medical Center, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (1965). In the latter two cases, the adult who objected to treatment was the parent of a minor child. \textit{See also} Winters v. Miller, 446 F.2d 65 (3d Cir.), \textit{cert. denied}, 404 U.S. 955 (1971), where the court held that an adult female who was given medication at a psychiatric hospital over her religious objections had standing to assert a violation of her civil rights.

In the following two cases, the patients' objections to medical treatment were not based upon religious beliefs: Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978) (elderly woman was held to have a right to refuse amputation of a gangrenous foot); Satz v. Perlmuter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978) (patient held to have right to refuse further use of artificial respirator).

\textsuperscript{100} Sharpe & Hargest, \textit{supra} note 9, at 696-97.
make that choice for him, except in instances where the treatment offers no hope for recovery.

In Minor, the court rejected the parents' attempt to compare the fundamental right of competent adults to make personal decisions about health care with the rights of parents to make these decisions for their children. The court held that the parents could not assert on their own behalf the privacy rights of their minor child; the child's privacy rights are protected by the application of the substituted judgment doctrine and the best interests of the child test. Therefore, there is a marked difference in the willingness of the state to intervene in medical decisions concerning adults, and its willingness to intervene in those concerning children. Whereas a state generally cannot impose treatment on a competent adult concerning his own body without violating his right of privacy, the state has the power to impose treatment on an adult parent concerning his child's body.

The Minor court also examined the parents' interests in preventing further discomfort to their child which could result from the continuation of chemotherapy treatments. The court considered the side effects which the child suffered as a result of the treatments and found them to be minor in nature. The parents, however, asserted that the side effects were detrimental to the child's physical and mental welfare. They claimed an interest in having their child free from pain and suffering, and in ensuring a healthy family relationship during the remainder of their child's life. The mother in this case commented: "We would love for [our 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."

The Minor court did not discuss the harmful effects that the continued treatment of the child might have on the parents. Among these are stress on family relationships and emotional

103. 393 N.E.2d at 844.
104. Id.
105. See notes 99-100 & accompanying text supra.
106. Goldstein, supra note 4, at 653. See notes 6-8 & accompanying text supra.
107. 379 N.E.2d at 1064.
108. Id. at 1058.
109. The father stated to the press that "Chad becomes restless and violent after treatments. He's like a wild animal." N.Y. Times, Apr. 6, 1978, § 1, at 18, col. 1.
110. 379 N.E.2d at 1064.
strains on the parents resulting from the child’s discomfort and the related medical expenses.\textsuperscript{111} However, the court may have reached the same result even if the emotional effects on the parents had been given full consideration since there was a lack of evidence that the child suffered from severe side effects from the chemotherapy treatment.

Nevertheless, the \textit{Minor} court should have examined these factors in their decision. It should be recognized that the best interests of the child may be tied invariably to the interests and desires of his parents, and that potential emotional strains on parents resulting from certain types of medical treatments have a bearing on which alternative furthers the best interest of the child. Therefore, it may be impossible for a court to interfere with a family relationship and parental decisions and interests without indirectly harming the child. As one author suggests, in arguing for parental autonomy in this area, “[t]he law is too crude an instrument to nurture, as only parents can, the delicate physical, psychological, and social tissues of a child’s life.”\textsuperscript{112}

\section*{3. The State’s Interests}

Three state interests were indentified by the \textit{Minor} court: (1) protection of the welfare of children living within the state’s borders, (2) the preservation of life, and (3) the protection of the ethical integrity of the medical profession.\textsuperscript{113} In regard to the first interest, the court decided that because the child’s life was threatened by the parental decision to refuse continued medical treatment, the state’s interest in protecting the child’s welfare superseded parental autonomy.\textsuperscript{114} In examining the state’s interest in the preservation of life, the court distinguished the child’s circumstances from the incompetent’s situation in \textit{Saikewicz}. The \textit{Minor} court noted that chemotherapy treatment “offers the child his only real chance of survival,”\textsuperscript{115} whereas in \textit{Saikewicz} the treatment would only afford a possibility of prolonging life for a brief period. “[T]here is a substantial distinction in the State’s insistence that human life be saved where the affliction is curable,

\begin{itemize}
  \item \textsuperscript{111} One author urges that if society insists that children receive medical treatment and the parents do not agree, society should have to bear the resulting financial, physical and psychological costs for “making real for the child ‘it saves’ the value it prefers.” Goldstein, \textit{supra} note 4, at 657. The possibility of strains on the family relationship as a result of medical neglect proceedings has been noted elsewhere. Bennett, \textit{supra} note 4, at 319.
  \item \textsuperscript{112} Goldstein, \textit{supra} note 4, at 657.
  \item \textsuperscript{113} 379 N.E.2d at 1066.
  \item \textsuperscript{114} \textit{Id.} The commentators agree: see Baker, \textit{supra} note 4, at 296; Goldstein, \textit{supra} note 4, at 650; Note, \textit{supra} note 22, at 1439.
  \item \textsuperscript{115} 379 N.E.2d at 1066.
\end{itemize}
. . . [and] the State interest where . . . the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended."

The court focused on the medical profession's interest in curing the curable in discussing the state interest in protecting the ethical integrity of the medical profession. Unlike what the treatment in Saikewicz offered the adult incompetent, the proposed chemotherapy offered more to the child than a brief prolongation of life. The treatment offered a "substantial chance for cure." Therefore, the court in Minor found that this state interest also required that the chemotherapy be administered to the child.

4. Balancing The Interests

A major problem confronting the legal system when the issue is raised as to whether a court should intervene in parental medical decision-making is how to balance the competing interests of the child, the parents, and the state so as to maximize the autonomy of the family unit while still protecting the welfare of the child. The Minor decision, while reflecting a concern for parental interests, emphasizes that when a child's well-being is placed in issue parental interests are secondary to those of the child.

In order to protect the maintenance of the family unit, the law


117. 379 N.E.2d at 1067. One commentator has suggested that the ethical duty of the medical profession would require the administration of treatment under circumstances similar to those in the Minor case. Because it was found that chemotherapy would afford a substantial chance of curing the child's disease, this type of treatment would be considered to be an "ordinary" means of care:

      Despite the existence of the duty in the doctor to preserve the life of his patient, he is not under an obligation to use every conceivable means to do so. Catholic theologians express the point in the distinction they draw between ordinary and extraordinary means. Doctors are under an obligation to use the first but not the second. Ordinary means have been described as 'all medicines, treatments and operations which offer a reasonable hope of benefit, and which can be obtained and used without excessive expense, pain or other inconvenience.' Extraordinary means are those which do involve these factors, or which if used would not offer a reasonable hope of benefit.

N. St. JOHN-STEVAS, LAW AND MORALS 53 (1964).

118. 379 N.E.2d at 1063. One commentator stresses that the child's interest should always be considered before the interest of the parent in determining whether medical treatment should be ordered, because it is the child and not the parent who suffers from a lack of medical care, and because it is the child's interests and future that are primarily affected by the court's decision. Note, supra note 22, at 1438.
imposes a policy of minimum state intervention. The minimum standards required of parents by the neglect statutes impose on the state the burden of overcoming the presumption of parental autonomy. "The presumption of parental capacity to decide is meant to hold in check judges or doctors who may be tempted to use the power of the state to impose their personal preferences, their 'adult parental' judgments upon parents whose own adult judgments may give greater weight to another preference." One commentator has identified five factors governing the judicial determination of whether the state can order medical care for a minor child when the parents have refused treatment. These criteria include: (1) the danger to the life and limb of the child posed by non-treatment; (2) the degree of danger involved in the treatment; (3) the chances of improvement from the treatment; (4) the cooperation of the child; and (5) the burden to the community in permitting the condition to continue. Other authors have taken a more subjective view of the appropriate criteria for state intervention, focusing on such factors as short-term pain or discomfort associated with the proposed treatment and long-term, non-health consequences of state intervention in a particular case. Another important factor appears to be the extent to which the medical profession is in agreement about what medical treatment is appropriate for the child.

In balancing the interests of parent, state and child, the Minor court stressed that the parental interest in autonomy generally outweighs the other interests if the child's condition is not life-threatening or if the proposed treatment presents great risks to the welfare of the child. Yet, the court found that in this case the

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119. See In re Hudson, 13 Wash. 2d 673, 674, 126 P.2d 765, 775-76 (1942) where the court stated:

The authorities are uniform that the maintenance of the natural family relations is favored and the parental affection is not only entitled to consideration as constituting a strong claim in behalf of the parents but as an element of priceless advantage to the infant when the question of custody of a child is to be determined; and the parents will therefore be preferred as guardians if they are fit for the trust.

120. Goldstein, supra note 4, at 654.

121. Id. at 664.


123. See, e.g., Bennett, supra note 4, at 311.

124. See id.; Goldstein, supra note 4, at 652.

125. 379 N.E.2d at 1062. The commentators are generally in agreement that the right of state intervention should overcome the presumption in favor of parental autonomy only where the parent refuses medical treatment when the child's condition is very serious, see Bennett, supra note 4, at 330, or where the child's life is threatened, see Goldstein, supra note 4, at 664. But see Note, supra note 22, at 1440, where the author argues that the interests of the child
child's interests were paramount since the child would die within a few months without treatment, and since the proposed chemotherapy treatments did not pose great risks of harm to the child.\textsuperscript{126} The treatment offered the child the great benefit of extended life and a possible cure. Although side effects of chemotherapy could be detrimental to the child in the short run, the weight of this factor against treatment was overcome by the child's long-term interest in life.

The court found that the state interest in protecting the welfare of the child superseded parental perogatives, since the parental refusal to treat the child's disease threatened the child's chances for continued life. The court also decided that the state interest in the preservation of life weighed strongly in favor of continued treatment, although it was noted that this interest will not invariably supersede other interests in all circumstances.\textsuperscript{127}

In reference to whether the parents' proposed alternative treatment of metabolic therapy should be administered to the child, it was decided that the interests of the child and of the state should overcome parental prerogatives in the decision-making process. The parents argued that metabolic therapy would help to ease the side effects of chemotherapy treatment and would help to cure the child's disease. However, the court found that there was no reliable evidence that metabolic therapy would either help to cure the child's disease or ease the effects of chemotherapy. The positive placebo effect, often associated with metabolic therapy, would be nonexistent in the case of a three-year-old child. Furthermore, the proposed alternative therapy posed substantial dangers to the child's health and well-being.\textsuperscript{128} In balancing parental rights to determine which treatment to give their child against the state's interests in protecting the child's welfare, the court stated:

\begin{quote}
Under our free and constitutional government, it is only under serious provocation that we permit interference by the state with parental rights.
\end{quote}

and the state may be just as strong when the child's condition is not life-threatening, because the injury to the child's right is only different in degree and not in kind.

\textsuperscript{126} 379 N.E.2d at 1063.
\textsuperscript{127} Id. at 1066 n.12.
\textsuperscript{128} Custody of a Minor, 393 N.E.2d at 844-45. The court noted that the use of laetrile posed several dangers to the child's health: (1) because laetrile is not approved by the FDA, the quality obtainable in the United States is poor and is often contaminated; (2) laetrile could possibly compromise the effectiveness of chemotherapy treatments; and (3) laetrile could result in chronic cyanide poisoning. Id. There was also evidence that the excessive dosages of vitamin A being administered to the child could cause liver and central nervous system damage, the enzyme enemas could result in bacterial infection, the folic acid could interfere with the effectiveness of the anti-leukemia drugs, and that the vitamin C could cause kidney damage. Id.
That provocation is clear here. It is beyond argument that a drug or course of treatment is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefit. The position of the parents in this case, however well-intentioned, is indefensible against the overwhelming weight of medical evidence.\(^{129}\)

The supreme judicial court in *Minor* recognized that all of the parties to the decision-making process have competing interests in the outcome.\(^{130}\) Moreover, the court expressly recognized in the first appeal of *Minor* that the parents, in refusing to consent to further chemotherapy treatments for their child, did not wish their child harm;\(^{131}\) in fact, the court found that the parents “wanted what was best for him.”\(^{132}\) Therefore, it is evident that the conflict in the case did not center on conflicting objectives of the parties, but on the means to achieve the common objective of promoting the child's best interests.

Unlike other proceedings where state intervention is justified under the neglect statutes, intervention to ensure proper medical care is often not founded on a lack of parental concern for the child, but, instead, on a difference of opinion as to the proper means of dealing with a physical problem. The parents may be acting in the belief that their decision to refuse medical care for their child is in the child's best interests. The parents may also be suffering from emotional stress as a product of the daily struggle to cope with an ailing, physically handicapped, or dying child. Therefore, from a parent's perspective state intervention in this type of situation, and the resulting adversary process, may appear particularly offensive and less justified than in other neglect proceedings where there has often already been a breakdown in the family relationship.

Furthermore, court intervention in the family relationship in order to ensure proper medical care for a minor child potentially involves serious and prolonged problems of court supervision over the enforcement of its decision. Because of parental love and deep concern for the child, physical removal of the child from their custody may be not only unwarranted, but also extremely detrimental to the child's emotional well-being.\(^{133}\) On the other hand, if the child remains in the physical custody of his parents, there are potential problems of state reliance on parental cooperation to ensure that the treatment proceeds in accordance with the best interests of the child's physical health.\(^{134}\) Since parents may feel

\(^{129}\) *Id.* at 846.

\(^{130}\) *Id.* at 843-44.

\(^{131}\) 379 N.E.2d at 1064.

\(^{132}\) *Id.*

\(^{133}\) Wald, *supra* note 4, at 993-96.

\(^{134}\) *Id.* at 1030-31.
justified in having made their decision against treatment, parental cooperation with the treatment program may be particularly difficult to achieve.

_Minor_ involved serious and prolonged problems of court supervision over the enforcement of its decision. Unlike situations where operations could be ordered or blood transfusions given immediately, the treatment in this case was required to extend over several years.\(^{135}\) Either prolonged and continuous parental cooperation with the court order or the removal of physical custody of the child from the parents was required to insure treatment. Because the parents had a beneficial relationship with their child, removal from their physical custody would have been detrimental to the child's emotional well-being. On the other hand, the problems of enforcing state-ordered treatment when the child remains in the physical custody of the parents are tragically illustrated by the parental response to the court's decision in _Minor_,\(^ {136}\) which resulted in the inability of the state to protect the child's physical well-being.

Future medical advances may have a substantial impact on the court's application of the various criteria in determining whether to order medical treatment for a minor child in a particular case. The more certain a cure becomes, the more substantial becomes the state's interest in ensuring that the child receives that treatment. In areas of health-care where the medical judgments concerning the treatment of a particular ailment become less controversial, the parental interest in making the decision is lessened, and correspondingly, the case for public intervention becomes stronger.\(^ {137}\)

Moreover, if medical technology is capable of reducing the adverse effects of a treatment, the courts may be more willing to find that treatment is in the child's best interests. For example, the _Minor_ court discussed the fact that although the child's parents complained of adverse effects of the chemotherapy treatments, the severity of the side effects was reduced by adjustments in the medication.\(^ {138}\) In contrast, it was the adverse effects of the treatment in _Saikewicz_ which led the court to conclude that it was in the patient's best interests to terminate the treatment.\(^ {139}\) Thus, the cases seem to indicate that if medical technology can eliminate or counteract the adverse effects of a proposed treatment, the interests of the patient may require treatment in more cases.

\(^{135}\) 379 N.E.2d at 1057.
\(^{136}\) See note 63 & accompanying text supra.
\(^{137}\) Bennett, supra note 4, at 318.
\(^{138}\) 379 N.E.2d at 1058.
\(^{139}\) 373 Mass. at 750, 370 N.E.2d at 430.
Advancements in medical technology may tip the balance of the interests in favor of state intervention and against parental autonomy in future instances where a parent has refused medical treatment for his minor child. On the other hand, the more treatment alternatives available, the less substantial becomes the state's interest in forcing the parents to use a particular mode of treatment if another is recognized by a portion of the medical community as being effective against the child's disease.

Medical advances will also alter the meaning of "neglect" under the statutes. As the medical profession improves its ability to cure, societal expectations of what constitutes reasonable care on the part of parents may also increase. For example, in 1945 half of the children who developed acute lymphocytic leukemia died within two to four months. The chances for survival have been greatly increased since that time due to advances in treatment techniques. As the Minor decision illustrates, the responsibilities of parents toward children who have been afflicted with this disease have expanded accordingly. This expansion of the meaning of "neglect" under the statutes has also increased the power of the state to intervene in the health care field.

C. The Substantial Chance for Cure Test

In Minor the results of the proposed treatment, as opposed to those of non-treatment, were not clear-cut. The court was confronted with a strong possibility of death for the child, regardless of which option it chose to follow. The choice was therefore not between life and death for the minor, but, rather, between almost certain death without treatment, and a "substantial chance for cure" if chemotherapy were continued.

In applying this "substantial chance for cure" test, the court did not depart from a balancing of the interests; instead, the test merely aided the court in weighing the interests of the parties. The Minor decision established that where the evidence demonstrates that the treatment affords the child a "substantial chance for cure" of a life-threatening illness, the child's interests in the possibility of life will supersede the parents' interests in autonomy. While not defining what constitutes a "substantial chance" under this test, the court indicated that even when a treatment offers less than a fifty percent chance for cure, it is preferable to no

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142. Id.
143. 379 N.E. 2d at 1057.
treatment at all, and justifies state interference over parental objections.\textsuperscript{144}

In Massachusetts, the "substantial chance for cure" test had previously been applied in \textit{Saikewicz}, where the court found that chemotherapy treatments might prolong the patient's life but that there was no substantial chance for cure.\textsuperscript{145} The \textit{Minor} court distinguished \textit{Saikewicz} by stating that in the child's case,

\begin{quote}
[c]hemotherapy was more than a brief means of prolonging life—it offered the child a substantial hope for cure. To withdraw the child from his chemotherapy program, without offering an effective alternative, would be tantamount to treating him 'as if he were dying.' According to the child's attending physician, this emphatically was not the case.\textsuperscript{146}
\end{quote}

Although the "substantial hope for cure" language has not been expressly employed in other jurisdictions, the concept has been widely utilized in determining the justification of state intervention to order medical treatment for an incompetent adult.\textsuperscript{147} It is recognized that the feasibility of cure is an important factor to be considered because it is helpful in estimating the value of a proposed treatment to an individual patient. The concept that the state should not intervene to force treatment on an incompetent where a cure is impossible has received widespread acceptance.\textsuperscript{148} The notion of the substantial chance for cure has also been employed in distinguishing between "extraordinary" and "ordinary" care.\textsuperscript{149} The \textit{Minor} court emphasized that the chemotherapy treatment ordered for the child was ordinary medical care in the view of the medical profession.\textsuperscript{150}

The use of expert testimony and statistics was vital in the court's determination that there was a substantial chance for cure.

\textsuperscript{144} 393 N.E.2d at 840.
\textsuperscript{145} 373 Mass. at 734, 370 N.E.2d at 421.
\textsuperscript{146} 379 N.E.2d at 1067.
\textsuperscript{147} \textit{See}, e.g., \textit{In re Nemser}, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (1966). The court in \textit{Nemser} denied a petition for an order directing the amputation of the leg of an eighty-year-old patient who had a gangrene condition due to diabetes. The court based its decision not to order the amputation on the ground that the evidence demonstrated uncertainty as to whether amputation would prolong the patient's life or correct her condition. \textit{See also In re Quinlan}, 70 N.J. 10, 355 A.2d 647 (1976). The \textit{Quinlan} court allowed life-support measures to be terminated when the incompetent had no chance of ever returning to a "cognizant sapient state". \textit{Id.} at 55, 355 A.2d at 671-72.
\textsuperscript{149} \textit{See} N. ST. JOHN-STEVAS, supra note 117.
\textsuperscript{150} 379 N.E.2d at 1064.
in the *Minor* case. The court's use of statistical evidence reflects a recognition that it is always difficult to ascertain with absolute certainty the outcome of any medical treatment. In *In re Vasko*, the New York Appellate Division also used probability data to predict possible results of the proposed medical treatment of a child who was suffering from an eye tumor. Despite the uncertainty as to the possibility of cure, the court, over parental objections, ordered an operation to be performed to remove the eye, noting that "[m]edicine and surgery are not exact sciences, and the result of an operation may not be foretold with accuracy...". However, in the case of *In re Sampson*, medical treatment was ordered for a minor, over parental objections, even though expert testimony indicated that there was no chance for a cure of the child's disease.

Because of the uncertainty of the possibility of cure in *Minor*, the substantial chance for cure test represents an expansion of judicial authority to intervene under the neglect statutes in order to authorize medical treatment over parental objections. Although this test does not represent a marked departure from previous considerations in the decision-making process, it affords greater possibilities for legally justifying state intervention where the results of treatment are speculative. However, because the concept of a "substantial chance" has not been defined with precision, it is difficult to evaluate just how low the "odds" must be before state intervention would be unwarranted under this test. The experts in *Minor* were unable to evaluate with precision just what were the child's chances for a cure. However, the court noted that only a short while ago available treatments for the child's condition may not have afforded him a substantial chance for cure. As medical

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151. 238 A.D. 128, 263 N.Y.S. 552 (1933).
152. The *Vasko* court found that there was a fifty percent chance for cure with treatment. *Id.* at 131, 263 N.Y.S. at 555.
153. *Id.* at 131, 263 N.Y.S. at 555.
155. 65 Misc. 2d at 661, 317 N.Y.S.2d at 645. The child in *Sampson* suffered from Von Recklinghausen's disease, which had caused a massive deformity of his face and neck. Medical treatment was ordered over parental objections in this case because there was evidence that surgery would improve the child's physical appearance, thereby benefiting his psychological well-being. 65 Misc. 2d at 660, 317 N.Y.S.2d at 644-45. However, the *Sampson* decision has been sharply criticized. Goldstein, *supra* note 4, at 667.
156. Goldstein argues that there should be no coercive intrusion by the state in a life or death situation if there is a less than high probability that the treatment will cure the child or enable him to have a life of normal healthy growth toward adulthood. Goldstein, *supra* note 4, at 653.
157. 379 N.E.2d at 1063-64. *See also* notes 141-42 & accompanying text *supra.*
knowledge in this area of study improves, the courts may be able to define a "substantial chance" with more precision.

It is also interesting to speculate as to what effect the finding that a treatment offers a substantial chance for cure may have where parental objections to medical treatment are based upon religious convictions. While the parents did not raise this issue in Minor, it is apparent that a finding of a substantial chance for cure of a life-threatening illness may even overcome parental objections based on religious grounds.\(^{158}\)

D. The Alternative Medical Treatment Test

Another important factor in the decision of whether to allow parents to refuse medical treatment for their minor child is the determination of whether there are alternative treatments available which would be effective against the child's disease or injury.\(^{159}\) When a life-threatening disease is involved, the existence of an effective alternative may be crucial to the preservation of parental autonomy. However, if the condition is not perceived by the court as being a threat to the child's life, the absence of an alternative treatment will not necessarily result in state-enforced treatment.\(^{160}\)

An important element in the court's decision in Minor was the absence of any effective alternatives to the chemotherapy treatment. In the original hearing before the supreme judicial court, the parents argued that chemotherapy should not be given to their child over their objections, regardless of whether an alternative treatment was available. However, in the review and redetermination hearing the parents argued that, while they accepted the necessity of chemotherapy treatments for their child, they desired to supplement these treatments with an alternative program of metabolic therapy.

In determining whether to allow this supplemental treatment, the court asked whether this treatment was "consistent with good


\(^{159}\) Bennett, supra note 4, at 311; Goldstein, supra note 4, at 653. See also State v. Perricone, 37 N.J. 463, 479-80, 181 A.2d 751, 760 (1962).

\(^{160}\) In re Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942). Another important factor in Hudson was that the proposed operation to correct a congenital deformity was a dangerous procedure. Id. at 677, 126 P.2d at 768.
medical practice." Thus, the testimony of experts in the profession was critical in the judicial decision to interfere with parental rights by rejecting the alternative treatment, just as it had been crucial in the court's original interference with parental autonomy by affirmatively ordering the chemotherapy treatment.

The parents presented four expert witnesses, in support of the assertion that metabolic therapy was an effective medical treatment for their child's illness. Although two of the parents' witnesses were physicians, none were licensed to practice medicine in Massachusetts and none had expertise in the treatment of leukemia. The court weighed the testimony of the parents' witnesses against the testimony of experts presented by the state. The state experts, several of whom had expertise in the treatment of leukemia, were all physicians. Their testimony was that the chemotherapy program was an effective means of treating the child's disease and was accepted as such by the medical community. They also testified that the supplemental treatment program of metabolic therapy proposed by the parents was ineffective as a treatment of leukemia and was potentially harmful to the child.

The court emphasized that the issue was the effectiveness of the alternative mode of treatment in curing the child's particular disease. The court based its decision to order the continuation of chemotherapy treatment and to prohibit the parents from treating their child with metabolic therapy on both the lack of proven effectiveness of the proposed treatment and on the potential negative effects of the treatment on the child's health, including the possibility that the metabolic therapy could interfere with the effectiveness of the chemotherapy program.

The importance of expert testimony in influencing the outcome of a court's determination of whether an alternative means of treatment is "medically effective," is illustrated by a comparison of Minor and the case of In re Hofbauer. The Court of Appeals of New York decided Hofbauer between the time of the original decision of the Supreme Judicial Court of Massachusetts in Minor and the rehearing of the case. In Hofbauer, the court was confronted with the issue of whether custody of an eight-year-old child, who was suffering from Hodgkins disease, should be removed from the parents under the New York neglect statute. The parents in this case refused to treat their child's disease with radiation and chem-

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161. 393 N.E.2d at 838.
162. 393 N.E.2d at 839.
163. Id.
164. Id. at 844-45.
otherapy, which was the mode of treatment recommended by the child's attending physician. Instead, the parents placed the child under the care of another physician who advocated metabolic therapy, including injections of laetrile. The court refused to remove legal custody of the child from the parents under the neglect statute, on the ground that the parents had exercised the minimum degree of medical care for their child required by the statute.\textsuperscript{167}

There are marked similarities between the \textit{Hofbauer} case and \textit{Minor}. Each child was afflicted with an illness which was fatal if not treated,\textsuperscript{168} and the generally accepted mode of treatment in each instance was chemotherapy.\textsuperscript{169} However, the court in \textit{Hofbauer} distinguished the first \textit{Minor} decision on the ground that the parents in \textit{Hofbauer} had not made an "irreversible decision to deprive their child of a certain mode of treatment" in favor of no treatment.\textsuperscript{170} In other words, the \textit{Hofbauer} court characterized the parental rights at issue in the first \textit{Minor} decision to be the right to choose \textit{between} different methods of treatment, rather than the right to refuse \textit{all} treatment.

The child in \textit{Hofbauer} was under the care of a physician who was licensed to practice medicine in the state and this doctor testified as to the positive effects of metabolic therapy. Another significant fact was that the metabolic therapy was controlling the child's illness, and the physician and the parents both agreed that a more conventional treatment, including chemotherapy treatments, would be administered to the child if his condition deteriorated.\textsuperscript{171}

In the second \textit{Minor} decision, the Supreme Judicial Court of Massachusetts distinguished the \textit{Hofbauer} decision on the ground that the evidence introduced in that case indicated that the alternative medical treatment proposed by the parents was an effective alternative in treating the child's illness. The \textit{Minor} court stated:

\begin{quote}
The medical evidence in that case [\textit{Hofbauer}] was sharply conflicting, with two physicians opining that there had been a progression of the disease and denouncing nutritional therapy as ineffective. However, there was also evidence from two other physicians that nutritional therapy is effective and further testimony from an attending physician that the nutritional treatment being administered to the child was controlling his condition and that conventional treatment would be utilized if necessary. In short, there was substantial evidence, even though contradicted by other evidence, to warrant the trial judge's decision. This is a far cry from the unsupported stance of the parents in the instant case, and the compelling
\end{quote}

\textsuperscript{167} 47 N.Y.2d at 656-57, 393 N.E.2d at 1015, 419 N.Y.S.2d at 940-41.
\textsuperscript{168} \textit{Id.} at 652, 393 N.E.2d at 1011, 419 N.Y.S.2d at 938; Custody of a Minor, 379 N.E.2d at 1063.
\textsuperscript{169} \textit{In re} Hofbauer, 47 N.Y.2d at 653, 393 N.E.2d at 1012, 419 N.Y.S.2d at 939; Custody of a Minor, 379 N.E.2d at 1057.
\textsuperscript{170} 47 N.Y.2d at 656, 393 N.E.2d at 1014, 419 N.Y.S.2d at 941.
\textsuperscript{171} \textit{Id.} at 653-54, 393 N.E.2d at 1012, 419 N.Y.S.2d at 939.
evidence that for this child metabolic therapy, including the use of laetrile, is useless and dangerous.\textsuperscript{172}

\textit{Hofbauer} has been interpreted to stand for the proposition that a parent has a "certain freedom of choice in determining the therapy for a desperately sick child."\textsuperscript{173} While the case may be interpreted in this manner, it is apparent, in view of the second \textit{Minor} court's reading of the case, that this parental "freedom of choice" to administer non-conventional forms of alternative treatment may only arise after the parent has met a high burden of proof to demonstrate that the alternative is in accordance with sound medical practice. Through the testimony of expert physicians who were familiar with the treatment of the child's disease, the parents in \textit{Hofbauer} were able to meet their burden of proof. However, the parents in the rehearing of \textit{Minor} did not meet this burden. The conflicting results of the two cases make it evident that expert testimony is crucial in the determination of what constitutes an effective alternative treatment and whether parental prerogatives will prevail.

The court emphasized in the rehearing of \textit{Minor} that what constitutes an effective alternative medical treatment depends on its acceptance by physicians licensed in that state who specialize in treating the type of disease with which the child is afflicted.\textsuperscript{174} Therefore, as the state of the art improves in this area of medicine, the meaning of "effective alternative treatment," as interpreted by the medical profession and by the courts, will change.

V. CONCLUSION

The decision of the Supreme Judicial Court of Massachusetts in \textit{Custody of a Minor} constitutes a judicial expansion of the state's authority to intervene in traditional realms of parental autonomy. The court's application of "the substantial chance for cure" test enlarges the state's power to interfere with parental rights to refuse medical treatment for their children. By placing a heavy burden of proof on the parent to show that a preferred alternative treatment is, in fact, a "medically effective" procedure, the court's decision indicates a judicial willingness to limit parental rights to choose between possible means of treating a child's illness. The court's reliance on expert testimony and statistical data signifies the important impact future advances in medical technology may have on judicial weighing of the rights and interests of the parties, defi-

\textsuperscript{172} \textit{Custody of a Minor}, 393 N.E.2d at 846.
\textsuperscript{173} Pendergast, \textit{supra} note 57, at 580-81.
\textsuperscript{174} 393 N.E.2d at 845-46.
nition of a "substantial chance for cure," and determination of what constitutes an "effective alternative medical treatment."

With constantly advancing medical technology, the legal determination of when to intervene in parental autonomy in the decision-making process involving the medical care of minor children will necessarily change. As the medical profession increases its ability to offer hope for cures for childhood illnesses, the scope of parental rights to refuse medical treatment for minor children will necessarily narrow. The advancement of medical technology, therefore, has the effect of broadening the state's authority to intervene in the parental decision-making process of whether to treat a child's illness. As more "cures" are developed, more diseases will be recognized as "curable" within the "substantial chance for cure" test.

On the other hand, the advancement of medical technology may provide more parental autonomy, not in the decision of whether to treat a child's illness, but in determining which method of treatment to use. As more treatments are recognized as medically effective alternatives, parents may acquire more autonomy to choose between treatments, and to weigh the benefits and disadvantages of any particular alternative treatment on their minor child.

Finally, the potential disruption of family relationships, arising from state intervention in the medical decision-making process, is a factor which should be given more consideration in future court decisions. Even when treatment may afford physical benefits, it may, under some circumstances, be contrary to the best interests of the child. This is particularly true in a case like Minor where proposed medical treatment offers only a possibility of cure, albeit a "substantial" one. In such instances, stress within the family, resulting from both intervention and adverse effects of treatment, may be severe enough to outweigh the potential benefits.

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