Do Fourteenth Amendment Considerations Outweigh a Potential State Interest in Mandating Cochlear Implantation for Deaf Children?

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Currently, the decision concerning pediatric cochlear implantation for children remains a personal choice for parents to make. Economic factors, educational outcomes, and societal attitudes concerning deafness could result in an increased governmental interest in this choice. This article examines case law related to the issue of parental autonomy to determine whether the state, acting in the role of parens patriae, could use economic and social reasons to mandate the provision of cochlear implants for all eligible children. The author uses previous cases as a framework to develop an opinion on whether a constitutional protection for parents may exist.

Parental rights exist in a shadowy area of the Constitution. Although many believe these rights exist, they are neither explicitly included within the text of the Constitution nor formally defined and acknowledged by the Supreme Court (Meyer v. Nebraska, 1923). Despite the lack of formal recognition, Meyer v. Nebraska is part of a long tradition that supports the subrogation of a child’s rights in favor of those exercised on behalf of the child by the parent or guardian. In the United States, unlike the ancient Greek city-state of Sparta, both the courts and families usually believe that a child belongs to the parents instead of to the state (U.S. Const. amend. XIII). Unfortunately, as child abuse and child neglect statistics show (Merrick & Browne, 1999), assuming responsibility for a child does not automatically convey to a parent or guardian the traits of wisdom, kindness, or even common sense. Trends and fads in parenting influence parental choices. Some of these parental choices have little lasting importance, but others create a permanent, irreversible impact on the child, limiting what Dena Davis termed “the child’s right to an open future.” (Davis, 1997, p. 9)

This article asks whether the state has the right and perhaps the obligation to take an active role in decisions made about the use of cochlear implants for prelingually deaf children. It questions whether the parental rights implied under the due process protections of the Fourteenth Amendment (U.S. Const. amend. XIV) are all-encompassing or whether the state could ever usurp parental prerogatives by requiring cochlear implants for children. The state’s interest in protecting its vulnerable citizens from harm parallels its economic interest in having children grow up to become productive members of society. The costs incurred if society recognizes deafness as one aspect of an individual rather than only as a disability capable of mitigation are potentially significant due to the standards established by the Americans with Disabilities Act (1990) and the Individuals with Disabilities Educa-

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tion Act (1997). Constitutional considerations must be examined before deciding whether such a state action could ever be justified.

Impact of the Fourteenth Amendment on Parental Rights to Make Decisions on Behalf of Children

Historical Development of Due Process Protections for Parental Choices

The constitutional issue at question asks whether the state has an overriding interest in endorsing or mandating cochlear implantation. Traditionally, whenever the state intervenes in the parent-child relationship, it usually finds its support in one of the four state interests that allow it to override an individual's right to refuse treatment (73 Op. Att'y Gen. 162). In a 1988 opinion, the U.S. Attorney General wrote, "Courts have recognized four state interests that might outweigh an individual's right to refuse treatment. These interests are: the preservation of life; the prevention of suicide; the protection of the interests of innocent third parties; and the maintenance of the ethical integrity of the medical profession" (p. 162).

State endorsement of cochlear implantation would place the state's interest in protecting vulnerable children in opposition to the protections of privacy interests associated with the Fourteenth Amendment of the Constitution (U.S. Const. amend. XIV). This amendment's due process clause has already lent support for the right of parents to make nontraditional medical (Newmark v. Williams, Del. 1991) and educational decisions for a minor child, based on family values and beliefs (Wisconsin v. Yoder, 1972). The parents and advocates of deaf and profoundly hearing-impaired children may find that the language of the Fourteenth Amendment can help to support their right either to accept or to reject cochlear implants on behalf of their children. Many parental decisions concerning education or nonemergency medical intervention, even those having a significant potential impact on a child's future, already receive deference from the courts (Curtis v. School Comm., Mass. 1995). It would take a considerable state interest to override this tradition of implied constitutional protection.

Recognizing an Early Right of Privacy Concerning Parenting Issues

Meyer v. Nebraska (1923) began the debate concerning whether there was any constitutional support of parental rights and if so, what its parameters were. In Meyer, the Supreme Court overruled the conviction of a teacher who instructed young children in the German language in accord with parental preference, despite a Nebraska statute forbidding this type of activity. When striking down the Nebraska Supreme Court rulings, the U.S. Supreme Court held that the due process clause granted liberty to parents "to acquire useful knowledge, to marry, establish a home and bring up children." (1923, p. 397) Although this Supreme Court's ruling opened the door to the concept of parental autonomy over children, it offered little direct guidance on whether parental choices not based on religion were also protected.

Recognizing Parental Autonomy for Decisions Involving Education

Weighing state interests in education. Pierce v. Society of Sisters (1925) challenged an Oregon state law requiring children to receive education from the state-supported public school system. This eliminated the option of choosing a religious education for children. In holding that the lower court ruling should be overturned, the Supreme Court said, "The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations." (1925, p. 535) Pierce echoed the ruling made in Meyer but took it one crucial step forward. The Supreme Court implied that the state role concerning vulnerable children became applicable only in cases where the parents failed to do their job adequately. The mere existence of a state responsibility was not enough to justify overriding valid parental choices, even when the state disagreed with those choices.

In Wisconsin v. Yoder (1972), Old Order Amish parents brought suit in court to protest Wisconsin's requirement that all children must be educated until 16 years of age. U.S. law in all states requires all children to receive educational instruction through the age of 16.
The Amish community viewed exposure to a broad base of information from mandatory education after eighth grade as having an immediate and deleterious impact on acceptance of Amish values by their children.

The state’s argument made a close connection between children’s levels of education and their eventual options in the job market. The state reasoned that with an education, an Amish child could elect to enter the secular world or remain in the traditional Amish lifestyle. However, without an adequate education, the only option available to these children was to remain within the Amish lifestyle. The state justified its educational requirement as an action taken in support of its *parens patriae* role, but the court was not persuaded (73 Op. Att’y Gen. 162). Unlike in *Yoder*, the state would find it difficult to prove conclusively that cochlear implantation consistently results in better educational, social, and employment outcomes for deaf persons.

The Supreme Court used the precedent set in *Meyer* (1923) and in *Pierce* (1925) to support its noninterventionist holding in *Yoder* (1972). All three cases involved a course of action that parents wished to follow in support of their individual beliefs on how best to raise a child. Although the state’s rationale for mandatory education supported the opinion that education opens options for children, the very experience of participation in advanced education could mean that the option of easily adapting to an Amish lifestyle as an adult would be forever lost to the child (*Yoder*, 1972). Just as the earlier cases first recognized a constitutional right to parental autonomy, then prioritized this right over any state rights concerning children unless parental choices place the child at risk, *Yoder* advanced the substantive due process argument a little further. Based on this Supreme Court ruling, parental decisions did not have to qualify as the best option, as long as they were made in what the parents viewed as the best interests of their children.

On other occasions, the courts have again refused to authorize parental decisions that would result in the complete elimination of some future options for a child if those options cannot be readdressed when that child reaches adulthood (Hawkins, 1999). The reasoning in those cases suggested the mindset that parents were meant to shape a child’s future with their decisions but not to determine its outcome completely. Though not explicitly stated, the Court’s actions in *Yoder* (1972) suggested an opinion that there is no one window of opportunity in which to receive an education. Although the Court declined to speculate how likely it was that the adult Amish would ever seek out the education denied in childhood, it was the potential for this opportunity that seemed to matter.

### Recognizing State Interest in Medical Situations Where a Child’s Future Is at Risk

Unlike the reversibility of educational decisions, some medical choices have life-or-death outcomes. There has been a showing of deference to the state for interventions needed by minors in emergency situations, even when there are religious reasons to forego the treatment. The Jehovah’s Witness tenets forbid the use of blood transfusions or blood products by its practitioners, even in life-threatening situations (Fontanarosa & Girogio, 1989). Followers of Christian Science rely on prayer for healing and do not seek medical interventions (Benson & Dusek, 1999). Despite these religious tenets, courts have authorized blood transfusions, appendectomies, and other emergency medical care for children, regardless of the wishes of the parent or guardian. This allows the state to act in the best interest of the child and to protect a future productive citizen (73 Op. Att’y Gen. 162). The holding in *Prince v. Massachusetts* (1944) explains the deference paid to the state position in these actions by stating, “Parents may be free to become martyrs themselves. But it does not follow that they are free . . . to make martyrs of their children” (1944, p. 170). Allowing the state to exercise its *parens patriae* role offered these children the best chance to survive into adulthood. Deference to the state preserved all the options available to a child because any error will be on the side of life, rather than death.

Despite this, deference to the state is not absolute for every life-threatening issue. There are some urgent medical interventions for which the courts did not show the state deference but instead deferred to the parents’ desires. In *Newmark v. Williams* (Del. 1991), doctors offered to treat a three-year-old child affected by an aggressive and potentially fatal form of pediatric
cancer with a chemotherapy protocol that offered a 40% chance for success. His parents refused, preferring to forego medical intervention in favor of healing efforts performed by a Christian Scientist practitioner. By ruling in favor of the parents, the court decided that the best interests of the child were better determined by the parents who knew and loved him, rather than by the court. The distinction here seems to be the questionable benefit offered by the procedure. The state’s interest lies in protecting its future citizens, and the outcome of a forced intervention in Newmark could not guarantee to preserve the future of the child.

Cochlear implantation is considered an elective procedure. The legal reasoning already applied in emergency medical care cases suggests that greater parental deference could be expected for this non-urgent medical intervention. One major distinction between the situation encountered in Newmark (1991) and cochlear implantation is that the former involved parental rejection of recommended interventions. There was no guarantee that the chemotherapy would save the child, but a failure to receive the intervention would result in the death of the child. The literature offers conflicting data on the medical, psychological, economic, and social implications of cochlear implants (Harris, Anderson, & Novak, 1995; Li, Bain, & Steinberg, 2003; Pollard, 1996; Swanson, 1997). As in Newmark, the state cannot say with any certainty whether cochlear implantation will affect the future of the child in a positive manner. Unlike Newmark, the state has no proof that failure to undergo implantation will place a child in a more vulnerable position. As scientific and technologic advances such as cochlear implantation open more life-altering options for parents to either embrace or reject (Anstey, 2002), it will be essential to have clearer guidance from the courts to determine the appropriate role for the state.

Few Court Challenges to Parental Decisions for Nonemergency Medical Care

There are already several elective surgical and medical procedures requested by parents for reasons that are not related to an improvement in a child’s physical health. Procedures such as infant circumcision and human growth hormone (HGH) treatments may be provided more often for parental preference than to address a significant medical problem (Kelnar, 2000; Povenmire, 1999). These elective medical interventions place children in a potentially vulnerable position. Potential risks of circumcision include pain, infection, constriction due to scar tissue, and interference with maternal child bonding (Povenmire, 1999). Articles suggest that the HGH protocol may lead to psychological risks to self-esteem, affect the parent-child relationship, and build a dependency on HGH based on a perceived “handicap” (Powers, 1998, p. 146).

The First Amendment upholds the choice of those parents who request circumcision for male infants as part of a recognized religious practice (U.S. Const. amend. 1). Religious reasons are cited by only a small percentage of those parents choosing this surgical procedure compared with those electing this procedure based on personal preferences (Povenmire, 1999). There are no religious grounds to support HGH intervention. The FDA originally approved the treatment for children with growth deficiencies. In 1994, only 7,000 U.S. cases of classic growth deficiency were reported but approximately 20,000–35,000 children received HGH treatments (Powers, 1998). These figures suggest that more than a few parents may have opted for the HGH treatments for personal reasons not related to the child’s physical well-being. Despite the evidence indicating that neither circumcision nor HGH intervention are completely risk-free procedures, there is little guidance on whether parental right to consent to elective medical procedures exists. Related case law, including those previously cited and expanded by considerations of Stanley v. Illinois (1972) involving the parental rights in a nonmarital situation and Griswold v. Connecticut (1972) involving the right of a married couple to obtain contraception, seem to contain a common thread supporting parental privacy rights. Each case offers the general consensus that some right of parental autonomy exists but does not establish any clear boundaries to mark the perimeter of such a right. Precedent suggests that courts heavily weigh the life-altering nature and permanence of the proposed intervention, be it educational or medical, as an important factor when determining whether the state can overrule a parent’s wishes. These factors seem
to carry more importance than considerations of whether the proposed decision violates traditional state or societal opinions concerning which action ought to be acceptable behavior.

Assessing the State’s Potential to Benefit by Mandating Cochlear Implantation

Precedent suggests that when considering parental choices, courts typically defer to the state when a child’s future will worsen if there is no intervention but defer to the parents in most other situations. A child’s future in terms of physical life span is relatively unaffected by either the presence or absence of a hearing loss. The implantation of the cochlear device, similar to any surgical procedure, carries a slight chance of an undesirable surgical outcome (Gastman, Hirsch, Sando, Fukui, & Wargo, 2002). The procedure cannot be evaluated only in terms of the immediate post-operative outcome because the implantation of the cochlear device has a permanent impact on any available hearing and on the anatomical structures within the ear. There are ongoing efforts to develop treatments for deafness and hearing loss (Rose, 1999), and cochlear implantation may make future medical interventions unavailable to these children (Raphael, 2002). There is also the potential for failure of the device, raising the possibility of another surgery for reimplantation (Parisier, Chute, Popp, & Suh, 2001).

The surgical procedure is only the first stage of the cochlear implantation process. An intensive and prolonged rehabilitation period is required after the surgery, and the final outcome for each child is unknown. The prolonged nature of this endeavor highlights the problem of clearly defining where the state involvement ends. Could it be enough intervention to require the cochlear implantation surgery or does this merely trigger an ongoing state involvement throughout the life of the child? An Iowa appellate case, In the Interest of K.S., a Minor Child (1993), involved a battered and neglected child who was also deaf. The court ruled in favor of termination of the natural mother’s parental rights and used as part of its reasoning the requirements surrounding the demanding rehabilitation needed for a planned cochlear implantation procedure. In K.S., although it was not the only reason for the court’s decision to terminate the mother’s rights to the child, the failure of the mother to learn American Sign Language and her unsuitability to participate in a recommended cochlear implantation program were factors in the decision. It is difficult to know for certain whether the case’s outcome, termination of maternal rights, would have been the same had there been no physical abuse involved. Still, the judge’s language in the decision does not mention the abuse when stating that a cochlear implant would be beneficial to the child and that unless placed in a “stable and structured environment,” the child was unlikely to get the extensive rehabilitation needed after the surgery in order to benefit fully from the implant (K.S., 1993, p. 820).

The K.S. case (1993) raises the question that if cochlear implants were mandated by the state, could any subsequent failure of the parent to carry through with the aural training rehabilitation potentially result in harsh consequences? The final statement by the K.S. court clearly signaled that it did not view parental rights as sacrosanct. Although other case law is almost nonexistent and the weighting given to the abuse factor is not clear, the holding in K.S. suggests that the state had the power to compel both willing and reluctant parents to allow the cochlear implantation surgery but to later remove children from these same homes if the parents were not adequately involved or successful with the lengthy rehabilitation process. Other research indicates that educational outcomes after cochlear implantation are greatly affected by the amount of support available in the classroom (Brusky, 1995; Geers et al., 2002; Lohle et al., 1999; Moog & Geers, 2003). The decision to mandate cochlear implantation may result in increasing both the economic costs and the need for ongoing involvement of the state throughout the entire rehabilitation process. To paraphrase an old proverb, once the camel sticks his nose into the tent, is it possible to get him out again? (Friedman, 1990, p. 917)

Conclusion: Does the Issue of Cochlear Implantation Justify State Intervention?

State intervention must find its support in one of the four state interests (73 Op. Att’y Gen. 162). Should the
state choose to exert its *parens patriae* authority and implement a policy mandating cochlear implantation, its reasons may have more to do with economics and society’s attitudes toward the disabled than with a true concern for the future of these children. High-quality deaf education is a significant expense for the state and for the family. The overall costs for deaf education are difficult to predict, because traditional education must be supplemented with ongoing American Deaf Association (ADA)-mandated support to allow effective functioning in society. The cochlear implantation surgery and the necessary years of rehabilitation also require a significant financial investment with no guarantee of the outcome. Public and private health insurance plans cover varying amounts of the cost of the surgery and rehabilitation (Garber, Ridgely, Bradley, & Chin, 2002). It is difficult to put a price on the cost in terms of family commitment and time (Allegretti, 2002; Foster, 2000). Despite some uncertainty about the length (and therefore cost) of aural rehabilitation, the state could view a successful cochlear implant procedure as having a relatively high but more predictable cost than the alternative. With this in mind, the state may pragmatically view even cochlear implants as the lesser of financial burden.

If economics direct the state’s choice of a position in the cochlear implant controversy, endorsement of the procedure could seem like a logical and even desirable result. Issues ranging from educational costs, accommodation costs mandated by the ADA, discomfort of society in dealing with persons with disabilities, and a statewide need to ensure that all its future citizens are capable of performing the technically oriented jobs of the new millennium might encourage a state to view mandated cochlear implantation surgery as the most economically feasible alternative (Tucker, 1998).

This is a complex issue that cannot easily be reduced to dollars and cents. Over 75 years ago, *Pierce* (1925) established that the state is not as capable as are those persons who love the child to decide what is best for that child. The cochlear implantation decision is affected by a myriad of cultural, psychological, socioeconomic, and personal issues. When examining the decision from an isolated legal perspective, the matter of parental rights comes to the foreground. Allowing the state to usurp the original decision of whether to have the surgery invites intervention for every subsequent aspect related to the cochlear implantation. Extensive postsurgical cochlear rehabilitation spanning several years is necessary in order to benefit fully from the surgical procedure. This requires a great deal of time, money, energy, and dedication from the family. Only the family can identify and weigh all the tangible and intangible factors in order to make an informed decision. Every family’s decision will be different.

At present, there is no medical guarantee concerning the outcome from any cochlear implant surgery. Despite expected advances in medical science, it will never be possible to offer such a guarantee. Any attempt of the state to mandate participation in this surgery raises constitutional questions. As compared with the significant due process rights of parents concerning their children, the state’s interest in advocacy for cochlear implantation surgery is practically nonexistent, given the present state of medical technology. Without concrete proof that cochlear implantation will improve reading scores, facilitate community assimilation, and enhance the future opportunities of deaf children, the risk of mandating cochlear implantation is significant. The state could be backing the wrong horse. It is true that the parents, left to their own devices, could also make incorrect decisions for their children. When dealing in futures, there is no crystal ball. There is no precedent to suggest that the state’s potentially “wrong” decision is worthy of any more deference than would be accorded to the same “wrong” decision made by parents. Although the state’s are laboratories for just this sort of social experimentation, few parents would tolerate having participation in a state experiment forced on them.

Case law indicates that the Constitution allows parents considerable liberty interests in determining the type of lives their children will lead. The founding fathers did not restrict these choices to only those options embraced by mainstream America. Every day, parents make many life-altering decisions for their children, and the result of each choice is subtly to alter the options that will exist for a child’s future. From the
moment the child is born, his or her future is “open” (Davis, 1997) in the sense that there are many things available to the child but no child has access to everything. The result of selecting any course of action is to make other options potentially less accessible or unavailable. The cochlear implantation decision is no more or no less crucial than many other everyday decisions faced by parents that will have a potential impact on a child’s future life. There are some decisions that are better left to the family to make. A more suitable role for the state is involvement in the support of educational programs on cochlear implantation. This would ensure that the decisions parents make for their children on this issue reflect a fully informed choice.

References


In the Interest of K.S., a Minor Child, 512 N.W.2d *17 (Iowa App. 1993).


U.S. Const. amend. I.

U.S. Const. amend. XIII.


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