**Adolescents ought to have the right to make autonomous medical choices.**

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# Topic Analysis

**Adolescents ought to have the right to make autonomous medical choices.**

This topic asks debaters to explore the rights of adolescents in making choices for themselves, which is a relevant topic for High School students, given your current location smack dab in the center of adolescence. Merriam-Webster defines “adolescent” as “A young person who is developing into an adult; a young person who is going through adolescence, and Merriam-Webster defines “adolescence” as “1. The state or process of growing up; 2. The period of life from puberty to maturity terminating legally at the age of majority; 3. A stage of development (as of a language or culture) prior to maturity.” This resolution is asking debaters to discuss the importance of autonomy, or the ability to make choices for yourself, in the liminal space between childhood and adulthood.

This topic places medical decisions at the forefront, meaning that the topic touches on questions of terminal illnesses, pregnancy, sexual transmitted diseases, palliative care, and all the other types of decisions that minors have to make. In order to answer this question, debaters must explore questions relating to the level of competence adolescents have when making choices for themselves. Currently, the legal systems evaluation of minors is based on the notion that children are the property of their parents, and as such, parental rights are generally viewed as sacrosanct. This means that adolescents exist in a very interesting space—as people developing into adults, adolescents are not in need of as much protection as children, but they still might lack some of the cognitive function of those who have reached their adulthood. Most scientific studies that have been conducted in relation to adolescents generally indicate that by age 14, adolescents have reached the point where they are capable of making decisions that are at least on par with the decision making capacity of young adults. At the same time, there is still some differential, and most of the scientific data studying adolescents is not as comprehensive as would be possible with extensive further study.

Most medical professionals, especially those who work extensively with adolescents, recognize some tension in the belief that adolescents need to be treated as children. In the status quo, the age of 18 is treated as a magical number, at which point adolescents have reached the point where they are capable of making choices for themselves. Still, the treatment of adolescents across different segments of our society create some problems with even this magical number. For instance, the fact that adolescents can, and often are, tried as adults for criminal acts they comment indicate that at least in some circumstances, society is willing to set aside the magical number 18, and recognize the ability of adolescents to make competent decisions, at least in as far as they are competent enough to be punished for their choices. Similarly, regulations governing adolescents mean that it is conceivable that adolescent parents could be tasked with making medical choices for their babies, that they are not allowed to make for themselves. By and large, research and work being done in the world of medicine indicate that current treatments of adolescents need to be reformed in order to come into compliance with the research that is currently being conducted.

For the purposes of this file, you have cases and cards that deal with the topic in a broad manner. Attention is paid to questions of adolescent competence, and the ability to make choices for themselves. The affirmative position advocates treating children with the presumption of capacity to make medical choices for themselves, functionally flipping the way that adolescents are treated in the status quo. Through providing adolescents with the ability to make their own medical decisions, the affirmative argues that we can achieve justice through the recognition of autonomy. The negative position agrees, in large part, with the affirmative. Adolescents are generally able to make their own choices. It differs from the Affirmative, because it requests a presumption that medical decisions should be shared between adolescents and their parents. In this method, medical decisions become a tool that parents can use, with the support of doctors, in order to help allow their adolescents develop into competent, responsible decision makers. This file is primarily composed from “cards.” If you debate in a more “traditional” district, it would probably be best to use these cards as guides to paraphrase and construct an argument that is mostly written in your own words.

If you are interested in taking this debate in a more “progressive” direction, these cases should provide some good baseline research. Additional routes you can pursue in case construction include evaluating specific areas where adolescents should be able to make their own decisions. For example, you could limit the range of your case to the issue of adolescents with terminal diseases, particularly because most research indicates that adolescents who have been struggling with illness for most of their life are uniquely situated in a position to make smart, comprehensive choices about their own medical care. Another angle that an interested progressive LD’er could pursue for an affirmative strategy is to focus on “intersex” babies, children who are born with abnormal sex organs. In the status quo, these children are arbitrarily assigned a gender, and surgery is conducted in order to bring their sexual organs into line with the gender their parents assign them. A strong affirmative could advocate allowing adolescents to make the decision about the gender they want to be assigned to, or if they want to have a gender assigned to them. This case, of course, requires a progressive pool, but it could be a very strong position.

This topic provides a variety of interesting routes for an enterprising LD debater, and it draws on an emotionally loaded group of topics. It also asks debaters to explore a space where social norms have not kept up with scientific discovery, and allows an interesting range of ethical questions be to asked.

## Additional Reading:

#### Shaw, Mike. “Competence and Consent to Treatment in Children and Adolescents.” *Advances in Psychiatric Treatment* (2001) 7: 150-159. Available online: <http://apt.rcpsych.org/content/7/2/150.full>

#### Hartman, Rhonda Gay. “Adolescent Autonomy: Clarifying an Ageless Conundrum.” Hastings Law Journal; August 2000. 51 Hastings L.G. 1256.

Mutcherson, Kimberly M. “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.

# Definitions

#### Adolescents are between the ages of 14 and 18.

Hartman, 2002 (Rhonda Gay [Professor in the University of Pittsburgh School of Medicine & Affilitated with the Center for Bioethics and Health Law]. “Coming of Age: Devising Legislation for Adolescent Medical Decision-Making.” *American Journal of Law and Medicine* 28 Am. J. L. and Med. 409. Via LexisNexis Academic)

A substantial segment of the American population consists of adolescents. Adolescents, defined as persons between the ages of fourteen and eighteen, have traditionally been regarded as "minors" by law. Minors, as a group, are legally disabled, meaning they are presumed to lack the skills necessary for capable decision-making. Capable decision-making is requisite to the exercise of legal rights. Although the U.S. Supreme Court has extended federal constitutional guarantees to minors, including the liberty right for decision-making in intimate, personal matters, the Supreme Court has observed that vulnerability impairs their decision-making capability. Accordingly, the law regulates decision-making liberties of minors far more extensively than those of adults.

#### Adolescence is a Vague Concept

Marcia, 1980 (James E. [Clinical and Developmental Psychologist and Emeritus Professor of Psychology at Simon Fraser University in British Columbia] “Identity in Adolescence.” Handbook of Adolescent Psychology Ed. J. Adelson. New York, NY: Wiley & Sons)

One difficulty in studying adolescence is the definition of the period itself. It is somewhat variable but specific in its beginnings with the physiological changes of puberty; it is highly variable and nonspecific in its end. If the termination of adolescence were to depend on the attainment of a certain psychosocial position, the formation of an identity, then, for some, it would never end.

#### **Current Research Conceptualizes Adolescence in three categories, Ages 10-22.**

Allison and Schultz, 2004 (Barbara N. [Professor of Family and Child Sciences, Florida State University] and Jerelyn B. [Professor of Human Development and Family Science, The Ohio State University] “Parent-Adolescent Conflict in Early Adolescence.” *Adolescence* Vol. 39.153 (Spring 2004): p. 105)

Finally, Laursen, Coy, and Collins (1998) studied changes in parent-adolescent conflict across adolescence via meta-analysis of the results of studies of conflict in the dyadic exchanges between 12- through 22-year-old adolescents and parents in nonclinical samples. The effect size estimates revealed a linear decline in the frequency of parent-adolescent conflict across adolescence, with conflict levels highest during early adolescence (ages 10 to 12), lower during mid-adolescence (ages 13 to 16), and lowest during late adolescence (ages 17 to 22).

#### **The current state of medical choices, for adults and adolescents:**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

Health care decision-making deeply affects each one of us, at various stages and in various ways. The governing legal consensus is two-fold: first, adults have a legal right to be fully informed about the benefits, risks, and options of medical treatment and to provide consent for their own care, competently and voluntarily; second, competent adults have the corollary right to refuse life-sustaining medical treatment. From Quinlan to Cruzan - and the numerous state court decisions in between - judges and legislatures zealously guard these rights under the rubric of individual autonomy or, as the Supreme Court observed, more appropriately analyzed as a vital liberty concept. Adolescents also possess these rights in theory but the legal presumption of decisional incapacity impairs the exercise of these rights in practice. Anyone under 18 must obtain the consent of a parent or legal guardian for medical treatment or surgical procedures because, whether seven or seventeen, they are presumed incapable of making the decision. According to Professor Laurence Tribe, the legal presumption of adolescent incapacity "cuts both ways": "a rule has emerged that a minor too young to consent to a particular form of treatment is also too young to refuse such treatment when a parent [\*1307] insists upon the minor's receiving it." Moreover, when a parent or legal guardian consents to treatment for an adolescent patient, despite the adolescent's capability, it is akin to surrogate decision-making for adults, whereby another, usually a family member, consents to treatment. A critical difference is that the standard for surrogate decision-making is substituted judgment, i.e., how the patient would decide if he or she could communicate. Yet, with adolescent patients, parents or guardians decide treatment based on best interests when the patient herself may be fully capable of directing her own care.

# Affirmative Case

## Top of Case

#### Professor Angela Holder once explained:

As quoted in Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic

Social customs have undergone significant change within the past 30 years, and teenagers are much more independent in all areas of their lives... Adolescents are engaging in more "adult' behaviors than many of the health care professionals caring for them would have believed possible during their own adolescent years. The courts and legislatures of this country have not been unmindful of these societal changes, and there is a definite trend toward allowing adolescents more freedom to make decisions, and to exercise autonomy and self-determination in their relationships with health care providers and with others in the social system.

#### It is because I agree with Professor Holder, that I affirm the resolution: Adolescents ought to have the right to make autonomous medical choices.

#### In order to uphold this resolution I offer the VALUE of JUSTICE, which

Rawls explained in 1969 (John Rawls [Professor of Philosophy at Harvard University] THE JUSTIFICATION OF CIVIL DISOBEDIENCE, Civil Disobedience, 1969, p. 245.)

The two chief virtues of social institutions are justice and efficiency, where by the efficiency of institutions I understand their effectiveness for certain social conditions and ends the fulfillment of which is to everyone’s advantage. We should comply with and do our part in just and efficient social arrangements for at least two reasons: first of all, we have a natural duty not to oppose the establishment of just and efficient institutions (when they do not yet exist) and to uphold and comply with them (when they do exist); and second, assuming that we have knowingly accepted the benefits of these institutions and plan to continue to do so, and that we have encouraged and expect others to do their part, we also have an obligation to do our share when, as the arrangement requires, it comes our turn.

#### To help contextualize JUSTICE, I offer the criteria of AUTONOMY, which

The Stanford Encyclopedia of Philosophy described in 2009 (Stanford Encyclopedia of Philosophy. *Autonomy in Moral and Political Philosophy*, Aug. 11, 2009. Online: http://plato.stanford.edu/entries/autonomy-moral/)

Viewing autonomy as an intrinsic value or as a constitutive element in personal well-being allows one to adopt a generally consequentialist moral framework while paying heed to the importance of self-government to a fulfilling life (for discussion see Sumner 1996). It may also be unclear why autonomy — viewed here as the capacity to reflect and endorse one's values, character and commitments — should have value independent of the results of exercising that capacity. Why is one person's autonomy intrinsically valuable when she uses it to, say, harm herself or make rash or self-destructive choices? This question becomes more acute as we consider ways that autonomy can obtain in degrees, for then it is unclear why personal autonomy should be seen as equally valuable in persons who display different levels of it (or different levels of those abilities that are its conditions, such as rationality). Indeed, autonomy is often cited as the ground of treating all individuals equally from a moral point of view. But if autonomy is not an all-or-nothing characteristic, this commitment to moral equality becomes problematic (Arneson 1999). It can be argued that insofar as the abilities required for autonomy, such as rational reflectiveness, competences in carrying out one's decisions, and the like, vary across individuals (within or between species as well), then it is difficult to maintain that all autonomous beings have equal moral status or that their interests deserve the same weight in considering decisions that affect them. The move that must be made here, I think, picks up on Korsgaard's gloss on Kantianism and the argument that our reflective capacities ultimately ground our obligations to others and, in turn, others' obligations to regard us as moral equals. Arneson argues, however, that people surely vary in this capacity as well — the ability to reflectively consider options and choose sensibly from among them. Recall what we said above concerning the ambiguities of Korsgaard's account concerning the degree to which the self-reflection that grounds obligation is idealized at all. If it is, then it is not the everyday capacity to look within ourselves and make a choice that gives us moral status but the more rarified ability to do so rationally, in some full sense. But we surely vary in our ability to reach that ideal, so why should our autonomy be regarded as equally worthy? The answer may be that our normative commitments do not arise from our actual capacities to reflect and to choose (though we must have such capacities to some minimal degree), but rather form the way in which we must view ourselves as having these capacities. We give special weight to our own present and past decisions, so that we continue on with projects and plans we make because (all other things being equal) we made them, they are ours. The pull that our own decisions have on our ongoing projects and actions can only be explained by the assumption that we confer status and value on decisions simply because we reflectively made them (perhaps, though, in light of external, objective considerations). This is an all-or-nothing capacity and hence may be enough to ground our equal status even if, in real life, we express this capacity to varying degrees.[3] Much has been written about conceptions of well being that rehearse these worries (see Sumner 1996, Griffin 1988).

#### In today’s debate, I will specifically support that adolescents, age 14 or older, should be presumed competent to make medical choices for themselves.

## Contention One: Current Standards of Medical Care are Inadequate

#### First, law governing adolescent medical autonomy is contradictory and stagnant.

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” *Hastings Law Journal* 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

The conundrum of adolescent autonomy reverberates beyond pediatric offices and hospitals, generating uncertainty, especially among those who regularly deal with adolescents. The crux of the conundrum is decisional capability, a complex concept that eludes precise definition. At best, it is defined as the ability to "perform a task," entailing an ability to understand information, deliberate, and decide. In contrast to adults, who are presumed decisionally capable, minors are presumed incapable by law. With regard to adolescents (approximately 14 through 17 years), this legal presumption is problematic for a host of reasons. Foremost, social norms that are closely allied with governing law treat adolescents as though they are decisionally capable, producing a kaleidoscope approach to adolescent rights with endless variegated exceptions and circuitous results. For example, a 15-year-old may decide medical treatment for a sexually transmittable disease but may not decide treatment for a complication related to the STD. Or, a 16-year-old, who is presumed incapable of deciding a surgical procedure for herself is nonetheless presumed capable to decide a medical procedure for her infant child. Further examples of anomalous results abound, such as when a 17-year-old may confront a criminal conviction with punitive and retributive sanctions, including the death penalty, but is deemed incapable to refuse life-sustaining treatment. While the divisive issue of adolescent violence has captured the collective conscience, the visceral response of statutory amendments expediting the transfer of adolescent offenders to adult criminal court for categorically delineated crimes is deficient to the overall task of constructing a cohesive model for legal governance of adolescence. Because these statutes glaringly omit the core consideration of decisional capability, notably whether an adolescent suspect possesses the capacity to stand trial as an adult, this treatment of adolescents is not only contradictory but fundamentally unfair. It seems the only thing fair about the current legal approach to adolescence is to say that it remains a stagnant enclave in law and policy, suffering not so much from benign as serial neglect. The rules that result from presumptive decisional incapacity "meander like a restless wind inside a letter box, tumbling blindly" as they inadequately address adolescent issues. Paradoxically, the United States Supreme Court has held society to a "high duty" to ensure that adolescents develop into meaningful participants in their own lives and hence society, while also declaring that vulnerability and mature decision-making inability justifies a presumption of decisional incapacity, despite a quarter century of [\*1268] mounting scientific and developmental research that contradicts the Supreme Court's declaration. Remarkably, a paucity of scientific and social science evidence legitimates presumptive decisional incapacity. This impoverished legal approach toward adolescence is especially striking because acknowledging individual autonomy fosters self-determination and self-confidence by cultivating an important sense of responsibility and accountability, not only to oneself but to others.

#### **Second, history demonstrates disrespect for adolescents resulted in their abuse. Only shifts in how they were perceived allowed for their protection.**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

Essentially, legal treatment of adolescence has been shaped by the establishment of the juvenile justice system, the crafting of parens patriae, and jurisprudence balancing the interests of parents, state, and youth. Adolescents were erstwhile cast without rights, regarded as property or chattels of parents, and captive to the peculiarities and particularities of family environments. They were put to work in fields or mines for endless hours or subjected to abuse at home-all of which was completely within the family sphere. Even during the Salem witchcraft trials of 1692 Puritan New England, the circle of adolescent witch-mongers largely responsible for the false allegations and tragic executions of nearly twenty innocent people during that fateful summer, were not punished by the state but left to parental discretion. When adolescents were thought wayward or incorrigible, they were subjected to brute punishment by either their parents or the religious community. Later, in the eighteenth and nineteenth centuries, they were socialized to almshouses, asylums, and apprenticeships. In the mid-1800's, children's rights renegade Dorothea Dix - a kindred spirit to her twentieth century counterpart, Jane Addams - rallied for a more humanistic view of youth and a measure of dignity for adolescents by forging the establishment of reformatories for wayward youth that culminated in the 1899 passage of the first juvenile court act by the state of Illinois. This demarcated a distinct legal system to address the specific needs of children and adolescents. This new legal system dealt largely with offenses based on status alone. [\*1273] By the early part of the twentieth century, each state had enacted a version of the Illinois act, ensconced in paternalistic recognition that the state may justifiably intercede into family life in order to protect the health and welfare of a vulnerable segment of the population - children and adolescents - and deter those "treading the downward path." Then, as now, the jurisdiction of the juvenile justice system hinged upon age (i.e., age, rather than the act conferred juvenile court jurisdiction). The goal of the paternalistic policy underlying juvenile jurisdiction regarding a disobedient youth was to "take him in charge, not so much to punish as to reform, not to degrade but to uplift, not to crush but to develop, not to make him a criminal but a worthy citizen." Referred to as parens patriae, this policy, stemming from English feudal law, sought to promote the well being of its citizenry. Deeply entrenched in this concept is a morality requiring the respectful treatment of others and an ethos that "physically, mentally, and morally" benefits disempowered persons. This concept is richly reflected in the benevolence of law, i.e., disposition to act for the benefit of another, and the ethical principle of beneficence, i.e., [\*1274] moral obligation to act for the benefit of others. Accordingly, parens patriae is poised for laws governing persons thought vulnerable within the populace, most notably youthful and senior citizens.

## Contention Two: Ignoring Adolescent Autonomy Harms Society

#### First, Forcing Adolescents to receive treating they do not want causes non-compliance and combative behaviors.

Wells and Stephenson, 2014 (Dr. Robert Wells [Associate Professor of Pediatrics and Psychiatry] and Dr. Steve Stephenson [Associate Professor of Pediatrics; University of California. San Francisco Valley Children’s Hospital]. “Challenging Case: Adolescence—Decision Making about Medical Care in an Adolescent with a Life-Threatening Illness” *Pediatrics* Vol. 107.4: p. 980)

It is neither developmentally appropriate nor practical to force a teenager to accept prolonged and invasive oncologic treatment against his or her will. As a teenager confronts further loss of control of major life decisions, noncompliance and potentially combative behaviors may occur. The anger is often directed at parents and the health care team who feel compelled to “take over” decision making in the best interest of the adolescent patient. Every effort to help a family resolve these internalized conflicts is a valuable part of the treatment plan.

#### Second, Complex medical treatment requires respect for autonomy.

Schneiderman, 2014 (Dr. Lawrence J. Schneiderman [Professor of Family and Preventitive Medicaine; University of California, San Diego]. “Challenging Case: Adolescence—Decision Making about Medical Care in an Adolescent with a Life-Threatening Illness” Pediatrics Vol. 107.4: p. 981)

This case exemplifies the chaos theory of medical ethics, namely how small nuances in initial conditions have immense final consequences—in this case, either life or death. Jorge is described as young, yet “quite mature.” What then can we say about his capacity to make rational decisions? Do we emphasize that he is young and therefore subject to short-sighted emotional impulses? Or do we accept that he, like many other 13-year olds with long exposure to illness, is capable of making a decision that other reasonable people might make, namely to forego a burdensome treatment in which the odds of success are less than even? No doubt different observers (with their own agendas and temperaments) would evaluate Jorge differently and draw contrary conclusions. Nor is there any “proof” that either conclusion is right or wrong. Ethical reasoning is not a process that proves answers right or wrong, but rather is one that examines whether they are ethically defensible, as opposed to arbitrary and incoherent. In my view, it is important that everyone involved in Jorge’s care recognizes that his best interests can be met only by enhancing his autonomy. This is important for ethical reasons, because respect for autonomy is a fundamental principal of ethics in this country. In Jorge’s case, it is important for medical reasons, because it will be almost impossible to involve him in a complex treatment program without his full understanding and participation. Probably everyone wishes that Jorge would take a chance and undertake the bone marrow transplantation. If he comes out at the other end alive and well, won’t he be grateful that his objections were overcome? Certainly it is ethical to try. What are the small nuances in initial conditions that might be altered? Jorge apparently “did not get along well” with the supervising oncologist at the transplant referral center. This is certainly an initial condition that needs to be addressed. Does the oncologist know how Jorge feels? Is there any way the oncologist can reach out to mend that relationship? Possibly the oncologist has personal traits that did not mix well with Jorge? Are there other available choices in oncologists or transplant centers? Of course, it is possible that the messenger is being blamed for bearing the news. Jorge is described as having developed a “close relationship” with the oncology social worker. How does this person feel about Jorge’s choice? What about allowing this person time to explore Jorge’s feelings, perhaps clear up misunderstandings (if there are any), and reconsider his fears and hopes? Might this person serve as an intermediary? The question arises about placing Jorge on the transplant list. I would not risk violating his trust by doing this without Jorge’s agreement. However, I would try to persuade him that listing him does not obligate him; it simply leaves the door open to the possibility that he might change his mind. I would emphasize the freedom it gives him, something he may crave as he sees his disease and the pressure of his parents closing around him. Whatever efforts are made, in the end, Jorge must accept the treatment willingly. And everyone must accept his decision if he does not. Whatever his choice, it is the obligation of the health providers to help his parents cope with it so that they maintain a relationship that is supportive and loving.

## Contention Three: Just Governments Respect Adolescent Autonomy in Medical Decisions

#### **First, Scientific and Developmental research supports the perspective that adolescents possess decisional capacity.**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

The view that adolescents should be accorded a level of decisional autonomy is supported by scientific and developmental research during the last half of the twentieth century. During the 1950's, Swiss psychologist Jean Piaget published seminal research explaining that adolescents reach a stage of formal operational thinking that allows them to reason deductively and think both abstractly and hypothetically. Dr. Piaget theorized that a moment occurs in the course of human development when children discover that the categories of their reason cannot encompass the facts of their experience. This moment of recognition results in a shift from a metaphysical to an empirical truth that charts "the path from adolescence to the true beginnings of adulthood." Dr. Piaget's findings suggest that adolescents who have reached this realization or formal operational stage possess cognitive abilities equivalent to those of adults. Although contemporary researchers challenge the Piagetian model and focus instead on specific task attainment, they nonetheless underscore its value to understanding cognitive development. [\*1286] Since the research of Dr. Piaget and his progeny, a compilation of published studies on adolescent decisional capacity has accumulated, comprising examinations of adolescent decisional capacity in various contexts. These studies, some of which directly confirm Dr. Piaget's findings, suggest that adolescents, aged 14 and older, possess the cognitive capability to reason, understand, appreciate, and articulate decisions comparable to young adults. Perhaps more significantly, there is a paucity of scientific or social science study that supports the present legal view of adolescent incapacity. Despite the statistical and scientific evidence, which merits serious consideration by policy makers, the principle of decisional incapacity is the raison d' etre for law and the lack of a coherent legal approach for accommodating adolescent issues. A backward glance over the twentieth century reveals a promising legacy for the recognition of adolescent autonomous rights. Realizing more meaningful exercise of those rights should be a legacy for the twenty-first century.

#### Finally, Recognizing adolescent decisional autonomy is necessary for the promises of justice to be real.

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

Adolescent decisional ability should direct the law to optimize personal development, individual dignity, and respect for adolescent expression of values. That scientific research quantitatively suggests capability for autonomous decision-making underscores qualitative calculation that adolescents are involved in decision-making to a larger extent than presently presumed by law. A legal model embracing adolescent decisional ability would comport with both quantitative and qualitative measurement and accommodate adolescent issues in a way that would improve vastly the kaleidoscope approach and variegated outcomes. Accordingly, such a legal model would ensure a suitable measure of stability and predictability in the law governing adolescence. In his distinguished work, The Changing Legal World of Adolescence, Franklin E. Zimring queries, "why not the eighteenth birthday as a presumptive age of majority... unless there is a very good reason not to." This Article attempts to present very good reasons. Injustice has been adduced by adherence to presumptive incapacity, resulting in injustice not only for adolescents but also for adults interacting with them, as the areas of medical care and contract [\*1362] law illustrate. Moreover, the laws governing juvenile delinquency raise concerns of fundamental fairness, generating deeply rooted issues of justice as well as issues of professional responsibility and advocacy for attorneys representing adolescents. The current legal approach with its disengaged connection to adolescent decisional ability is vulnerable to constitutional challenge, especially when the legal presumption of incapacity appears unrelated to social and scientific fact. To date, proposed legal reform has been either cosmetic or radical, rather than restructuring legal framework to recognize adolescent decisional ability. The proposed model discussed in this Article embraces social reality and would be responsive to resolving issues related to adolescence, with clarity and cohesive guidance. It also cultivates the deeper promise of adolescent independent thought and identity. This legal model encourages the establishment of a President's Commission for the Study of Adolescence as an important initial step toward thorough examination of adolescent issues, and entails Congress' recognition of adolescence as a distinct legal category. This recognition should lead to the passage of federal legislation enabling states to style laws that address adolescent autonomy, including the scope and extent of adolescent decision-making in various contexts, while preserving parens patriae. No less intense is that this proposal revolutionizes the juvenile justice system in a way that retains its special distinction, recognizes the enormous value of family and social institutions in the lives of adolescents, and optimizes adolescent freedom for personal development. Indisputably, one's sense of identity and autonomy should not depend on the capricious, archaic demarcation of a birthday; rather, it is a life-long journey that, as Dr. Jean Piaget determined, develops cognitively from childhood and continues through adolescence and into adult life. The twenty-first century should be a dawning for an enlightened view of adolescent autonomy, rather than a mythical age of majority, whereby one is suddenly endowed with decisional ability, the import of which is poignantly punctuated by the timeless reflection of William Butler Yeats - "I whispered, "I am too young,' And then, "I am old enough.'"

# Affirmative Extensions

#### **Respect for autonomy includes treating underlying causes of resistance to treatment.**

Wells and Stephenson, 2014 (Dr. Robert Wells [Associate Professor of Pediatrics and Psychiatry] and Dr. Steve Stephenson [Associate Professor of Pediatrics; University of California. San Francisco Valley Children’s Hospital]. “Challenging Case: Adolescence—Decision Making about Medical Care in an Adolescent with a Life-Threatening Illness” *Pediatrics* Vol. 107.4: p. 980)

The first step in this case is to suggest that Jorge and his parents agree to hold a series of meetings with the physician and social worker. It is also advisable to request a mental health consultation to determine whether Jorge is clinically depressed. Children and teenagers who are being treated for life-threatening illnesses have high rates of depression that may be amenable to treatment. From the history, it appears that something changed when Jorge and his family went to the transplantation center, and it is important to learn more about this experience. Because the social worker may have the best relationship with this teenager, a series of individual sessions should be held to help support him and to listen to his concerns. If Jorge identifies significant concerns about this particular center and its staff, a referral to a different center should be considered. If Jorge is clinically depressed, all other medical decisions should be deferred, and he should be treated for depression. A combination of antidepressant medication and individual therapy may be needed. Jorge may have reduced bioavailability of serotonin, and he is unlikely to experience an optimistic social environment for some time. Individual therapy can help him focus on ways to improve the quality of his life and to enhance his capacity to use nonavoidant coping techniques, such as problem solving, seeking social support, making positive appraisals, and utilizing information. He can also be helped to find ways that have a positive impact on his environment. The findings of one recent study demonstrated that the vast majority of depression in pediatric oncology patients is related to their overuse of avoidance coping, their depressive attributional style, and their lack of social involvement. It may be helpful to have Jorge and his family meet with other teenagers who have faced the same decision to observe firsthand how they are faring. Discussions about posttreatment quality of life should also be held. As many as 96% of autologous bone marrow recipients report that the quality of their life is good. Forty percent reported no disability, and 33% reported only minimal disability. Counseling and support for the family and health care team is also critical to help them recognize and cope with issues of control and medical decision making. They need to avoid forming a “new team” that excludes the recalcitrant teenager.

#### Five Distinct Goals for Involving Children in Medical Decisions.

McCabe, 1996 (Mary Ann McCabe [Department of Hematology/Oncology, Children’s National Medical Center]. “Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations.” *Journal of Pediatric Psychology*. Vol. 21.4: p. 506)

There are at least five distinct goals for involving children and adolescents in decisions regarding their medical treatment: (a) First, we are compelled by the ethical principle of patient self-determination, or autonomy (Beauchamp & Childress, 1983). This principle applies to children as well as to adults, although its application is clearly more complicated for young people, (b) Children's involvement in medical decision making improves open communication among physicians, parents, and children. Doctor-patient-parent communication is fundamental to both children and parents' satisfaction with medical care (e.g., Korsch, Gozzi, & Francis, 1968), and satisfaction with medical care is important for patient compliance (e.g., Becker & Maiman, 1975; Francis, Korsch, & Morris, 1969; Krasnegor, Epstein, Johnson, & Yaffe, 1993; La Greca, 1988). (c) Children's involvement in goal setting and treatment planning may directly facilitate their cooperation with treatment (Melton, 1983; Putnam, Finney, Barkley, & Bonner, 1994). (d) Children's involvement may also promote a sense of control (e.g., Nannis et al., 1982; Weisz & Stipek, 1982), which, in turn, may be related to positive adjustment (e.g., Averill, 1973; Miller, 1980). (e) Finally, involving children in medical decision making demonstrates respect for children's capacities, and may provide opportunities for further development (Melton, 1983).

#### Principals of Informed Consent

McCabe, 1996 (Mary Ann McCabe [Department of Hematology/Oncology, Children’s National Medical Center]. “Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations.” *Journal of Pediatric Psychology*. Vol. 21.4: p. 506-507)

There are three legal requirements for consent to medical treatment: (a) The decision must be informed, including information about the risks and benefits of alternative treatments; (b) the decision must be voluntary, or free from coercion; and (c) the individual must be "competent" (e.g., Lidz, et al., 1984; Weithom, 1984). There are actually various standards for competence, including (a) evidence of a choice; (b) a "reasonable" decision; (c) a reasonable decision-making process; and (d) the most stringent standard, "appreciation" of the information provided, with the ability to make inferences about it (Roth, Meisel, & Lidz, 1977). Competence is rarely challenged in adults' medical decision making; this usually occurs when their decisions vary from prevailing opinion, and most often in choices to refuse treatment.

#### Conflict Situations for Family and Adolescent Autonomy.

McCabe, 1996 (Mary Ann McCabe [Department of Hematology/Oncology, Children’s National Medical Center]. “Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations.” Journal of Pediatric Psychology. Vol. 21.4: p. 507)

Parents are provided with both the right and the responsibility to provide consent for their minor children's health care. Historically this was because children were viewed as the property of their parents, with no legal rights of their own. However, when children were given protection by the Constitution, parents still maintained a right for family autonomy. The prevailing spirit underlying parental consent requirements is that parents are the most motivated and capable people to act in their children's best interests, that they often have similar interests to their children, and that they are more competent to make medical decisions than their children. There are, of course, decision-making situations where parents have different interests than their children, have a conflict of interests, or cannot be certain what is in their children's best interests. Parental discretion is legally challenged when (a) parents refuse life-saving treatment; (b) treatment would not be of direct benefit for the minor (e.g., organ or tissue donation, research); (c) treatment involves rights to privacy of minors, or "sensitive treatments" (e.g., reproductive care, substance abuse, psychotherapy); (d) situations arise that involve significant loss of liberty for the minor; and (e) situations arise that involve "emancipated minors" (e.g., Koocher & DeMaso, 1990; Plotkin, 1981; Weithom, 1984). In many of these situations, minors are allowed to consent for treatment themselves. Ironically, in many states teenage parents are allowed to provide consent for their children in medical situations where they are not yet allowed autonomy in decisions for themselves.

#### Autonomy includes getting important and relevant input into decision making.

Moulton & King, 2010 (Benjamin [Lecturer in Health Law at Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making] and Jamie S. [Associate Professor of Law at the University of California, Hastings College of the Law]. “Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice.” *Journal of Law, Medicine, & Ethics.* Spring 2010: p. 6)

Autonomy need not come at the expense of beneficence. Demonstrating respect for patient autonomy does not require physicians to remain neutral sources of information in the care of their patients. Health services research conducted in the last ten years has found that the vast majority of patients want to be informed and involved in medical decision-making.52 In addition, patients also strongly preferred that the physician’s opinion remain an integral part of the treatment decision. Respecting a patient’s autonomy means respecting their wishes regarding what information is relevant to their decision and how much they want to participate in making their treatment decision.

#### Research reveals that adolescents are capable of making competent choices.

McCabe, 1996 (Mary Ann McCabe [Department of Hematology/Oncology, Children’s National Medical Center]. “Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations.” Journal of Pediatric Psychology. Vol. 21.4: p. 507)

It is clear that neither rights to self-determination, nor the capacities for decision making, appear on the 18th birthday. However, applied research in children's medical decision making is limited. Most studies have involved healthy children who were asked to make decisions about hypothetical medical situations (Lewis, 1980, 1981; Weithorn & Campbell, 1982). The most creative of these studies (Weithorn & Campbell, 1982) compared decisions of four age groups (9, 14, 18, and 21 years) on outcome measures that were specifically designed to reflect the four standards of competency to consent (evidence of choice, reasonable outcome, rational reasons, and inferential understanding). Results suggested that children in the 9-year-old group were less competent than adults in terms of the higher standards of understanding the information provided and rational reasons; not surprisingly, they used one or two concrete factors in their decisions. However, they did not differ from adults in the standards of evidence of choice or reasonable outcome; that is, they still tended to arrive at logical decisions which were similar to those of adults. In terms of all four standards, the 14-year-old group demonstrated the same level of competency as the two "adult" groups; they showed a similar level of understanding and reasoning, and made similar choices. We should continue this line of research with ill children in order to explore the impact of physical illness and emotional adjustment upon children's medical decision making.

#### Relationships between the Parent or Doctor and the Adolescent should be based on the notion of “shared decision making” with an emphasis towards adolescent autonomy.

Moulton & King, 2010 (Benjamin [Lecturer in Health Law at Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making] and Jamie S. [Associate Professor of Law at the University of California, Hastings College of the Law]. “Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice.” Journal of Law, Medicine, & Ethics. Spring 2010: p. 6)

For purposes of this article, we define shared medical decision-making as a process of communication in which the physician and patient use unbiased and complete information on the risks and benefits associated with all viable treatment alternatives and information from the patient on personal factors that might make one treatment alternative more preferable than the others to come to a treatment decision.58 While this definition encompasses the traditional disclosure essential for legal informed consent to treatment, it goes beyond the mere recitation of facts, risks and alternatives. Shared decision-making involves a more robust discussion, which engages both the patient and the physician in evaluating the patient’s medical goals and lifestyle preferences to come to an informed choice. As a result, shared decision-making promotes both autonomy and beneficence. While valuable for any medical decision, its methods prove most effective for use with preference sensitive conditions. In this instance, the provider and patient share information to better understand the full scope of the options the patient faces, and to think about the patient’s personal values as they relate to the risks and benefits of each option. While the physician and patient jointly participate in the treatment decision, shared decision-making prioritizes patient autonomy over beneficence, but only enough to tip an otherwise even balance. In instances of disagreement after discussion, the patient’s preference should determine the treatment. By protecting patient autonomy and acknowledging the importance of provider opinion and analysis, shared decision-making provides the most effective method of enabling physicians to satisfy their ethical obligations to patients.

#### **Valuing patient autonomy through shared decision making results in better information and health outcomes for patients.**

Moulton & King, 2010 (Bejamin {Lecturer in Health Law at Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making] and Jamie S. [Associate Professor of Law at the University of California, Hastings College of the Law]. “Aligning Ethis with Medical Decision Making: The Quest for Informed Patient Choce.” *Journal of Law, Medicine, Ethics.* Spring 2010: p. 7]

While shared decision-making may appear to place a significant burden on physicians, tools exist to facilitate disclosure. A number of organizations have created patient decision aids that provide patients with current scientific evidence on the risks and benefits of treatment options for a specific condition in a format comprehensible to patients. Decision aids often include patient testimonials on the experience of undergoing different treatment options and patient worksheets to help patients identify advantages and disadvantages specific to them of pursuing particular options. Research demonstrates that after patients have time to review a decision aid, digest the information in it, and think about their personal preferences, their communication with their physician during the treatment decision proves significantly more fruitful. Studies examining the use of patient decision aids, when used in conjunction with shared decision-making with the physician, have found improvements in patient comprehension and reductions in decisional conflict. In addition, a number of studies have found an association between increases in patient participation and improved health outcomes. For instance, two studies found that patients who were more active in their treatment decision had better control of their hypertension than patients who were less involved and expressed fewer opinions about treatment. Researchers have found similar outcomes in other areas of medical care, including obesity treatment, diabetes management, and breast cancer treatment.

#### **Adolescents can make competent medical decisions: Weithorn & Cambell**

Shaw, 2001 (Mike [Dr. of Medicine; Consulting Child and Adolescent Psychiatrist at South West London & St. Georges Mental Health Trust; Senior Lecturer at St. George’s Medical School] “Competence and Consent to Treatment in Children and Adolescents” *Advances in Psychiatric Treatment* Vol 7 (2001) doi: 10.1192/apt.7.2.150; Online <http://apt.rcpsych.org/content/7/2/150.full>)

The law imposes a dichotomy (competent v. incompetent) on what, from a developmental perspective, is a spectrum of ability. Weithorn & Campbell (1982) compared decision-making in four age groups (9, 14, 18 and 21 years) using healthy subjects and hypothetical situations. The 14-year-olds showed a level of competence similar to that of the two adult groups. There were deficits in the 9-year-olds' understanding and reasoning, but their conclusions were very similar to those of the other groups.

#### **Adolescents can make competent medical decisions and are likely to respect parents and medical advice: Alderson**

Shaw, 2001 (Mike [Dr. of Medicine; Consulting Child and Adolescent Psychiatrist at South West London & St. Georges Mental Health Trust; Senior Lecturer at St. George’s Medical School] “Competence and Consent to Treatment in Children and Adolescents” *Advances in Psychiatric Treatment* Vol 7 (2001) doi: 10.1192/apt.7.2.150; Online <http://apt.rcpsych.org/content/7/2/150.full>)

Alderson (1993) interviewed 120 young people (aged 8–15 years) undergoing elective orthopaedic surgery; she also spoke to their parents and health professionals. Surgery was being undertaken for relief of chronic pain, disability or deformity, and on average the patients had already had five operations. The young people were asked, “How old do you think you were or will be when you're old enough to decide?” (about surgery). Their parents were asked, “At what age do you think your child can make a wise choice?” The two groups gave a very similar mean age (the young people said 14.0 years, the parents 13.9). But girls and their parents thought they would be ready to decide 2 years earlier than boys and their parents (girls: 13.1 years; girls' parents: 12.8; boys: 15.0; boys' parents 14.9). Alderson also asked 983 ordinary school pupils (aged 8–15 years), “At what age do you think someone is old enough to decide with their doctor about surgery, without their parents being involved?” They gave a slightly older age than the orthopaedic group (mean of 15–17 years, compared with 14). It seems likely that past exposure to treatment decisions made the orthopaedic group more confident, suggesting that young people can be prepared for making treatment decisions. In response to the question “Children vary greatly, but what is around the youngest age you think some of your patients could be trusted to make sensible, wise, mature decisions about proposed surgery?”, health professionals recommended a mean age of 10.3 years, much younger than their patients or the parents. This suggests that these health professionals were in danger of expecting too much of their young patients. Only a few young people in the orthopaedic group wanted to be the ‘main decider’ (21 out of 120). Asked what they might do if they disagreed with their parents over the decision on surgery, relatively few said they would try to get their own way (22% of boys, 11% of girls). This suggests that conflict of this sort was relatively unlikely.

#### Internationally, the autonomy of children is becoming increasingly respected.

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

Despite inattention toward adolescent autonomy by American courts, the United Nations Convention on the Rights of the Child, which convened on November 20, 1989, called for coherent planning of policies directly tailored to children and adolescents "rather than the accumulation of individual measures which affect [them] without being set in a policy framework." Heralded as a "landmark in the history of childhood," the Convention proclaimed the capacity of adolescents to express views and encouraged respect for those views, in order to further their full participation in life and to promote dignified treatment consistent with respect for human rights and freedoms. The Convention inspired the Childhood Policies Project of the Council of Europe, spanning a four year period from 1992 through 1995, and presents a powerful and persuasive force regarding recognition of adolescent decisional rights. Both France and Great Britain have ratified the United Nations Convention on the Rights of the Child, which has been reinforced through passage of laws in both countries. n83 Australia and Canada have also embraced it; yet, decisional law in those countries has ricocheted in various directions.

#### **The legal system has long held adolescents as decisionally capable for the purposes of Tort Law.**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

For well over a century, adolescents have also been held legally responsible for contributory or comparative negligence. For example, the Georgia Supreme Court in 1883 reversed a verdict in favor of Jefferson Brinson on the basis of contributory negligence. n180 Jefferson, who was 15-years-old, brought suit against Central Railroad, for injuries and ultimate amputation of his leg when a plank extending from a rail car injured him as he was walking to school. The Georgia high court in Central Railroad v. Brinson held Jefferson responsible for his own care and negligence and found that a person "who is neither a lunatic, idiot nor insane and who has arrived at 14 years of age" should be held responsible in cases of tort. Unlike the antiquated age demarcation of contract law, which assumes decisional inability for all minors under eighteen years of age, tort law has consistently recognized adolescent decisional capability for engaging in particular activities and accountability when those activities result in injury to another. Adolescents are likewise deemed decisionally capable to initiate and maintain legal action against an adult tortfeasor. In the rare instances where adolescents have been restricted from maintaining a tort action, the courts' reasons have little to do with decisional capacity. Rather, the courts' reasons are based on the social policy of encouraging family harmony and discouraging collusion and depletion of family resources, such as when an adolescent seeks to hold a parent responsible for injuries resulting from the adult's negligence.

#### **Legalistic approaches to adolescents are hamstringing the medical communities desire to allow adolescents to make autonomous medical choices.**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

Certainly, the emergence of adolescent patient decision-making implicates issues of autonomy, personhood, and dignity in a fundamental way. The doctrine of informed consent, embracing distinct concepts of personal respect and dignity, would seem especially viable for adolescents by enabling them to actively participate and be decisionally accountable. Therapeutically, recognition of an adolescent patient's decisional capability "often leads to better patient care and outcome." Although the American Academy of Pediatrics Committee on Bioethics encourages pediatricians to obtain the informed consent of adolescent patients, the Committee's ethical recommendations, approved by the Council on Child and Adolescent Health, are circumscribed by current law and public policy that generally requires parental permission except in exceptional circumstances. This ethical quandary is proving [\*1308] especially frustrating among physicians who perceive adolescents as possessing decisional ability. For example, the chairperson of the Ethics Committee for a large Pittsburgh health care system described his tireless attempts to revise the health system's policy to recognize adolescent decisional capability and to permit adolescent medical decision-making, only to be "stonewalled" by legal counsel. As the following sections discuss, adolescents are expanding their wings of freedom in decision-making in a way heretofore thought unimaginable, and, as a result, are encountering legal constraints as varied as the social and medical situations facing them.

#### **A lack of legal clarity surrounding adolescent medical choices results in making treatment more difficult, and reflect the general belief that adolescents are capable of decisional capacity.**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

With regard to medical treatment and procedures, minors are presumed incapable of decision-making and the consent of a parent or legal guardian is required. In actual medical and legal practice, it becomes more complicated, especially due to the exceptions that confound this seemingly straightforward rule. As Professor Holder has observed, "the question of what to do with the young person of 13, 14, 15, or 16 years of age who requests treatment is becoming a [\*1309] problem for many physicians." One exception is emancipation, generally defined as the freedom or liberty of one who had previously been under the power and control of another. Emancipation for medical care statutes demarcate circumstances that free the adolescent from a parent or guardian's control, including marriage, military enlistment, and independent living (presumably not only a self-supporting college student but also a runaway). However, ascertaining each of the categories with confidence can be problematic for a medical practitioner. If the adolescent continues as a patient and wishes to consent to treatment, the physician must once again assess de novo the status of emancipation. Even more problematic and impractical is the ill-defined phrase found in several emancipation statutes, "has been pregnant." Precisely how this phrase is to be accurately determined and whether it means that the adolescent must actually be a parent in order to be emancipated is left to endless speculation. Understandably, these interpretative questions not only cause concern and consternation for physicians practicing adolescent medicine, but deserve thoughtful and careful scrutiny by legal policy makers. Adding to the confusion are several other exceptions to the rule of decisional incapacity, including an adolescent's ability to consent to treatment for drug, alcohol, and sexually transmitted diseases, a relic of the early 1960's when adolescents were found to be the primary culprit for the spread of STDs. The underlying policy stems [\*1310] from a desire to encourage adolescents to obtain treatment without the deterrent effect of having to inform a parent and to protect adolescents who might be the victim of an abusive environment. Even this seemingly straightforward statutory provision generates uncertainty among physicians. Consider the following scenario. A young woman, age 16 presents herself at a hospital with symptoms related to a sexually transmitted disease. Under the law of most states, the physician may provide treatment without contacting the parent. A routine test given to the adolescent for STD detection also reveals an abnormality that may require a biopsy. In all likelihood, the abnormality may simply be a result of the STD; there is a possibility, however, that the abnormality is an indication of a more serious medical problem. Should the treating physician consider the biopsy as an extension of the STD treatment, thereby allowing adolescent consent for the procedure, or should the physician perceive this complication as a development outside the scope of the STD exception? There is no clear answer in law, which leaves physicians to determine their course with legal vulnerability. Moreover, statutory law granting decisional authority to adolescents has been enacted under auspices of "mature minor" provisions, permitting "mature" adolescents to decide their own health care treatment, even though the provisions lack a gauge for determining "maturity." These statutes typically engraft an age limitation, usually 14 or 15, and limit adolescent decisional autonomy to consent, rather than refusal, of treatment. Louisiana is exemplary, giving decisional carte blanche to an adolescent "who is or believes himself to be afflicted with an illness or disease" by providing that his consent shall be "valid and binding as if the minor had achieved his majority." n201 Adding that a physician or other member of the health care team is not obligated to inform a parent or guardian [\*1311] and cloaking the physician in civil and criminal immunity (except for negligence), the legislators in Louisiana intended to empower minors to seek medical treatment and advice without the necessity of prior parental approval, in an attempt "to actively and positively encourage the betterment of the health and welfare" of the citizenry. Despite the liberal breadth of the law, which omits any age restriction to the ability of a minor to consent to treatment, the corollary right to refuse treatment is notably absent.

#### **Multiple studies unequivocally demonstrate that adolescents are capable of decisional capacity, and thus should be granted autonomous medical choices.**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

Several studies suggest that adolescents are rather thorough and thoughtful about their choices in health care. The Journal of the American Medical Association published a study by six researchers that asked adolescents to identify characteristics in a health care provider that affect their decision to seek medical care. The study population consisted of a cross-section of 6,821 ninth graders (aged 14 through 16) from the Philadelphia public school system, who responded over a ten month period by open-ended oral discussion and by written survey. The researchers report a high level of thoughtful and mature perceptions by adolescents, enabling the researchers to clarify which variables influence their decisions to seek medical care. The influential variables include providers who are skilled in adolescent care, competent, compassionate, unpretentious, nonjudgmental, and willing to respect confidentiality. The adolescent study respondents further expressed that respect by providers toward adolescent patients was paramount, demonstrated by clear communication, candor, sensitivity toward individual needs, and equal treatment. This particular finding is further supported by a published study in the Journal of Adolescent Health, whose results "highlight the independent effect that health care providers' interpersonal style can have on adolescent patient satisfaction," similar to that of adult patients. [\*1319] Moreover, researchers have found that adolescents wish to chart their own course within the health care system by visiting providers on their own, exercising decision-making in medical care, and being responsible for those decisions. According to researchers, this finding "illustrates that adolescents are not passive recipients of care. They actively interpret interactions and evaluate services." Reporting that the findings indicate a reciprocal element to the health care system, researchers urge adolescents to become more actively involved in health care, which in turn would better serve "the needs and ultimately improve the health status of youth." Other researchers have also found that acknowledging the self-determination of adolescents in routine medical decision-making is therapeutic by "improving their response to treatment and encouraging the development of self-efficacy." According to the results of a study focusing on voluntariness in medical decision-making comparing children, adolescents, and young adults, Professor David G. Scherer found that adolescents and young adults appeared to approach "medical decision-making with a quality of intentionality that is not seen in the decisions made by children." Professor Scherer further found that "older adolescents appear to be comparable to young adults in their reactions to parental influence in some medical treatment decision circumstances," suggesting "that older adolescents should not be excluded from making treatment decisions on the presumption that they lack the requisite capacities for volition." Professor Scherer underscored the import of these findings, stating "there is no conclusive evidence to presume that adolescents are incapable of a voluntary consent comparable to that of young adults." Several years earlier, Professor Scherer and N. Dickon Reppucci measured the volition of adolescents in decision-making and found that the nature of a treatment decision greatly [\*1320] impacts the quality of an adolescent's response to parental influence: "Adolescents are more likely to resist parental influence when the consequence or gravity of the decision has serious implications for the adolescent's health." Last, but notably not least, is the seminal study published by Lois Weithorn and Susan Campbell who studied 96 participants ages 9, 14, 18, and 21 to determine developmental differences in medical decisional capacity. Specifically, they compared the decision-making ability among young adults, adolescents, and children, and found that, in contrast to the 9-year-olds, the 14-year-old adolescents reasoned about medical decisions in much the same way as the young adults. They further found that children as young as nine appear able to participate meaningfully in their health care decisions. The investigators concluded that their findings are consistent with Piaget cognitive development theory, which predicts that, by the age of 14, minors reach a stage of formal operational thinking that allows them to reason hypothetically. The authors take the position that their results do not support the denial of adolescent self-determination in health care situations. This research confirms earlier preliminary findings that there is "little evidence that minors age 15 and above as a group are any less competent to provide consent than are adults." The fact that scientific and social science research suggests no perceptible difference between the capacity of adolescents and young adults in medical treatment decision-making indicates that the law should refrain from capriciously constructing a dichotomy of presumptive differences in decisional autonomy.

#### **The Federal Government could, and should, enact “an adolescent autonomy model.”**

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

An adolescent autonomy model recognizes decisional ability, as opposed to decisional incapacity. The United States Congress is empowered to enact enabling legislation that could establish a separate area of the law for adolescents apart from that governing younger children, due to the discerning ability of adolescents and accoutrement of distinctive concerns. Such enabling legislation [\*1356] should direct the states to comport with an adolescent autonomy model, while providing states the freedom to fashion laws balanced with sovereign needs and concerns regarding the scope and extent of adolescent decision-making in various contexts. Indeed, Congress has navigated national policy concerning other distinct segments of the population, such as the Older Americans Act, the Patient Self-Determination Act, and the Child Abuse Prevention and Treatment Reform Act, each directing the states to pass comprehensive legislation consistent with and in furtherance of national policy. Congress' constitutional authority to commandeer state legislatures to comply with an adolescent autonomy model has several potential bases. One basis may be found in the Commerce Clause, as an enumerated power contained in Article I, Section 8, in conjunction with the Necessary and Proper Clause that endows Congress with authority to make laws necessary and proper for executing Article I powers. The Supreme Court acknowledged in Alden v. Maine Congress' broad power under Article I, Section 8 to enact legislation that binds the states without having to satisfy a test of undue incursion into state sovereignty, authorizing Congress to impose requirements on the states that are generally applicable for facilitating Congress' regulation of interstate commerce. Although under current Commerce Clause regulation the Court has raised questions concerning the extent to which Congress may enact social [\*1357] legislation to safeguard individual rights, the Court has nonetheless reaffirmed the considerable latitude enjoyed by Congress when exercising commerce power. In United States v. Morrison, the Court reinforced that Congress may regulate pursuant to commerce power for the protection of "persons or things in interstate commerce, even though the threat may come only from intrastate activities." As discussed throughout this Article, compelling issues attendant to adolescent rights, along with the disenfranchising and aggregate damaging effect that presumptive decisional inability has on adolescence, are pervasive and require a national, rather than a local, response. Another basis to support Congressional action concerning adolescence may be found in Section 5 of the Fourteenth Amendment, which mandates the "power to enforce by appropriate legislation" the guarantees of the Due Process and Equal Protection Clauses. Congress, then, arguably has a proper constitutional basis for enacting enabling legislation of this genre and furthering the vital role reserved to the states by the constitutional design. Prior to Congressional action, a President's Commission for the Study of Adolescence should be appointed and convened to examine legal and social issues impacting adolescents; this would represent a significant step toward shaping Capitol Hill policy debates.

#### Enacting an adolescent autonomy model is the only way to make national policy regarding adolescents cohesive.

Hartman, 2000 (Rhonda Gay [J.D., Ph.D.] “Adolescent Autonomy: Clarifying an Ageless Conundrum” Hastings Law Journal 51 Hastings L.G. 1256. August 2000. Via LexisNexis Academic)

Furthermore, federal and state legislation based upon an adolescent autonomy model would not eviscerate parens patriae, but would revolutionize it in a way that effectively comports with the reality of adolescence. In other words, parens patriae should evolve responsively to social norms that assume adolescent decisional ability. Notably, Dr. Gary Melton expressed a decade ago within the context of juvenile delinquency that the tenets and spirit of In re Gault should be reconsidered and reevaluated to "implement procedures consistent with meaningful justice for youth." The same may be said about the doctrine of parens patriae. An adolescent autonomy model would allow the states to guide the development and promote the welfare of adolescents while furthering responsibility. Therefore, law based on such a model would effectively govern adolescence, [\*1358] ensuring individual development into and throughout adulthood, and eliminate ethereal rules and erratic results that now blight legal governance of adolescents, from juvenile delinquency to health care to family law. That public policy should evolve to address the distinct decisional issues attendant to adolescents finds expression in myriad laws governing family affairs generally, including laws permitting termination of parental rights and prosecution for child abuse and maltreatment. Public policy should likewise evolve to embody adolescent decisional ability, which is supported by scientific evidence and developmental research. Indeed, national policy reflected through state law would effectively resolve adolescent issues without disrupting the role of important institutions in the lives of adolescents, including family, and preserve a distinctive juvenile justice system. Commentary has disparaged, discredited and debased the juvenile justice system; however, reports of its demise are rather premature. Though generating thoughtful discourse, such commentary is devoid of resolution, with some notable exception. Calling for the abolition of juvenile court jurisdiction, Professor Janet A. Ainsworth invokes "social constructivist theory" to conclude that a separate juvenile court system contravenes current cultural and historical context. She reasons, "we can no longer justify maintaining a procedurally and practically inferior justice system for juveniles [because] our interpretive construct of childhood and adolescence has changed, and we no longer view young people as essentially and uniformly different from adults." Other commentators, like Professor Donald L. Beschle, have explored the discordance within the legal system, where recognition "for adolescent autonomy in a wide range of non-criminal justice contexts clashes with a commitment to a more paternalistic, rehabilitative approach to juvenile crime as compared with adult crime," though reticent toward "a consistent position of respect for adolescent autonomy." While I very much agree with Professor Beschle's observation that "to simply disregard the dissonance created by inconsistent [\*1359] treatment of adolescent autonomy would be to ignore something significant," I think the time is especially appropriate to establish explicitly what the law has been embracing implicitly - adolescent decisional ability. However, recognizing adolescent decisional ability does not preclude state guidance for developing autonomous rights that preserves parens patriae as foundational. And, while I wholeheartedly agree with Professor Ainsworth's assessment that "our interpretive construct of childhood and adolescence has changed," I depart from her proposal to abolish the system. The same social constructivist reasoning employed by Professor Ainsworth to conclude that changes in the nature of adolescence "undermine the ideological legitimacy of a separate juvenile court system" normatively and descriptively may be used to advance an adolescent autonomy model that reflects the social reality of these changes, yet maintains parens patriae of state power to assist in the meaningful development of adolescent decisional issues. Indeed, parens patriae, as the basis for juvenile jurisdiction, promotes benevolence toward others, and no commentator has persuasively argued that it should not be preserved for adolescents. [\*1360] These proposals fall short of considering the core issue of decisional capability and apply only superficial balm to soothe the irascibility of the governing law. Offering an international perspective, Professor Jane Fortin rightly recognizes that adolescents "like other minority groups... are affected by various branches of law, all with their own distinctive character, with no particular coherence or similarity in policy or objectives" and eloquently observes: Our society quite obviously values well educated adults with highly developed critical faculties and powers of initiative, who are able to take responsibility for their own lives. These are the qualities that the United Kingdom should encourage its adolescents to develop, since they require their "dry run" at adulthood. When fulfilling their rights therefore, attention must be given to promoting their decision-making abilities, through treating them with respect and consulting them whenever possible. At the same time, it is unlikely that adolescents who have been brought up to develop these qualities, and like their parents, to value autonomy, will respond well to being treated without any powers of initiative, whenever it suits society. Indeed, recognition in 1970 by the Chairman of the White House Conference on Children of the pronounced differences between adolescence and childhood presage an adolescent autonomy model, as young people aged 14 through 24 have become "more and more concerned with what was once considered adult domain of public affairs, while children still live in their own special world." An adolescent autonomy model would unite disparities existing in current law, elucidate firm precedent for clear and uniform guidance, and promote the development of adolescent rights. Roscoe Pound once declared that "the legal order must be flexible as well as stable." A legal model predicated on adolescent decisional ability would accomplish just that.

#### **Current presumptions about Adolescent capacity is based on nothing but “collective wisdom.”**

Hartman, 2002 (Rhonda Gay [Professor in the University of Pittsburgh School of Medicine & Affilitated with the Center for Bioethics and Health Law]. “Coming of Age: Devising Legislation for Adolescent Medical Decision-Making.” American Journal of Law and Medicine 28 Am. J. L. and Med. 409. Via LexisNexis Academic)

The underlying tenet of law governing adolescents--that they lack the skills required for capable decision-making--seems well-settled. It is an artifact from an industrial society that spawned legislation authorizing governmental regulation of adolescents for education and labor in order to protect and promote their health and well-being. Known as parens patriae, this philosophy for legislation governing minors has been invoked by courts as a basis for upholding statutes that require [\*410] parental involvement in reproductive decision-making and that permit involuntary commitment of adolescents to mental health institutions by parental consent coupled with psychiatric evaluation. Upholding parental consent and psychiatric evaluation as sufficient safeguards against a due process challenge in Parham v. J.R., the Supreme Court observed that inexperience limits minors' legal autonomy "for making life's difficult decisions." That adolescents lack the life experience of adults seems axiomatic due to having lived less years and having been exposed to fewer challenges. Why, then, should lawmakers reconsider this underlying tenet and focus on this segment of the population? There are several important reasons. One reason is the void in knowledge about adolescent decision-making capability and the corollary void in policy-making attention. Reflected conspicuously by the silence of federal and state legislators "lacking any clear vision of adolescence as a developmental stage," this "lack of vision" has resulted in disparate legal treatment of minors. State statutes that permit a death sentence for minors who commit murder but prevent terminally ill minors from declining aggressive, non-therapeutic medical measures to prolong life aptly illustrate this. State legislation that regulates minors' consent to medical care for non-life-threatening conditions, such as substance abuse and sexually transmitted disease, likewise warrants legislative attention due to protracted policy that confounds judges responsible for determining how much legal autonomy should be given to adolescents and medical practitioners who care for adolescent patients. For example, disparity in policy disadvantages medical practitioners who try to fulfill professional responsibilities in a way that maximizes the ethics of patient care, which includes maintaining patient confidentiality, patient [\*411] autonomy, and beneficent and just approaches. Compliance with legal policy is made more difficult by the failure of legislators to understand and contemplate the decisional issues related to adolescent patient care. Moreover, the presumptive decisional incapacity that undergirds legislation governing minors is tenuous at best. Despite its century-old shelf life, there is comparatively little, if any, evidence to support it. The Supreme Court's observation that adolescent inexperience and vulnerability impede capable judgment for decision-making is, and was, not supported by any evidence beyond the collective "conventional wisdom" of a majority of the justices. In a dissenting opinion to Wisconsin v. Yoder in 1972, Justice Douglas underscored the lack of evidentiary support and emphasized scientific studies that existed at the time to criticize the Court's failure to recognize preferences of the adolescents at issue concerning public school attendance.

#### **Denying adolescents autonomy in medical decisions fractures family communication.**

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” *Cornell Journal of Law and Public Policy*. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

The law as currently configured discourages family communication in at least two ways. First, by making the parent the only party legally capable of consenting to most adolescent healthcare, the law allows parents to avoid difficult conversations with young people about illness, including terminal illnesses or diseases with particularly difficult treatments. Parents in crisis may choose to keep information from their [\*279] child that the parents feel would be overwhelming or discouraging. Anthropologist Myra Bluebond Langner observed in a study of children dying from leukemia that "some parents felt that protection also meant shielding the children from knowledge of the prognosis. They rationalized withholding information ... even using deception with statements like 'You'll get better'... on grounds that this protected children from unhappiness and the possibility of an inadvertent premature death." Often, young people will be well aware that something very serious is wrong with them, and the deception by caregivers and parents will heighten the patient's sense of alienation, disconnect, and powerlessness created by the illness. Similarly, when young people find themselves in crisis moments - i.e., pregnant, drug dependent, or infected with an STI - healthcare emancipation statutes allow them to access care without parental knowledge or consent, but do not necessarily give healthcare providers clear guidance about whether, or when, the healthcare provider has the legal authority or legal responsibility to involve an adult caretaker in decision-making. Thus, a young person may engage in independent decision-making even where an informed parent would have been willing and able to provide non-injurious adult guidance. The needs of young people are [\*280] better served by encouraging healthcare providers to engage in dialogue with young people about parental involvement and to consider both the wishes of the patient and the risks and benefits of parental involvement based on confidential conversations with the patient.

#### **Autonomy in health care is a primary ethical concern.**

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

Though the rhetoric behind these statutes gave little credence to the idea of adolescent self-determination, it is clear that advocates for young people, particularly as they pursued cases in the courts, recognized the benefit of framing their positions in terms of adolescent rights. For instance, in Carey v. Population Services International, decided in 1977, the Supreme Court, while admitting reluctance to "define 'the totality of the relationship of the juvenile and the state," described adolescents as important rights-bearers, reiterating earlier contentions that "minors, as well as adults, are protected by the Constitution and possess constitutional rights." While the case struck down a New York statute restricting access to contraceptives to those under sixteen, the Court specifically declined to speak to the question of what level of Constitutional protection for private and consensual sexual conduct existed for adolescents or adults. Even in making these judgments, the Court did not focus on the issue of adolescent capacity for thoughtful decision-making to ground its determination that young people should have access to contraceptives. The preceding discussion should not diminish the importance of the public health purpose that appears to have been a motivating force behind some adolescent healthcare emancipation statutes. However, in an ever-evolving world, it is wise to reflect on what other loftier and perhaps more intangible ethical goals, not explicitly a part of earlier campaigns, might be served in the present. While it may not have been prudent to speak in terms of adolescent capacity or autonomy during previous eras, there is value in re-evaluating the underlying premises of such laws, explicit and implicit, and ascertaining whether an evolving world and expanding knowledge can breathe new life into old statutes. In that vein, it is prudent to speak to the importance of autonomy and respect for decision-making capacity as a cornerstone principle of the provision of healthcare for young and old. Part of the ethical analysis of how healthcare is provided focuses on the extent to which a patient's autonomy is protected and respected. Applying an autonomy analysis to the healthcare provided to an adolescent who cannot consent to her own care, one must "reject[] the formulation that the adolescent is being protected [and i]nstead ... view[] the insistence on parental consent as a denial of the adolescent's rights as a person, separate from his parents." [\*273] The personal autonomy at issue in this context refers to "the realm of inviolable sanctuary most of us sense in our own beings." Personal autonomy, as manifested in the healthcare context by requiring informed consent, is widely understood to be of enormous value and benefit to individuals. As one philosopher has noted, "Whatever else we mean by autonomy ... it must be a good and admirable thing to have, not only in itself but for its fruits - responsibility, self esteem, and personal dignity. Autonomy so conceived is not merely a 'condition,' but a condition to which we aspire as an ideal."

# Negative Case

## Top of Case

#### Kofi Annan once stated “Knowledge is power. Information is liberating. Education is the premise of progress, in every society, in every family.”

#### It is because I agree with these words, that I negate the resolution: Adolescents ought to have the right to make autonomous medical choices.

#### Because I believe that questions of autonomy in medical choices for adolescents are tied in with concerns including education and community, I offer an evaluative mechanism of Communal Autonomy which was explained by

Mutcherson in 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

Autonomy is often presented as a state of being that is attainable by all. It is also perceived as an individually (and autonomously) developed characteristic that ultimately [\*274] reflects the worth (or lack thereof) of the person. In this simplistic version of autonomy, the realities of ... dependency are absent. In fact, the world that this vision of autonomy imagines is a world that can only be populated by adults, and then only by those adults possessing sufficient capabilities and competencies to make it possible that their only demand of government (aside from the provision of security and courts of law) be for rules that guarantee their right to be left alone to realize the gains and glory their individual talents may bring... . Such a vision is a chimera, and [] this version of autonomy is both undesirable and unattainable on an individual level, and therefore, destructive from a policy perspective. We all experience dependency, and we are all subsidized during our lives (although unequally and inequitably so). As used in this article, autonomy does not demand a rugged or radical individualism in which people are outside of communities, but instead embraces individuals who make decisions with the support of and in conjunction with the communities, large and small, to which they belong. As philosopher Joel Feinberg elucidates: If we so desire, we can minimize our commitments and thus achieve a greater amount of de facto moral independence. We may, if we wish, go through life unmarried, or forgo having children, or near neighbors. We may make as few promises as possible to others, incur no debts, join no partnerships. The picture that emerges from all of this is that of an uncommitted person, maximally independent of the demands of others. Yet it is hard to imagine such a person with the moral virtues that thrive on involvement - compassion, loyalty, cooperativeness, engagement, trust. If we think of autonomy as the name of a condition which is itself admirable, a kind of ideal condition, then the uncommitted person is subject to demerits on this score. He is clearly no paragon. Few well-functioning human beings can, or would wish, to claim a completely independent existence. We live in various webs of interdependence [\*275] formed by families, friendships, employment, and citizenship in various communities and countries. Feinberg explains, There is a danger in discussing, in the abstract, the ideal qualities of a human being. Our very way of posing the question can lead us to forget the most significant truth about ourselves, that we are social animals. No individual person selects "autonomously" his own genetic inheritance or early upbringing. No individual person selects his country, his language, his social community and traditions. No individual invents afresh his tools, his technology, his public institutions and procedures. And yet to be a human being is to be part of a community, to speak a language, to take one's place in an already functioning group way of life. We come into awareness of ourselves as part of ongoing social processes... . One could, then, accurately describe all human beings who do not live completely isolated lives as being simultaneously autonomous and dependent, with the balance between the two shifting based on changes in age, location, health status, and other factors.

#### In today’s debate, I will support a method of Shared Medical Decision making, which would require communication between adolescent patients, their parents, and their health providers. In order to demonstrate the need to balance adolescent rights with the needs of the family, I offer

## Contention One: Adolescents need guidance in their medical choices,

#### **Because, adolescents often make bad choices based on immediate circumstances.**

Canadian Press, 2006 (“Teens with Cancer may Balk at Chemo, Risk Death: Study.” *The Leader-Post* [Regina, Saskatchewan]. April 1, 2006. Pg. A9)

Parents and doctors must keep a close eye on adolescents with cancer, who may not keep up with pills and other chemotherapy regimens because they're more concerned with surviving the debilitating treatment than beating the disease itself, researchers say. A study conducted in part by researchers at Toronto's Hospital for Sick Children suggests compliance in adhering to chemotherapy among teens may not be as high as expected -- and that could put young people's lives at risk, says co-author Dr. Gideon Koren. "The success of cancer therapy is closely dependent on you taking your medications in a very religious manner," said Koren, a Sick Kids pediatrician and pharmacologist who supervised the study. "There's no question that drug therapy changes the prognosis, how these young people do." But some adolescents may balk at taking the medications, which can have "terrible" side-effects, he said, especially when pills must be taken day-in and day-out for several years, as is the case of maintenance doses to keep leukemia from recurring. "You may have hair loss, you may not feel well, you may be sick, you may lose weight, you may not look very cool for your friends ... body image is a big issue for the kids, social acceptance -- all these reasons often lead them not to take their medications," Koren said. Lead author Dr. Benjamin Gesundheit, a pediatric oncologist at Hadassah Hospital of Hebrew University in Jerusalem who studied with Koren in Toronto, said non-compliance with therapy appears to be widespread among adolescents with cancer. In a presentation this week to the 4th International Conference on Teenage and Young Adult Cancer Medicine in London, Gesundheit said the study found that some teens' improper drug use is not always intentional. Adolescents list a variety of reasons, including inadequate supply, forgetfulness, misunderstanding of directions and stopping treatment because symptoms seemed to have cleared. The study involved a review of international medical research carried out mainly in the 1980s and '90s, but Gesundheit said the authors "believe from our own experience, and that of our colleagues, that non-compliance is still a major issue." "Adolescents have been described both as 'abusers of non-prescribed drugs' and 'non-users of prescribed drugs,' he said in a release from the U.K conference. "The challenge for today's clinicians is to identify and then help those teenagers who prefer to dice with death rather than do all they can to survive their cancer." Koren said some teens also may rebel against chemotherapy as a way of asserting their independence, especially if they feel parents are treating them as children. "Adolescence is not an easy time for anyone and adolescents don't like adults to tell them what to do." Currently, determining whether teens are not taking their treatment properly is done in a number of ways, said Gesundheit. Adolescents and their parents can be interviewed, pills counted, drug levels measured in blood and urine, and measurements taken of markers added to drugs. However, these methods can backfire, with adolescents either taking their medication just before a blood or urine test, or vomiting, spitting out or simply discarding drugs, he noted. The researchers found a number of factors were involved in adolescents' failure to take their medications, including the length of treatment (compliance decreased over time), side-effects, family support, the teen's understanding of the disease and overload of information. If patients were given too much information, this tended to have a negative effect on drug-taking. "There are a number of other simple things that could make a huge difference to a teenager grasping the idea that taking his treatment is frankly a matter of life and death," Gesundheit advised doctors. These include discussing treatment goals with the patient and his/her family; providing regular written information and other reminders such as regular telephone calls; addressing the issue of compliance with the teen and his/her family, and keeping the issue foremost in the minds of the team looking after the patient. "Unless you understand them and know how to address them, you may get a lot of kids not treated optimally and they may endanger their lives," Koren said. "You have to do everything possible to ensure that the adolescent is exposed to enough of (their drugs) so they can get the benefits."

## Contention Two: Shared Decision Making in Healthcare works best for all parties involved.

#### **First, Shared decision making is distinct from adolescent autonomy.**

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

Though chronological age is an imprecise measure that does not do justice to the intricacies and variations of individual cognitive development, this article does not dispute the reality that chronological age is a useful and pragmatically necessary tool for determining a baseline presumption of competence for purposes of healthcare decision-making. However, it is appropriate and ultimately beneficial to a variety of parties to lower the age at which the law extends the right to make autonomous healthcare decisions to young people facing a variety of healthcare dilemmas. A reduction in the age of consent for healthcare decision-making from eighteen to fourteen in most circumstances will promote the development of adolescent autonomy by protecting minor's inherent right to know about their own health status and share in decision-making about their own healthcare in consultation with a parent or other trusted adult and healthcare providers. In a shared decision-making model as envisioned in this article, most healthcare decisions would require the consent of both patient and parent, rather than just parental consent, with some necessary exceptions for particularly difficult circumstances in which sole decision-making by the young person or parent would be most appropriate. Such a change may improve the actual physical health of young people by encouraging access to care and providing the psychological benefits that come from wielding some measure of power over one's own healthcare.

#### Second, Effective reforms requires balancing the desire for increased adolescent autonomy with the needs of the communities in which adolescents take part.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

With adolescents, respect for persons means balancing respect for the emerging capacity of an adolescent for independent decision-making with the need for continued special protections, where necessary. This article advocates that laws regulating adolescent access to healthcare should encourage, or at least not impede, healthcare decision-making that avoids unnecessary fracturing of families, respects the capacity of the involved parties, supports positive healthcare provider-patient relationships, minimizes the need for state interference through the child welfare system or courts, and provides for an environment in which affected parties can make decisions that protect the physical and emotional health of the patient. The primary goal of law in the arena of adolescent healthcare should be to facilitate sound medical decision-making by and for young people through ethically sound legislation. This overarching goal can best be achieved by encouraging family communication, recognizing and supporting real-life decision-making patterns put in place by well-functioning families, and facilitating optimal healthcare provider/patient relationships to maximize the potential for good health outcomes. This section will address the importance of each of these factors and the ways in which the current system of laws fails to achieve them.

#### Finally, Shared-Decision Making in healthcare requires a negotiation between parties, and a reformulation of our notion of autonomy.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

Cultural evolution, the expansion of scientific knowledge, and respect for the adolescent all provide a valid basis for transforming the legal landscape to embrace a model of shared healthcare decision-making within families. The legal system should support a more balanced relationship between the goals of protecting adolescents from themselves and granting them rights that allow them to take actions to protect their own interests. Striking this balance requires working within the familial unit and recognizing the power of that unit while avoiding romanticization and unattainable aspiration. Rather than a myopic focus on eighteen as a magic year, more precise and multi-disciplinary thinking suggests the law should create a younger age at which people have a legal right to substantially and substantively participate in decisions about their own healthcare and, in some circumstances, act independently in the healthcare arena. This proposal does not envision or advocate across the board emancipation from the disabilities of age for young people. Rather, it focuses on a particular area where adolescent decision-making would accrue to the benefit of the patient. Any change in the law's treatment of young people in the healthcare context must start from the premise that children are not monolithic, meaning that all of those who are legally minors, because they are below the age of eighteen, should not be labeled immature, incapable, and decisionally dependent. Protectionist policies necessary to maintain the health of young children - those under the age of fourteen - are not automatically appropriate for adolescents who have the capacity to comprehend and respond to their own healthcare circumstances. Either/or reasoning focused on 100% autonomy or 100% lack of autonomy is an inappropriate view of the interests at stake here. No member of a functioning family is radically autonomous and each family member is regularly called upon to understand her exercise of rights within the broader context of an impact on family members. [\*301] As described earlier, the model of autonomy upon which this shared decision-making model rests is one that embraces rather than ignores the idea of community, interdependence, and cooperative decision-making. In this proposal, most of the decision-making will require joint consent by patient and parent, rather than assent by one and consent by the other. In this way, the proposal seeks to elevate the adolescent to a position of greater power while preserving a place for the parent in much of the healthcare decision-making for adolescents. In some ways, the shared decision-making model is akin to a learner's permit for healthcare decision-making. Before young people reach eighteen and are completely unfettered, at least legally, from parental dominance in healthcare decision-making, they will have opportunities to share in the process of self-regulation with both healthcare providers and parents to offer support and guidance. This graduated process conforms to the idea that making good decisions is a learned behavior and that "the right kind of growing up in the law takes place over time rather than on a particular birthday."

# Negative Cards

#### While autonomy is valuable, adolescents should be treated in context, with a presumption of incapacity.

Moon, 2012 (Margret [MD, MPH] “Adolescents’ Right to Consent to Reproductive Medical Care: Balancing Respect for Families with Public Health Goals.” Virtual Mentor Vol. 14.10; Online. <http://virtualmentor.ama-assn.org/2012/10/msoc1-1210.html>)

If we understand the limited nature of minors’ rights to consent to care for specific reproductive and mental health services and their origin as a public health objective, it is a little easier to understand why the 17-year-old in room B may not be able to consent to routine care for a minor illness. While respect for autonomy of the patient is a basic principle of biomedical ethics, its application in the pediatric context is complex. Children are generally not considered to be autonomous, but support for and protection of developing autonomy is a fundamental goal of pediatric practice. Capacity to consent to medical care is a presumption for adults and incapacity is the presumption for minors. (On rare occasions, minors become emancipated by marriage, military service, or financial independence, thereby gaining full rights to consent to care.) Presumptions are always flawed, and it is particularly absurd to anticipate that capacity magically develops on someone’s eighteenth birthday. Ideally, individuals with the capacity to consent would be allowed to do so, no matter what their age. Assessment of capacity, however, is rarely straightforward for adolescents. Capacity to consent requires the abilities to communicate a choice, to understand the options, to reason effectively about those options, and to make an uncoerced decision. The level of capacity required varies with the risk of the choice to be made. The capacities to understand options and to reason effectively are tricky notions and often difficult to test. Life experience and cognitive capacity have significant impact on both. At every stage of adolescence, there is remarkable variability in cognitive development and experience and, correspondingly, variability in capacity to consent. Adolescent care requires ongoing assessment of the developing level of autonomy and its practical application—capacity for consent. We presume incapacity, always ready to be wrong. The default is to rely on parents to help fill in the gaps in adolescent capacity to consent. Most parents begin to defer to their teenage children as the child’s capacity grows. Physicians can support parents and teens in this shift in control, encouraging teens to take an active role in medical communication and decision making and helping parents learn to yield authority. This is the ideal for management of adolescents’ medical care, slow and careful development of capacity guided by a supportive parent and an assessing clinician. Asking adolescents to make independent choices about such high-risk issues as sexual behavior, reproductive health, addiction, and mental health is no one’s idea of an optimum safety net. It is pragmatic, it is necessary, but it is rarely satisfactory.

#### **Adolescent health care requires complex negotiations between health care providers and parents.**

Moon, 2012 (Margret [MD, MPH] “Adolescents’ Right to Consent to Reproductive Medical Care: Balancing Respect for Families with Public Health Goals.” Virtual Mentor Vol. 14.10; Online. <http://virtualmentor.ama-assn.org/2012/10/msoc1-1210.html>)

Support for confidential care for adolescents has always been a pragmatic notion, directed toward public health outcomes. It is not a normative statement about the relative value of the autonomy of adolescents and the rights of their parents. Most clinicians, including those most vigorously in support of confidential care, agree that the active involvement of a concerned and capable parent is the best possible situation for sexually active teens. Parents are in the best place to know the emotional needs of their adolescent—they are usually the best bet for consistent love and care and are, unlike minors, presumed to be competent decision makers. Parents also have legal and financial duties to care for minor children. In light of those duties, we honor parents’ rights to direct the moral and spiritual upbringing of children—within specific limits. Unfortunately, it is obvious that some teens do not enjoy the support of capable parents. For those teenagers, access to confidential care may be necessary.

#### **Empirical data suggests shifts toward autonomy result in less information being available to patients.**

Moulton & King, 2010 (Benjamin [Lecturer in Health Law at Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making] and Jamie S. [Associate Professor of Law at the University of California, Hastings College of the Law]. “Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice.” *Journal of Law, Medicine, & Ethics.* Spring 2010: p. 2)

As a result, over the last three decades, medical ethicists have shifted from guiding physicians to focus on beneficence and improving patient health as emphasized in the Hippocratic oath toward a more subjective and “patient-centered” practice, which also prioritizes patient autonomy in medical decision-making. While this shift toward autonomy is well represented in the literature and ethical guidelines, health services research demonstrates that in clinical practice many physicians have yet to strike the ideal balance between absolute patient autonomy and beneficence. Recent studies have found that most physicians still undervalue disclosure and underestimate the variability in patient preferences. Alternatively, in an effort to promote a more “patient-centered” model of decision-making, we have received anecdotal reports that other physicians have altered their disclosure practices to provide patients with information on the risks and benefits of the treatment options, but then require the patient to make the treatment decision without the benefit of the physician’s medical opinion. In these infrequent instances, the pendulum has swung too far. The unmitigated rise of autonomy can result in the decline of beneficence. In today’s medical practice, patients frequently receive either too little medical information to make an informed treatment decision or too little physician opinion to feel confident in their choice. To satisfy their ethical obligations to patients, health care providers should implement a system of medical decision-making that balances the importance of both ethical principles.

#### **Autonomous Medical Choices Defined:**

Moulton & King, 2010 (Benjamin [Lecturer in Health Law at Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making] and Jamie S. [Associate Professor of Law at the University of California, Hastings College of the Law]. “Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice.” *Journal of Law, Medicine, & Ethics.* Spring 2010: p. 4)

Respect for autonomy has become the dominant and controlling principle in both informed consent law and medical ethics. The American Medical Association’s Code acknowledges that “[t]he patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice” and that “the patient should make his or her own determination about treatment.”23 The AMA requires physicians to disclose “all relevant medical information to patients” to enable them to make medical decisions based upon their personal beliefs, values, and life goals. Under this standard, physicians must respect patients’ decisions even when those decisions do not promote their physical well-being or conform with the physician’s medical judgment.24 At the extreme, courts have upheld a competent patient’s right to decline medical treatment even when that treatment would be life saving.

#### Insuring Enough Information for Adults to make informed, autonomous medical choices is incredibly difficult on its own because of disconnections in patient-doctor communication and the difficult level of comprehension required.

Moulton & King, 2010 (Benjamin [Lecturer in Health Law at Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making] and Jamie S. [Associate Professor of Law at the University of California, Hastings College of the Law]. “Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice.” Journal of Law, Medicine, & Ethics. Spring 2010: p. 4-5)

While the medical community has espoused the value of autonomy in principle, much more work must be done to promote patient autonomy in practice. Health services research conducted in the last 15 years reveals a consistent pattern of inadequate information disclosure and low patient comprehension and retention. In a multi-national study conducted in 2004, the Commonwealth Fund found that 31 percent of sicker patients in the United States left their physician’s office without having important questions answered, which was the highest percentage among the five countries studied (Australia, Canada, New Zealand, and the United Kingdom). Likewise, 47 percent of sicker patients reported that the physician did not ask their ideas and opinions about treatment and care. This startling data suggests not only a consistent failure to meet the disclosure requirements necessary to obtain a legal consent, but also a breach of fundamental medical ethics on a systemic level. Variation between the United States and the four other nations studied may have occurred for a number of reasons. Some variation may result from financial incentives within the U.S. health care system, as physicians are generally reimbursed based on the volume of procedures they perform, not time spent discussing the procedures with patients. Other inadequacies may result from physicians’ lack of understanding of patients’ informational needs. In a study comparing physicians’ and patients’ opinions on the importance of different aspects of outpatient care, patients prioritized the factors related to the provision of information second only to clinical skill, while physicians prioritized it sixth out of the nine domains of outpatient practice. In a study of physician and patient encounters in outpatient care, Braddock et al. found that while physicians disclosed the nature of the patient’s condition 83% of the time, they only discussed the risks of the procedure with the patient in 9% of all cases and in 22% of more serious cases, such as an invasive in-office procedure or change in medication. Alternatives to the physician’s recommended treatment were discussed even less frequently. In addition to the underprovision of information, Calkins et al. found that physicians tend to overestimate patient comprehension of their discharge instructions. A study conducted at the Mayo clinic found that patients failed to report 54% of the “most important health problems” discussed by physicians with respect to their medical care when asked to recount the health problems discussed during the encounter. Despite ethical mandates requiring disclosure of all relevant medical information and legal standards obligating physicians to obtain an informed consent based on those disclosures, clinical evaluation research studies suggest that patients are routinely asked to make decisions about treatment choices in the face of what can only be described as avoidable ignorance. Decisions made under a shroud of ignorance have negative consequences for both individuals and the U.S. health care system as a whole, in the form of unnecessary procedures. In the absence of complete information, individuals frequently opt for procedures they would not otherwise choose. Mounting clinical evaluative evidence suggests that the number of surgical procedures performed, even when justified by practice guidelines, actually exceeds patients’ desires when they are fully informed through a shared decision- making process. This incongruence occurs most often in cases of preference sensitive care, where for a specific condition the patient faces multiple treatment options with varied risks and benefits. Selecting between preference sensitive treatment options often involves significant tradeoffs that affect the patient’s quality or length of life. To make an informed decision, patients need evidence-based medical information on the risks and benefits of all treatment options. However, they also need proper health provider guidance to make a decision that aligns their personal values and medical goals. Not all clinically appropriate patients will prefer to have surgery over less invasive treatments, if the long-term outcomes are similar or the surgery has significant side effects. For instance, a study of patients who satisfied the clinical guidelines for knee arthroplasty found that when fully informed, no more than 15% preferred to have the surgery. Inadequate disclosures can result in costly, unwanted and unnecessary procedures that are often accompanied by significant complications or side effects. On a systemic level, differences in the information disclosed to patients and their level of comprehension can produce significant variations in the rates of preference sensitive treatments options. Respecting a patient’s autonomy requires physicians to provide patients with sufficient information to make an informed decision and to ensure their comprehension of the various altenatives, risks, and benefits.

#### **Allowing Adolescents autonomy in medical decisions would include allowing them to refuse to make any decision at all.**

Moulton & King, 2010 (Benjamin [Lecturer in Health Law at Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making] and Jamie S. [Associate Professor of Law at the University of California, Hastings College of the Law]. “Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice.” Journal of Law, Medicine, & Ethics. Spring 2010: p. 6)

Balancing autonomy and beneficence may result in several different, but equally appropriate outcomes. In rare cases, a competent patient may refuse all relevant information and defer all decision-making authority to the physician. The decision to not receive information is a valid expression of her autonomy. Tom Beauchamp and James Childress argue that “[t]here is a fundamental obligation to ensure that patients have the right to choose, as well as the right to accept or decline information. Forced information, forced choice, and evasive disclosure are inconsistent with this obligation.” In the majority of cases in which physicians provide information to patients, four possible outcomes exist. First, the physician and the patient arrive at a mutual treatment decision. Second, the patient selects a treatment option that the physician does not prefer, but will provide. Third, the physician and patient do not agree and the patient seeks care elsewhere, or fourth, the patient can defer the treatment choice to the physician. A physician’s ethical obligation with respect to treatment decision-making should be to assist patients to select both a decision making pathway and a treatment option that best satisfies their personal and medical goals.

#### Autonomy is always subject to “inevitable dependencies,” which deny neither autonomy nor the importance of others.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

Like most adults, adolescents have both voluntary and involuntary commitments that impact their autonomy without depriving them of that autonomy. There are "natural" commitments, described by Martha Fineman as inevitable dependencies, n89 formed by youth and biological dependence, but as we age we also make voluntary choices to continue to be influenced in large and small ways by others including parents, teachers, and friends. We commit to being a part of a family and being both a leader and follower in our families. In other words: If there is such a thing as "personal sovereignty," that presumably belongs to all competent adults and to no newborn infants, but before the point of qualification for full sovereignty, children must be understood to have various degrees of "local autonomy."... . It becomes difficult, however, to think of the near-adult teenager as deriving all of his autonomy by parental delegation. A certain minimum, at least, he has by natural right, even if his privileges to use the family car, to stay out past midnight, and the like, are delegated and revocable. Equally as important is a recognition that an autonomous actor need not always act rationally, or with kindness or compassion. For, "[a] self- [\*277] governing person is no less self-governed if he governs himself badly, no less authentic for having evil principles, no less autonomous if he uses his autonomy to commit aggression against another autonomous person. The aggressor is morally deficient, but what he is deficient in is not necessarily autonomy." In this way, then, it is false to suggest that young people lack autonomy because they may make decisions that appear irrational, cruel, or otherwise deficient. Autonomy need not rest on an assessment of the decision that might have been made by another, but instead is premised upon the process by which an actor reaches a decision.

#### Both parental and adolescent autonomy, alone, destroy family communication.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

The law as currently configured discourages family communication in at least two ways. First, by making the parent the only party legally capable of consenting to most adolescent healthcare, the law allows parents to avoid difficult conversations with young people about illness, including terminal illnesses or diseases with particularly difficult treatments. Parents in crisis may choose to keep information from their [\*279] child that the parents feel would be overwhelming or discouraging. Anthropologist Myra Bluebond Langner observed in a study of children dying from leukemia that "some parents felt that protection also meant shielding the children from knowledge of the prognosis. They rationalized withholding information ... even using deception with statements like 'You'll get better'... on grounds that this protected children from unhappiness and the possibility of an inadvertent premature death." Often, young people will be well aware that something very serious is wrong with them, and the deception by caregivers and parents will heighten the patient's sense of alienation, disconnect, and powerlessness created by the illness. Similarly, when young people find themselves in crisis moments - i.e., pregnant, drug dependent, or infected with an STI - healthcare emancipation statutes allow them to access care without parental knowledge or consent, but do not necessarily give healthcare providers clear guidance about whether, or when, the healthcare provider has the legal authority or legal responsibility to involve an adult caretaker in decision-making. Thus, a young person may engage in independent decision-making even where an informed parent would have been willing and able to provide non-injurious adult guidance. The needs of young people are [\*280] better served by encouraging healthcare providers to engage in dialogue with young people about parental involvement and to consider both the wishes of the patient and the risks and benefits of parental involvement based on confidential conversations with the patient.

#### Even if adolescents are largely as competent as adults, competence is not an all or nothing proposition.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

Professional groups have taken note of the literature on the cognitive development of adolescents. The American Academy of Pediatrics ("AAP") notes that "review of the limited relevant empirical data suggests that adolescents, especially those age 14 and older, may have as well developed decisional skills as adults for making informed health care decisions." n139 The Society for Adolescent Medicine ("the Society") has also indicated that its membership shares the view that adolescent decisional skills may be as developed as those of adults. n140 Based on this data and their own experience with young patients, these medical professionals have expressed support for granting young people, specifically those who are fourteen or older, greater rights to participation in decisions about their own healthcare. It is worthwhile to note that "competence is not an 'all or nothing' quality; it develops gradually, particularly if the child has opportunities to try out budding skills. A child does not always have a general level of competence. Rather, a child may be competent in one area, but not in another, and may be competent to take on part of a given task, but not the whole." Furthermore, "while the words 'competence,' 'competent' and 'capable' may cover some of the same qualities as 'intelligent' does, they imply abilities that are more than merely cognitive." In other words, even if a young person lacks competence or decision-making capacity in one arena, that lack would not necessarily preclude a finding of decision-making capacity for the purpose of an individual healthcare decision.

#### Adolescents should practice competent decision making, in conjunction with others.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

A required aspect of developing decision-making capacity is the grant of opportunities to actually make decisions. In other words: [\*289] The important point here is that children come to develop capacities for decision-making and for exercising liberties through guidance and practice. Just as a child learns to read or gather roots by actively participating in these endeavors with adults or older children, so too a child learns what is right and wrong, acceptable or unacceptable, by active participation in the moral community. Among the most important capacities a child ought to develop is the capacity to recognize her interests, to prioritize them, and to balance competing interests (both other interests of her own and those of other persons). For the development of these abilities, however, she needs careful and considerate assistance by those persons who have some concern that her best interests are met, and who are able to assess the possible consequences for the sake of certain long term interests, and vice versa. To be given age-appropriate information about one's own health and make decisions based on consultation with whoever is deemed an appropriate source of advice is a fitting show of respect for a young person's need to grow into full maturity. Even without the support of the law, many healthcare providers working with young people have determined that professionally appropriate and ethically sound care for an adolescent requires that the healthcare provider allocate significant decision-making power to an adolescent patient, including maintaining the confidentiality of the healthcare provider-patient relationship against the parent's desire to know what is taking place with his child. Healthcare providers may assume this posture even though in most states and circumstances the law does not require or necessarily allow this balance.

#### Shared-Decision Making can use the courts as a final mechanism to adjudicate conflict.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

Under the shared decision-making model offered here, the option of seeking a court order would remain available for a parent or provider who felt that a young person or parent was making a decision that would ultimately work to her detriment. This option should be exercised sparingly and with caution. Referrals for family counseling or mediation might be a more appropriate option where families are willing, time is not of the essence, and violence is not an issue. As healthcare providers have noted, the availability of the resort to court "allows healthcare providers to intervene along a spectrum from recommendation to persuasion to coercion. This power must be used responsibly, and should not be taken as license to ignore patients with the capacity to make decisions." When faced with a difficult decision about treatment for an adolescent, a judge should engage in ethical decision-making meaning that she should "decide cases not on the basis of personal experiences, societal beliefs, or personal assessments about 'how things should be' but on the facts presented in court, the law as it has developed, and on scientific rather than conventional wisdom regarding life around [her]." Though courts are given little guidance about how to make such an assessment, the evaluation would essentially be a "mature minor" assessment. The court's goal should be to determine whether the adolescent has the capacity for mature and thoughtful decision-making and can therefore make a treatment decision that is informed, intelligent, and voluntary. An adolescent would need to show that she could articulate her health problem and its consequences as well as indicate an understanding of the available treatment options and why she has made a particular decision about that treatment. Only where a young person lacks decision-making [\*315] capacity should a court make a determination as to what course of action would be in that young person's best interest.

#### This model rejects extremes, and allows for adolescent autonomy within the context of community and family.

Mutcherson, 2005 (Kimberly M. [Assistant Professor of Law at Rutgers School of Law—Camden.] “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents.” Cornell Journal of Law and Public Policy. Summer 2005. 14 Cornell J. L. & Pub. Pol’y 251.)

A shared decision-making model avoids extremes in healthcare decision-making for adolescents. It rejects a vision of a familial unit in which parents are paramount, barring decisions that work to the detriment of young people, but also rejects the idea that most adolescents would not benefit from the participation of an adult in decisions about healthcare. The vision of family upon which this proposal rests is one of families as cooperative units in which young people are confronted with both the burdens and benefits of being a rights-bearing player in the healthcare arena. An adolescent's obvious interest in her own health, combined with her growing capacity to understand her health situation, evaluate alternatives based on her own value system, and articulate her healthcare preferences, must coexist with a parent's interest in protecting the child. The form of autonomy granted to young people in this context is grounded in connectedness and community. Therefore, it seeks to include parents or caretakers as a vital component of healthcare decision-making for adolescents while according greater respect to the young person as a thinking entity with an inherent right to be intimately involved in any decisions made concerning her own health.