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LET'S GET REAL: QUILTING A PRINCIPLED APPROACH TO ADOLESCENT EMPOWERMENT IN HEALTH CARE DECISION-MAKING

Jennifer L. Rosato*

INTRODUCTION

"Where the reason fails the rule should not apply."¹

There are a number of contrasting images of adolescents reflected in existing law. One image is of adolescents being judged on their abilities (as in the tort context);² another image is one of adolescents being presumed competent and treated as adults (as in the juvenile justice context).³ In the health care context, however, even older adolescents are presumed incompetent to make basic health care decisions.⁴

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1. *Brown v. Shelby*, 332 S.W.2d 166, 169 (Tenn. 1960).

2. RESTATEMENT (SECOND) OF TORTS 283A (1965) (stating a minor's standard of conduct is based on that of a reasonable person of like age, intelligence, and experience under like circumstances); see also Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1304 (2000) [hereinafter Hartman, *Adolescent Autonomy*] (claiming that tort law, as opposed to contract law, allows adolescents to sue and be sued after taking into account the minors diminished maturity based on his/her age).

3. This presumption is reflected primarily in transfer or waiver statutes, which increasingly permit or require juveniles who commit certain crimes to be tried as adults. See, e.g., Barry C. Feld, *Juvenile and Criminal Justice Systems' Responses to Youth Violence*, 24 CRIME & JUST. 189, 195-212 (1998); BUREAU OF JUSTICE ASSISTANCE, *JUVENILES IN ADULT PRISONS AND JAILS: A NATIONAL ASSESSMENT* Ch. 6, at 170-82 (Oct. 2000); cf. Hartman, *Adolescent Autonomy*, supra note 2, at 1294-1301 (stating that with transfer and waiver statutes there is a presumption of capacity without an assessment of whether the minor actually has it).

4. See Hartman, *Adolescent Autonomy*, supra note 2, at 1306; Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have A Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS L. REV. 1 (1996) [hereinafter Rosato, *Life-Sustaining Treatment*]; see also Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547 (2000). For other references to these contrasting images, see Donald L. Beschle, *The Juvenile Justice Counterrevolution: Responding to Cognitive Dissonance in the Law's View of the Decision-Making Capacity of Minors*, 48 EMORY L.J. 65, 88-95 (1999); ROGER J.R. LEVESQUE, *ADOLESCENTS, SEX, AND THE LAW: PREPARING ADOLSCENTS FOR REASONABLE CITIZENSHIP* 331 (2000).

This presumed incompetence pervades the law governing health care decision-making. For the most part, persons under the age of eighteen cannot make basic health care decisions on their own.⁵ Although obtaining an abortion is a constitutional right for young women, there are significant restrictions on that right.⁶ And when it comes to participating in health care decisions that would assist others—such as participation in clinical trials—sixteen-year-old adolescents are treated like seven year olds.⁷

This disparate treatment of children would not be problematic were it based in reality, but it is not. There is no set of findings that suggests that most children under the age of eighteen lack the capacity to make these decisions.⁸ In fact, evidence suggests that some minors gain the requisite capacity considerably before reaching adulthood. Yet, as Section II illustrates, the existing legal doctrine permits minors to make decisions only in a narrow set of circumstances that are unrelated to the minor's actual capacities and is unresponsive to their need to develop decision-making competence prior to adulthood.

This Article proposes changes in the existing doctrine that would make it more based in the realities of the older adolescent.⁹ First, this Article will analyze the weaknesses in existing law as they pertain to adolescent health care decision-making.¹⁰ Second, this Article will examine the lessons that can be learned from the disciplines of developmental psychology and bioethics to inform a more reality-based jurisprudence in this area.¹¹ Finally, this Article will propose changes to existing law that are informed by these disciplines and quilted to-

5. See Hartman, *Adolescent Autonomy*, *supra* note 2, at 1306; Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 11; see also Christine M. Hanisco, Note, *Acknowledging the Hypocrisy: Granting Minors the Right to Choose Their Medical Treatment*, 16 N.Y.L. SCH. J. HUM. RTS. 899, 920 (2000).

6. See also discussion *infra* notes 22-54 and accompanying text.

7. See, e.g., Jennifer L. Rosato, *The Ethics of Clinical Trials: A Child's View*, 28 J.L. MED. & ETHICS 362, 366, 369 (2000) [hereinafter Rosato, *Clinical Trials*] (stating under existing law, older children can assent but not consent). A committee recently proposed that certain mature adolescents be permitted to enroll in clinical trials without their parents' consent or knowledge. See Susan Okie, *FDA Urged to Broaden Study Rules; Current Policy Prevents Teens From Enrolling Without Parents' Consent*, WASH. POST, July 31, 2001, at A2.

8. See discussion *infra* notes 95-169 and accompanying text.

9. See, e.g., Emily Buss, *Confronting Developmental Barriers to the Empowerment of Child Clients*, 84 CORNELL L. REV. 895, 919 (1999) (advocating for the law to recognize the "increased prevalence of certain capacities" as children mature rather than assuming that they are not as capable as adults); Donald N. Bersoff & David J. Glass, *The Not-So Weisman: The Supreme Court's Continuing Misuse of Social Science Research*, 2 U. CHI. L. SCH. ROUNDTABLE 279, 302 (1995) (discussing the need for "empirically justified decisions that match the real world.").

10. See *infra* notes 14-93 and accompanying text.

11. See *infra* notes 94-185 and accompanying text.

gether to create a more coherent doctrine than the one that currently exists.¹² Quilting accurately reflects this analytical process, as it involves intellectually sewing together seemingly unrelated patches to create a unique and meaningful whole.¹³ The ultimate objective is to respect and nurture the burgeoning autonomy rights of minors at the brink of adulthood while protecting them from harm where it is necessary.

II. ADOLESCENTS IN HEALTH CARE: PARENTS RULE

“Obey Thy Mother and Father—and Anyone Else Bigger Than You Are.”¹⁴

The law that governs children in the health care decision-making context is fairly well established and has not changed significantly over the last two decades. The general rule is that children under eighteen are not permitted to consent to or refuse medical treatment without their parents' consent.¹⁵ In fact, only the parents' consent matters: the parents' decision trumps even if the child disagrees.¹⁶

This general rule is justified by two equally strong rationales. The first is that children are not mature enough to make these decisions for themselves: they lack the requisite capacity and experience.¹⁷ On their own, it is believed that they will make bad decisions and will be vulnerable to the pressure of others.¹⁸ As stated by the United States

12. See *infra* notes 186-223 and accompanying text.

13. JANET CATHERINE BERLO, *QUILTING LESSONS NOTES FROM THE SCRAP BAG OF A WRITER & QUILTER* 59 (2001). In this book the author reflects on (among other things) the similarities between writing and quilting.

14. Patricia Keith-Spiegel, *Children's Rights as Participants in Research, in CHILDREN'S RIGHTS AND THE MENTAL HEALTH PROFESSIONS* (Gerald P. Koocher ed., 1976).

15. FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* 5.1 (3d ed. 1998). The common law stated that a minor was unable to consent to medical treatment by themselves and, with the exception of emergencies or other impractical situations, imposed a requirement on doctors to seek the consent of the minor's parent before performing any medical procedures. *Id.*

16. See Scott, *supra* note 4, at 566 (discussing a battery as when medical treatment is given without informed consent and because minors can not give that type of consent, the parents must do so for them even if the child does not agree); see also ROZOVSKY, *supra* note 15, at 5.1.

17. See, e.g., *Hodgson v. Minnesota*, 497 U.S. 417, 444-45 (1980) (noting that because of adolescents' lack of experience, the state is justified in requiring parental consent for such events as having an operation); see also Hartman, *Adolescent Autonomy*, *supra* note 2, at 1308 (discussing that minors are presumed incapable of making medical decisions).

18. *Bellotti v. Baird*, 443 U.S. 622, 635 (1979) (plurality opinion). Because children are often unable to recognize the gravity of their choices, the United States Supreme Court has a history of limiting their freedoms when they need to make “important, affirmative choices with potentially serious consequences.” *Id.* The Court has often taken a protective role with minors because their “inexperience, less education, and less intelligence make the teenager less able to evaluate the consequences of his or her conduct while at the same time he or she is much more

Supreme Court, “[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment.¹⁹

The second rationale is that parents deserve deference to make decisions on behalf of their children. This reasoning is based on common law and constitutional law, and reflects the idea that parents know best what will serve their own child’s interests. To perform their role most effectively in a free society, parents need the space—free from governmental interference—to make these decisions.²⁰

Exceptions to the parental consent rule do exist, but they are fairly narrow and unrelated to the adolescent’s actual ability to make the decision at issue. The most common exceptions are constitutional, (notably abortion), status-based, and those based on certain diseases or conditions.²¹ The existing law reflects a great reluctance to recognize a true mature minor exception, one that would give decision-making power to an older adolescent capable of making the decision at issue.

A. *Minors’ Constitutional Right(s): The Case of Abortion*

Minors have been granted some constitutional rights, even though the level of protection given to them has been less than that for adults.²² In the area of health care, for example, minors have been

apt to be motivated by mere emotion or peer pressure than is an adult.” *Thompson v. Oklahoma*, 487 U.S. 815, 835 (1988).

19. *Parham v. J.R.*, 442 U.S. 584, 603 (1979); *cf. Wisconsin v. Yoder*, 406 U.S. 205, 242-43 (1972) (Douglas J., dissenting in part) (discussing that in freedom of religion case, lower court should have consulted teenagers on their religious views rather than simply defer to parents).

20. Jennifer L. Rosato, *Using Bioethics Discourse to Determine When Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 *TEMPLE L. REV.* 1, 6-7 n. 25 (2000) [hereinafter Rosato, *Bioethics*]; *see also* Janet L. Dolgin, *The Fate of Childhood: Legal Models of Children and the Parent-Child Relationship*, 61 *ALB. L. REV.* 345, 374-75 (1997) (discussing the U.S. Supreme Court’s use of the “Traditional Model” of the parent-child relationship where the parent has the right to make the decisions for the child and the child’s rights are essentially nonexistent).

21. *See* Rosato, *Bioethics*, *supra* note 20, at 6-7 n.22 (stating that because parents have a fundamental right to make decisions for the care, custody, and control of their minor children, it takes a compelling state interest for the government to interfere); *see also* Dolgin, *supra* note 20, at 379 (citing *Meyer v. Nebraska*, 262 U.S. 390, 400-03 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510, 521, 534-35 (1925) as examples of the U.S. Supreme Court protecting parental rights from government intrusion); James Dwyer, *Parents’ Religion and Children’s Welfare: Debunking the Doctrine of Parents’ Rights*, 82 *CALIF. L. REV.* 1371, 1372 (1994) (arguing that any attempt by the state to improve the lives of children is restricted by parents’ fundamental rights).

22. *See, e.g.*, Emily Buss, *The Parental Rights of Minors*, 48 *BUFF. L. REV.* 785, 794 (2000); Jennifer C. Friedman, *Parental Notice in State Abortion Statutes: Filling the Gap in Constitutional Jurisprudence*, 29 *COLUM. HUM. RTS. L. REV.* 437, 443-44 (1998); *see also* Catherine J. Ross, *An Emerging Right for Mature Minors to Receive Information*, 2 *U. PA. J. CONST. L.* 223, 223-24, 233-42 (1999) (discussing the First Amendment).

granted the right to obtain an abortion.²³ Consequently, states are not permitted to place an undue burden on a girl's right to obtain an abortion.²⁴

Even with this restriction, states are permitted to limit a girl's abortion right in significant ways without running afoul of the federal Constitution.²⁵ A girl below the age of eighteen cannot obtain a first-trimester abortion on her own, unlike an adult woman who generally can early in her pregnancy.²⁶ In contrast, a pregnant girl must involve either her parents or a court in her decision.²⁷ The parental involvement required by the state can be categorized as one-parent consent,²⁸ two-parent consent,²⁹ one-parent notice,³⁰ or two-parent notice.³¹ If

23. See, e.g., *Hodgson v. Minnesota*, 497 U.S. 417, 435 (1990); *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52, 73-75 (1976); see also J. Shoshanna Ehrlich, *Minors As Medical Decision Makers: The Pretextual Reasoning Of The Court In The Abortion Cases*, 7 MICH. J. GENDER L. 65, 67-68 (2000) [hereinafter Ehrlich, *Medical Decision-Makers*]; J. Shoshanna Ehrlich, *Journey Through The Courts: Minors, Abortion And The Quest For Reproductive Fairness*, 10 YALE J.L. & FEMINISM 1, 3, 26-27 (1998) [hereinafter Ehrlich, *Reproductive Fairness*].

24. See Rosato, *Bioethics*, *supra* note 20, at 16-20; see also Katheryn D. Katz, *The Pregnant Child's Right to Self-Determination*, 62 ALB. L. REV. 1119, 1141-42 (1999).

25. Under state constitutions that provide more expansive rights, fewer restrictions may be permitted. See discussion *infra* notes 42-50 and accompanying text (discussing *Farmer* decision, which invalidated New Jersey's parental notification statute under state's equal protection clause). Federal laws essentially represent the floor of constitutional decisions, and state laws the ceiling. Whereas the federal Constitution serves as the minimum protection afforded to a minor's right to privacy, the states can provide even more under their individual state constitutions. See Rachel Weissman, *What Choice Do They Have? Protecting Pregnant Minors' Reproductive Rights Using State Constitutions*, 1999 ANN. SURV. AM. L. 129, 143 (1999).

26. The undue burden standard applies to adult women, as well as minors. See *Steinberg v. Carhart*, 530 U.S. 914, 921, 938-46 (2000) (applying undue burden standard to review "partial birth" abortion statute). Although theoretically adult women are subject to the same standard as girls, fewer restrictions on their abortion rights are permitted. See, e.g., *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 887-95 (1992) (striking down spousal consent provision under undue burden standard but upholding parental consent provisions).

27. The framework for reviewing a girl's abortion decisions was articulated in *Bellotti v. Baird*, 443 U.S. 622 (1979) (*Bellotti II*). Although *Bellotti II* initially was considered an advisory opinion, it is now well-established as setting forth the legal framework for reviewing the constitutionality of minor abortion statutes. See Ehrlich, *Reproductive Fairness*, *supra* note 23, at 50, 55.

28. See, e.g., TENN. CODE ANN. § 37-10-303 (2001); KAN. STAT. ANN. § 65-6705 (2000); ARIZ. REV. STAT. ANN. § 36-2152 (West 2000); OHIO REV. CODE ANN. § 2919.12 (West 2001); LA. REV. STAT. ANN. § 40:1299 [1299.3015] (West 2000); CAL. HEALTH & SAF. CODE § 123450 (West 2001); 18 PA. CONS. STAT ANN. § 3206 (West 2001); S.C. CODE ANN. § 44-44-31 (Law. Co-op. 2000); WIS. STAT. ANN. § 48.375 (West 2001); IND. CODE ANN. § 16-34-2-4 (2001). Most states have one-parent consent statutes. See *Planned Parenthood of Massachusetts, Inc. v. Attorney General*, 677 N.E.2d 101, 107-08 (Mass. 1997).

29. See MASS. GEN. LAWS ANN. ch. 112, § 12S (West 2001).

30. See, e.g., MONT. CODE ANN. § 50-20-204 (2001); WYO. STAT. ANN. § 35-6-118 (Michie 2001); DEL. CODE ANN. tit. 24, § 1783 (2000); GA. CODE ANN. § 15-11-112 (2001); MD. CODE ANN. HEALTH GEN. § 20-103 (2000); see statutes cited in Katz, *supra* note 24, at n.180 (citing examples from Delaware, Georgia, Illinois, Kansas, Maryland, Nebraska, Nevada, Ohio, and West Virginia as examples of states that use one-parent notification statutes).

the girl does not wish to involve her parents in the manner the state prescribes, she must obtain the court's permission through a judicial bypass.³² In this proceeding, the minor ordinarily must show either that she is mature enough to obtain an abortion or that the abortion is in her best interests.³³ Although a few judicial bypass procedures have been struck down as unconstitutional under the federal Constitution,³⁴ others have been upheld.³⁵

Overall, the existing doctrine is out of touch with reality. For example, the doctrine reflects an overwhelming desire for parents to be involved,³⁶ even though the reality is that such forced involvement is unnecessary³⁷ and, worse yet, may be harmful to the minor.³⁸ Specifically, it is important for the law to recognize that for some girls, just notifying a parent can be as significant a burden on her decision as

31. See, e.g., MINN. STAT. § 144.343 (2000); N.D. CENT. CODE § 14-02-1-03 (1999); cf. UTAH CODE ANN. § 76-7-304 (2000) (requiring doctors, "if possible," to notify the minor's parent before performing the abortion).

32. See, e.g., VA. CODE ANN. § 16.1-241 V (Michie 2001); N.D. CENT. CODE § 14-02-1-03 (2001); MONT. CODE ANN. § 50-20-212 (2001); MASS. GEN. LAWS ANN. ch. 112, § 12S (West 2001); LA. REV. STAT ANN. § 40:1299.35.5(B)(4) (West 2001); OHIO REV. CODE ANN. § 2919.12 B(1)(a)(iii) (West 2001); ARIZ. REV. STAT. ANN. § 36-2152B (West 2000); KAN. STAT. ANN. § 65-6705(a) (2000); TENN. CODE ANN. § 37-10-303(b) (2000); CAL. HEALTH & SAF. CODE § 123450(b) (West 2001); 18 PA. CONS. STAT. ANN. § 3206(c) (2001). See generally Wallace J. Mlyniec, *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 FORDHAM L. REV. 1873, 1889-92 (1996); Suellen Scarnecchia & Julie Kunce Field, *Judging Girls: Decision Making in Parental Consent to Abortion Cases*, 3 MICH. J. GENDER & L. 75, 89-93 (1995) (both reviewing judicial bypass provisions).

33. See, e.g., MONT. CODE ANN. § 50-20-204 (2000); LA. REV. STAT. ANN. § 40:1299(A)(5) (West 2000); ARIZ. REV. STAT. ANN. § 36-2152B (West 2000); KAN. STAT. ANN. § 65-6705(e)(2) (2000); CAL. HEALTH & SAFETY CODE § 123450(c) (West 2000); PA. CONS. STAT. ANN. § 3206(d) (2001). See generally Friedman, *supra* note 22, at 448 (discussing the requirements for judicial bypass as including either the requirement of a best interests determination or that the minor is mature enough to make an informed decision).

For cases evaluating the level of maturity required to make an abortion decision, see *Ex Parte Anonymous*, 2001 WL 587223 (Ala. 2001); *In re Anonymous*, 771 So.2d 1043 (Ala. 2000); *In re Jane Doe*, 19 S.W.3d 346, 358-361 (Tex. 2000); *In re Anonymous*, 253 Neb. 485 1044-47 (1997).

34. *Planned Parenthood of S. Arizona v. Neely*, 804 F. Supp. 1210, 1216 (D. Ariz. 1992) (holding one-parent consent law is unconstitutional); *Planned Parenthood of Central New Jersey v. Farmer*, 762 A.2d 620, 630 (N.J. 2000) (finding most federal cases have upheld state's parental participation laws). Other bypass procedures have been found unconstitutional under state constitutions that provide greater protection of a minor's abortion right. See Weissman, *supra* note 25, at 152.

35. See *Manning v. Hunt*, 119 F.3d 254, 257 (4th Cir. 1997) (upholding parent consent); *Planned Parenthood of the Blue Ridge v. Camblos*, 155 F.3d 352, 255, 384 (4th Cir. 1998); see also Weissman, *supra* note 25, at 140 (discussing several federal court decisions involving judicial bypass provisions that have been upheld).

36. See discussion *infra* notes 66-78 and accompanying text.

37. See Preston A. Britner et al., *Evaluating Juveniles' Competence to Make Abortion Decisions: How Social Science Can Inform the Law*, 5 U. CHI. L. SCH. ROUNDTABLE 35, 59-60 (1998).

38. See discussion *infra* notes 40-53 and accompanying text; Weissman, *supra* note 25, at 129.

obtaining parental consent.³⁹ Moreover, most pregnant girls consult with a parent and do not need to be coerced into doing so.⁴⁰ The law operates under the mistaken notion that even though a minor may be too immature to have an abortion, she is mature enough to make major medical decisions related to her pregnancy and subsequently to make decisions regarding the upbringing of the child. This selective burdening of the abortion right is not justified.⁴¹

Recently, one court stopped to carefully consider the actual experiences of pregnant teens before finding a restriction on teen abortion unconstitutional. In *Planned Parenthood v. Farmer*,⁴² the New Jersey Supreme Court struck down New Jersey's parental notification law as violative of the state's equal protection clause.⁴³ The court concluded that it was unconstitutional for a pregnant minor to be permitted to make all of her health care decisions during pregnancy—including whether she will have a caesarean section—but not permit the same minor to terminate her pregnancy.⁴⁴

Although the New Jersey Supreme Court did not speak directly to a minor's competence to make these kind of decisions, the court took a reality-based perspective and focused on the actual burdens faced by girls seeking an abortion.⁴⁵ It found that notifying parents—even without requiring their consent—can be a burden on a minor and may prevent her from exercising her constitutional rights.⁴⁶ Requiring such permission delays the minor's decision when time is of the essence and, worse yet, may lead to parental interference in the form of parental disappointment and disapproval, physical or emotional abuse, withdrawal of financial support, or actual obstruction of the abortion decision.⁴⁷ Moreover, the judicial bypass procedure does not

39. See *Farmer*, 762 A.2d at 640-41; see also Rosato, *Bioethics*, *supra* note 20, at 16-19; Friedman, *supra* note 22, at 455-56 (urging that notice and consent statutes should have similar procedural protections).

40. See Am. Acad. of Pediatrics, Committee on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746 (1996) [hereinafter AAP, *Abortion*].

41. See Ehrlich, *Medical Decision-Makers*, *supra* note 23, at 84.

42. See *Farmer*, 762 A.2d at 637-38.

43. *Id.* at 638.

44. *Id.* at 636.

45. *Id.* at 635.

46. *Id.* at 634. See generally Rebekah Saul, *Teen Pregnancy: Progress Meets Politics*, The Alan Guttmacher Institute, available at <http://www.gottmacher.org/pubs/journals/gro20306.html> (last visited March 7, 2002) (stating research indicates that requiring parental involvement, either through consent or notification, discourages minors not only from seeking abortions but family planning services in general).

47. See *Farmer*, 762 A.2d at 634; accord Rosato, *Bioethics*, *supra* note 20, at 18 n.94; Ehrlich, *Reproductive Fairness*, *supra* note 23, at 17.

alleviate that burden: in the bypass process, her anonymity may be breached, she must seek legal representation, and she must somehow absent herself from school without her parents' knowledge.⁴⁸ All of these impediments can cause the pregnant girl to delay her decision, leading to a more costly and dangerous abortion or foreclosing the option altogether.⁴⁹ The *Farmer* court concluded that these barriers to obtaining an abortion were not justified by any competing interests, including the desire to promote family communication.⁵⁰

Most courts, however, do not appear to take the reality-based approach reflected in the *Farmer* decision.⁵¹ Instead, the courts (led by the United States Supreme Court) continue to hold on to the outmoded presumptions of juvenile incompetency⁵² and parental deference.⁵³ The overall result is a doctrine that fails to recognize the actual competence of minors and the burdens they endure in attempting to exercise their right to health care.⁵⁴ The other exceptions to the parental consent rule are similarly limited.

B. Status Exception

Most exceptions to the parental consent rule are not constitutional in nature, but are based on a state's statutory or common law. The status exception is one such exception, which includes exemptions for marriage, military service, emancipation, and the like.⁵⁵ Some types

48. See *Farmer*, 762 A.2d at 635. See generally Ehrlich, *Reproductive Fairness*, *supra* note 23, at 15-16 (criticizing Massachusetts court for minimizing the burdens minors face in going to court for judicial bypass proceeding).

49. See *Farmer*, 762 A.2d at 626, 635; see also Weissman, *supra* note 25, at 129; Ehrlich, *Reproductive Fairness*, *supra* note 23, at 16 n.94; AAP, *Abortion*, *supra* note 40.

50. See *Farmer*, 762 A.2d at 637; see also Ehrlich, *Reproductive Fairness*, *supra* note 23, at 2 (criticizing parental involvement laws as "limiting abortion rights rather than promoting family communication.").

51. See Rosato, *Bioethics*, *supra* note 20, at 16-20; Katz, *supra* note 24, at nn. 294-98; Ehrlich, *Reproductive Fairness*, *supra* note 23, at 8-9, n.42.

52. See Bersoff & Glass, *supra* note 9, at 295-96 (noting courts continue to ignore relevant evidence that proves minor's capacity, choosing instead to rely on assumptions of incompetency); Ehrlich, *Reproductive Fairness*, *supra* note 23, at 27 (the Court's abortion law reflects a "distorted vision of the decisional capacity of teens."). The existing studies actually show that older adolescents possess the competence necessary to make an abortion decision. See also *infra* note 106.

53. See Rosato, *Bioethics*, *supra* note 20, at 16. See generally Dwyer, *supra* note 21, at 1373 (parental rights are comparable to the traditional rights that husbands had to control their wives in that both represent a more powerful group dominating a less powerful one, yet we continue to uphold the notion of parental rights).

54. See Ehrlich, *Reproductive Fairness*, *supra* note 23, at 23-24 (abortion is thought of as somehow different from other medical decisions and thus an examination of the minor's decisional capacity can be avoided).

55. See Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 28 (minors who possess a particular status can make decisions for themselves without parental consent).

of status, such as emancipation, act as a proxy for maturity.⁵⁶ Emancipation primarily considers financial independence as a measure of the maturity that an adult possesses to make major life decisions.⁵⁷

Other types of status do not provide even a rough approximation of competence. These exceptions include married minors,⁵⁸ pregnant minors,⁵⁹ and minor parents.⁶⁰ The simple fact that a minor is married or has children does not make him or her more mature. Actually, the opposite may be true.⁶¹ These exceptions appear to exist because of an ease of application and a need for consistency, rather than a recognition of the minor's autonomy.⁶²

The following example illustrates the limitations in using status rather than autonomy as a guide. A teen mother who goes to a pediatrician's office because her baby is ill or needs a check-up has the right to consent to the baby's medical care. If the baby's grandmother tries to interfere, the court is likely to defer to the teen mother because of her status as a mother and the constitutional protection that accompa-

56. See Ehrlich, *Medical Decision-Makers*, *supra* note 23, at 78; cf. Carol Sanger & Eleanor Willemssen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. MICH. J.L. 239, 259-60 (1992) (stating emancipation was designed to be a way to legitimize a minor's independence and ability to make decisions before they reached age eighteen).

57. See Sanger & Willemssen, *supra* note 56, at 262 (stating "legal emancipation was intended to recognize and validate, but not to create, physical and financial independence between minors and parents."); Ehrlich, *Medical Decision-Makers*, *supra* note 23, at 78 (noting emancipation honors the ability of minors to make appropriate life choices).

58. See Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 26 (citing examples from Alabama, Delaware, Georgia, Indiana, Maine, Maryland, and Michigan).

59. See *id.* at 26 (citing examples from Alabama, Alaska, Arkansas, Maryland, and Minnesota). Some states do place restrictions on pregnant minors' decision-making ability. For example, Delaware law provides that a minor must be twelve years old before she can consent to treatment. See DEL. CODE ANN. tit. 13, § 214.185 (Michie 2001).

60. See Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 26. Generally, minor parents are given authority to make decisions for their children but not for themselves. See DEL. CODE ANN. tit. 13, § 707(b)(4) (Michie 2000); GA. CODE ANN. § 31-9-2(a)(2) (2000); MINN. STAT. ANN. § 144.342 (West 2000); R.I. GEN. LAWS § 23-4.6-1 (2001). Some statutes, however, do allow minors to consent to treatment for themselves as well as for their children. See ALA. CODE § 22-8-5 (2001); ALASKA STAT. § 25.20.025(a)(3) (Michie 2001); ILL. COMP. STAT. 410/210-1 (West 2000); MD. CODE ANN., HEALTH-GEN. II § 20-102(a)(2) (2001); MASS. GEN. LAWS ANN. ch. 112, § 12F (West 2001).

61. See Rhonda Gay Hartman, *Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices*, 8 U. CHI. L. SCH. ROUNDTABLE 87, 93 (2001) [hereinafter Hartman, *Physician Perceptions*]; cf. *State v. Koome*, 84 Wash. 2d 901, 911-14 (1975) (noting a state may not require that unmarried minors get parental consent for an abortion but not married minors in the absence of a finding of increased maturity); Buss, *supra* note 22, at 829 (providing minor parents with equal rights as adult parents may seriously harm the minor parent as she is not mature enough to handle the responsibility).

62. See Hanisco, *supra* note 5, at 932 (stating what the courts and legislatures have done is simply react to teen problems and "have not actually carved out these consent exceptions because they believe minors have a right to privacy or self-determination.").

nies that status.⁶³ Even though the teen mom may be making medical decisions for her own child, she may not be able to make medical decisions for herself, even those with lesser consequences.⁶⁴ If competence were the guiding principle, her ability to decide for her daughter would encompass the ability to decide for herself.⁶⁵ Her maternal status—based essentially on her ability to get pregnant and give birth—has little, if anything, to do with competence.

C. Condition/Disease

Like the status exception, the condition/disease exception to the parental consent rule is not based on a competence rationale. Instead, the basic rationale of this type of exception is that the cost of a minor failing to seek treatment is greater than the state's desire to involve parents in their child's health care decision-making.⁶⁶ Therefore, many states allow a minor to consent to medical treatment relating to venereal disease,⁶⁷ mental health treatment,⁶⁸ or sexual abuse.⁶⁹ Although this condition/disease exception serves public policy well because it encourages teens to seek needed medical treatment without having to speak to their parents about it, the exception does not provide a basis for adopting a mature minor doctrine that is actually based on maturity.

63. See JAMES M. MORRISSEY ET AL., CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS: A LEGAL GUIDE 41 (1986) (citing *Meyer*, *Yoder*, *Santosky* and *Pierce*, the authors recognize that even if a state does not have an actual "enabling statute," a minor parent is going to have the same "fundamental right as against all others to the custody and control of their offspring"). See generally *Troxel v. Granville*, 530 U.S. 57 (2000) (plurality opinion) (reaffirming constitutional protection for parental rights).

64. See *supra* note 60 (referring to statutes that permit decisions for children, but not teen moms themselves).

65. See Ehrlich, *Reproductive Fairness*, *supra* note 23, at 20-21 (expressing concern that we have such a disparate approach with teen moms, particularly as to making medical decisions for themselves and their children).

66. See Scott, *supra* note 4, at 568. By not requiring children to obtain parental consent prior to seeking treatment, it not only will encourage them to get help but also serve society's interests because the likelihood of untreated conditions, such as mental illness and sexually transmitted diseases, will be reduced. *Id.* Although children may not have the same level of maturity as adults in these situations, they need to be protected from the potential harm that could result from telling their parents. *Id.*

67. See statutes cited in Hanisco, *supra* note 5, at n. 8; Hartman, *Adolescent Autonomy*, *supra* note 2, at n. 197; Rosato, *Life-Sustaining Treatment*, *supra* 4, at n.109; and Scott, *supra* note 4, at n. 80.

68. See statutes cited in Hartman, *Adolescent Autonomy*, *supra* note 2, at n. 285; Rosato, *Life-Sustaining Treatment*, *supra* note 4, at n.111; and Scott, *supra* note 4, at n. 80.

69. See statutes cited in Rosato, *Life-Sustaining Treatment*, *supra* note 4, at n. 112; and Scott, *supra* note 4, at n. 80.

D. *Reluctance to Adopt a "True" Mature Minor Doctrine*

Efforts to adopt a true mature minor doctrine have been limited. A true mature minor doctrine would permit adolescents who possess the requisite capacity to make health care decisions on their own.⁷⁰ Such a doctrine could be reflected in a bright-line rule (assuming that minors of a particular age are deemed competent)⁷¹ or in an individualized determination of competence by a health care provider or a judicial officer.⁷²

Even for states that have passed these kinds of mature minor statutes, the scope of the statutes may be more limited than they appear. For example, the statute may extend to consent to treatment, but not for refusal of treatment.⁷³ From a competence perspective, this distinction between consent and refusal is not a meaningful one: the ability to consent should encompass the ability to refuse, as it does for adults.⁷⁴ Limiting the doctrine in this manner avoids the hard questions (like what to do when a minor refuses treatment and the parent consents) and limits the development of a principled approach.

A few courts, acknowledging the absence of recognition for mature minors in statutes, have adopted a common law doctrine to accom-

70. On this point, I am neither as cynical as Professor Hartman nor as optimistic as Professor Scott. Professor Hartman questions whether one could call the limited recognition of the mature minor doctrine a doctrine at all. See Hartman, *Adolescent Autonomy*, *supra* note 2, at 1311-17. I think that some of the thoughtful decisions by appellate courts do qualify as an emerging doctrine. See discussion *infra* pp. 780-782. Professor Scott gives the impression that the mature minor doctrine in the health care area is well-established and evolving. See Scott, *supra* note 4, at 566-68. A few states did recognize the mature minor early on, but this limited recognition failed to develop. Instead, only the narrow exceptions proliferated.

71. See S.C. CODE ANN. § 20-7-280 (Law. Co-op. 2000) (creating a bright-line rule for minors that are aged sixteen or older to consent to medical treatment); see also Scott, *supra* note 4, at 598 n.38 (referring to statutes where legislatures have used a bright-line rule to recognize the maturity of adolescents as a group).

72. See ARK. CODE ANN. § 20-9-602(7) (Michie 2000) (allowing unemancipated minors to consent to medical treatment if they are of sufficient intelligence to understand and appreciate the consequences of their decision); IDAHO CODE § 39-4302 (Michie 2000) (stating that any person of competent intelligence to comprehend the nature and the significant risks posed by the medical treatment is competent to consent on his own behalf); NEV. REV. STAT. ANN. § 129.030 (2) (Michie 2001) (permitting a minor that understands the purpose of the examination and treatment and its probable outcome to consent to the medical treatment, but provider must make efforts to seek minor's consent to communicate with parents in most instances); cf. ALASKA STAT. § 25.20.025(2) (Michie 2000) (allowing a minor to consent to medical treatment without parental consent where the minor is first counseled before such treatment).

73. See Op. La. Atty Gen. No. 88-232, 2 (1988) (explaining that the language of the Louisiana statute [Section 40:1095] does not extend to minors the right to refuse treatment). See generally Jan Costello, *If I Can Say Yes, Why Can't I Say No?*, in CHILD, PARENT & STATE 490 (1994) (reviewing minor consent and refusal under existing law).

74. See Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 15-16.

plish that result.⁷⁵ Other courts presented with the issue have declined to adopt a mature minor doctrine altogether or have determined that the minor patient in the case was not sufficiently mature.⁷⁶

Even the decisions that have adopted the mature minor doctrine may not be considered precedent for treating mature minors as adults for all health care decisions. For example, some cases have adopted the mature minor doctrine in the context of a minor's (or her representative's) ability to sue for damages caused by the tortious conduct of a health care provider.⁷⁷ It is unclear, however, whether the doctrine would be extended to different contexts—such as when a minor is refusing life-sustaining treatment and death could result. Here, the state's interest in preserving life may be a significant countervailing consideration.⁷⁸

Moreover, at least one court has suggested that its recognition of a mature minor's decision depends at least in part on whether the parents agree with the minor's decision. In *In re E.G.*⁷⁹ for example, the Supreme Court of Illinois upheld a trial court's determination that a seventeen-year-old Jehovah's Witness was mature enough to refuse a

75. See, e.g., *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837, 838 (W. Va. 1992) (remanding the case to determine whether the minor had the capacity to refuse life-sustaining treatment); *In re Chad Eric Swan*, 569 A.2d 1202 (Me. 1990) (respecting the minor's wishes to refuse artificial life-support); *In re E.G.*, 549 N.E.2d 322 (Ill. 1990) (holding that the minor was mature enough to exercise her First Amendment right of freedom of religion in refusing blood transfusions); *Cardwell v. Bechtol*, 724 S.W.2d 739, 748 (Tenn. 1987) (holding that the court should consider the totality of the circumstances in deciding whether a seventeen-year-old girl had the capacity to assent to medical treatment); cf. *In re Rena*, 705 N.E.2d 1155, 1157 (Mass. 1999) (holding that a determination of minor's maturity must be assessed in deciding whether a minor has the capacity to make an informed decision to refuse a blood transfusion because of religious convictions).

76. See *Commonwealth v. Nixon*, 761 A.2d 1151, 1155 (Pa. 2000) (finding no legislative intent to create an exception for minors who have the capacity to consent or refuse life-sustaining medical treatment); *In the Matter of Long Island Jewish Med. Ctr.*, 147 Misc. 2d 724 (N.Y. Sup. Ct. 1990) (finding the seventeen year old minor insufficiently mature to understand the consequences of refusing a blood transfusion because of religious convictions); *O.G. v. Baum*, 790 S.W.2d 839, 841 (Tex. 1990) (refusing to consider the maturity of a minor to refuse blood transfusion where the minor offered no testimony for the court to evaluate the minor's capacity to understand the consequences of such a decision); see also *Novak v. Cobb-Kennestone Hosp. Auth.*, 849 F. Supp. 1559, 1575 (N.D. Ga. 1994) (upholding the statutory intent to limit the right to refuse medical treatment to persons eighteen years or older).

77. See *Cardwell v. Bechtol*, 724 S.W.2d 739, 751 (Tenn. 1987); *Belcher*, 422 S.E.2d 827.

78. Although the state's interest may not be a reason to make a different finding regarding competence, it may affect the ultimate balance of interests. See *infra* notes 175-176 and accompanying text.

79. 549 N.E.2d 322 (Ill. 1989). For critical analyses of the *E.G.* decision, see Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 43-45; Rosato, *Bioethics*, *supra* note 20, at 14-15; Hartman, *Adolescent Autonomy*, *supra* note 2, at 1313-14.

blood transfusion as part of her cancer treatment.⁸⁰ In its opinion, the court implicitly limited the reach of the mature minor doctrine by concluding that the parents' failure to agree with the minor could justify limiting the minor's autonomy.⁸¹

If the court had been committed to respecting the autonomy of mature minors, it would not have limited the doctrine in this manner. The mature minor doctrine should not be so fragile that it depends on whether the parent agrees or disagrees with the child. If a minor is determined to be competent enough to make adult decisions, then the disagreement of a third person, even if it is the parent, should not be sufficiently compelling to override the young person's right of autonomy.⁸² Under this theory, the minor fills the shoes of the adult and should be able to walk in them.

It appears that so far only one court has committed itself to the mature minor doctrine when the minor is refusing life-sustaining treatment. In *In re Chad Eric Swan*,⁸³ the Supreme Judicial Court of Maine permitted removal of Chad's nutrition and hydration—even though it meant that he would die.⁸⁴ The court made it clear that its decision was based on Chad's previously held beliefs, not the court's or the parents' view of what was best for him.⁸⁵ Before his accident (and while he was a minor), Chad expressed his wishes not to be sustained in a persistent vegetative state. The court determined that his wishes should be followed.⁸⁶ However, Chad's case was an easy one in that he was seventeen when he expressed his views, his views were clearly expressed, his parents held the same views, and his physical condition was a persistent vegetative state with no hope of improvement.⁸⁷ In light of these facts, the precedential value of this case is

80. 549 N.E.2d at 328.

81. *Id.*

82. See Rosato, *Bioethics*, *supra* note 20, at 49-54; see also Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 73-81 (discussing the interests of parents in making medical decisions for their children).

83. 562 A.2d 1202 (Me. 1990). For other analyses of the Chad Eric Swan case, see Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 40-43; Hartman, *Adolescent Autonomy*, *supra* note 2, at 1326-28; Hanisco, *supra* note 5, at 915-16; Robert Stenger, *Exclusive or Concurrent Competence to Make Medical Decisions for Adolescents in the United States and United Kingdom*, 14 J.L. & HEALTH 209, 215 (1999/2000).

84. 569 A.2d at 1206.

85. *Id.* at 1205, 1206.

86. *Id.* at 1206.

87. In the context of parent decision-making for a child in a persistent vegetative state, the courts have been more deferential to parents, even though it means that the child probably will die as a result of the parents' decision to refuse treatment. See Rosato, *Bioethics*, *supra* note 20, at 65-67.

probably limited. Therefore, a stronger basis for a mature minor doctrine is needed to sustain it.

E. Making the Case for Mature Minors

A number of commentators have criticized the existing presumption of incapacity, particularly in the health care context.⁸⁸ Considering the fact that at least some adolescents achieve the requisite capacity before they reach the age of maturity,⁸⁹ presuming incapacity for all adolescents seems unjustified. Professor Rhonda Gay Hartman has argued quite persuasively that this approach has led to a “discordant” legal approach to adolescent decision-making ability.⁹⁰ The approach represents a stagnant enclave in law and policy, “suffering . . . from . . . serial neglect.” Professor Hartman believes that this approach ends up harming adolescents, and the larger society, because it stunts the minors’ “life-long development of decision-making ability.”⁹¹ In its place, she proposes an adolescent autonomy model, based on existing developmental literature, that respects the actual capabilities of young persons.⁹²

Although I agree with Professor Hartman that the existing doctrine inadequately reflects the realities of adolescents’ capabilities, an adolescent autonomy model cannot completely remedy the problems with the existing doctrine. Thus far, the developmental literature does not support the conclusion that all older minors deserve deference.⁹³ For that reason, I propose that the existing knowledge on competence be patched together with other relevant perspectives to create a new doctrinal quilt of adolescent empowerment.

88. See Hartman, *Adolescent Autonomy*, *supra* note 2, at 1266 (there is a dearth of definitive legal guidelines other than the age-old formality that anyone under 18 years of age is presumed to lack decisional authority, as if on one’s 18th birthday an enormous epiphany occurs); see also Hanisco, *supra* note 5, at 900, 923 (by relying on the traditional dependency doctrine, the best interests of the child are ignored); Susan Hawkins, Note, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 *FORDHAM L. REV.* 2075, 2118 (1996) (within the informed consent context, empirical research fails to show that children have as diminished capacity as the legal community once believed); Mlyniec, *supra* note 32, at 1881 (in general, little research exists that there is significant difference in the decision-making ability of older adolescents as compared to adults).

89. See discussion *infra* notes 142-169 and accompanying text.

90. See Hartman, *Adolescent Autonomy*, *supra* note 2, at 1287. Others agree. See *supra* note 4 and accompanying text.

91. Hartman, *Adolescent Autonomy*, *supra* note 2, at 1269.

92. *Id.* at 1358-61. In her most recent article, Professor Hartman builds on her initial work by examining physician’s attitudes and practices regarding adolescent patients. See Hartman, *Physician Perceptions*, *supra* note 61, at 87-134.

93. See *infra* notes 95-116 and accompanying text.

Formulation of this proposal involves examining the insights offered by the patches of developmental theory and bioethics, and setting forth the guidance they have to offer. Properly stitched together, they can bring needed coherence and realism into the existing doctrine.

III. CREATING A MATURE MINOR DOCTRINE: "KIDS RULE"

"[W]e swim in a sea of empirical ignorance and uncertainty about the consequences of regulating youth."⁹⁴

The existing legal doctrine is still in need of some principled guidance. But from where can such guidance come, which will allow the doctrine to become more reality-based and respectful of a young person's rights? This section articulates a number of the lessons that can be learned from the disciplines of developmental psychology and bioethics. These lessons form the basis for an incremental transformation of existing law.

A. *Learning from Developmental Psychology*

As discussed in the previous section, the existing law on health care decision-making does not reflect the realities of families and children.⁹⁵ Specifically, the existing law fails to take into account a developmental perspective that "examines the soundness of age-based legal policies in light of scientific research and theory on psychological development."⁹⁶ The social policy reflected in the current approach "may be practical or politically expedient, but . . . makes no sense from the vantage point of developmental psychology."⁹⁷

The findings of developmental psychology provide useful guidance that ultimately should inform the law.⁹⁸ In the past, however, such findings generally have been ignored by the courts, including the

94. FRANKLIN E. ZIMRING, *THE CHANGING LEGAL WORLD OF ADOLESCENCE* 67 (1982).

95. See *supra* discussion notes 14-93 and accompanying text.

96. Laurence Steinberg & Elizabeth Cauffman, *A Developmental Perspective on Serious Juvenile Crime: When Should Juveniles be Treated as Adults?*, 63 *FED. PROBATION* 52, 52 (1999) [hereinafter Steinberg & Cauffman, *A Developmental Perspective*]; see also Laurence Steinberg & Elizabeth Cauffman, *The Elephant in the Courtroom: A Developmental Perspective on the Adjudication of Youthful Offenders*, 6 *VA. J. SOC. POL'Y & L.* 389, 390 (1999) [hereinafter Steinberg & Cauffman, *Elephant in the Courtroom*] (stating developmental psychology informs the discussion of "moral, political, and practical questions").

97. See Steinberg & Cauffman, *Elephant in the Courtroom*, *supra* note 96, at 416 (commenting on the importance of developmental psychology to inform social policy in the context of juvenile justice).

98. *Id.* at 397; see also Buss, *supra* note 9, at 919-20; Jennifer L. Woolard et al., *Theoretical and Methodological Issues in Studying Children's Capacities in Legal Contexts*, 20 *LAW & HUM. BEH.* 219, 225-26 (1996).

United States Supreme Court.⁹⁹ For example, in *Parham v. J.R.*,¹⁰⁰ the Court simply presumed minors' incompetence without any empirical support.¹⁰¹ This unjustified presumption generally has been followed by courts in the health care context.¹⁰²

However, the opposite presumption has emerged in the context of juvenile justice. Older adolescents are presumed to have the requisite competence to be held criminally responsible and to stand trial as adults.¹⁰³ Simply stated, if the minor can "do the [adult] crime," he can "do the [adult] time."¹⁰⁴

But which of these presumptions is justified? The answer is neither when we stop to consider findings as to the minor's competence and moral development. In the health care context, these findings should lead to a more contextual determination based on the lessons that can be learned from the existing competence and moral development literature.

1. Competence

The presumption of incompetence in health care decision-making has been questioned by developmental psychologists over the last twenty years.¹⁰⁵ Early studies concluded that adolescents aged four-

99. See Bersoff & Glass, *supra* note 9, at 291-93, 301-02 (using case examples "of the 'puzzling disjunction' between the world depicted through the lens of empirical social science and the world as it is perceived by the Supreme Court"); see also Donald N. Bersoff, *Autonomy for Vulnerable Populations: The Supreme Court's Reckless Disregard for Self-Determination and Social Science*, 37 VILL. L. REV. 1569, 1597 (1992) ("Courts cite the results of psychological research when they believe it will enhance the elegance of their opinions, . . . but empiricism is readily discarded when more traditional legally acceptable bases for decision-making are available."); Richard E. Redding, *How Common-Sense Psychology Can Inform the Law and Psychological Research*, 5 U. CHI. L. SCH. ROUNDTABLE 107, 114 (1998) ("[T]he law ignores social science when social science fails to consider adequately the common-sense psychology inherent in law."); accord Scott, *supra* note 4, at 560 n.56 (providing case examples of the United States Supreme Court choosing to ignore developmentally-based legal arguments).

100. 442 U.S. 584 (1979).

101. See Bersoff & Glass, *supra* note 9, at 279; see also *Thompson v. Oklahoma*, 487 U.S. 815, 824-25 (1988) (choosing to base its decision that a minor is not competent to receive the death penalty on the fact that "legislation is consistent with the experience of mankind, as well as the long history of our law, that the normal 15-year-old is not prepared to assume the full responsibilities of an adult" rather than on specific findings of developmental psychology) (citation omitted).

102. See *supra* notes 4-7 and accompanying text.

103. See *supra* note 3 and accompanying text.

104. See Jon Sorenson, *Pataki Plan on Juvenile Offenders Includes Longer Sentences in Adult Jails*, BUFF. NEWS, Dec. 10, 1995, at A16 (quoting New York's Governor George Pataki as saying "Adult crime should mean adult time.").

105. See L.A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589, 1596 (1982) (finding that empirical results do not support policies based on a presumption of incompetence in adolescence treat-

teen and above possess the requisite understanding and reasoning to make health care decisions: their choices and decision-making processes resemble those of young adults.¹⁰⁶ The researchers examined various indicia of competence, including evidence of choice, a reasonable outcome, rational reasons for the choice, and understanding.¹⁰⁷ These studies continue to be cited to support the abandonment of the incompetence presumption,¹⁰⁸ although they have done little to change the law in this area.¹⁰⁹

The studies have been criticized by other scholars on a number of grounds. Some critiques have been based on methodological limitations, such as the researchers' use of hypotheticals and white, middle-class subjects.¹¹⁰ Others have questioned how these earlier studies defined competence. Because the early studies defined competence nar-

ment decision-making); see also Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 LAW & HUM. BEHAV. 129, 130 (1992) (finding no evidence to support the long-standing presumption of incompetence below age of eighteen).

106. See, e.g., Weithorn & Campbell, *supra* note 105, at 1593-96 (noting 14 and above); Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Development Perspective*, PROF. PSYCHOL., Aug. 1978, at 412, 416-24 (15 and above).

These findings were affirmed in later studies on health care decision-making in general. See David G. Scherer & N. Dickon Reppucci, *Adolescents' Capacities to Provide Voluntary Informed Consent*, 12 LAW & HUM. BEHAV. 123 (1988) (adolescents 14-15 years old are more likely to resist parental influence when the consequences of a health care decision has serious implications for their health); David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 LAW & HUM. BEHAV. 431, 440-46, 445 (1991) (finding that although adolescents were more vulnerable to parental influence than younger adults in making treatment decisions, "older adolescents should not be excluded from making treatment decisions on the presumption that they lack the requisite capacities for volition.").

They also were affirmed specifically in the abortion context. See, e.g., Britner et al., *supra* note 37, at 56-57 (reviewing developmental studies that found that adolescents ages fourteen and older are equal to adults in their decision-making competency).

107. See Weithorn & Campbell, *supra* note 105, at 1595-97; see also Grisso & Vierling, *supra* note 106, at 416-23 (developing concepts of a knowing, intelligent, and voluntary consent).

108. See, e.g., Hartman, *Adolescent Autonomy*, *supra* note 2, at 1318 n.235; Mlyniec, *supra* note 32, at 1881, n.38; Robert F. Weir & Charles Peters, *Affirming the Decisions Adolescents Make About Life and Death*, HASTINGS CENTER REPORT 29, 31 (Nov. - Dec. 1997); Bersoff & Glass, *supra* note 9, at 296 n.129.

109. See *infra* notes 98-102 and accompanying text.

110. Even critics of the studies do not dispute their actual findings. See, e.g., Elizabeth Cauffman & Laurence Steinberg, *The Cognitive and Affective Influences on Adolescent Decision Making*, 68 TEMPLE L. REV. 1763, 1768-70 (1995) [hereinafter Cauffman & Steinberg, *Affective Influences*]; Thomas Grisso, *The Competence of Adolescents as Trial Defendants*, 3 PSYCHOL. PUB. POL'Y & L. 3, 12, 15 (1997) [hereinafter Grisso, *Competence*]; Thomas Grisso, *Society's Retributive Response to Juvenile Violence: A Developmental Perspective*, 20 LAW & HUM. BEHAV. 229, 233 (1996) [hereinafter Grisso, *Retributive Response*]; Scott, *supra* note 4, at 567 n.77; Elizabeth S. Scott et al., *Evaluating Adolescent Decision Making in Legal Contexts*, 19 LAW & HUM. BEHAV. 221, 224-26 (1995); Elizabeth Scott & Thomas Grisso, *The Evolution of Adolescence*, 88 J. CRIM. L. & CRIMINOLOGY 137, 158-60 (1997).

rowly through the components of understanding and reason, they overlooked the psychosocial factors that distinguish adolescents from adults.¹¹¹ These psychosocial factors include the adolescents' conformity and compliance in relation to peers and parents,¹¹² their attitude toward and perception of risk,¹¹³ and temporal perspective.¹¹⁴ For example, later studies showed that adolescents are more subject to peer influences, they weigh risks differently than adults, and they focus on short-term consequences. Greater impulsiveness and moodiness may also limit adolescents' judgment.¹¹⁵ Finally, the tremendous variability among adolescents makes generalizations as to this population even more difficult than for adults.¹¹⁶ For these reasons, it is important to determine what conclusions (if any) can be drawn about adolescent decision-makers in the juvenile justice context and whether those conclusions are equally applicable in the health care decision-making context.

a. Lessons from the Juvenile Justice Context

The body of research that has emerged over the last decade focuses on the psychosocial factors that distinguish adolescents' and adults' decision-making ability. These studies have been conducted in the juvenile justice context where at least three different kinds of competence can be measured: whether the youth is sufficiently culpable to

111. See Scott, *supra* note 110, at 226-29; Grisso, *Retributive Response*, *supra* note 110, at 233-35; Richard E. Redding, *Juveniles Transferred to Criminal Court: Legal Reform Proposals Based on Social Science Research*, 1997 UTAH L. REV. 709, 724-30.

112. See Scott & Grisso, *supra* note 110, at 160-61. This factor has been further reflected in social comparison, *id.* at 162; conformity, Scott et al., *supra* note 110, at 230; and complacency, Redding, *supra* note 111, at 726-27.

113. See Scott & Grisso, *supra* note 110, at 161, 163.

114. *Id.* at 161, 164; see also Laurence Steinberg & Elizabeth Cauffman, *Maturity of Judgment in Adolescence: Psychosocial Factors in Adolescent Decision Making*, 20 LAW & HUM. BEHAV. 249, 252 (1996) [hereinafter Steinberg & Cauffman, *Maturity of Judgment*] (psychosocial characteristics divided into responsibility, perspective, and temperance).

115. See Grisso, *Competence*, *supra* note 110, at 18 (noting, "to the extent that moodiness . . . is more characteristic of adolescents than adults . . . greater inconsistency in problem-solving effectiveness would be expected among adolescents"); Redding, *supra* note 111, at 729 (noting, "[R]esearch on sensation seeking, impulsivity, moodiness, and pubertal hormones converges to suggest that adolescents are moodier and have poorer impulse control than adults."); Steinberg & Cauffman, *Maturity of Judgment*, *supra* note 114, at 261-62 (noting, "[G]iven that adolescents' moods are more volatile than adults', one reasonable hypothesis is that adolescents' judgment is less consistent than that of adults.").

116. See Laurence Steinberg & Robert G. Schwartz, *Developmental Psychology Goes to Court*, in YOUTH ON TRIAL 9, 24 (Thomas Grisso & Robert G. Schwartz eds., 2000) (stating, "This intraindividual variability makes it difficult, if not impossible, to make generalizations about an adolescent's average level of maturity on the basis of any one indicator alone."). See also Steinberg & Cauffman, *A Developmental Perspective*, *supra* note 96, at 57 (stating, "variability among adolescents of a given chronological age is the rule, not the exception.").

account for his criminal conduct; whether the youth is competent to stand trial; and whether the youth would be amenable to treatment.¹¹⁷

The tentative conclusion of these studies seems to be that the juvenile justice law that currently embodies a presumption of competence is not reflective of adolescent development, particularly as it applies to younger adolescents.¹¹⁸ Consequently, automatically trying younger adolescents as adults is unsupported by the existing literature.¹¹⁹

The studies seem less clear as to how the law should treat older adolescents,¹²⁰ although a few choices are possible. A bright-line test could be adopted that would allow minors over a particular age to be tried as adults. This approach would be based on the assumption that older adolescents are competent enough to be held accountable for their acts and to stand trial, and would be less amenable to treatment. Alternatively, a case-by-case approach could be adopted, which would require an individualized determination to ascertain whether a particular minor was mature enough to be punished or to stand trial.

The trend so far is in the direction of requiring an individualized determination of competence, even for older adolescents. The well-respected work of Professors Elizabeth Cauffman and Laurence Steinberg is illustrative. Although their work consistently favored an individualized determination for younger adolescents, the earlier studies had distinguished between adolescents aged seventeen and older, and those aged sixteen and younger.¹²¹ Most of the oldest group probably possessed the capacity to be tried as adults.

117. See Steinberg & Schwartz, *supra* note 116, at 19.

118. Although there is no consensus as to what constitutes a "younger adolescent," I generally will use that reference for a teenager younger than fourteen years. Cf. Weithorn & Campbell, *supra* note 105 at 1590-91, 1595-96 (comparing 9, 14, and 18 year olds); David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 LAW & HUMAN BEH. 431 (1991) (noting that 14 and 15 year-olds tested as adolescents).

119. See Scott & Grisso, *supra* note 110, at 188-89.

120. *Id.* at 181-89; see also Steinberg & Cauffman, *Elephant in the Courtroom*, *supra* note 96, at 413-15. I consider older adolescents those who are aged sixteen and older, although Steinberg and Cauffman seem to make the cut-off at seventeen. See *infra* note 121 and accompanying text.

121. See Cauffman & Steinberg, *Affective Influences*, *supra* note 110, at 1789 (concluding tentatively that there are important psychosocial differences between early adolescents (under the age of seventeen) and adults); Steinberg & Cauffman, *Maturity of Judgment*, *supra* note 114, at 268 (encouraging empirical research involving individuals sixteen and younger versus those seventeen and older in order to justify their hypothesis of maturity differences between the two); Steinberg & Cauffman, *A Developmental Perspective*, *supra* note 96, at 57 (separating individuals into three categories: juveniles (under the age of thirteen) who should not be adjudicated in adult court; adults (over the age of seventeen) who should; and youths (between the ages of thirteen and sixteen) who may or may not be developmentally appropriate to stand trial as an adult).

More recently, however, Professors Cauffman and Steinberg seem to question the appropriateness of automatically transferring even the oldest adolescents to adult court. Finding that significant development in psychosocial characteristics takes place during older adolescence,¹²² the authors suggest that a more individualized approach is preferable. Other scholars also seem to favor this approach.¹²³

Although the individualized approach seems to be the favored approach at this time, it is still based on tentative findings.¹²⁴ Even the authors of these studies admit that more research must be conducted to determine, from a developmental perspective, when adolescents who commit crimes deserve to be tried as adults or as juveniles.

b. Lessons for Adolescent Health Care Decision-Making

Even if an individualized determination were favored in the juvenile justice context, it does not necessarily mean that the same approach should be adopted in the health care decision-making context. The degree of competence required here is qualitatively different and, even more significantly, the balance of interests in the health care context weighs in favor of giving adolescents greater decision-making power than they currently have.

The first reason why the psychological findings in the juvenile justice context may not be useful in the health care context is because the measure of competence is qualitatively different.¹²⁵ Some competence criteria do overlap. For example, in both contexts, the minor must possess what has been termed "decisional competence," "the capacity to engage in cognitive and judgment processes in making important decisions that defendants must make for themselves"¹²⁶ The psychosocial factors described above are relevant to evaluate judgment processes.¹²⁷ These aspects of decisional competence are

122. See Elizabeth Cauffman & Laurence Steinberg, *(Im)maturity of Judgment in Adolescence: Why Adolescents May Be Less Culpable Than Adults*, 18 BEHAV. SCI. & L. 741, 750-56 (2000) [hereinafter Cauffman & Steinberg, *Immaturity*].

123. See, e.g., Scott, *supra* note 4, at 589-97; see also Redding, *supra* note 111, at 743-63; Grisso, *Competence*, *supra* note 110, at 22 (both proposing use of presumptions and individualized determinations).

124. See Cauffman & Steinberg, *Immaturity*, *supra* note 122, at 757-58; cf. Britner et al., *supra* note 37, at 47-54 (outlining additional research necessary to determine competence in medical treatment setting).

125. See generally Britner et al., *supra* note 37, at 40, 50 (noting difficulties of transferring competence findings between contexts and concluding that contextually specific competence must be ascertained).

126. See Thomas Grisso, *What We Know About Youths' Capacities as Trial Defendants*, in *YOUTH ON TRIAL*, *supra* note 116, at 143.

127. See discussion *supra* notes 112-116 and accompanying text.

particularly important in determining whether the youth is culpable and amenable to treatment. For example, the minor may differ from an adult in his limited ability to understand the long-term consequences of his acts, may not give the appropriate weight to certain risks posed by his conduct, and may not be able to resist peer pressure to engage in wrongful conduct.¹²⁸

Similar components make up the competence necessary for health care decisions. Although there is no consensus as to these components, some appear to be well established: the presence or absence of a decision; a reasonable outcome; a reasonable (rational) decision-making process; and understanding.¹²⁹ Psychosocial factors are relevant here, as they are in the juvenile justice context. For example, the way that adolescents focus on short-term consequences may cause them to reject treatments for reasons such as their effects on physical appearance.¹³⁰ And adolescents' diminished ability to comply may reduce their ability to follow prescribed treatment regimens.¹³¹

Considering the components together, however, the competence required for making decisions in these contexts is not identical. Generalizations are therefore difficult to make. This is particularly true when trying to compare health care decisional competence with adjudicative competence, which is the competence of a juvenile to stand trial. To achieve adjudicative competence, the minor must understand the trial process and be able to participate in his defense with his attorney.¹³² In addition, he must know "not only that [he] has certain rights, but also what a right is."¹³³ The explicit rights recognition is not a prerequisite to being able to consent to or refuse medical treatment. Rather, a careful assessment of the risks/benefits of treatment is necessary, whether the treatment involves treating an infection with antibiotics or cancer with chemotherapy.¹³⁴

128. See Scott & Grisso, *supra* note 110, at 160-64.

129. These criteria are derived from the taxonomy articulated in 1977 by Roth, Meisel, and Lidz and has been widely used by others. See Samantha Weyrauch, Comment, *Decision Making for Incompetent Patients: Who Decides and By What Standards?*, 35 TULSA L.J. 765, 773-77 (2000); accord Britner et al., *supra* note 37, at 40-42.

130. Cf. Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 61 (dying adolescents may be overly concerned with physical appearance). See generally Britner et al., *supra* note 37, at 48 (adolescents may be more vulnerable where body image is involved).

131. Cf. Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 61-62 & n.255 (discussing difficulties of complying with AIDS treatment regimens, which may require higher degree of competence).

132. See Grisso, *supra* note 126, at 142-45.

133. *Id.* at 143.

134. The maturity determination has been made in the context of minor and major medical interventions. See, e.g., *Belcher v. Charleston Area Med. Ctr.*, 22 S.E.2d 827 (W.Va. 1992) (reintubation/resuscitation); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987) (osteopathic manipu-

As such, the individualized approach that appears to be favored for determining whether juveniles should be tried as adults may not be the right approach for determining when older adolescents should be able to make health care decisions on their own.¹³⁵ Therefore, the findings of the older studies still provide the best evidence that older adolescents (by age sixteen and perhaps earlier) are mature enough to make health care decisions on their own.¹³⁶

Even if the competence in both contexts encompassed similar criteria, it does not necessarily mean that the individualized approach should be favored here. Unlike the juvenile justice context, the balance of interests weighs much more favorably toward giving older adolescents the ability to make their own health care decisions. First of all, the state's interests in incapacitating youthful offenders and deterring wrongful behavior¹³⁷ that are important when dealing with criminal behavior are not implicated in the health care context. Rather, the state's interests are infringed primarily when the minor's refusal of needed treatment would cause her serious bodily harm or death.¹³⁸

Not only are the state's interests lower here, but the interest in nurturing adolescent autonomy is much stronger than in the juvenile justice context. Allowing adolescents to make health care decisions is beneficial because it is likely to improve their self-esteem and sense of control in the short-term, and make them better decision-makers and citizens in the long-term.¹³⁹

Moreover, the failure to respect adolescents' burgeoning autonomy is likely to cause harm to their personhood, especially when the health care decision involves the exercise of moral judgment.¹⁴⁰ If adolescents cannot make these decisions for themselves, they may be forced to live a life that they have not chosen and certain future opportunities may be foreclosed to them permanently.¹⁴¹

lation of neck, spine, and legs); *Younts v. Saint Francis Hosp. & School of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970) (surgical repair of fingertip).

135. In interpreting the existing findings, researchers, policy-makers, and judges must be careful not to reach conclusions too quickly regarding what appears to be the right result. What may be a desirable result in the juvenile justice context, trying juveniles in family court, may result in disempowerment in another context.

136. See discussion *supra* notes 105-107 and accompanying text.

137. See generally Barry C. Feld, *The Juvenile Court Meets the Principle of the Offense: Legislative Changes in Juvenile Waiver Statutes*, 78 J. CRIM. L. & CRIMINOLOGY 471 (1987).

138. See Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 68-72, 83-87.

139. See discussion *infra* notes 156-160 and accompanying text.

140. See generally discussion *infra* notes 186-223 and accompanying text.

141. See Joel Feinberg, *The Child's Right to an Open Future*, in *WHOSE CHILD? CHILDREN'S RIGHTS, PARENTAL AUTHORITY AND STATE POWER* 124, at 138-51 (William Aiken & Hugh Lafollette, eds., 1980).

Consequently, we must look beyond the competence literature for needed guidance on how the law can encourage autonomy in adolescent decision-makers. Categorically preventing minors from making health care decisions before the age of majority—as the law currently provides—is not the way to accomplish that objective. Moral development theory offers some important lessons.

2. *Moral Development Theory*

During adolescence, the minor has a number of important tasks. Among the most important are development of one's identity and the skills and values necessary to become a productive citizen in a democratic society.¹⁴² The role of parents and the state should be to encourage independent decision-making during adolescence to help ensure that the minor will grow into a capable adult.¹⁴³ This role is particularly important when it comes to encouraging moral development, where the child is faced with decisions in which he must choose among competing values.¹⁴⁴

Such value-laden choices are implicit in many medical decisions that involve more than determining whether to prescribe an antibiotic for a bad case of strep throat or to put a cast on a broken bone. For example, in the abortion context, the minor must consider not only her views about when life begins,¹⁴⁵ but also about how she would like to live her life. Will she choose life as a mother, with all its corresponding responsibilities, or life as a (relatively) carefree teenager?¹⁴⁶ In the life-sustaining treatment context, the minor must think deeply about sustaining a certain quality of life versus valuing life for its own sake.¹⁴⁷ When a minor acts as a donor (donating an organ or blood marrow to a sibling) or as a research subject in a clinical trial, the

142. See Emily Buss, *The Adolescent's Stake in the Allocation of Educational Control Between Parent and State*, 67 U. CHI. L. REV. 1233, 1253, 1288, 1359-60 (2000).

143. See *id.* at 1250-51; cf. Richard L. Roe, *Valuing Student Speech: The Work of the Schools as Conceptual Development*, 79 CAL. L. REV. 1271, 1313-15 (1991) (following work of Amy Gutmann, who believes the central purpose of public education is to establish learning processes that prepare young people for "civic participation and deliberation within a democratic government."); LEVESQUE, *supra* note 4, at 337 (the law should ensure the "development of democratic citizens"). See generally Gary B. Melton, *Decision Making by Children*, in CHILDREN'S COMPETENCE TO CONSENT (1983).

144. See JOSEPH REIMER ET AL., PROMOTING MORAL GROWTH: FROM PIAGET TO KOHLBERG 45-48 (1983). Kohlberg's work addresses the question of which values to follow in a particular situation.

145. See ZIMRING, *supra* note 94, at 66. See generally RONALD M. DWORKIN, LIFE'S DOMINION 3-24 (1993) (stating that abortion addresses fundamental moral questions).

146. The stark differences between these two roles are illuminated *infra* notes 194-195 and accompanying text.

147. See Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 12-16.

minor's altruistic tendencies are an integral part of her decision.¹⁴⁸ All of these difficult choices shape a minor's identity and reflect her values.

However, the existing law does not permit adolescents to make these decisions for themselves. Instead, the law embodies the view that "parents know best" and should make all health care decisions, from the most insignificant to the most value-laden.¹⁴⁹ This approach is not supported by the literature on moral development, which favors respecting the child's autonomy absent a compelling, countervailing reason.

Moral development progresses through a number of stages during childhood. According to psychologist Lawrence Kohlberg,¹⁵⁰ moral development evolves sequentially through six separate stages.¹⁵¹ With each stage, the child becomes less self-centered and more concerned with the larger society and its expectations.¹⁵²

Although Kohlberg posits that the sequence of these stages cannot be altered, children may advance more quickly when provided with more morality-based education and more decision-making opportunities prior to adulthood.¹⁵³ Take altruism for example. Altruism, which has been defined as "behavior carried out to benefit another without anticipation of rewards from external sources,"¹⁵⁴ is a desirable trait that all adults should possess. But the trait does not just appear magically at the age of eighteen. Its development needs to be nurtured during childhood through adult role modeling, moral education, and experiences in acting altruistically towards others.¹⁵⁵

148. See discussion *infra* notes 209-216 and accompanying text.

149. See discussion *supra* notes 14-87 and accompanying text.

150. Professor Kohlberg's theories on moral development are still followed, although over time they have been criticized and their relevance narrowed. See DAVID MOSHMAN, CHILDREN, EDUCATION AND THE FIRST AMENDMENT 83-85 (1989); NANCY EISENBERG & PAUL H. MUSSEN, THE ROOTS OF PROSOCIAL BEHAVIOR IN CHILDREN 119-24 (1989).

151. See Beschle, *supra* note 4, at 99 (citing Professor Kohlberg).

152. These stages are identified as follows: heteronomous morality; individualism, instrumental purpose, and exchange; mutual interpersonal expectations, relationships, and interpersonal conformity; social system and conscience; social contract or utility and individual rights; and universal ethical principles. See charts reprinted in EISENBERG & MUSSEN, *supra* note 150, at 121-22; REIMER, *supra* note 144, at 58-61; see also MOSHMAN, *supra* note 150, at 79-82 (brief overview of Kohlberg stages). Most persons do not achieve the highest (sixth) stage. See MOSHMAN, *supra* note 150, at 82.

153. See LEVESQUE, *supra* note 4, at 344; MOSHMAN, *supra* note 150, at 86-88; Melton, *supra* note 143, at 27-28.

154. See MORTON HUNT, THE COMPASSIONATE BEAST 18 (1990) (citing mainstream definition).

155. *Id.* at 109-15, 209-12, 212-19; EISENBERG & MUSSEN, *supra* note 150, at chs. 6, 7, and 11.

Providing more opportunities for independent decision-making is beneficial for a number of reasons. Individually, greater autonomy leads to improved self-esteem and the reduction of dependency on adults.¹⁵⁶ Societally, greater autonomy leads to better outcomes and adults who are better prepared to meet the responsibilities of citizenship.¹⁵⁷ To achieve these benefits, the law should "foster dynamic self-determination" and "allow for adolescent participation,"¹⁵⁸ which includes allowing adolescents to make decisions on their own.¹⁵⁹ Otherwise, adolescents might be denied their essential personhood.¹⁶⁰

The learner's permit approach articulated by Professor Frank Zimring provides an appropriate way to conceptualize adolescence and the law's role that accords with the moral development literature. Benefits accrue to the minor and the greater society if the minor is permitted to practice making some decisions prior to adulthood.¹⁶¹ Adolescents need to practice "making decisions," "taking risks," and "choosing the path of [their] lives in a free society."¹⁶² Autonomy must be valued, and the law needs to encourage its development during adolescence so that it can be appropriately exercised.¹⁶³

Professor Zimring does not suggest that all decisions should be made by adolescents. The development of decision-making authority should be incremental in nature.¹⁶⁴ And even though the adolescent's choices should be respected whenever possible, the law must "preserve the life chances for those who make serious mistakes"¹⁶⁵

156. See generally Buss, *supra* note 22, at 158-62, 1287-88; Rosalind Ekman Ladd & Edwin N. Forman, *Adolescent Decision-making: Giving Weight to Age-Specific Values*, 16 THEORETICAL MEDICINE 333, 343 (1995).

157. See LEVESQUE, *supra* note 4, at 334-37; Roe, *supra* note 143, at 1312-15, 1343.

158. See LEVESQUE, *supra* note 4, at 342-45.

159. *Id.*

160. Accord Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 10-17 (reaching similar result in context of refusing life-sustaining treatment). See generally Gary B. Melton, *Toward "Personhood" for Adolescents: Autonomy and Privacy as Values in Public Policy*, AM. PSYCHO. 99, 102 (1983) (giving greater autonomy to minors to respect their personhood).

161. See ZIMRING, *supra* note 94, at 89-96.

162. *Id.* at 89.

163. *Id.* at 58-59, 89.

164. *Id.* at 96, 108-110; accord Gary B. Melton, *Parents and Children: Legal Reform to Facilitate Children's Participation*, AM. PSYCHO. 935, 936 (Nov. 1999).

165. ZIMRING, *supra* note 94, at 91. The Zimring approach has been cited approvingly in the First Amendment and juvenile justice contexts. See Barry C. Feld, *Abolish the Juvenile Court: Youthfulness, Criminal Responsibility and Sentencing Policy*, 88 J. CRIM. L. & CRIMINOLOGY 68, 113-15 (1997); see also Martin L. Forst & Martha-Elin Blomquist, *Cracking Down on Juveniles: The Changing Ideology of Youth Corrections*, 5 NOTRE DAME J.L. ETHICS & PUB. POL'Y 323, 326 (1991) (discussing juvenile justice); Ross, *supra* note 22, at 258-59 (discussing the First Amendment).

The desire to develop autonomy must be balanced against the countervailing interests of parents and the state. Sometimes a bright-line age cut off will be appropriate, sometimes individualized competence determinations will be necessary, and sometimes parental discretion will suffice.¹⁶⁶ In general, the state or parent should be permitted to make decisions on behalf of older adolescents only when a compelling reason exists and the intrusion into the minor's decision-making authority is narrowly circumscribed.¹⁶⁷ For example, preventing serious physical harm to the minor would justify such an intrusion,¹⁶⁸ but determining a "better life" for the child would not.¹⁶⁹

The most important lesson learned from the developmental literature is that the law should encourage independent decision-making of older adolescents, as long as the choice will not cause serious harm to the adolescent or to others. However, the way the balance should be struck for different kinds of medical decisions is not clear. The discipline of bioethics can provide some additional guidance.

B. *Learning from Bioethics*

Bioethics offers another perspective from which to create a more reality-based quilt of health care decision-making law relating to adolescents. Bioethics is a relevant discipline to consider because it deals specifically with the moral authority of medical decision-making, including the issues of who should make health care decisions and under what standard.¹⁷⁰ Specifically, the discipline provides us with three lessons that can assist in reforming existing law: medical decision-making is contextual; it implicitly involves the exercise of moral authority; and it is patient-centered.

166. See ZIMRING, *supra* note 94, at 131-32.

167. Cf. Moshman, *supra* note 150, at 83-87 (burden on government to show, based on relevant empirical evidence, that fundamental right should be denied).

168. See Ladd & Forman, *supra* note 156, at 343 (limiting adolescents' medical choices where those choices "might threaten life itself, to the degree that no future at all can be envisioned or threaten quality of life to a profound degree"); ZIMRING, *supra* note 94, at 91 (choice must be limited to "preserve the life chances for those who make serious mistakes"); cf. Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 83-94 (noting a minor's decision regarding life-sustaining treatment should be respected, unless the treatment "is a nonexperimental life-sustaining treatment that has a significant probability of either curing the condition or disease or alleviating all of the major symptoms of the condition or disease in the foreseeable future.").

169. See generally LEVESQUE, *supra* note 4, at 343 (focusing on responsible citizenship involves the freedom and opportunity to choose a life plan and control its implementation); ZIMRING, *supra* note 94, at 89 (Adolescents should be able to "choos[e] the path of [their] lives in a free society.").

170. See Rosato, *Bioethics*, *supra* note 20, at 30 (stating "bioethics directly addresses the moral authority of medical decision making, particularly the issues of who should possess authority to make health care decisions for others and what standard should guide.").

1. Medical Decision-Making is Contextual

The bioethics approach to medical decision-making is contextual, involving the balancing of the following core principles: autonomy (respect for persons), beneficence, non-maleficence, and justice.¹⁷¹ In each case, the decision-maker, whether it is a health care provider or judge, exercises controlled discretion in determining the weight given to each value.¹⁷²

Ascertaining the patient's competence is an important threshold issue. If the decision-maker determines that the patient is competent to make the health care decision at issue (which is itself a fact-based determination),¹⁷³ then the autonomy principle generally trumps the other principles: the essential inquiry becomes what the patient wants rather than what is in her best interests, even if warranted by the beneficence principle.¹⁷⁴

The preeminence of autonomy is well-established in common law and constitutional jurisprudence.¹⁷⁵ In narrow circumstances, autonomy must give way to strong countervailing state interests, such as preserving life, protecting the rights of third parties, protecting the integrity of the medical profession, or preventing suicide.¹⁷⁶ The facts in each case need to be carefully considered to determine whether autonomy is implicated at all and then to determine if a countervailing reason justifies interfering with the patient's decision.¹⁷⁷

171. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 12 (5th ed. 2001) (arguing that the principles of autonomy, non-maleficence, beneficence and justice should provide the analytical framework in any bioethics situation).

172. See Rosato, *Bioethics*, *supra* note 20, at 31-32 (discussing how the decision-maker must make their decisions through a process of balancing these four principles, without looking to outside factors).

173. *Id.* at 32-33 (stating that competence, which is generally defined as a person being able to understand the risks and benefits of a proposed treatment, is determined on a case by case basis).

174. See *Thor v. Superior Court*, 855 P.2d 375, 387 (Cal. 1993) (holding that when a competent person chooses to forego medical treatment, that decision should be respected even if the alternative is death).

175. See *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 633 (Mass. 1986) (stating that the [competent person's] right to refuse treatment is grounded in both the common law and the constitutional right to privacy); see also *In re Fiori*, 652 A.2d 1350, 1353 (Pa. Super. Ct. 1995).

176. See Rosato, *Bioethics*, *supra* note 20, at 33 (discussing how only in limited circumstances is the state interest enough to trump the competent person's wishes).

177. See generally *Brophy*, 497 N.E.2d at 634; *In re Roche*, 687 A.2d 349, 351-52 (N.J. Super. Ct. Ch. Div. 1996); *Wright v. Johns Hopkins*, 728 A.2d 166, 168 (Md. 1999) (discussing how the right to refuse treatment is not absolute and that the right to autonomy must be considered along with countervailing state interests).

2. *Medical Decision-Making Implicates Moral Authority*

The contextual determinations that must be made in a health care setting are not usually value-neutral, but involve the exercise of moral authority.¹⁷⁸ Therefore, moral considerations, as well as medical facts, must be weighed.

On the moral side, medical decisions may need to balance the patient's core values, such as when life begins and ends,¹⁷⁹ what constitutes a meaningful life,¹⁸⁰ and what weight to give altruistic motives.¹⁸¹ Because these value-laden decisions are seldom supported by a broad social consensus and are intensely personal, they are best made by the person who would be most impacted by the decision: the patient, subject, or donor herself.¹⁸²

3. *Medical Decision-Making is Patient-Centered*

Regardless of the competence of the patient, bioethics emphasizes a patient-centered approach. When the patient is competent, his wishes are usually controlling even though the decision may not be the best one for him and may even lead to his death. And when the patient is incompetent, the proxy decision-maker may be limited to determining what the patient would have wanted (substituted judgment)¹⁸³ or what choice is in the patient's best interests.¹⁸⁴ The interests of third parties

178. See Rosato, *Bioethics*, *supra* note 20, at 29 (observing that bioethics is the combination of a number of disciplines, resulting in a system that "deals with the moral issues of health care and medicine").

179. See *In the Matter of Storar*, 438 N.Y.S.2d 266, 274 (N.Y. 1981). A New York court allowed a guardian to turn off the respirator of an eighty-three year old, terminally ill man, who had made it clear that prior to becoming incompetent that he did not want to receive artificial support when there was no hope of recovery. *Id.*

180. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304-5 (1986) (holding that a twenty-eight year old woman with severe cerebral palsy, who was completely bedridden and dependent on others, was permitted to have feeding tube removed, as she was mentally competent enough to decide what kind of life she wanted to live).

181. *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91-2 (Allegheny County Ct. 1978) (refusing to order a person to donate their bone marrow against their wishes, saying that to do so would defeat the sanctity of the individual); see also Jennifer K. Robbennolt et al., *Advancing the Rights of Children and Adolescents to be Altruistic: Bone Marrow Donation By Minors*, 9 J.L. & HEALTH 213, 230 (1994/1995).

182. See generally *Bouvia*, 225 Cal. Rptr. at 305 (discussing how courts should not be the ones to decide what is an acceptable decision for a competent person to make, especially when the consequences could mean a life of suffering and pain).

183. See BEAUCHAMP & CHILDRESS, *supra* note 171, at 99-100 (stating that the reasoning behind substituted judgment is that the actual decision belongs to the incompetent person and, as such, we should try as much as possible to honor what they would have wanted if able to make the decision).

184. *Id.* at 102-03 (explaining how under the best interest standard, the decision-maker needs to weigh all of the options and determine what is best for the patient, regardless of what they, themselves, would have wanted).

(even the significant burdens they might bear) should not be relevant considerations.¹⁸⁵

IV. A PREVIEW OF THE QUILT

"[T]he critical question is not so much whether children will be granted absolute autonomy and privacy but instead whether they will be treated with respect."¹⁸⁶

Health care decisions cannot be analyzed in the same way for purposes of determining what independent decision-making authority older adolescents should possess. Different kinds of decisions suggest a different balance of interests. For example, some decisions implicate the minor's core values more than others; some decisions involve direct benefits to the minor and others do not. The competence literature remains inconclusive and, thus, is not a determinative factor in any context. Rough estimates of maturity may be required, however, where the benefits of creating a bright-line rule for certain decisions outweigh the harm of including minors who may not meet the requisite competence.

In light of these considerations, this Article proposes the following categorization of cases: abortion, life-sustaining treatment (and other health care decisions implicating core values), decisions with no direct medical benefit to the child, and ordinary health care decisions. For each category, this Article proposes how the lessons learned from developmental psychology and bioethics can be integrated into the existing doctrine. These lessons include the following: moral development should be nurtured by increasing an adolescent's participation in decision-making, and the relevant inquiry should be contextual and patient-centered to satisfy well-established bioethics principles.

A. Abortion

STANDARD: For girls aged sixteen and over, access to abortion should be permitted to the same extent as adult women; for girls under the age of sixteen, one-parent notice or a judicial bypass procedure should be permitted.

As discussed earlier,¹⁸⁷ the existing law governing abortion is misguided and requires change. It is not based on reality and ultimately

185. See generally *In re Matter of Dubreuil*, 629 So.2d 819, 827-28 (Fla. 1993) (holding that a woman could not be compelled to have a blood transfusion even if it left open the possibility that she would die leaving minor children); see also Rosato, *Bioethics*, *supra* note 20, at 40-41.

186. See Melton, *supra* note 164, at 936.

187. See discussion *supra* notes 22-54 and accompanying text.

harms the personhood of girls who are forced to become mothers against their will.¹⁸⁸

Moreover, individual determinations of competence have not been very useful in this context. Under the existing law, any minor who does not wish to involve her parents must show that she is competent to make the decision on her own or that an abortion is in her best interests.¹⁸⁹ But judges understandably have found it difficult to differentiate between mature and immature minors in this context.¹⁹⁰ In jurisdictions in which the bypass process has been studied, most petitions based on maturity have been granted.¹⁹¹ These results reveal a problem that is unique to the abortion context: it is difficult to conclude that a minor is too immature to have an abortion yet mature enough to raise a child.¹⁹²

The reality is that the ability to make abortion decisions is not really about capacity in most cases. Instead, it is about who should possess the power in our society to make reproductive decisions.¹⁹³ And it is made in a political climate that is increasingly anti-choice.

The proposed law reflects the principle that the older adolescent should make moral decisions for herself unless there is a strong interest to the contrary. Consistent with the principles of bioethics, the authority to make health care decisions ordinarily resides with the patient. It is even more important to do so when the decision involves core values, as abortion clearly does. An abortion decision is a reflection of the girl's views as to when life begins and how she wants to live her life.¹⁹⁴ A teen mom faces a number of long-term effects of the choice that she has made, including a greater chance of ending up in poverty with poor academic performance and a failed marriage.¹⁹⁵

For these reasons, the proposal provides that girls, aged sixteen and over, be permitted to make this important decision to the same extent as adult women.¹⁹⁶ For these girls, autonomy should be the overriding

188. *Id.*

189. See discussion *supra* notes 32-35 and accompanying text.

190. See Britner et al., *supra* note 37, at 58.

191. See Ehrlich, *Reproductive Fairness*, *supra* note 23, at 18; cf. *Planned Parenthood v. Farmer*, 762 A.2d 620, 637 (N.J. 2000) (noting experience of courts in Minnesota and Massachusetts of granting most petitions).

192. See *Hodgson v. Minnesota*, 497 U.S. 417, 474 (1990) (Marshall, J., dissenting).

193. See Jennifer Soper, Comment, *Straddling the Line: Adolescent Pregnancy and Questions of Capacity*, 23 *LAW & PSYCHOL. REV.* 194, 214-15 (1999).

194. See discussion *supra* notes 33, 41 and accompanying text.

195. See Am. Acad. of Pediatrics, Committee on Adolescence, *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 *PEDIATRICS* 516 (1998).

196. Cf. Martha Minow, *The Role of Families in Medical Decisions*, 1991 *UTAH L. REV.* 1, 23-24 (finding that a minor should be trusted to make the abortion decision on her own); Am. Ass'n

principle. The state's interests are not sufficiently strong to override the girls' choices¹⁹⁷ because its interest in the preservation of the life of the unborn is no greater than exists when an adult woman seeks an abortion. Moreover, the interests of third parties are not sufficiently strong when the child reaches older adolescence.¹⁹⁸ Even the parents' interests in protecting the minor against her own immature decisions are diminished where the proposed age cut-off exceeds the estimates of maturity proposed by developmental psychologists.¹⁹⁹

For girls under age sixteen, the proposed law seeks a compromise between competing values. Girls under the age of sixteen are more likely to be immature and in need of the support and guidance of adults, presumptively their parents. At the same time, when a supportive adult is not available, a bypass procedure must be provided that accords with constitutional principles and is not simply a way to further the state's pro-life values. Generally, any bypass procedure should be viewed from the teenager's perspective, as in *Farmer*. Specifically, consent and two-parent notice statutes should be viewed with suspicion, as one-parent notice should be sufficient to satisfy the state's concerns.

B. Life-Sustaining Treatment Decisions (and Other Health Care Decisions Involving Core Values)

STANDARD: Any minor seeking to consent to or refuse life-sustaining treatment must demonstrate to a health care provider (or a judge, if no resolution is possible with the health care provider) his or her competence to make the decision. If found competent, the minor may refuse or consent to the treatment, unless the state can demonstrate a compelling interest to deny decision-making authority.

As this Article has previously argued, decisions regarding life-sustaining treatment involve the patient's core values and, as such, deference should be given to a mature minor's decisions in this area.²⁰⁰ And because these cases do not arise frequently, an individual determination of competence is a practical and effective way to determine which minors should be permitted to make these decisions.²⁰¹ The

of Pediatrics, Committee on Adolescence, *The Adolescent's Rights to Confidential Care When Considering Abortion* (1996) (noting that adolescents should be permitted to make abortion decision without parental or court intervention).

197. The state's interests are articulated *supra* notes 176-177 and accompanying text.

198. See discussion *supra* notes 20-21 and accompanying text.

199. See discussion *supra* note 106 and accompanying text.

200. Rosato, *Life-Sustaining Treatment*, *supra* note 4, at 14-16.

201. *Id.* at 50.

neutral decision-maker should examine a number of criteria to assess whether the minor "understands the illness and treatment alternatives," "whether the minor has the capacity of rational decision-making[,] and whether the minor has the ability to make and communicate a choice."²⁰²

Although the state generally possesses a strong interest in preserving life, such an interest would not be compelling in this context unless the minor's decision would threaten her life or cause permanent physical harm. For example, the state could trump the minor's choice if she refused a life-saving transfusion or insulin injections that control her diabetes.²⁰³

Minors need to "choose their path in a free society,"²⁰⁴ which includes making decisions about the quality of their lives. Refusal of life-sustaining treatment is an expression of a certain quality of life, and it is the minor who ultimately must bear the consequences of the decision. To deny minors this decision-making authority, as the existing doctrine currently does, is inconsistent with autonomy.²⁰⁵

This proposed approach to life-sustaining treatment decisions should extend to other health care decisions that implicate core values, even though they may not involve life-sustaining treatment. Examples include whether a minor should receive surgery to correct scoliosis,²⁰⁶ whether a limb should be amputated,²⁰⁷ or whether the minor should be institutionalized in a mental health facility.²⁰⁸

C. *Decisions with No Direct Physical Benefit to the Child*

STANDARD: A minor aged sixteen and older should be permitted to consent to non-beneficial treatment (e.g., as research subject or donor), as long as the proposed procedure is unlikely to pose more than a minimal risk.

Consistent with moral development theory, pro-social values, such as altruism, should be nurtured during adolescence.²⁰⁹ By permitting a minor to agree to serve as a research subject and help other people

202. *Id.* at 64-67. The Article proposes that the criteria be shown by clear and convincing evidence, which may be a difficult hurdle to overcome in some cases.

203. *Id.* at 83-94.

204. See discussion *supra* notes 161-163 and accompanying text.

205. See discussion *supra* notes 142-169 and accompanying text.

206. See *In re Green*, 292 A.2d 387 (Pa. 1972) (remanding to determine minor's views about surgery to correct scoliosis).

207. See Ladd & Forman, *supra* note 156, at 343.

208. See Rosato, *Bioethics*, *supra* note 20, at 45.

209. See discussion *supra* notes 142-169 and accompanying text.

or to donate bone marrow to an ailing sibling, both the minor and society at large will benefit.²¹⁰

The existing law does not permit minors to express these values on their own or against their parents' wishes. Minors are permitted to become donors only if they will receive some tangible benefit from the process, either physical or psychological.²¹¹ Moreover, even the oldest adolescents are not permitted to consent to participate in clinical trials. Parents must consent to non-beneficial research that poses even a minimal risk to the minor.²¹²

Allowing older adolescents (ages sixteen and older) to consent to even a limited number of non-beneficial decisions would strike the right balance between protecting minors and encouraging altruism. A bright-line rule is offered because an individualized determination in each instance is not feasible, this group is likely to be sufficiently competent,²¹³ and they are likely to benefit from the experience of helping others.

Consistent with Zimring's learner's permit approach,²¹⁴ minors can only give consent to non-beneficial treatment that is unlikely to pose more than a minimal risk.²¹⁵ This standard helps prepare adolescents for making more significant decisions upon reaching adulthood while ensuring that they will not subject themselves to a great risk with little or no hope of a tangible benefit. As a society, we must practice what we preach. We cannot expect children to grow up into altruistic adults if we have not adequately trained them to make some of these choices before reaching adulthood.²¹⁶

D. Ordinary Health Care Decisions

STANDARD: For ordinary health care decisions, minors should be encouraged to participate by being provided with relevant medical information and having their views respectfully considered. Where

210. *Id.*

211. See Rosato, *Bioethics*, *supra* note 20, at 45.

212. See Rosato, *Clinical Trials*, *supra* note 7, at 364 (summarizing law).

213. In the research context, the medical decision-making developmental literature has been used to assess competence. See Weir & Peters, *supra* note 108, at 31. In the proposed guidelines for Adolescent Health Research, minors would be able to consent to research that does not involve a greater than minimal risk to her. See Guidelines for Adolescent Health Research, 17 J. ADOLESCENT HEALTH 264, 265-66 (Nov. 1995).

214. See discussion *supra* notes 161-169 and accompanying text.

215. Lois A. Weithorn & David G. Scherer, *Children's Involvement in Research Participation Decisions: Psychological Considerations*, at 147-55, and Esther H. Wender, *Assessment of Risk to Children*, at 181-92, in CHILDREN AS RESEARCH SUBJECTS: SCIENCE, ETHICS, AND THE LAW (Michael A. Grodin & Leonard H. Glantz, eds., 1994).

216. Cf. Roe, *supra* note 143, at 1316.

minors and parents disagree, the parents should be permitted to make these kinds of health care decisions for their minor children, provided that the parents do not have a conflict of interest that would interfere with their ability to make a decision in their child's best interests and their actions/omissions would not violate applicable abuse or neglect laws.

For ordinary health care decisions, the need for autonomy is reduced because the minor's core values are not at stake. In most cases, a minor's developing identity does not depend on whether an antibiotic is taken or a broken bone is set, and the need for medical intervention is not in dispute.²¹⁷

Moreover, it is important for health care to be provided to children in an effective and efficient manner. An individualized competence determination cannot be made each time a child goes to the doctor, and in this age of managed care the doctor's office needs to know at the time of the visit that the medical bill will be paid.²¹⁸ Designating the parent as the responsible decision-maker will help ensure these results because parents generally protect their child's health and will act in their best interests.²¹⁹

Even though the parental and state interests may not be considered compelling, they should be sufficient in most circumstances to outweigh the reduced autonomy interest implicated in ordinary health care decisions.²²⁰ As such, parents generally should make these decisions for the minor. But if the parents possess a conflict of interest that would interfere with their ability to make a decision in their child's best interests, then a neutral third-party decision-maker (such as a doctor or judge) must determine what is in the minor's best interests. For example, there could be emotional or financial conflicts.²²¹

Even if minors do not possess decision-making authority to make ordinary health care decisions, they should be active participants in the decision-making process.²²² For example, Professor Gary Melton

217. An exception would be when a minor or her parent refuses medical treatment for religious reasons. See, e.g., Daniel Billent, *The Prosecution of Christian Scientists: A Needed Protection for Children or Insult Added to Injury*, 48 CLEV. ST. L. REV. 479, 481 (2000) (discussing how Christian Scientists resist modern medicine because they think illness is the result of error in thinking, and drugs continue the errors, preventing the person from getting better).

218. See generally Melton, *supra* note 164, at 938 (noting that parents' payment is a relevant consideration).

219. See Rosato, *Bioethics*, *supra* note 20, at 38-39.

220. See Scott, *supra* note 4, at 560.

221. See Rosato, *Bioethics*, *supra* note 20, at 43-49.

222. See Melton, *supra* note 164, at 940-42; accord Am. Acad. of Pediatrics, Committee on Bioethics, *Informed Consent, Parental Permission and Assent in Pediatric Practice*, 95 PEDIATRICS 314 (1995) (advocating that doctors consider minors' developing capacities when seeking informed consent).

has proposed an approach that would provide information to the minor and ask for her opinion throughout the process, even if it is not binding.²²³ Using a participatory model, competence and moral development will be encouraged.

V. CONCLUSION

Although the state of the competence literature remains inconclusive, a change in existing law cannot wait any longer.²²⁴ The proposal set forth in this Article is designed to be a textured quilt with patches that are reflective of the lessons learned from the competence literature, moral development theory, and bioethics principles. Although recent literature shows promise, more empirical research must be done in this area. In the meantime, we must begin to give some decision-making authority to older adolescents. To begin to recognize this group as qualitatively different than younger children will respect the minor's personhood and yield positive results for the minor, her family, and the society-at-large. Dismantling the presumption of incompetence in the health care decision-making context is a good place to start.

223. Melton, *supra* note 164, at 942.

224. *See generally* Buss, *supra* note 9, at 919.

[Developmental psychology offers] a general picture of how we change as we grow up. [Lawyers then must] determine when bright-line rules are justified despite the lack of developmental clarity, when society is better off with discretionary standards that defer to the decision-maker's assessments of an individual child's capacity, and to what extent extra developmental considerations also should be given weight.

Id.

