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Paul Arshagouni

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### Recommended Citation

Paul Arshagouni, *"But I'm an Adult Now ... Sort of" Adolescent Consent in Health Care Decision-Making and the Adolescent Brain*, 9 J. Health Care L. & Pol'y 315 (2006).

Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol9/iss2/8>

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# ARTICLE

## “BUT I’M AN ADULT NOW . . . SORT OF”

### ADOLESCENT CONSENT IN HEALTH CARE DECISION- MAKING AND THE ADOLESCENT BRAIN

PAUL ARSHAGOUNI\*

#### I. INTRODUCTION

Imagine that you are a fourteen-year-old boy who has gone on a camping trip with a group of friends. Your parents have thoughtfully provided the adults supervising the trip with a medical release form authorizing them to consent to any required emergency medical care. After leaving you with these responsible adults, they head off on their own backpacking trip in the Sierra Nevada Mountains. To your surprise, when you arrive at the camp you discover that the camp authorities will not allow you in without proof of a tetanus vaccine. As far as you can remember, the last time you got shots it was before you started kindergarten. Fortunately, the camp is near a clinic that can administer a tetanus shot. You are relieved that your week of camping will not be lost. But when you arrive at the clinic, the health provider tells you that she cannot administer a tetanus injection without proper consent. You are stuck. The medical release your parents signed was for emergency care. This does not even resemble emergency care. Your camping trip is ruined. Now you will have to spend the next two weeks until your parents return with your Aunt Gertrude, who can’t tell an X-box from a xylophone. Should this adolescent be allowed to consent to a vaccination? This may seem a trivial question. What difficulty could the ability to consent to a simple and risk free procedure such as a tetanus booster pose? The question often becomes much more serious when we consider cases such as the fifteen-year-old who wants to refuse further life-saving care after his second liver transplantation fails.

Adolescents are in a curious in-between stage of life. They are neither children nor adults. They are capable of much adult-like thought, yet they have not generally acquired all the tools necessary to live independently. They want to be treated like adults, except when they don’t want to be. This is a seeming paradox, but it follows what is becoming an increasingly better understood developmental

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\* Associate Professor of Law & Director of the Health Law Program, Michigan State University College of Law. J.D., 1999, University of California Los Angeles, School of Law; M.P.H., 1994, University of California Los Angeles, School of Public Health; M.D., 1988, University of California Irvine, College of Medicine; B.A., 1984, University of California.

stage. Significant scientific study has been performed in the last several years attempting to explain much of this paradox. The law has yet to fully catch up with this growth in scientific information. In recent years a number of legal scholars and medical practitioners have argued to expand the rights of adolescents to consent to or refuse medical services in a variety of circumstances.

The question of whether adolescents should have the ability to consent to their own health care is not merely academic. Substantial health consequences flow from adolescents' lack of consent capacity. The lack of consent capacity limits adolescents' access to care. Diminished access to health care leads to poorer health outcome. A significant number of American teenagers often do not seek health care in situations where they themselves have deemed it necessary. In a 1999 report within *The Journal of the American Medical Association* (JAMA), researchers at the University of North Carolina, Chapel Hill, surveyed over 20,000 American youths in grades seven through twelve and found that 18.7% (or nearly one in five) of respondents had foregone health care within the preceding year.<sup>1</sup> Forgone healthcare was measured by the response to the question "[h]as there been any time over the past year when you thought you should get medical care, but did not?"<sup>2</sup> In forgoing health care for the treatment of a medical condition, these teens placed themselves at risk for developing health care complications that could jeopardize their lives and futures.

After Massachusetts enacted its 1974 law requiring parental notification for underage abortion,<sup>3</sup> many minors went to other states without such prerequisites in order to prevent their parents from knowing.<sup>4</sup> Of the minors who attended family planning clinics in Massachusetts at the time of the decision, 9% said they would rather undergo a self-induced or illegal abortion than tell their parents.<sup>5</sup>

Finding a better formulation for determining when adolescents can and should be allowed to make independent health care decisions will help mitigate the deleterious consequences resulting from adolescents' avoiding timely and necessary medical treatment.

This article seeks to find this better formulation. Section II will discuss the nature of what it is to be adolescent and how the law has evolved with respect to attaining the right of consent. Section III will discuss the recent scientific studies that have been done to better understand the nature of adolescents. Section IV will consider some of the proposals made by several scholars in recent years, discussing

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1. Carol A. Ford et al., *Foregone Health Care Among Adolescents*, 282 JAMA 2227, 2227, 2230-31 (1999).

2. *Id.* at 2230.

3. MASS. GEN. LAWS ANN. ch. 112, § 12P (2003).

4. Virginia G. Cartoof & Lorraine V. Klerman, *Parental Consent for Abortion: Impact of the Massachusetts Law*, 76 AM. J. PUB. HEALTH 397, 399 (1986).

5. See *H. L. v. Matheson*, 450 U.S. 397, 439-40 n.26 (1981) (Marshall, J., dissenting).

their strengths and shortcomings. Section V will draw from the recent scientific understanding of adolescent development to craft a more rational and consistent approach to adolescent consent. The article will conclude with a proposal as to how the law should regard adolescents and their decisional capacity.

We must recognize, however, that any hoped-for resolution of the adolescent consent issue within the health care setting will have potential consequences throughout all legal disciplines. Understanding how adolescents think, approach and deal with problems, handle crises, and face long-term consequences can, and should, inform how we assess adolescents' place in regards to the formation of a contract or the commission of a tort or a crime. While this article focuses primarily on adolescents within the health care setting, the principles discussed here have equal applicability in the settings of a contract enforcement action, a tort action, or within the criminal justice arena.

## II. WHAT IS AN ADOLESCENT ANYWAY?

Before we can adequately discuss what decision-making capacity adolescents should have, we need to try and understand just what constitutes an "adolescent." The transition from childhood to adulthood has often been a bit of a gray area. Americans rank the completion of school as the most important indicator of adulthood. The data from a 2002 General Social Survey (GSS) showed that 72% of respondents considered completing school the most important indicator of the transition to adulthood.<sup>6</sup> This ranked even higher than being employed full time or the ability to support a family.<sup>7</sup> The traditional high school and college graduation are celebrated enthusiastically nationwide and often serve as markers of the transition from adolescence to adulthood. After school, the rankings of indicators of adulthood follow with acquiring a full-time job, ability to support a family, and financial independence. The mean time for the acquisition of these traits and, thus, the transition from adolescence to adulthood is a little over five years.<sup>8</sup>

Comparing the United States to other nations, the move to a college education from a secondary education occurs at an earlier age with a higher proportion of youths in college. American youths also leave home at an earlier age and there is wider gap in the age and occurrences of transitions. In terms of socially maturing, American adolescents experience this at an earlier age than those of youths in other nations.<sup>9</sup>

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6. Tom W. Smith, *Coming of Age in Twenty-First Century America: Public Attitudes Towards the Importance and Timing of Transitions to Adulthood*, 29 AGEING INT'L 136, 138 (2004).

7. *Id.* at 138-40.

8. *Id.* at 140.

9. *Id.* at 137.

The onset of puberty provides the most overt manifestation of the beginning of adolescence. Although physical maturation appears to be occurring at an earlier age than in the past, puberty remains a generally accepted demarcation for the start of adolescence. Secondary sexual characteristics begin to develop at different times and at different rates in each individual. The average age for menarche, a girl's first menstrual period, is approximately 12.4 years in the United States.<sup>10</sup> One large study of over 17,000 girls found that the average age for the first physical sign of puberty (pubic hair growth and/or breast development) was between eight and ten years of age.<sup>11</sup> As many as one in six began by age eight.<sup>12</sup>

Of course physical development is not everything. Even with the early physical development, many adolescents fail to achieve adulthood status because they choose not to, or are not permitted to, fulfill the requirements that recognize their adulthood. A study funded by the MacArthur Foundation and led by sociology researcher Frank F. Furstenberg, Jr. states:

Many [young people] have not become fully adult yet—traditionally defined as finishing school, landing a job with benefits, marrying, and parenting—because they are not ready, or perhaps not permitted, to do so. The life events that make up the transition to adulthood are accompanied by a sense of commitment, purpose and identity.<sup>13</sup>

Marriage and parenthood are no longer seen as the same primary markers of adulthood as they were only a few decades ago. The earlier onset of physical development and the rise in teenage pregnancies have diminished the view of adulthood through biological standards. In fact, in the 2002 GSS survey concerning factors that determine adulthood, having a child ranked the lowest, at below 16%.<sup>14</sup> Education, employment, and supporting a family were the top three factors and rated as extremely important in the survey, with each of these adulthood transition items reporting over 60% for all respondents.<sup>15</sup> Furstenberg

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10. William Cameron Chumlae et al., *Age at Menarche and Racial Comparisons in US Girls*, 111 PEDIATRICS 110, 111 (2003).

11. Marcia E. Herman-Giddens et al., *Secondary Sexual Characteristics and Menses in Young Girls Seen in Office Practice: A Study from the Pediatric Research in Office Settings Network*, 99 PEDIATRICS 505, 505, 508-09 (1997).

12. *See id.* at 509 fig. 4 (reporting that 48.3% of 1,639.39 African-American girls (791.83) and 14.7% of 15,437 white girls (2,269.25) showed prevalence of pubic hair and/or breast growth by age eight). We cannot simply look to physical development when determining the onset of adolescence. Some children begin sexual maturation early in what is medically referred to as precocious puberty (commonly defined as the onset of secondary sexual characteristics before the age of eight years). Unfortunately, children with precocious puberty often begin sexual activity at an earlier age, thereby putting them at risk of health complications—both physical and psychological—at an earlier age.

13. AM. SOCIOLOGICAL ASS'N, *Achieving "Adulthood" Is More Elusive for Today's Youth; Transition to "Adulthood" Occurring at a Later Age*, ASA NEWS, Aug. 2, 2004, at 1 (quoting Frank F. Furstenberg, Jr.), <http://asanet.org/page.wv?name=Adulthood&Section=Press>.

14. Smith, *supra* note 6, at 139-40.

15. *Id.* at 139 tbl.1A.

remarks that these are “concrete steps associated with the ability to support a family.”<sup>16</sup> These results reveal the contrast in how adulthood was defined by American society in the 1960s in comparison to today’s standards. In all other areas, young adults may meet the requirements of adulthood, but in terms of financial independence many are incapable of achieving this prerequisite of full adulthood. The inability to pay for medical care also complicates the issue of adolescent consent to health care. For a much larger proportion of today’s adolescents, early adulthood represents a longer transition period where they learn the skills of employment while remaining economically dependent on their family.

Furstenberg’s research team reviewed the U.S. Census data from 1900 and 2000 and found that it does take much longer to make that transition from adolescence to adulthood.<sup>17</sup> Some authors have referred to this transitional period as early adulthood or emerging adulthood. Based upon traditional benchmarks, only 31% of males in 2000 reached adulthood by age thirty, while 65% of males at that same age attained adulthood in 1960.<sup>18</sup> For women in 2000, only 25% would have reached adulthood by age twenty-five, while 70% of women in 1960 would have acquired adulthood status at that age.<sup>19</sup> It now takes longer for men and women to complete an education and find a job that earns enough to support a family.<sup>20</sup>

Jeffrey Jensen Arnett of the University of Maryland, College Park, has proposed that a period from the late teens through the early twenties be classified as a fourth category of development, termed “emerging adulthood.”<sup>21</sup> This age group would fall between the ages of eighteen and twenty-five.<sup>22</sup> Arnett argues that this stage of development is distinct from adolescence and young adulthood.<sup>23</sup> He makes the further observation that emerging adulthood exists only in societies where there is an extended period of independent role exploration in the late teens and early twenties.<sup>24</sup>

Arnett provides an example of someone he feels typifies his views of the youth as the emergent adult. This individual is a student in her early twenties who will soon finish college but does not yet see a clear path for her unknown future.<sup>25</sup>

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16. AM. SOCIOLOGICAL ASS’N, *supra* note 13, at 1.

17. Frank F. Furstenberg, Jr. et al., *Growing Up Is Harder to Do*, 3 CONTEXTS: UNDERSTANDING PEOPLE IN THEIR SOC. WORLDS 1, 3 (2004), [http://www.contextsmagazine.org/content\\_sample\\_v3-3.php](http://www.contextsmagazine.org/content_sample_v3-3.php).

18. *Id.*

19. *Id.*

20. *Id.* at 4.

21. Jeffrey Jensen Arnett, *Emerging Adulthood: A Theory of Development From the Late Teens Through the Twenties*, 55 AM. PSYCHOLOGIST 469, 469 (2000).

22. *Id.*

23. *Id.*

24. *Id.* at 469-70.

25. *Id.* at 469.

She knows that at the same age her mother already had a ring on her finger.<sup>26</sup> We can analogize Arnett's emergent adulthood stage as similar to the chrysalis stage of the butterfly. It is at these stages that adolescent youths are transforming themselves into the final form that they will take in adulthood. The male and female roles that exist for adolescents today are not as fixed and certain as they were for their parents or grandparents a mere few decades ago. The expectation of growing up, getting married, and having kids with a house in the suburbs is no longer the mindset of the majority. From the survey numbers already seen, having a child ranks the lowest as the most important indicator of attaining adulthood whereas a few decades ago it ranked as the highest.<sup>27</sup>

Arnett also cites these changing roles. He notes that the U.S. Census statistics indicating the median age of marriage in 1970 was twenty-three for men and twenty-one for women, whereas in 1996, the median age of marriage had risen to twenty-seven for men and twenty-five for women.<sup>28</sup> Along with delay of marriage, many more young Americans seek a higher education. The percentage of individuals seeking a post-secondary education has grown from 14% in 1940 to over 60% in the mid-1990s.<sup>29</sup> The delay in marriage and parenthood, along with extending education, has altered the timing for transition into long-term adult roles. The late teens and early twenties are now marked with numerous changes and explorations that will determine adolescents' future life course.<sup>30</sup>

The United States is not the only country where the age of marriage has shifted upwards. A median age of marriage for women in 1996 at twenty-six to twenty-seven years of age is typical of industrialized nations such as Germany, Japan, and Australia.<sup>31</sup> In developing countries the median age for marriage in women is lower, ranging from nineteen to twenty-two in countries like Nigeria, India, and Brazil.<sup>32</sup> Arnett emphasizes that emerging adulthood is not a phenomenon that typifies countries, but instead typifies cultures. Even in the United States where the median age of marriage has risen, in Mormon culture, where emerging adulthood is diminished or nonexistent and youths are expected to marry early and have large families, the median age of marriage still remains low.<sup>33</sup> Emerging adulthood occurs only in cultures that delay the onset of adult roles and duties. This is seen most frequently in industrialized nations.<sup>34</sup>

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26. *Id.*

27. Smith, *supra* note 6, at 139-40.

28. Arnett, *supra* note 21, at 469.

29. *Id.*

30. *Id.*

31. *Id.* at 478 tbl.1.

32. *Id.*

33. *Id.* at 478.

34. *Id.*

The emerging adulthood stage is marked by immense change and importance where the education and training that a person receives will form the basis of their adult life. These frequent changes occur in relationships, employment, and world opinions. Arnett, like other authors and studies, points out how the life-changing decisions that occur at this time in life often have long-lasting implications for the future course of that youth's life.<sup>35</sup> In a study of life span analysis by Peter Martin and Michael Smyer, adults most often point to the events of this stage as one of the most important in their lives.<sup>36</sup> Because this stage of life is so crucial in the development towards adulthood, the health care decisions made at this time must also be taken with considerable care. Conversely, policies that inhibit access to health care or delay decisions regarding health care treatment can equally jeopardize the future of these youths, and so need to be addressed.

The proposition that Arnett makes for the theory of emerging adulthood marks this stage as a distinct entity, wholly separate from adolescence or young adulthood.<sup>37</sup> It is a period that is independent from social roles and typical expectations. The transformative stage of emergent adulthood is free from both the dependency of adolescence and the anchors that mark adulthood. The degree of freedom and exploration possible at this stage of life is often greater than in any other.<sup>38</sup> As Arnett states, "For most people, the late teens through the mid-twenties are the most *volitional* years of life."<sup>39</sup>

Arnett points to Erik Erikson's work from the 1950s, which commented on the "prolonged adolescence" that typified industrial societies and the "psychosocial moratorium" given to youths to experiment in order to find their role and place in society.<sup>40</sup> The basis for risk prone behaviors can be partially explained through science in brain development studies showing that adolescent brains do not physically mature in cognitive areas that can assess long-term consequences of such behavior until youths reach their early twenties.<sup>41</sup> It is because of such risk behaviors that many adolescents need access to confidential health care, which will help treat these health events at earlier stages before they develop into major life-threatening and life-altering complications in the future. There must be avenues

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35. *Id.* at 469.

36. See Peter Martin & Michael A. Smyer, *The Experience of Micro- and Macroevents: A Life Span Analysis*, 12 RES. ON AGING 294, 305 (1990) (reporting that, when rating life events in order of importance, older adults indicated that their young adult years represented "an especially dense period of life-event reminiscence").

37. Arnett, *supra* note 21, at 469, 476-77.

38. *Id.* at 469.

39. *Id.*

40. ERIK H. ERIKSON, *IDENTITY: YOUTH AND CRISIS* 156 (1968).

41. See Nat'l Inst. of Mental Health, *Teenage brain: A Work in Progress* (2001), <http://www.nimh.nih.gov/publicat/teenbrain.cfm> (reporting differences in brain composition between young adults and teens show that adults have increased capabilities for cognitive processing).



that address the need for open medical care for our youths as they enter into this stage of transition.

### *A. The Adolescent Dilemma*

We are still left with the question of what is an adolescent? We have the simple answer. It is the developmental transition from childhood to adulthood. While functionally true, this is unhelpful. We need to know what demarcates the outer borders of the transition. The onset of adolescence seems more certain. Once puberty hits, the transition has begun. The dilemma we face here is determining when it ends and what adolescents should be allowed to do during the transition.

Adults often understand the potential long-term consequences resulting from the lack of necessary medical treatment based on their own knowledge and experience. However, teenagers generally do not possess such knowledge and may lack the ability to make long-term projections about their health. As such, adequate foresight may not be as prevalent. In fact, the single biggest reason that adolescents give for avoiding necessary health care treatment was the belief that the problem would go away. According to Carol Ford, an overwhelming 63.3% stated this as their primary reason for avoiding treatment.<sup>42</sup> This belief well eclipsed the next closest reason, fear of what the physician would say or do, by almost 50%.<sup>43</sup>

Several factors contributed to the likelihood of adolescents' deciding to forego health care. The overall average rate of self-reported forgone health care was 18.7%.<sup>44</sup> Interestingly, of the adolescents surveyed, those who practiced risky behaviors (such as smoking, drinking, and sexual activity) had forgone health care services at a rate higher than the average.<sup>45</sup> Adolescents who were frequent smokers made up 21.6% of all respondents and had a 26% rate of forgoing health care.<sup>46</sup> Frequent alcohol users constituting 5.7% of respondents had forgone health care rates of over 30%.<sup>47</sup> Adolescent who were sexually active made up 38.3% of respondents and had medical care avoidance rates of 25.1%.<sup>48</sup> Statistically speaking, those who displayed two or more of these health risk behaviors were more prone to health complications, and were even more likely to forego health care.

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42. Ford et al., *supra* note 1, at 2232.

43. *Id.*

44. *Id.* at 2230.

45. *Id.* at 2230 tbl.2, 2231.

46. *Id.* at 2330 tbl.2.

47. *Id.*

48. *Id.*

The study also measured the rates of forgone health care in youths who had symptoms of physical or mental health problems. Adolescents who reported that they had frequent physical symptoms constituted 12.7% of respondents and had rates of 32.4% in forgone health care.<sup>49</sup> Frequent criers made up 1.8% of adolescent respondents and had health care avoidance rates of 38.5%.<sup>50</sup> Adolescents with symptoms of dysuria (painful or frequent urination) occurred in 1.4% of respondents and had health care avoidance rates of 38.2%.<sup>51</sup> Notably, the burning sensation upon urination may be caused by a sexually transmitted disease or bacterial urinary tract infection that affects the bladder. Both causes can lead to greater health complications with delayed treatment.<sup>52</sup>

The concerning results of this research data indicate that adolescents with high health risk activities and/or health care problems and who have an even greater need for medical treatment show the highest rates of forgone health care.

Of those who reported that they did not seek needed health care, 11.5% said that the reason they did not seek care was that they did not want their parents to know.<sup>53</sup> Another 11.7% indicated that there was no adult available to take them to a health care provider.<sup>54</sup> Fifteen-and-a-half percent were afraid of what the physician would say or do.<sup>55</sup>

The concern of teenagers regarding privacy and not wanting their parents to know brings up significant questions about the need for adolescent consent and privacy in medical treatment. Adults expect privacy in medical treatment as a universal right. Adolescents, who must obtain parental consent before even the most innocuous health care visit, are not afforded this same right. We could ask what health care services competent adults might forego if their employers, spouses, or family members were notified of their medical procedures and consultations. When should adolescents, navigating the path to full autonomy, also have the same rights of confidentiality?

Adolescents' fear regarding what the physician might say or do may result from misconceptions regarding medical treatment generally or misconceptions regarding the specific conditions for which they would seek care. This suggests an inability to project to future circumstances, which may be a sound reason for limiting adolescent consent in medical decisions. Viewed from another

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49. *Id.*

50. *Id.*

51. *Id.*

52. See MedicineNet.com, Burning Urination Symptoms & Signs Index, <http://medicinenet.com/script/main/forum.asp?articlekey=24704> (last visited Sept. 21, 2006); MedicineNet.com, Sexually Transmitted Diseases (STDs in Men), [http://www.medicinenet.com/sexually\\_transmitted\\_diseases\\_std\\_in\\_men/page13.htm](http://www.medicinenet.com/sexually_transmitted_diseases_std_in_men/page13.htm) (last visited Sept. 21, 2006).

53. Ford et al., *supra* note 1, at 2232 tbl.4.

54. *Id.*

55. *Id.* at 2232.

perspective, we may see this as an argument in favor of expanding adolescent consent. When adolescents believe they can seek medical advice without the fear of their parents' knowledge, they may actually seek advice and treatment for their condition. As with most diseases, early detection and prevention help to prevent major complications in the future. This is a health care policy that has been strongly advocated for years.<sup>56</sup> If we wish to foster such responsible behavior in our youth, in order that they may continue toward sound health practices, then we need to nurture such attitudes at an early age.

Another 2002 study published in JAMA reported a survey of Planned Parenthood clinics throughout Wisconsin, which polled 950 females under the age of eighteen.<sup>57</sup> It found that 59% (nearly six in ten) of respondents would stop using health care services, including delaying testing or treatment for HIV or STDs, if parental consent were required.<sup>58</sup> Astonishingly, 99% of these respondents said that they would continue to have sex.<sup>59</sup> Opponents of adolescent consent for medical treatment without requiring parental notification or consent argue that such consent will lead to increased risky behavior.<sup>60</sup> The results of this survey would indicate that adolescent activities in risky behavior would more than likely continue with or without parental knowledge or permission. In fact, parental consent or notification would actually factor negatively in youth behavior that would promote health precautions in prevention of disease or unwanted pregnancies.

The Centers for Disease Control (CDC) Youth Risk Behavior Surveillance System (YRBSS) measures six areas of high health-risk behaviors among American youths and young adults.<sup>61</sup> These include tobacco use, alcohol and drug use, physical inactivity (obesity), and risky sexual behavior. The national survey measured responses from youths in 9th through 12th grade from October 2004 through January of 2006.<sup>62</sup> The results showed that within thirty days preceding

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56. See, e.g., Frances A. Althaus, *An Ounce of Prevention . . . STDs and Women's Health*, 23 FAMILY PLANNING PERSPECTIVES 173 (1991) (arguing for increased prevention, screening, and treatment to prevent the consequences of untreated STDs); COMM. ON ADOLESCENCE, AM. ACAD. OF PEDIATRICS, *Counseling the Adolescent About Pregnancy Options*, 83 PEDIATRICS 135 (1989) (extolling the benefits of early pregnancy identification in teenagers); see also COMM. ON ADOLESCENCE, AM. ACAD. OF PEDIATRICS, *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 749 (1996) (recognizing the danger in delaying medical advice and care for teenage pregnancy).

57. Diane M. Reddy et al., *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 JAMA 710, 711 (2002).

58. *Id.* at 713.

59. *Id.*

60. See Angela Diaz et al., *Legal and Ethical Issues Facing Adolescent Health Care Professionals*, 71 MOUNT SINAI J. MED. 181, 182 (2004).

61. Danice K. Eaton, Ph.D. et. al, *Youth Risk Behavior Surveillance – United States, 2005*, 55 MORBIDITY & MORTALITY WKLY. REP. 1 (2006).

62. *Id.*

the survey, 28.5% had ridden in a car with someone who had been drinking,<sup>63</sup> while 43.3% (or approximately 7.25 million) said they had drunk alcohol.<sup>64</sup> About half these numbers, 20.2% (or 3.4 million) had used marijuana.<sup>65</sup> Only 2.1% of the adolescent respondents reported that they had ever injected an illegal drug.<sup>66</sup> These statistics, as well as many others drawn from the YRBSS, demonstrate that adolescents engage in risky behavior with a frequency that would trouble any parent.

The 2005 YRBSS results also revealed that 46.8% or roughly 7.8 million high school students have had sexual intercourse.<sup>67</sup> Of those who were sexually active, only 62.8% reported using a condom in their last sexual encounter.<sup>68</sup> The low rate of condom use is surprising considering that no state laws require parental notification in order for a minor to purchase nonprescription contraceptives. State laws do not generally prohibit physicians from writing prescriptive contraception for a minor.<sup>69</sup> A few states also give an age, usually sixteen, at which a minor can request contraceptives, but do not punish the doctor for treating patients who are even younger than this specified age.<sup>70</sup> However, many states permit a physician to breach confidentiality and inform the parent when writing a contraceptive prescription for a minor.<sup>71</sup> Such breaches of a youth's privacy would undoubtedly deter an adolescent from seeking a contraceptive prescription from a physician. This interaction of rules brings into conflict issues of the minor patient's concerns for privacy against the adolescent's actual cognitive and decisional capacity, as well as the parents' right to know about their child's behavior.

Multiple factors may result in the low incidence of adolescent condom use, including careless neglect and willful reckless behavior. Additional factors include access to such contraception and the negative stigma minors may feel when purchasing contraceptives. Changing public views and judgments of an adolescent's purchase of contraceptives may prove difficult, but access is something that can be modified. Some pharmacies and stores place condoms and contraceptives in locked drawers that require notification and access from a store employee. The statistics we have seen indicate the high rate of sexual activity among adolescents. Adolescents will continue their sexual activity irrespective of the requirements of parental consent and notification before they are allowed

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63. *Id.* at 5, 38 tbl.4.

64. *Id.* at 13, 62 tbl.28.

65. *Id.* at 14, 64 tbl.30.

66. *Id.* at 15, 66 tbl.32.

67. *Id.* at 19, 78 tbl.44.

68. *Id.* at 21, 80 tbl.46.

69. EDWARD P. RICHARDS & KATHARINE C. RATHBUN, *LAW AND THE PHYSICIAN: A PRACTICAL GUIDE* 377 (1993).

70. Diaz et al., *supra* note 55, at 182.

71. *Id.*

access to contraceptives. While a primary goal is to discourage teenage sexual activity, the realities of their behavior necessitate the need for them to have confidential access to contraceptives that can prevent unwanted pregnancies and STDs.

While state laws do not require parental notification when a minor purchases nonprescription contraceptives, certain state laws do place restrictions in the free distribution of contraceptives to minors. In one case, New York Public Health Law section 2504 allows minors to consent to “medical, dental, health and hospital services,” without specifying those services.<sup>72</sup> New York City high schools instituted a condom availability program to stem the rise of HIV/AIDS among the student population.<sup>73</sup> The distribution program was part of the New York City Board of Education’s mandated HIV/AIDS education curriculum.<sup>74</sup> Parents of the students brought a suit in which the appeals court determined that condom availability fell under a “health service” as used by section 2504(1), which required parental consent for adolescents to participate in the program.<sup>75</sup> The requirement for parental consent defeats the purpose of such a distribution program in helping adolescents gain access to contraceptives that would help to prevent HIV/AIDS and STDs.

To emphasize the need for private and accessible contraceptives for adolescents we need only look back to the statistics. In spite of declining teen pregnancy rates over the years, approximately one in thirteen teenage girls are pregnant at least once before their twentieth birthday.<sup>76</sup> During 1994, within the U.S., 78% or approximately 630,000 teen pregnancies were unintended.<sup>77</sup> Approximately four million sexually active teenagers contract an STD each year, accounting for one fourth of all newly diagnosed STDs.<sup>78</sup>

For adults older than twenty-five years of age, two factors, cardiovascular disease and cancer, account for 62.9% of all deaths.<sup>79</sup> The 2005 YRBS indicated

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72. N.Y. PUB. HEALTH LAW § 2504(3)-(4) (McKinney 2002) (allowing any pregnant person to consent to services related to hospital care, and waiving certain parental consent requirements in emergencies).

73. *Alfonso v. Fernandez*, 606 N.Y.S.2d 259, 261 (N.Y. App. Div. 1993).

74. *Id.*; N.Y. EDUC. LAW § 135.3(a)(2) (McKinney Supp. 2005).

75. *Alfonso*, 606 N.Y.S.2d at 264; Nancy Batterman, *Under Age: A Minor’s Right to Consent to Health Care*, 10 *TOURO L. REV.* 637, 674 (1994).

76. STANLEY K. HENSHAW, ALAN GUTTMACHER INST., U.S. TEENAGE PREGNANCY STATISTICS WITH COMPARATIVE STATISTICS FOR WOMEN AGED 20-24, at 5 (2004), available at [http://www.guttmacher.org/pubs/teen\\_stats.pdf](http://www.guttmacher.org/pubs/teen_stats.pdf).

77. Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30 *FAMILY PLANNING PERSPECTIVES* 24, 26 tbl.1 (1998).

78. CYNTHIA DAILARD, ALAN GUTTMACHER INST., FAMILY PLANNING CLINICS AND STD SERVICES 8 (2002), available at <http://www.guttmacher.org/pubs/tgr/05/3/gr050308.pdf>.

79. ROBERT N. ANDERSON & BETTY L. SMITH, CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL VITAL STATISTICS REPORTS, DEATHS: LEADING CAUSES FOR 2002, at 7 (2005), available at [http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53\\_17.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf).

that the risk behaviors linked with these two causes of death were initiated during adolescence. Within thirty days of the survey, 23% (or 3.8 million) high school students had smoked cigarettes.<sup>80</sup> The YRBS also asked about diet and exercise. Nearly four fifths (79.9%) of adolescents reported that they had fewer than five servings per day of fruits and vegetables in the preceding seven days.<sup>81</sup> Nearly two thirds (64.2%) reported failing to meet currently recommended levels of physical activity.<sup>82</sup> Not surprisingly, the survey found that 13.1% of adolescents were overweight, with another 15.7% at risk for becoming overweight.<sup>83</sup> Such poor health care decisions early in life lead to lifelong patterns of poor health behaviors and undoubtedly contribute to the high rate of heart diseases and cancer in adult causes of death.

The statistical data on youth risk behavior paints a very grim picture of adolescents' behavior. These results suggest that the reckless and careless behavior of adolescents would predispose them against making sound medical decisions regarding their own health care. This argues strongly against permitting adolescents to provide consent for their own treatment. Proponents of unrestricted adolescent consent capacity argue that the stigma associated with the indiscretions of youth behavior often prevents them from seeking medical treatment even when they may fully understand the consequences of their behavior.<sup>84</sup> The social stereotypes and restrictions that we wish to impose upon our youths often create an atmosphere of secrecy. Risky behavior among adolescents can occur through careless neglect or disregard for the consequences of such behavior.

However, that same attitude of disregard need not cloud the judgment or impair that adolescent's ability to seek medical care and advice. Realizing that a mistake has occurred and accepting the consequences of one's behavior is the first step. The second step in seeking treatment for the ill effects resulting from such behavior should never be denied to an individual, especially in cases involving adolescents. Making mistakes is a part of adolescent behavior and is an essential part of the growing up process. Making amends and mitigating the ill effects of one's misjudgment are traits that we want to instill in our children. In a society that cherishes independence and freedom, when we grant children autonomy and consent over their own medical treatment, we help to foster these traits.

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80. Eaton, *supra* note 61, at 11, 56 tbl.22.

81. *Id.* at 22, 84 tbl.50.

82. *Id.* at 23, 86 tbl.52.

83. *Id.* at 26, 94 tbl.60.

84. See Elizabeth Cauffman & Laurence Steinberg, *(Im)maturity of Judgment in Adolescence: Why Adolescents May Be Less Culpable Than Adults*, 18 BEHAV. SCI. & L. 741, 758 (2000) (discussing the unavoidable skew in self-reporting studies toward a reporting of more socially acceptable responses).

Fears of poor medical decisions on the part of adolescents are largely misdirected. We must consider the statistics cited above, which indicate a high rate of poor choices, with the proper perspective. The choices they represent correspond to independent decisions made by adolescents within their own peer group. They may reflect the adolescent's decision whether to seek health care services or not. However, once that first decision has been made, the adolescent's subsequent decisions are made with the guidance of a health care professional. A doctor or nurse possesses the knowledge and expertise to advise an adolescent regarding a given medical decision. As is true for most adults, when we visit a doctor, we depend on him or her to give us sound advice. Adolescents may well be better off seeking medical treatment on their own than doing without care and risking potentially serious health complications arising from a lack of timely medical care.

Adults have the option to treat and rectify the consequences of risky behaviors in which they may have been willing participants. Such options are not as easily available to adolescents who engage in such risky behaviors. Research has shown that the same media campaigns to encourage responsible behavior and medical treatment among adults do not often work as effectively for adolescents.<sup>85</sup> We need a more uniform and effective health care policy toward adolescent consent to medical treatment.

The health risk behaviors of adolescents, which create adverse effects in later life, demonstrate the need to provide medical information and access to health care for them. The numerous studies that we have seen all indicate that teens are less likely to seek health care if they are required to obtain parental consent before they are allowed access to medical treatment or care.<sup>86</sup>

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85. See, e.g., Cornelia Pechmann et al., *What to Convey in Antismoking Advertisements for Adolescents: The Use of Protection Motivation Theory to Identify Effective Message Themes*, 67 J. MKTG. 1, 11-14 (2003) (reporting that the most effective anti-smoking advertising conveyed risks of social disapproval); see also Paula G. Williams et al., *Adolescent Health Psychology*, 70 J. CONSULTING & CLINICAL PSYCHOL. 828 (2002).

86. The general rule, of course, is that parents make all health care decisions for their minor children. The presumption of parental rights, while strong, is not inviolable. The presumption also rests in large part on the notion that parents are in the best position to act in the minor's best interests. This is generally true. However, in some circumstances parents act in accordance with their own perceptions. For example, American parents commonly circumcise male newborns. There is little evidence to support this practice from a medical perspective. The American Academy of Pediatrics (AAP) does not currently recommend routine circumcision. See TASK FORCE ON CIRCUMCISION, AM. ACAD. OF PEDIATRICS, *Circumcision Policy Statement* 103 PEDIATRICS 686, 691 (1999), available at <http://aappolicy.aapublications.org/cgi/reprint/pediatrics;103/3/686.pdf> (finding that potential medical benefits of newborn male circumcision may exist, but that these data are not sufficient to recommend routine neonatal circumcision). The practice nonetheless remains common, largely for religious and cultural reasons. We accept that parents can and should make such decisions for their infant sons.

A similar argument could be made for female circumcision as it is practiced in some cultures, although, unlike male circumcision, there isn't even a weak medical justification. The AAP has come out strongly opposed to any female circumcision. See COMM. ON BIOETHICS, AM. ACAD. OF

The adolescent dilemma has at least two sides. The right of an adolescent to give consent to health care services has an equally important counterpart. What right does an adolescent have to refuse consent for health care services? Numerous cases have hit the courts wherein a minor refuses potentially beneficial medical treatment, sometimes with and sometimes without his or her parents' agreement. Such cases test the physician's and state's duty to the protection and health of a minor. They also test the application of the mature minor doctrine.

Take, for example, the case of Angelica Niebla.<sup>87</sup> Angelica and her parents were Jehovah's Witnesses whose religion dictates that they "abstain from blood." They interpreted this to mean that they must refuse all blood transfusions, even in life threatening situations. Angelica had been admitted to the University of California, San Diego Medical Center with a declining blood count. Her parents refused to permit a transfusion, citing religious objection. Angelica, then fifteen years old, agreed with this view and refused transfusion. The county obtained emergency *ex parte* orders giving the county custody of Angelica and authorizing a blood transfusion.<sup>88</sup> Angelica sought the right to make her own medical decisions under the mature minor doctrine. The court declined to make such a finding.<sup>89</sup>

More peculiar are circumstances that seem almost paradoxical in nature. Most state laws require parental permission for a minor to obtain an aspirin at school. However, in some states, such as California, it is perfectly legal for that

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PEDIATRICS, *Female Genital Mutilation*, 102 PEDIATRICS 153, 155-156 (1998), available at <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;102/1/153.pdf> (warning that performance of female genital mutilation violates principles of nonmaleficence as well as standards of basic human rights). The issue of female circumcision pits the desire of the parents against the duties of the doctors to the care of their patients.

The issue becomes even more controversial when we come to the topic of ambiguous genitalia. Ambiguous genitalia has multiple causes, including congenital adrenal hyperplasia, pseudohermaphroditism, and various chromosomal abnormalities. When a baby is born with ambiguous genitalia it may become difficult to classify the newborn as male or female. The condition is usually not life threatening; however, the question of gender assignment can prove difficult. In earlier times, it was almost always common practice to reassign the baby as a female with the appropriate surgery for that gender reassignment. Currently the decision process is more complex and often involves special teams of specialists, including neonatologists, geneticists, endocrinologists, and psychiatrists or social workers. See Medline Plus Medical Encyclopedia, Ambiguous genitalia, <http://www.nlm.nih.gov/medlineplus/ency/article/003269.htm> (last visited Sept. 21, 2006). Scholars have argued that when possible, such surgeries be delayed until the child is mature enough to participate in the decision-making process. See Laura Hermer, *Paradigms Revised: Intersex Children, Bioethics & the Law*, 11 ANNALS HEALTH L. 195, 198, 213 (2002).

These situations highlight the argument that parental consent and decision-making, while the proper default mechanism, may not always be in the best interest of a child even if done with the best of intentions.

87. See *Niebla v. County of San Diego*, No. 90-56302, 1992 WL 140250, at \*1 (9th Cir. June 23, 1992).

88. *Id.*

89. *Id.*



minor to give his own consent for tongue piercing.<sup>90</sup> Parental consent is not currently required, though a bill pending in the California legislature would require parental presence or notarized consent for a body piercing.<sup>91</sup> Other states, such as Michigan, require written parental consent for any piercing other than the ear.<sup>92</sup> Almost every state, including California, requires parental consent for tattooing of a minor.<sup>93</sup>

### *B. Old Enough to Walk, But Not Old Enough to Run*

Recent research involving MRI scans has indicated that adolescent brain development may not be fully developed until youth reach their early twenties.<sup>94</sup> Higher levels of cognitive development involving reasoning, risk-taking, and impulse control are not fully matured in adolescents as revealed through these studies. This evidence would serve as a scientific basis to deny adolescents autonomy in medical decision-making, but a look at social history and law would contradict this position.

Additional dilemmas exist when health care professionals diagnose conditions that may not correspond to the one first contemplated by the minor or the minor's parents. How do we resolve the situation where a sixteen-year-old comes to the emergency room with her mother for the diagnosis and treatment of a throat complaint? Both adolescent and parent initially believe it is a bacterial throat infection such as strep throat. The ER staff instead diagnoses oral gonorrhea. Should the ER staff inform the parent regarding the diagnosis? Equally problematic is a situation with the reverse diagnostic result. Most states give adolescents the statutory power to consent to the diagnosis and treatment of sexually transmitted disease.<sup>95</sup> What should happen when an adolescent arrives at a clinic for treatment of a presumed oral gonorrhea infection? In these states, a fourteen-year-old has the independent capacity to give consent for the diagnosis

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90. Jim Sanders, *Bill Would Require Parents to OK Child's Body Piercing*, SACRAMENTO BEE, May 12, 2005, at A3, available at <http://www.sacbee.com/content/politics/ca/story/12877469p-13726502c.html>.

91. CAL. PENAL CODE § 652(a) (West Supp. 2006).

92. See MICH. COMP. LAWS ANN. § 333.13102 (West 2001) (prohibiting "tattooing, branding, or body-piercing of minors" without written informed consent of parent or legal guardian).

93. E.g., CAL. PENAL CODE § 653 (West 1999 & Supp. 2006).

94. E.g., Jay N. Giedd et al., *Brain Development During Childhood and Adolescence: A Longitudinal MRI Study*, 2 NATURE NEUROSCI. 861, 861-862 (1999); Elizabeth R. Sowell et al., *In Vivo Evidence for Post-Adolescent Brain Maturation in Frontal and Striatal Regions*, 2 NATURE NEUROSCI. 859, 861 (1999).

95. E.g., ALA. CODE § 22-11A-19 (LexisNexis 1997); ARIZ. REV. STAT. ANN. § 44-132.01 (2003); CAL. FAM. CODE § 6926 (West 2004); DEL. CODE ANN. tit. 13, § 710 (1999); 410 ILL. COMP. STAT. ANN. 210/4 (West 2005); MICH. COMP. LAWS ANN. § 333.5127 (West 2001); OHIO REV. CODE ANN. § 3709.241 (LexisNexis 2005); S.D. CODIFIED LAWS § 34-23-16 (1994); W. VA. CODE ANN. § 16-4-10 (LexisNexis 2001).

and treatment of a venereal disease. The physician diagnoses instead a common strep throat. Must the physician stop all activity and turn the minor away, thereby delaying necessary treatment? Some states resolve this dilemma by granting the adolescent the power to consent upon professing affliction with a transmitted disease.<sup>96</sup>

Consider also a recent Florida case. In West Palm Beach, a thirteen-year-old teenage girl became pregnant while living in a state-run group home.<sup>97</sup> She was on her way with her caseworker to a clinic to undergo an abortion when officials from the Florida Department of Children and Families (DCF) objected to the abortion and filed for an emergency hearing on April 26, 2005. DCF alleged that Florida law prevented the agency from consenting to the procedure. The girl, known only as L.G. because she was a minor, had been in foster care since she was nine years old. Her mother had parental rights terminated due to abuse and neglect. DCF became her legal guardian following the termination of her parents' rights. DCF sought prevention of the abortion on the basis that L.G. was not mature enough for such a decision. After a competency hearing, L.G. was determined to be competent and understood the consequences of her decision. The original judge who had ordered that the abortion be halted now granted her the right to an abortion.<sup>98</sup>

### *C. Adolescent Limbo: Where Do Adolescents Stand Under the 'Bar' of the Law?*

The general age of majority in the United States has shifted downwards from twenty-one to eighteen. The most significant aspect of this manifested with the Twenty-Sixth Amendment, lowering the voting age in 1971.<sup>99</sup> Significant markers of full adulthood remain set at twenty-one (e.g., consuming alcohol), but in most

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96. See, e.g., HAW. REV. STAT. ANN. § 577A-2 (LexisNexis 2005); UTAH CODE ANN. § 26-6-18 (1998).

97. Kathleen Chapman, *Diocese Employee: Deny Judge Communion*, PALM BEACH POST, May 6, 2005, at 1A.

98. *Id.*

99. U.S. CONST. amend. XXVI, § 1. The country wanted to redress the inconsistency of requiring eighteen-, nineteen-, and twenty-year-olds to fight the country's wars, while not permitting them participation in the political process that led to declaring and waging those wars. Two options existed. First, the country could either have raised the age at which young men were drafted or permitted to volunteer for the military. Alternatively, the country could have lowered the voting age to eighteen. It is interesting that we chose the latter option. One wonders what effect raising the age one could join the military to twenty-one would have had on recruiting in an all-volunteer military. Given the change in risk assessment and valuation of long-term consequences that occurs over those years, it is likely that far fewer individuals would opt to join the military. Currently, the significant majority of military recruits are under age twenty-one. In 2003, 70.35% of applicants were aged sixteen to twenty (23% under age eighteen). See DEP'T OF DEF., POPULATION REPRESENTATION IN THE MILITARY SERVICES: FISCAL YEAR 2003, tbl. A-1, available at <http://www.dod.mil/prhome/poprep2003/download/AppendixA.pdf>.

legal contexts, the age of majority is now eighteen years. This is certainly true with respect to matters of health care consent.

### 1. *The Rule of Sevens*

Courts have recognized the varying levels of minor maturity and capacity for well over a century. The 1845 English case of *The Queen v. Smith* laid out the common law rule known as the Rule of Sevens.<sup>100</sup> Under this rule, minors under seven years of age carry an irrebuttable presumption of no capacity (incapable of harmful intent). Minors between the ages of seven and fourteen have a rebuttable presumption of no capacity. Minors from the ages of fourteen to twenty-one have a rebuttable presumption of capacity. Those over twenty-one are presumed to have full capacity.<sup>101</sup>

While the common law has evolved considerably since 1845, the Rule of Sevens retains some of its vitality. As recently as 1996, the Tennessee Court of Appeals cited approvingly to *The Queen v. Smith* and the Rule of Sevens in the case of *Roddy v. Volunteer Medical Clinic*.<sup>102</sup> In *Roddy*, a mother and her sixteen-year-old daughter brought a malpractice suit against the doctor who performed an abortion procedure and the clinic where the medical procedure occurred.<sup>103</sup> The court found, on summary judgment, for the defendants because the plaintiffs failed to show that the daughter, who was sixteen at the time of the procedure and had sought the abortion without the knowledge or consent of her mother, lacked capacity to consent to the medical procedure.<sup>104</sup> The suit contended that the physician and clinic violated the Tennessee Parental Consent for Abortions by Minors Act.<sup>105</sup> The Tennessee Court of Appeals cited to the landmark case of *Cardwell v. Bechtol*,<sup>106</sup> which, relying upon *The Queen v. Smith*, held that mature minors have the capacity to consent in medical cases.<sup>107</sup> The *Roddy* court directly cited *Cardwell* in holding that “recognition that minors achieve varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century,”<sup>108</sup> referring to *The Queen v. Smith*. The court then applied principles of the Rule of Sevens, explaining that “at the time Miss Roddy signed

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100. *The Queen v. Smith*, (1845) 1 Cox C.C. 260 (Crim.).

101. *Id.*

102. *Roddy v. Volunteer Med. Clinic*, 926 S.W.2d 572, 576 (Tenn. Ct. App. 1996) (citing *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn.1987)).

103. *Id.* at 572.

104. *Id.* at 578.

105. TENN. CODE ANN. § 37-10-301 (2005). This act was later found to be unconstitutional as it placed an undue burden upon a minor's ability to seek an abortion. However, this ruling was reversed by the Sixth Circuit. See *Memphis Planned Parenthood v. Sundquist*, 175 F.3d 456 (6th Cir. 1999).

106. 724 S.W.2d 739 (Tenn. 1987).

107. *Roddy*, 926 S.W.2d at 576 (citing *Cardwell*, 724 S.W.2d at 744).

108. *Id.*

the consent to abortion document, she was just one month from her 16th birthday and Appellants failed to rebut the presumption of capacity.”<sup>109</sup>

The *Roddy* case illustrates how rules such as the Rule of Sevens, while seemingly arbitrary, can serve as a guideline for courts when deciding the boundaries of relative minor capacity. However, these rules ought not act as absolute, bright-line demarcations.<sup>110</sup> Adolescent maturity development proceeds

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109. *Id.*

110. Bright line rules have a highly useful function. They give courts a clear way to determine how to decide a particular case. If the person is seventeen years and 364 days old, he does not have capacity. If he is eighteen years and one day old, he does have capacity. Bright line rules give courts simple, easy means to determine results. The ease for the court, however, is not the strongest argument for their use. Courts, with time to assess the relative merits of a situation, may be required to move beyond a simple bright line rule. Arguably, one of the roles of the court should be to determine in which circumstances a bright line rule should be discarded. Otherwise, an administrator could easily replace the court.

The more important function of a bright line rule is to guide parties. Such rules tell parties how they can and cannot behave. It relieves the provider of risk in making a wrong judgment as to the maturity of a given adolescent. Predictability and consistency are the greatest value for bright line rules.

Bright line rules have several real problems, however. A bright line rule is intended to draw a clear line between those who fall above and below the line. This works well when there is a real distinction between those groups. The power of a bright line rule begins to falter when the individuals who fall just above the line are indistinguishable from those who fall just below the line. The error is small or large depending on the width of the gray zone.

Wherever one draws a bright line, there will inevitably be a certain number of individuals who in truth should have fallen on the other side of the line. Epidemiologically, these are known as false positives and false negatives. The greater the number of false positives and false negatives, the less usefulness we have for a given bright line rule. Generally speaking, the more we try to limit false negatives, the more we will increase the false positives. This can be a very good thing. As a society, we are willing to accept a relatively high number of false positives in certain circumstances, such as the initial screening of passengers boarding an airplane. A large number of passengers who are not carrying dangerous metal objects are asked to undergo further screening if any metal appears when passing through. We allow this so as to minimize the false negatives (the few individuals who were carrying knives intent on hijacking the airplane).

Lines must often be drawn somewhere. Ideally, we will draw the line so as to have the highest possible predictive value. This is a particularly hard thing to do with respect to adolescent decision-making capacity. The range of time over which children develop into adults is very wide, spanning over a decade. While we can say with some assurance that adolescents at the ends of the range mostly fall on the correct side of the bright line, the closer we get to the line, the less confidence we have. This is complicated even further in that all aspects of development do not occur at the same time. As discussed through this article, certain aspects of cognitive thought occur early, while others occur later. Each of these has its own range of occurrence. A single bright-line rule of maturity applied to all aspects serves only to magnify the errors.

The proposal I discuss below essentially splits the bright line rule. We have done this already with respect to specific services for specific conditions. We have a general bright line rule at age eighteen. We have another bright-line rule for treatment of sexually transmitted diseases (age fourteen in some states, twelve in California). What I propose is a different division of the bright line rule to better reflect adolescents' actual capabilities. Two bright line rules: one for high risk procedures (kept at age eighteen—though the science tells us it should be closer to twenty-two), one for low risk procedures (lowered to age fourteen or fifteen). This would minimize the error rate with respect to whether the adolescent had the capacity to make a decision of the sort that is in question.

at highly varied rates from individual to individual. Strict demarcations based solely upon chronological age, while highly precise in their results, generate far too many false positives and false negatives. This, of course, begs the question of how courts may determine capacity if it is not based strictly upon age. First, let us examine how the law has sought to affix capacity based upon the living conditions or circumstances of the minor.

## 2. *The Emancipated Minor*

There remain two significant exceptions to the general rule that minors may not legally make medical decisions until they reach the age of majority—in emergencies and for emancipated minors. Most states permit adolescents to consent to needed emergency care without the knowledge of the parent or guardian if there is insufficient time to notify the legal guardians.<sup>111</sup> This exception, however, does little to aid our understanding of when adolescents should or should not be given broader consent capacity. The emergency exception analysis rests primarily on the nature of the service being rendered and not on the actual capacity of the adolescent. The emergency exception functions not as a presumption that adolescents may consent in times of emergency but as a presumption of parental consent.

The emancipated minor statutes provide greater help. Once a minor is deemed emancipated, he or she obtains nearly all the rights and responsibilities as an adult. Circumstances that define an emancipated minor vary from state to state, but most states grant majority rights and obligations if the minor joins the military, marries, lives away from his or her parents and is self-supporting, or becomes a parent.<sup>112</sup> The last condition that allows emancipation of a minor through parenthood is granted in only a few states. Michigan is not one of those states. Some states also include college students and runaways under the umbrella of the emancipated minor.<sup>113</sup> A court can also declare a minor emancipated.

The conditions for emancipation in most of these situations are obtained primarily through free choice. This creates a seeming end-run opportunity in which minors, who could not previously consent to their own medical treatment, may do so by satisfying any of these requirements. The change in circumstances creates the justification for granting health care decision-making privileges, without regards to any changes in the adolescent's actual mental capacity to make these medical decisions.

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111. See, e.g., ARIZ. REV. STAT. ANN. § 44-133 (2003); CAL. BUS. & PROF. CODE § 2397(a)(3) (West 2003); FLA. STAT. ANN. § 743.064(1) (West 2005); NEV. REV. STAT. § 129.040 (LexisNexis 2004); TENN. CODE ANN. § 63-6-222 (2004).

112. COMM. ON PEDIATRIC EMERGENCY MED., AM. ACAD. ON PEDIATRICS, *Consent for Emergency Medical Services for Children and Adolescents*, 111 PEDIATRICS 703, 704 tbl.1 (2003).

113. *Id.*

The right to medical consent based purely upon circumstances would seem to defy common sense practice. The emancipated minor is not granted full majority rights and is still bound by other age-restrictive laws (e.g., smoking, drinking, voting). Many states' laws recognize that adolescents become emancipated for purposes of pregnancy care and may be held accountable and deemed competent to consent to medical treatment during the pregnancy, along with the ability to make medical decisions for the fetus or newborn.<sup>114</sup> Some states permit a minor to consent to any legal medical services simply by becoming pregnant or professing to be pregnant.<sup>115</sup> No state law requires parental consent should a minor want to continue a pregnancy in the face of her parents' belief that pregnancy termination would serve the best interest of their adolescent.<sup>116</sup> The situation where a minor becomes pregnant and suddenly gains a measure of medical autonomy would seem to defy logic and common sense principles. Should the same minor who only a month before becoming pregnant required her parents' consent to obtain a throat swab diagnosing a throat infection suddenly be competent to decide all aspects of her and her fetus's health care?

Several state courts have helped define the scope of the emancipated minor. For example, the Supreme Court of the State of Washington defined the bounds of the emancipated minor doctrine in the case of *Smith v. Seibly*.<sup>117</sup> The court recognized that the emancipation of a minor could occur in the absence of a statute<sup>118</sup> and that "age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents [were] all factors to be considered in such a case."<sup>119</sup> Such a definition by the courts also takes into account the mental capacity (maturity) of the minor in granting emancipation and is a path that seems more reasonable than one that takes into account only the circumstances of the minor.

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114. See, e.g., FLA. STAT. ANN. § 743.065 (West 2005); MINN. STAT. ANN. § 144.343(1) (West 2005); N.Y. PUB. HEALTH LAW §§ 2504 (2), (3) (McKinney 2002); OKLA. STAT. ANN. tit. 63, §§ 2602(A)(1), (3), (4) (West 2004); VA. CODE ANN. §§ 54.1-2969(E)(2), (G) (2005).

115. See, e.g., DEL. CODE ANN. tit. 13, § 710(a) (1999); HAW. REV. STAT. ANN. § 577A-2 (LexisNexis 2005); MONT. CODE ANN. § 41-1-402(2)(c) (2005); 35 PA. STAT. ANN. § 10101 (West 2003).

116. COMM. ON ADOLESCENCE, AM. ACAD. OF PEDIATRICS, *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746, 748 (1996).

117. See 431 P.2d 719, 723 (Wash. 1967). The case involved a man attempting to invalidate his previous consent to a vasectomy when he was age eighteen. The court noted that although the general legal age of consent was twenty-one years of age, at the time he consented he was a married eighteen-year-old with children. *Id.* at 723.

118. *Id.*

119. *Id.*

### 3. *The Mature Minor Doctrine*

Another means of bypassing the general rule wherein minors under eighteen are unable to consent to their own medical care arises through the mature minor doctrine. Mature minors are similar in concept to the emancipated minor. They are adolescents, usually between fourteen and eighteen, who demonstrate a sufficient level of maturity, but who do not satisfy the criteria for being emancipated.

Courts have used the mature minor doctrine for several decades. As early as 1926, a Michigan court held that a nineteen-year-old could consent to using a local anesthetic for tonsil removal.<sup>120</sup> His family sued after he died in the surgery. In 1955, a New York court held that a fourteen-year-old boy could refuse surgery to correct a cleft palate.<sup>121</sup> His parents thought that “mental healing” would work better than surgery. The court found the adolescent to be “mature” and able to decline the surgery. It did qualify its ruling, however, by adding that “his condition is not emergent and there is no serious threat to his health or life.”<sup>122</sup>

Michelle Oberman has suggested that laws determining the health care of minors have been formulated to address society’s views of adolescent health care needs.<sup>123</sup> Oberman speculates that “maturity” acts as a euphemistic “code word.”<sup>124</sup> It permits society to grant minors the ability to make independent medical decisions where it is deemed beneficial.<sup>125</sup> However, where society perceives potentially negative consequences from such decision-making, it denies the adolescent the distinction of “maturity.”<sup>126</sup> Such an arbitrary use of the mature minor doctrine denies any true right of autonomy such minors may believe they have. The following cases help to illustrate this point.

Benny Agrelo was a minor who suffered from an enlarged, malfunctioning liver since birth.<sup>127</sup> By the time he was fifteen in 1994, he had already undergone two liver transplants. The first transplant occurred when he was eight and was rejected after five years when the anti-rejection drug cyclosporin was no longer effective. He underwent a second transplant and took another anti-rejection drug, which had side effects of headaches and irritability that prevented him from

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120. *Bishop v. Shurly*, 211 N.W. 75, 78 (Mich. 1926).

121. *See In re Seiferth*, 127 N.E.2d 820, 822-23 (N.Y. 1955).

122. *Id.* at 822.

123. *See* Michelle Oberman, *Minor Rights and Wrongs*, 24 J.L. MED. & ETHICS 127, 127 (1996).

124. *Id.*

125. *Id.*

126. *Id.*

127. For a full discussion of Benny Agrelo’s situation, see Ann Eileen Driggs, *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?*, 11 HEALTH MATRIX 687, 687-88 (2001); Christine Gorman, *A Sick Boy Says, “Enough,”* TIME, June 27, 1994, at 65; Oberman, *supra* note 123, at 129; Jessica A. Penkower, *The Potential Right of Chronically Ill Adolescents to Refuse Life Saving Medical Treatment—Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165, 1167-68 (1996).

leading a normal life. Benny on his own began to decrease his dosage of the drug until, against the wishes of his mother and doctor, he stopped taking the drug completely. When his doctors discovered this, the hospital filed a petition under Florida's child neglect statute where social workers removed him from his home and placed him in the hospital. There, Benny continued to refuse his medication. Florida law stipulated that a minor had no right to refuse life-saving medication. At the hearing though, Benny was found to be of sufficient maturity to make his own decision to not take his medication and was granted the right to return home where he died a few months later.<sup>128</sup> Benny's case was one of the first that established a minor's right to refuse treatment on his or her own behalf.<sup>129</sup> One important fact to note with Benny is that, in the end, his family supported his decision to discontinue treatment.<sup>130</sup>

Another interesting case is that of sixteen-year-old Billy Best.<sup>131</sup> He was diagnosed with Hodgkin's lymphoma, a type of cancer with a high success rate of cure. Billy underwent two-and-a-half months of chemotherapy before he began to refuse treatments. He complained of the painful chemotherapy and believed he couldn't face four more months of the treatments despite his doctors giving him an 80% chance of recovery should he complete the treatments. Near the end of 1994, Billy ran away from his parents' Massachusetts home. It was not until a month later that he returned. He did this only because his parents in a television interview promised that if he returned home they would not force him to continue his treatments. Ironically, had Billy stayed away another few months and demonstrated that he supported himself, in many states the courts may have declared him an emancipated minor, thereby granting him the ability to refuse care on his own. The twist in this case is that Billy's lymphoma went into remission following alternative treatments.<sup>132</sup>

Cases like Billy's push the limits of the mature minor doctrine in granting minors the right to their own medical treatment. We are left pondering the question of whether minors like Billy should ever be designated as mature minors and allowed to decide their own medical treatment, or should we intervene in such instances where we realize they have made unwise decisions, even in cases where their parents agree with their decision. If only such cases were so easily determined as in situations where a child refuses to eat his or her vegetables and the parents are left with the unenviable task of forcing that child to eat the peas and

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128. One can only speculate on how this case may have evolved today in light of another prominent end-of-life case in Florida, that of Terri Schiavo, eleven years later.

129. Driggs, *supra* note 127, at 687-88 (citing Nancy San Martin, *Defiant Transplant Patient Dies at Home*, SUN-SENTINEL (Ft. Lauderdale, Fla.), Aug. 21, 1994, at 1A).

130. Oberman, *supra* note 123, at 129.

131. Driggs, *supra* note 127, at 688.

132. Christopher B. Daly, *Teenage Cancer Patient Seeks to Return to Normalcy—Chemotherapy Will Not be Part of Treatment*, WASH. POST, Nov. 25, 1994, at A3.



carrots. If the child does enough kicking and screaming, as in the case of Billy, many parents would opt to excuse that child from that task. In matters of life and death with the health of a child, such decisions ought not to be handled so simply.

We come back to Oberman, who believes that the mature minor doctrine was adopted not in the belief that adolescents are mature enough to make their own medical decisions, but out of society's desire to avoid negative consequences that may flow from a minor's "bad" choice.<sup>133</sup>

In 1979, the U.S. Supreme Court held that a blanket state law requiring pregnant minors to obtain parental consent for an abortion was unconstitutional.<sup>134</sup> In *Bellotti v. Baird*, the plaintiff challenged a Massachusetts law regulating minors' access to abortions. The Court held that if the state requires minors to obtain parental consent, it must also provide for an alternative procedure for authorization.<sup>135</sup> Any alternative procedure must allow the minor "to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests."<sup>136</sup> The Court seems to accept the underlying rationale of the mature minor doctrine, though it provides little guidance on how a lower court should determine whether or not a minor was sufficiently mature. It only says that this determination should be on a case-by-case basis.<sup>137</sup>

The mature minor doctrine has much to recommend it. In theory, at least, it permits a sufficiently mature minor to make decisions on his or her own. This is theoretically consistent with what we as a society accept as a fundamental pillar in health care policy: autonomy of the individual. Competent individuals have the absolute right to consent to or refuse health care services.<sup>138</sup> The difficulty faced by minor adolescents is that they are presumed to be incompetent. The mature minor doctrine gives such individuals the opportunity to rebut that presumption. Again, this is entirely consistent with our notions of individuality and autonomy. The problem with the mature minor doctrine is in how it is applied. Courts have spent precious little time trying to define actually what it is to be "mature." There is no good test to determine whether or not an individual minor adolescent has sufficiently rebutted the presumption.

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133. See Oberman, *supra* note 123, at 131 (arguing that the doctrine is limited to the extent that lack of agreement on a course of treatment will default to a denial of minor access to decision-making).

134. *Bellotti v. Baird*, 443 U.S. 622, 643 (1979).

135. *Id.*

136. *Id.* at 643-44.

137. *Id.* at 644 n.23.

138. Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109, 112, 121 n.38 (2000).

In cases where courts employ the mature minor doctrine, the court generally looks to the adolescent's situation and the decision he or she wants to make. The court then determines whether the decision is a good one or not.<sup>139</sup> If the decision is "appropriate," the court deems the minor "mature." It follows that where the court determines the decision "inappropriate," it will deem the minor immature. This is a fundamentally flawed approach. The "correctness" of a decision should not be the overriding determinative factor.

Arguably, competent adults make "bad" decisions every day. Competent adults make decisions they later regret on a regular basis. The ability to make a "correct" decision certainly is one indicator of competency, but it ought not be the sole deciding factor. If it were, we would all be in serious trouble. Adolescents should be allowed to make "bad" choices. This is not only a normal state of adult being; it is an important developmental learning device.<sup>140</sup> The mark of maturity should not rest solely upon the final decision. It should include the process by which the individual reaches that decision. Is he capable of adequately assessing the cost, benefits, risks, and consequences of whatever decision he reaches? Is she capable of recognizing and considering the variety of options available to her? If yes, the minor may be adjudged mature and allowed to make decisions. If no, then she is immature and should not be allowed to make decisions independently.

We will see below from the scientific literature that the adolescent brain continues to develop well into the early twenties.<sup>141</sup> It is the unusual minor adolescent that is fully mature. This should not be construed to mean that adolescents are incapable of any decision-making abilities. They merely lack certain decision-making tools, and so they are less capable of independently assessing risk and long-term consequences. We need to differentiate the types of decisions that carry significant risk or have potentially significant long-term consequences. Those that do not should be open to adolescents; those that do may require more to rebut the presumption of incompetence.

Maturity, however, is a complex phenomenon. Certain aspects of maturity do occur relatively early in adolescents. Abstract thinking develops around puberty.<sup>142</sup> Other aspects, such as long-term consequence analysis and risk assessment, appear to develop much later.<sup>143</sup> This makes it potentially impossible for a court to say "this adolescent is fully mature." Most of the time, a given

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139. See, e.g., Oberman, *supra* note 123, at 129 (reasonably inferring that the judge in Benny Agrelo's case applied the mature minor doctrine).

140. See Paula G. Williams et al., *Adolescent Health Psychology*, 70 J. HEALTH CONSULTING & CLINICAL PSYCHOL. 828 (2002).

141. See *infra* Section III (providing an overview of studies indicating continues brain developed into the twenties).

142. See JEAN PIAGET, *THE ESSENTIAL PIAGET* 434-44 (Howard E. Gruber & J.Jacques Vonèche eds., 2d ed. 1995) (1977).

143. See *infra* Section III.

adolescent is mature with respect to some aspects of development and immature with respect to others. Trying to find a bright line rule is a difficult task when the gray zone of maturity development is so wide.

#### 4. *Adolescents and the Death Penalty*

The U. S. Supreme Court recently decided the case of *Roper v. Simmons*.<sup>144</sup> The case, which dealt with constitutionality of the juvenile death penalty, turned largely on the question of adolescent autonomy and cognitive development. In this case, the American Medical Association (AMA), the American Psychiatric Association (APA), the American Society for Adolescent Psychiatry (ASAP), and others filed amicus briefs asking the Court to consider the scientific and social research, which indicated immature brain development and lowered inhibition in adolescents.<sup>145</sup>

In their amicus brief, the AMA, APA, and ASAP argued against the juvenile death penalty on the basis of research evidence that indicated diminished mental capacity in adolescents in general and even more so in juvenile offenders:

The adolescent's mind works differently from ours. Parents know it. This Court has said it. Legislatures have presumed it for decades or more. And now, new scientific evidence sheds light on the differences. Scientists have documented the differences along several dimensions. Adolescents as a group, even at the age of 16 or 17, are more impulsive than adults. They underestimate risks and overvalue short-term benefits. They are more susceptible to stress, more emotionally volatile, and less capable of controlling their emotions than adults. In short, the average adolescent cannot be expected to act with the same control or foresight as a mature adult.<sup>146</sup>

The research presented in the brief supports the contention that "regions of the adolescent brain do not reach a fully mature state until after the age of 18. These regions are precisely those associated with impulse control, regulation of emotions, risk assessment, and moral reasoning. Critical developmental changes in these regions occur only after late adolescence."<sup>147</sup>

Until *Roper*, the United States had been the only industrialized nation that practiced capital punishment against juveniles. The prior convictions of juveniles as adults suggest that a large portion of the American population believed that juveniles possess the same capacity and sufficient cognitive development to be tried as adults. The majority of the world's leading nations would seem to believe

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144. 543 U.S. 551 (2005).

145. Brief of the Am. Med. Ass'n et al. as Amici Curiae Supporting Respondent, *Roper v. Simmons*, 543 U.S. 551 (2005) (No. 03-633), 2004 WL 1633549, at 10, 16.

146. *Id.* at 2.

147. *Id.* at 2-3.

that juveniles are a protected class who have not developed the mental capacity to realize the consequences of their crimes.<sup>148</sup> The majority in *Roper* based its opinion in part on the scientific evidence indicating juveniles under the age of eighteen lack maturity and have an underdeveloped sense of responsibility.<sup>149</sup> Such an argument may work against advocating for adolescent consent, but the gray area of treating this age bracket between childhood and adulthood indicates a need to develop a policy for medical decisions in this age group.<sup>150</sup>

Prior to *Roper*, the Supreme Court had concluded that minors under sixteen years of age and mentally retarded persons display similar traits of “disabilities in areas of reasoning, judgment, and control of their impulses,”<sup>151</sup> which categorically disqualify them from the death penalty. The Court has concluded that members of these protected groups “do not act with the level of moral culpability that characterizes the most serious adult criminal conduct.”<sup>152</sup> Based on this precedent and rationale, the AMA brief argued strongly that if a categorical disqualification applies to younger adolescents and the mentally retarded, “the same must be true of 16- and 17-year-old offenders.”<sup>153</sup>

“Relative to individuals at other ages, human adolescents as a group exhibit a disproportionate amount of reckless behavior, sensation-seeking and risk-taking.”<sup>154</sup> The behavior stems not from an inability to tell right from wrong as argued in the brief, but arises from “deficiencies in the way adolescents think.”<sup>155</sup> Within the AMA *Roper* brief, the authors mention how adolescents focus on the here and now without consideration of the future effects of their current actions.<sup>156</sup> The three cognitive deficiencies noted within adolescents included responsibility, perspective, and temperance.<sup>157</sup> The differences seen in adolescent versus adult decision-making in risky behavior represent a question of differences in

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148. Brief of European Union & Members of the International Community as Amici Curiae Supporting Respondent, *Roper v. Simmons*, 543 U.S. 551 (2005) (No. 03-633), 2004 WL 1619203, at 1.

149. *Roper*, 543 U.S. at 569-70.

150. Arguably, Justice O'Connor had the better rationale, at least with respect to medical consent. She accepted that adolescents, as a class, are less mature, but that this should not provide an across the board bright line rule against the death penalty's application for some juveniles. See *id.* at 587-89 (O'Connor, J., dissenting). This view is reinforced by the Supreme Court's decision in *Hodgson v. Minnesota*, 497 U.S. 417, 444-45 (1990), and *Ayotte v. Planned Parenthood of New England*, 126 S. Ct. 961, 966 (Jan. 18, 2006) (see discussion *infra*).

151. *Atkins v. Virginia*, 536 U.S. 304, 306, 318 (2002).

152. *Id.* at 306.

153. Brief of the Am. Med. Ass'n et al., *supra* note 145, at 4.

154. L.P. Spear, *The Adolescent Brain and Age-Related Behavioral Manifestations*, 24 NEUROSCI. & BIOBEHAVIORAL REVS. 417, 421 (2000).

155. See Cauffman & Steinberg, *supra* note 84, at 742.

156. Brief of the Am. Med. Ass'n et al., *supra* note 145, at 6.

157. *Id.* at 7.

capabilities and not just priorities.<sup>158</sup> The study by Elizabeth Cauffman and Lawrence Steinberg, composed of more than 1,000 adolescents and adults, found that adolescents do not reliably achieve psychosocial maturity until at least nineteen years of age.<sup>159</sup> The absence of long-term views, lack of perspective, and inability to restrain from aggressive impulses marked this adolescent period. The remainder of the AMA amicus brief follows along the same line of topics as presented in the following research of the brain imaging studies using MRI.

### 5. Parental Notification Statutes

Early this year, the U.S. Supreme Court decided a case involving a challenge to New Hampshire's parental notification statute.<sup>160</sup> The New Hampshire statute required the health care provider to notify the parent of any adolescent seeking an abortion at least forty-eight hours prior to performing the procedure.<sup>161</sup> The bases for the challenge to the statute include a lack of a "health of the mother" exception, limited exceptions for abortions necessary to prevent death, and placement of an undue burden on the adolescent's ability to access care. (The undue burden argument rested on a failure of the statute to ensure confidentiality for a minor seeking judicial bypass. The First Circuit did not reach this issue in its decision. The court described the provision as being in a "grey area," but having already determined the law to be unconstitutional based on the other claims, it did not need to address the undue burden issue.)<sup>162</sup>

The statute's exceptions for the prevention of death are limited to circumstances where there is insufficient time to notify the parent.<sup>163</sup> This time window can be very difficult to determine. It would effectively require the physician to make an effort to notify. How else could she know that there was insufficient time? Also, the statute does not provide for the situation where an abortion is the best, but not the only, medical option available for saving the minor's life. The statute allows the judge to permit an abortion without parental notification if the judge determines that it is in the minor's best interest or if the judge finds that the minor is "mature and capable of giving informed consent to the proposed abortion."<sup>164</sup>

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158. See Cauffman & Steinberg, *supra* note 84, at 743 (discussing the possibility of inherent disabilities in adolescents when faced with choices in potentially antisocial situations).

159. See *id.* at 756 (reporting that the greatest psychosocial development occurs between sixteen and nineteen, and then stabilizes).

160. *Ayotte v. Planned Parenthood of Northern New England*, 126 S. Ct. 961 (Jan. 18, 2006).

161. N.H. REV. STAT. ANN. § 132:25 (LexisNexis Supp. 2005).

162. *Planned Parenthood of Northern New England v. Heed*, 390 F.3d 53, 65 (1st Cir. 2004), *cert. granted sub nom. Ayotte v. Planned Parenthood of Northern New England*, 125B S. Ct. 2294 (2005) (No. 04-1144), *vacated*, 126 S. Ct. 961 (Jan. 18, 2006).

163. N.H. REV. STAT. ANN. § 132:26(I)(a) (LexisNexis Supp. 2005).

164. *Id.* § 132.26 (II).

The First Circuit held that the statute did place constitutionally invalid restrictions upon the adolescent's ability to obtain an abortion.<sup>165</sup> It further held that any parental notification statute must include exceptions for the adolescent's health and a broader definition of what a threat to her life encompassed.<sup>166</sup> In vacating the decision in *Heed*,<sup>167</sup> the Supreme Court reinforced two legal principles. First, the Supreme Court made clear that states have the right to require parental notification in certain circumstances.<sup>168</sup> Second, the Supreme Court reaffirmed its holding in *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992), that states may not restrict access to abortions necessary to preserve the life and health of the mother.<sup>169</sup>

The *Ayotte* case is significant in that the Supreme Court expressly reinforces its rationale as to why minors' rights may be restricted. The Court said, "States unquestionably have the right to require parental involvement when a minor considers terminating her pregnancy, because of their 'strong and legitimate interest in the welfare of (their) young citizens, whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely.'"<sup>170</sup> It follows, therefore, that in circumstances where adolescents are not immature, or inexperienced, or lacking in judgment, their rights ought not to be infringed. For a great many health care decisions, adolescents do not suffer from a degree of immaturity, inexperience, or lack of judgment to render their decisions sufficiently unwise to deprive them of their rights.

#### 6. *What Can We Learn from Private Industry?*

A look at industry practices gives us some insight into how those with a profit motive view the decision-making capacities of adolescents. Industry advertising that targets teenagers takes advantage of the perception that adolescents are less capable than adults in considering long-term consequences. In a released 1981

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165. *Heed*, 390 F.3d at 62, 64, 65.

166. *Id.* at 64-65.

167. While vacating the decision in *Heed*, the Supreme Court agreed with the First Circuit's holding that the statute had violated constitutional principles. However, the Court believed that invalidating the entire statute was unnecessary if invalidating only the offending aspects was feasible. The Court remanded the case to the First Circuit for a determination if a less than total invalidation would satisfy the constitutional concerns. See *Ayotte*, 126 S. Ct. at 969.

168. *Id.* at 966.

169. *Id.* at 967.

170. *Id.* at 966 (quoting *Hodgson v. Minnesota*, 497 U.S. 417, 444-45 (1990)). *Ayotte* is seemingly in contrast with the decision in *Roper*, which asserts that adolescents are always incompetent. However, *Ayotte* appears to reinforce a general principle regarding adolescent status. *Roper* applies that principle in the specific circumstance of adolescents' facing capital punishment and finds that teenagers do, in fact, lack the maturity and judgment necessary to face the death penalty. As noted in footnote 150, I believe that Justice O'Connor's dissent is more in keeping with the rationale in *Hodgson v. Minnesota*, as quoted in *Ayotte*.

document, tobacco industry giant Philip Morris stated, "Today's teenager is tomorrow's potential regular customer, and the overwhelming majority of smokers first begin to smoke while in their teens."<sup>171</sup>

Many ads target teens to appeal to their desires for independence, popularity, and fun. One of the tobacco industry's most popular icons was Joe Camel. This advertising campaign was so popular that among adolescents and even in small children, Joe Camel was as well known as Mickey Mouse.<sup>172</sup> A look at the 1993 statistics from The Maxwell Consumer Report showed that \$43 million was spent on advertising for Camel that year, the second highest among all cigarette brands, yet was only fourth in brand preference among adults.<sup>173</sup> However, Camel was the second in brand preference among adolescents.<sup>174</sup> It would not be a difficult to predict where the tobacco industry would stand on the issue of lowering the age of consent. We know from the tobacco industry and its research that adolescents have a far greater susceptibility to addictive drugs. Their lowered inhibition and willingness to experiment with drugs and tobacco make them ideal targets for the marketing campaigns that solicit them. It is well known that most smokers start, and have a brand preference, before they reach eighteen years of age.<sup>175</sup> The tobacco industry knows that once they get teens addicted to smoking, they have a lifelong customer.<sup>176</sup> The same message and targeted audience that the tobacco industry focuses on is not too far off from that of the alcohol industry.

The automobile insurance industry gives us another insight into industry recognition of adolescent risk-taking. Everyone who has teenage drivers in the home (or who remembers when they were first learning to drive) knows that insurance rates drop dramatically once a driver reaches the age of twenty-five. The insurance industry, whose livelihood depends upon accurate statistics, clearly understands that risk behavior is most prevalent among adolescents. Automobile

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171. Kathiann M. Kowalski, *How Tobacco Ads Target Teens*, CURRENT HEALTH 2, Apr./May 2002, at 6.

172. Paul M. Fischer et al., *Brand Logo Recognition by Children Aged 3 to 6 Years: Mickey Mouse and Old Joe the Camel*, 266 JAMA 3145, 3147 fig.1 (1991).

173. Ctrs. for Disease Control & Prevention, *Comparison of Advertising to Brand Preference in Adolescents and Adults*, 1993, [http://www.cdc.gov/tobacco/research\\_data/advcoadv/brndtbl.htm](http://www.cdc.gov/tobacco/research_data/advcoadv/brndtbl.htm).

174. *Id.*

175. See Kowalski, *supra* note 171, at 6 ("Relatively few people start smoking or switch brands after age 18."); CTRS. FOR DISEASE CONTROL & PREVENTION, *Effect of Ending an Antitobacco Youth Campaign on Adolescent Susceptibility to Cigarette Smoking – Minnesota, 2002-2003*, 53 MORBIDITY & MORTALITY WKLY. REP. 301, 301 (2004), available at <http://www.cdc.gov/mmwr/PDF/wk/mm5314.pdf> ("The majority of persons who become regular cigarette smokers begin smoking during adolescence.").

176. See Kowalski, *supra* note 171, at 8, 9 (noting that tobacco companies attempt to recruit teenagers to be life-long customers).

rental companies either will not rent cars to anyone under age twenty-five, or place added restrictions on those rentals.<sup>177</sup>

Statistics from the National Highway Traffic Safety Administration (NHTSA) show year after year that vehicle crashes are a leading cause of teenage deaths.<sup>178</sup> Teenagers are also the most likely among all age groups not to wear seat belts.<sup>179</sup> In 1996, vehicle accidents accounted for one-third of all deaths in those aged fifteen-twenty.<sup>180</sup> This group makes up only 7% of drivers on the road, yet account for 14% of all traffic deaths.<sup>181</sup>

Industry statistics and practices suggest that it would be imprudent to lower generally the age of consent any further than has already been done. These statistics would bear out a presumption that teenagers are immature and incapable of making decisions without consideration for long-term impacts stemming from their present course of action.

### III. "BRAIN AND BRAIN! WHAT IS BRAIN?" WHAT DOES THE SCIENCE SAY ABOUT ADOLESCENT MATURITY?

Adolescence represents a time of development that is perhaps the most turbulent in a child's life. This stage of development, with its dramatic physical and psychological changes, often creates internal conflicts that make this period such an emotional roller coaster. In order to craft a policy that recognizes this as the gradual process that it is, we need to be careful to grant adolescents as much, but not more, than they are psychologically and physiologically able to accept. We can, and should, look to science to enhance our understanding of adolescent development.

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177. Avis Rent A Car System generally does not rent to any driver under age twenty-five. Avis, Policies & Procedures: Age, [http://www.avis.com/AvisWeb/JSP/global/en/rentersguide/policies/us/US\\_Age.jsp](http://www.avis.com/AvisWeb/JSP/global/en/rentersguide/policies/us/US_Age.jsp) (last visited Sept. 21, 2006). In the limited Avis branches that do rent to those under age twenty-five, surcharges typically are applied. *Id.*

178. See NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS 2000, at 2, available at <http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/TSF2000/2000ovrfacts.pdf> (last visited Sept. 21, 2006) (reporting motor vehicle accidents as the leading cause of death for every age between four and thirty-three in 2000); NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS 2004, at 2 (reporting motor vehicle accidents as the leading cause of death for every age between three and thirty-three years in 2004).

179. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., SAFETY BELT USE IN 2003 – DEMOGRAPHIC CHARACTERISTICS 16, tbl.5 (2004), available at <http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/Rpts/2004/809729.pdf>.

180. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., Saving Teenage Lives, Introduction: The Need for Graduated Driver Licensing I, <http://www.nhtsa.dot.gov/people/injury/newdriver/SaveTeens/sect1.html> (last visited Sept. 21, 2006).

181. *Id.*



*A. The Psychology of the Teen Brain*

Much has already been written concerning the psychology of the adolescent.<sup>182</sup> Jean Piaget, the noted cognitive developmental psychologist, held the view that the most complex of thought processes, formal operations, developed during adolescence.<sup>183</sup> Piaget believed the development of formal operations occurred rapidly between the ages of twelve and sixteen years and is marked by a shift from a young child's transition in thought from the real and present world to the teenage mindset of a future world of possible occurrences.<sup>184</sup> This period marks thoughts of forecasted events or expectations for tomorrow. The teenager contemplates about his or her various future paths and roles in life. Such roles can include choices of following a higher education, marriage, or the prospects of raising a family. The ability to shift their frame of reference to the future allows adolescents at this stage to make long-term plans.<sup>185</sup>

Piaget's cognitive development theories also mark the period of adolescence as a time in which there is a shift from concrete operations typical of a ten-year-old child to the formal operations seen in a fifteen-year-old.<sup>186</sup> Given a problem involving multiple factors, the ten-year-old child working at the concrete operational level will alter more than one factor, making it nearly impossible to deduce a clear conclusion as to which factor made the contribution to the change. This is in contrast to the fifteen-year-old, who would use a more methodical approach, varying one factor at a time in order to determine which factor contributes the most to solving the problem. The methodical approach to problem solving is one factor differentiating the period of adolescence from childhood.<sup>187</sup>

Formal operations separate thought from reality.<sup>188</sup> They involve the consideration of non-real possibilities that can be tested and evaluated for their potential outcomes and consequences. It is a stage where outcomes can be predicted in different situations. With the development of formal operations, adolescents move from inductive reasoning, where a conclusion is reached based upon previous individual experiences, to hypothetical-deductive reasoning, where hypotheses are used to deduce a conclusion. This development in thought process is a hallmark of the transition from childhood to adolescence.<sup>189</sup>

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182. See generally Laurence Steinberg & Elizabeth Cauffman, *Maturity of Judgment in Adolescence: Psychosocial Factors in Adolescent Decision Making*, 20 LAW & HUM. BEHAV. 249 (1996) (examining research conducted on psychosocial maturity and development in adolescents).

183. HELEN BEE, *THE DEVELOPING CHILD* 188 (9th ed. 2000) (1975).

184. *Id.*

185. *Id.*

186. *Id.*

187. See *id.*

188. Peter Sutherland, *The Application of Piagetian and Neo-Piagetian Ideas to Further and Higher Education*, 18 INT'L J. LIFELONG EDUC. 286, 289 (1999).

189. BEE, *supra* note 183, at 188.

Merely possessing the tool of formal operations and abstract thought, however, does not necessarily mean that the adolescent is yet competent to use that tool well. Other psychological and developmental studies have indicated that adolescents, though capable of good hypothetical-deductive reasoning, often do not utilize those skills. In their 2001 study, Bonnie Halpern-Felsher and Elizabeth Cauffman demonstrated that adolescents were far less likely than adults to consider risks and long-term consequences when making decisions in a series of hypothetical scenarios.<sup>190</sup> The statistical data on adolescent risk behavior bears out this research in the real world.<sup>191</sup>

Adolescents, it seems, have many of the basic tools for adult-type decision-making. The remaining question is why they do not utilize those tools in an adult-like manner. Recent studies of physical brain development may give us an answer.

### *B. The Adolescent Brain: Site Still Under Construction*

As recently as a decade ago, most neuroscientists believed that by twelve years of age, the brain had already reached its final adult structural maturity.<sup>192</sup> In terms of sheer mass, the brain attains 90-95% of its adult size by the time a child reaches six years of age.<sup>193</sup> Even several decades ago, however, neuroscientists recognized that mass alone did not give the full story. Most lay people are aware that the brain is divided into gray matter and white matter. The gray matter primarily consists of the actual brain cells, while white matter consists of the connections among the cells and other support structures.<sup>194</sup>

While the total brain mass does not increase significantly after age six, the gray matter continues to thicken and increase throughout the remainder of childhood, particularly in the regions responsible for higher order thinking and reasoning. This thickening peaks roughly at the age of eleven or twelve, shortly before the onset of puberty. A thinning of the gray matter then follows as the brain reorganizes itself into its final form.<sup>195</sup>

Essentially two powerful processes occur during brain development. During the first process, the brain vastly overproduces. Once the overproduction is complete, the brain begins a process of pruning or culling. Neuroscientists have long been aware of this two-phase process with respect to the number of brain cells. Late in gestation, the fetal brain generates massive numbers of brain cells. This process continues into the first several months after birth. Before the age of

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190. Bonnie L. Halpern-Felsher & Elizabeth Cauffman, *Costs and Benefits of a Decision: Decision-Making Competence in Adolescents and Adults*, 22 J. APPLIED DEVELOPMENTAL PSYCHOL. 257 (2001).

191. See *supra* notes 41-63 and accompanying text.

192. Claudia Wallis et al., *What Makes Teens Tick*, TIME, May 10, 2004, at 56.

193. *Id.*

194. See Nat'l Inst. of Mental Health, *supra* note 41, at 1.

195. Giedd et al., *supra* note 94, at 861-62.

two years, however, the explosive proliferation of brain cells completely reverses course. Over the next few years of life, there is a competitive elimination of brain cells. In the end, only a minority of cells survive. This process leaves behind a reorganized brain with more efficient and improved neural pathways. Recognition of this rapid brain reorganization during the first few years of life has led to a significant commerce in baby stimulation and education aids.

Until recently, most neuroscientists believed that this dual process of overgrowth and culling occurred only during the late fetal through toddler aged period of life. Recent studies at the NIH and at UCLA have discounted that belief.<sup>196</sup> Researchers have utilized longitudinal MRI studies of children, taking brain scans every two years in the subjects' lives. These studies have demonstrated that the brain undergoes a second dramatic wave of overproduction, particularly in the frontal cortex, just prior to puberty. Then throughout adolescence, the brain prunes back the overgrowth until the final mature adult emerges in the early twenties.<sup>197</sup>

The second wave of growth and culling operates differently from the first, however. In the period prior to age three, much of the growth and culling involves the number of brain cells. The second wave during adolescence involves the number of connections among brain cells. Brain cells interact with each other through finger-like cell extensions called dendrites. Adolescent brain development primarily consists of growth and pruning of the dendritic connections.<sup>198</sup> Along with the reorganization of brain cell interconnections, the adolescent brain significantly increases the myelination of the dendrites as well. The presence of myelin sheaths indicates mature, efficient connections between cells. Increased myelin sheaths improve the speed and efficiency of electro-chemical transmission, much like insulation in electric wiring. MRI studies comparing myelination between twelve- to sixteen-year old adolescents and twenty-three- to thirty-year old adults demonstrated a significant increase in the presence of myelin over those years.<sup>199</sup> Researchers saw the greatest difference in the frontal lobes.<sup>200</sup> Other

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196. *Id.* at 861; Sowell et al., *supra* note 94, at 859, 861.

197. *See* Giedd et al., *supra* note 94, at 861-63 (reporting increased gray matter production during pre-adolescence, followed by a decline in post-adolescence); Sowell et al., *supra* note 94, at 860 (reporting reduction of gray matter between adolescence and adulthood).

198. *See* Giedd et al., *supra* note 94, at 863; Sowell et al., *supra* note 94, at 860.

199. *See* Elizabeth R. Sowell et al., *Mapping Continued Brain Growth and Gray Matter Density Reduction in Dorsal Frontal Cortex: Inverse Relationships During Postadolescent Brain Maturation*, 21 J. NEUROSCI. 8819, 8826 (2001) (discussing the dramatic increase in local gray matter density in the frontal lobes between adolescence and adulthood, and suggesting that this may indicate increased myelination).

200. *Id.* at 8821 (2001).

regions of the brain, such as the parietal and temporal lobes,<sup>201</sup> had largely matured by mid-adolescence.<sup>202</sup>

In addition to the frontal cortex, the cerebellum also shows ongoing development throughout adolescence. Jay Giedd (and others) have discovered that the cerebellum does not reach maturity until well into the early twenties.<sup>203</sup> Neuroscientists once thought that the cerebellum functions primarily to coordinate motor activity. A well-tuned cerebellum can be associated with an athlete or dancer. However, recent studies indicate that the cerebellum also provides critical coordination of cognitive thought as well.<sup>204</sup> It appears that the cerebellum coordinates both mental as well as physical adeptness. The importance of the cerebellum lies in its usage to solve more complex problems or situations. Any skill that requires high thought (such as mathematical, musical, philosophical, and decision-making) utilizes the cerebellum.<sup>205</sup>

It also appears that cerebellum development is more influenced by environmental factors than genetic ones. Twin studies have found a weak genetic link. Brain scans of identical twins showed that their cerebellums were no more alike than those of non-identical twins.<sup>206</sup> The significance of this finding should not be underestimated and has a potentially significant effect on the nature of the legal response to the question of adolescent consent. Giedd's studies demonstrate a growth and culling of dendritic connections in the pre-frontal cortex during adolescence. The important, and not fully answered, question at this point is how does the brain know which connections to reinforce and which connections to cull. Certainly in other areas of neurological development the age-old saying of "use it or lose it" applies.<sup>207</sup> It stands to reason that similar processes are in place during the development of the adolescent brain. The skills and activity that an adolescent decides to take on at this time will form the final mental mold that he or she will occupy in adult life. This suggests that the law ought to foster a system that

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201. The parietal and temporal regions of the brain are primarily responsible for special, sensory, auditory, and language development. Their maturation in early adolescence may help explain the timing for various skills development. For example, individuals tend to have difficulty learning foreign languages after early adolescence.

202. Sowell, *supra* note 194, at 860.

203. Interview by PBS with Jay Giedd, M.D., Neuroscientist, Nat'l Inst. of Mental Health 5, <http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html> (last visited Sept. 21, 2006).

204. *Id.*

205. *Id.* at 6.

206. *Id.* at 5.

207. *Id.* For example, proper development of the visual cortex follows certain critical periods. If the visual cortex does not receive visual signals during this period, that part of the brain does not properly develop and the corresponding eye becomes functionally blind. See Nicoletta Berardi et al., *Critical Periods During Sensory Development*, 10 CURRENT OPINION IN NEUROBIOLOGY 138, 138 (2000).

encourages adolescents to develop their own critical reasoning and risk assessment skills during this critical phase of brain development.

A study on adolescent brains by the team of Deborah Yurgelun-Todd at Harvard's McLean Hospital has also revealed the role of the amygdala, contained within the medial temporal lobe of the brain, in emotional processing in teens.<sup>208</sup> The research team utilized functional MRI (fMRI) to uncover differences in teenage versus adult identification of emotions. The subjects were shown images of facial expressions and asked to identify the emotion displayed, during which their brain activities were scanned. The adult subjects were able to identify correctly the emotion of fear nearly every time, but only half the teens correctly identified the emotion. Instead, the teens typically responded by saying they saw shock, confusion, or sadness. The surprising results of the study showed that the teens that performed poorly on this task had activated the amygdala, a brain region responsible for fear and other "gut" reactions, rather than the frontal lobe. Conversely, adults used their frontal lobe, the reasoning part of the brain, in order to correctly identify the facial feature.<sup>209</sup>

This study showed teenagers relied more on the emotional regions of their brain. Reactions, versus rational thought, are derived from the amygdala, which resides deep in the brain. Yurgelun-Todd and other neuroscientists believe that an immature brain leads to impulsivity, or what some researchers label as risk-taking behavior.<sup>210</sup> The implications of this are enormous for teens where such behavior is ubiquitous. This reliance on an emotional versus a rational response can often lead to misjudgments and mistakes in decision-making. These impulsive decisions characterize the irrational behavior of teens. The teenage brain responds differently to its external environment than do adult brains. The difference in the responses between teens and adults to the same visual cues shows the lack of inhibition to an internal emotional response within teenagers.<sup>211</sup>

Taken together, the work of Giedd and Yurgelun-Todd demonstrate the importance of the frontal lobe in adolescent development and decision-making. The frontal lobe contains the prefrontal cortex, which is associated with numerous cognitive abilities, including decision-making, risk assessment, and the ability to judge future consequences. The frontal lobe moderates neural signals from the amygdala, an indication that both regions are highly linked to one another. An

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208. See Abigail A. Baird et al., *Functional Magnetic Resonance Imaging of Facial Affect Recognition in Children and Adolescents*, 38 J. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 195, 198 (1999).

209. See Nat'l Inst. of Mental Health, *Teenage Brain: A Work in Progress*, available at <http://www.nimh.nih.gov/publicat/teenbrain.cfm> (last visited Sept. 21, 2006), at 2.

210. See Interview by PBS with Deborah Yurgelun-Todd, Director of Neuropsychology and Cognitive Neuroimaging, McLean Hospital, <http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/todd.html> (last visited Sept. 21 2006).

211. See Baird, *supra* note 208, at 198.

undeveloped frontal lobe in a teenager holds less control over the amygdala and has reduced influence over behavior and emotions than a fully developed frontal lobe of an adult. As the teenage brain progresses into adulthood, the focus of brain activity gradually relocates to the frontal lobes, and with that transition adolescents gain a greater ability to make reasoned decisions.

The implications of neural research into adolescent brain development have potentially far-reaching consequences, as seen in the recent Supreme Court ruling on the juvenile death sentence, *Roper v. Simmons* (2005).<sup>212</sup> A year before the Court's ruling barring the death penalty for minors, the American Bar Association made a statement based upon current neural research urging all state legislatures to ban the juvenile death penalty because "for social and biological reasons, teens have increased difficulty making mature decisions and understanding the consequences of their actions."<sup>213</sup> Melvin Lewis, a child psychiatry and pediatric expert at Yale University School of Medicine, describes adolescents' emotional states as "really both part child and part adult."<sup>214</sup> Adolescence is a process through which individuals mature from the childlike state into the adult state. The behaviors associated with this process include self-absorption, mood-swings, unique dress, and escapism that can include video games, music, talking on the phone, as well as risky behavior such as drugs or sex.<sup>215</sup>

Dr. Ruben Gur, the director of the University of Pennsylvania Medical Center, states, "The evidence now is strong that the brain does not cease to mature until the early twenties in those relevant parts that govern impulsivity, judgment, planning for the future, foresight of consequences, and other characteristics that make people morally culpable . . . ."<sup>216</sup> Such statements and the research that supports them would seem to be contradictory to commonly held beliefs that neural development had mostly peaked or leveled off in early childhood even before the onset of puberty. As shown by the evidence, this is simply not the case.

Prior to the brain imaging studies by Giedd and his collaborators, the belief among scientists was that the brain was a finished product by the age of twelve, the point at which it has reached its full size.<sup>217</sup> Coincidentally, this apparently final stage of physiological development matched with the psychological literature traced back to Swiss psychologist Jean Piaget, who theorized that the highest level

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212. 543 U.S. 551 (2005); see discussion *supra* section II.C.4.

213. Wallis, *supra* note 192.

214. *Adolescence, Brain Development and Legal Culpability*, CRUEL & UNUSUAL PUNISHMENT: THE JUVENILE DEATH PENALTY (ABA/Juvenile Justice Ctr., Washington, D.C.), Jan. 2004, at 2, available at <http://www.abanet.org/crimjust/juvjus/Adolescence.pdf>.

215. *Id.* at 3.

216. *Id.*

217. See Shannon Brownlee et al., *Inside the Teen Brain*, U.S. NEWS & WORLD REP., Aug. 9, 1999, at 44.

of cognitive development—formal operations—was attained starting at the age of twelve.<sup>218</sup>

The significant reorganization of the brain during the adolescent years comes as no surprise to many adults, especially those with teenagers. Since before the developmental stage of adolescence was first recognized, all parents have known that “adolescents as a group exhibit a disproportionate amount of reckless behavior, sensation seeking and risk taking.”<sup>219</sup> The contributions these studies make is a better understanding of why adolescents behave the way they do. Their behavior stems from “deficiencies in the way adolescents think.”<sup>220</sup> The frontal lobe forms the most complex thinking and reasoning areas of the brain and is the region that undergoes some of the most important changes in adolescence. The teenage brain at this stage is undergoing construction and may be incapable of adult levels of organizational skills or rational decision-making. This helps explain the poor choices and irrational behavior that characterize the turbulent years of adolescence.

#### IV. OTHER RECENT PROPOSALS

While there have been a number of calls to expand adolescent consent capacity over the past few years, such calls are not new. Adele Hofmann, an early expert in adolescent medicine, called for a rational approach to adolescent consent and confidentiality twenty-five years ago.<sup>221</sup> There has not been significant progress in the last quarter century.

In recent years, several scholars have written on the issue of adolescent capacity in the health care setting. The general inclination has been to expand the scope of adolescent consent. This general predilection has a strong appeal. Each of the proposals to date has aspects that I find appealing. However, they fail to account for much of the recent science concerning adolescent brain development.

Andrew Newman, a physician and lawyer in private practice, makes a strong argument in favor of reducing the age of medical consent to sixteen years.<sup>222</sup> Newman’s proposal has the significant benefit of simplicity. It would free courts and health care providers from having to determine whether a particular minor has met the requirements of maturity. Newman supports his position by pointing to incongruities in the rules of adolescent medical decision-making. He questions

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218. Wallis, *supra* note 192.

219. Spear, *supra* note 154, at 421.

220. Cauffman & Steinberg, *supra* note 84, at 742.

221. Adele D. Hofmann, *A Rational Policy Toward Consent and Confidentiality in Adolescent Health Care*, 1 J. ADOLESCENT HEALTH CARE 9, 9 (1980) (proposing an approach based on “contemporary adolescent cognitive and psychosocial developmental principles”).

222. Andrew Newman, *Adolescent Consent to Routine Medical and Surgical Treatment*, 22 J. LEGAL MED. 501, 531-32 (2001).

how a minor suddenly becomes competent simply by virtue of emancipation.<sup>223</sup> One must wonder how a pair of seventeen-year-olds, who need their parents' permission to get married, become infused with decisional competency at the moment the minister says, "I now pronounce you husband and wife." Newman is also dubious of the ability of a judge, who has little or no training in medicine or psychology, to appropriately determine that a fourteen-year-old child is a mature minor capable of making his or her own medical decisions.<sup>224</sup> We can add to Newman's list of incongruities by including all the factors that establish emancipation of a minor. Why should joining the military at seventeen years old, which requires parental consent, bestow competency on the adolescent? Why should (in some states) giving birth to a baby at fifteen years of age create competency that didn't exist the week before delivery?

On first reading, Newman's argument is somewhat compelling. There is little logical consistency in accepting as competent an adolescent whose parents permit him to join the military, but denying as competent the similar adolescent whose parents do not permit him to join the military.<sup>225</sup> Bright-line rules are simple and easy to enforce. Bright-line rules do have some detractors, however. As discussed above, whenever one tries to draw a line through a zone of gray, there will inevitably be a number of false positives and false negatives.<sup>226</sup> Ideally, when determining where to draw the bright line, one would try to set the line so as to minimize the number of false positives and false negatives. The problem, therefore, is how to determine where to draw the line. This difficulty is made all the more problematic by the wider the gray zone of uncertainty.

Newman argues for reducing the age of consent for routine medical and surgical treatments. However, his argument concludes with the logical assertion that "in the absence of any scientific studies showing that a 16-year-old has less judgment than an 18-year-old (or older), the general consensus on a 16-year-old having sufficient competency should carry the day."<sup>227</sup> Unfortunately for Newman's argument, we now have scientific studies that demonstrate that sixteen-

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223. *See id.* at 504-06.

224. *See id.* at 506-07.

225. One could argue that in this circumstance, we are deferring to the parents' judgment as to the adolescent's decisional capacity. Parents who believe their child is competent would not stand in the way of his or her joining the military, while parents who believe that their child is not yet competent would not give their permission. This argument, however, carries two assumptions of dubious validity. First, it assumes that parents only assess the adolescent's decisional capacity when they determine whether to permit their child to join the military. Second, it assumes that parents are actually capable of making that determination. While the second assumption may actually be true in many, or even most, circumstances, the first assumption is less likely to be correct.

226. Under a sixteen-year-old rule, false positives would include those adolescents that are deemed competent at this age who, in fact, had not yet reached true decisional capacity. False negatives would include the fifteen-year-old who, in fact, had reached true decisional capacity.

227. Newman, *supra* note 222, at 531.



year-olds are less competent than eighteen-year-olds. The scientific evidence further indicates that eighteen-year-olds have less competency than twenty-three-year-olds. This may argue more for elevating, rather than reducing, the age of general capacity.

Newman notes that the current law assumes a minor is not competent and forces the minor to prove maturity. He asks why not assume the reverse and instead require proof that the minor is incompetent to deny medical consent for that adolescent. He proposes that the legal age of consent for routine and standard medical and surgical procedures be lowered to sixteen across all fifty states, with no further adult consent required.<sup>228</sup> He defines routine medical and surgical procedures (including all elective surgery except those that are life-threatening and require immediate surgery), which do not include STDs, abortions, psychiatric treatment, contraceptive issues, or life-threatening diseases and conditions.<sup>229</sup> The problem with this proposal, besides its simple cutoff of sixteen, is that it excludes so many procedures for which teenagers would seek medical treatment. Teenagers who would seek care for STDs and for contraception would likely wish to keep the knowledge of such medical care from their parents.

Newman points out that the age of eighteen for medical consent has never been a marker set in stone. He cites the Twenty-Sixth Amendment, which lowered the voting age from twenty-one to eighteen, as evidence of societal flexibility to notions of adulthood. Many of our age restrictions are set upon an arbitrary basis such that lowering the age of medical consent to sixteen would not be such a revolutionary idea.<sup>230</sup>

To be fair, however, Newman argues only for lowering the age of competency to sixteen for routine medical and surgical care (including elective surgeries). But he does not adequately define what is or is not “routine” care. He would include in the definition of routine any “medical and surgical procedures that, by custom, physicians consider generally non-life-threatening.”<sup>231</sup> But would excluding services related to sexual matters and end-of-life decisions be considered non-life threatening?<sup>232</sup> His apparent rationale for these carve outs is the social/political connotations of these services. Such exceptions, of course, create their own incongruities. Nonetheless, Newman’s proposal still carries some

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228. *Id.* at 527.

229. *Id.* at 508 n.57.

230. Newman asserts that some states, such as South Carolina, Kansas, and Rhode Island, have already set medical consent at age sixteen. This is correct only up to a point. South Carolina does grant minors over age sixteen the right to consent for non-surgical health care. S.C. CODE ANN. § 20-7-280 (1996). However, the Kansas statute referenced refers to a pregnant minor seeking pregnancy-related care. KAN STAT. ANN. § 38-123 (2000). Rhode Island permits minors over sixteen to consent to “routine *emergency* medical or surgical care.” R.I. GEN. LAWS § 23-4.6-1 (1996) (emphasis added).

231. Newman, *supra* note 222, at 502 n.6.

232. *See id.* at 502 n.6, 528 n.219.

persuasive force. Given further context, a bright-line sixteen-year-old rule has a place in a more comprehensive approach to adolescent decision-making capacity.

Elizabeth S. Scott in her 1992 article, *Judgment and Reasoning in Adolescent Decision-making*, raises the issue of bright line rules versus determination of competency on an individual basis.<sup>233</sup> She understands that case-by-case determination of the maturity of a minor can be a costly proposition and can be tainted with the inherent prejudices of the decision-maker. Scott states that “although bright line rules concededly will result in error in individual cases . . . it is not clear that individualized inquiries will greatly enhance accuracy.”<sup>234</sup>

Michelle Oberman also discusses bright-line rules in her work, *Minor Rights and Wrongs*, which describes their simplicity.<sup>235</sup> She cites research indicating that minors between the ages of twelve and fourteen “undergo a major shift in cognitive functioning that enables them to reason abstractly, as well as to consider cause and effect relationships.”<sup>236</sup> The subjective nature of determining the mature minor can lead to more erroneous decisions than that of the objective bright-line rules. Oberman also notes the personal bias of the decision-maker in determining whether the minor’s decision meets with the approval of the health care provider or judge.<sup>237</sup> Bright-line rules fail to recognize that the mature minor doctrines and the emancipated minor statutes were instituted to compensate for the deficiencies in bright-line chronological rules before these exceptions were adopted. Bright-line rules still leave far too many “mature, but underage” adolescents, and too many “immature, but above age” adolescents. Oberman herself states, “[I]ronically, the flaw with any bright-line standard is its imprecision. In health care, the stakes are so high that the efficiency-related benefits of chronological markers are far outweighed by their arbitrary and potentially cruel results.”<sup>238</sup> Were it as easy to just give an adolescent a standardized test to determine his or her competency, there would not even be a need for this discussion.

Elizabeth Cauffman and Lawrence Steinberg, who researched and wrote on the issue of adolescent decision-making, are not content with guidelines that emphasize only cognitive aspects in comparing adolescents to adults.<sup>239</sup> Instead, they advocate maturity of judgment and see differences in decision-making between adolescents and adults arising from psychosocial, non-cognitive factors such as responsibility, perspective, and temperance.<sup>240</sup> They stress that there is a

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233. Elizabeth S. Scott, *Judgment and Reasoning in Adolescent Decisionmaking*, 37 VILL. L. REV. 1607, 1610 (1992).

234. *Id.* at 1668.

235. Oberman, *supra* note 123, at 132.

236. *Id.*

237. *Id.* at 134.

238. *Id.* at 133.

239. See Cauffman & Steinberg, *supra* note 84, at 744-45.

240. *Id.* at 745.

lack of research proving a link between decision-making and psychosocial variables.<sup>241</sup> Their research had adults and adolescents complete assessments of their psychosocial maturity in the three areas previously mentioned. Following this, the participants were asked questions on hypothetical situations that tested their decision-making abilities on antisocial or risky behavior. The adolescents scored much worse on average than the adults, but the adolescents had much greater variability among scores than the adults.<sup>242</sup> This would support the argument that some teens possess high decision-making capabilities while others are on the low end in their decision-making skills.

Another author, Martin Harvey, advocates for a sliding scale of adolescent competency.<sup>243</sup> His proposal would give adolescents an increasing ability to refuse a given treatment depending on the therapeutic benefit of the medical treatment in question.<sup>244</sup> Thus, if a particular therapy had a high potential benefit to the adolescent, he would not allow the adolescent to refuse the treatment. Conversely, if the therapy had little potential benefit, he would allow the adolescent to decline the service. Harvey's proposal has some appeal. However, he focuses his discussion on the ability of an adolescent to refuse unwanted health care. He does not fully consider how his proposal would play out when a teenager seeks health care. More significantly, Harvey's proposal effectively eliminates the adolescent from the equation. An adolescent's actual capacity to make decisions does not figure into the analysis. Only the relative therapeutic benefit of the health care service in question matters. Removing the adolescent from the equation leaves an unsatisfying result.

Harvey's proposal may seem like an answer that provides a logical solution to the problem of adolescent consent, but a closer examination reveals that it has the same limitations as that of the mature minor doctrine. In the mature minor doctrine, the decision in determining the capacity of a minor is left to the health care worker and judge and, as previously alluded to by Oberman, such decisions can be tainted with the prejudices or personal bias of the decision maker without regard to the actual capacity and maturity of the minor. Harvey's sliding scale simplifies the process and eliminates the need for intervention by adult decision-makers, but takes the adolescent entirely out of the process. At least in front of a judge, the minor can attempt to make a case by proving his or her mental capacity and maturity, whereas no such avenue of recourse is available to the minor in Harvey's sliding scale proposal. Harvey's sliding scale concept may have

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241. *Id.*

242. *See id.* at 756-57.

243. Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 298 (2003).

244. *Id.* at 313.

produced a favorable outcome in the case of the teen who rejected the treatment for his highly curable illness. But it can also produce unfavorable results.

In the case of fifteen-year-old Benny Agrelo, who displayed a high level of maturity and capacity, yet refused to take his immunosuppressant drugs to prevent organ rejection, the Harvey scale would have taken that decision out of this adolescent's hands and forced him to continue his treatment even though there was only a slight chance that he would have survived for more than a few years.

Rhonda Gay Hartman is one author who addresses the issue confronted in the Benny Agrelo case. In her article *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*,<sup>245</sup> Hartman notes that denial of legal autonomy in making important decisions in life stems from adolescents' lack of life experiences and exposure to (adversity) obstacles in life that would challenge and teach them the consequences of their decisions.<sup>246</sup> The presumption here is that experience is a good teacher and the absence of such life experiences limits the decision-making ability of adolescents. For most of us, exposure to adversities and obstacles in life normally make us wiser in our choices and decisions. For some adults, however, even in some with many years of experience, numerous exposures to life challenges can still fail to impart wise decision-making abilities.

Hartman also stresses that the lack of studies on the decision-making capacity of adolescents exacerbates the problem of the absence of policies on adolescent capacity.<sup>247</sup> It is this absence in understanding adolescent capacity that creates paradoxes in policies that are obviously contradictions of one another, such as allowing death sentences for minors who commit murder while disallowing minors diagnosed with a terminal illness from declining medical treatment to prolong their existence. In states where legislation exists that control the treatment of medical care for adolescents in non-emergency cases, such as substance abuse and STDs, Hartman urges a change in the lengthy legal process where a judge must determine the maturity of a minor before granting that minor the status of mature or allowing health care providers legal authority to treat that minor.

Hartman argues against the presumption of incapacity within adolescents despite the century-old laws that are in place. She states that there is little evidence to support this position,<sup>248</sup> but recent research involving brain studies of adolescents has indicated that adolescent brains are not physically—and thus cognitively—mature in certain areas until their early twenties.<sup>249</sup> Hartman backs up her stance by referencing cognitive development studies that support the

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245. Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J. L. & MED. 409 (2002).

246. *Id.* at 410.

247. *Id.*

248. *Id.* at 411.

249. *See supra* Section III.

capacity of adolescents in decision-making, which appear at odds with the findings from the brain imaging studies and research into adolescent decision-making.

She raises the issue of *parens patriae* in forming the philosophy that governs legislation which assumes adolescent incapacity. The doctrine of *parens patriae* takes a preventative stance in guarding the interests of minors. Hartman believes that the stance of creating a protective bubble around adolescents hinders the development of their responsible decision-making abilities.<sup>250</sup> Her position is that it is to the benefit of society to develop mature adolescents with the capacity to make decisions independently. The argument of *parens patriae* can be placed in an analogy of those adolescents who live constantly under the protective roofs of their parents' homes even into young adulthood. Many will never fully develop and mature in both the mental and social sense because those adolescents will always lack the independent-mindedness that will allow them to think and decide for themselves the course of action that serves their best interests.<sup>251</sup>

Hartman calls for scientific research to help inform us in developing policies involving adolescent medical decision-making. She acknowledges the disparity in the guiding philosophy between scientific research and legal policy. Science invites change and reversal of previously held beliefs based upon new findings, while law stands on a foundation of precedents that discourages reversal of tradition. She believes each should be a guiding force for the other. With the new research results from the study of adolescent brains, policies on adolescent medical consent should also change accordingly.

In her very well-written article, Jennifer Rosato argues in favor of extending as much decision-making authority to adolescents as they are capable of handling.<sup>252</sup> She wishes to foster adolescent development by providing them the opportunity to make independent decisions.<sup>253</sup> However, she recognizes that this must be balanced against the need to protect adolescents from unwise decisions.<sup>254</sup> She would differentiate in part based on the sort of medical decision-making involved. On the whole, her approach of expanding decisional capacity where possible is appealing, especially for those of us who come into the discussion

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250. See Hartman, *supra* note 245, at 411.

251. The case of Terry Schiavo also comes to mind here. Despite the wishes she expressed before her condition, that she not be kept on long-term life saving measures, her parents insisted that such measures be instituted. We only find out after her death through an autopsy that her brain had atrophied to a state where she could not possibly have been aware of those around her. This is the illusion of the physical state versus that of the invisible and indeterminable mental state. Only through medical devices and scans would it be possible to determine the mental state of a patient. Scientific research and studies can aid us in determining the mental capacity of patients who are incapacitated and unable to decide by themselves, just as it can also help us understand the mental capacity of adolescents.

252. Jennifer L. Rosato, *Let's Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decision-Making*, 51 DEPAUL L. REV. 769, 770-71 (2002).

253. *Id.* at 791-92.

254. *Id.* at 794.

predisposed to encourage adolescent development. However, she does not give sufficient consideration to the realities of adolescent brain immaturity. Adolescent brain development places real limits on what teenagers should be allowed to do. We need to incorporate our understanding of the adolescent brain into our approach to granting expanded decisional capacity.

#### V. WALKING THE TIGHTROPE OF ADOLESCENT CONSENT: FINDING THE BALANCE BETWEEN CHILDHOOD AND ADULTHOOD

As we have just seen, numerous scholars and practitioners have proposed policies and solutions on the question of adolescent capacity. There lies a general consensus that adolescents are caught in that intermediate and turbulent state between childhood and adulthood. This transitional period is often marked by moments of indiscretion and careless neglect or disregard for the future consequences of these immediate actions. Such is borne out the expression of the “wild and carefree” days of youth. As one prominent politician is reported to have said, “When I was young and irresponsible, I was young and irresponsible.”<sup>255</sup>

The dilemma of adolescence is that the average teenager on one day acts more like an adult, on another day acts more like a child, and on that all too often third day acts like something from outer space. Advocates for the expansion of adolescents’ rights focus primarily on the first day. Opponents of expanding adolescents’ rights focus primarily on the second day. (Advertisers seem to notice that third day.) Neither side is fully correct or always wrong. We should give adolescents more rights and responsibilities, but only up to a point.

Adolescents should be granted the independence and autonomy that they are capable of exercising. At the same time, they need to be protected from their own improvidence. I propose that adolescents be granted a presumption of capacity for all routine, low-risk health care procedures that do not involve potential adverse long-term consequences. For high-risk medical procedures, or procedures with potentially adverse long-term consequences, adolescents should carry a rebuttable presumption of no decisional capacity.

The advantage of such a system is obvious. Our understanding of the adolescent mind has expanded greatly over the past few years. We are in a position now to align more accurately adolescents’ decision-making rights with adolescents’ actual decision-making capabilities. We have seen that adolescents are capable of rational thought, but they tend to inadequately assess risk and long term consequences.

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255. See BBC News: George W. Bush: Out of His Father’s Shadow, [http://news.bbc.co.uk/1/hi/in\\_depth/americas/2000/us\\_elections/profiles/576504.stm](http://news.bbc.co.uk/1/hi/in_depth/americas/2000/us_elections/profiles/576504.stm) (last visited Sept. 21, 2006).

The question is not as simple as determining at what age adolescents should be treated as adults. Adolescents achieve certain adult capacities early in development. They can engage in reasoned rational abstract thought well before age sixteen. However, certain other adult capacities, such as good risk assessment, do not fully develop until well after the current age of majority. As we have seen above, adolescents do display a relative incapacity to prudent decision-making, particularly with respect to high-risk situations and long-term consequences. However, adolescents also display relatively sound cognitive functions in situations less fraught with risk-taking. Dividing health care procedures along a matrix of relative risk allows us to give adolescents the capacity to decide those things they are capable of deciding, while still protecting them from their more significant improvidence.

The most difficult aspect of this system will be determining what procedures should be classified as low-risk and which should be classified as high-risk. At the margins, the question is easy. Nearly everyone would agree that a tetanus shot falls in the low-risk category. Similarly, nearly everyone would agree that a complex cosmetic surgery would fall into the high-risk category. But there are thousands of identifiable health care procedures. Fortunately, the margins are fairly wide and the gray zone of uncertainty relatively narrow. I would suggest that the health care professional societies, in conjunction with consumer groups and state and federal regulators, devise a listing of low-risk procedures. Such a list should include most diagnostic procedures, blood testing, simple radiography, and physical examinations. Most common therapies would also be included. The line gets harder to draw with respect to surgical treatments. It is likely that the majority of surgical procedures should be left on a high-risk list.<sup>256</sup>

With the insight of age and experience, the adults of society often seek to deny adolescents the right to consent to their own medical treatment, even in situations that involve routine care and non-life threatening situations. This is due to a misplaced belief that minors are so wanton in their actions that they are incapable of making medical decisions that would best serve their interest.

Bright-line rules in which age serves as the sole line of demarcation often lead to unsatisfactory results. This is especially true in cases of a mature minor who is capable and fully aware of the consequences of his or her decisions and yet is still denied access to medical care without receiving prior parental consent. We have seen studies that demonstrate adolescents' willingness to forego needed health care in order to avoid parental notification. We have also seen how most states create statutory exceptions to the default rule in certain circumstances. What we need is a more comprehensive approach that grants adolescents the ability to self-consent as much as they are developmentally capable yet protects them from

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256. A more detailed listing of what sorts of health care procedures should belong in which category should be left to health care experts and may be the subject of subsequent articles.

their predilection towards high-risk behavior and disregard for future consequences.

As most rational individuals will agree, reaching the age of majority does not automatically and magically instill capacity into adolescents. All that it grants is the legal authority to decide any medical treatment they may wish to undertake or refuse. The day before their eighteenth birthdays, adolescents may not seek care for a sore throat, obtain a tattoo, have plastic surgery, or get a tetanus shot without parental consent. On the day of their birthdays they can do any of these things irrespective of what their parents may say. That these situations are all treated the same reveals an obvious flaw in the system of adolescent medical consent that we have in place.

The research bears out the lack of foresight in many of their actions. Adolescents tend to act more impulsively than adults. However, the research does not exclude their capacity to determine when they need routine health care. Adolescents are far more capable than infants or children in medical decision-making. This does not mean that adolescents should gain full legal medical consent capacity. This would be imprudent. Many medical decisions carry high risk and potentially adverse long-term consequences. However, where health care decisions do not involve high risk or long-term consequences there is little reason not to grant adolescents the power of consent.

It is often said that success builds upon success and experience is the greatest teacher. Over-sheltering adolescents from the difficult decisions in life and persistently making such choices for them inhibits development of their own decision-making skills. Transitioning from childhood to adulthood is a natural progression from dependence to independence. Granting them the right to make their own choices in routine medical care aids in this progression. There is a legitimate concern that adolescents will, on occasion, make poor choices. Bad choices are a part of life and a part of learning. Adolescents' making poor choices, even in low-risk routine care, will be inevitable. Nonetheless, adolescents deserve the same right to make poor choices as adults have. We need only protect them from their own inability to assess risk. Where there is little risk, there is little need for protection.<sup>257</sup>

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257. The abortion issue raises one potentially and politically difficult implication for this proposal. If the calculus of low risk equals consent capacity holds true, then it follows that any adolescents should be permitted to consent to any low-risk health care service. Does this, or should this, include abortion? How low-risk is abortion? An abortion performed early in the first trimester carries less risk to the adolescent than does carrying a pregnancy to term. Certainly, permitting consent for an abortion allows an adolescent who is not yet able to deal with long-term risk and responsibility an avenue to avoid those long-term consequences at a relatively low short-term risk. This would seem to argue in favor of permitting adolescents to self-consent to abortion. But even under the rubric of this proposal, the answer is not so simple. Merely distinguishing the relative risk between two potential health care options does not provide any insight into the actual risks of either option. Should both options carry moderate or significant risk, neither should be left to the adolescent's sole judgment. The relative risk



Adolescents should be allowed to make choices in their own routine medical care. For those of us who fear that they may make the wrong choices, this is safeguarded largely by the presence of the health care worker whose knowledge and expertise in such matters will help to guide and advise these adolescents towards a reasonable and informed decision. As adults we should recognize that we are often faced with choices in our own medical care, and for most of us, we depend upon the advice and experience of our medical caretaker to help guide us in making the most prudent choices for own health care. We should also recognize that the act of seeking medical care also demonstrates a level of maturity on the part of the adolescent who understands the nature of his or her condition and realizes the need for medical assistance. To deny these youths medical treatment without the consent of their parents in routine medical matters would be a slap in their faces, pronouncing loudly our lack of confidence in their judgment even if we are in complete agreement with their decisions.

This proposal does not seek to dismantle the bright-line rules that set the age of majority. Rather, it seeks to grant legal decision-making abilities in routine medical care cases to adolescents who have not yet reached that set age limit. It helps to cover the orphans on the periphery of adolescent medical care who are physically no longer children but who are often left facing medical situations that are adult in nature without the rights and confidentiality that are enjoyed and taken for granted by adults.

#### *A. Other Implications Within Health Care*

We should note that while expanding the theoretical and legal capacity of adolescents to seek health care without the consent or knowledge of their parents may be a good idea, there are additional health care realities that interfere with their actual ability to obtain care. Most significant is the financial hurdle adolescents face. Health care can be very expensive. As a general rule, adolescents do not have financial independence from their parents. Parents also tend to be the source of most adolescents' health insurance. Adolescents will not obtain true health care independence until they also obtain financial access to health care services. This is a reality that this article does not attempt to address. It is a necessary future step. However, the lack of financial independence ought not serve as a bar to age-appropriate independent decision-making.

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argument grows in strength with respect to such treatments as Plan B, which is of sufficiently low risk that many advocates legitimately favor permitting it to be sold over the counter. Plan B carries considerably less risk than does a more traditional abortion, carrying a pregnancy to term, or the responsibility of caring for a newborn baby.

### *B. Implications Beyond Health Care*

The issues and proposals discussed in this article are primarily intended to address the realities and needs of adolescents within the health care system. In doing so, I attempt to outline the boundaries of adolescent consent and capacity. While I focus on adolescents and the health care system, we must remain cognizant of the implications beyond health care. The same rationales employed here can and arguably should be applied equally to all areas of the law, including contract, tort, and criminal law. If adolescents have obtained competence to make certain decisions within health care, have they not attained the same in other areas as well?

I have argued that adolescents should be granted the right to consent to health care services that do not carry high risk or involve potential long-term adverse consequences. What impact should this have in other areas? When should adolescents be held to short-term contract obligations? When should adolescents be liable for the torts they commit? When should adolescents be held liable for the crimes they commit? These are all valid questions, and they need to be addressed. The more complete our understanding of the development from child to adult, the better we will be able to assign rights and responsibilities.

It would be a mistake, however, to suggest that the answer to each of these questions must necessarily be the same. Yes, the same understanding of adolescent development should be applied across the board. But that does not necessarily mean that we will get the same answer in each discipline. Each discipline must look to its own unique needs and expectations. Each may place different emphasis on particular aspects of cognitive thought. Each may have differing policy concerns with which to contend.

Once the various disciplines have worked out their unique underlying considerations, they should then look to the science of adolescent development. They can then construct their own matrix of what rights and obligations should be awarded and imposed upon adolescents of various ages. This article is intended to answer that question only in the context of health care decision-making. Future articles may examine this question in other areas.

## VI. CONCLUSION

We know that adolescents are not children, and they should not be treated as such. Yet neither are they adults, and we should not require or expect them to act as full adults. They are caught in a terrible in-between, neither child, nor adult, but in transition from one to the other. The path of adolescents is neither simple nor uniform. All teenagers progress at their own pace and in their own way. Ideally we could give each adolescent individualized assessments at each decision-making point. But this is neither realistic nor practical. In order to have some efficiency in the system we need a certain level of bright-line rules. The ones we have in place

currently do not accurately reflect the best that we can do with the knowledge that we now possess. I do not insist that the proposal laid out here is and will remain the best indefinitely. As our scientific understanding of adolescent development progresses, we may need to revise again our approach to adolescent decision-making. Should we develop a simple, easily applied test for adolescent decision-making capacity, that too will necessitate a revision in our approach. As science further expands our knowledge, we will revisit this question. And while we ought not make major modifications with every small advance, a sufficiently critical mass of information has developed over the past several years to justify an expansion of adolescent decision-making for low-risk health care procedures and a restriction on adolescent decision-making for high-risk health care procedures.