

Coming of age: Devising legislation for adolescent medical decision-making

By Hartman, Rhonda Gay

Publication: [American Journal of Law and Medicine](#)

Date: [Tuesday, January 1 2002](#)

You are viewing page 1

I. INTRODUCTION

A substantial segment of the American population consists of adolescents. Adolescents, defined as persons between the ages of fourteen and eighteen, have traditionally been regarded as "minors" by law. Minors, as a group, are legally disabled, meaning they are presumed to lack

[Ads by Google](#)

[Photography College in MN](#)

Train in Digital Photography at Brown College in Minneapolis, MN.

BrownCollege.edu/Photography

[Malpractice Law Firms](#)

Medical Malpractice Lawyers In Your Area. Contact Legal Help.

www.InjuryHelpLineLawyer.com

[Board Certified Attorneys](#)

Specialized in business litigation, personal injury, family law & more.

fordlaurel.com

the skills necessary for capable decision-making. Capable decision-making is requisite to the [exercise](#) of legal rights. Although the U.S. Supreme Court has extended federal constitutional guarantees to minors,¹ including the liberty right for decision-making in intimate, personal matters,² the Supreme Court has observed that vulnerability impairs their decision-making capability.³ Accordingly, the law regulates decision-making liberties of minors far more extensively than those of adults.

The underlying tenet of law governing adolescents—that they lack the skills required for capable decision-making—seems well-settled. It is an artifact from an industrial society that spawned legislation authorizing governmental regulation of adolescents for education and labor in order to protect and promote their [health](#) and well-being. Known as *parens patriae*, this philosophy for legislation governing minors has been invoked by courts as a basis for upholding statutes that require parental involvement in reproductive decision-making⁴ and that permit involuntary commitment of adolescents to mental health institutions by parental consent coupled with psychiatric evaluation.⁵ Upholding parental consent and psychiatric evaluation as sufficient safeguards against a due process challenge in *Parham v. JR.*, the Supreme Court observed that inexperience limits minors' legal autonomy "for making life's difficult decisions."⁶ That adolescents lack the life experience of adults seems axiomatic due to having lived less years and having been exposed to fewer challenges.

Why, then, should lawmakers reconsider this underlying tenet and focus on this segment of the population? There are several important reasons. One reason is the void in knowledge about adolescent decision-making capability and the corollary void in policy-making attention. Reflected conspicuously by the silence of federal and state legislators "lack[ing] any clear vision of adolescence as a developmental stage,"⁷ this "lack of vision" has resulted in disparate legal treatment of minors. State statutes that permit a death sentence for minors who commit murder⁸ but prevent terminally ill minors from declining aggressive, non-therapeutic medical measures to prolong life aptly illustrate this.⁹ State legislation that regulates minors' consent to medical care for non-life-threatening conditions, such as substance abuse and sexually transmitted disease, likewise warrants legislative attention due to protracted policy that confounds judges responsible for determining how much legal autonomy should be given to adolescents and medical practitioners who care for adolescent patients. For example, disparity in policy disadvantages medical practitioners who try to fulfill professional responsibilities in a way that maximizes the ethics of patient care, which includes maintaining patient confidentiality, patient autonomy, and beneficent and just approaches.¹⁰ Compliance with legal policy is made more difficult by the failure of legislators to understand and contemplate the decisional issues related to adolescent patient care.

Moreover, the presumptive decisional incapacity that undergirds legislation governing minors is tenuous at best. Despite its century-old shelf life, there is comparatively little, if any, evidence to support it. The Supreme Court's observation that adolescent inexperience and

vulnerability impede capable judgment for decision-making is, and was, not supported by any evidence beyond the collective "conventional wisdom"¹¹ of a majority of the justices. In a dissenting opinion to *Wisconsin v. Yoder* in 1972, Justice Douglas underscored the lack of evidentiary support and emphasized scientific studies that existed at the time to criticize the Court's failure to recognize preferences of the adolescents at issue concerning public school attendance.¹²

Since *Yoder* was decided, results from other studies related to adolescent cognitive development and capacity for decision-making contravene the presumption of incapacity that underlies legislation.¹³ These studies, along with evolving societal and cultural norms, should inform and shape *parens patriae*. *Parens patriae*, or the philosophy that government should be proactive in protecting the welfare of minors, is central to crafting cohesive legislation that recognizes adolescent legal autonomy for medical decision-making. Early protective constraints that were absorbed into the concept of *parens patriae* to limit adolescent legal autonomy devalue adolescent cognitive ability in a way that vitiates the development of responsible decisionmaking. Societal and cultural norms that influence policy evolve over time and, therefore, constraints based on age markers that were reasonable a century ago may be refutable today.¹⁴ Statutory exceptions that now afford adolescents a measure of legal autonomy for medical decision-making illustrate this.¹⁵ Thus, *parens patriae*, which directs legal policy governing minors, should be responsive to the social and cultural norms that influence it. As the Supreme Court suggested in 1967 when it declared that constitutional guarantees are not for adults alone,¹⁶ elasticity characterizes *parens patriae* as a concept that expands traditional notions to mirror more accurately the reality of adolescent decision-making capability and to promote, rather than restrict, adolescent legal autonomy.¹⁷

Whether addressed distinctly or in combination, these reasons command closer consideration of policy for devising law governing adolescent decision-making, especially in the context of medical care where decision-making is essential to health and well-being, and where practitioners and adolescent patients confront critical and life-altering decisions. Scientific research is required for optimal understanding about adolescent medical decision-making in order to shape policy and devise legislation.

Scientific research and legal policy formulation intuitively seem strange bedfellows due to distinct orientations. Science, as a source for knowledge acquisition, is continuous; findings from a scientific study are neither authoritative nor binding and invite reversal. By contrast, law establishes authority. A court decision or legislative action is binding and does not encourage reversal. Yet, reciprocity endures for both law and science. Law and science guide one another, as illustrated by legislative hearings and proposals to regulate stem cell, genetic and cloning research. Despite the lack of training provided by legal education for critical examination of the scientific method, 18 courts engage information from science and related disciplines by utilizing scientific findings and empirical data when deciding cases of constitutional magnitude.¹⁹

Law's "scavenger-like"²⁰ existence depends on science, as well as "other disciplines for the knowledge and data with which legal doctrine is shaped."²¹ Science informs law about facts that give rise to legal issues, and law reciprocates by relying on science for factual information to optimize the understanding of issues. Both law and science involve adversarial problem solving, along with the examination and refutation of claims. Thus, trial-and-error characterizes both law and science, which depend on the evolving growth of knowledge through intellectual revolutions-that is "through new and great ideas."²² Indeed, methods of scientific inquiry for the discovery and growth of knowledge have proved vital for formulation of legal policy in economics,²³ antitrust,²⁴ forensic evidence ²⁵ and due process rights.²⁶ Scientific methods of inquiry also present promise for developing legal policy and legislation that focuses on adolescent medical decision-making.²⁷

The identification of testable assertions is a threshold for applying the scientific method to devise legislation related to adolescent medical decision-making. Judicial opinions are a rich source of such testable assertions. For example, the Supreme Court's observation that vulnerability impairs decision-making capability is itself an assertion amenable to critical examination and falsification. Intentionality and susceptibility to external influence are factors associated with vulnerability. Limited scientific findings related to adolescent vulnerability suggest that adolescents are no less intentional in medical decision-making than young adults, and that adolescents do not demonstrate intimidation when confronted by coercive parental influence attempts or by the gravity of a medical treatment decision.²⁸

The void in empirical data to support the Court's observation leads researchers to note the frequent grounding of "assumptions that do not withstand empirical scrutiny or for which no empirical evidence exists,"²⁹ to criticize policy analysis bereft of data³⁰ and to reprove legal policy based "on anecdotal observation" about adolescents.³¹ Even assuming the existence of corroborating evidence to support the Court's observation, a question remains as to whether this "impairment" is adequate to justify legal policy that disables adolescent autonomy for medical decisionmaking. Although the Court's observation constitutes a source of knowledge, it is but one step—a starting point—toward knowledge acquisition. A general test of any observation is whether it agrees with the facts—the existence of corroborating evidence.³²

Legislators draw a line between the decision-making abilities of minors and adults at age eighteen, which has traditionally demarcated the exercise of legal rights and has influenced judicial observation about impairment in adolescent judgment. Paradoxically, the legislative line demarcation remains in place largely due to judicial observation about adolescent judgment, which begs the question: What is the reality? Legislative policy should correspond to the reality of adolescent decisional capability, and information about adolescent ability gleaned from the scientific method can enrich our understanding. Decision-making capability is an empirical question because it assumes the existence of a baseline standard by which personal decisions deserve legal protection. Deviation from the standard by adults or by adolescents compels investigation about the adequacy of decision-making capability that merits legal protection for medical choices.³³

Reported case law addressing adolescent medical decision-making is sparse. Several cases entail state allegations of parental neglect to consent for a minor's medical care based on religious grounds³⁴ and parents' claims of negligence when their child is harmed following a surgical procedure to which a physician permitted the minor to consent.³⁵ Most of the relatively few reported cases regarding adolescent medical decision-making have focused largely on end-of-life care. This case law is important because courts, in their legal analyses, assert points that compel research through the scientific method to facilitate understanding by policymakers about the issues and interests related to adolescent medical decision-making. Medical decision-making has been safeguarded for adults through constitutional guarantees that respect intimate choices.³⁶ The federal Constitution carefully safeguards medical decision-making as a private, personal and life-enhancing liberty right,³⁷ and there

is infinitesimal evidence to support the presumptive decisional inability that underpins laws that govern adolescents. As such, adolescent medical decision-making commands a multi-disciplinary exploration and testing of assertions in order to ensure that policy-makers have a firm grasp of the issues and that policymaking corresponds to reality.

State courts confronting issues concerning life-prolonging care for adolescent patients have articulated testable assertions for exploration. These assertions invite collaboration with the scientific method to investigate and inform a constellation of legal issues that include: whether discussions between adolescent patients and their physicians should be confidential and whether (and what) circumstances would justify disclosure of confidential information to third parties, such as parents or guardians; whether preponderance of the evidence or clear and convincing evidence would be appropriate when determining adolescent wishes to forego treatment; whether a proxy decision-maker acting on behalf of an adolescent patient should decide by best interests or by substituted judgment (i.e., what the adolescent would want); whether information about an adolescent patient's diagnosis, prognosis and treatment should ever be withheld from the adolescent patient; whether ethics committee involvement and guardian ad litem appointments are appropriate and deserve deference by courts when confronted with conflict in medical decisionmaking concerning adolescent patients; and whether a stance of non-intervention should be invoked by courts when asked to address issues related to adolescent patient care. These issues merit scrutiny as well as careful consideration of court analyses that set forth testable assertions. Knowledge acquisition is crucial, specifically to flesh out points amenable for the scientific method, for framing the factual and legal issues for legislative consideration, and for shaping policy regarding the scope of legal autonomy afforded adolescents for medical decisionmaking.

This Article advocates for knowledge acquisition about adolescent decisionmaking for shaping national policy to guide uniform legislative enactment in this area. The thesis of the Article is that, prior to devising legislation related to adolescent legal autonomy for medical care, methods of scientific inquiry should be utilized to test assertions set forth by courts that have identified issues related to adolescent medical decision-making. To this end, the Article is subdivided into five parts. Part II details state legislative treatment of adolescent medical decisionmaking, including the anomalies and ambiguities in policy underpinning current legislation that extends legal decision-making autonomy to adolescents for medical care. Part III discusses legislative proposals for adolescent legal autonomy in medical decision-

making that elucidate testable assertions for knowledge inquiry and acquisition. Part IV briefly clarifies the issues that necessitate knowledge acquisition to establish a thorough understanding about the complexities of adolescent medical decision-making. Finally, Part V and Part VI closely examine the case law addressing adolescent medical decision-making and the decisionmaking process, and the assertions that require multi-disciplinary research as a requisite for crafting cohesive legislation.

II. STATE LEGISLATIVE TREATMENT OF ADOLESCENT MEDICAL DECISION-MAKING

State legislation affords a measure of legal decision-making autonomy to adolescents for medical treatment. The legislation is piecemeal, and it particularizes the conditions and circumstances that permit physicians to obtain consent from an adolescent patient in the absence of parent permission and notification. Yet, these legislative provisions create a tension among convergent policies due to the absence of any cohesive underlying policy that takes into account whether adolescent patients are capable of determining medical treatment. This lack of cohesive policy has, in turn, resulted in a lack of clarity for interpretation and application. By lacking clarity, these provisions tend to thwart the policy goals intended for promotion. Statutes allowing minors to consent for sexually transmitted disease (STD) treatment explicate the problem. Presumably, policy that inspired passage of these statutes recognized adolescent sexual activity and attempted to deter the spread of disease through sexual contact. The parental consent requirement was omitted in order to encourage adolescents to seek treatment without the deterrent of having to inform parents of their activity.

Most state statutes provide that consent from a minor for treatment of a venereal or communicable STD is valid and binding "as if the minor has achieved majority."³⁸ Michigan is one of the few states that expressly includes HIV.³⁹ In the majority of states that do not include HIV, physicians must resort to other legislative and professional guidelines. Less clear under these legislative provisions are situations in which an adolescent seeks out medical care for an STD, but treatment for another related condition is necessitated. Should the condition be treated with adolescent consent alone in furtherance of the policy underpinning these provisions? Should the actual ability of the adolescent to provide informed consent be pivotal, or should a parent's consent be necessary?⁴⁰ Several statutory

provisions do include an age requirement,⁴¹ although its purpose is unclear if the policy being furthered is simply one of treatment without the deterrent of parent notification.

While the STD statutes are routinely regarded as an exception to the legal presumption of adolescent decisional incapacity and the accompanying requirement for parental consent prior to non-emergent medical treatment, a number of states have also enacted legislation that affords adolescents legal autonomy when accessing medical care for conditions related to substance abuse.⁴² A few states conjoin substance abuse and STDs as conditions for which minors may consent to treatment despite distinct policy considerations.⁴³

Although age limitations in statutes provide guidance concerning adolescent consent to medical treatment regarding substance abuse,⁴⁴ interpretive problems and inconsistency among policy goals largely plague these statutory provisions. Several states focus solely on the judgment of an adolescent. Short of a "right to consent" to substance abuse treatment that Georgia extends to adolescents,⁴⁵ Michigan allows adolescents who "profess to be a substance abuser" to consent to treatment, and Louisiana extends legal decisional autonomy to minors who "believe" they are addicted to a narcotic or other drug.⁴⁶ Other states incorporate professional assessment of adolescent decisional ability by delegating this task to the treating physician,⁴⁷ or by requiring the confirmation of substance abuse by two or more physicians prior to affording adolescents legal autonomy for treatment decisionmaking.⁴⁸ Once physicians have confirmed the substance abuse dependency by the adolescent, Illinois, for instance, specifies that the scope of the adolescent's consent includes any condition related to that dependency, entrusting to medical judgment the interpretive points regarding the extent of the relationship to the condition of drug or alcohol dependency.⁴⁹

The obligation of the treating physician to involve parents likewise generates tension in policy and practice among principles of patient confidentiality and beneficence, specifically, the promotion of the patient's well being. For example, Pennsylvania policy-makers relieve physicians of any obligation to inform parents about an adolescent's treatment for substance abuse,⁵⁰ and Oklahoma lawmakers prohibit healthcare professionals from revealing "any information whatsoever."⁵¹ By contrast, Michigan permits disclosure of otherwise confidential information regardless of the minor's express refusal or lack of consent,⁵² and California mandates parent involvement, leaving a determination of the appropriateness of

that involvement under the circumstances to physicians.⁵³ California further requires disclosure about the minor's treatment when requested by a parent or guardian, expressly characterizing its policy as striving to strike a balance between promoting family relationships and minors' physical and psychological health.⁵⁴ Other states require "reasonable efforts" by physicians to involve family, yielding to physicians a determination whether such involvement would adversely affect the minor's progress and care.⁵⁵ Although the timing and documentation of these "reasonable efforts" are important and impact the minor, they are not addressed by the legislation.

States also promote access to family planning and pregnancy-related services for adolescents by extending legal autonomy in decision-making to minors for treatment and procedures.⁵⁶ Several states expressly include birth control⁵⁷ and exclude procedures such as abortion and sterilization.⁵⁸ A few states also differentiate between married and unmarried pregnant minors. Florida and Kansas, for example, afford decisional autonomy to unwed pregnant minors,⁵⁹ presumably because in those states marriage emancipates minors for treatment decision-making. California not only recognizes legal decisional autonomy for pregnant minors, but precludes them from disaffirming an arbitration provision entered into as part of the informed consent agreement for medical or surgical care related to their pregnancy.⁶⁰ Other states include language that prevents a minor from disaffirming the agreement for consent to treatment due to minority status.⁶¹

Sexual assault likewise constitutes a condition for which qualifying minors can exercise legal autonomy for medical care.⁶² Arizona mandates that a minor's consent is "not subject to incapacity because of the victim's age," while engrafting an age restraint of "12 years or older" for applicability of the provision.⁶³ California requires the same age limitation for rape victims as well.⁶⁴ Legislation in Illinois and Texas affords legal autonomy to minors for mental health counseling related to assault, abuse, suicide prevention and chemical dependency.⁶⁵ A number of states have followed suit with legislation permitting minors, usually at age fourteen, to consent to voluntary, outpatient mental health treatment.⁶⁶ Most states, however, retain parental consent requirements for involuntary civil commitment and hospitalization.⁶⁷

Affording adolescents legal autonomy for mental health treatment has occupied recent state legislative activity, resulting in varying requirements and policy goals that are aimed at

encouraging adolescent access to treatment. States that recognize a minor's legal consent for mental health treatment usually place the onus for treatment determination on the minor, as illustrated by Pennsylvania's provision that a minor who is fourteen years or older may consent to examination and treatment if the minor "believes that he is in need of treatment and substantially understands the nature of voluntary treatment."⁶⁸ Other states have followed suit but require providers to determine and document that the services are clinically indicated for the minor's well-being.⁶⁹

Several state legislatures have, however, devised more extensive requirements by placing a responsibility to determine and document the adolescent's need for treatment on clinicians in the absence of parental consent. Connecticut, for example, omits the age limitation and instead requires the clinician to document that: (1) parental consent would cause the minor to reject treatment; (2) treatment is clinically indicated; (3) failure to provide treatment would be detrimental to the minor's wellbeing; (4) treatment has been knowingly and voluntarily sought by the minor; and (5) the clinician is of the professional opinion that the minor is mature enough to participate productively.⁷⁰

State mental health legislation has been moving toward restricting the time period for which an adolescent may consent to treatment or services without parental notification or consent. These limitations vary considerably from state to state. For instance, Michigan allows for twelve sessions or four months of treatment before the clinician must either terminate treatment or require parental notification and consent,⁷¹ while Ohio permits an adolescent to consent for six sessions or thirty days ⁷² and Florida permits a mere one-week period or two sessions.⁷³ At the point where the legislation requires parental involvement for continuance of treatment, it directs clinicians to assess and document whether such notification and consent by parents would prove detrimental to the minor and that treatment is necessary for the minor's best interests.⁷⁴ Should the clinician determine that continued treatment is medically indicated and authorized by the adolescent's consent, these statutes eliminate parent or guardian liability for the costs of treatment.⁷⁵ While these provisions are aimed at outpatient treatment, several states allow adolescent consent for inpatient services⁷⁶ and psychotropic medications, though, again, the provisions vary considerably from state to state.⁷⁷

Beyond legislative provisions that afford legal protection for adolescent consent to particular medical conditions, a few states have enacted statutes that give fifteen-- or sixteen-year-old

minors legal decision-making authority for "routine medical care."⁷⁸ These statutes can raise interpretive problems for practitioners trying to determine, with precision, the scope and meaning of "routine." Rather than crafting a broad legislative provision to afford legal decision-making power to adolescents for consent to primary care, most states have enacted emancipation for medical care statutes that extend legal autonomy to adolescents based on their individual or social circumstances. These circumstances include a minor who is homeless,⁷⁹ married or divorced,⁸⁰ has home a child,⁸¹ is pregnant⁸² or has been pregnant,⁸³ has graduated from high school,⁸⁴ is living separately and independently,⁸⁵ or is a member of the armed forces.⁸⁶ Several states statutorily extend minors' legal autonomy in medical decision-making for their children.⁸⁷ Age restraints for recognizing the minor's legal consent to medical care usually do not accompany these circumstances, and accuracy in determining these circumstances can prove difficult. States, however, usually afford physicians immunity from civil liability when they rely in good faith on the adolescent's representations.⁸⁸ While legislative records are devoid of information regarding whether these circumstances evidence adolescent decisionmaking capability, a policy presumption of decisional capability seems inherent in these provisions regardless of whether it is warranted.

Even when a minor has been emancipated by a court and, thus, afforded legal protection for decision-making in matters beyond medical care, the conditions of the emancipated status vary from state to state. When a court emancipates a minor in Virginia, the minor is excluded from dependency proceedings, juvenile delinquency proceedings and guardian ad litem appointment.⁸⁹ Court-emancipated minors in Nevada may convey property and are responsible for their debts and contract obligations as if they were adults, yet they are still subject to state law that prohibits gaming employment for and liquor sales to minors.⁹⁰ Evidence of indigence or other insufficient means of support, or a showing of fraud or misrepresentation of material information, would strip the minor of the emancipated legal status in Nevada.⁹¹ With respect to medical decision-making, state law protects autonomous decisionmaking by an emancipated minor.⁹² This is in contradistinction to the emancipation for medical care statutes, by which legal protection for the minor's decision is contingent on physician assessment and documentation of a minor's individual circumstances.

Collectively, legislation that affords legal decision-making to minors for medical care raises a number of important points for examination in shaping policy and devising-or revising-

legislation. First, there is no indication that the policies underpinning current statutes have considered the actual decision-making ability of adolescents to decide treatment for STDs, mental health, or because they have graduated from high school or have married. This is particularly the case when requirements for capacity assessments have not been imposed as a condition for according legal autonomy in decision-making to minors about these conditions or in these circumstances. Several statutory provisions simply proclaim adolescent capacity to consent for treatment and use "capacity" and "consent" as coterminous,⁹³ even though interchanging these terms would be inaccurate. Capacity for decisionmaking is actually a prerequisite for legal recognition of a person's consent to medical care. Use of "shall" and "may" with respect to adolescent consent similarly requires policy consideration about whether evidence exists to support legal recognition of adolescent decisional ability and, therefore, whether legislation should mandate protection for adolescent medical decision-making or, conversely, whether it should delegate discretion to healthcare providers to determine the adequacy of an adolescent patient's consent on a case-by-case basis.⁹⁴ Even the focal point for discretion in decision-making varies. Several states accord adolescents the discretion of whether to consent to treatment,⁹⁵ while others accord discretion to professionals for determining whether to recognize adolescent consent.⁹⁶

While scientific findings suggest that adolescents possess levels of cognitive capacities-as measured by Piagetian stage ⁹⁷ and task-specific schema⁹⁸-which are ignored by the empirical and normative values that influence legal policy regarding minors, those findings do not evidence the same capacities for minors less than fourteen years of age. Scientific studies suggest that minors demonstrate decisionmaking comparable to young adults by age fourteen in healthcare decision-making,⁹⁹ pregnancy decision-making,¹⁰⁰ for stating parental preferences in custody disputes¹⁰¹ and for waiving constitutional rights in criminal proceedings.¹⁰² That level of decision-making capacity, however, is not present in younger minors.¹⁰³

It is also unclear whether policy-makers intuitively realize a difference in decision-making between adolescents and children. Perhaps they intended to empower older minors with language such as "minors shall have the right to decide medical care," leaving no discretion to medical practitioners. This fails to explain, however, legislation that focuses not on the minor, but on the healthcare provider who may "examine, prescribe for or treat a minor" in

the absence of parental consent or notification without risk of liability.¹⁰⁴ In other words, questions remain as to whether legislative policy is aimed at protecting providers, who decide that it is professionally and ethically appropriate to treat an adolescent patient in the absence of parental consent, from liability or to facilitate decision-making by adolescents. These policy points compel clarification for developing a legislative framework to effectively govern adolescent medical decision-making.

Second, adolescents require guidance for fostering responsible decision-making. Studies with adolescents¹⁰⁵ and physicians¹⁰⁶ have suggested that adult involvement in adolescent decision-making is valued and beneficial. However, a crucial point for policy consideration is the scope of adult guidance and whether the adolescent or the state should decide who provides the guidance. Statutes requiring parent notification or consent for an adolescent's abortion, which the U.S. Supreme Court has upheld under the federal Constitution,¹⁰⁷ are a paradigmatic example. While adult involvement could provide an adolescent with emotional sustenance and support in making this difficult decision, a policy point that should be considered is whether the state should dictate through notification and consent requirements that a parent provide the guidance, or whether the adolescent is capable to choose for herself the adult with whom she would be most comfortable in seeking guidance. Studies have shown that the person to whom most adolescents prefer to turn for guidance in pregnancy decision-making, as well as in medical decision-making in general,¹⁰⁸ is a parent.¹⁰⁹ Studies also suggest that adolescents facing unplanned pregnancies demonstrate decision-making ability comparable to young adults in the same situation.¹¹⁰

State legislation that requires parental involvement in abortion and medical decision-making attempts to foster a policy of strengthening parent and child relationships. Whether (and how) the state should attempt to achieve this goal, however, is questionable. The nature and strength of any parent-child relationship arguably rests with the parents who have the primary responsibility for minors' care and nurturance.¹¹¹ Worthy of examination, then, is whether legislating the dynamic of this relationship accomplishes the policy goal or whether, in effect, it merely makes medical practitioners' provision of care for adolescent patients more difficult. Indeed, legislation indicates a trend toward yielding to physicians' judgments regarding whether a parent should be notified. Recent legislation delegates to physicians a responsibility to expend "reasonable efforts" to assist minors in accepting parental involvement.¹¹²

Additionally, parents would benefit from cohesive legal guidelines. Studies have shown that "in general, parents are not knowledgeable of laws affecting adolescent medical care . . . and that parents are not aware that the laws have affected them or their children."¹¹³ Such unawareness may cause parents to feel "powerless and ineffective,"¹¹⁴ which could negatively impact their relationship with an adolescent. Thus, legislative clarity could strengthen the parent-adolescent relationship by increasing parental receptiveness to initiating communication with adolescents and by respecting the emerging adult within the adolescent.

A closely associated point is the conflict created by competing and convergent policies for medical practitioners who attempt to discern professional obligations from legislative provisions. Their task is made more difficult by the failure of legislators to understand and to contemplate the issues presented to practitioners when caring for adolescent patients. California, for example, seeks to encourage adolescent access to medical care and counseling for drug dependency and alcohol-related problems by affording adolescents legal consent at age twelve or older.¹¹⁵ The legislative policy seeks to promote the mental, emotional and physical health of minors, and to preserve the parent-child relationship.¹¹⁶ Yet, a subsection to the provision that affords adolescents legal autonomy further states that physicians shall disclose confidential information upon request of the parent, notwithstanding provisions to the contrary.¹¹⁷

Conflicts are inherent in legislative provisions that strive for balance between promotion of family ties and adolescent autonomy, and they heighten with respect to confidentiality. On one hand, California's provision defers the appropriateness of parent involvement in care and counseling related to a minor's substance abuse to provider judgment; on the other hand, the same statutory provision mandates disclosure of the medical information to a parent upon request, regardless of whether the minor resists and whether the provider believes such disclosure would confute a duty of confidential care owed to the adolescent patient.¹¹⁸ These contradictory provisions undermine, in part, California's policy goal of reducing obstacles that may prevent minors from accessing needed medical treatment. These provisions also compromise professional obligations to maintain patient confidences. While family unity and parental ties are legitimate state interests, they should not be furthered at the expense of all personal rights or conflicting interests. Reported findings from a study of physicians who care for adolescent patients ranked family support and harmony

"considerably less persuasive in justifying disclosure of confidential patient information."¹¹⁹ Results from a study of adolescent patients indicate that adolescents regard confidentiality as "the most important characteristic" in their decision to access medical care.¹²⁰ In response, Massachusetts mandates the confidentiality of the minor's medical information unless the minor consents, and only allows provider notification to parents when the condition is "so serious that the minor's life or limb is endangered,"¹²¹ thereby promoting the mental and physical well-being of minors as the primary policy goal.

Third, refusal of unwanted medical treatment is noticeably absent from the statutory provisions that afford legal autonomy to adolescents for medical decisionmaking. Empowerment in decision-making to choose treatment—including self-image and self-esteem—waned in meaning without the corollary ability to refuse it. The ability to refuse unwanted treatment becomes especially meaningful for critically-ill and chronically-ill adolescents who understand their diagnosis and prognosis, and desire to decline vigorous measures. The absence from current legislation suggests that this point has not garnered adequate, if any, attention from policy-makers, despite federal and state laws that expressly protect refusals of treatment as central to the liberty right exercised by adults for medical decisionmaking.

Following the Supreme Court's recognition for medical decision-making by competent adults, including refusal of life-prolonging care as an intimate decisional right in the concept of liberty found in the Fourteenth Amendment's Due Process Clause,¹²² the U.S. Congress passed the Patient Self-Determination Act in 1990. The Act's purpose was to further the policy of protecting these personal medical choices by law. This federal legislation enabled the states to pass legislation particularizing the procedures for expressing individual wishes in advance of medical crisis.¹²³ State legislation that has resulted from this federal initiative, however, has not expressly included minors. Several states have included, in advance directive legislation, situations from their emancipation for medical care statutes, such as marriage and high school graduation, which extend legal protection to adolescent decision-making.

124

Cohesive policy, either at the federal or state level, for legislation governing adolescent medical decision-making is nonexistent. Yet, it is timely and important, not only for the reasons expressed in the preceding discussion, but for fair and evenhanded treatment of adolescent ability and for promoting adolescent decisionmaking development as an

extension of *parens patriae*. To this end, commentators have proposed guidelines for policy-making and for crafting legislation concerning adolescent medical decision-making. These proposals raise testable assertions that invite multi-disciplinary research for policy formulation.

III. PROPOSALS FOR LEGISLATION CONCERNING ADOLESCENT MEDICAL DECISION-MAKING

Several commentators have proposed legislation to target a particular area of treatment, such as mental health.¹²⁵ Others have suggested modification to existing state legislation.¹²⁶ Comprehensive federal legislation regarding adolescent legal autonomy, that includes medical decision-making, however, offers a number of distinct advantages.¹²⁷ Federal legislation would establish a unified, national policy regarding adolescent decision-making capability. By recognizing decision-making ability of adolescents, the policy would be responsive to the reality of adolescent cognitive development and to the particular needs of adolescents, separate and apart from younger children.¹²⁸

The result would be The Younger Americans Act, which would be styled on the framework of The Older Americans Act, thereby establishing continuity in federal approach and expanding *parens patriae* to address the capacities and needs of the distinct populations for which the legislation is aimed. The Younger Americans Act would steer passage of state legislation, thereby offering a second ostensible advantage. The emergence of complexities due to state legislation, which is devoid of decisive policy, creates a role for Congress to set forth precise lines and drive state legislation in a direction that fosters responsible decision-making by adolescents based on their ability.

Although it could be argued that states have traditionally regulated matters involving minors and family relationships, federal legislation would both direct and enable states to enact statutes related to adolescent patient care. These statutes could achieve balance among competing interests by recognizing adolescent ability for medical decision-making, while encouraging adult guidance during the decisionmaking process. A federal policy for recognizing adolescent decisional ability coheres with parental involvement. It promotes parental receptiveness to adolescent decisional development by providing parents with a clearer understanding of adolescent legal autonomy, and by inviting parents to initiate communication with adolescents about their medical decision-making. Federal legislation,

moreover, would not establish that all adolescents are decisionally capable. Generally, policy formulation is aimed at the majority of a given population, but not all. Enabling states to enact legislation as to the particulars of adolescent decision-making gives expression to continuing knowledge acquisition about adolescent decisional ability. More information regarding the decision-making ability of adolescents for specific tasks, such as foregoing life-sustaining treatment or utilizing mental health therapy, to inform policy-making is desirable.

Other commentators have focused on adolescent decision-making for end-of-life care, proposing thoughtful approaches that raise testable assertions for research and investigation. Sanford Leikin, for example, advances the position that decisionally capable adolescent patients should determine their own end-of-life care.¹²⁹ In so doing, he emphasizes the importance to individual dignity when patients-- adolescents or adults-- perceive that their desires, feelings and potential for selfdetermination are respected. Particularly, Leikin proposes that any adolescent, irrespective of chronological age, who experiences long-term illness, understands the illness along with the benefits and burdens of treatment, and comprehends the personal significance and finality of death, should decide whether to forego lifesustaining treatment. ¹³⁰ Using experience with long-term illness, rather than age, as a chief determinant, Leikin offers a composite for affording adolescents autonomy for decision-making. Beyond the adolescent's decision-making capability, Leikin urges that caring support and counseling be afforded dying adolescent patients. This caring support and counseling "contribute[s] greatly to reducing the patient's anxiety and insecurity, thereby enhancing reasoned decision-making and providing personal meaning to all those involved."¹³¹

Should the adolescent not satisfy the criteria for decision-making capability under this framework, Leikin finds it unacceptable not to acknowledge any autonomy, because "it is inappropriate for the minor whose life is at issue to be totally on the sidelines in such a decision."¹³² In this situation, Leikin advocates for patient assent, meaning that the adolescent's preferences should be accommodated, pain should be managed, and emotional and psychological sustenance should be provided. Decisions about foregoing life-sustaining treatment, however, should be made jointly by parents and attending physicians.

In situations where adolescent patients would be assessed incapable of deciding to forego life-sustaining treatment by not satisfying the capacity criteria, the process for decision-making takes on added importance for Leikin. Other commentators concur and focus primarily on the decision-making process itself. Jennifer Rosato avers that adolescents should be afforded legal decisional autonomy for determining end-of-life care "when they are sufficiently mature and when the state's interest is not strong enough to circumscribe that right."¹³⁴ Rejecting a bright-line test for legal autonomy in executing healthcare directives as "potentially over- and underinclusive,"¹³⁵ Rosato contemplates legislative revision to existing advance directive statutes to include minors who are terminally ill and who obtain parental permission to execute a directive. She contends that:

Minors who are mature enough to make treatment decisions should be mature enough to choose in advance what treatment they desire or who they want to make these decisions for them. Executing an advance health care directive is simply an alternative way to exercise the right to make decisions regarding life-sustaining treatment.¹³⁶

Both Rosato and Leikin articulate testable assertions that would enrich knowledge about adolescent end-of-life care. Rosato asserts, for instance, that mature minors should be legally recognized for executing advance directives.¹³⁷ This assertion suggests that minors who are mature enough to determine medical care generally deserve legal autonomy to direct medical care in advance of incapacitation caused by terminal illness or permanent unconsciousness. Yet, there is a question whether maturity in the context of medical treatment decision-making translates into deciding end-of-life care where the consequences of decision-making are heightened and quality of remaining life is paramount. Thus, adolescent maturity and the criteria for assessing maturity in comparative contexts of treatment decision-making and refusal of life-sustaining treatment merit rigorous examination in order to inform legal policy-making.

Rosato proposes, moreover, that advance directive legislation should be revised to recognize minors who choose to execute advance directives.¹³⁸ This proposal sets forth significant points for knowledge acquisition. For instance, information is needed about how an advance directive potentially impacts the dynamic of family relationships, particularly the impact between parent and child, including whether an advance directive could allay parental guilt and grief in decision-making about the adolescent's care and whether advance

directives would impact the interpersonal responsiveness of parents to the adolescent during the dying process.

The impact of adolescent advance healthcare planning on the quality of medical care deserves investigation, especially into attending physicians and their approaches to patient care in this context and the development of goals for patients who are dying young. It is not altogether clear that affording adolescents legal autonomy through advance directives would result in their empowerment within the dynamic of a doctor-patient relationship. As commentators have cautioned, "physicians wield a power that is largely positive and salutary, and this power may result in a loss of patient autonomy if left unchecked or unguarded."¹³⁹ Additionally, researchers have found that physicians are unlikely to elicit or explore patient values for advance healthcare planning.¹⁴⁰ Points deserving critical exploration with physicians include emotional barriers for delving into adolescent patient values and amenability to advance healthcare planning discussions with adolescent patients, including the level of comfort with honoring a patient's advance directive. Points requiring research with adolescents include whether advance directives (and the discussions attendant thereto) provide terminally ill adolescents with a sense of empowerment, control or even relief. This includes providing adolescent patients with a sense that they can shape others' perceptions about their dying and achieve depths of personal meaning. Leikin conjectures that youths "benefit when one respects their capacity to express their desires, their feelings, and their potential for self-determination"¹⁴¹

The approaches elucidated by both Rosato and Leikin find support from the American Academy of Pediatrics, which recommends that "considerable weight" be given to the wishes expressed by mature minors.¹⁴² In a policy statement drafted by the Committee on Bioethics, the Academy maintains that the informed decision of a dying adolescent to refuse life-sustaining medical treatment "ought to be respected,"¹⁴³ and that a minor's advance directive "should serve as strong evidence" of those wishes.¹⁴⁴ The Academy reasons that, in the case of a mature minor, "the ethical and legal presumption of capacity should govern, unless countervailing evidence arises to call the presumption into question."¹⁴⁵ Accordingly, mature minor patients should be presumed capable for medical decision-making, including the decision to forego life-sustaining medical treatment. The substituted judgment standard of proxy decision-making, therefore, should apply in the event the minor becomes incapacitated, especially "when [the minor's] wishes are known or may be deduced."¹⁴⁶

Courts have similarly recognized substituted judgment as the appropriate standard by which proxy decisions are made on behalf of adult and adolescent patients-the proxy attempts to make the medical decision in the way that the patient would have made the decision.¹⁴⁷ Any previously expressed values and wishes of the patient, verbal or written, aid the proxy in this decision-making process.

Assertions set forth by the Academy of Pediatrics, such as presumed capacity of mature minors, are testable. The assertion of presumed capacity assumes a direct correlation between maturity and decision-making capacity. Yet, there is a question whether maturity sufficiently correlates to or should be requisite to decision-making capability for medical care. This is especially the case when that capability is "specific to a particular decision" and, thus, may vary depending on the particular decisional task at hand. ¹⁴⁸ Assuming there is more than a modest correlation between maturity and decision-making capability for medical care, there are questions concerning how maturity should be defined and determined in the context of end-of-life decision-making and by whom the determination of maturity should be made. ¹⁴⁹

Moreover, while the Academy qualifies the decisional capacity of a mature minor patient when "countervailing evidence arises to call the presumption into question," it provides no guidance regarding the nature of "countervailing evidence" or how the presumption should be questioned.¹⁵⁰ Would an adolescent's refusal of life-prolonging treatment constitute countervailing evidence under the Academy's framework? Would a challenge to that refusal by a parent or physician constitute countervailing evidence? Inasmuch as the Academy attempts to promote decisionmaking by dying adolescents, its reasoning suggests a parental rights approach, contrary to its objective for recognizing and respecting adolescent decisions in this specific context of care. Although the Academy's policy statement provides some guidance for physicians who care for dying adolescents, the policy statement exposes assertions that are both testable and refutable with respect to increased understanding of the issues related to adolescent end-of-life care and the decisionmaking process.

These proposals are important for generating ideas and challenging potentially outdated social and cultural norms that have shaped current law governing minors' medical decision-making. Along with cues from courts that have decided issues related to adolescent end-of-life care, which will be discussed in the next section, these proposals present testable

assertions that invite scientific scrutiny to build the metaphoric bridge between evidentiary findings and legislation so that legal policy corresponds to reality. Decision-making for critical and life-prolonging care is so closely connected with individuality and self-identity that the Supreme Court, in *Cruzan v. Director, Missouri Department of Health*, ruled that competent adults possess a liberty right to refuse life-sustaining medical treatment.¹⁵¹ Other than dicta concerning conventional notions about adolescence that are thought to impair competent decision-making, the Supreme Court has yet to determine the decisionmaking autonomy of adolescents, nor has Congress put forth a cohesive national policy regarding adolescent decision-making for medical care to guide the states. By contrast, the federal Patient Self-Determination Act is backed by a unified policy assumption of adult decision-making competency and, therefore, expressly directs states to further national policy and place obligations on medical practitioners and healthcare facilities to safeguard this right.¹⁵²

Several state courts, confronted with issues related to de-escalation of life-prolonging measures for dying adolescent patients, have thoughtfully highlighted assertions for knowledge inquiry. These assertions elucidate points for investigation related to adolescent ability to decide medical care, including the competing interests at stake and how these interests ought to be balanced. These judicial assertions present opportunities for inquiry through scientific method and, in turn, promote collaboration between science and legal policy-making to establish a legislative framework that is responsive to adolescent decision-making ability.

IV. CASE LAW AND ASSERTIONS FOR SCIENTIFIC INQUIRY

As the preceding discussion of state statutes and legislative proposals demonstrate, devising legislation related to adolescent medical decision-making is a challenge for legal policy-makers. Statutes that afford legal autonomy to adolescents for medical care foster, to some extent, a policy for encouraging responsible decision-making. These statutes are problematic, however, because they resonate with divergent policy goals, thereby lacking any solid framework concerning the actual decision-making ability of adolescents. A lack of cohesive framework that recognizes the decision-making ability of adolescents results in tension among policy aims that thwarts what policy exists to further adolescent decisional development. This generates confusion among practitioners who must interpret and apply these provisions when caring for adolescent patients.

Interpretation and application of legislative provisions by practitioners in the absence of decisive policy also heightens a risk for policy distortion. For instance, California promotes confidentiality in the physician-adolescent patient relationship on one hand, while placing physicians in the position of disclosing the information to a parent upon request, despite professional ethics to maintain patient confidentiality, on the other.¹⁵³ Results from a study of practices of physicians who care for adolescents reveal that physicians believe adolescents are capable for medical decision-making, and that it is ethically appropriate to protect adolescent confidential communications.¹⁵⁴ Adolescents likewise regard confidentiality as the single most convincing factor in their decisions to seek medical care.¹⁵⁵ While states such as California strive to promote patients' health, along with family relationships, this goal may be better accomplished by fostering relationships between parents and adolescents, rather than by legislating parental responsibility, which could compromise professional patient care obligations.

Because scientific study suggests a decision-making ability of adolescents that is currently not reflected in law, decision-making ability has become a determinant that is central to formulating policy and devising legislation. Although further research is required to accurately determine the elements for defining adolescent decisional capacity, the definition of medical decision-making capacity for adults found in the District of Columbia's legislative code is ubiquitous to law. It defines capacity as "the ability to understand and appreciate the nature and consequences of the proposed treatment, including the benefits and risks of, and alternatives to, the proposed treatment, and to make and communicate a decision regarding the proposed treatment."¹⁵⁶

Among issues that require research and rigorous testing is whether the components of this decisional standard—the ability for understanding, rational deliberation and communication of choices and concerns—are adequate for assessing both adult and adolescent ability for decision-making. Despite the ubiquity of the standard, there is an empirical question concerning the legitimacy of a singular standard by which to assess both adult and adolescent capacities given differences in the development of cognitive stages. One issue for research investigation, then, is the exploration of criteria for adequate assessment of adolescent decision-making ability. It is possible that adolescent decisional ability is sufficient to satisfy a capacity standard that deserves legal protection, but the ability is being assessed neither adequately nor accurately. ¹⁵⁷ A standard for assessing adolescent ability for

medical decision-making could emerge, for example, from study of adolescent ability within different medical settings or from a study of comparative groups of adolescents, children and young adults in specific healthcare contexts. Although decisional capacity defies a single construct, the definition found in the District of Columbia Code is, nonetheless, the standard for capable medical decision-making on which courts rely when determining the legal decisional autonomy of adolescents. 158

To formulate a legislative framework that can adequately address and resolve issues related to adolescent patient care, it is important to identify the interests at stake, as well as the underlying empirical questions that necessitate scientific inquiry. Court opinions that have addressed adolescent medical decision-making provide important cues for points that compel research through scientific method to inform and to illuminate understanding by policy-makers about adolescent decisionmaking ability. Investigation of these points through scientific method is crucial for a thorough understanding about adolescent decision-making ability and for development of a comprehensive legislative framework. Prior to establishing a legislative framework for adolescent legal autonomy in medical care, related but distinct areas for research must be realized. These areas include adolescent ability for medical decision-making and the decision-making process. A close examination of the case law is, therefore, warranted.

V. CUES FROM CASE LAW CONCERNING ADOLESCENT DECISIONMAKING

Beyond serving as precedent on which other courts and state legislatures rely when considering issues related to adolescent legal autonomy, these cases are important for several reasons. First, jurists in these cases identify points that merit in-depth examination for crafting legislation. Indeed, jurists in these cases have set forth testable assertions for cross-disciplinary knowledge progress, demonstrating the desirability of scientific method to enhance not only understanding by legislators about adolescent decision-making ability, but to increase guidance for jurists when confronting conflicts left unresolved by legislation.

These cases are also important because jurists have encouraged development by highlighting the gaps and inconsistencies in both knowledge and norms underpinning present legislation. The New York Supreme Court, for instance, urged the policy-makers of that state to undertake the examination and the development of policy related to adolescent medical decision-making.¹⁵⁹ Less directly, other jurists have leaned on the long-standing

pillar of checks and balances that supports the legal structure to defer prescription for rules "that concern such important public policy and societal concerns" to the legislative arena.¹⁶⁰ Consistent with deference to the policy domain, jurists have exposed fallacies and underlying inconsistencies in current legislation that suggest the need for exploration and refutation. Only through exposure may fallacies in present policy be subject to rigorous testing in order to carefully consider whether the assumptions supporting the fallacies can be corroborated or eliminated—a method of trial and elimination of error in knowledge acquisition through collaboration between science and law. Jurists' abilities to influence policy-makers' consideration and conceptualization of adolescent legal autonomy—and the scope of that autonomy—are closely allied when deciding medical care.

A. BELCHER V. CHARLESTON AREA MEDICAL CENTER 161

Of the courts that have addressed issues related to medical decision-making by and on behalf of adolescents for critical and life-prolonging care, the Supreme Court of Appeals of West Virginia in *Belcher v. Charleston Area Medical Center* 162 focused primarily on the decision-making ability of the adolescent patient at issue. Larry Belcher, then seventeen, was afflicted with muscular dystrophy. When his disease exaggerated the effects of a cold, he was intubated and put on a respirator. Physicians spoke about Larry's condition with his father, who ultimately consented to a Do Not Resuscitate (DNR) order, which would prevent re-intubation or resuscitation of Larry in the event of respiratory failure. 163 Despite his debilitating condition, Larry was not cognitively impaired and he was able to communicate. Yet, no one discussed the option of a DNR order with Larry. Larry died when physicians failed to resuscitate him as a result of the DNR order that his father had authorized.¹⁶⁴

The *Belcher* court demonstrated concern, not only for the integrity of the decision-making process, but for safeguarding preferences of the adolescent whose condition (and life) was at issue. While highlighting state statutes that recognize legal autonomy for adolescent medical decision-making, the court noted the void in legislative intent to establish a comprehensive policy framework. The court determined, therefore, that a proactive stance by the judiciary was appropriate, and adopted a "mature minor doctrine" that would extend to adolescents an opportunity to be assessed capable for mature judgment and afforded legal protection for medical decision-making. 165

In making this determination, the court reasoned that physicians, rather than judges or parents, possess the expertise to assess an adolescent's capacity to "appreciate the nature, risks, and consequences of the medical procedure to be performed, or the treatment to be administered or withheld."¹⁶⁶ The court, however, did reserve a measure of discretion by noting "no hard and fast rule" for making this determination.¹⁶⁷ Deferral to medical practitioners, however, may be an impetus for legislators not to develop cohesive policy in this area. While a study of physician perceptions and practices toward adolescent medical decision-making suggests that doctors believe they are deserving of this deference,¹⁶⁸ such deference is warranted only if a solid policy framework is in place to guide these determinations in a fair and even-handed way. This is especially so given the profound potential impact on adolescent lives.

While the Belcher court's adoption of the mature minor doctrine, moreover, may seem to represent a possible solution, the doctrine itself is problematic from both a practical and policy standpoint. A court's factual findings on the elements that comprise this doctrine will be ad hoc short of a policy framework that recognizes adolescent ability. Although ad hoc decision-making by judges is inherent to individual assessment, it also accords unlimited discretion that invites rulings made on a pretext of maturity (or immaturity). The concept of maturity has been sacrosanct to courts when determining ability for legal decision-making, but it defies any precise definition to guide judges.¹⁶⁹ It has also been grist for scholarly commentary and critique.¹⁷⁰ As several commentators have emphasized, "the nature and development of maturity among adolescents is poorly defined by empirical evidence."¹⁷¹ Maturity, along with other elements comprising the mature minor doctrine as a legal standard, needs to be fleshed out through scientific method for thorough examination. Examination should include whether these elements are effective measures for evaluating adolescent competency for medical decisionmaking, whether these elements merit equal weight, whether each element requires evidentiary findings by a court and, if so, how the balance among the elements should be struck.

In addition to maturity, the Belcher court asserted that experience, rather than age, seems a more reliable indicator for affording legal protection to adolescent medical decisions, although the court appeared to equate experience with maturity. As to this assertion, the court reasoned, "[i]t is difficult to imagine that a young person who is under the age of majority, yet, who has undergone medical treatment for a permanent or recurring illness over

the course of a long period of time, may not be capable of taking part in decisions concerning that treatment."¹⁷² By linking experience with the condition of long-term or life-threatening illness, the court acknowledges personal suffering in a way that signifies recognition and respect by legal policy. Accordingly, Larry's death notwithstanding, the court remanded the matter back to the trial court to determine whether Larry had been a mature minor and, therefore, should have decided whether he would have consented to a DNR for de-escalation of aggressive measures to prolong his life.¹⁷³

B. APPLICATION OF LONG ISLAND JEWISH MEDICAL CENTER¹⁷⁴

The New York Supreme Court's analysis in *Application of Long Island Jewish Medical Center* provides a striking contrast to *Belcher* in that it departs from the trend toward individualizing the decisional capability of adolescents.¹⁷⁵ The New York Supreme Court considered whether to afford legal protection to seventeen-year-old Phillip Malcolm's decision to refuse a blood transfusion to treat his tissue cancer that caused him to suffer from severe anemia.¹⁷⁶ Physicians recommended a course of chemotherapy and radiation, which could not be undertaken without consent to the transfusion. ¹⁷⁷ As Jehovah's Witnesses, both Phillip and his parents withheld consent. Physicians believed that, without the transfusion, Phillip would die, although the prognosis, even with treatment, was less than fifty percent.¹⁷⁸

Unlike the patient-centered approach employed in *Belcher*, the New York court proceeded in "its role of *parens patriae*" to determine whether it should order unlimited blood transfusions for Phillip.¹⁷⁹ Ruling that it should order the transfusion, the court rejected the patient-oriented approach advocated by Phillip and his parents, namely, that "an intelligent, articulate young man, just weeks shy of his eighteenth birthday, has a due process right to make medical decisions for himself consistent with his values and convictions prior to losing the right to control his body."¹⁸⁰ The court also dismissed Phillip's testimony about his religious beliefs and why he would not accept blood transfusions. ¹⁸¹

Although it cited to New York statutes that permit adolescent legal autonomy for certain forms of treatment, such as STDs, and finding "much merit" in the mature minor doctrine that had been adopted by the West Virginia Supreme Court of Appeals in *Belcher*, the New York court declined to adopt the doctrine, ¹⁸² The court also failed to adopt any framework for considering whether Phillip was a "mature minor." In finding that he was not, the court noted

that "his refusal to consent is not based upon a mature understanding of his own religious beliefs or the fatal consequences to himself."¹⁸³

A major deficiency in the court's reasoning was its failure to undertake any analysis of what maturity meant in the context and whether Phillip was, in fact, mature enough to make the decision. The court also failed to analyze the factual record before it and to take seriously Phillips refusal of treatment based on his religious beliefs. Using *parens patriae* as a pretext to possibly mask an unease for allowing a young man to refuse treatment that could potentially extend his life, the New York court's narrow view of *parens patriae* thwarted the benevolence underlying it, along with existing state legislative policy-which the court referenced-that increasingly recognizes adolescent legal decision-making for medical treatment.

The court's cribbed view of *parens patriae* devalued the personal experience of Phillip and his suffering from serious illness in a way that marginalizes adolescent dignitary and decisional interests adversely affecting individual growth. In fact, results from the scientific study of adolescents suggest that they feel respected when they are taken seriously, which positively impacts their self-identity and personal involvement in their medical care.¹⁸⁴ By debilitating the exercise of liberty rights for private, intimate decision-making and by relinquishing responsibility as a guardian of those rights, the court's view reduced the increasing legal recognition for adolescent decisional autonomy. Instead, the court simply stated that Phillip will shortly "become an adult and his life will then be in his own hands,"¹⁸⁵ and deferred the task for taking "a hard look at the mature minor doctrine for either statutory or decisional law in New York" to the legislature. ¹⁸⁶

Legal reasoning by courts plays a constructive role in comprehensively addressing the many significant aspects of adolescent medical decision-making that require legislative attention. The quality of that reasoning tends to simplify and clarify points, not only for policy examination, but for scientific testing. Simplification and clarification are indispensable to imaginative ideas, and to challenging assumptions on which ideas are based.¹⁸⁷ Although the New York court was poised to assist state legislators to whom it deferred the ultimate determination about adolescent medical decision-making, its reasoning defies even a basic structured argument that requires warrants, backings and rebuttals for the position advocated.¹⁸⁸ The absence of these elementary components in legal reasoning obscures

the fallacies of judges' analyses, and prevents clarification and emergence of assertions to enrich knowledge acquisition and policy formulation.¹⁸⁹ When judges incorporate components of structured argument in legal analysis, they simplify and clarify assertions for continued exploration and critical examination, thereby assisting in knowledge acquisition for developing legislative policy.

C. COMMONWEALTH V. NIXON¹⁹⁰

Without a cohesive legislative policy in place to guide courts, distortion of existing piecemeal policy and invocation of inapposite policy is not uncommon in cases involving adolescents and medical care. The Pennsylvania Supreme Court illustrated this distortion when it addressed whether parents convicted of involuntary manslaughter and child endangerment in the death of their adolescent daughter from diabetic acidosis could raise the mature minor doctrine as an affirmative defense.¹⁹¹ Rejecting the defense, the Pennsylvania high court relied on the West Virginia Supreme Court of Appeals' decision in *Belcher* that discussed whether a DNR order could be approved by a parent without consulting the adolescent patient.¹⁹²

The court's invocation of inapposite policy and its juxtaposition of distinct policy considerations are problematic. The policy considerations underlying *Belcher* implicate adolescent liberty rights and dignitary interests in decision-making about whether resuscitation is desirable for a patient suffering from the long-term condition of muscular dystrophy. In *Commonwealth v. Nixon*, however, the court dealt with the policy considerations related to parents' responsibility and culpability in the death of their daughter, based on their own religious beliefs, in the absence of any evidence regarding the adolescent decedent's autonomous choice.¹⁹³ Thus, judges' understanding of the issues and use of analogies would be sharpened by exploring the policy points related to adolescent decisional autonomy through scientific method. Pitfalls would be prevented and precise legal reasoning and precedent would be promoted.

Beyond distorting policy and marginalizing Phillips decisional and dignitary interests, the New York court overlooked an important opportunity to identify policy points that merit in-depth examination and that otherwise evade a public policy forum due to the intimate nature of the decision-making conflict. Judicial reasoning can heighten policy-making attention to adolescent legal autonomy, as well as contribute to scientific research related to adolescent

decisional capability that informs policy makers about how to define and conceptualize adolescent legal autonomy. Indeed, the New York court could have highlighted policy concerns specific to adolescents whose deeply-held religious beliefs influence medical decision-making about life-threatening illness in order to identify the relevant interests for policy-making deliberation that otherwise would not be exposed for exploration.

The New York court, for instance, should have further developed its analysis of the ability of an adolescent just weeks shy of legal majority to forego medical care for a terminal condition that had caused him personal struggle and suffering, and the effect of strongly-held religious views on that ability.¹⁹⁴ Development of these points is salient to law because they impact not only individual values, but legal rights and, ultimately, the quality of life when any person, adolescent or adult, confronts the challenge of a life-threatening condition. Thus, the court "in its role of *parens patriae*" should have devoted far greater attention to elaborating points for policy exploration by the New York legislature, to which it deferred judgment about adolescent legal autonomy.

This failing by the New York Supreme Court to expose pitfalls in existing legal policy and to articulate points for policy examination reinforces a problem of unfettered discretion in the absence of legislative guidance. The court's decision indicates a level of discomfort with authorizing an adolescent's refusal of life-prolonging treatment akin to that exhibited by trial court judges in cases of decisionmaking conflicts concerning adult patients when life hangs in the balance.¹⁹⁵ The absence of policy guidelines with respect to adolescent medical decision-making has led judges to impose personal values and preferences in a way that they believe would be best for the adolescent, regardless of the adolescent's desires, and then buttress the desired result by using, as pretext, an evidentiary record from which judges selectively draw to achieve the result.¹⁹⁶ For example, the court referred to a testimonial statement by Phillip that, if the court ordered the transfusion therapy, he would not be responsible, which the court interpreted as a personal lack of understanding about his religious beliefs.¹⁹⁷ The community of Jehovah's Witness, however, maintains that compulsory transfusion without the individual's consent does not implicate personal responsibility and accountability inconsistent with religious tenets of their faith. This would seem to actually strengthen a finding by the court about Phillips ability to understand the teachings and tenets of his religion.

D. IN RE SWAN,¹⁹⁸ IN RE GUARDIANSHIP OF CRUMB¹⁹⁹ & IN RE ROSEBUSH²⁰⁰

Even courts favorably inclined toward recognizing the medical decision-making of adolescents and respecting their personal preferences have likewise tended to frame issues and evaluate evidence in ways that are outcome determinative. In these cases, however, it is not clear whether the courts, by extending legal recognition to adolescent expressions, intended to influence policy by empowering adolescent decision-making, or whether the courts were essentially using evidence of adolescent expressions as subterfuge for ultimate deferral to the decision-making of parents. In re Swan, In re Guardianship of Crum and In re Rosebush are instructive in this respect.

In Swan, the Maine Supreme Judicial Court recognized an adolescent patient's legal right to refuse life-sustaining treatment-reinsertion of a gastrostomy tube while in a persistent vegetative state-by relying on evidence of the adolescent patient's previously expressed wishes regarding medical care.²⁰¹ An automobile accident had rendered seven teen-year-old Chad Swan vegetative, necessitating the insertion of a gastrostomy tube for hydration and nutrition. When the tube eroded, the court was asked whether it should be reinserted despite "virtually no hope" for improvement or for regaining any form of cognitive function.²⁰² The attending physicians recommended that the tube, which presented surgical risks along with gagging, irritation and diarrhea, not be reinserted, and Chad's parents agreed. Concerned about the potential for civil and criminal liability, the Swans sought and obtained declaratory relief in the trial court of Maine.²⁰³ Evidence, adduced through testimony by Chad's mother about his prior expressed wishes on two separate occasions regarding unwanted medical treatment, persuaded the court to conclude that Chad would not consent to reinsertion of the gastrostomy tube.²⁰⁴

The district attorney, on grounds of preservation of human life, prevention of suicide, medical profession integrity and third party interests, challenged the relief granted by the trial court, appealing the decision to the Supreme Judicial Court of Maine. The district attorney argued that any right that Chad might possess to refuse life-sustaining medical treatment was significantly reduced because Chad was under the legal age of majority when he expressed those wishes. The state high court rejected the district attorney's argument, characterizing Chad's wishes expressed prior to his eighteenth birthday as "at most a factor to be considered by the fact finder in assessing the seriousness and deliberateness" of his

declarations 205 and emphasizing an evidentiary record that reflected Chad's "expressed well-formed desires as to medical treatment."²⁰⁶

In *Crum*, similar to the situation in *Swan*, the parents of an adolescent requested that the Ohio Probate Court authorize the withdrawal of a gastrostomy tube that was sustaining an adolescent's life.²⁰⁷ At age twelve, Dawn *Crum* acquired viral encephalitis, which caused a rapid deterioration into a chronic vegetative state and the need for respiratory support. The Ohio court's analysis cited to common law precedent recognizing a competent adult's liberty right to refuse life-sustaining treatment. The court framed the issue as "whether an incompetent individual-both mentally and due to age-also possesses a right to terminate or refuse life-sustaining nutrition and hydration."²⁰⁸

Based on cases dealing with privacy interests in the context of treatment refusal, and the Supreme Court's *Cruzan* decision, the *Crum* court found that the state's interests of preservation of human life, prevention of suicide, third party interests and medical profession integrity were each outweighed by Dawn's right to refuse continuation of the gastrostomy tube to prolong her life.²⁰⁹ The court also cited pending state legislation at the time, finding a policy intent of the Ohio legislature to expand legal protection for adolescent medical decision-making, and based its authority regarding the decision to forego life-sustaining medical treatment for or on behalf of a minor on Ohio probate law.²¹⁰

In granting the parents' request, the court highlighted hearsay testimony that Dawn had previously commented about a foster child who suffered from spina bifida, saying that it was unfair for him to live like that and that she would not want to live like that. While acknowledging her minor legal status that prevented her from having "the experience [or] the insight to make informed decisions as to her future care," the court nevertheless found this evidence persuasive, stating that "if she were aware of her condition, [she] would not want to remain in her current state."²¹¹ By authorizing the withdrawal of nutrition and hydration, the court concluded that Dawn would be able "to die peacefully, painlessly, and with dignity."²¹²

By focusing on evidence relating to the adolescent's express wishes, the courts in *Swan* and *Crum* signaled expanding legal recognition and respect for adolescent autonomous wishes. Both courts structured their analytical framework in a way that maximizes recognition for adolescent legal autonomy in medical decision-making. In contrast to the New York Supreme Court's statement of the issue as whether the court in its role of *parens patriae* may order

blood transfusion therapy for a minor, the courts stated the issue as whether a minor may refuse life-sustaining treatment. Yet, a closer reading of these cases suggests that, contrary to the analytical framework, judicial intent for recognizing adolescent decisional rights is not altogether clear from the analyses.

Although the courts addressed the importance of liberty rights in intimate, personal matters such as medical decision-making, the courts' reliance on hearsay testimony from parents suggests that they may have been influenced by the cultural and legal norm that the care and nurturance of minors reside first with the parents. Thus, the courts afforded parents the legal decisional autonomy they desired for authorizing de-escalation of aggressive measures to prolong the lives of their minor children who were in persistent vegetative states. Aside from a fiction of furthering adolescent, rather than parental, autonomous wishes, a principle problem in the line of reasoning by these courts was the failure to employ any standard by which to assess whether the minors at issue had been decisionally capable at the time their wishes were expressed, in contrast to the decisional capability analysis used by the Belcher court. The Ohio Probate Court's reliance on hearsay testimony that Dawn reacted to a specific context with an off-handed remark about a child with spina bifida to conclude that Dawn would wish to decline life-prolonging measures for her condition was even less reliable. The Michigan Court of Appeals stretched the evidentiary record and raised issues sua sponte in determining whether life-support could be removed from twelve-year-old Joelle Rosebush.²¹³ Joelle was eleven when she was involved in an automobile accident that left her in a persistent vegetative state and unable to breathe without a respirator. A medical prognosis of "no recovery" prompted Joelle's parents to authorize the removal of their daughter's life-support.²¹⁴ Staff at the facility where Joelle had been transferred, however, contacted the local prosecutor, who obtained injunctive relief from the circuit court to enjoin the life-support removal. Following a week-long trial, the circuit court dissolved the preliminary injunction and authorized Joelle's parents to "make any and all decisions regarding [her] medical treatment."²¹⁵ The prosecutor appealed to the Michigan Court of Appeals, which affirmed the circuit court's decision.²¹⁶

The appellate court in Rosebush framed the issue as whether a patient has a right to forego life-sustaining treatment that stems from the common law doctrine of informed consent.²¹⁷ Although the court recognized, as did the Supreme Court in Cruzan, that states may advance interests in the preservation of life, prevention of suicide, medical profession

integrity, and third parties, the Michigan appellate court found that these interests were outweighed by Joelle's right to forego unwanted life-prolonging treatment and that her youth did not impede exercise of this right.²¹⁸ Although the court did not squarely address the issue of adolescent patient decisional capacity as a prerequisite for the exercise of this right, the court ruled that minors have the same right to decline life-sustaining treatment as their adult counterparts and that parents are appropriate proxy decision-makers for this right.

While the Michigan appellate court's reasoning relied on guesswork about Joelle Rosebush and extended beyond the precise issues presented, it was, nonetheless, sensitive to evolving cultural norms prevalent in adult patient care that impact adolescent patient care. For example, the court's assertion about parents as appropriate proxy decision-makers incorporates terminology widely used in adult patient care. Despite reinforcing the long-standing norm of deferral to parental determinations that was evidenced by the reasoning of the courts in *Swan* and *Crum*, this assertion by the Michigan appellate court further suggests points for empirical study and policy examination. These points include a basis on which parental decision-making for an incapacitated minor patient may be vulnerable to challenge in the clinical setting, and whether the parent or adolescent, or the adolescent's previous expressed wishes, should prevail in a case of decisional conflict. This is especially so if the adolescent had been deemed decisionally capable by medical professionals.

The Michigan appellate court's assertion that adolescents should be included in legislation that affords legal protection for advance directives, including DNR orders, invites scientific scrutiny. DNR orders, which express a patient's wishes, are largely a product of a policy-driven process within a medical institution, so there is little incentive for legislators to address them. However, given the legal issues related to the decisional rights at stake, legislative guidelines are warranted. Legislative guidelines may also prevent the dilemma faced by physicians at the Charleston Area Medical Center that resulted in a request for declaratory judgment in *Belcher*. In addition to the points discussed previously in relation to commentators' proposals for recognition of adolescent patients in advance directive legislation,²¹⁹ scientific study about adolescent decision-making capability is desirable to drive policy consideration concerning legislative enactment to this end or revision to current legislation that would explicitly include minors.

Living will and power of attorney statutes that provide express legal protection for individual treatment preferences and for proxy decision-makers in the event of incapacitation do not include adolescents.²²⁰ Several statutes, however, implicitly include adolescents by engrafting circumstances, such as marriage or high school graduation, that, if satisfied, would extend legal protection to an adolescent's advance directive.²²¹ An adolescent's written declaration of wishes that was executed prior to existence of these circumstances would, of course, be problematic for the interpretations of these statutes. A policy encouraging the expression of wishes from chronically or critically ill adolescents in advance of medical crisis may allow them to derive a sense of meaning and control from an otherwise uncontrollable situation.²²² Thus, empirical studies should examine whether encouraging adolescents to articulate preferences for medical care in advance of incapacitation would contribute to self-realization and personal fulfillment, especially when confronted with life-threatening conditions.

Similarly, judicial assertions concerning proxy decision-making on behalf of an adolescent patient invite research. The Georgia Supreme Court, in a case involving the interpretation and application of a DNR statute for an incapacitated, dying adolescent, endorsed the view "that medical decision-making for incompetent patients is most often best left to the patient's family (or other designated proxy) and the medical community."²²³ How this "designated proxy" is decided and who makes this designation require exploration. If an adolescent patient desires a person other than a parent as a proxy decision-maker, should that decision be honored and implemented? The dynamic of that decision raises points meriting investigation, including how discussions about proxy decision-making should be conducted with the adolescent patient and who should be involved in those discussions. The reasoning by the courts in Maine, Michigan and West Virginia seem to suggest that the adolescent patient's proxy designation is determinative. A related inquiry is, by what standard should the proxy decide the adolescent's medical treatment-- substituted judgment, best interests, or a combination thereof? In *Rosebush*, for example, the Michigan Court of Appeals advanced the testable assertion that "where a patient . . . is a minor of mature judgment-the substituted judgment standard is appropriate" when a proxy is making a decision on behalf of an adolescent patient.²²⁴ Yet, as several courts have indicated, even a substituted judgment standard suggests a degree of speculation, rather than specificity, regarding adolescent patient preferences.

The West Virginia Supreme Court of Appeals also showed sensitivity to evolving societal and cultural norms in its recognition of experiences that shape adolescent perception. Those experiences, however, seemed irrelevant to the New York Supreme Court when it declined to extend legal protection to Phillips judgment about his medical care. In *Belcher*, the West Virginia high court set forth an important, though frequently overlooked, testable assertion that experience with illness, rather than age, should be a chief determinant for assessing an adolescent as competent for medical decision-making. Referencing maturity in judgment, which has been the mainstay for judges when considering adolescent wishes, the court linked maturity not to coming of age, but to confronting the challenge of illness.²²⁵

Although the court acknowledged that adolescent decision-making capacity is inherently a factual assessment based on numerous determinants—age, ability, experience, education, training, and degree of mature judgment, as well as conduct and demeanor—it underscored experience with critical illness as a more reliable and predictive indicator of decision-making capacity than age markers that traditionally characterize laws governing minors. Limited scientific research does suggest that maturity levels in adolescents afflicted with terminal disease experience an escalation in cognitive development and responsible judgment in decision-making that surpasses even the decision-making capabilities of adults who have not experienced disease.²²⁶ However, more research is desirable to discover, among other points, whether serious and life-threatening illness heightens cognitive development for mature judgment in adolescents regardless of their age, how their personal circumstances, including their emotional and psychological support, impact this development, and the extent to which illness surpasses chronological age in that development. Comparing groups of critically and terminally-ill with non-critically or chronically-ill adolescents, for example, could adduce information valuable to assessing key determinants for affording legal autonomy to adolescents for medical care and to assigning weight to these determinants.

By focusing attention on the experience of illness and the dying process, the *Belcher* court responded to a changing social and cultural norm. This evolving norm respects individuality in dying and acknowledges the struggle and suffering of an individual, rather than subordinating the experience to silence and conformity that "degrade[s] the awesome, solemn act of dying," as poignantly described by Leo Tolstoy in his classic *The Death of Ivan Ilych*.²²⁷ The quality of care provided to a dying adolescent patient is a point that compels policy attention. The courts in *Swan*, *Crum* and *Rosebush* emphasized the quality of life at

the adolescent's end of life. Indeed, in *Swan*, the Maine Supreme Judicial Court punctuated its opinion with palliation treatment concerns, stating that, although it was "appropriate to leave to the parents the effectuation of Chad's medical decision," they should "ensure that Chad receives the palliative care necessary to meet his needs for humane treatment."²²⁸ In so doing, the court shifted its focus from the medical outcome and life prolongation to quality of care while dying. Although one might argue that the court, "perpetuat[es] the myth that palliative care is second best,"²²⁹ the court nevertheless highlights important inquiries about the effective use of treatments for palliation in the context of adolescent patient care. The court suggests, for instance, that parents, especially those who determine that de-escalation of aggressive care is appropriate for the adolescent, may be influenced in making palliative decisions by the way the issues concerning de-escalation have been resolved. This includes psychological and emotional responses, preparedness for the adolescent's death and bereavement support.

Assertions drawn from case law that are articulated by judges about adolescent decisional autonomy, including their decision-making ability to direct care through advance directives and to distinguish among options-conventional, complementary, experimental and palliative care-when confronted with terminal conditions, command consideration. The assertion by the Maine Supreme Judicial Court concerning "humane treatment" for Chad Swan, for example, requires further exploration: at what stage should physicians discuss palliative treatment with parents and, when possible, the adolescent patient, who should be involved in the discussion, and what treatment options constitute "humane treatment"?²³⁰ Although it did not squarely address humane treatment, the Ohio Probate Court in *Crum* underscored the importance of pain management, comfort and dignity for a dying adolescent²³¹, qualities commonly associated with palliation and hospice. Information about symptom and pain management, along with treating the emotional and spiritual needs of dying adolescents, adds richness to "humane treatment."²³² Although death is inherently individual and solitary because one dies alone, the process of dying should be inscribed with support and empathy for the emotional and spiritual needs of any patient, adolescent or adult.

The Maine high court's assertion in *Swan* further suggests that physicians and parents should discuss palliation with the adolescent patient prior to incapacitation, when possible, as a viable option, rather than as an option of last resort.²³³ Attention to exhausting all curative options prior to considering palliative care arguably delays the timely introduction of

palliation or referral to palliation specialists. Points related to palliation for adolescent patients should be closely examined in the clinical environment where medical perceptions and approaches to death and dying continue to evolve. Issues regarding palliative treatment of adolescent patients, along with points related to adolescent capability for deciding and directing medical care, underscore the benefit of collaborative efforts between science and law to inform policy-making. Complementary and distinct points related to the decisionmaking process likewise invite empirical examination and policy-making attention. State courts, once again, provide cues.

VI. CUES FROM CASE LAW REGARDING THE DECISION-MAKING PROCESS

Process is as important to legal determinations as method is to scientific findings. Both increase the quality and reliability of results and reduce the probability for error. Thus, the process for determining adolescent capability for medical decision-making is crucial to ensure just and accurate determinations for adolescent legal autonomy. Although continued testing through scientific method is desirable for establishing criteria to adequately gauge adolescent decision-making for medical care, a related question is who should make this determination.

One approach could be a legislative presumption that adolescents are decisionally capable, placing the burden on the person challenging the adolescent's capability. This approach signals two concerns. First, it assumes that the level of adolescent decision-making ability warrants a legal presumption. Adolescents may, in fact, be decisionally capable by scientifically indicated criteria, though still lack the life experience of adults that is thought to enhance responsible judgment. A legal presumption also presents an issue related to the strength and interpretation of evidence to rebut the presumption. As mentioned earlier, the Academy of Pediatrics proposes professional guidelines that include presumptive decision-making capability for "mature minors" but qualifies it when "countervailing evidence arises."²³⁴ Without any guidance regarding "countervailing evidence," the nature and weight of the evidence is subject to broad interpretation that essentially undermines a step toward recognizing adolescent decisional ability. For example, would a critically ill adolescent's refusal of life-prolonging treatment itself constitute countervailing evidence under such presumptive framework?

Second, a legislative presumption of adolescent decision-making capability could restrict physicians in their professional assessment of adolescent patient capability, compromising the quality of care. A study of primary care physicians suggests, for instance, that physicians believe their expertise qualifies them to determine whether an adolescent patient is capable for medical decision-making.²³⁵ Yet, as with judges ascertaining adolescent capability for expressing parent preferences in custody disputes,²³⁶ physicians do not believe that the law should limit their ability when making this determination, whether through a legal presumption or other legislative restraint.

In *Belcher*, the West Virginia Supreme Court of Appeals concurred by emphasizing the professional expertise of physicians and by urging those who care for adolescents to assess the patient's decisional capabilities guided by that expertise. While directing physicians to consider the adolescent's ability to "appreciate the nature, risks, and consequences of the medical procedure to be performed, or the treatment to be administered or withheld," the court noted "no hard and fast rule" for making this determination.²³⁷ The court deferred instead to physicians' exercise of their "best medical judgment." Placing the assessment solely within the realm of medical expertise, the court advised that the assessment should "be duly noted as part of the patient's records," and added that a physician's "good faith assessment" based on this expertise would provide immunity from liability for failing to obtain parental consent.²³⁸

By placing the assessment responsibility on doctors, the court asserts several points that are germane to the contours of the physician-adolescent patient relationship. A physician treating an adolescent patient may be viewed as a steward to *parens patriae*, and that stewardship may include assessing adolescent decisionmaking capacity and actualizing adolescent choices and desires, as suggested by the West Virginia Supreme Court of Appeals in *Belcher*.²³⁹ Medical decision-making capability, especially decision-making concerning chronic conditions, critical illness and end-of-life care is not monolithic; rather, it requires a set of collaborative skills between patient and physician. Such collaboration entails a dialogical model of physician involvement to facilitate patient skills for imagining the treatment process and for fitting it in with who the patient is. This allows the physician to determine how the patient processes information, including the concept of dying, to obviate psychological and emotional barriers that prevent a patient from being able to process

information and confront a condition, and to optimize adolescent patient decision-making capability for determining his or her well-being.

Facilitating the exercise of these skills by an adolescent patient through dialogue is an altruistic measure of the physician as a steward to *parens patriae* that fosters decision-making autonomy by enabling adolescents to achieve self-knowledge. In the end, beneficent treatment requires a proactive, rather than inactive, stance by physicians when caring for adolescent patients, thereby promoting the patient's sense of autonomous well-being. A failure to engage the adolescent arguably transforms into harm to adolescents confronting physical limitations and dying, and undercuts the physician's ethical obligation of nonmaleficence, do no harm.²⁴⁰ Consequently, the contours of both beneficence and nonmaleficence for adolescent patient care command consideration and clarification through further research.

Of course, physician assessment of adolescent patient decision-making ability not only raises research questions related to the scope of professional responsibility in adolescent patient care, but evidentiary standards to guide physicians when facilitating the patient's decision-making process and respecting patient preferences. While courts have required evidentiary standards as a matter of constitutional law when fundamental rights are at stake,²⁴¹ state policy-makers commonly establish evidentiary standards,²⁴² which courts have approved.²⁴³ Yet, courts have also highlighted policy points related to the establishment of evidentiary standards.

Swan, Crum and Rosebush are, once again, instructive in this respect. Testimony by Chad Swan's family members about his wishes persuaded the Maine Supreme Judicial Court by clear and convincing evidence that Chad would not agree to reinsertion of the gastrostomy tube to prolong his life.²⁴⁴ By contrast, the Michigan Court of Appeals in Rosebush rejected that same standard for respecting an adolescent's previously expressed wishes "because its adoption would always preclude the termination of life-support efforts for minors and other persons who have never been legally competent, in direct contradiction of the right to refuse medical treatment,"²⁴⁵ thereby inviting empirical exploration of the connection between the evidentiary requirement and implementation of oral or written directives of minors and other legally disabled persons to refuse treatment. According to the Michigan appellate court, the

best approximation of any patient's preferences on the basis of available evidence suffices.²⁴⁶

The range of reasoning employed by these courts emphasizes the desirability of information and policy development for determining the evidentiary standard by which courts should decide the legal autonomy of an adolescent to forego lifesustaining treatment. Although the court in *Rosebush* was concerned that a more exacting evidentiary standard would impede respect for adolescent decisions, this standard may actually be more true and empowering to adolescent medical autonomy by necessitating clear proof of the adolescent's wishes rather than reliance on speculative and ambiguous evidence. The Ohio Probate Court illustrated this when it was persuaded that "Dawn, if she were aware of her present condition, would not want to remain in her current state" based on a previous off-handed observation she had made about the plight of a child afflicted with spina bifida.²⁴⁷

As the court's analysis in *Crum* demonstrates, evidentiary standards are significant as a restraint on judicial discretion and for promoting consistency in analytical approaches to evaluating evidence. Consistency in the way that evidence related to patient decision-making is evaluated narrows the latitude for judges' personal views and values that, consequently, impact constitutional guarantees of liberty for personal, intimate medical decision-making. Just as heuristics and biases influence scientists in methodological processes,²⁴⁸ heuristics and biases influence judges who may be prone toward pretext when ruling on the extent of legal protection to afford adolescent preferences and decisions. Consistency in the way evidence is evaluated also provides guidance to medical practitioners with a measure of predictability that promotes beneficent and just treatment in adolescent patient care by reducing actual and perceived arbitrariness in their professional attitude and approach.

Courts' convergent approaches to evidentiary standards by which to evaluate adolescent decisions about medical treatment segue into a question concerning the role of courts, rather than institutional procedures, to discern adolescent decisions and to resolve conflict related to discernment of those decisions. The courts in *Doe* and *Rosebush*, for instance, refer to recommendations by institutional ethics committees.²⁴⁹ Ethics committees are comprised of cross-disciplinary viewpoints and are guided by bioethical values, rather than by legal concepts, raising questions concerning the degree to which deference is appropriate should the situation advance to court for resolution. Since the New Jersey Supreme Court's ruling in

Karen Quinlan's case,²⁵⁰ state courts have highlighted ethics committees as an institutional device appropriate for conflicts involving medical decision-making. While courts have encouraged, though not required, ethics committee intervention, questions remain regarding the extent to which courts should defer to ethics committee recommendations.

The Georgia Supreme Court, for example, was confronted with a decisionmaking dispute concerning the medical care of thirteen-year-old Jane Doe who suffered from a degenerative neurological disease that necessitated the use of a respirator and insertion of tracheostomy and gastrostomy tubes.²⁵¹ Jane had been afflicted with medical problems since birth.²⁵² Physicians discussed a DNR order with Jane's mother, who agreed to the DNR and supported the de-escalation of lifesupport for her daughter in the event of cardiac arrest. The institutional bioethics committee at Scottish Rite Hospital backed the mother's decision, but the father did not support it, so the hospital initiated a petition for declaratory relief.²⁵³

Following a hearing, the court entered an order to enjoin the de-escalation of treatment or the enforcement of a DNR order unless both parents agreed.²⁵⁴ The Georgia Attorney General intervened and appealed the trial court's order on the ground that the hospital lacked standing to petition the court for declaratory relief. Determining that the hospital constituted an "interested party" and, thus, had a stake in the case, the Georgia Supreme Court affirmed the trial court's order that both parents equally shared the decision-making responsibility, and that a Georgia statute permitted any parent to revoke the other parent's consent to a DNR for a child or adolescent, which Jane's father did. The court rejected the Attorney General's position that de-escalation of medical treatment was inappropriate on the basis that physicians could not diagnose with certainty the disease causing Jane's neurological degeneration and, therefore, death was not imminent.²⁵⁵ Although the court recognized a right of adolescent patients to refuse even life-sustaining treatment, it reasoned that adults possess what adolescents lack in decision-making capability and, thus, parents have the authority to decide the medical treatment for their adolescent daughter. Once the court established this broad decision-making scale for parental authority, the Georgia high court determined that the state statute controlled ²⁵⁶ -a determination not altogether unpredictable given the tendency of courts to order life-sustaining treatment-despite patient preferences to the contrary.²⁵⁷

Reference to the ethics committee recommendation pro forma by the Doe court appears inconsequential to its interpretation of the statute related to parents' decision-making about DNR orders. Despite the court's recognition for adolescent decision-making preferences, the opinion is devoid of any evidence as to whether Jane's preferences had been expressed and considered by the ethics committee. Jane had suffered with her physical afflictions since birth and may have expressed thoughts and preferences about her life. The court, moreover, failed to explain the extent to which the recommendation impacted the court's analysis, if at all, and why the court departed from the recommendation in its ruling.

Because the evidentiary status of an ethics committee recommendation remains unclear, courts appear to rely on the recommendation only when it bolsters the court's ultimate determination, as did the Michigan Court of Appeals in *Rosebush*. This, of course, generates an issue deserving empirical attention and policy consideration—specifically, whether a court is obliged to discuss in its analysis an ethics committee recommendation from which it diverges given the judicial disposition toward the value of ethics committee involvement in patient decisionmaking matters. The weight assigned to an ethics committee recommendation likewise merits attention.

An ethics committee is intimately associated with clinical care and concomitant conflicts in decision-making and, therefore, is poised to identify the personal values and individual interests involved in each case. Members of ethics committees, unlike judges, approach conversations with patients and family members one-on-one in an attempt to understand those values and interests. Confronting illness and dying is inherently individual, and a value-based approach to decisional conflicts through ethics committee consultation may be more true and meaningful to the narrative of a patient's life than an adversarial atmosphere of court. Lessons learned from the interests and underlying values at stake identified by ethics committee consultation also enriches policy-making with respect to contours for patient decision-making and the decision-making process.

Due to intimate interests and personal values related to patient decision-making, state courts concede their limited ability to effectively resolve disputes involving patient decision-making that may be more ably addressed through conversations in the clinical setting rather than through adversarial proceedings. Courts, therefore, maintain a stance of non-intervention in these private, clinical matters when possible. The Pennsylvania Supreme Court illustrated

this in its statement that judicial review is "neither necessary nor required" and is reserved for intractable conflict "among interested parties."²⁵⁸ The Michigan Court of Appeals similarly cautioned against judicial intervention into the medical decision-making process "even for minors" and relegated the court's role to assisting in the event of impasse.²⁵⁹ Yet, the New York Supreme Court in *Application of Jewish Medical Center* implicitly rejected a non-interventionist stance to justify proactive involvement under the aegis of *parens patriae* in Phillips' medical decision-making process. The appropriateness of judicial non-intervention in cases related to medical decision-making, then, is worthy of examination in the specific context of adolescent patient care.

Of the matters that do proceed to court for review, the appointment and role of a guardian ad litem becomes relevant. Courts appoint guardians ad litem in cases involving minors, whether children or adolescents. Guardians ad litem advance the best interests of the minor following an independent investigation and evaluation of the facts. Yet, the court in *Rosebush* stated that a guardian ad litem should only be appointed to exercise legal rights on a minor's behalf when either the parents as proxy decision-makers are incompetent or other family members are unavailable or unwilling to act as surrogates.²⁶⁰ Insofar as the appointment of a guardian ad litem is contingent on the absence of a proxy decision-maker for the purpose of exercising the minor's decisional autonomy, the Michigan appellate court recasts the role of guardian ad litem akin to a patient advocate that is afforded adults by statute or by institutional procedures. Guardians ad litem are largely a legislative creation. Their role in proceedings involving an adolescent's medical decision-making, therefore, merit close consideration to ensure consistency in policy, including the necessity and desirability of such appointments should legal policy recognize adolescents as decisionally capable.

The courts in *Swan* and *Crum*, for instance, reinforced rulings authorizing the withdrawal of life-support by referring to the guardian ad litem's agreement concerning withdrawal.²⁶¹ This presents questions for empirical examination about the nature of guardian ad litem appointments, the guardian ad litem's role, including contributions in matters of medical decision-making conflict related to adolescent patients, and the evidentiary weight that should be assigned to a guardian ad litem's recommendation. Stated differently, if the guardians ad litem in *Swan* and *Crum* had disagreed about the withdrawal of life-sustaining treatment, it is uncertain whether that disagreement would have been altogether persuasive to the courts' analyses, or whether it would have mattered at all. Thus, the appointment of

guardians ad litem in medical decision-making cases present assertions amenable to empirical examination by scientific method.

VII. CONCLUSION

Adolescent legal autonomy is a conundrum.²⁶² Decision-making ability of adolescents exists somewhere between child and adult cognitive development. Knowledge acquisition is essential to achieve optimal understanding about adolescent decision-making capability for shaping legal policy that affords medical autonomy to adolescents. Although some knowledge does exist, there is a deepening chasm between scientific findings and legislation that discounts the decision-making ability of adolescents. Medical decision-making deepens this divide due to the personal intimacy and life-altering determinations involved that profoundly impact the lives of adolescents. Protracted and piecemeal state legislation devalues adolescent cognitive ability and lessens the potential for cognitive development toward responsible decision-making.

Because scientific findings refute the presumptive incapacity that underpins current legislation related to adolescent decision-making, knowledge about adolescent decisional capability continues as a work in progress.²⁶³ Collaboration between science and law is vital for crafting legislation that is responsive to adolescent decision-making ability and for delineating with adequacy the scope of legal autonomy that should be afforded adolescents for medical decision-making. Legislation based on a framework that recognizes adolescent decision-making ability could yield positive, lasting effects on adolescent development, including the attainment of self-identity and self-image that results from respect and recognition. To this end, *parens patriae* should be used proactively by policy-makers to promote adolescent decisional development.

As this Article has demonstrated, case law is crucial to that collaboration by elucidating points that compel scientific research to inform and to illuminate policymaking about adolescent decision-making capability. Far greater thought should be given to the policy concerns specific to adolescent patient care, including the relevant interests in this context, and how legislation should protect and promote these interests. Like the heroic hearts made weak by time and fate during Ulysses' odyssey, so too should legal policy-makers set out "[f]o strive, to seek, to find, and not to yield"²⁶⁴ when learning about adolescent decisional capability in order to devise legislation that corresponds to a reality of adolescent ability. As

with the dawning of an adolescent's eighteenth birthday, legislation based on a framework that recognizes adolescent decision-making ability may be an idea that has come of age.

FOOTNOTE

I wish to acknowledge with gratitude the Committee on Health, Education, Labor and Pensions of the U.S. Senate for amenability to formulating national policy related to adolescence and devising The Younger Americans Act. I am equally grateful for the ever-gracious support provided by the American Journal of Law & Medicine.

¹ *In re Gault*, 387 U.S. 1 (1967); *Kent v. United States*, 383 U.S. 541 (1966).

² While the Supreme Court has extended constitutional guarantees to adolescents, including privacy interests, expressive choice and liberty rights, the Court has observed that immaturity and inexperience limit legal autonomy for decision-making because adolescents lack the capable judgment "for making life's difficult decisions." *Troxel v. Granville*, 530 U.S. 57, 68 (2000) (quoting *Parham v. J.R.*, 442 U.S. 584, 602 (1979)); see also *Bd. of Educ. v. Earls*, 122 S. Ct. 2559 (2002); *Tinker v. Des Moines*, 393 U.S. 503 (1969); *In re Gault*, 387 U.S. 1 (1967).

³ *Parham*, 442 U.S. at 602 (1979); *Ginsberg v. New York*, 390 U.S. 629, 638 (1968); *Prince v. Massachusetts*, 321 U.S. 158, 168 (1944).

FOOTNOTE

⁴ See generally *Bellotti v. Baird*, 443 U.S. 622 (1979) (discussing the constitutionality of statutes that require minors to obtain parental consent for abortions).

⁵ *Parham v. J.R.*, 442 U.S. at 605. See Gail S. Perry & Gary B. Melton, *Precedential Value of Judicial Notice of Social Facts: Parham as an Example*, 22 J. FAM. L. 633 (1983-1984) (exposing factual assumptions and empirical speculations throughout the Supreme Court's decision in *Parham*); Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS LT 1265, 1333-34 (2002) (advocating revisitation by the Supreme Court of the issue presented in *Parham v. J.R.*).

FOOTNOTE

6Parham, 442 U.S. at 605; see also *Troxel v. Granville*, 530 U.S. at 68.

7Elizabeth S. Scott, *The Legal Construction of Adolescence*, 20 HOFSTRA L. REV. 547, 548 (2000) (stating that policy-makers "ignore this transitional developmental stage, classifying adolescents legally as children or adults, depending on the issue at hand").

8See *Stanford v. Kentucky*, 492 U.S. 361, 380 (1989) (finding that state statutes authorizing the death sentence for adolescents who were sixteen or seventeen years old at the commission of a capital offense do not offend the Eighth Amendment of the Constitution); see also *Patterson v. Texas*, 153 L.Ed. 2d 887 (2002) (denying an execution stay for Toronto Patterson who was sentenced to death for the conviction of a capital crime he committed when he was seventeen years old). Justice Stevens disagreed with the majority's denial and urged the Supreme Court to "revisit the issue at the earliest opportunity." *Patterson*, 153 L.Ed. 2d at 887 (Stevens, J., dissenting). Justice Ginsberg joined Justice Stevens's dissent and implied that reconsideration might be appropriate in light of recent case law. *Patterson*, 153 L.Ed. 2d at 887 (Ginsberg, J., dissenting). See Hartman, *supra* note 5, at 1295 (advocating reconsideration by the U.S. Supreme Court of the issue due to legal policy rife with inconsistency).

FOOTNOTE

9Several states permit only "competent adult[s]" or persons "eighteen years or older" to make legally valid advance directives, such as the execution of a living will that authorizes the termination of life-sustaining treatment. See ALA. CODE 22-8A-4 (Supp. 2001) ("competent adult"); GA. CODE ANN. 31-32-3(a) (2001) ("competent adult"); W. VA. CODE 16-30-4(a) (2001) ("competent adult"); N.D. CENT. CODE 23-06.4-03 (2002) ("eighteen years or older"); N.H. REV. STAT. ANN. 137-H:3 (1996) ("eighteen years or older").

FOOTNOTE

10 See generally TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (5th ed. 2001); TIMOTHY E. QUILL, *A MIDWIFE THROUGH A DYING PROCESS* (1996); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

11 See Scott, *supra* note 7, at 556.

FOOTNOTE

12 Wisconsin v. Yoder, 406 U.S. 205, 243 (1972) (Douglas, J., dissenting in part).

13 See, e.g., Bruce Ambuel & Julian Rappaport, Developmental Trends in Adolescents Psychological and Legal Competence to Consent to Abortion, 16 LAW & HUMAN BEHAV. 129 (1992); Michael J. Dolgin et al., Caregivers' Perceptions of Medical Compliance in Adolescents with Cancer, 7 J. ADOLESCENT HEALTH CARE 22 (1986); Robert D. Felner et al., Party Status of Children During Marital Dissolution: Child Preferences and Legal Representation in Custody Disputes, 14 J. CLINICAL CHILD PSYCHOL. 42 (1985); Carrie S. Fried & N. Dickon Reppucci, Criminal Decision Making: The Development of Adolescent Judgment. Criminal Responsibility, and Culpability, 25 LAW & HUMAN BEHAV. 45 (2001); Kenneth R. Ginsburg et al., Factors Affecting the Decision to Seek Health Care: The Voice of Adolescents, 100 PEDIATRICS 922 (1997); Kenneth R. Ginsburg et al., Adolescents' Perceptions of Factors Affecting Their Decisions to Seek Health Care: The Voice of Adolescents, 273 JAMA 100 PEDIATRICS 922 (1997)1 Kenneth R. Ginsburg et al., (1995); Ellen Perceptions of Factors Affecting Their Decision, Children's Competency, to Participate in Divorce, 273 JAMA Custody Decisionmaking, 20 J. CLINICAL CHILD PSYCHOL. 78 (1991); Thomas Greenberg Garrison, Children's Capacities to Participate in Divorce Custody Waive Miranda Rights: An Empirical Analysis, 68 CLINICAL CHILD PSYCHOL. LAW REV. 1134 (1980); Thomas Grisso, Juveniles' Capacities to Waive Miranda Rights: Adolescent Empirical Autonomy for Medical Care: Physis, 68 CAL. LAW REV. 1134 Perceptions and Practices, Gay U. CHI. L. SCH. ROUNDTABLE 87 (2001); Nancy Kaser-Boyd et al., Minors' Ability to Identify Decisional Autonomy for Medical Care: Physician Perceptions and Practices, 8 and Benefits of Therapy, 16 PROF. PSYCHOL. SCH. ROUNDTABLE 411 (1985); Nancy Kaser-Boyd et al., Minors' Ability to Identify Lewis, A Comparison of Minors' and Benefits of Pregnancy Decisions, 50 AM. J. ORTHOPSYCHIATRY 446 PROF. PSYCHOL. RES. & PRAC. 411 (1980); Catherine C. Lewis, A Alfio Maggiolini, Self-Image of Adolescent Survivors of Minors' and Adults' Pregnancy Decisions-term Childhood Leukemia, 50 Am. J. ORTHOPSYCHIATRY 446 (1980); PEDIATRIC HEMATOLOGY/ ONCOLOGY 417 (September/October 2000); Marilyn Jacobs Quadre)-Image of Adolescent Survivors of Long-term Childhood Leukemia, 221. Adolescent (In) Vulnerability, 48 AM. PSYCHOLOGIST 102 (September/October 2000); David Jacobs Scherer, The Capacities of Minors to Exercise Voluntariness in Medical

Treatment (In) Vulnerability, 48 Am. PSYCHOLOGIST 15 (1993); David HUMAN BEHAV. Scherer, The Capacities of (1991); David G. Scherer & N. Dickon Reppucci, Adolescents' Capacities to Provide Voluntariness in Medical Treatment Decisions, 15 LAW & HUMAN BEHAV. 431 (1991); David Consent: The Effects of Parental Influence and Medical Dilemmas, 12 LAW & HUM Adolescents' Capacities to Provide Voluntary BEHAV. 123 (1988); Paul V. Consent: The Ability of Parental Influence and to Predict Future Outcome Dilemmas, 12 LAW & HUMAN Assessing Paul V. Trad. The Abilities, 28 ADOLESCENCE 533 (1993); Lois to Predict Future Outcome Part B. Campbell, Assessing Predictive Competency of Children and Adolescents to Make Informed Treatment Decisions, 28 ADOLESCENCE 53 (1993); Lois A. Weithorn & Susan B. CHILD DEV. 1589 (1982).

FOOTNOTE

14 See OLIVER WENDELL HOLMES, JR., THE COMMON LAW 35 (Boston, Little, Brown & Co. 1881) (explaining that "precedents survive in the law long after the use they once served is at an end and the reason for them has been forgotten. The result of following them must often be failure and confusion from the merely logical point of view."); see also KARL R. POPPER, IN SEARCH OF A BETTER WORLD: LECTURES AND ESSAYS FROM THIRTY YEARS 37 (Laura J. Bennett trans., Routledge 1992) (exhorting the uncertainties of knowledge and emphasizing its evolving nature).

15 See *in* notes 38-92 and accompanying text. The Supreme Court has pinpointed legislation as "the clearest and most reliable objective evidence of contemporary values." Harmelin v. Michigan, 501 U.S. 957, 1000 (1991). The Court emphasized that the significance of the legislative evidence is not so much in the number of enacted state statutes but in "the consistency of the direction of change." Atkins v. Virginia, 122 S. Ct. 2242, 2249 (2002). The Court's ascription of primacy to legislative enactments "follows from the constitutional role legislatures place in expressing policy of a State." *Id.* at 2253 (Rehnquist, C.J., dissenting). According to Justice Scalia, the Court must grant legislative enactments such weight "because it `will rarely if ever be the case that the Supreme Court will have a better sense of the evolution in views of the American people than do their elected representatives.'" *Id.* at 2261 (Scalia, J., dissenting) (quoting Thompson v. Oklahoma, 487 U.S. 815, 865 (1988) (Scalia, J., dissenting)).

16 *In re Gault*, 387 U.S. 1, 13 (1967).

FOOTNOTE

17 For example, when deciding that seventeen-year-old Alexis Demos should have the opportunity to explain her medical choices to the court, rather than through representation by counsel or by parents, the Massachusetts Court of Appeals held that the power of *parens patriae* is strong only when the minor is immature and thus lacks the capacity to make medical decisions on her own. *In re Rena*, 705 N.E.2d 1155, 1157-58 (Mass. App. Ct. 1999).

18 See *Craig v. Boren*, 429 U.S. 190, 204 (1976) (conceding that expecting judges or legislators to be "well versed in the rigors of experimental or statistical technique" is unrealistic). Accord *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993).

FOOTNOTE

19 See *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797 (Cal. 1997) (finding no evidentiary justification for distinguishing adolescent from adult privacy rights based on scientific data, and interpreting affirmative grants of rights emanating from state constitutions as guaranteeing adolescents' ability to make decisions about pregnancy termination independent of parental consent or judicial oversight). see also Preston A. Britner et al., *Evaluating Juveniles' Competence to Make Abortion Decisions: How Social Science Can Inform the Law*, 5 U. CHI. L. SCH. ROUNDTABLE 35 (1998). Analyses in cases of "first impression" likewise engage scientific study and social science evidence. *Grimes v. Kennedy Krieger Inst. Inc.*, 782 A.2d 807 (Md. 2001) (examining issues attendant to regulatory policy governing non-therapeutic pediatric research).

20 E. Donald Elliott, *The Evolutionary Tradition in Jurisprudence*, 85 COLUM. L. REV. 38, 38 (1985) ("Law is a scavenger. It grows by feeding on ideas from outside, not by inventing new ones of its own.").

FOOTNOTE

21 Richard E. Redding, *Reconstructing Science Through Law*, 23 S. ILL. U. L.J. 585, 585 (1999) ("Law is an empty vessel, relying on other disciplines to fill it with substantive knowledge.").

22 Popper, *supra* note 14, at 91; see also Karl R. Popper, *Campbell on the Evolutionary Theory of Knowledge*, in *EVOLUTIONARY EPISTEMOLOGY, RATIONALITY, AND THE SOCIOLOGY OF KNOWLEDGE* 116 (Gerald Ratnitzky & W.W. Bartley III eds., 1987) ("[A]ll human knowledge is fallible and conjectural. It is a product of the method of trial and error.").

23 See, e.g., Thomas F. Cotter, *Legal Pragmatism and the Law and Economics Movement*, 84 *GEO. L.J.* 2071 (1996); Martha C. Nussbaum, *The Future of Law and Economics*, 64 *U. CHI. L. REV.* 1197 (1997); Richard A. Posner, *Rational Choice, Behavior Economics, and the Law*, 50 *STAN. L. REV.* 1551 (1998); Jeanne L. Schroeder, *The End of the Market: A Psychoanalysis of Law and Economics*, 112 *FI ARV. L. REV.* 483 (1998); Avery Wienerkatz, *Positivism and the Separation of Law and Economics*, 94 *MICH. L. REV.* 2229 (1996).

24 See, e.g., Lawrence A. Sullivan & Wolfgang Fikentscher, *On the Growth of the Antitrust Idea*, 16 *BERKELEY J. INT'L L.* 197 (1998).

25 Gary Edmond & David Mercer, *Trashing "Junk Science"*, 1998 *STAN. TECH. L. REV.* 3; Andrew E. Taslitz, *Interpretive Method and the Federal Rules of Evidence: A Call for a Politically Realistic Hermeneutics*, 32 *HARV. J. ON LEGIS.* 329 (1995); David L. Faigman, *The Evidentiary Status of Social Science Under Daubert: Is it "Scientific," "Technical," or "Other Knowledge"*, 1 *PSYCHOL. PUB. POL'Y L.* 960 (1995). See *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 579 (1993) (recognizing that in toxic tort litigation, the Supreme Court can relevantly gauge the admissibility of scientific evidence under Federal Rule of Evidence 702).

26 Erica Beecher-Monas, *The Heuristics of Intellectual Due Process: A Primer for Triers of Science*, 75 *N.Y.U. L. REV.* 1563 (2000).

27 For example, a prominent method that has influenced formulation of legal policy is evolutionary epistemology. Evolutionary epistemology, as conceived by Sir Karl Raimond Popper, envisages a multi-stage knowledge acquisition apparatus, consisting of problem identification, assertion advancement, examination and refutation of assertions, and ongoing exploration of ideas that withstand examination and refutation. See POPPER, *supra* note 14; see also KARL R. POPPER, *CONJECTURES AND REFUTATIONS: THE GROWTH OF SCIENTIFIC KNOWLEDGE* 27-29 (Routledge & Kegan Paul Limited 2nd ed. 1965).

According to Popper, simplicity and clarity are indispensable to

FOOTNOTE

the quality of examination and falsification; otherwise, exposure of inconsistencies and fallacies of assertions are inhibited. See POPPER, *supra* note 14, at 91-92.

28 Scherer, *supra* note 13, at 444-46; Scherer & Reppucci, *supra* note 13, at 135.

29 William Gardner et al., *Asserting Scientific Authority: Cognitive Development and Adolescent Legal Rights*, 44 AM. PSYCHOLOGIST 895, 896 (1989).

30 Michael J. Saks, *Legal Policy Analysis and Evaluation*, 44 AM. PSYCHOLOGIST 110, 1110 (1989).

FOOTNOTE

31 Quadrel et al., *supra* note 13, at 11. 32 See POPPER, *supra* note 27, at 27.

33 See Hartman, *supra* note 13, at 87-88 (stating that "[d]ecisional autonomy is an elusive conceptDespite descriptive terms for decisional capacity that seem as varied as a standard by which to measure it, debates about how it should be measured and in what ways each of us diverge from the standard remain unresolved"(footnote omitted)).

34 *In re Rena*, 705 N.E.2d 1155 (Mass. App. Ct. 1999) (recognizing the capability of an adolescent to refuse a blood transfusion due to her spiritual faith as a Jehovah's Witness); *In re E.G.*,

FOOTNOTE

549 N.E.2d 322 (111. 1989) (finding that the mature minor doctrine was sufficient grounds for the trial court to hold a minor capable of refusing medical treatment); *In re Green*, 307 A.2d 279 (Pa. 1973) (affirming the trial court's order that respected the wishes of an adolescent to decline a spinal operation stemming from his faith as a Jehovah's Witness). But see *In re J.J.*, 582 N.E.2d 1138 (Ohio Ct. App. 1990) (ordering gonorrhea treatment for an adolescent despite his refusal of treatment based on a belief in faith healing).

FOOTNOTE

35 *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987).

36 See *Cruzan v. Dir., Mo. Dep't. of Health*, 497 U.S. 261 (1990). 37 *Id.* at 261 n.7.

FOOTNOTE

38 ALA. CODE 22-IIA-19 (1997); ALASKA STAT. 25.20.025(A)(4) (Michie 2001); ARIZ. REV. STAT. ANN. 44-132.01 (West 1994); ARK. CODE ANN. 20-16-508 (Michie 2000); CAL. FAM. CODE 6926 (West 1994); COLO. REV. STAT. 25-4-402(4) (2001); CONN. GEN. STAT. ANN. 19A216(a) (West 1998); DEL. CODE ANN. tit. 13, 710 (1999); FLA. STAT. ANN. 384.30 (West 2002); GA. CODE ANN. 31-17-7(a) (2001); HAW. REV. STAT. ANN. 577A-2 (Michie 1999); IDAHO CODE

39-3801 (Michie 2002); 410 ILL. COMP. STAT. ANN. 210/4 (West 1997); KY. REV. STAT. ANN. 214.185(1) (Michie [998]); LA. REV. STAT. ANN. 40:1065.1(A) (West 2000); ME. REV. STAT. ANN. tit. 22, 1823 (West 1992 & Supp. 2001); MD. CODE ANN., HEALTH-GEN. 20-102c(3) (2000); MICH. COMP. LAWS ANN. 333.5127 (West 2001); MINN. STAT. ANN. 144.343 (West 1998); Miss. CODE ANN. 41-41-13 (1999); Mo. ANN. STAT. 431.061 (West 2002); MONT. CODE ANN. 41-1-42(1)(c) (2001); N.J. STAT. ANN. 9:17A-4 (West 1993); OHIO REV. CODE ANN. 3709.241 (Anderson 2002); OKLA. STAT. ANN. tit. 63, 1-532.1 (West 1997); OR. REV. STAT. 109.610 (2001); PA. STAT. ANN. tit. 35 521.14a (West 1993); S.D. CODIFIED LAWS 34-23-16 (Michie 1994); UTAH CODE ANN. 26-6-18 (1998); VT. STAT. ANN. tit. 18 4226 (1982); VA. CODE ANN. 54.1-2969(E)(1) (LexisNexis 2002); W. VA. CODE ANN. 16-4-10 (Michie 2001). 39 MICH. COMP. LAWS ANN. 333.5127 (West 2001).

FOOTNOTE

40 For a case description of this genre and the policy and practical questions presented, see Hartman, *supra* note 13, at 92; see also Hartman, *supra* note 5, at 13 10.

41 E.g., ALA. CODE 22-1 IA-19 (1997) (twelve years or older); CAL. FAM. CODE 6926 (West 1994) (twelve years or older); IDAHO CODE 39-3801 (Michie 2002) (fourteen years or older); VT. STAT. ANN. tit. 18, 4226 (1983) (twelve years or older); WASH. REV. CODE ANN. 70.24.110 (West 2002) (fourteen years or older).

FOOTNOTE

42 See, e.g., ALA. CODE 22-8-6 (1997); ARIZ. REV. STAT. ANN. 44-133.01 (West 1994); CAL. FAM. CODE 6929(b) (West 1994); COLO. REV. STAT. 13-22-102 (2001); CONN. GEN. STAT. ANN. 17A-688 (West 1998 & Supp. 2002); FLA. STAT. ANN. 397.601(4)(a) (West 2002); GA. CODE ANN. 31-17-7(b) (2001); HAW. REV. STAT. ANN. 577-26 (Michie 1999); 410 ILL. COMP. STAT. ANN. 210/4 (West 1997); IND. CODE ANN. 12-23-12-1 (West 2002); KAN. STAT. ANN. 652892a (1992); KY. REV. STAT. ANN. 222.441 (Michie 1998); LA. REV. STAT. ANN. 40:1096A (West 2000); ME. REV. STAT. ANN. tit. 22, 1502 (West 1992 & Supp. 2001); MD. CODE ANN., HEALTH-GEN. 20-102(c)(1)-(2) (2000); MASS. GEN. LAWS ANN. Ch 112, 12E (2000); MICH. COMP. LAWS ANN. 333.6121(l) (West 2001); MINN. STAT. ANN. 144.343(1) (West 1998); MISS. CODE ANN. 41-41-14 (1999); NEB. REV. STAT. 71-5041 (1996); NEV. REV. STAT. 129,050 (2001); N.J. STAT. ANN. 9:17A-4 (West 1993); OHIO REV. CODE ANN. 3719.012 (Anderson 2002); OKLA. STAT. ANN. tit. 43A, 9-101 (West 1997); PA. STAT. ANN. tit. 71, 1690.112 (West 1993); VT. STAT. ANN. tit. 18, 4226 (1982); VA. CODE ANN. 54.1-2969(E)(3) (Michie 2002); W.VA. CODE ANN. 60A-5-504 (e) (Michie 2001); Wis. Stat. Ann. 51.47 (West 1997).

47 COLO. REV. STAT. 13-22-102 (2001). 48 MASS. GEN. LAWS ch. 12, 12E (2000).

49 410 ILL. COMP. STAT. ANN. 210/3 (West 1997 & Supp. 2002). 50 PA. STAT. ANN. tit. 71, 1690.112 (West 1993).

51 OKLA. STAT. ANN. tit. 63, 2602(A)(3) (West 1997).

FOOTNOTE

52 MICH. COMP. LAWS ANN. 333.5127(2) (West 2001). Several states have similar legislation that enables medical staff to disclose a minor's confidential medical information to a spouse, parents, custodians or guardians. See DEL. CODE ANN. tit. 13, 710(c) (1999); GA. CODE ANN. 31-17-7(b) (2001); MISS. CODE ANN. 41-41-14 (1999).

53 CAL. FAM. CODE 6929(c) (West 1994); see also 410 ILL. COMP. STAT. ANN. 210,14 (West 1997) (requiring expenditure of "reasonable efforts" by a physician to involve family and assist a minor in accepting involvement); NEV. REV. STAT. 129.050(3) (2001) (requiring reasonable efforts to report treatment to parents or guardians "within a reasonable time after treatment"); VT. STAT. ANN. tit. 18, 4226 (2001) (mandating parent or guardian notification

"if the condition of a minor child requires immediate hospitalization"); Wis. STAT. 51.47(3) (2001) (mandating parental notification "as soon as practicable").

FOOTNOTE

54 CAL. FAM. CODE 6929(g) (West 1994); see id. 7050(e)(1) (declaring that an emancipated minor shall be considered an adult for the purpose of consenting to medical care); see also HAW. REV. STAT. 577A-4 (Michie 1999) (promoting a policy of "open[ing] up lines of communication between parent and child").

55 410 ILL. COMP. STAT. ANN. 210/4 (West 1997); NEV. REV. STAT. 129.050(3) (2001).

56 ALA. CODE 22-8-6 (1997); ALASKA STAT. 25.20.025(a)(4) (Michie 2001); CAL. FAM. CODE 6925(a) (West 1994); DEL. CODE ANN. tit 13, 710 (1999); FLA. STAT. ANN. 743.065(1) (West 2002); HAW. REV. STAT. ANN. 577A-4 (Michie 1999); KAN. STAT. ANN. 38-123 (1992); KY. REV. STAT. ANN. 214.185 (Michie 1998); MD. CODE ANN., HEALTH-GEN. 20-102(c)(4)

FOOTNOTE

(2000); MASS. GEN. LAWS cb. 112, 12F (2000); MINN. STAT. ANN. 144.343 (West 1998); Mo. ANN. STAT. 431.061 (West 2002); MONT. CODE ANN. 41-1-402(1)(c) (2001); OKLA. STAT. tit. 63,

2602(3) (West 1997); 35 PA. CONS. STAT. 10103 (2002); VA. CODE ANN, 54.1-2969(e)(2) (2002).

FOOTNOTE

57 See MD. CODE ANN., HEALTH-GEN. 20-102(c)(5) (2000); VA. CODE ANN. 54.12969(E)(2) (2002). But see NEV. REV. STAT. 430A.180 (2001) (disallowing administration of contraceptives to minors unless a parent or guardian grants consent). The Court of Appeals for the Third Circuit, however, interpreted federal law to extend confidentiality to minors' consent for reproductive services, thereby superseding state parental consent requirements. *Parents United for Better Schools, Inc. v. Sch. Dist. of Phila. Bd. of Educ.*, 148 F.3d 260, 269-70 (3d Cir. 1998).

58 MD. CODE ANN., HEALTH-GEN. 20-102(c)(5) (2000); MASS. GEN. LAWS ch. 112, 12F (2000); VA. CODE ANN. 54.1-2969(E)(2) (2002).

59 FLA. STAT. ANN. 743.065 (West 2002); KAN. STAT. ANN. 38-123 (1992). 60 CAL. CIV. PROC. CODE 1295 (2001).

61 DEL. CODE ANN. tit. 13, 710(b) (1999); HAW. REV. STAT. ANN. 577A-2 (Michie 1999). See JOHN EDWARD MURRAY, JR., MURRAY ON CONTRACTS 40 (3d. ed. 1990). For commentary and critique of the power of minors to disaffirm and discharge their contractual obligations, see Hartman, *supra* note 5, at 1301-05; Larry A. DiMatteo, Deconstructing the Myth of the 'infancy Law Doctrine': From Incapacity to Accountability, 21 OHIO N.U.L. REV. 481 (1994); Robert E. Edge, Voidability of Minors Contracts: A Feudal Doctrine in a Modern Economy, 1 GA. L. REV. 205 (1967).

62 See, e.g., COLO. REV. STAT. 13-22-106 (2001); 410 ILL. COMP. STAT. ANN. 210/3 (West 1997); ME. REV. STAT. ANN. tit. 22, 1823 (West 1992 & Supp. 2001); MD. CODE ANN., HEALTHGEN. 20-102(c)(6)-(7) (2000); OHIO REV. CODE ANN. 2907.29 (Anderson 2000); see also N.J. STAT. ANN. 9:17A-4 (West 1993) (requiring immediate notification of parents).

63 ARIZ. REV. STAT. ANN. 13-1413 (West 1994). 64 CAL. FAM. CODE 6927, 6928 (West 1994).

65 410 ILL.. COMP. STAT. ANN. 210/3 (West 1997); TEX. FAM. CODE ANN. 32.004 (2002). 66 ALA. CODE 22-8-4 (1997) (fourteen years or older); CAL. FAM. CODE 6924(b) (West 1994) (twelve years or older); COLO. REV. STAT. 13-22-103(1) (2001) (fifteen years or older if living apart from parent or guardian); FLA. STAT. ANN. 394.4784(l)-(2) (West 2002) (thirteen years or older); KY. REV. STAT. ANN. 214.185(2) (Michie 1998) (sixteen years or older); MICH. COMP. LAWS ANN. 330.1707(1) (West 2001) (fourteen years or older); MISS. CODE ANN. 41-41-14(1) (1999) (fifteen years or older); MONT. CODE ANN. 53-21-112(2) (2001) (sixteen years or older); OHIO REV. CODE ANN. 5122.04 (Anderson 2000) (fourteen years or older); OR. REV. STAT. 109.675 (2001) (fourteen years or older); VA. CODE ANN. 54.1-2969E(4) (Michie 2001) (fourteen years or older); WASH. REV. CODE ANN. 71.34.042 (West 2002) (thirteen years or older); WIS. STAT. 51.14 (2001) (fourteen years or older).

FOOTNOTE

67 DEL. CODE ANN. tit. 16, 5161 (1999); WIS. STAT. 51.13(2)(a) (2001). See *Parham v. J.R.*, 442 U.S. 584 (1979) (relying on the Due Process Clause to uphold the constitutionality of a state involuntary commitment procedure requiring parent consent coupled with psychiatric evaluation).

68 PA. ST.AT. ANN. tit. 50, 7201 (West 1993); see also COLO. REV. STAT. 13-22-101 (2001) (stating that a minor fifteen years or older may consent to receipt of mental health services); FLA. STAT. ANN. 394.4784 (West 2002) (stating that a minor thirteen years or older has the right to request professional assistance after experiencing an emotional crisis to such a degree that he or she perceives the need for professional assistance); MONT. CODE ANN. 53-21-112 (2001) (stating that a minor sixteen years or older may consent to receipt of mental health services); WIS. STAT. 51.14 (2001) (a minor fourteen years or older may consent to receipt of mental health services).

69 D.C. CODE ANN. 7-1231.14(b)(1) (2002); N.Y. MENTAL HYG. LAW 33.21(c) (Consol. 2002); see also CAL. FAM. CODE 6924 (West 1994) (stating that a minor who is twelve years or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services if the minor is mature enough to participate intelligently in outpatient or residential shelter services and the mental health provider determines that the minor poses a serious physical or mental harm to himself or others or is the alleged victim of incest or child abuse).

70 CONN. GEN. STAT. ANN. 19a-14-c (West 1998). 71 MICH. COMP. LAWS ANN. 330.1707 (West 2001). 72 OHIO REV. CODE ANN. 5122.04(A) (Anderson 2000). 73 FLA. sTAT. ANN. 394.4784(1) (West 2002).

FOOTNOTE

74 MICH. COMP. LAWS ANN. 330.1707(1) (West 2001) (disclosure to parents after six sessions or thirty days is not required unless a mental health professional determines that there is "compelling need for disclosure based on substantial probability of harm to minor or to other persons and minor is notified of mental health professional's intent to inform parent or guardian"); OHIO REV. CODE ANN. 5122.04(A)-(B) (Anderson 2000) (stating that a mental health professional will not inform a minor's parent of that minor's treatment unless

there is a "compelling need for disclosure based on substantial probability of harm to the minor or another individual and if the minor is notified of the mental health professional's intent to inform the minor's parent, [or] guardian"); OR. REV. STAT. 109.680 (2001) (mental health provider may advise parents of the minor's treatment when clinically appropriate to advance the minor's best interests).

75 CONN. GEN. STAT. ANN. 19a-14-c(d) (West 1998); MD. CODE ANN., HEALTH-GEN. 20104(c) (2001); MICH. COMP. LAWS ANN. 330.1707(4) (West 2001); OHIO REV. CODE ANN. 5122.04(c) (Anderson 2000).

FOOTNOTE

76 LA. CH. C art. 1467 (1995) (knowing and voluntary consent by minor for inpatient care is required, including a finding that minor has ability to understand nature of treatment facility); TEX. HEALTH & SAFETY CODE 572.001(a) (2002) (a person sixteen years or older or a married individual younger than sixteen may consent to inpatient mental health care).

77 Compare MICH. COMP. LAWS ANN. 330.1707 (West 2001) (excluding only outpatient services and psychotropic medications from the scope of adolescent consent), with D.C. CODE ANN. 7-1231.14 (2002) (a person sixteen years or older may consent to psychotropic medication if parent or guardian is not available and the treating physician determines that the minor has capacity to consent for clinically indicated medication); N.Y. MENTAL HYG. LAW 33.21(c)(2) (2002) (a person sixteen years or older may consent to psychotropic medications once a second physician who specializes in psychiatry and is not an employee of the mental health facility has determined that the minor has capacity for decision-making and the medication would serve the minor's best interests). The decision to administer psychotropic medications shall be provided to the parents or guardian and documented in the clinical record. *Id.*

FOOTNOTE

78 See, e.g., R.I. GEN. LAWS 23-4.6-1 (2001). 79 ARIZ. REV. STAT. ANN. 44-132(A) (West 1994).

80 KY. REV. STAT. ANN. 214.185(3) (Michie 1998); ME. REV. STAT. ANN. tit. 22, 1503 (West 1992 & Supp. 2001); MD. CODE ANN., HEALTH-GEN. 20-102(1) (2002); MASS.

GEN. LAWS. ch. 112, 12F (2000); MONT. CODE ANN. 41-1-402(1)(a) (2001); OKLA. STAT. ANN. tit. 63, 2602A(1) (West 1997); R.I. GEN. LAWS 23-4.6-1 (2002); VA. CODE ANN. 54.1-2969 F (Michie 1999).

FOOTNOTE

81 ALASKA STAT. 25.20.025 (Michie 2001); KY. REV. STAT. 214.185(3) (Michie 2001); MD. CODE ANN., HEALTH-GEN. 20-102(a)(2) (2000); MINN. STAT. ANN. 144.342 (West 1998); MONT. CODE ANN. 41-1-402(1)(a) (2001).

82 MD. CODE ANN., HEALTH-GEN. 20-102(c)(4) (2000); MONT. CODE ANN. 41-1402(l)(c) (2001).

83 PA. STAT. ANN. tit. 35, 10 101 (West 1993).

FOOTNOTE

84 MONT. CODE ANN. 41-1-402(1)(a) (2001); PA. STAT. ANN. tit. 35, 10101 (West 1993).

85 ME. REV. STAT. ANN. tit. 22, 1503 (West 1992 & Supp. 2001) (sixty day period attached to living separately and independently); MINN. STAT. ANN. 144.341 (West 1998) (no time period indicated); MONT. CODE ANN. 41-1-402(1)(b) (2001) (no time period indicated); OKLA. STAT. ANN. tit. 63, 2602(A)(2) (West 1997) (no time period indicated).

86 ME. REV. STAT. ANN. tit.22, 1503 (West 1992 & Supp. 2001); MASS. GEN. LAWS Ch. 112, 12F (2000).

FOOTNOTE

87 See, e.g., MONT. CODE ANN. 41-1-402(d)(2) (2001); OKLA. STAT. ANN. tit. 63, 2602A(4) (West 1997); VA. CODE ANN. 54.1-2969(G) (Michie 1999).

88 See, e.g., ALA. CODE 22-8-47(b) (1997); KY. REV. STAT. ANN. 214.185(5) (Michie 1998); MASS. GEN. LAWS ch. 112, 12F (2000); MINN. STAT. ANN. 144.345 (West 1998); OR. REV. STAT. 109.685 (2001).

89 VA. CODE ANN. 16.1-334 (Michie 1999); see also N.M. STAT. ANN. 32A-21-5 (Michie 1999) (adding to emancipated status the purchase and sale of real property and the termination of vicarious liability of parents or guardians for minors' torts).

Source: <http://www.allbusiness.com/legal/3587436-1.html> (January 5th, 2010)

DISCLAIMER: FAIR USE NOTICE: This may contain copyrighted (C) material the use of which has not always been specifically authorized by the copyright owner.

Such material is made available for educational purposes, to advance understanding of human rights, democracy, scientific, moral, ethical, and social justice issues, etc.

It is believed that this constitutes a 'fair use' of any such copyrighted material as provided for in Title 17 U.S.C. section 107 of the US Copyright Law. This material is distributed without profit.