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ESSAY

WHAT ARE THE IMPLICATIONS OF *ROPER'S* DILEMMA FOR ADOLESCENT HEALTH LAW?

*Jennifer Rosato**

I. INTRODUCTION

Adolescents engage in adult activities: they have sex,¹ they sext each other,² they get pregnant,³ they get abortions,⁴ and they

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¹ See, e.g., *Facts on American Teens' Sexual and Reproductive Health*, IN BRIEF (Guttmacher Inst., New York, N.Y.), Aug. 2011 [hereinafter *Facts*], available at <http://www.guttmacher.org/pubs/FB-ATSRH.pdf>. Like adults, teens also get sexually transmitted diseases. See *STDs in Adolescents and Young Adults*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/STD/stats09/adol.htm> (last updated Nov. 22, 2010).

² See, e.g., Dionne Searcey, *A Lawyer, Some Teens, and a Fight over 'Sexting'*, WALL ST. J., Apr. 21, 2009, at A17; Riva Richmond, *Sexting May Place Teens at Legal Risk*, N.Y. TIMES GADGETWISE BLOG (Mar. 26, 2009, 12:00 PM), <http://gadgetwise.blogs.nytimes.com/2009/03/26/sexting-may-place-teens-at-legal-risk>.

³ See GUTTMACHER INST., U.S. TEENAGE PREGNANCIES, BIRTHS AND ABORTIONS: NATIONAL AND STATE TRENDS AND TRENDS BY RACE AND

refuse life-sustaining treatment (among a myriad of adult activities).⁵ But just because they do engage in these activities does not mean that they should. Courts, psychologists, and legal academics have grappled with one of the overarching questions addressed by the Adolescents in Society Symposium: to what extent should law and policy treat teenagers differently from adults?

This question cannot be answered without first understanding the underlying bases for treating them differently. One basis is the “commonsense reality”⁶ that children are different than adults. In the United States Supreme Court’s recent decision in *J.D.B. v. North Carolina*, the majority relied on “the settled understanding that the differentiating characteristics of youth are universal”⁷ in reaching its conclusion that age should be considered a factor in the determination whether a suspect is in custody for purposes of providing *Miranda* warnings. Specifically, the Court pointed to the “objective conclusions . . . that children are more susceptible to influence” and “outside pressures.”⁸

ETHNICITY (2010) [hereinafter U.S. TEENAGE PREGNANCIES], available at <http://www.guttmacher.org/pubs/USTPtrends.pdf>; see also *Facts, supra* note 1 (citing statistics that each year almost 750,000 U.S. women aged fifteen to nineteen become pregnant, and that in 2006 that number represented seventy-two women per 1,000).

⁴ U.S. TEENAGE PREGNANCIES, *supra* note 3.

⁵ See cases discussed in Jennifer Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment*, 49 RUTGERS L. REV. 1, 4–8 (1996) [hereinafter Rosato, *The Ultimate Test of Autonomy*] (describing instances in which minors refused medical treatment). See generally Laurence Steinberg, *Risk Taking in Adolescence: New Perspectives from Brain and Behavioral Science*, 16 CURRENT DIRECTIONS IN PSYCHOL. SCI. 55, 58 (2007) [hereinafter Steinberger, *Risk Taking*] (“More than 90% of all American high school students have had sex, drug, and driver education in their schools, yet large proportions of them still have unsafe sex, binge drink, smoke cigarettes, and drive recklessly (often more than one of these at the same time.)”).

⁶ This term was used by the majority in *J.D.B. v. North Carolina*, 131 S. Ct. 2394, 2398 (2011).

⁷ *Id.* at 2403–04.

⁸ *Id.*

Recent neuroscience research, or “brain science,” offers another basis for treating adolescents differently. These findings support the “commonsense reality” that adolescents are unpredictable, reckless, and impulsive. This research has identified a number of significant changes in the brain that occur through adolescence and into the mid-twenties. Those well-documented changes include decrease in the grey matter in the brain; increase in the white matter in the prefrontal regions of the brain; changes in the numbers and distribution of dopamine receptors (“dopaminergic activity”); and more connections among different areas of the brain.⁹

Although teens’ behavior is consistent with the neurological changes documented in this research, some teenagers are capable of making some decisions, especially as they approach the age of majority.¹⁰ The vexing question now facing advocates for children’s rights is how to use this neuroscience literature (if at all) in guiding public policy and supporting greater autonomy for adolescents.¹¹

This Essay addresses how this literature should inform the law relating to health care decisions that need to be made by or for adolescents—from birth control to refusal of life-sustaining

⁹ See, e.g., Laurence Steinberg, *Should the Science of Adolescent Brain Development Inform Public Policy?*, 64 AM. PSYCHOLOGIST 739, 742–43 (2009) [hereinafter Steinberg, *Public Policy*]; see also Laurence Steinberg, *Commentary: A Behavioral Scientist Looks at the Science of Adolescent Brain Development*, 72 BRAIN & COGNITION 160, 161 (2010). See generally DANIEL R. WEINBERGER ET AL., THE NAT’L CAMPAIGN TO PREVENT TEEN PREGNANCY, THE ADOLESCENT BRAIN: A WORK IN PROGRESS (2005), available at <http://www.thenationalcampaign.org/resources/pdf/BRAIN.pdf> (describing how advances in neuroscience and imaging are altering scientific perceptions of adolescent cognition).

¹⁰ See Steinberg, *Public Policy*, *supra* note 9, at 744; Laurence Steinberg et al., *Are Adolescents Less Mature than Adults? Minors’ Access to Abortion, the Juvenile Death Penalty, and the Alleged APA “Flip-Flop,”* 64 AM. PSYCHOLOGIST 583, 592 (2009) [hereinafter Steinberg, *Flip-Flop*]; see also studies cited *infra* Part III.

¹¹ See Steinberg, *Public Policy*, *supra* note 9, at 745–48; Steinberg, *Flip-Flop*, *supra* note 10, at 592–93.

treatment.¹² Recent cases integrating the neuroscience literature, primarily in the criminal law context, have embraced the view of adolescents as vulnerable, incapable of considering long-term consequences, and in need of protection.¹³ This view creates a dilemma for those policymakers and advocates, like myself, who consider adolescents mature or “adult-like” outside of the context of these criminal law cases. This dilemma is not simply an abstract one. It may affect adolescents’ ability to participate in decisions as important as whether they should be able to get the Human Papillomavirus (“HPV”) vaccine;¹⁴ decline genetic testing for late-onset diseases;¹⁵ obtain treatment for mental

¹² I addressed the issue of health care decision making by adolescents and the relevance of the existing evidence on capacity in Jennifer L. Rosato, *Let’s Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decision-Making*, 51 DEPAUL L. REV. 769 (2002) [hereinafter Rosato, *Let’s Get Real*]. Other authors who have written thoughtfully on this issue include Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J.L. & MED. 409 (2002) [hereinafter Hartman, *Coming of Age*], and Kimberly M. Mutcherson, *Whose Body Is It Anyway? An Updated Model of Health Care Decision-Making*, 14 CORNELL J.L. & PUB. POL’Y 251 (2005) [hereinafter Mutcherson, *Whose Body*].

¹³ See *infra* Part II.

¹⁴ See, e.g., Carol A. Ford et al., *Increasing Adolescent Vaccination: Barriers and Strategies in the Context of Policy, Legal, and Financial Issues*, 44 J. ADOLESCENT HEALTH 568, 570 (2009); Abigail English et al., *Legal Basis of Consent for Health Care and Vaccination for Adolescents*, 121 PEDIATRICS (SUPPLEMENT 1) S85, S87 (2008); Ruth M. Farrell & Ellen S. Rome, *Adolescents’ Access and Consent to the Human Papillomavirus Vaccine: A Critical Aspect for Immunization Success*, 120 PEDIATRICS 434, 435 (2007). The HPV vaccine prevents the onset of many cervical cancers caused by the human papillomavirus. See Ctrs. for Disease Control & Prevention, *Quadrivalent Human Papillomavirus Vaccine, Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, 56 MORBIDITY & MORTALITY WKLY. REP. 1256, 1256 (2007).

¹⁵ Late-onset diseases are those that would arise during adulthood, such as breast cancer or Alzheimer’s disease. See Am. Coll. of Med. Genetics, *Points to Consider: Ethical Legal and Psychosocial Implications of Genetic Testing in Children and Adolescents*, 57 AM. J. HUM. GENETICS 1233, 1233 (1995). See generally Rosamond Rhodes, *Why Test Children for Adult-Onset Genetic Diseases?*, 73 MOUNT SINAI J. MED. 609 (2006) (arguing that

health problems;¹⁶ consent to participation in research trials;¹⁷ or elect treatment to change gender identity.¹⁸

This Essay grapples with this problem in the context of health care decision making by adolescents and concludes that core values underlying public policies, not science, ultimately will help resolve this dilemma.¹⁹ First, the Essay summarizes the existing law related to health care decision making, which (with few exceptions) considers the adolescent as a child, incapable of making these decisions on his or her own. Second, the Essay discusses what effect the neuroscience literature should have on the development of this area of law. Third, the Essay advocates for the adoption of a “contextual capacity” determination, which would allow some mature minors to make health care decisions in areas justified by compelling public policies. These policies will allow a more principled and nuanced doctrine to develop that respects the capacity and dignity of these minors as science continues to “inform,” but not “dictate,” public policy in this area.²⁰

consensus against predictive testing of children for adult onset genetic conditions is not justified).

¹⁶ See CAL. HEALTH & SAFETY CODE § 124260 (West Supp. 2011) (allowing mature minors twelve years and older to consent to outpatient treatment).

¹⁷ See generally INST. OF MED. OF THE NAT’L ACAD., THE ETHICAL CONDUCT OF CLINICAL RESEARCH INVOLVING CHILDREN (Marilyn J. Field & Richard E. Behrman eds., 2004); Rhonda Gay Hartman, *Word from the Academies: A Primer for Legal Policy Analysis Regarding Adolescent Research Participation*, 4 RUTGERS J.L. & PUB. POL’Y 151 (2006) [hereinafter Hartman, *Word from the Academies*] (both advocating greater participation by adolescents in research).

¹⁸ See, e.g., Maureen Carroll, Comment, *Transgender Youth, Adolescent Decisionmaking, and Roper v. Simmons*, 56 UCLA L. REV. 725, 725 (2009); see also Cara D. Watts, *Asking Adolescents: Does a Mature Minor Have a Right to Participate in Health Care Decisions?*, 16 HASTINGS WOMEN’S L.J. 221, 223 (2005).

¹⁹ Other commentators have recognized this dilemma. See Kimberly M. Mutcherson, *Minor Discrepancies: Forging a Common Understanding of Adolescent Competence in Healthcare Decision-Making and Criminal Responsibility*, 6 NEV. L.J. 927, 927–99 (2006) [hereinafter Mutcherson, *Minor Discrepancies*]; see also Carroll, *supra* note 18, at 726–29.

²⁰ Steinberg, *Public Policy*, *supra* note 9, at 746.

II. THE *ROPER* DECISION POSES THE DILEMMA

In recent cases, the United States Supreme Court has concluded that juveniles differ from adults and therefore should be treated differently. Most notably, in *Roper v. Simmons*, the Court concluded that imposing the death penalty on juveniles was unconstitutional as a violation of the Eighth Amendment.²¹ Prior to this decision, the Court had permitted execution of sixteen- and seventeen-year-olds.²² In reaching its conclusion that imposing the death penalty on any person under eighteen was unconstitutional, the Court relied on a number of authorities: precedent prohibiting the execution of mentally retarded persons, the record of states that had abolished the death penalty for juveniles, international norms prohibiting the juvenile death penalty, and the differences between adults and juveniles.²³

The Court identified three areas of difference between juveniles and adults that justified the differential treatment. First, their lack of maturity and underdeveloped sense of responsibility leads to greater recklessness and more impulsivity than adults.²⁴ Second, they are more vulnerable and subject to pressures (particularly peer pressure).²⁵ Third, the character of the juvenile is not yet well-formed.²⁶ The *Roper* Court referred to neuroscience research in reaching its conclusion that juveniles were different from adults. The Court, drawing upon what “any parent knows and . . . the scientific and sociological studies respondent and his *amici* cite tend to confirm,” found that “[a] lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults”²⁷

This neuroscience research was relied upon even more

²¹ *Roper v. Simmons*, 543 U.S. 551, 568 (2005).

²² *Id.* at 562.

²³ *Id.* at 563–78.

²⁴ *Id.* at 569.

²⁵ *Id.*

²⁶ *Id.* at 570.

²⁷ *Id.* at 569 (alteration in original) (quoting *Johnson v. Texas*, 509 U.S. 350, 367 (1993) (internal quotation marks omitted)).

explicitly in *Graham v. Florida*,²⁸ in which the Court held that imposing a life sentence without parole on a juvenile who had not committed homicide was a violation of the Eighth Amendment.²⁹ Reinforcing *Roper*'s conclusions regarding juvenile incompetence, the *Graham* Court stated, "developments in psychology and brain science continue to show fundamental differences between juvenile and adult minds."³⁰ Most recently, in *J.D.B. v. North Carolina*, the Court acknowledged that "social science and cognitive science authorities" supported its conclusion to consider age in the *Miranda* custody analysis, although the acknowledgment was not necessary to the Court's disposition.³¹

Roper and its progeny have created a dilemma: can adolescents be considered immature for some purposes, yet mature for others? This dilemma was highlighted by Justice Scalia in his dissent in *Roper*, in which he pointed out that the American Psychological Association ("APA") had taken what he perceived to be the "opposite position" in cases involving abortion rights: in that context, the APA, in its amicus brief, provided scientific evidence that persons under eighteen are capable of making decisions regarding abortion.³² Justice Scalia admonished the majority for "picking and choosing the studies that support its position."³³

Justice Scalia's perspective underscores the vexing and important dilemma posed by the *Roper* decision: considering the brain science research, is it possible under the law to consider children incapable for some purposes—such as punishment under the criminal law—and capable for others—such as medical decision making?

Scholars and policymakers who have consistently advocated for greater autonomy for adolescents making health care

²⁸ *Graham v. Florida*, 130 S. Ct. 2011 (2010).

²⁹ *Id.* at 2030.

³⁰ *Id.* at 2026.

³¹ *J.D.B. v. North Carolina*, 131 S. Ct. 2394, 2403 n.5 (2011).

³² *Roper v. Simmons*, 543 U.S. 551, 617 (2004) (Scalia, J., dissenting).

³³ *Id.* (alteration in original).

decisions³⁴ should be more than a bit concerned about the implications of *Roper* and its progeny. Although it is encouraging that the Court appears to be integrating scientific literature into its decisions in a more thoughtful way,³⁵ these decisions have made it more difficult to support adolescents as mature or “adult-like” outside of the context of these cases.³⁶ This difficulty is exacerbated by the existing law, which provides little protection for children’s autonomy—particularly in the health care area.

III. THE EXISTING LAW RELATED TO HEALTH CARE DECISION MAKING: THE MORE THINGS CHANGE, THE MORE THE LAW STAYS THE SAME

The law related to health care decision making, with a few limited exceptions, treats adolescents as children: vulnerable, incapable, and in need of protection from their parents.³⁷ Therefore, parents make most minor and major health care decisions on behalf of their children.³⁸

A few exceptions do exist. Minors may make autonomous decisions related to the choice whether to have an abortion, an area protected by federal constitutional law.³⁹ A minor is able to

³⁴ I have been one of those advocates in my prior scholarship. See generally Rosato, *Let’s Get Real*, *supra* note 12; see also Jennifer Rosato, *The Ethics of Clinical Trials: A Child’s View*, 28 J.L. MED. & ETHICS 362 (2000) [hereinafter Rosato, *The Ethics of Clinical Trials*]; Rosato, *The Ultimate Test of Autonomy*, *supra* note 5.

³⁵ I have previously criticized the Court for making conclusions relating to children’s development without relying on the existing scientific or psychological literature. See Rosato, *Let’s Get Real*, *supra* note 12, at 783–84.

³⁶ See Mutcherson, *Minor Discrepancies*, *supra* note 19, at 935–53; Steinberg, *Flip-Flop*, *supra* note 10, at 583–85, for a discussion of the difficulties presented by alternating conceptions of adolescent decision making abilities.

³⁷ See *infra* notes 49–50 and accompanying text.

³⁸ See Mutcherson, *Whose Body*, *supra* note 12, at 259–63; see also Rosato, *Let’s Get Real*, *supra* note 12, at 771–72.

³⁹ See Rachel Rebouche, *Parental Involvement Laws and New*

obtain an abortion without parental consent or permission if she is able to demonstrate to a judge that she is mature or the abortion is in her best interest.⁴⁰ Other exceptions to parental control of health care decisions are narrow and vary state-by-state.⁴¹ In most states, minors can make decisions based on their maturity (a “mature minor doctrine”) only in the abortion context. Some states allow minors to consent when adolescents achieve a certain status, such as when minors are emancipated or married.⁴² Some also allow minors to consent when public policy (or public health) warrants, such as allowing minors to consent to treatment of sexually transmitted and other reportable diseases, care related to drug and alcohol use, and outpatient mental health services.⁴³ In other areas of health care decision making, most states do not have laws that protect a minor’s ability to make a health care decision based on his or her maturity.⁴⁴ Moreover, even states recognizing a mature minor doctrine may limit that right in some significant way by, for example, extending decision making to consent but not necessarily refusal of treatment (including life-sustaining treatment);⁴⁵ imposing conditions such as those related to

Governance, 34 HARV. J.L. & GENDER 175, 179–88 (2011).

⁴⁰ See Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18 COLUM. J. GENDER & L. 409, 429–32 (2009); see also *Parental Involvement in Minors’ Abortions*, STATE POLICIES IN BRIEF (Guttmacher Inst., New York, N.Y.), Sept. 1, 2011, available at http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf.

⁴¹ See Amy T. Campbell, *State Regulation of Medical Research with Children and Adolescents: An Overview and Analysis*, in ETHICAL CONDUCT OF CLINICAL RESEARCH INVOLVING CHILDREN, *supra* note 17, at app. B at 324.

⁴² See Rosato, *Let’s Get Real*, *supra* note 12, at 776–78; see also ABIGAIL ENGLISH ET AL., *STATE MINOR CONSENT LAWS: A SUMMARY* 3–4 (3d ed. 2010).

⁴³ See ENGLISH, *supra* note 42, at 4–6.

⁴⁴ See, e.g., ALA. CODE § 22-8-4 (2006); CAL. FAM. CODE § 6922 (West 2004); OR. REV. STAT. ANN § 109.640 (West Supp. 2011); S.C. CODE ANN. § 63-5-340 (2010); see also Rosato, *Let’s Get Real*, *supra* note 12, at 779–81. See generally Campbell, *supra* note 41, app. B at 347–52 tbl.B.4; ENGLISH, *supra* note 42, at 3–6.

⁴⁵ See Rosato, *Let’s Get Real*, *supra* note 12, at 779–81.

financial independence and other indicia of emancipation;⁴⁶ limiting the doctrine to a particular context;⁴⁷ or requiring parental participation.⁴⁸

The reasons undergirding this protective view of children in the health care context were articulated decades before the recent adolescent neuroscience research was conducted. In *Bellotti v. Baird*,⁴⁹ decided by the United States Supreme Court in 1979, the plurality reasoned that children should be treated differently because of “the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing.”⁵⁰

An ever-growing body of neuroscience research supports this differential treatment, even of older adolescents. According to this research, the adolescent brain functions differently from the adult brain in important respects, including long-range planning, risk assessment, and complex decision making involving emotion and cognition.⁵¹ Thus far this research seems to be accepted by

⁴⁶ See CAL. FAM. CODE § 6922 (West 2004); see also Campbell, *supra* note 41, app. B at 325, 347–52 tbl.B.4 (citing states that include emancipation criteria).

⁴⁷ See Rosato, *Let's Get Real*, *supra* note 12, at 780.

⁴⁸ See *id.* at 780–81.

⁴⁹ *Bellotti v. Baird*, 443 U.S. 622 (1979) (plurality opinion).

⁵⁰ *Id.* at 634; see also *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (“[P]arents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions [P]arents . . . act in the best interests of their children.”).

⁵¹ See, e.g., WEINBERGER ET AL., *supra* note 9, at 13–19; Laurence Steinberg, *Cognitive and Affective Development in Adolescence*, 9 TRENDS COGNITIVE SCI. 69, 69–71 (2005) [hereinafter Steinberg, *Cognitive Development*]; Steinberg, *Public Policy*, *supra* note 9, at 743–44; Steinberg, *Risk Taking*, *supra* note 5. Additional research continues to explore the differences between adolescents and adults in a variety of contexts. See, e.g., Eveline A. Crone et al., *Developmental Changes and Individual Differences in Risk and Perspective-Taking in Adolescence*, 20 DEV. & PSYCHOPATHOLOGY 1213 (2008); Bonnie L. Halpern-Felsher & Elizabeth Cauffman, *Costs and Benefits of a Decision: Decision-Making Competence in Adolescents and Adults*, 22 J. APPLIED DEVELOPMENTAL PSYCHOL. 257 (2001); Thomas Grisso et al., *Juveniles’ Competence to Stand Trial: A*

courts, based on holdings that have allowed adolescents to be treated differently in the criminal justice system.⁵²

At the same time, the existence and credibility of the neuroscience research has created a dilemma for those who advocate for greater autonomy for children in other areas, including health care. If the neuroscience research “carries over” to this context, it would make it difficult to argue that older adolescents possess the autonomy to make certain health care decisions. *Roper*’s Dilemma seems difficult to resolve.⁵³

IV. *ROPER*’S DILEMMA FOR HEALTH CARE DECISION MAKING: CAN A CHILD BE TREATED AS A CHILD FOR ONE PURPOSE AND AN ADULT FOR ANOTHER?

Researchers have been studying the maturity of adolescents in a number of different contexts,⁵⁴ and their findings suggest that *Roper*’s dilemma can be resolved. At least one group of

Comparison of Adolescents’ and Adults’ Capacities as Trial Defendants, 27 LAW & HUM. BEHAV. 333 (2003); Berna Güroglu et al., *Fairness Considerations: Increasing Understanding of Intentionality During Adolescence*, 104 J. EXPERIMENTAL CHILD PSYCHOL. 398 (2009); Anna C.K. van Duijvenvoorde, *Affective and Cognitive Decision-Making in Adolescents*, 35 DEVELOPMENTAL NEUROPSYCHOLOGY 539 (2010).

⁵² See discussion *supra* Part II.

⁵³ This dilemma may extend into young adulthood as the law’s view of adolescence (and whether minors are capable) may be increasingly affected by the greater dependency of young adults on their parents in their early and mid-twenties. See AFL-CIO WORKING AMERICA, *YOUNG WORKERS: A LOST DECADE 15* (2009); Rich Morin & Wendy Wang, *Home for the Holidays . . . and Every Other Day*, PEW RESEARCH CTR. (Nov. 24, 2009), <http://www.pewsocialtrends.org/2009/11/24/home-for-the-holidays-and-every-other-day/>; cf. Patient Protection and Affordable Care Act, 42 U.S.C. 300gg-14 (West 2006 & Supp. 3 2009) (requiring covering of young adults under parents’ health insurance until age 26). This demographic shift not only has the potential of affecting the overall view of adolescents in society, but also may diminish their actual decision making capacities, since the “commonsense reality” is that they probably have had less chance to exercise their decision making skills before reaching young adulthood.

⁵⁴ Steinberg, *Flip-Flop*, *supra* note 10, at 585–86, 593; see also studies cited *supra* note 51.

researchers has concluded that, because adolescents' capacity to make decisions varies for different types of decisions, it is consistent to conclude that adolescents can be deemed incapable in the *Roper* and *Graham* contexts, yet considered capable of making health care decisions.⁵⁵ Consequently, in their view, the APA is not "flip flopping" when it simultaneously advocates both views of adolescents.⁵⁶

Based on empirical evidence, these researchers have distinguished those decisions "that allow for unhurried, logical reflection and those that do not."⁵⁷ Medical decisions fall into this first category, as well as decisions to participate in clinical research. As to these kinds of decisions,

where emotional and social influences on judgment are minimized or can be mitigated, and where there are consultants who can provide objective information about the costs and benefits of alternative courses of action, adolescents are likely to be just as capable of mature decision making as adults, at least by the time they are 16.⁵⁸

The researchers conclude that these decisions are primarily cognitive or intellectual in nature, rather than psychosocial.⁵⁹

In reaching their conclusions, these researchers emphasize that science should "inform" rather than "dictate" public policy.⁶⁰ They remind judges and advocates (among others) that one competency standard does not necessarily fit all adolescents, and therefore these professionals should engage in "a careful and nuanced consideration of the particular demands placed on the individual for 'adult-like' maturity in different domains of functioning."⁶¹ These findings are consistent with an earlier body of research supporting the capacity of older adolescents to make health care decisions.⁶²

⁵⁵ Steinberg, *Flip-Flip*, *supra* note 10, at 586–87, 592–93.

⁵⁶ *Id.* at 592–93.

⁵⁷ *Id.* at 592.

⁵⁸ *Id.*

⁵⁹ *Id.* at 586–87, 592–93.

⁶⁰ *Id.* at 593.

⁶¹ *Id.*

⁶² See Hartman, *Word from the Academies*, *supra* note 17, at 174 & nn.119–23, 176 & nn.128 & 131–32 (concluding that adolescents may be

Professionals dealing with these issues need to look beyond the existing research and consider giving mature minors the right to make certain health care decisions, depending on the context in which the decision is made and the competing values underlying the public policies at stake. The individual variations in maturity also should be taken into account in the mature minor determination, which more broadly acknowledges the volatility and transitional nature of adolescence.

V. MOVING TOWARDS “CONTEXTUAL CAPACITY”

Ultimately, the existing scientific evidence does not (yet) provide a useful guide for determining whether the law should recognize that some minors are able to make decisions in the health care context. Although researchers and commentators have concluded that such decisions are different from those facing the juveniles in the *Roper* and *Graham* cases,⁶³ this distinction is not entirely convincing. Some health care decisions are made with “unhurried, logical reflection”⁶⁴ but others are not. Many minors do not consult adults in making these decisions, but others will.⁶⁵ Sometimes minors use their cognitive abilities in making these decisions, and sometimes they are guided by psychosocial considerations.⁶⁶ Teenagers may not

competent to consent to research, although more study is necessary); Rosato, *Let's Get Real*, *supra* note 12, at 784–85; *see also* Brief for Amicus Curiae American Psychological Association in Support of Appellees and Cross-Appellants at 6–10, *Hodgson v. Minnesota*, 853 F.2d 1452 (8th Cir. 1988) (No. 86-5423-MN/No. 86-5431-MN), *available at* <http://www.apa.org/about/offices/ogc/amicus/hodgson.pdf>.

⁶³ *See supra* Part II; *see also* Mutcherson, *Minor Discrepancies*, *supra* note 19, at 952–65.

⁶⁴ Steinberg, *Flip-Flop*, *supra* note 10, at 592.

⁶⁵ *See id.* at 586 (pointing to studies indicating that approximately half of pregnant girls contemplating an abortion do not consult their parents, but do consult with a nonparental adult other than medical staff).

⁶⁶ For example, it is possible that teen girls sometimes have babies so that they will be loved unconditionally or so a boyfriend will stay with them, and some teens may refuse treatment because of how it will make them look or to allow them to keep up with their friends. *See generally* Amanda

be deliberative in the ways that the researchers assume, and although some teens are deliberative, others may not be.

More research into neurology and developmental psychology is needed to provide greater reliability and predictability as to what capacities are needed for particular decisions.⁶⁷ This knowledge will give judges and advocates a better sense of whether the view of adolescents as incapable in *Roper* and *Graham* should carry over to other areas.

However, even additional scientific evidence may not help resolve individual cases: consequently, the type of health care decision and its context will remain important to determining whether a minor is mature enough to make a particular decision at a certain time and place.⁶⁸ Health care decisions range from abortion, to life-sustaining treatment, vaccinations, antibiotics, and treatment for sexually transmitted diseases. Participation in clinical research is similar to a health care decision, as related considerations are weighed: the primary distinction is that the objective of research is to advance knowledge to help others rather than to improve the individual patient's health.⁶⁹ Some of these decisions require a simple risk/benefit analysis regarding the efficacy and safety of a particular treatment, but others require the teenager to grapple with value-laden issues such as determining the quality of one's life as a terminally/chronically ill child, or taking on the major responsibilities of single parenthood before finishing high school.

Memrick, *Surprising Reasons Teens Say They Get Pregnant*, GASTON GAZETTE (May 8, 2010, 12:19 PM), <http://www.gastongazette.com/articles/teens-46910-pregnant-information.html>.

⁶⁷ More studies are being conducted to test capacity in particular contexts. See studies cited *supra* note 51.

⁶⁸ See Hartman, *Coming of Age*, *supra* note 12; Mutcherson, *Whose Body*, *supra* note 12; Rosato, *Let's Get Real*, *supra* note 12, at 795; Steinberg, *Public Policy*, *supra* note 9, at 747-48.

⁶⁹ See 45 C.F.R. § 46.102(d) (2010) (defining "research"); see also Hartman, *Word from the Academies*, *supra* note 17, at 157-58 & nn.31-32 ("Underlying those regulatory protections for children are bifurcated aims of safeguarding minors' best interests while yielding generalized knowledge about drug therapies and other medical treatments beneficial to younger age groups.").

All of these reasons lead me to a conclusion that I reached ten years ago, and of which I have become even more convinced post-*Roper*: that mature minors should be able to make some important health care decisions.⁷⁰ Specifically, a contextual capacity doctrine would allow a health care provider to assess the minor's maturity and, if appropriate, agree to the minor's decision without parental permission or consent.⁷¹ This approach should be privatized, in the sense that it would not require court intervention in most circumstances.⁷² For some decisions, such as refusal of life-sustaining treatment, the court may retain a limited role as a "safety net" to ensure that the adolescent's decision would not threaten his or her life or cause permanent physical harm.⁷³

Although the limits of this Essay do not allow development of a detailed approach, it is important to set forth the compelling public policies that should guide this inquiry and inform different outcomes depending on the context. One guiding ethical principle in the health care context is the protection of the mature minor's autonomy and bodily integrity. Other compelling policies in this context include: identity formation, promoting moral development, parity, and public health. Consideration of these policies will enable law and policy to move in a direction that is more principled and coherent.

A. Identity Formation

Where a decision impacts a minor's formation of his or her identity, a mature minor should be able to decide on his or her

⁷⁰ Rosato, *Let's Get Real*, *supra* note 12, at 797–803; Rosato, *The Ultimate Test of Autonomy*, *supra* note 5, at 83–103.

⁷¹ See Rosato, *Let's Get Real*, *supra* note 12, at 795–803. Although this approach varies somewhat from the "categorical, contextual" approach I proposed in 2002, it seems more feasible, practical, and consistent with the current cultural, legal, and ethical environment.

⁷² *But see* Sanger, *supra* note 40, at 461–63 (criticizing the determination of maturity by the courts in the abortion context).

⁷³ Rosato, *Let's Get Real*, *supra* note 12, at 799–800.

own.⁷⁴ Some decisions, such as whether to choose to have an abortion or have a child, the refusal of life-sustaining treatment, or a gender identity change are major life decisions implicating core values that will affect the quality of a minor's entire life. The decision whether to have an abortion or have a child is a decision to take on the life-long responsibilities of a parent and to forego the incremental path to independence as a high school and college student focusing on studies and extracurricular activities. The decision to refuse life-sustaining treatment is a decision to choose a certain quality of life over length of life, and may reflect deeper values such as bodily integrity, dignity, and core religious tenets. The decision to choose to change gender identity—to choose to be male or female—is a life-altering choice especially in a society that places great value on gender distinctions.

The controversial and important decision regarding the genetic testing of minors for adult-onset diseases (such as breast cancer or Alzheimer's disease) affects a minor's identity and is worth highlighting.⁷⁵ Who should decide whether minors should be tested for a predisposition to a serious, chronic, or terminal disease that may not manifest itself until late adulthood (if at all)?⁷⁶ This tension becomes a conflict when a parent wants the

⁷⁴ *Id.* at 790, 800; see Joel Feinberg, *The Child's Right to an Open Future*, in WHOSE CHILD? CHILDREN'S RIGHTS, PARENTAL AUTHORITY AND STATE POWER 124, 138–51 (William Aiken & Hugh LaFollette, eds., 1980). To preserve the child's future, it is important to keep options open that would be foreclosed in adulthood—such as parenthood, gender identity, and quality of life.

⁷⁵ See generally Rhodes, *supra* note 15; Stephen Robertson & Julian Savulescu, *Is There a Case in Favour of Predictive Genetic Testing in Young Children?*, 15 *BIOETHICS* 26 (2001) (all sources confronting the issue of predictive genetic testing in young children); Benjamin Wilfond & Lainie Friedman Ross, *From Genetics to Genomics: Ethics, Policy and Parental Decision-Making*, 34 *J. PEDIATRIC PSYCHOL.* 639 (2009).

⁷⁶ For a discussion of this issue, see Am. Coll. of Med. Genetics, *supra* note 15; Rhodes, *supra* note 15; Robertson & Savulescu, *supra* note 75; Wilfond & Ross, *supra* note 75; see also Beth N. Peshkin et al., *Brief Assessment of Parents' Attitudes Toward Testing Minor Children for Hereditary Breast/Ovarian Cancer Genes: Development and Validation of the Pediatric BRCA ½ Testing Attitudes Scale (P-TAS)*, 34 *J. PEDIATRIC*

minor to be tested and the minor wants to refuse the testing: should he or she be able to veto the parents' decision and prevent the violation of bodily integrity and breach of privacy?⁷⁷ The implications of the testing and the knowledge gained from it implicate core values and may affect the quality of the minor's entire life. For example, the testing and knowledge may have psychological effects, as an individual will need to deal with the anxiety and related emotions that may be caused by the acquired knowledge of one's predisposition to a serious disease that may already have caused death in the family.⁷⁸ It also may affect the health care received (including further testing and other surveillance), childbearing decisions, and other "life planning."⁷⁹

For all of these reasons, this testing decision is identity-forming and mature minors need to be able to participate significantly in the decision.⁸⁰ At a minimum, minors with capacity to make this health care decision should be able to veto the parents' decision to compel testing and knowledge acquisition. The mature minor should be able to guide the quality of his or her life, and make a decision to test when he or she is ready in all respects.⁸¹

PSYCHOL. 627, 628 (2009).

⁷⁷ See Anne Marie Laberge & Wylie Burke, *Testing Minors for Breast Cancer*, 9 VIRTUAL MENTOR 6, 8 (2007) (discussing the potential consequences of honoring autonomous parental decisions).

⁷⁸ See, e.g., Am. Coll. of Med. Genetics, *supra* note 15, at 1233, 1235–36; Rhodes, *supra* note 15, at 612–15; Robertson & Savulescu, *supra* note 75, at 34, 45.

⁷⁹ See Am. Coll. of Med. Genetics, *supra* note 15, at 1233–37; cf. Angela Bradbury et al., *Should Genetic Testing for BRCA ½ be Permitted for Minors? Opinions of BRCA Mutation Carriers and Their Adult Offspring*, AM. J. MED. GENETICS 70, 74 (2008) (providing evidence that the most common reason to support testing was to foster healthy behavior in minors, and in parents encouraging minors' healthy behavior).

⁸⁰ See Robertson & Savulescu, *supra* note 75, at 40 ("Learning to become autonomous requires actually making important decisions for oneself about oneself, and one such decision might be whether to know some fact about one's genetic make-up."); see also Bradbury et al., *supra* note 79, at 76 ("Given that some individuals achieve social, emotional and intellectual maturity well in advance of their peers, it may be permissible to allow genetic testing of minors on a case-by-case basis.").

⁸¹ See Peshkin et al., *supra* note 76, at 628 (citing, *inter alia*, Am. Coll.

B. Promoting Moral Development

Respecting mature minors' decisions in certain health care decisions not only will allow them to chart their own futures, but also assist in developing independent decision-making skills and promoting moral development. One such type of decision is giving informed consent to research. Allowing mature minors to consent to nontherapeutic research will encourage them to develop values such as altruism, as well as to better assess the risks and benefits of a clinical trial.⁸²

In 2004, the Institute of Medicine ("IOM") issued a comprehensive report relating to children's participation in research trials, which furthers this model of decision making for adolescents:

Institutional review boards should consider granting waivers of parental permission for adolescent participation in research when

- the research is important to the health and well-being of adolescents and it cannot reasonably or practically be carried out without the waiver. . . or
- the research involves treatments that state laws permit adolescents to receive without parental permission (consistent with the definition of children in the [federal regulations]);

of Med. Genetics, *supra* note 15; Bradbury et al., *supra* note 79) (discussing case-by-case approach, considering minor's maturity).

⁸² See INST. OF MED. OF THE NAT'L ACAD., *supra* note 17, at 7; cf. Rhonda Gay Hartman, *Gault's Legacy: Dignity, Due Process and Adolescents' Liberty Interests in Living Donation*, 22 NOTRE DAME J.L. ETHICS & PUB. POL'Y 67, 103-06 (2008) (furthering similar values in organ donation context); Hartman, *Word from the Academies*, *supra* note 17, at 169-70 (crediting the numerous benefits of autonomous decisions to participate in research); Rosato, *The Ethics of Clinical Trials*, *supra* note 34, at 370 (stating that empowerment of mature minors "would lead to a number of desirable results, including adolescents being more informed about these decisions; being allowed to practice decision making before formal adulthood begins, thus permitting them to become better decision makers in adulthood; and being able to play a role in shaping their own identities, including their desire to be beneficent.").

and when

- the investigator has presented evidence that the adolescents are capable of understanding the research and their rights as research participants and
- the research protocol includes appropriate safeguards to protect the interests of the adolescent consistent with the risk presented by the research.⁸³

The policy should not be limited to treatments that state laws permit adolescents to receive without parental permission, since those laws may be limited.⁸⁴ Also, the standard should clearly allow mature minors to consent to nontherapeutic research if it poses only a minimal risk.⁸⁵

This approach appropriately balances the relevant public policies, including respect for the child's bodily integrity, autonomy, and dignity; protection of the child's health; and the societal benefit of the knowledge gained through the research. As an additional benefit, allowing minors to make these kinds of decisions may also enable them to accelerate their brain development, since there is support for the conclusion that greater use of their decision-making capacities may increase those capacities.⁸⁶

⁸³ INST. OF MED. OF THE NAT'L ACAD., *supra* note 17, at 19; *accord* Hartman, *Word from the Academies*, *supra* note 17, at 197–99 (advocating for legal reform and further research consistent with the IOM's recommendations); Rosato, *Let's Get Real*, *supra* note 12, at 800–01 (proposing similar approach).

⁸⁴ *See supra* Part II.

⁸⁵ *See* Rosato, *The Ethics of Clinical Trials*, *supra* note 34, at 370–71. In the federal regulations, “minimal risk” is defined as “the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.” 45 C.F.R. § 46.102(i) (2010); 21 C.F.R. § 50.3(k) (2011); *see also* INST. OF MED. OF THE NAT'L ACAD., *supra* note 17, at 117–36 (discussing interpretations of minimal risk and recommendations related to risk).

⁸⁶ *See* Rosato, *Let's Get Real*, *supra* note 12, at 792–93; *see also* Steinberg, *Cognitive Development*, *supra* note 51, at 71 (“Performance in

C. Parity

Similar kinds of decisions should be regarded as similar so that the minor's autonomy is truly respected. For example, an adolescent who becomes a parent should be able to make health care decisions for herself and for her child;⁸⁷ and a minor who makes decisions regarding sexually transmitted diseases should be able to consent to the HPV vaccine, which prevents certain cancers caused by the Human Papillomavirus.⁸⁸

Access to the HPV vaccine is a cutting-edge issue that illustrates an existing lack of parity among decisions related to sexually transmitted diseases. Adolescents seek the HPV vaccine and may not be able to get it, and other adolescents who need it may not know about the vaccine or how to ask for it.⁸⁹ Furthermore, it is unclear whether state laws allow this decision to be made without notifying or seeking the consent of a parent, even if the law allows for treatment of STDs.⁹⁰ If the vaccine is considered general health care, parental involvement is required. Under this paradigm, without parity, a sexually active teen can get a pregnancy

everyday settings are likely affected by emotional states, social influences and expertise.”); *cf.* Hartman, *Word from the Academies*, *supra* note 17, at 169–70 (developing cognitive abilities, improving self-image, enhancing sense of identity and accomplishment). *See generally* INST. OF MED. OF THE NAT'L ACAD., *supra* note 17, at 179 (cognitive development depends in part on experience and training).

⁸⁷ For a discussion of this issue, see Rosato, *Let's Get Real*, *supra* note 12, at 777–78.

⁸⁸ *See* sources cited *supra* note 14.

⁸⁹ *See* Farrell & Rome, *supra* note 14, at 435–36; Ford et al., *supra* note 14, at 570–71; Saribel G. Ceballos, *HPV Vaccination for Adolescents; An Ethics Case Study*, ADVANCE FOR NPs & PAs, Oct. 26, 2009, at 31, available at <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Article/HPV-Vaccination-for-Adolescents.aspx>; Cynthia S. Marietta, *High Incidence of HPV in Minors Spotlights Need for State Legislators to Consider Amending Child “Consent to Treatment” Laws*, HEALTH L. PERSP. 6 (May 21, 2010, 8:23 AM), [http://www.law.uh.edu/healthlaw/perspectives/2010/\(CM\)%20HPV.pdf](http://www.law.uh.edu/healthlaw/perspectives/2010/(CM)%20HPV.pdf).

⁹⁰ *See* English et al., *supra* note 14, at S86–87; Ford et al., *supra* note 14, at 570. A few state laws appear to allow minor consent to vaccination. *See, e.g.*, N.C. GEN. STAT. ANN. § 90-21.5 (West 2008 & Supp. 2010).

test or whatever medication is necessary to treat a sexually transmitted disease, but cannot get a vaccination to prevent some of the most serious, long-term health consequences of contracting one of the most prevalent sexually transmitted diseases.⁹¹

The HPV vaccine should be given without the need for parental consent or permission, as it should be regarded as a decision involving the transmission of sexually transmitted diseases.⁹² State laws should be changed to allow minors to consent to this treatment, which affects their long-term health, in determining whether it will increase the probability of serious conditions.⁹³ In addition, parental consent waivers to treatment should clearly include preventative treatment such as vaccinations.⁹⁴ Preserving this parity with STD treatment will best protect the minor's autonomy and health.

D. Public Health

The law has given some deference to minors in areas implicating public health concerns. These areas of decision making include mental health, drug and alcohol treatment, birth control, and treatment for STDs.⁹⁵ These areas address a number of important public health concerns, including preventing the

⁹¹ See Farrell & Rome, *supra* note 14, at 436; Marietta, *supra* note 89, at 6-7; cf. English et al., *supra* note 14, at S87 (describing how laws could include vaccinations).

⁹² See Farrell & Rome, *supra* note 14, at 436.

⁹³ For example, a state could enact a law that allows minors to consent to vaccination as health care related to the prevention of STDs. See N.C. GEN. STAT. ANN. § 90-21.5 (West 2008 & Supp. 2010); see also S. 4779, 231st Leg., Reg. Sess. (N.Y. 2009), <http://open.nysenate.gov/legislation/bill/S4779-2009> (the language of the bill reads, "A health care practitioner may provide health care related to the prevention of a sexually transmissible disease, including administering vaccines, to a person under the age of eighteen years without the consent or knowledge of the parents or guardians of such person, provided that the person has capacity to consent to the care, without regard to the person's age, and the person consents.").

⁹⁴ See Ford et al., *supra* note 14, at 572-73.

⁹⁵ See *supra* Part III. The area of decisional autonomy may also include the HPV vaccination. See Farrell & Rome, *supra* note 14, at 436-37.

spread of communicable diseases and ensuring that the minor obtains needed treatment to prevent serious harm to herself or to others. In these contexts, the safety of the minor and the community is more important than ensuring that parents know about or are involved in the decisions.⁹⁶ For example, we do not want to deter teens from obtaining medication to treat an STD because they do not want to tell their parents they have been sexually active (probably without protection) and caught a disease as a result.

Although these areas of decision-making authority are already recognized by most states,⁹⁷ they should be expanded as necessary to protect against the dangers that teenagers pose to themselves and to others.⁹⁸ For example, as discussed above, the minors' right to obtain treatment for STDs should include the right to consent to the HPV vaccine. In addition, statutes relating to minors' consent to mental health treatment need to better reflect the reality of their lives, including the deterrent effect that parental involvement may have on seeking needed treatment. A recent California mental health statute⁹⁹ seems to go only halfway: it recognizes a mature minor doctrine for outpatient mental health services,¹⁰⁰ but then requires that a parent or guardian be involved unless the involvement would be "inappropriate" and requires parental contact to be recorded.¹⁰¹ True autonomy for minors considered mature should not require parental involvement or proof that it is inappropriate. The fact that the mature minor is seeking mental health treatment on his or her own without an

⁹⁶ See Halpern-Felsher & Cauffman, *supra* note 51, at 271–72 (suggesting treatment for STDs despite adolescents' immaturity).

⁹⁷ See *supra* Part II.

⁹⁸ CAL. HEALTH & SAFETY CODE § 124260 (West Supp. 2011) (adopting mature minor doctrine, but significantly limiting it with requirement of parental involvement).

⁹⁹ *Id.*

¹⁰⁰ *Id.* See generally Sana Loue, *Faith-Based Mental Health Treatment of Minors*, 31 J. LEGAL. MED. 171, 195 (2010) ("A number of states . . . currently provide for minors' access to mental health services absent parental consent and notification, subject to various restrictions relating to the nature and duration of treatment.").

¹⁰¹ Loue, *supra* note 100.

adult involved should be enough of an indication that the minor would not desire nor benefit from consultation with a parent. Recognizing these compelling public policies and “privatizing” the law as much as possible would only build respect for the adolescents’ dignity and right to self-determination.

VI. CONCLUSION

The recent scientific literature on adolescent brain development should not dictate the development of the law,¹⁰² even if it is consistent with the “commonsense reality” that teens have a lot of growing up to do. We know teenagers who are as capable, or more capable, than some adults. Even as teens, they raise healthy children, have successful careers, and make other important decisions on their own. For those minors who are deemed mature enough to make a decision in a particular context, compelling public policies suggest that we should give their voices recognition, and give their choices the dignity and respect that they deserve.¹⁰³

¹⁰² Steinberg, *Public Policy*, *supra* note 9, at 746–48.

¹⁰³ See Hartman, *supra* note 82 (proposing that, consistent with *Gault*, minors should be allowed to consent to organ donation to protect their dignity); *cf.* Sanger, *supra* note 40 (arguing that abortion bypass hearings fail to respect the dignity of minors).