



September/October 2015 LD Topic Analysis

Lincoln-Douglas debaters will kick off the 2015-2016 competitive season debating the topic **“Resolved: Adolescents ought to have the right to make autonomous medical choices.”** This guide will provide a basic introduction to key considerations for debating on both sides of this topic. Along the way, I will provide evidence to help you get your cases started. When we finish, you should be prepared to start your LD season with a bang!

We’ll start out, as always, by considering what the words in the resolution mean.

Definitions

Adolescents is maybe the trickiest word in this resolution. It seems obvious—adolescents are young people: not children, not adults. But it’s really more complicated than that. Specifically, what age ranges are included? Or is it determined by some other factor than numerical age alone, such as the onset of puberty? On this topic, both sides of the debate may have a competitive incentive to seek an interpretation that is either extremely narrow (aff) or broad (neg). The aff will probably want to choose an interp that is limited to older adolescents, since it is easier to defend that an 18-year-old should make her own medical choices than a 10-year-old. The neg, obviously, will want the opposite.



The **World Health Organization** defines “adolescents” thusly:

(WHO, “Adolescent Development,”

http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/, 2015)

WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. It represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy. Biological processes drive many aspects of this growth and development, with the onset of puberty marking the passage from childhood to adolescence. The biological determinants of adolescence are fairly universal; however, the duration and defining characteristics of this period may vary across time, cultures, and socioeconomic situations. This period has seen many changes over the past century namely the earlier onset of puberty, later age of marriage, urbanization, global communication, and changing sexual attitudes and behaviors.

This is an excellent definition to use, due to its credibility and contextual specificity. The WHO is a worldwide authority on healthcare, so it would be difficult to argue that its interpretation is incorrect. However, the aff may not appreciate the broad age range it invokes. The neg, however, should find this very useful.

The neg might also use some of the un-underlined portion to argue that “adolescence” is not a specific term with a stable definition, and therefore is unsuitable for determining any sort of legal rights. It may be problematic to, in practice, guarantee “adolescents” a formal right to autonomy, due to the highly imprecise nature of the category.



Here is another definition of “adolescence” that is a bit narrower, from **Psychology Today**:

(Psychology Today, “Adolescence,” <https://www.psychologytoday.com/basics/adolescence>, 2015)

Adolescence describes the teenage years between 13 and 19 and can be considered the transitional stage from childhood to adulthood. However, the physical and psychological changes that occur in adolescence can start earlier, during the preteen or “tween” years (ages 9 through 12). Adolescence can be a time of both disorientation and discovery. The transitional period can bring up issues of independence and self-identity; many adolescents and their peers face tough choices regarding schoolwork, sexuality, drugs, alcohol, and social life. Peer groups, romantic interests and external appearance tend to naturally increase in importance for some time during a teen's journey toward adulthood.

Here is another, from the **Merriam-Webster Medical Dictionary**:

(Merriam-Webster Medical Dictionary (online), “adolescence,” <http://www.merriam-webster.com/dictionary/adolescence>, 2015)

the period of life from puberty to maturity terminating legally at the age of majority.

If none of those are ideal for you, there are plenty of links to other possible interpretation evidence on the [Wikipedia page for “adolescence.”](#)

Ought is a word that all LDers are undoubtedly already familiar with, so we won’t beat a dead horse here. If for some reason this term confuses you, check out the discussion in [this month’s PF analysis.](#)



There is one thing about “ought” that is worth noting, however. The phrasing of the resolution, and its use of “ought,” implies that debates should be about whether or not adolescents should have medical autonomy *as a general principle*. Discussions of current laws, and to what degree they allow adolescent autonomy, are mostly irrelevant. While you might be able to use these arguments for empirical reasoning (“[state] allows autonomy for adolescents and the results have been...”), these kinds of points should not be used for policy-style inherency arguments, like “autonomy is already the status quo in [state], therefore there’s no reason to vote aff.” The debate is about whether autonomy is a good idea, *not* about whether it currently exists in any particular circumstances or location.

On the subject of **rights**, there are longstanding academic debates regarding the precise definition. If you are interested in delving deeper into this subject, [here](#) is a good starting spot. However, I don’t foresee very many debates centering on this issue, so we’ll just define it in a general manner.

According to the **American Heritage Dictionary**, “rights” are:

*(American Heritage Dictionary (online), “Rights,”
<http://dictionary.reference.com/browse/rights>, 2015)*

That which is due to anyone by just claim, legal guarantees, moral principles, etc



Autonomous means independently—an “autonomous” choice is one you make for yourself. In the context of the resolution, it indicates that the choices made by adolescents would be wholly free from outside influence.

Merriam-Webster defines “autonomy” as:

(Merriam-Webster Dictionary (online), “autonomy,” <http://www.merriam-webster.com/dictionary/autonomy>, 2015)

self-directing freedom and especially moral independence

That interpretation is particularly solid for LD debates, because of its focus on morality. However, numerous other slightly different interpretations are easily available—just look in any dictionary.

Most of us think of anything within the field of healthcare when we hear **medical**. While this understanding is workable for most debates, it is important to know that many sources consider “medical” as distinct from “surgical.” In other words, treatments involving surgery are not included. Some of you might find tricky ways to use this information on the neg.



The **Oxford American College Dictionary** defines “medical” as:

(Oxford American College Dictionary (online- via Google), “medical,” 2015)

of or relating to the science of medicine, or to the treatment of illness and injuries.

OR

of or relating to conditions requiring medical but not surgical treatment.

The **American Heritage Dictionary** likewise also excludes surgery:

(American Heritage Dictionary (online), “Medical,”

<http://dictionary.reference.com/browse/medical>, 2015)

pertaining to or requiring treatment by other than surgical means.

Finally, we’ll close our discussion of definitions with the last word in the resolution: **choices**. This one is exactly as simple as it sounds—“choices” are decisions. Medical choices are decisions pertaining to healthcare treatment (perhaps excluding surgeries).

One last general note about this resolution: based on my research, it seems that the body of academic literature on this subject is relatively narrow, which has caused many scholars to quote passages from the same group of studies. As a result, you might hear a phrase attributed to two different authors; the cause would be that the debater is reading a passage written by one researcher, and then quoted by another in a later study. I tell you this in order to caution you to be



extra-careful before you attempt to make any ethical challenges against your opponents on this topic.

Now, let's move on to our discussion of strategic options. We'll start with the aff.

Aff Options

The first, and perhaps most common, affirmative argument is that **adolescents are capable** of making their own choices. In this context, "capable" refers to intellectual and emotional maturity to make healthy decisions for one's future.

Here is one piece of **evidence**, discussing studies conducted on this exact subject—comparing the medical decision-making processes of adolescents to that of adults:

(Mary Ann McCabe, current president of div. 37 of the American Psychological Association and current chair of the APA Interdivisional Task Force on Child and Adolescent Mental Health, assoc. clinical professor of pediatrics at George Washington University School of Medicine, affiliate faculty in psychology at George Mason University, "Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations," Journal of Pediatric Psychology, Vol. 21.4 pg. 507, 1996)

However, applied research in children's medical decision making is limited. Most studies have involved healthy children who were asked to make decisions about hypothetical medical situations (Lewis, 1980, 1981; Weithorn & Campbell, 1982). The most creative of these studies (Weithorn & Campbell, 1982) compared decisions of four age groups (9, 14, 18, and 21 years) on outcome measures that were specifically designed to reflect the four standards of competency to consent (evidence of



choice, reasonable outcome, rational reasons, and inferential understanding). Results suggested that children in the 9-year-old group were less competent than adults in terms of the higher standards of understanding the information provided and rational reasons; not surprisingly, they used one or two concrete factors in their decisions. However, they did not differ from adults in the standards of evidence of choice or reasonable outcome; that is, they still tended to arrive at logical decisions which were similar to those of adults. In terms of all four standards, the 14-year-old group demonstrated the same level of competency as the two "adult" groups; they showed a similar level of understanding and reasoning, and made similar choices. We should continue this line of research with ill children in order to explore the impact of physical illness and emotional adjustment upon children's medical decision making.

More evidence:

(Tara Kuther, "Medical Decision-Making and Minors: Issues of Consent and Assent," Proquest.com, 2013, Web, <<http://search.proquest.com/docview/195942431/fulltextPDF?accountid=7122>>.)

Despite these criticisms, many theorists argue that there is little evidence that minors aged 15 and older are less able to provide consent than are adults (Ambuel & Rappaport, 1992; Embree & Dobson, 1991; Grisso & Vierling, 1978; Lewis, 1987; Melton, 1983; Weithorn & Campbell, 1982). By age 14, minors perform comparably to older minors and adults in their ability to make rational choices in many contexts (Beyth-Marion et al., 1993; Embree & Dobson, 1991; Lewis, 1987; Quadrel et al., 1993; Weithorn & Campbell, 1982). The evidence suggests that many adolescents are as able as adults to conceptualize and reason about treatment alternatives, and, therefore, to make healthcare decisions. In addition, we must recognize that adolescents do not make decisions alone, but, rather, with the assistance of licensed professionals who provide information and advice. Croxton et al. (1988) argue that "this tandem, the minor and professional provider, protects the interests of both the minor in informed decision making and the interests of the state in protecting the minor from harm" (p. 11). Finally, the research suggests that we must exert caution concerning assumptions about the ability of minors aged 11 to 14 to consider treatment alternatives, risks, and benefits, and to provide voluntary consent (Grisso



& Vierling, 1978). Minors below the age of 11 generally do not have the intellectual ability and volition to give informed, voluntary, and rational consent (Grisso & Vierling, 1978; Weithorn & Campbell, 1982).

Another piece of **evidence**:

(Rhonda Gay Hartman, J.D., Ph.D., "Decisional Autonomy for Medical Care: Physician Perceptions and Practices," The University of Chicago Law School Roundtable, vol 8 iss 1 art 5, : <http://chicagounbound.uchicago.edu/roundtable/vol8/iss1/5>, 2001)

Existing literature related to adolescent decision-making capability for medical care suggests a level of decisional capacity not presently presumed by law. In fact, several studies reveal that adolescents decide on their medical care with an intentionality and thoughtfulness not usually attributed to them.⁵⁸ Particularly, commentators have found "little evidence that minors of age 15 and above as a group are any less competent to provide consent than are adults."⁵⁹ For example, Lois Weithorn and Susan Campbell, when studying differences in decisional abilities among children, adolescents, and young adults using standardized measures of competency and clinical vignettes, reported that "minors aged 14 were found to demonstrate a level of competency equivalent to that of adults."⁶⁰ These results, according to Weithorn and Campbell, confirm the "formal operational stage" concept proffered in the 1950s by Jean Piaget, who postulated that cognitive development and reasoning ability is attained by early adolescence. Contemporary researchers in cognitive development challenge the Piagetian stage model,⁶¹ instead opting for "specific task performance attainment," while extolling the Piagetian tradition as a valuable contribution to an understanding of the self.

Strengthening this research are the results of several studies conducted by David Scherer, who likewise compared children, adolescents, and young adults to discern differences in ability to decide hypothetical medical treatment and conditions.⁶³ Scherer reported that "there is no conclusive evidence to presume that adolescents are incapable of a voluntary consent comparable to that of young adults," but found differences between adolescents and young adults in the "quality and quantity of decision-making autonomy that they may exercise in medical treatment decisions" due to parental influence and treatment decision gravity.⁶⁴ Scherer found that young adults and adolescents seem to approach medical decision making "with a quality of intentionality that is not seen in the decisions made by children,"⁶⁵ suggesting that recognizing adolescent autonomous decision making for medical care "may improve their response to treatment and encourage the development of self-efficacy."⁶⁶ Scherer and N. Dickon Reppucci had previously studied an adolescent sample to determine how adolescents respond to and are impacted by parental influence in medical decision making.⁶⁷ They found that, while



adolescents are responsive to parental influence, adolescents reserve "the prerogative to make treatment decisions that have consequential bearing on their lives" 68 and "do not appear to be intimidated by either the gravity or severity of a treatment decision or by the forcefulness of coercive parental influence attempts." 69 Kenneth Ginsburg and his research team also found a measure of intentionality and independence exhibited by adolescents in medical decision making. The team discovered when examining adolescent choice in health care providers that adolescents perceive honesty and mutual respect as fundamental requisites to a successful patient-physician relationship, along with straightforward, understandable communication, and that "their expectations of health care providers are forthright and clear... know[ing] what draws and offends them."70 In a related study, Ginsburg and fellow researchers found that "adolescents are not passive recipients of care. They actively interpret interactions and evaluate services." 71 These researchers also suggest that adolescents "want to navigate the system independently" and identified honesty, respect, equal treatment of patients, confidentiality, and interpersonal skills as paramount characteristics of providers, which positively impact their decision to seek health care and comply with treatment recommendations. 72 While researchers have found that consultation with a trusted adult benefits adolescents, particularly in reducing risky behavior,7 3 adolescents emphasize that it is caring and connectedness from which they derive benefit, regardless of familial ties.7

Even more **evidence**, arguing that—when well-informed about the decision—teens are often actually *more* risk-averse than adults (indicating that they won't make reckless choices):

(MedicalXpress, "Study: Tolerance for ambiguity explained by adolescents' penchant for risky behaviors," <http://medicalxpress.com/news/2012-10-tolerance-ambiguity-adolescents-penchant-risky.html>, October 1 2012)

These findings, which are reported in the journal the Proceedings of the National Academy of Sciences, point to basic differences between adolescents and adults and offer new insights into how to communicate about risk to teenagers and pre-teens.

"Our findings show that teenagers enter unsafe situations not because they are drawn to dangerous or risky situations, but, rather, because they aren't informed enough about the odds of the consequences of their actions," explained Agnieszka Tymula, a post-doctoral researcher at NYU's Center for Neural Science and one of the study's co-authors. "Once they truly understand a risky situation, they are, if anything, even more risk averse than adults." The study also offers new possibilities for



communicating with this age group—providing adolescents with statistics highlighting the risks of dangerous behaviors or training that allows them to learn about risks in a safe way, which may be effective in limiting them."

"What we found was that when risks were precisely stated, adolescents avoided them at least as much, and sometimes more, than adults," added Ifat Levy, an assistant professor of comparative medicine and of neurobiology at the Yale School of Medicine and one of the study's co-authors. "Adolescents were, however, much more tolerant for ambiguity: when risks were not precisely known, they were more willing to accept them compared to adults. Biologically this makes a lot of sense: young organisms need to be open to the unknown in order to gain information about their world."

Many negs will attempt to contradict capability claims by arguing that, while they may be able to make smart choices in controlled settings, adolescents are bad decision-makers when they are exposed to peer pressure or made to choose rapidly. This **evidence** explains why those concerns don't apply in the context of medical choices:

(Alicia Ouellette, Dean & Prof of Law @ Albany Law School, "Body Modification and Adolescent Decision Making: Proceed with Caution," Journal of Health Care Law and Policy, vol 5 iss 1 art 7, <http://digitalcommons.law.umaryland.edu/jhclp/vol15/iss1/7/>, 2012)

Specifically, proponents argue that the state's interest in promoting the development of fully capable, mature, engaged, and functioning citizens is served by respecting adolescent autonomy in the healthcare. 30 Essentially, the argument is that adolescents need to be given the opportunity to work out their decision-making "muscles" in order to develop them more fully.¹³¹ Giving adolescents the power to direct their own medical care gives them the opportunity to make important choices for themselves, choices they will have to live with, in a presumptively safe environment—one that is relatively separate from peer influence, and one that necessarily involves the adolescent with adult professionals who serve as a sounding board during the decision-making process.¹³² Respecting adolescents' choices in this context allows them to develop and learn. ¹³³ It "is likely to improve their self-esteem and sense of control in the short term, and make them better decision-makers and citizens in the long-term." ³⁴ By contrast, protecting adolescents from the consequences of their decisions hinders their development. The fact that adolescents may sometimes make bad decisions does not outweigh society's need to develop mature adolescents and engaged citizens "with their entitlement to life-deciding liberty intact." ³⁶ Moreover, the involvement of professional adults in medical decision making minimizes the risk of devastating consequences.



The aff may also want to build credibility by introducing **evidence** pointing out that the American Medical Association and American Academy of Pediatrics each support some degree of adolescent medical autonomy:

(Tara Kuther, "Medical Decision-Making and Minors: Issues of Consent and Assent," Proquest.com, 2013, Web, <<http://search.proquest.com/docview/195942431/fulltextPDF?accountid=7122>>.)

Given the increasing recognition that most adolescents have the capacity to participate in decisions about their healthcare, parents and physicians have shown a greater willingness to include them in decision-making (Weir & Peter, 1997). The American Medical Association (1992) and the American Academy of Pediatrics (Committee on Bioethics, 1995) take a developmental perspective toward informed consent and recognize that as minors approach and progress through adolescence, there is more of a need for an independent relationship with their physicians. Respect for their autonomy compels physicians to involve minors in decisions about their treatment (McCabe, 1996). Both the American Medical Association and American Academy of Pediatrics advise that physicians have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities. The American Academy of Pediatrics adds, "as children develop, they should gradually become the primary guardians of personal health and the primary partners in medical decision-making, assuming responsibility from their parents" (Committee on Bioethics, 1995, p. 316).



The majority of physicians also take this opinion, and in fact see adolescent autonomy as an ethical obligation. Here's **evidence**:

(Rhonda Gay Hartman, J.D., Ph.D., "Decisional Autonomy for Medical Care: Physician Perceptions and Practices," The University of Chicago Law School Roundtable, vol 8 iss 1 art 5, : <http://chicagounbound.uchicago.edu/roundtable/vol8/iss1/5>, 2001)

Lastly, physicians were asked whether they believe that they have an ethical obligation to involve adolescent patients in the informed consent process and to honor the medical decisions of adolescent patients. Interestingly, a strong majority of physicians (**87.2 percent**, n=151) believe they are ethically obligated to involve adolescent patients in the informed consent process. About two thirds (**65.9 percent**, n=114) further believe they are ethically required to honor adolescent decisions, which is commensurate with the finding that physicians honor adolescent patient wishes regardless of conflict with a parent, guardian, or institution. There were also statistically significant differences between responses by pediatricians and internists (p=.033), as the former were more likely to respond that they believe they are ethically obligated to honor adolescent patient decisions.

Of course, it isn't enough to simply win that adolescents are *capable* of making medical choices. In order to win, the aff must also prove that they "*ought*" to—that is, that there is a *benefit* to allowing adolescent medical autonomy. Just because I am *able* to do something doesn't always mean I *should* do it. As the aff, it's as important as ever to pay attention to your case impacts.

The most obvious aff impact would be that the ability to make one's own healthcare choices is a **human right**. If you can't make decisions pertaining to your own body, this line of reasoning goes, you don't really have any freedom at all. If you plan to make this argument, though, be sure to spend some time considering why it applies to adolescents, but not younger children. You need to be able to articulate a clear brightline that still functions under the moral framework you've set up.



Here is some **evidence** focused on rights and individual liberty:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, "Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents," Cornell Journal of Law and Public Policy, Summer 2005, pg 251)

However, in an ever-evolving world, it is wise to reflect on what other loftier and perhaps more intangible ethical goals, not explicitly a part of earlier campaigns, might be served in the present. While it may not have been prudent to speak in terms of adolescent capacity or autonomy during previous eras, there is value in re-evaluating the underlying premises of such laws, explicit and implicit, and ascertaining whether an evolving world and expanding knowledge can breathe new life into old statutes. In that vein, it is prudent to speak to the importance of autonomy and respect for decision-making capacity as a cornerstone principle of the provision of healthcare for young and old. Part of the ethical analysis of how healthcare is provided focuses on the extent to which a patient's autonomy is protected and respected. Applying an autonomy analysis to the healthcare provided to an adolescent who cannot consent to her own care, one must "reject the formulation that the adolescent is being protected and instead ... view the insistence on parental consent as a denial of the adolescent's rights as a person, separate from his parents." [*273] The personal autonomy at issue in this context refers to "the realm of inviolable sanctuary most of us sense in our own beings." Personal autonomy, as manifested in the healthcare context by requiring informed consent, is widely understood to be of enormous value and benefit to individuals. As one philosopher has noted, "Whatever else we mean by autonomy ... it must be a good and admirable thing to have, not only in itself but for its fruits - responsibility, self esteem, and personal dignity. Autonomy so conceived is not merely a 'condition,' but a condition to which we aspire as an ideal."



More **evidence:**

(Dr. Lawrence J. Schneiderman, Professor of Family and Preventive Medicine @ University of California, San Diego, "Challenging Case: Adolescence—Decision Making about Medical Care in an Adolescent with a Life-Threatening Illness," *Pediatrics*, Vol. 107.4: p. 981, 2014)

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



possibility that he might change his mind. I would emphasize the freedom it gives him, something he may crave as he sees his disease and the pressure of his parents closing around him. Whatever efforts are made, in the end, Jorge must accept the treatment willingly. And everyone must accept his decision if he does not. Whatever his choice, it is the obligation of the health providers to help his parents cope with it so that they maintain a relationship that is supportive and loving.

Even more **evidence**:

(Rhonda Gay Hartman, J.D., Ph.D., "Adolescent Autonomy: Clarifying an Ageless Conundrum" Hastings Law Journal, 51 p. 1256, August 2000)

Adolescent decisional ability should direct the law to optimize personal development, individual dignity, and respect for adolescent expression of values. That scientific research quantitatively suggests capability for autonomous decision-making underscores qualitative calculation that adolescents are involved in decision-making to a larger extent than presently presumed by law. A legal model embracing adolescent decisional ability would comport with both quantitative and qualitative measurement and accommodate adolescent issues in a way that would improve vastly the kaleidoscope approach and variegated outcomes.

Accordingly, such a legal model would ensure a suitable measure of stability and predictability in the law governing adolescence. In his distinguished work, *The Changing Legal World of Adolescence*, Franklin E. Zimring queries, "why not the eighteenth birthday as a presumptive age of majority... unless there is a very good reason not to." This Article attempts to present very good reasons. Injustice has been adduced by adherence to presumptive incapacity, resulting in injustice not only for adolescents but also for adults interacting with them, as the areas of medical care and contract law illustrate. Moreover, the laws governing juvenile delinquency raise concerns of fundamental fairness, generating deeply rooted issues of justice as well as issues of professional responsibility and advocacy for attorneys representing adolescents. The current legal approach with its disengaged connection to adolescent decisional ability is vulnerable to constitutional challenge, especially when the legal presumption of incapacity appears unrelated to social and scientific fact. To date, proposed legal reform has been either cosmetic or radical, rather than restructuring legal framework to recognize adolescent decisional ability. The proposed model discussed in this Article embraces social reality and would be responsive to resolving issues related to adolescence, with clarity and cohesive guidance. It also cultivates the deeper promise of adolescent independent thought and identity. This legal model encourages the establishment of a President's Commission for the Study of Adolescence as an important initial step toward thorough examination of adolescent issues, and entails Congress' recognition of adolescence as a distinct legal category. This recognition should lead to the passage



of federal legislation enabling states to style laws that address adolescent autonomy, including the scope and extent of adolescent decision-making in various contexts, while preserving *parens patriae*. No less intense is that this proposal revolutionizes the juvenile justice system in a way that retains its special distinction, recognizes the enormous value of family and social institutions in the lives of adolescents, and optimizes adolescent freedom for personal development. Indisputably, one's sense of identity and autonomy should not depend on the capricious, archaic demarcation of a birthday; rather, it is a life-long journey that, as Dr. Jean Piaget determined, develops cognitively from childhood and continues through adolescence and into adult life. The twenty-first century should be a dawning for an enlightened view of adolescent autonomy, rather than a mythical age of majority, whereby one is suddenly endowed with decisional ability, the import of which is poignantly punctuated by the timeless reflection of William Butler Yeats - "I whispered, "I am too young,' And then, "I am old enough."

Finally, this **evidence** says that denying adolescents the right to autonomous healthcare decision-making is blatantly unethical:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, "Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents," Cornell Journal of Law and Public Policy, Summer 2005)

The law gives wide latitude to parents to make decisions about healthcare treatment for minor children and companion decisions about whether their children should even be made aware of their own diseases.¹¹ In circumstances in which a child is too young to comprehend the nature of an illness and the risk and benefits of treatment, it is certainly justifiable or at least understandable to let the parent be sole arbiter of what is best for the child with an understanding that the state can interfere based on reports from other parties about the risk to the health of the child. Parents are the logical decision makers if one presumes that "parents, in contrast to their minor children, possess the intelligence, maturity, and experience needed for adequate and appropriate health care decisionmaking; and . . . that parents usually have an identity of interest with their minor children and will act in their best interests."¹² Nevertheless, even if it is appropriate to withhold information from a young child, cloaking an adolescent in ignorance is much less defensible. At some point, it becomes patently inappropriate, unethical, and practically unwise to make a decisionally-capable individual an outsider in conversations and decisions about her own health.



Some of you may choose to use “**autonomy**” or “**self-determination**” or similar concepts as your value. If that appeals to you, here is some **evidence**, which also declares respect for autonomy to be an ethical mandate:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents,” Cornell Journal of Law and Public Policy, Summer 2005)

Consent, specifically informed consent, is a cornerstone of providing non-tortious medical care to a patient. 168 A healthcare provider who treats an individual in a non-emergency situation without first obtaining the informed consent of the patient or a person authorized to make decisions for an incompetent patient subjects herself to serious legal consequences for breaching her professional duty. 169 Informed consent is not simply a way of protecting physicians from legal liability. Rather, it is a primary means of respecting the autonomy of patients because one cannot act autonomously when denied access to information that is pertinent to the decision at hand. 170 As described by the American Medical Association (“AMA”), “[i]nformed consent is more than simply getting a patient to sign a written consent form.” 171 At minimum, the AMA recommends that a physician, not a representative, inform the patient of his diagnosis, the nature of the treatment and alternatives as well as the risks and benefits of treatment or foregoing treatment. 172 The obligation to obtain informed consent is both legal and ethical. 173 The idea of informed consent in no less important for adolescents, but the law deems consent offered by parents sufficient to satisfy the physician’s duty to her patient.

More **evidence** on autonomy:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents,” Cornell Journal of Law and Public Policy, Summer 2005)

An assumption of general adolescent incapacity, with exceptions for certain times of crisis that may burden or threaten the public health, does not recognize young people as autonomous human beings who exist within family networks in which other parties share an interest in their lives and health. Recognizing this interconnectedness, it is possible to imagine a regime that strikes a balance between the autonomy and dependence of adolescents. On one hand, most of those who are fourteen and older are mentally or psychologically capable



of providing knowing, intelligent, and voluntary consent for healthcare treatment.

Simultaneously, the unique relationship between parent and child and the strong public and legal support for reinforcing, rather than severing, those ties demands acknowledgement of the emotional and financial dependence that young people may have and their potential need for support and guidance in making medical decisions.

Autonomy can also be connected to the capacity for moral reasoning. In other words, if a person cannot control him or herself, then he or she lacks the basic ability to define his or her own morality. This, it can be argued, is the greatest violation of a person's humanity that is possible—the inability to choose one's own ethical code. Here's **evidence** that connects this concept to adolescent medical rights:

(Alicia Ouellette, Dean & Prof of Law @ Albany Law School, "Body Modification and Adolescent Decision Making: Proceed with Caution," Journal of Health Care Law and Policy, vol 5 iss 1 art 7, <http://digitalcommons.law.umaryland.edu/jhclp/vol15/iss1/7/>, 2012)

First, adolescents are rights bearing citizens who deserve respect as full human persons.¹⁰⁶ Although their ability to exercise their rights, or to act as fully autonomous beings may be developing, the adolescent has rights to bodily integrity, self-determination, and privacy.⁰⁷ To best respect the person of the adolescent, these rights should be recognized and protected to a degree commensurate with the ability of the individual involved to exercise them.⁰⁸ The costs of disrespecting the adolescent as a rights bearing person are high.¹⁰⁹ As Professor Jennifer Rosato, a strong proponent of increased decision-making rights for adolescents argues, failure to respect the "burgeoning autonomy" of adolescents will likely harm "their personhood, especially when the health care decision involves the exercise of moral judgment. If adolescents cannot make these decisions for themselves, they may be forced to live a life they have not chosen and certain future opportunities may be foreclosed to them permanently."



More **evidence**, which also provides several other impacts:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, "Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents," Cornell Journal of Law and Public Policy, Summer 2005)

Some would also decry the increased pressure placed on adolescents by this proposal because it may require them to participate in conversations with which they are uncomfortable or that require complex decision-making. First, the proposal involves young people in a variety of decision-making processes thus giving them opportunities to "practice" their skills in less charged environments and making them more likely to make informed, reasoned decisions when faced with more challenging questions. Second, increasing autonomy is a step in the process of moral development for young people: Both cognitive-developmental and social learning theorists emphasize that significance of participation in role-taking in determining the rate of moral development. Essentially, moral-development theorists conceptualize achievement of milestones in cognitive development as necessary but not sufficient for progress in moral development. For example, from a cognitive developmental perspective, formal operational thought (the capacity to think abstractly) is necessary for the attainment of principled moral reasoning. However, attainment of such reasoning based on abstract ethical principles also requires extensive experience with resolving ethical problems in social interaction and exposure to diverse, "higher" points of view. ²⁰¹ Thus, by allowing young people to give consent to routine care, we create better healthcare consumers over the long-term. By requiring that young people play an active role in discussions and decisions about their own healthcare, this proposal seeks not only to impact the actions of parents and healthcare providers, but also to create opportunities for positive growth and acceptance of self-regulation in young people. ²⁰² While the burden created here may be heavy in some circumstances, that burden is part of autonomy, and we do not aid adolescents in learning how to direct their own destiny if we are afraid of giving them control over that destiny. By placing them on equal footing with their parents, the law teaches young people lessons about intra-family respect and lessens reliance on outdated notions of parental dominance.



Another possible option would be arguing that autonomy leads to **superior health outcomes** for the adolescent patient.

Here is **evidence** drawing from studies researching the correlation between involvement in decision-making and positive treatment outcomes:

(Benjamin Moulton & Jamie S. King, Lecturer in Health Law @ Harvard School of Public Health and Senior Legal Advisor at the Foundation for Informed Medical Decision Making & Associate Professor of Law at the University of California @ Hastings College of the Law, "Aligning Ethics with Medical Decision Making: The Quest for Informed Patient Choice," Journal of Law, Medicine, Ethics, Spring 2010: p. 7)

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



More **evidence**:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents,” Cornell Journal of Law and Public Policy, Summer 2005)

By neglecting to support high quality healthcare provider-patient relationships, the law can discourage or prevent the use of the best medical practices, thus compromising the quality of care offered to an adolescent patient. The law in its convoluted state does not mirror the current state of medical practice in which healthcare providers, particularly pediatricians and specialists in adolescent medicine, have a much broader sense of the ability of young people to understand and meaningfully participate in their own healthcare. ¹⁶⁷ Too often, in its attempts to balance the interests of both parents and young people, the law forces healthcare providers to privilege concerns about legal liability over their assessment of the needs of a patient. Thus, in some circumstances, the law constrains the healthcare provider from offering the highest quality of care to an adolescent patient in violation of basic professional obligations.

Even more **evidence**, this time focused on compliance. If a patient doesn't want a treatment, he or she will probably not follow the instructions carefully, making the treatment ineffective:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents,” Cornell Journal of Law and Public Policy, Summer 2005)

Assent and the knowledge that it implies are also important because they help to increase a young person's interest in participating in treatment. For: In order to achieve maximum compliance,¹⁸³ the patient must not only be actively involved, but also a participant in his or her own care. Participation will include discussions related to choice of therapy as well as what mode of administration such therapy might necessitate ... The healthcare provider can no longer be the mere administrator of treatments, but must become involved in a relationship marked by mutual



respect and concern. ^{1 84} The ability to give consent, not just assent, specifically in the context of chronic diseases, "may be crucial to carry out a given treatment protocol. With the acquisition of further knowledge about the child's disease, the child learns to feel more in control of not only the therapy but also of his or her life ... A more positive self-image often follows this sense of body control and this in turn leads to an increase in compliance."^{1 85} Some healthcare providers that advocate increased healthcare decision-making rights for adolescents state that integrating young people into the decision-making process will "(1) increase their ownership of the decision and encourage them to obtain the necessary follow-up care, (2) increase their ability to make such decisions in the future, and (3) perhaps make healthcare less threatening and more attractive to them as future healthcare consumers."

As an impact, you could use this **evidence**, which states that patients who do not receive necessary healthcare during adolescence are likely to continue facing worse health problems throughout their adulthoods:

(Stephen Feller, UPI, "Unmet teen healthcare needs cause problems as adults," http://www.upi.com/Health_News/2015/08/18/Unmet-teen-healthcare-needs-cause-problems-as-adults/2741439912495/ August 18 2015)

Previous research has shown that unmet medical needs during adolescence can lead to lifelong habits of not seeking care, as well as the development of avoidable conditions.

"In many countries, cost is a significant barrier to health care access, and the World Health Organization has identified universal health coverage for adolescents as a global health priority," researchers wrote in the study, which is published in the Journal of the American Academy of Pediatrics. "However, even when adolescents have access to services, many forgo health care for other reasons, including concerns about confidentiality, stigma, and judgmental attitudes among health care providers."

Researchers analyzed data from the National Longitudinal Study of Adolescent to Adult Health on 14,800 people who participated in the first and fourth waves of surveys. Participants had mean ages of 15.9 years old at the first wave and 29.6 years at the second wave.

The surveys included 5 self-reported measures of health: general health; functional impairment; time off of work or school; depressive symptoms; and suicidal ideation. The researchers also considered baseline health, health insurance, age, gender, race, income and parental education when judging access to health care.



Unmet health care needs were reported by 19.2 percent of adolescents. The odds of adverse outcomes among adolescents with unmet needs increased by between 13 and 52 percent when compared with adolescents who received needed care, depending on the specific health concern.

"Teenagers have the same broad range of health needs as other age groups," Dr. Dougal Hargreaves, a pediatrician and health services researcher at University College London, told HealthDay. "Teen needs also include mental health problems and preventive care, such as immunizations and obesity prevention. Some health problems are particularly common in adolescence. For example, anxiety, depression and other mental health problems often start in adolescence and early adulthood, but many young people experience long delays in getting the help they need."

Autonomy may also result in better **public health** outcomes, by reducing the barriers to adolescents receiving treatment for conditions such as STIs, which they may be embarrassed or fearful to bring up to their parents.

Here is **evidence**:

(Vivian E. Hamilton, Assoc. Prof. of Law @ William & Mary School of Law, J.D. Harvard Law School, Brigham Young University Law Review, "Immature Citizens and the State," <http://digitalcommons.law.byu.edu/cgi/viewcontent.cgi?article=2543&context=lawreview> DOA: 8-15-15, p. 1140, 2010)

Along the same lines, the Supreme Court has held that states may not impose parental consent requirements on adolescents seeking abortions, unless those requirements contain bypass procedures in which an adolescent may instead opt to have a judge assess her decision-making maturity in an individualized hearing. 340 Minors deemed sufficiently mature may thus consent to abortion procedures without first notifying their parents. 341 Numerous states, moreover, have gone further, declaring that adolescents have an absolute right to consent to abortion procedures. 342 Medical decisions intimately concern adolescents' lives. To the extent that negative externalities result from their choices (as in the spread of sexually transmitted diseases), these are more likely to occur when adolescents are denied decisional autonomy. 343 Policies that explicitly permit adolescents to obtain medical treatment for sexually transmitted diseases without parental



notification or consent not only recognize adolescents' decision-making competence in this sphere but also arguably prevent negative externalities by making it more likely that adolescents will seek treatment. Given evidence that by mid-adolescence they have the capacity to make mature decisions about their health care, applying the doctrine of presumed incapacity to these teens denies them decisional autonomy with insufficient justification.

Similarly, the aff may choose to argue that autonomy **helps adolescents cope** with extremely difficult situations, such as diagnoses of illnesses that are debilitating or fatal. Having an active role to play and a sense of ownership over one's health may help ease the emotional burden of serious illness.

Here is **evidence** on that point:

(Tara Kuther, "Medical Decision-Making and Minors: Issues of Consent and Assent,"

Proquest.com, 2013, Web,

<<http://search.proquest.com/docview/195942431/fulltextPDF?accountid=7122>>.)

In addition to promoting autonomy and decision-making skills, assent offers other benefits for minors. Research with pediatric cancer patients has shown that open communication about illness and treatment enhances patients' perceived control and their ability to cope with treatment, reduces their anxiety, and may enhance long-term emotional and social adjustment (McCabe, 1996). Children as young as 8 years of age show a desire to understand their illness, treatment, and prognosis; with increasing age, children express more interest in taking an active role in medical decision-making (Ellis & Leventhal, 1993). The communication and disclosure required for assent fulfills children's desire for information and need to feel a part of decisions that influence their welfare. Assent is a means of empowering minors to their full abilities. Soliciting assent involves helping the minor to understand his or her condition and what can be expected from treatment, assessing his or her understanding of this information, and determining his or her willingness to accept the proposed care.



The aff might also suggest that making autonomous medical choices helps adolescents to **develop into mature, responsible adults**, by allowing them to “practice” taking ownership of their lives and their bodies. The best way to argue this is that adolescents at different stages of development should have different levels of autonomy: a 13-year-old, for example, would be made responsible for fewer/less significant choices than an 18-year-old. Through this graduated system of autonomy, adolescents are able gain familiarity with the decision-making progress as they move towards adulthood.

Here is **evidence**:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents,” Cornell Journal of Law and Public Policy, Summer 2005)

A required aspect of developing decision-making capacity is the grant of opportunities to actually make decisions. 144 In other words: The important point here is that children come to develop capacities for decision-making and for exercising liberties through guidance and practice. Just as a child learns to read or gather roots by actively participating in these endeavors with adults or older children, so too a child learns what is right and wrong, acceptable or unacceptable, by active participation in the moral community. Among the most important capacities a child ought to develop is the capacity to recognize her interests, to prioritize them, and to balance competing interests (both other interests of her own and those of other persons). For the development of these abilities, however, she needs careful and considerate assistance by those persons who have some concern that her best interests are met, and who are able to assess the possible consequences for the sake of certain long term interests, and vice versa. 1 45 To be given age-appropriate information about one's own health and make decisions based on consultation with whoever is deemed an appropriate source of advice is a fitting show of respect for a young person's need to grow into full maturity. Even without the support of the law, many healthcare providers working with young people have determined that professionally appropriate and ethically sound care for an adolescent requires that the healthcare provider allocate significant decision-making power to an adolescent patient, including maintaining the confidentiality of the healthcare provider-patient relationship against the parent's desire to know what is taking place with his



child. 146 Healthcare providers may assume this posture even though in most states and circumstances the law does not require or necessarily allow this balance.

More evidence:

(Tara Kuther, "Medical Decision-Making and Minors: Issues of Consent and Assent," Proquest.com, 2013, Web, <<http://search.proquest.com/docview/195942431/fulltextPDF?accountid=7122>>.)

Solicitation of assent from minors engages them in graduated levels of decision-making, in which they participate in developmentally appropriate ways. Assent thus serves as a "learner's permit" for decision-making, enabling adolescents to gradually assume independence so that full decision-making autonomy is not exercised until they have some experience with the task (Melton, 1999). Assent provides minors with opportunities to gain decision-making experience within safe contexts.

In addition to promoting autonomy and decision-making skills, assent offers other benefits for minors. Research with pediatric cancer patients has shown that open communication about illness and treatment enhances patients' perceived control and their ability to cope with treatment, reduces their anxiety, and may enhance long-term emotional and social adjustment (McCabe, 1996). Children as young as 8 years of age show a desire to understand their illness, treatment, and prognosis; with increasing age, children express more interest in taking an active role in medical decision-making (Ellis & Leventhal, 1993). The communication and disclosure required for assent fulfills children's desire for information and need to feel a part of decisions that influence their welfare.

Assent is a means of empowering minors to their full abilities. Soliciting assent involves helping the minor to understand his or her condition and what can be expected from treatment, assessing his or her understanding of this information, and determining his or her willingness to accept the proposed care (Committee on Bioethics, 1995). All of this must occur with a keen understanding of the child's developmental capacities. The pediatrician's role is to determine the extent to which children can take part in decisions and how children's decision-making can be enhanced (King & Cross, 1989).



Even more **evidence**:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents,” Cornell Journal of Law and Public Policy, Summer 2005)

As the world changes and adolescents grow up exposed to adult-like experiences at earlier ages, restricting young people from exercising the skills they acquire in the course of their own lives as well as lessons they glean from observing the lives of others is injurious to both their physical and psychological health. That young people lack life experiences to draw upon when confronted with difficult decisions is also true of many young adults or even older adults when faced with a unique or unexpected medical crisis. In such circumstances, the lack of experience does not transform these adults into children who cannot make decisions. Instead, we count on their ability to confer with others including friends, family members, and healthcare providers to make informed choices that best reflect their outlook on life. The same could be expected of adolescents when given the opportunity to act as decision-makers, along with their parents, about their own lives and health.

If you would like to make arguments about the importance of developing self-sufficiency, you may want to connect parental over-involvement with adolescents to the inability to function as adults, mental health issues, and even suicide. Here is **evidence**:

(Dr. Peter Gray, research professor at Boston College focusing on developmental psychology, “Declining Student Resilience: A Serious Problem for Colleges,” Psychology Today, <https://www.psychologytoday.com/blog/freedom-learn/201509/declining-student-resilience-serious-problem-colleges>, September 22 2015)

Faculty at the meetings noted that students’ emotional fragility has become a serious problem when it comes to grading. Some said they had grown afraid to give low grades for poor performance, because of the subsequent emotional crises they would have to deal with in their offices. Many students, they said, now view a C, or sometimes even a B,



as failure, and they interpret such “failure” as the end of the world. Faculty also noted an increased tendency for students to blame them (the faculty) for low grades—they weren’t explicit enough in telling the students just what the test would cover or just what would distinguish a good paper from a bad one. They described an increased tendency to see a poor grade as reason to complain rather than as reason to study more, or more effectively. Much of the discussions had to do with the amount of handholding faculty should do versus the degree to which the response should be something like, “Buck up, this is college.” Does the first response simply play into and perpetuate students’ neediness and unwillingness to take responsibility? Does the second response create the possibility of serious emotional breakdown, or, who knows, maybe even suicide?

Two weeks ago, that head of Counseling sent us all a follow-up email, announcing a new set of meetings. His email included this sobering paragraph:

“I have done a considerable amount of reading and research in recent months on the topic of resilience in college students. Our students are no different from what is being reported across the country on the state of late adolescence/early adulthood. There has been an increase in diagnosable mental health problems, but there has also been a decrease in the ability of many young people to manage the everyday bumps in the road of life. Whether we want it or not, these students are bringing their struggles to their teachers and others on campus who deal with students on a day-to-day basis. The lack of resilience is interfering with the academic mission of the University and is thwarting the emotional and personal development of students.”

He also sent us a summary of themes that emerged in the series of meetings, which included the following bullets:

Less resilient and needy students have shaped the landscape for faculty in that they are expected to do more handholding, lower their academic standards, and not challenge students too much.

There is a sense of helplessness among the faculty. Many faculty members expressed their frustration with the current situation. There were few ideas about what we could do as an institution to address the issue.

Students are afraid to fail; they do not take risks; they need to be certain about things. For many of them, failure is seen as catastrophic and unacceptable. External measures of success are more important than learning and autonomous development.

Faculty, particularly young faculty members, feel pressured to accede to student wishes lest they get low teacher ratings from their students. Students email about trivial things and expect prompt replies.

Failure and struggle need to be normalized. Students are very uncomfortable in not being right. They want to re-do papers to undo their earlier mistakes. We have to normalize being wrong and learning from one’s errors.

Faculty members, individually and as a group, are conflicted about how much “handholding” they should be doing.

Growth is achieved by striking the right balance between support and challenge. We need to reset the balance point. We have become a “helicopter institution.”

Reinforcing the claim that this is a nationwide problem, the *Chronicle of Higher Education* recently ran an article by Robin Wilson entitled, “An Epidemic of Anguish: Overwhelmed by Demand for Mental-Health Care, Colleges Face Conflicts in Choosing How to Respond” (Aug. 31, 2015). Colleges and universities have traditionally been centers for higher academic education, where the expectation is that the students are adults, capable of taking care of their own everyday life problems. Increasingly, students and their parents are asking the personnel at such institutions to be substitute parents.



There is also the ever-present threat and reality of lawsuits. When a suicide occurs, or a serious mental breakdown occurs, the institution is often held responsible.

On the basis of her interviews with heads of counseling offices at various colleges and universities, Wilson wrote:

"Families often expect campuses to provide immediate, sophisticated, and sustained mental-health care. After all, most parents are still adjusting to the idea that their children no longer come home every night, and many want colleges to keep an eye on their kids, just as they did. Students, too, want colleges to give them the help they need, when they need it. And they need a lot. Rates of anxiety and depression among American college students have soared in the last decade, and many more students than in the past come to campus already on medication for such illnesses. The number of students with suicidal thoughts has risen as well. Some are dealing with serious issues, such as psychosis, which typically presents itself in young adulthood, just when students are going off to college. Many others, though, are struggling with what campus counselors say are the usual stresses of college life: bad grades, breakups, being on their own for the first time. And they are putting a strain on counseling centers."

In previous posts (for example, here and here), I have described the dramatic decline, over the past few decades, in children's opportunities to play, explore, and pursue their own interests away from adults. Among the consequences, I have argued, are well-documented increases in anxiety and depression, and decreases in the sense of control of their own lives. We have raised a generation of young people who have not been given the opportunity to learn how to solve their own problems. They have not been given the opportunity to get into trouble and find their own way out, to experience failure and realize they can survive it, to be called bad names by others and learn how to respond without adult intervention. So now, here's what we have: Young people, 18 years and older, going to college still unable or unwilling to take responsibility for themselves, still feeling that if a problem arises they need an adult to solve it.

Dan Jones, past president of the Association for University and College Counseling Center Directors, seems to agree with this assessment. In an interview for the *Chronicle* article, he said:

"[Students] haven't developed skills in how to soothe themselves, because their parents have solved all their problems and removed the obstacles. They don't seem to have as much grit as previous generations."

In my next post I'll examine the research evidence suggesting that so-called "helicopter parenting" really is at the core of the problem. But I don't blame parents, or certainly not just parents. Parents are in some ways victims of larger forces in society—victims of the continuous exhortations from "experts" about the dangers of letting kids be, victims of the increased power of the school system and the schooling mentality that says kids develop best when carefully guided and supervised by adults, and victims of increased legal and social sanctions for allowing kids into public spaces without adult accompaniment. We have become, unfortunately, a "helicopter society."



If we want to prepare our kids for college—or for anything else in life!—we have to counter these social forces. We have to give our children the freedom, which children have always enjoyed in the past, to get away from adults so they can practice being adults—that is, practice taking responsibility for themselves.

This card also has the benefit of providing uniqueness—it says that the trend towards reducing adolescent autonomy has gotten much worse in the past decade, which has correlated with dramatically more mental health struggles in young adults. This sets you up to argue that, even if medical autonomy was not so important in prior generations, today's youth desperately need to be given opportunities to take responsibility for themselves.

Here is one more piece of aff **evidence**, which should be useful for any aff—it says adolescent medical autonomy is justified according to any value system: legal, utilitarian, or deontological:

(Rhonda Gay Hartman, J.D., Ph.D., "Decisional Autonomy for Medical Care: Physician Perceptions and Practices," The University of Chicago Law School Roundtable, vol 8 iss 1 art 5, : <http://chicagounbound.uchicago.edu/roundtable/vol8/iss1/5, 2001>)

Beyond these contradictions that compel careful examination, considerable social, ethical, and legal reasons exist for reconfiguring presumptive incapacity for adolescent medical decision making. Presumptive decisional incapacity contravenes social norms that are closely allied with governing law and trends in other arenas, including juvenile delinquency and family court, where adolescents are afforded decisional autonomy and accompanying accountability. 9 Indeed, several courts have observed in dictum that legal recognition of adolescent waiver for fundamental constitutional rights and adolescents' legal ability to bring personal injury suits against their parents stand in contradistinction to the lack of autonomy afforded adolescents for medical decision making.¹⁰ Remarkably, the legal presumption of decisional incapacity for adolescent patients rests on scant scientific and social evidence. Developmental research suggests that adolescents are decisionally capable, at least beyond the level presently presumed by law. Unless legal policymakers assert other important or compelling reasons for denying autonomous decision making for adolescent patients, the presumption of decisional incapacity potentially lacks even a rational basis, raising equal protection and due process problems. Lack of an evidentiary foundation to sustain presumptive decisional incapacity has several unfortunate



consequences. First, it unnecessarily debilitates rights recognition for adolescents, despite the United States Supreme Court's declaration that the federal Constitution is not for adults alone. Second, presumptive decisional incapacity for adolescent patients potentially offends ethical concepts of utilitarianism by not promoting maximum good, especially if it arbitrarily disempowers adolescents. Moreover, from a deontological perspective, the presumption lacks requisite good will. Recognizing and respecting adolescent autonomy for medical decision making would cultivate the development and dignity of the emerging adult within the adolescent by promoting personal potential and a self-perception of empowerment, as well as by fostering comprehension and compliance with therapeutic treatment.

Finally, some affs might bring up specific medical scenarios. Some of the more popular ones concern minors who want to terminate a pregnancy and are unable to obtain parental consent, or trans adolescents who would like to begin hormone therapy despite parental objection. There are many possible approaches to these kinds of strategies, but we won't go in-depth here in the interest of time and space. Just remember that you do have the option.

Neg Options

The first argument the neg will probably want to have prepared is an answer to the aff's contention that adolescents are capable of making medical choices. The negative can say that adolescents have brains that are not yet fully formed, and lack the skills to make long-term decisions, making them ill-equipped for autonomy. Studies demonstrate that adolescents' **brains are physiologically under-developed** in areas that are key to rational decision-making, such as the prefrontal cortex. Moreover, even though adolescents may perform well in academic studies on reasoned decision-



making, in practice in the real world, they are extremely prone to be swept away by emotion. This is because the emotional centers of the brain are much more developed in adolescents than are the risk-avoiding and planning areas.

Here is **evidence** on this point:

(Mark J. Cherry, prof of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making," Journal of Medicine and Philosophy, 35:553-572, 2010)

The Convention and its advocates also appear to ignore the substantial array of scientific evidence indicating that children, even so-called mature minors, are generally not in fact mature decision makers. There is a significant body of neurobiological evidence that the adolescent and teenage brain is not yet fully developed in its cognitive and affective capacities. The adolescent brain's executive functions (cognitive faculties that support planning, inhibition, mental flexibility, reasoning, problem solving, and working memory, action initiation and monitoring, experience of reward and punishment, self-regulation of behavior and decision making) are still slowly developing during adolescence (Chan et al., 2008). The prefrontal cortex, which is important for cognition and reasoning, for controlling impulses and emotional responses, continues to develop, maturing slowly through adolescence and into adult dimensions even during the early twenties (Gilbert and Burgess, 2008).²¹ The ventral striatum, an area of the brain associated with reward response, for example, is more active during adolescence. Imaging studies demonstrate that the brain continues to change dynamically throughout adolescence and into adulthood, with a late full maturation of the frontal lobes, which are necessary for effective use of the executive functions. These are the areas of the brain that are utilized for the realization of responsible and reasonable choices, but which are among the last to reach full adult development (Geidd, Blumenthal, and Jeffries, 1999; Spear, 2000). The apparent contradiction between the known high risk behavior of adolescents and their observed abilities to engage in acute observation, rational discussion, and even intellectual risk-assessment is explained, according to Casey et al., by the fact that in emotionally charged situations, the more mature limbic system dominates the less mature prefrontal control system. This means that adolescents may know better, may even be able accurately to rehearse probabilities of risks and benefits



associated with particular actions, but very routinely will be driven to make a different and more risky decision given the emotional context or an immature perception of how such risks apply to oneself. Mature cognitive development requires the ability to suppress emotion and otherwise not act on inappropriate thoughts, choosing instead proper goal directed choices(Casey, Giedd, and Thomas, 2000; Casey, Galvan, and Hare, 2005). This ability develops throughout adolescence, as children gain better impulse and cognitive control with maturity. However, the brain's overall state of development is such that even mature adolescents lack the proper self-control necessary to good decision making even though they may, in principle, understand the relevant factual issues.

More **evidence:**

*(NPR, Fresh Air, "Why Teens Are Impulsive, Addiction-Prone And Should Protect Their Brains," transcript of interview with Dr. Frances E. Jensen, MD neurologist & co-author of book *The Teenage Brain*, <http://www.npr.org/sections/health-shots/2015/01/28/381622350/why-teens-are-impulsive-addiction-prone-and-should-protect-their-brains>, January 28 2015)*

Teens can't control impulses and make rapid, smart decisions like adults can — but why?

Research into how the human brain develops helps explain. In a teenager, the frontal lobe of the brain, which controls decision-making, is built but not fully insulated — so signals move slowly.

"Teenagers are not as readily able to access their frontal lobe to say, 'Oh, I better not do this,' " Dr. Frances Jensen tells *Fresh Air's* Terry Gross.

Jensen, who's a neuroscientist and was a single mother of two boys who are now in their 20s, wrote *The Teenage Brain* to explore the science of how the brain grows — and why teenagers can be especially impulsive, moody and not very good at responsible decision-making.

"We have a natural insulation ... called myelin," she says. "It's a fat, and it takes time. Cells have to build myelin, and they grow it around the outside of these tracks, and that takes years."

This insulation process starts in the back of the brain and heads toward the front. Brains aren't fully mature until people are in their early 20s, possibly late 20s and maybe even beyond, Jensen says.



"The last place to be connected — to be fully myelinated — is the front of your brain," Jensen says. "And what's in the front? Your prefrontal cortex and your frontal cortex. These are areas where we have insight, empathy, these executive functions such as impulse control, risk-taking behavior."

Another piece of **evidence**, which argues that adolescents can't make good long-term choices, because they have no reference point for truly understanding 20-30 years into the future. This makes them more likely to take risks and make poor decisions:

(Elizabeth S. Scott, N. Dickon Reppucci, Jennifer L. Woolard, "Evaluating Adolescent Decision Making in Legal Contexts," Law and Human Behavior, vol 19 no 3 pp 221-244, <http://www.jstor.org/stable/1394002?origin=JSTOR-pdf>, June 1995)

Some differences have been demonstrated in other components of risk perception and attitudes. Compared to adults, adolescents appear to focus less on protection against losses than on opportunities for gains in making choices (Furby & Beyth-Marom, 1990; Gardner et al., 1991). Adolescents appear to weigh the negative consequences of not engaging in risky behaviors more heavily than adults, although overall response patterns of adults and adolescents were quite similar (Beyth-Marom, Austin, Fischhoff, Palmgren, & Quadrel, 1992). Differences in risk perception have also been observed. Research suggests that perception of risks increases through adolescence (perhaps with increased experience). Adolescents may sometimes be unaware of risks that adults perceive or they may calculate differently the probability or magnitude of a given risk (Furby & BeythMarom, 1990; Kulbok, Earls & Montgomery, 1988; Lewis, 1981; Phelps, 1987). For example, adolescents may be less willing than adults to risk disfiguring side effects of a medical treatment regimen due to concerns about body image and peer approval, but they may be more willing than adults to engage in behaviors such as bungee jumping.

Attitude toward risk is closely linked to differences in temporal perspective (Cottle, 1969; Greene, 1986; Grisso, 1981; Monks, 1968). In general, adolescents seem to discount the future more than adults and to weigh more heavily the short-term consequences of decisions-both risks and benefits-a response that in some settings contributes to risky behavior (Gardner & Herman, 1991). Gardner and Herman (1991) hypothesize that this tendency may be linked to the greater uncertainty



that young people may feel about their own futures, an uncertainty that might make short-term consequences seem more salient to an evaluation of different options (Allen, Leadbeater, & Aber, 1990). It may also reflect the reality that adolescents have had less experience. It may be harder for an adolescent than for an adult to contemplate the meaning of a consequence that will be realized 10 to 15 years in the future, because such a time span is not easily made relevant to adolescent experience. Nurmi's (1991) review of the adolescent future orientation literature confirms that adolescents are most interested in major developmental tasks of late adolescence and early adulthood (i.e., career, education, marriage). Future planning skills grow more efficient with age but continue to develop at least into the early 20's.

Similarly, this **evidence** suggests that bad adolescent decision-making isn't caused by them being irrational, but rather that adolescents calculate risks and rewards very differently from adults. Because teens tend to care more about things like peer approval and appearance that adults do, they will **weigh choices differently**. For example, they may not want to wear a brace that will eventually correct a permanent problem, because in the short-term they see their utility as being maximized by not leaving the brace off, so they will not look "like a geek":

(Elizabeth S. Scott, N. Dickon Reppucci, Jennifer L. Woolard, "Evaluating Adolescent Decision Making in Legal Contexts," Law and Human Behavior, vol 19 no 3 pp 221-244, <http://www.jstor.org/stable/1394002?origin=JSTOR-pdf>, June 1995)

Research evidence supports the view that youthful decision makers, because of developmental influences, sometimes differ from adults in the subjective value that they attach to various perceived consequences in the process of making choices (Furby & Beyth-Marom, 1990; Gardner & Herman, 1991; Gardner, 1992; Kulbok et al., 1988). In undertaking a cost-benefit calculus, minors might weigh a particular cost or benefit differently from adults (or view as a benefit what adults would count as a cost) (Benthin et al., 1993; Hampson, Bums, Severson, & Slovic, 1992; Lavery, Siegel, Cousins, & Rubovits, 1992). For example, if adolescents care more about personal appearance and peer approval than adults, and differ in temporal perspective, an adolescent more readily than an adult might reject a treatment (for example, a brace for scoliosis) that



offers a long-term benefit but short-term embarrassment. Medical research has provided some evidence regarding adolescent concern with body image and treatment regimens (Cromer & Tarnowski, 1989; Korsch, Fine, & Negrete, 1978; Weithorn & Campbell, 1982), but it is unclear whether the extent of this concern exceeds that of adults.

Adolescents and adults might also calculate dissimilarly the probability of a given risk. Adolescents are more likely than adults to engage in risky behavior, perhaps because it seems less risky to them than to adults.⁶ In part, this may be due to differences in information access, but it could also involve dissimilar attitudes toward risk and different temporal perspectives. For example, an adolescent's choice to hold up a convenience store with his friends might reflect a risk-preferring attitude and a tendency to give relatively more weight to short-term consequences (and less to long-term consequences) than would an adult. In another context, adolescents and adults might both think sexual experimentation poses a risk of pregnancy and AIDS. However, the two groups may assess differently the probability that the negative consequences will occur, or, due to dissimilar risk preferences, differ on whether a risk of a given magnitude is prohibitive or acceptable (Bauman & Udry, 1981; Zabin, Kanter, & Ford, 1980)

It would be irrelevant in assessing competence under an informed consent framework that adults and minors attach different values to particular consequences and reach different outcomes. The risk-benefit calculus explicitly measures subjective utility, the value to the decision maker of the potential consequences of each option. A rational decision maker makes the choice that best promotes her personal values. The outcome is not measured against any external standard for reasonableness; what might seem like an onerous cost of a particular option to one person could appear trivial to another.⁷ Social scientists who study decision making also tend to agree that these kinds of differences are not legitimate or useful measures. The study of adolescent risk-taking behavior by Furby and Beyth-Marom (1990) provides a clear illustration. These psychologists consider, from a decision-making perspective, risky activities that teens engage in more commonly than adults: sex without contraceptives, reckless driving, and health-threatening use of drugs and alcohol. The authors argue persuasively that the adolescent who engages in risk-taking behavior is not necessarily an irrational sensation seeker who miscalculates risk. Instead, she might well be rationally choosing the option that maximizes her subjective utility, and which therefore holds less risk of loss and more potential gain than the alternative choices. Since loss and gain are defined according to the decision maker's own values, conduct could well appear unacceptably risky to adults but not to adolescents. Thus a teen, deciding whether to accept an invitation to join her friends in taking drugs, might conclude that the costs of saying "no," in terms of self image (who wants to be a geek?) and peer rejection, weigh more heavily than the risk of addiction or apprehension, and that the



benefit of feeling good and sharing in the group experience is greater than that of being a clear-headed law-abiding citizen. Saying "yes" under these circumstances is simply the rational cost-avoiding choice and not risky behavior at all. This analysis demonstrates the problem (if data useful to policymakers is the goal) with thinking about adolescent legal competence in the constricted framework in which adult decision making is studied and evaluated. Scientists studying decision making are appropriately reluctant to get involved in the business of subjecting the values that shape the decision-making calculus to an "objective" normative standard. This neutrality does not, by and large, characterize the response of policymakers, who are quite ready to conclude that adolescent choices that are health threatening or life threatening, or that restrict future opportunity, are risky choices that reflect poor judgment, even if they rationally promote the decision maker's values at the time the decision is made. Moreover, if the values that drive risky choices are associated with youth, and predictably will change with maturity, then the paternalistic inclination is to protect the young decision maker-and society-from the outcome of his bad judgment. This impulse is not quelled by the knowledge that, in making the "poor" decision, the youthful decision maker has engaged in a rational process.

The above card can also be used to answer aff arguments that say doctors can help teens fill in knowledge gaps in order to ensure they make good decisions. This is not true, says the neg, because teens can make choices that are *perfectly rational* for them at the time, but they will end up regretting when they reach adulthood and their priorities change.

Here is another piece of **evidence** from the WHO, which says adults have a responsibility to help adolescents make good choices:

(WHO, "Adolescent Development,"

http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/, 2015)

The process of adolescence is a period of preparation for adulthood during which time several key developmental experiences occur. Besides physical and sexual maturation, these experiences include movement toward social and economic independence, and development of identity, the acquisition of skills needed to carry out adult relationships and roles, and the capacity for abstract reasoning. While adolescence is a time of tremendous



growth and potential, it is also a time of considerable risk during which social contexts exert powerful influences.

Pressures to engage in high risk behaviour

Many adolescents face pressures to use alcohol, cigarettes, or other drugs and to initiate sexual relationships at earlier ages, putting themselves at high risk for intentional and unintentional injuries, unintended pregnancies, and infection from sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV). Many also experience a wide range of adjustment and mental health problems. Behavior patterns that are established during this process, such as drug use or nonuse and sexual risk taking or protection, can have long-lasting positive and negative effects on future health and well-being. As a result, during this process, adults have unique opportunities to influence young people.

Adolescents are different both from young children and from adults. Specifically, adolescents are not fully capable of understanding complex concepts, or the relationship between behavior and consequences, or the degree of control they have or can have over health decision making including that related to sexual behaviour. This inability may make them particularly vulnerable to sexual exploitation and high-risk behaviours. Laws, customs, and practices may also affect adolescents differently than adults. For example, laws and policies often restrict access by adolescents to reproductive health information and services, especially when they are unmarried. In addition, even when services do exist, provider attitudes about adolescents having sex often pose a significant barrier to use of those services.

Family and community are key supports

Adolescents depend on their families, their, communities, schools, health services and their workplaces to learn a wide range of important skills that can help them to cope with the pressures they face and make the transition from childhood to adulthood successfully. Parents, members of the community, service providers, and social institutions have the responsibility to both promote adolescent development and adjustment and to intervene effectively when problems arise.



Finally, here is **evidence** critiquing the research methodologies of the studies the aff will cite to support the claim that adolescents are capable of reasoned decision-making. It has many good warrants, and should be a great all-purpose neg card for many of you:

(Elizabeth S. Scott, N. Dickon Reppucci, Jennifer L. Woolard, "Evaluating Adolescent Decision Making in Legal Contexts," Law and Human Behavior, vol 19 no 3 pp 221-244, <http://www.jstor.org/stable/1394002?origin=JSTOR-pdf>, June 1995)

Applying this framework, advocates of adolescent self-determination on issues such as abortion have drawn on child development theory and empirical research to argue that no significant differences separate adolescents and adults in their capacity to make informed medical decisions. In our view, although the limited relevant research generally supports their position, these advocates exaggerate the robustness of the scientific evidence. We concur with Gardner, Scherer, and Tester's (1989) careful and persuasive argument that advocates (e.g., Interdivisional Committee on Adolescent Abortion, 1987) overstep the limits of science in claiming that the research demonstrates that no differences distinguish the decision-making capability of adolescents and adults.² We highlight and expand upon the important points of this critique. First, the early researchers (e.g., Weithorn & Campbell, 1982; Grisso & Vierling, 1978) relied on the principles of Piaget's stage theory of cognitive development (Flavell, 1985; Inhelder & Piaget, 1952) that are no longer widely accepted among cognitive psychologists (Gardner et al., 1989). These researchers linked competence to make informed medical decisions to the formal operations stage of cognitive development (that children reach between the ages of 11 and 14). At this stage, Piaget posited, children can think hypothetically about a problem and consider alternative solutions, weighing and comparing consequences. Today, few psychologists believe that children at a given stage engage in a characteristic reasoning across many tasks and that this process differs from reasoning at other stages. Rather, collaborative models which include organismic and environmental components have been proposed (Fischer & Silvern, 1985), and most psychologists believe that similar skills develop at different rates in different task domains (Flavell, 1985; Siegler, 1991). This conception does not support the notion of a cognitive ability (i.e., to engage in formal operations) that is linked to general decision-making capacity. Moreover, research on decision making under conditions of uncertainty indicates that neither adolescents nor adults perform at an optimal level under many circumstances involving complex decisions (Shaklee, 1979; Kahneman et al., 1982). Adolescents and adults may differ in their ability to perform at optimal capacity; personal and environmental



characteristics may differentially enhance and impair performance. Thus, a finding of competence to make one kind of decision may not be generalizable to other decisions in other contexts. Even if the theoretical foundation were more credible, only a handful of studies have compared decision making by adults and adolescents in legally relevant contexts, and most have examined only a small number of subjects³ (Ambuel & Rappaport, 1992; Garrison, 1991; Lewis, 1980; Scherer, 1991; Weithorn & Campbell, 1982). Furthermore, many of the studies provide only indirect evidence that adolescents are competent decision makers. A few studies compare the comprehension of adults and minors in legal settings, but do not focus on decision making (Belter & Grisso, 1984; Grisso, 1980), and a few examine adolescents' understanding of treatment issues, but do not compare adolescents and adults (Kaser-Boyd, Adelman, & Taylor, 1985; Kaser-Boyd, Adelman, Taylor, & Nelson, 1986). Although several studies found differences between older and younger adolescents (Ambuel & Rappaport, 1991; Belter & Grisso, 1984; Garrison, 1991; Scherer, 1991), suggesting that the methodologies were not necessarily insensitive to differences, a great deal more empirical substantiation using convergent methodologies is needed. A few studies have included factors outside the strict confines of the informed consent framework. For example, Lewis (1980), in a study of adolescent women awaiting results of pregnancy tests, examined knowledge of legal context and social influences upon their decision making. Ambuel and Rappaport (1992) studied adult and adolescent women contemplating a decision about an unplanned pregnancy and included an assessment of voluntary decision making, global quality of decision making, and consideration of immediate and long-term consequences. Both of these studies are consistent with our approach. Other methodological factors limit the extent to which claims about adolescent competence can be drawn. Most studies were conducted in a laboratory setting in which subjects were provided with hypothetical treatment information (Belter & Grisso, 1984; Garrison, 1991; Kaser-Boyd et al., 1985, 1986; Scherer, 1991; Scherer & Reppucci, 1988; Weithorn & Campbell, 1982). With few exceptions (e.g., Ambuel & Rappaport, 1992), no adequate research compares adolescent and adult performance under conditions that adequately resemble daily life. Moreover, as Gardner et al. (1989) point out, much of the information about subjects' cognitive decision-making processes consists of retrospective selfreport, a poor substitute for contemporaneous observation. Furthermore, White middle class samples, which do not adequately represent adolescents of diverse racial, ethnic, and socioeconomic backgrounds, are the norm. As will be discussed later, it is possible that different cultural experiences may systematically affect decision-making ability and performance. Finally, the potential effects of problem framing (e.g., information presentation, question formation) have been documented (Fischhoff & Quadrel, 1991; Kahneman et al., 1982), yet are rarely acknowledged, and comparative studies are few.



With any of these arguments about capacity for rational decision-making, the impact is obviously that adolescents may make decisions that adversely affect their health, present or future. In addition to the physical harm associated with this, it would most likely also lead to unnecessary emotional anguish and suffering. Parents and other loved ones may also be negatively affected, such as if an adolescent's poor choices caused him to die of a preventable cause.

Some affs might argue that adolescents should be granted medical autonomy because we allow even adults with diminished intellectual capacity and/or poor judgment to make their own choices. The following evidence explains why this comparison doesn't hold up:

(Elizabeth S. Scott, N. Dickon Reppucci, Jennifer L. Woolard, "Evaluating Adolescent Decision Making in Legal Contexts," Law and Human Behavior, vol 19 no 3 pp 221-244, <http://www.jstor.org/stable/1394002?origin=JSTOR-pdf>, June 1995)

Two arguments support the claim that the evaluation of adolescent legal capacity appropriately considers judgment as well as reasoning and understanding. The first is that a different response would carry a significant social cost. Informed consent policy reflects a conclusion that the importance of respecting adults' autonomy in the context of health care decisions outweighs the social cost of poor decisions by occasional "outliers", particularly given the substantial costs of any other approach. It is plausible to assume that most people are motivated to make health-promoting medical decisions (i.e., use good judgment), and thus that the social cost of respecting autonomy is tolerable. If adolescents as a class have poorer judgment (and choose different outcomes) than adults, then the social cost of according them freedom and of holding them to adult standards of responsibility might be significant. In fact, in many legal contexts, anticipated social cost of poor judgment by adults justifies restriction of freedom (e.g., seat belt and motorcycle helmet laws, product safety regulations) and reduced responsibility (e.g., laws allowing "cooling off periods" before enforcing door-to-door sales contracts). If immature adolescent decision making creates costs that fall primarily on minors themselves, then the societal interest in preventing harm to this group may be particularly acute.



Another health-related argument open to negatives can be found in this piece of evidence—it cites a study which revealed that establishing too much autonomy in adolescence is associated with **negative health outcomes** later in life. It suggests this may be due to raised stress levels.

(Association for Psychological Science, “Close Friendships in Adolescence Predict Health in Adulthood,” original study by Joseph P. Allen, Bert N. Uchino, and Christopher A. Hafen, <http://www.psychologicalscience.org/index.php/news/releases/close-friendships-in-adolescence-predict-health-in-adulthood.html>, August 31 2015)

“Although autonomy-establishing behavior is clearly of value in modern Western society, in which daily survival threats are minimal, it may have become linked to stress reactions over the course of human evolution, when separation from the larger human pack was likely to bring grave danger.” Allen and colleagues write. “From a risk and prevention perspective, difficulty forming close relationships early in adolescence may now be considered a marker of risk for long-term health difficulties.” Allen explains.

If you want to use this argument, please be aware that the study itself was looking at adolescent peer-bonding and friendships. However, it is reasonable to argue that the same stress effects would likely also be associated with too-early independence from parents when making particularly weighty and consequential decisions, such as those regarding healthcare.

A prepared negative will also probably want to have **some defense to arguments about bodily autonomy/freedom/human rights**. For example, it would be useful to be prepared to win that denying an adolescent medical autonomy would not sacrifice her human rights.



Here is **evidence** arguing that denying adolescents the right to make independent health decisions actually protects autonomy, because it preserves their rights as a future adult. If, as an adolescent, one makes a terrible choice, one's adult self will later have his/her freedom constrained, due to the implications of that earlier decision. So, the neg says, restraining decision-making during adolescence actually protects overall, life-long autonomy:

(Elizabeth S. Scott, N. Dickon Reppucci, Jennifer L. Woolard, "Evaluating Adolescent Decision Making in Legal Contexts," Law and Human Behavior, vol 19 no 3 pp 221-244, <http://www.jstor.org/stable/1394002?origin=JSTOR-pdf>, June 1995)

The second argument for considering judgment hinges on an important distinction that can be drawn between the poor choices made by individuals and those that the law presumes are made by minors as a group. The adult's "poor" decision (to refuse recommended treatment, for example) is presumed to reflect the subjective values and preferences of the individual. In the case of the adolescent refusing treatment, the values and preferences are presumed to reflect common age-linked developmental characteristics that predictably will change. It is assumed that with maturity, most individuals will make a different choice. If this is so, then the autonomy claim seems less compelling than is that of adults. Moreover, implicit in the presumption that developmental factors affect judgment is a prediction (or hope, in the case of delinquent behavior) that the adolescent will become an adult with different values and preferences from her youthful self. If this is so, then the case for protecting the opportunities and prospects of that future adult from the costs of her immature youthful judgment and choices seems powerful (Scott, 1990).

Here is some **evidence** that says the Supreme Court has ruled that parental control doesn't violate adolescent rights, and for good reason. It goes on to argue that treating adolescents as immature decision-makers is also a necessary legal underpinning for the juvenile criminal justice system. Presuming that adolescents are less able to make rational, adult choices is the reason adolescents



are sentenced less severely than adults for criminal acts. Without this tenet, juveniles may be subject to the death penalty. Finally, it points out that other legal tools exist to protect adolescents from truly malicious parents:

(Alicia Ouellette, Dean & Prof of Law @ Albany Law School, "Body Modification and Adolescent Decision Making: Proceed with Caution," Journal of Health Care Law and Policy, vol 5 iss 1 art 7, <http://digitalcommons.law.umaryland.edu/jhclp/vol15/iss1/7/>, 2012)

The complexity of law respecting decision making by teenagers reflects the varied roles adolescents play in our constitutional system, and the interests that arise from each. First, teenagers are rights-bearing citizens, and in some cases, the law protects them as such. 60 Second, teenagers are minors, "whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely." 61 As such, states often seek to protect teens from the consequences of poor decision making.62 And finally, minor adolescents are part of an autonomous family unit, over which parents have a constitutionally protected right of control. 63 Although these interests have been analyzed in depth elsewhere, it is useful to review briefly how the Supreme Court understands and balances each before considering their weight in the context of body modification. The first interest, that of the teenager as a rights bearing citizen,65 is in many respects the least robust. The Supreme Court has consistently declared adolescents to be "persons" generally "protected by the same constitutional guarantees against government deprivations as are adults."66 In a case recognizing a minor's right to terminate her pregnancy, the Court explained that "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority."67 Thus, the Court has recognized, for example, that adolescents have a first amendment right to wear black armbands in protest of the Vietnam War, 68 due process rights in juvenile proceedings, 69 and an interest in freedom from unnecessary medical treatment and confinement. 70 Protection of the adolescents' interests as a rights holder is tempered, however, in almost all cases, by the state's interest in accounting for "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in childrearing." 71 The state's interest in protecting minors justifies "state-imposed requirements that a minor obtain his or her parent's consent before undergoing an operation, marrying, or entering military service." 72 It also allows states to criminalize conduct involving minors, such as the sale or exposure to dangerous products and activities, in a manner that would be unconstitutional if it involved adults. 73 In other words, it is well settled that "the States validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences." 74 Although the protection of teenagers through the curtailment of the liberties often draws sharp criticism among advocates for adolescent rights, the Supreme Court's recognition that teenagers are not fully formed adults was



celebrated by juvenile justice advocates when the Supreme Court held in Roper v. Simmons⁷⁵ that the death penalty could not be applied to adolescent offenders. In addition to two lines of reasoning not relevant to this essay, Justice Kennedy, writing for the majority in Roper, reasoned that adolescents lack the maturity necessary to be held as morally reprehensible as adult offenders. ⁷⁶ Critically, Kennedy relied on research in developmental science that confirms "[a] lack of maturity and an underdeveloped sense of responsibility ... in youth .. often result[s] in impetuous and ill-considered actions and decisions."⁷⁷ Further, Kennedy cited studies that demonstrated that youth are especially susceptible to external and peer pressure, and that their identities are more transitory and less fixed than that of adults.⁷⁸ Consistent with its conclusion that juveniles cannot be trusted to exercise their own right to make medical decisions, the Court concluded that the differences between adults and adolescents are legally significant when it comes to criminal punishment.⁷⁹ According to the majority in Roper: The susceptibility of juveniles to immature and irresponsible behavior means "their irresponsible conduct is not as morally reprehensible as that of an adult." Their own vulnerability and comparative lack of control over their immediate surroundings mean juveniles have a greater claim than adults to be forgiven for failing to escape negative influences in their whole environment.⁸⁰ In addition to state-sponsored protections for vulnerable youth, the Supreme Court has affirmed the important role of parents in care, custody, and control of adolescents.⁸¹ Parental control is rooted in familial autonomy.⁸² The Court has long recognized the "family as a unit with broad parental authority over minor children" in which the parents have the authority to raise children as the parents see fit.⁸³ The right to familial autonomy allows parents to make most decisions about the care and keeping of children without government oversight or interference.⁸⁴ Parental authority extends to medical decision making for adolescents.⁸⁵ Indeed, in a case involving psychiatric care for a teenager, the Court said parents "can and must" make medical judgments for children.⁸⁶ "Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment."⁸⁷ reasoned the Court. The child's wishes are essentially irrelevant. "The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority to decide what is best for [a] child."⁸⁸ Of course, parental rights are not unfettered. They must be balanced against the State's interest in protecting children and preservation of the child's rights. ⁹ Thus, States may limit parental rights through abuse and neglect proceedings, ⁹⁰ child labor laws,⁹¹ and mandatory vaccination laws.⁹² With respect to medical decision making, then, States can take certain choices out of the hands of parents through prohibitions (laws against female circumcision, for example),⁹³ mandates (mandatory vaccination laws), ⁹⁴ or laws that shift decision-making power to the minor (for contraception or drug treatment).⁹⁵ And when the interest of the youth is especially strong, such as with decisions about whether to carry a pregnancy to term, the State cannot totally divest an adolescent of decision-making power by giving a parent the right to veto an abortion. ⁹⁶ Nonetheless, the general rule and operating presumption at law is that parents are best equipped to make medical decisions



for their adolescent children. 97 That rule applies to body modification procedures except where state law makes an exception for tattooing or body piercing.

Taking a different approach to the question of rights, here is some **evidence** critiquing the idea of pure patient autonomy as the top priority in medical decision-making. It suggests instead that families should work together as an inter-dependent decision-making unit:

(Kimberly Mutcherson, Assistant Professor of Law @ Rutgers School of Law—Camden, “Whose Body is it Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents,” Cornell Journal of Law and Public Policy, Summer 2005, pg 251)

Cultural evolution, the expansion of scientific knowledge, and respect for the adolescent all provide a valid basis for transforming the legal landscape to embrace a model of shared healthcare decision-making within families. The legal system should support a more balanced relationship between the goals of protecting adolescents from themselves and granting them rights that allow them to take actions to protect their own interests. Striking this balance requires working within the familial unit and recognizing the power of that unit while avoiding romanticization and unattainable aspiration. Rather than a myopic focus on eighteen as a magic year, more precise and multi-disciplinary thinking suggests the law should create a younger age at which people have a legal right to substantially and substantively participate in decisions about their own healthcare and, in some circumstances, act independently in the healthcare arena. This proposal does not envision or advocate across the board emancipation from the disabilities of age for young people. Rather, it focuses on a particular area where adolescent decision-making would accrue to the benefit of the patient. Any change in the law's treatment of young people in the healthcare context must start from the premise that children are not monolithic, meaning that all of those who are legally minors, because they are below the age of eighteen, should not be labeled immature, incapable, and decisionally dependent. Protectionist policies necessary to maintain the health of young children - those under the age of fourteen - are not automatically appropriate for adolescents who have the capacity to comprehend and respond to their own healthcare circumstances. Either/or reasoning focused on 100% autonomy or 100% lack of autonomy is an inappropriate view of the interests at stake here. No member of a functioning family is radically autonomous and each family member is regularly called upon to understand her exercise of rights within the



broader context of an impact on family members. [*301] As described earlier, the model of autonomy upon which this shared decision-making model rests is one that embraces rather than ignores the idea of community, interdependence, and cooperative decision-making. In this proposal, most of the decision-making will require joint consent by patient and parent, rather than assent by one and consent by the other. In this way, the proposal seeks to elevate the adolescent to a position of greater power while preserving a place for the parent in much of the healthcare decision-making for adolescents. In some ways, the shared decision-making model is akin to a learner's permit for healthcare decision-making. Before young people reach eighteen and are completely unfettered, at least legally, from parental dominance in healthcare decision-making, they will have opportunities to share in the process of self-regulation with both healthcare providers and parents to offer support and guidance. This graduated process conforms to the idea that making good decisions is a learned behavior and that "the right kind of growing up in the law takes place over time rather than on a particular birthday."

Finally, negatives will want to be prepared to answer common aff arguments, such as the **special medical circumstances** discussed in the aff section.

One way to do this is to apply the definition that "medical excludes surgical." There is court precedent available to define abortions, for example, as a surgical procedure. Therefore, whether or not adolescents should be able to autonomously decide to have an abortion is a question outside of this resolution.

That definitional argument won't always be strong against arguments about trans adolescents, though. Often, doctors allow trans adolescents to begin hormone therapy, but not necessarily to receive any surgeries. However, there are other options.



The primary arguments in favor of allowing children to transition during adolescence are that it improves their mental health, and that allowing them to block puberty symptoms of their birth-gender will make transition easier and make them more likely to “pass” for the gender they identify as in adulthood. However, some studies have indicated that the majority of children with trans identification revert to identifying as their birth gender after puberty. This makes deciding to halt puberty a bit of a sticky question. They may change their mind, and begin to experience gender dysphoria longing for their birth-gender.

There is also a possible definitional issue: many would argue that pre-pubescent children are by-definition not “adolescents.” If this is the case, then the aff has to win that there are compelling benefits to post-puberty but pre-adulthood transitioning. This isn’t really too difficult—there are lots of studies indicating that trans teens, especially those forced to present as a gender they don’t identify with, are dramatically more at risk for mental health issues and suicide than their cis-gender counterparts. However, there are also LGBTQ activists and doctors alike who suggest that physical transitioning should begin as late as possible. They cite a number of reasons—a lot of them trace back to the debate about decision-making capability. The fact that there is essentially zero research on the long-term effects of hormonal therapy in adolescents is another; scientifically, we largely have no idea whether it could cause health problems down the line. There are also statements from trans adults who transitioned early, and now feel that they would have been better off living how they wished, but leaving their bodies physically unchanged. These are also possible responses to these types of affs you could explore.



That concludes our overview of the September/October 2015 LD topic. Don't forget, however, that this is only an introduction—it will be crucial for you to continue the research process on your own.

You can also always submit completed cases to rachel.stevens@ncpa.org for a confidential, personalized critique. Questions about this guide, the resolution, or debate in general? Don't hesitate to email!

Good luck!