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The Decisional Capacity of the Adolescent: An Introduction to a Critical Reconsideration of the Doctrine of the Mature Minor

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Do adolescents have the decisional capacity of adults? Or, are they in crucial ways still immature, that is, are they deficient decisionmakers? This question has been answered in quite different ways in medical versus criminal law. In medical law, an exception from the requirement of parental consent was crafted to allow adolescents to make decisions in restricted circumstances associated with quasi-medical emergencies. Over the last few decades, this exception has grown into an almost blanket acceptance of the decisional capacity of adolescents under the age of 18 and generally over the age of 14 to give valid consent to treatment. At the same time, a seemingly contrary view of the decisional capacity of minors developed in American criminal law, especially around cases such as *Eddings v. Oklahoma* (1982), *Johnson v. Texas* (1993), *Roper v. Simmons* (2005), *Graham v. Florida* (2010), *Jackson v. Hobbs* (2012), and *Miller v. Alabama* (2012). These Supreme Court decisions recognize adolescents as having a substantive lack of maturity and an underdeveloped sense of responsibility that distinguishes adolescents from adults. The Court in *Graham v. Florida* (2010) noted, for example, that "developments in psychology and brain science continue to show fundamental differences between juvenile and adult minds . . . [in] parts of the brain involved in behavior control" (560 U.S., at __ [slip op., at 17]). The result is that courts have accepted the view that the decisional capacity of adolescents is not fully developed and that as a consequence adolescents cannot have the same degree of criminal culpability as adults. In evaluating the decisional capacity of minors, one thus faces the challenge of how to harmonize these two quite different trends in the assessment of adolescent decision making.

This issue of *The Journal of Medicine and Philosophy* brings together psychological and neurophysiological data with philosophical–bioethical reflections on what should count as decisional capacity or decisional agency.

Some of the articles address as well the issue of the authority of parents over their children and how this bears on the question of whether adolescents under the age of 18 should generally make medical decisions without the involvement of their parents. The conclusions one reaches on these matters regarding adolescent decisional capacity and parental authority will determine the concrete character of medical law and public policy. In particular, it will determine whether the default position should be that of presuming that minors over the age of 14 do or do not possess decisional capacity equivalent to that of adults. Where one places the burden of proof will also turn on empirical data regarding the contribution of authoritative, even authoritarian, parenting to the successful maturation of minors into adults, for this will give a further indication of the importance of parental involvement.

This issue of *The Journal of Medicine and Philosophy* opens with a paper from a psychologist who has been involved in developing briefs to the Supreme Court (Miller, 2012) that have influenced holdings that recognized the diminished legal culpability of adolescents (*Miller v. Alabama*, 2012). Laurence Steinberg in his article "Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?" argues that, because adolescents are less mature than adults, when making decisions characterized by emotional arousal and peer pressure as when committing crimes, culpability is diminished (Steinberg, 2013). However, Steinberg also argues that recent studies of the adolescent brain and of behavioral development do not undermine the mature minor doctrine. Instead, the data indicate important ways in which the doctrine should be applied. First, Steinberg stresses the difference between adolescents and children, making plausible the old rule of 7's (i.e., infants under 7 years, children 7–14, and adolescents over 14). He holds that adolescents in the right circumstances have decisional capacity equivalent to that of adults. Second, Steinberg takes the view that healthcare practitioners can enhance the ability of adolescents to make informed and knowledgeable decisions by being involved in the decisional process and by creating a context that circumscribes impulsive decision making (i.e., decision making that does not take into account long-term as well as short-term consequences of alternative courses of action). Thus, given peer pressure and circumstances in which impulsive decision making is not counteracted, adolescents lack adult decisional capacity and, therefore, adult culpability with regard to criminal acts. However, Steinberg argues that in the context of most medical decision making, adverse influences on the decisional capacity of minors can be counteracted so that adolescents can function as mature minors.

In contrast, Evan Wilhelms and Valerie Reyna advance grounds to restrict the mature minor exception to quasi-emergency situations. They come to this decision because they find a more fundamental qualitative difference between adolescent and adult decision making. In "Fuzzy Trace Theory and Medical Decisions by Minors: Differences in Reasoning between Adolescents

and Adults," they report data that show that it is not merely impulsive behavior or even the failure of adolescents to take into account long-term as well as short-term consequences that makes adolescents bad decisionmakers (Wilhelms and Reyna, 2013). More importantly, it is their failure to grasp the gist of what is at stake in making a decision. Wilhelms and Reyna develop their argument through engaging "fuzzy trace theory":

> Fuzzy trace theory (FTT) is a comprehensive theory of reasoning, judgment, and decision-making that integrates the prior standard reactive model with documented cognitive developmental differences to explain risk-taking behavior in adolescents. . . . According to FTT, deliberative, analytic reasoning and impulsive reactivity are distinct routes to risk taking, and, surprisingly, the former accounts for a great deal of risk-taking in adolescence. . . . Thus, adolescents are not just more emotional and impulsive than adults; their understanding of the gist of such decisions is not mature. (Wilhelms and Reyna, 2013, 272)

The point is that it is "gist processing" that appears to be a necessary condition for mature decision making. Even when adolescents can intellectually analyze and lay out long-term as well as short-term consequences of their decisions, they still fail crucially to apprehend what is at stake in the decisions they face.

> Although adolescents are capable of encoding mathematical probabilities about risks and rewards, they still do not have the mature appreciation for the meaning of those risks and rewards, and their implications for their future adult lives. Put another way, it could be said that some adolescents know "the price of everything but the value of nothing." (Wilhelms and Reyna, 2013, 279)

Adolescents, in short, differ qualitatively from adult decisionmakers, so that Wilhelms and Reyna "conclude that circumstances in which adolescents are equivalent to consenting adults are unusual" (Wilhelms and Reyna, 2013, 270). They, therefore, recommend that "if [mature minor] exception is necessary for an emergency situation, the physician or medical experts involved should emphasize the bottom-line gist of risks involved during the process of consent or deciding on treatment options" (Wilhelms and Reyna, 2013, 279).

The next essay in this issue, "The Mature Minor: Some Critical Psychological Reflections on the Empirical Bases" (Partridge, 2013), takes a position closer to that of Wilhelms and Reyna than to that of Steinberg. This essay concludes that there are grounds to bring into serious question the advisability of exempting minors from parental authority and guidance, save in emergency or quasi-emergency circumstances, given the qualitatively different character of adolescent decision making. These differences are not just due to differences in decisional behavior, such that adolescents tend more than adults to be impulsive decisionmakers, who often inadequately take account of the long-term consequences of their choices and who very frequently fail fully to apprehend the significance of near- and long-range consequences of decisions. In addition, the brains of adolescents are simply different from

those of adults. One can through brain imaging literally see the differences. When adolescents make decisions, there is a greater engagement of limbic structures with less of an engagement of prefrontal cortical areas in comparison with adults making the same decisions. These data justify a strong but rebuttable presumption that, in general, minors lack mature decisional abilities, and that they would benefit from the guidance of those who know them well, in particular parents and guardians. A second body of data is also relevant, which shows the importance of effective parenting for the maturation of adolescents (Baumrind, 1989; Adaljarnardottir and Hafsteinsson, 2001; Huver et al., 2007). These findings indicate that one should be more concerned about false positives than false negative determinations of decisional capacity, given the benefits from parental involvement. Here matters are complex, in that the character of the family in the West is changing, with some 41% of children in the United States now being born outside of a traditional marriage (Martin et al., 2011, 2). Any actual approach to adolescents will need frankly to take into account their social context.

The papers by Rachelle Barina and Jeffrey Bishop, by Mark Cherry, and by Ana Iltis locate the examination of the mature minor exceptions more explicitly within moral and bioethical concerns. In their paper, "Maturing the Minor, Marginalizing the Family: On the Social Constitution of the Mature Minor, Sexual Politics, and the Family," Barina and Bishop address the historic and social context in which the formation of the mature minor doctrine develops, and in doing so illustrate the adversarial nature between the goals of the state and the contextual role played by families. Barina and Bishop embed their analysis of this development within a "phenomenological account of the care of the body in the family" and its subsequent application to reproductive health policy. They argue that,

> legally and medically, the concept of the mature minor does not actually depend upon the notion of maturity. Instead, the invocation of the doctrine of "mature minor" in the context of adolescent reproductive health has become a means to assert better health outcomes for the state. A careful consideration of maturity is unnecessary because contraception is an unqualified good in the case of every teen. Socially destructive and expensive health risks, more than the adolescent's mature ability to understand and appreciate health information, merit the provision of reproductive health services without parental consent. (Barina and Bishop, 2013, 306)

They also argue that the focus on public health to the exclusion of all other factors creates a clear conflict between state interests and parental authority. In so doing, the state is interrupting the conveyance of "the moral, social, and existential goods that belong to the particular family within which the child's life-world is formed." (Barina and Bishop, 2013, 309)

Mark Cherry takes a stronger stand against the universal application of the mature minor doctrine in his paper "Ignoring the Data and Endangering

Children: Why the Mature Minor Standard for Medical Decision Making Must Be Abandoned." Unlike Steinberg who is able to reconcile the apparent differences in the medical and legal understanding of adolescent decision making with the neuropsychological evidence, Cherry contends clearly that the mature minor doctrine must be abandoned. In his analysis of the neuropsychological data, Cherry argues in support of the Supreme Court's interpretation that adolescents make decisions qualitatively differently than adults. He writes:

> Current trends in pediatric decision making in support of the "mature minor" standard constitute moral and legal movement in direct opposite to what the science bearing on the matter demonstrates to be reasonable and the United States Supreme Court judges to be constitutionally appropriate. To put the matter bluntly, the "mature minor" standard for medical decision making ignores the scientific data and endangers children. (Cherry, 2013, 326)

Ana Iltis examines both the decisional capacity of adolescents as well as the authority of parents over their children and the implications this has for adolescents giving consent. In her paper, "Parents, Adolescence, and Consent for Research Participation," Iltis (2013) concludes that adolescents often do not possess a decisional capacity that will allow sufficient appreciation of information so as to be able to give valid consent for participation in research, and indeed for consent to medical treatment generally. In part, she embraces this conclusion because of data that show that, although adolescents understand the information relevant to making a treatment decision, their appreciation or evaluation of reasonable and foreseeable consequences is usually different from that of adults. Here, Wilhelms and Reyna's reflections through fuzzy trace theory regarding the importance of getting the gist of what is at stake in a decision may be crucial. Iltis advances as well a second claim, a moral one, that minors even if they are mature are still children, and that there are, therefore, strong principled arguments for recognizing parents as being in authority to guide their children. We confront again the complexity of the issues at stake in assessing the status of the mature minor. In controversy are not merely the facts of the matter regarding how adolescents make decisions but also moral and social issues, namely, how we should regard the relationship between children and their parents. The intersection of these two areas of contention compounds the disputes in pediatric bioethics regarding the status of children.

The articles in this issue are not unanimous on any point. However, all the authors appear to concur that judgments regarding the decisional capacity of an adolescent will depend on the particular adolescent and the particular context. There are clearly significant variations among persons with respect to decisional capacity. In addition, persons do not take a uniform journey from infancy to mature adulthood. Some persons become mature decisionmakers much earlier than others, while others appear never fully

to achieve this status. Sorting matters out will in part require further philosophical reflection on what we want to mean by mature decisionmakers. That is, we will need to reflect on the moral issue as to what characterizes a person who has decisional capacity. Bernat, Culver, and Gert (1981) in reflecting on the definition of death developed a distinction among concepts of death, criteria for death, and tests for death. A concept of death for them is a philosophical issue, a view of what it means to be dead (e.g., loss of personhood). A criterion of death involves an intersection of philosophy and physiology (e.g., a neurological criterion such as the irreversible cessation of all functions of the brain as an indicator of death). Tests for death are the actual diagnostic determinations employed by physicians in declaring death. We will likely need to fashion similar distinctions with regard to competency, so as to be clearer as to what should be compassed by the concept of decisional capacity as well as what should serve as criteria for crucial elements of decisional capacity such as, perhaps, "gist-processing." We will need as far as possible to determine the necessary and sufficient capacities that can serve as criteria for competent decision making. Then we need to determine what one should look for when making the judgment that a person under the age of 18 but over the age of 14 has decisional capacity. These essays point the way to further work.

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