Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices

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ADOLESCENT DECISIONAL AUTONOMY FOR MEDICAL CARE:
PHYSICIAN PERCEPTIONS AND PRACTICES

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I. INTRODUCTION

Decisional autonomy is an elusive concept. Some patients are presumed by law to possess it, while others are not. Decisional autonomy is predicated on decision-making capacity, which is eclectic and multidimensional in its own right. At best, it has been defined as a “thicket of variables” composed of an ability to understand information, to deliberate about it, and to communicate a choice with clarity, yielding a rather low threshold of decisional ability. Despite descriptive terms for decisional capacity that seem as varied as a standard by which to measure it, debates about how it should be measured and in what
ways each of us diverge from the standard remain unresolved.

Within the context of medical care, adult patients are presumed decisionally capable by law, regardless of their "far from ideal" reasoning ability\(^4\) or even reckless, irresponsible, and irrational decision making.\(^5\) However, adolescent patients (fourteen through seventeen years) are presumed incapable of medical decision making. Physicians caring for them are required by law to secure consent from a parent or guardian for medical treatment or procedures, subject to delineated exceptions. Among the many problems associated with adolescent patient care are ethical conflicts confronted by physicians. Doctors may be inclined to honor an adolescent's wishes regardless of parent or guardian objection, but are constrained by law to accede to the decision of the adult.

Intriguing, though hitherto unexamined, issues in adolescent patient care include finding a precise justification for precluding adolescent medical decision making and examining whether physicians caring for adolescent patients believe the latter are decisionally capable and practice accordingly. Because decisional capacity defies a concise, definitive standard and because scientific research suggests that adult patients do not demonstrate reasoning skills superior to adolescent patients (or that, in some circumstances, adolescent patients actually demonstrate reasoning abilities that equal those of some presumably capable adults),\(^6\) adolescent decisional autonomy for medical care merits heightened bioethical discourse, empirical examination, and legal policymaking attention.

In specific situations, such as emancipation or emergency, and for specific conditions, such as sexually transmitted disease or substance abuse, adolescents have legal decisional autonomy regardless of actual decision-making capability. These exceptions to the legal presumption of decisional incapacity governing adolescent patient care arise from public policy concerns. For example, the STD exception promotes adolescent access to treatment, preventing spread of the disease by eliminating the deterrent of having to inform a parent or guardian of sexual activity. Because the critical determinant of decision-making capability is unknown, anomalies arise that require closer scrutiny. For example, a seventeen-

134 Am J Psychiatry 279, 283 (1977) (likening a single standard for decisional capacity to "a search for a Holy Grail").

4. Gary B. Melton, Parents and Children: Legal Reform to Facilitate Children's Participation, 54 Am Psychol 935, 937 (1999) (noting that cognitive psychologists have found adult reasoning in general to be far from ideal).

5. Dan W. Brock and Steven A. Wartman, When Competent Patients Make Irrational Choices, 322 New Eng J Med 1595, 1599 (1990) (stating that "even truly irrational choices are not sufficient to establish a patient's incompetence and to justify overriding them").

6. See Thomas Grisso and Linda Vierling, Minors' Consent to Treatment: A Developmental Perspective, 9 Prof Psychol 412, 421 (1978). As these commentators observe:

[There is evidence, of course, that adolescents represent a heterogeneous group in terms of cognitive abilities, so that it would be inaccurate to conclude that all adolescents are intellectually capable of providing independent consent. But the same might be said for a random sample of the adult population, and at present there is no clear evidence to suggest that heterogeneity of abilities is any greater at various adolescent ages than in adulthood.]
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A sixteen-year-old may agree to STD treatment while being unable to decide upon treatment for a complication resulting from the STD. Most strikingly, the legal presumption of decisional incapacity governing adolescent patients prevents a sixteen-year-old suffering with malignant disease from refusing debilitating treatment with low therapeutic value, while the same sixteen-year-old, if convicted of a violent crime, could be subjected to retributive sanction, including the death penalty.

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. 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. 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 arbi-

8. Stanford v Kentucky, 492 US 361, 380 (1989) (adolescents aged sixteen and seventeen years at the commission of a capital crime may face the death penalty under the federal Constitution).
10. See In re Green, 292 A2d 387, 391-92 (Pa 1972). This sentiment is captured in a scathing dissenting opinion related to adolescent waiver of the privilege against self-incrimination, wherein Judge McKay of the United States Court of Appeals for the Tenth Circuit lamented a legal system that, on the one hand, assumed the reduced ability of minors to make decisions on their own behalf, yet, on the other hand, upholds a minor's ability to make an informed judgment regarding waiving important Fifth Amendment rights. United States v Palmer, 604 F2d 64, 68 (10th Cir 1979) (McKay dissenting).
11. See text accompanying notes 58-84.
trarily 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.\(^1\)

Furthermore, literature related to adolescent decision making suggests a level of capacity for voluntary consent comparable to that of young adults.\(^2\) Nevertheless, as several commentators astutely acknowledge, understanding adolescent autonomy for medical decision making "requires a more detailed analysis of the composite information processing skills required by a specific decision than has been offered in the literature to this point."\(^3\) Despite examination of adolescent decision making in various medical contexts, little is known about the perceptions and practices of physicians caring for adolescent patients. Indeed, physician views related to adolescent medical decision making are rarely articulated, let alone explored. Particularly, do physicians believe that adolescent patients are decisionally capable and, if so, do they practice medicine with adolescent patients accordingly? Physician knowledge and experience are valuable to promote learning about adolescent decisional autonomy because physicians regularly interact with adolescents in intimate and inherently stressful environments. Thus, their knowledge and experience provide extraordinary insight into adolescent decision-making capacity. An understanding of physician perceptions and practices is especially important to legal policymakers in crafting laws impacting adolescent patient care.

In order to enhance understanding about adolescent patient decision-making ability and to contribute a unique dimension to the literature regarding adolescent patient care, three specialty groups of primary care physicians were studied to determine: (1) whether physicians believe adolescent patients are decisionally capable; (2) whether physicians approach medical practice with adolescent patients as though they are decisionally capable; and (3) whether physicians believe that adolescent patients derive benefit from the presence of a trusted adult during the decisional process.

This Article discusses and analyzes results of the study that inform both adolescent patient care and legal policymaking. Specifically, Part II explains the


\(^{15}\) Gardner, et al, *44 Am Psychol at 898* (cited in note 3) (noting a lack of strong data "supporting the assertion of equivalent decision making competence" since few studies explicitly compare adolescent and adult abilities).
current legal framework governing adolescent patient care. Part III explores literature related to adolescent cognitive development and decisional capability in health care. Parts IV and V detail the study of physician perceptions of adolescent patient decisional capacity and practices with adolescent patients, including the research design, sample, methodology, and results. Lastly, Part VI addresses the implications of these findings and suggests proposals for optimizing adolescent decisional autonomy for medical care.

II. LAW REGULATING ADOLESCENT PATIENT CARE

Legal treatment of adolescent autonomy for medical decision making is based on a presumption of decisional incapacity. Specifically, minors (defined as persons under eighteen years) are presumed incapable of medical decision making. The law’s presumption of decisional incapacity for adolescent patients stems from a paternalistic paradigm in existence since the turn of the twentieth century. Social policy during the Industrial Age provided the impetus for establishing a separate and distinct legal system for addressing the needs of youth “not so much to punish as to reform, not to degrade but to uplift, not to crush but to develop.”

Underlying this paternalistic approach to adolescence is the idea that juveniles lack decisional capability and hence responsibility and accountability attendant for their acts, and that the state as parens patriae should show solicitude toward youth through rehabilitation and reformation. Although presumptive decisional incapacity has underpinned laws governing adolescent decision making for over a century, there is comparatively little statutory or case law on the subject.

Most states reverse the presumption by statute in certain cases and permit adolescent decision making for medical care in the event of emergency, emancipation, sexually transmitted disease, drug or alcohol dependency, mental health treatment, contraception, and pregnancy. These exceptions, of

17. For historical analysis of legal treatment of adolescence throughout the twentieth century, see Hartman, 51 Hastings L J at 1271-86 (cited in note 9).
18. See, for example, Ala Code § 22-8-3 (1999); Ariz Rev Stat § 44-133.01 (West 1999); Fla Stat Ann § 743.064 (West 2001); Kan Stat Ann § 38-123b (1999); Minn Stat Ann § 144.344 (West 2000); Title 35 Pa Stat Ann § 10104 (West 2000); RI Gen Laws § 40.1-22-23 (1999); SC Code Ann § 20-7-290 (Law Co-op 1999); SD Cod Laws § 20-9-4.2 (2000).
19. See, for example, NC Gen Stat § 90-21.5(b) (1999).
22. See, for example, Cal Family Code § 6924(b) (West 2000); Conn Gen Stat Ann § 19a-14c (West
course, resonate with multiple competing values and social norms. For example, the STD exception furthers policy concerns of preventing endangerment to the health and welfare of adolescents and other persons potentially affected by an adolescent's disease. Adolescents may consent to medical treatment for an STD without parental or guardian consent because obtaining adult consent may deter an adolescent from seeking treatment. If society deems an adolescent capable of consenting to some forms of medical treatment, such as for an STD, should that same adolescent be presumed capable of providing consent to other forms of treatment? If the STD condition results in a more serious diagnosis, should the attending physician allow the adolescent to decide her own treatment under the aegis of the STD exception? Or should the physician revert to the general rule of presumptive decisional incapacity for adolescent patients and require the consent of a parent or guardian, despite the risk that the adolescent patient may not return for care due to the deterrent of parental consent? These are significant questions that remain unanswered.

Moreover, escalating rates of adolescent suicide\(^2^5\) have propelled several state legislatures to encourage access to mental health treatment through statutory enactments that allow adolescents of specified age to consent to treatment without parent contact or consent. While California, for example, permits minors "twelve years of age or older" to consent to mental health treatment, it requires health care providers to determine whether the minor is "mature enough to participate intelligently," whether she would endanger herself or others, or whether she is the alleged victim of incest or child abuse.\(^2^6\) Pennsylvania recognizes the consent of "[a]ny person fourteen years of age or over," requiring the provider to discern that the adolescent "believes that he is in need of treatment and substantially understands the nature of voluntary treatment" and that the adolescent's decision to submit to examination and treatment "is made voluntarily."\(^2^7\) Virginia\(^2^8\) and Connecticut\(^2^9\) do not impose age restrictions for adolescent consent to mental health treatment. However, Connecticut requires physicians to determine that parental consent or notification would cause the minor not to obtain care, that treatment is "clinically indicated," that a failure to provide it would be injurious to the adolescent's well-being, that the adolescent

\(^2^3\)See Md Health-General Code Ann § 20-102(c)(5) (2000); Va Code Ann § 54.1-2969(E)(2)


\(^2^5\)See American Academy of Pediatrics, Committee on Adolescence, Suicide and Suicide Attempts in Adolescents, 105 Pediatrics 871, 871 (2000) (reporting the dramatic increase in adolescent death from suicide in the United States).

\(^2^6\)Cal Family Code § 6924(b) (West 2000).

\(^2^7\)Title 50 Pa Stat Ann § 7201 (West 2000).


\(^2^9\)Conn Gen Stat Ann § 19a-14c (West 2000).
knowingly and voluntarily seeks treatment, and that the adolescent “is mature enough to participate in treatment productively.”

Emancipation exceptions likewise allow adolescents to decide treatment if one of an assortment of conditions has been met, including high school graduation, military enlistment, marriage, sexual assault, incarceration, parenthood, pregnancy, or even if the adolescent “has been pregnant.” Not only are these statutory situations difficult for attending physicians to interpret and apply with confidence, but each is contingent on a societal assumption that any one of these circumstances gives rise to adolescent decisional autonomy despite the absence of a crucial decisional capacity determinant. An adolescent who, for example, “has been pregnant” is not necessarily more capable of understanding the nature of her condition, the proposed medical intervention, and the likelihood of various outcomes entailing benefits, risks, and alternatives than is the adolescent who has not been pregnant, especially when the latter may very well be more mature and adept at deliberation.

Several state legislatures have enacted “mature minor” provisions that permit adolescent patients who are at least fourteen or fifteen years of age a measure of decisional autonomy for medical care. The inadequacy of these provisions as exceptions to presumptive decisional incapacity has prompted derision from commentators, who claim that “describing adolescents’ abilities has been made difficult by issues only obliquely related to empirical research.” Louisiana’s statute is instructive in this respect; it provides that adolescent consent to treatment shall be “valid and binding as if the minor had achieved his majority.” Rhode Island recognizes medical decision-making ability of sixteen-year-old adolescents for “routine care,” assigning physicians the potentially arduous

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30. Id.
32. See Mass Ann Laws ch 112, § 12F (Law Co-op 2000).
34. See Md Health-General Code Ann § 20-102(c)(6) (2000).
35. See Md Health-General Code Ann § 20-102(c)(6) (2000); NY Corrections Law § 140 (Law Co-op 2000).
38. See Title 35 Pa Stat Ann § 10101 (West 2000).
40. See, for example, Cal Family Code § 6922(a) (West 2000) (fifteen years and managing affairs independently); Or Rev Stat § 109.640 (1999) (fifteen years or older); Wis Stat Ann § 51.14(3)(a) (West 1999) (fourteen years or older).
41. Lexcen and Reppucci, 5 U Chi L Sch Roundtable at 64 (cited in note 3).
42. La Rev Stat Ann Art 40:1095(A) (West 2000).
task of distinguishing between routine and non-routine medical care.\textsuperscript{43} Yet, both Louisiana and Rhode Island circumscribe adolescent medical decision making to choosing treatment rather than refusing it, which is common among similar statutes of other states.\textsuperscript{44} For decisional autonomy in medical care to be accorded full meaning, however, the right and ability to choose treatment should entail the corollary right and ability to refuse it.

Since most states, unlike Louisiana and Rhode Island, lack “mature minor” statutory provisions for adolescent medical decision making, a few state courts have rendered decisions regarding whether an adolescent patient may choose or refuse treatment and created “mature minor doctrines,” which vary from state to state. It is, however, misleading to elevate such judicial action to “doctrine” status. The reported decisions treating the issue have carefully cautioned that rulings concerning adolescent patients do not constitute “a general license to treat minors without parental consent, and its application is dependent on the facts of each case.”\textsuperscript{45} Indeed, an appellate court in New York expressly issued an invitation to the state legislature to take a “hard look” at the “mature minor doctrine” for legal reform.\textsuperscript{46}

Confidentiality is also a paramount concern because safeguarding patient confidences is highly valued and regarded as the touchstone of a trusting, therapeutic physician-patient relationship. As several researchers have found, adolescents seek providers who are caring, nonjudgmental, and able to keep their confidences.\textsuperscript{47} Current law in most states does not expressly provide statutory protection for adolescent patient confidences nor explicitly include adolescent patients within adult patient confidentiality protections found in licensure and informed consent statutes. However, both Louisiana and Massachusetts expressly protect the confidentiality of adolescent patient information concerning treatment and counseling.\textsuperscript{48} Massachusetts mandates that all information and records “shall be confidential [and] shall not be released except upon the written consent of the minor or a proper judicial order.”\textsuperscript{49} Additionally, federal law protecting adolescent confidences in the area of procreative practice and contraception\textsuperscript{50} prompted the United States Court of Appeals for the Third Circuit to assert that federal law related to adolescent patient confidentiality for reproduc-

\begin{footnotes}
43. RI Gen Laws § 23-4-6-1 (1999).
44. See Op La Atty Gen, No 88-232 (Nov 16, 1988). See also, for example, Cal Family Code § 6922 (West 2000); RI Gen Laws § 23-4-6-1 (1999). But see SD Cod Laws § 27A-15-47 (2000) (stating that failure to obtain informed consent from a minor for psychotropic medical treatment shall be regarded as a refusal of such treatment).
\end{footnotes}
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52. See, for example, Planned Parenthood v Casey, 505 US 833, 899 (1992); Belotti v Baird, 443 US 622, 647-48 (1979).

53. Casey, 505 US at 899-900. See also American Academy of Pediatrics, Committee on Adolescence, Counseling the Adolescent About Pregnancy Options, 101 Pediatrics 938 (1998) (recommending that adolescents acquire "the advice and counsel of adults in whom they have confidence, including other relatives, counselors, teachers, or clergy" in the absence of parental support).

54. American Acad of Pediatrics v Lungren, 940 P2d 797, 800 (Cal 1997); In re TW, 551 So 2d 1186, 1194 (Fla 1989).

55. See In re Rena, 705 NE2d 1155, 1157 (Mass App Ct 1999) (finding error by hearing judge for failing to consider the adolescent's maturity); Novak v Cobb County-Kennestone Hosp Auth, 849 F Supp 1559 (ND Ga 1994) (granting summary judgment to defendant physician and hospital, finding no issue of triable fact regarding the decisional ability of a sixteen-year-old adolescent who refused a blood transfusion, and also finding no mature minor exception); Application of Long Island Jewish Med Ctr, 557 NYS2d at 243 (relying on parens patriae and "varying degrees of maturity and responsibility" to rule that seventeen-year-old adolescent could be transfused despite the patient's desire to refuse the treatment); In re EG, 549 NE2d 322, 328 (III 1989) (ruling that seventeen-year-old adolescent was a mature minor and, therefore, could decline a blood transfusion based upon "sincerely held religious beliefs").
for medical care is understanding adolescent patient decisional ability in various contexts. In this regard, science, both hard and soft, should be the bellwether for educating legal policymakers about the issue. Otherwise, laws and judicial decisions related to adolescent medical decision making constitute “policy analysis without benefit of data.”56 As the following section discusses, reported data about adolescent decision making for medical care suggests that adolescents should not be denied decisional autonomy based solely on presumed decisional incapacity.57

III. LITERATURE RELATED TO ADOLESCENT PATIENT DECISION MAKING

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.62

57. See also Scherer, 15 Law & Hum Behav at 445 (cited in note 14); Grisso and Vierling, 9 Prof Psychol at 420-21 (cited in note 6).
58. See, for example, Ginsburg, et al, 273 JAMA at 1918 (cited in note 13); Scherer, 15 Law & Hum Behav at 443 (cited in note 14).
59. Grisso and Vierling, 9 Prof Psychol at 423 (cited in note 6).
60. Lois A. Weithorn and Susan B. Campbell, The Competency of Children and Adolescents to Make Informed Treatment Decisions, 53 Child Dev 1589, 1595 (1982). The standardized measures employed by Weithorn and Campbell led to “evidence of choice, reasonable outcome, rational reasons, and understanding.” Id. See also Nancy Kaser-Boyd, Howard S. Adelman and Linda Taylor, Minors’ Ability to Identify Risks and Benefits of Therapy, 16 Prof Psychol: Res & Prac 411, 413, 416 (1985) (reporting “a tendency for older and more experienced minors to be able to identify more risks and benefits and to use more abstract concepts in their discussions of risks and benefits” based on a study sample ranging in ages from ten to twenty years and drawn from a population of those with learning and behavioral problems).
62. See generally Gil G. Noam, et al, The Interpersonal Self in Life-Span Development Perspective: Theory,
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. 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. 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," suggesting that recognizing adolescent autonomous decision making for medical care "may improve their response to treatment and encourage the development of self-efficacy." 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. 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" 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."

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." In a related study, Ginsburg and fellow researchers found that "adolescents are not passive recipients of care. They actively interpret interactions and evaluate services." These researchers also suggest that adolescents "want to navigate the

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63. Scherer, 15 Law & Hum Behav at 431 (cited in note 14); David G. Scherer and N. Dickon Reppucci, Adolescents' Capacities to Provide Voluntary Informed Consent: The Effects of Parental Influence and Medical Dilemmas, 12 Law & Hum Behav 123 (1988).

64. Scherer, 15 Law & Hum Behav at 446 (cited in note 14).

65. Id at 444.


68. Id at 135.

69. Id.


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.\textsuperscript{72} While researchers have found that consultation with a trusted adult benefits adolescents, particularly in reducing risky behavior,\textsuperscript{73} adolescents emphasize that it is caring and connectedness from which they derive benefit, regardless of familial ties.\textsuperscript{74}

Several researchers examined the issue of adolescent patient compliance with cancer treatment through two separate studies of the perceptions of health care providers via a questionnaire.\textsuperscript{75} They reported a higher degree of adolescent patient noncompliance in the first study. Note that the first study was conducted at an inner-city hospital, suggesting that the lower socioeconomic status may have had an impact on compliance rates.\textsuperscript{76} Although the researchers advocate the necessity of future research to "explore and refine appropriate methods for assessing patient compliance,"\textsuperscript{77} the noncompliance by adolescent cancer patients in the study may suggest that they "strive for greater autonomy than younger children in health and illness behavior as well as in general decision making."\textsuperscript{78}

Other researchers examining adolescent decisional capability have focused on pregnancy decision making. For example, Bruce Ambuel and Julian Rappaport tested the underlying legal presumption that adolescents are not competent to consent to abortion by studying adolescents and young adults confronted with unplanned pregnancies. Specifically, they reported results "consistent with other developmental research examining minors' legal, cognitive, and social cognitive competence,"\textsuperscript{79} ascertaining that adolescents aged "14 to 17 appear to be similar to legal adults in both cognitive competence and volition"\textsuperscript{80} and that they "remain competent decision makers when facing an emotionally challenging real world decision."\textsuperscript{81} The results indicate that adolescents benefit from adult counsel and actively "consult parents and other adults when making significant personal decisions."\textsuperscript{82} Ambuel and Rappaport's results confirm, in significant part, those of Catherine Lewis. Lewis previously found when comparing

\begin{itemize}
  \item \textsuperscript{72} See id at 1917.
  \item \textsuperscript{74} See id at 330-31.
  \item \textsuperscript{75} See Michael J. Dolgin, et al, \textit{Caregivers' Perceptions of Medical Compliance in Adolescents with Cancer}, 7 J Adolescent Health Care 22 (1986).
  \item \textsuperscript{76} Id at 25-26.
  \item \textsuperscript{77} Id at 26.
  \item \textsuperscript{78} Id.
  \item \textsuperscript{79} Bruce Ambuel and Julian Rappaport, \textit{Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion}, 16 Law & Hum Behav 129, 147 (1992).
  \item \textsuperscript{80} Id at 148.
  \item \textsuperscript{81} Id.
  \item \textsuperscript{82} Id at 149, 151.
\end{itemize}
adolescent and adult pregnancy decision making that adolescents do not differ from adults "in their knowledge of the legality and confidentiality of abortion, nor do they make pregnancy decisions on the basis of legal misinformation." Based on her findings, Lewis concluded that adolescents were no less capable than adults of "imagining various effects on their own lives of the pregnancy decision."

The preceding review of the literature suggests several important implications. First, the construct of decisional capacity is complex and no single indicator, such as chronological age, appears to be a reliable and adequate measure for capacity. As Ambuel and Rappaport observed, there is no "'bright line' reliably distinguishing legally competent and incompetent minors." Second, presumptive decisional incapacity for adolescent patients appears to have no empirical basis to sustain it. In this regard, "legal policy has often been grounded on assumptions that do not withstand empirical scrutiny or for which no empirical evidence exists." Third, the presence of a trusted adult during an adolescent's decision-making process is important, regardless of whether the adolescent agrees with the adult's input or opinion. Although studies suggest adolescent susceptibility to parental influence, "adolescents are not indiscriminate about when they challenge parental authority," as Scherer discovered. Collectively, this compilation of scientific study contributes to framing future research for adolescent decision making to improve understanding of the concept of decisional capacity and the process of decision making in a myriad of medical care contexts. Additional research is desirable for determining how legal policy should be shaped. Consequently, decisional autonomy is an issue "overarching" the area of medical decision making and adolescent patient care.

Despite the current compilation of scientific study that informs understanding about adolescent capability for medical decision making, physician perceptions and practices with adolescent patients have not been explored heretofore.

84. Id at 452. See also Preston A. Brimer, Suzanne J. LaFleur and Amy J. Whitehead, *Evaluating Juveniles' Competence to Make Abortion Decisions: How Social Science Can Inform the Law*, 5 U Chi L Sch Roundtable 35, 50 (1998) (encouraging study of "adolescents and adults who are facing the stress and consequences of real treatment decisions" to determine "competence and the influence of judgment factors" that are based on data from valid samples).
85. Ambuel and Rappaport, 16 Law & Hum Behav at 148 (cited in note 79). See also Lexcen and Reppucci, 5 U Chi L Sch Roundtable at 103 (cited in note 3) (reasoning that "the bright line of adulthood cannot be distinguished biologically and that maturation of the normal central nervous system continues well beyond the age of 18").
87. Scherer, 15 Law & Hum Behav at 447 (cited in note 14).
88. As other researchers reprove, "policies should not be based on anecdotal observations and cultural presumptions about adolescents." Marilyn Jacobs Quadrel, Baruch Fischhoff and Wendy Davis, *Adolescent (In)vulnerability*, 48 Am Psychol 102, 111 (1993).
Bioethicists have expressly assumed that adolescents possess a level of decisional capacity not presently presumed by law and, accordingly, that physicians "[involve] minors in decision-making about their care to a greater extent" than required by law.\textsuperscript{90} This study, in part, empirically tests that assumption and thus contributes a distinctive dimension to the literature related to adolescent medical decision making.

\section*{IV. Research Design and Methodology}

The objectives for this study were three-fold: (1) to determine whether physicians believe that adolescent patients are decisionally capable; (2) to determine whether physicians approach medical practice with adolescent patients as though they are decisionally capable; and (3) to determine whether physicians perceive that adolescent patients benefit from the presence of a trusted adult during the decision-making process. Physicians for the study were randomly selected from three of the major health care systems in Pittsburgh, Pennsylvania—UPMC Health System, St. Francis Health System, and Mercy Health System. The physician sample was comprised of three primary care specialties, pediatrics, family practice, and internal medicine.

\subsection*{A. Data Collection and Response Rate}

A two-step approach was employed with regard to the research procedure. A four-page questionnaire with fifty-four items was mailed to 423 physicians with an attached cover letter and postage-paid, self-addressed envelope. Each cover letter was personalized to the individual physician and personally signed. Following the initial response deadline, another questionnaire was mailed to nonrespondent doctors along with a personalized reminder note. The postage-paid, self-addressed envelopes enclosed with each mailing were coded with an identifying number. The identification coding was approved by the Institutional Review Board with the stipulation, which was complied with, that the identifying marker be disposed of once the envelopes were opened to record the data. Employing variables used in adult decisional capacity assessments, a five-point Likert scale ranging from strongly agree to strongly disagree measured physician responses.

Of the 423 questionnaires mailed, 147 physicians responded that they do not treat adolescent patients, leaving 276 physicians potentially eligible for the research pool. Of the potentially eligible physicians, 173 completed questionnaires, resulting in an overall response rate of 62.7 percent. A higher response rate was achieved than originally expected. Although the first mailing yielded

\textsuperscript{90} See Allen E. Buchanan and Dan W. Brock, \textit{Deciding for Others: The Ethics of Surrogate Decision-making} 216-17 (Cambridge 1989).
only 43.8 percent, the second mailing increased the overall return. With respect
to specialties, pediatricians comprised the highest response rate with 77.1 per-
cent, not surprising given the concentration on adolescent patients. Response
rates for family practice and internal medicine were 57.9 percent and 43.9 per-
cent, respectively. Due to the overall response rate, a third procedural step of
telephoning and interviewing each of the remaining nonrespondent physicians
was not employed because of the pressing demands of medical practice and the
unlikelihood that additional attempts at communication would result in a higher
response rate than the one already achieved.

B. DEMOGRAPHICS OF THE STUDY POPULATION

Of the 173 total physicians, 63.0 percent (n=109) indicated they were male
and 35.3 percent (n=61) that they were female. One plausible reason for the
slight disparity in gender response may be the male-female ratio in the practice
of medicine generally.\textsuperscript{91} Of the respondent physicians, 79.8 percent (n=138)
were Caucasian, 9.8 percent (n=17) Asian/Pacific Islander, 1.7 percent (n=3)
African American, and 0.6 percent (n=1) Hispanic/Latino, representing the
overall population from which this sample was drawn.\textsuperscript{92} With regard to age, 71.7
percent (n=124) were between the ages of thirty and fifty, with 13.9 percent
(n=24) between the ages of fifty and sixty, and 8.7 percent (n=15) over sixty
years of age. The median was forty-five years. On average, physicians in this
study have eleven to twenty years of experience, and two thirds devote at least
half of their practice to caring for adolescent patients. [Table 1 shows the demo-
graphics for the physicians included in this study.]

\textsuperscript{91} See Report of the Task Force on Women in Academic Medicine, University of Pittsburgh (June
Physicians: Results from the Women Physicians’ Health Study}, 159 Archives Internal Med 1417 (1999) (reporting
that although women physicians generally report career satisfaction, almost half would choose a different
specialty).

\textsuperscript{92} National demographics for pediatrics, family practice, and internal medicine compiled and
maintained by the American Medical Association (April 2000). Also state demographics for pediatrics,
family practice, and internal medicine compiled and maintained by the Pennsylvania Medical Society
(2000).
<table>
<thead>
<tr>
<th>Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>63.0% (n=109)</td>
</tr>
<tr>
<td>Female</td>
<td>35.3% (n=61)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>1.7% (n=3)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>9.8% (n=17)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>79.8% (n=138)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>0.6% (n=1)</td>
</tr>
<tr>
<td>Other</td>
<td>1.2% (n=2)</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 30</td>
<td>2.3% (n=4)</td>
</tr>
<tr>
<td>31-40</td>
<td>31.8% (n=55)</td>
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<tr>
<td>41-50</td>
<td>37.6% (n=65)</td>
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<tr>
<td>51-60</td>
<td>13.9% (n=24)</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>8.7% (n=15)</td>
</tr>
<tr>
<td><strong>Age of Oldest Child (years)</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 1</td>
<td>4.0% (n=7)</td>
</tr>
<tr>
<td>2-5</td>
<td>12.1% (n=21)</td>
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<td>6-12</td>
<td>17.3% (n=30)</td>
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<td>13-18</td>
<td>15.0% (n=26)</td>
</tr>
<tr>
<td>&gt; 18</td>
<td>27.7% (n=48)</td>
</tr>
<tr>
<td><strong>Years of Medical Practice</strong></td>
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<tr>
<td>≤ 10</td>
<td>31.2% (n=54)</td>
</tr>
<tr>
<td>11-20</td>
<td>34.1% (n=59)</td>
</tr>
<tr>
<td>21-30</td>
<td>18.5% (n=32)</td>
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<tr>
<td>31-40</td>
<td>6.9% (n=12)</td>
</tr>
<tr>
<td>&gt; 40</td>
<td>3.5% (n=6)</td>
</tr>
<tr>
<td><strong>Percentage of Practice Direct Adolescent Patient Care</strong></td>
<td></td>
</tr>
<tr>
<td>≤ 25</td>
<td>16.8% (n=29)</td>
</tr>
<tr>
<td>26-50</td>
<td>71.7% (n=124)</td>
</tr>
<tr>
<td>51-75</td>
<td>1.2% (n=2)</td>
</tr>
<tr>
<td>76-100</td>
<td>3.5% (n=6)</td>
</tr>
</tbody>
</table>

Note: Total percentages do not equal 100 percent due to calculation with missing data included.
C. STATISTICAL METHODS

With regard to statistical methods, bivariate analysis was employed to determine associations and differences in responses to various items by subsets of physicians, for example by specialty. To examine differences between specialty groups concerning response tendencies to specific questions, t-tests were used to measure any meaningful differences, allowing for a determination to be made about the probability of differences between those populations, such as pediatrics and family practice, from which the samples were drawn. Additionally, a Pearson correlation was done regarding perception and practice variables. Statistical significance for the correlations was set at greater than .400. (.400 to .600 indicates a moderate correlation; greater than .600 indicates a strong correlation.)

V. REPORTED FINDINGS AND INTERPRETATION OF RESULTS

A. RESEARCH QUESTION #1: DO PHYSICIANS BELIEVE THAT ADOLESCENT PATIENTS ARE CAPABLE OF MEDICAL DECISION MAKING?

The majority of physicians (more than 50 percent) in the study reported that adolescent patients understand information about medical treatment and conditions, engage in rational deliberation during the decisional process, and communicate choices and concerns clearly. There were moderate correlations between physician responses concerning beliefs about adolescent rational deliberation and understanding of information. Notably, more than four fifths of physicians (86.7 percent, n=150) agreed that adolescent patients demonstrate an ability to understand information about their medical condition and treatment. More pediatricians than family practitioners and internists believed that adolescent patients are capable of understanding information related to medical care. This indicates that pediatricians may project a demeanor, style, and comfort level conducive to conversing with young patients, compared with family practitioners and internists who largely treat adult patients. Remarkably, interpersonal style and rapport are not lost on adolescent patients, who are discerning consumers of health care and seek out providers "who are competent, warm, compassionate, unpretentious, nonjudgmental, and willing to respect confidentiality."93

The majority of physicians in this study (58.4 percent, n=101) reported that

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adolescent patients are able to communicate their concerns and choices. This is an important finding because it reinforces previous research with adolescent patients, whom researchers found capable of communicating their concerns cogently when seeking health care providers and identifying desirable characteristics of health care providers.94 The ability to understand information about medical care entails the capability to understand causal relations and the probability of outcomes.95 According to Paul Appelbaum and Thomas Grisso, it involves the idea "that persons who cannot understand what they have been told about a treatment are not competent to decide whether to accept or reject it."96 Indeed, there appears to be a link between physician capability to converse with patients, adolescents or adults, about their medical care and effective patient understanding of that care.97 As Jay Katz counseled, "How to converse [with patients] must be taught just as thoroughly as principles of surgery and medicine."98 Other researchers have found that "physicians can learn to modify their communication style."99

Moreover, approximately half of the physicians (50.9 percent, n=88) agreed that adolescents demonstrate rationality when deliberating their medical care. This finding lends support to prior research, concluding that adolescents demonstrate presence of mind and logic when making a serious and often emotionally challenging decision such as medical treatment.100 This conclusion corroborates findings of other researchers who determined that adolescents decide to seek health care providers and maintain appointments with an intentionality and logical deliberation that they had been assumed to lack.101 There was also a strong correlation between physician responses indicating their beliefs about adolescent rational deliberation when deciding medical treatment and adolescent patient ability to engage in mature judgment about the consequences of a medical treatment decision (.668, p=.000).102 One plausible explanation for the correlation in the findings may be related to physician perception of maturity. A measured and calculated weighing of information during a deliberative process has been linked to maturity.103 If physicians perceive an adolescent as mature by

96. Id.
97. Paul V. Trad, The Ability of Adolescents to Predict Future Outcome, 28 Adolescence 533, 537 (1993) (assessing that "[d]ecision-making skills may also be influenced by the sophistication of other skills, such as communication").
100. Scherer, 15 Law & Hum Behav at 444 (cited in note 14).
102. Physicians were equivocal regarding adolescent ability to exercise mature judgment about medical treatment, as 32.9 percent (n=57) agreed that adolescents are capable of exercising mature judgment about medical treatment, 31.2 percent (n=54) were undecided, and 33.5 percent (n=58) disagreed.
103. See Lexcen and Reppucci, 5 U Chi L Sch Roundtable at 63-64 (cited in note 3). See generally
virtue of his or her demeanor and discourse, they may be more likely to accept the adolescent patient's ability to deliberate rationally. Although maturity, like decisional capacity, is an amorphous concept, it has nonetheless become a beacon in law and policy for recognizing adolescent decisional ability. Commentators have attempted to define this enigmatic quality as “the ability to resist pressure from others to engage in behavior that is contrary to one's own wishes” and “free from social influences.”

In addition to variables used for competency assessments, the study also examined those variables commonly associated with adolescence, such as risk taking, emotional fluctuations, and susceptibility. With regard to risk taking, less than half of the physicians (41.0 percent, n=71) thought that adolescent patients were prone to greater risk taking in medical decision making than young adults. Adolescents' perception that they are invulnerable to harm has been used to justify paternalistic legal policy approaches to adolescent patient care, including barriers to autonomous decision making for medical care. Other researchers have reported that, while adolescents seem prone to risky behavior due, in part, to a desire for freedom and control, such risk taking is “neither simple nor unidimensional” and risk-taking prevalence actually evidences thoughtfulness by adolescents with respect to the types of risks taken and their consequences. Indeed, existing research is contrary to the unsubstantiated view that adolescent risk taking is mindless, aimless, or mere sensation seeking. Several researchers have further found when comparing adolescents and adults that the risk-taking tendency of adolescents did not exceed that of adults. In fact, others report that the perception of “invulnerability is no more pronounced among adolescents than among adults” and that “the claim that this error in logic [based upon invulnerability] is more characteristic of adolescents than adults” is unsubstantiated. Likewise, Paul V. Trad studied adolescent risk taking, concluding that

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105 Laurence Steinberg and Elizabeth Cauffman, Maturation of Judgment in Adolescence: Psychosocial Factors in Adolescent Decisionmaking, 20 Law & Hum Behav 249, 253 (1996). See also Lexcen and Reppucci, 5 U Chi L Sch Roundtable at 75 (cited in note 3) (cautioning that "the nature and development of maturity among adolescents is poorly defined by empirical evidence").


107 Id at 157-58.

108 Id at 157.


adolescents "may not engage in significantly more risks than adults"; instead, they simply may possess a "different conception of risky behavior" with "decision-making skills [that] differ from those of adults."

More than half of the physicians (54.9 percent, n=95) in the study reported that adolescent patients are not necessarily prone to greater risk taking in medical decision making than young adults. This finding comports with those of Trad and others, and provides a basis for research related to how adolescents perceive risk in medical care environments.

Other variables associated with decisional capacity are the conveyance of a stable set of values and emotional stability. Physicians in the study were somewhat equivocal when viewing adolescent patients as capable of conveying their values and demonstrating emotional stability when discussing and deciding their medical care. There was a moderate correlation between this response and physician views toward rational deliberative ability of adolescent patients (.423, p=.000), suggesting a possible link between physician judgment about the nature of an adolescent's values and assessment of an adolescent's emotional state, including biases that may shape physician attitudes. Perceived irrationality in an adolescent's judgment may be adjudged by a physician as emotional instability, yet irrational decision making does not equate with decisional incapacity, as emphasized in the realm of adult patient care. Notably, this finding coincides to some extent with previous research finding that moodiness, though more prevalent in adolescents, is not measurably different between adolescents and young adults in its impact on quality of decision making. It is fair to state that although stress and fluctuating hormones prompt rapid emotional changes in adolescents, adults are equally affected by and susceptible to mood swings yet are still able to maintain decisional capability. It is also fair to say that stress inherent in a medical treatment environment is likely to affect anyone's decisional ability, regardless of age or life experience. It seems reasonable, then, that an elevated state of emotion may be attributable to medical decision making that compromises any decision-making autonomy. However, more research is necessary to determine the level of emotional fluctuation, whether such fluctua-

111. Trad, 28 Adolescence at 550 (cited in note 97).
112. Id. See Shapiro, et al, 21 J Adolescence at 143 (cited in note 106) ("Adolescents differ in both the extent to which they take risks, and in their reason for engaging in risky behaviors" (emphasis in original)).
113. 37.0 percent (n=64) agreed, 34.7 percent (n=60) were undecided, and 26.1 percent (n=45) disagreed.
114. 45.7 percent (n=79) agreed, 26.6 percent (n=46) were undecided, and 25.5 percent (n=44) disagreed.
115. See Brock and Wartman, 322 New Eng J Med at 1596 (cited in note 5).
116. Steinberg and Cauffman, 20 Law & Hum Behav at 261 (cited in note 105).
117. See also Mann, et al, 12 J Adolescence at 275 (cited in note 66) (observing that "like all humans, adolescents do not consistently behave as competent decision makers, particularly when facing conflictual, stress-arousing choices," consequently, "adolescents may sometimes show less competence in decision-making than their real potential and capability").
tion impairs decisional ability, and the nature and extent of emotional fluctuation among adolescent and adult samples within a medical care setting.

Similarly, susceptibility to external influence has been closely related to perceptions about adolescent decision making. In fact, 92.5 percent (n=160) of the physicians surveyed responded that adolescent patients are susceptible to external influence. However, as other researchers have determined, "it is not entirely clear whether adolescents actually do adopt the parents' choice or whether they are maintaining their original decision but losing confidence that it is the best choice." Yet physicians may believe that adolescents' susceptibility to influence is no more than the actual susceptibility of adult patients. As Scherer discovered, adolescents appear "comparable to young adults in their reactions to parental influence in some medical treatment decision circumstances." As previously noted, the quality and quantity of adult influence may vary from one treatment decision to another, an aspect this study did not examine. However, other researchers have found that while adolescents appear generally deferential to parents' wishes, "[a]dolescents are more likely to resist parental influence when the consequences or gravity of the decision has serious implications for the adolescents' health." It further seems plausible that adults, especially parents, exert influence over their children into and throughout adulthood, but a comparison between the influential impact of parents and family on adolescents versus adults has not been made. As Scherer similarly noted, "adolescents are just as likely as children and young adults to change their treatment choice when faced with parental pressure to do so," suggesting that adolescent patients should not be singled out and "excluded from making treatment decisions on the presumption that they lack the requisite capacities for volition."

Remarkably, physicians were also somewhat equivocal when reporting whether they believe that adolescent patients possess the capacity to determine their own best interests. "Best interests" is largely devoid of substantive meaning, despite its ubiquitous usage in law and psychology. According to N. Dickon Reppucci and Catherine Crosby, lack of scientific knowledge concerning adolescent development and family functioning renders what is in the best interests of an adolescent indeterminate. A best interests inquiry lends itself to a

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118. Scherer and Reppucci, 12 Law & Hum Behav at 132 (cited in note 63).
120. Scherer and Reppucci, 12 Law & Hum Behav at 136 (cited in note 63). See also Scherer, 15 Law & Hum Behav at 444 (cited in note 14) (highlighting adolescent "quality of deliberation regarding parental influence").
121. See also Trad, 28 Adolescence at 548 (cited in note 97).
122. Scherer, 15 Law & Hum Behav at 442 (cited in note 14).
123. Id at 445.
124. 45.0 percent (n=78) agreed, 27.2 percent (n=47) were uncertain, and 26.1 percent (n=45) disagreed.
125. Reppucci and Crosby, 17 Law & Hum Behav at 5 (cited in note 89). As these commentators explain, "the difficulty in making legal determinations of what is in the best interests of children reflects
subjective, value-laden assessment rather than an objective, value-free assessment. It is also unpredictable because it is usually contingent on changing circumstances as well as short, versus long-term, consequences. The indeterminacy of best interests as a concept is also closely allied with evolving social and cultural norms, which also result in legislative indeterminacy of best interests. Such indeterminacy is apparent in legal proceedings such as custody disputes, court-authorized abortions for adolescents, and adolescent refusal of medical treatment, to name a few examples. While it is difficult to determine with either accuracy or adequacy the best interests of any adolescent, the concept’s vitality is not disputed—illustrated by the United States Supreme Court’s invocation of the “free-ranging” best interests standard in Troxel v Granville, wherein the Court invalidated a Washington law that permitted non-parents to petition for visitation rights with children and adolescents. Present legal policy assumes that adolescents are incapable of determining their own best interests. However, one fourth of the study’s physicians reported that adolescent patients demonstrate an ability to determine their own best interests for medical care. This finding suggests that the long-standing societal and legal supposition that adolescents are incapable of determining their best interests warrants closer scrutiny. Further research is necessary to examine adolescent interests in various treatment circumstances in order to determine the interests at stake and how these interests should be weighed and balanced. [Table 2 shows physician beliefs about variables related to adolescent decisional capability for medical care.]

society’s desire to recognize and preserve heterogeneity of upbringing, plurality of ideas, and diversity of values. In part, it is society’s respect for the moral indeterminacy of children’s best interests that results in legal indeterminacy.” Id (emphasis in original).


127. See Lampert v Wicklund, 520 US 292, 293, 297 (1997) (upholding state parental notice requirement that allows judicial waiver of notice based upon a finding that it would not be in the adolescent’s best interest).

128. In re Rena, 705 NE2d at 1156-57 (1999) (finding that the adolescent patient’s testimony regarding her reasons why she wanted to refuse a blood transfusion was pivotal to determining her best interests).

129. 120 SCt at 2054 (2000). See id at 2066 (Souter, concurring). Accord 120 SCt at 2073 (Stevens, dissenting) (acknowledging the “entirely well-known best interests standard”).

130. Id at 2061-65.
Table 2 Physician Beliefs About Adolescent Patient Decisional Capability

<table>
<thead>
<tr>
<th>Variables</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to understand information about medical treatment</td>
<td>86.7% (n=150)</td>
<td>5.8% (n=10)</td>
<td>5.8% (n=10)</td>
</tr>
<tr>
<td>Ability to communicate concerns and choices</td>
<td>58.4% (n=101)</td>
<td>17.3% (n=30)</td>
<td>23.1% (n=40)</td>
</tr>
<tr>
<td>Ability to rationally deliberate</td>
<td>50.9% (n=88)</td>
<td>28.9% (n=50)</td>
<td>18.0% (n=31)</td>
</tr>
<tr>
<td>Ability to exercise mature judgment</td>
<td>32.9% (n=57)</td>
<td>31.2% (n=54)</td>
<td>33.5% (n=58)</td>
</tr>
<tr>
<td>Greater risk taking in medical care than adults</td>
<td>41.0% (n=71)</td>
<td>26.0% (n=45)</td>
<td>28.9% (n=50)</td>
</tr>
<tr>
<td>Ability to demonstrate emotional stability when deciding medical care</td>
<td>45.7% (n=79)</td>
<td>26.6% (n=46)</td>
<td>25.5% (n=44)</td>
</tr>
<tr>
<td>Ability to convey stable set of values</td>
<td>37.0% (n=64)</td>
<td>34.7% (n=60)</td>
<td>26.1% (n=45)</td>
</tr>
<tr>
<td>Susceptibility to external influences</td>
<td>92.5% (n=160)</td>
<td>4.0% (n=7)</td>
<td>1.7% (n=3)</td>
</tr>
<tr>
<td>Ability to determine own best interests</td>
<td>45.0% (n=78)</td>
<td>27.2% (n=47)</td>
<td>26.1% (n=45)</td>
</tr>
</tbody>
</table>

Note: Total percentages do not equal 100 percent due to calculation with missing data included.

Physicians were also asked to identify factors that inform and influence their perceptions of adolescent decisional capacity for medical care. Physicians were asked to place checkmarks by relevant listed factors, which included experience with adolescent patients, personal/religious values and views, experience with one’s own teenagers, and “other,” whereby a physician could identify by writing on a blank line any factor not listed in the questionnaire that influences and informs his or her perception of adolescent decision-making capability for medical care. Physicians could select one factor, multiple factors, or no factors. Specifically, 94.2 percent (n=163) identified experience with adolescent patients as an influencing factor, 35.3 percent (n=61) indicated personal/religious values and views, with 37.0 percent (n=64) specifying experience with their own teenagers. Another 4.0 percent (n=7) wrote in “experience with other teens.” Although these factors are important to understanding the influences that shape physician
judgment, further research should explore the nature and extent of these factors. [Table 3 illustrates the factors that influence physician beliefs about adolescent medical decision making.]

Table 3 Influencing Factors that Inform Beliefs

<table>
<thead>
<tr>
<th>Experience with Adolescent Patients</th>
<th>94.2% (n=163)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own Teenagers</td>
<td>37.0% (n=64)</td>
</tr>
<tr>
<td>Personal/Religious Values</td>
<td>35.3% (n=61)</td>
</tr>
<tr>
<td>Experience with Other Teenagers</td>
<td>4.0% (n=7)</td>
</tr>
</tbody>
</table>

B. RESEARCH QUESTION #2: DO PHYSICIANS APPROACH MEDICAL PRACTICE WITH ADOLESCENT PATIENTS AS IF ADOLESCENTS ARE DECISIONALLY CAPABLE?

To determine physician practices with adolescent patients, the study employed a six-point Likert scale ranging from “always” to “never.” Internal consistency was achieved between physician perceptions of decisional capacity and their practices. A majority of physicians reported that they approach adolescent patient care as though adolescents are decisionally capable. [Table 4 shows physician responses to practice variables related to adolescent patient care.] Specifically, 96.0 percent (n=166) involve adolescent patients in the informed consent process, with no physician reporting noninvolvement of adolescent patients in the decision-making process. When asked whether they involve adolescent patients in the informed consent process in the absence of a parent or guardian, 73.5 percent of physicians (n=127) reported that they do. Interestingly, t-tests revealed meaningful differences between the responses of internists and those of pediatricians (p=.002). A possible explanation may be that pediatricians routinely treat adolescent patients and are more likely to focus on adolescent ability for decision making than internists, who may approach informed consent with adolescent patients from an adult patient paradigm. Approximately three fourths of physicians (76.9 percent, n=133) also reported that they involve a parent or guardian only after securing consent from an adolescent patient.
When asked whether they honor the adolescent patient's decision despite conflict with the decision of a parent or guardian, about two thirds of physicians (70.6 percent, n=122) reported that they do honor the adolescent patient's decision while only 18.5 percent (n=32) do not. A moderate correlation emerged between responses to this question and physician responses to involving adolescent patients in the informed consent process without a parent or guardian (.497, p=.000) and involving a parent or guardian in the adolescent decision-making process only with the adolescent's consent (.631, p=.000). Physicians reported that factors influencing their judgment for honoring adolescent patient decisions include seriousness of medical condition (68.8 percent, n=119), therapeutic value of treatment (63.6 percent, n=110), concerns for the adolescent's circumstances (69.9 percent, n=121), degree of maturity (72.3 percent, n=125), and degree of risk (6.9 percent, n=12). [Table 5 shows the factors that influence
physician judgment about honoring adolescent patient decisions along with their responses.] Physicians also reported that although they are seldom challenged in their judgment about honoring adolescent patient wishes, parents or guardians comprise the major source of challenge (28.9 percent, n=50).

Table 5 Factors for Honoring Adolescent Decisions

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of Maturity</td>
<td>72.3% (n=125)</td>
</tr>
<tr>
<td>Adolescent Circumstances</td>
<td>69.9% (n=121)</td>
</tr>
<tr>
<td>Seriousness of Condition</td>
<td>68.8% (n=119)</td>
</tr>
<tr>
<td>Therapeutic Value of Treatment</td>
<td>63.6% (n=110)</td>
</tr>
<tr>
<td>Other—Degree of Risk</td>
<td>6.9% (n=12)</td>
</tr>
</tbody>
</table>

There were statistically significant differences in responses by internists and pediatricians (p=.003). Internists appear less likely to honor an adolescent patient's decision in the event of conflict with a parent or guardian, revealing a conservative approach toward adolescent medical decision making. However, this approach may have less to do with internists' assessment of adolescent patient decisional capacity and more to do with external factors, such as the potential for challenge by a parent or guardian; t-tests also revealed a meaningful difference between internists and pediatricians (p=.035) regarding the source of challenge to their judgment about adolescent patient decision making. Internists revealed that, as a specialty group, they have been challenged more frequently than pediatricians, providing a plausible explanation for the cautious stance.

Approximately two thirds (63.6 percent, n=110) of physicians reported that they have honored adolescent patient decisions to choose or refuse medical treatment for a non-life-threatening condition, demonstrating a moderate correlation (.573, p=.000) to their responses that they honor adolescent patient wishes even when confronted with conflict by a parent or guardian. About two thirds (60.7 percent, n=105) of physicians reported that they have not honored adolescent patient wishes about life-threatening conditions, although the finding potentially stems from the nature of primary care. (Physicians in this study are less likely to care for adolescent patients with critical illnesses.)

Moreover, the vitality of confidentiality as a cornerstone for the physician-patient relationship is embraced by the Hippocratic Oath, as well as by codes of medical ethics and licensure statutes. Confidentiality is believed to facilitate candor and uninhibited disclosure, which is necessary for accurate diagnoses and treatments. As other researchers have found, "verbal reassurances of privacy will encourage [adolescents] to reveal more truthful histories."^^131 Ninety-two percent (n=159) of physicians reported that they honor the confidences of adolescent patients. This finding not only confirms the preeminent position of confidential-

Adolescent Dedical Autonomy for Medical Care

ity within the physician-patient relationship but also corroborates the results of a study reported in the *Journal of the American Medical Association*, wherein researchers underscored confidentiality as a prominent influential factor for adolescents when seeking medical care and choosing health care providers. Together, these findings suggest a reciprocal relationship for confidentiality perceived by both physicians and adolescent patients, and further bolsters the therapeutic nature of confidentiality that has traditionally been associated with other bioethical principles, including beneficence (promotion of patient health and well-being), nonmaleficence (doing no harm), and autonomy (respect for patient wishes).

The law, likewise, safeguards confidentiality in the physician-adult patient relationship through recourse and remedies for breaches of confidentiality or invasions of privacy, though it omits explicit reference to adolescent patients. This omission may reflect legal deference toward physician judgment or legal policymakers' inattention to the issue. Physicians in this study also reported that certain circumstances may justify disclosure of confidential information concerning an adolescent patient to a third party. Emotional or psychological state, including risk of harm to self or others (84.9 percent, n=147), ranked highest among physicians for justifying disclosure, reinforcing the recommendation by the American Academy of Pediatrics Committee on Adolescence that confidentiality should be breached when "an adolescent is at risk of suicide." According to physicians in the study, other circumstances include seriousness of medical condition (72.8 percent, n=126) and risk of treatment (54.3 percent, n=94). While concerns for family support and harmony rated as a consideration, physicians ranked it considerably less persuasive in justifying disclosure of confidential patient information (36.4 percent, n=63). [Table 6 shows factors that influence physician judgment about disclosing confidential information concerning adolescent patients to third parties.]

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133. But see Mass Ann Laws ch 112, § 12F (Law Co-op 2000).
Table 6 Factors Influencing Disclosure of Confidential Information

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional/Psychological State</td>
<td>75.1% (130)</td>
</tr>
<tr>
<td>Seriousness of Medical Condition</td>
<td>72.8% (126)</td>
</tr>
<tr>
<td>Risk of Recommended Treatment</td>
<td>54.3% (94)</td>
</tr>
<tr>
<td>Family Support/Harmony</td>
<td>36.4% (63)</td>
</tr>
<tr>
<td>Risk of Harm to Self or Others</td>
<td>9.8% (17)</td>
</tr>
<tr>
<td>Adolescent Consent</td>
<td>2.9% (5)</td>
</tr>
</tbody>
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C. RESEARCH QUESTION #3: DO PHYSICIANS BELIEVE THAT ADOLESCENT PATIENTS DERIVE BENEFIT FROM CONSULTATION WITH A TRUSTED ADULT DURING THE DECISION-MAKING PROCESS?

Nearly nine tenths of the physicians (88.5 percent, n=153) reported that they believe adolescent patients benefit from consultation with a trusted adult when deciding their medical care. This is an important finding because it confirms previous researchers' observations that trusted adults, especially parents, are assumed to occupy a significant place in the lives of adolescents.135 Indeed, 90.2 percent (n=156) of physicians believe that a parent or guardian plays a meaningful role in an adolescent's medical decision-making process. Although statistical studies are lacking with respect to assumptions about the role of family in adolescent life generally and adolescent medical decision making particularly, Sanford Leikin has advanced the position that an adolescent patient, especially one confronting a critical illness, “should not be left to deal with this matter alone”136 and “needs the caring support and counseling of family members, physicians, and other health care professionals [that] contribute greatly to reducing the patient’s anxiety, insecurity, and loneliness, thereby enhancing reasoned decision making and providing personal meaning to all involved.”137 Acknowledging the special challenges presented by a family-oriented approach to adolescent and adult medical decision making, other commentators are favorably disposed toward consideration of “the effects of a decision on all family members, their responsibilities toward one another and the burdens and benefits of a decision for each member.”138

135. See Beier, et al, 154 Archives of Pediatrics & Adolescent Med at 331 (cited in note 73) (ascertaining that “connectedness with a trusted adult makes a positive contribution to the life, development, and behaviors of an adolescent”).
136. Leikin, 71 Cancer at 3345 (cited in note 13).
137. Id at 3345-46.
Although a strong majority of physicians in this survey agreed on the importance of a trusted adult in an adolescent’s medical decision-making process, about three fourths of physicians (76.9 percent, n=133) would involve a parent or guardian only after securing the adolescent’s express consent, suggesting that while physicians believe in the benefit of adult guidance, the confidentiality and trust of their adolescent patients are paramount. Moreover, several of the physicians added the caveat that involvement of parents or family members is desirable only if they are supportive, caring, and understanding of the adolescent and his or her needs. They further indicated that, in some instances, parent or family involvement may be more harmful than helpful to the adolescent patient. These findings intimate that physicians might believe that they can fulfill the role of a trusted adult during the adolescent’s decisional process. However, a study published in the *Archives of Pediatrics & Adolescent Medicine* casts doubt on the legitimacy of this intimation, as adolescents did not rank physicians high on the list of trusted adults with whom they would consult. Adolescents’ doubts about whether physicians could fulfill this role raise questions about the nature of the physician-adolescent patient relationship, necessitating more research. Nonetheless, these findings indicate that physicians do not distinguish among patients—adolescent or adult—regarding their primary duties of care and challenge assumptions concerning family functioning that largely remain untested by scientific examination, including manipulation, coercion, and deference within a family dynamic.

Moreover, 88.5 percent of physicians (n=153) reported that they encourage adolescent patients to make decisions about medical care only after consultation with a parent or guardian. Among specialty groups, there was a statistically notable difference in the responses between pediatricians and family practitioners (p=.018). Family practitioners are more likely to encourage adult consultation. This suggests reliance on adult guidance due to regular interaction with adult patients. The notion that adults have more experience with decision making may dominate family practitioners’ interaction with adolescent patients, whereas pediatricians are more likely to compare decision-making ability among adolescents rather than between adolescent and adult patients. An additional reasonable inference is that someone other than a parent or guardian could provide this guidance. Of course, determinations related to who decides the identity of the trusted adult and how the trusted adult is involved in the adolescent patient’s decisional process require further research.
D. PHYSICIAN ATTITUDES TOWARD LEGAL, ETHICAL, AND INSTITUTIONAL GUIDELINES IMPACTING ADOLESCENT PATIENT CARE

The research instrument used for this study also asked physicians about their understanding of current legal, ethical, and institutional requirements and how they view the development of legal policy governing adolescent patient care. [Table 7 shows physician views and attitudes toward legal, ethical, and institutional requirements.] Researchers had hypothesized that the presumptive decisional incapacity underlying the law governing adolescent medical care and its policy exceptions generate confusion among medical practitioners. This hypothesis proved correct. Specifically, when asked whether they are legally required to involve adolescent patients in the informed consent process, roughly, one half of the physicians reported that they were, one fourth responded that they were not, and one fourth expressed uncertainty. The question whether physicians believe they are legally required to secure consent from a parent or guardian for an adolescent patient’s medical treatment yielded similar results. In fact, when asked about factors influencing their decision to secure adult consent, 40.5 percent (n=70) identified apprehension of litigation, 60.1 percent (n=104) ethical requirements, 52.0 percent (n=90) institutional requirements, and 56.1 percent (n=97) simply felt comfortable securing adult consent. [Table 8 illustrates factors identified by physicians that influence their decision to secure adult consent.] In most states, including Pennsylvania, there is an absence of definitive guidance directing physicians to involve adolescent patients in the informed consent process and secure their consent, other than a generic statutory duty to “obtain consent from a patient.” Of course, these statutory provisions are devoid of direction with respect to how informed consent is effectuated with any patient, adolescent or adult.

139. 44.6 percent (n=77) agreed, 38.7 percent (n=67) disagreed, and 11.0 percent (n=19) were uncertain.
Table 7 Physician Views Toward Legal, Ethical, and Institutional Requirements

<table>
<thead>
<tr>
<th>Variables</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law requires informed consent with adolescent patients</td>
<td>56.7% (n=98)</td>
<td>19.7% (n=34)</td>
<td>16.8% (n=29)</td>
</tr>
<tr>
<td>Law requires parent or guardian consent for adolescent patient medical care</td>
<td>44.6% (n=77)</td>
<td>11.0% (n=19)</td>
<td>38.7% (n=67)</td>
</tr>
<tr>
<td>Law should defer to medical judgment regarding adolescent patient decision making</td>
<td>48.0% (n=83)</td>
<td>25.4% (n=44)</td>
<td>21.3% (n=37)</td>
</tr>
<tr>
<td>There should be a legal presumption of decisional capability for adolescent patients</td>
<td>39.9% (n=69)</td>
<td>24.9% (n=43)</td>
<td>30.7% (n=53)</td>
</tr>
<tr>
<td>Would honor adolescent decision for choosing or refusing medical care for non-life-threatening condition only if law expressly permitted it</td>
<td>37.0% (n=64)</td>
<td>23.1% (n=40)</td>
<td>33.5% (n=58)</td>
</tr>
<tr>
<td>Would honor adolescent decision for choosing or refusing medical care for life-threatening condition only if law expressly permitted it</td>
<td>41.1% (n=71)</td>
<td>23.1% (n=40)</td>
<td>30.0% (n=52)</td>
</tr>
<tr>
<td>Institutional policy requires parent or guardian consent for adolescent patient care</td>
<td>58.4% (n=101)</td>
<td>11.6% (n=20)</td>
<td>22.0% (n=38)</td>
</tr>
<tr>
<td>Ethical obligation to involve adolescent patients in the informed consent process</td>
<td>87.2% (n=151)</td>
<td>3.5% (n=6)</td>
<td>2.9% (n=5)</td>
</tr>
<tr>
<td>Ethical obligation to honor adolescent patient decisions</td>
<td>65.9% (n=114)</td>
<td>16.8% (n=29)</td>
<td>8.6% (n=15)</td>
</tr>
</tbody>
</table>

Note: Total percentages do not equal 100 percent due to calculation with missing data included.
Table 8 Factors for Securing Parental Consent

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Medical Practice</td>
<td>69.4% (n=120)</td>
</tr>
<tr>
<td>Ethical Behavior</td>
<td>60.1% (n=104)</td>
</tr>
<tr>
<td>Feel Comfortable</td>
<td>56.1% (n=97)</td>
</tr>
<tr>
<td>Hospital Policy</td>
<td>52.0% (n=90)</td>
</tr>
<tr>
<td>Fear of Lawsuit</td>
<td>40.5% (n=70)</td>
</tr>
<tr>
<td>Adolescent Consent</td>
<td>8.1% (n=14)</td>
</tr>
<tr>
<td>Family Harmony</td>
<td>2.9% (n=5)</td>
</tr>
</tbody>
</table>

Most state laws require parent or guardian consent for the medical treatment of adolescent patients, with exceptions for emergency, emancipation, STD, mental health, substance abuse, contraception, and pregnancy, as discussed previously.141 Yet, over one third of physicians (38.7 percent, n=67) thought consent was not required even in the absence of circumstances satisfying these legally recognized exceptions to presumptive decisional incapacity. Thus, careful consideration should be afforded the informed consent process concerning adolescent patients, including whether physicians resort to legal requirements rather than rely upon their own judgment regarding adolescent decision-making ability. Interestingly, t-tests revealed statistically significant distinctions between pediatrician and internist responses on this point; internists demonstrated heightened inclination toward reliance on legal guidelines. One possible explanation may be that internists, unlike pediatricians in this study, are more focused on the law due to involvement in dispute resolution processes, as internists also indicated they have been formally challenged in their judgment.

Another important finding emerging from the study was physician belief that the law should defer to medical judgment about adolescent decisional capacity,142 although t-tests revealed a significantly notable difference in responses between pediatricians and family practitioners (p=.030) to this question. Pediatricians were more inclined toward legal deference to their judgment. Indeed, pediatricians appear to exercise judgment concerning adolescent decision making based more upon experience and less upon legal constraint or external guidance. This finding is consistent with prior findings in this study, whereby pediatricians reveal heightened proclivity for honoring adolescent patient decisions and for believing that adolescent patients possess decisional capability. One may infer from the finding that pediatricians are more favorably inclined toward legal protection for what they are now doing, which indicates a degree of comfort in making independent judgments about adolescent patient decision making.

141. See text accompanying notes 18-39.
142. 48.0 percent (n=83) agreed, 25.4 percent (n=44) were uncertain, and 21.3 percent (n=37) disagreed.
Less clear are the results regarding physician attitudes toward a legal presumption of decisional capacity for adolescent patients. Responses were equivocal: 39.9 percent (n=69) agreed with it, 30.7 percent (n=53) disagreed, and 24.9 percent (n=43) were undecided. Physicians expressed trepidation toward a legal presumption of adolescent decisional capacity, yet are favorably inclined toward legal deference to medical judgment. This seems to suggest that physicians are uncomfortable with legal interference with their judgment, discretion, and approach to adolescent patient care. In this respect, the finding underscores previous research examining the views of judges who, like the physicians surveyed, were recalcitrant toward a legal presumption that might impede their own moral, ethical, and professional judgment.\textsuperscript{143}

Another plausible explanation for this finding may be physician misunderstanding of how such legal presumptions would operate. For instance, a legal presumption for adolescent decisional capacity in medical care could operate in tandem with physicians who are ethically and professionally inclined to honor adolescent decision making, especially when confronted with conflict by a parent or guardian. Indeed, roughly two thirds of physicians (70.6 percent, n=122) reported that they honor adolescent patient wishes even when confronted with parent or guardian conflict. Also, 65.9 percent (n=114) reported that they perceive an ethical obligation to honor an adolescent patient's decision. Additionally, a presumption of decisional capacity is rebuttable with countervailing evidence resulting from a capacity assessment performed by the attending physician, as with adult patients.

No less important is the finding that slightly less than a majority of physicians (48.0 percent, n=83) believe that the law should delegate to their determination whether an adolescent patient has the decisional capability to decide medical care. This finding reinforces physician beliefs that judgments about adolescent capability are within their realm of expertise and that they should have the freedom to make this determination without being subject to formal challenge or legal liability. Should the law delegate the determination to physician judgment, there would be legal protection for the two thirds of physicians in this study who are inclined to honor adolescent patient decisions regardless of conflict or challenge.

As to whether physicians would honor adolescent patient decisions only if the law expressly permitted it, responses were once again equivocal: 37.0 percent (n=64) agreed, 33.5 percent (n=58) disagreed, and 23.1 percent (n=40) were uncertain. There were, however, statistical differences between pediatricians and family practitioners (p=0.049), as more family practitioners responded that they would honor an adolescent patient's decision to choose or refuse medical treatment for a life-threatening condition only if the law permitted it. This finding

strengthens previous findings in this study that demonstrate a pattern indicating that internists and family practitioners are more dependent on legal directives than are pediatricians and that pediatricians as a specialty group seem more inclined to rely upon their own judgment about adolescent medical decision making.

Agreement by less than half of the physicians (41.1 percent, n=71) that they would honor an adolescent’s decision to choose or refuse life-threatening treatment or surgery only with legal permission has several possible explanations. On the one hand, it may be postulated that physicians would honor an adolescent patient’s decision to refuse treatment for a life-threatening condition regardless of whether the law sanctioned it. In the absence of legal guidance, only 30.0 percent (n=52) of physicians would honor the adolescent patient’s decision. On the other hand, even if the law expressly directed physicians to honor the adolescent patient’s decision making in this situation, one third of them might not honor the adolescent’s decision. With respect to this latter possibility, physicians may be motivated by a myriad of factors including personal and religious values, rather than adolescent capability for the decision. Of the factors that influence physician judgment about honoring adolescent patient wishes, degree of maturity (72.3 percent, n=125), adolescent’s circumstances (69.9 percent, n=121), and seriousness of medical condition (68.8 percent, n=119) ranked among the most prevalent. [Table 5 shows factors that physicians identified as impacting their judgment about honoring adolescent patient decisions.]

In addition to variance among physicians in their views toward legal requirements governing adolescent patient care are variances in their understanding of institutional requirements for securing consent from a parent or guardian for adolescent patient medical treatment. A smaller percentage of physicians indicated uncertainty about institutional policy requirements (11.6 percent, n=20) than indicated uncertainty related to legal requirements (19.7 percent, n=34). Nonetheless, a majority (58.4 percent, n=101) believed institutional policy requires informed consent with adolescent patients, while less than one fourth (22.0 percent, n=38) believed that it was not required. Several reasons may be postulated to explain the variance. First, institutional guidelines related to adolescent patient care may lack clarity, or physicians may not consult the guidelines and simply proceed with adolescent patients based upon their own judgment and experience, as indicated by the vast majority of pediatricians in the study. Second, those responsible for implementing institutional policy (e.g., administrators, ethics committees) may have omitted or declined to address adolescent patient care. Remarkably, of those physicians who do secure parent or guardian consent for adolescent patient medical care, over one half (58.4 percent, n=101) revealed that they do so in order to comply with institutional policy. Third, the variance among physician responses may be attributable to the fact that they are employed by or have staff privileges with any one of three
different health systems and policy among the institutions may vary.

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.

Physicians are more sensitized to how they ought to treat adolescent patients than how they are legally or institutionally required to do so. Ethical guidelines are informed and shaped by both moral and social norms, which further indicates that legal policymakers should more carefully consider these norms in relation to law governing the physician-adolescent patient relationship. In fact, laws now governing adult patient care reflect the social and moral norms of an ethical model for the physician-adult patient relationship, the touchstone of which includes beneficence, nonmaleficence, and autonomy. A strong majority of physicians responded that when they engage adolescent patients in the informed consent process and secure their consent, a perceived ethical obligation guides them, indicating a powerful ethos encompassing adolescent patient care.

E. LIMITATIONS OF THE STUDY

Although this investigation is an important initial step toward understanding physician beliefs about adolescent decisional capacity and approaches toward adolescent decision making, several limitations should be acknowledged. Foremost, this study does not measure adolescent capacity for decision making in medical care but only physician beliefs about adolescent decision-making abilities and their practices with adolescent patients. Because physicians interact with adolescents in intimate and stressful environments and possess training and experience pertaining to patient decisional capabilities, physicians can provide exceptional insight into decision-making capacity. A related, though separate, limitation entails the variables used for this study, which were drawn from capacity assessments with adult patients; although validly included, these factors

144. See Patient Self-Determination Act, 42 USC § 1395 et seq (1992 & Supp 2000). See also Advance Directive for Health Care Act, Title 20 Pa Cons Stat Ann § 5402(a) (West 2000) (declaring that “all competent adults have a qualified right to control decisions relating to their own medical care” subject to societal interests, “such as the maintenance of ethical standards in the medical profession and the preservation and protection of human life”).
may be insufficient for thoroughly understanding adolescent decisional ability.\textsuperscript{145} Physicians were not asked whether they believed these criteria are suitable for adequate measurement of adolescent decisional capacity. Insofar as the criteria used affect physician beliefs about adolescent decision-making ability, this is another acknowledged limitation to the study requiring more research.

Moreover, physician participants in this study were drawn from three medical specialties of primary care—pediatrics, family practice, and internal medicine. Physicians in other specialties, such as oncology or transplantation, that routinely entail critical conditions for adolescent patients were not included in the study and, therefore, a comparative basis regarding the nature of adolescent patient care and effects of conditions confronting adolescent patients is lacking. Medical specialty groups may be distinguishable with regard to their beliefs and practices and, therefore, caution should be taken in extrapolating these findings to other medical specialties that care for adolescent patients. For example, it is possible that non-primary care physicians who regularly treat patients with critical conditions may be hesitant about following adolescent wishes, even in the absence of parent or guardian conflict. Conversely, they may be even more inclined toward respecting adolescent patient wishes. Hence, environments impacting particular medical specialties as well as physician religious or personal views about dying that may affect judgment require further study.

Additionally, the extent to which social norms shape physician attitudes and approaches to adolescent decision making was not examined in this study, although some inferences related to social norms may be drawn from the findings. Primarily, the study does not examine the pervasiveness of social norms and their role in regulating physician views and behavior with adolescent patients. For example, the study does not inquire about whether physicians have reshaped the legal presumption of adolescent incapacity for medical decision making so as to conform to a social norm that recognizes adolescent decision making in other areas, such as juvenile delinquency or tortious activity, or whether physicians choose to depart from a social norm in medical practice and perceive their role, in part, as reshaping social norms distinctly related to adolescent patient care. Closely associated with social norms are regional norms that may likewise affect physician beliefs about and approaches toward adolescent decision making. Because physicians in this study were either employed by or

\textsuperscript{145} See also Noam, et al, 10 Life-Span Dev & Behav at 100 (cited in note 62) (asserting that functional models that are task specific and resolve over time are needed to establish an adequate and encompassing theory of self-development); Steinberg and Cauffman, 20 Law & Hum Behav at 267-69 (cited in note 105) (urging developmental research on maturity that focuses specifically on middle and late adolescence and simultaneously examines both cognitive and non-cognitive factors); Jennifer L. Woolard, N. Dickon Reppucci and Richard E. Redding, \textit{Theoretical and Methodological Issues in Studying Children’s Capacities in Legal Contexts}, 20 Law & Hum Behav 219, 222 (1996) (exhorting a developmental approach to capacity research "using appropriate, ecologically valid target and comparison samples” and explaining that standards with inherent developmental assumptions about adolescent capacities should be “operationalized and investigated from both legal and psychological perspectives").
Adolescent Decisional Autonomy for Medical Care

have staff privileges with large urban medical centers, the results do not reveal anything about rural-urban differences. Physicians included in the study may also proceed from different cultural norms. However, the questionnaire did not elicit information directly related to cultural differences that may influence practice with adolescent patients and their decision making. Accordingly, the results may not be generalized to form conclusions regarding practices in non-urban areas or physicians of varied ethnic or cultural backgrounds.

Furthermore, the study did not ask physicians about perceived cognitive biases toward adolescent decision making, other than factors that may influence their judgment. Heuristic biases, for example, may influence physician judgment about adolescent decisional ability, requiring more sensitive research methods in order to learn how heuristic biases impact and shape physician perception and practice with adolescent patients.

Finally, the study does not inquire into the process by which physicians approach adolescent decision making and how they determine whether to honor an adolescent patient's wishes. A related inquiry is whether physicians perceive that adolescent patients think they are being treated fairly and the degree to which adolescent perceptions of the process impact their ability to make decisions. The study also does not ask physicians to compare and contrast adolescents with child patients regarding the degree and quality of decision making, nor does it inquire into the economic and psychosocial environmental factors of their adolescent patients, which may impact physician views about adolescent decisional capacity as such stressors may impede development of adolescent decisional ability. Nonetheless, the results of the study are important and informative as a leading step toward understanding physician beliefs about adolescent decisional capacity, approaches to adolescent patient decision making, and, ultimately, adolescent decisional autonomy for medical care.

VI. IMPLICATIONS OF THE STUDY

A. IMPLICATIONS FOR FUTURE RESEARCH

As an important initial step toward understanding adolescent decisional capacity within the context of medical care, these results encourage further exploration focusing on variables suitable for adolescent capacity measurement in order to develop a fuller understanding of the issue. Future research could


147. See Dolgin, et al, 7 J Adolescent Health Care at 26 (cited in note 75).

148. Also advocating precise measures for adolescent decision-making capability are Lexcen and Reppucci, 5 U Chi L Sch Roundtable at 105-06 (cited in note 3); Gardner, et al, 44 Am Psychol at 898
benefit by the development and use of measures that more closely approximate functions required by not only adolescent but also adult patient decision making. Physician approaches to assessing capacity also invite closer scrutiny, because varying approaches and attitudes may result in disparity among adolescent—and adult—patient capacity assessments.

A significant finding from this study is an emerging pattern among specialty groups, which shows less reliance on legal or institutional guidance by pediatricians, who tend to opt toward their own judgment in determining adolescent decision-making ability. Yet, this finding suggests that additional research is necessary to determine how pediatricians are trained differently from other primary care physicians, including research into the influence of the medical environment in which they practice. For example, adolescent medicine is a separate and distinct department at most pediatric hospitals, signaling specific needs and treatments for adolescents in contrast to child or adult patients.

Additionally, research should carefully consider social and cultural norms. Specifically, information is desirable concerning how these norms shape physician views and attitudes toward adolescent autonomy in decision making and, in turn, how they affect adolescent patient care, including the informed consent process. Notably, a strong majority of physicians in this study reported that they involve adolescents in the informed consent process; however, questions remain with regard to the procedure for informed consent with adolescent patients. As commentators have noted, “the way choices are formulated and presented, or framed, can have major effects on decisions.” Physicians also agreed on the importance of a trusted adult during the decisional process; yet, the study did not explore who usually fulfills the role of a trusted adult, how the trusted adult is chosen and included in the decisional process, and whether physicians serve in this role. As other researchers have reported, adolescents do not rank physicians among the trusted adults to whom they would turn for guidance and support, raising an issue about the physician’s role in adolescent patient care.

Results from this study also indicate that physicians place a high premium on patient confidentiality and disclose confidential information only in limited


149. See B.W. Stack, Treating Teens with Trust: Practitioners of a Young Medical Specialty Keep Teens Healthy Physically and Mentally, Pittsburgh Post Gazette G1 (March 23, 1999) (discussing the emerging medical specialty that includes 300 board-certified physicians in adolescent medicine across the country).


151. See Beier, et al, 154 Archives of Pediatrics & Adolescent Med at 331 (cited in note 73). As these researchers report, “the fact that fewer than 1% of adolescents in this study think of their physicians as the person they can usually turn to for help and advice gives us, as health care providers, something to think about.” Id.
circumstances, such as endangerment of the adolescent or adolescent patient consent. Because this finding underscores confidentiality as a cornerstone for the physician-patient relationship, further examination of the issue should delve into underlying reasons for its perceived importance by both adolescent patients and physicians, as well as the process for ensuring adolescent patient confidences, how an assurance of confidentiality affects the decision-making ability of adolescent patients, and language conveyed in the process. Other researchers, for example, have found that health care “providers must choose their words with care. For many youths, ‘confidentiality’ meant that the provider had confidence in the patient. ‘Privacy’ and ‘just between you and me’ were better understood.”

Moreover, this study provides a basis for framing research questions for specialized areas of medical practice with adolescent patients. In pediatric oncology, for example, research could be done with regard to physician approaches to palliative care with dying adolescent patients. For example, little is known about how physicians assist adolescents in dealing with both the emotional and physical pain of impending death. Research should explore whether physicians honor adolescent requests to halt or discontinue aggressive care and how physicians approach this discussion with adolescent patients. Results from this study reveal that only 14.5 percent (n=25) of physicians honor adolescent patient wishes regarding refusal of medical treatment for life-threatening conditions; however, this finding is limited. Few, if any, physicians in this study encounter patients in situations where the condition threatens life. There is also a question concerning how life-threatening conditions are defined. For example, does suffering from a severely chronic or other debilitating, though not terminal, illness constitute a life-threatening condition? These questions invite empirical exploration.

Because advance directives—living wills, durable powers of attorney, Do Not Resuscitate (DNR) orders—are widely recognized as instruments for recognizing and honoring patient decisional autonomy, research should likewise examine whether physicians speak with adolescent patients about or encourage adolescent patients to execute advance directives and under what conditions. If physicians do converse with adolescent patients about advance directives, research should address how they approach adolescent patients about advance directives and whether they honor adolescent advance directives. This information is important for informing and shaping policy with regard to whether adolescents should be able, as are adults, to direct their care through a DNR order.

153. Id at 928.
154. For recommendations related to end-of-life care for children and adolescents, see American Academy of Pediatrics, Committee on Bioethics and Committee on Hospital Care, Palliative Care for Children, 106 Pediatrics 351, 352 (2000); American Academy of Pediatrics, Committee on Bioethics, Guidelines on Forgoing Life-Sustaining Medical Treatment, 93 Pediatrics 532 (1994).
and legally execute living wills and durable powers of attorney in health care. \textsuperscript{155} With regard to the latter, important questions should be explored about persons that adolescents designate for proxy decision making, especially if the designated person is a non-family member, and what legal standard should govern the surrogate decision. For adults, substituted judgment, i.e., how the patient would decide his or her own care, rather than best interests, is considered legally appropriate. Of course, adult patients are legally presumed decisionally capable, unlike adolescent patients who are legally presumed decisionally incapable.

Furthermore, results from this study raise issues that require examination in areas of genetic testing, transplantation, and organ donation. A majority of physicians in this study suggest that adolescent patients are decisionally capable. This finding indicates that there are important issues concerning the emotional and psychological consequences presented by genetic testing or risky transplantation procedures, along with a regimen of extensive follow-up care. With respect to organ donation for family or non-family members, there are specific concerns that should be addressed regarding adolescent ability to make an altruistic decision that may provide psychological or emotional benefits, despite physiological risk and parent or guardian objection or lack of assent. Family dynamics, for instance, impact adolescent decision making regarding donation and, therefore, merit consideration by policymakers.

This study found that 88.5 percent of physicians (n=153) believe that adolescent patients should consult with trusted adults during the decisional process, underscoring previous research reporting that adolescents “identified a parent as the person they could turn to for help and advice” \textsuperscript{156} and that “many minors will choose to involve parents in treatment decisions.” \textsuperscript{157} A question for future research would entail the nature and quality of the influence exerted by the trusted adult on the adolescent’s decisional process and what precisely may be attributed to the role of a trusted adult, especially since approximately nine tenths of physicians (92.5 percent, n=160) in this study also reveal that adolescents are susceptible to external influence during the decision-making process.

Lastly, this study provides a basis for exploring physician beliefs about adolescent capacity to determine participation in clinical trials and their altruistic desires that affect their decisions regarding medical experimentation. Because medical experimentation raises contentious issues related to the informed consent process, this is an amenable area for exploration of research questions related not only to the informed consent process with adolescent subjects but also to how physicians apply federal regulatory guidelines for research with minor subjects, including how physicians determine minor increase over minimal risk

\textsuperscript{155} A critique of cases and commentary discussing advance directives for adolescent patients may be found in Hartman, 51 Hastings L J at 1271-86 (cited in note 9).
\textsuperscript{157} See Ambuel and Rappaport, 16 Law & Hum Behav at 150 (cited in note 79).
and how they determine parent consent and adolescent assent. Assent implies acquiescence or agreement with a parent’s determination. However, the process by which physicians approach informed consent warrants further exploration, because physicians may knowingly or unknowingly add a coercive or suggestive element to the process. Such research could inform policymakers concerning revisions to present federal regulatory guidelines and possible promulgation of additional guidelines tailored to adolescent research participants. The current guidelines do not delineate between child and adolescent participants and, accordingly, do not differentiate among decisional capacity levels for understanding, deliberation, and consent or assent to research involvement.

B. IMPLICATIONS FOR LEGAL POLICYMAKING

As noted earlier, decisional capacity is difficult to assess. There is evidence from different types of measures suggesting that adolescents possess a level of decisional ability comparable to young adults, based on criteria used for adult capacity assessments, although more research is necessary before definitive statements may be made. For example, Lois Weithorn and Susan Campbell found adolescents fourteen years and older comparable to young adults in health care decision making. Bruce Ambue and Julian Rappaport found the same age group similar to young adults for pregnancy decision making. The present study found that adolescent patients are believed and treated by physicians as decisionally capable, suggesting that chronological age markers are not necessarily reliable indicators of decisional capacity.

This finding is significant because family practitioners and internists largely treat adult patients and, thus, may approach adolescent patient decision making using the adult patient paradigm as a comparative basis. This finding also suggests that pediatricians as a specialty group engage in independent judgment based upon their own expertise and interaction with adolescent patients rather than on legal or institutional dictates and that their experience shapes their approach to adolescent patient care. If additional research indicates there are no scientifically measurable differences between adolescents and young adults in the nature and degree of decisional ability, then the idea that adolescents should not be precluded from medical decision making on the basis of presumptive incapacity becomes clearer. What is less clear is whether legal policymakers may

159. See Grisso and Vierling, 9 Prof Psychol at 423 (cited in note 6) (reasoning that “the presence of parents who have already agreed to the proposed treatment might produce an increased likelihood of conformity on the part of the minor and further reduce the probability of truly voluntary dissent or veto by the minor”).
160. See Gardner, et al, 44 Am Psychol at 898 (cited in note 3); text accompanying notes 58-84.
161. See Weithorn and Campbell, 53 Child Dev at 1595 (cited in note 60).
162. Ambue and Rappaport, 16 Law & Hum Behav at 148 (cited in note 79).
still decide that there are other compelling reasons for withholding legal privileges for medical decision making from adolescents in general. The supported thesis for this study—that physicians believe adolescent patients are decisionally capable and treat them as though they are decisionally capable—only suggests that adolescents should not be excluded from making treatment decisions on the presumption that they lack requisite decisional capacity. Standing alone, the results from this study may not provide a formidable basis for affording adolescents decisional autonomy for medical care, especially in the absence of adult guidance. Indeed, the study supported the thesis that physicians believe that adolescents derive benefit from consulting a trusted adult during the decisional process.

Furthermore, the quantity and quality of adolescent decision-making capacity in various medical treatment situations should be emphasized. Different treatment settings, such as cancer treatment, may result in adolescents wanting to exercise different levels of autonomy from parental attempts at control. About nine tenths of physicians (92.5 percent, n=160) in this study indicated that adolescents are prone to external influences, including parental influence; however, the questionnaire measured neither quality nor quantity of external influences—only whether adolescent patients are especially prone to them. Thus, more research is needed regarding the sources of influence exerted on adolescents for particular medical treatments and conditions before definitive statements may be reached by social and legal policymakers about the decisional capacity of adolescents to respond to treatment decisions with autonomy from undue external influences.

C. IMPLICATIONS FOR MEDICAL PRACTITIONERS

In addition to assisting further research and shaping legal policy related to adolescent patient decision making, the results from this study are informative for medical practitioners because the findings foster the pursuit of knowledge about adolescent patient care. Specifically, application of the results of this study to physician practice may improve adolescent patient care. For example, physicians in this study believe that adolescent confidences, subject to limited exceptions including patient consent or endangerment, are significant to adolescent patient care. They also believe that a trusted adult plays an important role during the adolescent patient’s decision-making process. This finding implies that physicians believe they could serve as trusted adult counselors for adolescent patients. Such an inference is buttressed by the fact that physicians also indicated that they involve an adolescent patient in the informed consent process without a parent or guardian, that they honor adolescent decisions even when con-

163. See also Grisso and Vierling, 9 Prof Psychol at 420-21 (cited in note 6).
fronted with conflict from a parent or guardian, and that they honor adolescent patient confidentiality. Yet, other researchers have found that adolescents do not regard their physicians as someone to whom they may turn for guidance and advice, meriting more careful consideration and clarification of the physician-adolescent patient relationship.

This study could also serve to facilitate discussions among physicians in different specialties in order to forge a collaborative and consistent approach to adolescent patient care, as this study revealed divergence in approaches between pediatricians and other primary care practitioners. Consequently, these findings signal the need for physicians to communicate and consult with one another regarding adolescent patient care. Physicians could provide support for one another when ethically inclined to honor an adolescent patient's wishes, especially within an acrimonious context where they may be vulnerable to formal challenge. As Sanford Leikin contends, physicians should actively advocate for adolescent patient self-determination when they deem it medically and ethically appropriate. It is also important that physicians treating adolescent patients in primary care specialties learn about and understand how other physicians care for adolescent patients in order to promote meaningful physician-adolescent patient relationships. Paradoxically, the conventional wisdom is that adolescents perceive themselves as more "grown up" than children and prefer family practitioners or internists, rather than pediatricians, as primary care physicians. Yet, results from this study reveal that pediatricians are more likely to treat adolescents like adults by affording them decisional autonomy in medical care. The study further suggests that pediatricians as a group seem more comfortable in conversations with adolescent patients that ease adolescent decision making. As other researchers have found, decision-making ability is enhanced when adolescent patients perceive they are respected and when they feel comfortable and not judged, highlighting the desirability for "health care providers to maximize their adolescent-specific interpersonal skills."

Finally, this study underscores the desirability of educational forums focused on adolescent patient care. Because adolescent patient care presents distinct issues that are not adequately addressed in other areas of health care, national medical associations, such as the American Medical Association, the Institute of Medicine, and the American Academy of Pediatrics, along with state medical organizations, should consider sponsoring conferences and colloquia, appointing task forces and committees to address issues related to adolescent patient decision making, and providing guidance to physicians caring for adoles-

166. Leiken, 71 Cancer at 3346 (cited in note 13).
167. See also Ginsburg, et al, 100 Pediatrics at 927 (cited in note 13) (reporting that, according to adolescents, physicians "should treat [them] more as adults").
168. Id at 929.
cent patients. This, in turn, may facilitate trust and comfort in the physician-adolescent patient relationship by promoting better compliance with treatment regimens, especially when adolescents emphasize these qualities as influential in their decision to seek medical care.  

D. IMPLICATIONS FOR HEALTH CARE INSTITUTIONS

While this study informs legal policy and medical practice with adolescent patients, its conclusions may also educate and guide health care institutions. Because physicians in the study revealed their beliefs about adolescent patient decision-making capability and how they practice medicine with adolescent patients, health care institutions should carefully consider the results of the study when developing and implementing policy. Essentially, institutional policymakers may want to consider a policy premised on a qualified decisional capacity model for adolescent patients, which would allow adolescent patient decision making subject to the attending physician’s assessment that a particular adolescent has diminished capacity for decision making. Alternatively, because decisional capacity seems to defy a single construct, perhaps no presumption of adolescent patient decision making should operate and attending physicians should determine the decisional capability of their adolescent patients on a case-by-case basis, documenting the determination in the medical record. Notably, a majority of physicians in the study indicated that they are seldom challenged in their judgment concerning adolescent patient decision-making capability and that this medical judgment merits deference. These proposed institutional policy approaches may actually be less risky for adolescent patient care than continued allegiance to presumptive decisional incapacity, which falters when confronted by scientific data measuring both adolescent ability and physician perceptions.

Despite the absence of legislative or judicial pronouncements related to adolescent patient decisional capacity, health care institutions may be encouraged to initiate guidelines for physicians treating adolescent patients, addressing adolescent decision-making capability both substantively and procedurally. Indeed, the process (and perceived fairness of the process) for assessing patient decision-making ability may, in some important respects, be as significant as the outcome of the capacity assessment. Not only are physicians seldom questioned in their judgment regarding adolescent patient decision making according to physicians in this study and the dearth of reported cases, but reasoning from reported state court decisions provides support for deference to medical judgment—and to ethics consultants and committees—in resolving issues regarding patient deci-

171. See Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics 134-36 (Oxford 4th ed 1994) (suggesting that assessments of decisional capacity should occur in context, implying that a single standard based on precise measures is neither adequate nor achievable, and thus concluding that decisional competence may be best understood as specific rather than general).
Adolescent Decisional Autonomy for Medical Care

In re Fiori, decided by the Pennsylvania Supreme Court, is exemplary. There, the state high court wisely conceded that judges are not the only (nor the most appropriate) resource for resolving private decisional issues attendant to health care. It seems plausible that judges will continue to defer to medical and institutional expertise in determining patient decisional capacity.

Until legal policymakers carefully consider the issue of adolescent patient decision making, institutional policy could navigate the direction for adolescent patient care. As with adult patient care, institutional policy has led the way in areas of informed consent and refusal of life-sustaining treatment, and the law has followed. Additionally, institutional policy that is based on findings from this study, along with other research in the area of adolescent decision making, would foster knowledge and understanding of institutional policy requirements, of which nearly half of the physicians in this study reported being uncertain. It would also assist with correcting contradictory patterns among medical practitioners, whereby young adult patients are sometimes not afforded decisional autonomy. For example, a health care provider interviewed during the course of this study revealed that young adult cystic fibrosis patients, who are usually cared for by the same physician since childhood, are not determining their own treatment despite ability to decide and communicate a decision. Rather, the attending physician tends to secure consent for treatment from a parent or guardian, hampering the ability for patient autonomous expression. One explanation for this may be that parents or guardians have made decisions for cystic fibrosis patients since childhood and the legal presumption of decisional incapacity that has accompanied the patients through adolescence prolongs distortions in physician perception about decision-making ability—even after the eighteenth birthday, as cystic fibrosis patients are now thriving into and throughout adulthood. A related reason may be that the patient has depended on the family dynamic for decision making and may be reluctant to upset the decisional dynamic in a condition of dependency, indicating the potential need for the attending physician to ensure that the patient's choices are recognized and respected. Consequently, this specialized area of patient decision making warrants closer ex-

172. 673 A2d 905 (Pa 1996). The Pennsylvania Supreme Court has declined to recognize a mature minor rule, leaving it to the state legislature for future consideration. The state high court's decision in Commonwealth v Nixon, 761 A2d 1151 (Pa 2000), is, however, quite narrow and holds only that the court will not recognize the mature minor rule as a defense to parental responsibility for providing adequate medical care for their children and adolescents. In Nixon, Dennis and Lorie Nixon, members of the Faith Tabernacle Church, a religious community that addresses illness through spiritual rather than medical treatment, were convicted of both manslaughter and endangering the welfare of a child after their sixteen-year-old daughter, Shannon Nixon, died from diabetes acidosis, a treatable though incurable condition.

amination. This study provides incentive not only for institutional policies to address adolescent patient decision making but also for discourse among physicians concerning their care and treatment of adolescent, as well as young adult, patients.

E. IMPLICATIONS FOR ADOLESCENT PATIENTS

Adolescent patients may ultimately be the benefactors of this and future studies. In several important respects, the findings heighten awareness of legal treatment of adolescent decision-making responsibility and accountability that extends to other areas. One such area is juvenile delinquency, where adolescents increasingly confront criminal trial with concomitant penal sanction. This study may provide momentum for research on the beliefs and practices of judges, attorneys, and jurors regarding adolescent competency for criminal trial, which entails important constitutional rights. Indeed, this study could garner attention from national policymakers, prompting consideration for legislation that establishes adolescence as an area of the law distinct from that governing younger children and that enables the states to revise, amend, or enact laws that are premised on adolescent decisional capability. Prior to possible Congressional action, a President’s Commission for the Study of Adolescence should be appointed and convened to examine legal and social issues impacting adolescence, representing a significant step toward shaping Capitol Hill policy debates. In addition, state policymakers could either approach adolescent decision making in health care through legislative enactment or promulgation of regulatory guidelines by state departments of health.

Perhaps most potently, social policy is aimed at facilitating individual responsibility and accountability, which entails personal development and fulfillment. Because adolescent decision making implicates self-esteem and self-identity, studies such as this one that steer policy attention toward autonomy may provide a deeper promise that adolescents will be able to extend themselves to the limits of their ability in medical care and beyond. The fact that about three fourths of physicians (76.9 percent, n=133) in this study involve a parent or guardian in the informed consent process only with the adolescent patient’s consent reinforces other research concluding that “sole reliance on adults (some of whom lack competence in decision making) is [not] the best way for adoles-

174. See Thomas Grisso, The Competence of Adolescents as Trial Defendants, 3 Psychol, Pub Pol, & L 3, 26 (1997) (asserting that the “need to proceed with more extensive research on youths’ capacities as defendants is urgent, if we are to assist the law in assuring that adolescents who are tried in criminal courts are prepared to assist counsel and to make decisions in their defense”).

175. For development of federal and state policy proposals for addressing issues regarding adolescence, see Hartman, 51 Hastings L J at 1355-62 (cited in note 9).

176. Id.
Adolescents desire freedom and empowerment, especially in medical situations where any patient, adolescent or adult, may feel powerless, as the study on adolescent compliance with cancer treatment demonstrates. When adolescents perceive they are treated fairly, taken seriously, and shown respect, they relate and interact well with adults in terms of responsible behavior and understanding. Indeed, approaching adolescent patients as decisionally capable, as most physicians have reported in this study, enables adolescents to "feel important, respected, and valued" and "promote better patient compliance with treatment regimens." Thus, the age-old nature versus nurture debate that permeates science and biology, especially prevalent in discourse related to the reported progress of sequencing the human genome, is similarly alive within the context of adolescent patient decision making, as adolescents who believe they are empowered demonstrate a strong sense of self-worth and are more likely to become mature, meaningful decision-makers in medical care.

**VII. CONCLUSION**

Adolescent decisional autonomy is an anomaly though "a work in progress." Thus far, scientific and social scientific study of adolescent medical decision making suggests a level of decisional capacity not presumed by law and that adolescents should not be precluded from medical decision making on the sole basis of purported incapacity. Despite the law's fidelity toward presumptive decisional incapacity for adolescents, there is comparatively little statutory or case law on the subject that supports its justification. Arguably, recognition of adolescent decisional autonomy in other areas, such as juvenile delinquency, belies presumptive incapacity for health care decision making. Most poignantly, respecting adolescent autonomy for medical decision making holds a deeper promise for individual development, independent thought, and self-identity.

While current scientific study of adolescent decisional ability may catalyze legal policy reform, further research in adolescent patient care is a requisite for meaningful and definitive recommendations. As Richard E. Redding rightly recognizes, "While emerging research indicates that young adolescents are probably capable of providing informed consent for treatment, more empirical research and theoretical development are still required if we are to be confident..."
of these findings and also to investigate competence in a wider variety of contexts. This examination of physician perceptions of adolescent medical decision making and practices with adolescent patients is among the first to determine what physicians actually believe about adolescent decisional capacity and how they approach adolescent autonomous decision making for medical care. Remarkably, the reported findings reveal that primary care physicians believe that adolescent patients are decisionally capable, that they approach patient care as though adolescents are decisionally capable, and that they believe adolescent patients benefit from consulting with a trusted adult during the decision-making process.

As previously discussed in this Article, these findings should direct further important research into the following areas: the inclusion of variables for measuring accurately adolescent decisional capacity; adequate decision-making comparisons among child, adolescent, and adult samples in order to discern precise differences in distinct health care contexts; biases such as cultural environment and the nature of medical specialty that may influence and shape physician judgment regarding adolescent patient decision making; and how the decisional process with adolescent patients is effectuated. Also meriting independent examination are the scope and impact of a trusted adult during the decisional process and whether physicians believe that they are appropriately poised to fulfill this role, particularly when prior research with adolescents indicates that a physician is not someone with whom they would choose to consult.

Although an acknowledged limitation of this research is that it does not address adolescent decisional capacity per se, the study nonetheless enhances the literature related to adolescent decision making. Indeed, interpretations and inferences gleaned from these results provide important information about physician perceptions and practices, which, in turn, may guide legal policy impacting adolescent patient care. However, proceeding with extensive examination of adolescent decisional capacity is imperative to assist legal policymakers in assuring that adolescent, like adult, patients are treated respectfully and ethically, as emphasized by a strong majority of physicians in this study. Not only does this research add a measure of empirical and theoretical development for investigating adolescent decisional autonomy in a distinct context, envisaged by Redding and other researchers, but it ultimately provides incentive for continued exploration of the elusive concept that is decisional autonomy.

185. 87.2 percent (n=151).
186. See Grisso, 3 Psychol, Pub Pol, & L at 26 (cited in note 174).