

MEDICAL DECISION-MAKING AND MINORS: ISSUES OF CONSENT AND ASSENT

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ABSTRACT

The physician-patient relationship has been described as an egalitarian partnership in which patients and physicians work together to make healthcare decisions. Although adults receive considerable encouragement to become active participants in medical decision-making, children and adolescents often have little voice in such decisions and are granted limited access to confidential medical care. After a brief discussion of legal perspectives on informed consent, the present review examines the developmental literature on children and adolescents' capacities to make medical decisions that are informed, voluntary, and rational. The purposes and benefits of assent are identified. Remaining questions of how to evaluate capacity and balance parental and minor autonomy are explored.

In recent years, the physician-patient relationship has transformed from one of paternalism into an egalitarian and participatory partnership in which patients and physicians work together to make healthcare decisions (Committee on Bioethics, 1995). Today there is general societal acceptance that "patients have a right to know about their health, to know about available diagnostic and treatment options and their risks and probable benefits, and to choose among the alternatives" (Committee on Bioethics, 1995, p. 315). Informed consent is an essential part of the communication process between physicians and patients. The information provided by physicians about illness and treatment options is vital to patients' decision-making and influences their psychological well-being (Rushforth, 1999).

Although adults receive considerable encouragement to become active participants in healthcare decisions, children and adolescents often have little voice in decisions about their medical treatment (Kunin, 1997; Lidz et al., 1984). As minors, adolescents often are unable legally to provide informed consent and are granted limited access to confidential medical care. Confusion and mixed messages abound about the

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ADOLESCENCE, Vol. 38, No. 150, Summer 2003
Libra Publishers, Inc., 3089C Clairemont Dr., PMB 383, San Diego, CA 92117

abilities and rights of adolescents. The present review examines the developmental literature on children and adolescents' capacities to make medical decisions that are informed, voluntary, and rational.

INFORMED CONSENT: THE CORNERSTONE OF HEALTHCARE

In its simplest form, informed consent is the treatment authorization given by a patient to a physician. Legally, it is an intentional authorization in that it must be given knowingly, rationally, with volition, and without coercion (Grisso & Vierling, 1978; King & Cross, 1989; Scott, 1992). By informed, it is meant that the decision must be based on knowledge of the situation and potential consequences. Consent must be voluntary; it must be volitional and not reflect mere acquiescence. Consent also must be rational, implying that it is rendered by an intellectually competent and mature individual.

Informed consent is more than a legality; it is a moral responsibility on the part of healthcare providers, based in the recognition of individual autonomy, dignity, and the capacity for self-determination (King & Cross, 1989; Kuther, 1999). Consent is not a single event or episode, but a complex process, one feature of the therapeutic alliance between physician and patient (Krener & Mancina, 1994). Both have roles and responsibilities in the consent process. Decision-making power is shared by physicians and patients, with them as partners (American Medical Association [AMA], 1992; Committee on Bioethics, 1995).

AMBIGUITIES IN CONSENT: MINORS

The process of informed consent becomes more complicated when considering minors because there is only limited direct application of the doctrine of informed consent in pediatrics (Committee on Bioethics, 1995). Informed consent only can be given by those with legal entitlement and decisional capacity, otherwise a parent or guardian must provide permission. The fundamental issue in informed consent for minors is a question of how decisions should be made for those who are not fully competent to decide for themselves (Krener & Mancina, 1994). Parents or guardians are entitled to provide permission because they have legal responsibility and, in the absence of abuse or neglect, are assumed to act in the best interests of the child. Part of why consent issues are so difficult with minors is that the best interests of the child are hard to define, and are often subjective. Additional issues include questions of how to define and assess decision-making capacity.

Minors and Consent: Legal Perspectives

In the U.S., state legislation requiring parental consent for medical treatment reflects the conception that minors (those under the age of 18) are incapable of understanding and making decisions about medical treatment (Melton, 1983). The state recognizes that the legal age of majority (age 18) is arbitrary and that there are minors who are competent and others, of legal age, who are not (AMA, 1992); however, legislation is designed to protect minors from the consequences of poor decisions. Minors are viewed as incompetent decision makers with three exceptions: emancipated minors, those seeking medical treatment for certain health problems, and mature minors (Broome & Stieglitz, 1992; Weir & Peter, 1997).

Emancipated minors are those who live independently of their parents. Emancipated minors may consent to medical care, and refuse it, as if they were adults (Kunin, 1997). The criteria for emancipation vary by state, but generally include the following situations: marriage, military service, parental consent (parents who have surrendered their rights and responsibilities), parenthood, judicial order, and financial independence (AMA, 1992; Committee on Bioethics, 1995; Kunin, 1997; Weir & Peter, 1997). Most states have statutes to determine emancipation through a judicial process and some without court involvement.

Minors who do not merit the criteria for emancipation can provide consent for certain problem-related treatments. Most states allow minors aged 13 through 18 to provide consent for some medical care, including contraception, sexually transmitted diseases, pregnancy, alcohol and drug abuse, and psychiatric problems, varying by state (Committee on Bioethics, 1995; Broome & Stieglitz, 1992). The nature of these health issues is such that some minors would choose to go without treatment rather than seek parental consent (i.e., adolescents may not want parents to be aware of the problem). Allowing minors to give consent in these instances ensures unrestricted access to care for those who otherwise might have been deterred from seeking help (Brody & Waldron, 2000).

Mature minors are those who meet the conditions set forth by the mature minor rule, legal doctrine that enables minors who are deemed mature (able to understand the nature and consequences of medical treatment) to consent to or refuse treatment (AMA, 1992; Kunin, 1997; Weir & Peter, 1997). Determination of maturity requires a full assessment of the minor's capacities, as well as his or her understanding of the nature of treatment and the potential consequences. Usually the determination of maturity is left to physicians, except in the case of

termination of pregnancy, where many states require a judge to determine maturity (AMA, 1992). In some states, mature minor legislation extends older minors the authority to provide informed consent for all general medical treatment, with ages varying by state (Scott, 1992). The main difficulty of the mature minor doctrine lies in assessing maturity; there are no firm guidelines for assessing maturity or decision-making capacity (Embree & Dobson, 1991; Kuther, 1999).

Minors and Consent: Developmental Perspectives

Developmental perspectives toward understanding minors' decision-making capacities attempt to determine when minors are cognitively and psychosocially mature enough to provide informed consent. Although standards of competence for providing informed consent are poorly specified by law, they generally are thought to encompass the following abilities: to understand the situation, factual issues, and vital information including possible outcomes; effectively consider the consequences of each alternative; compare alternatives based on one's evaluation of the consequences and an understanding of how each fits within the framework of one's values and goals; and make a voluntary, uncoerced decision (Ambuel & Rappaport, 1992; Embree & Dobson, 1991; Kaser-Boyd et al., 1985; Kuther, 1997).

Minors' capacity to be informed about treatment. Consent must be made with knowledge or understanding. Competent medical decisions require an understanding of the situation at hand, as well as an understanding of health and illness. Children's conceptions of illness are thought to progress developmentally, parallel to developments in cognition (Bibace & Walsh, 1980).

Young children tend to understand illness in global and nonspecific ways (Burbach & Peterson, 1986). For example, they do not differentiate between the symptoms and causes of illness, and view illnesses as transmitted "magically" (Millstein et al., 1981; Perrin & Gerrity, 1981). Young children often perceive illness in a moralistic fashion, as if it is caused by misbehavior (Kister & Patterson, 1980). With advances in cognitive maturity, from older childhood through adolescence, youth develop more advanced conceptions of illness. They begin to conceptualize illness in terms of specific symptoms and diseases, to appreciate the psychological, affective, and social aspects of physical illness, to associate illness with infection and germs, and to demonstrate a more advanced understanding of contagious illness. Children's illness concepts appear to develop systematically and predictably, consistent with cognitive developmental theory. In fact, research has shown that cogni-

tive development is associated with more mature conceptions of illness, even when chronological age is partialled out statistically (Brewster, 1982; Kister & Patterson, 1980).

Although research has examined children's *performance* on measures of illness understanding, children may have the *potential* to understand more about illness than is recognized (Rushforth, 1999). Misunderstandings and confusion about illness are not the inevitable consequences of cognitive immaturity; children have the potential to understand many illness concepts, if they are presented in developmentally appropriate ways (Kister & Patterson, 1980). While there are limits to children's potential, the limits are fluid and dynamic. Instruction provided at an appropriate developmental level can prompt children to advance their reasoning and achieve a better understanding of complex concepts like illness (Vygotsky, 1962). Parents and physicians have an important role in aiding children to develop a more adequate understanding of illness. Supporting this contextual perspective on children's illness concepts are findings that ill children (i.e., those who experience frequent hospitalizations) tend to have more mature illness concepts than do healthy peers; presumably discussions with parents and doctors over the course of an illness enhance children's understanding (Crisp, Ungerer, & Goodnow, 1996).

Minors' capacity to provide voluntary consent. Voluntary consent reflects a deliberate choice that is made freely and is not constrained by others (Grisso & Vierling, 1978; King & Cross, 1989; Scott, 1992). The voluntary element of informed consent often is neglected because it is difficult to conceptualize and assess. Voluntariness is a capacity that emerges with social and emotional maturity (i.e., self-confidence; Scherer & Reppucci, 1988). Young children tend to view authority figures such as physicians and parents as legitimate and powerful, and are likely to comply with their requests because of differences in perceived social power (Damon, 1977). With increasing age, authority figures tend to be viewed as cooperative and oriented toward promoting social welfare; adolescents are more likely to question demands that seem unreasonable and are less susceptible to coercive influence (Thompson, 1990). Despite these developmental changes in minors' views of authority figures, the capacity of minors to provide voluntary consent has been questioned.

Given their physical, emotional, and financial dependence as well as their relative inexperience with disease, pain, medicine, and making complex decisions, it is uncertain whether younger minors can ever provide truly voluntary and informed consent regarding medical treatment. Research examining conformity to peers in laboratory settings

with group perceptual judgment tasks has shown that conformity peaks in early adolescence (at about age 11 or 12) and declines thereafter (Lewis, 1987). Similarly, other research suggests that young adolescents are sensitive and conforming to social norms and expectations (Berndt, 1979). During the adolescent years, minors become better able to consider information and opinions from diverse sources, and capable of owning their judgments (Lewis, 1987). Between the ages of 15 and 17, most adolescents become capable of providing voluntary consent that is not unduly influenced by others (Grisso & Vierling, 1978).

There have been few empirical examinations of voluntariness; however, the available studies are encouraging. Scherer and Reppucci (1988) examined minors' decisions across several hypothetical medical treatment contexts, with varying levels of parental influence. Adolescents were mindful of, and deferential to, parents, but were more likely to resist parental influence when they perceived the consequences of the decision as having serious implications for health. Similarly, Scherer (1991) compared the decisions of children, adolescents, and young adults across several hypothetical medical treatment contexts, with varying levels of parental influence, and found no clear developmental trends across the different contexts. The findings suggested that for more serious treatment decisions, confidence in the face of parental opposition increases with age, but that parents remain influential through young adulthood. It appears that the voluntary element of consent is complex. The ability of minors and adults to provide voluntary consent may vary with contextual factors, such as the decision at hand, the desires of authority figures and significant others, and personal experience.

Minors' capacity to make rational decisions. A rational decision demonstrates an understanding and appreciation of the relevant information disclosed about the treatment (including consequences, risks, benefits, and alternatives) and an ability to use the information to weigh the risks and benefits of different options while making a choice (Beyth-Marom, Austin, Fischhoff, Palmgren, & Quadrel, 1993; Scott, 1992). The decision-making capacity underlying consent that is rational appears with advances in cognitive development during late childhood through adolescence, in which minors develop the ability to reason abstractly about hypothetical situations, to reason about multiple alternatives and consequences, to combine multiple variables in complex ways, and to examine information in a systematic, exhaustive manner (Keating & Clark, 1980).

Given these predictable cognitive developments, children are thought to differ meaningfully from adolescents and adults in their ability to provide consent that is rational. Studies of decision-making

ability within research contexts have shown that children ages 7 to 12 have difficulty identifying and describing risks and benefits to research participation (Abramovitch et al., 1995). Through middle school and high school, minors become better able to understand the importance of objective sources of information. With increasing age, minors are better able to understand and recognize the vested interests of advice givers, are more likely to consult independent sources of information, and are more likely to spontaneously consider the future consequences of medical decisions (Lewis, 1987). In middle to late adolescence, minors' goals extend a greater length of time into the future, and entail more planning and a greater number of steps (Verstraeten, 1980).

Within the context of psychotherapy, Kaser-Boyd, Adelman, and Taylor (1985) assessed the abilities of sixty-two adolescents (10 to 20 years of age) to generate potential risks and benefits of treatment. Although there were no clear developmental differences between younger (10 to 13 years of age) and older adolescents, nonsignificant trends suggested that older adolescents were able to generate a greater number of risks and benefits, and anticipated consequences of a more abstract nature. Despite the fact that some of the adolescents surveyed had experience with therapy and all understood the process and goals of treatment, almost 50% reported that there were no risks to therapy or that they did not know of any risks. Nearly 75% of the adolescents surveyed were able to discuss at least one benefit to therapy.

Research comparing the decision-making capacity of adolescents and adults is rare. Comparisons of adolescent and adult decision-making with regard to risky behaviors (e.g., substance use, alcohol use, unprotected sexual activity) have demonstrated that adolescents and adults are equally able to identify possible consequences of risky behavior (Beyth-Marom et al., 1993). In addition, adolescents and adults assess the consequences similarly; they estimate similar probabilities or likelihoods of consequences (Quadrel et al., 1993).

In one of the few studies to compare decision-making of children, adolescents, and adults, Weithorn and Campbell (1982) examined persons aged 9, 14, 18, and 21 regarding decision-making in response to hypothetical medical dilemmas. Participants were assessed on four areas related to the capacity to give informed consent: evidence of choice, reasonable outcome (i.e., the option selected corresponds to what a reasonable person would choose), rational reasons (i.e., selection on the basis of logical reasoning), and understanding (i.e., selection based on a comparison of costs and benefits for each alternative). Nine-year-old participants were competent in two of the assessed areas (evidence of choice and reasonable outcome), but, overall, were less compe-

tent than adults; however, 14-year-old participants tended to exhibit decision-making abilities equivalent to adults on all four components assessed.

These findings suggest a surprising degree of decision-making capacity on the part of adolescents, but also have met with criticism. Because an individual's performance in a given setting is determined by general developmental processes as well as individual and ecological factors, studies of cognitive development and decision-making may not be adequate to describe whether minors are competent to make medical decisions (Gardner, Scherer, & Tester, 1989). In addition, most studies are not ecologically valid because they are conducted in laboratory settings, where participants are provided with all the relevant information for making a hypothetical decision (Scott, 1992). Laboratory studies may not be generalizable to real-world settings, in which minors often are not provided with all relevant information in a structured situation.

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

MINOR ASSENT: DEVELOPMENTALLY APPROPRIATE DECISION-MAKING

Given the increasing recognition that most adolescents have the capacity to participate in decisions about their healthcare, parents and

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

Ethical Perspectives on Assent

Assent is a means of involving minors in treatment decisions. It is an interactive process between a minor and a physician that involves developmentally appropriate disclosure about the illness, and solicitation of the minor's willingness and preferences regarding treatment (Committee on Bioethics, 1995; Kunin, 1997). This commonly accepted definition of assent as a minor's agreement to participate sets a lower standard of competence than informed consent because it does not require the depth of understanding or the demonstration of reasoning ability required for informed consent (Weithorn, 1983).

According to Melton (1999), discussions of minors' abilities to provide informed consent have been misguided. Instead of asking, "Should minors be granted absolute autonomy in decision making?" we ought to ask, "Should we treat minors like people?" Parents have the legal responsibility to make decisions on behalf of their minor children; however, there is a moral and ethical "need to respect the rights and autonomy of every individual, regardless of age" (Kunin, 1997, p. 44). Respecting the personhood of minors does not mean viewing them as rational and autonomous decision-makers, but rather it implies that we must promote their developmentally appropriate participation in shared decision-making with parents and physicians. As Melton (1999) notes, "Nothing is more fundamental to the experience of being taken seriously than simply having a say, being heard politely and having one's perspective considered—in effect, being part of a conversation about matters of personal significance" (p. 936). Giving minors a say, and making them feel heard by parents and physicians, will bring all

three parties together in shared decision-making. The ethical principles of autonomy and beneficence (the obligations to respect personhood, and freedom of choice and action, and to promote the welfare of others) support providing minors with opportunities to exercise increasing levels of independence through discussion and shared decision-making (Blustein, Dubler, & Levine, 1999; Fisher et al., 1996).

Benefits of Assent

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

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

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

Although the intent of assent is to involve the child in decisions, the way in which participation is framed is important (Kunin, 1997). The decisions offered to minors must be developmentally appropriate. If, for example, the goal is to provide a child with information without giving veto power, then this must be made clear. Seeking a child’s

assent to a decision that already has been made is pointless. If the child must receive medical treatment despite objections, he or she should not be deceived; in other words, a patient's view must not be solicited without the intent to weigh it seriously (Committee on Bioethics, 1995). For example, in the case of a 7-year-old who is about to receive a shot, a developmentally appropriate decision might be to choose which arm to receive the shot. Even simple choices demonstrate a recognition of children's autonomy and provide some control of their situation and validation of their experience. As Kunin (1997) argues, "it is not necessary to treat children as autonomous, rational decision makers in order to treat them with respect as autonomous individuals" (p. 45).

ASSENT AND CONSENT: UNRESOLVED QUESTIONS

When may a minor give consent, and when assent? Legally, unless he or she is an emancipated minor, mature minor, or seeking treatment for a specific disorder (e.g., alcohol or substance abuse, sexually transmitted diseases, or psychiatric problems, varying by state), an adolescent must be 18 years of age in order to provide informed consent. Assent evolved as a means of engaging minors in choices; however, it is not clear to what degree minors should be involved in medical decisions. Although participation in decision-making generally increases with age, must minors wait until age 18 to participate fully in decisions? At what age should they be given veto power or the ability to refuse treatment?

Decision-Making Capacity and Consent

Physicians are given great responsibilities in that it is largely their judgment that determines a minor's decision-making capacity, when he or she is capable of providing consent, and whether to seek parental permission. Unfortunately, there are no strict criteria for evaluating decision-making ability; it is based on the physician's opinion. Without training in psychological and cognitive development and assessment, physicians may not be prepared to make such judgments (Ross, 1997).

Despite difficulties in assessing decision-making capacity, current ethical guidelines for physicians encourage them to obtain the informed consent of adolescent patients (in addition to parental permission when legally required or desired by the patient; AMA, 1992; Committee on Bioethics, 1995). Physicians are encouraged to involve parents in decision-making when it is in the best interests of the patient or required by law, but it is also acknowledged that parental permission should not keep adolescents from obtaining needed treat-

ment. Unanswered questions include how to best assess a minor's capacity, how to balance the sometimes conflicting need to promote and respect the autonomy of both minors and parents, and how to respond to a minor's refusal of treatment.

Minors and Treatment Refusal

The paucity of ethical guidelines on how to proceed should a minor refuse treatment, or when there are disagreements between parents and adolescents, reflects the lack of legal criteria governing these matters. Although statutes seldom accord minors a right to refuse treatment, few legal cases have addressed these issues (Scott, 1992). Most states have not addressed treatment refusal by teens, especially when the refusal of life-sustaining treatment would result in death (Weir & Peter, 1997).

In cases of treatment refusal, physicians are urged to consider the seriousness of the situation, or the risk-benefit ratio (AMA, 1992). If a treatment is elective, there is no ethical difficulty; Silber (1984) recommends that in these cases physicians should respect the adolescent's decision, regardless of parental insistence. If a treatment is judged to have a low probability for success, it does not need to be initiated, or may be discontinued. There is no moral obligation to perform a futile action. However, if an adolescent resists treatment when the risks are low relative to the expected benefits, competency comes into question (Davis & Shah, 1997); it is ethical and a moral responsibility for the physician to probe further in these cases. The minor's preferences are particularly important in cases where both the risks and benefits are high. Despite these recommendations, several questions remain. How should physicians weigh the risks and benefits of treatment? How can physicians best promote the autonomy of minors while respecting parental autonomy? How should physicians navigate disagreements between parents and minors?

Disagreements Between Minors and Parents

Although guidelines for physicians recommend that they respect adolescents' autonomy by encouraging their participation and by respecting their decision, there are few recommendations on how to handle disagreements among parents (or guardians), adolescents, and physicians. It is unclear how to proceed when parents and minors disagree on treatment.

According to current medical guidelines, if a minor is judged to be competent, he or she is entitled to the same degree of autonomy in decision-making as an adult patient (AMA, 1992; Committee on Bio-

ethics, 1995). Competent minors are encouraged to consult with their parents, but parental involvement should not pose a barrier to care. If there is disagreement, and the minor is judged to have decision-making capacity, mediation should be encouraged, but the minor's decision should be binding (Committee on Bioethics, 1995). Similarly, the American Medical Association (1992) advises physicians to mediate conflicts between parents and patients, and unless the law requires otherwise, to allow competent minors to make decisions on their own behalf. The American Academy of Pediatrics also affords *immature minors* rights in that if the minor has developing capacity, or is capable of providing assent to treatment, his or her wishes should be respected; disagreements between parents and minors should be mediated through counseling and consultation (Committee on Bioethics, 1995). Physicians must strive to provide appropriate care and must be prepared to seek legal intervention should parental refusal of treatment place the patient at risk (AMA, 1992; Committee on Bioethics, 1995); however, legal intervention should be a last resort.

Other than suggesting mediation and possible legal intervention, the American Medical Association and American Academy of Pediatrics offer no clear guidelines on how to proceed when parents and adolescent patients disagree on treatment. Suggestions include medical consultations and short-term counseling for the family, as well as consultation with those trained in ethics. King and Cross (1989) have argued that in cases of disagreement between parents and older minors, "the issue may be essentially one of payment" (p. 16). In resolving disputes between parents and minors, physicians must balance several goals: promoting the minor's autonomy, avoiding excessive influence by parents, recognizing the parents' values and life plans for their child, and serving the child's best interests. This is an exceedingly difficult task, especially without training in psychological techniques. It is questionable whether physicians can resolve such ethical dilemmas without assistance from mental health professionals and experts in medical ethics (e.g., members of the institutional ethics committee).

CONCLUSION

Despite empirical research suggesting that adolescent minors demonstrate decision-making capacities similar to adults, their ability to make medical decisions often is limited. Legal and medical standards offer conflicting guidelines about the role of minors in medical decision-making. While physicians are encouraged to include minors in such

decisions and to respect their autonomy, statutes permit parents to make decisions on behalf of their children.

Physicians must walk a fine line between respect for minors' autonomy, respect for parental rights, and the law. There are no easy answers to these issues. Although supporting the decisions of minors is in accord with the ethical principles of beneficence and respect for autonomy, it may breach the autonomy of parents, pose harm to the family unit, and violate the law. As Bauman (1999) articulates, "laws may be ethical or unethical; ethical actions may be legal or illegal" (p. 346). Physicians must adhere to what is moral and ethical, using their conscience, professional guidelines, and understanding of the law as guideposts; however, questions of minors' ability to participate in medical decision-making clearly pose burdensome dilemmas.

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