

## **Introduction**

Hi all,

This is Premier's first brief of the 2015-2016 season on the topic "Resolved: Adolescents ought to have the right to make autonomous medical choices." We've gotten a lot of great feedback over the past year on our free briefs, and while we can't make them any freer, we can make them better. Please, let us know what you think! And send them around. Not everyone has the resources to pay for briefs and this is one important way to level the playing field. If you use these briefs please help us and direct other debaters to [PremierDebate.com/Briefs](http://PremierDebate.com/Briefs). The more people that are aware of the service, the more likely it gets to those who need it most.

We want to remind the readers about standard brief practice to get the most out of this file. Best practice for brief use is to use it as a guide for further research. Find the articles and citations and cut them for your own personal knowledge. You'll find even better cards that way. If you want to use the evidence in here in a pinch, at the very least, you should re-tag and highlight the evidence yourself so you know exactly what it says and how you're going to use it. Remember, briefs can be a tremendous resource but you need to familiarize yourself with the underlying material first.

As far as content is concerned, we have a couple hundred cards here, and this time around, they're organized more thematically than Aff/Neg. On this topic, the aff defends autonomous choices, but that autonomy could be freedom from parental influence with the help of the state or freedom from state influence with the help of one's parents or religion. This makes for some tricky division of ground! A piece of evidence that defends rights to religious expression could be used as a neg card in one debate to justify parental rights, but it could just as easily be an aff card in another debate to justify a rejection of state-imposed medical treatment. When you look at a card, think of all the different ways you can use it!

Lastly, we want to thank Adam Tomasi for his help with this season's first brief. Together we make a pretty good team! If you don't know Adam, find him online and send him a thank you for his hard work.

Good luck everyone. See you 'round!

Bob Overing & John Scoggin  
Directors | Premier Debate

## **Table of Contents**

Introduction	1
Table of Contents	2
 <b>COMPETENCE AND MATURITY</b>	 <b>7</b>
<b>Aff</b>	<b>8</b>
Empirics / Science	9
Contextual Good – Adolescents Meet	10
Rule of Sevens Good	11
AT Linear Increase	12
AT Bad Decisions	13
AT Emotions / Peer Pressure	14
AT Impulsivity / Risk-taking	15
 <b>Neg</b>	 <b>17</b>
Laundry List	18
Emotions	21
Limited Life Experience	23
Linear Development / Still Developing	25
Risk-taking	27
Stress	30
Weighing	31
AT Understanding the Risks	32
 <b>General</b>	 <b>33</b>
AT Critiques of Capacity Tests	34
Don't Know That Much / Inconclusive	35
Age Cut-off	37
Sliding Scale Test > Age Cut-off	38
Sliding Scale Test Bad	39
Capacity Tests are Difficult	40
Objective Rationality Tests are Bad	41
Medical Expertise Good	42
Medical Expertise Bad	44
Legal Issues	45
Their Research is White	46
AT Munby Vulnerability Test	47
 <b>FAMILY/PARENTAL RIGHTS</b>	 <b>48</b>
<b>Aff</b>	<b>49</b>
Family = Patriarchy	50
AT Legal Arguments	51
AT Constitution	52
Parental Religious Rights ~> Adolescent Religious Rights	54
Rawls	55
 <b>Neg</b>	 <b>56</b>
Aristotle	57

Autonomy Violates Parents' Rights	58
Better Decision-Making/Judgment	59
Consistency	61
Constitution	62
Laundry List	64
Prerequisite to Autonomy	65
Presume Parents	67
AT Child's Best Interest	68
AT Maturity Takes Parents' Rights	69
<b>General</b>	<b>70</b>
Constitution Unclear	71
AT Yoder	72
<b>RELIGIOUS RIGHTS</b>	<b>73</b>
<b>Advantage Areas</b>	<b>74</b>
Advantage – Disease	75
Advantage – Preventable Deaths	76
<b>Competency</b>	<b>77</b>
Yes Religious Maturity	78
Religion ~> Undue Influence	79
<b>Mechanisms</b>	<b>81</b>
Conscientious Objection	82
Solvency Advocate for Religious Autonomy	83
AT Vaccines	84
CP – Mandate	85
<b>Religious Groups</b>	<b>86</b>
Christian Scientists	87
Jehovah's Witnesses	88
Jehovah's Witnesses: Exceptions	89
<b>Weighing</b>	<b>90</b>
Right to Live Outweighs Religious Rights	91
<b>Framework</b>	<b>92</b>
Children Must Comply w/ Parents' Religion	93
Autonomy ~> Religion	94
AT Religion ~> Autonomy	96
<b>MORALS</b>	<b>97</b>
<b>Autonomy</b>	<b>98</b>
Autonomy as Intrinsic Good	99
Dworkin's Account of Autonomy	100
AT Aff Contention	101
AT Autonomy = Wholly Internal	104

<b>Kant</b>	<b>105</b>
Aff	106
Neg	107
<b>Utilitarian Rights</b>	<b>108</b>
<b>No Morally Relevant Distinction “Burdens”</b>	<b>109</b>
Presume Autonomy	110
Yes – Core of the Topic	111
No – Not Core of the Topic	112
<b>Misc.</b>	<b>113</b>
Adolescent Legal Identity	114
Authority/Polls	115
Doctor-Patient Trust	118
Evolution	119
Pluralism	120
<b>SPILLOVER</b>	<b>122</b>
<b>Rights/Protections Spillover</b>	<b>123</b>
<b>Criminal Justice Spillover</b>	<b>124</b>
Yes Spillover	125
No Spillover	127
<b>COUNTRIES</b>	<b>129</b>
<b>Toolbox</b>	<b>130</b>
Ev Must Be Specific	131
<b>Canada</b>	<b>132</b>
Inherency	133
<b>China / East Asia</b>	<b>134</b>
<b>COUNTRIES</b>	<b>135</b>
Inherency	136
Solency	137
Solency	138
CP – Laundry List	139
<b>INTERNATIONAL LAW</b>	<b>141</b>
<b>Aff</b>	<b>142</b>
<b>Neg</b>	<b>146</b>
CP – Expand the Convention	148
<b>General</b>	<b>149</b>

Ambiguous Framework	150
Not about Adolescents	151
Sliding Scale	154
I-Law Ignores Minorities	155
<b>GENERAL MECHANISMS</b>	<b>157</b>
<b>Mature Minor Doctrine (MMD)</b>	<b>158</b>
Inherency	159
Solvency – Promotes Autonomy	161
Solvency – Doesn’t Care About Competency	162
Solvency – MMD + Case-by-Case	163
No Solvency	164
Topicality	165
<b>Counterplan Stuffs</b>	<b>166</b>
AT Informed Consent / Decision-Making	167
AT CPs for Dignity/non-Autonomy Rights	168
AT Welfare Principle	169
CP – Substituted Judgment	170
CP – More Ethics Consultants	171
CP – Consent but not Refusal	172
<b>MEDICAL AREAS</b>	<b>173</b>
<b>Abortion</b>	<b>174</b>
Inherency	175
Impacts	177
Solvency	178
Competence/Maturity	179
Politics	181
Mechanism – Counseling Requirement Only	182
Harms of Court Requirements	183
AT Abortion Unsafe	186
AT Family Ties DA	187
AT Undue Burden Test	188
<b>End of Life Decisions</b>	<b>189</b>
Inherency + Solvency	190
<b>Gender Reassignment</b>	<b>192</b>
Inherency	193
I-Law	195
<b>Genetic Testing</b>	<b>196</b>
<b>Mental Health</b>	<b>198</b>
Inherency	199
Solvency	200
Weighing	201

Neg	202
<b>Obesity</b>	<b>204</b>
Impacts	205
<b>Non-Western / Alternative Medicine</b>	<b>206</b>
Aromatherapy	207
General	209
<b>Non-Abortion Sexual Health, Contraceptives</b>	<b>210</b>
Inherency	211
Impacts	213
Solvency	214
Mechanism – Sex Licensing	216
<b>Vaccines</b>	<b>217</b>
 <b>KRITIKS AND CRITICAL LITERATURE</b>	 <b>219</b>
<b>Autonomy</b>	<b>220</b>
AT Critiques of Autonomy	221
Communitarian Critique of Autonomous Subject	222
Feminist Critique of Autonomous Subject	223
<b>Biopower</b>	<b>225</b>
Mature Minor Doctrine	226
<b>Race</b>	<b>228</b>
Capacity Tests	229
 <b>THEORY</b>	 <b>230</b>
Applied Ethics K2 Topic	231
Ethics Good on Topic	233
Ethical Modesty (EM) Good on Topic	234
 <b>TOPICALITY AND WORD CHOICE</b>	 <b>235</b>
<b>Adolescents</b>	<b>236</b>
Definitions of Adolescence	237
Must Exclude Little Kids	238
Science + Social	239
Historical definition	241
Teen > Adolescent	242

**Competence and Maturity**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Aff

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)



## Empirics / Science

### **Empirics show adolescent decision-making is on par with adult decision-making Sloninat 07**

Mary Irene Sloninat, JD from Case Western, "State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment" 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The limited amount of **empirical research on cognitive development and medical decisions supports Piagetian theory that around age fifteen children have the same decision-making capabilities as an adult**.<sup>89</sup> **In a well-known 1982 study**, two researchers wanted to test the proposition of the late Supreme Court Justice, William O. Douglas that "the moral and intellectual maturity of the 14-year-old approaches that of the adult." <sup>90</sup> They hypothesized an empirical comparison of the competency of fourteen-year-olds and adults would support Justice Douglas' statement. **They took a test group of 96 subjects**, and divided them into four groups of twenty-four subjects by age: (1) eight and a half to nine and a half, (2) fourteen, (3) eighteen, and (4) twentyone. <sup>91</sup> The subjects were presented with four hypothetical medical dilemmas and were asked to choose treatment options for each of the illnesses in the situations.<sup>92</sup> **The subjects' responses to questions were evaluated and scored by a panel of twenty experts on four standards of competency: evidence of choice, reasonable outcome, rational reasons, and understanding. The results indicated that fourteen-year-olds demonstrated a competency equal to that of eighteen and twenty-one-year-olds.** The nine-year-olds demonstrated less competency than the fourteen-year-olds, but the former group still appeared to be fairly competent in making treatment decisions.<sup>93</sup> Another study asked sixty-two adolescents, age ten to twenty, to list the potential benefits and risks of certain medical treatments.<sup>94</sup> Non-significant trends in responses revealed that **the older adolescents** (age fourteen and up) **were able to list a greater number of benefits and risks of the medical treatments and were able to anticipate the consequences of treatment in more abstract manner**.<sup>95</sup> As one psychologist has noted on developmental research outside the medical treatment context: **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. In addition, adolescents and adults assess the consequences similarly; they estimate similar probabilities or likelihoods of consequences**.<sup>96</sup>

### **14 and older is competent according to research Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Taken together, these **studies suggest that older adolescents are no less** • <sup>182</sup> **competent to provide consent than adults. Lois Weithorn and Susan Campbell specifically compared the decision-making capabilities of variously aged minors and young adults. They found that minors aged fourteen and older "demonstrate a level of competency equivalent to that of adults."** <sup>83</sup> **These results support earlier work performed by Jean Piaget which suggested that individuals enter the "formal operational stage" during adolescence, and thereafter "possess the cognitive capability to reason, understand, appreciate, and articulate decisions comparable to young adults."** <sup>84</sup>

## Contextual Good – Adolescents Meet

**Judgments of adolescent maturity should be contextual—adolescents are uniquely mature enough for medical decisions**

**Steinberg 13**

Laurence Steinberg (PhD, Department of Psychology, Temple University). “Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?” Oxford University Press. 2013. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

To the extent that we wish to rely on developmental neuroscience to inform where we draw age boundaries between adolescence and adulthood for purposes of public policy, it is therefore important to match the policy question with the right brain science. **The notion that adolescents are too immature to be subject to capital punishment or life without parole but mature enough to make autonomous medical decisions may seem inconsistent at first glance, but it is**

**entirely plausible to posit that an adolescent might be mature enough for some decisions**

**but not others** (Steinberg et al., 2009a). **In particular, the circumstances under which individuals make medical decisions and commit crimes are very different and make different sorts of demands on individuals’ brains and abilities. For example, state laws governing adolescent abortion require a waiting period before the procedure can be performed as well as consultation with an adult—a parent, health care provider, or judge. These policies discourage impetuous and short-sighted acts and create circumstances under which adolescents’ decision-making has been shown to be just as competent as that demonstrated by adults. In contrast, violent crimes are usually committed by adolescents when they are emotionally aroused and with their friends—two conditions that increase the likelihood of impulsivity and sensation-seeking, and that exacerbate adolescent immaturity. Thus it makes perfect neurobiological sense to have a lower age for autonomous medical decision-making than for eligibility for capital punishment, because brain systems important for deliberative decision-making mature earlier than those important for self-regulation.**

This point was made by the American Psychological Association in response to accusations in the wake of Roper that psychologists were trying to have their scientific cake and eat it too—spinning the research for the sake of youth advocacy. The APA pointed out that the type of decision under consideration in Roper was not the same as that at issue in Hodgson: We [APA] took note of the Hodgson brief in the approval process for APA’s brief in [Roper] but concluded that the two cases were distinguishable in several respects. [Roper] and Hodgson, while both dealing with adolescent decision-making, involved Recent Research on Adolescent Brain Development 261 at Univ of Southern California on August 31, 2015 <http://jmp.oxfordjournals.org/> Downloaded from very different legal issues and different types of decisions. Therefore the research, which was different in each of the two cases, addressed distinct aspects of adolescent behavior and attributes. (Gilfoyle, 2005, 1)

## **Rule of Sevens Good**

### **Doctors adopting a “rule of sevens” approach is most consistent with science Steinberg 13**

Laurence Steinberg (PhD, Department of Psychology, Temple University). “Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?” Oxford University Press. 2013. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Recent studies of adolescent brain and behavioral development do not undermine the mature minor doctrine, but they do suggest two important ways in which the doctrine should be applied. **First, the inclination of health care and legal practitioners to treat older adolescents differently from younger ones is consistent with research on adolescent brain and behavioral development, which suggests that adolescents 14 and younger are likely to be less competent than those who are 15 and older. This is not to suggest that a bright chronological age line should be drawn in applying the doctrine (both because there is variation in competence among children of the same chronological age and because one could envision some extreme circumstances when the interest of a younger adolescent might be better served by treating the juvenile as a mature minor), but it is to note that the “rule of sevens,” which distinguishes among infants (under 7), children (between 7 and 14), and adolescents (over 14) appears to have some reasonable grounding in science.**

### **Adolescents over 14 can make rational medical decisions—studies prove Derrington 9**

Sabrina Derrington (MD, Fellow of the American Academy of Pediatrics). “Advocating Autonomy: Fulfilling Our Duty to Adolescents at the End of Life.” Section on Bioethics 2009 Essay Contest, 1st prize winner.

<https://www2.aap.org/sections/bioethics/PDFs/EthicsEssayDerrington.pdf> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Pediatricians, ethicists, and lawmakers continue to debate the decision-making capacity of adolescents and the degree of autonomy they ought to possess. **Weithorn and Campbell tested specific components of competency, showing that adolescents ≥ 14 years of age did not differ from young adults in their ability to understand diagnostic and treatment information, rationally consider alternatives, and make reasonable choices.**<sup>1</sup> **Developmental analyses indicate that by age 11 children begin to understand the physiologic basis of disease, and children as young as 8-10 years may be capable of an “adult” understanding of death as universal, unalterable, and permanent.**<sup>3</sup> **With support from legal cases and professional societies this body of work has resulted in general agreement that we ought to obtain informed consent from adolescents with “appropriate decisional capacity”, usually those ≥ 14 years, and that we should seek the assent of younger children along with informed permission of their parents.** These guidelines are followed stringently in research settings and less consistently in clinical practice. Permitting adolescents to dissent, especially to life-sustaining medical treatment (LSMT), is more controversial – and more difficult for both parents and pediatricians to accept.

## **AT Linear Increase**

**Reject the linear increase in decision-making hypothesis – if it were true, young children would have even worse decision-making outcomes**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**This general pattern, of improved cognitive control with maturation of the prefrontal cortex, suggests a linear increase in development from childhood to adulthood. Yet suboptimal choices and actions observed during adolescence represent a nonlinear change in behavior that can be distinguished from childhood and adulthood**, as evidenced by the National Center for Health Statistics on adolescent behavior and mortality. **If cognitive control and an immature prefrontal cortex were the basis for suboptimal choice behavior, then children should look remarkably similar or even worse than adolescents, given their less developed prefrontal cortex and cognitive abilities. Thus, immature prefrontal function alone, cannot account for adolescent behavior.**

## AT Bad Decisions

**You can make bad decisions and still be competent – that's how we treat adults when they make bad decisions**

**Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**"[A]lthough rights to speech, procreation and the like are justified for adults in terms of their capacity for rational choice, the extension of these rights to minors has never been explained on grounds assuming the same capacity for choice."**<sup>123</sup> Justice Stewart explained in a concurring opinion in *Ginsberg v. New York*<sup>124</sup> that **the only constitutionally tolerable justification for denying children rights would be that children lack full capacity for individual choice.**<sup>125</sup> **This argument relies on children making seemingly immature decisions and adults finding these children lack capacity; however, if adults made the same decisions, they would merely be considered bad decisions and adults would still be viewed as capable.**<sup>26</sup>

## AT Emotions / Peer Pressure

**Reject sweeping statements about adolescent brains—there’s a difference between cognitive and psychosocial maturity—the former entails that teenage medical decisions are mature**

### **Steinberg 13**

Laurence Steinberg (PhD, Department of Psychology, Temple University). “Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?” Oxford University Press. 2013. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The importance of maintaining a distinction between cognitive and psychosocial maturity in discussions of the legal status of adolescents is supported by other research that has examined age differences in each of these domains. Studies that have examined basic information processing skills and logical reasoning, for instance, find no appreciable differences between adolescents who are at least 15 and adults; any gains that take place in these domains during adolescence occur very early in the adolescent decade, and improvements after this age are very small (Hale, 1990; Kail, 1997; Keating, 2004; Overton, 1990).**

This general pattern, indicating that adolescents attain adult levels of competence to make decisions somewhere around age 15, has been reported in similar studies of decision-making across a wide variety of domains (e.g., Grisso, 1980; Grisso et al., 2003; Jacobs-Quadrel, Fischhoff, and Davis, 1993) and in many studies of age differences in individuals’ competence to provide informed consent (Belter and Grisso, 1984; Grisso and Vierling, 1978; Gustafson and McNamara, 1987; Weithorn and Campbell, 1982). **When it comes to decisions that permit more deliberative, reasoned decision-making, where emotional and social influences on judgment are minimized or can be mitigated, and where there are consultants who can provide objective information about the costs and benefits of alternative courses of action, adolescents are likely to be just as capable of mature decision-making as adults, at least by the time they are 15 or so. In contrast, the literature on age differences in psychosocial characteristics such as impulsivity, sensation-seeking, future orientation, and susceptibility to peer pressure shows continued development well beyond middle adolescence and even into young adulthood (Scott, Reppucci, and Woolard, 1995; Steinberg and Cauffman, 1996). Consistent with this, and in contrast to the pattern of age differences seen in the information-processing, logical reasoning, and informed consent literatures, studies of age differences in the sorts of risky behavior likely to be influenced by the psychosocial factors listed above—such as reckless driving, binge drinking, crime, and spontaneous unprotected sex—indicate that risky behavior is significantly more common during late adolescence and early adulthood than after (Steinberg, 2008). In other words, adolescents may demonstrate adult-like levels of maturity in some respects by the time they reach 15, but in other respects they show continued immaturity well beyond this point in development. Taken together, these bodies of neurobiological and behavioral research indicate that it is not prudent to make sweeping statements about the relative maturity of adolescents and adults, because the answer to the question of whether adolescents are as mature as adults depends on the aspects of maturity under consideration.**

Based on extant research, it seems reasonable to distinguish between two very different decision-making contexts in this regard: those that allow for unhurried, logical reflection and those that do not. It is also in keeping with our emerging understanding of adolescent brain maturation, which suggests that brain systems responsible for logical reasoning and basic information processing mature earlier than those that undergird more advanced executive functions and the coordination of affect and cognition necessary for psychosocial maturity

(Steinberg, 2008). **In essence, the skills and abilities necessary to make an informed decision about a medical procedure are likely in place several years before the capacities necessary to regulate one’s behavior under conditions of emotional arousal or coercive pressure from peers.**

## **AT Impulsivity / Risk-taking**

**Best brain evidence rejects that impulsivity has an overwhelming effect on adolescent behavior**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Adolescent behavior has repeatedly been characterized as impulsive and risky** (Steinberg, 2004, 2007), **yet this review of the imaging literature suggests different neurobiological substrates and different developmental trajectories for these behaviors.**

Specifically, impulsivity is associated with immature ventral prefrontal development and gradually diminishes from childhood to adulthood (Casey, Galvan et al., 2005). **The negative correlation between impulsivity ratings and age in the study by Galvan et al.**

**(2007) further supports this notion.**

In contrast, risk-taking is associated with an increase in accumbens activity (Kuhnen & Knutson, 2005; Matthews et al., 2004; Montague & Berns, 2002), that is exaggerated in adolescents, relative to children and adults (Ernst et al., 2005; Galvan et al., 2006). Thus **adolescent choices and behavior cannot be explained by impulsivity or**

**protracted development of the prefrontal cortex alone, as children would then be predicted to be greater risk takers. The findings provide a neural basis for why some adolescents are**

**at greater risk than others,** but further provide a basis for how adolescent behavior is different from children and adults in risk-taking.

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7  
August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)



Neg

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Laundry List

### Adolescents are poor decision-makers, laundry list of evidence

#### Cherry 10

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The Convention and its advocates also appear to ignore the substantial array of scientific evidence indicating that children, even so-called mature minors, are generally not in fact mature decision makers. There is a significant body of neurobiological evidence that the adolescent and teenage brain is not yet fully developed in its cognitive and affective capacities. The adolescent brain's executive functions (cognitive faculties that support planning, inhibition, mental flexibility, reasoning, problem solving, and working memory, action initiation and monitoring, experience of reward and punishment, self-regulation of behavior and decision making) are still slowly developing during adolescence (Chan et al., 2008). The prefrontal cortex, which is important for cognition and reasoning, for controlling impulses and emotional responses, continues to develop, maturing slowly through adolescence and into adult dimensions even during the early twenties (Gilbert and Burgess, 2008).<sup>21</sup> The ventral striatum, an area of the brain associated with reward response, for example, is more active during adolescence. Imaging studies demonstrate that the brain continues to change dynamically throughout adolescence and into adulthood, with a late full maturation of the frontal lobes, which are necessary for effective use of the executive functions. These are the areas of the brain that are utilized for the realization of responsible and reasonable choices, but which are among the last to reach full adult development (Geidd, Blumenthal, and Jeffries, 1999; Spear, 2000).

Such structural differences between the adult and the adolescent brain appear correlated with adverse outcomes when adolescents engage in unguided decision making. In general, cognitive and affective control over behavior is still immature throughout the teenage years (Jernigan et al., 1991; Sowell et al., 1999, 2003, 2004; Gogtay et al., 2004; Casey, Getz, and Galvan, 2008; Cauffman et al., 2010), leading to more novelty seeking and poor choices, including traffic accidents, experimentation with risky sexual practices, as well as drugs and alcohol, with an increased risk of addiction.<sup>22</sup> Adolescents routinely make suboptimal decisions resulting in an increased incidence of injury, unintended pregnancy, and sexually transmitted disease, as well as homicide, suicide, and other forms of violent behavior.<sup>23</sup>

The apparent contradiction between the known high risk behavior of adolescents and their observed abilities to engage in acute observation, rational discussion, and even intellectual risk-assessment is explained, according to Casey et al., by the fact that in emotionally charged situations, the more mature limbic system dominates the less mature prefrontal control system. This means that adolescents may know better, may even be able accurately to rehearse probabilities of risks and benefits associated with particular actions, but very routinely will be driven to make a different and more risky decision given the emotional context or an immature perception of how such risks apply to oneself. Mature cognitive development requires the ability to suppress emotion and otherwise not act on inappropriate thoughts, choosing instead proper goal directed choices (Casey, Giedd, and Thomas, 2000; Casey, Galvan, and Hare, 2005). This ability develops throughout adolescence, as children gain better impulse and cognitive control with maturity. However, the brain's overall state of development is such that even mature adolescents lack the proper self-control necessary to good decision making even though they may, in principle, understand the relevant factual issues.

## **Brain studies show adolescents are impulsive, violent, and assess outcomes differently**

### **Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," Journal of Medicine and Philosophy, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Moreover, **adolescents, whose frontal lobes are not fully developed, are known to have more impulsivity in making decisions.** When compared to adults, **adolescents tend to assess threat–safety scenarios very differently.** **Lau et al. (2011) have attributed these differences to** be grounded in the **lack of maturity in the subcortical and prefrontal regions of the brains of adolescents.** **Adolescents** tend to **show higher tendencies toward violence and self-destructive behaviors,** again likely **grounded in the immaturity of the prefrontal cortex of adolescent brains** (Schwartz et al., 2009). **Adults assess outcomes very differently** from adolescents (Reyna et al., 2005; Galvan et al., 2007). **For adolescents, the “subcortical systems will win out (accelerator) over control systems (brakes) given their maturity relative to the prefrontal control systems”** (Casey, Jones, and Somerville, 2011, 22).

## **Adolescents make bad decisions – peer pressure, risk-taking, poor long-term thinking**

### **Jetha & Segalowitz 12**

Michelle K. Jetha, Ph.D. & Sidney J. Segalowitz, Ph.D., “Summary and Implications” in Adolescent Brain Development Implications for Behavior. 2012. Academic Press. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Children and adolescents have not reached the adult levels of processing efficiency in the brain networks supporting social cognition despite apparent sophistication in some contexts. The circuitry supporting mature levels of perspective taking and empathic understanding have not fully matured.** It is important that policies take into account the normal developmental timeline of these mental processes. **Adolescents make some decisions as well as adults do, and they appear highly competent in calm contexts. However, there is increasing evidence to show that this is not the case when adolescents are in emotional contexts, such as when they are excited and with peers. Decision making can be quite impaired during such “hot” contexts, with adolescents showing a greater propensity for immediate reward and less consideration of long-term consequences.** Considering that much adolescent misbehavior is done in a social context, **this has implications for forensic issues related to young offenders.** This is an issue of some discussion in the legal system in the USA concerning taking into account issues relating to diminished capacity for decision making during adolescence.<sup>250,251</sup> 6. Adolescents compared to adults are more sensitive to social evaluations and yet are less able to effectively regulate the emotions surrounding such evaluations because their frontal brain regions are not fully mature. **Adolescence is also a time when sensitivity to peer evaluation increases and seems to be more influential in determining concepts of self-worth. These factors are especially important considering that adolescence is a time of increased risk-taking behavior and increased risk for the emergence of psychopathology. Adolescence is a time of heightened propensity for reward-seeking and risk-taking behavior, characterized by an emphasis on shortterm goals and discounting future implication.** Given the vulnerability at this stage of development, we can be sure that outcomes will be heavily dependent on guidance from parents, adult role models and institutions. Reward-seeking behavior is a part of healthy social development. Thus, guidance should include providing ample opportunities for adolescents to engage in positive reward-seeking behaviors, so that they will have alternatives that help them

avoid expressing these drives in negative contexts. 8. When puberty begins, the sensitivity to rewards is at its peak, a time when cognitive control is relatively immature. This imbalance may become even more of a societal focus if the age of puberty onset continues to recede, as it has for over a century. The timing of these changes may have implications for interventions designed to reduce adolescent risk-taking behavior.

## Emotions

### **Adolescent brains aren't as capable of self-control/not letting emotions take over Steinberg 13**

Laurence Steinberg (PhD, Department of Psychology, Temple University). "Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?" Oxford University Press. 2013. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Adolescence is also a time of important changes in how the brain works, as revealed in studies using functional magnetic resonance imaging.** What do these imaging studies tell us about the adolescent brain? **First, over the course of adolescence and into early adulthood, there is a strengthening of activity in brain systems involving self-regulation (Luna, Padmanabhan, and O'Hearn, 2010). During tasks that require self-control, adults employ a wider network of brain regions than do adolescents, which may make self-control easier, by distributing the work across multiple areas of the brain rather than overtaxing a smaller number of regions. Second, there are important changes during adolescence in the way the brain responds to rewards.** When one examines a brain scan acquired during a task in which individuals who are about to play a game are shown rewarding stimuli, like piles of coins or pictures of happy faces, it is usually found that adolescents' reward centers are activated more than are children's or adults' when they expect something pleasurable to happen (Galvan, 2010). (Interestingly, these age differences are more consistently observed when individuals are anticipating rewards than when they are receiving them.) **Heightened sensitivity to anticipated rewards motivates adolescents to engage in acts, even risky acts, when the potential for pleasure is high, such as unprotected sex, fast driving, or experimentation with drugs. This hypersensitivity to reward is particularly pronounced when adolescents are with their friends (Chein et al., 2011; O'Brien et al., 2011). A third change in brain function over the course of adolescence involves increases in the simultaneous involvement of multiple brain regions in response to arousing stimuli, like pictures of angry or terrified faces (Steinberg, 2008). Before adulthood, there is less cross-talk between the brain systems that regulate rational decision-making and those that regulate emotional arousal. During adolescence, very strong feelings are less likely to be modulated by the involvement of brain regions involved in impulse control, planning ahead, and comparing the costs and benefits of alternative courses of action. This is one reason that susceptibility to peer pressure declines as adolescents grow into adulthood; as they mature, individuals become better able to put the brakes on an impulse that is aroused by their friends (Grosbras et al., 2007).**

### **Brains still developing – adolescents are more emotional Driggs 01**

Ann Eileen Driggs, R.N., J.D., "The Mature Minor Doctrine: Do Adolescents Have the Right to Die?" Health Matrix, Vol. 11:687 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Two recent studies** have contributed to this theory. One study tracked changes over a number of years in the brains of children.<sup>123</sup> The other compared brain maturation in twelve to sixteen year olds with adults in their twenties.<sup>124</sup> **Areas of the brain that control functions such as planning, organization, inhibition, and emotions were found to continue to develop between adolescence and adulthood.**<sup>125</sup> A complex system of neurons in the brain interconnect and are responsible for communicating information to the various areas of the brain.<sup>126</sup> **It was previously believed that most brain growth and increase in the number of these neurons was complete by the age of six.**<sup>127</sup> Scientists believed until recently that, after this age, the number of neurons decreased and there were no new connections formed.<sup>128</sup> However, **recent studies indicate that a significant number of new connections continue to form well into adolescence.**<sup>129</sup> **Included in this growth are new connections in the two**

halves of the brain's cerebrum, areas that are involved with judgment-making and the controlling of emotions. <sup>130</sup> Because of this continued development and growth during adolescence, teens may rely more on the emotional centers of the brain rather than the areas that will eventually be relied upon as an adult when making judgments.<sup>131</sup> As a result, decisions made during the teen years may be made strictly on an emotional basis rather than a more appropriate judgment basis. <sup>132</sup>

## Limited Life Experience

**Not competent because they have limited life experience**

**Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Allen Buchanan and Dan Brock suggest that **there are three capacities necessary for decision-making competence: capacities for communication and understanding of information, capacities for reasoning and deliberation, and capacities to have and apply a set of values.**<sup>53</sup> **These capacities are necessary to ensure that the individual's choice is truly in line with his or her conception of well-being,**<sup>54</sup> **and thus, deserving of respect as autonomous. Persons can be deemed incompetent, and thus, have their decisions set aside, where an inquiry indicates that they are "mistaken about what will. . . best satisfy their underlying and enduring aims and values," and/or they "fail to accept or choose in accord with objective ideals of the person and personal well-being."**<sup>55</sup> Recall, however, that adults are presumed to have this capacity, and a full blown inquiry into an adult's competence will only be triggered by peculiar circumstances that indicate to a health care professional that the adult's<sup>56</sup> competence should be questioned. In practice, therefore, unless clear and convincing evidence is supplied to the contrary, adults possess "[a]n unqualified liberty interest... to [consent to or] refuse any and all medical treatments."<sup>57</sup> Those under the age of eighteen, on the other hand, are presumed to lack capacity sufficient to rise to the level of competence requisite for autonomous authorization. Returning to the capacities suggested by Buchanan and Brock, **there is a real question, and limited empirical data, regarding the ability of minors to understand and communicate about the semantic content of treatment discussions.**<sup>58</sup> While it may be unnecessary for patients to truly grasp the technical medical data, **it is essential that they understand the "impact that treatment alternatives will have on their lives."**<sup>59</sup> **Some argue that because minors have limited life experience, their decisions are "not part of a well-conceived life plan."**<sup>6</sup> Importantly, **minors "may give inadequate weight to the effects of decisions on their future interests, and also fail to anticipate future changes in their values that may be predictable by others."** **Minors tend to place greater emphasis on the present effects of a decision than long-term consequences,**<sup>62</sup> **are more susceptible to peer pressure,**<sup>63</sup> **and studies have shown that minors participate in unhealthy risk-taking more often than do adults.**<sup>64</sup> Taken together, these claims lend themselves to the notion that **minors "need a protected period in which to develop 'enabling virtues' (habits, including the habit of self control), which advance their lifetime autonomy and opportunities."**<sup>65</sup> In other words, **minors need time to develop a true conception of well-being that would be reflected in a competent decision deserving respect as autonomous.** As Elizabeth Scott has observed, **"this account of childhood leads quite naturally to the conclusion that children must be subject to adult authority, and that the deeply ingrained political values of autonomy, responsibility, and liberty simply do not apply to them."**<sup>66</sup>

**Even if adolescents are competent, they have limited life experience—their parents should make medical decisions for them**

**Ross 97**

Lainie Friedman Ross (PhD, American physician and bioethicist who works at the University of Chicago). “Health Care Decisionmaking by Children: Is It in Their Best Interest?” Hastings Center Report. 1997. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**\*\*Brackets in original, except the brackets for gendered language**

A second reason to limit the child's present-day autonomy is the fact that the child's decisions are based on limited world experience and so her decisions are not part of a well-conceived life plan. Again, many adults have limited world experience, but children have a greater potential for improving their knowledge base and for improving their skills of critical reflection and self-control. As Willard Gaylin explains: Surely, part of what goes into our abridgement of the child's autonomy is the recognition that although he may be [competent the limitations of his experience have] distorted his capacity for sound judgment.<sup>9</sup> By protecting the child from his own impetuosity, his [their] parents help him [them] obtain the background knowledge of the world and the capacities that will allow him [them] to make decisions that better promote his [their] life plans. His parents' attempt to help him flourish may not be achieved, but that does not invalidate their attempt.



## **Linear Development / Still Developing**

**Lit shows linear increase in competence with age**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A number of cognitive and neurobiological hypotheses have been postulated for why adolescents engage in suboptimal choice behavior. In a recent review of the literature on human adolescent brain development, Yurgelun-Todd (2007) suggests that cognitive development through the adolescent years is associated with progressively greater efficiency of cognitive control capacities. This efficiency is described as dependent on maturation of the prefrontal cortex as evidenced by increased activity within focal prefrontal regions (Rubia et al., 2000; Tamm, Menon, & Reiss, 2002) and diminished activity in irrelevant brain regions (Brown et al., 2005; Durston et al., 2006).**

**MRI scans prove the adolescent brain is still developing – pre-frontal cortex develops last**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Several studies have used structuralMRI to map the anatomical course of normal brain development (see review by Durston et al., 2001). Although total brain size is approximately 90% of its adult size by age six, the gray and white matter subcomponents of the brain continue to undergo dynamic changes throughout adolescence.** Data from recent longitudinal MRI studies indicate that gray matter volume has an inverted U-shape pattern, with greater regional variation than white matter (Giedd, 2004; Gogtay et al., 2004; Sowell et al, 2003; Sowell, Thompson, & Toga, 2004). In general, regions subserving primary functions, such as motor and sensory systems, mature earliest; higher-order association areas, which integrate these primary functions, mature later (Gogtay et al., 2004; Sowell, Thompson, & Toga, 2004). For example, studies using MRI-based measures show that cortical gray matter loss occurs earliest in the primary sensorimotor areas and latest in the dorsolateral prefrontal and lateral temporal cortices (Gogtay et al., 2004). **This pattern is consistent with nonhuman primate and human postmortem studies showing that the prefrontal cortex is one of the last brain regions to mature** (Bourgeois, Goldman-Rakic, & Rakic, 1994; Huttenlocher, 1979). In contrast to gray matter, white matter volume increases in a roughly linear pattern, increasing throughout development well into adulthood (Gogtay et al., 2004). These changes presumably reflect ongoing myelination of axons by oligodendrocytes enhancing neuronal conduction and communication.

**Brain research proves adolescents process immediate rewards more strongly**

[terminology note: accumbens is a part of the brain, generally speaking, concerned with rewards and dopamine reception]

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Our findings were consistent with rodent models** (Laviola, Macri, Morley-Fletcher, & Adriani, 2003) and **previous imaging studies** (Ernst et al., 2005) **suggesting enhanced accumbens activity to rewards during adolescence. Indeed, relative to children and adults, adolescents showed an exaggerated accumbens response in anticipation of reward.** However, both children and adolescents showed a less mature response in prefrontal control regions than adults. These findings suggest different developmental trajectories for these regions may underlie the enhancement in accumbens activity, relative to children or adults, **which may in turn relate to the increased impulsive and risky behaviors observed during this period of development** (see Fig. 4).

**Differential recruitment of prefrontal and subcortical regions has been reported across a number of developmental fMRI studies** (Casey et al., 2002b; Monk et al., 2003; Thomas et al., 2004). Typically these findings have been interpreted in terms of immature prefrontal regions rather than an imbalance between prefrontal and subcortical regional development. Given evidence of prefrontal regions in guiding appropriate actions in different contexts (Miller & Cohen, 2001) **immature prefrontal activity might hinder appropriate estimation of future outcomes and appraisal of risky choices, and might thus be less influential on reward valuation than the accumbens.** This pattern is consistent with previous research showing elevated subcortical, relative to cortical activity when decisions are biased by immediate over long-term gains (McClure, Laibson, Loewenstein, & Cohen, 2004). Further, accumbens activity has been shown with fMRI to positively correlate with subsequent risk-taking behaviors (Kuhnen & Knutson, 2005). **During adolescence, relative to childhood or adulthood, immature ventral prefrontal cortex may not provide sufficient top-down control of robustly activated reward processing regions** (e.g., accumbens), **resulting in less influence of prefrontal systems** (orbitofrontal cortex) **relative to the accumbens in reward valuation.**

**Most advanced brain studies prove development of the brain proceeds through adolescence**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The MRI-based morphometry studies reviewed suggest that cortical connections are being fine-tuned with the elimination of an overabundance of synapses and strengthening of relevant connections with development and experience. Recent advances in MRI technology, like DTI provide a potential tool for examining the role of specific white matter tracts to the development of the brain and behavior with greater detail.** Relevant to this paper are the **neuroimaging studies that have linked the development of fiber tracts with improvements in cognitive ability.** Specifically, **associations between DTI-based measures of prefrontal white matter development and cognitive control in children have been shown.** In one study, development of this capacity was positively correlated with prefrontal- parietal fiber tracts (Nagy, Westerberg, & Klingberg, 2004) consistent with functional neuroimaging studies showing differential recruitment of these regions in children relative to adults. **Using a similar approach, Liston et al. (2005) have shown that white matter tracts between prefrontal-basal ganglia and -posterior fiber tracts continue to develop across childhood into adulthood, but only those tracts between the prefrontal cortex and basal ganglia are correlated with impulse control,** as measured by performance on a go/nogo task. The prefrontal fiber tracts were defined by regions of interests identified in a fMRI study using the same task. Across both developmental DTI studies, fiber tract measures were correlated with development, but specificity of particular fiber tracts with cognitive performance were shown by dissociating the particular tract (Liston et al., 2005) or cognitive ability (Nagy et al., 2004). These findings underscore the importance of examining not only regional, but circuitry related changes when making claims about age-dependent changes in neural substrates of cognitive development.

## Risk-taking

### **Brain study proves—adolescents are more likely to engage in risky behaviors**

#### **Steinberg 8**

Laurence Steinberg (PhD, Dept of Psychology, Temple University). “A social neuroscience perspective on adolescent risk-taking.” Developmental Review. January 28th, 2008. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Several findings from a recent study my colleagues and I have conducted on age differences in capacities that likely affect risk-taking are consistent with the notion that early adolescence in particular is a time of important changes in individuals’ inclinations toward and risk-taking** (see Steinberg, Cauffman, Woolard, Graham, & Banich, submitted for publication for a description of the study). **To my knowledge, this is one of the only studies of these phenomena with a sample that spans a wide enough age range** (from 10 to 30 years) and is large enough (N = 935) to examine developmental differences across preadolescence, adolescence, and early adulthood. Our battery included a number of widely used self-report measures, including the Benthin Risk Perception Measure (Benthin, Slovic, & Severson, 1993), the Barratt Impulsiveness Scale (Patton, Stanford, & Barratt, 1995), and the Zuckerman Sensation-Seeking Scale (Zuckerman, Eysenck, & Eysenck, 1978),<sup>1</sup> as well as several new ones developed for this project, including a measure of Future Orientation (Steinberg et al., submitted for publication) and a measure of Resistance to Peer Influence (Steinberg & Monahan, 2007). The battery also included numerous computer-administered performance tasks, including the Iowa Gambling Task, which measures reward sensitivity (Bechara, Damasio, Damasio, & Anderson, 1994); a Delay Discounting task, which measures relative preference for immediate versus delayed rewards (Green, Myerson, & Ostaszewski, 1999); and the Tower of London, which measures planning ahead (Berg & Byrd, 2002). **We found a curvilinear relation between age and the extent to which individuals reported that the benefits outweighed the costs of various risky activities, such as having unprotected sex or riding in a car driven by someone who had been drinking, and between age and self-reported sensation seeking** (Steinberg, Albert et al., submitted for publication). Because our version of the Iowa Gambling Task permitted us to create independent measures of respondents’ selection of decks that produced monetary gains versus their avoidance of decks that produced monetary losses, we could look separately at age differences in reward and punishment sensitivity. Interestingly, we found a curvilinear relation between age and reward sensitivity, similar to the pattern seen for risk preference and sensation-seeking, but not between age and punishment sensitivity, which increased linearly (Cauffman et al., submitted for publication). **More specifically, scores on sensation-seeking, risk preference, and reward sensitivity all increased from age 10 until mid-adolescence (peaking somewhere between 13 and 16, depending on the measure) and declined thereafter.** Preference for short-term rewards in the Delay Discounting task was greatest among the 12- to 13-year-olds (Steinberg et al., submitted for publication), also consistent with heightened reward sensitivity around puberty. In contrast, scores on measures of other psychosocial phenomena, such as future orientation, impulse control, and resistance to peer influence, as well as punishment sensitivity on the Iowa Gambling Task and planning on the Tower of London task, showed a linear increase over this same age period, suggesting that the curvilinear pattern observed with respect to sensation-seeking, risk preference, and reward sensitivity is not simply a reflection of more general psychosocial maturation. As I will explain, these two different patterns of age differences are consistent with the neurobiological model of developmental change in risk-taking I set forth in this article. **The increase in sensation-seeking, risk preference, and reward sensitivity between preadolescence and middle adolescence observed in our study is consistent with behavioral studies of rodents showing an especially significant increase in reward salience around the time of puberty (e.g., Spear, 2000). There is also evidence of a shift in the anticipation of consequences of risk-taking, with risky behavior more likely to be associated with the anticipation of negative consequences among children but with more positive consequences among adolescents, a developmental shift that is accompanied by an increase in activity in the nucleus accumbens during risk-taking tasks** (Galvan et al., 2007).

### **Adolescents take too many risks**

#### **Driggs 01**

Ann Eileen Driggs, R.N., J.D., “The Mature Minor Doctrine: Do Adolescents Have the Right to Die?” Health Matrix, Vol. 11:687 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Lynn Ponton, an adolescent psychiatrist at the University of California**, has studied adolescent behavior, especially in the area of risk-taking. She has **found that adolescents are frequently involved in varying degrees of unhealthy risk-taking**.<sup>104</sup> Although most risk-taking during these years is a normal, developmental behavior (positive risk-taking) teaching adolescents how to think, act, and understand consequences of their behavior, **it can be potentially dangerous when it has predominantly negative results**.<sup>105</sup> During this time, teens want their maturity and independence recognized. However, although they can make independent choices, parents need to set limits and let them know they are not permitted to do everything they want to do in every situation.<sup>106</sup> **Risk-taking is the beginning of a lifelong process that involves learning to make decisions based on good judgment, but adolescents are not as yet able to fully assess the risks that may be inherent in any given decision**. They tend to look at one side of a problem, not the complete picture. As yet, **they do not have the wealth of life experiences of an adult to adequately assess the consequences of their actions**.<sup>107</sup> Furthermore, **many factors such as illness, culture, onset of puberty, peer involvement, and other social factors affect the ability of the adolescent to adequately assess risk**.<sup>108</sup>

**Adolescent brains are worse at goal-directed action; they're impulsive risk-takers.**

**Best science proves,**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A cornerstone of cognitive development is the ability to suppress inappropriate thoughts and actions in favor of goal-directed ones, especially in the presence of compelling incentives** (Casey, Galvan, & Hare, 2005; Casey et al., 2000b; Casey, Thomas, Davidson, Kunz, & Franzen, 2002a; Casey, Tottenham, & Fossella, 2002b). **A number of classic developmental studies have shown that this ability develops throughout childhood and adolescence** (Case, 1972; Flavell, Feach, & Chinsky, 1966; Keating & Bobbitt, 1978; Pascual-Leone, 1970). **Several theorists have argued that cognitive development is due to increases in processing speed and efficiency** and not due to an increase in mental capacity (e.g., Bjorkland, 1985; Bjorkland, 1987; Case, 1985). **Other theorists have included the construct of “inhibitory” processes in their account of cognitive development** (Harnishfeger & Bjorkland, 1993). According to this account, **immature cognition is characterized by susceptibility to interference from competing sources that must be suppressed** (e.g., Brainerd & Reyna, 1993; Casey, Thomas, Davidson, Kunz, & Franzen, 2002a; Dempster, 1993; Diamond, 1985; Munakata & Yerys, 2001). **Thus goal-directed behavior requires the control of impulses or delay of gratification for optimization of outcomes and this ability appears to mature across childhood and adolescence. Adolescent behavior has been described as impulsive and risky, almost synonymously, yet these constructs rely on different cognitive and neural processes, that suggest distinct constructs with different developmental trajectories. Specifically, a review of the literature suggests that impulsivity diminishes with age across childhood and adolescence** (Casey et al., 2002a; Casey, Galvan et al., 2005; Galvan et al., 2007) and is associated with protracted development of the prefrontal cortex (Casey, Galvan et al., 2005), although there are differences in the degree to which a given individual is impulsive or not, regardless of age. In contrast, to impulse/cognitive control, **risk-taking appears to increase during adolescence relative to childhood and adulthood and is associated with subcortical systems known to be involved in evaluation of rewards. Human imaging studies that will be reviewed, suggest an increase in subcortical activation** (e.g., accumbens) **when making risky choices** (Kuhnen & Knutson, 2005; Matthews & et al., 2004; Montague & Berns, 2002) **that is exaggerated in adolescents, relative to children and adults** (Ernst et al., 2005; Galvan et al., 2006). **These findings suggest different trajectories for reward- or**

**incentive-based behavior, with earlier development of these systems relative to control systems that show a protracted and linear developmental course, in terms of overriding inappropriate choices and actions in favor of goal-directed ones.**

## Stress

### **Stress in medical decision-making leads adolescents to make poor decisions**

#### **Driggs 01**

Ann Eileen Driggs, R.N., J.D., “The Mature Minor Doctrine: Do Adolescents Have the Right to Die?” Health Matrix, Vol. 11:687 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Exposure to stress can also result in ineffective or flawed decision-making. Cauffman and Steinberg discuss “three primary ways in which stress can cause decision-making errors. The first, premature closure, occurs when a decision is reached before all available alternatives have been considered. The second, nonsystematic scanning, refers to the consideration of alternatives in a disorganized, almost ‘panic-like’ fashion. Finally, temporal narrowing may produce faulty decisions because the person acts impulsively and does not give ample time to consider alternatives.”<sup>103</sup> There is no doubt that an adolescent suffering from a serious illness is under severe stress that could compromise rational and effective reasoning and thinking. The resulting decisions made by him could then be, not only irrational, but not in his best interest.

## Weighing

**Weighing – we should presume no competence unless proven otherwise**  
**Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Recall, however, that **adults are presumed to have this capacity, and a full blown inquiry into an adult's competence will only be triggered by peculiar circumstances that indicate** to a health care professional that the adult's 56 **competence should be questioned**. In practice, therefore, unless clear and convincing evidence is supplied to the contrary, **adults possess** “[a]n unqualified **liberty** interest... **to** [consent to or] **refuse any and all medical treatments**. 57 **Those under the age of eighteen, on the other hand, are presumed to lack capacity sufficient to rise to the level of competence requisite for autonomous authorization.**

## AT Understanding the Risks

**Advanced models prove adolescents make more sub-optimal decisions compared to adults – even when they understand the risks, their emotions win out**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**We have developed a neurobiological model of adolescent development within this framework that builds on rodent models** (Laviola, Adriani, Terranova, & Gerra, 1999; Spear, 2000) **and recent imaging studies of adolescence** (Ernst et al., 2005; Galvan, Hare, Voss, Glover, & Casey, 2007; Galvan et al., 2006). Fig. 1 below depicts this model. On the left is the traditional characterization of adolescence as related almost exclusively to the immaturity of the prefrontal cortex. On the right is our proposed neurobiological model that illustrates how limbic subcortical and prefrontal top-down control regions must be considered together. The cartoon illustrates different developmental trajectories for these systems, with limbic systems developing earlier than prefrontal control regions. According to this model, the individual is biased more by functionally mature limbic regions during adolescence (i.e., imbalance of limbic relative to prefrontal control), compared to children, for whom these systems (i.e., limbic and prefrontal) are both still developing; and compared to adults, for whom these systems are fully mature. **This perspective provides a basis for nonlinear shifts in behavior across development, due to earlier maturation of this limbic relative to less mature top-down prefrontal control region.** With development and experience, the functional connectivity between these regions provides a mechanism for top-down control of these regions (Hare, Voss, Glover, & Casey, 2007a). Further, **the model reconciles the contradiction of health statistics of risky behavior during adolescence, with the astute observation by Reyna and Farley (2006) that adolescents are able to reason and understand risks of behaviors in which they engage. According to our model, in emotionally salient situations, the limbic system will win over control systems given its maturity relative to the prefrontal control system. Evidence from behavioral and human imaging studies to support this model are provided in the context of actions in rewarding and emotional contexts** (Galvan et al., 2006, 2007; Hare, Voss, Glover, & Casey, 2007b; Hare et al., 2007a). In addition, we speculate on why the brain may develop in this way and why some **teenagers may be at greater risk for making suboptimal decisions leading to poorer long-term outcomes** (Galvan et al., 2007; Hare et al., 2007b).



General

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **AT Critiques of Capacity Tests**

**No test is perfect – capacity tests already have a ton of legal backing and are the best available starting point for revision**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**In spite of the limitations identified, however, a standard based on capacity would still seem to offer the best option in respect of sorting healthcare decisions. Although there is still a good deal of work to be done in this regard, there is a better chance of developing a rigorous legal framework around the concept of capacity than there is in respect of alternatives**

based on vulnerability or significantly impaired decision-making. However, a better legal framework for capacity would serve only to diminish rather than to remove the limitations which arise from a binary sorting of decisions. This becomes especially clear in the discussion of the operation of capacity assessment in practice in the next chapter.

## **Don't Know That Much / Inconclusive**

### **Err against simple explanations of adolescent brains**

#### **Steinberg 8**

Laurence Steinberg (PhD, Dept of Psychology, Temple University). "A social neuroscience perspective on adolescent risk-taking." Developmental Review. January 28th, 2008. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**It is important to point out that our knowledge of changes in brain structure and function during adolescence far exceeds our understanding of the actual links between these neurobiological changes and adolescent behavior, and that much of what is written about the neural underpinnings of adolescent behavior—including a fair amount of this article—is what we might characterize as “reasonable speculation.” Frequently, contemporaneous processes of adolescent neural and behavioral development—for example, the synaptic pruning that occurs in the prefrontal cortex during adolescence and improvements in long-term planning—are presented as causally linked without hard data that even correlates these developments, much less demonstrates that the former (brain) influences the latter (behavior), rather than the reverse. It is therefore wise to be cautious about simple accounts of adolescent emotion, cognition, and behavior that attribute changes in these phenomena directly to changes in brain structure or function.**

Readers of a certain age are reminded of the many premature claims that characterized the study of hormone–behavior relationships in adolescence that appeared in the developmental literature in the mid-1980s soon after techniques for performing salivary assays became widespread and relatively inexpensive, much as brain imaging techniques have in the last decade. Alas, the search for direct hormone–behavior linkages proved more difficult and less fertile than many scientists had hoped (Buchanan, Eccles, & Becker, 1992), and there are few effects of hormones on adolescent behavior that are not conditioned on the environment in which the behavior occurs; even something as hormonally driven as libido only affects sexual behavior in the right context (Smith, Udry, & Morris, 1985). There is no reason to expect that brain–behavior relationships will be any less complicated.

**There is, after all, a long history of failed attempts to explain everything adolescent as biologically determined dating back not only to Hall (1904), but to early philosophical treatises on the period (Lerner & Steinberg, 2004).** These caveats notwithstanding, the current state of our knowledge about adolescent brain development (both structural and functional) and possible brain–behavior links during this period, although incomplete, is nonetheless sufficient to offer some insight into “emerging directions” in the study of adolescent risk-taking.

### **Adolescent medical autonomy is too ambiguous to make a categorical judgment on Johnson 9**

Christopher Johnson (pediatric intensive care physician and author). “Adolescents and autonomy—the ethics of children making their own choices for medical care.” May 15th, 2009. <http://www.chrisjohnsonmd.com/2009/05/15/adolescents-and-autonomy-the-ethics-of-children-making-their-own-choices-for-medical-care/> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

One of the four key principles of standard medical ethics is the principle of autonomy, which I’ve written about here. Autonomy means that patients are in control of their own bodies and make the key decisions about what sort of medical care they will (or will not) receive. For children, this principle means that the child’s parents make these decisions. There are exceptions, as with all things in medicine. For example, if a child’s physicians believe that the parent’s choice will harm the child, the physician can ask a court to intervene. This is a very rare occurrence, but it happens sometimes. I have been involved in a few of those cases. But that’s not what I’m writing about now — I’m writing about nearly-adults, those children who are almost independent, but not quite. **The law generally defines the age of majority, the point at which a child is no longer a child and may decide these things for herself, at age eighteen, although there are variations between states.** (The age is younger for so-called emancipated minors — those children who are entirely self-supporting or who are married.) **What should we do when such a near-adult and her parents disagree about the treatment the child should get?**

There have been several recent examples of the variety of things that can happen then. One case is that of Dennis Lindberg, a fourteen-year-old boy who died from leukemia in 2007. Dennis was a Jehovah’s Witness and, like others in his faith, rejected blood transfusions, even in life-saving situations. It is common for the courts to mandate transfusions in very small children over the objections of Jehovah’s Witness parents. The rationale for this is that a small child is too young to decide himself if he agrees with his parents. Dennis’s doctors went to court to get such an order. But this case was different — Dennis was not a toddler or small child. He was an aware, articulate, young man who understood the meaning of both his illness and the consequences of not getting the transfusion. The court ruled that

Dennis had the right to make his own choice, which he did. His case dramatized a very grey area in medical ethics — when ought a young person be able to make these decisions on his own? In my own career I have had several occasions when an adolescent disagreed with the doctors, his parents, or both about what to do. In all those situations everyone eventually came to an understanding. That’s the best outcome, of course, but **these will always be ambiguous situations because children mature at differing rates. Some thirteen-year-olds are wiser than seventeen-year-olds.** For that matter, some young adolescents are wiser than others who have already attained the magic age beyond which we give them the right to make all these decisions.

## Age Cut-off

**An age cut-off would be easy but neglect specific case factors**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Along with commentators' individually created standards, **there are calls to institute a bright-line rule as a standard for the mature minor doctrine.**<sup>155</sup> **The most obvious bright-line rule would be to allow minors to make their own medical decisions starting at a certain age, such as sixteen. A rule like this would not require a health care provider, or the legal system, to become involved in the decisions of minors who are near the age of majority, the age range of most patients in mature minor cases.**<sup>156</sup> One proponent of the age sixteen bright-line rule notes that there is nothing "sacred" about age eighteen in our so-ciety,<sup>157</sup> and, **since no scientific evidence shows that sixteen-year-olds have less judgment than eighteen-year-olds, the bright-line rule should triumph.**<sup>158</sup> **The problem with a bright-line rule is that it will disregard questions of maturity completely, and, although maturity-based standards with their many factors are not ideal, neither is a standard that ignores the individual facts of a case.**

## Sliding Scale Test > Age Cut-off

**Illinois Supreme Court decided brightlines are bad and sliding scale maturity tests are good**

**Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The Illinois Supreme Court began by acknowledging that **the common law age of majority, eighteen, is not "an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood.**<sup>275</sup> It went on to detail statutory exceptions where minors are granted the right to seek medical attention including treatment.<sup>276</sup> The court also noted that **the Illinois Criminal Code provides a "sliding scale of maturity" that permits certain minors to be tried and convicted as adults.**<sup>27</sup> Finally, like the appellate court, it looked to the abortion arena where the United States Supreme Court has extended protection to minors under the Constitution.<sup>278</sup> With this backdrop, the Illinois Supreme Court determined that, **if adjudged a mature minor by clear and convincing evidence, Ernestine had the right to control her own health care.**<sup>279</sup> **The court felt that a trial judge must be employed to make this determination** in light of the State interests involved; namely, in the sanctity of life and the State's duty as *parens patriae* to protect minors.<sup>28</sup> **The court created a common law right to consent to or refuse medical treatment for minors "mature enough to appreciate the consequences of [their] actions," and "mature enough to exercise the judgment of an adult."**<sup>28'</sup>

**Solvency advocate for testing on a case-by-case basis**

**Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

One potential solution to this systemic problem would be to adopt a uniform age at which minors may make independent decisions based on research on minors' capacity to decide.<sup>139</sup> **If all persons of a certain age will have their decisions treated equally, however, society must be absolutely certain that all members of that age group can and will make decisions with a certain level of competence.**<sup>140</sup> Another solution could be to appoint representatives for a child.<sup>141</sup> At a minimum, perhaps children should have the right to be heard, even if society still denies them the ultimate right to decide.<sup>142</sup> **Society should shift the focus more significantly to capacity and require adolescents to demonstrate appropriate ability to reason abstractly and consider the future before granting rights.**<sup>143</sup> **The assessment of capacity would have to expand beyond traditional cognitive measures to consider a child's "judgment."**<sup>144</sup> **The real question should be whether a child is capable of engaging in rational decision-making,** and if so, the child should then be allowed to make independent decisions about his or her own life.<sup>145</sup> Some scholars envision a middle ground between the flat rule suggested above and this individual-capacity rule.<sup>146</sup>

## **Sliding Scale Test Bad**

**Physicians defer to parents when determining competency – the mechanism results in restricted autonomy**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

It may seem worrisome to defer such a determination, which can become legally binding, to someone outside the judiciary or the government.

**There are constraints to a physician's determination of maturity.** For instance, **the AAP policies tell physicians to take into consideration the opinions of the minor and her parents.**<sup>64</sup> **and physicians themselves recognize the importance of these opinions.**<sup>65</sup> Medical studies on maturity have all

established that a child reaches the apex of cognitive development between fourteen and fifteen; 166 physicians would have a difficult time ignoring so much medical precedent in declaring anyone under the age of thirteen or fourteen mature enough to make her own medical decision. If a physician were to make a clearly erroneous judgment, she would be accountable to peers in her profession. 167

**Sliding scale allows abuse, harms autonomy**

**Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Inherent to any sliding scale approach to competence is the potential for abuse from practitioners.** For instance, **one evaluating competence could set the standard so high or low that no person or any person-autonomous or not-could meet it. In this way, the practitioner would promote his or her own values, rather than those of the individual in question.**

Acknowledging that no test of competence is without error, the sliding scale attempts to err--out of the two possible errors--on the side that is more ethically defensible.

## Capacity Tests are Difficult

**Testing capacity in the abstract is impossible: the person, decision and emotional context they're in affects their reasoning**

**Michaud et al 15**

Pierre-André Michaud, University of Lausanne, M.D., Robert Wm Blum, M.D., M.P.H., Ph.D., Johns Hopkins, Lazare Benaroyo, M.D., Ph.D., Jean Zermatten, Ph.D. and Valentina Baltag, M.D., M.Sc., Ph.D. "Assessing an Adolescent's Capacity for Autonomous Decision-Making in Clinical Care?" Journal of Adolescent Health xxx (2015) 1e6 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Deciding on decision-making capacity must take into account the cognitive and affective aspects of reasoning and how they evolve during adolescence [15e18]. **The appraisal of adolescents' capacity is difficult for several reasons: First, the capacity to understand the short- and long-term aspects and consequences of a decision is highly dependent to the situation.** For instance, is Carlos able to appraise the clinical impact of stopping his medication? **Second, the fact that the pace of cognitive and affective development varies from one adolescent to another** [8,18,19] **makes the delimitation of age cutoffs for decisions regarding health very challenging.** As Fischhoff [16] notes, "**competence varies by individual and by decision,** leading to domain-specific policies and interventions, affording teens as much autonomy as they can manage". **Third, there is increasing evidence from neurodevelopmental research that the capacity to foresee the consequences of a behavior or a decision is, under certain circumstances, hampered by the relatively slow growth and maturation of the prefrontal cortex and by the emotional context** [20,21]. **As functional connectivity of the brain increases with age, increasing socioemotional maturity can be expected** [20], **but adolescents react in a variable manner depending on their emotional state, which has lead some authors to distinguish an "analytic" versus a "heuristic" reasoning process** [17], or, to put it in a simpler way, "**cold versus hot cognition**" [19]. Hot cognition refers to decisions made under conditions of high emotional arousal, whereas cold cognition refers to nonstressed decisionmaking. **If Carlos is asked about his future in the presence of his parents, his reasoning capacity may be hampered by the emotions linked with the conflicts with them.** On the other hand, **if his health care practitioner or other members of the health care team provide a safe and empathetic atmosphere and explore his thinking process calmly, they will promote optimal decisionmaking capacity, a climate of "cold cognition", which improves competence** of Carlos [22].



## **Objective Rationality Tests are Bad**

**Objective decision-making tests for competence assume certain standards that are inconsistent with liberal notions of autonomy and feminist critiques of rationality**  
**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In order to assess the relationship between capacity and rationality, it is necessary to distinguish between two different manifestations of rationality. **First, there is the view of rationality as objectively defensible;** and, secondly, there is the view of rationality as a logical process of reasoning. **The first view of rationality would require individuals whose capacity is questioned to have the ability to make objectively reasonable or ‘good’ decisions. Such an account is difficult** to reconcile with the liberal account of autonomy endorsed by the law. Mill defended the principle of non-interference, not on the basis of the objective defensibility of individuals’ decisions, but because, through liberty, individuality can develop. <sup>34</sup> **Recourse to ‘objective’ standards, whether on the basis of objective conceptions of ‘the good’ or on any other basis, would appear to be inconsistent with the liberal acknowledgement of the individual’s ‘right to a life structured by his own values’.** <sup>35</sup> **Feminist commentators have identified another difficulty with a requirement for rationality in this sense, pointing out that ‘women have long been portrayed and perceived as irrational, as incapable of objectivity or of engaging in reasoned decisionmaking’.** <sup>36</sup>

## Medical Expertise Good

**Medical expertise on competence is most important – medical communities have debated the issue**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

As discussed in Part II, there are different judicial opinions as to the most useful standard to apply the mature minor. Yet review of these standards shows that none incorporate any medical concepts on maturity or show a correlation with medical opinions and policies on respecting a minor's right to choose their own path of treatment when ill with a life threatening disease. In order to develop a better judicial standard for the mature minor doctrine, the courts should look to the guidelines and opinions of the medical community in ascertaining a minor's maturity. Individual health care providers have scientific knowledge and experience in determining maturity that judges do not possess. As demonstrated by the discussion in Part III, the medical community has extensively debated the subject of maturity, researched the issues surrounding a minor's maturity in relation to making medical treatment decisions, and incorporated ethical considerations. The legal community should reflect on the medical scholarship and recognize that maturity determinations are best left in the hands of science-oriented disciplines. By allowing the treating physician to make the determination of maturity of the minor, a court will be deferring to a well-educated, experienced, and unemotional party. Hopefully, the repetition of physicians' scientific bases for determinations of maturity will establish a more consistent and defined standard of application for the mature minor doctrine.

**Judges are in no position to decide maturity – it's a scientific, biological question better suited for health care professionals**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

A legal standard to determine a "mature minor" has had obvious difficulty in being defined. The difficulty is demonstrated by the courts in such decisions as Cardwell, In re E.G., and Long Island, as well as by legal scholars who have attempted to craft their own standards. The failure of the legal discipline in defining a standard for maturity is a result that should not be surprising; a determination of maturity is a scientific one, something that takes into consideration biological and social factors and can only be made by a person who has a frame of reference on the variety of capabilities of children at different ages.<sup>59</sup> Health care providers, or, more appropriately, pediatricians, have a better ability to evaluate these factors because of their medical education, training, and experience. The medical community has researched and debated the issue of maturity, which provides physicians with all the necessary tools to determine the maturity of a minor. First, there is the Piaget Cognitive Development Theory and supporting empirical research that guides medical professionals as to at what age a person should have certain cognitive functions.<sup>60</sup> Second, the AAP has promulgated several policy statements, taking into consideration experiences with parents,

minor patients, medical knowledge, and the bioethical responsibilities of physicians, that support the notion a doctor is the best suited to make determinations of maturity.' 61 Lastly, physicians themselves have studied their role in maturity determinations and recognize the important role they can, and should, play in determining the maturity of a minor.<sup>162</sup> **Would a judge have access to all the same information on maturity as a physician? The simple answer is no. Society should not even expect a judge to possess all this knowledge.**<sup>163</sup>

## **Medical Expertise Bad**

**Physicians are bound to medical precedent, the judgments of their peers, and are too unrestrained by the political and judicial process**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**It may seem worrisome to defer such a determination, which can become legally binding, to someone outside the judiciary or the government. There are constraints to a physician's determination of maturity. For instance, the AAP policies tell physicians to take into consideration the opinions of the minor and her parents;<sup>64</sup> and physicians themselves recognize the importance of these opinions.<sup>65</sup> Medical studies on maturity have all established that a child reaches the apex of cognitive development between fourteen and fifteen;<sup>166</sup> physicians would have a difficult time ignoring so much medical precedent in declaring anyone under the age of thirteen or fourteen mature enough to make her own medical decision. If a physician were to make a clearly erroneous judgment, she would be accountable to peers in her profession.<sup>167</sup>**

## Legal Issues

**There is no legally agreed upon definition of maturity. It's all up to judges' discretion**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, "State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment" 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The development of the mature minor doctrine at common law was intended to create an exception to the general rule that parental consent was always needed to medically treat minors.**<sup>13</sup> Minors that demonstrate "maturity" could provide consent without their parents. But the unintended result of the application of the mature minor doctrine can be found in the majority of mature minor cases: **there are so many factors a judge (or jury) must take into consideration when determining if a minor is mature that a well-reasoned, unambiguous, and uniform standard has failed to emerge. A trial judge's discretion, not guidelines, determines maturity.**<sup>14</sup> **Accordingly, the concept of maturity is not easily defined.**<sup>15</sup> **but there has been no movement within the judiciary or legislatures to clarify or simplify the doctrine's standards so minors, parents, and physicians know what to expect when legal action is necessary.**

**No agreement on competency tests means it must be decided on a case-by-case basis. Lots of factors make a difference**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, "State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment" 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The mature minor doctrine** is the fourth, and most recent, exception to the general rule that minors are incompetent and subject to the decisional control of their parents or guardians.<sup>47</sup> Its **increased development in judicial opinions in the last twenty years or so has allowed "a minor who exhibits the 'maturity' of an adult to make decisions** that traditionally have been reserved for persons who have attained the age of majority.<sup>48</sup> The application of this maxim has seen many different interpretations when applied to life-threatening illnesses, as opposed to illnesses that are not serious.<sup>49</sup> The result is the lack of a clear standard and reasonable expectations in the way a mature minor case will be decided by the courts. Case law is the primary place to study the standards of applying the mature minor doctrine. In *Cardwell v. Bechtol*,<sup>50</sup> **the Supreme Court of Tennessee** expressly adopted the mature minor doctrine. The court reinstated the trial court judgment that an osteopath had not committed battery in treating a minor, age seventeen and seven months, for back pain without the consent of her parents.<sup>51</sup> Although the facts did not involve a life-threatening illness, the court **supplied a comprehensive list of characteristics to take into consideration when determining whether a minor had the capacity to agree to any medical treatment: age, ability, experience, maturity, education, training, and demeanor.**<sup>52</sup> **The court indicated that these factors were to be taken in the context of the whole medical situation, including the ability of the minor to understand the treatment, the risks, and the consequences.**<sup>53</sup> The Rule of Sevens' age presumptions were the final determining factor.<sup>54</sup>

## **Their Research is White**

**Reject their studies – previous research is biased or incomplete.**

[Also AT “presume competence unless proven otherwise]

### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Although these studies cast doubt on the appropriateness of applying a presumption of incompetence to all adolescents, there are critics. **Some have argued that the findings are limited because the subjects were typically white and middle-class.**<sup>1 85</sup> **Others suggest that these studies define competence too narrowly, or fail to consider psychosocial factors that impact adolescents differently than adults.**<sup>s6</sup> In one of the first studies, Thomas Grisso and Linda Vierling articulated that **“it would be inaccurate to conclude that all adolescents are intellectually capable of providing independent consent.”**<sup>1 87</sup> **At the very least, these critiques indicate that it would be imprudent to reverse the current practice and adopt a presumption of competence for all adolescents.**

## AT Munby Vulnerability Test

**Munby's test is too wide, re-invokes capacity anyway, and distracts**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A vulnerability standard along the lines advanced by Munby J is problematic for a number of reasons.** Dunn et al . point out some of these difficulties. **First, because vulnerability is construed in a way which is ‘tied to the personal, social, economic and cultural circumstances within which individuals find themselves at different points in their lives’, it has the potential to be extraordinarily wide in its ‘scope and application’.** <sup>191</sup> **Secondly, while the assessment of capacity has become task-specific, a vulnerability approach ‘reawakens the ghost’ of an approach to capacity based on status.** <sup>192</sup> **A person may be deemed vulnerable** (and deprived of decision-making freedom) **simply on the basis of her disability.** **Thirdly, cases based on vulnerability ‘raise the possibility that a judgement that a person has the capacity to make an autonomous decision will be considered an inconvenient truth’ which may be ignored as the focus for discussion shifts to other matters.** <sup>193</sup>

**Family/Parental Rights**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)



Aff

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Family = Patriarchy

### **Upholding the family above individual autonomy is another instance of patriarchy Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

An initial challenge is that the modern liberal state often appreciates itself as having a somewhat adversarial relationship with the traditional family. Left to itself, as John Rawls recognizes, the family makes it impossible "... in practice to secure equal chances of achievement and culture for those similarly endowed," which implies that for reasons of justice, "... we may want to adopt a principle which recognizes this fact and also mitigates the arbitrary effects of the natural lottery itself" (Rawls, 1999, 64). **Consider Susan Okin's** disparaging **characterization** of "the sentimental family" and its reliance for "its health on the total dedication of women."

... **the family had become characterized as entirely distinct from the outside world.**

Allegedly united in its affections and interests, **this special sphere of life was held to depend for its health on the total dedication of women, suited for these special tasks on account of the very qualities that made them unsuited for the harsh world of commerce, learning, and power. Thus anyone who wished to register an objection to the subordinate position of women had now to take considerable care not to be branded as an enemy of that newly hallowed institution—the sentimental family** (Okin, 1982, 88; see also 1994).

As Okin rightly perceives, **the traditional family embodies particular understandings of proper family structures, including appropriate gender roles.** Consequently, she concludes: **"The liberal state . . . should not only not give special rights or exemptions to cultural and religious groups that discriminate against or oppress women. It should also enforce individual rights against such groups when the opportunity arises and encourage all groups within its borders to cease such practices"** (Okin, 2002, 229–30).<sup>1</sup> **Okin argues, for example, against permitting traditional religious groups to nurture and educate their children within the religion itself, decrying such pedagogy as indoctrination** (Okin, 2002, 218, 226). Or as Rawls puts the matter: "if the private sphere is alleged to be a space exempt from justice, then there is no such thing . . . the equal rights of women and the basic rights of their children as future citizens are inalienable and protect them wherever they are" (Rawls, 1997, 791). Such ideals of justice are invoked to reform and reconstruct the family<sup>2</sup> as well as to recast the bioethics of pediatric decision making.

## AT Legal Arguments

**Legal arguments for parents rights are bad – they have no basis in mental capacity and are overly protective. At a certain point, protectionism violates the child's autonomy**

### **Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Three main reasons explain why children's rights may be ignored in the legal system:**

**measuring capacity, protecting children because parents know best, and preserving and promoting family relationships.**<sup>131</sup> **While capacity has been acknowledged as a main reason**

for denying children's rights, **no serious measurement of capacity has been established**.<sup>132</sup> As discussed above,

**scholars disagree about the correct measurement** of capacity.<sup>133</sup> **Legislatures often claim that parents know best when it comes to their own children, but typically fail to provide support for this reasoning.**<sup>134</sup> This **protectionism** argument **stems from viewing children as vulnerable** and in

need of protection.<sup>135</sup> **Perhaps more accurately, neither judges nor legislative bodies will place the rights of children above those of parents.**<sup>136</sup> Further, **judges and legislatures appear concerned by placing the interests of children and parents in competition or contention.**<sup>137</sup> **Recognizing parental privacy rights over a child's rights gives parents nearly absolute autonomy over their child's decision-making.**<sup>138</sup>

**There are four common exceptions to parental decision-making**

### **Sloninat 07**

Mary Irene Sloninat, JD from Case Western, "State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment" 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The recognition of children's rights by the mid-twentieth century did not encompass a minor's decisional rights in relation to general medical procedures.** As with many legal concepts, several

exceptions developed from the general rule. **The four recognized exceptions to parental consent are: (1)**

**emergencies, (2) emancipation, (3) minor treatment statutes, and (4) the mature minor doctrine.**<sup>37</sup> The earliest exceptions to common law addressed the need of a minor to receive treatment in an emergency and those minors

who had been legally emancipated from their parents or guardians.<sup>38</sup> The emergency exception reflects a societal notion that it is cruel to allow a minor to sit in pain because a medical professional, wishing to avoid a lawsuit, refuses to treat the minor without parental consent. <sup>39</sup> One commentator has defined "[a]n 'emergency' . . . as anything requiring relatively urgent attention or that is causing a child pain or fear." <sup>40</sup> The second exception, emancipation, recognizes the legal rights a minor earns once a court has granted her emancipated minor status. If an emancipated minor has the same legal rights as an adult, she is allowed to make her own medical decisions like an adult.<sup>41</sup>

## AT Constitution

**The Supreme Court decided in Prince v. Massachusetts that parents' rights have limits and that the state can violate those rights to protect the welfare of the child**  
**Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The State of Massachusetts was successful in raising such an interest in the case of Prince v. Massachusetts.<sup>81</sup> **Prince involved the conviction of a nine-year-old girl's custodial aunt for violation of the Massachusetts child labor laws.** <sup>82</sup> **The aunt, a member of the Jehovah's Witness Church, took her niece with her as she traveled throughout her neighborhood distributing religious materials.** <sup>83</sup> By the time the case reached the United States Supreme Court it was uncontested that this activity violated state statute. Rather, the Court granted certiorari to determine whether the statute itself was constitutional as construed and applied in this context.<sup>84</sup> **The aunt argued that it violated her First Amendment right to freedom of religion,** <sup>85</sup> **and her parental rights secured by the Due Process Clause of the Fourteenth Amendment.** <sup>86</sup>

**The Supreme Court presented the conflict as the "obviously earnest claim for freedom of conscience and religious practice," coupled with the "parent's claim to authority in her own household and in the rearing of her children," against the "interests of society to protect the welfare of children, and the state's assertion of authority to that end."** <sup>87</sup> Although the Court acknowledged the strength of the former, **it made clear that neither religious nor parental rights are beyond limitation.** <sup>88</sup> **The Court concluded that the State, as parens patriae,** <sup>8,9</sup> **has a "wide range of power for limiting parental freedom and authority in things affecting the child's welfare; and that this includes, to some extent, matters of conscience and religious conviction."** <sup>90</sup> After describing the potential dangers of street propagandizing, the Court delivered one of its most oft quoted statements: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." <sup>9</sup>

**On abortions, the Supreme Court has ruled that mature adolescents should have the right to decide autonomously**  
**Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

During the next two decades, **the Supreme Court heard a number of cases involving legislation aimed at regulating adolescent abortion. Specifically, the cases dealt with the level of involvement parents should have in their adolescent daughter's decision to have an abortion.** <sup>16</sup> Starting with Bellotti, however, **the Court made clear that adolescent girls must be given an opportunity, through judicial bypass, to establish that they are "mature and well enough informed to make intelligently the abortion decision on [their] own."** <sup>61</sup> **Though the Court did not provide an excessive amount of guidance in maturity determinations, the principle was set: pregnant adolescents adjudged to have sufficient maturity must have their decision to have an abortion respected.**

## **Minors have Constitutional rights**

### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J.

Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Minors do possess rights protected by the Constitution. The Supreme Court has noted that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."**<sup>13 1</sup> Further,

although recognizing the importance of the age of majority, **the Court has stated that "[c]onstitutional rights do not mature and come into being magically only when one attains the stated defined age of**

**majority. Minors, as well as adults, are protected by the Constitution and possess**

**constitutional rights."**<sup>32</sup> It is clear, however, that these rights are much more limited than those of adults.<sup>1 33</sup> What is less clear is the extent to which the rights of minors, when recognized, are distinguishable from those of their parents. <sup>134</sup> The following discusses those situations where minors are afforded rights independent of their parents.

## **Parental Religious Rights ~> Adolescent Religious Rights**

**Minors have rights – if parents have religious rights based on the First Amendment, then mature children should have the same right to accept or reject the religious reasons of their parents**

### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Perhaps the first manifestation by the Supreme Court of the importance of inquiring into the wishes of adolescents came in Justice Douglas' partial dissent in Yoder. 17 **Recall that the majority in Yoder considered the issue to involve a conflict between the Amish parents and the State.**<sup>171</sup> **Justice Douglas disagreed** with this characterization, **stating that "[w]here the child is mature enough to express potentially conflicting desires, it would be an invasion of the child's rights to permit such an imposition without canvassing his views."**<sup>172</sup> Importantly, Douglas went on to suggest that **if a child disagrees with his or her parents' decision "and is mature enough to have that desire respected, the State may well be able to override the parents' religiously motivated objections."**

**If we care about religious rights, then we should allow MMD so children's religious rights are respected too**

### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Another possibility under the current status of the law is that minors with deeply held religious convictions will be prevented from acting according to their beliefs in violation of their autonomy.** For instance, **it is conceivable that Gregory Novak was deeply committed to his beliefs, so much so, that forcing him to undergo a blood transfusion would compromise his religious integrity. The district court's wholesale rejection of the mature minor doctrine with respect to treatment refusals fails to adequately protect the potential that Gregory's decision was ethically deserving of respect as autonomous.**

## Rawls

**We should try to minimize family's role in law – it's arbitrary and based on the lottery of birth**

**Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

An initial challenge is that the modern liberal state often appreciates itself as having a somewhat adversarial relationship with the traditional family. **Left to itself, as John Rawls recognizes, the family makes it impossible "... in practice to secure equal chances of achievement and culture for those similarly endowed," which implies that for reasons of justice, "... we may want to adopt a principle which recognizes this fact and also mitigates the arbitrary effects of the natural lottery itself"** (Rawls, 1999, 64).

Consider Susan Okin's disparaging characterization of "the sentimental family" and its reliance for "its health on the total dedication of women." ... the family had become characterized as entirely distinct from the outside world. Allegedly united in its affections and interests, this special sphere of life was held to depend for its health on the total dedication of women, suited for these special tasks on account of the very qualities that made them unsuited for the harsh world of commerce, learning, and power. Thus anyone who wished to register an objection to the subordinate position of women had now to take considerable care not to be branded as an enemy of that newly hallowed institution—the sentimental family (Okin, 1982, 88; see also 1994).

As Okin rightly perceives, the traditional family embodies particular understandings of proper family structures, including appropriate gender roles. Consequently, she concludes: "The liberal state ... should not only not give special rights or exemptions to cultural and religious groups that discriminate against or oppress women. It should also enforce individual rights against such groups when the opportunity arises and encourage all groups within its borders to cease such practices" (Okin, 2002, 229–30).<sup>1</sup> Okin argues, for example, against permitting traditional religious groups to nurture and educate their children within the religion itself, decrying such pedagogy as indoctrination (Okin, 2002, 218, 226). Or as Rawls puts the matter: "if the private sphere is alleged to be a space exempt from justice, then there is no such thing ... the equal rights of women and the basic rights of their children as future citizens are inalienable and protect them wherever they are" (Rawls, 1997, 791). Such ideals of justice are invoked to reform and reconstruct the family<sup>2</sup> as well as to recast the bioethics of pediatric decision making. At times,

**Rawls concedes that equal liberty and social justice tend toward the dissolution of the family. Individuals do not morally deserve their initial starting place in life,** their advantaged or disadvantaged placement, gender, or family role, he argued. **"That we deserve the superior character that enable us to make the effort to cultivate our abilities is also problematic; for such character depends in good part upon fortunate family and social circumstances in early life for which we can claim no credit"** (Rawls, 1999, 89). The consistent application of the principle of fair opportunity requires us to view persons independently from the influences of their social position. But how far should this tendency be carried? It seems that even when fair equality of opportunity (as it has been defined) is satisfied, the family will lead to unequal chances between individuals. ... Is the family to be abolished then? Taken by itself and given a certain primacy, the idea of equal opportunity inclines in this direction (Rawls, 1999, 448). **As long as some form of the family exists, he concludes, fair equality of opportunity and social justice can only be imperfectly carried out in society.** Consequently, **advocates of the liberal state seek to limit the bonds of family loyalty, to reduce the influence of parental authority vis-à-vis children, and to paint the traditional family in an unflattering light with wide ranging implications for the bioethics of pediatric decision making.**

Neg

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)



## Aristotle

### **Providing the material necessities of existence is the sole domain of the family**

#### **Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," *Journal of Medicine and Philosophy*, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Aristotle's view on the family is slightly more nuanced. **Aristotelian philosophy has a kind of organic notion of the state grounded in families, which, when they have grown large enough, bind together into a polis. The “state comes into existence, originating in the bare needs of life, and continuing in existence for the sake of the good life”** (Aristotle, 1984, 1252b29–30). **The material needs of bare life are the domain of the family, which seems to exist only for the purpose of procuring and sustaining the material needs of human life. The polis is the domain of the good life, the life of eudaimonia as described in the Nicomachean Ethics** (Aristotle, 1987). The “earlier forms of society” in **the family are natural to the human animal**, just as politics is natural to humankind (Aristotle, 1984, 1252b31). **So, just as life within the family or household is natural, so it is that the bios politikos is natural to man.** Aristotle also distinguishes zoē and bios in the *Politics*—zoē is bare life, the life we have by virtue of being alive; bios politikos is that form of life that is always qualified as the good life. **The despotēs (the head of the family) and the oikonomos (the head of a household/estate) are each concerned with the siring, birthing, and raising of children and the material sustenance of the members of the family or household** (Aristotle, 1984, 1252a25–35). **Thus, the realm of the family is zoē, bare life, the material necessities of existence.** The good life—the moral life—is the domain of the polis.

## **Autonomy Violates Parents' Rights**

**Aff measures like MMD disrespect familial health norms**

**Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," Journal of Medicine and Philosophy, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The policy recommendations made possible by the doctrine of the mature minor fail to recognize that the meaning of the body is founded in these sorts of familial practices and experiences of the family. Instead, the recommendations focus on consequences to individuals and to the state. This focus on consequences becomes a justification to undermine the normal familial communication of sexual mores, eroding the contextualizing function and foundational ground played by the family.**

**Only the neg respects parents' rights**

**Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," Journal of Medicine and Philosophy, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

We are not advocating an absolute withholding of contraception and other reproductive health care services without parental consent. **Instead of presuming that minors should be emancipated in the context of reproductive health, we are arguing for a strong presumption against the provision of contraception/abortion/EC without or against parental consent.** The expansion of the doctrine of the mature minor erodes the contextual conditions for the possibility of the moral goods of sex and sexuality, which are typically inculcated in the family. **The burden of proof should be on the medicolegal apparatus and individual practitioners to show the maturity of a particular minor and the necessity of providing contraception and EC without and against the consent of that minor's parents/guardians.** Of course, some kids who would obtain contraception may now be unwilling to obtain it and suffer the negative health consequences. But, others who would otherwise pursue contraception/abortion/EC without their parents may choose to involve their parents. In doing so, **the sexuality of adolescents will not be cut off from its familial context or the realm where the care of the body finds its origins and its moral significance.**

## **Better Decision-Making/Judgment**

**Parents make best decisions – best position to know what's best and foster the autonomy of the child**

**Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**There is also a considerable body of data demonstrating the positive impact of the more authoritative parenting styles and boundary setting typical of traditional family structures on the development of effective, autonomous, decision making. The data support the conclusion that adolescents who grow up with parents who are authoritative, setting strict limits on the adolescent's behavior and choices, are more likely to develop into effective adult decision makers. In contrast, adolescents raised with parents who utilize permissive parenting styles, in which the child himself is treated as the authoritative decision maker, develop significantly poorer effective decision-making skills. Authoritative parenting styles in general support, rather than undermine, the ability of the child to mature into a competent adult decision maker.**

Authoritative parenting is related to a wide range of positive cognitive and emotional outcomes, including better academic achievement (Dornbush et al., 1987; Weiss and Schwarz, 1996; Wintre and Ben-Knaz, 2000; Wintre and Yaffe, 2000), less psychological distress, fewer adjustment and problem behaviors (Brown et al., 1993; Fuligni and Eccles, 1993; Slicker, 1998), and better relationships with their peers, as well as higher levels of competence and self-esteem, personal reliance, and individual autonomy (Baumrind, 1991a, 1991b; Buri et al., 1998). Authoritative parenting styles improve the adolescent's ability to resist peer pressure, substance abuse, and other potentially harmful circumstances (Weiss and Schwarz, 1996; Adalbjarnardottir and Hafsteinsson, 2001; Huver et al., 2007).

**The family has normally functioned as a central social and moral category, with parents appreciated as possessing significant authority over their children substantially to guide their minor children's major life choices. For example, there has generally existed the normative presumption that, absent emergency or other exigent circumstances, medical treatment of minor children should occur with the consent of the parents. It is unclear why government bureaucrats, state legislators, hospital administrators, or clinical bioethicists would be better situated to make pediatric medical decisions than parents. Given the empirical data, traditional accounts of parental authority offer significant benefits to children. Parents by setting limits and giving direction, letting adolescents deliberate and choose within limited circumstances, while also withholding for themselves the right to veto adolescent decisions, help protect children from the long-term consequences of poor choices. Given the adolescent inability adequately to envision the long-term consequences of decisions, parents are able to guide and protect their children during a period of intellectual, physical, and emotional development when their decisional capacity is not yet that of an adult nature. The data support the conclusion that adolescents who grow up within functioning traditional families, who engage in authoritative parenting styles, are benefited. Such traditional family structures in the end augment positive characteristics (cognitive, emotional, and adaptive) associated with becoming an adult. Such data in total justifies the conclusion that parents should not be reduced simply to being trustees of what others judge as the child's best interests. Parents themselves are usually the best judges of their child's best interests as well as the best guides of the development of the autonomous decisional capacity of the adults that their children will become.**

## Adolescent medical autonomy entails the physician's judgment overtaking the parents', but parents know better

Ross 97

Lainie Friedman Ross (PhD, American physician and bioethicist who works at the University of Chicago). "Health Care Decisionmaking by Children: Is It in Their Best Interest?" Hastings Center Report. 1997. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

One of my major concerns with the AAP's recommendations is their willingness to involve third-parties in the decisionmaking process. My concern is that these decisions undermine the family. **Physicians provide only for the child's transient medical needs; his parents provide for all of his [their] needs and are responsible for raising the child in such a way that he becomes an autonomous responsible adult. Goldstein and colleagues at Yale University's Child Study Center expressed their concern that health care professionals sometimes forget where their professional responsibilities end, and described the harm that we do when we think we can replace parents.<sup>19</sup> By deciding that the child's decision should be respected over the parents' decision, physicians are replacing the parents' judgment that the decision should be overridden with their judgment that the child's decision should be respected. To do so makes this less an issue of respecting the child's autonomy, and more about deciding who knows what is best for the child. In general, parents are the better judge as they have a more vested interest in their child's well-being and are responsible for the day-to-day decisions of child-rearing. It behooves physicians to be humble as they are neither able nor willing to take over this daily function.**

## Parents make better decisions

Cherry 10

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The Convention similarly ignored key questions regarding who ought to be appreciated as in authority over children, as well as who is most appropriately situated to define and defend the best interests of the child (e.g., bureaucrats, bioethicists, or parents). **Parents have usually been identified, within rather broad side constraints, as the source of authority over their children and as the best judges of what constitutes the best interests for the family as a whole as well as the best interests of their minor children in areas of medical decision making. That is, parents themselves have usually been identified as the best judges for balancing costs and benefits, articulating values and inculcating virtues, to determine appropriate judgments for themselves and their children, and the family as a whole.** Parents, for example, must routinely think in terms of the best interests of the family as a whole and, as a result, families accept a wide range of choices that are in the best interests of the family, but not necessarily in the best interests of any particular child (such as, moving to accept a better paying job in a city with greater pollution<sup>19</sup> or an increased crime rate<sup>20</sup>).

## Consistency

**Denying adolescent medical autonomy recognizes that children and adolescents need different sorts of rights to flourish**

**Ross 97**

Lainie Friedman Ross (PhD, American physician and bioethicist who works at the University of Chicago). “Health Care Decisionmaking by Children: Is It in Their Best Interest?” Hastings Center Report. 1997. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A final argument against respecting the health care decisions of minors is based on placing the notion of health care rights in context.** Most individuals who support health care decisionmaking for children view it as an exception and do not seek to emancipate children in other spheres. **But why should a child who is competent to make major health care decisions not have the right to make other types of decisions? That is, if a fourteen-year-old is competent to make life-and-death decisions, then why can't this fourteen-year-old buy and smoke cigarettes? Participate in interscholastic football without his parents' consent? Or even drop out of school?** Child liberationists explore what it means to give children equal rights with adults in all spheres. In recent years, this position has become popular in both academic circles,<sup>12</sup> and the White House.<sup>13</sup> **Child liberationists argue that children are the last oppressed group in society. They lament that child-protection and not child liberation remains the legal ideal. They support the view that children have equal rights with their adult counterparts. But the rights that enable adults to flourish are not the same as those needed by children. In general, adults need mostly negative rights (the rights of noninterference and self-determination). Children also need negative rights (the right not to be physically, sexually, or emotionally abused), but they also need a wide variety of positive rights (the right to an education, adequate nutrition, and medical care).** Childprotectionists justify this difference in treatment on the grounds that children are less powerful, more vulnerable, and more needy of protection; child liberationists claim that such treatment further increases their powerlessness and vulnerability.

## Constitution

### **Recent court decisions grant parents decision-making power**

#### **Sloninat 07**

Mary Irene Sloninat, JD from Case Western, "State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment" 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The onset of the Industrial Revolution saw the emergence of children's advocacy groups and the promotion of child labor law, resulting in the state taking away some parental right to control the actions of children.<sup>28</sup> **But major recognition of children's rights in the United States did not occur until the 1960s and 1970s. In *In re Gault*,<sup>29</sup> the Supreme Court held that the Due Process Clause of the Fourteenth Amendment extended to children. In *Tinker v. Des Moines* Independent Community School District,<sup>30</sup> the Court recognized the fundamental rights of minors** (high school students in that particular case) and stated that "[s]tudents in school as well as out of school are 'persons' under our Constitution."<sup>31</sup> **Reproductive and privacy rights that had been constitutionally guaranteed to adults<sup>32</sup> were extended to minors**, although often in some limited form.<sup>33</sup> In 1971, ratification of the Twenty-Sixth Amendment lowered the voting age from twenty-one to eighteen.<sup>34</sup> **But, even with these decisions, there remained the general rule that the law granted parents broad decision-making power over their children**, as observed by the Supreme Court in *Parham v. J. R.*<sup>35</sup> **in 1979: The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has been recognized that natural bonds of affection lead parents to act in the best interests of their children.**<sup>36</sup>

### **Wisconsin v. Yoder proves**

#### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The Supreme Court reached a seemingly contrary result **in the case of *Wisconsin v. Yoder*,<sup>92</sup> where three sets of Amish parents were convicted at trial of violating the State's compulsory education law.<sup>93</sup> The statute in question required children to attend private or public school until the age of sixteen,<sup>94</sup> but the parents acting in accordance with their religious beliefs,<sup>95</sup> withdrew their children after they completed eighth grade.**<sup>96</sup> The parents did not challenge the fact that their actions violated the statute; rather, **they argued that the statute unconstitutionally infringed upon their First Amendment rights.**<sup>97</sup> The trial and appellate courts agreed that the compulsory education law interfered with the freedom of the parents to act in accordance with their religious beliefs, but concluded that the State's interest in education made enactment of the statute a "reasonable and constitutional" exercise of government power.<sup>98</sup> Wisconsin's Supreme Court, on the other hand, asserted that this interest was not sufficient to override the parents' rights.<sup>99</sup> It therefore reversed the convictions holding that the compulsory education law violated the Free Exercise Clause of the First Amendment.<sup>100</sup> The United States Supreme Court granted certiorari. **The Court began by noting that although the State's interest in universal education is strong,<sup>101</sup> it is not "totally free from a balancing process when it impinges on fundamental rights and interests, such as those specifically protected by the Free Exercise Clause of the First Amendment, and the traditional interest of parents with respect to the religious upbringing of their children."**<sup>102</sup> **The Court found that the Amish way of life was protected under the First Amendment**

**because their tradition is "one of deep religious conviction, shared by an organized group, and intimately related to daily living."**<sup>0 3</sup>

In this case, **the Court determined that forcing Amish children to attend high school would expose them to "worldly influences in terms of attitudes, goals, and values contrary to beliefs" in contravention of "the basic religious tenets and practice of the Amish faith."**<sup>1 °4</sup>

It determined that **to do so**, especially during the crucial developmental stage of adolescence, **would interfere with "the religious development of the Amish child and his integration into the way of life of the Amish faith community."**<sup>1 5</sup> In finding the Wisconsin statute unconstitutional, the Court concluded that "enforcement of the State's requirement of compulsory formal education after the eighth grade would gravely endanger if not destroy the free exercise of respondents' religious beliefs."

The majority's analysis in Yoder was framed as a conflict between the Amish parents and the State.<sup>0 7</sup> The Court specifically noted that the parents were charged under the Wisconsin statute, and therefore "their right[s] of free exercise, not that of their children," were at stake.<sup>°8</sup> The State did not argue that the parents were preventing their children from attending high school against the expressed wishes of the children. Thus, the Supreme Court did not address situations involving conflicts between parents and their children.<sup>10 9</sup>

## Laundry List

### **Parents should have the right to raise their children as they see fit – many warrants Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

### **Parents have a fundamental right, protected by the Due Process Clause of the Fourteenth Amendment, 70 to raise their children as they see fit.<sup>71</sup> This right, grounded in both law and ethics, extends to inculcating religious values and making medical decisions<sup>73</sup> for their**

incompetent children. In *Parham v. JR.*, the United States Supreme Court stated:

The law's concept of the family rests on a presumption that **parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions.**

More important, historically it has been recognized that **natural bonds of affection lead parents to act in the best interests of their children.**<sup>74</sup>

### **Buchanan and Brock offer four reasons in support of the position that parents are the proper surrogate decision-makers for their children:**<sup>75</sup>

**[First b]ecause in most cases parents both care deeply about the welfare of their children and know them and their needs better than others do, they will be more concerned as well as better able than anyone else to ensure that the decisions made will serve their children's welfare...**

**[Second] parents must bear the consequences of treatment choices for their dependent children and so should have at least some control of those choices....**

**[Third] a right of parents, at least, within limits, [is] to raise their children according to the parents' own standards and values and to seek to transmit those standards and values to their children...**

**[Fourth] the family is a valuable social institution, in particular its role in fostering intimacy. . . The family must have some significant freedom from oversight, control, and intrusion to achieve intimacy ....**<sup>76</sup>

Additionally, Lainie Friedman Ross argues that **the intimate family is itself autonomous, and as such, "promotes the interests and goals of both the children and the parents."**<sup>77</sup> She suggests that **parents are in the best place to understand familial goals, and therefore, should retain final decision-making authority in continual pursuit of those goals.**<sup>78</sup>

This being said, **parents generally enjoy the right to make decisions on behalf of their children without state interference. The Supreme Court has stated that "[i]t is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.**<sup>79</sup> In fact, intervention is only justifiable where the state demonstrates "a powerful countervailing interest."



## Prerequisite to Autonomy

**Parental rights to care for a child's development are a prerequisite to moral autonomy**

**Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," Journal of Medicine and Philosophy, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

For example, **a child requires that the family spend inordinate hours caring for and nurturing her; her survival depends on it. Even while a larger communal context is necessary to support the family, for the most part the child's parents, grandparents, aunts and uncles, and older siblings are responsible for the direct care of a child. No child would ever survive without the family to offer the necessities of feeding and cleanliness.** Certainly, the child will learn to feed and bathe herself by year four, but the habits for eating a healthy diet or maintaining cleanliness are usually not in place until well into the child's adolescence. Whereas other mammals do not require long and intensive periods of care for development to full adult activity, the human animal exhibits extreme bodily dependency for at least a decade and a half, **dependency that is attenuated by the social bonds of family.** Thus, **there is a kind of radical dependency that the child has on her family to meet each of her material needs.**

**Care for bare material life is a condition for the possibility of the development of a robust intellectual life,** which requires that even more care be provided to the minor. In most contemporary industrialized nations, education is usually funded by the state, but educators have consistently noted that familial involvement in the child's education is one of the most important factors in the child's intellectual development. **In the early years, children do not yet have sufficient cognitive development** to understand the value of education, for example, and **so they require the structure of the family to ensure that education takes place.** In fact, the family is essential to the cultivation of habits of education, such as reading and writing, in order to maintain those skills into adulthood. It is only after the child has reached her teenage years that her higher thinking and evaluative skills begin to develop. After the intellectual habits are acquired, the adolescent might begin to choose to engage in scholarly activities. Thus, **the capacity for reason necessary for a rich intellectual life as well as the habits that sustain intellectual development are largely goods internal to the family. Without the family, a child would not reach her greatest potential for rationality, including moral rationality.**

**The empirical data further demonstrate the dependency of children not only for the intellectual capacity for decision making but also for the importance of maturity in decision making. It seems clear that adolescents under the age of 16 are mostly unable to prioritize long-term goals over short-term benefits. Even while adolescents might be able to articulate intellectually the causal relations between their actions and the results of their actions, they tend to lack the emotional maturity to understand the richer complexity of decisions. For instance, several studies have shown that adolescents weigh more proximate benefits higher than distal benefits and weigh more distal costs lower than proximate costs** when compared to people over the age of 21 (Reyna et al., 2005; Reyna and Farley, 2006; Galvan et al., 2007). Thus, it is apparent that **the family can act as an external locus of control and contextualizing site for decision making for adolescents** under the age of 21.

Thus, **the dependency of adolescent children is not merely one of bodily or even cognitive capacity but also of their evaluative and axiological capacities. These dependencies are best addressed in a context where families can attenuate the deficiencies of minority.** Developmentally speaking, the child learns that her activities are not, or at least ought not to be, directed at some immediate material goal but are, or ought to be, directed at other higher goals and goods, and possibly even to the good for humans qua human as MacIntyre (1999) has noted. In other words, while the child and the adolescent are receiving care directed at material bodily needs, something much richer is

also being communicated and cultivated about the importance and content of the intellectual and moral life, as well as the meanings of the body. The ability to weigh different goods is still developing as the child moves from childhood to adolescence to independence in reasoning, including moral reasoning.

Put differently, **it is within the giving and receiving of care that the child learns not only the goods of the body but also the moral, social, and existential goods that belong to the particular family within which the child's life-world is formed. The intimacy of the care provided by the family conveys and cultivates the meaning of the body in all its facets, including the sexual and reproductive.** The cultivation of sexual mores does not begin as a response to the commencement of sexual attraction or decontextualized biological understandings of "teen hormones," but, rather, grows out of lifelong experiences of embodied living and decision making. Beginning from birth with simple practices of care for the material needs of bare life, like changing a diaper or reinforcing hygiene habits, **children subconsciously learn about the goods of the body.** And **before complex capacity for intellectual evaluation emerges, children are already infused with implicit ideas about what bodies are for in relationships.** Even small children learn of acceptable kinds of play, what it feels like to be comforted after falling down, and how to touch and not touch others.

As children grow, the cultivation of sexual mores progresses in more complex ways. Parents teach children explicitly about when to be cautious and protective of the body. Parents comment on what their children wear and how they comport their body in the world, suggesting that there are better and worse ways to dress and carry oneself. The kinds of visual images viewed for family entertainment and subtle parental responses to those images inform children's relational expectations. **Children begin to notice differences in gender, and parental responses to related questions carry robust content about sexuality, all while the brain has not yet achieved neurological maturity. While these neurological capacities are developing, the contextualizing actions of the family help to shape the meanings of sex and sexuality. The way that parents explain and contextualize the physical changes of puberty is tremendously formative of the child's understanding of sexuality.**

**Parental autonomy comes first and is in the best interests of the child—that outweighs even if adolescents are competent**

**Ross 97**

Lainie Friedman Ross (PhD, American physician and bioethicist who works at the University of Chicago). "Health Care Decisionmaking by Children: Is It in Their Best Interest?" Hastings Center Report. 1997. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

\*\*Brackets for gendered language

A third reason childhood competency should not necessarily entail respect for a child's autonomy is the significant role that intimate families play in our lives. **Elsewhere, I have argued that when the family is intimate, parents should have wide discretion in pursuing family goals, goals which may compete and conflict with the goals of particular members.**<sup>10</sup> In general, parental autonomy promotes the interests and goals of both children and parents. **It serves the needs and interests of the child to have autonomous parents who will help him [them] become an autonomous individual capable of devising and implementing his own life plan. It serves the adults' interest in having and raising a family according to their own vision of the good life. These interests do not abruptly cease when the child becomes competent. If anything, now parents have the opportunity to inculcate their beliefs through rational discourse, instead of through example, bribery, or force.**

## Presume Parents

**Err on the side of parental decision-making – the aff gives power to judges to determine competency, which in the context of life-or-death decisions is too important to be decided by one judge**

### **Driggs 01**

Ann Eileen Driggs, R.N., J.D., “The Mature Minor Doctrine: Do Adolescents Have the Right to Die?” Health Matrix, Vol. 11:687 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

It would, therefore, be difficult for judges to apply these concepts in a uniform manner to cases involving the mature minor doctrine because the stage of development of the child cannot be fully known by the judge.<sup>144</sup> Strong opinions and preferences of the adolescent, in addition to societal effects on this age group, greatly influence the adolescent’s decisions. When they voice a preference, they may think they know what they want, but it is difficult to evaluate the rationale for the decision made at that time. They express strong opinions and preferences, but at times do not really know what they want.<sup>145</sup> In custody cases, a juvenile may choose one parent over the other due to material benefits received from the chosen parent; they may choose emancipation to escape from what they perceive as a too controlling environment; they may choose to reject painful medical treatment because they believe life would be easier without it. Adolescents tend to think in terms of immediacy, not the future. Judges are forced to evaluate valid scientific information presented to them about child development, and then render what they believe to be an ethical decision that will govern the life and/or death of the child. In the instance of allowing a minor to reject life-sustaining treatment, judges are in effect, giving a death sentence. If they allow the minor to refuse the treatment in the face of parental opposition, the minor will most assuredly die. It is the only judicial circumstance whereby the judge issues what can amount to a death sentence for an individual that does not constitute punishment for a previously committed action. Is it fair to ask the judge to allow the minor to make this decision to end his life?

The necessity of deciding that a minor is mature places a judge in a most precarious position. Because his decision may result in the death of a child, he is understandably reluctant to permit a minor to reject life-sustaining medical treatment, whether the child’s decision is a valid “adult” decision or not. Court hearings can result from circumstances that arise when there is a conflict between the parental decision to administer treatment and the minor’s rejection of that treatment. It does not seem reasonable that a judge, although impartial and objective, should make a decision to reject a minor’s medical treatment. He does not know the child or the child’s behavior and environment intimately enough, even with the assistance of existing but inconsistent expert testimony. He is in fact a stranger to the immediate situation in most instances and, if the case is one of first impression, has little or no case history to evaluate. The responsibility to make the decision should ultimately fall to the parents, but only after consultation with the appropriate health care professionals and possibly ethics committees.

## AT Child's Best Interest

**Determining what's in the best interests of the child is impossible**

**Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

A core challenge for the Convention on the Rights of the Child is the articulation of a canonical moral anthropology—the nature and content of the basic goods central to human flourishing, such that one could articulate an account of the best interests of the child, without straightforwardly begging crucial questions. **As a matter of empirical reality, instead of moral unity, one finds a**

**considerable array of incommensurable moral accounts of the basic goods central to human flourishing—the moral norms necessary for judging the best interests of the child. One finds as well significantly diverse theories for rationally debating the merits of these divergent understandings of morality and human good. Even merely ranking central moral concerns, such as liberty, equality, justice, and security in different orders of importance will affirm different moral visions, divergent understandings of the good life, and varying senses of what it is to act appropriately in the best interests of children. There appear to be at least as many competing secular moral anthropologies, with attendant accounts of the basic human goods and the best interests of children, as there are major world religions and secular worldviews**

## AT Maturity Takes Parents' Rights

**Even if the adolescent is mature, the parent still has rights**

### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J.

Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**In sum, the Illinois Supreme Court held that if Ernestine were found to be a mature minor by clear and convincing evidence, she would have had the right to control her medical care.**

Interestingly, because Ernestine was eighteen by the time of this ruling, the court found no point in remanding the case to the trial court for a proper determination of whether she was a mature 285 minor at the time of the initial hearing. This appears to be very empowering for future cases, but is limited for two reasons. First, Ernestine's particular circumstance was not considered by the Illinois Supreme Court, so cases with

similar facts cannot point to the Supreme Court's ruling as dispositive of maturity. Second, **even if the Supreme Court had**

**held Ernestine to be mature, it stated that if her mother had not agreed with her decision, it**

**would "weigh heavily against the minor's right to refuse."** <sup>286</sup> Thus, **even if mature,**

**Ernestine's decision would not have been respected as autonomous. Paradoxically, this**

**suggests that a mature minor is only empowered to refuse life-saving or sustaining medical**

**treatment to the extent that his or her decision coincides with a parent's belief that alone**

**would be restricted by the State.** <sup>287</sup> Compare the analyses used by the Illinois courts to that utilized by a trial court in New

York.

General

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Constitution Unclear

### **Courts applying the same standard come to different results**

#### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Although the courts in Sampson and Green had similar facts before them, they came to very different results. While Green furthered the "life-threatening exception" to parental control, Sampson at least implicitly suggested that the child's quality of life is a relevant consideration, and can justify state intervention as an additional exception.**

### **No right to autonomy in the Constitution proper**

#### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**It is perhaps surprising that there is no express reference to a right of 'autonomy' (or 'self-determination') to be found in any of the leading bills of rights. Rather, the right is part of what Laurence Tribe calls, in respect of the United State Constitution, the 'invisible constitution'**

1 While this does not diminish the degree of support the right enjoys (not least because the right also has a basis in the common law), **it has meant that the ambit of the right receives relatively little legal analysis.** Rather, the right tends to be invoked, oft en in a medical context, without any attempt to fi t the right as applied within a broader analytical framework. Since Cardozo J's dictum in *Schloendorff v. Society of New York Hospital*, 2 **the status of autonomy as a principle of non-interference has been largely uncontested in healthcare law.** Th is is not least because, in many ways, respect for this form of autonomy sits comfortably with the law. Not only are the legal tools for enforcing this form of autonomy long established in the tort of trespass, 3 respect for the principle also allows courts to avoid engaging in judgments about the utility or morality of particular conduct and provides neat answers to diffi cult dilemmas.

### **Yes, some legal reasoning links autonomy and consent within tort law, but it's still not legally justified or recognized as a right**

#### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Th e legal linkage between respect for autonomy and the requirement for consent became established in a series of early twentieth century American decisions in the tort of battery. 32 However, as subsequent case law has shown, the fact of consent does not, of itself, provide legal justification in respect of all medical interventions. Superior courts across the common law world have rejected autonomy-based arguments in favour of a right to assisted suicide. 33 Th e fact of consent may also not provide the basis for the lawful amputation of healthy limbs. 34 Th us, in practical terms, the most prominent consequence of the right of autonomy in respect of healthcare decisionmaking has been the legal recognition of a right to refuse treatment.**

## AT Yoder

**Yes – there’s a First Amendment right to religious development of children, but not if it threatens the child’s livelihood. Yoder was decided for the parents because it didn’t harm the kids to take them out of school**

### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Although the Court was careful to limit its decision in the education setting to the specific facts before it," 0 **the Yoder decision** is important because it **signifies the strength of a parent's First Amendment right to foster the religious development of their children. The majority opinion rejected the State's reliance on Prince stating that there was no demonstration of "any harm to the physical or mental health of the child or to the public safety, peace, order, or welfare."** In the years between Prince and Yoder, state courts were substantially on their own in determining when to intervene when parents made medical decisions on behalf of their children based upon religious beliefs."12 **Prior to Prince, courts utilized a "life threatening exception"** that typically involved state intervention in situations where medical care would "obviate almost certain death for a minor whose parents refused to consent to a blood transfusion." 13 **In cases where the child's life was not in imminent risk, however, courts were hesitant to override parental objections to medical care.** 114 Thus, **debate surrounded the issue of when children are placed in risk sufficient to rise to the level of Prince-like martyrdom.**"15



## Religious Rights

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Advantage Areas

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Advantage – Disease

### **Resisting immunization for religious reasons spreads disease and kills**

#### **Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265–276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**In the United States, children are exempt from immunizations** in all states, except Mississippi and West Virginia, **if their parents object on the basis of religious convictions**.<sup>16</sup> **In 1994, the four-year-old son of Christian Scientists living in Massachusetts died of diphtheria as a result of not being vaccinated. Three dozen or more people, mostly children, were exposed to this child prior to his death.**<sup>17</sup> In 1985, **there was a measles eruption at a Christian Science college.** Of the college's 700 students, **120 became sick with measles and three died – a death rate more than 20 times the mortality from measles in the general population.**<sup>18</sup> In 1972, **a polio outbreak at a Connecticut Christian Science boarding school went unreported until 11 children were paralyzed.**<sup>19</sup> In 1988 and again in 1997 the American Academy of Pediatrics, joined by the National District Attorneys Association, the National Committee for the Prevention of Child Abuse, and the American Medical Association adopted policy statements calling for the complete repeal of religious exemptions in child abuse and neglect and criminal statutes.<sup>20, 21</sup>

## **Advantage – Preventable Deaths**

### **Hundreds of children die because their parents' religions prevent proper treatment Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265–276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The ardent followers of spiritual healing rarely seek medical care for their children** and it is unclear how many have died or are suffering from untreated illness. **A study conducted by Asser in 1998 concluded that 172 children of faith-healing sects died from 1975– 1995. Of these, 142 deaths were from conditions with survival rates of greater than 90%, 18 had survivals of over 50%, and three would have derived some benefit from medical care.**<sup>15</sup>

Competency

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **Yes Religious Maturity**

### **Adolescents are religiously and spiritually mature**

#### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Although courts seem loathe inquiring into the religious identities of children and adults, substantial scholarship exists contemplating religious development.**<sup>406</sup> **Ronald Goldman mapped religious thought development onto three of Piaget's stages in the development of operational thinking:** (1) 407 intuitive (pre-operational), (2) concrete, and (3) abstract. **He found that by age fourteen many adolescents entered the final stage, and were at least capable of more mature, abstract religious thinking.**<sup>408</sup> Goldman acknowledged, and later studies supported, that age is not a bright line indicator of religious thought development. For example, recent scholarship suggests that "[b]oth children's and adults' god concepts are limited by context demands in their cognitive complexity" such that the "concrete-to-abstract shift may not occur over the course of development but instead may manifest from one situation to another."<sup>409</sup>

Elizabeth Ozorak theorized that "[a] model of religious development in adolescence should be grounded in the process of maturation, especially in cognitive changes, but it should also weigh the influences of the parents and their chosen religious organization (if any) against the more diverse influences of peers."<sup>410</sup> In other words, religious development does not occur in a vacuum; "children actively process the information they receive and draw inferences from it."<sup>411</sup> **The ultimate question, then, is whether adolescents have the ability to express religious identities independent of third parties: do they have the capability to formulate a deeply rooted self-conception that will promote their well-being based upon their understanding of their religious values?**

**Robert Coles, a pediatric psychiatrist, performed a study involving the religious experiences of hundreds of children.**<sup>412</sup> **Coles found that "his subjects revealed an intense interest in an engagement with traditionally religious questions and concepts," in a way that made their beliefs central to their lives.**<sup>413</sup> Centrality alone, however, is not sufficient. For instance, the Cheema children's religious beliefs played a central role in their lives, but that does not mean that the children had the cognitive capacity to establish a self-identity based upon those beliefs. This requires a greater degree of sophistication than younger children likely possess. On the other hand, the studies reported in Part III of this article, coupled with those involving religious development, suggest that that **many adolescents have the cognitive capacity to formulate deeply rooted religious identities.**

## Religion ~> Undue Influence

**Adolescents can be manipulated or influenced by parents; it's hard to tell whether their religious beliefs are authentically their own**

### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The goal of the mature minor doctrine is to ascertain those adolescents who have developed underlying and enduring aims and values, and thus, the capability of making decisions that would promote their well-being without the aid of their parents or the State. **Under the current framework, it is possible that a minor could be permitted to refuse live-saving or sustaining medical treatment based upon religious beliefs because they understand and appreciate the medical aspects of their situation, yet do not have authentic beliefs that are integral to their lives. This is a dangerous precedent.** For instance, **the trial court** believed that Ernestine was mature enough to understand the medical nature of her condition, but **was concerned that her expressed religious beliefs were not necessarily her own.** **In extending decisional authority to Ernestine, the majority opinions** from the appellate courts in Illinois downplayed the religious aspect of the decision by **emphasizing her maturity with respect to the medical aspects of the decision.**<sup>347</sup> Further, Justice Cappy implied in his concurrence that if Shannon had understood the nature of her condition and appreciated the consequences of her decision, she should have been permitted to refuse medical treatment. This ignores the possibility that **Shannon may have been impermissibly influenced by her parents and religious community in coming to a refusal decision in contravention of her true sense of well-being. Disregarding the religious aspect of the decision-making process leaves open the possibility that practitioners will allow adolescents to choose to die for their expressed beliefs in a way that fails to protect and promote the adolescents' well-being.**

**Religion doesn't guarantee autonomy – adolescents can be brainwashed!**

### **Spike 11**

Jeffrey P. Spike, University of Texas Health Sciences Center, "When Ethics Consultation and Courts Collide: A Case of Compelled Treatment of a Mature Minor" Narrative Inquiry in Bioethics, Volume 1, Number 2, Fall 2011, 123-131 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

But we also had some doubts. Is it possible, we asked ourselves, that in some larger sense he does not understand the consequences? **Perhaps he has been so immersed in his family that he has not had the chance to realize there are other religions, or even people who reject all religion** because they consider them each to be defined by some set or another of nonrational beliefs ("revealed truth" that one cannot question). This made us wonder: might the goal of ethics sometimes be to talk people out of their religious beliefs (or into a better, healthier set of religious beliefs)? This thought could seem almost comical, were not the situation so grave. We were concerned that perhaps **a younger person might be prone to absolutist, fundamentalist, literal religious beliefs—an abstract but not yet critical level of thinking.** **Everything might be seen through a distorting ideological or religious prism** that makes all issues appear to be black and white. **Perhaps truly mature people have the ability to question their beliefs,** although we also had to admit there is certainly much evidence of adults who, to the contrary, are willing to die or kill for their religious beliefs. We considered both questions among ourselves: could we find some sort of chink in his armor, or was our very search unfair as we would not do it to an adult? We returned Monday as promised. The chart indicated that the tests had revealed what we had all feared, a crit of 14–15, hemoglobin of 4.5, platelet count of 5: severe aplastic anemia. We proceeded to his room. Luke greeted us without any sense of resentment. We tried to ask questions to determine **if he had been so protected by his community that he was little more than brainwashed,** so that we could conclude that **he didn't have true free will or Autonomy.** He intuited the

meaning of the questions before we finished them, and answered them. He had, he admitted, had a period of doubt about Jehovah's Witnesses a year earlier. He goes to a public school, he explained, so most of his friends and teammates were not Jehovah's Witnesses. He went with some of them to their churches, to see if he liked them. But none of them felt like home; he felt like his friends had their traditions which he could respect, but he felt more strongly that he wanted to be a Jehovah's Witness afterwards, and wanted to remain that way for the rest of his life. How many adults, we asked ourselves, have done as much?



Mechanisms

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Conscientious Objection

### **Conscientious objection for religious and moral reasons allows for autonomous refusal of medical treatment**

#### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

#### **When individuals refuse to act in a certain prescribed way, they do so under what is**

**commonly referred to as conscientious objection**. For instance, physicians may seek to avoid performing controversial procedures, such as abortion or physician-assisted suicide when patients so request. Refusing to treat the patient could be viewed as a breach of the physician's duty to act in the patient's expressed best interests, but many ethicists argue that physicians should not be forced to act in a way that violates their personal moral integrity. 389 Mark Wicclair suggests that the moral weight given to the physician's objection is a function of the "centrality of the beliefs upon which they are based to the physician's core ethical values." 390

Conscientious objection also occurs frequently with respect to military duty. **During the draft associated with the Vietnam War, many individuals objected to joining the war effort based upon appeals to conscience**. The statute authorizing the draft provided an exception for individuals conscientiously opposed to participation in war in any form by reason of religious training and belief.<sup>391</sup> In a series of cases related to conscientious objectors, **the Supreme Court of the United States established that decisions based upon conscientious objection "must be sincere** and not based on political grounds; nor may [they] be a simple matter of expediency or selfinterest." 392 Further, **"[t]o act conscientiously is to act in the honest and sincere belief that what one is doing is morally right, even if it is illegal."** 39

The language of the Court's decision in *Welsh v. United States* is explicative. Elliot Welsh was convicted for violating the federal statute that mandated he submit to induction to the Armed Forces because, although he had strong beliefs opposing the war, those beliefs were not religiously based. 394 In reversing Welsh's conviction, the Supreme Court first made clear that **conscientious objection does not apply to "those whose beliefs are not deeply held and those whose objection to war does not rest at all upon moral, ethical, or religious principle but instead rests solely upon considerations of policy, pragmatism, or expediency."** 395 The Court relied on Welsh's testimony: I believe that human life is valuable in and of itself; in its living; therefore I will not injure or kill another human being. This belief... is essential to every human relation. I cannot, therefore, conscientiously comply with the Government's insistence that I assume duties which I feel are immoral and totally repugnant. 396 The Court was persuaded that Welsh's convictions were "spurred by deeply held moral, ethical or religious beliefs" to the extent that requiring him to "become an instrument of the war" would give him "no rest or peace." 397 In other words, **his beliefs were so tied to his sense of well-being that to order him to act contrary would cause "self-betrayal and loss of self-respect,"** 398 in clear violation of his autonomy.

Like conscientious objectors to war, **adults who refuse medical treatment based upon their religious convictions do so under the belief that to act otherwise would cause grave harm to their sense of well-being. In choosing to die for their beliefs, these adults are presumed** 399 **to have religious integrity, marked by a deeply rooted self-conception that is founded in religious values and is so central to the person's life that it guides daily activities and decision-making**

## Solvency Advocate for Religious Autonomy

**Solvency advocate for religiously-based autonomous choices – courts should allow autonomous choices when there is proven religious motivation**

### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In addition, **the courts should require adolescents to explain the relationship between the centrality of their beliefs and their established sense of well-being.** When asked about the suffering Ernestine would experience from a blood transfusion, a Jehovah's Witness minister likened it to that of a rape victim: **“'[f]orcing anyone to violate his consideration [sic] is the most painful indignity that an individual could have perpetrated against him.’”**<sup>434</sup> In fact, the minister's sentiment is a common argument against violating the principle of respect for autonomy.<sup>435</sup> Again, however, **it is only a violation if the person's choice is truly autonomous; that is, based on underlying and enduring aims and values representing a true conception of well-being.** It is possible that Ernestine also felt this way, but that was not elucidated at trial. Given the subjective nature of religious integrity, **it is likely impossible to know for certain how central a given individual's religious beliefs are to their identity. However, a psychological inquiry is still an improvement over lawmakers' guesses as to expressed religious sincerity,**<sup>436</sup> **especially where the decision is life or death in nature.** When it comes to religious refusals by adolescents, “[t]he value of the inquiry is not that it can simplify the analysis but rather that it can facilitate a more intelligent consideration of the complexities.”<sup>437</sup> Further research may extinguish these shortcomings.

## AT Vaccines

### **Adolescents want to participate in vaccination decisions but don't want complete autonomy for them**

#### **Pyrzanowski et al 13**

Jennifer Pyrzanowski, MSPH , C. Robinette Curtis, MD, MPH , Lori A. Crane, PhD, MPH, Jennifer Barrow, MSPH , Brenda Beaty, MSPH, Allison Kempe, MD, MPH, and Matthew F. Daley, MD. "Adolescents' Perspectives on Vaccination Outside the Traditional Medical Home: A Survey of Urban Middle and High School Students." Clinical Pediatrics. 2013. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Although the vaccination of adolescents in the United States generally requires parent or guardian consent,<sup>33,34</sup> based on the limited data available, adolescents appear to be participating in vaccination decisions. A majority of urban 6th- and 11th-grade adolescents in the current study reported being involved in decisions about their health care, and three quarters of 11th-grade adolescents reported that teens younger than 18 years should be allowed to receive a vaccine to prevent a sexually transmitted infection without their parents' permission.** Few other studies on this subject have been published.<sup>21,35,36</sup> In a postlicensure survey about HPV vaccination in urban California private and public high schools, 48% of female students reported that they participated in the decision whether or not to receive HPV vaccine<sup>35</sup>; however, the study was small and most students came from highly educated families, which may limit generalizability of these findings. **In a recent national study by Kennedy et al,<sup>36</sup> 72% of minor adolescents disagreed with the statement "I should be allowed to get vaccines without [parental] permission."** **Although these findings seem in conflict, it may be that many adolescents want to be involved in vaccine-related decisions but do not want the ultimate responsibility of providing their own independent consent for vaccination.** Adolescents' attitudes about vaccine decision-making may also vary based on factors such as the type of vaccine, where the adolescents live (urban versus rural), and their parents' socioeconomic status and education level.

### **Vaccine scares cause outbreaks**

#### **O'Donnell 04**

Kath O'Donnell, University of Hull, "Re C (Welfare of Child: Immunisation) - Room to refuse? Immunisation, welfare and the role of parental decision making" 16 Child & Fam. L. Q. 213 2004 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Concern over the effects of childhood vaccination is not a recent phenomenon. **There is a very clear parallel between the current MMR controversy and the events surrounding the pertussis** (whooping cough) **vaccination** in the 1970s. Immunisation against whooping cough was administered as part of a combined inoculation against diphtheria, tetanus and pertussis (DTP). There, too, **high profile reporting of potential side effects of one element of the combined inoculation** (in that case, a potential link between brain damage causing epilepsy and the pertussis vaccine) **resulted in considerable parental concern and a loss of confidence in the vaccine.** **Immunisation levels dropped and a whooping cough epidemic followed,** in the wake of which vaccination levels rose again.<sup>7</sup> The alleged link between the whooping cough vaccine and neurological damage gave rise to litigation by the families of affected children, and was a significant factor in the development of the Vaccine Damage Payments Act 1979, as well as the formation of groups campaigning against vaccination which are still active today.

## **CP – Mandate**

### **Compulsory vaccination is key to prevent outbreak**

#### **Trevena and Leask 09**

Lyndal and Julie, pfs @ University of Sydney, “Decision aids for MMR vaccination.” In Edwards, Adrian, and Elwyn, Glyn, eds. Shared decision-making in health Care : Achieving evidence-based patient Choice (2nd Edition). Oxford, GBR: Oxford University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The role of legislation and regulation in promoting justice over autonomy **At some point, society needs to overrule autonomy for the sake of justice and impose regulation or even legislation. In the case of immunization, these measures might include compulsory vaccination, incentives provided to doctors or parents for children to be vaccinated, or exclusion of the unvaccinated during an outbreak of a vaccine preventable disease.**

Religious Groups

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **Christian Scientists**

### **Christian Scientists reject standard medical treatment**

#### **Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265–276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

### **For Christian Scientists, the power of prayer is superior to standard medical treatment.**

**The solicitation of medical care demonstrates weakness of faith.**<sup>8</sup> Corroborative evidence for the success of spiritual healing is provided through member testimonials by the recently cured and supported by at least three other church members present during the patient's recovery. Since 1900, **Christian Scientists have reported over 53,000 healings from**

**many diseases**.<sup>9</sup> However, the validity of this statistic is questionable for three reasons: (1) members are infrequently diagnosed by physicians, (2) Christian Scientists generally keep no written records, including a count of total membership and documentation of healings, and (3) unsuccessful spiritual healings are not documented or recorded through oral history.

## Jehovah's Witnesses

### **Jehovah's Witnesses reject blood transfusions**

#### **Brezina and Moskop 07**

Paul R. Brezina, MD, MBA; John C. Moskop, PhD, "Urgent Medical Decision Making Regarding a Jehovah's Witness Minor: A Case Report and Discussion" NC Med J September/October 2007, Volume 68, Number 5 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The Religious Context: **Jehovah's Witnesses Jehovah's Witnesses are members of an international religious community who adopt a literal interpretation of the Bible and assert that their faith is a restoration of early Christianity**<sup>4</sup> Jehovah's Witnesses comprise a small proportion of the population in both North Carolina and the nation. In 2001 approximately 0.6% of the US population and less than 0.5% of North Carolina residents identified themselves as Jehovah's

Witnesses.<sup>5</sup> **Jehovah's Witnesses cite** the following **biblical passages from the King James Bible to support their belief that accepting blood products is a serious sin**:<sup>6,7</sup> Genesis 9:4 "Blood ye shall not eat." Leviticus 17:12-14 "No soul of you shall eat blood... whosoever eateth it shall be cut off." Acts 15:29 "That ye abstain...from blood." Acts 21:25

"Gentiles...[should] keep themselves from things offered to idols and from blood." **This sin is considered so grave by the faith that any direct partaking of blood results in the "loss of eternal life."**<sup>3</sup> **Therefore, it is common for Jehovah's Witnesses in critical need of blood transfusions to choose death over acceptance of blood products. The right of adults to make this decision is well accepted in the medical and bioethics literature and widely respected in medical practice.**<sup>3</sup> **The ability of minors, however, to comprehend the gravity of such a decision or to make an autonomous decision independent of the wishes of their parents is much less clear.**

### **Jehovah's Witnesses reject blood transfusions**

#### **Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265-276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

This is in sharp contrast to the case of refusal of blood transfusion for a child of a Jehovah's Witness. **The refusal is almost universally overridden by court order, but in the eyes of the Jehovah's Witness may carry a very significant burden.** The Watchtower Society, **the official agency of the Jehovah's Witnesses, maintains that transfusions are synonymous with eating blood, which is forbidden in the Bible** in Genesis 9:4 and Acts 15:28-29.<sup>38</sup> **Accepting a blood transfusion disobeys God's commandments and may lead to eternal damnation.**<sup>39</sup> Until recently, **a secondary but still significant burden included exclusion or banishment from the religious community.** It is a compelling existential concept: the idea of sacrificing a very short (in relation to eternity) life on earth to assure eternity with one's creator.



## **Jehovah's Witnesses: Exceptions**

**Jehovah's Witnesses now pardon children who receive blood transfusions without consent**

**Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265–276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**There is significant heterogeneity in the Jehovah's Witness communities, and many have asserted various "pardons" for both adults and children in the instance that blood products are administered to them without their knowledge and/or consent. Jehovah's Witness parents may be comforted by the hope that their children may still see heaven even if they receive blood.** It is interesting that this seemingly more theologically compelling argument for refusal of treatment (and only refusal of blood products; Jehovah's Witnesses embrace all other forms of medical treatment) has not received the same degree of consideration and deference as that of the Christian Scientists.

Weighing

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **Right to Live Outweighs Religious Rights**

**Right to live outweighs right of the parent to their religious expression**

**Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265–276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Consider a brief application of ethical principles to the particular situation of a sick child of a Christian Scientist parent. **The withholding of lifesaving medical treatment on the basis of the parents' belief that the child may be otherwise healed through prayer would suggest that parental autonomy outweighs prevention of harm to the child. However, the harm to the child, potentially resulting in severe morbidity and even death, far outweighs the harm to the parent by disregarding their autonomy and authority to make decisions about their child. The ethical calculus of benefit/burden is clearly in favor of benefit of medical treatment. It would seem that medical treatment of a Christian Scientist's child does not impose specific or harsh burdens on the child or the parent. Alternatively, the burdens imposed if the child is not treated are considerable, including severe morbidity and even mortality.**

**Framework**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **Children Must Comply w/ Parents' Religion**

**Children have an obligation to reasonably comply with their parents religious beliefs; they owe it to their parents**

**Lester 04**

Emile Lester, pf @ William & Mary, "Gratitude and parents' rights over their children's religious upbringing," Journal of Beliefs & Values: Studies in Religion & Education, 25:3 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The preceding analysis of gratitude also suggests moral limits on how parents may transmit their religious beliefs in the home even though such transmission is not the subject of legitimate state interference. The obligation of gratitude is not strong enough to cancel out the child's compelling interest in having a reasonable ability to exit his/her religious community, and parents ought to refrain from behavior that significantly interferes with this ability. For instance, parents do not have the right to threaten to shun their children or cease financial and emotional support if the child changes his/her religious beliefs, nor should they attempt to convince children that life could not be tolerable outside of their community. They should not tell children to disregard completely the alternative religions to which a liberal education exposes them. Such attempts to determine exclusively the child's religion are self-defeating because they lack altruistic concern for whether the child wants or would want retrospectively to be a member of the religion he/she is raised in. Outside of these restrictions, **the gratitude**

**argument does confer substantial rights on parents over their children's religious upbringing. Children owe goodwill and respect to their parents and ought to comply with reasonable requests of parents concerning participation in religious rituals, attendance at religious services and participation in sectarian religious education classes. Reasonable requests based on obligations of gratitude are those aimed at educating children about the beliefs and traditions of their parents' religion, and helping children to understand the value that parents do and children themselves might find in this religion. Parents can reasonably request their children's participation in religious rituals that make the child a member of a particular religion** as long as they do not prevent the child from believing that he/she has a right to exit. **Children owe it to their parents to comply with reasonable religious requests because a refusal to learn about their parents' religious beliefs is contrary to their obligation to show goodwill. Parents' religious beliefs are often a significant part of their identity, and their children's refusal to at least acknowledge the value their beliefs have for them is likely to be the source of considerable pain. Without a sectarian religious education or attendance at religious rituals and ceremonies, children often will not be able to understand fully their parents' religious perspective. Most religious believers feel a strong religious duty to at least make a good faith effort to pass on their religious beliefs to their children and future generations. Children surely do not have an obligation to adopt their parents' religion permanently, but they should not go out of their way to thwart their parents' reasonable attempts to transmit beliefs.**

## Autonomy ~> Religion

**Respecting autonomy as a moral agent means respecting one's religion**

**Brezina and Moskop 07**

Paul R. Brezina, MD, MBA; John C. Moskop, PhD, "Urgent Medical Decision Making Regarding a Jehovah's Witness Minor: A Case Report and Discussion" NC Med J September/October 2007, Volume 68, Number 5 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**By acknowledging a family's religious beliefs and values as the reason for their refusal of treatment, members of the health care team can demonstrate that they have listened to and understood that reason and that they respect the importance of those beliefs and values.**

**We hold that it is important to do this as a sign of respect for the patient and parents as moral agents.**

For similar reasons, it is important for the health care professionals to articulate the reasons for their treatment recommendation. In this way, the health care professionals make clear the values that underlie that recommendation and commend those values to the patient and family. By offering reasons for their recommendation, the health care professionals also make clear that they too are moral agents responsible for their actions.

When professionals, patients, and parents express their opinions, beliefs, and guiding values, they can begin to seek common ground.

**Recognizing the value of respecting family wishes and religious freedom, for example, physicians might pledge to the patient and family that they will not pursue blood transfusions or will not do so unless the patient's life is in imminent danger.**

Recognizing the value of life, the patient and parents might express a willingness to accept blood products if absolutely necessary to save the patient's life, although they did not do so in this situation. This search for common ground can identify shared beliefs and values and can sometimes lead to a resolution of conflict.

**Freedom of religion good – it's the 1<sup>st</sup> Amendment and within the rights of parents**  
**Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265–276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Christian Scientists and other advocates of religious exemption laws base their convictions on two premises. First, the Constitutional right to freedom of religion is articulated with, "To hold that adults may be Christian Scientists but that if they are parents they may not raise their children according to Christian Science principles is to deny Christian Scientists the full right to practice their religion."**<sup>22</sup> **Second, they take exception to the government interfering with their rights as parents. They argue that no entity should have the ability to abrogate the decisions, medical or otherwise, made by parents for their minor children.**

**Forced treatment against an adolescents' will is humiliating and violates their bodily integrity – anecdotal evidence from Jehovah's Witnesses proves**

**Spike 11**

Jeffrey P. Spike, University of Texas Health Sciences Center, "When Ethics Consultation and Courts Collide: A Case of Compelled Treatment of a Mature Minor" Narrative Inquiry in

Bioethics, Volume 1, Number 2, Fall 2011, 123-131 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Though the hospital was in the jurisdiction of well informed city courts, they chose to take the case to the rural family court where Luke's family lived. As one person speculated, it looked as if the hospital attorneys "picked their venue." The parents were there, but they felt totally powerless. No one from the ethics consultation service was asked to participate in the hearing; and the two ethics consultation notes (one handwritten the day of the request, the other typed up with references a few days later) were never presented to the court or mentioned in testimony. Later **Luke** added that he **was not asked to testify on his own behalf, and felt disrespected**. Since both parents were public servants in that county, **the proceedings were highly intimidating and embarrassing**. They feared losing their jobs if they were found to be neglectful, and not empowered to defend themselves (even though they could have had free counsel from the Jehovah's Witnesses). **The court** followed the requests of the hospital, **concluding that the parents were medically neglectful, requiring that they bring Luke in for treatment even if it is against his will, threatened them with loss of parental rights if they failed to do so, adding "any health care provider is hereby directed to restrain and/or sedate the child if necessary."** When the decision became known, Luke's oncologist refused to perform the transfusions. The faculty in her department that had supported the legal maneuvers accepted her decision, and took on that responsibility. Interestingly, in other Jehovah's Witness cases, **when I asked Jehovah's Witnesses how they saw court authorized transfusions, they described it as "like being raped."**

## AT Religion ~> Autonomy

### **Religious freedom requires maturity – devolves to the debate over competence Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The limited cases addressing the religious expression of children are as inconsistent and provide as little guidance as those involving the mature minor doctrine. The decisions in the aforementioned cases imply that certain children are capable of establishing their own independent religious identities; and although the courts suggest notions of sincerity and maturity, they do not provide guidance as to accurate measures of the same. That being said, the majority opinion in Zummo, and Judge Wiggins's dissent in Cheema at least attempt to establish a conception of religious identity for minors. The opinions point to the intellectual development of the children in question as well as their understanding of how religious beliefs shape various life activities and decisions.**



## Morals

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Autonomy

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Autonomy as Intrinsic Good

**Autonomy is an intrinsic good especially in the health care context – all other values can be questioned**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Respect for the principle of individual autonomy remains central to modern liberal theorists**. Ronald Dworkin echoes Mill in his defence of individual autonomy. In *Life's Dominion*, Dworkin argues that: **Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives . . . rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves.** 65 For Ronald Dworkin, however, **autonomy also has an intrinsic value.** Thus, he argues, that **'[f]reedom is the cardinal, absolute requirement of self-respect: no one treats his life as having any intrinsic, objective importance unless he insists on leading that life himself, not being ushered along it by others, not matter how much he loves or respects or fears them'.** 66 As Alexander McCall Smith describes it, **even if the non-autonomous individual avoids significant suffering in her life, it is commonly perceived that '[t]he moral texture of such a life is drab'.** 67 **In the healthcare context, this recognition means that, in Dworkin's words, '[w]e allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values'.** 68

Other liberal theorists question the feasibility of alternatives to autonomy based on objective conceptions of the individual's good. Becky Cox White points out that, in spite of centuries of effort, all attempts have failed to develop a 'universally shared plausible list of things that are objectively good or evil'. 69 **Even the seemingly uncontroversial values that are supported by healthcare professionals, such as life, health and the absence of pain, are not necessarily shared by patients.** 70 Kim Atkins describes **respect for autonomy as 'an acknowledgement of the limitations of our knowledge of other people'.** 71 She argues that **when we incorporate autonomy into our world view, 'we accede to our fundamental fallibility and an epistemological humility'.** 72

## **Dworkin's Account of Autonomy**

**Gerald Dworkin defines autonomy as the ability to reflect critically upon one's desires and to be independent from others' undue influence**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A presumption of agency underlies the liberal conception of autonomy. Our choices are autonomous because they are, in a fundamental sense, our choices. This is evident in the foundational accounts of autonomy within moral psychology. Gerald Dworkin's well-known account of autonomy is based on a hierarchical ordering of first- and second-order desires and a presumption of agency.** <sup>90</sup> These premises are reflected in the two components of his account. **First, he defines autonomy as 'a second order capacity of persons to reflect critically upon their first-order preferences, desires, wishes and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values'.** <sup>91</sup> **Secondly, he includes a requirement for 'procedural independence'. This requires 'distinguishing those ways of influencing people's reflective and critical faculties which subvert them from those which promote and improve them'.** <sup>92</sup> Gerald Dworkin identifies a number of potentially subverting conditions, including 'hypnotic suggestion, manipulation, coercive persuasion, subliminal influence'. <sup>9</sup>

## AT Aff Contention

### **Limiting adolescent medical autonomy now is key to teens' long-term autonomy** **Ross 97**

Lainie Friedman Ross (PhD, American physician and bioethicist who works at the University of Chicago). "Health Care Decisionmaking by Children: Is It in Their Best Interest?" Hastings Center Report. 1997. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**One reason to limit the child's present-day autonomy is based on the argument that parents and other authorities need to promote the child's life-time autonomy.** Given the value that is placed on self-determination, it makes sense to grant adults autonomy provided that they have some threshold level of competency. Respect is shown by respecting their present project pursuits. But **respect for a threshold of competency in children places the emphasis on present-day autonomy rather than on a child's life-time autonomy.** **Children need a protected period in which to develop "enabling virtues"—habits, including the habit of self-control, which advance their life-time autonomy and opportunities.** Although many adults would also benefit from developing their potentials and improving their skills and self-control, **at some point** (and it is reasonable to use the age of emancipation as the proper cut-off), **the advantages of self-determination outweigh the benefits of further guidance** and its potential to improve lifetime autonomy.

### **Endorsing equal rights for children marginalizes children over the long-term** **Ross 97**

Lainie Friedman Ross (PhD, American physician and bioethicist who works at the University of Chicago). "Health Care Decisionmaking by Children: Is It in Their Best Interest?" Hastings Center Report. 1997. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

What would it mean to endorse **equal rights for children?** **It is a radical proposal with wide repercussions.**<sup>14</sup> **It would mean that children could make binding contracts, and that there would be the dissolution of child labor laws, mandatory education, statutory rape laws, and child neglect statutes.** **As such, it would give children rights for which they are ill-prepared and deny them the protection they need from predatory adults.** **It would leave children even more vulnerable** than they presently are. Endorsement of **child liberation would make a child's membership in a family voluntary.** For example, Howard Cohen argues that children should be allowed to change families, either because the child's parents are abusive, or because a neighbor or wealthy stranger offers him a better deal.<sup>15</sup> **Such freedom ignores the important role that continuity and permanence play in the parent-child relationship—a significance the child may not yet appreciate.**<sup>16</sup>

### **Implementation fails – policymakers neglect to consider discrimination, minority status, and other factors that could impact access to health services**

#### **Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, "Background to Health Policy-Making" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Given these omissions, **there is little impetus for policy-makers to consider how young people's involvement in these activities influences or is influenced by social, economic, and cultural conditions mentioned within other Convention articles, such as discrimination and minority status, standard of living, access to education, and access to health services. The emphasis on protection of children in the Convention may also translate into policy approaches that simplistically assume that efforts to remove adolescents from exploitative or violent lifestyles will be embraced by the adolescents they target.** The notion of children's evolving capacities to make decisions about their participation in social, cultural, and economic life must be integrated in policy aimed at stemming violence related to these activities. Instead of a simplistic top-down "protection" approach, the input and participation of adolescents might be sought to ensure the design of needs-based and contextually appropriate harm and risk reduction programs.

## **Autonomy is a sham – it doesn't do much for the patient**

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

A third normative critique is that **autonomy provides a basis for healthcare ethics which is both intellectually and practically limited in what it offers**. In Callahan's words, autonomy lacks the 'intellectual strength or penetration' 180 to deal with important ethical issues. **It is**, he says, **'a thin gruel for the future of bioethics'**. 181 **At the level of healthcare decisionmaking**. O'Neill notes that '[w]hat is rather grandly called "patient autonomy" oft en amounts to a right to choose or refuse treatments on off er, and the corresponding obligation of practitioners not to proceed without patients' consent' . 182 While the individual's right to be left alone is protected, **the traditional view of autonomy does little to ensure the delivery of appropriate treatment or adequate choice or options. Th us, autonomy, as a principle of non-interference, fails to shift the locus of power to the patient in a meaningful way.** Th e limits of the take-it-or-leave view are rather graphically illustrated in the following practitioner account of the death of a patient (in an Australian hospital): [A] young mother in [her] early 30's [ sic ] had an inoperable tumour at back of her nose and throat. In the end stages, this girl refused pain relief or sedatives. She did not want much medical intervention. It was the most distressing death I ever witnessed as she could not breathe and depended on a nasal tube as her only airway. Th is [was] frequently blocked and needed regular suctioning. It was very distressing for her, her family and staff . She was from a very poor social background and had little or no education. Staff tried to assist her as much as possible but it was an awful death for her. 183

## **You can respect someone as an autonomous being without respecting their choices as autonomous**

### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The principle that one deserves respect as an autonomous person is different than whether that person's decisions should be respected as autonomous. For instance, "[a]utonomous persons can and do make nonautonomous choices" in the presence of "temporary constraints such as ignorance or coercion.** 44 Informed consent is founded on the idea that if you give competent individuals sufficient information, absent coercion, they will use that information to make an autonomous decision "that they believe will best promote their own well-being as they conceive it." 45 The analytical elements of informed consent are: (1) disclosure, (2) comprehension, (3) voluntariness, (4) competence, 46 and (5) some decisional action. 47

**Even if the child's freedom matters, that doesn't mean respecting their horrible decisions**

**Ross 97**

Lainie Friedman Ross (PhD, American physician and bioethicist who works at the University of Chicago). "Health Care Decisionmaking by Children: Is It in Their Best Interest?" Hastings Center Report. 1997. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**My objection to the child liberationist position should in no way suggest that I do not place great value on freedom. My objection is that respect for an individual's autonomy means respecting her good and bad decisions. Child liberation requires that I respect a child's present-day autonomy regardless of its long-term impact on her developing personhood. Imagine, then, that a fourteen-year-old with new-onset diabetes refuses to take insulin because she fears needles (or because her boyfriend's religious beliefs proscribe medical care) even though she understands that she will die without it. Who is willing to abandon her to her autonomy? The laws that give adolescents the right to consent to treatment often do not give them the right to refuse treatment.**<sup>17</sup>

**Autonomy violations inevitable – some competent adolescents will be found incompetent, and some incompetent adolescents will be found competent, both leading to non-autonomous decisions**

**Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**When practitioners inquire into competence, they run the risk of two errors: (1) that autonomous individuals will be found incompetent and, thus, have the principle of respect for autonomy violated when a surrogate decision-maker is appointed; or (2) that incompetent individuals will be permitted to make harmful, non-autonomous decisions that are contrary to their well-being.**<sup>4 16</sup> Because an individual's conception of well-being is tied closely to his or her religious beliefs, part of the competency determination will rest upon the integrity of those beliefs.<sup>4 17</sup>

## AT Autonomy = Wholly Internal

**Autonomy involves choosing one's life plans in accordance with their own self-conceptions; it doesn't mean completely uninfluenced by external factors**

### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

From the Greek autos (self) and nomos (rule or law) "**personal autonomy has come to refer to personal self-governance; personal rule of the self by adequate understanding while remain.in.g. free from controlling" interferences by others and from personal limitations that prevent choice.** That persons are autonomous is "rooted in the liberal Western tradition" **that emphasizes the "importance of individual freedom and choice, both for political life and for personal development."**<sup>39</sup>

Edmund Pellegrino and David Thomasma refer to **a "fundamental and universal moral truth... that humans are owed respect for their ability to make reasoned choices that are their own and that others may or may not share."**<sup>40</sup> **Yet, individuals do not develop personal identities in a vacuum. Indeed, persons are "socially embedded" and form identities "within the context of social relationships" and a complex intersection of "social determinants."**<sup>41</sup> **It is not necessary that a person make decisions completely free from influence; rather, autonomous individuals act "freely in accordance with a self-chosen plan."**<sup>42</sup> In other words, **their decisions are not controlled by third parties, but are governed by a self-conception developed over time in**<sup>43</sup> **relation to cultural and social experiences.**



Kant

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Aff

### **Kantian ethics requires autonomy**

#### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**At first sight, the linkage between Kant's work and the principle of autonomy seems obvious, not least because Kant frequently employed the term 'autonomy'.**<sup>40</sup> Gillon argues that **Kant's fundamental principle of morality, or 'Categorical Imperative', is premised on the actions of an autonomous individual.**<sup>41</sup> As expressed in 'The Formula of Universal Law', this Categorical Imperative is that **'I ought never to act except in such a way that I could also will that my maxim should become a universal law'**.<sup>42</sup> Explaining the relevance of the Universal Law to individual autonomy **in a healthcare context**. Gillon argues: **It is by both rationally recognising the validity of the moral law and willing or choosing to accept it for ourselves that we can be subject to the universal moral law and yet at the same time also authors of it.**<sup>43</sup> **Thus, unless individuals have a choice about whether or not to accept a universal moral law, they cannot be bound by such a law. On this basis, Gillon argues that autonomy in the sense of individual freedom of choice is an essential component of Kantian ethics.**

## Neg

**Kant's conception of autonomy is one where only those who act morally act autonomously – the autonomous will is not the same thing as choosing a treatment in the health care context. Two warrants,**

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Many Kantian scholars dispute the linkage between the Kantian conception of autonomy and a conception of autonomy as individual freedom of choice.** <sup>44</sup> Onora O'Neill argues that, in setting out the Categorical Imperative, Kant was not concerned with 'any special sort of act of choice, by which each actually chooses laws or principles for everyone else'. Rather, he was concerned to express a requirement regarding which principles 'could be chosen by all, that is to say which principles are universalisable, or fit to be universal laws'. <sup>45</sup> Thus, Kant states that '[t]he concept of autonomy is inseparably connected with the idea of freedom and with the former there is inseparably bound the universal principle of morality, which ideally is the ground of all actions of rational beings'. <sup>46</sup> As summarised by Barbara Secker, **the Kantian position is that while all rational people have the capacity to act autonomously, only those people who act morally** (i.e. act in accordance with the Categorical Imperative) **actually do so.** <sup>47</sup> **Self-legislation in the Kantian sense is therefore 'a self-enforced constraint'.** <sup>48</sup> **It is 'morality which we impose on ourselves'.** <sup>49</sup> O'Neill uses the terms 'individual autonomy' and 'principled autonomy' to distinguish the two meanings of autonomy. **Individual autonomy is autonomy in the sense which we associate with healthcare ethics and law; it is concerned with 'carving out some particularly independent trajectory in this world'.** <sup>50</sup> **Principled autonomy, on the other hand, is an action, the principle for which could be adopted by other people.** <sup>51</sup>

Meir **Dan-Cohen identifies a further distinction between the conception of autonomy as a choice (or 'choice autonomy') and 'will autonomy', the latter concept according more closely with the Kantian conception.** <sup>52</sup> **Will autonomy,** he argues **'captures the sense of inevitability that is an important aspect of our moral experience'.** <sup>53</sup> Thus, '[o]nce we realize what our moral duty in a situation is, we also appreciate that the moral course is in an important sense non-optional'. <sup>54</sup> This view is clearly at odds with the free choice model. Dan-Cohen argues that the difference between choice autonomy and will autonomy lies not just in the absence of moral context from choice autonomy. Additionally, **the Kantian conception of autonomy captures an 'inner necessity' or force** (which he analogises to the experience of falling in love or the exercise of creative processes) **that drives us to actions and which cannot be captured simply by representation as a choice among options.** <sup>55</sup>

**A Kantian conception of autonomy, therefore, is not about free choice but about the drive to appropriate or moral action.** Thus, **while,** in O'Neill's caustic terms, **autonomy's admirers within bioethics may 'crave and claim Kantian credentials,'** <sup>56</sup> **it would seem to be difficult to establish convincingly these credentials.**

# Utilitarian Rights

## **Mill defended rights on utilitarian grounds**

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Mill defended the principle of individual liberty on the utilitarian basis that it is through liberty that human individuality can develop. In his words, It is not by wearing down into uniformity all that is individual in themselves, but by cultivating it and calling it forth**, within the limits imposed by the rights and interests of others, **that human beings become a noble and beautiful object of contemplation.** <sup>62</sup> For Mill, **allowing people a sphere of freedom had other instrumental benefits** also. **It encouraged originality and allowed persons of genius to develop.** <sup>63</sup> **It also recognised the essential differences between people and ensured that all people had the best chance to achieve happiness and moral growth.** <sup>64</sup>

No Morally Relevant Distinction “Burdens”

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Presume Autonomy

**There's a presumption of autonomy in the health care setting**

### **Will 06**

Jonathan F. Will, JD from Pitt, "My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs," 22 J. Contemp. Health L. & Pol'y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**One of the founding principles of civilized society is that individuals acting in a private capacity may not violate the bodily integrity of one another without consent.<sup>27</sup> This principle extends to the health care setting, requiring that physicians and other practitioners obtain consent from a patient before performing medical procedures.** Justice

Cardozo put it this way, **"[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."**<sup>29</sup> Although consent has been required for centuries, the concept of informed consent has only existed since the midtwentieth century. <sup>30</sup>

## Yes – Core of the Topic

**The core of the topic controversy is how we see adolescents – are they closer to adults with independence and autonomy or children who need parents to decide for them**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**There is no question of an adult's right to make decisions concerning life-sustaining medical treatments, regardless of whether the decisions are in line with the opinions of doctors and society's norms.**<sup>5</sup> Once a person has reached the age of eighteen,<sup>6</sup> **she is legally independent to make her own medical decisions without interference.**<sup>7</sup> **On the opposite side of the age spectrum, there is little debate as to parents' rights to make medical decisions for their newborn or infant child.'** **Somewhere in between young child and adult patient floats the adolescent patient.**

Adolescence is the time span when a person tries to develop a sense of independence and self-sufficiency, while utilizing the guidance, knowledge, and experience of older persons, usually parents. <sup>9</sup> Inconsistencies abound in the levels of respect and responsibility society provides to adolescents: The laws devised to govern teenagers are layered, reflecting society's alternating perceptions of teenagers as adult-like and child-like, and our accompanying impulses to respect as well as to protect this population... [W]e trust eighteen year olds enough to let them fight and die in the military, but not enough to let them drink alcoholic beverages.<sup>10</sup> **A life-stage fraught with conflict, the addition of a life-threatening illness brings the independence issues of an adolescent to the foreground, as the patient, parents, and physicians ask who has the final decision in how this minor's illness should or should not be treated?**

**The core question is whether 1) an adult would have the right, and 2) whether an adolescent is significantly different**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In Asking Adolescents: Does a Mature Minor Have a Right to Participate in Health Care Decisions?, Cara Watts analyzes courts' approaches in determining if a minor has the right to make a medical decision without parental consent.<sup>149</sup> She develops a three-part standard for determining whether **a minor should have autonomy to make a medical decision: if there is (1) no reason to deny an adult the right to make her own decision in the situation, (2) no reason to treat a minor differently than an adult in the situation, and (3) no state interest in protecting the minor, then the minor should have the same decisional rights as an adult in the situation.**<sup>150</sup> **To determine if a minor should be treated differently than an adult in the same medical situation, a court would consider a treatment's effectiveness, a minor's chance of survival with or without the treatment, and the emotional and physical effects of the treatment on the minor.**<sup>151</sup> **Watts evaluates her standard to be "fair, systematic, accurate and critical."**<sup>52</sup>

## **No – Not Core of the Topic**

**Medical emancipation and treatment exceptions are granted for pragmatic reasons, not because adolescents are competent. Disproves that the core controversy of the resolution is about treating adolescents as adults.**

### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Like the emancipation statutes, there is no indication that the treatment exceptions are founded on consideration of the minors' actual decisionmaking capabilities.** Elizabeth Scott contends that “[n]o one argues that minors should be deemed adults because they are particularly mature in making decisions in these treatment contexts. Rather, **the focus is on the harm of requiring parental consent.**” 147 For example, a young girl may be afraid to tell her mother that she is being sexually abused by her father, and therefore will go untreated. In this sense, **the treatment exceptions seem to be an extension of the state's parens patriae authority; however, rather than the state stepping in, it gives decision-making authority directly to minors.**

**Another policy behind the treatment exceptions stems from public health and safety. Adolescents may be hesitant to inform their parents of their sexual activity or substance abuse problems, and therefore will forego medical treatment. Allowing minors to consent to these treatments without involving their parents removes a substantial obstacle.** As Scott points out, **society also has an interest in reducing the incidence of sexually transmitted diseases, substance abuse, mental illness, and teenage pregnancy.** Together, these social benefits largely explain why **lawmakers shift the boundary of childhood for the purpose of encouraging treatment of these conditions.**

**A purely medical view of the topic is insufficient – fails to capture the religious and ethical dimensions**

### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Situations involving the refusal of medical treatment based upon religious beliefs are not simply medical in nature, and therefore, addressing the patient's understanding of the medical aspect of the decision alone is insufficient. In fact, in the cases presented in this article, the decisions to refuse medical treatment were based solely or primarily upon religious beliefs.** The parents of Kevin Sampson, Ricky Green, Ernestine Gregory, and Philip Malcolm consented to medical procedures aimed at alleviating their children's ailments. 348 **These decisions were medical in nature taking into account-assuming informed consent was obtained--diagnoses, risks, and the potential for success associated with the procedures, and feasible alternatives.** 34



Misc.

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **Adolescent Legal Identity**

### **Status quo inconsistencies treat adolescents as both adults and children**

[Maybe use this card in conjunction with a legally-minded framework or one about how we treat the identities of adolescents]

#### **Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A sixteen-year-old female may decide to give birth and become a mother, but she cannot independently obtain an abortion or marry the father of her child.**<sup>2</sup> A young mother may relinquish rights to her child without judicial intervention, but that same teenager may not decide independently with which parent she wishes to live.<sup>3</sup> **The passage of the Twenty-Sixth Amendment highlighted inconsistencies in the law that allowed eighteen-year-olds to fight for their country but deprived those same individuals of the right to vote for the politicians who sent them to war.**<sup>4</sup> Although this debate changed the way many individuals feel, **society has failed to fully integrate young people into the legal and social worlds currently populated only by adults.**<sup>5</sup> Similar inconsistencies still remain regarding minors' abilities to choose with whom they wish to live.<sup>6</sup>

## Authority/Polls

### **Study proves—adolescents prefer making difficult medical choices themselves**

**Ruggeri et al 14**

Azzurra Ruggeri (Postdoctoral Fellow in the Psychology Department at University of California, Berkeley and a Researcher in the ABC (Adaptive Behavior and Cognition) group of the Max Planck Institute for Human Development, Berlin), Michaela Gummerum (Associate Professor (Reader) in Psychology, School of Psychology at Plymouth University), and Yaniv Hanoch (Associate Professor (Reader) in Psychology, School of Psychology at Plymouth University).

“Braving Difficult Choices Alone: Children's and Adolescents' Medical Decision Making.”

PLOS One. 2014. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118856/> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Objective What role should minors play in making medical decisions? The authors examined children's and adolescents' desire to be involved in serious medical decisions and the emotional consequences associated with them. Methods **Sixty-three children and 76 adolescents were presented with a cover story about a difficult medical choice. Participants were tested in one of four conditions:** (1) own informed choice; (2) informed parents' choice to amputate; (3) informed parents' choice to continue a treatment; and (4) uninformed parents' choice to amputate. **In a questionnaire, participants were asked about their choices, preference for autonomy, confidence, and emotional reactions when faced with a difficult hypothetical medical choice. Results Children and adolescents made different choices and participants, especially adolescents, preferred to make the difficult choice themselves, rather than having a parent make it. Children expressed fewer negative emotions than adolescents. Providing information about the alternatives did not affect participants' responses. Conclusions Minors, especially adolescents, want to be responsible for their own medical decisions, even when the choice is a difficult one. For the adolescents, results suggest that the decision to be made, instead of the agent making the decision, is the main element influencing their emotional responses and decision confidence.** For children, results suggest that they might be less able than adolescents to project how they would feel. **The results, overall, draw attention to the need to further investigate how we can better involve minors in the medical decision-making process.**

### **Robust data proves adolescents want to make difficult medical choices—we shouldn't focus on cognitive capacity alone**

**Ruggeri et al 14**

Azzurra Ruggeri (Postdoctoral Fellow in the Psychology Department at University of California, Berkeley and a Researcher in the ABC (Adaptive Behavior and Cognition) group of the Max Planck Institute for Human Development, Berlin), Michaela Gummerum (Associate Professor (Reader) in Psychology, School of Psychology at Plymouth University), and Yaniv Hanoch (Associate Professor (Reader) in Psychology, School of Psychology at Plymouth University).

“Braving Difficult Choices Alone: Children's and Adolescents' Medical Decision Making.”

PLOS One. 2014. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118856/> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Our data clearly indicate that children and adolescents want to be involved in the decision process, even when the outcome involves serious negative consequences.**

Participants preferred making the decision themselves rather than having an authority figure (a parent) decide for them. Desire for autonomy was independent of the decision made by parents (i.e., amputate in Condition 2 vs. not amputate in Condition 3) and of the decision made by participants in Condition 1 (i.e., whether to

amputate or not). **As hypothesized (Hypothesis 1), this willingness to make autonomous decisions and not to let parents make the choice was stronger for adolescents than children. Our findings, thus, are nicely aligned with results of previous developmental research showing adolescents' greater desire for autonomous decision making in more everyday contexts with less difficult outcomes (e.g., [9], [10]). Adolescents might feel that they are grown up and as such deserve to be independent and are entitled to decide about their own medical treatment.** In Condition 1, most of the adolescents (87%) chose not to amputate, whereas only 27% of the children chose not to amputate. This was an unexpected result. Children consistently reported to be worried about feeling pain for their entire life if they do not amputate. This was the only other alternative to amputation mentioned by the doctor in the given scenario. Because the doctor is an expert adult, it is not too surprising that children believed that the given alternatives were the only two available and decided to avoid the possibility of future pain and amputation. They might even have perceived that the doctor was indirectly suggesting that it would have been better to amputate, because he presented the other alternative as very unattractive. Indeed, two children explicitly mentioned that "this is what the doctor would do". Adolescents, in contrast, reported that they "did not want to give up" and to "believe there was still hope of saving the leg without necessarily having to suffer in the future", even though this possibility was not mentioned by the doctor in the scenario. This result might relate to adolescents' well-documented illusion of invincibility [17]. Invincibility is a typical phase of social and cognitive development of adolescence that peaks in early adolescence and is dominated by egocentric thinking, a side effect of the teen's search for identity. Teens believe that they are the focus of everyone's attention and are constantly being evaluated by others. This belief further engenders feelings of uniqueness, as teens perceive their feelings and experiences as exceptional and not subject to the laws governing others' lives, and promote the illusion of being special and invulnerable to the consequences of dangerous or risky behavior [18], [19]. Such illusion and feeling of uniqueness might help explaining why adolescents, ignoring the options given by the doctor, thought there was still a chance for them to save their legs without having to suffer pain forever. **We know that adolescents are very accurate and predictive when they make probability judgments for a number of significant life events, except for judging the probability of dying prematurely [20], [21]. What about children's and adolescents' ability to forecast their emotional reactions to difficult choices? Even though there has been a growing interest in adults' ability to forecast their emotional responses to various health decisions and conditions [22], [23], to our knowledge, this line of investigation has not been applied to minors (see [24]).** **Botti et al. [6] proposed that personal responsibility was associated with greater negative emotional responses (Hypothesis 2). However, we found that participants in Condition 1 (own informed choice) reported similar negative emotions to those of participants in Condition 3 (informed parents' choice to continue treatment), and lower negative emotional responses than participants in Conditions 2 and 4 (informed parents' choice to amputate; uninformed parents' choice to amputate). In this sense, it is evident that the choice condition alone is not enough to predict participants' emotional responses, but the decision outcome (amputate vs. not amputate) has to be considered as well.** Indeed, participants reported lower negative emotional responses when the decision choice was "no amputation". Future research might systematically vary the seriousness of the decision outcome and investigate its effect on emotional responses. Treatment choice (amputate vs. not amputate) also affected decision confidence, and our results support both Hypotheses 3a and 3b: Participants reported higher confidence that the right decision has been made when they themselves (versus the parents) made the decision. Furthermore, those who chose not to amputate expressed higher decision confidence. Moreover, children's decision confidence was overall lower than that of adolescents, and they also reported fewer negative emotions than adolescents. A possible interpretation of these results is that children are less able than adolescents to project how they would feel, that is, to form a counterfactual scenario of how it would feel to have lost a leg or live with pain (see [25], [26]). In contrast to Botti et al.'s findings [6], we also found that not providing information about the alternatives at stake (in Condition 4 compared to Condition 2) did not affect participants' responses (see Hypothesis 4). These results might be due to children's and adolescents' inability to conceptualize and utilize the information provided. This result reinforces the need to design health and risk communications in a transparent and easy-to-understand way for patients of all ages [27]–[29]. Our study is not without limitations. First, our sample is one of convenience and the study was conducted at school rather than in a clinic or in a hospital. Second, the scenarios presented to children were hypothetical by nature and only focused on a single health related problem. It is unclear whether our results are robust enough to generalize to other health issues such as diabetes or cancer. While future studies should examine clinical samples, our novel results, nonetheless, highlight the need to further explore children's and adolescents' desire to be actively involved in their health decision making. **In conclusion, our results suggest that age and cognitive competence are not the only factors that should be taken into account when considering whether minors deserve a voice in medical decision making. Children and adolescents want to be involved in medical decisions, even when the choice is a difficult one.** A future direction would be to investigate how medical decisions are and should be negotiated within families, for example, to minimize the negative emotional impact the choice and the choice outcomes have on all family members. This line of research would tap not only into the literature on shared decision making about health [30]–[32], but also into the more recent studies reporting systematic differences between the treatment choice one recommends for another person vs. makes for oneself (see [23], [33]). How can we better involve minors and their families in the process of making medical decisions?

## Health care providers think adolescents have capacity to make abortion decisions on their own

### Clyde et al 13

Jessie Clyde, program officer of the International Planned Parenthood Federation, Jennifer Bain, Kelly, Castagnaro, Marcela Rueda, Carrie Tatum, Katherine Watson, "Evolving capacity and decision-making in practice: adolescents' access to legal abortion services in Mexico City" *Reproductive Health Matters* (2013; 21(41):167-175 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A good proportion of clinic staff in this study acknowledged adolescents' evolving capacities, facilitated autonomous decision-making on abortion, and expressed positive**

support for counselling that would meet adolescents' specific needs and situations. All of them believed older adolescents had a higher decision-making capacity than younger ones, including the decision to terminate a pregnancy; 79% of providers believed older adolescents had the capacity to decide while 51% felt younger ones possessed the same capacity.

## **Doctor-Patient Trust**

**Autonomy erodes doctor-patient trust because now the physician's main goal is non-interference rather than providing the best treatment option**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A second basis for normative critique is the cost to other values arising from the endorsement of a liberal conception of autonomy. Onora O'Neill argues that the important value of trust between doctors and patients has been lost because of the liberal view of autonomy 'simply as independence from others'.<sup>161</sup> Contrasting the different features of trust and autonomy, she notes, '[t]rust flourishes between those who are linked to one another; individual autonomy flourishes where everyone has "space" to do their own thing'.<sup>162</sup> As O'Neill reminds us, '[t]rust is most readily placed in others whom we can rely on to take our interests into account, to fulfil their roles, to keep their parts in bargains'.<sup>163</sup> If we do not believe in our healthcare professionals' commitment to our welfare, our trust in them will be fatally undermined notwithstanding that our right of autonomy is respected.**

## Evolution

**There are evolutionary reasons for gradual adolescent brain development corresponding with increased independence-seeking and autonomy**

**Casey et al 08**

BJ, Sarah Getz, Sackler Institute @ Cornell, Adriana Galvan, pf of psychology @ UCLA, "The adolescent brain," Developmental Review 28 (2008) 62–77 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Adolescence is the transitional period between childhood and adulthood often co-occurring with puberty. Puberty marks the beginnings of sexual maturation (Graber & Brooks-Gunn, 1998) and can be defined by biological markers. Adolescence can be described as a progressive transition into adulthood with a nebulous ontogenetic time course (Spear, 2000). **Evolutionarily speaking, adolescence is the period in which independence skills are acquired to increase success upon separation from the protection of the family, though increase chances for harmful circumstances** (e.g., injury, depression, anxiety, drug use and addiction (Kelley, Schochet, & Landry, 2004)). **Independence-seeking behaviors are prevalent across species, such as increases in peer-directed social interactions and intensifications in novelty-seeking and risk-taking behaviors. Psychosocial factors impact adolescent propensity for risky behavior.** However, **risky behavior is the product of a biologically driven imbalance between increased novelty- and sensation-seeking in conjunction with immature “self-regulatory competence”** (Steinberg, 2004). **Our neurobiological data suggest this occurs through differential development of these two systems (limbic and control).** **Speculation would suggest that this developmental pattern is an evolutionary feature. You need to engage in high-risk behavior to leave your family and village to find a mate and risk-taking at just the same time as hormones drive adolescents to seek out sexual partners.** In today's society when adolescence may extend indefinitely, with children living with parents and having financial dependence and choosing mates later in life, this evolution may be deemed inappropriate. **There is evidence across species for heightened novelty-seeking and risk-taking during the adolescent years. Seeking out same-age peers and fighting with parents, which all help get the adolescent away from the home territory for mating is seen in other species including rodents, nonhuman primates and some birds** (Spear, 2000). Relative to adults, periadolescent rats show increased novelty-seeking behaviors in a free choice novelty paradigm (Laviola et al., 1999). Neurochemical evidence indicates that the balance in the adolescent brain between cortical and subcortical dopamine systems, begins to shift toward greater cortical dopamine levels during adolescence (Spear, 2000). Similar protracted dopaminergic enervation through adolescence into adulthood has been shown in the nonhuman primate prefrontal cortex as well (Rosenberg & Lewis, 1995). **Thus this elevated apparent risk-taking appears to be across species and have important adaptive purposes.**

## Pluralism

**Pluralism solves deficiencies in autonomy – especially addressing principles like beneficence and justice in the healthcare context**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

A third normative critique is that **autonomy provides a basis for healthcare ethics which is both intellectually and practically limited in what it offers**. In Callahan's words, autonomy lacks the 'intellectual strength or penetration' 180 to deal with important ethical issues. **It is**, he says, **'a thin gruel for the future of bioethics'**. 181 **At the level of healthcare decisionmaking**, O'Neill notes that '[w]hat is rather grandly called "patient autonomy" oft en amounts to a right to choose or refuse treatments on offer, and the corresponding obligation of practitioners not to proceed without patients' consent'. 182 While the individual's right to be left alone is protected, **the traditional view of autonomy does little to ensure the delivery of appropriate treatment or adequate choice or options**. **Th us, autonomy, as a principle of non-interference, fails to shift the locus of power to the patient in a meaningful way**. The limits of the take-it-or-leave view are rather graphically illustrated in the following practitioner account of the death of a patient (in an Australian hospital): [A] young mother in [her] early 30's [ sic ] had an inoperable tumour at back of her nose and throat. In the end stages, this girl refused pain relief or sedatives. She did not want much medical intervention. It was the most distressing death I ever witnessed as she could not breathe and depended on a nasal tube as her only airway. Th is [was] frequently blocked and needed regular suctioning. It was very distressing for her, her family and staff . She was from a very poor social background and had little or no education. Staff tried to assist her as much as possible but it was an awful death for her. 183

We do not, of course, know the options that were available to this woman. It may be the case that she had a range of options and chose freely to reject all of these. What is clear, however, is that **the traditional view of autonomy does nothing to require the provision of these options**. **It protects the right to refuse treatment** (and, in a case like this, to die in distress if one chooses); **it does not require the provision of alternatives**. **Nor does the traditional view of autonomy require efforts to educate** (within the limited context of the particular decision to be made) **or engage with the patient, to create a space for her to make the decision which best serves her needs**. In this context, it is worth recalling Schneider's argument that respect for autonomy could become 'a welcome and acceptable way of passing on burdensome problems to patients'. 184 Th us, Schneider notes a study suggesting that doctors 'oft en seemed too ready to concede patients' "right to refuse" rather than to recognize the clinical problems that lay at the bottom of the refusal (e.g. poor or inconsistent communication) and to take steps to remedy them'. 185

**It might be suggested that this deficiency in autonomy could be addressed by placing greater reliance on other principles in healthcare ethics, such as beneficence or justice**. **Th us, respect for beneficence would require that healthcare professionals negotiate and seek to reach a consensus with the patient regarding the appropriate mode of treatment** 186 **and respect for justice would require that a range of options is available to patients**. 187 On this basis, it might be argued that the appropriate response to the 'take-it-or-leave-it' critique is to accord greater significance to other principles. However, it might also be argued that the fl aw lies not with the principle of autonomy but with the way in which the principle has been framed within (certain) ethical discourse . It will be argued below that the principle of autonomy can encompass the concept of meaningful choice and that this view of autonomy should be further developed.

**Autonomy in the medical context is at odds with Western liberal pluralism**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]



It has also been argued that, because of its association with Western, liberal political philosophy, the endorsement of autonomy may have adverse implications for the values of pluralism, tolerance and the recognition of cultural difference and diversity. <sup>164</sup> Different cultures have different views of the individual and her relationship with society and these may not fit within the individualistic autonomy-based model. <sup>165</sup> Moreover, Callahan argues that the elevation of liberalism leads to the marginalisation of religious or conservative perspectives. <sup>166</sup> For those who feel alienated on these bases, the likely consequence is a further diminution in trust.

**Spillover**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **Rights/Protections Spillover**

**Recognizing decisional capacity in the adolescent removes the impetus for their protections such as child labor laws, mandatory education, statutory rape law, and child neglect**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, "State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment" 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Although the Midwest Bioethical Center's guidelines have found general support from the medical community and reflect the enumerated policy of the AAP and other scholars, <sup>137</sup> **there are detractors who criticize the concept that once a minor is determined to have "decisional capacity" she should be allowed to make any medical decision.** Dr. Lainie Friedman Ross questions the impact such a policy would have on the intimate relationship of a family.<sup>138</sup> **She also sees equating a child's decisional capacity to her right to make a decision as removing long standing societal protections of children: "[t]o empower children with the same rights as adults is to deny them protection they need. It would mean the dissolution of child labor laws, mandatory education, statutory rape laws, and child neglect statutes.'** <sup>39</sup> Ross takes great contention with the notion that a "bad" decision by a child must be respected because the child possesses decisional capacity. <sup>40</sup> James Caccamo writes that successful implementation of the guidelines requires extensive education for parents of critically ill children. <sup>14</sup> The concepts of minor treatment decisions, from "child assent" to "informed parental/guardian permission," are difficult for parents to grasp; <sup>142</sup> if they cannot grasp them, how are they to participate in decision they technically have a legal right to make? <sup>43</sup>

Criminal Justice Spillover

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Yes Spillover

### **Accepting general competence opens up adolescents to adult criminal sanctions Mutcherson 06**

Kimberly M. Mutcherson, pf @ Rutgers, “Minor discrepancies: forging a Common understanding of Adolescent competence in Healthcare decision-making and Criminal responsibility” Nevada Law Journal, 6:927 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

If the law presumes that young people are decisionally capable in the healthcare context, it is more likely that minor patients can form trusting, confidential relationships with their healthcare providers thus potentially improving treatment outcomes. Further, there will be less incentive for young people to avoid needed medical care for fear of reprisals from their parents. **On the negative side, if the legal system presumes that youthful offenders are decisionally capable, these young people will become eligible for severe adult sanctions, including the death penalty, and have fewer opportunities for education and rehabilitation.**<sup>26</sup>

### **Arguments in the healthcare context that imply adolescents are wrongly characterized as incompetent could be used as ammunition for those who argue adults and adolescents are the same**

#### **Mutcherson 06**

Kimberly M. Mutcherson, pf @ Rutgers, “Minor discrepancies: forging a Common understanding of Adolescent competence in Healthcare decision-making and Criminal responsibility” Nevada Law Journal, 6:927 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

If the same collection of people can offer such competing images of young people, all supported by research, it is not surprising that the law struggles with how best to understand adolescent patients and defendants. The fact that those on both sides, all of whom seek to do what is best for young people, assert such disparate positions on adolescent competence is of no great surprise given the overall legal and political climate in which these advocates find themselves. In no small part, the work of advocates reflects a reasoned response to the rhetoric of their political opponents whom they oppose. **In the juvenile justice arena, advocates for young people battle a system that dangerously and inaccurately assumes "that there are no psychological differences between adolescent and adult offenders that are important to criminal responsibility or to participation in adult criminal proceedings."**<sup>14 7</sup> **To accept this regime is to accept that there is no reason to treat a fourteen-year-old criminal differently than a forty-yearold criminal-a position that leaves young people exceedingly vulnerable to abusive and unjust treatment at the hands of the legal system.** Those who advocate for an expanded understanding of adolescent competence in healthcare do so in response to arguments of incapacity that would leave young people subject to the desires of their parents or caretakers when making incredibly intimate and personal decisions about a range of healthcare issues, including abortion. **Advocates for young people in the healthcare arena use available data, limited though it may be, to argue that the law's treatment of young people for purposes of making autonomous healthcare decisions is problematic and results in a regime that works to the detriment of young people.**<sup>1 48</sup> **Significant literature from healthcare providers and professional organizations for these providers supports a view that legal decision makers have unfairly characterized adolescents collectively as incompetent.**<sup>149</sup>

### **Autonomy rights lead to full adult penalties in the criminal justice system Mutcherson 06**

Kimberly M. Mutcherson, pf @ Rutgers, “Minor discrepancies: forging a Common understanding of Adolescent competence in Healthcare decision-making and Criminal responsibility” Nevada Law Journal, 6:927 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

It is not given that disagreeing about the pace at which young people develop means that these two groups of advocates are fundamentally at odds. However, as one author wrote: **[A]s the legal system recognizes more and more autonomy rights belonging to teenagers in a wide range of non-criminal matters, it inevitably creates a dissonance with the idea that in the criminal sphere, paternalism is still appropriate.** This dissonance is evident at both ends of the political spectrum. The stereotypical liberal calls for expanded recognition of adolescents' rights in a wide range of civil contexts, while defending a juvenile justice system that is based on the premise that an adolescent's choice to commit a crime is rendered less culpable because of the adolescent's age. In contrast, **the stereotypical conservative will call for full application of adult penalties to adolescent criminals.** but will deny the right of teenagers to make decisions that must be respected by the law in a wide variety of other contexts, presumably on the grounds that one so young cannot be fully capable of making such significant choices. 154 The question then becomes whether it is possible to simultaneously embrace the arguments made by juvenile justice advocates and healthcare decision-making advocates or if the law must pick one set of arguments over the other.

## **Rulings on capacity are interrelated**

### **Mutcherson 06**

Kimberly M. Mutcherson, pf @ Rutgers, “Minor discrepancies: forging a Common understanding of Adolescent competence in Healthcare decision-making and Criminal responsibility” Nevada Law Journal, 6:927 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Were the Supreme Court to abandon its baseline assumption of adolescent incapacity or incompetence, it does not then follow that its death penalty jurisprudence would be any different, though it is quite likely that its abortion jurisprudence would shift. For instance, in a case like Roper, the Court's focus would still be on the developmental capacity of young people and the literature on young people and criminal activity would still be quite relevant.** However, the inquiry would focus much more squarely on two issues: (1) the context in which criminal decisions get made, and (2) how this context impacts whether a minor criminal defendant can be said to be criminally culpable and the extent to which opportunities for rehabilitation are more available for young people whose personalities, and thus their futures, are more malleable.

## No Spillover

**There's a way out – law-makers can and have argued that context makes a difference, so we should treat criminal and healthcare matters separately**  
**Mutcherson 06**

Kimberly M. Mutcherson, pf @ Rutgers, "Minor discrepancies: forging a Common understanding of Adolescent competence in Healthcare decision-making and Criminal responsibility" Nevada Law Journal, 6:927 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In his article that reflects on cognitive dissonance in the law's understanding of adolescent autonomy, Professor Donald Beschle opines that **one way to reconcile conflicting views of adolescents in criminal law and abortion decision-making is to believe "that competence varies in different contexts, and the ability to make a responsible decision as to things like health care and reproduction issues is noticeably different from the ability to choose to obey or not obey the criminal law."**<sup>5</sup> He then explores the various difficulties that may arise from taking such a position, though he does not delve into whether that position is even supportable. This section takes seriously the idea

that the context of decision-making is relevant to a young person's competence to make a given decision. The core claim is that **decision-making in different contexts is so qualitatively dissimilar that it is not incongruous to find that the same individual's decision-making abilities may be sufficient to support autonomous decision making in one realm but insufficient to support a finding of autonomous decision-making in a distinct set of circumstances.** It is an accepted principle among many authors that competence is not a rigid concept and

that, say in the midst of a physician-patient relationship, a patient may be competent to make some treatment decisions and not others. For instance, a physician might be comfortable honoring a patient's wish to not take an antibiotic to stave off a minor infection, but might balk at that patient's decision to refuse a life-saving blood transfusion. The degree to which the healthcare provider would want to ensure decision-making capacity would be enhanced in the latter case. While decision-making capacity might be found when refusing antibiotics, the provider would not necessarily be mistaken in finding that the patient did not have capacity to refuse the transfusion that would save her life. The conflicting findings would presumably reflect the patient's deficiency in one of the hallmarks of decision-making capacity namely her ability to comprehend relevant information, contemplate choices, and communicate a decision.<sup>56</sup> A determination of a lack of decision-making capacity when the patient refused the blood transfusion might logically flow if the patient, in discussions with her healthcare provider, clearly indicated that she did not comprehend the seriousness of her illness. Likewise, a lack of decision-making capacity might exist if the patient was in such a state of deterioration that she could not communicate a treatment choice to her healthcare provider. In either of these circumstances, the healthcare provider would be justified in believing that the patient lacked decision-making capacity and would therefore be found legally incompetent to make treatment decisions for herself. When discussing questions of competence and young people, it is equally valid to believe that determinations of competence cannot be rigid. As described by one commentator: Competence is not an "all or nothing" quality; it develops gradually, particularly if the child has opportunities to try out budding skills. A child does not always have a general level of competence. Rather, a child may be competent in one area, but not in another, and may be competent to take on part of a given task, but not the whole.<sup>157</sup> This is so in part because of the shifting terrain upon which an individual stands when making various decisions. In their piece on the juvenile justice system and adolescent criminal responsibility, Scott and Grisso explore the possibility that decision-making capacity varies in part based on the circumstances in which a decision takes place. The authors critique available scientific literature on adolescent decision-making by highlighting the fact that the highly structured setting of such research perhaps makes it more appropriate for understanding the decisionmaking capacities of young people in the context of court hearings rather than the off-the-cuff decision-making of "the street."<sup>158</sup> In other words, how adolescents make decisions in informal settings in conjunction with peers may be very different than how those same young people embark on decision-making in more organized, formal, and monitored settings such as a courtroom or a physician's office. In a critique related to that offered by Scott and Grisso, those reporting on their own research finding comparable levels of competency to make healthcare-related decisions among adults and young people fourteen and older note that "[t]he generalizability of these finding may be somewhat tempered by the fact that subjects were 'normal,' white, healthy individuals of high intelligence and middle-class background and that the situations they considered were hypotheticals."<sup>59</sup> Even accepting that the findings of these authors may not be applicable to all young people, the fact that a sizeable portion of young people possesses high levels of competence cuts in favor of a more

nuanced approach to understanding adolescent decision-making capacity in both criminal and healthcare law. **The law, in many respects, has taken the position that** as Scott and Grisso assert in the criminal context, **"because of inexperience and immature judgment, youths will make mistakes during this period"**<sup>16</sup> **and the best way to protect young people from the consequences of such mistakes is to assume their incompetence. But the decisions being made by young people who choose to engage in criminal activity and those being made by young people seeking out healthcare are substantially different in kind and character. Thus, when viewed as a product of the circumstances under which decision-making takes place, a bad decision about engaging in criminal activity might largely reflect areas in which adolescents are deficient in the ability to make reasoned decisions. In contrast, a decision to pursue a certain type of healthcare treatment might reflect the best and highest level of that young person's decision-making capabilities.**

**No spillover – it’s just an analogy and the legal reasoning for medical decisions vs. being tried as an adult is very different. The link is tenuous at best,**  
**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Criminal courts often take little or no issue with declaring a minor competent to be tried as an adult.** As one commentator has noted, "Many criminal courts certainly are convinced that juveniles can be tried as adults. **Can we thus say that the 16-year-old has the right to be treated as an adult and make his or her own medical decisions?"**" 12 (Andrew Newman, Adolescent Consent to Routine Medical and Surgical Treatment, 22 J. LEGAL MED. 501, 501-02 (2001) (arguing there should be a brightline statutory rule that any minor over the age of 16 should be allowed to make her own medical decisions). The practice of trying minors as adults has been on the rise. "Between 1988-1998, the number of juveniles prosecuted as adults for major violent felonies rose 47%." Id. at 522. In raising questions as to the arguments that can be made from trying minors as adults and

then not allowing minors to make their own medical decisions, **the author qualifies his analogy by stating "there**

**is probably only a tenuous relationship between the concepts and values brought to bear on the area of teen criminal defendants and on teens who are looking to make their own medical decisions.**" Id. at 525.) **The analogy may not be perfect, but it is one that further indicates the inconsistencies the legal community has created** in handling adolescents' rights.



Countries

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Toolbox

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Ev Must Be Specific

**Negative evidence must be specific to the plan**

**Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

While today the government aspires to evidence-based policymaking, **this impetus must be carefully monitored to ensure that it does not deteriorate into policy-making based on “whatever works” according to incompletely articulated criteria.** In such circumstances, **the tendency could be to adopt initiatives from other countries** (often the United States or the United Kingdom) **and to try to apply them** to Canada. **The problem with this pragmatic “whatever works” approach to policy-making is that it produces plenty of initiatives but no single vision that uniquely fits** the Canadian experience. Consequently, policy-makers have been increasingly attracted to the Convention on the Rights of the Child and similar treaties in order to guide “big picture” research.

Canada

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Inherency

### **Canadian policy not targeting adolescents now**

#### **Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, "Background to Health Policy-Making" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary.

[[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

On all these counts, **it can be said that federal policy initiated in the name of the Convention has yet to show a demonstrable effect in improving the health of adolescents. It should be noted that adolescent health has not been formed as a major focus of the National Children's**

**Agenda.** Adolescents living in low-income families may have benefitted to the same degree as young children through income supplements like the cctb and the ncbs . Likewise, adolescents with children may have benefitted from Health Canada community programs, even if some, as teenaged parents, were not the prime targets. **Canadian child health policy in the past decade and a half has not, however, reflected a substantive focus on adolescent issues or needs. Broader social, health, and education policy trends may have in fact contributed to conditions of structural disadvantage that can negatively affect adolescent health.**

## **China / East Asia**

Countries

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Inherency

**Autonomy is undermined by a strong focus on family values**

**Hui 08**

Edwin Hui, pf @ University of Hong Kong, “Parental Refusal Of Life-Saving Treatments For Adolescents: Chinese Familism In Medical Decision-Making Re-Visited” Bioethics, Volume 22 Number 5 2008 pp 286–295 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

As one may expect, **the family’s role in MDM in Confucian societies is significantly different from that of its Western counterparts.** In a 2004 issue of the Journal of Medicine and Philosophy (Volume 29, No. 2) Chinese

writers from China and Hong Kong described and defended Confucian familism as it applied to MDM in a variety of clinical scenarios. Even though their discussion mainly referred to vulnerable but competent elderly patients, we believe that the descriptions have relevance for APs.

According to Fan & Li, **if a family in Mainland China decides that it is not in the best interest of a seriously ill patient to know the truth, the physician is morally obliged not to contradict the family. ‘Indeed, from time to time the physician will be obliged to lie to the patient in order to cooperate with the family.’**<sup>14</sup> Dai, a Mainland Chinese legal scholar, also opined that under these circumstances, **the physician is not legally bound to inform the patient, but the duty to inform the patient’s family is always legally required.**<sup>15</sup> **The moral and legal requirements to inform the patient’s family and not the patient underscore the dominance of family autonomy over individual autonomy in this tradition. The same approach of familial dominance is used in treatment decisions, for which the family’s consent alone is deemed sufficient, but not the patient’s. Although this ethic regards patient’s best interest as important, it is family members who are ‘in authority as interpreters of the patient’s best interests’<sup>16</sup> and ‘families are to be treated as autonomous entities and the source of legitimating authority’.**<sup>17</sup> **Fan concluded that the Western principle of autonomy, understood as self-determination, can only be understood as ‘family-determination’ in East Asia,**<sup>18</sup> and the ‘contemporary practice of medicine in mainland China can be seen as conducted rightly if it is . . . set within a larger commitment to the autonomy of the family. . . .’<sup>1</sup>



## Solvency

**Stronger focus on patient autonomy is needed to override authoritarian family control**

**Hui 08**

Edwin Hui, pf @ University of Hong Kong, “Parental Refusal Of Life-Saving Treatments For Adolescents: Chinese Familism In Medical Decision-Making Re-Visited” Bioethics, Volume 22 Number 5 2008 pp 286–295 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The crux of this paper is to emphasize the special duties of HCPs when authoritarian MDM is detected, as in our two cases. In the first place, **when parents refuse to give consent, the doctors’ duty and responsibility to protect the APs’ well-being remain unchanged. It is not the case that when parents refuse to give consent and adolescents don’t protest, the doctors are thereby ‘relieved’ of their duties and responsibilities.** On the contrary, **their responsibilities increase because they are left as the APs’ only advocates** in the APPPR. Secondly, APX’s father was allowed to take the AP away for herbal treatment, and the father’s good-will towards the HCPs was preserved and persevered to the end even when subsequent treatment outcomes were unfavorable. Some doctors argued that the original decision not to seek a court order was justified, because if the unsuccessful treatments were imposed by court at their request, they would be left in a vulnerable position. We find this line of reasoning unacceptable. Firstly, **complex medical judgments are generally too complex for lay people,** and APY’s tragic death supports the argument that, as APs’ advocates, **doctors can not leave the APs’ interests at the mercy of their parents when the latter make ill-informed, irrational and authoritarian decisions that jeopardize the APs. Parental authority must be limited in order that APs’ interests be protected.** Secondly, while family rapport and goodwill are highly desirable, **doctors must not allow the family to use them as leverages to manipulate the MDM process. Doctors make their treatment recommendations to patients or law courts on good faith, and they render treatments to patients with their best skills and abilities. But they should never have to make decisions under the pressure that their best professional judgment and ability must guarantee favorable therapeutic outcomes.**

## Solvency

### **Rights-based approaches key in Canada**

#### **Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Rights-based approaches to policy-making are increasingly valued and applied in the Canadian context. Canada ratified the United Nations Convention on the Rights of the Child** ( unrcr ) (United Nations 1989 ) in 1991 . **The National Children’s Agenda, and a range of policy and program measures aimed at fulfilling it, have subsequently been developed.** Policy aimed at improving children’s health has been a key focus of the broader effort to meet the requirements of the Convention. This chapter discusses and assesses the implications of the Convention as a framework for adolescent health policy in Canada. **We argue that a rights-based approach to adolescent health holds much promise but that concerted efforts to integrate evidence-based research with Convention principles and topics, or articles, are still needed to ensure appropriate and effective policy in this area.**

## CP – Laundry List

### Litany of policy proposals

#### Boyce 09

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, "Recommendations for Developing Adolescent Health Policy" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

With adolescent participation, **the key elements of policy change can occur. As a first step, leadership must inform and educate the public about the health promotion perspective and the commercial or professional interests and forces that threaten it. Such leadership must be multidisciplinary** and able to appreciate a range of health domains and influences. In Canada, leadership could come from the minister of health or from a new secretary of state for adolescents. The Childhood and Youth Division of Health Canada is a natural leadership focus, particularly regarding education of policymakers and interest groups. The Division has already articulated a report on adolescent health, Healthy Development of Children and Youth (Health Canada 1999 ), that can provide a focus for discussion if properly disseminated. Training grounds for adolescents to become such leaders would be new interdisciplinary schools of public and human health. A new generation of leaders could emerge from such training. **Second, a range of incentives should be built into policy initiatives. These include: economic incentives and disincentives; information interventions to combat misleading advertising and media; direct regulation; indirect regulation through the court systems; and de-normalization of harmful social conditions, physical environments, and behaviours.** Many of these incentives have been discussed by the authors in this book. Consideration should also be given to providing incentives to health care providers to increase their attention to high-risk populations. Such incentives could, for example, provide higher compensation to providers of services to teenage mothers, based on best-practice guidelines. Overall, prioritizing policy initiatives should be influenced by quality-of-life outcomes and population health status rather than by short-term costeffectiveness measures. **Third, improving the science base is necessary for improving adolescent health policy.** In particular, identifying the mechanisms through which social determinants of health operate, and the theories that link these mechanisms, is crucial. Research is also needed to develop and test socio-cultural interventions that might affect adolescent health. **Finally, assessments of the effect of policy (health and otherwise) on adolescent health are necessary. These health impact assessments, similar to environmental and gender impact assessments, consider a policy's likely intended and unintended consequences for health and use that information in the decision making process** (Lurie 2002 ). The inclusion of the Institute for Human Development, Child and Youth Health in the Canadian Institutes of Health Research is an encouraging sign, although we would argue that the emphasis on adolescence is minimal at this point. This Institute could initially sponsor a report on adolescent health that identifies the key questions for research action. It could then sponsor a national funding competition on adolescent health that is widely based and stimulate innovation and confirmatory research on key adolescent health issues. For example, such a report and competition could assist in focusing a research agenda that would improve adolescent health by studying how social (family, peer, school, neighbourhood) environments affect adolescents' health. Similarly, cihr and the Social Sciences and Humanities Research Council, which funds educational research, could sponsor a research theme on School Health. Fourth, monitoring and reporting on key adolescent health indicators, as well as interventions, is necessary in order to see where we are going. The nlscy and hbsc , in combination, allow examination of longitudinal cause-effect relationships and emerging cross-sectional prevalence indicators of adolescent health. These datasets provide useful information for monitoring program objectives, but there have been insufficient resources for their analysis. Joint efforts of Statistics Canada, Health Canada, cihr , and the Canadian Institute for Health Information could provide such resources. Reports from both of these adolescent datasets should be routinely produced and widely disseminated. Linkages should be encouraged between the two national datasets as well as with other regional datasets (e.g., Better Beginnings Better Futures, Ontario) that deal with disadvantaged neighbourhoods. For all such reports, there needs to be a set of clear communication objectives and tools that increase their public educational value. Adolescent organizations, such as the Centre of Excellence for Youth Engagement, should be partners in this dissemination process so as to ensure that adolescent-friendly messages are produced. **Fifth, differentiation of policy approaches for adolescent health is advisable. Universal-type programs of social marketing and behaviour change for adolescents are designed to work at the population level. These may have the best chance of success with adolescents who, while keen to differentiate themselves in subcultures for the purposes of self-identity, are loath to subordinate other adolescents on the basis of their needs. At the same time, participatory targeted programs for adolescents**

**who are estranged from family and school, living on the street in poverty, or raising their own children are crucial. Developing a sense of control and a meaningful role in such programs, rather than being “serviced” or receiving a handout, is vital for their acceptance and benefit to adolescents.**

Finally, new linkages across sectors are necessary. Numerous federal, provincial, municipal, professional, and business sectors need to openly discuss the health of the next generation with adolescents themselves. An adolescent agenda in Canada would contribute to the visibility and viability of policy initiatives. A population health perspective is pointless if it does not focus on populations – women, children, ethnic minorities, Aboriginals, adolescents, and so on. Among these groups, adolescents have had little attention, in part because of their transitional character, independence seeking, and uneasy relationship with adults. The relationship of health ministries with other policy sectors should not be one-way (i.e., just recruiting the cooperation of others in developing new health policies). The formal health sector should also contribute its expertise when other bureaucracies are developing their own policies. Experts on adolescent issues must become more prominent in the policy field, as have experts in women’s and children’s issues. Standing committees on adolescence could take the coordinating lead in many jurisdictions. Alternatively, senior health officials could be assigned liaison responsibilities with each federal or provincial department and as staff on key parliamentary committees with responsibilities for policies likely to have a health effect on adolescents.

**International Law**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Aff

**UN Convention goes aff – it’s all about involving children in decision-making and reducing the scope of parental authority**

**Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Such rights, the authors of the Convention judged, children hold independently of their parents and are enforceable by children over against their parents through the medium of the state.** As Richard Reading et al. summarize the implications: **One of the far-reaching consequences of the UNCRC [United Nations Convention on the Rights of the Child] is that it makes the child**

**an individual with rights and not just a passive recipient, and hence the child has the right to actively participate at all levels of decision making.** The traditional association between the state, the family,

and the child could be conceptualized as a series of concentric circles with the child at the centre. **The UNCRC implies that this association should now be understood to be triangular in which the state has a direct responsibility to the child to promote her or his rights. The child has the right to make a direct call** on the state to be heard in the development of legislation and policy, besides receiving protection (Reading et al., 2009, 335).

Karin Ringheim similarly notes: **“The responsibilities and duties of parents are to provide direction and guidance in the exercise by the child of his or her human rights”** (Ringheim, 2007, 246). In short, the Convention assumes the existence of corresponding governmental obligations and the legitimate moral political authority to enact public policy to protect children in the enjoyment of such rights, independent of the permission or interests of parents.<sup>4</sup> **Parents are perceived within a very limited role as custodians of their child’s best interests, with parental motives vis-à-vis their children mistrusted and parental decisional authority perceived as in need of significant regulatory oversight. Again, the implications for the bioethics of pediatric decision making are considerable.**

**The UN Convention on the Rights of the Child ensures right to life, health, and health care**

**Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The Convention is based on four general principles formulated in Articles 2 , 3 , 6 , and 12**

(United Nations 1989 ). Article 2 expresses the principle of **“non-discrimination,” or equality of opportunity for all children to enjoy their rights.** Article 3 contains **the principle of “best interests of the child,”** with respect to decisions made by courts of law, administrative authorities, legislative bodies, and public and private social welfare institutions. Article

6 addresses **the “inherent right to life” and “to the maximum extent possible the survival and development of the child,” referring to children’s basic physical health** and survival and implying

broader concern for other forms of personal and social development. **Article 12 describes the principle of “the views of the child,” stating that those views should be given “due weight in accordance with the age and maturity of the child.”** According to the United Nations, these four principles should guide interpretation of the Convention as a whole and, in so doing, inform the development and implementation of programs and policies (United Nations High

Commissioner for Human Rights 2006 ). **Following from these four principles, the Convention can be seen as containing three broad categories of rights: the right to survival and development, to protection, and to participation. These rights include:** provision of adequate resources for survival and proper development, such as food, shelter, clean water, **health care**, and formal primary education; protection from all forms of harm, such as physical abuse, violence, and exploitation; **and participation, without discrimination, in exercising rights, such as taking part in decision making and speaking up on matters that directly affect their lives and futures.**

## **The UN Convention requires a sliding scale model – rights expand as children develop their capacities**

### **Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Article 1 of the Convention defines the child as “every human being below the age of eighteen years unless[,] under the law applicable to the child, majority is attained earlier” (United Nations 1989 ). **The Convention emphasizes child protection, but it also makes reference to the relevance of age and maturity and the “evolving capacities of the child” in the exercise of rights. Article 5 recognizes the rights and duties of parents to provide appropriate direction and guidance to the child in the exercise of rights “in a manner consistent with the evolving capacities of the child.” Article 12 refers to the child’s right to express opinions and be heard in matters affecting his or her life, in accordance with “age and maturity.” Article 14 provides for the child’s right to freedom of thought, conscience, and religion and for the parents’ right and duty to provide guidance in a manner consistent with the child’s “evolving capacities.” Overall, the “evolving capacities of the child” are to be taken into consideration when it is decided how, when, and to what extent a child can exercise his or her rights independent of parents or guardians.**

## **UN Convention recognizes adolescent agency**

### **Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The rights principle of child protection is very consistent in the Convention, with many of its articles beginning with or including close variations on the statement: “States Parties shall take all appropriate measures to protect the child from ...” The protection of children from harm emerges as a key objective in twenty-one of the Convention articles.** These articles are identified in Note 3 and variously contain explicit statements or implicit assumptions that children must be protected from harm as it is directed at them from the adult world. 3 **Such a view positions children as objects requiring institutional and legislative measures to ensure their protection and not as subjects or participants who play a range of interactive roles – as victims, perpetrators, willing participants, unwilling participants, coerced yet consenting participants, decisive agents, resisters of protective**

**measures** – in the issues enumerated in Note 3 . In other words, children – or for our purposes specifically **adolescents** – **play an active, and at times confrontational, independence-seeking role** **that goes beyond the ideas of gradual development and protection.** **A nuanced interpretation of the principle of participation via evolving capacities would look at the more complex, active role that adolescents, in particular, play in harmful as well as health-promoting situations.** Policy approaches to these issues must recognize this duality, otherwise programs will only address the unilateral protection of young children from harmful, adult-generated forces and fail to adequately consider adolescents' agency in their lives.

## **Several articles in the Convention on the Rights of the Child guarantee autonomous access to health care**

### **Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, "Background to Health Policy-Making" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

### **Articles 13 , 14 , and 15 of the Convention, respectively, give adolescents the right to the fundamental freedoms of expression; thought, conscience, and religion; and association.**

Article 5 refers to adolescents' evolving capacities to exercise their own rights with regard to all other articles in the Convention. **These include the right to the highest attainable standard of health and health services** (Article 24 ); to education directed at the development of their personality, talents, and mental and physical abilities to their fullest potential (Article 29 ); **and to appropriate information aimed at the promotion of social, spiritual, and moral well-being and physical and mental health (Article 17 ).** **Recognition of adolescents' evolving capacities to gain access to resources on their own, to exercise their rights to health and education, and to make decisions about their own personal development and lives should be part of any adolescent health policy.** From this approach, **adolescents' right to participation in decision making regarding substances would be integrated into policy aimed at reducing rates of substance use and corresponding high-risk behaviours.**

## **ILaw goes aff – they have the right to be heard in proportion to maturity**

### **Ruggeri et al 14**

Azzurra Ruggeri (Postdoctoral Fellow in the Psychology Department at University of California, Berkeley and a Researcher in the ABC (Adaptive Behavior and Cognition) group of the Max Planck Institute for Human Development, Berlin), Michaela Gummerum (Associate Professor (Reader) in Psychology, School of Psychology at Plymouth University), and Yaniv Hanoach (Associate Professor (Reader) in Psychology, School of Psychology at Plymouth University). "Braving Difficult Choices Alone: Children's and Adolescents' Medical Decision Making." PLOS One. 2014. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118856/> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**As part of an attempt to increase children's participation in decision making, Articles 12 and 13 of the United Nations Convention on the Rights of the Child specify that minors have the right to express themselves freely, be heard on all matters affecting them, and have their views taken seriously** [1]. In recent years, there has been a shift from a paternalistic medical model, where physicians and parents hold an authoritative



role in determining a child's treatment, to one advocating minors' involvement in their medical treatment [2]. **Simultaneously, the US Supreme Court has come to recognize that minors who show maturity and competence deserve a voice in determining their medical treatment** and even allows minors, in cases such as abortion, treatments for substance abuse and sexually transmitted diseases, and contraception, to receive treatment without parental consent or notification [3]. **According to the Article 6 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine:** Convention on Human Rights and Biomedicine, **ratified in Italy in 2001, “the opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.”** Yet, a number of important questions remain open. Do children and adolescents welcome this change, wishing to be actively involved and taking responsibility for medical decisions regardless of the severity of the decision? Can they anticipate their emotional reactions to these choices?

## Neg

**Aff misinterprets the Convention – it upholds the parents role in providing guidance on exercising rights**

**Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The inclusion of the right to participation makes the Convention not only the most comprehensive statement of child rights but also the target of some critics who fear that it may undermine the authority of parents and schools or that it may legitimize undesirable youth activities, such as gang membership. **This is an inaccurate and unfortunate interpretation. The Convention emphasizes responsibilities as well as rights and, throughout, clearly and repeatedly upholds the importance of parents’ roles. It states that governments must respect the responsibility of parents for providing appropriate guidance to their children, including guidance as to how children shall exercise their rights.**

**No autonomy under Convention – rights of the parent still play a role**

**Poulin 09**

Christiane, chair of population health and pf @ Dalhousie University, in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Article 5 reads: “States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.”**

**Convention assumes family involvement in decision-making**

**Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The provision or existence of social supports and programs does not, however, automatically translate into improved health and development for all children. Unless national planners consider them holistically and in their complexity, **articles referring to the healthy development of the child assume that children are passive recipients of care who automatically accept whatever has been decided as being in the best interest of their development. This interpretation potentially undermines the principle that children – and**

**again particularly adolescents – play a major participatory role in their own and others’ ability or inability to develop healthfully in social, peer, school, and community environments.** It also ignores the reality that adolescents make active choices about whether to accept or reject information or programs aimed at improving their health. Finally, **it may be argued that these articles are based on the problematic assumption that children live in families and that programs made accessible to parents or guardians** (e.g., social benefits, standard of living programs, community activities) **will necessarily benefit children**. Such benefits may not reach adolescents who live alone, who are homeless, who rely on their own income for survival, or who, for a variety of other reasons, do not benefit from measures aimed at the family.

## CP – Expand the Convention

### **Expand the Convention**

#### **Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**It is evident that effective implementation of health promotion programs would benefit from the critical interpretation of principles within the Convention to ensure that they apply to the issues of adolescents. Likewise, the Convention needs to be expanded to include issues of adolescent sexuality, reproductive health, high-risk behaviour, and suicide, among others, if it is to be used in Canada and other countries as a tool for policy development or evaluation in the area of adolescent health.** In Chapter 5 , by Anderson and Boyce, for example, **the authors make the case that the Convention, in principle, can be interpreted as supporting the implementation of educational and resource initiatives** based on the Comprehensive School Health ( csh ) model. The csh model is based on the strategies of instruction, support services, social support, and a healthy environment, which can be and have been successfully applied to many different health issues, such as eating patterns, body image, substance use, nutrition, physical activity, sexual and reproductive health, and different high-risk behaviours. Articles 24 and 27 of the Convention can be interpreted as supporting the use of these four strategies in school health programs. **It is first necessary, however, for adolescent-specific health issues and risks to be identified as requiring attention and for research to be conducted to illuminate what the focus** of each csh strategy **should be for adolescents. Finally, more inclusive and diverse approaches are required in the promotion of adolescent health – approaches that distinguish it from the issues and dynamics involved in child health. These efforts would require attention to the living situations, educational status, and risk factors associated with different groups of adolescents. These groups and their issues must be identified and corresponding programs implemented in a variety of institutions, communities, and family types in order to reach out to the broadest range of adolescents.**

General

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Ambiguous

### **Convention not easily applied to policy – ambiguous and conflictual**

#### **Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Canada has a formal responsibility to comply with the Convention, but **the use of a macro-level framework to direct policy-making and to assess policy has limitations. The Convention sets out broad, basic standards for child rights but lacks clear definitions or standards with which to evaluate whether policy truly meets the diverse needs of both adolescents and younger children. This becomes particularly apparent when the Convention is used to frame or evaluate policy related to adolescent health and well-being. The Convention contains potentially conflicting principles of equity, protection, development, and participation, despite these being considered indivisible.** This tension is analyzed in detail in Chapter 13 . **It also lacks clear definitions with regard to what constitutes an “adolescent,” and it is unclear with regard to how states are to allow for children’s “evolving capacities” and their “participation” in the exercise of rights or decisions** (as opposed to simply having their rights “protected” by the state). **This problem has made policymaking at once complicated and limited in the area of adolescent health.** Finally, **the UN Convention on the Rights of the Child’s emphasis on overall youth policy-making and assessment may have further entrenched the invisibility the specific needs and concerns of adolescents.** The Convention, with its focus on young children, may be contributing to the neglect of adolescence as a substantive or productive target for policy-making or scientific research.

## Framework

### **UN declarations, rules and principles, are not legally binding**

#### **Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Previous international declarations of the rights of children exist** (i.e., at Geneva in 1924 and the United Nations in 1959 ), **as do official UN documents containing rules or principles relevant to children; however, none of these has been legally binding. Documents known as “declarations” act as proposals for future conventions, and they contain recommendations and suggestions for human rights definitions and convention articles. “Rules,” “codes of conduct,” “guidelines,” and “principles” are all intended to stimulate action on the part of governments. These represent minimum conditions and standards accepted by the United Nations but are not intended to describe a model system for human rights. The enforcement of rules or principles is the responsibility of nations, not the UN; and the observance of rules, codes of conduct, principles, or guidelines is only legally binding where these are incorporated into national legislation. Adherence to UN rules or principles is therefore the prerogative of individual states. There is no formal obligation to comply** (Bazilli 2000 ).

### **Conventions are legally binding**

#### **Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**By contrast, conventions – known interchangeably as covenants or treaties – create legally binding international obligations for signatory member states that define their mutual duties and obligations. When national governments ratify UN conventions, they commit to adopting laws, policies, and measures to implement the rights stated therein. Special UN committees are created, with the adoption of such treaties, to monitor and evaluate states’ progress in implementing convention articles. Upon ratification, states agree to submit progress reports or objective evaluations of their progress in implementing the treaty** (United Nations High Commissioner for Human Rights 2006 ).

**I-Law just begs the question – why is the one ethic it supports the correct one when there are many many others?**

#### **Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A core challenge for the Convention on the Rights of the Child is the articulation of a canonical moral anthropology—the nature and content of the basic goods central to human flourishing, such that one could articulate an account of the best interests of the child, without straightforwardly begging crucial questions. As a matter of empirical reality, instead of moral unity, one finds a considerable array of incommensurable moral accounts of the basic goods central to human flourishing—the moral norms necessary for judging the best interests of the child.**

One finds as well **significantly diverse theories** for rationally debating the merits of these divergent understandings of morality and human good. Even merely ranking central moral concerns, such as liberty, equality, justice, and security in different orders of importance will affirm different moral visions, divergent understandings of the good life, and varying senses of what it is to act appropriately in the best interests of children. **There appear to be at least as many competing secular moral anthropologies, with attendant accounts of the basic human goods and the best interests of children,** as there are major world religions and secular worldviews. **Which account of human nature,** with whose view of human flourishing and basic goods, **should be appreciated as morally normative for judging the best interests of the child?** One must first specify the normative criteria for determining best interests—that is, how appropriately to balance costs and benefits and rank human goods or cardinal moral concerns. Which consequences ought to be avoided, which virtues inculcated and values embraced, and at what costs? Despite its invocation as a decision-making standard,<sup>17</sup> there does not exist a universal canonical account of the best interests of the child to guide medical decision making. **Universal moral truths cannot be read straightforwardly off** of reason, **canonical intuitions,** or a sense of profanation or moral outrage so as conclusively to inform judgments regarding the best interests of the child (Engelhardt, 1996). **Unfortunately, the Convention neither clarifies why one ought to adopt its particular moral account as uniquely authoritative nor does it ever fully articulate why the child's freedoms of expression, speech, religion, conscience, association, and education are essential to protecting the best interests of the child. Adopting the Convention's particular, perhaps idiosyncratic, moral viewpoint to enforce through public policy, and a recast bioethics of pediatric decision making would, at best, appear to assume what must be proven.**

## **I-Law's meta-ethical assumptions are grounded in coherence with other I-Law Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The more universally binding moral content, such as a child's rights to privacy and freedoms of expression, conscience, and religion, are accepted, the easier it is to claim the moral political authority to regulate the conduct of persons to promote the creation and maintenance of such fundamental concerns. The challenge, however, is that the Convention's appeal to "human rights" rhetorically supports the existence of moral truth and binding moral content without ever having provided a definitive argument to ground its extensive claims. For its intellectual and moral foundation, the Convention appeals neither to philosophical argument nor to empirical data, but to its coherence with similar pronouncements on human rights:**

Bearing in mind that **the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person,** and have determined to promote social progress and better standards of life in larger freedom Recognizing that the United Nations has, **in the Universal Declaration of Human Rights and in the International Covenants on Human Rights,** proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status . . . (Preamble). No



definitive argument has been given; nor has a canonical moral or authoritative political foundation been established for these claims and the pediatric bioethics they would establish.

## **I-Law is based on a faulty global consensus**

### **Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The authors of the Convention affirm what they claim are the moral views of the “peoples of the United Nations.” Yet, many religions and secular worldviews do not share such a consensus about human rights. Forging an actual global consensus likely faces insurmountable obstacles given the real differences among religions** (e.g., Jewish versus Muslim), **political viewpoints** (e.g., socialism versus libertarianism), **and secular worldviews** (e.g., those who affirm the authority of parents over children until such time as the child fully emancipates himself versus those who perceive the minor child as in authority to make his own medical and life-style decisions even while living with his parents). **Even if widespread agreement existed, it would still be necessary to connect such consensus with moral truth. At various times and places, there has been widespread acceptance of activities that many persons currently decry (e.g., hereditary slavery).** The Convention’s intent often appears to be primarily rhetorical: to influence the international political agenda and the formation of specific laws within member states.<sup>18</sup> If the words of the Preamble are taken at face value, fundamental human rights are to a certain extent matters of “faith” and so, as a consequence, would be the bioethics they support.

## **Not about Adolescents**

**Convention is mostly about small children, not adolescents**

**Boyce 09**

Emily, PhD in Sociology at Simon Fraser University, “Background to Health Policy-Making” in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Apart from Articles 5 , 12 , and 14 , however, **the Convention makes no other mention of children’s “evolving capacities,” nor does it make further reference to how rights might be thought about in terms of the unique developmental stage of adolescence.** Other articles refer to children’s rights regarding “participation,” though without reference to adolescents in particular, and these include Articles 13 (freedom of expression), 15 (freedom of association), 17 (access to information and media), 23 (social integration and participation of children with disabilities), and 31 (cultural, leisure, artistic and recreational activity). Despite these articles, however, the Convention is dominated by the language of protection, with nuances characterizing the state and family as care providers. **The Convention reads principally as a document outlining the need to protect young children from violations of their rights and the need for states and families to ensure the maximum survival and development of young children. It takes a great deal of interpretation and imagination to properly apply the Convention to the social problems of adolescents** (e.g., unemployment, poverty, street life, independent living, sexuality, reproductive health, substance abuse, high-risk behaviours, suicide, peer relations, peer violence, and gendered violence) **and their rights** (e.g., their right to social security and a decent standard of living and their rights as young parents or persons with a disability). Chapter 13 attempts to examine some of these issues.

## **Sliding Scale**

**UN rights apply on a sliding scale – rights increase with age and maturity**

**Poulin 09**

Christiane, chair of population health and pf @ Dalhousie University, in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Article 12 reads: “ 1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”**

## **I-Law Ignores Minorities**

**I-law proceeds from a view from nowhere – it doesn't discuss minority access to health services and ignores social determinants of health**

**Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, "Background to Health Policy-Making" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In addition to being based on the broad rights principles of development, participation, and protection, the Convention may be read as addressing a series of salient social, political, family, and cultural issues on which children are accorded human rights. These rights topics range from violence and exploitation to standard of living to access to media and arts. **For the most part, rights topics are named in separate statements or articles within the Convention, and there is little cross-referencing between them.** For example, **the rights accorded to children with disabilities or children of minority and indigenous groups are** spelled out in their own articles, but the implications of disability and minority status are **not cross-referenced in articles referring to access to health services, violence and exploitation, or access to education.** **Another example**, of particular relevance to health planners, **is the lack of reference** within Article 24 (on health) **to many social determinants of health.**

## General Mechanisms

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Mature Minor Doctrine (MMD)

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Inherency

### **Status quo is inconsistent**

#### **Driggs 01**

Ann Eileen Driggs, R.N., J.D., “The Mature Minor Doctrine: Do Adolescents Have the Right to Die?” Health Matrix, Vol. 11:687 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**State courts have not been consistent in their decisions when a minor rejects life-sustaining treatment, and in most states unemancipated minors are not afforded the right to make their own medical decisions. However, three states have adopted the mature minor exception to consent or refuse specific medical treatment.**<sup>41</sup> Also, minors who are fourteen years of age or older in Alabama are permitted to give consent for medical treatment.<sup>42</sup> **However, there are no cases in that state addressing the right of a minor to refuse life-sustaining treatment. When the circumstances involve a life-threatening situation, courts have generally not extended the right to reject lifesustaining treatment to minors and are reluctant to apply the mature minor doctrine.** The mature minor doctrine permits a minor who exhibits the maturity of an adult to make decisions traditionally reserved for those who have attained the age of majority.<sup>43</sup> **Adolescent minors are somewhere between childhood and adulthood. The years between approximately fourteen and eighteen have become a veritable never-never land when attempting to evaluate their capacity and competence in the world of informed consent. Legally, children in this age group are considered minors and, traditionally, they are considered legal incompetents.**<sup>44</sup>

### **Status quo use of MMD is inconsistent and has no clear standards**

#### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Review of the aforementioned cases reveals several important implications. **First, the mature minor doctrine has yet to be fully developed or consistently applied. Some courts have deferred adoption of the doctrine to State Legislature, preferring to stay out of the debate entirely. Other courts have extended decision-making authority to minors for the purpose of consenting to, but not refusing medical treatment. Still others would allow minors adjudged mature to refuse even life-saving medical treatment if they had agreement from their parents. Second, although all courts willing to entertain the mature minor doctrine speak of the minors' ability to understand their circumstances and appreciate the consequences of their decisions, none provide specific guidelines for measuring the capacity of minors to do so. In addition, the courts do not recognize a significant difference between the refusal of and consent to medical treatment, especially where the consequences are life or death in nature.** Ethically speaking, a higher level of competence is required to refuse than consent to such treatment.<sup>346</sup> The cases dealing with the mature minor doctrine in situations involving life or death decisions are deficient in their discussions regarding whether minors are in fact capable of choosing to refuse life-saving or sustaining medical treatment in accordance with their underlying and enduring aims and values.

### **Status quo law is hashed out on the state level and only in certain contexts**

#### **Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The court noted that minors do have constitutional rights, but added that Greg and his counsel pointed to no authority for the proposition that a mature minor "has a constitutional right to refuse a blood transfusion pursuant to either the minor's First or Fourteenth Amendment rights; nor could they. 312 This is an important distinction. The cases that have adopted the mature minor doctrine have done so under state law, not federal constitutional law. The United States Supreme Court has yet to extend constitutional protection to minors in the medical setting beyond the abortion context. 313**

Therefore, Greg was required to show that Georgia state law supported his claim.

**Current MMD law requires that the minor’s right is weighed against the interest of the state in preserving life and preventing suicides – the state can always win a competency case**

#### **Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In the case of In re E.G.,<sup>55</sup> the petitioner, E.G., was a seventeenyear- old suffering from leukemia. As a Jehovah's Witness, E.G. refused recommended blood transfusion treatments; without the treatments, E.G. would certainly have died within a month.<sup>56</sup> Her mother, also a Jehovah's Witness, supported the decision. **Because of the treatment refusal, the State filed a petition in juvenile court seeking to take custody of E.G. and perform the blood transfusions.**<sup>57</sup> During the hearings, E.G. testified that she was refusing the treatments because of her own religious convictions and not because she had a determination to die.<sup>58</sup> **Several witness, including a psychiatrist, testified as to the maturity of E.G. and the sincerity of her religious beliefs. 59 The trial court** noted the maturity of E.G. but **ruled that the State's interest outweighed her right to refuse treatment.** On appeal, the appellate court reversed and ruled that, as a "mature minor," E.G. had a constitutional right to refuse medical treatment. <sup>60</sup> The State appealed to the Illinois Supreme Court, which upheld the determination that a mature minor had a constitutional right to refuse medical treatment. As with the common law right of an adult to refuse life-sustaining medical treatment, <sup>61</sup> **the court noted that a mature minor's right to refuse treatment had to be weighed "against four State interests: (1) the preservation of life; (2) protecting the interests of third parties; (3) [the] prevention of suicide; and (4) maintaining the ethical integrity of the medical profession.** <sup>62</sup> In cases involving minors, protecting the interest of third parties or, more precisely, the interests of the parents was the criteria courts were to give the highest regard.<sup>63</sup> Since E.G. and her mother agreed to refuse treatment, this interest was moot. E.G. was allowed to make her own medical decisions concerning the leukemia.



## Solvency – Promotes Autonomy

### **Exemptions like emancipation or mature minor doctrine respect autonomy**

#### **Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Another related solution would provide status exemptions for certain children.<sup>147</sup> Current law provides categorical exemptions for marriage, military service, emancipation, and in certain cases when maturity has been proven.<sup>148</sup> **Black's Law Dictionary defines an "emancipated minor" as a "person under eighteen years of age who is totally self-**

**supporting**.<sup>149</sup> Simply put, emancipation occurs when a child is free from parental authority and regarded as an adult.<sup>150</sup> Emancipation may occur when a child marries, joins the military, lives separately and apart from his or her parents, or is otherwise economically self-supporting.<sup>151</sup> **Financial independence and control, rather than psychosocial indicators of**

**developmental maturity, often determine emancipation**.<sup>152</sup> **If emancipation fails to provide a solution, the "mature minor" doctrine might be used to allow for individualized**

**competency detenninations**.<sup>153</sup> **Currently the law uses the mature-minor doctrine to allow minors to make medical decisions against a parent's wishes**.<sup>154</sup> **Perhaps one solution to the**

**problem would be an expansion of the mature-minor doctrine allowing minors who reach the age of sexual consent to petition the court to obtain mature-minor status before ever becoming pregnant**.<sup>155</sup> **In general, the evolution of exceptions to the parental consent**

**requirement reflects an increasing sensitivity to the child as a person; the focus of the exceptions has shifted from emphasis on bodily integrity (emergency) to judicial recognition of de facto majority (emancipation) to concern over the characteristics and mental capabilities of the minor (maturity)**.<sup>156</sup>

### **We should extend full rights to children**

#### **Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Finally, the most extreme option would **simply extend full rights to children**.<sup>163</sup> Children could borrow capacities from others in order to exercise their rights.<sup>164</sup> **Agents would inform children about the possible consequences of their decisions and help children reach a sensible decision**.<sup>165</sup> **This type of system**, some say, would interfere with family autonomy, but giving children full rights **would not preclude parents from offering incentives for the children to make decisions that the parents prefer**.<sup>166</sup> **The theory of full rights for children bases its conclusions on equality and justice**.

## Solvency – Doesn't Care About Competency

**MMD has developed in medical and legal discourse without a concern for maturity standards – caring only about the best interests of the state**

[Could answer burdens that require you to discuss competency – proof that ongoing legal/medical developments within the topic have nothing to do with maturity!]

### **Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," *Journal of Medicine and Philosophy*, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**This evolution of the doctrine of the mature minor and support for adolescent access to reproductive health services are shockingly neglectful of robust discussions of the doctrine's most intrinsic concept—maturity.** It seems that, **legally and medically, the concept of the mature minor does not actually depend on the notion of maturity. Instead,** the invocation of the doctrine of **“mature minor” in the context of adolescent reproductive health has become a means to assert better health outcomes for the state.** A careful consideration of **maturity is unnecessary because contraception is an unqualified good in the case of every teen. Socially destructive and expensive health risks, more than the adolescent's mature ability to understand and appreciate health information, merit the provision of reproductive health services without parental consent.** Thus, **while the doctrine of mature minor appears to be another iteration of the primacy of autonomy,** the principle of autonomy may only have been the justifying spark that began the practices and legal norms of providing contraception to minors. **In all reality, the public good and the goods imposed uniformly on every minor** (avoid pregnancy and STDs) **are** equally **central forces** in the development of the mature minor.

Ironically, in failing to build the doctrine of mature minor on a well-defined concept of maturity and instead by focusing on the health consequences of risky adolescent behavior, law and medicine attest to and then compensate for the immaturity and neediness of minors. In short, the immaturity of minors leads to the assertion of their maturity for making decisions around sexuality. In the context of contraception and abortion, the invocation of the “mature minor” appears as an effort to cope with the minor's immature and detrimental effect on public health by unqualifiedly moving the adolescent into the realm of adulthood when it comes to sex and sexuality. Thus, **the real dilemma is not about adolescents' ability to consent, because contraception is perceived as beneficial and good regardless of consenting ability. The real conflict is between state interests in public health and parental authority.** **Under the guise of the adult-like developmental stage of adolescence, health outcomes have clearly been prioritized above parental authority and the primacy of the family structure without significant attention to what maturity is or if adolescents actually possess it.**

Once a doctrine to allow for emergency exceptions in life-and-death situations when a parent happened to be absent, the doctrine of mature minor has evolved into a medicolegal foundation to emancipate minors for the purposes of sexual health, further inculcating a new norm of sexuality for adolescents. Now, the doctrine enables adolescents to make decisions about sexual health with the intention of excluding their parents. **The state, in its alliance with medicine, provides the consequentialist moral content** for decontextualized goods of sexuality—to allow sexual gratification and liberation, while avoiding pregnancy and disease. With the systematic implementation of mature minor into reproductive health care, parents no longer have—or need—a say in their children's decisions. Parental authority has become dislodged by the presumed higher sexual morality of the state, allied with a medicine that leads to the propagation of the ideal controlled female body, isolated from her family and placed within the governance of the state.

## Solvency – MMD + Case-by-Case

**States should adopt statutes like the West Virginia MMD where medical professionals determine competence on a case-by-case basis**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The West Virginia legislature followed the opinion of the appellate court. 17 9 From this medical malpractice case, **the legislature crafted the above statutory definition of a mature minor to give power to the medical professionals in deciding if a minor was mature enough to make health care decisions. This is the only state statute that gives explicit control to the medical community in determining a mature minor**.<sup>180</sup> West Virginia has taken the proposal of this Note a step further, from encouraging the judiciary to defer to physicians' maturity determinations, a rule that could exist in the common law, to codifying it in statutory law. Two commentators have predicted the positive effects of the West Virginia statute on the mature minor doctrine:

**As health care providers in West Virginia follow the mandates of their new statute[,] they have a unique opportunity to develop guidelines and report baseline data relative to practice patterns, as well as develop standards for determining mature minor status vis-a-vis advanced care planning. The way in which these providers determine and document decisionmaking capacities of mature minors, and the impact of autonomous health care decisions concerning advance directives and end-of-life care, may be the foundation for initiating new and improved legislation concerning mature minors and their participation in medical decision making.** i1

This quote demonstrates how, **for policies like the West Virginia statute to be most successful and universally implemented, it will be up to the legislatures to enact mature minor statutes and revise them as needed.** 182

CONCLUSION **Health care professionals need to assert their knowledge and experience when confronted with a minor who should, or should not, be allowed to make her own medical treatment decisions.** 8 3 **The knowledge and experience of health care professionals should not be ignored in making life and death decisions for a minor. By incorporating judicial deference to a physician's determinations of a child's maturity in mature minor cases, the common law will start to see the development of a defined standard for the mature minor doctrine based on scientific research and empirical data instead of relying on the standards of judges, which are usually based on personal experience and brief impressions of the minor.** 18

## No Solvency

### **Adults retain control on MMD, and it's expensive**

#### **Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

If emancipation fails to provide a solution, the "**mature minor**" doctrine might be used to allow for **individualized competency detenninations**.<sup>153</sup> Currently the law uses the mature-minor doctrine to allow minors to make medical decisions against a parent's wishes.<sup>154</sup> Perhaps **one solution** to the problem **would be an expansion of the mature-minor doctrine allowing minors who reach the age of sexual consent to petition the court to obtain mature-minor status** before ever becoming pregnant.<sup>55</sup> In general, the evolution of exceptions to the parental consent requirement reflects an increasing sensitivity to the child as a person; the focus of the exceptions has shifted from emphasis on bodily integrity (emergency) to judicial recognition of de facto majority (emancipation) to concern over the characteristics and mental capabilities of the minor (maturity).<sup>156</sup> **This method, however, does not provide an ultimate solution** because it will not work in cases where minors are unable to plan ahead or the **determination of competency will be based on an adult's decision, and** because **it requires significant costs and increased litigation**.<sup>157</sup>

## Topicality

**MMD is T – it’s all about allowing adolescents autonomy in medical decisions**

**Spike 11**

Jeffrey P. Spike, University of Texas Health Sciences Center, “When Ethics Consultation and Courts Collide: A Case of Compelled Treatment of a Mature Minor” Narrative Inquiry in Bioethics, Volume 1, Number 2, Fall 2011, 123-131 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The mature minor doctrine holds that a person who is legally a minor but who has decision-making capacity, fully capable of engaging in the process of informed consent, has the right to use that capacity. It can be seen, ethically, as an extension of the Principle of Autonomy—arguing that it should apply to anyone capable of making autonomous decisions, even if they have not yet reached the legal age of majority.**

**MMD is distinct from “rights,” which are extensions of Constitutional rights to privacy**

**Spike 11**

Jeffrey P. Spike, University of Texas Health Sciences Center, “When Ethics Consultation and Courts Collide: A Case of Compelled Treatment of a Mature Minor” Narrative Inquiry in Bioethics, Volume 1, Number 2, Fall 2011, 123-131 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

There are two quick lessons I reviewed for my two clerks. First, mature minors are different from emancipated minors and from **legal carve-outs such as the right to birth control or termination of pregnancy.** Those **are** important topics in pediatric ethics as well, but **not the same thing as a mature minor. The carve-outs are usually interpreted to result from the constitutional notion of a zone of privacy. That zone, in effect, expands the territory of rights to lower ages only concerning issues of reproduction.**

And, as to emancipated minors, one doesn’t have to be emotionally or decisionally mature to get pregnant; in fact, some might say that pregnancy is an indication of physical maturity combined with emotional or decisional immaturity. I often explain that emancipated minors are people who have escaped from childhood; usually as a result of finding their own childhood so awful that they would rather leave it behind prematurely.

Counterplan Stuffs

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## **AT Informed Consent / Decision-Making**

### **More information doesn't improve adolescent decision-making**

#### **Fischhoff 08**

Baruch Fischhoff, pf @ Carnegie Mellon, "Assessing adolescent decision-making competence"  
Developmental Review 28 (2008) 12–28 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

A question that occupies many people concerned about teens' welfare is, "**Does information work?**", as a way to **improve teens' decision making. From a behavioral decision research perspective, there can be no simple answer. In some situations, teens would not change their choices, whatever (truthful) information they received.** In those cases, information has "worked," leading them to stable decisions (Reyna & Farley, 2006). Those choices might not please people who disapproved of the values that those decisions embodied; however, **the problem would not be how teens had used the information.** Stable choices might not even please the teens making them, if they wished that they had better options (e.g., those unable to stop smoking or escape abusive relationships).

## AT CPs for Dignity/non-Autonomy Rights

Other standards don't solve – too hard for courts to apply

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Notwithstanding widespread endorsement in human instruments, the courts in England and Wales have, as described above, shown little enthusiasm for establishing a conceptual grounding in human rights, such as dignity or bodily integrity, for decision-making for people lacking capacity. <sup>198</sup> While there may be many reasons for this, one reason for judicial reluctance may be the inherently vague nature of the rights in question. When compared with the straightforwardness of an autonomy-based legal framework, references to rights such as dignity or bodily integrity seem to lack a clear focus and scope. <sup>199</sup> There are undoubtedly challenges in defining the scope of rights such as dignity or bodily integrity in respect of healthcare decision-making for people lacking capacity. What does a right to dignity mean in the context of physical restraint of a resistant patient in order to administer medical treatment which may save her life? What does a right to physical integrity mean for a patient who lacks even a basic understanding of the proposed treatment and what it is intended to achieve? In the light of the difficulties, it is perhaps understandable that courts prefer to avoid these questions, leaving the matter, as much as possible, to be determined by medical professionals and to the fluidity of the best interests standard. However, as will be seen below, there is a basis in ECtHR jurisprudence for the development of a more rigorous conceptual framework around dignity and other rights.



## AT Welfare Principle

**Welfare and best-interest standards are just smoke-screens for subjective decision-making by judges**

**O'Donnell 04**

Kath O'Donnell, University of Hull, "Re C (Welfare of Child: Immunisation) - Room to refuse? Immunisation, welfare and the role of parental decision making" 16 Child & Fam. L. Q. 213 2004 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The welfare principle asserts its neutrality, claiming to consider only the child as an individual and not wider social policy considerations. But this neutrality and objectivity are highly questionable: whose values are being applied to resolve the dispute? In general, the values applied represent majority norms, as interpreted by the judiciary.** In cases concerning disputes over medical treatment, **the values applied are those of medical norms.** **The indeterminate nature of the welfare principle means that it is left to judges to decide which values to apply and how much weight to attribute to them. The welfare principle becomes a smoke screen for subjective values that may be smuggled into the decision-making process.**<sup>24</sup> Herring argues that the inherent flexibility of the welfare principle means that it can successfully accommodate other issues where courts feel that it is appropriate to do so, 25 but this hardly provides a sufficient answer to criticisms based upon its subjectivity and indeterminacy.

## **CP – Substituted Judgment**

**In cases where a patient lacks capacity, a decision should be made according to what they would want had they the capacity to decide**

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Decision-making on the basis of substituted judgment involves asking what the patient would have decided if she had capacity.**

As noted above, like the best interests standard, this too has its antecedents in the parens patriae jurisdiction where it was used in respect of property and affairs. The **first reference to the standard in a medical context seems to have been by the Kentucky Court of Appeals in Strunk v. Strunk**.

<sup>56</sup> The case concerned a proposal to remove a kidney from a man with a significant degree of intellectual disability, for transplant purposes in order to save the life of his brother. **The Court considered that ‘[t]he right to act for the incompetent in all cases has been recognized in this country as the doctrine of substituted judgment and is broad enough to cover not only property but also matters touching on the well-being of the ward’.**

<sup>57</sup> On the facts of the case, however, the decision was based more on an assessment of the intellectually disabled man’s best interests. The Court regarded the procedure as involving ‘minimal danger’ <sup>58</sup> and noted the close relationship between the brothers and the (emotional) cost to the man if his brother was to die. <sup>59</sup>

## CP – More Ethics Consultants

**Ethics consultation serves a crucial role in health care decisions – needs more funding**

**Swota and Bradfield 15**

Alissa Swota, University of North Florida, & Scott Bradfield, Nemour’s Children’s Clinic, “Eliciting Parental Values and Preferences in the Medical Decision-Making Process” The American Journal of Bioethics 15:5, 34-35 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Lastly, **from a wider perspective, the ethics consultation process needs to be appreciated for serving a crucial role in educating health care providers in modeling the mechanisms to elicit patient and parental values**.

In ethics consultation, primary emphasis is placed on communication with the parties concerned, often a clarifying practice that may serve as the sole function of some consults. Yet we know funding is limited for ethics consultation. As Kesselheim and colleagues state, **“The lack of fiscal and administrative support for ethics programs raises concern** about whether the freestanding children’s hospitals are adequately invested in providing ethics services.

**Budgets dedicated to ethics would likely allow ethicists to be better trained and may increase the quality of their work**” (Kesselheim, Johnson, and Joffe 2010, 746). Increased budgets would help to obtain and maintain ethics programs and ethics consultants in a reframing of the services as a true resource to the families, the hospital, and its physicians.

**Greater exposure to alternate decision-making processes through regular bioethics rounding on the wards and intensive care units (ICUs), involvement of more providers in consults by increasing consult frequency and thereby consult “routineness,” and educating the hospital ethics committee members beyond the common on-the-job training will all require funding.** However, these efforts are the ones necessary to change perceptions. This involvement and positive contact will keep

“attending physicians from feeling a consult request reflects negatively on their decision making” (Johnston et al. 2015, 15). **It empowers patients and families and other nonphysician care providers to request a consult as well.**

**We prefer to see difficult yet important communications start early and be revisited often, and when ethics consultation is required, it should be regarded as another available and powerful method to clarify alternate perspectives, values, directions, and goals, rather than as a reflection that failure in the decision-making process has occurred.** &

## CP – Consent but not Refusal

**According to some, adolescents should have the right to consent to treatment independent of their parents but not to refuse life-saving treatment**

**Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The West Virginia court did not draw a distinction between consenting to or refusing**

**medical treatment.** In support of this, one might argue that once minors are deemed mature they should be afforded rights equal to those of adults; and **adults clearly may refuse medical treatment, even where death is the probable result.**<sup>21 9</sup> **Many commentators, however, are not ready to go this far when it comes to minors refusing life-saving, or life-sustaining medical treatment.**<sup>222</sup> Complicating this issue further, is the fact that **parents are typically not permitted to make decisions that put their children's lives at risk.**

**Counterplan represents a morally relevant difference**

**Will 06**

Jonathan F. Will, JD from Pitt, “My god my choice: the mature minor Doctrine and adolescent refusal of Life-saving or sustaining medical Treatment based upon religious beliefs,” 22 J. Contemp. Health L. & Pol’y 233 2005-2006 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Recall that the determination of competence requires an inquiry into "a particular person's capacity to perform a particular decision-making task at a particular time and under specified conditions."**<sup>420</sup> For purposes of this article, **the task involves the refusal of medical treatment based upon religious beliefs. Ethically speaking, this is important because the**

**competencies required to consent to and refuse medical treatment are not necessarily equivalent.**

Buchanan and Brock suggest a sliding scale and supply this example: **"consent to a low-risk life-saving procedure by an otherwise healthy individual should require only a minimal level of competence, but refusal of that same procedure by such an individual should require the highest level of competence."**<sup>421</sup> Put another way, **"[t]he greater the risk relative to other alternatives-where risk is a function of the severity of the expected harm and the probability of its occurrence-the greater the level of communication, understanding, and reasoning skills required for competence to make that decision."**<sup>4 22</sup>

**Medical Areas**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Abortion

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Inherency

**Judge exemptions in the status quo are not enough – they don't protect privacy and might deter**

**Bermuglia 01**

Jessica Bermuglia, JD, "Preserving the Right to Choose: A Minor's Right to Confidential Reproductive Health Care" 23 Women's Rts. L. Rep. 63 2001-2002 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Some states allow for a judicial bypass exception to the mandatory parental involvement laws, but "a judicial bypass option is not an adequate alternative for young women."<sup>65</sup> Judicial bypass procedures allow for a minor to appear before a judge in an attempt to bypass the parental involvement requirement.<sup>166</sup> "In order for the [minor] to receive a waiver, the judge must decide that the [minor] is mature enough to make the decision herself or that the abortion is in her best interest."<sup>167</sup> Pregnant minors experience fear, and anxiety, as well as shame proceeding before a Judge since they are "forced to reveal the details of their private lives to strangers in the courtroom.,<sup>168</sup> Even a judicial bypass procedure that attempts to ensure the confidentiality of the teen often requests that she provide her parents' names. Particularly in small towns where a young woman may be recognized by the judge or other court personnel, procedures meant to protect confidentiality do not ensure anonymity. In states requiring two-parent involvement, an adolescent must go to court even if . . . she has informed, has the consent of, and/or is accompanied by one parent. Some statutes require a minor to notify both her biological parents, making no exception for non-custodial parents or parents who have never met the minor. <sup>169</sup>

**Parental consent laws in the status quo**

**Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

A sixteen-year-old pregnant teenager may consent to have her child adopted but may not decide to have an abortion without parental consent.<sup>82</sup> Most states permit a minor, biological parent to consent to the adoption of her child without any advice from parents or counsel.<sup>83</sup> In Massachusetts, a biological mother must consent to the adoption proceedings for a valid adoption to occur, and the statute does not provide an express minimum age at which such consent may be given.<sup>84</sup> In California, a minor parent has a legal right to consent to an adoption, and that consent will not be subject to revocation because of the individual's minor status, but the law does require that consent be signed in the presence of a State Department of Social Services agent or a licensed county adoption agency.<sup>85</sup> Legislators have viewed parental consent as so vital to adoption proceedings that in many states the law allows a birthmother as long as six months or a year to revoke her consent to adoption.<sup>86</sup> The rationale behind the consent requirement for biological parents in adoption cases lies in the Supreme Court's finding that parents have a fundamental right to raise their children as they wish, including giving a child up for adoption.<sup>87</sup> This standard, however, ignores the need to balance a child's right to choose continuity and stability against a parent's privacy right to raise (or not raise) a child.<sup>88</sup>

## Supreme Court has hugely limited abortion rights for adolescents Baldwin 13

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Every year, hundreds of thousands of women between the ages of fifteen and nineteen become pregnant.**<sup>103</sup> These teenagers may legally consent to engage in sexual relations, but **they do not have the right to independently decide to obtain an abortion if they do become pregnant.**<sup>104</sup> If a young woman chooses to become a young mother, she immediately obtains adult-like rights, but if the same young, pregnant teenager decides to abort, her choice is subject to adult involvement.<sup>105</sup> **The Supreme Court has held that minors have some privacy rights, but the extension of those rights has been limited.**<sup>106</sup> The Supreme Court recognized the right to obtain an abortion as part of the right to privacy and then extended part of that right to minors.<sup>107</sup> In 1977, the Court held that the right of personal privacy included "the interest in independence in making certain kinds of important decisions."<sup>108</sup> The Court wrote in 1972, "[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."<sup>109</sup> **The Court, however, has consistently withheld this full right from children due to a purported lack of capacity.**<sup>110</sup> But if a child has sexual-consent capacity at a certain age, the corresponding protection should be granted for that child's privacy right to an abortion at the same age." **In thirty-four states, females under the age of eighteen must have some form of parental involvement in order to obtain an abortion.**<sup>112</sup> States offer different reasons for the parental consent or notification requirement, including protecting immature minors, fostering family structure, and protecting parents' ability to control their children.<sup>113</sup> Some states give the abortion physician discretion to determine whether the abortion should be performed.<sup>114</sup> Parental-consent requirements may expose pregnant teenagers to the same dangers that caused the Court to strike down spousal-consent requirements.<sup>115</sup>



## Impacts

### **Parental involvement delays abortion decisions, which can pose serious health risks Bermuglia 01**

Jessica Bermuglia, JD, "Preserving the Right to Choose: A Minor's Right to Confidential Reproductive Health Care" 23 Women's Rts. L. Rep. 63 2001-2002 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Parental involvement laws also pose health risks to the pregnant minors.<sup>40</sup> Pregnant minors are more likely to have later abortions than adult pregnant women.<sup>141</sup> Parental involvement laws only make the situation worse. Pregnant minors might fear telling their parents, which can cause delays, and for those minors who choose not to involve their parents, having a judicial bypass hearing causes further delays.<sup>42</sup> Even though abortion is safer than giving birth to a child, "the risk of death from abortion increases 30% with each week of gestation from 8 to 20 weeks.<sup>143</sup>**

## Solvency

**Parental rights inhibit adolescents' access to abortions – autonomy is good and most adolescents talk to their parents anyway**

**Bermuglia 01**

Jessica Bermuglia, JD, "Preserving the Right to Choose: A Minor's Right to Confidential Reproductive Health Care" 23 Women's Rts. L. Rep. 63 2001-2002 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**An equally important, more current threat, especially to minors' reproductive rights, appears in "parental rights" legislation.**<sup>9</sup> Proposed at both state and federal levels, **such legislation severely limits minors' access to abortion services by requiring parental notification or consent where no such requirement is presently required.**<sup>20</sup> **Not only does this interfere with the minor's right to privacy, but it also gives parents a way to challenge the very existence of programs that they perceive as conflicting with their personal values.**<sup>21</sup> So even

though the right to choose was recognized some twenty years ago, states have been permitted to restrict a minor's ability to access abortion services through parental consent and notification laws. What most of those who support such restrictions fail to realize is that **parental involvement laws do more harm than good.** A study by the Alan Guttmacher Institute ("AGI") found that each year, close to **"1 million teenage women"** 10% of all women aged 15-19 years old and 19% of those who have had sexual intercourse **become pregnant . . . [and] 78% of these teenage pregnancies are unplanned, accounting for about 1/4 of all accidental pregnancies annually.**<sup>22</sup> Fifty-six percent of pregnant teenagers gave birth,

fourteen percent had miscarriages, and thirty percent had abortions. <sup>123</sup> Forty-three states currently enforce laws that mandate parental involvement in a minor's decision to have an abortion. <sup>24</sup> Some of these laws require a physician to obtain the consent of the minor's parent(s) before the abortion can take place, while others require the notification of parent(s) prior to the procedure. <sup>125</sup> Ten states have laws that have been successfully challenged. <sup>26</sup> As a result, those statutes are now enjoined from being enforced or are otherwise unenforced.<sup>127</sup>

Proponents of parental involvement in a minor's decision to have an abortion argue that parental guidance is especially important. <sup>28</sup> The general objective of parental involvement regulations is two-fold. <sup>29</sup> First, to assure that the minor women "make well-reasoned pregnancy disposition decisions with their parents." <sup>130</sup> Second, in situations where a pregnant minor chooses not to involve her parents, to as-sure that she is mature enough or is seeking an abortion in her best interest.' <sup>3</sup> On the contrary, **studies have concluded that parental involvement regulations are not functioning as intended.**<sup>32</sup> Thus, **parental involvement laws do not actually encourage a pregnant minor to involve her parents in her decision.**<sup>33</sup> **In fact, the opposite occurs. Absent mandatory parental involvement laws, most minors involve parents in the decision whether to have an abortion.**<sup>134</sup> **A majority of minors who have abortions do so with at least one of their parent's knowledge. Based on a national survey of**

more than 1,500 unmarried minors having abortions in states without parental involvement laws, **61% of young women discussed the decision to have an abortion with at least one of their parents.** The younger the minor, the more likely she was to have voluntarily discussed the abortion with her parent. Such communication was not mandated by law. <sup>35</sup>

## Competence/Maturity

### **No difference in decision-making in the abortion context specifically**

#### **Bermuglia 01**

Jessica Bermuglia, JD, "Preserving the Right to Choose: A Minor's Right to Confidential Reproductive Health Care" 23 Women's Rts. L. Rep. 63 2001-2002 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The decision-making capability of a minor must be acknowledged since minors can consent, without parental involvement, to other important medical and personal decisions. Parental involvement was first desired because of the notion that minors lack the ability to make informed choices.<sup>83</sup> But the Court has held that minors may be mature enough and well informed to make a decision independent of parental involvement.<sup>84</sup> However, the Court presumes that a minor does not have the capability to consent to an abortion and thus mandates the judicial bypass procedure.<sup>185</sup> Why can a minor make most other decisions without parental involvement or a judicial bypass procedure, but not decide to have an abortion? **Studies show that minors do not differ from adults in their ability to**

**understand and reason about medical decisions. 86 A study of minor and adult women making decisions regarding pregnancy found that they did not differ in four respects: (1) knowledge of the law and factors affecting a decision to abort, deliver and put the baby up for adoption, or carry to term and keep the baby; (2) the number of individuals consulted or expected to be consulted about her choice to deliver or abort; (3) the tendency to consult the partner, parents, or members of peer group; and (4) the expectation that conflicting advice will be received from each source, or the expectation that advice will favor pregnancy or abortion.**<sup>187</sup> Despite the fact that minors actually have the capability to make important life impacting decisions, states have limited their capability to make decisions without parental involvement to abortion, thus, not preserving the fundamental right an adult woman has to a pregnant minor. Furthermore legislation is still proposed providing further:: restrictions and upholding parental involvement in a young woman's right to choose.

### **Reasoning about abortion in interviews proves competence**

#### **Ehrlich 13**

J. Shoshanna Ehrlich, pf of law @ UMass, "Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents" September 2013, Berkeley Journal of Gender, Law & Justice, 18:1 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Although some of the young women responded to the news of the pregnancy with a sense of disbelief or denial, **all recognized the importance of making a relatively prompt decision.** In this regard, Amy noted how abortion requires the making of an affirmative decision, whereas becoming a mother can simply happen by default by letting nature take its course-something she thought might explain why some teens might become mothers before they are ready (i.e., by not making a decision). **For most of these young women, the decision was quite clear. They were certain that at this moment in their lives, they were not ready or able to have a child. Despite this, several mentioned that the decision was nonetheless an emotionally difficult one to make. The clarity that the minors brought to the decision-making process does not suggest an unthinking or mechanical response to their pregnancies.** Rather, as developed in the following section, **they all had clearly-articulated reasons for why having a child was not a present option for them, reflecting both an understanding of their present circumstances and a dynamic grasp of future possibilities.**

Also, as discussed below, **they all involved at least one other person in the decision-making process.**

### **Competent to imagine long-term impacts in abortion decisions**

#### **Ehrlich 13**

J. Shoshanna Ehrlich, pf of law @ UMass, "Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents" September 2013, Berkeley Journal of Gender, Law & Justice, 18:1 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Before discussing the final thematic reason for why teens in the sample chose to terminate their pregnancy, a brief comment about an emerging theme is in order. **During the course of the interview, most of the minors imagined the possibility of a different, older self who might make another decision at some point in the future.** Thus, for example, Bianca expressed this sentiment in very direct terms, stating that had she been "old enough, and had my own house... I would've kept the baby ....ju st five years down the line, you know, it would've been alright."<sup>229</sup> **Other young women expressed this sentiment in less direct ways, through an emphasis on the immediate, such as in "I just can't do it right now."**<sup>23</sup> **This ability to imagine a divergent self at a different moment in time suggests both a future orientation and an awareness of the situational nature of the abortion decision. Anticipating future developmental changes, or a more integrated self, most of the young women in this sample grasped the dynamic quality of their lives. Their responses embodied an awareness of the shifting nature of the present, and a recognition of life's passages.** As developed more fully below in Section V, this is a potentially significant finding with important implications for framing the dialogue regarding the decisional capacity of teens confronting the abortion decision. **The future orientation and the abstract quality of their thinking suggests an ability to reason in an "adult-like" manner about the abortion decision, in contrast to the concrete and present-oriented thinking generally associated with younger children.**

## Politics

### **Adolescent reproductive rights are a politically controversial issue**

#### **Haider 8**

Aliya Haider (received her J.D. from Harvard Law School (2003), her M.Sc. from the London School of Economics (2000), and her B.A. from Columbia University (1999). She is a Harry Truman Scholar and a member of the Phi Beta Kappa Society.). “Adolescents Under International Law: Autonomy as the Key to Reproductive Health.” William and Mary Journal of Women and the Law. 2008.

<http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=1026&context=wmjowl> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Advocating for adolescents' reproductive rights is fraught with politicization. Because adolescence is a borderline stage of life, it often becomes a legal battleground for control over provocative issues, such as sex, contraception, abortion, and sexually transmitted diseases.' 4 Despite the critical health issues at stake, discussing the sexuality of young persons typically sparks controversy.'**

5 Sometimes the issue is age or maturity level.' 6 The charge is that talking to teens about sex is tantamount to pushing them into sexual encounters.' 7 Sometimes the issue is the relativity of rights. 8 Advocates in this scenario are confronted with the assertion of culture as a justification and a defense for violations of adolescents' rights.' 9 Refuting the cultural relativist defense opens one up to charges of human rights imperialism and a lack of respect for local culture because of a refusal to accept the dictates of local authority. 20 Despite these challenges, all of which have strong replies in moral theory and social science, the importance of advocating for adolescent reproductive health rights is only growing as the adolescent population grows. 2' **Despite the fact that adolescent autonomy is often a political issue, policies concerning adolescents' reproductive health are becoming more prevalent alongside a growing acknowledgment of adolescents as agents of development and change.** 22

## Mechanism – Counseling Requirement Only

**Add a counseling requirement – solves competency concerns while leaving the decision entirely up to the adolescent**

**Ehrlich 13**

J. Shoshanna Ehrlich, pf of law @ UMass, “Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents” September 2013, Berkeley Journal of Gender, Law & Justice, 18:1 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The following are the suggested policy changes**, beginning with the least restrictive option: **1. Counseling Requirement:** As an alternative to a parental involvement/ judicial bypass provision, **a statute could simply include a counseling requirement, such as the one found in the Connecticut statute. Any such statute should specify that the counseling be nondirective, include a discussion of all pregnancy options, and encourage the possibility of parental involvement. To minimize any potential burden, professionals from the facility performing the abortion should not be prohibited from providing the counseling.** **2. Expanded Pool of "Alternative Adults":** If a law is to contain a parental involvement requirement, **the pool of "alternative adults"** whom a young woman could involve in lieu of seeking court authorization **should include both professionals and adult relatives. Each category should be as inclusive as possible, and no restrictions or pre-conditions** (such as that the minor demonstrate fear of parental abuse or that the professional not be affiliated with the abortion provider) should be imposed on a minor's ability to involve one of these designated adults. **3. Preference for Professionals over Relatives: If a choice must be made between allowing adult relatives or professionals to constitute the pool of alternative adults, the results of this study suggest that preference should be given to professionals.** However, all relevant factors need to be assessed. For example, a nonrestrictive option that includes a broad pool of adult family members may be preferable to a professional option that excludes otherwise qualified persons because they work for the facility where the abortion is to be performed. **4. Nature of Professional Involvement: With respect to professional involvement, a counseling role is preferable to a decision-making role, as this would provide guidance to the minor while allowing her ultimate authority over the decision.** **5. Retention of Judicial Bypass: Judicial bypass should remain an option for those minors who lack a relationship with or access to an alternative adult.**

## Harms of Court Requirements

Anecdotal evidence from the lived experience of adolescents demonstrates that s'quo methods of court approval are costly, humiliating, stress-inducing, unfair, and irrational

### **Ehrlich 13**

J. Shoshanna Ehrlich, pf of law @ UMass, "Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents" September 2013, Berkeley Journal of Gender, Law & Justice, 18:1 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

As previously mentioned in the description of the methodology, **all of the young women in the sample had gone to court for a judicial bypass hearing and had been found mature by a judge**. As part of the interview, they were asked to discuss what being in court had been like for them. Although not the focus of our inquiry, many of the young women, when asked about the nature of court experience, mentioned some of the **logistical difficulties they had encountered in arranging to get to court**. Although not examined systematically, it is clear from their spontaneous descriptions that **these difficulties weighed heavily on them and were an integral part of their overall reaction to the court experience**.<sup>295</sup>

**Critically, a number of young women reported getting incorrect information from various sources about their legal options**. For example, one young woman was told that she could not get an abortion in Massachusetts if she was under the age of 18; another was given inaccurate information about the court process. In both cases, the minors were ultimately referred to PPLM, where they were given appropriate information, but the incorrect information resulted both in delay and significantly increased anxiety.

Many of the young women also recounted difficulties in arranging to get to court. **Transportation was often hard to obtain and unreliable**. One young woman had originally planned to go out of state, but her ride backed out on her twice, thus causing her to delay the abortion. <sup>96</sup> **Another young woman described being so worried that she would not make it on time to court that she made a dry run**: Two days before I was actually going, I drove out there and looked for it. And I found my parking space, the exact one I was going to park in. And I went in, and I found exactly where I was going to sit, and then I went home. And two days later I went. I sat. I parked. I did all the stuff that I had practiced doing.<sup>297</sup> **A number of young women mentioned how lucky they were to be old enough to drive or have a friend who could drive them**, and they wondered what getting to court would be like for younger teens. Similarly, several mentioned how grateful they were to have a friend or boyfriend accompany them and imagined how frightening and lonely it would be to have to go alone. As Mary Souza explained, "I think that a girl, a young girl under 18, that finds out she's pregnant... [it's] already nerve-wracking.. <sup>298</sup>

**Virtually all of the young women reported being extremely nervous or frightened about going to court. Overall, the greatest fear was that the judge would deny them consent for the abortion**. Over and over they described how, despite the assurances of their lawyers that almost all teens in Massachusetts are granted consent, **they worried that they would be the one teen to be denied permission**. Focusing on the fear of being turned down, Monique explained: "I was actually scared .... Because my doctor... she's like '99% of [the time] she [the judge] agrees to' but I'm like 'what about the 1%'? I could be the 1%... and I was nervous.. <sup>299</sup> The following quotes also capture this anxiety. As Mary Jane describes it, "I was nervous because [I'd] never been to court before .... It was a little nerve-wracking for me ... I was just nervous." <sup>300</sup> Similarly, Amy described her feelings upon entering the court: "I was ... aaaaah! ... scared just thinking about... if I don't get this, what am I going to do?... If this doesn't work, what am I going to do next? ... What if the judge says 'no'? That's the only thing you think about, I think. What are you gonna do next?" <sup>301</sup> O' Melissa described being so frightened that she forgot the answers to some of the questions she was asked: "They asked me, 'How do you know you're pregnant?' and I was going to say 'ultrasound,' but I couldn't think of the words because I was so nervous .... I was like, 'Oh, my God,' then I said 'test,' because I forgot. <sup>302</sup>

Afraid of being denied consent, **these young women worried about making a mistake that would make them appear stupid or immature. They worried that they would not be able to convey their maturity to a judge who knew nothing of them or their life circumstances, or that their reasons for not involving their parents would not be considered satisfactory**. Taylor worried about how she would come across to the judge: "They're, like, judging you to see if you're mature or not. And, like, just wondering, like, what you're gonna say. Like, 'what if I say this, and then maybe they don't think I'm mature enough,' or, like, 'what if I do this' and ... stuff like that . . .

"O' In worrying that she would be denied consent, Jill's primary fear was that the judge would not approve of her reason for not involving her parents: I felt... uncomfortable. I was proving something to her .... I felt like my reason for not telling my parents wasn't good enough. Like I needed to have a better reason, like 'oh, my mom and dad would throw me out of the house if I told them,' and that's the only way that I would be able to get her to say 'ok'.... I've never felt my hands so sweaty... [from] nervousness, being uncomfortable. Intimidated. Scared that she would say 'no,' that was the main thing.' <sup>94</sup>

**Aware of the power that the judges had over their futures, this fear of being denied consent for an abortion reflects the minors' sense of powerlessness and lack of control over the outcome. What if I say the wrong word? Give the wrong reason? Or convey the wrong impression? Will this lead to my being turned down and forced into motherhood? These kinds of worries played themselves out over and over again as these young women entrusted their futures to the court.** The following quote from Beth captures this sense of powerlessness in describing how court made her feel: "Just unsure of myself. I'm very, very confident of myself and my decisions, and then going through all that I just felt very unsure of myself. Very uncomfortable. Very weak and vulnerable. And I'm not a weak and vulnerable person. <sup>30</sup> 5

Closely related, **a number of the young women, some angrily, questioned how a judge who knew nothing about them or their life circumstances could possibly make a meaningful determination about their maturity or readiness to have a child.** The following quote from the interview with Mary Jane captures this concern: I don't understand why you have to go to court and have another procedure, another step .... I mean, if we [are] old enough or mature enough..., however you want to see it... to have sex [and] get pregnant... **I think that we should be able to make our own decisions. I don't think that someone else should be able to make our decision for us and tell us if they think we're old enough, mature enough, you know, have the right mentality. I don't think that someone else should have to judge you on that. Because then, well, what they see and what you know by living your own life, they don't know. I mean, they might listen to** <sup>306</sup> **you and think one way, you know how it is another way.**

Another important reaction expressed by a number of young women was that it was uncomfortable to have to divulge such intimate details about their lives to complete strangers. **Some expressed this as feeling exposed or invaded; one young woman expressed it as a loss of boundaries. Others spoke about a sense of shame or wrongdoing. As Beth put it, it was just so overwhelming. I mean to have so much going on and then to have to go to a huge courthouse to sit and talk to a judge who was going to make this decision that really doesn't involve them ...I mean, it was very uncomfortable... having to share something so intimate and so personal with strangers** ....I don't want to say [it's] embarrassing to have been pregnant, but it didn't fit in my picture of what I was supposed to be, how I'm supposed to be viewed by people. And then here was my big mistake, ... [and] strangers saying if it was, if my decisions were right or wrong.<sup>107</sup>

For Mary Smith, going to court made her feel as if she had done something wrong: "I was like, 'wow, I've never been to court before.' You would think that when you went to court, you were doing something wrong .... It kind of made me feel like, 'oh well, I'm doing something wrong here. I have to get the court's permission to let me, like, fix it.'" <sup>3</sup> 8 Mary Souza reported similar feelings when describing what it was like to have to connect with a lawyer to go to court: That was actually the most nerve-wracking thing for me ....L ike, I just found out I'm pregnant... and then, you know, you have to go to a courtroom with a lawyer. To me, I've never seen anything good go on with authority in courtrooms and stuff ... you're getting locked up, you know ....A nd it's just, like, so nerve-wracking. Like, I was so nervous the day I had to go .... and then after that, you have to look forward to your appointment .... I'm only 16, and usually at this age, you know, you don't see people going to court for good things ....I mean, I see kids going there because [they're] arrested... not for something great, you know? So... I look at it as something

just frightening." <sup>9</sup> For Taylor, the sense of wrongdoing engendered by the court experience was particularly unsettling because she planned to be a lawyer, and court now felt to her like a very scary and horrible place.

Several young women characterized the experience as overwhelming-that it was simply too much to have to handle at a single time. Thus, **apart from the worry, they experienced a sense of tremendous stress from having to negotiate too many things at the same time. For some, the stress was due to the burden of keeping secrets; for others, it was caused by having to negotiate complex arrangements without revealing the underlying situation.**

In this regard, Jill raised an important concern. **For her, the focus on having to negotiate the legal requirements meant that she did not have time or energy to focus on the emotional aspects of her situation-the burden of arranging to go to court interfered with what she thought was important in this situation: The big issue is that I'm pregnant.** And that's what I'm crying about, and

yet all we talk about is, am I going to be able to have an abortion .... I had to be focusing on, like, what am I going to do .... [You're] crying because you didn't want this to happen to you ... because it's emotional. I mean it's not just nothing, you know ... you could have a child. That's huge. But, then you also have to add in... what if I go and try to do this and they say no. What am I supposed to do.<sup>9</sup> O It should be noted that a



few young women in the sample did not find court to be such a frightening experience. They saw it more as something that had to be done—a task that needed to be completed in order to actualize their abortion decision.

**For the majority of the young women interviewed, there was nothing positive about the court experience that counterbalanced the overwhelming sense of fear and anxiety.** A few

minors, however, did mention a sense of pride in being found mature by a court; and for Stephanie, whose family's mistreatment of her had forced her to become independent before she was ready, court was a positive affirmation of her separate self.

Already clear about their decision to abort and their inability to involve their parents, the minors, with the exception of Melissa, who appreciated having supportive adult contact, did not feel that going to court helped them with their decision. As Beth put it, "the court really wasn't a supportive thing. It was more just this person who didn't know you saying whether or not you're stable enough to get an abortion."<sup>3</sup> "

Similarly, Angel, in explaining that the court did not help her with her decision in any way, stated: "I don't see what was helpful about some person just trying to decide whether I was mature or not .... All they did was ask questions . ... I just think that going to court was completely

pointless." <sup>3</sup> <sup>1</sup> <sup>2</sup> For Corey, court was a lesson in irony: **I think that it was ridiculous, because they either were going to decide whether I was mature enough to make the decision, but if I wasn't mature enough, then why would I have the kid, you know? Obviously, if I wasn't mature enough to make a decision like that, I wasn't mature enough to have a child** .... It was just like a big huge step that I really felt didn't need to be taken. <sup>1</sup> <sup>3</sup>

In reflecting on their experiences, **a number of the young women mentioned that it would make better sense for there to be an alternative to court for minors who cannot involve their parents. Focusing on the logistical difficulties,** Theresa explained it this way: It would be easier **if you could just go with someone over 18, because the whole court thing,** you have to spend a whole day getting into

Boston. My parents, I had to lie to them about the whole day.... **I think actually there should be someone at the abortion center to decide if you're mature enough to make your own decision .... It would have been much easier instead of worrying, am I going to get there on time? Am I going to get [consent] from the court?... . It's just so confusing. I was so full of stress for like the month before. Just trying to get everything in order and trying to get there and get it done before it was too late, and it's just so stressful for you.**<sup>314</sup>

For almost all of the young women in the sample, **court was like a highstakes test they had to pass. Terrified of failing and being forced into motherhood, their focus was on avoiding mistakes or not giving the wrong impression to the judge. They did not experience court as a supportive or informative process that enhanced their decision-making capacities or helped them view their decision in a new light. They felt anonymous and resentful that a stranger held such power over their lives, such that she or he had the authority to undo an essential decision they had made regarding their futures.**

## **AT Abortion Unsafe**

**Adolescent abortions are even safer than abortions generally**

**Grimes and Raymond 11**

David A Grimes, pf of medicine @ UNC, Elizabeth G Raymond, Gynuity Health Projects, “Medical abortion for adolescents,” BMJ 2011 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Decades of experience have established that surgical abortion is safe for adolescent women.**<sup>1</sup>

**Because young women are generally healthier and have less comorbidity than adults, they fare better.**

However, few studies have specifically assessed the risks of medical abortion in adolescents. In the linked retrospective cohort study (doi:10.1136/bmj.d2111), Niinimäki and colleagues assessed outcomes in 3024 adolescent women and 24 006 adults who underwent medical abortion between 2000 and 2006.<sup>2</sup> The development of modern methods for medical abortion began in the 1970s.<sup>3</sup> Initial approaches used prostaglandins alone. When given at any point in pregnancy, prostaglandins induce uterine contractions that can lead to expulsion of the embryo or fetus. However, the effectiveness of medical abortion with early prostaglandin compounds alone was suboptimal. Moreover,

gastrointestinal side effects limited their acceptability. **Medical abortion improved in the 1980s** with the development of mifepristone. Early in pregnancy, this antiprogesterone causes the trophoblast to detach from the uterine wall and softens the cervix. Mifepristone also increases endogenous prostaglandin release while sensitising the uterus to uterotonic prostaglandin effects. Although mifepristone alone is not effective enough for routine clinical use in abortion,<sup>3</sup> success rates are high when it is used in conjunction with a prostaglandin; between 92% and 99% of women treated with this combination in the first trimester of pregnancy will abort without need for vacuum aspiration. The most common contemporary regimen for medical abortion is a single oral dose of mifepristone 200 mg, followed in one to two days by administration of misoprostol, a prostaglandin E1 derivative. Misoprostol is usually swallowed or placed in the vagina, under the tongue, or against the cheek. In some countries such as Canada, where mifepristone is not registered, clinicians use methotrexate (which is toxic to the trophoblast), followed by misoprostol or misoprostol alone as alternative regimens.<sup>4 5</sup> Mifepristone and misoprostol have an excellent safety record. In typical clinical use

(not in research studies), only about two women per 1000 experience a complication requiring inpatient or outpatient hospital treatment.<sup>6</sup> **The most common complication is heavy bleeding. In early pregnancy the risk of mortality is**

**similar to that with surgical abortion, about one per 100,000.**<sup>6 7</sup> Data on the efficacy and safety of medical

abortion in adolescents are scarce. Several studies suggest that **the procedure is more effective in younger women.**

Nulliparity is associated with success, and most adolescent women have not given birth.<sup>8</sup> **A small study of 28 patients** aged 14-17

years undergoing early abortion with mifepristone and misoprostol **found no medical or psychological**

**complications.**<sup>9</sup> Most larger clinical trials of medical abortion excluded adolescents. Younger women may have more pain than other women during medical abortion.<sup>10</sup> The alarmingly high “adverse event” rates in both adolescents and adults reported by Niinimäki and colleagues,<sup>2</sup> which range from 20 to 100 times higher than recent large studies with more specific outcome definitions,<sup>6</sup> should be interpreted with caution because the reported outcomes were mainly office visits by the worried well and not validated complications.<sup>11</sup> For example, the outcome of “haemorrhage” was neither defined nor measured because clinicians and patients are notoriously inaccurate at estimating vaginal blood loss.<sup>6</sup> A more useful outcome measure would have been haemorrhage requiring transfusion.<sup>7</sup> Currently, medical abortion is more common than surgical abortion in some European countries. A recent randomised controlled trial from the United Kingdom compared mifepristone-misoprostol abortion with suction curettage under general anaesthesia in women who were no more than 13 weeks’ pregnant. Medical abortion was more cost effective than surgical abortion, although its complication rate was higher and acceptability lower, especially in women who were

at a later stage of pregnancy.<sup>12</sup> Having a choice of abortion methods is important to women. **No evidence suggests that**

**medical abortion is more risky or less successful in adolescents than in older women.**

**Indeed, women who have not previously given birth seem to have higher success rates with**

**medical abortion.** Hence, all women, independent of age, may be offered the full range of abortion services.

## **AT Family Ties DA**

### **Parental rights on abortion create family problems rather than solve them**

#### **Bermuglia 01**

Jessica Bermuglia, JD, "Preserving the Right to Choose: A Minor's Right to Confidential Reproductive Health Care" 23 Women's Rts. L. Rep. 63 2001-2002 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Contrary to belief, parental involvement laws do not strengthen family relationships." Instead they create family and personal problems.** <sup>45</sup> **Parental involvement laws do not encourage young women to tell their parents about a pregnancy. In the minority of cases in which minors do not voluntarily consult a parent, many come from families where such an announcement would only exacerbate an already volatile or dysfunctional family situation.**

One study showed that **14% of minors having abortions believed that, if forced to tell their parents about their pregnancies, they would face physical abuse, and 11% feared violence between their parents. Others feared exacerbating a parent's drug or alcohol problem.** A pregnant minor can be confronted by physical or emotional abuse from her family, including child neglect, withdrawal of financial support, or obstruction of her decision to have the abortion.<sup>1 47</sup> It is ironic, and definitely pathetic that the Court in Casey, in holding spousal notification unconstitutional, acknowledged the impact domestic violence has on a pregnant minor, but ignored the problems and violence of child abuse. <sup>48</sup>

## AT Undue Burden Test

### Undue burden test fails

#### Bermuglia 01

Jessica Bermuglia, JD, "Preserving the Right to Choose: A Minor's Right to Confidential Reproductive Health Care" 23 Women's Rts. L. Rep. 63 2001-2002 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The undue burden test is flawed for many reasons. First, the undue burden standard for parental involvement laws "requires courts to focus on the law's impact on a minor's constitutional right rather than on the state's justifications for limiting it."**<sup>99</sup> **This shift in analysis, focusing on the law's impact, gives broad power to States to regulate abortion from the point of contraception to viability.**<sup>100</sup> **Second, the undue burden standard requires the court to "engage in extensive fact-finding examinations to determine whether a law sets up impermissible barriers to the exercise of a minor's constitutional right to have an abortion."**<sup>101</sup> Such analysis of whether a barrier is being placed is from the Court's viewpoint and **such analysis invites the Court to ground their decisions on the subjective analysis of judges.**<sup>102</sup> In other words, the court's decisions are from **a reasonable male perspective**, given the predominant number of males on the bench.<sup>103</sup> **Third, many scholars predict that a variety of problems will arise concerning how the undue burden standard is applied.**<sup>104</sup> Such problems can include **lack of guidance and clarity, increase in abortion litigation, and inconsistent and arbitrary outcomes.**<sup>105</sup> In practice, the undue burden standard will also present problems for those women who wish to have an abortion.<sup>106</sup> "First, **the undue burden standard has a disparate impact upon low-income women, women in rural areas, women of color, and young or battered women.** ...<sup>107</sup> Second, **lower courts have almost automatically denied facial challenges brought regarding new abortion regulations just because they appear to be the same as those regulations in Casey.**<sup>108</sup> Finally, the interpretation of the undue burden standard will vary due to the differences in the political composition of the court.<sup>109</sup> **A fourth flaw of the undue burden standard is commonly referred to as the federal circuit courts split. "[T]he federal circuit courts are split in their decisions as to the proper standard of review for facial challenges as opposed to as applied challenges.**<sup>110</sup> The Third, Sixth, Eighth, Ninth, and Tenth Circuits "have held that Casey effectively overruled the strict standard for facial challenges [that was] set out in United States v. Salerno,"<sup>111</sup> which, in order to succeed, "required 'the challenger [to] establish that no set of circumstances exists under which the Act would be valid .... These courts, choosing instead to apply the standard set out in Casey for a facial challenge, require the plaintiff to show only that "in a large fraction of the cases in which [the statute] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." The Fifth Circuit, however, has held that the standard set out in Salerno "remains the appropriate standard, and the Fourth Circuit [also] continues to apply Salerno."<sup>112</sup> 4 The conflict between the Salerno and Casey standard has yet to be reviewed by the Supreme Court."<sup>113</sup> 5

End of Life Decisions

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Inherency + Solvency

**Adolescent autonomy for end of life decisions is hardly granted now—granting it is in the best interests of the patient**

**Derrington 9**

Sabrina Derrington (MD, Fellow of the American Academy of Pediatrics). “Advocating Autonomy: Fulfilling Our Duty to Adolescents at the End of Life.” Section on Bioethics 2009 Essay Contest, 1st prize winner.

<https://www2.aap.org/sections/bioethics/PDFs/EthicsEssayDerrington.pdf> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

The AAP has stated that **because of the gravity inherent to EOL situations the wishes and feelings of children in regards to treatment ought to be carefully elicited and respected. They support the right of competent adolescents to make their own decisions regarding EOL care.**<sup>6, 7</sup> and this position has been echoed by the courts.<sup>8</sup> But how often do we give adolescents this opportunity? Based on published cases it seems **this right is not routinely offered to all**, rather granted only to those assertive enough to claim it. When adolescents are asked about their preferences their responses are not dissimilar to those of adults. They **want their physician to initiate discussions about EOL issues and they want to share** (but not abdicate) **the decision-making process with their family.**<sup>9</sup> Why then do we so often exclude our adolescent patients from these discussions? Often it is **in deference to parental wishes.** Even when adolescents are cognitively capable their parents may fear that they will be unable to deal emotionally with the information. Parents want to avoid burdening their child with difficult decisions, and they may believe that the adolescent will lose hope if the truth of the prognosis is revealed. These concerns echo those of families of adult patients who ask physicians not to disclose a terminal diagnosis. This dilemma is dealt with in several ethical discussions and invariably the primary duty of the physician to respect the autonomy of the patient is upheld.<sup>10, 11, 12</sup> **By gently eliciting the preferences of the patient (What do you wish to be told? How do you want decisions to be made?), a physician allows the patient to choose their level of involvement without forcing them to accept unwanted burdens, and may open important avenues of communication within the family.**

**Adolescent autonomy for EOL issues is key to giving teens a voice—that has a healing effect during hospitalization**

**Derrington 9**

Sabrina Derrington (MD, Fellow of the American Academy of Pediatrics). “Advocating Autonomy: Fulfilling Our Duty to Adolescents at the End of Life.” Section on Bioethics 2009 Essay Contest, 1st prize winner.

<https://www2.aap.org/sections/bioethics/PDFs/EthicsEssayDerrington.pdf> [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Common experience holds that **children with chronic illness are likely to have a more mature appreciation of their disease, the possibility of their death, and the consequences of various treatment options than healthy peers.**<sup>13</sup> But when stressed by a prolonged or recurrent hospitalization they may regress emotionally and behaviorally. Depression, fatigue, and constant pain may contribute to a feeling of helplessness, making it difficult to advocate for a place at the

**decision-making table.13** Adolescents are sensitive to the expectations and desires of their families and may hesitate to assert their own wishes when in conflict with those of their parents. Conversely, parents who are stressed, grieving, or in denial may be unable to initiate EOL discussions with their children. Therefore it is dangerous to assume both that a sick adolescent has not asked about EOL issues because he or she does not want to be involved and that a parent always knows what their adolescent wants. **If we do not ask dying adolescents about their hopes, desires, and concerns, we risk leaving them without a voice. We do not expect children to advocate for themselves in any other circumstance; why then would we require them to do so at the end of life? If we ever hope to reconcile our devotion to advocacy with the principle of autonomy, we must respect the persons our adolescents are becoming. We must offer them the opportunity to become medical decision-makers not only by providing them with factual information but by assisting them in recognizing their personal values, by soliciting their thoughts and answering their questions, and by facilitating the uncomfortable transition they must undergo within the child-parent dyad. Rather than clashing or colluding with parents in medical paternalism, we must help families recognize the vital importance and healing effect of open communication with their child, and we should model respect and support as the adolescent begins to deal with the reality of their mortality.** This discussion should begin as early in the disease process as possible and at least as soon as the probability of death is recognized. We owe it to our patients – and their families – to remain their advocates until the very end.

Gender Reassignment

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)



## Inherency

**Autonomy and privacy are violated by status quo laws restricting self-determination of gender identity. Columbia's new jurisprudence on intersex infants provides a promising model**

**Romero and Reingold 13**

Katherine, senior attorney Women's Link Worldwide, and Rebecca, consultant attorney, "Advancing adolescent capacity to consent to transgender-related health care in Columbia and the USA," Reproductive Health Matters 2013; 21(41):186-195 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Many sexual and reproductive health care services facilitate reproductive autonomy and self-determination of gender identity. The decision to undergo (or not undergo) gender reassignment treatment, for example, has lifelong consequences for the individual who undergoes (or does not undergo) the treatment. As a result, individuals who are unable to refuse or consent to these services on their own behalf, such as adolescents, are at risk of violations of their rights to privacy and self-determination.** In some parts of the world, particularly in Europe, courts and legislatures have extended the right to access transeender-related health care services to adolescents.<sup>5.6</sup> **Countries in the Americas, like the USA and Colombia, have been slower to develop jurisprudence and legislation that explicitly protect transgender adolescents' capacity to consent to gender assignment treatment. Courts in Colombia, however, have developed juris-prudence that restricts parents' ability to make medical decisions on behalf of their infant intersex children, which lays a strong normative foundation for advancing adolescent capacity to consent to transgender-related health care. It is a strategy that may prove effective in other countries** in the region, even those with different frameworks for adolescent medical decision-making capacity, **such as the USA.**

**Status quo age cut-offs are rigid and deny autonomous sexual/reproductive health decisions**

**Romero and Reingold 13**

Katherine, senior attorney Women's Link Worldwide, and Rebecca, consultant attorney, "Advancing adolescent capacity to consent to transgender-related health care in Columbia and the USA," Reproductive Health Matters 2013; 21(41):186-195 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Health care providers' experience with young patients in some countries, including the USA, has shown that **adolescents possess a decision-making capacity on a par with that of young adults.**<sup>8</sup> According to Prof Kimberly Mutcherson, in one study, American health care providers reported that **adolescent patients "understand information about medical treatment and con-ditions, engage in rational deliberation during the decisional process, and communicate choices and concerns clearly"**.<sup>8.9</sup> **They also perceived their adolescent patients as possessing communication skills that allowed them to successfully discuss and share their health care preferences, prefer-ences which they perceived as products of rational thought**.<sup>8</sup> Despite the growing scientific and deve-lopmental research discrediting the presumption of adolescent decisional incapacity," domestic laws continue to limit adolescents' ability to con-sent to many types of health care. **Legislatures and courts in the USA, as well as Colombia, have struggled to balance the rights of adolescents to make autonomous and confidential decisions pertaining to their**

**sexual and reproductive health, with the rights of their parents.** As is the case in many societies, age is the key determinant in the acquisition of formal rights, marking the threshold at which adolescents achieve greater autonomy over their own lives. **Unfortunately, the rigid application of laws that prescribe ages at which rights come into play does not always reflect the reality of adolescents' capacity to make decisions.**<sup>9</sup>

**Presumption of incapacity hurts adolescents who would otherwise consent to gender reassignment – emancipation is not enough**

**Romero and Reingold 13**

Katherine, senior attorney Women's Link Worldwide, and Rebecca, consultant attorney, "Advancing adolescent capacity to consent to transgender-related health care in Columbia and the USA," *Reproductive Health Matters* 2013; 21(41):186-195 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The general presumption of decisional incapacity currently governs adolescents' ability to consent to gender reassignment treatment and other transgender-related health care in the USA** In other words, **if a parent or guardian refuses to give consent to such care, transgender adolescents are prevented from medically transitioning to the gender with which they identify until they reach 18**, the legal age of majority. While the advocates of transgender adolescents argue that legislatures

should "explicitly codify the right of transgender adolescents to consent to their own medical care", **they have identified alternative legal strategies** which aim to ensure that adolescents can consent to and access transgender-related health care.<sup>29</sup> First, a transgender adolescent might seek **emancipation from his or her parents**. As discussed above, many states allow adolescents who bear certain legal statuses to consent to their own health care, including those who are married, parents or emancipated.<sup>29</sup> More than 30 states have codified the emancipation exception in some form. While emancipation statutes vary, most provide a number of factors that must be considered in determining whether a minor should be considered emancipated for purposes of consenting to health care.<sup>29</sup> In New York, for example, the Public Health Law's emancipation exception and related case law provide that minors are emancipated and competent to consent to their medical care if "they support themselves, have been inducted into military service, have been abandoned by their parents, have constructively abandoned their parents, or have assumed a status 'inconsistent with subjection to control by his parent'".<sup>29</sup>

**Unfortunately, the emancipation doctrine provides adolescents with an incentive to leave their parental home, perhaps prematurely. It also terminates the emancipated adolescent's right to continued financial and other support from his or her parents.**<sup>29</sup>

## **I-Law**

### **International law mandates autonomous sexual and reproductive health services Romero and Reingold 13**

Katherine, senior attorney Women's Link Worldwide, and Rebecca, consultant attorney, "Advancing adolescent capacity to consent to transgender-related health care in Columbia and the USA," Reproductive Health Matters 2013; 21(41):186-195 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**International human rights norms call for the protection and promotion of adolescents' right to access confidential and comprehensive sexual and reproductive health services.<sup>3</sup>**  
**The Convention on the Rights of the Child**\* (the Convention), adopted by the UN General Assembly in 1989, **requires States "to ensure that no child is deprived of his or her right of access to... healthcare services", including preventive health care and family planning education and services.**<sup>2</sup> Moreover, the Convention recognizes "the evolving capacities of the child" when considering the role of parents in guiding a child's exercise of her rights? According to the International Planned Parenthood Federation, "**the evolving capacities of the child**" standard requires a balance between recognizing children as active agents in their own lives, as people and as rights-bearers with increasing autonomy, and as being entitled to protection in accordance with their vulnerability." Countries that have failed to ratify the Convention, such as the USA, have participated in conferences that adopt its "**evolving capacities of the child**" standard in the context of addressing adolescents' sexual and reproductive health needs.<sup>5°</sup>

# Genetic Testing

## **MMD could be applied to genetic testing**

### **Denbo 13**

Susan M. Denbo, J.D. and pf @ Rider University, “Balancing the rights of children, parents and the state: the legal, ethical and psychological implications of genetic testing in children”

Southern Journal of Business and Ethics, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

\*brackets in original

**The application of the mature minor doctrine requires a subjective evaluation of when each minor is sufficiently mature to make his or her own medical decisions because there are no definitive guidelines that provide an exact range of ages for when minors satisfy the requirements of the mature minor doctrine.** Borry et al., supra note 78, at 134: **The differences that distinguish children from adolescents refer to the gradual development of a child’s cognitive skills and moral reasoning and the fact that as children progress through successive states of development, they become capable of greater participation in decisions about their own welfare. When adolescents meet conditions of competence, voluntariness, and adequate understanding of information, are able to participate in the decision as an autonomous individual, have decision-making capacity, or are mature enough to take control of his or her own healthcare, they can be considered mature enough to request a [genetic] test.**

## **Genetic testing should be post-poned until competency/autonomy can be established**

### **Denbo 13**

Susan M. Denbo, J.D. and pf @ Rider University, “Balancing the rights of children, parents and the state: the legal, ethical and psychological implications of genetic testing in children”

Southern Journal of Business and Ethics, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

\*brackets in original

The HDSA concurs that testing should be deferred until the age of majority to protect a young person’s autonomy: This [**autonomy**] **means having the right or power to govern oneself i.e. to determine things for yourself.** **Research has shown that during adolescence young people may be influenced by many things** that can change what decisions they make e.g. family, friends, media etc. Of course this is true for adults too, but **young people may be strongly influenced by other people’s opinions. In order to avoid this it is advised that young people put off testing until they are older and can be certain that it is their choice to take the test.** Also, **recent research shows that the part of our brain that helps us make decisions and judgements only fully matures once we have reached early adulthood. Because of this it is advised that teenagers put off making such an important life decision until their brain has fully matured.** Overall, **professionals want to make sure that people who take the test** for HD **are choosing to do it themselves, and that they are certain this is the right choice for them.**

## **Genetic testing can help predict late-onset diseases or conditions**

### **Denbo 13**

Susan M. Denbo, J.D. and pf @ Rider University, “Balancing the rights of children, parents and the state: the legal, ethical and psychological implications of genetic testing in children”

Southern Journal of Business and Ethics, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

### **Genetic tests provide DNA sequence information that can be used to detect gene variants associated with specific diseases or conditions.**

<sup>19</sup> Significantly, one’s genotype (genetic code) does not always predict one’s phenotype (physical state). The relationship between genotype and phenotype is measured by the penetrance of the genetic disorder.

### **When the disorder is highly penetrant, 100% of the individuals with the genetic mutation will develop the disease; nevertheless, it is not possible to predict when and to what degree the disease will manifest itself in the individual.**

<sup>20</sup> Since Huntington’s disease is highly penetrant, the presence of a mutated gene correlates with an estimated 100% lifetime risk of developing the disease.<sup>21</sup> Most diseases, however, have a range of penetrance that is determined by environmental factors, the gene’s protein product and the influence of other genes.<sup>22</sup> Individuals with a mutated gene for a less penetrant disease may never develop any symptoms of the disease; furthermore, since genetic diseases have “variable expressivities,... individuals who do develop the disease will experience symptoms of varied severity.”<sup>23</sup> Genetic tests are typically classified based upon the following purposes for which the tests are performed:

## **Forced genetic testing is a violation of a child’s autonomy – they should have the choice**

### **Denbo 13**

Susan M. Denbo, J.D. and pf @ Rider University, “Balancing the rights of children, parents and the state: the legal, ethical and psychological implications of genetic testing in children”

Southern Journal of Business and Ethics, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

### **A significant concern raised by critics of predictive genetic testing of minors for adult-onset disorders is that the practice violates the child’s right to an “open future” by denying the child the right to make a choice about such testing as an autonomous adult.<sup>143</sup> As such, it violates the principle of autonomy. Proponents of predictive genetic testing of children contend that while it is a serious wrong to deny a child the freedom to choose as an adult to have children or to deny a child a life-saving medical procedure on the basis of a parent’s religious beliefs, “a choice about whether to be tested for a genetic condition that might appear later in life... is not a life choice as significant as these others. It does not affect the basic activities important to human functioning, such as having children, remaining alive, or selecting a way of life.”<sup>144</sup> Furthermore, some commentators opine that predictive genetic testing during childhood can actually enhance the welfare of children by expanding important choices for the child and the adult-to-be:**

The adult autonomy of children who undergo predictive testing is not violated by such testing, for it allows them time to grow in their understanding of their situation and options, thereby increasing the likelihood that they will exercise their capacity for autonomous choice in an informed and even wise way when they reach adulthood

Mental Health

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Inherency

**Many aren't getting the mental health services they need**

**Day and Flynn 03**

Day, Lesley, BA, MSc (Econ), MSc (Psychotherapy), head of services @ Cassel Hospital, adult psychotherapist, prof @ Brunel University, and Flynn, Denis, Consultant psychotherapist, trained philosopher and social worker, eds. Internal and External Worlds of Children and Adolescents : Collaborative Therapeutic Care. 2003. ProQuest. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The paucity of mental health services means that many children, adolescents, and their families do not receive the psycho-therapeutic treatment that they need. The consequence of this may be mental illness in adulthood and generational cycles of psycho-logical disturbance and abuse. If ignored, these social and psycho-logical problems do not simply go away. Indeed, they are likely to increase the demands on adult mental health services.**

Target and Fonagy (1996), for example, point out that **children who have symptoms of depression and anxiety are referred less frequently to mental health services** than those who are diagnosed as having disruptive disorders. **Yet we know that children and adolescents with symptoms of depression are three times more likely, as adults, to make a suicide attempt or be hospitalized** than matched non-depressed children in the mental health system (Target & Fonagy, 1996).

**Adolescents with mental health issues like phobias and anxiety can't get treatment because their parents assume they'll just "grow out of it"**

**Mallott & Beidel 14**

Michael A., pf of psychology @ UCF, and Beidel, Deborah C., pf of psychology @ UCF. "Anxiety Disorders in Adolescents." in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Among adolescents, prevalence is highest for specific phobia (19.3%), followed by social phobia - (9.1%), separation anxiety disorder (7.6%), posttraumatic stress disorder (5.0%), agoraphobia (2.4%), panic disorder (PD) (2.3%), and generalized anxiety disorder (GAD) (2.2%) (Merikangas et al., 2010), illustrating the number of adolescents who are seriously impacted by these disorders. Even though highly prevalent, the impact of these disorders may be underestimated. Parents may not seek treatment for an anxious adolescent because they incorrectly assume that the adolescent will simply grow out of the problem. However, the importance of early treatment for adolescents with anxiety disorders is highlighted by a number of studies that reflect the chronicity and severity of these issues. Anxiety disorders are characterized by a chronic unremitting course (Woodward & Fergusson, 2001), and the trajectory of anxiety disorders is generally in the direction of increased rather than decreased prevalence over the period of adolescence (Essau, Conradt, & Petermann, 2000; Newman et al., 1996). These disorders also are associated with significant impairment in a number of domains that affect development (Langley, Bergman, McCracken, & Piacentini, 2004). Consequently, delays in treatment may exacerbate the already negative impact associated with anxiety disorders.**

## Solvency

**Autonomy is key to treat mental health – otherwise minors might not seek help**

**Driggs 01**

Ann Eileen Driggs, R.N., J.D., “The Mature Minor Doctrine: Do Adolescents Have the Right to Die?” Health Matrix, Vol. 11:687 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Confidentiality is also an issue in the treatment of mental health problems. Some states have recognized the fact that many minors might not seek help with problems such as alcoholism, drug abuse,<sup>37</sup> depression, and other psychiatric care<sup>38</sup> if parental consent were required. These exceptions to the general rule are considered by some to be an outgrowth of the emergency treatment exception for minors and the states’ role in the protection of minors.<sup>39</sup> This can be further evidenced by studies indicating that factors such as family stressors and parental psychopathology may play a part in the mental health care decision.<sup>40</sup> These exceptions are not based on the level of maturity of the minor, but rather are based on the issues of the possible transmission of venereal disease, an increase in teenage pregnancy, and confidentiality.**

**Treatment is very effective**

**Mallott & Beidel 14**

Michael A., pf of psychology @ UCF, and Beidel, Deborah C., pf of psychology @ UCF. “Anxiety Disorders in Adolescents.” in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Most studies and meta-analyses examining treatment outcome reveal consistent support for exposure-based cognitive behavioral therapies (CBTs). In fact, the outcome data are so consistently positive that CBT is recognized as the treatment of choice for adolescents with anxiety disorders** (e.g., Kendall, 1994; Ollendick & King, 1998; Silverman, Pina, & Viswesvaran, 2008). Often, treatment samples have been transdiagnostic in nature and the CBT interventions are likewise transdiagnostic, allowing their implementation across the broad spectrum of anxiety disorders. Thus, **the core elements of CBT are seen as equally applicable to separation anxiety disorder, social phobia, and GAD as these disorders share many features and appear to be distinct from other anxiety disorders** (cf. Velting, Setzer, & Albano, 2004). These interventions attempt to address underlying commonalities across forms of problematic anxiety (physiological arousal, subjective distress, behavioral avoidance). Many CBT protocols follow a similar format and include identical elements: psychoeducation, skills training (somatic management and problem solving), cognitive restructuring, exposure, and relapse prevention (Velting et al., 2004). Next, we describe each of these elements as they pertain to the treatment of anxiety disorders in adolescents.



## Weighing

**Prefer evidence specific to adolescents, not children**

**Mallott & Beidel 14**

Michael A., pf of psychology @ UCF, and Beidel, Deborah C., pf of psychology @ UCF. “Anxiety Disorders in Adolescents.” in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Although many interventions for adolescents with anxiety disorders were developed concurrently with treatments for younger children, treatment with adolescents poses unique challenges. First, attention to developmental issues may be a particularly important part of treatment planning, given the wide range of physical, cognitive, and emotional maturation found even among same-age adolescents** (Oetzel & Scherer, 2003). For example, it may be more important in group treatment to consider developmental age rather than chronological age when making group composition decisions. **Group dynamics may be affected by the social and cognitive development of its constituents, and individuals in the group may benefit more from a group composed of developmentally similar adolescents to maximize relevance, interpersonal interactions, and comprehension.** In individual treatment, emphasis on cognitive components of treatments likewise should consider development rather than age to determine how much time and complexity should be devoted to cognitive therapeutic techniques. Further, **engagement in treatment can be complicated in adolescents because of normal developmental processes that favor the development of autonomy** and resistance to authority (Sauter, Heyne, & Westenberg, 2009). Compounding this problem, **adolescents typically do not seek therapy** (Piacentini & Bergman, 2001), so they may enter treatment already resistant to the process. As a consequence, motivational issues need to be addressed early in treatment. Promoting an open, active, and cooperative treatment environment may help mitigate some of these issues (Friedberg & McClure, 2002).

## Neg

### **Parental involvement in treating depression is important**

#### **Jeffreys and Weersing 14**

Megan, phd candidate in clinical psychology at SDSU, V. Robin, pf of clinical psychology at SDSU, “Depressive Disorders in Adolescents,” in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**CBT manuals for adolescent depression have involved parents to differing degrees.** The role of parental involvement in treatment has been most extensively examined in the CWD-A manual. **In two trials of this protocol, an adolescent-only treatment was compared to treatment augmented with a parallel parent group** (Clarke et al., 1999; Lewinsohn et al., 1990). **The parent group was designed to review skills taught to adolescents while also targeting family conflict reduction.** Lewinsohn and colleagues (1990; N = 59) found that **both groups improved significantly** compared with wait-list control. Although the adolescent-alone and parent groups did not differ significantly on most measures, youth randomized to treatment with the parallel parent group had lower rates of depressive illness at posttreatment (52.4% compared with 57.1%). In a larger trial of the same manual (N = 123), Clarke and colleagues (1999) found that the adolescent-only and adolescent plus parent groups improved, but **the groups did not differ significantly.** In this trial, a trend was found as well for adolescents randomized to the treatment plus parent group to have higher rates of being diagnosis free (68.8%) compared with adolescents not receiving the parent component (64.9%). Failure to detect a significant difference across treatments may be due to low power or moderate to poor attendance, especially for fathers (M = 5.8 of 9 sessions). As IPT-A is a treatment designed to address interpersonal problems, there is reason to believe the relationship with the parent is critical to program success. Indeed, modifications made in the development of the IPT-A protocol from the original adult manual include discussion of parental relationship issues (e.g., separation, negotiating autonomy) and addition of a fifth problem related to single-parent households (Mufson et al., 1999). Although IPT-A is designed to target interpersonal problems, the treatment itself is largely implemented through building skills in session with the therapist that can later be applied in real-life interpersonal contexts. Examination of the impact of explicitly including the parent in session in IPT-A with adolescents diagnosed with a depressive disorder is needed.

### **Parental involvement for mental health treatment is good**

#### **Mallott & Beidel 14**

Michael A., pf of psychology @ UCF, and Beidel, Deborah C., pf of psychology @ UCF. “Anxiety Disorders in Adolescents.” in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Research on the role of incorporating parents and family into treatment of adolescents with anxiety disorders has yielded mixed findings.

**Some studies report that parental involvement in treatment may lead to better outcomes**

(Barrett, Dadds, & Rapee, 1996; Mendlowitz et al., 1999), **but these better outcomes may be limited to younger**

**children** (Barrett et al., 1996). **Other studies have suggested that parental involvement may**

**enhance treatment when the parents themselves also have anxiety** (Cobham, Dadds, & Spence, 1998).

Also, studies suggest that parenting characteristics can affect adolescent anxiety symptomatology (Hale, Engels, & Meeus, 2006). A few issues related to implementing parental involvement in treatment have been provided. A number of studies have established a link between parental and child anxiety (Ginsburg & Schlossberg, 2002; Rapee, 2001), so it seems reasonable that the focus of parental involvement in treatment may address how anxiety in parents might impact the maintenance of anxiety in the children. Four characteristics of parental anxiety that may be particularly relevant to parental involvement in the treatment of adolescents with anxiety disorders include: parental overinvolvement/overcontrol, parental assumptions/beliefs, modeling/reinforcement of anxious behavior, and family conflict/dysfunction (Breinholst, Esbjörn, Reinholdt-Dunne, & Stallard, 2012). In an effort to manage their anxiety, anxious parents may develop an overcontrolling style that may hinder efforts of adolescents to develop confidence in their own ability to navigate new situations (Breinholst et al., 2012). To counteract these issues, they recommend that treatment include components that address the parents’ own difficulty with allowing their adolescent to face fears adaptively. Parents need to understand how excessive control may inadvertently foster increased anxiety in their adolescent. - Along these lines, parents may need to face and challenge underlying assumptions and beliefs about their adolescent and/or their own ability to protect him/her. Doing this may allow parents to relinquish control and allow the adolescent to engage in exposure necessary to treatment progress. In addition,

**contingency management strategies** (e.g., Cartwright-Hatton, Laskey, Rusk, & McNally, 2010) **can be used in treatment to help parents model and reinforce appropriate, adaptive behavior in anxiety-provoking situations. Parents can learn to identify and reward these behaviors and provide consistent encouragement of approach-related behavior in these situations. Finally,**

**treatment may include parental skill development in the areas of positive communication and problem solving** (Breinholst et al., 2012). **Parents may need to develop more positive and proactive behavior rather than rely on rejection and criticism as parenting tools. Parents are taught about the importance of consistency, develop conflict-resolution skills, and model these skills for their adolescent.**

Obesity

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Impacts

**Obesity creates a lot of mental and physical health problems**

**Vannucci and Tanofsky-Kraff 14**

Anna, pf of clinical psychology at Uniformed Services University of Health Sciences, Marian, pf of clinical psychology at USU, “Overweight and Obesity” in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Obesity among children and adolescents is a pressing public health concern. Rates of pediatric obesity saw staggering increases over the past several decades. Although the overall prevalence of obesity appears to have stabilized in recent years, it remains high.**

Estimates from 2009 to 2010 indicate that **more than one third of children and adolescents in the United States are overweight** (body mass index [BMI]  $\geq$  85th percentile for age and sex) or obese (BMI  $\geq$  95th percentile) (Ogden, Carroll, Kit, & Flegal, 2012). Of serious concern, rates of extreme obesity (BMI  $\geq$  99th percentile) are increasing disproportionately faster than the rates of moderate levels of obesity (BMI between the 95th and 98th percentiles) (Koebnick et al., 2010). **Obesity in youth has been linked to numerous medical conditions. Pediatric obesity is not only associated with cardiovascular disease risk factors such as hypertension, dyslipidemia, carotid artery atherosclerosis, insulin resistance, and type 2 diabetes** (Freedman, Dietz, Srinivasan, & Berenson, 2009; Rosenbloom, Joe, Young, & Winter, 1999; Weiss et al., 2004), **but it is also predictive of coronary artery disease and early death during adulthood** (Baker, Olsen, & Sorensen, 2007; Franks et al., 2010). **Orthopedic problems, asthma, and allergies are more common in obese youths as compared to their nonobese peers** (Halfon, Larson, & Slusser, 2013). Pediatric obesity also is associated with a poor health-related quality of life (Fallon et al., 2005; Schwimmer, Burwinkle, & Varni, 2003; Tsiros et al., 2009). In addition to adverse medical sequelae, pediatric obesity has detrimental effects on psychosocial functioning. **Overweight and obese children and adolescents are more likely than nonoverweight children to report symptoms of depression, anxiety, disordered eating, and attention-deficit/ hyperactivity disorder** (Kalarchian & Marcus, 2012). **Obese youth frequently have a negative body image and low self-esteem** (Puder & Munsch, 2010). **These emotional issues may be linked to the social problems reported by this vulnerable population, including stigmatization, social discrimination and exclusion, and teasing and bullying** (Gundersen, Mahatmya, Garasky, & Lohman, 2011).

Non-Western / Alternative Medicine

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Aromatherapy

### **Aromatherapy good for kids**

#### **Koocher et al 14 summarizes**

Gerald P. Koocher, pf health and science @ DePaul, Madeline R. McMann, pf psychology @ Simmons College, Annika O. Stout, pf psychology @ Simmons, "Controversial Therapies for Children" in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

#### **In the Western world, aromatherapy is regarded as a complementary and alternative medicine**

(CAM). However, this "nonscientific folk remedy" (Herz, 2009; Takeda, Tsujita, Kaya, Takemura, & Oku, 2008) has become increasingly popular throughout the Western world in recent years. Perry and Perry (2006), a mother and daughter research team from New Zealand who focus extensively on aromatherapy, describe it as the fastest-growing CAM today. In one study on CAM use in children with attention-deficit/hyperactivity disorder (ADHD) (Sinha & Efron, 2005), **researchers reported that out of 23 CAM**

**treatments, aromatherapy was the second most frequently used**, behind diet modifications. **Review of the extant literature reveals claims that aromatherapy can successfully treat demen-tia,**

**ADHD, autistic spectrum disorders, schizophrenia, anxiety, depression, and sleep disorders. Some even claim that certain essential oils can promote hippocampal**

**neurogenesis** (Perry & Perry, 2006). Thus far results have proved inconclusive. In one study, a combination of aromatherapy and massage reportedly helped to increase shared attention in four preschool-age children with comorbid autism spectrum disorders and severe learning deficits (Solomons, 2005). In another study, 5 minutes of lavender inhalation through an oxygen mask showed a significant effect on perceived pain reduction during needle insertion, lowered the need for anesthesia, and decreased stress (Kim et al., 2011). **This decrease in**

**stress may indeed be due to the pharmacological effects of the essential oil lavender.**

**Researchers have found linalool, the sedative component of lavender, is responsible for eliciting a parasympathetic nervous system response.** Sayorwan et al. (2012) found linalool to decrease blood

pressure, heart rate, respiratory rate, and skin temperature. In this same study on the effects of lavender oil inhalation on emotional states, autonomic nervous system, and brain electrical activity, electroencephalograms showed significant increases in theta and alpha wave activity, both of which are associated with relaxation and inhibition.

### **Aromatherapy bad for kids**

#### **Koocher et al 14**

Gerald P. Koocher, pf health and science @ DePaul, Madeline R. McMann, pf psychology @ Simmons College, Annika O. Stout, pf psychology @ Simmons, "Controversial Therapies for Children" in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Yet when researchers tested whether expectancy bias or the pharmacological effects of laven-der were responsible for anti-anxiety effects, they found that expectations of relaxation enhance relaxation prior to a stressful cognitive task** (Howard & Hughes, 2008).

**Additionally, aromatherapy can prove harmful. Researchers diffused bergamot for inhalation to pediatric patients undergoing stem-cell infusion and to their parents.** Bergamot is

an essential oil thought to reduce anxiety and nausea. The authors of this study report that patient anxiety and nausea increased significantly. Interestingly, parents of the children undergoing stem-cell infusions reported being less anxious after exposure to the essential oil (Ndao et al., 2012). Most published research literature on aromatherapy is based on anecdotal evidence, case studies, and animal models. Many of the studies conducted on human participants have major methodological problems, such as small sample sizes, ascertainment biases, lack of control groups, and others. Most important, apart from the few studies mentioned here, **very little research of any kind has focused on**

**child and adolescent populations. Use of aromatherapy in the clinical treatment of psychopathology in child or adolescent popula-tions poses risks. No consensus exists on safe**

**dosages. Little research has focused on essential oils and drug interactions. No governmental or regulatory organization ensures high quality of essential oils as the U.S. Food and Drug Administration does for prescription drugs.**

Another factor contributing to unreliability and invalidity in the literature on aromatherapy involves inconsistency among researchers as to what product to use or in which dose, concentration, or delivery system. In addition, by some estimates up to 70% of those using herbal and aromatic therapies do not report such use to their primary care provider (Cline et al., 2008).

**The current state of science in aromatherapy as a treatment for childhood ADHD or any other psychological conditions amounts to little more than traditional folkloric medicine.**



## General

**Alternative interventions bad – prefer evidence from licensed, practicing professionals who are overseen by a board or committee**

**Koocher et al 14**

Gerald P. Koocher, pf health and science @ DePaul, Madeline R. McMann, pf psychology @ Simmons College, Annika O. Stout, pf psychology @ Simmons, "Controversial Therapies for Children" in Comprehensive Evidence Based Interventions for Children and Adolescents. 2014. Wiley. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The key to ethical and effective treatment of children and adolescents involves careful assessment and intervention that flows from a sound evidentiary basis combined with individual, cultural, and family preferences that ensure the most effective outcome. We have provided six examples of supposed psychotherapeutic techniques that all lack a substantive foundation of supporting empirical data.**

Some such interventions, such as the D.A.R.E. program, will doubtless continue despite a lack of positive outcome data, because they feel good to many segments of society and at least seem to do no harm. Other interventions, such as intense boot camps and rebirthing techniques, actually have caused the death of some children and adolescents. Still others, such as reparative or sexual preference conversion therapies, cause harm by virtue of ineffectiveness and delaying or denying more effective interventions for children and adolescents who experience depression, stigmatization, or bullying because of same-sex attraction.

**Profession ethics require us to make truthful statements about the efficacy of our work and to demonstrate competence in treating patients whom we agree to care for. When practitioners hold a license or belong to a professional association, they fall under the jurisdiction of the licensing board or an ethics committee. It is hoped that such groups will not shy away from acting in response to complaints about practicing with discredited techniques. Unfortunately, many of the practices we describe here are carried out by people whose conduct does not fall under regulation by such bodies. In such instances, speaking out to the public becomes the ethical obligation of well-trained professionals who know better.**

Non-Abortion Sexual Health, Contraceptives

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Inherency

### **Inherency in the developing world – millions subject to violence, disease, unsafe abortions**

**Cook et al 07**

R.J. Cook, J.N. Erdman, B.M. Dickens, pfs of law and medicine @ UToronto, "Respecting adolescents' confidentiality and reproductive and sexual choices" International Journal of Gynecology and Obstetrics, 98, 182-187 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The reproductive and sexual health needs of the world's adolescent population present a serious challenge for gynecologists, particularly in economically developing countries. It has been estimated that of the more than 1.2 billion of the world's population aged from 10 to 19 years, 87% live in developing countries [2]. A deplorably high proportion of adolescents, in countries at all stages of economic development and particularly females, are vulnerable to sexual abuse and exploitation of dependency, so that their participation in sexual acts is nonconsensual even when non-violent [3].** The medical profession joins in their defence by the reinforcement of familial and social protections. The profession's special responsibility arises, however, regarding adolescents' voluntary sexual activity, due to their observed greater tendency than adults to engage in sexual experimentation and risk taking, including unprotected sex and concurrent sexual partnerships. Most adolescent sexual activity remains unprotected worldwide [4]. **Rates among adolescents of sexually transmitted infections (STIs), including HIV, and pregnancy resulting in childbirth or abortion (frequently unsafe), and of maternal mortality and morbidity, demonstrate the urgent need to supply reproductive and sexual health services, and to remove social, legal and other barriers to their delivery. Worldwide, 15- to 24-year olds exhibit highest reported rates of STIs, with up to 60% of newly infected people and one half of people living with HIV being in this age group [4]. In 2005, over half the estimated 5 million people worldwide who contracted HIV were in this age group, the majority being young women and girls [5]. In sub-Saharan Africa, 75% of HIV infections in this age group are among females [6].** Young age, aggravated for instance by poverty, malnutrition, poor education, low or marginalized social status and inaccessibility of health services, contributes to adolescent pregnancy, which is not less threatening to maternal survival and health because it occurs within marriage. **Each year, more than 14 million adolescents give birth [7], over 90% in developing countries [8], accounting for an estimated 15% of the global burden of disease due to maternal conditions and 13% of maternal deaths [9]. Further, adolescents account for over 14% of all unsafe abortions [9], between 2.2 and 4 million of an estimated 19 million illegal abortions each year involving adolescents [10].**

### **Sex and reproductive health education in the s'quo is not enough**

**Tonkin et al 09**

Roger S, MDCM, FRCPC, OBC. President, International Association for Adolescent Health, Aileen Murphy, Colleen Poon, "Sexuality and Reproductive Health in Adolescence," in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In many countries, **national youth health policies place heavy emphasis on sexual and reproductive health.** In A Report from Consultations on a Framework for Sexual and Reproductive Health , recently authored by Health Canada ( 1999 ), however, fewer than one page out of twenty-four addresses youth, and, as a result, the report reflects the tendency to meld youth with adult issues and omit youth-specific input to policy formulation. Many family planning and sexual health services expect adolescents to fit into what are essentially adult-oriented programs. National policies must become more specific about adolescents' service needs, standards of sexual and

reproductive health care, and special issues such as those raised by early age of sexual maturity. Within that context, **policies need to foster and evaluate health-promoting/disease-preventing strategies that target adolescents at risk for early sexual debut and its attendant concerns. In a matter of a few decades, the range of effective contraceptive technologies, such as injectable and emergency contraceptives, has expanded enormously.** In addition, **the introduction of modern antibiotics and access to safe, legalized abortions have changed the outcomes of many std s and unplanned pregnancies among adolescents.** Access to these alternatives becomes a contemporary issue for sexually active teens, although controversy over harm reduction strategies, such as condom dispensers in schools, remains a sensitive topic in schools and communities. The newer problems associated with hepatitis B and C and youths' risk of exposure to hiv / aids , especially when coupled with low rates of condom use, have introduced new policy pressures in this regard. Lack of knowledge about normal adolescent development hampers effective adolescent reproductive health care. **Commonly held negative attitudes towards the emerging sexuality of today's adolescents are an important source of resistance to addressing their needs.** Adolescents themselves often lack appropriate information about their own development. While the Internet has put pornography at young people's fingertips, it also provides access to many useful web-based, youth-oriented information and chat services about sexual health. The extent to which adolescents use the information available through these sources is unclear. Sixty-four percent of Canadian adolescents report that they have attended sex education classes at school (Statistics Canada 1998 ). It is uncertain, however, whether this education is translated into actual knowledge. The ahs assessed British Columbia students' knowledge of std prevention and found that fewer than half ( 43 %) replied that condoms were very effective in std prevention, and only 33 % knew that oral contraceptives did not prevent std s (Table 7 . 7 ). In addition, only 59 % of sexually active British Columbia adolescents over 14 years of age used a condom the last time they had sex, and 21 % used withdrawal, or no method, to prevent pregnancy the last time they had sexual intercourse (Table 7 . 8 ). **When asked whom they would go to first for issues related to contraception or std s, fewer than half of adolescents listed health professionals** (Table 7 . 9 ). Clearly, there are gaps in young people's knowledge and less than optimal likelihood of gaining access to reproductive services, despite Canada's long history of health promotion programs in schools and in the community. Adolescents' life skills, such as refusal skills, proper use of condoms, and help-seeking strategies, seem to need further development and reinforcement.

## Impacts

### **STDs/STIs are prevalent worldwide among adolescents**

#### **Cook et al 07**

R.J. Cook, J.N. Erdman, B.M. Dickens, pfs of law and medicine @ UToronto, "Respecting adolescents' confidentiality and reproductive and sexual choices" International Journal of Gynecology and Obstetrics, 98, 182-187 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**It is estimated that every day, more than 7000 young people become infected with HIV, accounting for at least half of all new infections** [29]. Discounting the female condom, contraceptive services to female adolescents will not reduce this burden. Counselling female adolescents on premarital abstinence from intercourse is appropriate, with supporting advice on means to negotiate partners' use of condoms in case of a lapse; abstinence-only education and counselling often fail to protect against disease and pregnancy in practice [30]. **Abstinence advice affords no protection against rape and comparable nonconsensual intercourse, of course and, while educating young females on avoidance of risk-laden behaviors, such as illicit drug and alcohol use, is helpful, strict enforcement of anti-risk strategies can deny them social normalization and induce unjustified apprehension.** Health service providers may bear special educational responsibilities in the protection of adolescents against sexually transmitted infections including HIV. The techniques of accommodating diversity that underpin education in life skills, such as negotiation of safer sex, may not be taught in schools committed to fidelity to religious beliefs [31].

## Solvency

**Right to autonomy is key in the context of birth control – otherwise adolescents might not get it**

**Driggs 01**

Ann Eileen Driggs, R.N., J.D., “The Mature Minor Doctrine: Do Adolescents Have the Right to Die?” Health Matrix, Vol. 11:687 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Confidentiality is a crucial factor in the dispensing of birth control to minors. If this confidentiality were not respected, teenagers would be deterred from seeking contraception with the possible result of an escalating teenage pregnancy rate.<sup>34</sup> There is also the health risk of an increase in sexually transmitted diseases,** which was actually the motivating factor in the states’ enactment of these laws, and not the maturity of the minor. <sup>35</sup> Furthermore, **the facts demonstrate that most minors would cease to use contraception, but not cease sexual activity, if it were necessary to involve their parents in the decision.**<sup>3</sup>

**Autonomous decisions are needed to deal with violent sex crimes in many places in the world**

**Cook et al 07**

R.J. Cook, J.N. Erdman, B.M. Dickens, pfs of law and medicine @ UToronto, "Respecting adolescents’ confidentiality and reproductive and sexual choices" International Journal of Gynecology and Obstetrics, 98, 182-187 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A worldwide aspect of many adolescent and younger children’s first experience of sexual intercourse is that it is nonconsensual, and perhaps violent. Vulnerability is greater where the belief is held that men’s HIV infection can be cured by intercourse with a virgin. Conditioning lawful care of STIs and pregnancy on parental approval in these circumstances is dysfunctional. Accommodation of a parental veto would violate** Article 24 of the CRC, which recognizes **“the right of the child to the enjoyment of the highest attainable standard of health.”** Where sexual assaults are reasonably anticipated, such as during military conflicts and in displaced or refugee communities, the same Article is relevant, since it requires access to “preventive health care...and family planning education and services” (Art. 24(2)(f)).

**Adolescent sex is inevitable – autonomous access to contraceptives is key to public health, preventing unintended pregnancies, abortions, and STDs**

**Bermuglia 01**

Jessica Bermuglia, JD, "Preserving the Right to Choose: A Minor's Right to Confidential Reproductive Health Care" 23 Women's Rts. L. Rep. 63 2001-2002 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Moreover, **studies show that parental involvement laws interfere with medical practice and undermine the public health.**<sup>54</sup> Specifically, **almost all states allow for minors to consent to medical services for themselves without parental involvement, in particular, for medical services related to reproductive health care and sexual activity.**<sup>155</sup> If minors can give consent themselves for services related to childbirth, such as consent to delivery by cesarean section, which is significantly more dangerous than having an abortion, **there should be no reason based on health concerns for denying a minor the right to have an abortion.**<sup>56</sup> "For example, no state requires a young woman to obtain parental consent for prenatal care and delivery services; all but

four states and the District of Columbia allow a minor to put her child up for adoption; all states but one allow adolescents to consent to treatment for sexually transmitted diseases. 1 57 Most importantly, **mandating parental involvement for contraception would substantially increase the number of unintended pregnancies, the number of children being born, abortions, and sexually transmitted disease, including HIV/AIDS.**" 58 **Parental involvement requirements deter minors from seeking important health care services. Medical experts concede that minors who obtain contraceptives confidentially tend to protect themselves from unintended and un- wanted pregnancy as well as protect themselves from sexually transmitted diseases.** 159 Furthermore, **when minors learn that medical facilities will not provide contraceptive services without disclosing the information to their parents, the minors may avoid clinic visits altogether, either because "their incentive for keeping an appointment is to obtain contraceptives or because they fear that any sign of sexual activity will lead to a report to their parents."** 161 **When minors do not get to the clinic, for whatever reason, they "miss or dangerously postpone routine gynecological exams, screening[s] and treatment for sexually transmitted diseases, pregnancy testing, and the vital counseling that attends these services."** 161 Proponents of parental involvement laws also argue that the laws would reduce adolescent sexual activity. They believe "that confidential access to contraceptives encourages teens to become sexually active and, conversely, that requiring parental involvement would discourage teenage sexual activity." 162 Research and studies report that a minor's behavior actually belies this prediction.' 63 For example, **most minors have already been sexually active for almost a year before seeking family planning services.** 1 6 1

**Autonomy good – treating adolescents with respect and seeing them as part of the solution is key**

**Tonkin et al 09**

Roger S, MDCM, FRCPC, OBC. President, International Association for Adolescent Health, Aileen Murphy, Colleen Poon, "Sexuality and Reproductive Health in Adolescence," in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**There is a growing recognition of the need for a significant shift in adolescent policy frameworks and program strategies.** The Government of New Zealand's document Youth Development Strategy Aotearoa provides an example of such a shift (Ministry of Youth Affairs 2002 ). Researchers in Minnesota, Melbourne, Gothenburg, Vancouver, and

Boston are developing the evidence base in favour of policies and practices for **youth-positive development**, which **involves moving away from perceiving youths as the "problem" towards acknowledging youths as part of the "solution."** Such policies are being advocated by the Pan American Health Organization, unicef , and foundations such as the W.T. Grant Foundation. They have as their goal the promotion of resiliency and connectedness, reinforcing the importance of families, peers, and schools in setting a positive tone and **emphasizing a youth's assets and the creation of youth-friendly health services.** As well, there continues to be a need for competent, caring, comprehensive services that enable young people to connect (and reconnect) with their families and that offer them the experience of continuity of relationships with caring adults. Finally, **a youth-positive society would offer a different "vocabulary" when discussing youths and their issues.** The way that adults address the sexual and reproductive health of adolescents is analogous to the position of these young people in contemporary society. To influence sexual behaviour and to promote safe sex practices among today's youth, we must change some of our own attitudes and practices. **This change of perspective requires us to address adolescent issues and needs by helping them to value themselves, their health, and their connections with others.** This change also requires us to reconsider the significance of early sexual debut, to be more creative and protective in the face of exploitation and sexual abuse, and to understand what it is that sexually active adolescents seek when they approach us for care. If we can grasp those opportunities, we will learn more about adolescents as persons. **Only then can we begin to help them see their issues less as problems and more as a part of the process of becoming fully functioning adults.**

## **Mechanism – Sex Licensing**

**Sex licensing could ensure education and assessment**

**Baldwin 13**

Sarah J., Suffolk University Law School – J.D., summa cum laude, "Choosing a Home: When Should Children Make Autonomous Choices About Their Home Life?" Suffolk Law Review XLVI:503 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Yet another system similar to emancipation would be a comprehensive regulatory system of minor licensing.<sup>158</sup> A minor's ability to consent to sex would depend on successful completion of an education program and qualitative assessment.<sup>159</sup> By granting consensual capacity and legal maturity in one license, the uncertainty of a minor's status would be eliminated.<sup>160</sup> This proposal would replace age as the baseline for maturity by instead assessing the voluntary manifestation of objective knowledge.<sup>161</sup>** While this system may make the most

sense academically, it is highly unlikely ever to be put in place because **it would eliminate parental involvement** and would cost a significant amount to create a new licensing system.<sup>162</sup>



Vaccines

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

**See the Religion section**

**Kritiks and Critical Literature**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Autonomy

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## AT Critiques of Autonomy

Even if autonomy is problematic, if we're concerned with oppression, it's better to have autonomy in the healthcare context. The alternative just lets power be and endorses paternalism

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

There are difficulties with addressing concerns about agency in this way. First, within current social contexts, freedom from oppressive social conditions requires, inevitably, freedom from society. Thus, these relational accounts would seem to have something in common with the derided

individualistic stereotype of autonomy as independence and self-sufficiency. 141 Secondly, and of more practical concern, this approach has the effect of designating a good number of decisions as non-autonomous. To be fair, relational theorists do not necessarily suggest that non-autonomous decisions should be overridden. 142

Nonetheless, any widespread designation of decisions made in oppressive social conditions as non-autonomous presents an obvious difficulty for the redistribution of power within the healthcare context. While oppressive social conditions remain extant, this way of addressing concerns about agency would serve to perpetuate, and indeed justify, a denial of decision-making power to people who live in oppressive circumstances. Furthermore, if, as argued above, it is recognised that illness itself is oppressive, this leaves open the possibility that a significant number of healthcare decisions of their nature cannot be categorised as autonomous. Thus, the recognition of a lack of agency could lead all too quickly back to a position of old-style paternalism.

## Communitarian Critique of Autonomous Subject

**Complete autonomy is a view from nowhere, a disembodied subject that denies the influence one's identity and community has**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In his communitarian critique of liberalism, Michael Sandel provides a critical analysis of the 'antecedently individuated' <sup>84</sup> liberal subject on both metaphysical and normative grounds. He argues that the liberal subject is individualistic, not necessarily in the sense of selfi sh or uncaring, but in the more fundamental sense that it is conceived as 'standing always at a certain distance from the interests it has'. <sup>85</sup> Th us, the liberal subject is separate (and separable) from her views, beliefs and interests. These are, in a sense, something she can take off or put on. A consequence of this is that '[n]o commitment could grip me so deeply that I could not understand myself without it'. <sup>86</sup> Sandel disputes this view of the subject on metaphysical grounds, arguing that 'community describes not just what [members of society] have as fellow citizens but also what they are, not a relationship they choose (as in a voluntary association) but an attachment they discover, not merely an attribute but a constituent of identity'. <sup>87</sup>

## Feminist Critique of Autonomous Subject

**A right to autonomous decisions ignores the social context of agency – in an oppressive system with norms for health care and body ideals, no choice is truly autonomous. Even those who benefit from privilege aren't making autonomous choices since they benefit from their privilege, not their own free will...**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

There is an extent to which, as sociologist Paul Wolpe argues, **the idea of 'free choice' is 'socially constructed and situated'**.<sup>104</sup> Wolpe notes some of the **structural factors** that **may impede a person's ability to make free decisions about health care**.<sup>105</sup> **These include the power and prestige of the medical profession and the coercive influence of families and communities. In addition, class, race, education, cultural and religious factors all impact on the way in which people make decisions**.<sup>106</sup> Furthermore, **'life circumstances, such as the need to get back to a job that will not tolerate long medical absences, coerce patients to make certain types of decisions'**.<sup>107</sup>

**Feminist theorists have been to the forefront in questioning the social and structural context in which individuals (and particularly women) make decisions and in identifying the impact of power relations and oppressive social factors on agency and decision-making freedom**.<sup>108</sup> **While early feminist work was concerned primarily with gender-based oppression, more recent work has focused on the diverse or 'intersectional' bases of oppression**.<sup>109</sup> **Attention is increasingly drawn to the role of race, class, religion, social and cultural contexts in limiting agency**. Applying feminist theory in a healthcare context, Celia Wells identifies the 'awkward questions' raised by the role of religion in some treatment refusal cases.<sup>110</sup> In some such cases, Wells suggests that it is arguable that 'the paternalism of law or of medicine is no more oppressive than that of religion or of marriage'.<sup>111</sup> Other **feminist theorists identify the impact of 'Western' social norms on agency**. Susan **Sherwin questions the freedom of women's choices in respect of cosmetic surgery, reproductive technology, abortion, pre-natal genetic testing and hormonal replacement therapy**.<sup>112</sup> while Natalie Stoljar questions some **decisions about contraception** along similar lines.<sup>113</sup> Stoljar argues that **decisions to avoid using contraception which are based on views that it is inappropriate for women to have an active sex life or to plan and initiate sex or that pregnancy and childbearing promote one's worthiness are informed by 'oppressive and misguided norms'**.<sup>114</sup>

While an oppressive social environment may impact on an individual's agency, a focus on such factors alone fails to recognise the impact of health crises on agency more generally. Susan Dodds cites the example of **a 'bastion of patriarchy' (male, white, able-bodied, tertiary-educated, professional) faced with a decision about treatment for prostate cancer and shows the range of factors 'over which he has no control but which affect the quality of his care'**.<sup>115</sup> Indeed, as she points out, **the factors inculcated in him by his (privileged) enculturation may impede his decisionmaking freedom. He may accept invasive medical procedures because he considers that it would be 'weak or unmanly to accept his condition passively' or may be pushed towards risky experimental treatment because of a fear of dependency**.<sup>116</sup> Thus, structural concerns about agency pervade many aspects of healthcare decision-making, even if they are more acute in oppressive circumstances.

**Traditional accounts of agency do not provide a framework within which to deal with the impact of social or structural contexts on agency**. Accounts, such as that of Gerald Dworkin are, to use Marina Oshana's term, 'internalist'.<sup>117</sup> Thus, while Dworkin acknowledges that 'the choice of the kind of person one wants to become ... may

be influenced by other persons or circumstances in such a fashion that we do not view those evaluations as being the person's own', 118 the subverting factors which he identifies as possible limits on agency do not include any reference to social context. **A close reading indicates that this is not an accidental omission but is core to** Dworkin's view of **autonomy**. This is clear in Dworkin's response to the classic liberal dilemma of whether a person can autonomously agree to become a slave. He argues: There is nothing in the idea of autonomy which precludes a person from saying: 'I want to be the kind of person who acts at the commands of others. I define myself as a slave and endorse those attitudes and preferences. My autonomy consists in being a slave.' 119 Thus, for Gerald Dworkin, the circumstances and context leading to such a choice are irrelevant to the autonomous nature of the decision made. Unlike libertarian theorists, 120 Dworkin is not content with this outcome. Rather, he regards this as a limitation on the ethical value of autonomy and he acknowledges the need to seek other reasons, besides respect for autonomy, for why **a person's voluntary agreement to become a slave does not make slavery morally acceptable**. 121 For Dworkin, the answer to the moral questions lies in limited paternalism. He argues that '[t]he argument will have to appeal to some idea of what is a fitting life for a person and, thus, be a direct attempt to impose a conception of what is "good" on another person'. 122

## **Frameworks must account for the embodied nature of the subject**

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Traditional conceptions of autonomy accord little significance to the embodied nature of the subject. Yet, all agents are essentially embodied.** Thus, arguing **from a feminist perspective**, Dodds points out that **'[m]enstruation, pregnancy, childbirth, and breast-feeding, for example, are not activities in which participation can be chosen or rejected in the same way that, for example, purchasing a book, deciding to practice the piano, or building a bookshelf are chosen or rejected'**. 123 **Failure to recognise the patient as embodied also leads to a failure to appreciate the potentially coercive impact of illness on agency.**

## **Notions of agency and autonomy must recognize social embeddedness**

### **Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Feminist theorists also identify the role of connection in the creation of the self, drawing especially on the role played by conditions of dependency which are inevitable aspects of childhood in the creation of one's moral personality.** Annette Baier argues that **'our understanding of personality relates to its genesis, and, for us, that is in the conditions of biological life, in which one generation nurtures its successor generation, preparing it to take its place'**. 88 In simple terms, **we are who we are because of where we come from; we are inevitably 'socially embedded'**. 89 **Recognising this has consequences for the role of agency within liberal conceptions of autonomy.**



Biopower

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Mature Minor Doctrine

**MMD seeks to bring moral development on sex into the purview of the state**

**Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," Journal of Medicine and Philosophy, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Implied in the recommendation, and foundational for its justification, is **the doctrine of the mature minor**. Since many jurisdictions de jure and many other jurisdictions de facto deploy emancipation to children around all questions of sexual health, oral contraceptives do not require parental consent. Thus, the Committee on Adolescence of the AAP also presumes that EC would not require parental consent.<sup>1</sup> The medical justification for this new recommendation is that levonorgestrel is safe, effective, and does not require pregnancy testing before usage. Moreover, the recommendation **finds its ultimate justification in the consequentialist public health initiatives** to reduce teen pregnancy. **While the family has traditionally been the locus for the cultivation of the mores and meanings of sex** and sexuality, **the state has become the locus** of an increasingly thin notion of sexuality. Reflecting this shift, the AAP's new recommendation that EC be prescribed at the same time as oral contraceptives neglects any mention of the patient's or the family's moral commitments with regard to pregnancy or sexual activity. **The thin commitment of the polis to promote public health by reducing teen pregnancy takes precedence over the thick metaphysical moral content surrounding sex and sexuality typically cultivated in children by the family**. The AAP's new policy recommendation, grounded in **the doctrine of the mature minor, is part and parcel with Western political philosophy that seeks to move moral decisions outside the unit of the family and to bring it into the domain of the polis**. A short survey of Western political philosophy demonstrates this erosion. In the Republic, Plato describes the just city as requiring the removal of children from traditional families (which at the time were not nuclear families, even though they were still biologically related families) and placed in the care of the guardians (Plato, 1991, 375a–383d). The same holds for Rousseau who must remove Emile from his family and society and to raise him in virtual isolation (Rousseau, 1979). **Even as recent as John Rawls, we find that the family is thought to be a threat** to equality of opportunity (Rawls, 1999, 64, 265, and 448). Aristotelian philosophy has a kind of organic notion of the state grounded in families, which, when they have grown large enough, bind together into a polis. The "state comes into existence, originating in the bare needs of life, and continuing in existence for the sake of the good life" (Aristotle, 1984, 1252b29–30). The material needs of bare life are the domain of the family, which seems to exist only for the purpose of procuring and sustaining the material needs of human life. The polis is the domain of the good life, the life of eudaimonia as described in the Nicomachean Ethics (Aristotle, 1987). The "earlier forms of society" in the family are natural to the human animal, just as politics is natural to humankind (Aristotle, 1984, 1252b31). So, just as life within the family or household is natural, so it is that the bios politikos is natural to man. Aristotle also distinguishes zoë and bios in the Politics—zoë is bare life, the life we have by virtue of being alive; bios politikos is that form of life that is always qualified as the good life. The despotēs (the head of the family) and the oikonomos (the head of a household/estate) are each concerned with the siring, birthing, and raising of children and the material sustenance of the members of the family or household (Aristotle, 1984, 1252a25–35). Thus, the realm of the family is zoë, bare life, the material necessities of existence. The good life—the moral life—is the domain of the polis. Several philosophers like Michel **Foucault** (1988, 2004) and Giorgio **Agamben** (1998) have **pointed out that, in modern politics, bare life—formerly the domain of the family—has become the domain and concern of the state**. Yet, there is a corollary to this point that has not been made explicit in the philosophical literature: **the polis or state has also crossed over into a domain that had been implicitly the realm of the family, namely, the material conditions of life itself**. In this paper, we will argue that **the doctrine of the mature minor**, once intended to permit exceptions to parental consent requirements for emergency medical interventions, **has become justification for the provision of routine reproductive health care services without parental consent**. We will do so by **plac**ing the **mature minor doctrine in a wider history of shifting sexual mores being cultivated by secular society**. In this shift, **the cultivation of sexual mores is increasingly becoming the domain of a state primarily concerned with public health outcomes**. Then, we will argue that it is typically within the family that thick metaphysical moral content around sexuality is implicitly and explicitly cultivated in the practices of caring for the bodily needs of children. Appreciating moral content about the meaning of the body and integrating this content into complex decision making are abilities that, according to new scientific evidence, adolescents do not yet fully possess. The application of the mature minor doctrine to reproductive health services encourages separating decisions about sexuality from the context within which the meaning of sexuality has been understood. In doing so, the doctrine of the mature minor facilitates the erosion of the goods internal to the family, where bodily needs, including needs of intimacy, are met and understood.

**MMD allows the state to exclude parents and families from decision-making, bringing adolescent health fully into its purview. The state defines autonomy and the ideal body**

### **Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," *Journal of Medicine and Philosophy*, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

This evolution of the doctrine of the mature minor and support for adolescent access to reproductive health services are shockingly neglectful of robust discussions of the doctrine's most intrinsic concept—maturity. It seems that, **legally and medically, the concept of the mature minor does not actually depend on the notion of maturity**. Instead, **the invocation of the doctrine of “mature minor” in the context of adolescent reproductive health has become a means to assert better health outcomes for the state. A careful consideration of maturity is unnecessary because contraception is an unqualified good in the case of every teen**. Socially destructive and expensive health risks, more than the adolescent's mature ability to understand and appreciate health information, merit the provision of reproductive health services without parental consent. Thus, **while the doctrine of mature minor appears to be another iteration of the primacy of autonomy, the principle of autonomy may only have been the justifying spark that began the practices and legal norms of providing contraception to minors**. In all reality, the public good and the goods imposed uniformly on every minor (avoid pregnancy and STDs) are equally central forces in the development of the mature minor. Ironically, in failing to build the doctrine of mature minor on a well-defined concept of maturity and instead by focusing on the health consequences of risky adolescent behavior, law and medicine attest to and then compensate for the immaturity and neediness of minors. In short, the immaturity of minors leads to the assertion of their maturity for making decisions around sexuality. In the context of contraception and abortion, the invocation of the “mature minor” appears as an effort to cope with the minor's immature and detrimental effect on public health by unqualifiedly moving the adolescent into the realm of adulthood when it comes to sex and sexuality. Thus, the real dilemma is not about adolescents' ability to consent, because contraception is perceived as beneficial and good regardless of consenting ability. **The real conflict is between state interests in public health and parental authority. Under the guise of the adult-like developmental stage of adolescence, health outcomes have clearly been prioritized above parental authority and the primacy of the family structure without significant attention to what maturity is or if adolescents actually possess it. Once a doctrine to allow for emergency exceptions in life-and-death situations when a parent happened to be absent, the doctrine of mature minor has evolved into a medicolegal foundation to emancipate minors for the purposes of sexual health, further inculcating a new norm of sexuality for adolescents.** Now, the doctrine enables adolescents to make decisions about sexual health with the intention of excluding their parents. **The state, in its alliance with medicine, provides the consequentialist moral content for decontextualized goods of sexuality—to allow sexual gratification and liberation, while avoiding pregnancy and disease. With the systematic implementation of mature minor into reproductive health care, parents no longer have—or need—a say in their children's decisions. Parental authority has become dislodged by the presumed higher sexual morality of the state, allied with a medicine that leads to the propagation of the ideal controlled female body, isolated from her family and placed within the governance of the state.**

Race

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Capacity Tests

**Capacity tests disproportionately disadvantage minority groups, reflecting the alienation and marginalization of the group writ large**

**Donnelly 14**

Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Impediments may also be gender-based or racially or ethnically derived**. For example, a person who has always assumed a particular gendered role within a marriage may find it difficult to act outside of this role if his or her spouse dies. 109 **In respect of race and ethnicity, a study of rates of incapacity among psychiatric patients in a London hospital found proportionately higher numbers of black and minority (in particular African Caribbean) patients to lack capacity. 110 Although they did not comment in detail on why this was likely to be the case, the authors of the study noted the role played by 'contextual and environmental factors' in whether or not a person has capacity. 111 A United States-based anthropological study found that African American patients with mental illnesses were less likely to describe their illness in medical terms and more likely to ascribe it in 'socio-situational terms'. 112 This, in turn, led to higher findings of incapacity based on a lack of understanding by the patients of their illness. The authors suggest that these patterns may 'reflect the alienation and marginalization of this group, expressed through the rejection of white, middle class, professionally conceived and delivered psychiatric diagnosis and treatment'. 113**

**Theory**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Applied Ethics K2 Topic

**A combination of science and moral principles is essential to evaluate adolescent health policy**

**Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, "Background to Health Policy-Making" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Scientific approaches** have been promoted by the health research establishment as **providing** ideas and **rational evidence that** may help to **guide policy**. At the same time, however, the multiple forces comprising globalization – not only those with respect to economies **but also** those concerning **culture, security, and moral values** as represented in various United Nations agreements – **have assumed greater importance for policy-makers in every jurisdiction. Both of these influences – scientific evidence and abstract principles – are reflected in the policy-making typologies** described by Hall ( 1996 ) and Coleman ( 1985 ). It could be argued that Pless's typology ( 1995 ), although overtly focused on the role of evidence in policy development, allows for the influence of principles and values in Stage 1 (social significance) and Stage 4 (interest group assessment). **Evidence-based policy-making and principled policy-making are two dominant frameworks that have been promoted to guide the development of adolescent health policy.** This book presents an examination of how these two frameworks have been or may be applied, their respective shortcomings, the ways in which **they may be combined for the creation of more comprehensive and complete policies**, and the areas in which they potentially conflict.

**Combining science, policy, and ethics is the way to go**

**Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, "Recommendations for Developing Adolescent Health Policy" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**If we are interested in combining science, policy, and human rights, then we need to simultaneously address the inconsistencies and similarities between these values and practices. Adolescent development patterns may not lend themselves easily to holistic approaches.** For example, the optimal healthy life profile is one of rapid attainment and maintenance of health, peaking in the adolescent years, with increasing attention to preventing problems as one ages: this leads first to protective and then, later, to preventive health policy strategies. The optimal education profile, however, is one of more gradual attainment of knowledge and skills, peaking in middle-to-later adulthood, with more attention to lifelong learning over the life course: this leads to health-promotive strategies in education. One opportunity that these distinct sectoral profiles allow is the pursuit of cross-cutting policy impacts (such as the use of mass public education and a focus on active learning in the education system to achieve healthy living goals). One problem to be aware of, however, is that differing human development patterns in health, education, and productive work may result in unforeseen policy consequences. For example, assuming that the problems of adolescent health can always be addressed later on may miss potential critical periods for optimizing lifelong health that occur in adolescence (e.g., delaying smoking onset in adolescents). Finally, as mentioned numerous times in the text, **what is the role of adolescents in applying localized "evidence"** (or experiences from their own communities) **and their particular "values"** (or hopes and ideals) **in the development of policy and programs?**

**Applied ethics especially key on this topic – there are ethical consultants who specialize in providing advice to adolescents making medical decisions**

### **Spike 11**

Jeffrey P. Spike, University of Texas Health Sciences Center, “When Ethics Consultation and Courts Collide: A Case of Compelled Treatment of a Mature Minor” Narrative Inquiry in Bioethics, Volume 1, Number 2, Fall 2011, 123-131 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Over the years I have been surprised by the hostility some otherwise intellectual people have towards ethics. This can include people in the medical humanities.** One of the accusations against ethics that I have heard many times appears to result from some sort of resentment. Why, some ask, should ethicists be allowed to make such crucial decisions? **Implicit** (and sometimes explicit) **is skepticism that there be expertise in ethics** to allow such authoritative decision-making power. No amount of discussion can dissuade these critics that their presumption is simply false. This is the same sort of complex question as “Have you stopped beating your wife?” The truth is that no one needs to follow the advice given in an ethics consultation note. That is not a reflection on ethics consultation: no attending needs to follow the recommendations of any consultant. Thus **the misperception of the threat of ethics authorities “making decisions”** (or taking decisions away from doctors or patients) **provides more insight into the naïveté of the accuser than anything else.** On the other hand, if the skeptics are implying that there is no such thing as expertise, they are wrong. Ethics, like law, is always open to interpretation. But **well informed people, as well as a wealth of experience, can enable some people to provide reliable, well informed, and helpful opinions within a constrained timeframe.** Hence one way to see this case is simply that the attending and the hospital took the responsibility upon themselves, ignoring the recommendations of the ethics consultation service, as is their prerogative. We might then conclude that well meaning doctors and lawyers used the legal system to save his life, more of a praiseworthy act than one deserving condemnation. However, true to the complexity of real life, the correct lesson to be learned from **a case is never incontrovertible.** Certainly there is more than one lesson that might be drawn from this case. Thus an alternative conclusion we might draw, for example, is that Luke and his parents were outsmarted by a complex legal system they could not be expected to understand.



## Ethics Good on Topic

**Framework debate is key – there are a million different moral frameworks that could be used to determine what’s best for children. We have to pick and apply**  
[Could also be used to justify an ‘ethical modesty’ view]

### **Cherry 10**

Mark J. Cherry, pf of philosophy @ St. Edward's University, "Parental Authority and Pediatric Bioethical Decision Making" Journal of Medicine and Philosophy, 35:553-572, 2010 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**A core challenge for the Convention on the Rights of the Child is the articulation of a canonical moral anthropology—the nature and content of the basic goods central to human flourishing, such that one could articulate an account of the best interests of the child,** without

straightforwardly begging crucial questions. As a matter of empirical reality, instead of moral unity, **one finds a considerable array of incommensurable moral accounts of the basic goods central to human flourishing—the moral norms necessary for judging the best interests of the child. One finds as well significantly diverse theories for rationally debating the merits of these divergent understandings of morality and human good. Even merely ranking central moral concerns, such as liberty, equality, justice, and security in different orders of importance will affirm different moral visions, divergent understandings of the good life, and varying senses of what it is to act appropriately in the best interests of children. There appear to be at least as many competing secular moral anthropologies, with attendant accounts of the basic human goods and the best interests of children, as there are major world religions and secular worldviews. Which account of human nature, with whose view of human flourishing and basic goods, should be appreciated as morally normative for judging the best interests of the child? One must first specify the normative criteria for determining best interests—that is, how appropriately to balance costs and benefits and rank human goods or cardinal moral concerns. Which consequences ought to be avoided, which virtues inculcated and values embraced, and at what costs?** Despite its invocation as a decision-making standard,<sup>17</sup> **there does not exist a universal canonical**

**account of the best interests of the child to guide medical decision making. Universal moral truths cannot be read straightforwardly off of reason, canonical intuitions, or a sense of profanation or moral outrage so as conclusively to inform judgments regarding the best interests of the child** (Engelhardt, 1996). Unfortunately, the Convention neither clarifies why one ought to adopt its particular

moral account as uniquely authoritative nor does it ever fully articulate why the child’s freedoms of expression, speech, religion, conscience, association, and education are essential to protecting the best interests of the child. Adopting the Convention’s particular, perhaps idiosyncratic, moral viewpoint to enforce through public policy, and a recast bioethics of pediatric decision making would, at best, appear to assume what must be proven.

## Ethical Modesty (EM) Good on Topic

Authors within the lit defend an ‘ethically modest’ approach – overriding rights are never wholly overriding and can be violated based on a weighing of various principles. Here’s an example of EM-style reasoning,

### **Hickey and Lyckholm 04**

Kenneth S. and Laurie, chief resident and prof of internal medicine @ Virginia Commonwealth Medical Center, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" Theoretical Medicine 25: 265–276, 2004. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Although we have concluded that the benefits of conventional medical treatment of a sick child of a Christian Scientist parent outweigh the burdens to the parents and family, that does not mean that the beliefs of the Christian Scientist practitioner should be disrespected or ignored.**

**The imposition of the law between a parent’s belief and values and their children constitutes a delicate situation that requires extensive consideration.** In the case of overriding such a precious principle as the primacy of parents as guardians of and decision-makers for their children, the burden of proof is on those choosing to override it. It may be useful to consider the **conditions** of Beauchamp and Childress that **must be met to justify infringing one prima facie norm in order to adhere to another** (in italics, below).<sup>40</sup> These conditions include the following:

**1. Better reasons can be offered to act on the overriding norm than on the infringed**

**norm.** The argument can be made that a child’s life is more important than a set of beliefs or morals. These are not the child’s morals. It has often been argued, and most recently by Jeffrey Spike, who said, “The children are being raised in that community, yes, and by true believers, yes, but they deserve a chance to survive until they can judge for themselves whether to adhere to those beliefs.”<sup>41</sup>

**2. The moral objective justifying the infringement has a realistic prospect of achievement. If a child has an illness, for which there is no cure, such as a fatal brain tumor, then overriding the parents in order to give chemotherapy that has a 15% chance of shrinking the tumor, and no chance of eradicating it, would not be justified. However, if a child has bacterial meningitis, and the chance of recovery with IV antibiotics is greater than 90%, the infringement would be justified.**

3. No morally preferable alternative actions can be substituted. If the child has an acute life-threatening illness, such as meningitis or diabetic ketoacidosis, or if the child is in pain, there are no morally preferable alternatives to medical care. However, if the illness is less acute, or not curable, then alternative actions could be sought which were more in keeping with the parents’ preferences and beliefs.

**4. The form of infringement selected is the least possible commensurate with achieving the primary goal of the action. When the parents’ desires are overridden, the action of overriding must be restricted to the specific circumstance, if possible. The rights of the parents to make other decisions for their children should be respected.**

However, in a situation in which a child has died, many would question whether the parents who allowed a child to die for lack of medical care would be “fit” to care for other children, and even further, whether they should be prosecuted for neglect and wrongful death. In that case, this is clearly a more difficult condition to meet.

**5. The agent seeks to minimize the negative effects of the infringement.** When parental rights are overridden to provide proper medical care to the child, the parents should still be allowed to make other decisions relevant to the situation, to visit their child, and to be informed of their child’s condition.

**Topicality and Word Choice**

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

Adolescents

# Premier Debate

Sign Up for Camp Now!



July 24 - August 7

August 7 - 21

[Premier Debate Institute](#)

[Premier Debate Today](#)

[Premier Facebook](#)

[Premier Twitter](#)

## Definitions of Adolescence

**Adolescence goes up to age 15**

**Sloninat 07**

Mary Irene Sloninat, JD from Case Western, “State v. Physicians et al.: Legal standards guiding the Mature minor doctrine and the Bioethical judgment of Pediatricians in life-sustaining Medical treatment” 17 Health Matrix 181 2007 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

A. Defining "Adolescence" As each person is unique in her physical and emotional state, so is the uniqueness of the development of each person into an adult. Many researchers have nonetheless attempted to develop a theory generalizing the development of children. **Jean Piaget is argued to be the most influential child development researcher.<sup>72</sup> He spent years observing children with the end result being the creation of the Piagetian Cognitive Development Theory. The theory posits that there are four basic levels of cognitive development.<sup>73</sup> Level Four, the last cognitive development stage, takes place between ages eleven and fifteen. It is at this stage that a child can imagine the past, present, and future conditions of a situation and hypothesize how the situation might occur in different conditions. At this level, children can solve problems by applying theories and engaging in pure thought aside from real-world actions. <sup>74</sup> "In Piagetian theory, by the age of fifteen, a child's thinking has evolved into a mature state[,] and adult thought exists within the child's repertoire of mental functions.**<sup>75</sup>

## **Must Exclude Little Kids**

**Excluding small children is key to addressing adolescents' issues specifically**

### **Boyce & Boyce 09**

William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, and Emily, PhD in Sociology at Simon Fraser University, "Background to Health Policy-Making" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary.

[[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

Second, and **connected to this paucity of data, is the tendency for adolescent issues and needs to be "lumped in" with those of either adults or younger children. Policy and programs may seek to improve adolescent health, but this is usually a secondary focus or afterthought. Examples of adult-oriented policy that may not be particularly adolescent-friendly – and yet are assumed to cover adolescent needs – can include community sexual and reproductive health programs, mental health programs, and harm/risk reduction programs related to substance use and to physical activities such as bicycling or driving.**

Similarly, **adolescent issues are assumed to be covered by early childhood initiatives**, such as those aimed at eliminating poverty or malnutrition within families.

## Science + Social

**Most functional definition includes the scientific and social definitions of adolescence**

### **Rootman and Boyce 09**

Irving, pf at the University of Victoria and a Michael Smith Foundation for Health Research Distinguished Scholar, William, pf of community health and epidemiology and education and director of the Social Program Evaluation Group, Queen's University, "Evidence Based Policy-making: Adolescent Health Research" in Adolescent Health: Policy, Science, and Human Rights. Montreal, QC, CAN: McGill-Queen's University Press, 2009. ProQuest ebrary. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

In general scientific usage, **adolescence refers to the period beginning with puberty and ending with achieving the age of majority. The period of youth incorporates adolescence but extends beyond that into the young adult years. Confusion can occur since the start of puberty varies significantly among individuals, between genders, and across cultures. From a policy perspective, therefore, the timing and length of adolescence is variable.** Childhood merges with adolescence and adolescence merges with, or extends into, the period of youth. **Our definition of adolescence is, consequently, more functional in nature: "Adolescence begins with the onset of physiologically normal puberty and ends when an adult identity and behaviour are accepted. This period of development corresponds roughly to the period between the ages of 10 and 19 years" (Canadian Pediatric Society Board of Directors 1994 , reaffirmed in 2000 ). As such, adolescence is a period in the life cycle that has a biologic definition for its beginning but a socio-cultural definition for its end and that is of variable length.**

**Adolescence is a prolonged transitional phase**

### **Healy 03**

Kevin Healy, Consultant psychotherapist, clinical director of Cassel Hospital, "Adolescence: a transitory world" in Day, Lesley, and Flynn, Denis, eds. Internal and External Worlds of Children and Adolescents : Collaborative Therapeutic Care. 2003. ProQuest. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The idea of adolescence as a prolonged transitional phase seems to be very much a twentieth-century phenomenon** (Ander-son & Dartington, 1998). Adolescence is one of the most radical of all the developmental periods. **In the few years between the onset of puberty and adulthood one's sense of oneself must adapt to the physical changes of size, build, shape, strength, appearance, and being sexually mature.**

For boys, this means being able to impregnate and an exponential increase in strength, and for girls to carry a pregnancy, to have breasts, and to menstruate. **The social and psychic corollaries of this are to develop the capacity to become intimate with others, to form sexual relationships, to become less dependent on parents, and to move towards separation from the family.** Adolescents will also have to survive the modern initiation of manhood and womanhood, completion of their education, and hopefully securing a job—**in short, to move towards becoming an independent person both internally and externally. If the adolescent is successfully to achieve adulthood, he or she must renegotiate every aspect of relationships with him/herself and with external and internal objects, in a new context.**

**Some expert named Winnicott said that adolescence is a number of different things, not just physical changes**

### **Healy 03**

Kevin Healy, Consultant psychotherapist, clinical director of Cassel Hospital, "Adolescence: a transitory world" in Day, Lesley, and Flynn, Denis, eds. Internal and External Worlds of Children and Adolescents : Collaborative Therapeutic Care. 2003. ProQuest. [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**Winnicott wrote several papers specifically on adolescence.** In his paper, "Hospital Care Supplementing Intensive Psycho-therapy in Adolescence" (1963b), **Winnicott wrote of adolescence as a phase in healthy growth where defiance is mixed with dependence.** He suggested that it was no easy thing and that there was only one cure for adolescence—the passage of time. He suggested that there was much that could be said about the management of care of disturbed adolescents. However, he picked out one thing for special mention: "There will be suicides." He introduces the term "adolescent doldrums" (1961) to describe the few years in which each individual has no way out. **In this phase the child does not know whether he or she is homosexual, heterosexual, or narcissistic. There is no established identity, and no certain way of life that shapes the future.** There is not yet a capacity to identify with parent figures without loss of personal identity. In his paper, "Contemporary Concepts of Adolescent Development and Their Implications for Higher Education" (1968b), **Winnicott goes on to develop the concept of adolescence as a long tussle to be survived.** He suggests that growing up means taking the parents' place and that **rebellion** belongs to the **freedom** that parents have given to their children. **He states that the adolescent is immature; immaturity is an essential element of health at adolescence.** He advises society, for the sake of adolescents and their immaturity, not to allow them to step up and attain a false maturity, by handing over to them responsibility that is not yet theirs, even though they may fight for it. **He concludes that the main thing is that adolescence is more than physical puberty, though largely based on it. Adolescence implies growth, and this growth takes time, and while growing is in progress, responsibility must be taken by parent figures. If parent figures abdicate, then the adolescents must make a jump to a false maturity and lose their greatest asset: freedom to have ideas and to act on impulse.**



## **Historical definition**

**Adolescence is historically a thematic period in one's development characterized by stress, conflict, and risky behaviors**

**Barina and Bishop 13**

Rachelle and Jeffrey P, Saint Louis University, "Maturing the Minor, Marginalizing the Family: On the Social Construction of the Mature Minor," Journal of Medicine and Philosophy, 38: 300–314, 2013 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**The concept of adolescence as a developmental stage is of recent invention**. Psychologist Granville **Stanley Hall is often credited as the first to describe** the developmental stage of “**adolescence**” at the beginning of the 20th century. **For Hall, adolescence was not merely an age-bound, biological time, but also a cultural phase of “storm and stress” associated with conflict with parents, mood disruptions, and risky behaviors involving crime and sex**. Jon Savage points out that **Hall’s theory responds to the infiltration of Darwinism into sociology and psychology and subsequent assumptions that laissez faire competition best leads to progress**. In a time when teenagers often entered the workforce, **Hall’s coining of “adolescence” aimed to differentiate the adolescent from the adult**. Hall believed that **ongoing education and formation during adolescence was necessary to cultivate maturity and ultimately to promote social progress** (Savage, 2008). **Hall’s sentiments** regarding the importance of protecting and guiding adolescents **coincide with** a set of 19th- and 20th-century legal developments regarding the regulation of child labor, requirements of school attendance, child abuse laws, and separation of juvenile and adult criminality (Oberman, 1996, 130). These **scientific and legal sentiments emphasize that the adolescent maintains a developmental proximity to the child and that, like the child, the adolescent necessitates special regulation**.

## **Teen > Adolescent**

**“Teen” is a better term than “adolescent”**

### **Spike 11**

Jeffrey P. Spike, University of Texas Health Sciences Center, “When Ethics Consultation and Courts Collide: A Case of Compelled Treatment of a Mature Minor” Narrative Inquiry in Bioethics, Volume 1, Number 2, Fall 2011, 123-131 [[Premier](#), [Premier Debate Today](#), [Sign-Up Now](#)]

**It might be noticed that I use the term teenager instead of adolescent. The reason is in part scientific: teenager is much more precise. There is no matter of clinical judgment of whether a person is or is not a teen. In particular, the end point (19) is closer to the legal concept of an adult than adolescence, whose end is ill-defined and extends into the mid-20s according to most texts. Further, being a teen is a highly prized status for those who have it; indeed many kids can't wait until it happens. But no one really wants to be called an adolescent; in fact, it can be used as a demeaning, deprecatory, and condescending term. Any reasonably self-aware patient would prefer to go to a “teen clinic” than an “adolescent clinic.”**