COMMUNITY ETHICS

Pardon Me, But Our "Academic" Side is Showing...

Rosa Lynn Pinkus, Ph.D.
Director of the Consortium Ethics Program

If you look on the CEP web page and read a description of the Consortium Ethics Program, you'll see that "the CEP is the ethics education network of western PA" and that it combines the best of the academic research on ethics with a "practical, hands-on approach to teaching." One of the goals of the CEP from the very beginning was to "bridge the gap" that often exists between the academic setting and the frontline practitioner. To bridge this gap, two basic tasks must be completed successfully. Both are integral, intertwined and delicately balanced. They involve both the CEP members and its' faculty.

All of the members of the CEP are professionals—experienced professionals with a wealth of practical knowledge regarding how to identify, resolve and prevent the "ethical dilemmas" they encounter daily. They all "live" in a world of action, of doing, and of continual learning. The CEP was designed to provide these busy practitioners with a framework for understanding and resolving the ethics issues they encounter, a time to reflect upon their actions and the justifications for those actions.

This can be a tough call for the faculty. Most of our faculty live in two worlds: that of the academic and that of the practical medical milieu. Oh how different the expectations of what counts as excellent are in these two! Basically, the faculty are "thinkers" and of course "doers" but the doing is researching a specific topic, thinking through issues, and keeping current on the literature of ethics, law, and medical humanities. We are all teachers; some having responsibilities in the medical, nursing or schools of Public Health, others actually teaching undergraduate courses at the various universities and colleges in western Pennsylvania and eastern Ohio. All of us also spend some time "on the front lines." We meet our CEP members on their own turf and walk with them as they confront dilemmas in their hospital.

The CEP has a ten-year track record of successfully combining these two worlds. So successful have we been, that we've created a "third world," if you will. This world implies none of the

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*Visit the CEP on the World Wide Web! http://www.pitt.edu/~cep/*
impoverished geographical space in the global community; rather, it’s a place where a hybrid clinician/scholar can move about with ease. Libby Moore, social worker from Sewickley Valley Hospital, is just about finished with her Ph.D. in Medical Ethics. Beth Chaitin, social worker at Shadyside has completed both her MA in medical ethics and her Doctor of Health Care Ethics. She’s added Co-chair of the Ethics Committee to her list of accomplishments as well as fulltime ethics consultant. Mary Ann Fello, our gifted teacher, is both CEP and “self taught” and has continually challenged herself to present her views formally in our seminar forum and at our retreats. Andy Thurman is a practicing lawyer and also a student in the PhD Program at Duquesne. Mark Wicclair is a philosopher, teacher, and ethics consultant. The CEP, in fact, nourishes both our clinical members and our academic faculty so they can each travel comfortably in the others’ world. It provides a forum where both can learn from each other. It’s a “safe haven” for the academics in which we have all learned to relax a bit when we teach, in order to engage you in conversation and learn FROM you.

But we all had to start somewhere. What we have come to take for granted in the CEP, our “moral community,” is quite unique. There are other programs that have accomplished this sense of sharing; Jack Coulehan, MD is the Director of the Institute for Medicine in Contemporary Society and Professor of Preventive Medicine at the State University of New York at Stony Brook. Marty Kohn, Ph.D., is Associate Professor of Behavioral Sciences, Northeastern Ohio Universities College of Medicine (NEOUCOM), where he directs the Human Values in Medicine Program as well. He also codirects the Center for Literature, Medicine and Health Care Professions, a cooperative project of Hiram College and NEOUCOM. Both Mark Kuczewski and Mark Aulisio have gone on to direct programs of their own which will, hopefully, carry this tradition forward. These are but a handful of programs on the ethics landscape, and to exist and flourish, we need to continue to “train” practitioners in both worlds. This is where the CEP’s expertise shines.

The three year cycle of reenrolling new members is about to begin. I am pleased to say that because of wise financial management, our participation fees will only increase to reflect a “cost of living” raise to cover supplies, faculty consultations and those fabulous salary raises that the University gives us—when they deem it possible. I am hopeful that those of you in the “Basic” class will graduate to the “Advanced Class” (You’ll get to be in the OTHER class!!!!) and that your institutions will send two new people to start the training again. We’ll be sending out materials to explain some new initiatives and also to get a reading from current members about their intent to re-enroll. If our current membership continues, the re-enrollment period takes on a less stressful air.

Beyond recruiting new members, I also have to be concerned with training and hiring new faculty to teach in the CEP. Some of our advanced and associate members are starting to “hit the road” and teach at other hospitals. You’ll be hearing from Robert Frampton, MPT and Cynthia McCarthy, MA this year, our newest faculty members. Having the four talented faculty from Allegheny College attend the retreat to see how to teach to a clinical audience; how to bridge the two worlds I discussed earlier is an important part of this recruitment. We can’t “enroll new faculty” in the program as we can our members. Instead, we have to build upon their desire to apply in practice what they think and learn about in the abstract. We can give them a place to work in, to write poems about, or to observe and then take back to their own centers. New faculty bring new perspectives and keep the CEP a vital educational program.

This newsletter falls into the category of trying something new. Rhonda Hartman was invited to guest edit Community Ethics, and the theme she selected was a topic near and very dear to her heart: Adolescence and the Law. Rhonda completed her Ph.D. last summer and her dissertation was devoted to this topic. The paper she presents in this newsletter is a succinct review of that body of work. Many of you know “Rhonda the teacher” and have marveled at her ability to explain complex issues. The body of work included here is where she derived her
A WORD FROM...
The Center for Bioethics and Health Law

Alan Meisel, J.D.
Director

There is a new academic program at Pitt that might be of interest to participants in the CEP.

Beginning in the fall of 2000, the University of Pittsburgh School of Law will offer a new one-year masters degree in health law. This degree, the Master of Studies in Law (MSL), is intended to provide legal education to people who use law—or will use law—in their careers and who want to learn more about it, but who do not want to become lawyers. The degree requires 30 credits, including an introductory course designed especially for this program, with the remainder of the courses to be chosen from among regular law school courses (including courses in health law) and electives outside of the law school, which could include graduate courses in Bioethics. The degree is available on a part-time basis over no more than four years, or full-time for a year. In addition to the concentration in health law, students may concentrate in a variety of other areas in law—such as business law and intellectual property law—or design their own concentration.

For further information, visit the University of Pittsburgh School of Law at http://www.law.pitt.edu/msl or call 412/648-7120 for descriptive materials.

information! I personally want to thank her for engaging us in the dialogue about the rights of adolescents and for enlisting the work of her co-presenter in our class series, Will Aiken, Ph.D., who expounds upon what “it” is that adolescents lack that makes them incapable decisions makers. Both articles challenge us to think hard about what type of public policy we would like to have in this neglected area.

To return to my earlier theme, it’s this ability for those of us working in the Consortium to span two worlds that keeps our program rich and vigorous. For those of you not accustomed to reading articles such as the ones featured here (and for those of us who ARE!), snuggle up with a hot cup of tea, coffee—and a dictionary—and enjoy. Comments and critiques of the work are welcomed and, with your permission, will be reprinted in our next edition of Community Ethics.

In closing, I would like to write a few words to honor my dear friend and mentor, K. Danner Clouser. Dan died on August 14th at the Hitchcock Memorial Hospital, about ten miles from his beloved home in Thetford, Vermont. Dan attended two of our retreats and many of you had the good fortune to meet him and shine in his presence. A Founding Fellow of the Hastings Center and a Charter Member of the Editorial Board of the Journal of Medicine and Philosophy, Dan was also an Associate Editor of the original four-volume Encyclopedia of Bioethics (1978). He was University Professor of Humanities Emeritus at the Pennsylvania State University College of Medicine at the time of his death. While his academic accomplishments are legendary in the Bioethics Community, it was Dan’s gentle spirit and his humor—especially his humor—that we remember him for. Dan was especially proud of the Consortium because it offered a collegial atmosphere for all of us to learn in. I am proud that he was proud of the work his mentorship inspired me to do!
Finding the right speaker or education seminar leader is a little easier for health care professionals with Hospital Council of Western Pennsylvania’s *Speakers’ Bureau*.

The *Speakers’ Bureau* was formed in early 1999 as a cache of quality speakers; many of whom have presented for Hospital Council sponsored programs. The directory serves as a one-stop shop for busy health care professionals who need to find a presenter quickly, without the hassle of checking the credentials of the person. All of that work is done by AmeriNet Central’s Education Services. “The speakers who are listed in the directory have been through a careful screening process,” Gretchen Bacco, program administrator, said. “We make sure that they are excellent speakers who are well-versed in health care issues. In fact, many of our speakers have worked in health care management or clinical settings. For convenience, we have posted the list of speakers on our Web site at www.amerinetcentral.org,”

Clinical and management areas aren’t the only specialties for which speakers can be found in the *Speakers’ Bureau*. Susan Campus, health educator for staff development at Monongahela Valley Hospital, Monongahela, Pa., found exactly who she needed when searching for a motivational speaker to address nurses on Nurse Appreciation Day. “Since we are a member of Hospital Council, we received the directory and immediately had a need for it. Nurse Appreciation Day is very important to us and we wanted to provide a speaker who was not as clinical, but more motivational – speaking to the importance of nursing,” she said. Monongahela Valley Hospital chose Sister Charleen Pavlik of Angelspring Consultants and was very happy with the results of her presentation. Angelspring Consultants offers wellness directed seminars covering five focus areas – management training, communication skills advancement, creative problem-solving, stress management and wellness, and spirituality. “Sister Charleen was exceptional. She took the time to meet with our nurses leaders and really learned what we wanted. She was very professional and gave a great presentation. The verbal response we got from those who attended was very positive,” Campus said.

Pavlik is happy to be associated with the *Speakers’ Bureau* and sees it as a great resource for health care professionals. “When I looked through the directory I noticed that I knew of many of the speakers listed. They have solid credentials and are well known. The directory itself covers a nice variety of topics. It’s a nice compilation of top-notch services and speakers,” Pavlik said.

Debbie Jones, coordinator for women’s health at Charles Cole Memorial Hospital in Coudersport, Pa., used the directory to find a speaker for National Cancer Survivor’s Day. She wanted to find just the right person to connect with the cancer survivors in the audience. “The directory was a big help because it offered very qualified speakers,” Jones said. “The person we ultimately chose was wonderful. She connected very well with the audience and provided a very uplifting presentation. The cancer survivors liked it very much because the emphasis was on fun and celebrating life. We were very happy with the speaker and would recommend the *Speakers’ Bureau* to other health care facilities,” Jones added.

The *Speakers’ Bureau* comprises more than 50 individual or group presenters. One group listed in the directory is GSA Healthcare Group, a consulting services company specializing in both the clinical and business sides of health care, including clinical and medical management, outcomes management, documentation and reimbursement, and physician practice reimbursements. Cynthia Gentile, president of GSA Healthcare Group, said the *Speakers’ Bureau* is a valuable tool for health care professionals. “As one who has worked on the provider side in health care, I view the *Speakers’ Bureau* as a wonderful resource that offers a broad array of topics and speakers to choose from. You know that Hospital Council has put thought into selecting the speakers, giving credibility to the people listed,” Gentile said.

The *Speakers’ Bureau* is available to all health care professionals. To receive a copy, or for more information, visit the *Speakers’ Bureau* online at www.amerinetcentral.org or call (800) 837-5800, ext. 218.
Farewell from Mark Aulisio...

THANKS

As many of you know, I have now moved on to a new position as Assistant Professor of Biomedical Ethics and Director of the Clinical Ethics Program (MetroHealth System) of Case Western Reserve University’s Center for Biomedical Ethics so I wanted to take this last opportunity to thank all of you for the good times we have had together over the last three years. Writing this “farewell” has given me pause to think back and reflect a bit on how my time at the CEP began and ended, really, with trips to Uniontown Hospital to give talks for the ethics committee and medical staff there.

I think back on the cold gray afternoon of October 27, 1997 when I met Rosie in Harmarville to trek out to Uniontown Hospital to talk about the case of Dax and the relevance of ethics for clinical practice (that’s right, the infamous “cave” case) — my first CEP talk as “Assistant Director to be.” I was pretty down as we headed to Uniontown since my favorite, the Cleveland Indians had just the night before (October 26) lost (let’s be blunt, “blown”) the World Series to the best team money could buy (in ’97 at least), the expansion Florida Marlins coached by Pittsburgh’s own Jerry Leyland. Rosie and I discussed this, and other things, on the ride down and back. I explained that losing the World Series championship in extra innings of game 7 after taking a lead into the bottom of the 9th inning was bad enough, but that there was much more to it for me. I desperately wanted a Tribe championship partly for me, I admit, but mostly for my Uncle Tony. You see, the Indians had not won a World Series since 1948 and Clevelanders had not seen a championship of any sort in my lifetime (still holds and I am now 35 years young). My Uncle Tony had followed the Indians all his life, but most avidly since he was paralyzed (quadriplegic) in 1962 at the age of 16, injured playing football for Elyria Catholic High School in Elyria, Ohio (my hometown, and my alma mater as well). He has precious few diversions from his extremely difficult life — classical music, wine tasting, food — and a passionate rooting interest for the Cleveland Indians (and, yes, those hated Cleveland Browns:) is chief among them. My Uncle Tony was injured on my parents’ wedding day and my Grandma’s birthday — the date was October 26. I know that my uncle cried hard after that Indians loss (though he swears up and down that he didn’t, even though no one was able to reach him by phone after the game and my Grandma, who takes care of him, says he did) — to be honest, so did I.

It was strangely appropriate that we were heading out to Uniontown, as that is where my Dad, Uncle Tony and their other siblings were born. My Grandma left Uniontown with her five children (moving to Elyria) back in the early ’50’s after her husband was tragically killed in a railroad accident (his grave is in Uniontown). Rosie and I got to know each other pretty well that day on the way down to Uniontown as we talked about the Indians’ loss, my Uncle’s disappointment, the role of sports in building community and lots of other things. Though we were a little late for our session, the talks at Uniontown went very well and the great dialogue we had with the ethics committee really picked me up. We were late together to Uniontown Hospital, and we got lost together on the way back, but all the while there was lots of good conversation.

Interestingly, my last CEP talk, almost three years after my first, was also at Uniontown Hospital. I can honestly say that from that first to the last visit to Uniontown and everywhere in between, though we were sometimes late or even lost, there was always good conversation in the CEP. From Rosie, from Jody and Betsy, from our dedicated and talented core of faculty, and from all of you whom form the CEP community and who are out there on the frontlines of clinical ethics — truly good conversation. Good conversation about how to better inform, keep confidences, make decisions at the end of life, deliver bad news, make the health care system more just, involve minors in decision-making and much more — and for all of this good conversation, one last time, my heartfelt thanks.

Mark P. Aulisio, Ph.D.
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<td>&quot;Images of Health Care in Film: Ethical Perspectives&quot;</td>
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<td>Jyotsna Vasudev, Ph.D.</td>
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<td>Margaret Mohrman, M.D, Ph.D.</td>
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Ninth Annual Current Controversies in Medical Ethics Conference
17th Annual Messer Lecture

Continuing its long-standing tradition of a collaborative approach to medical ethics education, the CEP was pleased to co-sponsor the 9th Annual Current Controversies in Medical Ethics Conference and 17th Annual Messer Lecture on May 15, 2000, along with the Ladies Hospital Aid Society of Western Pennsylvania, the Ira R. Messer Fund, the University of Pittsburgh School of Nursing, Children's Hospital of Pittsburgh, and the Center for Bioethics and Health Law. This year’s conference, entitled “Medical Mistakes: What Every Provider and Patient Should Know,” drew a large and varied audience from many different disciplines of the field of health care, as well as from the Western Pennsylvania community. Led by course directors Michael DeVita, MD and Mark P. Aulisio, Ph.D., the conference addressed the issue of medical mistakes, their consequences, and the impact of heightened requirements to report them.

Rosa Lynn Pinkus, Ph.D., set up the historical background of the reporting of mistakes with her presentation, “Learning to Keep a Cautious Tongue: A History of Truth-telling and Mistakes.” Dr. Pinkus traced the history of reporting mistakes from the time when mistakes were reported freely and thoroughly in medical journals to an era when mistakes were not reported in journals, but confined to “M&M” (Mortality and Morbidity) conferences. Using the practice of neurosurgeon Harvey Cushing as an example, Pinkus pointed out that the reporting of mistakes was seen as part of the process of setting standards for excellence in medicine. Later, though, as evidenced by the writing of such physicians as R.E. Semmes, Howard Nafzinger, and Walter Dandy, the admission of mistakes was buried in lessons for improved technique. Mistakes had “gone underground,” discussed only within the profession.

The second presentation, by Jerry Rabinowitz, MD, was titled “Malpractice: What is like to be Sued? Does Being Sued Mean You Made a Mistake?” Dr. Rabinowitz outlined his background, education, and professional life, then he detailed his experience with a malpractice lawsuit. He had been sued by the parents of a Carnegie Mellon University Student, because he missed a diagnosis of her spinal meningitis, from which she died within two days of her initial visit to him. Dr. Rabinowitz related the details of the case, his reactions to it, and the verdict—which was in his favor. Audience discussion centered around such issues as how well medical school prepares a physician for such experiences and how survival of a malpractice suit can change a physician's practice.

Following this presentation, Robert Arnold, MD, and Elizabeth Chaitin, DHCE, gave a panel discussion on physician and patient perspectives on others’ mistakes.

In the 17th Annual Ira R. Messer Lecture, Stuart J. Youngner, MD (Professor of Medicine, Biomedical Ethics and Psychiatry at Case Western Reserve University), an international expert in ethics, discussed medical error and living with uncertainty.
as a reality of contemporary medical practice and explored the effects it has on the physician-patient relationship. He explored ways in which medical professionals cope with error: Denial—shifting the blame for mistakes to "medical uncertainty" or outright repression; Discounting—blaming the system, superiors, subordinates, disease, or even the patient; and Distancing—"Everyone makes mistakes," "I did the best I could," "It couldn’t be helped." All these tactics, explained Dr. Youngner, are ineffective; the doubt and guilt still remain. Despite the commonly-held expectation that physicians are infallible, they do make mistakes; however, there are different kinds of mistakes. According to Charles Bosk, errors in judgment and technical mistakes or equipment failures are forgivable mistakes; it is important to learn from those mistakes but to let them undermine a physician’s practice. Moral errors (such as laziness or failure to meet certain standards), however, are not forgivable, and the underlying cause should be discovered and rooted out. Youngner further pointed out that there are other health care system changes which affect the physician/patient relationship: Fragmentation of care; discontinuity of care, increased technology resulting in decreased personal contact, the intrusion of corporations, alternative medicine, and the resurgence of religion and medicine interests.

Alan Meisel, J.D., Director of University of Pittsburgh Center for Bioethics and Health Law, responded to this session by maintaining that "quality control" is a big factor in coping with mistakes in health care. It is important, he stated, to "find the silver lining in the cloud" and take advantage of the changes in health care delivery to develop a more effective system, one that will eliminate many chances for error.

The afternoon concurrent breakout sessions included such topics as giving bad news, institutional accountability and journalistic integrity, institutional honesty policies, inter-professional perspectives on mistakes, religious perspectives on mistakes, coping with bad outcomes, improving clinical decision making, and appropriate institutional responses to mistakes.

EIGHTH ANNUAL CONFERENCE ON MEDICAL ETHICS AND RELIGION

As part of its 1999-2000 class schedule, the CEP encouraged its members to attend the Eighth Annual Conference on Medical Ethics and Religion: "Organization Ethics in Healthcare: Catholic, Jewish and Protestant Perspectives," held at the Bayer Learning Center of Duquesne University on May 10, 2000. Rosa Lynn Pinkus, Ph.D., Director of the Consortium Ethics Program, was the moderator for this year's conference, which focused on the business ethics part of medical ethics. As the business side of health care grows more and more complex, it becomes evident that such issues as advertising, billing, referring, merging, cost containment, and dealing with multiple insurers have a significant impact on patient care.

E. Haavi Morreim, Ph.D., Professor in the Department of Human Values and Ethics at the University of Tennessee College of Medicine, presented an overview of organizational ethics in health care from a philosophical perspective. She outlined several areas with potential for ethical challenges, such as error management, cost containment, privacy, and relations both within the institution and with other organizations. Pointing out that "visionary companies" (those concerned with more than the bottom line) were financially more successful than those who were less visionary, Dr. Morreim suggested that perhaps the most appropriate guide for organizational ethics is the "stakeholder approach," or, business conducted to benefit all the stakeholders. Inherent in this approach is the identification and prioritization of the key stakeholders in health care: patients, professionals, organizations, and society.
Rabbi Elliot Dorff, Ph.D., Rector and Professor of Philosophy at the University of Judaism in Los Angeles, California, spoke of the importance of learning how to probe a culture's tradition to discover its underlying values and apply it sensitively to contemporary situations. Religions, he pointed out, paint pictures of who we are and who we ought to be, tying us to various norms or standards. Because medical ethics is rooted in individual and community values, we tend to look to religion for guidance in ethical considerations. As an example, Rabbi Dorff explored several areas of Jewish tradition which are relevant to organizational ethics:

- **Labor law**, which supports the notion of respect for workers and timely payment of wages;
- **Contract law**, which indicates the importance of honoring one's agreements, as they are legally and morally enforceable;
- **Public law**, which gives insight into how the public sets its financial priorities, collects funds, and distributes monies. Public law also outlines a person's responsibilities to the community;
- **Theology**, which depicts God as a loving and just entity, and which indicates respect for persons, who are created in His image.

David H. Smith, Ph.D., focused on the impact of Protestant ethics on organizational ethics in health care, outlining the ethical principles of fidelity, stewardship, and justice as related to the distinctive features of health care organizations. He confirmed that the main purpose of health care organizations is *patient health*, that the welfare of the people the institution is out to serve is of paramount importance, and that all other points are subordinate. Then he went on to outline some basic requirements of organizational ethics. The board of trustees, he said, hold the primary responsibility for establishing priorities and goals for the organization, as well as for preserving institutional identity and integrity. Dr. Smith set forth medical need as the appropriate criterion for patient selection and maintained that the provision of quality services, through credentialing, support for clinical ethics, and effective dialogue between professional groups, is of the utmost importance. Even "institutional death" is to be considered preferable to a lack of quality care.

The final presentation, by Lawrence A. Plutko, Ph.D., System Integrity Officer for the Sisters of Providence Health System in Seattle, Washington, dealt with organizational ethics from a Catholic Perspective. To provide a backdrop, Dr. Plutko reviewed the current corporate compliance and ethics environment in health care as the new ground for organizational ethics, enumerating several challenges for healthcare systems. Then, he discussed the Catholic perspective on organizational ethics, emphasizing the key principles of stewardship, building right relationships, virtue, and Christian character. Finally, he identified an ethics of practice for the health care workplace, using the integrity guidelines and an ethics training video developed by Providence Health System as an example.

These presentations, along with the panel case discussions, contributed an important part to the ongoing discussion of organizational ethics, its meaning, and the challenges to a culture of integrity in today's health care delivery system. Each speaker encouraged institutions to find and maintain their "institutional identity," to remember that health care providers are stewards of a valuable resource, charged with the task of providing quality health care to their consumers; and to continue to develop the traditional covenant of trust between health care providers and patients.
As part of its educational plan, the Consortium Ethics Program is co-sponsoring, along with the Western Psychiatric Institute and Clinic Office of Education and Regional Planning and the University of Pittsburgh Center for Continuing Education in the Health Sciences, a four-part series of day-long programs which focus on ethical issues in the behavioral health fields. The second conference of this series, "Ethical Issues in Psychiatry and Clinical Psychology II: Dilemmas Created by the Emergence of Managed Care," took place on June 16, 2000, at the Frick Fine Arts Building of the University of Pittsburgh. This conference focused on helping behavioral health professionals develop best practices and understand the ethical dilemmas arising in the managed care environment from multiple perspectives.

After an introduction by course directors Paul Pilkonis, Ph.D. and Rosa Lynn Pinkus, Ph.D., Diane Holder, M.S.W., President of Psychiatric Services for the UPMC Health System, discussed the emergence of managed care and the challenges of a provider-owned behavioral health managed care organization in her presentation, titled "Behavioral Health Care of the Future: Managing Managed Care." She examined issues of quality, access, and financing against the backdrop of changing requirements for providers of psychiatric and substance abuse services. This was done with humor(!), an abundance of practical examples, and an obvious expertise that comes with first hand experience.

In the second session, "Balancing the Role of Government and Providers in Delivering Quality Patient Care," Mark J. Covall, Executive Director of the National Association of Psychiatric Health Systems (NAPHS) in Washington, D.C., focused on the growing role of government involvement in the delivery of psychiatric care and the impact of government intervention in the delivery of quality patient care. He highlighted some key areas where government regulations and oversight have created administrative difficulties for providers such as restraint and seclusion regulations, Medicare partial hospitalization requirements, and governmental fraud and abuse initiatives. Finally, he discussed with ways providers can avoid further government intervention by demonstrating that they are accountable to the key stakeholders in health care.

Paul Pilkonis, Ph.D., Professor of Psychiatry and Psychology at the University of Pittsburgh School of Medicine, emphasized the need for developing longitudinal models of care, as many disorders treated by behavioral health professionals are chronic or recurrent, and even episodic disorders carry risk factors which must be monitored continually. In a health care environment (including the mental health sector) which remains primarily oriented toward acute care, innovative models of care must be developed to ensure effective and ethical practice. State-of-the-art principles of chronic disease must be incorporated; compatibility with primary medical care practice should be considered; and an emphasis should be laid upon collaboration with patients, members of their families and social networks.

In "Privacy, Primacy, Peripatetic Psychiatry: Perplexing Privilege Problems," David Korman, Ph.D., Adjunct Professor at the University of Pittsburgh Graduate School of Public and International Affairs, explored problems faced by mental health caregivers in the management of confidential and privileged information. Pointing out that the importance of maintaining confidentiality as a crucial element of quality care is often perceived as being jeopardized by the financial/reimbursement and review of services protocols imposed by managed care programs, Korman discussed effective, lawful, and ethical means of resolving this apparent conflict.

Philip G. Levendusky, Ph.D., Associate Professor of Psychiatry at Harvard Medical School
and Vice President of Network Development at the McLean Hospital in Belmont, Massachusetts, spoke about the need to develop treatment programs that will meet the challenges of providing quality clinical services in an era of more limited financial resources. He stated that people tend to remember the "good old days" without remembering that past delivery services were not without their faults, and that the present changing world of managed care gives health care services a new opportunity for innovative program development. Using a case study method, he reviewed the impact of managed care on a well-regarded, regional behavioral health care delivery system, in which the accompanying necessary redesign of services resulted in a model of care more comprehensive of higher-quality and more fiscally viable than its predecessor.

Finally, Frank A. Ghinassi, Ph.D., Assistant Professor of Psychiatry at the University of Pittsburgh School of Medicine, focused on the use of medical necessity criteria as the basis of decision algorithms for both the initiation and the continuation of treatment. He examined a number of factors, including acuity scales, diagnostic information, individual history, risk variables, environmental stress, and HMO care management interventions.

The conference concluded with a panel discussion of a model for a well-run, ethical managed care system. Panelists included: Rosa Lynn Pinkus, Ph.D., James G. Gavin, Frank A. Ghinassi, Ph.D., Diane Holder, M.S.W., Philip G. Levendusky, Ph.D., John Lovelace, M.S., M.S.I.S., and Amy Dolan Strano, Esq. The panel also addressed questions from the audience and ended the day with a lively, controversial look at specific issues.

**Conradualations**

The CEP would like to extend its congratulations to Deborah Shtulman, who represented the Jewish Association on Aging during its membership in the CEP, on her new position as the Director of the South Hills Jewish Community Center. Deb greets the challenges and promises of her new position with characteristic enthusiasm, and we wish her the very best!

Congratulations to Libby Moore, of Sewickley Valley Hospital, who has completed her Doctorate of Health Care Ethics at Duquesne University this fall!

As always, we welcome comments, questions and suggestions from our readers. Please feel free to contact us!

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If you have suggestions or questions regarding the Consortium Ethics Program, wish to submit information for an upcoming edition of Community Ethics, or wish to receive this newsletter, contact Mark Aulisio, Ph.D., Consortium Ethics Program, 3708 Fifth Avenue, Suite 300, Pittsburgh, PA 15213, phone (412) 647-5734, FAX (412) 647-5877, e-mail <cep@pitt.edu>.
Adolescence, Medicine, and the Law: Dangerous Liaisons

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Introduction

Choderlos De Laclos charmed and captivated nineteenth century Parisian society with his provocative tale of the Marquise de Merteuil and Vicomte de Valmont, who were devoted to exploiting the susceptibilities of others for their own ends behind a facade of aristocratic elegance. This derisive alliance in Les Liaisons Dangereuses distorts reality through an exchange of correspondence that reveals only part of the story, deleteriously influencing the lives of others. Although the subject of adolescent patient care may not charm and captivate in the way of Choderlos De Laclos' imagination, it is, in its own right, a provocateur generating divisive issues and dangerous alliances due to presumptive decisional incapacity that falters when juxtaposed with factual studies, detrimentally impacts the physician-patient relationship, and perpetuates a legal facade that distorts adolescent autonomy for health care decision making. Inevitably, physicians proceed with uncertainty when caring for adolescent patients due to ethereal rules and erratic results, as when a 16-year-old is unable to decide her own medical treatment but capable of determining treatment for her infant child, or a 15-year-old is presumed unable to decide procreative issues but presumed competent to raise a child or consent to that child's adoption.

Decisional capacity is complex and multi-dimensional, eluding precise definition. At best, it is defined as ability to "perform a task," entailing an ability to understand information, deliberate about it, and make a decision. In contrast to adult patients, who are presumed decisionally capable, adolescent patients are presumed decisionally incapable; which is problematic for a host of reasons. First, exceptions to presumptive decisional incapacity for adolescent patients understandably confound health care practitioners, because these exceptions allow adolescent decision making for specific conditions (sexually transmittable disease, drug treatment) or in specific circumstances (emancipation). Because these exceptions lack the critical determinant of decisional capacity, contradictions abound, as when a 15-year-old adolescent may decide STD treatment but is unable to decide treatment for a complication concomitant to the STD. Second, presumptive decisional incapacity for adolescent patients contravenes social norms that are closely allied with governing law and trends in other legal arenas, including juvenile delinquency and family court, where adolescents are afforded decisional autonomy with accompanying responsibility and accountability. Indeed, the Pennsylvania Supreme Court has observed, in dictum, the anomaly of ignoring adolescent autonomy in health care while recognizing adolescent decisional ability to waive momentous constitutional rights in criminal proceedings or be held accountable for tortious activity. Third, a paucity of scientific and social science evidence legitimates presumptive decisional incapacity for adolescent patients. Conversely, mounting developmental research suggests that adolescents are decisionally capable. Unless legal policymakers are able to assert other important or compelling reasons for denying autonomous decision making for adolescent patients, the presumption of decisional incapacity potentially lacks even a rational basis, raising problems of constitutional proportion.

[D]ecis[ional incapacity] is damaging to adolescent self-image and the ongoing development of decision making ability, by inhibiting personal potential and entrenching a self-perception of powerlessness. Therefore, the state as parens patriae should protect adolescents as decision makers with legal recognition for adolescent rights and emphasis on adolescent decisional capacity.
If there is no evidentiary foundation to sustain presumptive decisional incapacity – which is disabling to rights recognition for adolescents, despite the United States Supreme Court's declaration that the federal Constitution is not for adults alone – then presumptive decisional incapacity for adolescent patients also arguably offends the concept of utilitarianism by not adding maximum good, and deontologically lacking requisite good will, especially if it is maintained due to impoverished attention toward adolescent autonomy or arbitrary attempts to disempower this segment of the populace. Lastly, and perhaps most significantly, the state as parens patriae has an interest in promoting the self-determination, self-esteem, and dignity of the emerging adult within the adolescent patient. Presumptive decisional incapacity is damaging to adolescent self-image and the ongoing development of decision making ability, by inhibiting personal potential and entrenching a self-perception of powerlessness. Therefore, the state as parens patriae should protect adolescents as decision makers with legal recognition for adolescent rights and emphasis on adolescent decisional capability.

In this article, I explore several reasons why presumptive decisional incapacity is a juggernaut in clinical practice, impeding ethical treatment of adolescent patients, and propose a concise approach to adolescent patient care that is supported by empirical evidence.

I. Adolescence and Clinical Practice

With regard to medical care, the patient role has evolved from 'doctor knows best' to 'I do,' except for adolescents who 'don't.' That adults have a legal right to be fully informed about the benefits, risks, and options for treatment and provide consent for their own care, competently and voluntarily, is axiomatic. However, minors (anyone under 18 years) are presumed incapable of decisional capacity by law and the consent of a parent or guardian is required, subject to statutory and regulatory exceptions including emergency, emancipation, treatment for sexually transmittable disease or drug/alcohol problems, mental health treatment, pregnancy, and contraception. These exceptions to presumptive de-cisional incapacity reflect situational social policy rather than decisional ability. For example, the STD exception is a relic of the 1960's when adolescents were thought the primary culprit of the spread of syphilis, gonorrhea, and the like. The public policy underlying this exception encourages adolescents to obtain treatment without the deterrent of having to inform a parent or guardian of sexual activity or if the adolescent is endangered by an abusive relationship at home. Inescapably, even this seemingly straightforward provision generates uncertainty among health care providers. Consider a 16-year-old adolescent who presents at the hospital with symptoms related to an STD. By law, physicians may provide treatment without contacting her parent or acquiring parental consent. A routine test given to the adolescent for STD detection, however, reveals an abnormality that may require a biopsy. Medical judgment is that the abnormality may likely be a result of the STD; there is, nonetheless, a possibility that it indicates a serious medical problem. Whether the physician should view this unexpected development and additional procedure that poses risk as an extension of the STD treatment, thereby allowing the adolescent's consent, or whether the physician should perceive the complication as a development outside the scope of the STD exception presents an ethical and legal conundrum. In this precise situation, a group of physicians shared with me anecdotally that they were split in their judgment how to proceed with the adolescent patient; of course, advice from Risk Management was to obtain parental consent, even though several physicians thought this course ethically inappropriate. Also problematic is the emancipation exception, which entails criteria that present interpretative quandaries for health care providers struggling to resolve with reasonable certainty whether an adolescent patient "has graduated from high school" or "has married" or "has been pregnant" and, therefore, may decide her own medical care. Such resolution, once again, lacks the crucial determinant of decisional capacity.

Several states, including Louisiana, permit mature adolescents the ability to decide medical care by statute, engrafting an age baseline of 14 or 15 and limiting adolescent decisional autonomy to choosing or consenting to treatment rather than refusing it. Although Pennsylvania does not recognize by statute or case law adolescent decisional autonomy for medical treatment generally, it does permit adolescents aged 14 or older to decide mental health treatment if an adolescent believes treatment is needed and "substantially under-stands the nature of voluntary treatment." Moreover, the 'mature minor doctrine' derived from common law is a misnomer. A doctrine is a rule of law established by a consensus of judicial decisions; however, several courts have simply ruled in specific situations that an adolescent patient presented to the court was either able or unable to choose or refuse medical treatment. Cardwell v. Bechtol explicates the point.
There, the Tennessee Supreme Court held that 17-year-old Sandra Cardwell, who never regained complete sensation of her lower extremities after consenting to treatment from a licensed osteopath for back pain, was a mature minor based upon evidence of Sandra’s age, ability, experience, education, and mature judgment. However, the state high court carefully circumscribed its ruling by not altering the general requirement of parental consent for an adolescent’s medical treatment, emphasizing that its finding Sandra Cardwell a mature minor “was by no means a general license to treat minors without parental consent and its application is dependent on the facts of each case.”

Cardwell is actually appurtenant in the genre of ‘mature minor’ cases, which usually focus on an adolescent’s refusal of treatment rather than consent to it. Nevertheless, an inadequate ad hoc approach prevails, as courts countenance decisions by concise circumstances, thereby providing scant guidance to health care practitioners who grapple with issues in adolescent patient care. Indeed, Matter of Rena, In re E.G., Application of Long Island Jewish Medical Center, and Novak v. Cobb County-Keenstone Hospital Authority aptly illustrate inconsistent analytical approaches accruing to the issue of adolescent patient refusal of treatment – namely whether a 17-year-old Jehovah’s Witness may refuse a blood transfusion – with varied results. Consequently, no consensus emerges that may legitimately constitute a ‘mature minor doctrine.’ Rather, the only consensus is that, like the courts themselves, practitioners are left to struggle with these issues on a case-by-case basis.

Exasperating this point is the reality that practitioners sometimes have difficulty even when operating under a clear legal consensus. For example, adult patient non-cooperation or noncompliance with physician recommendations may prompt a competency assessment, posing not only legal but ethical concerns. If Alexis Demos, Ernestine Gregory, Philip Malcolm or Greg Novak would have agreed to the blood transfusion on a misinformed basis, it is unlikely that the consent would have been challenged or even questioned. With adolescent patients, the temptation to treat in the absence of patient agreement may be especially acute and inapposite to self-determination, thereby disparaging the value of individual dignity at the heart of honoring the autonomous decision of any person, adult or adolescent.

Among issues attendant to adolescent end-of-life/palliative care are whether an adolescent patient may execute (or be encouraged to execute) an advance directive and whether it should (or ought to) be honored. Compounding the issue may be an adolescent’s designation of a surrogate, especially someone other than a parent or guardian, raising concerns about the appropriate decisional standard to be employed (substituted judgment or best interests) and the import of the surrogate designation to the decisional process. Pennsylvania, like most states, reserves execution of a written declaration for competent adults, though the Advance Directive for Health Care Act incorporates the high school graduation and marriage language from the emancipation statute, portending advance directive recognition for a minor. The policy underlying Pennsylvania’s law, embraced by federal enabling legislation – the Patient Self-Determination Act – would seem to imply respect for adolescent wishes when so doing would alleviate individual suffering, promote personal empowerment, and preserve dignity. The few courts that have addressed the issue of discontinuance of care for dying adolescents have utilized a composite of best interests and substituted judgment, according conclusive weight to the express wishes of the adolescent, as In re Swan, In re Crum, and In re Rosebush exemplify. And, as with adult patients, Do Not Resuscitate orders are an especial concern, similarly raising questions about adolescent initiation.

Another area of clinical practice involving adolescent decision making is medical experimentation, where contentious research questions converge with complexity of capacity. Particularly, the 1983 Department of Health and Human Services regulations, promulgated to guide minors’ participation in clinical trials, neither demarcate age nor distinguish adolescents from children, leaving to physicians and In-
Institutional Review Boards the arduous task of determining how adolescent decisional capacity impacts, if at all, regulatory requirements of parental consent/minor assent, minor increase over minimal risk, and adolescent altruism. Paradoxically, this lack of regulatory attention devoted to adolescent decisional autonomy exhibits a measure of lesser respect for research subjects that belies the spirit of the regulations and the historical atrocities to which consent requirements in research are aimed. That law and ethics bristle at nonconsensual medical experimentation is understandable, but bewildering is the barrier placed before adolescents who are capable of consenting to research. In addition to medical experimentation, medical treatment and end-of-life/palliative care are adolescent decisional issues concomitant to procreative practices, genetic testing, mental health treatment, transplantation, and rehabilitation.

II. Adolescence and Scientific Examination

The Supreme Court has observed, in the absence of supporting evidence, that adolescent inability for mature decision making justifies the legal presumption of decisional incapacity; in fact, this observation is distinctly at odds with scientific measurement of adolescent capability and empirical examination of professional perceptions and practices with adolescents. Specifically, study of adolescents suggests that they demonstrate a level of decisional capability comparable to young adults, who are afforded a full complement of decisional rights. Dr. Jean Piaget published research during the mid-twentieth century that explained a formal operational stage of thinking achieved by adolescence, allowing for deductive reasoning and abstract/hypothetical thinking. Although some contemporary theorists focus on task, rather than stage, dependency for cognitive development that varies among individuals, researchers extol the Piagetian model as a valuable contribution to understanding cognitive development, examining adolescent decisional capacity in various contexts including medical care, cancer treatment compliance, abortion, choice of health care providers, and custody determinations. Similarly, surveys of legal and mental health professionals involved in divorce proceedings suggest that adolescent decisions about custodial preference should be accorded great, if not dispositive, weight.

Within the medical treatment realm, I studied physicians specializing in pediatrics, family practice, and internal medicine to determine whether they believe adolescent (aged 14-17) patients are decisionally capable and practice accordingly. This study is among the first to examine physician perceptions of adolescent decisional capacity and practices with adolescent patients. Although an acknowledged limitation of the study is that it measures physician perceptions and practices, rather than adolescent decision making per se, it contributes a unique dimension to the literature related to adolescent decisional capacity. Physician knowledge, beliefs, and practices are valuable to learning about adolescent decisional ability, because physicians regularly interact with adolescents in intimate and inherently stressful circumstances, and provide extraordinary insight into understanding adolescent decisional capacity. In fact, 88.5 percent of the physicians in the study devote nearly half of their medical practice to caring for adolescent patients. Objectives for the study included determining: (1) whether physicians believe adolescent patients possess a level of decisional capacity not presumed by law; (2) whether physicians, who believe adolescent patients are decisionally capable, also approach medical practice with adolescent patients as if they are decisionally capable; and (3) whether physicians perceive that adolescent patients derive benefit from the presence of a trusted adult during the decisional process.

The study revealed that physicians treat adolescent patients as possessing a level of decisional capacity not presumed by law, underscoring empirical findings with adolescent samples regarding health care decision making. Specifically, the majority of physicians (>50 percent) in the study reported that adolescent patients understand informa-
The majority of physicians emphasized respect for adolescent patient confidences, as 92% honor the confidentiality of conversations with adolescent patients and indicated the importance of securing an adolescent’s trust.

The data also revealed internal consistency between physician beliefs toward adolescent decisional capacity and their practices with adolescent patients, as the majority of physicians involve adolescent patients in the informed consent process without a parent or guardian. Indeed, three-fourths of the physicians surveyed involve a parent or guardian only with the express consent of the adolescent patient, except in limited circumstances where a particular adolescent’s emotional or psychological state presents potential harm. An important finding emerged related to specialty groups. Tests to determine statistically significant differences revealed that pediatricians tend to rely on their own judgment for assessing adolescent patient decisional ability and for honoring adolescent patient wishes, in contrast to family practitioners and internists who indicate a strong reliance on legal and institutional guidance. A possible explanation for this finding may be extensive training, experience, and comfortability with young patients accompanying pediatrics, signaling inter alia both the need and desirability for education particularized to adolescent patient care in other primary care specialties.

Moreover, the majority of physicians emphasized respect for adolescent patient confidences, as 92.0 percent honor the confidentiality of conversations with adolescent patients and indicated the importance of securing an adolescent’s trust. This finding corresponds with results of a study published in the Journal of the American Medical Association, wherein researchers found that confidentiality was prevalent among factors that influence adolescents when both accessing and assessing health care providers. Of particular note, two-thirds of physicians surveyed honor adolescent decisions regarding non-life-threatening conditions, despite objection by a parent or guardian, which is consistent with previous findings that there is a quality and intentionality in adolescent decision making about medical decisions that physicians recognize and respect.

Remarkably, two-thirds of physicians also revealed that they rarely, if ever, honor an adolescent’s refusal of treatment for a life-threatening condition. One reason for the discrepancy may be due to the nature of medical practice, i.e., seldom treating adolescents suffering with life-threatening conditions. Physicians also reported that rarely, if ever, have they been challenged when honoring an adolescent’s decision to choose or refuse medical treatment.

Additionally, a majority of physicians in this study indicated that adolescents demonstrate an ability to determine their own interests, an important finding that contrasts with the long-standing societal and legal supposition that adolescents are incapable of doing so. Somewhat surprising was that physicians largely agreed that adolescents exhibit a stable set of values in the medical decision making process, yet are not especially poised to make the decision in the absence of consultation. Essentially, the same may be said about adult patients, especially when decisions conflict with physician recommendations. However, uncooperative patients may not necessarily be incompetent, no matter whether adult or adolescent.

Other variables, such as emotional stability, were examined. Nearly half of the physicians in the study view adolescent patients as demonstrating emotional stability during the informed consent process, coinciding with published research that moodiness, though more prevalent in adolescence, is not measurably different between adolescents and young adults in its impact on quality of decision making. It is also fair to say that, although stress and fluctuating hormones lend to variable emotional states in adolescents, adults are equally affected by and susceptible to emotional instability.
of moods, while maintaining decisional competency. Further, results from the study regarding adolescent temerity comport with research from the Cornell University Medical Center, as only one-third of physicians surveyed view adolescent patients as greater risk-takers than young adults, which had been hypothesized. However, additional research on how adolescents perceive risk in treatment settings is necessary to better understand the developmental impact of risk-taking factors on adolescent judgment and decision making. Another hypothesis proven was that physicians perceive adolescent patients do not resist external influences, although the questionnaire did not measure quality or quantity of external influences—only whether adolescent patients are especially prone to them. That 92.5 percent of physicians perceive adolescent susceptibility to influence may be no more than the influence by others on adult patients. Indeed, as another researcher has found, adolescents appear "comparable to young adults in response to parental influence in medical treatment situations," suggesting that adolescents "should not be excluded from making treatment decisions on the presumption that they lack the requisite capacity for volition."15

Beyond the results, findings gleaned from this study assist in framing future research about adolescent decisional capacity, including a threshold issue about salient criteria suitable for measuring adolescent decisional ability. Criteria employed in this study were drawn from adult competency evaluations;16 although a valid inclusion, these factors may be insufficient for thorough understanding of adolescent decisional ability. Variables used in this study also merit independent examination, including the nature and extent to which culture and environment shape physician protocol in practice and impact attitude toward adolescent decision making and confidentiality, along with heuristics that may bias physician judgment. Additionally, that most physicians believed they are ethically encouraged to involve adolescent patients in decision making but perhaps not ethically bound to do so raises a question about ethical guidelines (and social norms) that segue into governing law.

Conclusion

Empirical evidence of adolescent decisional capacity, coupled with ethical and legal emphasis on individual autonomy, supports a qualified decisional capacity model for adolescent patients in health care. A qualified decisional capacity model would allow adolescent decision making, subject to attending physician assessment that a particular adolescent has diminished capacity. Alternatively, because decisional capacity seems to defy a single construct,17 perhaps no presumption with adolescent patients should operate and attending physicians should determine the decisional capability of their adolescent patients, documenting the determination in the medical record. Notably, a majority of physicians in the study indicated that the law should defer to their judgment concerning adolescent decisional capability. Despite the absence of Pennsylvania legislative or judicial pronouncement related to adolescent patient decisional capacity, health care facilities may be encouraged to include guidelines in their institutional policies for physicians treating adolescent patients, addressing adolescent decision making capability, both substantively and procedurally. Not only are physicians seldom questioned in their judgment regarding adolescent decision making for medical treatment, according to physicians in this study and the dearth of reported cases, but the Pennsylvania Supreme Court's reasoning in In re Fiori18 provides support for deference to medical judgment—and to ethical consults and committees—for resolving issues regarding patient decision making. The state high court wisely conceded that judges are not the only (nor most appropriate) resource for resolving private decisional issues attendant to health care, and it seems equally plausible that judges will continue to defer to medical and institutional expertise for determining patient decisional capacity.

Moreover, a qualified decisional model or attending physician assessment of patient decisional capacity would not negate valuable adult guidance in the adolescent decisional process. Not surprisingly, a majority of physicians (84.3 percent) in the survey agreed on the importance of a trusted adult in an adolescent's decisional process about medical care, with 88.5 percent encouraging adult consultation for adolescent patients. Who should fulfill the role of a trusted adult, and how a trusted adult is chosen and involved in the adolescent patient's decisional process are issues warranting closer scrutiny. While it may be reasonably inferred from these findings that physicians believe they could serve as trusted adult counsel for adolescent patients during the decision making process, other researchers have found that adolescents do not regard their physicians as someone to whom they may turn for guidance and advice,19 meriting more careful consideration and clarification of the physician-adolescent patient relationship. Physicians added the caveat by written comments that parent or guardian involvement is desirable only if sup-
portive, caring, and understanding. Otherwise, according to physicians, such involvement may be harmful to adolescent patients, reflecting to some extent critical assumptions regarding family relationships that remain untested by empirical study, including coercion, manipulation, persuasion, and deference within a family dynamic.

Furthermore, legal recognition of adolescent autonomy in health care would enhance individual responsibility, accountability, and maturity in decision making, enabling meaningful development of adolescent self-esteem and dignity. It would also provide a measure of protection for health care providers who are ethically inclined to honor adolescent patient wishes. Ultimately, legal guidance for adolescent patient care should foster ethical concepts in the patient-physician relationship and provide definitive direction and, accordingly, assuage concerns that adolescence, medicine, and law constitute les liaisons dangereuses.

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Dr. Hartman's article entitled, "Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices," which analyzes the results of her study and its implications for legal policy and medical practice, has been selected for 2001 publication by the University of Chicago.

Notes


5. 50 P.S. Section 7201 (Supp. 2000).

6. 724 S.W.2d 739, 748-49 (Tenn. 1987).

7. See, e.g., In Matter of Rena, 705 N.E.2d 1155 (Mass. Appeals Court 1999); In re E.G., 549 N.E.2d 322 (Illinois Supreme Court 1989); Application of Long Island Jewish Medical Center, 557 N.Y.S.2d 239 (N.Y. Supreme Court 1990); Novak v. Cobb County-Keenstone Hospital Authority, 849 F.Supp. 1559 (N.D. Georgia 1994).

8. 569 A.2d 1202 (Maine Supreme Court 1990); 580 N.E.2d 876 (Ohio Probate Court 1991); 491 N.W.2d 633 (Michigan Court of Appeals 1992).

9. Part 97, Protection of Human Subjects, subpart D Additional Protec-


I shall assume that children have a complex set of moral rights (both liberties and entitlements) to protect them from harm and to promote their development and well being. These rights are claimable not only against their parents, but, when necessary, against society of well. This assumption, however, is not inconsistent with the view that children should not be considered morally autonomous agents and thus should not be empowered to make significant decisions (e.g. medical treatment) for themselves.

Whatever "it" is which qualifies one to be an "agent" and thereby to make decisions for oneself, the normal presumption is that adults have "it" and children do not. So unlike competent adults, children may be treated paternalistically so as to promote their welfare according to a best interest standard. What is "it"? The ability to give "informed consent"? The ability to make "autonomous choices"? These hinge on the psychological development of cognitive and volitional capabilities (such as empirical comprehension, operational thinking, appreciation of consequences, hypothesizing alternatives, assessment of benefits and burdens, and volitional fortitude in selection and implementation). This psychological capacity would seem to be a necessary condition for ascribing agency and decision making capacity. But is it sufficient? It seems that middle adolescents (at least from 15 years) have acquired these capacities; yet they are currently excluded from decision making. If this capacity sense of autonomy is all that is required, then consistency and fairness would dictate lowering the age of consent.

A moral version of this capability argument can be constructed on Kantian grounds. For Kant the only thing of intrinsic value is the moral agency capacity of human beings. So to act autonomously is to be self-determining in the sense of exercising one's ability to be a moral agent and to prescribe moral rules that would bind all rational agents. Whenever children outgrow their egoistic and narcissistic phases and reach the point in their development when they have autonomy capacity, they become capable of willing not only heteronomously (willing some act as a means to acquire a desired good), but also autonomously (willing it because it is right). Once they acquire this autonomy capacity, they should be treated as full moral agents who are responsible for their actions and choices. It is not the content of the choice that matters; it is rather the act of choosing and the moral willing of this choice as universal that matters. So once an adolescent has the capacity to will autonomously, others should treat that person as a responsible agent. If most 15 to 17 year olds have it, then it is a violation of their autonomy to fail to respect their decisions. Of course, it is not clear when this capacity is acquired. Although some moral development theorists might place it well beyond the middle adolescent period, I think this area needs...
more empirical study (especially since there is a disturbing trend in criminal law to lower the age of responsibility for violent crimes and prosecute middle adolescents as if they were adults).

But perhaps the "it" which middle adolescents lack is not any form of capacity at all, but simply sufficient \textit{moral understanding}. Even though they have developed the capacity to make judgements, even to autonomously will, they do not always make good decisions. They are more likely to make judgments that do not promote their best interests, are not universalizable, and are not compatible with the choices they would make when they become adults. They lack sophisticated understanding of the subtleties of value conflicts and the appropriate priorities and rankings of those values. They lack the moral understanding necessary for truly autonomous decision making. Until one can appropriately decide and act for oneself, one needs the counsel and guidance of mature others whose judgements should prevail. Thus (in the absence of qualified parental authority) some type of "best interest" standard reinforced by a "reasonable (adult) person" standard should be used to justify overriding unwise adolescent choices, especially those which entail significant life-threatening or future-altering consequences. This defense works best within the "well being" moral tradition (whether of the classic utilitarian version or the Aristotelian version) which assumes that some moral values (e.g. the goal of happiness or human flourishing) are universal, can be known through rationally inquiry by those with sufficient moral education, and can be adopted as guides to living by those with sufficient moral maturity. Once this understanding is attained, exercising autonomous decision making is an efficient and effective means of promoting one's well being.

But at what age is this understanding attained? Once again, this should be decided by empirical research to determine if the majority of middle adolescents have achieved this understanding. I doubt that they have. And I think it safe to presume that being 18 years of age or older will not in itself grant this understanding. So it would be more reasonable to ignore age altogether and to assess each person's "moral understanding" capacity before granting them decision making power. However, this would present substantial problems for medical practice. This approach normalizes specific moral content (e.g. acting to promote one's own well being) and would thus seem to justify extensive medical paternalism dictating that even adult choices be overridden when they do not promote welfare according to a "best interest" or a "reasonable person" standard (e.g. refusing blood transfusions). So although this path may justify denying decision making power to middle adolescents, it may also serve to deny that power to many adults who are clearly legally competent to give informed consent.

The current dominant approach to the issue of adult decision making avoids "objective moral content" altogether. To be considered capable of making autonomous choices, one (in addition to cognitive and volitional capability) must have a set of values (an awareness of one's preferences, interests, goals, conception of the good, and over all life plan) upon which one can base deliberations and thus make autonomous choices. We respect persons' autonomy when we respect their choices made on the basis of their own set of values—whatever these may be. Their values are not to be assessed on any outside standard, neither "best interest" nor "reasonable person" nor "universalizability." What "it" is, then, which 15 to 17 year olds lack, must be a \textit{set of moral values} from which to deliberate and decide.

But of course, middle adolescents do have sets of values and can (presuming cognitive and volitional capacity) deliberate and act on them. So there must be more to it than that. Is it that their values are not really their own? Are their values just a hodge-podge collection accumulated by osmosis from peers and parents, schools and religions, television and radio? To be their "own" must these values be identified and consciously affirmed? If so, then how are middle adolescents any different from others who may be in need of "values clarification" before they can clearly articulate their "own" values? Unless it can be empirically shown that in the process of val-
Is it not the case that virtually every “phase of life” can be characterized as having age specific characteristics that shape value choices? If so, then there would be normal “instability” in everyone’s set of values as they pass through the various phases of life from child to elderly.

Values acquisition, the affirmative “ownership” of values can not occur until around 18 years, this criteria should not serve to exclude middle adolescents from decision making. Similarly, some could object that middle adolescents’ value sets are “incomplete” (that is, not all value preferences and goals have been identified, nor a coherent conception of the good, nor a feasible life plan), so their choices should not be respected. But this is to set the bar too high, for clearly many adults well into their mature years have yet to develop such a complete value set in this enriched sense.

Perhaps they lack a “stable set of values;” the set may be incoherent, inconsistent, and subject to frequent alteration. Once again, this might also apply to many adults, especially if “stability” dictates that there be no change whatsoever. For many adolescents, the preservation of such age-specific values as concern for bodily image, peer acceptance, independence from parents, or concern with spiritual issues, can be quite stable. We might be tempted to say that such values are undesirable (by what criterion?), but they certainly can not be automatically characterized as unstable. Or we might say that these values will be outgrown, since adolescence is just a “phase in life,” with various distinctive personality characteristics which influence value choices (such as less risk adverse and risk perceptive, a tendency to overly discount future consequences, a tendency to see things as either black or white, a sense of invulnerability, a proneness to hasty judgments based on feelings). If this were just a phase, then the values of adolescents would be more prone to alteration and thus would be less stable than the value sets of older persons. But is this true?

Is it not the case that virtually every “phase of life” can be characterized as having age specific characteristics that shape value choices? If so, then there would be normal “instability” in everyone’s set of values as they pass through the various phases of life from child to elderly. Why are those values that are distinctive to adolescents treated differently from those of young adults or mature “prime-of-lifers”? Different phases of life with different concomitant values naturally lead to different choices. Why should the choices based on the values of one phase be given priority over others? This nebulous “set of stable moral values” criterion turns out not to be a very helpful candidate for whatever “it” is which excludes middle adolescents from decision making.

The temptation here is to say that middle adolescents simply have the wrong values—they are inauthentic, immature, unreasonable, shortsighted, or misguided values and so can be discounted. But to do this is to resort back to the “moral understanding” approach and to illicitly appeal to some substantial norm (such as reasonableness). But this moral understanding approach, as we saw, carries substantial implications of revived paternalism.

So the conclusion of these deliberations is that if a return to moral paternalism is not desired, and if there is currently no accurate way to determine when “autonomy capacity” has been attained, then consistency and fairness require that the group of legitimate decision makers include all those who have attained the cognitive and volitional capacity to deliberate and act on a set of values. And this includes middle adolescents.