Competence for Minors in Medical Decision-Making: A Life-Stage Approach[1]

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1. Introduction

The central function of patient competence (or capacity) determinations is to settle whose medical decisions have final authority. On the standard view, we may paternalistically override a patient's decision only when he is incompetent to make his own choice.[2] Historically, adults have been presumed competent unless shown otherwise, whereas those under the age of medical consent were deemed incompetent as a matter of status. However, many jurisdictions now hold that some minors are mature enough to make their own decisions.[3] But should we, then, think about the competence of adults and minors in the same way? The usual assumption is that there is, indeed, a single standard for judging competence, whatever the subject's age. I will make the contrary case, that adults and minors should be held to different standards. Part of the difficulty, here, is that we are not always clear on the nature of adult competence either. I believe adults

[1] I wish to express my thanks to the organizers and participants of the Children's Consent conference at the University of Oxford on March 21-22, 2019, an audience at the Bioethics Grand Rounds of SickKids Hospital in Toronto on April 21, 2022, and the comments of James Anderson, Dave Langlois, and an anonymous reviewer for this volume.

[2] Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision-Making* (Cambridge: Cambridge University Press, 1989), p. 27.

[3] Seminal "mature-minor doctrine" cases in English, American, and Canadian law include: *Gillick v West Norfolk and Wisbech Area Health Authority* (1985) 2 WLR 830 (HL); *In re E.G.* (1989) 549 N.E.2d 322; *A.C. v. Manitoba* (2009) 2 S.C.R. 181.

are entitled to a *robust* right to autonomy. As long as they have the ability to make a reasonable decision with access to all the available information, adults have the right to make their own choice, even if the decision they ultimately reach is unreasonable, as judged by their own values and convictions. By contrast, I think we should only defer to a questionable or risky decision of an adolescent if it is sensible in light of what is important to her, in spite of the fact that she has the abilities an adult would need to lay claim to the more robust right of autonomy. Taking this more protective stance toward the young is justified, I think, because we can fairly conceive of adolescence as a time-limited probationary stage of life during which we are protecting young people from serious mistakes, while at the same time recognizing that, if an important decision cannot be postponed, then it ought to be made in light of what she—not what someone else—cares about. Although this view is not commonly articulated, I think it actually accounts for some strands of our practice better than the more familiar alternatives.

I will proceed as follows. After sorting out some different senses of the word "competence" (§2), I distinguish two broad conceptions: one that appeals to the subjective reasonableness of the decision, the other that appeals to the possession of abilities requisite for making a subjectively reasonable decision (§3). When it comes to adults, I argue that the abilities-based view is superior (§4), but that most of us are more protective of adolescents (§5). I then explain why it is justifiable to employ the more restrictive reasonable-decision-based standard when we are dealing with minors (§6).

2. Meanings of Competence

According to conventional wisdom, it is important to respect the patient's decision about her own medical care, but not when the patient is—to put it vaguely—acting seriously irrationally or in significant ignorance. For example, a patient suffering from ICU delirium might insist he needs to go to the office, or an Alzheimer's patient might refuse medication which he doesn't remember needing. We don't think we should defer to such "choices." But in what sense must a decision be irrational to justify overriding it. What if a patient refuses a needed injection simply out of an aversion to needles? In outline, there is broad agreement on the relevant principle: *a decision about a proposed treatment is authoritative when it is voluntary, informed, and made*

by a competent patient. Things get controversial, however, once we try to fill this principle out in detail. Here our focus will just be on one part of that principle, the nature of competence.

Before considering different accounts, we should sort out some of the different meanings of the word. In general, "competence" refers to an ability to do something.[4] Often, in law and ethics, we are concerned with a person's epistemic or deliberative abilities. If Brown is competent to testify as an expert on structure fires, then he has the relevant knowledge to offer an informed opinion on such matters. But "competence" can also refer to the subject's *authority* to exercise a legal or normative power. If I insist that Green's court was not competent to hear my case, I am saying that the court lacks jurisdiction, not casting aspersions on the personal abilities of the judge. This second sense can refer to the authority of individuals as well—e.g., "It was within his competence to say that he would not appoint a new trustee."[5] In some countries, the law prefers the word "capacity" to "competence," and the same ambiguity is even *more* prominent here. A "capacity" can quite naturally refer to a person's natural ability to do something (e.g., "he has little capacity for thinking through problems of any complexity") or to an individual's authority to exercise certain legal powers (e.g., "I was acting in my capacity as executor of my father's will").[6]

Let's call the first of these meanings the *natural-abilities sense* (or competence$_A$) and the second the *legal-power sense* (or competence$_P$).[7] The kind of competence$_P$ relevant to our subject is patient "decisional authority": roughly, the formal power to give, withhold, and/or rescind consent to medical treatment.[8] As Dan Brock and Allen Buchanan put it, when a patient has decision-making authority, his decisions "must be respected by others and accepted as binding," whereas the decisions of patients without this authority may be set aside, and the final decision made for them by a surrogate on the basis of the patient's best interests.[9]

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[4] "Competence" in *Black's Law Dictionary* (St. Paul, MN: Thomson Reuters, 2014).

[5] "Competence" in *The Oxford English Dictionary Online*. September 2021. Oxford University Press. http://www.oed.com/viewdictionaryentry/Entry/11125 (accessed October 01, 2021).

[6] See the entries on "capacity" in the *OED* and *Black's Law Dictionary.*

[7] I shall focus on legal powers, but we could also consider non-legal, normative powers more generally.

[8] Dan W. Brock, "Decisionmaking Competence and Risk," *Bioethics* 5:2 (1992): 105-112, p. 105.

[9] Buchanan and Brock, *Deciding for Others,* p. 27.

Regrettably, it is common for usage to slide between competence$_A$ and competence$_P$, but I think the distinction is generally familiar. There is, however, a third meaning of the word that is not well understood, even though it is actually key to the philosophical debate. To bring this third meaning into resolution, let us ask what connection there might be between competence$_A$ and competence$_P$. A common thought is that competence$_A$ *grounds* competence$_P$. That is, it is in virtue of having the relevant natural psychological abilities to a sufficient degree that one properly has the legal power to make one's own medical decision. This is a plausible view, but not an analytic truth. Something other than the possession of certain natural abilities might ground decisional authority. For example, in an influential early essay, Roth, Meisel and Lidz canvas five possible standards of competence: (a) making a choice, (b) making an objectively "reasonable" choice, (c) making a choice based on "rational" reasons, (d) the ability to understand the relevant factors relating to making a choice, and (e) actual understanding of those factors.[10] Of these, only (d) represents a genuine ability. The others involve actual performance of the decision-making task in a particular way (or the performance of some preliminary to that task). They are not formal conceptions of authority or competence$_P$ either. What, then, are they conceptions of? Like (d), they identify facts about the decision-maker or his decision that purport to *ground* decision-making authority (competence$_P$). When philosophers offer accounts of competence, this is generally what they are talking about. So, let us call this "competence in the power-grounding sense" (or competence$_G$).

3. Two Conceptions of Competence

Our quarry is an account of the facts that ground decision-making authority (competence$_G$). Before we consider the *ability* to make a decision, however, let's consider, first, the paradigm case of patient decision-making, which goes something like this: The doctor explains to the patient the diagnosis, the symptoms he can expect, the prognosis without treatment, and the possible interventions along with their benefits, chances of success, and possible complications or side effects. The patient then takes that information and decides, often in dialogue with his

[10] Loren H. Roth, Alan Meisel, and Charles W. Lidz, "Tests of Competency to Treatment," *American Journal of Psychiatry* 134 (1977), 279-284.

medical team and loved ones, which option is best for him given his values and plans. If the patient is initially unsure what is important to him in this situation, his deliberation may need to involve deeper reflection on the nature of his values, which may also involve conversation with others. When the patient reaches a decision made in light of the relevant available information, and that follows reasonably well from his values, then we may say that he has made an *autonomous decision*.

This ideal of the autonomous decision is often presented as the ultimate aim of the shared decision-making process between doctor and patient.[11] Now, competence determinations also seem to have something to do with respecting or promoting the patient's autonomy. But what exactly is the connection? Let's focus on just two possible views.

One says that a patient is competent$_G$ so long as his choice is reasonably autonomous in the above sense. On this *decision-based* conception, competence is undermined when something goes seriously wrong with the patient's actual decision-making process: the patient makes a significant mistake in reasoning, refuses to accept the plain facts, is swayed by some errant passion, or otherwise comes to a conclusion that is deeply at odds with his own values. Competence, therefore, is tied to subjective rationality. Though competence$_A$ is a precondition for competence$_G$, the latter does not consist in the former.

An alternative position is that the patient is competent$_G$ so long as he is *capable* of making an autonomous decision in the above sense, even if his ultimate decision is not at all consistent with what is important to him. What matters, therefore, is not the character of the actual decision, but certain properties of the decision-maker at the time of the decision, namely, that he possesses, to a sufficient degree, the epistemic and deliberative abilities for understanding and appreciating the information relevant to the decision,[12] for effectively comparing the pros and cons of different courses of action, for evaluating those options in the light of one's enduring

[11] See, for example, Terrence F. Ackerman, "Why Doctors Should Intervene," *The Hastings Center Report* 12:4 (1981): 14-17; Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), esp. ch. 7; Dan W. Brock, "The Ideal of Shared Decision-Making," in his *Life and Death: Philosophical Essays in Biomedical Ethics* (Cambridge: Cambridge University Press, 1993).

[12] Thus, the abilities-based model, while not decision-*based*, remains decision-*relative*.

values, for resisting contrary inclinations, and so on. One needs to possess these abilities, furthermore, *at the time of the decision*; it is not enough to possess them most of the time.[13] On this approach, then, competence$_G$ *does* consist in competence$_A$.

You might suppose that the ordinary, commonsense understanding of what grounds decision-making authority is, as the second view says, the possession of certain natural abilities.[14] But when we turn to what is easily the most thorough and influential account of patient competence in the philosophical literature—that found in Buchanan and Brock's *Deciding for Others*—we get a different picture. Buchanan and Brock do, indeed, gloss competence as "decision-making capacity," and they outline certain "capacities needed for competence," which include the kinds of abilities for understanding, deliberation, and decision that I mentioned above.[15] But these capacities, they observe, are possessed and exercised by degrees, and when they finally come to articulating the criterion for assessing competence, they say that what matters is the quality of the "decision-making process" itself:

> The evaluation of the patient's decision making will seek to assess how well the patient has understood the nature of the proposed treatment and any significant alternatives, the expected benefits and risks and the likelihood of each, the reason for the recommendation, and then whether the patient *has made a choice that reasonably conforms to his or her underlying aims and values*.[16]

In fact, at least when the choice seems questionable from a medical point of view, Buchanan and Brock hold that, for a patient to make a competent decision, there should be "no significant mistakes in the patient's reasoning and decision making" and that the decision should be

[13] I assume we can make sense of the idea that people sometimes fail to make reasonable decisions they were capable of making. If, as skeptics allege, no satisfactory analysis is available of this ability to do otherwise, then that is an objection to this model.

[14] Eric Vogelstein says this is the orthodox view (which he rejects). I think most writers *say* that competence is about possessing abilities, but if you look closely, their accounts are not always truly abilities based. See Vogelstein, "Competence and Ability," *Bioethics* 28 (2014): 235-244.

[15] Buchanan and Brock, *Deciding for Others,* pp. 18, 23-25.

[16] Buchanan and Brock, *Deciding for Others*, p. 56. Emphasis added.

"reasonably related to the patient's interests" as defined by his own values.[17] This, then, is a decision-based, not an abilities-based, account of the facts that ground decision-making authority.[18]

These two conceptions of competence seem rooted in concern for two different values—both of which often travel under the name of "autonomy." Daniel Brudney and John Lantos distinguish these, dubbing them "authenticity" and "agency."[19] Whereas *authenticity* is the value of choosing in a way that expresses or conforms to one's enduring values, *agency* is the value of being able to make one's own choice, to exercise one's will, especially over one's own life and affairs. The decision-based conception appears closely related to the value of authenticity. As Buchanan and Brock put it, "The interest in self-determination … is people's interest in making important decisions about their lives for themselves according to their own values and aims."[20] Thus, we deem a person incompetent when his choice is seriously disconnected from those attitudes that ought to govern his behavior. The connection between authenticity and the abilities-based model is looser. People with the requisite abilities do ordinarily make important decisions in line with their values. But, as the phenomena of weakness of will and recklessness indicate, it is possible to err. It is, therefore, the exercise of agency that seems more directly protected by the abilities-based view. The point of competence determinations, so understood, is to ensure that a person's choice is appropriately connected to her agency, that it is genuinely her decision, that she bears direct responsibility for it, even if it runs contrary to her values.[21] A person's decision is her own, in this sense, only if making a subjectively reasonable decision was realistically within her power. Such a person, we may say, has the necessary abilities for accountable agency in this context. By contrast, if we say that a person was incompetent, we

[17] Buchanan and Brock, *Deciding for Others*, p. 54.

[18] In other writing, Brock does seem to assume an abilities-based model. See Brock and Steven A. Wartman, "When Competent Patients Make Irrational Decisions," in Brock, *Life and Death*.

[19] Daniel Brudney and John Lantos, "Agency and Authenticity: Which Value Grounds Patient Choice," *Theoretical Medicine and Bioethics* 32 (2011): 217-227. See also David Enoch, "Hypothetical Consent and the Value(s) of Autonomy," *Ethics* 128 (2017): 6-36.

[20] Buchanan and Brock, *Deciding for Others,* 229.

[21] Carl Elliott, "Competence as Accountability," *Journal of Clinical Ethics* 2:3 (1991): 167-177.

mean the choice was determined by internal factors that either prevented the agent from enjoying a real opportunity to be guided by his standing values *or* that prevented him from applying his values in light of the available relevant information.[22] In such cases, the agent does not seem directly responsible or accountable for his choice;[23] thus, it would be a mistake for anyone to fault him for making a *bad* decision, since it wasn't really his decision at all.

Appreciating the connection between competence and concepts like control and accountability permits us to be more precise about when a patient can be said to lack the ability to make his own decision. What matters is not whether there were factors that influenced the person to decide in an irrational way (there always are), but whether those factors were significant enough to deprive the person of a fair or reasonable opportunity to make an autonomous decision. If a person is procrastinating a needed operation out of an ordinary aversion to surgery, we probably wouldn't regard that as a responsibility-excusing incapacity. But if the aversion was powerful enough, perhaps rooted in past trauma, then we might. Likewise, it is not just any refusal to accept the facts that vitiates competence. There may be cases of pathological denial where we think the patient cannot be held responsible for ignoring the truth. But often people just refuse to accept what they are told on good authority and instead believe what they wish were true. Typically, we do not consider that a symptom of an incapacity, but as the manifestation of an epistemic vice for which they bear responsibility.[24]

4. Adult Competence: The Case for the Abilities-Based View

Which account of competence$_G$ should we prefer? Consider, first, just the case of adults. It seems that, to decide this, we need to reflect on how much we care about authenticity and agency.

[22] A person might be prevented from exercising accountable agency by certain external factors as well—like coercion or lack of access to information. The abilities constituting competence only comprise the internal conditions necessary for exercising accountable agency.

[23] If I get so inebriated that I cannot think clearly, then I am still *indirectly* responsible for whatever decision I make, even if I couldn't have decided reasonably at the time. I cannot explore the matter here, but competence seems related to our direct, not our indirect, responsibility for a decision.

[24] On epistemic vices and our responsibility for them, see Quassim Cassam, *Vices of the Mind*: *From the Intellectual to the Political* (Oxford: Oxford University Press, 2019).

Little need be said to motivate the importance of authenticity. Most of us do think there's something good about a person's life bearing the imprint of his projects and concerns. Indeed, when we mourn someone's passing, we often find it consoling to reflect on the ways that his life was successfully shaped by his passions and convictions, even when they are rather different than our own.

But the value of agency might seem more puzzling. What is so good about the bare fact of choosing?[25] After all, if I make a bad decision, it seems all the worse to regard it as an "unforced error." I would suggest that the chief importance of agency lies, not in its teleological "goodness," but in its deontological significance. That is, it is plausible to think that a part of respecting others as moral equals consists in recognizing each person's final authority over his own life, at least insofar as the interests of others are not immediately concerned. The moral importance of respecting this authority might be understood in different ways, but I think of it as bound up with the broadly Kantian notion that we should interact with others as reasoning agents in a relation of basic practical equality.[26] On this view, we do not have license to interfere with another person's choices simply because we might make better choices, even as judged by her own standards. Rather, we can only interfere when we cannot sufficiently attribute the choice to the person's agency—it was not really *her choice* at all.[27]

I think both values are important. But I submit that the best way of doing justice to each in the medical context is to adopt the abilities-based conception of competence. Here is why. To respect a person's agency is to recognize her as having content-independent authority over a decision.[28] As long as the choice has the right formal character – viz., that it was made by a person with the present ability to make an informed choice in line with his values – then we ought to

[25] Brudney and Lantos, for example, don't think agency is so valuable.

[26] Garrett Cullity, *Concern, Respect, and Cooperation* (Oxford: Oxford University Press, 2018), ch. 2. See also Stephen Darwall, *The Second-Person Stance* (Cambridge, MA: Harvard University Press, 2006) and Arthur Ripstein, *Freedom and Force: Kant's Legal and Political Philosophy* (Cambridge, MA: Harvard University Press, 2009).

[27] This resembles Joel Feinberg's "soft paternalism," though I place more importance on the individual's possession of the requisite abilities rather than on the voluntariness of the choice. See Feinberg, *Harm to Self* (New York: Oxford University Press, 1986), p. 12.

[28] On authority and content-independent reasons, see Joseph Raz, *The Morality of Freedom* (Oxford: Oxford University Press, 1986), ch. 2.

defer to the choice regardless of whether it seems like a sensible decision.[29] Let's call this "robust authority," in that it doesn't depend on the content of the decision.[30] The decision-based model, however, does employ a content-based test in asking whether the patient's choice is reasonably consistent with her own values.[31] Therefore, if we follow this approach, there's no room to protect agency.

Agency *is* protected, of course, if we adopt the abilities-based view. But this doesn't mean we have to neglect the value of authenticity; there are other ways of recognizing it. As I've indicated, an essential aim of the doctor-patient-shared-decision-making process is that of helping the patient make a decision that is right for her, given what she deems most important. Suppose that a patient is inclined to make a choice that will frustrate her most deeply held plans, perhaps because she is swayed by wishful thinking. Just because the patient is competent on the abilities-based view doesn't mean that the doctor ought to immediately abandon the patient to her irrationality and wash his hands of the matter. On the contrary, this would be a suitable occasion for the doctor to try to find a way of reaching the patient and encouraging her to reconsider her decision. For example, it might help if a trusted family member were brought into the conversation. The doctor *should* "intervene" in such a case; it is just that he should not override her final decision. In this way, we can give each value its due.

An example that, I think, supports the intuitions behind the abilities-based conception is the tragic case of Apple founder and former CEO Steve Jobs. In 2003, Jobs was diagnosed with a rare but often curable form of pancreatic cancer. Doctors recommended immediate surgery, but Jobs refused, disliking the idea of his body being "opened." According to his biographer, Walter

[29] Though doctors should not perform medically inappropriate treatments just because patients want them.

[30] This resembles "treating someone's will as decisive" in Daniel Groll, "Paternalism, Respect, and the Will," *Ethics* 122:4 (2011): 692-720.

[31] An anonymous reviewer has pointed out to me that a decision-based model could still recognize the patient's content-independent authority, as long as it only required that the decision was the outcome of the proper process and did not require (pace Buchanan and Brock) that the decision be in line with the patient's values. For instance, it might require that the patient actually understand his options and have given them consideration in consultation with the doctor. Although I am inclined to reject this view as well, what is most important to me is the distinction between views that require the decisions be authentic versus those that require (perhaps along with other process requirements) only the capacity for making an authentic decision.

Isaacson, Jobs instead chose to self-treat the cancer with "a strict vegan diet, … acupuncture, a variety of herbal remedies, and occasionally a few other treatments he found on the Internet."[32] Friends and family deplored how unreasonable Jobs's initial response to his diagnosis was. Some attributed it to his inclination "to ignore stuff he doesn't want to confront" and engage in "magical thinking," as though "he could will things to be as he wanted."[33] Nine months later, as his condition worsened, he reversed course and opted for the surgery after all. But it was, apparently, too late. The cancer had spread, and after a long illness, he finally died from resulting complications in 2011 at the age of 56. Although it is impossible to be sure that an earlier surgery would have saved him, Barrie R. Cassileth, the chief of integrative medicine at the Memorial Sloan Kettering Cancer Center, opined that the delay "likely cost him his life."[34] And, according to Isaacson, Jobs himself later regretted not going ahead with the operation sooner.[35] But though his initial refusal to undergo surgery seems irrational given his goals in life, no one seems to have seriously regarded him as incapable of making a reasonable decision. After all, that's why his friends and family were so angry with him. They certainly did not think his refusal was sensible given his values, and some earnestly tried to get him to change his mind. They were surely right to do so. But I think most of us would agree that it would have been wrong to go further and override his decision to refuse treatment, just because (in the words of Buchanan and Brock) it did not *reasonably conform to his underlying aims and values*.[36] He had a right to use his own faculties to make up his own mind about what was best for him. As it happens, he made a mistake. But the possibility of mistakes comes with having the authority to make your own decisions. If that's our verdict, then, at least when we are dealing with adults, we seem to be appealing to an abilities-based criterion of competence, not a decision-based one.

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[32] Walter Isaacson, *Steve Jobs* (New York: Simon & Schuster, 2011), p. 454.

[33] Isaacson, *Steve Jobs*, pp. 454-455.

[34] Liz Szabo, "Book raises alarms about alternative medicine," *USA Today*, June 18, 2013. https://www.usatoday.com/story/news/nation/2013/06/18/book-raises-alarms-about-alternative-medicine/2429385/ Retrieved September 31, 2021.

[35] See Isaacson's interview on *60 Minutes* (October 21, 2011).

[36] Buchanan and Brock, *Deciding for Others*, p. 56. Someone might say that Jobs's reckless refusal *was* authentic since it was consistent with his reckless character. But I doubt this is the relevant sense of authenticity.

5. Competence for Minors: The Single-Standard Model

How, then, should we think about competence as it relates to minors? As a preliminary, let me say a word about who counts as a "minor." Just about everywhere, there is a fixed age—often 18—at which a person is recognized as legally independent of his parents and as an adult for most purposes. Generally, then, our topic is persons younger than about 18. But things are a little more complicated than that. In a few jurisdictions, the age of medical consent is lower than the standard age of majority. And, in many places, minors can consent without parental notification to some forms of treatment (like treatment of sexually transmitted disease). Moreover, you might think that, although some people should be treated as minors, the law has drawn the line at the wrong place. All this is just to say that the extension of the word "minor" is not simple. Different views will take different positions, not only on the nature of minority competence, but also on who counts as a minor.

Now, if we adopt the abilities-based conception of adult competence, then the simplest position is to apply the same standard to the young. This could be done in a few different ways. We could use our abilities-based standard to make categorical generalizations on either side of a designated age. For example, we might maintain that, since those younger than (say) 18 usually fail to meet the standard, while those older than 18 tend to satisfy it, we will pick 18 as the standard age of consent. While such rough generalizations may be satisfactory in some domains, they increasingly appear problematic in medicine, since the decisions that need to be made are so consequential for the life of the patient, and since it is actually feasible in the medical context to make individual assessments (unlike, say, prior determination of capacity to give sexual consent). So, let's assume that we are applying the standard of competence in a more case-by-case manner. There are basically two ways of doing this. We might say that, just as the presumption of adult competence is rebuttable by sufficient evidence, the same ought to be true of the presumption of incompetence of minors. The other approach is to say that everyone is presumed competent until shown otherwise.[37] Occasionally, it will be necessary to distinguish these two versions of the view, but much of what I have to say applies to each of them.

[37] See, for example, Ontario's *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sched. A, §4.

The Single-Standard Model is attractive in its theoretical simplicity, and it provides a sensible explanation as to why we don't usually recognize young children as having the authority to make their own decisions. A 5-year-old child, for example, will probably lack the ability to appreciate the gravity of certain outcomes or deliberate rationally about probabilities. Furthermore, we may worry whether it really makes sense to treat the avowed beliefs and values of younger children as genuinely their own, as opposed to those of (say) their parents. For this reason, a young person may be incapable of bringing her values to bear on a decision, given that she doesn't really have values of her own in the first place. How to decide whether a person's values are authentically hers is, of course, a difficult question in its own right. Presumably, we will look to such things as whether the values seem to be deeply internalized, whether the youth can articulate their importance in her own words, whether she has been exposed to other perspectives and has had much opportunity to critically reflect on her values, and so on. In any case, the bottom line here is that there are abundant reasons to think that young children will lack various abilities necessary for competence.

The harder question is whether the Single-Standard Model handles adolescents, who are so much more like adults, in a plausible way. My suspicion is that, if we fairly apply the same competence-standard to adults and adolescents, then we are going to get results that will be hard to accept. On the abilities-based approach, recall, there will be cases in which a competent individual makes decisions that are quite unreasonable, even as judged by her own values and plans. I think that we are going to be reluctant, however, to let an adolescent, who apparently has all the abilities that an adult would need to count as competent, make a choice that is extremely harmful (from a medical point of view) and subjectively unreasonable.

Consider the following case:

> CASSIE: Cassie is a 16-year-old just diagnosed with leukemia. The doctors are optimistic about her prospects if she receives prompt and aggressive treatment. In fact, they think the probability of a full recovery in that case is about 85%. On the other hand, if the cancer is left untreated, her prognosis is grim; she will probably be dead inside of two years. Although Cassie understands what her doctors tell her, she is from the start unsettled by the prospect of chemotherapy. This aversion only grows once she starts following a

holistic medicine group on social media, and she is soon persuaded that, whatever her doctors may say, her condition can be more effectively treated with natural remedies than with the "poison" the doctors are prescribing. Moreover, she resents that her doctors have not presented this alternative treatment as an option, and she is coming to believe that doctors only prescribe chemotherapy drugs because they are bribed by the pharmaceutical companies. Since she has not yet reached the age of medical consent in her jurisdiction, she asks to be recognized as a mature minor who can make her own decision.[38]

Of course, in a briefly sketched hypothetical case like this, there is no way of determining whether the patient has the requisite abilities or not. My point is only that she might well possess them. After all, the case bears a striking resemblance to the Steve Jobs example. As I have been emphasizing, the mere fact that someone makes a subjectively unreasonable decision does not show that the person lacks the abilities for accountable agency. And yet, even if we were convinced that Cassie had the abilities an adult would need to count as competent, I still think we would be loath to let a 16-year-old make such a disastrous choice. On the other hand, there have been quite a number of court cases in which minors have been allowed to refuse medical treatment on religious grounds. What this suggests is that many of us are inclined to let adolescents with adult-like capacities make their own decisions, but only if the content of those decisions seems reasonable in light of the young person's own values and convictions. In other words, we *are* applying a different standard to adolescents—namely, a decision-based or authenticity standard. That may look dubious, but I will argue in the next section that it can be justified.

Before I do so, however, let me anticipate one response. Someone might agree that we shouldn't let Cassie refuse treatment but insist that this is because her unreasonable refusal is all the evidence we need to reach the conclusion that she probably lacks the requisite abilities. This argument will be on the firmest ground if we are working within a framework in which the young

[38] Compare the Connecticut case of *In re Cassandra C.* (SC 19426) January 8, 2015. For background, see: https://sciencebasedmedicine.org/the-sad-but-unexpectedly-hopeful-cancer-saga-of-cassandra-callender/ Retrieved September 31, 2021.

person is presumed incompetent and a strong case needs to be established to rebut the presumption. By contrast, when dealing with a normal adult, the same evidence, by itself, is usually not enough for a determination of incompetence, and this is because, here, the burden of proof faces the other way. That's an important argument, and maybe that's the whole explanation. No doubt this whole issue deserves fuller consideration than I can give it here. Presently, I will only observe that, if it turns out that we are, as a rule, ready to defer to the unreasonable decisions of apparently competent adults, whereas we almost never defer to the unreasonable decisions of adolescents, and if we cannot point to any difference in the abilities of the adult and the minor, then that suggests to me that we are not just relying on different presumptions. Whether we are forthright about it or not, we seem to be actually applying different standards to the two sorts of cases.

6. Competence for Minors: The Life-Stage Model

Could it be appropriate to apply a different competence standard to adults and to minors? I have said that respecting a person's agency over her own affairs is one part of recognizing her as a moral equal: that we each possess authority over our own lives. The view we have just been considering assumes that a person must immediately acquire full decision-making authority just when she adequately develops the capacity for making accountable decisions about her life.[39] But I want to suggest a different way of thinking about this.

As I see it, what is fundamental to respecting another as a moral equal (in this connection) is recognizing that she has a life of her own to lead—she has a right to "life-authorship," if you will. But the property of being the author of one's own life is a global one, referring to the character of a life as a whole. As a consequence, just when the young person is first handed over the reins to his life is not particularly important as far as the duty of respect is concerned, so long as this transfer of authority does eventually happen, it is not delayed too long, and everyone is treated in the same way. After all, we do not usually think that the limited freedom of childhood, though necessary, diminishes our ability to make our lives our own. Neither, I contend, does a tutelage

[39] Allowing, of course, that the boundaries for adequate possession of these abilities are vague.

that extends beyond childhood proper and through adolescence. This merely prolongs this preparatory stage before the projects that define adult life have been begun in earnest.

To draw that intuition out into the open, suppose that, in the country of Florin, people are recognized as adults at the age of 17, while in Guilder, the age of majority is 19. Now, just for the purposes of this example, let's assume that everyone acquires the capacity for accountable agency on their seventeenth birthday. Does it follow that, from the whole-life perspective, the people of Florin have more of an opportunity to lead their own lives than the people of Guilder? Does the society of Guilder fail to respect the moral equality of 17- and 18-year-olds. No, the ideal of leading one's own life is just not that sensitive to the timing of when we become full adults. In both countries, individuals will have plenty of time to assume full authority over their lives and make the sorts of decisions about career, place of residence, and family that shape people's lives. Therefore, both societies adequately recognize the moral equality of all. Of course, if the people of Guilder did not count as adults until the age of 50, and the average lifespan were what it is now, then that would be another matter. That *would* presumably be too late for the beginning of independence. But I assume that there is a range of ages which we might reasonably pick as the conventional beginning of adulthood.

If the line between childhood and adulthood is not marked by the acquisition of the abilities that underlie accountable agency, then how do we draw it? Basically, by considering the consequences. If young people generally benefit from having a longer preparation for adulthood, then we may, consistent with the duty to respect the equal right to life-authorship, legitimately delay adolescents' ability to enter into certain adult paths. Instead, we may keep them integrated in the formative institutions of the family and the school. During this imposed moratorium on adult pursuits, we aim at fostering more than the minimal abilities necessary for accountable agency. After all, that would be a pretty modest aim of education—to raise children just so they don't need wards as adults. Before letting the young leave the nest, we want to give them the time to develop really good judgment and to gain as much insight as they can into what is really worthwhile in life. But when a young person does reach the socially recognized age of adulthood, she becomes her own master, as long as she has at least reached the threshold for accountable agency. In this way, we can do justice to our more perfectionist intuitions about raising children

as well as our anti-perfectionist intuitions about respecting people's authority over their own lives. [40]

What age would be suitable for the onset of adulthood? I claim no special insight into this. Much will depend on local economic and cultural facts, including existing rites of passage. Perhaps the age of 18 is appropriate for many modern societies today. Of course, if you are convinced that a period of limited freedom in later adolescence is *not* generally beneficial, that it does not foster healthy maturation, then even if it were consistent with the duty of respect, it would lack justification.[41] I simply assume, here, the conventional view that it is beneficial.

But suppose you accept all that. This does not seem very helpful for thinking about important decisions that arise in the life of the adolescent that cannot be postponed without effectively deciding the matter one way or another. And, of course, medical decisions often have this character of *forced, momentous choices*. How, then, should we deal with these?

Keep in mind that we are assuming that the adolescent in question is someone who already has the requisite minimal abilities for accountable agency, including a set of values that can sensibly be said to really be her own. In that case, I think that out of a concern for the value of authenticity we ought to let the young person make a decision that is expressive of her own priorities, even if the choice is controversial or seems inadvisable from a strictly medical point of view. Further, if the young person does not yet know what is important to her, or how those values bear on the decision, then she has a right to figure these things out and decide accordingly. After all, if a decision has to be made that will have such important consequences on the youth's life, what other person's values have a stronger claim to guide us? It is only by recognizing the adolescent's right to make a decision based on her own values that we can really honor the fact that the young person's life is ultimately her own.

But this is still a *limited* form of autonomy, for I am also suggesting that we should not defer to an adolescent's decision that is harmful (from a medical point of view) and subjectively

[40] Andrew Franklin-Hall, "On Becoming an Adult: Autonomy and the Moral Relevance of Life's Stages," *The Philosophical Quarterly* 63:251 (2013): 223-247. See also the similar view defended in Joel Anderson and Rutger Claassen, "Sailing Alone: Teenage Autonomy and Regimes of Childhood," *Law and Philosophy* 31:5 (2012): 495-622.

[41] See Monika Betzler "The Moral Significance of Adolescence," *Journal of Applied Philosophy* 39 (2022): 447-461.

unreasonable.[42] That kind of robust authority should, of course, be extended to adults as a part of recognizing their moral equality. But, as I have just been saying, we can recognize others as equals, and thus as having the right to inherit this authority of life-authorship upon reaching the conventional start of adulthood, without thinking that this full authority must kick in as soon as a person is capable of accountable agency. In this way, we are letting the young person put her values into practice when faced with a forced momentous decision, but we are not entirely taking off the guardrails. Rather, we continue to shield the person from the worst effects of grave mistakes.[43]

But what if the adolescent's choice, though inconsistent with his values, is actually the medically advisable option? Perhaps out of fear, the youth chooses the option most likely to save his life rather than the one most in line with his religious convictions (which he typically regards as paramount).[44] Since the medically advisable choice has a lot to say for it, it will be hard in practice to distinguish these cases from those in which the young person is changing his mind about his priorities. But suppose we stipulate the facts are as described. This is a challenging case, but I think we should treat the decision as valid.[45] The adolescent lacks robust autonomy because he does not have the authority to make a decision that is subjectively unreasonable *and* harmful from a commonsense and medical point of view. If the young person can take responsibility for his choices, there is no reason why he shouldn't be allowed to make decisions that don't do him any harm.[46] Someone might object that the decision *is* harmful from his own evaluative

[42] As James Anderson has pointed out to me, this is not so unlike the standard we apply to substitute decision-makers for adult patients, since proxies are not entitled to make reckless or negligent decisions but must decide in line with the wishes or values of the patient. .

[43] On the value of "shielding," see Anthony Skelton, Lisa Forsberg, and Isra Black, "Overriding Adolescent Refusals of Treatment," *Journal of Ethics and Social Philosophy* 20 (2021): 221-247.

[44] My thanks to an anonymous reviewer for encouraging me to address this question.

[45] Alternatively, we could hold that the adolescent is incompetent to make this decision. In that case, a substitute decision-maker will have to be involved. And we might claim (consistent with current practice) that substitute decision-makers cannot refuse medically essential treatment for minors on religious or other controversial grounds. This, then, would bring us back to the medically advisable option which the adolescent originally chose.

[46] One might compare Buchanan and Brock's view that the threshold for competence requires subjective reasonableness only when the choice in question is potentially harmful and not obviously the best option from a medical point of view. Where there are few risks or the choice is quite reasonable from a medical perspective, the

perspective. Perhaps so, but while medical professionals have a responsibility to *defer* to decisions based on values that run counter to medical values, they don't have the responsibility—perhaps not even the authority—to ensure that patients avoid the temptation of goods like life and health while remaining true to particular religious or ethical doctrines.[47]

I think that this life-stage approach accounts for some of the ways that the "mature minor doctrine" is actually applied. Whatever they *say* they are doing, courts are not typically just looking to see whether the young person has the abilities an adult would need to count as competent. Few courts would recognize an adolescent as "mature" if he were acting as Steve Jobs did. The only people likely to be deemed mature minors by the courts are those who are making sensible choices that are in line with values and convictions that the young person has thought seriously about.[48] That is a higher standard of competence than we require of adults. This difference cannot be explained because the stakes are allegedly higher when we are dealing with an adolescent. The stakes are essentially the same when we are dealing with a 25-year-old patient.

Moreover, I submit that the life-stage account is more compelling than the alternatives. For instance, someone might say that, during the probationary stage of adolescence, we need not even defer to a young person's subjectively reasonable decision about some forced, momentous question—for that, too, is a perquisite of adulthood. But, as I have said, it is hard to see why, if a decision has to be made, someone else's values should take precedence over the person whose life it is (assuming, again, that the young person is capable of exercising accountable agency).

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decision is held to a lower standard, requiring only a basic understanding of the choice made (*Deciding for Others*, 51-57).

[47] This may seem to be in tension with my claim, above, that doctors ought to help the patient make a decision that is right for her, given what she deems most important. But my idea is that there is a difference between cases in which the best option, even from a medical point of view, depends on the patient's aims and values (e.g., what is more important: controlling anxiety or maintaining a normal libido?) and those in which the patient's religious or ethical convictions call, in some contexts, for choosing against the kinds of goods that medicine promotes (life, health, etc.). If a patient chooses health-related goods over her religious convictions, we should not expect the doctors to push back, even if the decision is not subjectively reasonable.

[48] Court decisions are frequently ambiguous between claiming that the adolescent patient must have the capacity to make a mature decision and that her decision must itself exhibit maturity. However, as James Anderson reminds me, in the real world, authorities also sometimes deem adolescents mature only if their decisions are "objectively reasonable" in the sense of being medically advisable.

To run to the other extreme, one might say that we should treat adolescents who are capable of accountable agency just like adults in these circumstances: let them make their own decisions and bear whatever consequences may come. That is a coherent position; I just think that the life-stage model offers a better balance between the young person's interest in autonomy and our protective responsibilities toward those in the transitional stage between childhood and adulthood.

Some say that, when choices need to be made about an adolescent's care, the decision-making process should, so far as possible, be a shared one between the adolescent, her guardians, and her medical team. This is quite plausible as a moral ideal. But I am asking where final authority lies when we can't reach consensus. The shared decision-making model doesn't provide us with that.

A final position, which has received considerable attention recently, is to say that young people should be able to consent to treatment proposed by their doctors, but should not be able to refuse life-saving treatment.[49] As I see it, though, this approach draws the line at the wrong place. Consider:

> DANA: Like Cassie, Dana is a 16-year-old leukemia patient. However, Dana has already been through two rounds of chemotherapy and each time the cancer has returned. The doctors are eager to try one more round of treatment, although they admit that the odds of driving the cancer into long-term remission are only about 15%. Her parents are even more adamant that the treatment is worth one more try. But Dana disagrees. She believes that, since the odds are that she is at the end of her life no matter what she does, she would rather ensure that her final months be as comfortable as they can be so that she can make something of the time she has left.

I think we ought to respect Dana's decision, notwithstanding the fact that she is refusing life-saving treatment. She is, to be sure, making a controversial decision, but it remains a reasonable

[49] Neil C. Manson, "Transitional Paternalism: How Shared Normative Powers Can Give Rise to the Asymmetry of Adolescent Consent and Refusal," *Bioethics* 29:2 (2015): 66-73; Faye Tucker, "Developing Autonomy and Transitional Paternalism," *Bioethics* 30:9 (2016): 759-766; Skelton, Forsberg, Black, "Overriding Adolescent Refusals of Treatment."

one in that it is consistent with all available information and is in line with what is most important to her. I think that the reason why the idea of an asymmetry between consent and refusal looks plausible in the first place is because we are thinking about examples more like Cassie's, where the refusal has little to be said for it. But Dana's story shows that this is just one sort of case. Whether a treatment has a chance of saving the patient's life is not the critical issue.

To my mind, then, our life-stage model looks the most reasonable. This means an abilities-based standard for adults and a decision-based standard for minors. But is the decision-based standard really a standard of *competence* at all? Or would it be more accurate to say that, even if an adolescent is competent, we should only defer to his decision if it is subjectively reasonable? Because of the aforementioned ambiguities of the word "competence," which I have discussed above, we could put it either way. I have presented an account of the facts that should ground the legal power of giving and withholding medical consent for adolescents. Therefore, in my terminology, this is a theory of competence$_G$. However, the theory says that, in determining whether to defer to an adolescent's decision, the sufficient possession of the abilities that underlie accountable agency are not decisive. Therefore, this is not an account of competence$_A$.

7. Conclusion

To say an adult has the mind of a child is to suggest that he lacks the capacity to care for himself. But to allege that he is acting like a teenager is usually only to impute vices like recklessness or short-sightedness, not incapacity. This suggests that older adolescents are often thought to sufficiently possess the abilities an adult would need to count as competent. As I have said, you might conclude that we should, therefore, treat adolescents like adults in medical decision-making. I disagree. When confronted with an important medical decision that cannot be postponed, an adolescent who would qualify as competent if an adult should be allowed to make a decision that is in line with her own values. But it remains justifiable to protect adolescents from foolhardy decisions, since we can fairly treat adolescence as a probationary stage, during which certain protections remain in place, but which is nonetheless on life's path to the more robust freedom we accord to adults. Although that robust autonomy is owed to people as moral equals, it is not necessarily owed to them at every stage of life. What is essential is that it is known that such independence will be assumed as a matter of course by everyone

capable of exercising it at the conventional start of adulthood. We should, therefore, think of "mature minors," whose decisions are owed deference, not as adolescents who merely possess the minimal capacities adults would need to decide for themselves, but as young people whose decisions, though perhaps controversial in content, nonetheless actually approach the ideal of subjective reasonableness and thoughtfulness.