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CHAPTER 9
AUTONOMY AND THE RIGHTS OF MINORS

Recognizing that minors, particularly adolescents, are often capable of engaging in medical decision-making long before they are legally considered adults, health professionals regularly struggle with the role that children and adolescents should play when faced with treatment decisions. In the United States, state laws now recognize a limited right for minors not only to participate in but to make certain treatment decisions on their own. The recognition of such rights challenges the traditional role of parents who were once entrusted with sole decisional authority. When should minors be permitted to make treatment decisions? When minors possess the capacity necessary to make treatment decisions, do parents and health professionals have an obligation to respect their wishes?

I begin with a review of several factors related to the rights of minors as decision-makers. I then outline the arguments in opposition to this trend, which favor the rights of parents as final decision-makers. Finally, I suggest that these arguments ultimately fail to take into consideration the wide range of difficult decisions minors may face, the variety of familial circumstances within which minors are raised, and the ethical obligations that health professionals have toward their adolescent patients. I argue that in cases where minors possess x, parents and health professionals have a *prima facie* moral obligation to respect their treatment decisions.

MINORS AND THE QUESTION OF DECISIONAL CAPACITY

The principle of autonomy and the closely related doctrine of informed consent, widely accepted in the United States as a fundamental right for patients, requires that health professionals show respect for the informed and voluntary treatment choices of their patients. Patients are capable of making treatment decisions when they possess the decisional capacity necessary to make informed and meaningful treatment decisions. When in possession of such capacities, their decisional authority, that is the *right* to have their wishes respected, is generally held to follow from a health professional's obligation to respect patient autonomy.

Historically, children were excluded from medical decision-making. Often, they were considered the chattel of their parents, particularly the father. "Accordingly, a father had the right to sue a physician who treated his son or daughter without his permission, even if the treatment had been perfectly appropriate, because such an intervention contravened the father's right to control his child (Holder 1989, 161)." Decisional authority rested solely with the parents, regardless of the minor's decisional capacity yet minors are no longer considered the legal property of their parents and there is growing debate surrounding the

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appropriate limits of parental control in medical decision-making. Some advocates, acknowledging the legitimacy of the relationship between decisional capacity and decisional authority, argue that parental control should decrease and the minor's control should increase, as the minor's capacity develops. An adolescent's decisional authority has been recognized under common law in several recent court decisions (See for example: *In re* E.G., 133 Ill2d 98, 103 (1989), and *In re Crum*, 580 NE2d 876 (1991)).

One challenge to increasing a minor's decisional authority stems from concerns regarding their capacity to participate in medical decision-making. As Robert Weir and Charles Peters suggest (1997, 29), "many still doubt the capacity of adolescents to make the truly important decisions that sometimes confront them." In light of this perceived deficit, parental consent is generally sought prior to initiating medical treatment. However, this general presumption of incapacity, especially for older adolescents, increasingly is becoming suspect.

One factor motivating the trend toward increasing respect for a minor's right to medical decision-making stems from studies in developmental psychology. These studies tend to suggest that minors often do have the decisional capacity necessary to make most of their health care decisions by the time they reach the age of 14 or 15. A classic and frequently cited study by Thomas Grisso and Linda Vierling (1978, 412), for instance, found "little evidence that minors of age 15 and above as a group are any less competent to provide consent than are adults." Sanford Leikin (1989, 173) reports similar findings, suggesting that:

> by age 14 years, many minors attained the cognitive developmental stage associated with the psychological elements of rational consent. Furthermore, there appears to be no psychological grounds for the general assumption that minors 15 years of age or older cannot provide competent consent.

These studies indicate that minors often have the capacity to make rational treatment decisions several years before they reach the legal age of majority.

LEGAL AND PROFESSIONAL CONSIDERATIONS REGARDING MINORS' RIGHTS

The Council on Scientific Affairs of the American Medical Association (1992a, 1423) "encourages physicians to allow emancipated or mature minors to give informed consent for medical and psychiatric care without parental consent and notification, in conformity with state and federal law." In the United States, state statutes do provide some recognition of a minor's decisional authority. As Isabel Traugott and Ann Alpers point out, "the law provides several mechanisms to allow adolescents to consent to medical treatment without parental notification or consent." (1997, 924) For example, health professionals are permitted to render appropriate medical care in emergencies even when the parents are unavailable. Additionally minors may often give effective consent for birth control, the treatment of sexually transmitted diseases, psychological counseling, and substance abuse.

Concerns that minors might elect to forgo necessary medical attention are legitimate. The need to provide minors with access to confidential medical treatment is supported in a study conducted by Tina Ching (1993, 1405). She found that 57.9%

of the minors who participated in her study indicated that there were some health concerns that they would not want their parents to know about. Furthermore, 25.3% of the minors claimed that, in these circumstances, they might not seek care if they knew that their parents would find out. A survey conducted by A. Marks et al. (1983, 456–60) found that only 45% of adolescents would seek treatment for depression, 19% for birth control, 15% for sexually transmitted diseases, and 17% for drug use if parental consent was mandatory.

In addition to minor treatment statutes, which allow minors to give consent for certain specified services, a growing number of judicial rulings tend to support the right of older, more mature minors to give consent to a wide range of medical services. These judicial rulings have given rise to what is known as the "mature minor rule." This rule is based on the fact that there have not been any successful cases of a parent suing a physician for providing appropriate medical treatment, that was for the minor's benefit, when the minor seemed mature enough to give consent for the treatment. As Angela Holder suggests, "if a young person (of 14 or 15 or over) understands the nature of the proposed treatment and its risks and can give the same degree of informed consent as an adult patient, and the treatment does not involve very serious risks, the young person may validly consent to receiving it." (1989, 163)

While most of these cases dealt with adolescents who were consenting to beneficial medical treatment, in at least one case the court ruled in favor of a minor's right to refuse unwanted life-saving medical treatment. In 1989, the Illinois Supreme Court heard a case which involved:

> A 17-year-old female patient with leukemia [who] refused to consent to a blood transfusion on the basis of her religious beliefs. She, not her parent, had independently refused the transfusion, although her mother's religious views were similar to hers. A psychiatrist who examined the patient testified that she had the maturity of an 18 to 21-year old person. The juvenile court made a finding of medical neglect and had a guardian appointed, who consented to transfusions. The case was appealed and the Illinois Supreme Court held that if there is convincing evidence that the minor is mature enough to appreciate the consequences of her actions and to exercise the judgment of an adult, then she has the right to consent to or refuse medical treatment. (Sigman 1993 523)

This case is significant in that it lends support to the right of a minor, with decisional capacity, to refuse unwanted medical treatment, even when failure to provide such treatment may be life-threatening.

Finally, professional health organizations now support the right of mature minors to make their own treatment decisions. The American Medical Association for instance, in its *Code of Medical Ethics* states that "physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities." (2000–01, 53) Similarly, the American Academy of Pediatrics states that,

> patients should participate in decision-making commensurate with their development; they should provide assent to care whenever reasonable. Furthermore, parents and physicians should not exclude children and adolescents from decision-making without persuasive reasons. In all cases involving emancipated or mature minors with adequate

> decision-making capacity, or when otherwise permitted by law, physicians should seek *informed consent* directly from patients. (1995, 314–7)

CHALLENGES TO MINORS AS DECISION-MAKERS

One area of controversy regarding minor's rights pertains to their access to contraceptive services. The seeds for such a right were planted in the landmark U.S. Supreme Court case of *Griswold v. Connecticut* (381 U.S. 479, 1965). In this case, the Supreme Court declared unconstitutional a Connecticut law that denied married adults the right to obtain prescription contraceptives. It was not until 1977, however, in the case of *Carey v. Population Services International* that the court established the right of contraceptive privacy for minors (431 U.S. 678, 1977). In *Carey*, Justice Brennan claims that: "The right to privacy in connection with decisions affecting procreation extends to minors as well as to adults, and since a state may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, Planned Parenthood of Missouri v. Danforth, 428 U.S. 52, the constitutionality of a blanket prohibition of the distribution of contraceptives to minors is a fortiori foreclosed"

While *Carey* prohibits states from instituting a blanket prohibition, there has been ongoing debate at the federal level over the rights of minors to receive contraceptives through Title X of the *Public Health Services Act*. In 1970, the United States Congress provided minors access to confidential contraceptive services through Title X. In 1981, the Act was amended to "encourage family participation." The Reagan administration then attempted to require parental notification for any minor who received contraceptive services. This requirement was subsequently ruled unconstitutional. Fifteen years later, On July 30th and October 7th, 1998, the United States Senate and House of Representatives, respectively, introduced legislation aimed at limiting the right of unemancipated minors to receive contraceptive services without parental consent or notification. These pieces of legislation specifically targeted minors who were otherwise eligible to receive services under Title X of the *Public Health Service Act*. According to Senate Bill 2380, introduced by senator Aschcroft:

> all federally funded programs that provide for the distribution of contraceptive drugs or devices to minors, or that provide abortion referrals to minors, are, except as provided in subsection (b), required to obtain informed written consent of a custodial parent or custodial legal guardian of a minor prior to the provision of contraceptive drugs or devices or abortion referral information to the minor.

Similarly, H. R. 4721, introduced in the House of Representatives by representatives Istook et al. sought to deny funds, appropriated according to Title X of the *Public Health Service Act*, to any provider who knowingly provides contraceptive drugs or devices to a minor without (1) providing written notification to the parents, or (2) receiving written consent from a parent or (3) the minor being emancipated, or (4) a court order authorizing such distribution to the minor. While these bills ultimately died in committee and were not brought to the floors of either the senate or house for a vote, they are indicative of the current and ongoing controversy in health care policy pertaining to the rights of unemancipated adolescents.

The spirit of such legislation is reflected in the work of ethicist Lainie Freidman Ross who argues against the rights of minors in medical decision-making (1997, 41–5). Ross challenges the position taken by the American Academy of Pediatrics in an article entitled Health Care Decision Making by Children: Is it in Their Best Interest?” In this article, Ross argues that we must reconsider the appropriateness of granting minors the right to make their own treatment decisions. She claims that in spite of recent studies into adolescent capacity, it is difficult, if not impossible, to determine whether any particular child has sufficient decisional capacity to make meaningful treatment decisions. However, unlike those who would deny that minors have decisional capacity, Ross argues that even when they have capacity it is misguided to grant them decisional authority. Capacity, Ross claims, “is a necessary but not a sufficient condition on which to base respect for a minor’s health care decision making autonomy” (1997, 41).

Three main themes arise out of Ross’s critique of minors as medical decision-makers. First, Ross claims that allowing minors to make treatment decisions places too much emphasis on “present-day-autonomy” and not enough emphasis on “life-time-autonomy.” She contends that a “child’s decisions are based on limited world experience and so are not part of a well-conceived life plan” (1997, 42). She is not alone in voicing this concern. Dan Brock, for instance, cautions that one difficulty with minors as decision-makers stems from their limited conceptions of their good. “An important issue,” Brock suggests, “is whether their values adequately reflect their future interests” (1989, 186). Ross suggests that minors should not be allowed to make any decisive treatment decisions that could adversely impact on their options in the future. Rather, she feels that parents are in a better position to protect their children’s “life-time” autonomy.

Second, Ross suggests that, given the “significant role that intimate families play in our lives . . . parents should have wide discretion in pursuing family goals, goals which may compete and conflict with the goals of particular members” (1997, 43). Accordingly, allowing minors to give effective, and exclusive, consent for prescription contraceptives, abortions, or other treatment decisions may circumvent legitimate parental rights.

Finally, Ross takes issue with a position supported by the American Academy of Pediatrics which states that “in cases of serious conflict [between the parent and the child], physicians and families should seek consultative assistance and only in rare circumstances look to judicial determinations” (1995, 314). Ross argues that seeking consultative assistance, or mediation, only serves to “undermine the family” by denying them the “moral and legal space within which to make decisions that will facilitate their child’s long-term autonomy” (1997, 44). In cases of disagreement between the parent and the child, Ross claims that “the child’s decisions should not be decisive nor should health care providers . . . seek third party mediation. Rather [Ross believes that] . . . the parents should have final decision making authority” (1997, 44).

Ross raises several important concerns that are perhaps relevant in many circumstances. If her arguments hold, they pose a serious challenge to those who seek to increase the rights of minors by granting them decisional authority. However, I find her overall position untenable. In the remainder of this paper, I will explore these arguments in greater depth and show why they ultimately fail to provide a blanket justification against the decisional authority of certain minors.

PEDIATRIC DECISION-MAKING AND “LIFE-TIME” AUTONOMY

One of Ross’s primary arguments against decisional authority for minors stems from a distinction she makes between “present-day” autonomy and “life-time” autonomy. She argues that “life-time” autonomy (ones ability to make autonomous decisions over one’s lifetime) must take precedence over “present-day” autonomy (one’s ability to make an autonomous decision today). She then suggests that while minors may possess “present-day” autonomy they may lack the ability to protect their “life-time” autonomy. It is the responsibility of the parents, Ross claims, to protect the minor’s “life-time” autonomy from the minor’s “present-day” autonomous self. Thus, minors’ “present day” autonomy need not entail their right to make their own treatment decisions. This argument, however, is problematic.

First, an autonomous agent is an individual who is capable of making reasoned decisions based on his or her own values and beliefs. Beauchamp and Childress classify autonomous agents in terms of “normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influence that determine their action” (2001, 59). They suggest that a “patient or subject has the capacity to make a decision if he or she is able to understand the material information, to make a judgment about the information in light of his or her values, to intend a certain outcome, and to freely communicate his or her wishes to caregivers or investigators” (2001, 71).

Ross, I believe, trivializes the significance of “present-day” autonomy for minors by appealing to an example of an adolescent who refuses medication because it requires the use of needles. “Imagine” she suggests, “that a fourteen-year-old with new-onset diabetes refuses to take insulin because she fears needles. ... Who is willing to abandon her to her autonomy?” This, it seems, is a particularly weak example of respect for adolescent autonomy (1997, 44). If, as Ross seems to suggest, such an individual lacks a well-conceived life plan within which to make this decision, or is making a rather frivolous decisions without giving adequate consideration to the long-term consequences of the act, then it seems inappropriate to refer to this as an autonomous choice in the first place.

An individual’s ability to make meaningful health care decisions must be considered in the context of the decision to be made. Capacity determinations require a match between the demands of the situation against the individual’s current abilities. To say that an individual is “presently” autonomous is to say that he or she currently has the capacity to consider the elements necessary to make a meaningful decision. “Present-day” autonomy, properly understood, would seem to necessitate the ability to make use of relevant information, including information regarding how a decision will affect us in the future, if such consideration is necessary. In this way, Ross’s introduction of the concept of “life-time” autonomy distorts the question of what is at issue for a presently autonomous agent.

Even if we were to accept Ross's distinction between "present-day" and "lifetime" autonomy as legitimate, it is not clear that it would establish the priority of parental decisions over those made by a minor. There may be circumstances that necessitate giving priority to a minor's decisions. For instance, in some circumstances, particularly during end of life care, parents may request that a physician withhold certain information from their child. Such a request may seem perfectly justifiable because parents have, as Sandford Leikin points out, "an overwhelming wish to protect a very sick child from disturbing information." Parents tend to fear that informing a child of a terminal condition, or a grim prognosis, may be psychologically overwhelming, so they tend to try and fulfil their obligation to protect their children by limiting their access to this information (1989, 18).

While most caring parents want to protect their children from unnecessary pain, either physical or psychological, health professionals must consider parental requests to withhold information in light of the harms associated with non-disclosure and the patient's desire to have access to that information. If a minor disagrees with his parents, and wants to participate in treatment decisions, should health professionals consider the parents' decision to exclude their child as final? There are at least two arguments that can be used against so excluding children.

First, it is unclear that withholding information from children, particularly those suffering from a terminal condition, will protect them from unwanted suffering. In an important work on this subject, Myra Bluebond-Langer (1978) studied children in oncology units who were suffering from Acute Lymphocytic Leukemia. Of her findings, compiled in a work entitled *The Private Worlds of Dying Children*, several observations are relevant to adolescent decision-making. First, Bluebond-Langner noticed that children in the oncology unit were more aware of what was going on around them than either their parents or members of the health care team believed (1978, 136–7). For instance, she noted that "the children were well aware of the multiple purposes hospital rooms served in addition to their designated function. ... Many of the children commented on how it seemed that 'if the doctor does not want your mother around, he takes you to the treatment room.'" Their observation accurately reflected the attitudes of many of the physician's who claimed that "they preferred carrying out procedures in the treatment room, because it was easier to keep the parents out and the children were easier to manage" (1978, 136–7). No one had explained this to either the children or the parents.

More importantly, the children in Bluebond-Langner's study understood their disease and its treatment, process, and prognosis. They understood the nature of their treatment, the purposes of individual medications, and for many, that they were going to die. Some of the children in Bluebond-Langer's study stated outright that they knew they were going to die. Others would less directly refer to the possibility of their death by indicating that they would "not be going back to school" or "not being around for a friend's birthday party." According to Bluebond-Langer, "all [of the children] knew that they were dying before death was imminent (1978, 165).

What is most troubling regarding this study is the fact that the children were not only aware of their own conditions and prognosis, but they also realized that their parents, and often members of the health care team, were uncomfortable discussing it. In some circumstances, the resistance was obvious. For example, Bluebond-Langner found that "if the children asked questions that might force the staff to reveal the prognosis, (e.g., what happens when the drug runs out) the staff members showed their unwillingness to talk about the matter by leaving the room, reprimanding the children, or by simply ignoring the question." Instead of confronting the issue in these situations, the children, parents, and staff engaged in an act of what Bluebond-Langer refers to as "mutual pretence"; each side wilfully avoiding a discussion of the undesirable possibilities, in order to protect the other (1978, 201).

While "mutual pretense" may make the interaction with the patient seem easier, as they no longer have to discuss the patient's poor prognosis, it is not clear that it makes the child's personal experience of disease any easier. In fact, in such cases the child is unable to express any of his or her feelings about death nor actively participate in end of life decision-making. As a result, these children may spend the last days of their life feeling very much alone and abandoned. James and Hilde Nelson in their book, *The Patient in the Family*, emphasize that "it takes courage to tell a five-year-old that she will soon die, but if this is not done the child faces death alone, with the additional burden of cooperating in a conspiracy of silence that requires her [the child] to take care of her caregiver's feelings" (1995, 103).

Second, it is not clear that Ross can sustain her argument against interfering with parental decisions in light of her emphasis on "life-time" autonomy. For instance, in a case reported in the *American Journal of Diseases of Children*, a young girl was diagnosed with Cystic Fibrosis. Like many of the parents in Bluebond-Langner's study, they were very upset and demanded that she not be told. The physician in this case agreed to the parent's request assuming that he would eventually be able to change their minds. He was not. According to Sigman, it was not until the girl was 18, and still against parental objections, that she was given the name of her condition and informed of the long-term prognosis (1993, 764–8).

While Cystic Fibrosis once killed a majority of its victims early in adolescence, current therapies allow patients to live well into adulthood. The physician, and her parents, would have to recognize that the girl would most likely become an adult. It would seem irresponsible, and ethically questionable, to withhold information from this girl as her capacity developed. Respect for autonomy entails some obligation to assist individuals into becoming autonomous agents. The parents' request in this case would certainly thwart that ability. Given the importance of "life-time" autonomy, the health care team may need to intervene and force the parents to allow disclosure, especially if the child is requesting access to that information.

Ross is not; I should point out, arguing that minors should be excluded from treatment decision-making. Ross clearly states that she does "not mean to suggest that children, particularly mature children should be ignored in the decision-making process." Ross emphasises that their inclusion should merely be used to "help them understand what is being done to them and to garner, when possible, their cooperation." However, whenever there is a conflict between the parents and the child, she believes that the parents', not the child's, decision should be decisive (1997, 44).

Finally, the distinction between "life-time" and "present-day" autonomy is not particularly useful in situations where a minor's treatment decisions will not significantly impact his or her future autonomy. Suppose that a sixteen-year-old patient, after several months of treatment, believes that burdens of aggressive treatment, which may offer at most a few weeks or months of life, far outweigh its benefits and decides to discontinue such care. If the minor has capacity, is able to understand his or her prognosis and the consequences of the decision being made, it seems irrelevant to introduce the concept of "life-time" autonomy where "present-day" autonomy is all that is required. While a parent may wish to preserve every possible moment of their child's life, the autonomous minor ought to have the right to refuse unwanted care.

There are several reasons to reject Ross's argument that denies decisional authority to minors based on her emphasis on lifetime autonomy. First, distinguishing between "life-time" and "present-day" autonomy does not help us to better understand what is required of a decision-maker. The very concept of autonomy entails the ability of a person to consider the future impact of their decision; and, some minors do seem capable of making such decisions. Second, acknowledging the importance of "life-time" autonomy in certain circumstances may provide legitimate justification for interfering with a parent's decisions, especially if those decisions interfere with the minor's well being or development into an autonomous agent. Finally, there are many relevant decisions that minors may face where an emphasis on "life-time" autonomy is irrelevant. Ross's emphasis on "life-time" autonomy does not adequately support a blanket argument against a minor's right to make treatment decisions.

PEDIATRIC AUTONOMY AND PARENTAL RIGHTS

I now want to turn to a second theme in Ross's argument, that of parental values in medical decision-making. Ross argues that health professionals have an obligation to respect the role of the family in the minor's development and to avoid interfering with legitimate parental rights. However, Ross does not take into consideration the wide range of familial relationships that mature minors may have with their parents. These relationships are not always beneficial. Some parents are abusive. In these cases, denying teens the right to make decisions regarding such issues as reproductive health may significantly increase the risk to their health and wellbeing.

Parents do have a wide range of decisions that they can control, to some degree. However, such control cannot always carry over to medical decision-making. Consider the following case involving a minor's refusal to participate in a non-therapeutic research protocol. For the study, healthy volunteers were needed to donate a small amount of blood. When approached for possible participation, a small boy declined, saying that he didn't want to get stuck with any needles. According to the account by Willard Gaylin, the boy's father then ordered his son to stick out his arm and allow the doctor to take some blood. According to the father, it was

> his moral obligation to teach his child that there are certain things one does, even if it causes a small amount of pain, to the service or benefit of others. [The father stated that] ‘This is my child. I was less concerned with the research involved than with the kind of boy I was raising. I’ll be damned if I was going to allow my child, because of some idiotic concept of children’s rights, to assume that he was entitled to be a selfish, narcissistic little bastard (1982, 29).

While I agree that there is value in teaching children to be sensitive to the needs of others and to accept certain amounts of discomfort for the benefit of others, there are some difficulties in using medical research to foster this goal. First, there are other ways for parents show their disappointment with the child’s decision. Second, health professionals, and the health professions in general, have their own ethical codes and values that may prevent them from adhering to parental requests. For instance, it is largely held that a minor’s *assent* is required before subjecting any child to a “non-therapeutic” research procedure, that is, any research that will not directly benefit the child. In this case, the parents’ decision to include the child cannot be decisive, and the child’s decision may prove decisive, as the parent’s decision does not create an ethical obligation on the part of the health professional to adhere to the parents’ request.

THIRD PARTY INTERESTS IN PEDIATRIC DECISIONS

Finally, Ross takes issue with the American Academy of Pediatrics’ willingness to include third party mediation when conflicts arise between minors and their parents. Her position is problematic in that it would ultimately exclude concerned health professionals from their legitimate roles as patient advocates. Ross bases her argument against mediation on her concern for protecting the integrity of the family and parental rights and responsibilities. She argues that, “parental autonomy promotes the interests and goals of both children and parents. It serves the needs and interests of the child to have autonomous parents who will help him become an autonomous individual capable of devising and implementing his own life plan” (1997, 43).

We must be cautious in our use of autonomy in these contexts. Susan Sherwin cautions that “the concept of autonomy, rather than working to empower the oppressed and exploited among us, in practice often serves to protect the privileges of the most powerful. “The concept of autonomy is also exclusionary,” Sherwin continues, “in that it is generally ascribed only to those persons who are recognized as rational.” In practice, “rationality has historically been constructed in ways that exclude not only children, but also women and members of other oppressed groups.” We should be careful not to construct autonomy in such a way that it arbitrarily excludes a vulnerable group of individuals (1996, 53).

Nevertheless, health professionals certainly need to be sensitive to the important role that parents play in a child’s development. Children typically share special relationships with their parents which may continue long after medical intervention. As James and Hilde Nelson point out:

> families are also crucial to the formation of a child’s conscience. If conscience is understood as ‘the exercise and expression of a reflective sense of integrity,’ as ‘the voice of one’s self as a whole,’ which integrates personal history, reason, emotion,

> imagination, and action, then insofar as the family gives a child its sense of self, it gives the child the stuff of conscience (1995, 79).

Disrupting the bond and trusting relationship that the child has with his or her parents could have serious long-term consequences.

The need to preserve familial relationships does not exclude the appropriateness of mediation. Conflicts between parents and children over medical therapies can originate from a variety of sources. There may be confusion regarding the implications of a medical intervention, or lack thereof. Children, and their parents, could be attempting to exert themselves and establish some control, especially if the medical condition or environment makes them feel vulnerable. Or, the disagreement could result from underlying tension within the family. Through mediation, health professionals may be able to sort through some of these variables.

In certain circumstances, there may be legitimate conflicts of values. A parent's decision may reflect deeply held familial values or religious beliefs. When the child is young, and these decisions do not seriously compromise the health and safety of the child, adhering to their wishes may be appropriate. Mediation in these circumstances may help the health care team to better understand the parent's position and to ensure that they do not jeopardize the patient's health. In other circumstances, particularly when minors are older and able to articulate their own values, mediation may allow the parents and the patient to work through their conflict and come to a reasonable resolution.

Ross emphasizes the importance of parental "rights" in raising their children. She is opposed to mediation because she believes that it ultimately allows the values of health professionals to override those of the parents. Our concern should not, however, be one of substituting parental values for those of health professionals. Rather we must acknowledge that as minors mature, health professionals have an obligation to give serious attention to the minor's own treatment decisions. Mediation can bring all of these issues into focus.

CONCLUSION

There is growing recognition of the legitimate role that minors should play in medical decision-making. Prominent professional organizations now emphasize the importance of including children in medical decision-making and, in certain circumstances, granting them decisional authority. In so doing, it is essential that we give serious consideration to the familial circumstances from which minors come, and to which they may return, after their interaction with the medical community. While it is important that we take into consideration parental rights and responsibilities, it is also important that we appreciate the developing capacities of minors to make treatment decisions and the moral obligation that such capacities create on the part of health professionals and parents alike. When a minor is capable of making an autonomous decision, parents and health professionals are obliged to acknowledge a minor's right to make those decisions.

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