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22. See note 21, AAP COB 1997:280.
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24. See note 23, AAP COB 1995:317.
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26. See note 20, Clayton 2009:320.
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30. Ridgway D. Court-mediated disputes between physicians and families over the medical care of children. *Archives of Pediatrics and Adolescent Medicine* 2004;158:891–6.
31. See note 30, Ridgway 2004.
32. *Prince v. Commonwealth of Massachusetts*. 321 U.S. 158 (1944).
33. See note 32, *Prince v. Commonwealth of Massachusetts* 1944:170.
34. See note 1, Blustein 2009:316.
35. Purdy L. *In Their Best Interest? The Case against Equal Rights for Children*. Ithaca, NY: Cornell University Press; 1992:81.
36. See note 35, Purdy 1992:78.

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Reply to Ross's "Arguments against Respecting a Minor's Refusal of Efficacious Life-Saving Treatment Redux"

JEFFREY BLUSTEIN

I want to make a few comments about Ross's reply to my criticism of her initial essay. First, Ross argues that I commit a logical fallacy. From the fact that (a) adults with decisional capacity may make their own medical decisions and (b) some adolescents have decisional capacity, we cannot conclude, as I am alleged to have done, that (c) some adolescents have the right to make their own medical decisions. One thing to say about this is that I did not propose something as strong as (c). I only argued for the more modest claim that "if adolescents are not a monolithic group with respect to their capacities for autonomous decision-making, if some are as good as adults in this respect, then this is an empirical fact that the ethical analysis should take into account." I meant there to point out that the possession of decisional capacity by some adolescents is ethically significant even if not ethically dispositive and that we need to understand how this feature interacts with others to yield an all-things-considered judgment about what is right in particular cases. But I also want to press the issue: If some adolescents are

as capable of autonomous decision-making as most adults, why shouldn't we treat their informed choices with the same deference as we treat those of adults? Of course, if a particular choice is irrational or ill informed or coerced, we should not defer to it, but this is equally true when capable adults make such decisions. To claim, as Ross does, that parents may override their child's refusal of medical treatment because they do not believe it is in his best interest and it is *their* assessment of his best interest that counts really doesn't get us very far. For the question remains: Why is *their* assessment of their mature child's best interest the deciding factor?

Second, Ross claims that if we allow older adolescents to make their own healthcare decisions, "we need to think about other areas" of social life where we do not allow even older adolescents to make their own decisions. I certainly agree that we need to think more about this, about the grounds for setting different requirements of decisional capacity for different tasks and about the social implications of revising our understanding of the decisional capacities of adolescents. Even setting healthcare aside, our society has displayed and continues to display a bewildering inconsistency when it comes to according adolescents and young adults the same rights (and responsibilities) as adults.

Third, Ross claims that adopting individualized assessment of adolescent decisional capacity rather than a single age of emancipation gives healthcare professionals too much discretion to impose their own values in deciding whether a child should be permitted to make his own healthcare decisions. But I did not argue that we should reject "bright line" cutoffs entirely. Jonathan Moreno and I stated our position on individualized assessments of decisional capacity for cases of treatment refusal in the article I mentioned in Part I of my reply to Ross (CQ 18, no. 3, July 2009).

> Among adults, a contrary decision in the face of a patently favorable risk/benefit ratio should be grounds for an individualized assessment of capacity.
>
> But because the principle of respect for patient autonomy has significantly greater weight among adults [than among adolescents], we do not initiate an assessment of capacity unless the risk–benefit ratio is *extremely* favorable. . . . In other words, the threshold for the risk–benefit ratio that should trigger an assessment of capacity is higher for adults than for adolescents.[1]

This assigns a place for individualized assessments of adolescent decisional capacity without dislodging well-grounded empirical generalizations about adolescent decisional capacity. I join with Professor Clayton in holding that pediatricians, perhaps with the assistance of an ethics committee, are not necessarily ill equipped to make these assessments. It *is* possible, as Carol Levine, Nancy Dubler, and I wrote, to implement the following guideline in clinical practice: "An adolescent's refusal of recommended treatment should initiate an extensive discussion with the teen and a consideration of mutually acceptable alternatives."[2]

Finally, Ross says that she has difficulty with my notion of a moral self, and she asserts, by way of objection, that even "some young children can have this moral sense." The notion of a moral self was intended to mark those cases in which the actions and traits of a young person are his or her own, in the sense important for autonomy, and to distinguish them from cases in which the actions and traits of a young person are not his or her own in this important moral sense. This is not a precise formulation, but

the basic idea should be clear enough. To have a relatively stable tendency to act for certain reasons, which I suppose can be true of some young children, is not sufficient for having a moral self. To possess a moral self the young person has to *take an interest in* the sort of person she is, and this interest is expressed either by accepting certain traits as self-defining and going on as that person, or by making certain traits her own by working to become a person with them. It would be very surprising to find a young child who takes much of an interest in this.

Notes

1. Blustein J, Moreno JD. Valid consent to treatment and the unsupervised adolescent. In: Blustein J, Levine C, Dubler NN, eds. *The Adolescent Alone*. Cambridge, UK: Cambridge University Press; 1999:100–110 at p. 104.
2. Blustein J, Levine C, Dubler NN. *The Adolescent Alone*. Cambridge, UK: Cambridge University Press; 1999:261.