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OVERRIDING ADOLESCENT REFUSALS OF TREATMENT

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ADOLESCENTS are routinely treated differently from adults, even when they possess agential capacities that are not dissimilar. Some instances of differential treatment rely on the assumption that responsible adults or institutions are better placed to direct an adolescent's life. In this article we attempt to make philosophical sense of one notable case of differential treatment of adolescents: the concurrent consents doctrine in the law of England and Wales (and other jurisdictions).[1] Our discussion of this doctrine may shed light on the justification for treating adolescents differently from (and paternalistically compared to) adults in medical and other domains.

According to the concurrent consents doctrine, adolescents found to have decision-making capacity have the power to consent to—and thereby, all else being equal, permit—their own medical treatment. However, adolescent refusals of treatment do not have the power to always render treatment impermissible; other parties—that is, individuals who exercise parental responsibility, or a court—retain the authority to consent on their behalf.

The concurrent consents doctrine is puzzling. The adolescents of interest to us possess the minimum rationality considered necessary for agency. When adults possess the same, their decisions in respect of medical treatment are normatively determinative. Yet under the concurrent consents doctrine, the consents of adolescents who possess the same threshold degree of rationality are treated as normatively determinative, but their refusals are not always so treated. At the same time, the concurrent consents doctrine seems intuitively plausible. It attempts to strike a balance between protecting adolescent well-being and respecting burgeoning autonomy.

How might we justify the asymmetry in the normative power of consent to

1 See, e.g., Child and Family Services Act, CCSM c. C80 (1985) (Manitoba); A.C. v. Manitoba (Director of Child and Family Services) [2009] 2 SCR 181 (Can.); Law Reform Commission (Ireland), *Children and the Law*, para. 2.160; Children (Scotland) Act, 1995 c. 36, sec. 2; Minister for Health v. AS, [2004] WASC 286.

and refusal of medical treatment posited by the concurrent consents doctrine?[2] In this article, we develop a view supporting some instances of differential treatment of adult and adolescent agents, including possibly the concurrent consents doctrine. Our account harnesses the strengths of rival defenses of differential treatment, while avoiding their infelicities.

In section 1, we briefly outline the legal regime for concurrent consents in England and Wales. In sections 2 and 3, we discuss and reject two attempts to defend the asymmetry in consent to and refusal of medical treatment by reference to transitional paternalism. In section 4, we consider and reject a stage-of-life justification for differential treatment. In section 5, building on the critical insights of the previous sections, we articulate a new rival justification for differential treatment based on a conception of adolescent well-being that is distinct from that of adults and younger minors. This seems to offer the most promising support for the concurrent consents doctrine. We then defend our view against three objections.

By way of preliminaries, it is important to clarify our focus. There seem to be at least two general strategies for justifying concurrent consents. The first strategy focuses on adolescent decision-making capacity—for example, by relying on a risk-relative standard of capacity, according to which refusal with likely very poor outcomes requires greater competence.[3] The second strategy attempts to justify concurrent consents, even on the assumption that adolescents possess decision-making capacity in respect of the choice to consent to or to refuse treatment. Our paper engages with justificatory strategies of the second kind.

We stipulate that the cases with which we are concerned are those in which the treatment is (at least) in the adolescent's clinical best interests, the treatment is standard with a high probability of success, and refusal carries a high probability of severe harm or death. For simplicity, we will often refer to such cases as relating to serious medical treatment.

1. THE LEGAL REGIME FOR CONCURRENT CONSENTS IN ENGLAND AND WALES

In England and Wales, health professionals must, as a general matter, gain valid

2 For legal consideration of this issue, see Eekelaar, "White Coats or Flak Jackets?"; Elliston, "If You Know What's Good for You"; Harmon, "Body Blow"; Gilmore and Herring, "'No' Is the Hardest Word"; and Lowe and Juss, "Medical Treatment."

3 See, e.g., Buchanan and Brock, *Deciding for Others*; Wicclair, "Patient Decision-Making Capacity and Risk"; Wilks, "The Debate over Risk-Related Standards of Competence." If one inclines toward the risk-relative approach to decision-making capacity, our discussion potentially supplements that argumentative strategy. If one rejects the risk-relative view but finds the asymmetry between adolescent consents and refusals intuitively plausible, our discussion explores alternative routes to justification of the concurrent consents doctrine.

consent for medical treatment to be lawful.[4] Adults eighteen years of age and over generally possess the power to determine whether to undergo medical treatment; no other party has the power to validly consent to or refuse their treatment.[5] Children aged under sixteen years generally have no power to make decisions (that is, consent or refuse) in respect of their own medical treatment; rather, any such decisions are to be made by individuals who exercise parental responsibility over the child.[6]

Notwithstanding the above, all else being equal (that is, assuming adequate information provision and the absence of undue influence), any minor under sixteen years of age may gain the power to consent to her own medical treatment when she satisfies the requirements of the test for decision-making capacity established in *Gillick v. West Norfolk and Wisbech* AHA—that is, when she "achieves sufficient understanding and intelligence to enable … her to understand fully what is proposed."[7] However, the acquisition of *Gillick* competence does not entail the disappearance of the power to consent to treatment on the adolescent's behalf by the individuals who exercise parental authority or by the courts.[8]

4 Aintree University Hospitals NHS Foundation Trust v. James, [2013] UKSC 67. Consent will be valid when *P* possesses adequate information about the intervention offered, per Chatterton v. Gerson, [1981] QB 432; *P* possesses decision-making capacity, per Mental Capacity Act, 2005, c. 9 (hereafter cited as MCA 2005); and autonomy-undermining external influence is absent, per Re T (Adult: Refusal of Treatment), [1993] Fam 95 (CA Civ). Treatment may be provided without consent to some individuals detained under the Mental Health Act 1983. This is special, rather than general, law. Treatment may also be provided without consent to individuals aged sixteen or over who lack decision-making capacity, subject to the requirement that the intervention is in the patient's best interests. In such cases, consent is deemed by operation of law; see MCA 2005, secs. 4 and 5.

5 See, e.g., Ms B v. An NHS Hospital Trust, [2002] EWHC 429 (Fam).

6 Children Act, 1989 c. 41, sec. 3(1); see, e.g., Gillick v. West Norfolk and Wisbech AHA, [1986] AC 112 (HL) (hereafter cited as *Gillick*).

7 *Gillick*, 189 (Lord Scarman).

8 In *Gillick*, Lord Scarman holds that "the parental right to determine whether or not their minor child below the age of 16 will have medical treatment *terminates*" upon the acquisition of *Gillick* competence (188–89, emphasis added). Some commentators interpret Lord Scarman's dictum as authority for the proposition that the legal power to consent to and refuse medical treatment transfers from individuals who exercise parental responsibility to adolescents upon the acquisition of *Gillick* competence by the latter—e.g., Bainham, "The Judge and the Competent Minor." Subsequent legal decisions reject this view, holding that "the parental right to determine" refers only to the ability to veto valid consent provided by competent minors; see Re R (A Minor) (Wardship: Consent to Treatment), [1992] Fam 11 (CA) (hereafter cited as *Re R*); and Re W (A Minor) (Medical Treatment: Court's Jurisdiction), [1993] Fam 64 (CA) (hereafter cited as *Re W*).

Rather, parents and the courts retain the power to consent concurrently with the adolescent.[9]

The position with regard to concurrent consents is similar for adolescents aged sixteen and seventeen. In virtue of the Family Law Reform Act 1969, section 8(1), consent to "surgical, medical or dental treatment" by these minors is legally effective upon meeting the conditions for valid consent applicable to adults. As such, adolescents sixteen and seventeen years of age benefit from a rebuttable presumption of capacity to consent to medical treatment.[10] However, the Family Law Reform Act 1969 section 8(3) preserves "any consent which would have been effective if [section 8(1)] had not been enacted." The courts have interpreted section 8(3) as preserving concurrent consents by individuals exercising parental responsibility or the courts on behalf of sixteen- and seventeen-year-olds.[11]

For competent adolescents there exists, then, an asymmetry in the normative power of consent and refusal. All else being equal, an adolescent may give legally effective consent to treatment (unlike minors lacking capacity), but their valid refusal of treatment may not (unlike adults) be legally effective if the individual(s) exercising parental responsibility or the court consent and thereby render medical treatment lawful.[12] In what follows, we consider how this asymmetry might be supported philosophically.

9 *Re R*, 23–24.

10 MCA 2005, secs. 1(2) and 2(5). See secs. 2(1) and 3(1) for the test for capacity.

11 *Re W*, 84. In the recent case of NHS Trust v. X, [2021] EWHC 65 (Fam), Munby expressed the view that both *Re R* and *Re W* remain good law.

12 There is some doctrinal uncertainty about the scope of the concurrent consents doctrine. On the one hand, in *Re W*, Lord Donaldson holds that "the inherent powers of the court under its parens patriae jurisdiction are theoretically limitless. . . . There can therefore be no doubt that it has power to override the refusal of a minor," which would suggest that the concurrent consents doctrine is applicable to all refusals of treatment (81). On the other hand, Lord Donaldson himself states that "prudence does not involve avoiding all risk, but it does involve avoiding taking risks which, if they eventuate, may have irreparable consequences or which are disproportionate to the benefits which could accrue from taking them," which suggests restriction of the (practical) scope of the concurrent consents doctrine to medical treatment decisions with potentially serious consequences (81–82). This interpretation aligns with the dictum of Balcombe who holds that the court's override will operate when the child risks death or "severe permanent injury" (88). Nolan also holds that the court has a duty where the child runs the risk of death or "grave and irreversible mental or physical harm" (94). Since we focus on medical treatment decisions with potentially serious consequences, it is not necessary to engage further with the issue of the scope of the doctrine.

2. THE PARITY ARGUMENT FOR ASYMMETRICAL TRANSITIONAL PATERNALISM

Neil Manson defends the concurrent consents doctrine by appeal to what he terms transitional paternalism. On this account, the "normative power to permit treatment is shared between the adolescent and other parties (parents and courts)."[13] Accordingly, it is possible for one party to authorize treatment even when another party with whom the power is shared validly refuses it.[14] This distribution of normative powers is paternalistic because it involves one party possessing the power to consent to another's treatment against the latter's expressed wishes, for her benefit. The paternalism is transitional insofar as adolescents gain, once competent, normative powers that are shared until they become adults.

What justifies transitional paternalism (generally)? Manson appeals to a parity argument:

P1. If we justifiably accept "paternalistic restrictions for adolescents … in areas where any harm is unlikely to be fatal … we should not reject paternalistic restrictions in cases where the risk of serious harm to the adolescent is clear and imminent."
P2. We are justified in accepting paternalistic restrictions in areas in which harm is unlikely to be fatal.
C. Therefore, we ought not reject "paternalistic restrictions in cases where the risk of serious harm to the adolescent is clear and imminent."[15]

This argument does not alone justify the consent/refusal asymmetry in adolescent decision-making about medical treatment. This is because transitional paternalism can be instantiated in different ways.

Manson distinguishes between two forms of transitional paternalism:

> *Restricted-Scope Version*: In some domains, the adolescent has the power to consent to and to refuse treatment; in other domains, to do neither. In some domains, the adolescent is treated like an adult, and in some, like a child. On the restricted-scope view, it might be that in respect of decisions about serious medical treatment, neither consent nor refusal has power.

13 Manson, "Transitional Paternalism," 70. Manson uses the example of a joint bank account to illustrate an asymmetrical distribution of normative powers. On the terms of the arrangement, each account holder possesses the power to consent to certain transactions, even in the face of a valid objection by another account holder (69). Of course, the asymmetrical sharing of normative powers in this context is justified by the agreement between the account holders and the bank.

14 Manson, "Transitional Paternalism," 70.

15 Manson, "Transitional Paternalism," 71–72.

> *Constrained-Power Version*: Consent and refusal have normative power in all domains, but refusals are constrained by the consents of others in certain domains (for example, those in which serious harm might ensue).[16]

Only the constrained-power account instantiates the asymmetry between adolescent consent and refusal. Manson argues that we should prefer the constrained-power version of transitional paternalism to the restricted-scope version by invoking Suzanne Uniacke's distinction between compliance respect and consideration respect.[17] On the constrained-power version of transitional paternalism, adolescents' autonomous wishes are in every case at least considered (given *consideration respect*); in every case in which an adolescent consents, her consent is complied with (given *compliance respect*). Whereas on the restricted-scope form of transitional paternalism, at least in the cases in which we take an interest, adolescents' wishes may only ever receive consideration respect:

	Restricted-Scope View	Constrained-Power View
P consent to ϕ	Consideration respect	Compliance respect
P refusal of ϕ	Consideration respect	Consideration respect

Compliance respect is a more robust form of respect for autonomy.[18] Therefore, the constrained-power account of transitional paternalism offers a "higher grade of respect for the adolescent as an independent decision-maker" than the restricted-scope version.[19]

We have two worries about Manson's argument. First, Manson favors the constrained-power version of transitional paternalism over the restricted-scope version on the grounds that the former involves greater respect for adolescent autonomy. However, Manson does not justify the claim that more autonomy is better for adolescents. Without a justification for this claim, Manson lacks support for his position that the constrained-power view is superior to the restricted-scope view, which in turn is necessary to support the asymmetry in adolescent consents and refusals. In addition, an adequate justification of the asymmetry should provide an account of how autonomy relates to other, competing values, including those Manson thinks warrant constraining autonomy in the case of adolescent refusals.

Second, we have a worry about the first premise of Manson's parity argument. The reasons underpinning restrictions of autonomy in the case of nonfatal harm

16 Manson, "Transitional Paternalism," 72.

17 Uniacke, "Respect for Autonomy in Medical Ethics."

18 Manson, "Transitional Paternalism," 72.

19 Manson, "Transitional Paternalism," 72.

may not carry over to the restrictions of autonomy in the case of serious harm. For example, paternalism in respect of smoking, alcohol, some drug use, or seat belts is likely attributable to the fact that these activities involve weakness of will or irrationality. However, such a justification does not seem to work for refusals of medical treatment, especially when motivated by robust religious or moral views. We can see this in the case of adults, for whom there are paternalistic restrictions on various everyday activities but no such limitations for medical treatment decisions, including those involving potentially serious harm.

These criticisms impugn only Manson's version of transitional paternalism. The asymmetry between adolescent consents and refusals might be justified by a different account of the constrained-power version of transitional paternalism.

3. The Fundamental-Interests Argument for Asymmetrical Transitional Paternalism

Faye Tucker attempts an alternative defense of constrained-power transitional paternalism.[20] She offers the following argument:

P1. Children, including adolescents, have a set of fundamental interests, including in the development of self-governance and faring well.
P2. Adults have an obligation to advance these interests.
P3. The application of transitional paternalism best advances these interests in the medical setting.
C. Therefore, transitional paternalism is justified in the medical setting.

Tucker's defense of transitional paternalism relies on Tamar Schapiro's justification of paternalism toward children, including adolescents.[21] On Schapiro's view, an individual's beliefs and actions are attributable to her when she is self-governing. An individual is self-governing when she has a will, and she has a will when she possesses the capacity to assess her perceptions and motivational impulses (nature's authority) critically and to determine for herself what to do and believe. According to Schapiro, children's beliefs and actions are not attributable to them; they are determined (at least in part) by nature. Children lack the ability to stand back from their motivational impulses and perceptions to determine rationally and freely how to behave and what to think.[22] Children in this sense lack a will. Children are therefore not self-governing and not (fully) responsible for their actions and beliefs. Paternalism is then permissible: for

20 Tucker, "Developing Autonomy and Transitional Paternalism."

21 Schapiro, "What Is a Child?" and "Childhood and Personhood."

22 Schapiro, "Children and Personhood," 590–91.

paternalism is problematic only when it disregards another person's will or another's authority.[23]

Schapiro argues that we have both an obligation to assist children in becoming self-governing and an obligation of beneficence. Tucker thinks that the constrained-power version of transitional paternalism is the most suitable way of discharging these obligations in a clinical context, since it best cultivates an adolescent's capacity for self-governance while safeguarding her well-being.[24]

Tucker's view is vulnerable to three objections. The first objection is that it is unclear whether the constrained-power version of transitional paternalism better facilitates the interest in self-governance than the restricted-scope version. We might plausibly cultivate self-governance (and protect well-being) through the restricted-scope view.

Indeed, Schapiro suggests an account of this sort. On her view, as children enter adolescence they gain "adult status with respect to some domains of discretion, but not others."[25] The acquisition of discretion is based not only on whether the actions or beliefs in the relevant domain were attributable to adolescents but also on whether those adolescents could perform the relevant tasks proficiently.[26] Granting adolescents discretion in any one domain assists them in developing principled stances that might extend their authority to new domains.[27] The expansion of domains of discretion as the adolescent matures is a plausible route through which to arrive at full self-governance, because it involves developing a set of principles that eventually will extend to all domains. But this leaves open the possibility that the restricted-scope version of transitional paternalism better facilitates the development of self-governance.

It is not clear, therefore, that Tucker is able to construct a good defense of the constrained-power version of transitional paternalism based on Schapiro's view alone. And none of the reasons she gives for thinking otherwise are compelling. First, Tucker suggests that the restricted-scope account is less good at facilitating self-governance than the constrained-power account because "only the asymmetric sharing of normative powers enables young people to be involved in a

23 It is not clear that this is paternalism, because paternalism at least on some readings involves overriding the authentic rational ends of another individual.

24 Tucker, "Developing Autonomy and Transitional Paternalism," 762.

25 Schapiro, "What Is a Child?" 734.

26 Schapiro, "Children and Personhood," 591. The proficiency concern is there because on Schapiro's view, the allocation of discretion to adolescents is to be done responsibly.

27 We think this is a plausible rendition of Schapiro's view, but we are not certain of its accuracy. Schapiro changes her mind about the nature of the reasons for granting domains of discretion to adolescents. For an account of the changes, see Schapiro, "Children and Personhood," 591.

set of important decisions from which they would otherwise be excluded, and participation of this sort is *central* to the cultivation of their self-governance."[28]

In reply, one might contend that even if the adolescent's views are not normatively definitive in restricted domains of discretion, participation in the decision through consultation may take seriously the duty to promote self-governance, in addition to the duty of beneficence on the part of involved adults.[29] Participation or involvement in a decision in which one does not have the final say may nevertheless form the basis for the development of "provisional principles of deliberation."[30]

Tucker's point here relies on an inaccurate rendering of the restricted-scope version of transitional paternalism. It does not follow from the fact that an adolescent's views are not normatively determinative that her views would not bear on the decision-making process at all. Even Manson grants that the restricted-scope view affords consideration respect and therefore at least some—possibly quite robust—involvement in important decisions.[31]

Second, Tucker's erroneous characterization of the restricted-scope version of transitional paternalism infects another reason she offers for thinking the restricted-scope view is less good at facilitating self-governance than the constrained-power view. Tucker argues that only the asymmetrical version of transitional paternalism—that is, the constrained-power account—gives "consideration to young people's voices in respect of *all* clinical actions."[32]

The problem here is that Tucker frames the restricted-scope account as entailing that decisions are made on behalf of adolescents without their involvement. However, the restricted-scope account is able to accommodate a duty to consider young people's voices in all clinical actions—that is, by decision makers giving minors' wishes space in the deliberation about what, all things considered, is in their best interests. Indeed, a duty of this kind appears to exist in law and professional guidance for all minors.[33]

Third, Tucker claims that the restricted-scope account is less effective at facilitating self-governance than the constrained-power account because the latter is consistent with "the kind of social arrangements that best support autono-

28 Tucker, "Developing Autonomy and Transitional Paternalism," 765, emphasis in original.

29 See, e.g., *Re W*, 84; Re P (Medical Treatment: Best Interests), [2003] EWHC 2327 (Fam); General Medical Council, *0–18 Years*.

30 Schapiro, "What Is a Child?" 736.

31 Manson, "Transitional Paternalism," 72.

32 Tucker, "Developing Autonomy and Transitional Paternalism," 765, emphasis in original.

33 See, e.g., Re X (A Child) (Capacity to Consent to Termination), [2014] EWHC 1871 (Fam); and General Medical Council, *0–18 Years*.

my."[34] However, this amounts to no more than the rather weak claim that the constrained-power account does not conflict with such social arrangements. Rival views, including other forms of transitional paternalism, might also be consistent with such social arrangements. Whether this is the case will depend on what count as the social arrangements that support autonomy and on various empirical claims about what supports these institutions. Tucker refers to the social arrangements that foster the skills and attitudes associated with autonomy and the development of a deliberative perspective.[35] However, it is, for example, not evident that the restricted-scope account is inconsistent with the social arrangements that best support these kinds of skills and attitudes. Indeed, the sort of reasoning employed in the restricted-scope context by other rational agents—who, for Schapiro, might serve as good models for adolescents insofar as they are self-governing and insofar as they exercise their authority over children responsibly—might facilitate equivalent or greater self-governance in adolescents.[36] We now turn to the second and third objections that Tucker faces.

On the second objection, if Tucker wishes to base her transitional paternalism in part on the fact that the adolescent's will is insufficiently developed, it will be hard for her to justify the asymmetrical treatment of adolescent consent and refusal. If refusal is not always capable of rendering treatment impermissible because an adolescent lacks a fully developed will, why does the same deficiency in the will not cast doubt on consent? Schapiro seems not to allow for adult-like respect with regard to consent but childlike respect with regard to refusal in the same domain. Indeed, Tucker seems to admit this; she writes that "Schapiro argues her lack of reason means the child is unable to make her own choices, *whether good or bad*."[37] If one has authority with respect to a domain, one's deliberative perspective is for that domain authoritative, for the deliberative perspective involves a settled set of values or principles undergirding the decision. One is then authoritative in both one's deciding to do and deciding not to do something. This follows even if facts about proficiency are ultimately relied on to allocate a domain of discretion to an adolescent. Proficiency tests determine whether an adolescent is able to perform the relevant task competently, not whether that decision is attributable to her. So Tucker cannot rely on Schapiro's view to justify the asymmetry in consent and refusal for which she advocates.

The third objection to Tucker's position is that children plausibly have fundamental interests beyond that of becoming self-governing. In addition to the latter,

34 Tucker, "Developing Autonomy and Transitional Paternalism," 765.

35 Tucker, "Developing Autonomy and Transitional Paternalism," 762–63.

36 Schapiro, "Children and Personhood," 592–93, and "What Is a Child?" 734–37.

37 Tucker, "Developing Autonomy and Transitional Paternalism," 761–62, emphasis in original.

Tucker mentions welfare interests and other fundamental interests.[38] Children have a range of interests including a great range of prudential interests, the existence of which might justify limiting or permitting certain decisions that adolescents might make. Until we hear more from Tucker about what these interests are, we will lack insight into the way in which they might constrain cultivating the interest in self-governance. Tucker's version of transitional paternalism does not, then, improve on Manson's account of the view.

To this point, we have addressed views that explicitly seek to justify a constrained-power (asymmetrical) version of transitional paternalism in respect of serious medical treatment decisions involving adolescents. We now turn to two general views that might justify paternalism toward adolescents. Our aim is to determine the extent to which these might justify asymmetry in the respective power of adolescent consent to and refusal of medical treatment.

4. A STAGE-OF-LIFE DEFENSE OF CONCURRENT CONSENTS

Andrew Franklin-Hall attempts to justify paternalism with respect to adolescents in the domain of education.[39]

According to Franklin-Hall, adults have a right to autonomy, entailing a duty to respect their practical authority in deciding what to do. In order to justify equal standing among adults in this regard, the basis of this standing (a threshold degree of rationality or agency) cannot be too robust, for then adults would not possess equal autonomy rights and their practical authority would not be accorded equal respect. However, if the threshold for rationality or agency is set at a level that grounds the equal status of (most) adults, it would seem to ground similar status in adolescents, for typically they possess the minimum level of competence required for agency.[40] This generates a duty to respect their autonomy, and therefore their practical authority.

Yet, in education, adolescent autonomy is routinely restricted to allow adolescents, for their own good, to develop more than the minimum level of rationality or minimum capacity for agency. Here, adolescent autonomy is restricted in order to foster various robust autonomy-related capacities or skills (for example, imaginative reflection) and other character traits or virtues (for example, perseverance and moderation).[41] Franklin-Hall calls the tension between the

38 Tucker, "Developing Autonomy and Transitional Paternalism," 762.

39 Franklin-Hall, "On Becoming an Adult."

40 We take it that the threshold for rationality or agency would not be set so low so as to afford full practical authority for adults who suffer from severe cognitive impairments, etc.

41 It is important to note here that not all the aims of education to which Franklin-Hall al-

duty to respect adolescent autonomy and its restriction to promote other educational goods the "dilemma of liberal education."[42]

How is it possible to justify both respect for the autonomy of adults and paternalism toward adolescents in education? Franklin-Hall offers a stage-of-life solution to the dilemma. He argues that paternalism toward adolescents in education is justified because it takes place at the stage before which an individual has taken up full responsibility for her life. At this stage, an adolescent's values are provisional, and therefore they do not provide a stable and settled basis for her practical identity.[43] Such paternalism has a preparatory aim: it is "oriented toward preparing a person for full practical authority in adulthood."[44] It is conducted with the explicit and public understanding that the adolescent will at some point in the future assume full responsibility for her life.[45] Paternalism toward adolescents can be seen, then, as a normal—and temporary—part of an autonomous life, and so consistent with living a complete one. Finally, paternalism in education, according to Franklin-Hall, does not *interfere with* adolescents living their own lives according to their values; rather, paternalism *delays* the exercise of autonomy.[46]

Important to Franklin-Hall's story is the distinction between global and local autonomy. Global autonomy refers to life authorship, the power to determine one's "roles, projects, values, styles of living."[47] Local autonomy refers to an individual determining (or having the capacity to determine) what to do in a particular case at a particular time. Global autonomy is the more important of the two. Franklin-Hall argues that paternalistic limitations on autonomy in education relate only to local autonomy. The interventions interrupt local autonomy but merely delay the onset of global autonomy. This is consistent with living a "complete autonomous life."[48]

Franklin-Hall's solution to the dilemma of liberal education might be used to support paternalism toward adolescents in the medical setting, and, in particular, the asymmetrical authority of adolescent consents and refusals. The paternalis-

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ludes are paternalistic. Some of the aims of education limit autonomy but for other than paternalistic reasons. It is unlikely, for example, that educating adolescents so as to foster "open-minded dialogue," "care," "toleration," and "mutual respect" is justified on paternalistic, rather than on moral, grounds (Franklin-Hall, "On Becoming an Adult," 234).

42 Franklin-Hall, "On Becoming an Adult," 235.

43 Franklin-Hall, "On Becoming an Adult," 229.

44 Franklin-Hall, "On Becoming an Adult," 240.

45 Franklin-Hall, "On Becoming an Adult," 239–40.

46 Franklin-Hall, "On Becoming an Adult," 239.

47 Franklin-Hall, "On Becoming an Adult," 237.

48 Franklin-Hall, "On Becoming an Adult," 241.

tic limitation of adolescent autonomy, despite the possession of the minimum capacity necessary for agency, occurs before an individual has assumed full responsibility for her life. At this stage of life, an adolescent's values are provisional—that is, the principles on which she acts do not constitute a stable and settled basis for her practical identity. The paternalism is developmental and temporary; its role is to prepare adolescents for the assumption of full practical authority in making medical decisions.[49] This provides a reason for giving adolescents some control over what happens to them in the medical setting. Moreover, paternalistic restrictions are instituted with the explicit and public understanding that the adolescent will at some point in the future assume full responsibility for her life. Paternalism toward adolescents in medicine can be seen, then, as a normal part of an autonomous life, and so consistent with living a complete one.

The power to give legally effective consent may play a role in preparing adolescents for the assumption of full practical authority, and may be useful from the point of view of developing a full inventory of capacities associated with autonomous choice. These and other preparatory reasons might warrant giving adolescents the authority to consent to treatment and permitting some role for refusals. But limitations on treatment refusal may be justified—in virtue of, in part, the provisional nature of an adolescent's values—in order to protect the adolescent from the full force of action on her principles. Finally, the limitation on refusal is imposed during the stage before control is important to shaping or authoring one's life. To wit, the paternalistic restriction on refusal interrupts local autonomy but merely delays the onset of global autonomy. The assumption is that the choice to determine whether to undergo medical treatment will be an adolescent's in the future—on passing the age of majority.

There is a potential complication with our attempt to extend Franklin-Hall's stage-of-life account to adolescent medical treatment. Franklin-Hall notes the existence of "forced, momentous" choices—choices both life shaping and in-

49 This claim is consistent with the dictum of Lord Donaldson in *Re W*:

> Adolescence is a period of progressive transition from childhood to adulthood and as experience of life is acquired and intelligence and understanding grow, so will the scope of the decision-making which should be left to the minor, for it is only by making decisions and experiencing the consequences that decision-making skills will be acquired. . . . "[G]ood parenting involves giving minors as much rope as they can handle without an unacceptable risk that they will hang themselves." I regard it as self-evident that [the paramountcy of children's welfare] involves giving them the maximum degree of decision-making which is prudent. Prudence does not involve avoiding all risk, but it does involve avoiding taking risks which, if they eventuate, may have irreparable consequences or which are disproportionate to the benefits which could accrue from taking them. (81–82)

capable of adjournment.[50] He argues that adolescents ought to be permitted to make decisions of this sort in some cases—for example, where "there is reason to believe it best for the adolescent to make her own decision," where making the choice for her "would violate her … conscience," or where being prevented from making the choice would unduly restrict the range of options open to her future adult self.[51] Some refusals of treatment might fall within these categories.

Consider a case in which an adolescent validly refuses an abortion. As Franklin-Hall notes, while in this case forcing a teenager to have an abortion might not deprive her of "a self-directed life—it would surely violate her … conscience."[52] It might be right, then, all things considered, to let her decide what to do. If, under the concurrent consents doctrine, another party has the power to consent to abortion, the refusal might nonetheless be honored because it would be wrong to exercise the power.[53] However, here the stage-of-life account buttresses the asymmetrical view, since in this case the refusal is not by itself presumed to be normatively determinative.[54] The refusal is permitted only because there are other factors present that make exercising the power of consent in some way problematic. So even when it is wrong not to let an adolescent decide, it does not follow that it is refusal alone that makes treatment impermissible. Thus the

50 Franklin-Hall, "On Becoming an Adult," 239.

51 Franklin-Hall, "On Becoming an Adult," 239–40.

52 Franklin-Hall, "On Becoming an Adult," 240.

53 In Re X (A Child) (Capacity to Consent to Termination), [2014] EWHC 1871 (Fam), Munby holds in respect of a minor who lacked capacity to consent to an abortion that

> It would not be right to subject X to a termination unless she was both "compliant" and "accepting." … Only the most clear and present risk to the mother's life or long-term health … could justify the use of restraint or physical force to compel compliance. … [M]ere acquiescence—helpless submission in the face of asserted State authority—is not enough. "Consent," of course, is not the appropriate word, for by definition a child of X's age who, like X, lacks Gillick capacity, cannot in law give a valid consent. (12)

If a court would generally not order an abortion unless an adolescent who lacked capacity was "accepting," *a fortiori*, it seems plausible that it would not order an abortion over an adolescent's valid refusal of treatment.

54 It is perhaps possible to argue that in the "forced, momentous" choice case, the power to give concurrent consents disappears. However, this seems inconsistent with the best interpretation of the law. In *Re W*, Lord Donaldson discusses the "hair-raising possibilities … of abortions being carried out by doctors in reliance upon the consent of parents and despite the refusal of consent by 16- and 17-year-olds." His Lordship acknowledges that "this may be possible as a matter of law," which suggests that the power to consent concurrently persists in such cases (79).

asymmetry between consent and refusal remains intact even when the adolescent faces a "forced, momentous" choice.

Having articulated how the stage-of-life account might support the concurrent consents doctrine, we now turn to two objections to relying on the former to justify the latter. First, on Franklin-Hall's view there is an important moral difference between delaying an individual in taking full control of her life and interrupting the control she has over her life. However, it is far from clear that delaying an individual in living a life in accordance with her values is less problematic than interrupting her living her life in accordance with the same. Consider a sixteen-year-old who is steadfast in her religious convictions and, though a hemophiliac, repeatedly refuses blood transfusions.[55] Would interference in this case really be less problematic because it is a case of delay rather than interruption? For the adolescent who is forced to receive treatment and perceives it as a grave insult, this may be of little or no comfort or of little moral significance. Our point is even stronger when we consider cases in which such interferences are liable to reoccur.

Even if we accept that interruption is generally worse than delay, there will still be cases in which paternalism toward adolescents is tantamount to interruption. Imagine our teen is a devout and eager member of a proselytizing religious sect. She has come sincerely to endorse various roles, projects, and so on. Preventing her from making her own choices in accordance with her values seems like an interruption, no different in kind to a similar interruption in an adult. The adolescent could very well claim that this is a case in which interference is inconsistent with being permitted to live a completely autonomous life. In this case, a different kind of justification for paternalism will be required.

Second, we doubt, in any case, that a stage-of-life justification can do the moral work required to permit paternalistic limitations on refusal of treatment. Instead, stage of life seems to be at best an indicator of the variety of considerations that do seem to matter directly to such limitations, including that adolescent values or concerns are in general provisional; that in the cases we consider, acting on these provisional values or concerns has serious consequences; that the limitations are temporary and designed to promote the development of autonomy-related skills; and that adolescent well-being possesses unique features. If we focus on these considerations directly, it may be possible to account for the asymmetry in adolescent consent to and refusal of medical treatment, without reliance on all the machinery employed in Franklin-Hall's view. In addition, it may be possible to provide a justification for paternalism in this form, even when it involves interrupting rather than delaying an adolescent living an autonomous life.

55 For a similar case, see Re E (A Minor) (Wardship: Medical Treatment), [1992] 2 FCR 219 (Fam).

5. A WELFARIST JUSTIFICATION OF CONCURRENT CONSENTS

In this section, we consider how the nature of adolescent prudential value or well-being, the provisional nature of adolescent values (in general), and the risks attached to action on such values may provide an alternative, potentially more promising, justification for the asymmetry in consent and refusal in respect of medical treatment.

There is strong reason to believe that a great measure of what makes an adult's life go well depends on what she wants or what she values.[56] That is, it seems likely that adult well-being depends in large part on what matters from the individual's own subjective point of view. It seems that much less of what makes an adult's life go well is due to the possession of so-called objective goods—things good for an individual regardless of her subjective attitudes toward them, including valuable relationships and intellectual activity—though such goods may be in part what an adult cares about or values. This is no doubt a reason why some find objective accounts of well-being for adults alienating.[57]

By contrast, it is plausible that what is good for a young child lies in part in the possession of objective goods and in part in positive experiences, including happiness and felt satisfaction. A full story about faring well for a young child plausibly involves appeal to both objective goods and positive subjective states.[58] However, much less important to what makes a young child's life go well is getting what she wants or what she values. Succinctly, the subject's point of view or schedule of concerns seems much more important to an adult's well-being than it is to a young child's well-being.

Adolescents occupy a middle position between young children, on the one hand, and typical adults, on the other hand. This is the case not only in respect of how adolescents are treated but also with regard to what might plausibly count as prudentially good for them. Indeed, the differential treatment of adolescents might result at least in some cases from the fact that what is good for them prudentially is distinctive.

We hold that the role the subject's point of view or schedule of concerns plays in an adolescent's well-being lies somewhere between children and adults. This is likely to do with the fact that as the typical human develops, their point of view matures and their schedule of concerns becomes more settled. It seems intuitive

56 For an introduction to the main theories of well-being, see Fletcher, *The Philosophy of Well-Being*; and Sumner, *Welfare, Happiness, and Ethics*.

57 Railton, "Facts and Values"; Rosati, "Internalism and the Good for a Person."

58 For discussion of children's well-being, see Skelton, "Utilitarianism, Welfare, Children," "Children's Well-Being," and "Children and Well-Being."

that adolescent well-being consists at least in part in the adolescent possessing what she subjectively cares about or values. Not just any values or concerns will do, of course. But where the values or concerns are authentic (however specified), they serve as a core feature of adolescent well-being. An adolescent is better off to the extent that her values and concerns are met. These are the subjective elements of adolescent well-being, for how well an adolescent fares depends on the adolescent's schedule of concerns—that is, what matters to her from her own perspective.

Subjective considerations likely do not exhaust what is noninstrumentally good for an adolescent. An adolescent's well-being seems to consist also in the possession of objective goods. Here, an adolescent is made at least somewhat better off to the extent to which she has or possesses these kinds of goods—for example, loving and supportive relationships, knowledge, and achievement. It might be true that more of what is good for an adolescent is determined by her schedule of concerns as she ages; that is, her well-being becomes increasingly based on subjective considerations or the passage of events meeting her expectations or aligning with her values. This is no doubt due to the maturation and development of her point of view or her subjective perspective. But it is intuitive that some constituents of her well-being will remain objective.

The above characterization of the general makeup of adolescent well-being distinguishes it from that of young children, on the one hand, and that of adults, on the other hand. What is distinctive about adolescent well-being might make a difference to our treatment of adolescents. For instance, we think that a clear articulation of the noninstrumental components of adolescent well-being may help to make philosophical sense of the asymmetry of consent and refusal in respect of medical treatment. Important for our purposes are the objective elements of adolescent well-being.

Plausibly, there is a range of objective goods that matter to adolescent well-being. Our focus here is the noninstrumental prudential good of shielding. Shielding consists in being insulated from the full brunt of, the full responsibility for, action on autonomous aims. Shielding is a variety of freedom: freedom from making certain kinds of decisions in the absence of a safety net of scrutiny and possible limitation on action. Shielding is delivered through valuable and supportive, even if not entirely personal, relationships in which adolescents are afforded the insurance of a safety net. So described, the value of shielding connects to the prudential good of valuable relationships.

Franklin-Hall suggests that one virtue of his stage-of-life account is that "it makes available to adolescents a form of freedom much scarcer in adulthood, namely, a measure of freedom from having to make certain decisions with long-

term consequences."[59] When we suggest that one can justify paternalism toward adolescents by appeal to the objective prudential good of shielding, we are expressing the idea that something like this variety of freedom is noninstrumentally prudentially good for an adolescent.

In addition, Franklin-Hall notes that at least some of an adolescent's autonomous aims are provisional. In adolescence, an individual is often attempting to determine her own values; as Franklin-Hall urges, in so doing, she is "toying with possible identities."[60] This form of play can be risky. Because of the risk and the provisional status of some of the values, there is reason for some safeguards—that is, scrutiny and possible limitation on action—even if one does not regard shielding as noninstrumentally good for adolescents: it is instrumentally prudentially good for an adolescent to be shielded from the full force of action on her autonomous, yet provisional, aims. The safety net is there to promote the prudential value for the adolescent of having the responsibility for what happens to her in part outsourced to another (sympathetic and reliable) party.

To recap, on the welfarist view that we are outlining, paternalism toward adolescents is justified in part by the fact that it is prudentially good for an adolescent to be shielded from the full brunt of the consequences of acting on her values; it is prudentially good to have the freedom from making decisions in the absence of a safety net. In addition, adolescent values are provisional in nature and action on them can be risky. It is therefore noninstrumentally and instrumentally good for an adolescent to be treated in some way paternalistically. Incorporating this value into an account of adolescent well-being, as we have done, helps to explain why the stage of life matters: in that stage lie important prudential goods.

The foregoing may justify paternalism toward adolescents in general and in the particular medical circumstances under consideration. But how might it justify the asymmetry between consent to and refusal of medical treatment? Acting on autonomous aims is developmentally important for an adolescent. Being able to exercise autonomous choice at least to some extent is useful from the point of view of preparing an adolescent for the kind of decisions she will have to make on the arrival of adulthood. When an adolescent considers treatment, she (ideally) contemplates whether to consent to or to refuse treatment (and which option to pursue in cases in which more than one intervention is offered). This involves exercising a broad range of skills, including understanding the facts of the situation, applying these to herself, and making a decision based on a sober assessment of what she most values. One might think, therefore, that the rule according to which consents always have the power to render treatment permis-

59 Franklin-Hall, "On Becoming an Adult," 246.

60 Franklin-Hall, "On Becoming an Adult," 229. See also Schapiro, "What Is a Child?" 733.

sible is justified by the fact that it involves promoting instrumentally beneficial exercises of autonomy without the threat of serious costs.[61] This account can explain why the power to consent and have that be normatively determinative is given compliance respect rather than mere consideration respect—namely, because the opportunity to consent allows the instrumental benefits of the exercise of autonomy to accrue to the adolescent to a greater relative degree.[62]

The instrumental benefits of exercising autonomy may also accrue in the case in which an adolescent refuses treatment. This may provide a reason to accord compliance respect to her refusal—that is, for it to be normatively determinative. However, greater reason seems to favor giving refusals mere consideration respect. This is supported by it being prudentially good for an adolescent to be shielded from making the decision without a safety net. In addition, the (sometimes) provisional nature of the values on which an adolescent acts and the fact that action on them may be very costly, especially in the cases we are considering here, provide a further reason not to give refusals full power. These various factors together provide strong reason to protect an adolescent from making such a decision herself. These values seem to provide us, then, with reason to treat refusals differently—that is, as not always capable of rendering treatment impermissible.

The welfarist view articulated above might, then, support an asymmetry between consent to and refusal of medical treatment—namely, the concurrent consents doctrine. The welfarist account is superior to its rivals in a number of respects. It is more comprehensive, specific, and economical. As such, we avoid the objections we have made to the welfarist account's rivals. First, our view provides a compelling reason for why (*pace* Manson) we might not accept that more autonomy is always better for an adolescent. The welfarist account situates autonomy among a wider range of values, and in turn is able to explain why refusals of treatment might not always be normatively determinative. Second, we (unlike Tucker) provide a compelling account of how to justify asymmetrical forms of transitional paternalism; we show how the values on which we draw provide specific support for the doctrine. Third, our view captures the attractive features of the stage-of-life justification of paternalism by reference to prudential values germane to that stage. It does so without reliance on the often very complex machinery found in Franklin-Hall's view. The welfarist view does not, for example, require that we put normative weight (*pace* Franklin-Hall) on the distinction between delaying and interrupting a life lived in accordance with certain values. The welfarist account is therefore more economical than the stage-of-life justifi-

61 There may also be prudential benefits if autonomy is among the prudential goods.

62 Recall that Manson was to his detriment unable to explain why more autonomy was better.

cation. In what remains, we further clarify our welfarist view and consider and reply to some additional potential objections to it.

Let us start with two clarifications. First, it might be inferred from the foregoing that refusals of treatment are alone problematic. We would stress that it need not, of course, be the case that consent is prudentially unproblematic all things considered, whereas refusal poses a prudential threat all things considered—we might envisage cases in which the converse is true. In some situations, refusal may be prudentially unproblematic because it concerns relatively insignificant medical interventions while consent is a prudential threat because it entails quite consequential risks.[63] In this case, it would be consent rather than refusal that should not always be normatively determinative. As such, an asymmetry in normative powers may track high- and low-stakes options.[64]

Second, we have assumed that an adolescent can meaningfully consent to and therefore permit treatment in circumstances in which another party has the power to override a refusal.[65] This assumption and this form of asymmetry in normative powers is a feature of English law (and that of other jurisdictions).[66] Because the concurrent consents doctrine is law, it is important to determine whether it admits of justification. Our idea is that *if* you accept the concurrent consents doctrine and its asymmetrical distribution of the normative powers of consent and refusal, then the most promising defense of this arrangement is provided by the welfarist view. We now turn to objections.

The first objection to the welfarist account focuses on the imposition that shielding involves. The idea that it is prudentially good for an adolescent to be free from making consequential decisions without a safety net has some intuitive plausibility. But for some, this intuitive plausibility may vanish when the

63 For example, we might think that consent to elective or cosmetic interventions carries higher risk of a bad outcome than refusal of the same. Thank you to David Brink for pressing us to clarify this point.

64 In *Re W*, 76 and 83–84, Lord Donaldson expresses the view that the valid consent of a minor of any age could be overridden by the court, but not parents. Interpreted in this way, Lord Scarman's dictum in *Gillick*, 188–89, may leave room for a *concurrent refusal* doctrine, but this, to our knowledge, has never been tested in litigation. If a concurrent refusal doctrine were to exist, this would support the view that the asymmetry in the normative power of consent to and refusal of medical treatment tracks high- and low-stakes options, rather than any essential feature of consent or refusal.

65 For discussion, see, for example, Manson, "Transitional Paternalism"; and Lawlor, "Ambiguities and Asymmetries in Consent and Refusal."

66 Indeed, the legal literature proceeds on this assumption. See, for example, Eekelaar, "White Coats or Flak Jackets?"; Elliston, "If You Know What's Good for You"; Harmon, "Body Blow"; Gilmore and Herring, "'No' Is the Hardest Word"; and Lowe and Juss, "Medical Treatment."

practical realities entailed in promoting or protecting the value of shielding emerge. Consider the adolescent who stubbornly and adamantly wishes to refuse treatment on the basis of her passionately expressed values. She experiences forced treatment as a deep insult, involving great pain and suffering, physical and psychological. This may intensify as the intervention becomes more invasive. These facts make it hard to maintain that it is prudentially good for her not to have the power to refuse treatment.

In reply, one option is to grant that the practical realities of shielding involve the imposition of harm but that the prudential benefits (albeit objective in nature) of being shielded, among other benefits, are worth the cost. The imposition of significant costs through forced treatment on an adolescent is, moreover, not unique to the view that we defend here. In the case of each of the views above, significant burdens will be imposed on the adolescent for her benefit. We seem to have an advantage over those accounts: we can tell the adolescent in what way denying her refusal full normative power is good for her now.

We are open to the idea, however, following Franklin-Hall, that perhaps there are cases in which it is best for an adolescent to have full power over her decisions—that is, full power to consent to or to refuse treatment. Consider two cases. The first involves a recalcitrant teen with anorexia, for whom forced feeding would be experienced by her as a form of tyranny, involving considerable confinement, violation of bodily integrity, suffering, and significant costs on those around her. In this case, we might think it is best for her to make the decision. The second involves an adolescent of First Nations descent living in a country marred by historic injustices toward her peoples, including neglect of their health needs and dismissal of their traditional forms of healing. Against such background injustice, it might all things considered be better to let the adolescent make the decision herself.

The second objection focuses on the general view that we have expressed about the differences between the nature of well-being in adults, adolescents, and young children. To justify the concurrent consents doctrine, we have relied on the idea that adolescent well-being is, in terms of its fundamental, nonderivative prudential constituents, distinct from adult well-being, on the one hand, and young children's well-being, on the other hand. More specifically, we have argued that so-called objective components of well-being are of lesser importance to adults than to adolescents and younger children and that so-called subjective constituents are of lesser significance to adolescents and younger children than to adults.[67]

67 Cf. Cormier and Rossi, "Is Children's Wellbeing Different from Adults' Wellbeing?"; Lin, "Welfare Invariabilism."

This is, of course, not the place to mount a full defense of our view. In reply to the worry, it is possible to recast our account of the prudential value of shielding in a way that makes it less dependent on the nature of well-being varying over the course of an individual's life.[68] There are two options in this regard.

The first option is to maintain that the well-being of children and of adolescents is more subjective in nature than we have suggested—more like what we maintain about adult well-being. In this case, we might hold that well-being consists in desire satisfaction or in life satisfaction or happiness for welfare subjects regardless of stage of life. In so doing, we would deny that there are radical differences in the nature of well-being across classes of welfare subject.

Taking this stance does not require denying that there are (even quite) significant differences in the instruments or causes of well-being across welfare subjects. It is likely that the breadth and depth of one's desires or expectations, not to mention the degree and sophistication of scrutiny that they are able to withstand, is going to be quite different at different stages of maturation or development. These differences are highly likely to occasion a change in the instruments of desire or life satisfaction or happiness.

It is plausible that shielding is one of the instruments of well-being for adolescents, in light of their level of maturation, the (in general) provisional nature of their values, the somewhat unstable nature of their identity, and so on. True, shielding may have some role as a cause of desire or life satisfaction or happiness even for adults. But it is likely that shielding will not have the same degree of influence given (as a class) adults' level of maturity, their stable values, their robust identity, and the value of autonomy to them.

The second option is to hold that the nature of adult well-being is more objective—more like what we maintain about child and adolescent well-being. It may be that well-being consists in the possession of some inventory of objective goods for all welfare subjects. An objective standpoint does not, however, rule out significant differences between the well-being of different welfare subjects. These differences could manifest in at least two different ways.

For one, it is possible that while the nature of well-being is objective, the items on the lists comprising the objective goods will vary across welfare subjects. This will, again, likely depend (at least in part) on the stage of life or development of the welfare subject. There is some reason to think that shielding would not feature on the list of objective prudential goods for adults. Indeed,

68 To be clear, we are not here retreating from our conception of adolescent well-being. Rather, we argue that even if one does not accept our account, shielding has an important role to play in thinking about what is prudentially good for an adolescent.

many of the objective lists for adults include autonomy, but omit shielding.[69] Of course, objective lists for adolescents do not mention shielding either, but that is because no such lists—other than our own—exist. We think, again, that adolescents' level of maturation or development, the provisional nature of (some of) their values, their need for freedom to form their own identity, and so on all make shielding a highly compelling objective good for adolescents.

For another, the objective lists for all welfare subjects might comprise the same items, but the strength of the prudential value of the goods may differ at different stages of life. For example, both autonomy and shielding may be noninstrumentally good for all welfare subjects, but autonomy may matter more (noninstrumentally) to the well-being of adults than to the well-being of adolescents and to that of young children. Likewise, shielding may matter more (noninstrumentally) to the well-being of adolescents and of young children than to that of adults. This would, again, depend in part on level of maturation, stability of values, identity formation, and so on.

It transpires then that reluctance to embrace the idea that fundamental constituents of adolescent well-being are distinct from those of adult and young child well-being, respectively, need not cast doubt on the importance of the prudential value of shielding to adolescent well-being.[70]

A third objection concerns whether our view is able to support the asymmetry between consent to and refusal of treatment. Facts about adolescent well-being may make the case for asymmetry, as suggested above. But it might be unclear whether the welfarist view indeed provides more support for the asymmetrical (constrained-power) version of transitional paternalism as opposed to the restricted-scope version. If reasons related to the prudential value of shielding are sufficient to warrant limiting refusals, these reasons may justify removing decisions about serious medical treatment from adolescents altogether.[71] For

69 Badhwar, *Well-Being*; Fletcher, *The Philosophy of Well-Being*; Griffin, *Well-Being*; Hooker, *Ideal Code, Real World*.

70 Anonymous referees for the journal suggested that we might work out a conception of well-being for children closer in nature to that of adults by reference to Rawlsian primary goods, including income, health, education, opportunity, and so on. This is a plausible suggestion. But even if primary goods play a role in well-being, it is still highly likely that at some level there will be marked differences between children and adults in the constituents or the causes of well-being. As Rawls notes, the content of primary goods depends on "various general facts about human needs and abilities, their normal phases and requirements of nurture, relations of social interdependence, and much else" (Rawls, *Justice as Fairness*, 58). We thank the referees for prompting us to clarify this point and our view in general.

71 This objection is similar to the one we leveled against Tucker's account.

even in cases of consent to treatment, an adolescent has to take responsibility for her decision.

There are two possible replies to this objection. The first involves arguing that in the cases of concern to us here, there is little reason not to grant consent compliance respect. As stipulated, consent pertains, after all, to treatment that is in an adolescent's clinical best interests and carries with it a high probability of success. There is little reason to be shielded or to have insurance against decisions that are in one's best medical interests. In any case, even if there is some reason to shield adolescents from consents, it is much weaker than the reason we might have to shield adolescents in cases in which a refusal emanates from a commitment to provisional values or in which the expected outcome runs contrary to their clinical best interests.

The second reply involves granting that the welfarist view we defend here provides only contingent support for the constrained-power view of transitional paternalism. We maintain that the welfarist view accounts persuasively for the asymmetry in consent and refusal. But it might turn out that the welfarist view provides support in some (legal and social) contexts for the restricted-scope view. We think that this is an attractive feature of the view. Whether the welfarist account in fact supports the constrained-power version over the restricted-scope version turns partly on empirical considerations and partly on facts about the institutional context, including those relating to the legal system.[72] We have told a story about how the asymmetry in consents and refusals might arise. Whether it does arise will most certainly depend on what best promotes the instrumental and noninstrumental prudential goods we discuss above and on other social and legal facts.

6. CONCLUSION

How is it that a competent minor's consent renders medical treatment lawful, yet a competent minor's refusal may not render treatment unlawful? In this article, we attempted to make philosophical sense of the concurrent consents doctrine in law, which posits an asymmetry in the normative power of adolescent consent and refusal.

We examined and rejected three possible justifications for the concurrent consents doctrine, two based on transitional paternalism and one based on stage of life. We developed a more philosophically promising, welfarist justification of the concurrent consents doctrine that takes up relevant considerations iden-

72 The kind of empirical facts that we have in mind include facts about how burdensome shielding turns out to be for individuals or classes of individuals.

tified in these rival views yet avoids their infelicities. This welfarist justification relies on the idea that there are distinct features of adolescent well-being that distinguish it from the well-being of adults, on the one hand, and young children, on the other hand. The main element of adolescent well-being of concern to us is the good of shielding. It is good for adolescents to be shielded from full responsibility for their decisions, and this explains why adolescent consent may be normatively determinative in the cases that we consider, but their refusal in such cases may not.

In this paper, our focus has been the philosophical justification of the concurrent consents doctrine in respect of serious medical treatment. However, in closing, it is important to note that the welfarist account that we defend may justify paternalism or differential treatment of adolescents more generally—that is, in other medical settings and other domains. The welfarist view is therefore a contribution to the literature on the general question of when and how paternalism toward adolescents may be justified philosophically.[73]

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