

1-1-2006

The Modern Age of Informed Consent

Barbara L. Atwell

Pace University School of Law

Follow this and additional works at: <https://scholarship.richmond.edu/lawreview>

Part of the [Consumer Protection Law Commons](#), [Health Law and Policy Commons](#), [Legislation Commons](#), and the [Torts Commons](#)

Recommended Citation

Barbara L. Atwell, *The Modern Age of Informed Consent*, 40 U. Rich. L. Rev. 591 (2006).

Available at: <https://scholarship.richmond.edu/lawreview/vol40/iss2/7>

This Article is brought to you for free and open access by the Law School Journals at UR Scholarship Repository. It has been accepted for inclusion in University of Richmond Law Review by an authorized editor of UR Scholarship Repository. For more information, please contact scholarshiprepository@richmond.edu.

THE MODERN AGE OF INFORMED CONSENT

Barbara L. Atwell *

Several years ago, Katherine, who at the time was a twenty-year-old Ivy League undergraduate, responded to an advertisement for egg donors. As a full-time college student, her financial resources were limited, and the promised \$7,500 fee enticed her to respond.¹ Katherine consented to the procedure despite the discomfort involved and the numerous hormone injections that were required.² She successfully donated nine eggs. Katherine subsequently graduated from college and is now married with a successful career. She recently gave birth to her first child. She has stated repeatedly over the years that she regrets having donated her eggs. Katherine wonders whether there are other children who are biologically related to her and to her newborn child. She is also concerned about the long-term health impact of the hormone injections that were part of the egg donation procedure.³

* Director, Health Law and Policy Program and Associate Professor of Law, Pace University School of Law; B.A., 1977, Smith College; J.D., 1983, Columbia University. I would like to thank Elizabeth Jobson and Ronald Long, Esq., for their generous editorial assistance. I am also indebted to my research assistants, Briana Fedele and Dr. Gail Wilder, for their invaluable help.

1. Cf. Jessica Cohen, *Grade A: The Market for a Yale Woman's Eggs*, ATL. MONTHLY, Dec. 2002, at 74 (citing an advertisement in the *Yale Daily News* "offer[ing] \$25,000 for an egg from the right donor"). Typically, egg donors are paid \$7,500. Sandra G. Boodman, *Using an Egg Donor and a Gestational Surrogate, Some Gay Men Are Becoming Dads—and Charting New Legal and Ethical Territory*, WASH. POST, Jan. 18, 2005, at F1.

2. See Egg Donation, Inc., *Donor Info*, <http://www.eggdonor.com/?section=donor&page=process> (last visited Nov. 16, 2005). "The medical procedures leading up to the actual aspiration begins with injections of Lupron to suppress your natural menstrual cycle. . . . [Subsequently], you will begin receiving daily injections of Gonal-f, Fertinex or Follistim to stimulate your ovaries." *Id.* When the eggs are sufficiently mature, a single injection of human chorionic gonadotropin is administered. *Id.* The final step is for the egg donor to undergo the actual egg retrieval procedure, which is performed under mild sedation. See *id.*; see also Cohen, *supra* note 1, at 74 ("Donating an egg is neither simple nor painless.").

3. Other forms of hormone manipulation like oral contraceptives and hormone replacement therapy have been linked to an increased incidence of breast cancer. See Nat'l Cancer Inst., U.S. Nat'l Inst. of Health, *Oral Contraceptives and Cancer Risk* (Nov. 3, 2003), <http://www.cancer.gov/cancertopics/factsheet/risk/oral-contraceptives> (last visited Nov. 16, 2005); Gina Kolata, *Study Is Halted Over Rise Seen in Cancer Risk*, N.Y. TIMES,

I. INTRODUCTION

Among the many innovations for which the twentieth century will undoubtedly be remembered are its diverse medical advances. Not only were cures or vaccines found for infectious diseases like polio but other medical advances made possible the initial diagnosis and treatment of many previously untreatable conditions.⁴ Although advances in medical technology have resulted in a better quality of life, they, like other scientific developments, have also created challenges. Among these challenges is the medical and legal issue of informed consent. When the informed consent doctrine was in its infancy, medical care and medical treatments were far less complex and extensive than they are today. Now, young adults may seek elective state-of-the-art medical procedures that result in life-altering changes. As a result of their youth, these young adults may be consenting for the first time to these high-tech procedures. Thus, the concern arises as to the capacity of young adults to understand the full impact of their decisions.

Advanced medical technology alone might warrant that we revisit the informed consent doctrine to determine whether it adequately conforms to today's needs. Compounding the challenge, though, is another phenomenon that has developed simultaneously. The last century has witnessed a social phenomenon in which fully realized adulthood has been delayed, in large part because of the increased number of years spent in post-secondary education. Advanced formal education has led to a delay in marriage, childrearing, and emotional and financial independence.⁵ In fact, mental health professionals now recognize a distinct post-adolescent stage of personal development known as transitional or emerging adulthood.⁶ Emerging adults are vulnerable to a so-

July 9, 2002, at A1 (stating the effects of hormone replacement therapy when used by post-menopausal women); cf. Lars Noah, *Assisted Reproductive Technologies and the Pitfalls of Unregulated Biomedical Innovation*, 55 FLA. L. REV. 603, 614-24 (2003) (discussing the safety concerns associated with the use of fertility drugs and the dearth of regulation related to fertility clinics).

4. The development of penicillin and other antibiotics, for example, made possible the treatment of bacterial infections.

5. See *infra* notes 82-83 and accompanying text.

6. Emerging adults are generally defined as young adults between the ages of eighteen and thirty, although other age parameters are occasionally used. See *infra* note 69 and accompanying text.

ciety in which they are treated as though they are fully adult when, in fact, they are still in the process of becoming adults.⁷

This essay explores the informed consent ramifications of the confluence of these two phenomena: developments in medical technology and emerging adulthood. In particular, it explores consent to medical treatments by emerging adults that are both elective and irreversible. In such cases, policy considerations dictate that additional safeguards be implemented to ensure that the consent given is truly informed.

Part II of this essay provides an overview of the informed consent doctrine and outlines a variety of advancements in elective medical technology. Part III explores the concept of emerging adulthood. Part IV suggests that when emerging adults seek medical treatments that are elective, non-emergent, and irreversible, the law should require deliberative consent, a process that mandates counseling by a patient advocate along with a waiting period.

II. INFORMED CONSENT AND MODERN MEDICINE

The doctrine of informed consent is well-rooted in American jurisprudence.⁸ It is a natural outgrowth of the common law tort of battery that prohibits intentional unauthorized bodily contact.⁹ This right to freedom from unwanted contact includes the examination and treatment by health care professionals as well as others. Thus, on a number of occasions, including the landmark case of *Mohr v. Williams*,¹⁰ courts have held that health care providers

7. See discussion *infra* Part III.

8. CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* 6 (1998); see George P. Smith, II, *The Vagaries of Informed Consent*, 1 *IND. HEALTH L. REV.* 109, 115–17 (2004).

9. Kate Haas, *Who Will Make Room for the Intersexed?*, 30 *AM. J.L. & MED.* 41, 61 (2004); Danuta Mendelson, *Historical Evolution and Modern Implications of Concepts of Consent to, and Refusal of, Medical Treatment in the Law of Trespass*, 17 *J. LEGAL MED.* 1, 29–35 (1996); Lars Noah, *Informed Consent and the Elusive Dichotomy Between Standard and Experimental Therapy*, 28 *AM. J.L. & MED.* 361, 364 (2002) (“Informed consent doctrine emerged from the intentional tort of battery. In order to avoid the risk of liability for unlawfully intruding into someone’s personal space, a healthcare professional would have to secure his or her patient’s consent before performing a surgical or other therapeutic intervention.”).

10. 104 N.W. 12 (Minn. 1905). In *Mohr*, the patient consented to surgery on the right ear, but the surgeon operated on the left ear. See *id.* at 13. This case was later remanded

may be liable for battery.¹¹ As Judge Cardozo explained in *Schloendorff v. Society of New York Hospital*,¹² “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”¹³ The logical outgrowth of common law battery, then, also provides the foundation for the principle of autonomy in medical decisionmaking. Today, autonomy is the fundamental principle underlying medical decisionmaking.¹⁴ Competent adults exercise that autonomy by deciding whether or not to consent to medical treatment.¹⁵ This principle has become such a fundamental part of our legal fabric that individuals are

for a new trial. *Mohr v. Williams*, 108 N.W. 818, 819 (Minn. 1906).

11. See *Duncan v. Scottsdale Med. Imaging, Ltd.*, 70 P.3d 435, 443 (Ariz. 2003); *Chouinard v. Marjani*, 575 A.2d 238, 242 (Conn. 1990); Rachel L. Alpers, Note, *Duncan v. Scottsdale Medical Imaging, Ltd.; Restoring a Patient’s Right to Sue for Battery*, 46 ARIZ. L. REV. 843, 843 (2004). *But see Kohoutek v. Hafner*, 383 N.W.2d 295, 298 (Minn. 1986) (holding that trial court did not abuse its discretion in refusing to submit claim of battery to jury).

12. 105 N.E. 92 (N.Y. 1914).

13. *Id.* at 93. See generally RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT, 235–73, 294 (1986) (providing a conceptual analysis of informed consent); Ken Marcus Gatter, *Protecting Patient-Doctor Discourse: Informed Consent and Deliberative Autonomy*, 78 OR. L. REV. 941, 945–55 (1999) (tracing the history of informed consent); Paula Walter, *The Doctrine of Informed Consent: To Inform or Not To Inform?*, 71 ST. JOHN’S L. REV. 543, 545–49 (1997) (outlining informed consent); Steven Horowitz, Note, *The Doctrine of Informed Consent Applied to Psychotherapy*, 72 GEO. L.J. 1637, 1640–41 (1984) (explaining informed consent in the context of psychotherapy).

14. Gatter, *supra* note 13, at 545–46. For patients who lack decisional capacity, courts generally adhere as closely as possible to the principle of autonomy by attempting to determine what the patient would choose if he or she were competent. This substituted judgment approach adheres as closely as possible to the principle of autonomy by taking into account the incompetent’s values and religious beliefs along with any prior statements that reveal what his or her wishes would be. See, e.g., *In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1989) (using substituted judgment to determine patient’s wishes before suffering from severe brain damage following a series of strokes.); *In re Eichner*, 420 N.E.2d 64, 72 (N.Y. 1981) (using pre-illness wishes as consent for patient in a persistent vegetative state). Another principle in medical decisionmaking is beneficence. It is generally applied when the primary principle of autonomy is impossible to apply and there is no rational basis for determining what the patient would choose if he were competent. See, e.g., *In re Storar*, 420 N.E.2d 64, 72–73 (1981) (holding that was impossible to determine what a mentally retarded man with a mental age of eighteen months would have chosen).

15. See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 300–01, 304 (Cal. Ct. App. 1986), *Pub. Health Trust of Dade County v. Wons*, 541 So. 2d 96, 98 (Fla. 1989). Competency may be determined by examining (1) the patient’s ability to evidence a choice, (2) the “reasonable” outcome of the choice, (3) whether the choice is based on “rational” reasons, (4) the patient’s ability to understand the choice, and (5) the patient’s actual understanding of the choice. Loren H. Roth, Alen Meisel, & Charles W. Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280 (1977).

permitted to refuse medical treatment even when the consequence of that refusal is death.¹⁶

Today, the failure to obtain informed consent generally gives rise to a negligence claim rather than a battery cause of action.¹⁷ Negligence as the basis of a complaint based on lack of informed consent more closely comports with the reality of medical practice. Medicine, being as much an art as it is a science,¹⁸ requires that doctors retain some judgment in determining appropriate treatments. Failure to exercise proper judgment in treatment decisions is rarely done intentionally.¹⁹ Therefore, medical malpractice claims typically are based on negligence.²⁰ Similarly, doctors' informed consent practices require the exercise of judgment. Disclosure may be excused, for example, if in the doctor's judgment the patient's emotional ability to handle the information is compromised.²¹ Similarly, disclosure may be excused in an emer-

16. In *Cruzan v. Director, Missouri Department of Health*, for example, the Supreme Court inferred that a competent adult "has a constitutionally protected liberty interest in refusing unwanted medical treatment" including artificial nutrition and hydration. See 497 U.S. 261, 278-79 (1990); see also *In re Quinlan*, 355 A.2d 647, 669-72 (N.J. 1976) (holding a father had permission to withdraw life-sustaining treatment from daughter); *Wons*, 541 So. 2d at 97-98 (allowing a Jehovah's Witness to refuse life saving blood transfusion). But see *Shorter v. Drury*, 695 P.2d 116, 620-21 (Wash. 1986) (en banc) (holding that a hospital's release of a patient based on her refusal as a Jehovah's Witness to accept blood transfusion did not preclude suit based on negligent performance of operation).

17. See *Harrison v. United States*, 284 F.3d 293, 298 (1st Cir. 2002) ("To recover under a theory of informed consent . . . a patient must prove that the physician has a duty to disclose certain information and that a breach of that duty caused the patient's injury.>").

18. See *Velazquez v. Portadin*, 751 A.2d 102, 107 (N.J. 2000); Barbara L. Atwell, *Mainstreaming Complementary and Alternative Medicine in the Face of Uncertainty*, 72 U.M.K.C. L. REV. 593, 604 (2004).

19. In extreme cases, for example, where surgery is performed on the wrong part of the body, a battery claim may still lie. See, e.g., *Chouinard v. Marjani*, 575 A.2d 238, 299-40 (Conn. App. Ct. 1990) (allowing battery claim when patient claimed that she consented only to surgery on her left breast and surgeon operated on both breasts); cf. *Rubino v. De Fretias*, 638 F. Supp. 182, 185-86 (D. Ariz. 1986) (overturning statutes that would have precluded actions against physicians based on battery).

20. See, e.g., *Velazquez*, 751 A.2d at 106-07; *Hall v. Hilbun*, 466 So. 2d 856, 866 (Miss. 1985); *Helling v. Carey*, 519 P.2d 981, 982 (Wash. 1974) (en banc).

21. See *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972) ("It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to . . . complicate or hinder the treatment, or perhaps even pose psychological damage to the patient."); see also *Scott v. Bradford*, 606 P.2d 554, 558 (Okla. 1979) (holding that withholding disclosure is allowed if it would alarm an emotionally upset patient). See generally Margaret A. Somerville, *Therapeutic Privilege: Variation on the Theme of Informed Consent*, 12 L. MED. & HEALTH CARE, Feb. 1984, at 4, 5; David E. Seidelson, *Medical Malpractice Actions Based on Lack of Informed Consent in "Full-Disclosure" Jurisdictions: The Enigmatic Affirmative Defense*, 29 DUQ. L. REV. 39 (1990) (discussing the proposition that non-disclosure to protect an emotionally frail patient should be eliminated).

gency,²² or in cases where the patient is unconscious.²³ Since the treating physician retains some flexibility in determining how much information to disclose, cases based on a failure to obtain informed consent, like other medical malpractice claims, are based on negligence.

The goal of informed consent is to obtain "a morally valid consent."²⁴ Thus, each patient must be apprised of the nature of the treatment, along with any corresponding risks.²⁵ In addition, the patient should be given information regarding alternatives to treatment.²⁶ Informed consent, then, is designed to protect patients by ensuring that they have the material information with which to make an informed choice.

In determining how much disclosure is required, some courts apply a reasonable physician or professional standard, while others apply a reasonable patient standard.²⁷ Pursuant to the professional standard, the question is whether the doctor has provided the same information that another reasonable doctor would provide under the same or similar circumstances.²⁸ Typically, expert testimony is required to establish the contours of this standard. In the landmark case of *Canterbury v. Spence*,²⁹ however, the court found that this professional standard failed to adequately protect the patient.³⁰ Instead, the court in *Canterbury* reasoned that whether or not adequate information has been given to the

22. See *Jackovach v. Yocum*, 237 N.W. 444, 451 (Iowa 1931); *Miller v. HCA, Inc.*, 118 S.W.3d 758, 768 (Tex. 2003).

23. *King v. Our Lady of the Lake Reg'l Med. Ctr.*, 623 So. 2d 139, 142 (La. Ct. App. 1993). The patient may also waive the right to material information on his or her own initiative. See *Noah*, *supra* note 9, at 368.

24. *Smith*, *supra* note 8, at 112.

25. See *Canterbury*, 464 F.2d at 780; see also *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990); *Harrison v. United States*, 284 F.3d 293, 298 (1st Cir. 2002).

26. *Canterbury*, 464 F.2d at 782.

27. See *Noah*, *supra* note 9, at 367 & nn.27-29 and accompanying text.

28. See, e.g., *Hondroulis v. Schuhmacher*, 553 So. 2d 398, 405 (La. 1988); *Walls v. Shreck*, 658 N.W.2d 686, 692 (Neb. 2003); *Robinson v. Bleicher*, 559 N.W.2d 473, 478 (Neb. 1997); *Weber v. McCoy*, 950 P.2d 548, 552 (Wyo. 1997). New York has codified the professional standard. See N.Y. PUB. HEALTH LAW 2805-d(1) (defining "lack of informed consent" as "the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.").

29. 464 F.2d 772 (D.C. Cir. 1972).

30. *Id.* at 783-84.

patient must be determined from the viewpoint of the reasonable patient—not the viewpoint of the medical professional.³¹ The court recognized that the “patient’s right of self-decision shapes the boundaries of the duty to reveal.”³² A “risk is . . . material when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.”³³ Today, jurisdictions are split on whether to use the reasonable patient or the professional standard.³⁴

In practice, informed consent is far from perfect, regardless of whether the reasonable patient standard or the professional standard is used. First, the process is often inadequate. It may involve a brief conversation lasting no more than a few minutes with a health care professional, followed by the signing of consent forms.³⁵ Second, a 1998 study suggests that physicians sometimes fail to discuss treatment options that are not covered by insurance.³⁶ Thus, the patient may be unaware of potentially beneficial treatments simply because insurance is not available to help pay for them. Third, the health care providers may be motivated as much by protecting themselves from litigation as they are by a desire to provide information to patients. A patient claiming a lack of informed consent may be met in court with a signed form outlining the risks and alternatives of treatment, making the informed consent claim difficult to win.³⁷ Finally, the doctor may be

31. *Id.* at 791.

32. *Id.* at 786.

33. *Id.* at 787. Some courts apply a subjective patient standard. See Noah, *supra* note 9, at 367–68.

34. Noah, *supra* note 9, at 367. From a bioethical perspective, the reasonable patient standard is much more compatible with the notion of patient autonomy than the professional standard. What another doctor would disclose may have little relation to what a reasonable patient deems material. The reasonable patient standard adheres most closely to the goal of making sure that consent is truly informed when given.

35. Cf. Jay Katz, *Informed Consent—Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL’Y 69, 81–84 (1994) (discussing the barriers to doctors and patients making joint medical decisions); Jay Katz, *Informed Consent—A Fairy Tale? Law’s Vision*, 39 U. PITT. L. REV. 137, 160 (1977) (explaining that the courts’ sole focus on disclosure, to the exclusion of consent, tends to perpetuate physicians’ disengaged monologues and to discourage a meaningful dialogue between doctors and patients).

36. Matthew K. Wynia et al., *Do Physicians Not Offer Useful Services Because of Coverage Restrictions?* HEALTH AFFS. July/Aug. 2003, at 190, 191–94.

37. The key to informed consent is the meaningful receipt of information rather than the signing of the form. In the hospital setting, some states presume valid consent when there is written documentation to that effect. The patient must then rebut that presump-

motivated by his or her own interests, rather than by the interests of the patient.³⁸ In practice, then, the informed consent doctrine, while laudable in theory, is not a panacea.

In addition to the shortcomings discussed above, there are other challenges associated with the informed consent doctrine. The doctrine of informed consent dates back to a time when medical practice was relatively rudimentary. Therefore, due to modern high-tech medical procedures, certain considerations that were not relevant when the doctrine was in its infancy are very relevant today. New medical treatments and procedures are being developed constantly. Thus, some treatments available today were unimaginable just a few years ago. Not only were medical treatments far simpler when the doctrine of informed consent developed, but there were far fewer elective procedures. Patients went to doctors because they had to, not because they wanted to.

By contrast, modern medicine includes a host of elective procedures, some of which are especially popular with young adults. Since the requisite age of informed consent is eighteen,³⁹ emerging adults are free to consent to any elective medical procedure. These procedures run the gamut from a wide variety of cosmetic surgeries, to an assortment of assisted reproduction techniques, to voluntary participation in human research experiments. A closer look at treatments popular with emerging adults is insightful.

In 1997, 6,643 cycles of egg donation were reported.⁴⁰ Egg donors generally must be between the ages of twenty-one and thirty-two,⁴¹ although some fertility clinics accept donors from a younger range of ages.⁴² Thus, virtually all egg donors are emerg-

tion. See FLA. STAT. ANN. § 766.103(4) (West 2005); WASH. REV. CODE ANN. § 7.70.060 (West 1992).

38. Cf. Deborah Sontag, *Abuses Endangered Veterans In Cancer Drug Experiments*, N.Y. TIMES, Feb. 6, 2005 (stating veteran cancer patients were informed that they were suitable candidates for experimental drug study when, in fact, they were not); see also *infra* notes 52–61 and accompanying text.

39. See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 899 (1992); *Cal. Med. Ass'n v. Lackner*, 177 Cal. Rptr. 188, 190 (Cal. Ct. App. 1981); *People v. Enea*, 665 P.2d 1026, 1028 (Colo. 1983); *In re L.D.F.*, 820 A.2d 714, 716 (Pa. Super. Ct. 2003).

40. See Owen K. Davis, *The Medical Aspects of Egg Donation*, RESOLVE; The National Infertility Association, at <http://www.resolve.org/main/national/treatment/options/donor/egg.jsp?name=treatment&tag=options> (last visited Nov. 16, 2005). A single egg donor can donate multiple eggs per egg donation cycle. See *Donor Info*, *supra* note 1.

41. See Boodman, *supra* note 1.

42. Fertility Futures International, *Become an Egg Donor*, at <http://www.fertilityfu>

ing adults, and they are often solicited in college or local newspapers.⁴³ Other assisted reproductive technologies (“ART”) have also become quite commonplace in recent years.⁴⁴ Surrogate mothers, for example, also frequently fall within the emerging adult age range, although a wider age range is used for surrogates than for egg donors. Organizations generally accept surrogates up to the age of forty.⁴⁵ The same is true of sperm donors.⁴⁶ Regardless of the form of ART they employ, fertility clinics are subject to very little regulation.⁴⁷ The combination of a largely unregulated industry and the involvement of emerging adults, who may be tempted by financial gain, is troubling.

Cosmetic surgery is also quite popular with emerging adults. The total number of patients who seek some form of cosmetic surgery is staggering. In 2002, 6.6 million individuals sought some form of cosmetic surgery.⁴⁸ For emerging adults, that number was approximately 1.6 million.⁴⁹ The most popular form of cosmetic surgery for emerging adults was breast augmentation.⁵⁰ The most popular non-surgical procedure was microdermabrasion.⁵¹

tures.com/donors/index.php (last visited Nov. 16, 2005) (requiring that egg donors be between the ages of eighteen and twenty-six). Yet other clinics accept donors up to the age of thirty-five. Davis, *supra* note 40.

43. Boodman, *supra* note 1; see Cohen, *supra* note 1.

44. ART also includes in vitro fertilization, sperm donation, and artificial insemination, among other things. Noah, *supra* note 3, at 608–12.

45. See Canberra Fertility Centre, *John James Memorial Hospital Ethics Committee Guidelines for Surrogacy* (Jan. 2003), http://www.canberrafertilitycenter.com.au/surrogacy_JJMemorial.htm (last visited Nov. 16, 2005); Reproductive Assistance Inc., *Become a Surrogate*, <http://www.reproductiveassistanceinc.com/surrogates.asp> (last visited Nov. 16, 2005).

46. See Fairfax Cryobank Donor Screening, http://www.fairfaxcryobank.com/donor_screen.aspx?menu=4&turn=on (last visited Nov. 16, 2005) (“All semen donor applicants must be 18 to 39 years of age.”).

47. See Noah, *supra* note 3, at 614–16.

48. American Society of Plastic Surgeons, *6.6 Million Americans Get a Nip, Tuck, and Lift with Cosmetic Plastic Surgery in 2002*, Apr. 15, 2003, http://www.plasticsurgery.org/news_room/press_releases/6-6-Million-Americans-Get-A-Nip-Tuck-And-Lift.cfm (last visited Nov. 16, 2005).

49. *Id.* The age breakdown by the American Society of Plastic Surgeons includes nineteen to thirty-four year olds. See *id.* Therefore, there is not an identical overlap with the ages of emerging adults. Eighteen year olds are omitted from this group, while those over thirty are included. See *id.*

50. See *id.*

51. Dermabrasion is the “[m]echanical scraping of the top layers of skin using a high-speed rotary wheel. Softens sharp edges of surface irregularities, including acne and other scars and fine wrinkles, especially around the mouth.” American Society of Plastic Surgeons, *Cosmetic Surgery Procedures at a Glance*, http://www.plasticsurgery.org/public_

Cosmetic surgery is not risk free. In fact, in 2004 a report revealed that two patients died during cosmetic surgery.⁵² While death during cosmetic surgery is unusual, the death of these two patients who were seeking face lifts is a reminder that all surgical procedures involve risks. Just two years earlier, the surgeon who performed one of the fatal surgeries “compared cosmetic surgery patients to ‘the lady who gets her hair done and her nails done People are wanting to do it as a part of personal grooming.’”⁵³ The effort to appease the public by analogizing surgery to personal grooming is the kind of reassurance that, while not unanticipated, may lure patients to the operating table, especially emerging adults who are still transitioning to adulthood.⁵⁴

One example of patient vulnerability on the part of emerging adults involves human experimentation.⁵⁵ Researchers have often been criticized for “exposing clinical trial participants to serious risk in the face of adverse data, omitting important information from informed consent forms, and having financial conflicts of interest.”⁵⁶ Perhaps the most famous case involving this kind of lapse was that of Jesse Gelsinger.⁵⁷ Gelsinger suffered from par-

education/procedures/CosmeticPlasticSurgery.cfm (last visited Nov. 16, 2005). Other forms of cosmetic surgery include breast enlargement or reduction, liposuction, rhinoplasty (nose jobs), botox injections, stomach stapling, adominoplasty (tummy tuck), breast lift, browlift, chemical peel, chin surgery, eyelid surgery, face lifts, facial implants and hair replacement. *Id.*

52. Alex Kuczynski & Warren St. John, *Why Did They Die In Cosmetic Surgery?*, N.Y. TIMES, June 20, 2004, at 1.

53. *Id.*

54. In fact, even adolescents are undergoing cosmetic surgery in significant numbers. Laurel Franck, *Plastic Surgery Not for Teens*, THE BATTALION, <http://www.thebatt.com/media/paper657/news/2003/02/26/Opinion/Plastic.Surgery.Not.For.Teens-14865.shtml> (last visited Nov. 16, 2005) (“While young adults age 18 or younger made up only 4 percent of all cosmetic surgery patients in 2001, that is still an astonishing 303,103 people.”); see also Shari Roan, *For Obese Teens, Surgery of Last Resort; Weight-loss Procedure is Risky, but Some Doctors Say it Saves Lives*, L.A. TIMES, Oct. 25, 2004, at F1 (noting the increase in bariatric surgery, or stomach stapling, among teens despite serious surgical risks). The death rate from bariatric surgery is 0.5% to 1%. *Id.*

55. See Noah, *supra* note 9, at 361. Noah notes that “[h]istorically, sponsors of clinical trials recruited subjects . . . around college campuses.” *Id.*

56. Josephine Johnston & Francoise Baylis, *Gene Therapy: Two Steps Forward, One Step Back*, CANADIAN MED. ASS’N J., <http://www.cmaj.ca/cgi/content/full/170/12/1785> (June 8, 2004) (citing Letter from Denis E. Baker, Associate Commissioner for Regulatory Affairs, Food and Drug Administration, Center for Biologics Evaluation and Research, to James Wilson, Institute for Human Gene Therapy, (Feb. 8, 2000), <http://www.fda.gov/foi/nooh/Wilson.htm>) (last visited Nov. 16, 2005); see also Kurt Eichenwald & Gina Kolata, *Drug Trials Hide Conflicts for Doctors*, N.Y. TIMES, May 16, 1999, at A1.

57. See Sally Lehrman, *The Gelsinger Story*, GENE LETTER, <http://www.genesage.com/professionals/geneletter/05-01-00/features/gelsinger1.html> (last visited Nov. 16, 2005).

tial ornithine transcarbamylase (“OTC”) deficiency, a disorder that creates dangerously high levels of ammonia in the blood.⁵⁸ Just after turning eighteen, Jesse decided to participate in a clinical trial that he believed would help scientists learn more about how to cure the disease, though he did not expect to benefit personally from the treatment.⁵⁹ In other words, the procedure was non-therapeutic for him. Nonetheless, he decided to participate.⁶⁰ Doctors injected a normal OTC gene attached to a therapeutic virus into Jesse’s liver; within hours, his system began to shut down.⁶¹ Shortly thereafter, he died.⁶²

Information later emerged disclosing the fact that prior to Jesse’s death two monkeys died after undergoing a similar gene therapy procedure.⁶³ Moreover, there were allegations of earlier severe adverse reactions that should have resulted in the study being aborted.⁶⁴ Later revelations by the National Institutes of Health (“NIH”) indicated that more than 650 adverse reactions to gene therapy, including several deaths, had occurred throughout the country.⁶⁵ Sometimes, even the doctors themselves are not aware of the risks associated with certain medical treatments. In the research arena, for example, it has been reported that it is

difficult for anyone, whether a member of the general public or a skilled scientist, to learn details about the problems cropping up in gene therapy studies. Even a new National Institutes of Health (“NIH”) database on clinical trials . . . will include no information about adverse reactions to gene therapy treatments. Further, financial alliances and conflicts-of-interest will not be included.⁶⁶

58. *Id.*

59. *See id.*

60. *See id.*

61. *Id.*

62. *Id.*

63. *Gene Therapy Business: The Tragic Case of Jesse Gelsinger*, NEWS WEEKLY, Aug. 12, 2000, www.newsweekly.com.au/articles/2000aug12_bio.html (last visited Nov. 16, 2005).

64. *See id.*

65. *Id.*

66. *Id.* The article goes on to state:

“We know that informed consent doesn’t work,” says Arthur Caplan, who directs a large bioethics program at University of Pennsylvania. . . . Caplan says the privatisation [sic] of science, combined with patients’ ardent desire for a cure, conspire to prevent meaningful protections for participants in all kinds of studies. Trade secrets, financial conflicts of interest and overloaded review committees obstruct informed consent by keeping news about ongoing

Given the realities of modern medicine and the shortcomings of informed consent, it may be advisable to completely revamp the doctrine of informed consent. For example, different categories of informed consent could be created for different kinds of medical treatments.⁶⁷ One process could apply in emergency situations, while another procedure might work best with routine, non-emergency treatments. Perhaps the law should be most demanding of informed consent with elective procedures since the patient could elect to forego treatment. The shortcomings of an imperfect system of informed consent are compounded when vulnerable, young, emerging adults consent to treatments that are elective and irreversible.⁶⁸ Such cases are the focus of the remainder of this discussion.

III. EMERGING ADULTHOOD

A recent body of social science literature has identified a separate phase of personal development that takes place approximately between the ages of eighteen and thirty⁶⁹ known as emerging adulthood.⁷⁰ Surveys suggest that individuals in this

studies beyond the reach of patients and researchers alike.

Id.

67. Cf. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 906 (1994) (arguing that informed consent must be contextualized).

68. For medically necessary treatments, emerging adults would continue to be treated as other competent adults. See *In re Quackenbush*, 383 A.2d 785 (N.J. 1978) (explaining that patient may have capacity for some purposes but not others). Traditional informed consent procedures may continue to be used for medically necessary procedures, while the enhanced, deliberative consent procedures described below would be implemented for elective and irreversible procedures.

69. E.g., The Network on Transition to Adulthood, *Between Adolescence and Adulthood: Expectations About the Timing of Adulthood*, <http://www.transad.pop.upenn.edu/news/between.pdf> (last visited Nov. 16, 2005) (studying young adults between the ages of eighteen and thirty) [hereinafter *Between Adolescence*]; *Election 2004 and Emerging Adults (18–30 year olds)*, <http://www.hs.ttu.edu/hdfs3390/fall04project.htm> (last visited Nov. 16, 2005) (defining emerging adults as eighteen to thirty year olds). Others have used similar, though not identical age ranges. Cf. Jeffrey Jensen Arnett, *Emerging Adulthood: A Theory of Development From the Late Teens Through the Twenties*, 35 AM. PSYCHOL. 469, 469 (2000) (stating that the age of emerging adults extends from “the late teens through the twenties, with a focus on ages 18–25”); Jeffrey Jensen Arnett, *Conceptions of the Transition to Adulthood Among Emerging Adults in American Ethnic Groups*, NEW DIRECTIONS FOR CHILD AND ADOLESCENT DEV., Summer 2003 at 63, 64 (defining emerging adults as aged eighteen to twenty-nine); David J. Hanson et al., *Rethinking Alcohol Use by the Emerging Adult*, at <http://www2.potsdam.edu/alcoholinfo/YouthIssues/1046347764.html> (last visited Nov. 16, 2005) (discussing the drinking habits of college-aged adults).

70. The transition between adolescence and adulthood has been given a variety of la-

age group consider themselves neither adolescents nor fully adult.⁷¹ Social scientists agree that this interval is a time of transition between the two. Emerging adults are engaged in a process of “change and exploration,” and are still defining their identities.⁷²

There are a number of characteristics, both internal and external, associated with emerging adults. Internal “characteristics that matter most to emerging adults . . . are . . . individualistic qualities of character.”⁷³ Emerging adults, for example, find themselves exploring what their own values and beliefs are as distinguished from those that were imposed upon them by their parents.⁷⁴ They consider full adulthood to be associated with those who have developed a concrete awareness of their values and beliefs.⁷⁵ In addition, the ability to make independent decisions, while limited in emerging adults, is a characteristic that is often associated with full adulthood.⁷⁶ For example, emerging adults who are in college and still dependent on their parents have a more limited range of independent decisionmaking than their counterparts who are full-time participants in the work force.

Another internal characteristic associated with emerging adults is the emerging ability to accept responsibility for one’s

bels, including: “early adulthood,” *Between Adolescence*, *supra* note 69; “emerging adulthood,” *A Theory of Development*, *supra* note 69, at 469; and “adulthood,” Annie Nakao, *They Can (And Do) Go Home Again: Empty Nest Syndrome? Parents of “Boomerang” Children Should Be So Lucky*, SAN FRANCISCO CHRON., May 30, 2004, at F1. Yet another research psychologist calls these young adults “thresholders” because they are on the threshold of adulthood. TERRI APTER, MYTH OF MATURITY: WHAT TEENAGERS NEED FROM PARENTS TO BECOME ADULTS 24 (2001). Finally, this period of transition between adolescence and adulthood has been called the “quarterlife crisis.” ALEXANDRA ROBBINS & ABBY WILNER, QUARTERLIFE CRISIS 5 (2001).

71. *E.g.*, *A Theory of Development*, *supra* note 69, at 471–72. Arnett argues that the period between ages eighteen and twenty-five “is neither adolescence nor young adulthood but is theoretically and empirically distinct from them both.” *Id.* at 469.

72. *Id.* at 471.

Emerging adulthood is a time of life when many different directions remain possible, when little about the future has been decided for certain, when the scope of independent exploration of life’s possibilities is greater for most people than it will be at any other period of the life course.

Id. at 469.

73. *A Theory of Development*, *supra* note 69, at 472–73 (citation omitted) (emphasis in original).

74. *See Ethnic Groups*, *supra* note 69, at 70.

75. *See id.*

76. *A Theory of Development*, *supra* note 69, at 472–73 (citations omitted).

self.⁷⁷ This can include being considerate of others.⁷⁸ It also includes developing the ability to minimize risk-taking behavior.⁷⁹ Risk-taking behavior related to drinking, drugs, and sexuality, for example, can be particularly challenging for the emerging adult.⁸⁰ Emerging adults identify these internal factors, rather than external societal markers, as the key to adulthood.⁸¹

Nonetheless, a second set of external factors further describes emerging adults. For example, more individuals in this age range than ever before are continuing their education.⁸² Consequently, they are delaying marriage, entering into the workforce, parenting, and other behaviors typically associated with adulthood.⁸³ Emerging adults are often still partially dependent on their parents, financially and emotionally.⁸⁴

Aside from some of the foregoing characteristics of emerging adults, both internal and external, emerging adults can be difficult to define. For example, data suggests that most adolescents [age twelve to seventeen] still live at home with one or both parents.⁸⁵ It also indicates that by the age of thirty, most people live independently outside their parents' home and are employed or participating in the work force.⁸⁶ Between the ages of eighteen and thirty, however, during this stage of emerging adulthood, the

77. *Id.*

78. See *Ethnic Groups*, *supra* note 69, at 63.

79. See *id.*

80. See *infra* notes 89–98 and accompanying text.

81. See *Ethnic Groups*, *supra* note 69, at 63.

82. See *A Theory of Development*, *supra* note 69, at 471 (“The proportion of American emerging adult who enter higher education in the year following high school is at its highest level ever, over 60%.”).

83. Only 32% of twenty-five to twenty-nine year olds, however, have completed four years of college. *Id.* Instead, emerging adults are engaged in a wide range of exploratory behavior including education, work, and exploring romantic partners. It has been suggested that other cultures with different ideas of adulthood may not experience the phenomenon of emerging adults. See Larry J. Nelson, *Rites of Passage in Emerging Adulthood: Perspectives of Young Mormons*, in *EXPLORING CULTURAL CONCEPTIONS OF THE TRANSITION TO ADULTHOOD* 33, 33 (Jeffrey Jensen Arnett & Nancy L. Galambos eds., 2003).

84. Cf. Jennifer Medino, *Stay Local, or Go South? It's the Geography*, *Cupid*, N.Y. TIMES, Feb. 13, 2005, at 14WC (“[Y]oung adults living at home now make up more than 30 percent of the 22 to 31-year-olds in the New York-North New Jersey area. Nationally, that figure is about 14 percent.”); Lynda Richardson, *Persuading Youth to Think Ahead (Way Ahead)*, N.Y. TIMES, Feb. 24, 2005, at B4 (“Almost 6 out of 10 college graduates are moving home to live with parents after graduating.”).

85. *A Theory of Development*, *supra* note 69, at 471.

86. See *id.*

demographics are quite varied.⁸⁷ It may be difficult, then, to find a way to balance independence, on one hand, with the need for clear rules and guidance, on the other. Acknowledging this challenge, the Skidmore College website queries: "What is the right balance between nurturing and challenge, rights and responsibilities, individualism and community? . . . Respect for our students' emerging adulthood means that . . . we will on occasion intervene with other offices and programs on the student's behalf. . . ." ⁸⁸

Challenges associated with alcohol consumption demonstrate the difficulty of striking the right balance between independence and rule-setting with emerging adults. As noted above, alcohol abuse, though not limited to emerging adults, is nonetheless a challenge with this age group. Legal recognition of the drinking problem prompted every state to raise its legal drinking age from eighteen to twenty-one.⁸⁹ Therefore, a segment of younger emerging adults cannot legally drink at all.⁹⁰ As soon as this group turns twenty-one, though, they can legally drink without supervision. Under-age drinking is relatively common and has led commentators to suggest that raising the drinking age to twenty-one has been largely ineffective.⁹¹ They suggest that the ability to drink, like the ability to drive in many states, be phased in so that emerging adults recognize drinking as an activity that can be a normal part of adult social life rather than something associated with binge drinking and getting drunk.⁹²

Having a bird's eye view of collegiate drinking as both keen observers of drinking and its outcomes and long-term members of campus life, we would like to suggest an alternative to zero-tolerance: a sys-

87. See *id.* ("[T]he years of emerging adulthood are characterized by a high degree of demographic diversity and instability. . . .").

88. Dean of Student Affairs, Skidmore College, *Students as Emerging Adults*, www.skidmore.edu/administration/dean-students/emerging-adults.html (last visited Nov. 16, 2005).

89. See Ken Sternberg, *Alcohol Consumer Must Be 21 Years Old in All States; Concerns Remain About Drunk Driving*, 260 J. AM. MED. ASS'N 2479, 2479 (1988). Access to federal funding was also a factor. A portion of federal highway funding can be withheld if a state reduces the drinking age below twenty-one. See 23 U.S.C. § 158 (2000); *South Dakota v. Dole*, 483 U.S. 203, 212 (1987) (upholding the constitutionality of 23 U.S.C. § 158).

90. Cf. Margaret Raymond, *Penumbral Crimes*, 39 AM. CRIM. L. REV. 1395, 1412-15 (2002) (arguing that underage drinking laws are marred by a high degree of noncompliance and lack of enforcement).

91. See, e.g., Hanson et al., *supra* note 69.

92. See *id.*

tem of gradual access to alcoholic beverages by consumption-inclined 19- and 20-year-olds. Why not teach responsible drinking behavior under mature supervision, rather than leave these young adults to experiment on their own?⁹³

Thus, the authors suggest that emerging adults under the age of twenty-one be permitted to obtain provisional drinking licenses.⁹⁴

Although the legal drinking age is twenty-one in every state, eighteen is the age of majority for most activities. Eighteen-year-olds can consent to many life-altering decisions, such as joining the military and getting married.⁹⁵ Eighteen-year-olds can also vote and enter into contracts.⁹⁶ Since society considers eighteen to be the age of majority for most activities,⁹⁷ one might argue that eighteen-year-olds should also be able to give informed consent to medical treatments without further inquiry. On the other hand, by raising the legal drinking age to twenty-one, every state has set limits around an activity that is also not medically necessary and that has potentially harmful repercussions.⁹⁸ Thus, there is universal legal recognition that prior to reaching the age of twenty-one, some activities should be restricted.⁹⁹ The next section explores the parameters that would best serve emerging adults who are considering medical treatments that are neither medically necessary nor reversible.

93. *Id.* The authors go on to note that “[t]he modern age-based prohibition seems to be working no better than the 1920s version; while a smaller percentage of young adults are now drinking, a sizable minority is drinking recklessly.” *Id.*

94. *Id.* Certain restrictions would apply to provisional licenses. *Id.* For example, drinking after a certain hour may be prohibited. *Id.* In addition, formal instructions on responsible drinking would be required. *Id.*

95. Barbara Bennett Woodhouse, *Youthful Indiscretions: Culture, Class, Status, and the Passage to Adulthood*, 51 DEPAUL L. REV. 743, 758 (2002).

96. *Id.*; U.S. CONST. amend. XXVI, § 1 (guaranteeing eighteen-year-olds the right to vote).

97. Woodhouse, *supra* note 95, at 758. The author notes the troubling exception in the criminal context of treating children like adults, particularly poor children of color. *Id.* at 757 (citing Barry C. Feld, *The Juvenile Court Meets the Principle of Offense: Punishment, Treatment and the Difference it Makes*, 68 B.U. L. REV. 821, 884 (1988)); see also *supra* note 39 and accompanying text (stating that individuals over the age of eighteen can legally consent to elective medical procedures).

98. See *supra* note 89–97 and accompanying text.

99. See *supra* notes 89–92 and accompanying text. Those who have studied emerging adults would arguably suggest that particular care must be paid to individuals up to the age of thirty. See *A Theory of Development*, *supra* note 69, at 473–74 (suggesting that people between ages eighteen and twenty-five are still struggling with evolving self-conceptions of love, work, and world views).

IV. DELIBERATIVE CONSENT

We live in a society in which we have a confluence of two distinct phenomena: advanced medical technology that now offers not only medically necessary treatments, but a whole host of elective ones, and a distinct stage of personal development known as emerging adulthood. The informed consent implications need to be explored.

If we begin by reviewing the goals of informed consent and the reasons why the doctrine was developed, it was clearly to protect autonomy and meaningful choice. By being fully informed, patients can make empowered and informed decisions. Informed consent was legally intended to partner the person with information so that his or her assent was based on full disclosure. Patients would then be allowed to make educated choices and not be unduly persuaded to consent to medical treatments without adequate deliberation.¹⁰⁰

The goals, then, behind the informed consent doctrine are laudable. Yet abuses may occur when material information is withheld. Moreover, third parties can manipulate the system when, for their own benefit, they withhold important facts from patients who believe they are getting complete information.¹⁰¹ If we revisit the example set forth at the outset of this piece, we can see the challenges faced by emerging adults like Katherine. When Katherine consented to the egg donation, she had limited financial resources and had just discovered that she could earn \$7,500 for donating her eggs. This procedure was not medically necessary for her and was irreversible. Moreover, the procedure itself was not simple. It involved hormone injections and surgery to retrieve the eggs.¹⁰² Should her consent to the procedure be valid?

Clearly, informed consent concerns are heightened in a case like this, where there is a financial inducement. However, even if Katherine consented to cosmetic surgery, a medical procedure with no financial gain, issues would remain about her maturity

100. See *supra* notes 8–38 and accompanying text.

101. See *supra* notes 55–67 and accompanying text regarding human experimentation. This manipulation of the system may also occur in the case of infertility clinics that need donors and surrogates to survive, particularly since they are poorly regulated. See *supra* note 47 and accompanying text.

102. See *supra* note 2 and accompanying text.

as an emerging adult, particularly given current concerns about whether the standard informed consent process adequately serves its original mission.¹⁰³ We can examine the validity of the informed consent under both the standard informed consent paradigm, as it is typically implemented today, and a proposed deliberative consent process.

Standard informed consent in today's medical decisionmaking generally involves a brief discussion with the health care provider of the risks and alternatives of the proposed treatment or procedure, followed by the immediate signing of consent forms. A key concern of the health care provider is getting the form signed rather than confirming that the patient understands the material facts. As long as the informed consent form is signed, the doctor can defend against a claim that the patient lacked informed consent. In Katherine's case, then, the doctors would presumably acknowledge that there are minor risks associated with hormone injections and sedation, but would be likely to reassure Katherine of the relative safety of the procedure. This brief explanation would be followed by the signing of the consent form.

Deliberative consent would require additional procedural safeguards to ensure that the emerging adult's decision has been properly considered. The first procedural safeguard would require the involvement of a patient advocate.¹⁰⁴ The patient advocate and the emerging adult would be required to have a conversation about the specific medical procedure being considered. That conversation should be at least forty-five to fifty minutes in duration, and the emerging adult should explicitly be given the opportunity to ask questions about the treatment. Moreover, the conversation needs to explore the emerging adult's motivation for undergoing the procedure and to examine whether he or she has considered the long-term ramifications thereof.¹⁰⁵ Second, following the con-

103. See *supra* notes 24–26 and accompanying text.

104. There are varying definitions of patient advocates. National Patient Safety Foundation, *The Role of the Patient Advocate: A Consumer Fact Sheet* www.npsf.org/download/PatientAdvocate.pdf (last visited Nov. 16, 2005). Patient advocacy is a relatively new field; see Sarah Lawrence College, Health Advocacy Program of Study, http://www.sl.c.edu/grad_healthadvocacy.php (describing masters program in health advocacy at Sarah Lawrence College.) (last visited Nov. 16, 2005).

105. There is no indication that this is effectively taking place right now. While reputable offices may provide some mechanism for assessing the competency of the emerging adult, it often appears to be for the purpose of protecting someone other than the emerging adult. At least one reporter concedes that "[e]thicists worry that the practice of buying

versation with the patient advocate, the emerging adult must wait an additional forty-eight hours before final consent is given. This process would help ensure that the ultimate decision has been properly considered.¹⁰⁶

Deliberative consent, then, would include all the components of informed consent as it is currently structured and would add new procedural safeguards. The key to determining whether a patient gave deliberative consent would not be whether the last step in the process—the signing of the consent form—was completed. Instead, the focus would be on the process leading up to the signing of the form.¹⁰⁷ In cases like Katherine's, a patient advocate would be able to ask questions that specifically address issues like how she thinks she might feel about the procedure in five to ten years, or how she will feel after having children of her own. Alternatively, she might simply ask what Katherine thinks may be the long-term implications of her decision. Simply asking the question may raise Katherine's awareness of nuances that she otherwise might not have considered. Emerging adults like Katherine have more limited life experience, based both on their youth and on limited exposure outside the educational setting. Their awareness of other options for achieving their goals may therefore be restricted. Katherine, for example, may have a host of other options for obtaining \$7,500. The patient advocate should ask, for example, whether Katherine has considered other sources that might be available to help her financially.¹⁰⁸ Thus, the focus of deliberative consent will be on full discussion and disclosure, includ-

eggs and renting a uterus raises questions about informed consent." Boodman, *supra* note 1, at F1. The author also notes that Creative Family Connections, a law firm based in suburban Washington, D.C., requires its donors and surrogates to "undergo medical and psychological evaluation." *Id.* It is not clear, though, that this evaluation is for the benefit of the donor or surrogate. It is, perhaps, to protect the law firm from future claims that consent was not fully informed.

106. While the legal age of consent for these medical procedures, like the legal drinking age, could be raised to twenty-one, there are too many other life altering decisions that can be made at the age of eighteen to justify a special exception for these procedures. Moreover, that would do nothing to address the special concerns of emerging adults between the ages of twenty-one and thirty.

107. See CHARLES W. WIDE, INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY 318, 326 (1985) (noting that informed consent forms are too complex, are often not read, and are presented too late in the decisionmaking process).

108. One might expect that a reputable fertility clinic would do this as a matter of course. Fertility clinics, however, are subject to little state regulation and presumably run the gamut in terms of professionalism. See Noah, *supra* note 3, at 614–16.

ing interaction with a patient advocate who has no personal stake in the patient's decision.¹⁰⁹

A two-pronged test can be used to determine when these heightened informed consent procedures should be implemented. First, the procedure must be one that is not medically necessary for the patient. Second, the procedure must be difficult or impossible to reverse. Procedures that might satisfy this two-pronged approach include egg donation, as mentioned above. It would also include sperm donation, surrogacy, breast implants, genetic tests, sterilization, many forms of cosmetic surgery, and perhaps even tattoos. Experimental treatments, particularly those that are non-therapeutic for the participant, would also be included. Live kidney and liver donations would be another, as would bone marrow donations.¹¹⁰

Some may suggest that since eighteen-year-olds can vote, marry, and join the armed services, among other things, they should also be free to consent to medical treatments without enhanced procedural protections. They may further argue that any modification of the informed consent process would be too paternalistic. Given the shortcomings of informed consent in its current incarnation, the better policy is to provide greater protection to this vulnerable population of emerging adults. A deliberative consent approach arguably would be ideal in many instances of medical decisionmaking, not just those involving emerging adults. Anyone undergoing medical treatments should be well-educated about the process and its risks and alternatives. In addition, a period of deliberation would be welcome. Other contexts for deliberative consent can be explored at another time. For now, an appropriate place to start, and a context in which deliberative

109. Financially, the patient advocate must remain in a position of neutrality. Thus, either this person must be paid a flat salary or another mechanism that will promote impartiality must be implemented.

110. This is not intended to be an exhaustive list. The decision to have an abortion is explicitly excluded from this list. First, an abortion may be medically necessary and emergent in some situations. Second, acting in a timely fashion can be critical. Third, the right to abort is founded on well-recognized constitutional principles, the parameters of which have been explored intermittently for more than three decades by the Supreme Court of the United States. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914 (2000); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Roe v. Wade*, 410 U.S. 113 (1973). The examples listed in the text have not been subjected to that kind of scrutiny. Finally, abortion is an emotionally charged, unique issue in American society as well as in American jurisprudence and should be considered separately.

consent should be required, is that involving emerging adults considering elective and irreversible medical treatments.¹¹¹

V. CONCLUSION

In this modern age of informed consent, an eighteen-year-old can undergo significant medical procedures that, while risky, are neither medically necessary nor reversible. Thousands of young emerging adults undergo elective, yet irreversible medical treatments each year. Given the continuing personal development of emerging adults and the failure of the traditional informed consent paradigm to fulfill its goals of patient protection, a new, deliberative consent paradigm should be implemented. Deliberative consent would require counseling by a patient advocate and a waiting period for emerging adults undergoing certain elective medical procedures. This would better fulfill the goals behind the informed consent doctrine of educating patients and obtaining thoughtfully provided consent.

111. Cf. Schuck, *supra* note 67, at 906 (arguing that informed consent should be contextualized to the particular setting in which it is given).
