Consent and Confidentiality in Adolescent Health Care

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Pediatric care traditionally involves two individuals communicating together on behalf of a third individual, the passive recipient of care. This situation occurs when the patient is a child. Providing adolescent care, however, involves direct communication with the recipient of the care, changing the traditional pediatric interactional model. This approach is important in providing health care to adolescents who are struggling for increased autonomy. In many circumstances, adolescents may even refuse to seek care if parental consent or notification is required. Thus, it is important that physicians understand issues of consent and confidentiality in practice.

Physicians providing healthcare to adolescents may sometimes need to render such care on the basis of the adolescent's own consent and to keep it confidential. Parental involvement may not be possible for a variety of reasons. Either the adolescent may be unwilling to discuss a personal problem with parents, eg, sexuality, substance abuse, emotional problems, and sexual abuse, or parental involvement may not be possible because of parental physical or mental disability, or serious parent-adolescent alienations. Also, parental involvement may not be possible when the adolescent is not living at home.

Informed Consent

According to the traditional common law view, a minor cannot be given medical or surgical treatment without the consent of his or her parent or legal guardian. The only exception is an emergency, when it is either impractical to obtain parental consent, or when delay would unduly endanger life. Thus, according to the common law doctrine, minors' own consent to treatment was insufficient. However, in recent years, this common law approach to minors and consent to treatment has changed, either because of case laws or
legislative actions. The concepts of mature minors and emancipated minors have evolved where a minor is considered competent to consent to treatment on his or her own behalf under most circumstances. Such consent should, however, be an informed consent. In most circumstances, the judgment of the treating physician is the only requirement for determining a minor's competence to give informed consent. From a practical standpoint, the physician should assess and record clearly that the minor is able to understand the nature, and risks and benefits of the treatment being considered, and that the treatment is for the young person's benefit.

Thus, the adolescent's age and his or her level of cognitive maturation are important factors. As the adolescent progresses through the phases of early, middle, and late adolescence, there is a change from concrete thinking to more mature abstract thinking and better ability to comprehend risks and benefits of a treatment.

Physicians should also assess the likelihood and extent of any adverse outcome if a particular treatment is delayed, i.e., while awaiting parental consent. Since parental consent implies parental notification, one needs to consider whether or not parents' knowledge of the situation would serve the best interests of the adolescent.

THE EMANCIPATED MINOR

In most states a minor is considered emancipated at age 18. Minors who are high school graduates, married, or have been married at one time, have children, are in the armed forces, or work and contribute to their own financial support are also considered emancipated. Some groups of minors living away from home are also considered emancipated, including minors living away from home with parental permission and earning their own living; those living away from home without parental permission, runaways and alienated youths who manage their own financial affairs, and minors living away from home for a specified period, usually 6 months, earning their own living and having established their own residence. An emancipated minor can consent to most medical care just like an adult, and no parental consent is required. Most states have specific statutes concerning emancipation of minors for healthcare purposes. Emancipated minors have a right to confidential care; parental notification is not necessary.

THE MATURE MINOR

The mature minor principle recognizes the capacity of some minors to give an informed consent to care. This capacity is based on another person's judgment of the minor's cognitive competence. The minor must demonstrate age-appropriate maturity of understanding and intelligence. Any minor capable of giving an

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informed consent is entitled to do so. Although there are no specific laws addressing the mature minor rule, it is generally agreed that this rule can be applied to protect the minor's health whenever necessary. The mature minor rule is an exception to the rule requiring parental consent.

Alternative Consent

Many states have statutes authorizing others to consent for the minor; these others generally include alternatives to parents, i.e., foster parents, family members, parents with temporary custody of the minor, probation officers, social workers. These statutes provide for family courts and juvenile courts to assume jurisdiction over neglected minors. It may be noted that unless specifically terminated, parents do not lose their right to give consent for medical care when their children are under court jurisdiction.

Immunity and Disaffirmance

Many state statutes have included provisions intended to protect healthcare workers from liability resulting from unauthorized care of a minor, when they have acted in good faith, believing that a minor has met the statutory criteria to be able to give consent. The good faith immunity does not protect against acts of negligence. Some statutes address the issue of "disaffirmance," rejecting the validity of a minor's consent) with a statement to the effect that consent of a minor is not subject to disaffirmance (not valid) due to his minority, or in some cases, on the basis that he or she is divorced or the marriage was annulled. These have implications as to who will pay for the healthcare provided to the minor.

SPECIFIC CIRCUMSTANCES

Contraception

The law generally recognizes the minor's right to obtain contraceptives and the right of privacy. An adolescent who requests contraception has a right to have it if she is seeking the service at a federally funded facility; however, a private physician can refuse to provide it or may refer the patient to a public clinic. It is generally agreed that there are no barriers to providing contraceptive services to competent minors on their own informed consent. We can encourage adolescents to notify their parents, but this may not always be possible for reasons beyond the control of the practitioner.

The issue of parental consent and notification continues to be a source of litigation and arguments.
The good-faith immunity does not protect against acts of negligence.

One argument is that the minor may not be aware of and thus may not be able to provide some essential medical information needed to prescribe oral contraceptives. The physician is expected to maintain accepted standards of medical care; neither parents' non-involvement nor respect for the adolescent patient's rights of privacy justify any lesser standards of medical care. Some states have legislation specifying which minors can receive contraceptive services, e.g., restricting such services to a minor who is married, a parent, or has consent of a parent or a legal guardian. Some state agencies have promulgated regulations regarding provisions of contraceptive services to minors. Physicians should be aware of current laws and regulations in their locality pertaining to contraception services.

Pregnancy
In most states, minors may consent to the diagnosis, prevention, and on-going care of pregnancy. Parental notification is not required once pregnancy is diagnosed; however, for obvious reasons, parental involvement becomes important at some point. It should be noted that when considering prevention, the issues of abortion and sterilization are dealt with separately in most states. Where there are no specific statutes, the rules of emancipation and mature minor apply.

Abortion
In 1976, the Supreme Court established the right of minors to consent to an abortion without parental consent. However, at present, the issue of abortion is complicated by moral, ethical, religious, and political debates. States are now permitted more autonomy with respect to abortion and parental notification laws, and it is advisable to refer to current local laws. In states where there are no specific statutes, adolescents may consent to an abortion according to the mature minor doctrine. If there is doubt about an adolescent's capacity to give an informed consent to an abortion, parental consent and notification seem to be the only obvious alternatives. Conversely, a parent may not force an adolescent to consent to an abortion against her will, if she is deemed cognitively mature enough to give an informed consent. As of May, 1990, 31 states have enacted parental consent or notification statutes, 11 of them are enforced, 8 are generally not enforced, and 12 have been enjoined by courts.

Most recently the Supreme Court issued decisions in Hodgson v. Minnesota and Ohio v. Akron Center for Reproductive Health. In both instances, the Court held that states may by statute require minors seeking the termination of pregnancy to notify their parents prior to the operation, as long as the statute contains a procedure to obtain a judge's permission to bypass the notice requirement. The court rejected the argument that any mandatory notification requirement need not necessarily violated the constitution.

Regarding the bypass procedures themselves, the court held that such procedures do not violate the Constitution even if they permit a hearing to be held as late as 5 days after the woman's filing of her request. The Court also struck the two parent notification requirement. Another unsettled argument is of consent and notification of the spouse or partner. Also, the question of parental notification in the case of emancipated and mature minors remains unanswered by the Supreme Court.

Sterilization
Sterilization can only be performed with an individual's fully informed and voluntary consent. The issue of sterilization at a young age and sterilizing the mentally compromised evokes considerable ethical controversy. In the case of mentally retarded minors and young adults, parents' consent to sterilization is not enough, a court order is required.

Rape, Incest, Sexual Abuse
In cases of rape, incest, and sexual abuse, adolescents may consent to treatment on their own, and in acute cases rules governing emergency care also apply. Several states have statutes authorizing examination and treatment of minors alleged to be victims of sexual assault, on their own consent. Physicians may be required to notify parents or guardians, except when there is suspicion that they may be one of the perpetrators. Minors should agree to examination and treatment and informed of availability of services, i.e., treatment of sexually transmitted diseases, pregnancy, and psychiatric care.

Substance Abuse
The issue of performing drug tests with or without consent of minors remains unclear. Sometimes a physician may be requested by parents or others to perform tests on a minor. The American Academy of Pediatrics recommends that, with rare exceptions, such tests should not be performed without the informed consent of the older adolescent. Adolescents can consent on their own for diagnosis and treatment of substance abuse, which also includes the use of alcohol in most cases. Parental notification is generally not required by law, and, in fact, some states prohibit such disclosure. Other states require parental notification when the minor is hospitalized or placed in a particular treatment program, e.g., methadone...
treatment program. It may be noted, however, that effective treatment may be difficult without family participation in most cases of substance abuse.

**Mental Health**

Laws vary widely from state to state in permitting minors to seek mental health services. While many states permit adolescents to voluntarily commit themselves to a mental hospital, others permit only outpatient treatment and some also require a parental consent. In most cases, a parent may voluntarily commit a minor with or without the minor’s consent, if such treatment is necessary and considered beneficial. A competent minor has the right to refuse treatment, except when the treating physician determines that an emergency situation exists or the serious nature of the condition warrants the proposed treatment. With regard to administration of medication to a minor, among other things, a therapeutic reason for giving the medication should be clearly documented. Areas lacking clear definition are forcible administration of medications to mental health patients and release from hospital of committed minor patients.

**Sexually Transmitted Diseases**

All treatment and prevention of sexually transmitted diseases may be administered to minors on their own consent. A few states require parental consent if the minor is <12 years old. In most states, parental notification is not required by law and the decision is left to the discretion of the treating physician. Under public health laws, sexually transmitted diseases should be reported to the state Health Departments, although such agencies are subject to strict privacy regulations. In general, the same rules apply to AIDS and HIV infections, because HIV virus is transmitted sexually and is contagious. A number of states, however, are enacting specific AIDS statutes, many of which require written or informed consent for HIV testing.

**Emergency Treatment**

Generally, emergency care can be rendered on a minor's own consent and in some instances not even the patient's consent may be required. Broadly defined, an emergency situation is one in which endangerment of life, limb, or simply of “health” or “mental health” in the absence of immediate treatment.

**Consent From a Minor Parent**

Several states have statutes where a minor who is a parent is authorized to give consent for the medical care of the child. In the absence of a specific statute, parental consent is adequate unless the minor's parent is considered incompetent to give an informed consent.

**Refusal of Consent to Treatment**

Sometimes a parent or an adolescent may refuse treatment. An adolescent, particularly during early to mid-adolescence, may be hostile or may dissent for a variety of reasons, ranging from side effects of chemotherapy to religious beliefs. An adolescent may also refuse to consent for an abortion. If treatment is indicated, all attempts should be made to identify and correct the underlying causes of refusal. Medical intervention may not be forced upon a minor against his/her wishes. In case of a mature or emancipated minor, the decision of the minor prevails. But, where a minor is not considered mature or emancipated, there is no simple answer. Different approaches depend upon the nature and need of the medical intervention required.

**CONFIDENTIALITY**

The law is not clear in areas of parental notification and confidentiality. In providing healthcare to adolescents, the need for confidentiality is important. Parents are unlikely to know everything about their adolescent's activities as the adolescent goes through the emancipation and individuation process. There may be a delay in seeking care if parents were to know, and in many families communication may be poor. However, wherever possible, parental involvement is preferred in the overall management process.

In some cases it may be difficult not to break the confidentiality in the best interests of the adolescent. Such situations usually involve possibility of physical harm to self or others. At times, physicians may have to honor legal obligations, for example, in cases of sexual abuse. In other cases, family involvement may be essential either because it is part of the problem or essential to its solution. Also, family involvement is essential in treating some serious illnesses. It is also likely that parents may discover that medical care was provided without their knowledge, (e.g., contraception, abortion). Because parents either directly or indirectly pay for the medical care provided to adolescents in a significant proportion of cases, payment becomes an added consideration in honoring confidentiality. Laws protecting the information in the medical record are not clear and uniform, and it is possible that such information may be accessible to many people and may be inadvertently passed on to parents or others.

The issue of confidentiality should be discussed with the adolescent and family at the time of the initial visit, in the context of the nature of adolescent
healthcare concerns. Otherwise, discovery by parents that care was given without their knowledge may result in anger and resentment. In discussing parental feelings, the physician should understand that such feelings may represent parents' reaction to the fact that they are losing control over their adolescent. Legally, minors are responsible for payment of services they consented for and parents may not be held responsible for such services.

It is important to discuss fully all the treatment options and mechanisms with the family at the initial visit and reach an advance agreement. As noted earlier, it may be difficult to assure confidentiality of the information recorded on the adolescent's health record. Alternative systems may be considered to record confidential information and legitimate requests for information release should be carefully monitored so that only the specific information requested is released. It is important to document the adolescent's maturity and competence to give an informed consent, that the informed consent was obtained, that parental involvement was encouraged and the nature and extent of the risk to the patient if no treatment is given.

CONCLUSIONS

Teens need someone in the healthcare system to work with them without their parents' full knowledge. Otherwise they often delay or fail to seek care, adversely affecting their health. It is increasingly becoming clear that adolescents should have freedom to consent to their own in most cases; moreover, every avenue should be explored to provide such care in a confidential manner. Over the years, the courts and legislatures have increasingly recognized the capacity of adolescents to make decisions, and to exercise autonomy. Adolescents can consent on their own in most circumstances, however, it should be noted that whenever possible, parental involvement is preferred.

Most authorities conclude that there is little risk of liability in providing any type of treatment to minors on their own consent if they are over 15 years of age and, in the physician's judgment, competent to give an informed consent, provided such treatment is of benefit to the minor. In the majority of cases, the adolescent and the family understand and are receptive to the confidentiality and payment options when discussed fully during initial visits, with the understanding that it is in the best interest of the adolescent.

Because laws may vary from state to state and may be inconsistent for different specific conditions, and because multiple sources govern what can be done, state and local resources should be consulted for specific information. These include local bar associations, health departments, medical societies, Planned Parenthood programs, local youth law centers, and the Attorney General's office.

REFERENCES