

THE WHITE HOUSE
WASHINGTON

April 13, 2000

Mr. Jacques d'Amboise
National Dance Institute
594 Broadway, Rm. 805
New York, NY 10012

Dear Jacques:

On behalf of the First Lady, thank you for your card and invitation for Mrs. Clinton to attend NDI's Benefit Performance week in June.

It is not yet certain whether Mrs. Clinton's schedule might permit her to accept your kind invitation. But I have forwarded the request to Patti Solis Doyle, Director of Scheduling for the First Lady. If Mrs. Clinton can participate, our scheduling office will be in touch with you.

As always very best wishes to you and your colleagues at NDI.

Sincerely,



Melanne Verveer
Chief of Staff to
the First Lady



*Melanne Verveel
Chief of Staff to the
First Lady
The White House
Washington, D.C.*

national dance institute



National Dance Institute's Event of the Year 2000
AMERICAN SONG: Life, Liberty, and the Pursuit of Happiness

All performances will be in the Concert Hall of The LaGuardia High School of Performing Arts located at 100 Amsterdam Avenue at 65th Street.

Thursday June 15, 2000	One performance from 6:30-7:30 p.m. Following the performance there will be a benefit dinner from 7:45- 9:30 p.m. at the Tent at Lincoln Center.
Friday June 16, 2000	One performance from 6:30 - 7:30 p.m.
Saturday June 17, 2000	Three performances at the following times: 11:30 a.m.- 12:30 p.m. 3:00 - 4:00 p.m. 6:30 - 7:30 p.m.

For more information you may call the NDI office at (212) 226-0083. If Jacques is unavailable please feel free to speak with his assistant, Tanya Nicholson. Should you wish to contact Jacques at home, his number is (212) 873-2917.



Gold Boat, Broughier, Co. Derry (Early Iron Age).

POSTCARD

march 29 2000

(P)

Dear first Lady Hillary ...

Greetings to you ... There maybe a possibility
that on your busy ~~schedule~~ there would be the
time and inclination to give yourself a treat ..

NATIONAL DANCE INSTITUTE will be hosting in its June
Benefit performance week, some 2000 children
dancing over several days - June 15th - 16th - 17th -

The 15th is the gala launch .. and enclosed is a
list of the following performances after that launch

A Smiles - night .. an optimistic and
Joyful event .. and with your participation
in the audience an opportunity for N.Y.C. children
to meet their future Senator ...

my love and admiration
Yours Gargues

GOLD BOAT: Part of a hoard of gold objects, found at
Broughier, Co. Derry, at the beginning of this century.

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THE WHITE HOUSE
WASHINGTON

May 23, 2000

Ms. Anne M. Dellinger
Professor of Public Law and Government
University of North Carolina at Chapel Hill
CB #3330 Knapp Building
Chapel Hill, NC 27599-3330

Dear Anne:

Thank you for the copy of your impressive work relating pregnant adolescents and the law, legal issues in health care which I read with great interest and have shared with my colleagues. This is an excellent contribution to meeting needs and hopefully will receive wide circulation.

It was great to hear from you and especially about your exciting project. We miss seeing you and hope before too long we can all get together.

Best wishes and thank you for all you do.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Melanne', with a long, sweeping horizontal line extending to the right.

Melanne Verveer
Chief of Staff to
the First Lady

May 10, 2000

D/C
Ms. Anne M. Dellinger
Professor of Public Law and Government
University of North Carolina at Chapel Hill
CB #3330 Knapp Building
Chapel Hill, NC 27599-3330

Dear Ann:

Thank you for the copy of your ^{impressive work relating} paper about pregnant adolescents and the law, which I read with great interest and have shared with my colleagues. You offer a great deal about this critical subject. ^{to meeting needs} This is an excellent contribution.

Mrs. Clinton recently convened a conference at the White House that brought together experts from across the country to discuss the wide range of issues confronting America's teens. There are so many reasons to be optimistic that more and more attention will be given to the vital importance of taking care of all of our nation's teenagers.

Best wishes and thank you for all you do.

Sincerely,

Melanne Verveer
Chief of Staff to
the First Lady

hope fully w. r. receive
wide ~~to~~ circulation
It was great to hear
from you + especially
about your exciting
project. ^{we} ~~me~~ ^{me}
Seeing you + hope
before too long we
can all get
together.

Legal issues
in health
care.



Ⓟ

INSTITUTE of GOVERNMENT

April 24, 2000

Melanne Verveer
The White House
1600 Pennsylvania Ave NW
Washington, D.C. 20500

Dear Melanne:

Several years ago I made a plan to try to help pregnant adolescents in North Carolina, by identifying resources for them and explaining their legal choices to them, their parents, school employees, social services workers and health providers. My own institution was supportive and the project was also funded by a state agency, by the Z. Smith Reynolds Foundation, the Ginter Foundation and The Mary Norris Preyer Fund.

Before writing, to get a sense of these young women's circumstances and the gaps in their care, my co-author and I reviewed 186 medical records of girls who became pregnant under the age of fifteen and 15 of their infants' records. The records were generated in private practitioners' offices, local health departments, a large hospital and a private abortion clinic in the state. In addition, we interviewed more than 70 people with some connection to adolescent pregnancy—nurses, doctors, social workers in health facilities; judges, clerks and lawyers involved with petitions for waiving parental consent to abortion; clinic owners and directors; adoption and adolescent parenting specialists; school officials; guardians and parents of pregnant teens.

The first document—the one for health providers—is now finished. For the next six months, 150 providers throughout the state will use it and tell us how to improve it. Meanwhile, I am beginning work on the next document.

I enclose a copy and the comments of reviewers, for your information. Since this is an ongoing project, I would greatly appreciate any suggestions you might have about this document or the others planned.

My best wishes to you.

Sincerely,

Anne

Anne M. Dellinger
Professor of Public Law
and Government



The University of North Carolina at Chapel Hill

CB# 3330 Knapp Building • Chapel Hill, NC 27599-3330
919 966-5381 • 919 962-0654 (Fax)

April, 2000

Comments on the health providers' document

"This document is refreshingly clear and precise, presented in an unobtrusive style that never interferes with the authors' important message. It will be a valuable tool for anyone working with pregnant adolescents."

--Gretchen Aylsworth, District Administrator, Guardian Ad Litem Program

"Thanks for your research and commentary. I think the combination yields a very useful tool for health and human service providers.... You have undertaken a huge task—and we will all benefit."

--Beth Harris Brandes, Assistant Director, Catawba County Department of Social Services

"My overall impression of the draft of this document is very positive.... I think this is a very worthwhile and needed document."

--Linda Childers, Regional Social Work Consultant, Winston-Salem Office, Women's and Children's Preventive Health Section, North Carolina Department of Health and Human Services

"Your first guide looks great—no specific comments, just excited to get it out there."

--Ennis Dellea, Early Childhood and Mental Health Specialist, Orange County Early Head Start Program; Founder, Voices for Healthy Adolescent Choices

"You have done an extraordinarily impressive job of finding and analyzing the complex body of law that is relevant to the health care of pregnant minors in North Carolina.... Although I have worked for more than two decades on legal issues in adolescent health care, I learned a lot from your document."

--Abigail English, Center for Adolescent Health and the Law (a project of Advocates for Youth)

"Congratulations on your wonderful efforts to take on a very difficult topic.... It is important work."

--Carol A. Ford, Assistant Professor of Internal Medicine and Pediatrics, and Director, Adolescent Medicine Program, The University of North Carolina at Chapel Hill

"Will you do 'Grand Rounds' [at the Hospital] on documentation, consent and other issues in caring for pregnant adolescents?"

--Ben Gilbert, Director of Legal Affairs, University of North Carolina Hospitals

"I was very excited....Never bored. Spent about three hours at home last night reading this straight through and I just wished there was more when I got through."

--Merle Green, Assistant Director, Guilford County Health Department

"The document is excellent. Very readable and understandable. It is an invaluable document!"

--Beth F. Lamanna, Director, Intensive Home Visitation Project, The University of North Carolina School of Public Health

"This is so good!"

--Janet Mason, Professor (and social services law specialist), Institute of Government, The University of North Carolina at Chapel Hill

"Hats off to Dellinger and Davis. The book is an excellent resource for health care providers as well as a fine example of University research serving the people of North Carolina."

--Laurie Mesibov, Professor (and education law specialist), Institute of Government, The University of North Carolina at Chapel Hill

"The document is an excellent, comprehensive source. I can't wait to have a final copy on my own shelf."

--Jill Moore, Assistant Professor (and health law specialist), Institute of Government, The University of North Carolina at Chapel Hill

"Fascinating" "It's an exciting piece of work."

--Merry K Moos, Research Associate Professor, Department of Obstetrics and Gynecology, The University of North Carolina at Chapel Hill; Director, UNC Hospitals' prenatal clinic for teens

"I really enjoyed reading your document! It was very interesting and informative. Thank you for what you're doing."

--Barbara Pullen-Smith, Executive Director, Office of Minority Health, North Carolina Department of Health and Human Services

"I have to believe that this will prove to be a very useful handbook. Your writing is very clear and succinct."

--Elizabeth L. Quick, Partner, Womble, Carlyle, Sandridge & Rice, PLLC; Chair,
The Winston-Salem Foundation

"This publication is going to be so helpful!! Looks really good."

--Linda Riggsbee, President, Adolescent Pregnancy Prevention Coalition of North
Carolina

"You have done a fine job."

--Deborah Ross, Executive Director, North Carolina Civil Liberties Union

"Extremely knowledgeable. I had no idea there was so much law and so much to say on
this topic. Very impressive."

--Joy Vermillion, Junior Program Officer, Z. Smith Reynolds Foundation, Inc.

"I did send the draft out to a number of people—some nurses, some social workers, etc.
Most of the comments were oral or e-mail responses simply expressing appreciation that
this work was being done and that it was so comprehensive. One of our nurse consultants
said, 'I read the entire paper. I wish I had had it when I was out in the county as a nurse
and health director. I think they address all and every issue one could think to ask about
in reference to teens. Thank them for me. I hope this will go out free to every licensed
practitioner of health care, including nurses, NP's, PA's, MD's and SW's as well as
school guidance counselors.'"

--Margaret Woodcock, Supervisor, Women's Preventive Health Unit, North
Carolina Department of Health and Human Services

DRAFT

*Legal Issues in Health Care for Pregnant Adolescents: A Guide
for North Carolina Providers*

Anne Dellinger and Arlene M. Davis

copyright Institute of Government 2000

Preface

This book offers health providers information about the law and resources for North Carolina adolescents who are pregnant. It focuses on the youngest girls, those under 15, for two reasons: they present the most difficult legal issues and they are arguably the neediest. Nurses, social workers, physicians and others should be better able to care for these patients if they know what choices are open to patient and provider. The material presented here should be equally useful in the care of older pregnant minors.

Our choice of topics emerged from four kinds of research. First, we reviewed 186 medical records of girls pregnant under 15 years of age and 15 records of their infants. Most of these patients had delivered at a hospital in North Carolina after prenatal care in local health departments. A smaller number had abortions performed at that facility or, in more cases, at an urban clinic in the state. The record review told us about medical and social problems affecting patients at the time of their pregnancy and sometimes years later; suggested the nature of interactions between patients, their families and health providers; and gave us an idea of what legal questions providers most want answered.

Second, we conducted legal research, and identified recommendations on the care of pregnant adolescents from national medical organizations. With one exception we could not locate any nursing guideline, although nurses probably provide more care for pregnant adolescents than any other profession.

Third, we interviewed 70 people with some role in adolescent pregnancy. A large majority were North Carolinians. These included nurses, nurse practitioners, physicians, and social workers in hospitals, health departments, medical faculties, community outreach programs, nonprofit agencies and private practice settings; maternity care

coordinators; an owner, directors and staff members of abortion clinics; a counselor in a pregnancy support center; adoption specialists; judges, attorneys and prosecutors; several parents of girls pregnant before age 15; and two adults who had given birth near that age. To protect their privacy, no effort was made to contact pregnant girls or their partners. However, Arlene Davis, who is a nurse as well as a lawyer, observed two sessions of a teen pregnancy clinic and we listened for 15 hours to telephone operators staffing a national abortion referral line.

In the fourth phase of research we gathered data on facilities, programs, individuals to contact, written material or other assistance for adolescents or those responsible for them.

We do not vouch for or endorse any resource, and this book does not offer legal advice. Since the law is constantly in flux, readers must check any statute or regulation cited to see whether it has been repealed or amended, and any decision for relevant subsequent decisions.

Besides the support of the Institute of Government, The University of North Carolina at Chapel Hill, we gratefully acknowledge support from the Z. Smith Reynolds Foundation, [a funder to be consulted before acknowledging], the Ginter Foundation, and the Mary Norris Preyer Fund, as well as the many contributions of our advisory committee, those who reviewed drafts of this manuscript, and those who graciously talked with us or assisted in other ways.

---*Anne Dellinger and Arlene M. Davis*

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Introduction

A pregnant adolescent is a challenging patient. Her youth, combined with her adult medical condition, leads health providers to consider more than medical issues in caring for her. They usually want to understand the legal context for provider and patient. Who consents for this patient? Who is responsible for payment? Should authorities be involved? What are her rights? To the extent they can, many providers also give some attention to the young patient's living situation, safety, health education needs, and the effect of pregnancy or parenting on her future.

The providers for whom this book is intended are nurses, physicians, social workers, students in those professions, administrators, educators and others delivering care in a variety of settings. The book's users will have differing levels of knowledge and experience with these patients. Some rarely diagnose or work with an early or pre-teen pregnancy; others frequently do. Primary care providers and private practitioners are likely to know patients for years, while specialists and hospital or clinic staff may meet a young woman only once, for pregnancy diagnosis or counseling, for abortion, prenatal care, or delivery. This book aims to answer many types of providers' legal questions about the care of pregnant girls, as well as some of the questions a patient will ask providers about her situation.

The information offered is of several kinds. We explain reasonably clear legal requirements; interpret less clear law and venture predictions about unresolved legal questions; refer to the literature on adolescent pregnancy; present advice on good practice taken from medical organizations, treatises, and individual providers; and describe our own observations from interviews with providers and others and medical record review.

Our goals are to make this aspect of adolescent care easier for providers and to insure that young patients' contact with providers benefits them as much as possible.

Consent to Treatment for Minors

Parents usually control minors' medical care--or if not parents, then custodians, guardians or another adult with authority. Minors do not need adult consent in a few circumstances: in emergencies; when the minor is seeking treatment for certain medical conditions including pregnancy; when she is consenting for her own child's treatment; or if she is emancipated. A minor's consent to treatment deserves special attention from providers to assess competence to consent, the voluntariness of the consent and whether the condition is one for which the law lets minors consent. It would be prudent to document these matters in the medical record.

General rule that parental consent required

In North Carolina, minors (people under 18) are "subject to the supervision and control of" their parents.¹ As part of supervision, parents must see that children get necessary medical care, and if parents don't, they can be charged with neglecting the child.² Since parents are responsible for a child's medical care, they usually have the legal right to control it—arranging it with providers, consenting to the treatment, and paying for it.

A few states consider older minors generally capable of making medical decisions, but North Carolina does not. Still, the General Assembly has made exceptions in recent decades to the traditional rule that parents control minors' treatment. The legislature has identified situations in which a minor may consent for herself, an adult other than a parent may consent for her, or a physician may treat her without consent.

Each exception is described below. While more than one exception may apply to a particular minor, any one is enough to allow the provider to treat a minor without parental consent.

¹ North Carolina General Statute (hereafter G.S.) §B-3400.

Consent from custodians, guardians or other adults

Sometimes an adult who is not a minor's parent may legally consent to her care. The most common situations in which this is true are these.

1) guardians. A guardian can consent to a minor's medical care as fully as a parent can.³ However, to become a guardian, a person must be designated by a court. An adult who will be consenting for a minor's care as her guardian should first be asked to show his or her court appointment as guardian as proof of legal authority.

2) custodians. If a minor is in the custody of a local department of social services (DSS), the department's director may consent to some types of treatment; namely, routine or emergency care.⁴ Sometimes a director will delegate to foster parents the ability to consent to a foster child's routine care, but a provider should verify that they have that authority. Unless a parent's rights have been terminated by a court, no custodian can consent to elective care. It remains the parent's prerogative. ("Routine," "emergency" and "elective" care do not seem to be defined in North Carolina statute or regulation.)

If a minor is confined in a correctional facility, legal custody is not transferred to the facility, but "remains with the parent, guardian, custodian, agency, or institution in whom it was vested."⁵

3) people *acting as if they were* parents. The law allows providers to accept consent for a minor from someone acting as her parent. (The legal term is a person standing *in loco parentis*.) Being *in loco parentis* means taking on informally the rights

³ G.S. 7B-101 (15).

³ G.S. 35A-124(a)(3); 7B-600; 7B-906(d); and 7B-2001.

⁴ G.S. 7B-903(a)(2)c; 7B-2503(1)c; and 7B-2506(1)c.

⁵ G.S. 7B-2513(g).

and duties of a parent, especially the burden of support.⁶ Unfortunately, it is quite difficult to be confident that that has occurred. A provider rarely knows who is supporting a child, and certainly cannot judge whether the adult *intends* to act as a parent—and if so, how fully and for how long. The American Academy of Pediatrics (AAP) advises providers who accept consent on this ground to “document the situation in the medical record, including attempts to obtain verbal or written consent from a parent.”⁷

4) people *acting for* an absent parent. A North Carolina statute⁸ lets a parent transfer the power to consent to treatment for a child to someone else when “the parent is unavailable for a period of time by reason of travel or otherwise.” To transfer power, the parent must have sole or joint custody of the child. The authority must be transferred in writing, and no parent may authorize another person to agree to the withholding or withdrawal of life sustaining procedures for the child. The statute does not say how long the transfer of authority is valid.

Parental consent not needed in emergencies

A physician may often treat⁹ a minor whose parents are unavailable or object to treatment. The doctor may treat at her or his own discretion if

1) despite reasonable efforts the physician cannot reach the proper adult when the minor needs treatment;

⁶ State v. Pitard, 45 N.C. App. 701, 263 S.E.2d 809 (1980).

⁷ “Consent for Medical Services for Children and Adolescents,” Policy Reference Guide (1998) at 130.

⁸ G.S. Ch. 32A, Art. 4.

⁹ “Treatment” does not include surgery, but is “any medical procedure or treatment, including X rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures employed by or ordered by a physician licensed to practice medicine in the State of North Carolina that is used, employed, or ordered to be used or employed commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in the community where said physician administers treatment to said minor.” G.S. 90-21.2.

2) delaying treatment, in order to seek consent, would endanger the life or seriously worsen the minor's physical condition;

3) the minor's identity is unknown;

4) the parent refuses to consent. If a parent refuses emergency surgical or medical treatment, a physician may ask a judge to order it.¹⁰ The physician may also treat if taking time to ask for a court order would endanger the life or seriously worsen the minor's physical condition. In this case, though, another North Carolina-licensed physician must agree—before the treatment—that it is needed to prevent immediate harm to the minor.¹¹

The statute letting physicians treat without consent does not say they can do so simply to relieve pain. However, that seems a reasonable inference. The statute refers to the "time when the minor needs treatment." This term could cover a period of pain or suffering, even if the minor's problem was not expected to produce immediate harm, a threat to life, or worsening of physical condition. AAP guidelines suggest that physicians assume an implied parental consent to treatment when a child is suffering or in pain.¹²

If a physician wants to perform surgery on a minor in the circumstances listed above, he must get a second opinion if that is feasible.¹³ The second opinion is not required in a "rural community" (not defined) or if it is impossible to reach another physician.

A physician's decision to treat a minor in an emergency would not justify treatment of nonemergency conditions at the same time.

¹⁰ G.S. 7B-3600, allowing a judge to consent to any treatment for any condition.

¹¹ G.S. 90-21.1.

¹² "Consent for Medical Services for Children and Adolescents," Policy Reference Guide (1998) at 131.

¹³ G.S. 90-21.3.

Emergency abortion on a minor is treated separately under the law.¹⁴ The physician may perform an abortion when in his or her “best medical judgement...based on the facts of the case...a medical emergency exists that so complicates the pregnancy as to require an emergency abortion.” A physician may also perform an abortion over a parent’s objection if delaying for a court order would endanger the minor’s life or seriously worsen her physical condition. In that instance, though—where the parent has refused consent—the physician must get a second opinion, from another North Carolina-licensed physician, that the abortion is needed to prevent immediate harm to the minor.

Consent from the minor only

Sometimes, no adult’s consent is needed to provide a minor with medical services. In our state, as in most others, a minor may obtain care on her own in a number of circumstances; namely, when she wants treatment for one of a few specified conditions, when she is consenting to care for her child, or when she is emancipated.

1) Minors seeking care for certain conditions. Minors can approach providers independently for contraception, treatment for sexually transmitted diseases (STDs) and prenatal care (but not abortion).¹⁵ They can consent to services for the prevention, diagnosis and treatment of the conditions specified in statute if the provider is a North

¹⁴ G.S. 90-21.9.

¹⁵ G.S. 90-21.5. The other conditions with respect to which minors may consent to treatment are any reportable communicable disease, abuse of controlled substances or alcohol, and emotional disturbance. The statute states that it does not cover abortion, sterilization or nonemergency hospitalization for mental health care. G.S. 90-21.6 through -10, described later, require a parent’s or other adult’s consent to abortion or a judicial waiver of the requirement. G.S. 130A-148(h) provides that, if parents refuse permission for HIV testing, a child may still be tested if “there is a reasonable suspicion that the minor has AIDS virus or HIV infection or that the child has been sexually abused.” We assume that this provision does not apply when the minor herself is consenting to diagnosis under G.S. 90-21.5

Carolina-licensed physician¹⁶ or working under the physician's direction and supervision or standing orders.¹⁷

Moreover, the law tells the physician not to notify the minor's parent about the request for treatment. There are important exceptions to this instruction, though. A physician *must* notify a parent about a minor's condition if the physician thinks notification may be essential to the minor's life or health and *may* talk with parents if they contact her or him.¹⁸ In weighing whether to notify a parent, providers should consider the minor's mental and physical health—hints that she may be thinking of suicide, for example, or her refusal to seek treatment for a serious health condition. In one instance, a health director intended to inform a parent when a family planning patient took no action for months after receiving a troubling PAP test result.¹⁹

Although the statute allowing minors to consent reads, "[a]ny minor may give effective consent," a provider should not take "any" literally. To consent validly a minor, like every other person, must understand her condition, the alternatives for treating it, and the risks and benefits of treatment or the lack of it. There is no specific age at which adolescents become capable of understanding these matters, and selecting an age arbitrarily seems especially problematic when the health issue is pregnancy. Legal commentators, psychologists and judges are divided, for example, on whether girls under 15 should be able to consent to abortion or childbirth. A national commission on consent to treatment recognized that "there is an age, below about 14 years old, at which the

¹⁶ G.S. 90-21.5(a).

¹⁷ Opinion of Attorney General to Ed McClearen, Staff Attorney, Mental Health Study Commission, 47 N.C.A.G. 83 (1977) and Opinion of Attorney General to Margie Rose, M.P.H., Branch Head, Family Planning Branch, Division of Health Services, 47 N.C.A.G. 80 (1977).

¹⁸ G.S. 90-21.4(b).

¹⁹ Personal communication from Jesse Williams, M.D., Cumberland County Health Director, to Anne Dellinger.

traditional presumption of incompetence remains sensible." Still, the commission advised against a generally applied rule for age of consent, thinking it "more reasonable to ask—of any person at any age—is *this* person capable of making *this* decision?"²⁰

The commission described a competent adolescent as one with "sufficient ability to understand a situation and to make a choice in the light of that understanding."²¹ Another definition is the ability to understand the situation, weigh the risks and benefits of the choices, compare choices, incorporate her own values in the final decision, and make a decision that is not overly affected by others' opinions.²²

One North Carolina specialist in adolescent medicine uses practical tasks to inform her judgement about a patient—for example, whether the patient demonstrates responsibility for her own health care by keeping appointments that have been described to her as important. In addition, this provider usually asks a pregnant adolescent to describe in writing what she thinks her life will be like in one year and in five years if she makes one choice or the other.²³ Simply talking with a patient about her situation and plans can help a provider form an opinion about her competence to make medical decisions.

If providers think that a minor patient is competent to consent, they must also assess whether her consent is voluntary. Are the pregnant girl's decisions unduly influenced by adults—family, partner, or advisers, including providers? People who have studied adolescents making medical decisions disagree on whether most of them acted

²⁰ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions (1983), at 122, note 5.

²¹ *Id.* at 123.

²² Ambuel, Bruce and Julian Rappaport, "Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion," 16 Law and Human Behavior 129, at 132 (1992).

autonomously.²⁴ Several staff members in North Carolina institutions (hospitals, clinics and adoption agencies) told us that they often feared that the decision of a young adolescent—whether about childbirth, abortion or keeping her child—was not truly her own. If providers suspect that a minor's consent is coerced, they should tell her she has a right to decide, and if necessary, they should ask the DSS to intervene on her behalf.²⁵ Treatment should be postponed until the issue is resolved and the minor's consent seems to be freely given.

The scope of a minor's consent is another important issue under this statute. When a minor is treated for one of the specified conditions—an STD, for example-- providers may not treat clearly unrelated conditions such as asthma or a sprained ankle. In fact, however, a provider may find it hard to decide whether a condition is related, and there are no guidelines to assist her or him.

2) A minor consenting to her child's treatment. When there is no law on a practical matter that must be settled, lawyers must look to other legal principles for guidance. As explained above, a parent is responsible for a child's basic needs including medical care. Thus, it would seem that a minor parent *must* be able to consent to her child's treatment because no one else has the responsibility or authority to do so.

²³ Interview with Carol A. Ford, Asst. Prof. of Pediatrics and Internal Medicine and Director, UNC Adolescent Medicine Program, Chapel Hill, NC, March 3, 1999.

²⁴ "[M]inors younger than 14 or 15 years are unlikely to assert themselves well against authority figures, such as physicians or parents....Also, there are significant social class differences that may modify willingness to express preference." Sanford L. Leikin, "Minors' assent or dissent to medical treatment," 102 *J. of Pediatrics* 169, at 173. But Leikin's views contrast with those of David G. Scherer: "Children [9-10 years old] were significantly more likely to defer to parents than either adolescents [14-15] or young adults [21-25]. Adolescents were more likely to defer to parents than young adults, although this finding only approximated statistical significance." "The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions," 15 *Law and Human Behavior* 431 (1991).

²⁵ Sec. 5-18, "Children's Refusal of Treatment" in Rozovsky, Faye A., Consent to Treatment: A Practical Guide, (2d Ed.) Little, Brown & Co.: Boston 1990, at 358-359.

Here is our reasoning. State statute allows an emancipated minor to consent for her child's treatment,²⁶ but very few minor parents are emancipated since only marriage or a court order--not parenting--is evidence of emancipation. (See section immediately following.) Unless an unemancipated minor parent could also consent to her child's treatment, many infants and small children could not be treated. The minor's parents or her partner's parents might seem logical parties to consent, but their potential support obligation for a grandchild confers no legal right to make decisions. If a minor is not a competent parent, a court can place her child in the custody of another person or of DSS. The guardian or custodian would then be the appropriate person to consent. However, unless that has happened, the minor retains the rights and duties of parenthood. The odd result is, in our opinion, that minor parents can consent to their children's treatment, even though it is generally believed that an unemancipated minor usually cannot consent to her own treatment.

3) Emancipated minors. An emancipated minor is one who has the right to transact business as if she were an adult.²⁷ 'Transacting business' includes consenting to medical care.²⁸ Most people are automatically emancipated by reaching 18, at which age they are treated as adults for most legal purposes, but North Carolina law also allows a 16- or 17-year old to petition a court for an order of emancipation.²⁹ Only fifty-three minors filed petitions for emancipation in 1999,³⁰ however, which shows how rarely the procedure is used.

²⁶ G.S. 90-21.5(b).

²⁷ G.S. 7B-3507.

²⁸ G.S. 90-21.5(b).

²⁹ G.S. 7B-3500 to -3509.

³⁰ Telephone conversation with Patrick Tamer, Administrative Office of the Courts statistician, Raleigh NC, February 22, 2000.

Marriage is the only other means of emancipation for someone under 18.

Becoming a parent does not emancipate a minor.

Documenting consent and other matters

Documenting patient consent is always an important legal matter, and especially so when the patient is a minor. Although the law does not require different documentation for minor patients, we suggest that providers take extra measures with pregnant adolescents both as a precaution against liability and to help these vulnerable patients.

We recommend recording the following information:

- whether an adult accompanied the minor on the first visit
- the name of that adult
- his or her relationship to the minor
- that the minor and adult were interviewed separately
- that the pregnancy diagnosis and all options were explained to the minor
- what option(s) she chose
- the legal basis for allowing her to consent—for example, “medical emergency,” “treatment of pregnancy,” “minor has court order allowing her to consent to abortion” or “minor and her mother consented to abortion,” or “minor showed certificate of emancipation”
- the physician’s conclusion about the minor’s competence to consent and whether her consent was voluntary
- counseling on STDs and
- counseling and the patient’s decision on contraception after the pregnancy is resolved.

Besides documenting consent, providers could help pregnant minors by asking about their living situation; sexual history; the possibility of abuse, neglect, or crime committed against the patient. Documentation should include the girl's age and that of the father of the fetus; whether she is enrolled in school, particularly after a child is born; and what reports or referrals providers made.

Treatment of Pregnant Minors

Informing a pregnant woman about options (abortion or childbirth) is a precondition for informed consent. For a minor, abortion requires the young woman's written consent and that of a parent or specified other adult, but a judge can waive the adult consent requirement. Minors who bear and raise a child can make decisions about perinatal care and the child's care. Providers could help patients by explaining the law on adoption, marriage and child support; by facilitating their return to school; and by referring young mothers to resources for parenting.

Options Counseling

Before providers ask for consent to treatment, medical³¹ and legal³² standards require them to explain the condition, the treatments available for it, and the risks and benefits of treatment or non-treatment.³³ North Carolina's law on informed consent is found both in statute and in court decisions.

Under the statute, a provider sufficiently informs a patient (and thus avoids liability) by acting like fellow practitioners,³⁴ explaining enough to give a reasonable person a "general understanding of the...treatments and of the usual and most frequent

³¹ For example, Standard RI.1.2.1 of the Joint Commission's 1997 Hospital Accreditation Standards.

³² G.S. 90-21.13.

³³ For a full discussion, see Rozovsky, Fay A., Consent to Treatment: A Practical Guide, (2d Ed.) Little, Brown & Co.: Boston 1990) and 1999 Cumulative Supplement.

³⁴ Specifically, "in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities." G.S. 90-21.13.

risks....³⁵ An alternative test for liability is whether a reasonable person would have consented if advised under the first test.³⁶

Our state courts occasionally hear claims from patients that they were not fully informed. Although no case has yet looked directly at liability for not explaining options for normal pregnancy,³⁷ a decision about unwanted conception may be relevant.³⁸ Allegedly, a woman's IUD was removed during surgery and she was not told, although her doctor knew she did not want more children. After bearing a healthy child, she sued for malpractice and the state supreme court upheld her right to sue. The justices said that there are "many reasons...to avoid pregnancy, some of which are matters of personal inclination and some of which are related to health."³⁹ When a patient conceives because of a provider's mistake, "it is the fact of the pregnancy *as a medical condition* that gives rise to compensable damages and completes the elements for a claim of negligence."⁴⁰ By viewing pregnancy as a medical condition that patients may seek providers' help to avoid, the decision, like the informed consent statute, suggests that failure to counsel a patient about pregnancy options is malpractice.

Considerations besides state law affect some providers. Most family planning programs in local health departments in North Carolina use federal funds. Those working in federally funded ("Title X") family planning programs are bound by federal

³⁵ *Id.*

³⁶ *Id.*

³⁷ The supreme court refused to recognize claims by a child born with a genetic defect and his parents. Assuming that the mother would have aborted but for the providers' inadequate counseling, the court told the child that "even life with genetic defects cannot be an injury in the legal sense." The court deferred to the General Assembly on the parents' claim. *Azzolino v. Dingfelder*, 315 N.C. 103, 337 S.E.2d 528 (1985).

³⁸ *Jackson v. Bumgardner*, 318 N.C. 172. (1986).

³⁹ *Id.* at 177.

⁴⁰ *Id.* at 181.

regulations⁴¹ and program guidelines.⁴² Whether Title X clinics are to counsel patients about abortion and refer them for it⁴³ has inspired public controversy and official action for years, involving Congress, the federal courts and several presidents. Since 1993, when the abortion counseling 'gag rule' was suspended, abortion counseling and referral is again required in Title X programs.⁴⁴

For adolescent patients, it is extremely important to explain options as soon as pregnancy is diagnosed. Typically, these young women lack information about pregnancy, the law, and health systems. They come for care near the deadline for obtaining an abortion and past the time prenatal care should have begun. In one group of 58 teens, for example, 74% "only recognized their pregnancy when someone else suggested the possibility, and half of them did not detect it until the second trimester...."⁴⁵

A pregnant adolescent requires individual counseling whether or not she is accompanied by another person. Most pregnant girls, especially the youngest, do come with a parent to visit a health facility. Ninety per cent of those under 15 say that one parent knows of the pregnancy and 43 per cent that both parents know.⁴⁶ Unless a provider tells them, however, many of these young patients will not realize the extent to which they are entitled to make health care decisions.⁴⁷

⁴¹ 42 U.S.C.A. Sec. 300a authorizes the Secretary of the U.S. Department of Health and Human Services to make grants to states for family planning services. The states, in turn, fund local agencies to provide services. Regulations for the operation of these programs are found at 42 C.F.R. Sec. 59.1.

⁴² U.S. Department of Health and Human Services, Program Guidelines for Project Grants for Family Planning Services, Bureau of Community Health Services, Office for Family Planning, Rockville, Md.

⁴³ 42 C.F.R. Section 59.8 (10-1-99).

⁴⁴ "Standards of Compliance for Abortion-Related Services in Family Planning Service Projects," 58 F.R. 7462 (February 5, 1993) and U.S. Department of Health and Human Services, Program Guidelines for Project Grants for Family Planning Services, Section 8.6.

⁴⁵ Sandven, Karl, and Resnick, Michael D., "Informal Adoption Among Black Adolescent Mothers," 60 Amer. J. of Orthopsychiatry 210, at 217 (1990).

⁴⁶ Sex and America's Teenagers, The Alan Guttmacher Institute, Washington and New York 1994, at 49.

⁴⁷ Except for abortion a pregnant girl is fully entitled if competent. In the case of abortion she must consent, but a parent or other specified adult must also consent or a judge must waive the adult consent.

Pregnant minors' preferences about confidentiality must almost always be respected. (For the exceptions under North Carolina law, see **Minors seeking care for certain conditions**, above.) If a parent is present, medical and nursing association policy statements advise providers to meet separately with the patient to counsel her, seek the most highly confidential information, and learn how and whether she would like her parent to be involved in her medical care.⁴⁸ The AAP policy is typical. It recommends delivering the diagnosis of pregnancy to a minor patient alone, and then urging her, particularly if she is a younger adolescent, to involve her parents and partner. While that is best for most patients, the Academy realizes that for some the parent or partner is not a supportive figure. In those instances, the Academy simply advises "appropriate action."⁴⁹

In dealing with pregnant minors providers have options too, although they may be limited by conditions of employment or grants, or other requirements. Both state⁵⁰ and federal⁵¹ laws allow providers to avoid participating in abortion on moral, ethical or religious grounds. State law *lets* a physician treat a pregnant minor who does not want a parent involved, but does not require accepting her as a patient.⁵² However, if a provider is unwilling to explain options or treat the minor, he should refer her. If the girl has been

requirement. On the subject of minors' competence, see Weithorn, Lois A., "Involving Children in Decisions Affecting Their Own Welfare: Guidelines for Professionals," in Melton, Gary B., Koocher, Gerald P., and Saks, Michael J. (eds.), Children's Competence to Consent, Plenum: New York 1983, at 252.

⁴⁸ ACOG Educational Bulletin, "Confidentiality in Adolescent Health Care," No. 249 (August 1998); AWHONN Position Statement: "Confidentiality in Adolescent Health Care," *Reaffirmed* 1995; AMA, "Guidelines for Adolescent Preventive Services: Recommendations for Physicians and Other Health Professionals".

⁴⁹ AAP, "Counseling the Adolescent About Pregnancy Options," Policy Reference Guide (1998) at 180.

⁵⁰ G.S. 14-45.1(e)—applicable to physicians and nurses.

⁵¹ 42 U.S.C.A. Sec. 300a-7, applicable to all health care personnel in federally funded programs.

⁵² G.S. 90-21.5.

a patient, referral may be necessary to avoid a claim of abandonment. The AAP,⁵³ the American College of Obstetrics and Gynecology (ACOG)⁵⁴ and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)⁵⁵ also advise referral. AAP recommends, "When abortion counseling is in conflict with the physician's moral code, this should be explained to the patient. It is also important that the physician respect the adolescent's moral decision and legal right to terminate her pregnancy and not impose any barriers to health services from another source."⁵⁶

Abortion.

For minors' abortions North Carolina requires written consent from the minor. In addition, an adult from one of several categories must consent in writing or a court must waive the adult consent requirement.⁵⁷ As noted, most minors considering abortion, especially the youngest, do talk with a parent. In North Carolina, as for the United States as a whole, the figure is approximately 90%.⁵⁸ But for those adolescents who will not or cannot get adult consent, the court process described in this section is an alternative means of gaining permission for abortion.

Minors generally depend, in the first instance, on health providers for information about abortion. Many young patients will not know how far into a pregnancy abortion is

⁵³ "Should a pediatrician choose not to counsel the adolescent patient about sexual matters such as pregnancy and abortion, the patient should be referred to other experienced professionals." Policy Reference Guide at 179.

⁵⁴ ACOG Educational Bulletin, Confidentiality in Adolescent Health Care, No. 249, August 1998, at 3.

⁵⁵ For women of all ages, AWHONN "supports and promotes a...right to accurate and complete information and access to reproductive health services." Position Statement: "Health Care Decision Making for Reproductive Care," *Revised and reaffirmed under a new title*, September 1999. See also, Position Statement: "Nurses' Rights and Responsibilities Related to Abortion and Sterilization," 1999 (both are available at <http://www.awhonn.org>).

⁵⁶ Policy Reference Guide at 142.

⁵⁷ G.S. 90-21.7.

⁵⁸ In a year in which 2,287 abortions were performed on minors aged 9 through 17 (State Center for Health Statistics, North Carolina Reported Pregnancies 1998), only 233 petitions for waiver of parental consent to abortion were filed (Administrative Office of the Courts, Raleigh, NC).

legally, practically, or medically available; where or how to obtain one; or that if they choose abortion they will need an eligible adult's consent or must ask a judge to waive that requirement.

For providers' information, abortion is legal for any woman in North Carolina until a fetus is viable.⁵⁹ Unless the physician concludes that the fetus is viable, abortion can legally be performed through the end of the second trimester (the 24th week of gestation). An abortion is legal at any point in pregnancy if "necessary to preserve the life or health of the mother."⁶⁰ North Carolina licenses clinics⁶¹ and ambulatory surgical facilities⁶² to offer abortions through twenty weeks' gestation—although not all licensed facilities do offer them for that length of time.⁶³ After twenty weeks' gestation, abortions in North Carolina must be performed in a hospital.⁶⁴

The requirements for a minor's obtaining an abortion are as follows.

1) With parent's or another adult's permission. Unless a judge waives the requirement, a provider must have written consent from the minor and from one of these adults: a custodial parent, a legal guardian or custodian, a parent with whom the girl is

⁵⁹ In *Roe v. Wade*, 410 U.S. 113 (1973), the U. S. Supreme Court established an unfettered right to choose abortion through the first trimester of pregnancy. Under *Roe*, in the second trimester a state may regulate to protect maternal health, and after viability a state may forbid abortion except where a woman's life or health may be at stake. Subsequent U. S. Supreme Court decisions have retreated from *Roe* by allowing states to impose restrictions that the Court does not find unduly burdensome to the exercise of a right to abortion.

Roe is understood to have invalidated the North Carolina statute, G.S. 14-45.1, that permitted abortion only through twenty weeks' gestation. Although the General Assembly has not enacted a new statute, we assume that North Carolina wishes to prohibit abortion after viability except, as required by *Roe*, to preserve a woman's life or health.

⁶⁰ *Roe v. Wade*, 410 U.S. 113 (1973), at 164.

⁶¹ 10 NCAC 3E.0101.

⁶² 10 NCAC 3Q.0204.

⁶³ For example, the Statesville, North Carolina, telephone book for 1998-99, listed under "Abortion Services" two clinics advertising abortions through 20 weeks; another, through 16 weeks; and a fourth, through 14 weeks. In addition to different time limits by facilities, physicians serving a single clinic sometimes have different numbers of weeks through which each is willing to perform abortions.

living or a grandparent with whom she has lived for six months immediately before the abortion.⁶⁵ If the adult is available, informed consent standards would seem to require providers to explain treatment options, risks and benefits to the adult as well as the minor patient.⁶⁶

If the minor is unaccompanied and presents a document as an appropriate adult's consent, providers may wonder how far they must go to verify it. The only North Carolina case on this point held that a physician could rely on the minor's word that the signed permission she presented was valid. The state court of appeals ruled that the parental consent statute "contains no requirement, express or implied, that the physician conduct an investigation into the circumstances of a purported written parental consent for an abortion to determine the validity of the writing."⁶⁷

2) With court waiver of the adult consent requirement. If a minor wants an abortion, but no eligible adult is available to consent, or will consent, or she does not want to ask them, she may ask a judge to let her decide.⁶⁸ (The official name for such a request is a "Petition for Waiver of Parental Consent for Minor's Abortion," which court staff usually call a "waiver petition" or "judicial waiver.") The judge must grant the request if he or she finds any one of the following to be true:

- 1) the minor is mature and well-informed enough to make the decision;
- 2) making the decision herself would be in her best interest; or

⁶⁴ In 1993 North Carolina hospitals reported performing 125 abortions after twenty weeks. Forty-one were performed on women 19 and under. These later abortions were less than one half of 1% (.4%) of the 29,868 abortions performed in the state that year.

⁶⁵ G.S. 90-21.7(a).

⁶⁶ G.S. 90-13. Informed consent to health care treatment or procedure.

⁶⁷ *Jackson v. A Woman's Choice*, 130 N.C. App. 590, at 503 S.E.2d 422 (1998) at

⁶⁸ G.S. 90-21.7.

3) she is a victim of rape or felonious incest.⁶⁹

If a minor wants a waiver, a provider should refer her to the district court clerk in a county courthouse for information and assistance.⁷⁰ The minor need not be a North Carolina resident to submit a waiver petition here,⁷¹ and if she is, she does not have to file her request in the county she lives in. Any minor may ask for a judicial waiver in any county in the state.⁷²

Health providers could, if they wished, further assist a patient who wants a waiver by explaining the court procedure and giving her written certification of pregnancy and the estimated gestational age of the fetus to take to court. Although neither the statute nor the court forms on waiver mention these items, a significant number of judges are asking for them. Having that information to present to a judge might save the minor a delay that would make it impossible for her to obtain an abortion.

State law requires that a court employee help a young woman prepare her request, if she wants help. The court employee will give her forms entitled "Instructions for Minor Petitioners."⁷³ She may have, without charge, the assistance of a lawyer or someone else,⁷⁴ or she may proceed on her own.⁷⁵ If she wants a lawyer, the court will find and appoint one to represent her. Court costs and fees are waived for this procedure, so that it costs the minor nothing. The minor's identity and the record of the hearing can

⁶⁹ The court must notify the department of social services if the pregnancy is the result of incest (G.S. 90-21.8.) or abuse or neglect (G.S. 7B-301).

⁷⁰ G.S. 90-21.8 through -21.10.

⁷¹ G.S. 90-21.8(a).

⁷² The statute says a petition may be filed "in the district court where the minor resides or where she is physically present." G.S. 90-21.7(b).

⁷³ G.S. 90-21.8(b). See also Rule 1C., Jack Cozart, Rules of Recordkeeping: Judicial Waiver of Parental Consent (JW) Proceedings, Raleigh, NC: October 1, 1995. (Hereafter, Rules of Recordkeeping.)

⁷⁴ The nonlawyer adult helper is called a guardian ad litem, that is, a guardian for purposes of the court proceeding. This could be someone suggested by the minor or identified by the clerk of court.

⁷⁵ G.S. 90-21.8(c). See also Rule 1B, Rules of Recordkeeping.

be kept confidential, except that the court must notify DSS if the pregnancy is the result of incest⁷⁶ or rape.⁷⁷ The DSS investigation or its consequences could cause parents to learn of the minor's abortion. Otherwise, the minor's parents are not notified if she makes it clear on the forms that they should not be, by checking the appropriate box.⁷⁸

When a waiver petition is filed a judge must decide within seven days whether to grant it. Some judges talk with the minor and come to a decision the day the petition is filed.⁷⁹ If the judge grants the request, she or he issues an order. The clerk of court then gives the minor a certificate to show an abortion provider which states that the minor does not need an adult's consent. If her request is denied, a minor has 24 hours to appeal. On appeal, she will be required to present her case anew, to a different judge. Or, since the statute does not limit a minor to a single petition, she could file another petition in a different county or before a different judge.

3) Payment for abortion. Many minors will find it hard to pay for an abortion. Medicaid very rarely covers the procedure.⁸⁰ A state abortion fund, which at some points paid for many abortion procedures, no longer functions.⁸¹ The absence of the fund may produce a significant difference in the number of pregnancies carried to term.⁸²

⁷⁶ G.S. 90-21.3(f).

⁷⁷ Under rules of the North Carolina Supreme Court.

⁷⁸ Form AOC-J-601. All the forms used for the waiver process can be found in Administrative Office of the Courts, Forms and Procedures for Judicial Waiver of Parental Consent, Raleigh, NC, October 1995.

⁷⁹ Interview with a North Carolina assistant clerk of court, April 7, 1999.

⁸⁰ Abortions that qualify for Medicaid reimbursement are those where the pregnancy is the result of rape or incest, or is life-endangering. A North Carolina-licensed physician must fill out and sign a statement to that effect. In 1998 Medicaid paid for 20 abortions in North Carolina, according to Lynda C. Dixon, N.C. Department of Health and Human Services, Division of Medical Assistance, March 22, 2000.

⁸¹ Since 1995 the fund has consisted of \$50,000 available under the same conditions as Medicaid, but the applicant must not be eligible for Medicaid despite her poverty status. Sec. 23.27, Ch. 324, SL-1995; Sec. 23.8A, Ch. 507, SL-1995; Sec. 11.29, Ch. 237, SL-1999. According to Lynda C. Dixon, North Carolina Department of Health and Human Services, Division of Medical Assistance, the fund has not paid for an abortion in years. Telephone conversation with Anne Dellinger, March 21, 2000.

⁸² Cook, Philip J. et al. "The effects of short-term variation in abortion funding on pregnancy outcomes." 18 J. of Health Economics 241-257 (1999).

However, some private health insurance policies cover a dependent's abortion, and clinics and hospitals sometimes reduce or waive charges for those unable to pay.

Childbirth.

Although many adolescents end their pregnancies, a majority now give birth⁸³ and raise their child. As a result, health providers may treat a young pregnant patient pre- and postnatally. They may also treat her child⁸⁴ and, occasionally, her partner, despite the fact that serving several members of a family can raise conflicts of interests. For example, as discussed earlier, a provider would have to report a mother who abused or neglected her child, and might urge a girl to report an older or abusive partner's statutory sexual offense or violence. Physicians have different policies on retaining minor patients who give birth. One pediatrician whom we interviewed stated that her practice group will no longer treat such a patient, but will accept her infant as a patient.

Continuing to treat an adolescent after she becomes a mother is likely to benefit her greatly. Familiar providers can best assess her needs for personal security, contraception, and protection from STDs, and encourage her to pursue education and employment while developing competence as a parent. The AAP notes that, "Adolescent parents and their offspring represent high-risk families that require intensive monitoring and a sensitive and caring approach by the pediatrician."⁸⁵ The Academy recommends interventions for adolescent mothers and fathers, both as parents and patients, as well as for their infants.⁸⁶

⁸³ In 1998 North Carolina reported 592 pregnancies in girls under 15. 328 of the pregnancies resulted in live births. State Center for Health Statistics, Department of Health and Human Services, Raleigh, NC.

⁸⁴

⁸⁵ "Care of Adolescent Parents and Their Children," Policy Reference Guide at 116 (1998).

⁸⁶ Id. at 93.

1) Perinatal care. The law governing the perinatal period is straightforward. Under the state statute letting minors consent to treatment for pregnancy,⁸⁷ an adolescent can consent for prenatal care, labor and delivery, and postnatal care.

But a minor who gives birth and keeps the child faces medical and financial challenges, which must be met while she learns to function as a parent and resumes school work. Previous pregnancies or other children may add to the difficulties. Nine of the 186 pregnancies in girls under 15 that we studied were second pregnancies. At least four girls had a child at home already.

Although most adolescent mothers do well physically, the medical risks of childbirth for them (especially the youngest) and their infants are substantially greater than for adult women.⁸⁸ In addition, they are disproportionately poor,⁸⁹ usually first-time mothers, and less prepared for parenthood than older women—facts which make a very brief postpartum stay a strain on their personal resources. The AAP calls short hospital stays for high-risk mothers a problem for their infants, and includes among early discharge risk factors “lack of social support, particularly for single, first-time mothers” and being a teen mother. “When these or other risk factors are present,” the AAP recommends that “the discharge should be delayed until they are resolved or a plan to safeguard the infant is in place.”⁹⁰ A 1999 policy statement advises pediatricians to

⁸⁷ G.S. 90-21.5.

⁸⁸ Adolescent Pregnancy—Current Trends and Issues: 1998,” 103 *Pediatrics* 516-520, citing Piccinino LJ, Mosher, WD, “Trends in contraception use in the US: 1982-1995,” 46 *Family Planning Perspect.* 4-10 (1998) and Satin, AJ, Leveno J, Sherman ML, Reedy NJ, Lowe TW, McIntire DD, “Maternal youth and pregnancy outcomes: middle school versus high school age groups compared with women beyond the teen years,” 171 *Am J Obstet. Gynecol.* 184-187 (1994).

⁸⁹ “Poverty is correlated significantly with adolescent pregnancy in the United States. Although 38% of adolescents live in poor or low-income families, ~83% of adolescents who give birth and 61% who have abortions are from poor or low-income families.” Adolescent Pregnancy—Current Trends and Issues: 1998,” 103 *Pediatrics* 516-520.

⁹⁰ AAP, “Hospital Stay for Healthy Term Newborns,” *Policy Reference Guide* 48” (reaffirmed 10/98).

"recommend that adolescent mothers not receive early postpartum discharge so that clinicians can ensure that the mother is capable of caring for her child and has resources available for assistance."⁹¹

North Carolina law requires private insurers to cover a 48-hour stay for any mother after a normal vaginal delivery. If a mother and her physician agree on earlier discharge, the insurer must cover "timely postdelivery care."⁹² Medicaid has similar postpartum coverage (1.9 days) but allows a longer stay if medically necessary. If a minor's parents' insurance does not cover her,⁹³ she is very likely eligible for Medicaid. Since Medicaid considers only the minor's income for childbirth, nearly all adolescents would qualify. As a last resort for pregnant women, a federal statute requires hospitals to treat anyone, regardless of ability to pay, who comes to the hospital in active labor.⁹⁴

Hospital staff often refer an adolescent mother to North Carolina's Child Services Coordination program. This voluntary program is open to all families, and consists of home visits for the first three years of a child's life by a nurse or social worker trained to identify services available for the child. Visits are made at least quarterly and more frequently if needed.

Young mothers' continued school attendance is crucial to the economic wellbeing of adolescents and their children.⁹⁵ School policies vary in how well they facilitate a new mother's returning to school and gaining credit for the semester or year in which she

⁹¹ Adolescent Pregnancy—Current Trends and Issues: 1998," 103 Pediatrics 516-520, Recommendation 6.

⁹² G.S. 58-3-169(c).

⁹³ Many policies exclude dependents' coverage for labor and delivery. Telephone conversation with Kim Shepherd, Life and Health Section, N.C. Department of Insurance, June 9, 1999.

⁹⁴ Emergency Medical Treatment and Labor Act, 42 U.S.C. Sec. 1395dd, *renamed in 1989* Examination and Treatment for Emergency Medical Conditions and Labor Act.

⁹⁵ For one of numerous studies reaching this conclusion, see J. Brooks-Gunn and Furstenberg, Frank F., Jr., "Continuity and Change in the Context of Poverty: Adolescent Mothers and Their Children," The Malleability of Children, J. Gallagher and C. Ramey (eds), Baltimore: Brookes Publishing 1989, 1-1-88.

gives birth. One district grants students who want it an excused absence for up to 30 days before and 30 days after delivery.⁹⁶ Another requires a doctor's letter before excusing absence even for physical necessities of the postpartum period. Given these differences in policy and practice regarding pregnancy and childbirth, if a physician and patient decide that an absence of more than a day or two is advisable--for instance, for maternal-child bonding, establishing breastfeeding or securing child care--a written statement from the physician to school officials may be essential for the student to have a chance of being allowed to continue working at home for credit.

2) Raising the child. In 1998 girls pregnant before they were 15 years old gave birth to 328 infants. In all, 5808 babies were born to North Carolina minors that year.⁹⁷ Nearly all minors who give birth intend to raise the baby. While most will manage, usually with family help, health providers may have questions about how and whether some young patients can bear the responsibility.

a. parent's competence.

There is no minimum age for raising a child. Instead, all parents have a legal duty to give a child life's necessities (including health care) plus education, and to keep a child from harm. Failing in these duties can carry civil and criminal penalties⁹⁸ and cause authorities to terminate a parent's rights.⁹⁹

⁹⁶ The "Homebound Instruction" policy of the Alamance-Burlington School System allows for such an absence. Telephone conversation with Jerry Ferguson, Director of Student Support Services, March 13, 2000. Moreover, under the system's "High School Attendance Policy Procedures," for "[a]bsences resulting from...life-altering circumstances of the student, the principal has the authority to exempt the student from the provisions of the individual class attendance policy."

⁹⁷ North Carolina Reported Pregnancies 1998, State Center for Health Statistics, North Carolina Department of Health and Human Services, Raleigh, North Carolina.

⁹⁸ For example, a caretaker who exposes a child to "a substantial risk of physical injury" commits a criminal misdemeanor, G. S. 14-318.2. The court of appeals finds the same duty in civil law. *Coleman v. Cooper*, 89 N.C. App. 188, 366 S.E.2d 2, *discretionary rev. den.*, 322 N.C. 834, 371 S.E.2d 275 (1988).

⁹⁹ Ch. 7B, N.C. General Statutes, especially Articles 3, 5, and 11.

Health providers should assume that a young mother, though not adult for most legal purposes, has the legal rights of a parent (and they can help young mothers gather resources for parenting by referring them to DSS). If, however, providers have reason to suspect that the mother, her child or both are being abused or neglected, they must contact social services. (See the section below on "Abuse, Neglect, Dependency, Sexual Assault" for more information.)

b. marriage.

North Carolina law strongly favors marriage and the legitimacy of children, although the benefit of very early marriage is debatable.¹⁰⁰ People are free to marry at 18 in North Carolina, when they become adults. Sixteen- and seventeen-year olds may marry with consent from an appropriate adult.¹⁰¹ A girl as young as twelve may marry if she (1) is pregnant or has a child by the person she wants to marry, and (2) has written consent from one of a number of adults. The adults eligible to consent are a parent she lives with; a person, agency or institution that is her guardian, custodian or stands *in loco parentis*; or the director of DSS where either the girl or her partner lives.¹⁰² In 1998

¹⁰⁰ According to one source, the policy "subordinates other interests, such as those of the parents and guardians of the underage applicant [for a marriage license] and the long-term welfare of both the child and its mother." Campbell, William A., "North Carolina Marriage Laws: Some Questions," *Popular Government*, Vol. 63, No. 2, Institute of Government, UNC CH: Chapel Hill, N.C. 1998, 53. Another legal writer points out that the Uniform Marriage and Divorce Act, which North Carolina has not adopted, allows no one younger than 16 to consent and "expressly rejects pregnancy as an automatic exception to an age requirement" because "marriages entered into under these circumstances are even more vulnerable than other youthful marriages." Reynolds, Suzanne, *Lee's North Carolina Family Practice*, (5th Ed.) Vol. 1, Sec. 2.8, The Michie Company: Charlottesville, Va. 1993, at 98. A third source concludes that "[a]dolescent childbearers may not be able to combine school attendance and marriage successfully." Scott-Jones, Diane, "Educational Levels of Adolescent Childbearers at First and Second Births," *American J. of Education* (August 1991) at 477.

¹⁰¹ An appropriate adult is any of these: a parent with whom the minor lives; guardian; legal custodian, or person *in loco parentis*, G.S. 51-2(a).

¹⁰² G. S. 51-2. Campbell, William A., *North Carolina Guidebook for Registers of Deeds*, (7th Ed.) Institute of Government, UNC CH: Chapel Hill, N.C. 1994, 126-127.

forty North Carolina girls pregnant under age 15 were married.¹⁰³ The law does not mention a minimum marriage age for a male whose partner is pregnant or has given birth. An emancipated minor does not need anyone's consent to marry.¹⁰⁴ But, the minor must file a copy of the certificate of emancipation with the register of deeds to obtain a marriage license

c. support obligations of parents, grandparents or others.

Whether they are married or not, parents owe financial support until a child is at least 18 or emancipated.¹⁰⁵ ("Support" is defined as an amount that satisfies "the reasonable needs of the child for health, education and maintenance" considering the family's "accustomed standard of living" and total circumstances.¹⁰⁶) Most unmarried fathers in North Carolina acknowledge paternity when their child is born, and the state's Child Support Enforcement program is able to establish paternity in most of the remainder of the cases.¹⁰⁷

A mother can ask a court to establish paternity.¹⁰⁸ The action can be filed any time until the child is 18, and it is the necessary first step in getting financial support from the father. Besides ordering support, a court may order a father to reimburse the mother for pregnancy and childbirth expenses and the cost of her legal action against him.¹⁰⁹

¹⁰³ North Carolina Reported Pregnancies 1998, State Center for Health Statistics, North Carolina Department of Health and Human Services, Raleigh, NC.

¹⁰⁴ G. S. 51-2.

¹⁰⁵ G. S. 50-13.4.

¹⁰⁶ G. S. 50-13.4(c).

¹⁰⁷ 52% of unmarried fathers acknowledge paternity at the hospital. Paternity is established later for 57% of the remaining children. Telephone conversation with Barry Berger, Asst. Chief of Program Operations, Child Support Enforcement, Division of Social Services, North Carolina Department of Health and Human Services, March 23, 2000.

¹⁰⁸ G. S. 49-14.

¹⁰⁹ G. S. 110-132.

A minor's parents and her partner's parents can be responsible for support too. The General Assembly requires both sets of grandparents to support a child when one or both parents are unemancipated minors who together do not provide full support for their child.¹¹⁰ If another person or agency, organization or institution stands *in loco parentis* to the minor parent, that party too can be responsible for support.

d. Out of home placement. A parent who feels unable, for any reason, to care for a child should contact DSS. Some departments will accept the child temporarily and let the parent reclaim her months later.¹¹¹ Other departments rarely accept custody unless a parent is willing to give up the child permanently or a court has found the child to be abused, neglected or dependent. (See the later section on "Abuse, Neglect, Dependency, Sexual Assault.") An important goal of social services today is "permanency planning;" that is, developing "a plan to achieve a safe, permanent home for the [child] within a reasonable period of time."¹¹² With that in mind, departments usually move within months, or at most a year or two, to reunite a family or arrange a permanent alternative, which may include termination of parental rights.¹¹³

3) Adoption. The most permanent arrangement for a parent to choose who cannot raise a child is adoption. Although minors of any age are legally able to offer a child for adoption,¹¹⁴ few make this choice—only three to five per cent of unmarried adolescent mothers.¹¹⁵ Apparently, far more teens consider placing their child for

¹¹⁰ G. S. 50-13.4.

¹¹¹ A court must review a parent's voluntarily placing her child with DSS within 180 days, and the child may not stay in voluntary placement more than a year unless DSS files a petition to have the child declared abused, neglected or dependent. G.S. 7B-910.

¹¹² G. S. 7B-907(a).

¹¹³ G. S. 7B-907.

¹¹⁴ G. S. 48-3-605(b).

¹¹⁵ One source reports five per cent. Musick, Judith, Young, Poor, and Pregnant: The Psychology of Teenage Motherhood, New Haven: Yale U' Press 1993, at 13; another, three per cent. Solinger, Rickie.

adoption than do so—12 per cent in one study, even though 89 per cent predicted a negative reaction from partner, friends or family.¹¹⁶

Health providers may not realize how important their views of adoption are to adolescent patients. Researchers have found that among teens considering adoption, “While the most influential person was the adolescent’s mother, over half of respondents solicited advice [on legal adoption] from a professional—usually a physician or a nurse (the importance of providing counseling in health care facilities seems salient.)”¹¹⁷ A North Carolina adoption specialist reports that it is “all too common and can be extremely destructive” for a minor who has tentatively decided on adoption to face disapproval from one or more providers. According to this source, such interactions occur most frequently during hospitalization for delivery.¹¹⁸

The AAP advises members to know state laws on adoption¹¹⁹ and to indicate repeatedly to patients during pregnancy that the provider is willing to discuss the subject.¹²⁰ For their legal protection, providers should counsel patients and other parties about adoption for the same fee (no more, no less) they normally charge patients for counseling. Otherwise, they might inadvertently violate criminal statutes barring unauthorized people from various kinds of involvement in adoptions.¹²¹

Below are some questions that patients may have about adoption and brief answers to them under North Carolina law.

Introduction, The Abortion Wars; and according to the AAP, two to four per cent. “The Adolescent’s Right to Confidential Care When Considering Abortion,” Policy Reference Guide at 31, citing another source.

¹¹⁶ Sandven and Resnick at 217.

¹¹⁷ *Id.* at 220.

¹¹⁸ Telephone conversation with Sandy M. Cook, Director, Children’s Home Society of North Carolina, March 2, 2000.

¹¹⁹ “Issues of Confidentiality in Adoption: The Role of the Pediatrician,” Policy Reference Guide at 473.

¹²⁰ “Counseling the Adolescent Concerning Pregnancy Options,” Policy Reference Guide at 180.

¹²¹ G.S. 48-101 and -102.

1) Do my parents have to agree to my baby's adoption?

No. Whatever your age, you alone can decide to let the baby be adopted.¹²² By the same token, if your parents want the baby to be adopted and you do not, you do not have to agree.

2) Does the baby's father have to agree to adoption?

The baby's father does have legal rights. He can stop an adoption if you and he married, if he took legal responsibility for the baby in any of a number of ways, supported you or the baby or was ordered to support the baby by a court.¹²³ He can lose the right to object to adoption, though, by not responding to notice that an adoption is scheduled to take place. Another way for an unmarried father to lose rights is to sign a notarized statement denying that he is the father or saying he does not have a legal interest in the baby.¹²⁴

3) If I agree to adoption, could the baby's father get the baby or his family adopt the baby?

A father can always try to get custody, whether or not you are trying to have the baby adopted. But you can prevent the father or his family's gaining custody of the child *as a result of* the adoption process. If you choose the person who adopts the baby,¹²⁵ you and that person can agree, in writing, that if the father tries to claim the baby before the adoption, you will take the baby back.¹²⁶ If an agency handles the adoption, you can agree to give up the baby only on condition

¹²² G. S. 48-3-605(b).

¹²³ G. S. 48-3-601.

¹²⁴ G. S. 48-3-603.

¹²⁵ This kind of adoption, if arranged by a baby's parent, is called direct adoption (*see* G. S. 48-3-202) or, if an agency is involved, a designated agency adoption (*see* G. S. 48-3-703a(5)(b)).

¹²⁶ G. S. 48-3-609(a)(2). Both you and the baby's father might then seek custody. A mother's having previously consented to adoption will not prevent her being awarded custody, G. S. 50-13-2(d).

that s/he be adopted by a particular family that's been described to you. (Setting a condition is called "designated relinquishment.") Be sure that the relinquishment form you sign says that you want to be notified if the adoption doesn't work out, so you can take the baby back.

4) Can I talk to an adoption agency or a person who wants to adopt my baby and then decide against adoption? What about changing my mind after the adoption?

You have time to think about adoption before deciding and a brief time to change your mind afterwards. A mother can't agree to her baby's adoption until the baby is born, though the baby's father can.¹²⁷ If the baby is three months or younger when you sign a consent to adoption, you have 21 days from the time you sign to change your mind. If the baby is older than three months, you have seven days.¹²⁸

5) Can I choose the family for my baby?

Yes, you may choose a family. You might choose someone you know, who would then (unless they were close relatives) have to be investigated before being approved as an adoptive parent. Or you could let an adoption agency or the DSS find a family. If you don't want to name a particular person, you can still say what kind of family you would like.¹²⁹ Most agencies would let you choose from the descriptions (and often pictures) they keep of families already approved for

¹²⁷ G.S. 48-3-604(a) and (b); 48-3-703(b).

¹²⁸ G. S. 48-3-608 and 48-3-706. These are the usual periods. In a few circumstances the period could be shorter or longer.

¹²⁹ G. S. 48-3-201 through 48-3-203.

adoption. Whatever way an adoptive parent is selected, though, a court must find that the person is suitable before it will approve an adoption.¹³⁰

6) If I don't choose someone I know or a family described to me, will I ever know anything about the parents?

Most agencies (including social services departments) will tell you about the adopting family, so long as you and the family aren't identified to each other. Some agencies will show pictures or let you and the adoptive parents speak by phone. If knowing about the family is important to you, ask adoption agencies before you choose one, how much information they would give you. You might learn the most from asking whether you could read the "home study" done on each possible adoptive family. Agencies are required by law to answer your questions.¹³¹

7) Will I have to pay to have my baby adopted?

No. There are no charges.

8) Can the adoptive parents give me money?

They can pay your ordinary living expenses during pregnancy and for six weeks afterwards. They can also pay counseling, medical and legal fees.¹³² You can accept this money and still change your mind about letting the baby be adopted. The money is not payment for the baby.¹³³

9) Can I visit or hear about my baby as it grows up?

¹³⁰ G.S. 48-2-501.

¹³¹ G.S. 48-3-203(6).

¹³² G. S. 48-10-103.

¹³³ It is a crime either to give or take money for a baby. G. S. 48-10-102.

You don't have a legal right to, not even if you chose the adoptive parents. If they promise you that you can contact the child, they might keep the promise but they do not have to.¹²⁴

10) Can the baby find me when he or she is grown?

If you both want to, probably yes. North Carolina has not created a system for adult children and birth parents to contact one another, but there are registries in the United States that match inquiries from birth parents and children.

11) Why should I think about adoption if a relative or friend will keep the baby?

Actually, more than half of adoptions are by relatives. Letting a friend or relative adopt, rather than just keep your baby, would help the person care for the baby.

As an adoptive parent, your relative or friend could more easily act for and gather resources for the baby—get the baby medical care, enter him or her in school, apply for health insurance or other benefits for the baby. Still, you must understand that after adoption the person becomes the baby's parent for all legal purposes.

12) Are there places where I could go for a while, have the baby and then return home? If so, how do I find one?

Yes. They are called maternity homes and there are several in North Carolina.

One way to locate a maternity home is to ask an adoption agency for information about them. Adoption agencies also have information about state funding that might be available to pay for a maternity home stay.

¹²⁴ G. S. 48-3-610.

Additional Care Considerations

The needs of pregnant minors, especially early adolescents, differ in some ways from those of adult patients. Many minors need advice on abstinence, contraception and sexually transmitted disease control. State law gives minors a right to confidential care in these areas except in extraordinary circumstances. Providers should watch for evidence that these patients are mistreated and, if found, report it or discuss the matter with the patient.

Taking the History

The girls who become pregnant at an early age often have been leading more difficult lives than older teens and, certainly, adults.¹³⁵ It would be prudent for providers to collect information about these patients for legal and medical reasons—to resolve questions about consent to treatment or patient discharge, for instance; and to understand risk factors, the patient's ability to comply with treatment, and the need for patient and family education.

A patient's sexual history can yield important clues about neglect, abuse and assault, which are known to be associated with early adolescent pregnancy.¹³⁶ The AAP recommends that pediatricians "be prepared to obtain a developmentally appropriate sexual history on all adolescent patients."¹³⁷

Certain data--age at first intercourse, number and age of partners, sexually transmitted diseases and concerns about intercourse or pregnancy—are often missing in pregnant adolescents' records. In one set we reviewed, age at first intercourse was recorded for only 31 of 50 girls. The possible value of the missing information can be

¹³⁵ Musick, Judith, Young, Poor and Pregnant: The Psychology of Adolescent Motherhood, especially 127-129. Also, interview with Carol A. Ford, Asst. Prof. of Pediatrics and Internal Medicine, and Director, UNC Adolescent Medicine Program, Chapel Hill, NC, March 3, 1999.

¹³⁶ Elders, M. Jocelyn, "Adolescent Pregnancy and Sexual Abuse," 280 *JAMA* 648-49 (August 19, 1998); Gershon, Harold P. et al., "The Prevalence of Coercive Sexual Experience Among Teenage Mothers," 4 *J. of Interpersonal Violence* 204-219 (June 1989).

¹³⁷ "Adolescent Pregnancy—Current Trends and Issues: 1998," 103 *Pediatrics* 516-520, Recommendation 2.

inferred from what was recorded: Two of the 31 said they were raped at age seven. A third stated that she began intercourse "voluntarily" (the provider's word) at age 10. Two more began intercourse at age 11.

Attending to a young patient's personal history and social context is appropriate recognition that she is still in part a pediatric patient, that sexual activity at a young age is often related to maltreatment,¹³⁸ and that early adolescent pregnancy can be either a cause or effect of psychic distress. Compiling a psycho-social history alerts providers to matters that a pregnant adolescent may want help with, which in turn improves the chances of good outcomes for her and her child.¹³⁹

Data collection will be easier if staff know the particular significance of history-taking for these patients, can allow additional time for it, and will check their assumptions and ask open-ended questions.¹⁴⁰ For example, "Who lives in your home?" is likely to be a more productive question than "Do you live with your mother?" The patient may answer "yes" to the latter to meet the provider's expectations, although her grandmother is the head of household and more constant presence. Or after her "yes," the patient may not mention other household members whose presence could affect her ability to care for a newborn.

¹³⁸ "Some 74% of women who had intercourse before age 14 and 60% of those who had sex before age 15 report having had sex involuntarily," Alan Guttmacher Institute, *Sex and America's Teenagers*. New York, NY: Alan Guttmacher Institute 1994, at 22.

¹³⁹ Personal communication to Anne Dellinger from Carol A. Ford, Asst. Prof. of Internal Medicine and Pediatrics, and Director, UNC Adolescent Medicine Program, Chapel Hill, NC, December 30, 1999.

¹⁴⁰ Based on authors' observation that the social worker's note in a medical record often contained the most complete and accurate patient history. Unfortunately, in the facility from which most of our records came, the social work interview usually took place just before discharge, so its results were not available to doctors, nurses and other staff when they might have acted on them.

Contraception

National organizations of providers advise confidential counseling of patients 11 and older about responsible sexual behavior, including abstinence, and offering them means to protect themselves from unplanned pregnancy.¹⁴¹ The AAP recommends that pediatricians encourage and support abstinence, but also inform teens about other contraceptive options.¹⁴² North Carolina law allows minors independent access to contraception.¹⁴³

Some young obstetric patients do not fully understand reproduction and reproductive health. In that respect, they are typical teens. A 1999 survey of over 1000 high school students showed widespread ignorance. Most girls did not know about emergency contraception. Of those who were sexually active, thirty-nine per cent did not know they could obtain birth control pills without a parent's permission. Forty-seven per cent did not know that an STD increases the chance of contracting HIV during sex. The high school students were quite aware that they lacked information. Roughly half of those surveyed—more or less, depending on the item--wanted information on contraception, STDs, HIV, handling pressure to have sex, and dealing with rape or sexual assault.¹⁴⁴

Nearly all minors who become pregnant in the United States say that it was unplanned, and half the pregnancies occur within six months of the girl's first sexual

¹⁴¹ American Medical Association (AMA), Guidelines for Adolescent Preventive Services (GAPS): Recommendations for Physicians and Other Health Professionals (hereafter, GAPS Recommendations), 1995-99. For American Academy of Pediatrics (AAP) recommendations, see "The Adolescent's Right to Confidential Care When Considering Abortion," Policy Reference Guide (1998) at 30; "Counseling the Adolescent About Pregnancy Options," Policy Reference Guide (1998) at 179; and "Contraception and Adolescents," 104 Pediatrics 1161-1166 (November 1999).

¹⁴² "Contraception and Adolescents," 104 Pediatrics 1161-1166 (November 1999).

¹⁴³ G. S. 90-21.5.

encounter.¹⁴⁵ Although sexually active teens are using contraception more often and more effectively,¹⁴⁶ the youngest are the least likely to do so.¹⁴⁷ Moreover, contraception is more likely to fail if a woman is young, unmarried, low-income, African-American or Hispanic.¹⁴⁸

Sterilization

Very rarely, a minor asks to be sterilized and a physician is willing to consider it.¹⁴⁹ Providers should proceed with considerable caution about liability in this area, however. Federal funds cannot be used.¹⁵⁰ State law allows married minors to be sterilized—after all, they are emancipated. An unmarried minor, though, may only be sterilized if

- she gives written consent,
- her parent files a request with a juvenile court,
- the court finds that the surgery would be in her best interest and
- the court issues an order authorizing a physician to perform the operation.¹⁵¹

Sexually Transmitted Diseases, including HIV

Sexually transmitted diseases (STDs)¹⁵² are serious health threats for teens in the United States.¹⁵³ In 1998, among 10 to 14 year old girls, North Carolina recorded 9 cases

¹⁴⁴ Kaiser Family Foundation National Survey of Secondary School Students about Sexual Health Issues and Services: The Facts and More (<http://www.kff.org>).

¹⁴⁵ Hatcher, Robert A., et al., Contraceptive Technology, (16th edition) 580 (1994). [Arlene, Carol Ford says there's a more recent edition of Hatcher.]

¹⁴⁶ When Teens Have Sex: Issues and Trends, The Annie E. Casey Foundation, Baltimore 1998, at 8-9.

¹⁴⁷ Alan Guttmacher Institute, Sex and America's Teenagers, New York, NY: Alan Guttmacher Institute 1994, at 33.

¹⁴⁸ Steiner, Markus J., "Contraceptive Effectiveness: What Should the Counseling Message Be?" JAMA (October 20, 1999) at 1405.

¹⁴⁹ In two records we reviewed the patient requested sterilization. One young woman had four, and the other five children before 18 years of age.

¹⁵⁰ Family planning (42 C.F.R. 50.203(a)) and Medicaid (42 C.F.R. 441.253) funds cannot be used to sterilize anyone under 21.

¹⁵¹ G.S. 90-272.

of syphilis, 254 of gonorrhea, and 536 of chlamydia.¹⁵⁴ STDs were often noted in the records of early adolescent pregnancies that we reviewed. About 20% (35 of 186) of the patients had STDs diagnosed during their pregnancy; for another 11 an STD was identified in the preparations for an abortion or during labor. These diseases disproportionately affect African-American and Hispanic youth,¹⁵⁵ and in North Carolina a majority of the youngest pregnant group are African-American.¹⁵⁶ The portion that is Latina, while still small, is growing.¹⁵⁷

The AMA recommends talking to adolescent patients annually about STDs and making latex condoms available.¹⁵⁸ The AAP emphasizes the danger of HIV transmission.¹⁵⁹ While the Academy deems general advice on HIV advisable for all teens, it recommends more specific counseling for teens in these high risk categories: drug abusers, homosexual or bisexual teens, teens with a history of STDs (particularly herpes or syphilis), teens with multiple partners, and those with partners who engage in

¹⁵² As used here "STDs" mean HIV, syphilis, gonorrhea, chlamydia, and the pelvic inflammatory disease that can follow from either of the last two diseases. Also included are trichomoniasis, herpes genitalis (HSV) and human papillomavirus (HPV). Hepatitis B may also be transmitted through sexual activity. Hatcher, et al., at 86-103.

¹⁵³ Ralph J. DiClemente, pH, Preventing Sexually Transmitted Infections Among Adolescents. A Clash of Ideology and Science. *JAMA*, May 20, 1998, Vol. 279, No.19, page 1574.

¹⁵⁴ N.C. Center for Health Statistics, Raleigh, NC, February 21, 2000.

¹⁵⁵ Shain, et al., at 93. See also Jemmott, John B., III, et al., "Abstinence and Safer Sex: HIV Risk-Reduction Interventions for African American Adolescents," *JAMA*, May 20, 1998, Vol. 279, No. 19, 1529; Rosenberg, Philip S., et al., "Trends I HIV Incidence Among Young Adults in the United States," *JAMA*, June 17, 1998, Vol. 279, No. 23, 1896-1899.

¹⁵⁶ 348 of 592 pregnancies reported in 1998 in girls 9 to 14. Telephone conversation with Sidney J. Evans, State Center for Health Statistics, NC Department of Health and Human Services, Raleigh, NC., March 10, 2000.

¹⁵⁷ The State Center for Health Statistics does not record pregnancies in an Hispanic or Latina category, but an increase can be inferred from the increase in Hispanic births to mothers of all ages between 1990 (1752) and 1995 (3095). Office of State Planning website, www.ospl.state.nc.us. In 1998 1381 children were born to Hispanic adolescents in North Carolina. Thirty-eight were born to girls under 15. State Center for Health Statistics, September 15, 1999.

¹⁵⁸ Recommendation 9, from AMA, Guidelines for Adolescent Preventive Services (GAPS): Recommendations for Physicians and Other Health Professionals, 1995-1999 (<http://www.ama-assn.org>).

¹⁵⁹ "Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention," Task Force on Pediatric AIDS, Policy Reference Guide, at 44.

high risk behaviors.¹⁶⁰ Under North Carolina law, a patient must specifically consent to be tested for HIV before a physician may order the test,¹⁶¹ and the patient must be “counseled appropriately” when told of the result.¹⁶²

STD testing and counseling are advisable for pregnant teens as well. Just as for birth control and pregnancy, North Carolina law lets minors ask for medical care for the prevention, diagnosis and treatment of “reportable” communicable diseases. All STDs are included in this category. The state Commission for Health Services decides which diseases are to be reported,¹⁶³ and physicians, diagnostic laboratories, school principals and child care operators must inform the local health director of each case they encounter.¹⁶⁴ Medical facilities may report, but not required to.¹⁶⁵ (The purpose of letting them report is to protect them from liability if they do.)¹⁶⁶ If a reportable disease is diagnosed, state law requires “the attending physician” to teach patients how to prevent its transmission.¹⁶⁷

Providers (and everyone else) must keep information and medical records about reportable disease cases confidential.¹⁶⁸ In this area facilities should be especially careful not to use billing practices that breach confidentiality without patient consent. Before releasing communicable disease information, providers must consult the confidentiality

¹⁶⁰ *Id.* Policy Reference Guide at 42.

¹⁶¹ G.S. 130A-148(h). Although not required, written consent would be advisable for liability protection.

¹⁶² G.S. 130A-148(g).

¹⁶³ G.S. 130A-134.

¹⁶⁴ Physicians must report if they have “reason to suspect” a case in someone “about whom the physician has been consulted professionally,” G.S. 130A-135. Principals and child care operators must report a suspected case in any person within the school or facility, G.S. 130A-136.

¹⁶⁵ G.S. 130A-137.

¹⁶⁶ G.S. 130A-142.

¹⁶⁷ G.S. 130A-144 requires the Commission for Health Services to prescribe control measures, which it does in the state’s administrative code: 15A NCAC 19A.0204 -- Control Measures -- Sexually Transmitted Diseases (1991, amended 1993); 15A NCAC 19A.0202 -- Control Measures -- HIV (1988, temporary amendment, recodified, or amended in 1989, 1990, 1991, 1992, 1994, 1995).

¹⁶⁸ G.S. 130A-143.

statute itself--the summary immediately following is not sufficiently detailed--and should have legal advice. The exceptions to the law, that is, the situations in which information about a reportable disease case could be released, fall into these general categories:

- release of nonidentifying statistical information
- with the patient's written consent
- to health care personnel caring for the patient
- for public health purposes
- for judicial or law enforcement purposes, and
- for research.

Abuse, Neglect, Dependency, Sexual Assault

Thirty per cent of 15 year olds giving birth in the United States are thought to have partners six or more years older.¹⁶⁹ In North Carolina, having sex with a person under 16 and four or more years younger than the older person is a sexual assault. (Sexual assaults are described more fully at the end of this section.) The older partner commits statutory rape, even though the younger person acquiesces. Then, too, a young girl's pregnancy might indicate that she has been abused by a parent or caretaker, or that she was not properly supervised. Failure to supervise one's child is legally defined as neglect.¹⁷⁰ A parent's approval of a daughter's inappropriate sexual relationship might also be considered neglect.

For these reasons, the fact that a young girl is pregnant should always raise a question for providers of whether she has been or is being sexually assaulted, or is neglected, abused or dependent. ("Dependent" is a legal term that does not imply fault

¹⁶⁹ Sex and America's Teenagers. The Alan Guttmacher Institute. Washington and New York, 1994, at 53

on the part of the caretaker. It means having "no parent, guardian, or custodian responsible for...care or supervision or whose parent, guardian, or custodian is unable to provide for the care or supervision and lacks an appropriate alternative child care arrangement."¹⁷¹ An adolescent, her baby¹⁷² or both might be abused, neglected or dependent. A provider's suspicion that any of these is true triggers a duty to report.

All providers (in fact, "any person or institution") must report possible abuse, neglect (that is, mistreatment by a *caretaker*) or the dependency of a minor. Here is the process. A provider with a reasonable suspicion that a young patient is abused, neglected or dependent tells what she or he knows or suspects to the DSS where the minor "resides or is found."¹⁷³ For his or her legal protection, a reporting provider should clearly document the date and time of the report, the name of the person to whom it was made, and what information the provider gave.

DSS then moves to protect the minor about whom the report was made and, if necessary, other children in the home.¹⁷⁴ If DSS opens an investigation, the provider must cooperate with it. A DSS director or representative has the right to see any information the director thinks may be relevant to an investigation.¹⁷⁵ Although a patient might guess where the report came from, DSS does not identify reporters.¹⁷⁶ After an investigation, DSS must tell the reporter the outcome of its inquiry.¹⁷⁷

¹⁷⁰ G.S. 7B-101(15).

¹⁷¹ G.S. 7B-101(9).

¹⁷² One study's major conclusion was that, "Childbearing at an early age was strongly associated with infant homicide, particularly if the mother had given birth previously." Overpeck, Mary, et al., "Risk Factors for Infant Homicide in the United States," 339 New Eng. J. of Med. 1211-1216 (October 22, 1998).

¹⁷³ G.S. 7B-301.

¹⁷⁴ 7B-302(b).

¹⁷⁵ G.S. 7B-302(e) and 7B-303.

¹⁷⁶ G.S. 7B-302(a).

¹⁷⁷ G.S. 7B-302.

Sometimes a provider who suspects that a minor patient is being mistreated will not know *who* is mistreating her or what the person's relationship is to the patient. In our opinion, unless providers know that the person who may be harming a minor is *not* a parent or caretaker, they should report their knowledge of a situation to the department of social services. The director of social services then deals with the matter if it is abuse, neglect or dependency, or if it is not, conveys the information to the district attorney.¹⁷⁸

Reporting Child Abuse and Neglect in North Carolina¹⁷⁹ by Janet Mason is a very useful source for providers. It explains essential terms such as "reasonable suspicion," "caretakers," "abuse," and "neglect," describes the reporting process and its possible resolutions, and offers helpful advice. Mason emphasizes, "*if in doubt, make the report.*"¹⁸⁰

Medical guidelines support legal requirements to report abuse and neglect. The AMA recommends that every adolescent patient "be asked annually about a history of emotional, physical, and sexual abuse."¹⁸¹ Similarly, the AAP urges providers to "be sensitive to the possibility of sexual abuse or incest in the young or developmentally delayed pregnant adolescent."¹⁸²

Only a few crimes must be reported in North Carolina. Treating physicians and health facilities are required to report illness or injury from firearms, knives or poison or where "there is grave bodily harm or grave illness if it appears...that the wound, injury or

¹⁷⁸ G.S. 7B-301.

¹⁷⁹ Institute of Government, UNC CH: Chapel Hill, N.C., 1996.

¹⁸⁰ Id. at 33.

¹⁸¹ Recommendation 21, GAPS.

¹⁸² AAP, "Counseling the Adolescent about Pregnancy Options," Policy Reference Guide at 180.

illness resulted from a criminal act of violence." These reports are made to law enforcement authorities.¹⁸³

Since providers are not required to report sexual assaults including statutory rape, unless they meet the definition above, what a provider should do in these instances is a hard question and, unfortunately, a common situation. Some providers will wonder whether any purpose is served if the crime is reported. Despite the state law making 16 the age at which minors can consent to intercourse, there are still perceptions, shared by some prosecutors, that younger girls are responsible for their sexual behavior, that sex between minors and older people is not a serious problem, that convictions are unlikely or that the penalty is too severe.¹⁸⁴ Or, providers may hesitate to raise the subject of sexual assault because they fear that asking about a girl's partner may drive her away from medical care. Finally, they may know they could be liable for violating patient confidentiality by reporting, since reporting sexual assault is not legally required.

On the first point, whether pre- and early-teen sexual activity is truly voluntary, there is considerable evidence that it often is not.¹⁸⁵ A young female ordinarily has less power and experience than her partner and, in addition, may have been directly coerced. A substantial age difference "may make it hard for the young woman to resist [a partner's] approaches and even more difficult for her to insist that contraceptives be used to prevent STDs and pregnancy."¹⁸⁶ Judith Musick, who researches teen pregnancy and

¹⁸³ G.S. 90-21.20.

¹⁸⁴ "No convictions under tougher statutory rape law," The News and Observer, Raleigh, NC. (November 26, 1997), 3A, Cols. 2-5.

¹⁸⁵ For example, the U.S. Department of Justice in a survey of 12 states including North Carolina, found that a majority of all forcible rape victims were minors and that 38% of those minors were under 12. Pierre Thomas, "Rape of Girls Is Common, Study Finds: Half of All Victims Are Under Age 18," The Washington Post (June 23, 1994), A1, Col. 1.

¹⁸⁶ Sex and America's Teenagers at 74. See also Landry, David J. and Forrest, Jacqueline Darroch, "How Old Are U. S. Fathers?" 27 Family Planning Perspectives 159-161, 165 (1995). For a general discussion of

works with teen mothers, states that, while girls may appear to be eager initiators of sex, that "is probably not the case for many girls who become mothers in their teens, and it is surely not the case for those who become pregnant in their very early teens."¹⁸⁷ In other research 61% of teen mothers reported at least one coercive sexual experience. Almost 30% reported coercion by a family member and over 50% by a male friend. 46% of the males involved were more than 10 years older than their partners.¹⁸⁸

Legally, the safest course for providers is to encourage a young patient to end a criminal relationship and consider reporting the crime herself or telling her parents so they can report. (Remember that a treating physician who learns of an imminent threat to a minor patient's life or health *must* tell her parents.¹⁸⁹) Providers should initiate discussions about an inappropriate relationship with the young pregnant patient and, if she is willing, with her parents. Providers can also help by knowing and explaining to patients and families the criminal law on intercourse with minors. For providers, patients' and families' information, then, the following activities are criminal in North Carolina:

- Intercourse between someone 12 or younger and a person at least four years older is first degree rape, a crime with severe penalties.¹⁹⁰
- If one partner is between 13 and 15 and the other is four to six years older, their intercourse is called statutory rape. Statutory rape means intercourse that is apparently consensual but with someone too young to consent. It is a

the legal context, see Elstein, Sharon and Davis, Noy, Sexual Relationships Between Adult Males and Young Teen Girls: Exploring the Legal and Social Responses, ABA Center on Children and the Law 1997

¹⁸⁷ Op. cit. at 74.

¹⁸⁸ Gershon, Harold P. et al., "The Prevalence of Coercive Sexual Experience Among Teenage Mothers," 4 J. of Interpersonal Violence 204 (June 1989).

¹⁸⁹ G.S. 90-21.4.

¹⁹⁰ G.S. 14-27.2.

serious felony, and if the older partner is six or more years older, the penalties are greater.¹⁹¹

- Intercourse "by force and against the will" of one partner, no matter what their ages, is second degree rape. The force need not be physical; inducing fear can be enough.¹⁹²
- Regardless of age, incest between grandparent and grandchild; parent and child or stepchild; or brother and sister is a felony,¹⁹³ as is intercourse with a minor residing in a home where the adult partner has the position of a parent.¹⁹⁴ (Some of these relationships would also be child abuse and as such would have to be reported.)

Patient's Reassurance and Education

To repeat and summarize points made above: The youngest pregnant girls represent a paradox. On the one hand, their condition (pregnancy) is adult in nature, and their right to deal with it must be respected. On the other, as the AAP reminds practitioners, the patient is still an early adolescent,¹⁹⁵ a pediatric patient,¹⁹⁶ and entitled to providers' broad attention and concern,¹⁹⁷ particularly if she becomes a mother.¹⁹⁸ Some pregnant minors do not understand the basic facts of sexual activity or pregnancy, and providers may help them to reject sexual activity¹⁹⁹ by telling them directly that they do not have to allow it. Counseling, referring and supporting pregnant adolescents,

¹⁹¹ G.S. 14-27.7A.

¹⁹² G. S. 14-27.3.

¹⁹³ G.S. 14-178.

¹⁹⁴ G. S. 14-27.7.

¹⁹⁵ The AAP defines adolescence as ages 10 or 12 to 21. "Adolescent Pregnancy," Policy Reference Guide at 27.

¹⁹⁶ AAP, "Age Limits of Pediatrics," Policy Reference Guide at 48.

¹⁹⁷ AAP, "Adolescent Pregnancy," Policy Reference Guide at 27.

¹⁹⁸ AAP, "Care of Adolescent Parents and Their Children," Policy Reference Guide at 94.

especially the youngest,²⁰⁰ is a difficult task for providers, but likely to benefit greatly the patients and children they may bear.²⁰¹

Confidentiality

As individuals, providers have divergent views on whether adolescents should have independent, confidential access to health services.²⁰² However, health professionals' organizations support such access. Numerous medical and nursing groups advise providers to 1) offer adolescents confidential care for sex-related conditions, while in most cases strongly encouraging parental involvement; 2) breach an adolescent's confidentiality in extreme circumstances; and 3) make their policies clear from the beginning to parents and patients.²⁰³ The National Association of Social Workers holds a similar view.²⁰⁴

As explained earlier, North Carolina law requires that physicians treating pregnant minors keep the minor's confidence "unless the situation in the opinion of the attending physician indicates that notification is essential to the life or health of the

¹⁹⁹ Musick at 85.

²⁰⁰ "[I]t is really the early adolescents who need the most help and counseling [from health providers], but...they are the least likely to report for followup appointments." Hatcher, Sherry Lynn Marcus, "The Adolescent Experience of Pregnancy and Abortion: A Developmental Analysis," 2 *J. of Youth and Adolescence* 53-102 (1973) at 72.

²⁰¹ For the difficulties of working with adolescents and likely gains from offering them services, see O'Leary, Kathleen M., Shore, Milton F., and Wieder, Serena, "Contacting Pregnant Adolescents: Are We Missing Cues?" *Social Casework: The Journal of Contemporary Social Work* (May 1984) 297-306.

²⁰² See, for example, Fleming, Gretchen, et al., "Pediatricians' Views of Access to Health Services for Adolescents," 15 *J. of Adolescent Health* 473 (1994).

²⁰³ The joint recommendation of the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics, NAACOG-The Organization for Obstetric, Gynecologic, and Neonatal Nurses, and the National Medical Association is found in AAP, "Confidentiality in Adolescent Health Care," *Policy Reference Guide* at 158. See also *Confidential Health Care for Adolescents: A Position Paper of the Society for Adolescent Medicine*. The AMA's policy is more limited, Recommendation 3, *GAPS*.

²⁰⁴ "Adolescent Pregnancy," *Social Work Speaks: NASW Policy Statements*, (4th Ed.) 1997.

minor.” However, if the adult responsible for the minor contacts the physician, he or she may give the adult information.²⁰⁵

Control of A Minor’s Records

Although there is no law on this point, the most reasonable assumption is that whoever consents to treatment controls access to records.

In general, the person who consents to medical care has the right to control access to records of the care. Since in most circumstances parents consent to children’s care, parents usually control access to children’s health records. But, the state law that encourages providers to offer minors independent access to care for a few conditions would be meaningless if parents or others could see the records of the care. For that reason, although North Carolina has no law on the point, we assume that a minor patient usually has exclusive control over records of her pregnancy or related conditions.

Provider’s Liability

Treating minors is legally more complicated than treating adults, but does not seem to expose providers to substantial additional liability. Except for handling special consent issues and the required reporting of maltreatment, the usual standards of medical care apply.

Treating a minor without parental consent

Although there do not seem to be reported North Carolina decisions, the general rule in law is that a provider will be liable for treating a minor without parental consent.²⁰⁶ As described above, the main exceptions are that a provider may rely on consent from someone the parent has appointed, in writing,²⁰⁷ may treat a minor in an

²⁰⁵ G.S. 90-21.4.

²⁰⁶ Lee, Robert E., North Carolina Family Law, Vol. 3, Sec. 240.2 (1981 and 1998 Supplement). See also, “Medical Practitioner’s Liability for Treatment Given Child Without Parent’s Consent,” 67 A.L.R. 4th 511 (1996).

²⁰⁷ G.S. 32A-33.

emergency,²⁰⁸ and may accept the minor's consent to her own treatment for certain conditions.²⁰⁹ Performing an abortion on a minor "with knowledge or reckless disregard" of the fact that she is a minor, and without proper consent, is a Class I misdemeanor.²¹⁰

Treating a minor without parental consent negligently

Physicians and other providers under their supervision who treat minors under one of the exceptions to parental consent are held to the usual standards of medical treatment. That is, just as with an adult patient, they could be liable if they did not use methods "commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in [their] community...."²¹¹

Treating a minor without her consent

Treating a minor at a parent's request, but against her will, is a murky area of the law with very few decisions reported anywhere in the United States. Medical and legal sources advise against it, however,²¹² and it is possible that a provider could be liable for forced treatment of an adolescent.

North Carolina law specifically forbids performing an abortion on a minor without her written consent.

²⁰⁸ G.S. 90-21.1 and -21.3. The former also tries to insulate a physician from liability for not treating [But *could* a physician get away w/ refusing to help a minor who came to him in an emergency—say ectopic pregnancy?]

²⁰⁹ G.S. 90-21.5.

²¹⁰ G.S. 90-21.10.

²¹¹ G.S. 90-21.2. See also, G.S. 90-21.4(a).

²¹² AAP, "Informed Consent, Parental Permission, and Assent in Pediatric Practice (RE9510)," 95 *Pediatrics* 316 (February 1995); Rozovsky, Faye A., Consent to Treatment: A Practical Guide. Little.

Not reporting abuse, neglect, dependency

Criminal and civil liability could result from not reporting a reasonable suspicion of child abuse, neglect, or dependency.²¹³ When a state statute does not specify a penalty for violation, failure to comply is a misdemeanor. At least two people, a psychologist and a school official, have been prosecuted in North Carolina for failure to report possible mistreatment of a child.²¹⁴

As for civil liability, according to Janet Mason, "[t]hus far, the threat of civil suit has materialized rarely. There are no appellate court decisions in North Carolina—and very few nationally—dealing with civil liability for failing to report child abuse, neglect, or dependency. But that does not mean that a person cannot be civilly liable for failing to report child abuse in North Carolina. The issue simply has not come before the courts in this state. Cases from other states and the literature in this area suggest that the potential for civil liability for failing to report is real"....²¹⁵

Reporting erroneously

Reporters of abuse, neglect or dependency are protected from liability in most circumstances, even if their suspicion proves incorrect. The law offers them immunity because acting on reasonable suspicion, which reporters must do, creates a significant risk of error. The state immunity statute aims to save people from legal consequences for honest error. A reporter's good faith is presumed; that is, in order to recover from a reporter the other party must prove that the reporter acted from malice or in bad faith.

Brown & Co. Boston 1990, 358-359; and Holder, Angela R., Legal Issues in Pediatrics and Adolescent Medicine (2d Ed.) Yale Univ. Press, New Haven 1985, 290-293 (abortion issue only).

²¹³ G.S. 7B-301.

²¹⁴ Mason, Janet, Reporting Child Abuse and Neglect in North Carolina. Institute of Government, UNC CH, Chapel Hill, NC 1996, at 43, notes 4 and 5.

²¹⁵ *Id.* at 40.

Unless bad motives are established, anyone who reports, cooperates in a DSS investigation, testifies or otherwise participates in a statutory process for protecting minors is immune from civil or criminal liability.²¹⁶

Performing an abortion on a minor who presents fraudulent parental consent

There is one North Carolina case on point. A physician performed an abortion on a girl who forged a consenting note from her mother. Six months later the girl and her parents sued the physician for assault and battery and infliction of emotional distress for performing an abortion on her without valid consent. The trial court dismissed their complaint and the court of appeals agreed that the doctor was entitled to rely on the patient's statement that her mother had written the note. The court found that the parental consent law "contains no requirement, express or implied, that the physician conduct an investigation into the circumstances of a purported written parental consent for an abortion to determine the validity of the writing."²¹⁷

Financial Responsibility for A Minor's Medical Care

Payment for pregnant adolescents' care is a major concern for them and providers. State or federal programs often cover prenatal care and delivery, contraception, STD treatment, mother and child nutrition and other needs, but there are few sources of payment for minors' abortions. Providers whose billing practices do not insure minors' confidentiality should let them know before treatment begins.

It is hard to be sure that a minor patient will be legally responsible for her own bill, and providers should not assume it. English, and then state courts including North Carolina's, long ago developed theories on this issue.²¹⁸ The basic rules are, first, that

²¹⁶ G.S. "B-309.

²¹⁷ Jackson v. A Woman's Choice, Inc., 130 N.C. App. 590 (1998).

²¹⁸ For a general discussion, see Hodson, John D., "Infant's Liability for Medical, Dental, or Hospital Services," 53 A.L.R. 4th 1249 (1998). Significant North Carolina cases include Freeman v. Bridger, 49 N.C. 1 (1856); Cole v. Wagner, 197 N.C. 692, 150 S.E. 339 (1929); Bitting v. Goss, 203 N.C. 424, 166 S.E. 302; In re Peacock, 261 N.C. 749, 136 S.E.2d 91 (1964); Lane v. Aetna Casualty & Surety Co., 48 N.C. App. 634, 269 S.E.2d 711 (1980); and Rhodes, Inc. v. Morrow, 937 F.Supp. 1202 (M.D.N.C. 1996).

parents (or another party responsible for the minor) must supply or pay others to supply the necessities of life for a minor, and medical care is a necessity. Second, those who provide necessities to a minor cannot collect for their services unless they contract with the responsible adult. That rule is meant to prevent minors being taken advantage of, their families from unknowingly incurring debt, and strangers from making decisions for the minor that properly belong to a parent.

For other good reasons, an exception to these rules developed, which can be particularly useful when a minor receives medical services that a parent does not know about. To encourage providers to help minors who are ill or injured, the law sometimes makes minors themselves responsible to providers. In North Carolina minors have been liable for a bill when the parent was unable or unwilling to pay it, or simply because the minor had a source of payment at his command--a damage award for an injury,²¹⁹ for instance, or insurance coverage.²²⁰

Although minors may not be able or legally required to pay for care themselves, they may qualify for assistance. For pregnant minors, the regular Medicaid program and Medicaid's "Baby Love" program²²¹ pay for prenatal care, labor and delivery, childbirth and parenting classes, maternity care coordination, nutrition therapy and postpartum home visits. Any minor on Medicaid ("Health Check") or enrolled in the Child Health Insurance Program ("Health Choice")²²² in North Carolina has contraceptive and STD treatment coverage. Under state law, any person is entitled to STD diagnosis and

²¹⁹ *In re Peacock*, 261 N.C. 749, 136 S.E.2d 91 (1964).

²²⁰ *Rhodes, Inc. v. Morrow*, 937 F.Supp. 1202 (M.D.N.C. 1996)

²²¹ Regular Medicaid enrollees are given a blue card and "Baby Love" enrollees, a pink one. The colors indicate financial eligibility at different income levels and coverage for specific services.

²²² Health Choice enrolls North Carolina children with family incomes just above that of Medicaid-eligible families.

treatment without charge at a local health department.²²³ Health Choice does not cover pregnancy-related care or abortion. However, if minors in Health Choice become pregnant, most qualify for Medicaid since only an adolescent's income, plus that of the father of the pregnancy if he lives with her, are counted. Medicaid covers abortion, but only in the case of rape or incest or when the pregnant woman's life is endangered. The program paid for 20 abortions in 1998.²²⁴ For fuller descriptions of these programs, see Pam Silberman, North Carolina Programs Serving Young Children and Their Families, North Carolina Institute of Medicine: Chapel Hill, NC, 1999.

Some private insurance policies pay for dependents' prenatal care and abortions; most cover STD treatment and contraception.

The billing processes of government or private insurance may or may not maintain a minor patient's confidentiality. For instance, Medicaid does not notify its enrollees about payments Medicaid has made for service to their dependents. Health Choice enrollees do receive such notices. As a result, minors could use Medicaid, but not Health Choice benefits without their parents becoming aware that the minor received a medical service.²²⁵ One medical association, ACOG, draws connections among minors' underutilization of health care, their concern about confidentiality, and the frequent loss of minors' confidentiality through billing procedures.²²⁶ Researchers report similar findings.²²⁷ ACOG correctly notes that some minors, in order to maintain confidentiality, may prefer to pay for tests and treatment themselves without parental involvement or to

²²³ G.S. 130A-144(e).

²²⁴ Information in this paragraph is based on correspondence with Lynda C. Dixon, State "Baby Love" Program Coordinator, N.C. Department of Health and Human Services, Division of Medical Assistance, Raleigh, North Carolina, March, 2000.

²²⁵ *Id.*

²²⁶ ACOG Educational Bulletin: "Confidentiality in Adolescent Health Care," No. 249, August 1998.

use only providers who can offer confidential care. Providers' and health facilities' practices, including billing practices, should be explained to minor patients so they can make these choices, and minors should be referred for confidential care if it is available in the community.

Emancipated minors are adults for purposes of financial responsibility for services.²²⁸ Remember, though, that very few North Carolina minors are emancipated.

When parents refuse consent for treatment and a judge consents in their place, he or she may order the parent or "other responsible parties" to pay. If the parent cannot, the judge may order the county to do so.²²⁹

Noncitizens who do not have legal immigration status in the United States are not eligible for Health Choice or for Medicaid (except for emergency care). However, hospitals must treat anyone with an emergency condition and any woman in active labor, or lose the right to Medicare and Medicaid reimbursement.²³⁰ In addition, federal agencies interpret the Welfare Reform Act²³¹ to require providers to offer the Women's, Infants and Children's supplementary feeding program (WIC) and federally funded prenatal care and family planning services regardless of recipients' ability to pay or citizenship status.²³²

²²⁸ Ford, Carol A., Bearman, Peter S., and Moody, James, "Foregone Health Care Among Adolescents," 282 *JAMA* 2227-2234 (December 15, 1999).

²²⁹ The emancipation decree gives a minor "the same right to make contracts...and to transact business as if [the minor] were an adult." G. S. 7B-3507.

²³⁰ G. S. 7B-3600.

²³¹ The Emergency Medical Treatment and Active Labor Act, colloquially known as the "anti-dumping" law, 42 U.S.C. Section 1395dd(a), et seq.

²³² Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

²³³ For definition of categories of foreigners in the United States and the government benefits for which they qualify, see articles by Jill D. Moore in *Popular Government*, Institute of Government, UNC CH: Chapel Hill NC, Fall 1999, 18-37: "ABCs of Immigration Law and Policy," "Migrants' Access to Public Benefits," and "A Guide to Immigrants' Eligibility for Public Benefits in North Carolina."