Confidentiality in Health Care

A Survey of Knowledge, Perceptions, and Attitudes Among High School Students

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Objective.—To assess adolescent knowledge, perceptions, and attitudes about health care confidentiality.

Design.—Anonymous self-report survey with 64 items addressing confidentiality issues in health care.

Setting.—Rural, suburban, and urban high schools in central Massachusetts.

Participants.—Students in ninth through 12th grades from three schools.

Results.—A total of 1295 students (87%) completed the survey: 58% had health concerns that they wished to keep private from their parents, and 69% from friends and classmates; 25% reported that they would forgo health care in some situations if their parents might find out. There were differences in response by gender, race, and school. About one third were aware of a right to confidentiality for specific health issues. Of those with a regular source of care, 86% would go to their regular physician for a physical illness, while only 57% would go there for questions about pregnancy, the acquired immunodeficiency syndrome, or substance abuse that they wished to keep private. Sixty-eight percent had concerns about the privacy of a school health center.

Conclusions.—A majority of adolescents have concerns they wish to keep confidential and a striking percentage report they would not seek health services because of these concerns. Interventions to address confidentiality issues are thus crucial to effective adolescent health care.

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PRIVACY is important to adolescents. As they struggle to forge a personal identity and establish social relationships, adolescents are particularly concerned about the judgments of others. Cooley[1] has described this egocentric perspective as the "looking glass self." Adolescent behavior, including care-seeking behavior, can be powerfully influenced by concerns about privacy.

Consequently, assuring confidentiality is a basic principle of adolescent health care. Confidential care for adolescents, however, is an issue with controversial medical, social, legal, ethical, and bureaucratic implications. The American Academy of Pediatrics Policy Statement *Confidentiality in Adolescent Health Care* states that "adolescents tend to underutilize existing health care resources," and that lack of confidentiality is "a significant access barrier to health care."[2] The Society for Adolescent Medicine's *Position Paper on Access to Health Care for Adolescents* emphasizes confidentiality as one of seven criteria for evaluating proposals to improve access to health care.[3] There has been little study, however, of adolescent confidentiality concerns and their effect on care-seeking behavior.

See also p 1420.

There have been many reviews of statutes pertaining to consent and confidentiality, as well as guidelines for disclosure of information.[4-7] Some studies have explored physicians' views on confidentiality[8] or the attitudes of adolescents on family planning and privacy.[9-11] Others have discussed youth attitudes about health care delivery.[12,13] None, however, has studied large numbers of adolescents regarding their knowledge, attitudes, and perceptions about confidential health care or whether perceived lack of confidentiality affects adolescent behavior.

This study begins to examine the interaction between perceptions of confidentiality and utilization of care. Understanding the importance of this barrier to health care is a crucial first step to improve service delivery to this high-risk group. It is particularly timely in light of recent efforts to require parental consent for birth control and abortion. In addition, managed care and other changes in health delivery have limited adolescents' health care options and may influence perceived or actual provision of confidential care.

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METHODS

Sample Population

During a 4-week period in the spring of 1992, we conducted a survey of ninth- through 12th-grade students in three public high schools in central Massachusetts. School A is located in a rural, working-class community. School B is in an upper-middle-class suburb of Worcester. School C is in urban Worcester and serves a large population of poor students. Schools A and B have school nurses. School C has a school-based health center that has been fully functioning for the past 4½ years (although gynecology examinations and contraception are not provided).

This study was approved by the Committee for the Protection of Human Subjects in Research at the University of Massachusetts Medical Center.

Questionnaire

An anonymous self-report questionnaire was administered in homeroom at the three schools with the help of homeroom teachers. Instructions were given over the intercom and surveys were collected in an envelope passed around the room and sealed. Following written notification of parents, passive consent was presumed unless parents returned a tear-off form withdrawing their child from participation. Surveys and parental consent forms were available in English and Spanish at school C, the only school with a sizable Spanish-speaking population.

The questionnaire contained 64 true/false and Likert scale questions that were piloted and refined prior to the study. The questions measured student knowledge of their rights in receiving confidential care, their perceptions about confidential health concerns and care-seeking behavior, their experiences with confidential health care, their perceptions about different health care locations, and their attitudes about confi-

dentiality on specific health issues. Demographic information including gender, grade, race, and school were also collected. The survey was designed at a seventh-grade reading level and took approximately 15 minutes to complete.

Statistical Analysis

Survey data were analyzed using Statistical Package for the Social Sciences/ Personal Computer Plus. Frequencies of responses to questions about attitudes, perceptions, and knowledge were tabulated and χ^2 tests with Yates' correction were used to determine if any differences existed with regard to gender, grade, school, and race. If significant differences were found, further stratification was performed to analyze interactions between variables that may confound the results.

RESULTS

Of the 1493 students present at the three schools on the day of the survey, 1295 (86.7%) returned completed surveys. Fourteen parents returned the form to withdraw their teenager from participation in the survey. Table 1 presents characteristics of the respondents in each school. Notably, school C had significantly more minority students than the other two schools. The mean age of the respondents was 16.2±1.4 years.

Students were asked about confidenhealth concerns and care-seeking behavior (Table 2). Overall, 57.9% had h concerns they would not want parents to know and 68.5% had concerns they wished to keep private from friends classmates. A total of 25.3% would forgo health care if parents might find out and 15.4% if friends or teachers might out. Those with health concerns they wished to keep private were more likely to forgo health care than those without such concerns (35.8% vs 10.9%; χ^2=95.38; P<.01).

Responses were analyzed with regard to demographic variables of gender, grade, race, and school. Females were more likely than males to have concerns they wished to keep from parents and thus forgo care. Females were less likely than males to forgo care if friends or teachers might find out. White students and rural and suburban students were more likely to have confidential concerns and forgo care if parents, friends, or teachers might find out than nonwhite students and urban students. Responses did not differ by grade.

To separate the effect of school from race, data from school C (the school with the highest proportion of lower-income students) were analyzed separately by race. There were no significant differences found between responses of white students and nonwhite students at school C when asked whether they had health concerns they wished to keep private from parents or friends and whether they would forgo health services because friends might find out. However, white students at school C were somewhat more likely than nonwhite students to forgo health services because parents might find out (24.4% vs 15.0%; χ^2=8.70; P<.01).

When given the statement, "I have a doctor I can trust," 64.4% of all respondents agreed, 31.1% disagreed, and 4.4% gave no answer. Over half (54.4%) of all students had never discussed confidentiality with a health care provider. Those who had discussed privacy with their physician were less likely to forgo health care because of confidentiality concerns than those who had not discussed privacy (forgo care because parents might find out: 21.8% vs 28.8%; χ^2=7.72; P<.01; forgo care because friends or teachers might find out: 12.0% vs 18.4%; χ^2=9.20; P<.01).

Adolescents were asked about their perceptions of different health care locations (Table 3). A list of five health care locations (their regular physician's office, other physician's office, teen clinic or other clinic, emergency department, and school health center) were given. Respondents were asked to check off all locations where they would consider going for care if they had an illness "like a bad sore throat," and also for "concerns about pregnancy, AIDS [acquired immunodeficiency syndrome], or drug or alcohol problems" that they "wanted to keep private." For those respondents with a regular source of health care, 85.5% reported they would go to their regular physician's office for an illness like "a bad sore throat," but only 56.9% would go to that physician's office for private health concerns. Students were then asked to choose the single most

Table 1.—Characteristics of Survey Respondents

Characteristic	School A, Rural, % (n=410)	School B, Suburban, % (n=183)	School C, Urban, % (n=702)	Total, %
Gender				
F	54.2	54.4	49.7	51.8
M	45.8	45.6	50.3	48.2
Racial/ethnic group				
Asian American	0.8	0.5	9.6	5.5
Black	0.8	0.5	8.5	4.9
Hispanic	6.0	0	25.5	15.6
White	90.5	94.5	53.0	70.9
Other	2.0	4.5	3.4	3.1
Grade				
9	26.8	24.6	29.4	27.9
10	22.5	27.9	27.9	26.2
11	27.8	21.8	21.4	23.5
12	23.0	25.7	21.3	22.5
Has a place to go for health care	82.7	87.8	81.5	82.8

Table 2.—Perceptions of Adolescents Regarding Health Concerns, Care-Seeking Behavior, and Health Care Experiences (N=1295)

			Yes Responses, %					
	Total Responses, %		By Gender		By School		By Race	
Survey Item	Yes	No	F	M	A and B	C	White	Nonwhite
"There are some health concerns that I would not want my parents to know."	57.9	38.8	64.2*	55.1	67.9*	52.9	63.6*	51.0
"There are some health concerns that I would not want my friends and classmates to know."	68.5	28.2	73.4	68.1†	76.3*	66.1	73.8*	64.8
"Would you ever not go for health care because your parents might find out?"	25.3	72.8	29.0*	21.3	32.2*	20.1	29.0*	16.6
"Would you ever not go for health care because your friends or teachers might find out?"	15.4	82.6	12.9	18.5*	19.0*	12.9	17.3†	11.5
"Since becoming a teenager, when you have gone to get health care has anyone ever talked to you about privacy?"	43.8	54.4	55.6*	32.9	39.5	49.0*	42.3	49.9†

*Significant differences between yes responses, P<.01.
†Significant difference between yes responses, P=.01 to .05.

Table 5.—Attitudes of Adolescents Regarding Confidentiality on Specific H lth Issues (N=1295)

Health Issue	Total Responses, %		Yes Responses, %					
			By Gender		By School		By Race	
	Yes, Should Keep Private	No, Should Not Keep Private	F	M	A and B	C	White	Nonwhite
Plan to run away from home	32.2	64.5	33.9	33.3	32.1	34.3	34.1	32.7
Pregnancy	55.5	40.3	65.4*	50.4	64.8*	51.8	63.4*	46.2
Plan to commit suicide	15.2	81.6	14.6	6.1	11.8	19.1*	13.4	21.2†
Sexual abuse	19.7	77.3	20.3	19.7	18.7	21.6	18.9	24.0
Having sex	77.7	18.8	83.8*	77.7	86.7*	75.2	84.9*	69.9
Physical abuse	18.0	78.0	17.9	19.6	16.8	20.4	17.2	22.5†
Sexually transmitted disease or venereal disease	46.3	50.1	53.6*	42.7	53.8*	42.9	52.4*	38.8
Alcohol or other drug problem	34.7	62.0	32.4	39.6†	39.3†	32.9	37.4	31.9
Homosexuality	57.0	38.2	66.9*	52.4	68.7*	52.0	65.5*	46.0
AIDS/HIV‡ Infection	35.2	60.3	39.8†	34.0	38.6	35.3	38.5	34.8

*Significant differences in yes responses, $P<.01$.
†Significant difference in yes responses, $P=.01$ to .05.
‡AIDS indicates acquired immunodeficiency syndrome; HIV, human immunodeficiency virus.

cerns and in willingness to seek care are intriguing. When controlling for school, both white and nonwhite students answered similarly regarding health concerns that they wanted to keep private parents and peers. However, there was a difference by race in response to the question on forgoing care because parents might find out, with white students less likely to seek care. It is unif these differences reflect ethnic, school, socioeconomic, or other differ-. One can hypothesize that in different racial or socioeconomic groups, relationships between adolescents and their parents are based on different expectations. Further study of the interaction among these variables is needed.

Differences by gender were evident on many questions. More females than males had health concerns that they wished to keep private from their parents and that would affect their behavior; more males than females had health concerns they wished to keep private their peers. More females had dis- privacy with their providers. Finally, females and males had different s about disclosure of information on specific issues. These differences may reflect different socialization of females and males regarding these issues and/or different relationships with friends and family. They may also stem from different physiologic needs for care or a different concept of susceptibility and risk in regard to these confidential issues. It is also possible that care providers address confidential issues differently in patients of different gender. The differences by gender illustrated in this study may be important in strategies for intervention.

The responses regarding confidentiality for specific health issues show that students perceive the need to balance privacy and disclosure. In particular, they appear to understand the need for disclosure in certain circumstances, depending on the issue. However, most lack knowledge of their legal rights in receiving confidential health care, again emphasizing the need for education.

Addressing barriers to adolescent health care, including perceived lack of confidentiality, is necessary to reduce adolescent morbidity and mortality. Health delivery systems must be structured to allow confidentiality, with mechanisms for appointment scheduling, billing, record keeping, and follow-up that ensure privacy for adolescents. Adolescents must be educated regarding their rights to confidential health care and how to access that care. Similarly, health care providers must be educated about consent and confidentiality guidelines. They need to be sensitive to confidentiality issues in interactions with adolescents and parents (for example, seeing adolescents and parents separately for part of the visit) and in the way their office handles confidential information. Also, care providers must be educated about techniques to enhance communication between adolescents and their families.

This study is an important first step in addressing perceived confidentiality as a barrier to adolescent health care. Further study is needed to explore why adolescents underutilize health resources and to discern how perceptions about confidentiality influence behavior. Studies of adolescent, parent, and provider variables that influence adolescent health care perceptions are also necessary. This information is particularly important in light of policy efforts to require parental consent for birth control and abortion, and with changes in health delivery and financing that may put confidentiality at risk.

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References

1. Cooley CH. Quoted by: Resnick M, Blum RW, Hedin D. The appropriateness of health services for adolescents: youths' opinions and attitudes. *J Adolesc Health Care.* 1980;1:140.
2. *Policy Reference Guide: A Comprehensive Guide to American Academy of Pediatrics Policy Statements Published Through December 1991.* Elk Grove Village, Ill: American Academy of Pediatrics; 1991:97.
3. Klein JD, Slap GB, Elster AB, Schonberg SK. Access to health care for adolescents: a position paper of the Society for Adolescent Medicine. *J Adolesc Health.* 1992;13:162-170.
4. English A. Treating adolescents: legal and ethical considerations. *Med Clin North Am.* 1990;74:1097-1112.
5. Hofmann AD. A rational policy toward consent and confidentiality in adolescent health care. *J Adolesc Health Care.* 1980;1:9-17.
6. Holder AR. Minors' rights to consent to medical care. *JAMA.* 1987;257:3400-3402.
7. Leikin SL. Minor's assent or dissent to medical treatment. *J Pediatr.* 1983;102:169-176.
8. Lovett J, Wald MS. Physician attitudes toward confidential care for adolescents. *J Pediatr.* 1985;106:517-521.
9. Zabin LS, Stark HA, Emerson MR. Reasons for delay in contraceptive clinic utilization. *J Adolesc Health Care.* 1991;12:225-232.
10. Torres A, Darroch Forrest J, Eisman S. Telling parents: clinic policies and adolescents' use of family planning and abortion services. *Fam Plan Perspect.* 1980;12:284-292.
11. Torres A. Does your mother know? *Fam Plan Perspect.* 1978;10:280-282.
12. Resnick M, Blum RW, Hedin D. The appropriateness of health services for adolescents: youths' opinions and attitudes. *J Adolesc Health Care.* 1980;1:137-141.
13. Marks A, Malizio J, Hoch J, Brody R, Fisher M. Assessment of health needs and willingness to utilize health care resources of adolescents in a suburban population. *J Pediatr.* 1983;102:456-460.
14. Jellinek B. Adolescents' knowledge of consent laws in a Massachusetts community. *Pediatr Nursing.* 1980;6:21-23.
15. Office of Technology Assessment. *Adolescent Health, III: Crosscutting Issues in the Delivery of Health and Related Services.* Washington, DC: Office of Technology Assessment; June 1991. Publication OTA-H-467.

Table 3.—Perceptions of Adolescents on Confidentiality of Health Care Locations (N=1295)

Health Care Location	Adolescents Willing to Use Health Care Location, %*		Adolescents' Assessment of Location Privacy, %†	
	For Illness	For Private Concern	Most Private	Least Private
Regular physician's office	77.5	50.5	63.6	5.5
Other physician's office	5.9	10.7	6.8	4.7
Teen or other clinic	11.5	44.6	23.1	5.9
Emergency department	16.1	2.4	1.5	28.0
School health clinic	13.7	12.4	3.1	51.0

*Students were asked to check off all locations where they would consider going for care.
†Students were asked to choose the single most private and least private locations.

Table 4.—Adolescent Knowledge of Confidentiality Laws (N=1295)

Question	Answer		
	Correct, %	Incorrect, %	"Don't Know," %
"In your state, teenagers can get treatment for sexually transmitted disease or venereal disease without parents' knowing."	35.3	18.8	43.8
"In your state, a teenager with a drug problem can get treatment without his/her parents' knowing."	29.9	21.4	47.0

private and least private health location from the same list of five locations (Table 3). The regular physician's office was chosen most frequently (63.6%) as offering the most privacy, while a school health center was selected most often as having the least privacy. Overall, 51.0% of respondents felt a school health center was the least private among the five locations listed. This was not significantly different among the three schools even though only school C has a school-based health clinic. However, when given the statement, "A school health clinic is good about keeping things private," significantly more students from school C agreed (41.2%) compared with students from the other two schools (34.0%; χ^2=6.44; P=.01). Also, when given the statement, "I might not use a school health clinic because other people (students, teachers, parents) might find out about my private business," more students in school C disagreed (39.2%) than did respondents from the other two schools (23.2%; χ^2=36.30; P<.01).

The survey also asked respondents to choose the definition of the word "confidential" from among four possible choices (to put an end to, to confirm, to keep a secret, to believe). Eighty-nine percent checked the correct definition, a proportion that did not significantly differ by grade. Students were also asked questions to assess their knowledge of their rights in seeking confidential care for specific health issues (Table 4). Unlike the question defining "confidential," only about one third of the respondents were knowledgeable about their rights to confidential care.

Adolescents were asked whether health providers should keep specific health issues confidential and responses were again analyzed with regard to demographic variables (Table 5). Differences were found by gender, school, and race. Differences were also found by grade, with students of lower grades more likely to favor disclosure on issues of running away, pregnancy, suicide, sexually transmitted diseases, and the human immunodeficiency virus and AIDS.

COMMENT

This article describes the knowledge, perceptions, and attitudes about the confidentiality of health care of adolescents in three high schools in central Massachusetts. A possible limitation is the generalizability of findings to other populations. In addition, use of schools as a survey site underrepresents high-risk groups of students who are not enrolled or may be chronically absent. There are also drawbacks in the use of self-report questionnaires because of the difficulty of validating replies. Finally, understanding the impact of adolescent perceptions about confidentiality in health care on care-seeking behavior is difficult because what adolescents say they will do (ie, regarding forgoing care) may be different from what they actually do. Our survey questions, however, did show strong internal consistency and, for the questions discussed, good face validity.

Our findings indicate that a large proportion of adolescents have health concerns they wish to keep private. Of importance, one fourth of the adolescents reported that they would not seek health care for these concerns if they thought that their parents, friends, or teachers might find out. This study confirms the notion that perceived lack of confidentiality may be a barrier to health care for some adolescents.

The majority of students (89%) were able to choose the correct definition of the word "confidential." However, only about one third were aware of their right to confidential care for certain health issues, confirming results of a small study of adolescents in Massachusetts.[14] Less than half of the respondents reported ever having talked about privacy with a health care provider. Clearly, educating adolescents about confidentiality in health care is needed. Those students who had discussed privacy in a health care setting were more likely to go for care. This finding may reflect the effectiveness of patient-provider discussions of confidentiality, although this may be confounded by utilization.

There have been reports regarding the difficulty care providers have in developing a confidential relationship with adolescents, independent of the already-established provider/parent relationship.[13,15] We found that a large percentage of respondents would go to their regular physician for private health concerns and the majority ranked their physician's office as the most private place. However, fewer would see their physician if they had a private health concern such as pregnancy, AIDS, or alcohol or other drug problems. Multiple avenues of health access may be necessary to meet the needs of adolescents as well education of both providers and patients about confidentiality issues.

Great concern was expressed about the confidentiality of school-based health centers. The majority of students felt it was the least private place to go compared with a physician's office, adolescent clinic, or emergency department. Students at the one school with a school-based health center (school C) were somewhat more favorable in their assessment of the privacy of a school health center, although a majority still expressed concerns. Clearly, perceptions of this school health center cannot be generalized to students at other schools with health centers. It is possible that students have little experience with or understanding of school-based health clinics. They may also confuse the role of the school nurse with the very different role of an independent health clinic located at a school. Nonetheless, the survey confirms adolescent skepticism about the confidentiality of school health care and emphasizes the importance of establishing procedures to ensure confidentiality at these sites.

The differences by school and race in attitudes about confidential health con-

Making a Difference in Adolescent Health

It has been said that a society is ultimately judged by its attention to its weakest members. While not our weakest, adolescents are perhaps the most vulnerable members of our society, as they make the transition from childhood to adulthood. Adolescence is a period of profound change. More changes take place in anatomy and physiology, mental and emotional functioning, and social development during adolescence than in any other life stage except infancy. The attitudes and behaviors molded during adolescence often determine the life-style and health habits of adulthood, creating long-term health implications. Improving the health status of adolescents is critical to improving the health status of the population.

How well are we doing as a society in attending to the health needs of adolescents? Consider the leading mortalities and morbidities of today's youth:

- Injury and violence account for three of four adolescent deaths.[1]
- Homicide is the second leading cause of adolescent deaths, with a 186% increase among 15- to 24-year-olds from 1960 to 1989.[1]
- Suicide is the third leading cause of adolescent deaths, with a 156% increase among 15- to 24-year-olds from 1960 to 1989.[1]
- Infection with the human immunodeficiency virus is now the sixth leading cause of death among 15- to 24-year-olds.[1]
- About one in ten 15- to 19-year-old girls gets pregnant a year.[2]
- Thirty-six percent of high-school students report current use of tobacco, 36.9% report binge drinking, 13.9% report current marijuana use, and 2.1% report current cocaine use.[3]
- Adolescents are more likely to be sexually, physically, and emotionally abused than any other age group of children. Approximately 26 of every thousand 12- to 17-year-olds have been victims of abuse or neglect compared with 16 of every 1000 children between 6 and 11 years of age, 10 per 1000 children 3 to 5 years of age, and six per 1000 children under 2 years of age.[4]

While chronic medical and psychiatric disorders affect approximately 6% of adolescents, many more adolescents today are at risk for death and other poor health outcomes that are not primarily biomedical in origin.[4] Contemporary threats to adolescent health are largely the result of social environment and/or behavior. Recognizing the strong link between personal behavior and health, we must offer all our adolescents the educational foundation and opportunities they need to develop life-styles that incorporate health promotion and disease prevention practices.

As Arkansas' state health director, one of us (M.J.E.) has been offering six prescriptions to respond to contemporary adolescent health needs.

1. Universal, early childhood education will prepare our children to learn and achieve, removing some of the disadvantages that hold them back. Given the success of Head Start in improving school performance, there is no good reason for not fully funding Head Start so all eligible children may participate.

2. Comprehensive health education should be taught to all children, starting in kindergarten and continuing through high school. An age-appropriate, sequential approach to school-based health education would provide every child with a foundation of knowledge for risk-reducing and health-promoting behaviors. A comprehensive curriculum provides teaching on growth and development, nutrition, safety, first aid, injury prevention, environmental health, tobacco and other substance use and abuse, consumer and community health, disease prevention and control, mental and emotional health, and family life.

3. Parents need more support in fulfilling their parenting responsibilities. For our future parents, today's children, this support can begin through a comprehensive school health education curriculum. For today's parents, more parenting education programs need to be provided, through which parents can learn child growth and development and effective communication and discipline.

4. Male responsibility needs reinforcement. Family planning and sex education have traditionally focused on young females. This strategy tacitly absolves young males of sexual responsibility. Some young males have few opportunities other than procreation to prove themselves. Accordingly, they must have opportunities for growth and self-expression in other arenas of life.

5. School-based clinics can increase access to primary and preventive health care. They are logical partners of comprehensive school health education. If children are taught health promotion practices, there should be an increased demand for preventive health care. Providing health care in schools makes services nearly universally accessible.

6. Opportunities for higher education should be guaranteed. All adolescents who make good grades, exhibit good citizenship, and have a low family income should be guaran-

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teed assistance at state-supported colleges.

These prescriptions would require greater expenditures in the recommended areas. At issue is whether we want to pay now or pay later. We can pay more for strategies that make an investment in our children's health and future, or we can continue to pay for costly intervention and treatment of preventable problems.

Our greatest chance of improving the health status of our adolescents lies in early and ongoing protection and promotion of their health and development. As a society, we must value our children enough to make a universal commitment to their future. With a consensus of values and a collaboration of effort, we can assist our adolescents in making a successful transition to adulthood.

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1. National Center for Health Statistics. *Health United States 1991*. Atlanta, Ga: US Dept of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention; 1992. DHHS publication PHS 92-1232.
2. Children's Defense Fund. *An Opinion Maker's Guide to Children in Election Year 1992*. Washington, DC: Children's Defense Fund; 1991.
3. *1990 Youth Risk Behavior Surveillance System: Chronic Disease and Health Promotion Reprints From the MMWR*. Atlanta, Ga: US Dept of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion; 1990.
4. American Medical Association. *America's Adolescents: How Healthy Are They?* Chicago, Ill: American Medical Association, Department of Adolescent Health; 1990 Profiles NLO12690.

Cholesterol Testing in Young Adults

Prudent or Profligate?

America's cardiovascular establishment has strongly supported the National Cholesterol Education Program (NCEP) and its clinical guidelines for detection and management of dyslipidemias.[1] In this issue of *JAMA*, Hulley et al[2] trenchantly criticize the NCEP guidelines for young adults—men under 35 years of age and premenopausal women. They conclude that routine testing of all such persons every 5 years is of unproven effectiveness for prolonging life, very inefficient from an economic and clinical standpoint, and perhaps unethical given that primary preventive maneuvers alter the lives of otherwise well persons.

See also p 1416.

Underpinning their criticisms is a simple observation. In isolation, an elevated total cholesterol (TC) or low-density lipoprotein cholesterol (LDL) level is a mediocre marker for short-term and even longer-term risk of coronary events.[3,4] This is especially so for young men and premenopausal women where coronary heart disease (CHD) is a rare cause of death. There is no discrete point beyond which all or even most persons develop CHD. Instead, there are trade-offs in the ratio of "true positives" to "false positives": the proportion of subjects treated who would not have developed CHD in the next few years rises as one lowers the threshold value separating "normal" from "abnormal" serum TC levels.[3,4] Since the incidence of CHD in young adults is already very small, aggressive testing and treatment of this population is particularly inefficient.

Would other lipid tests help? Measurement of high-density lipoprotein cholesterol (HDL) and, debatably, of triglyceride levels adds predictive value for some subgroups of patients[5,6] the LDL-to-HDL or TC-to-HDL ratio is also widely advocated. However, evidence for targeting treatment based on these measures draws largely on post hoc analyses from a trial in middle-aged men where overall mortality and morbidity yields remain debatable.[7] Newer markers, especially lipoprotein(a) and apolipoprotein B, should further improve the predictive value of lipid testing, but their use in intervention trials has been minimal.[8]

The poor predictive performance of the isolated TC level is not surprising, given that there are other potent risk factors for CHD. Selective testing based on nonlipid risk factors and family histories of CHD or dyslipidemias is thus one way to narrow the ambit of initial case-finding, but a proportion of patients with isolated dyslipidemias will be missed. Hulley et al believe that this is tolerable, since dyslipidemias in isolation among young adults confer such low absolute short term and intermediate-term risks of CHD.

Their critique highlights the lack of all-cause mortality benefits in lipid treatment trials among persons without pre existing CHD. Duration of follow-up may partly explain the findings, but trial evidence is inconsistent for a link between duration of follow-up and extent of all-cause mortality benefit. Moreover, as the authors argue, longer treatment also means longer exposure to drug side effects.

Hulley et al discuss trial meta-analyses and more circumstantial evidence showing how cholesterol lowering might cause harm. MacMahon,[9] in contrast, has argued that the increases in cancer or violent death in treated subjects are not significant when one aggregates all 26 completed cholesterol lowering trials, echoing the criticism by Chen et al[10] of "selective" meta-analyses. But the fact that 60% of all deaths in these trials were due to CHD[9] underscores the importance of separating secondary from primary prevention trials in meta analyses and younger from older adults in policymaking. A

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Confidential Health Services for Adolescents

Council on Scientific Affairs, American Medical Association

DURING the past 20 years rates of suicide,[1] illicit drug use,[2] sexually transmissible diseases (STDs),[3] and births to single mothers[4] have increased dramatically among adolescents. The changing nature of adolescent morbidity and mortality makes it critical that they receive medical care on a timely basis, and that barriers to care are removed.[5] One such barrier for many adolescents is their concern about whether sensitive information shared in private with their physician will remain confidential.

See also p 1404.

This report reviews adolescents' need for confidential health services and support by physicians and organized medicine for confidential care. Examined are two major barriers to confidential medical care: the prerogative to provide informed consent for medical treatment and payment for health services. The report describes how physicians can balance parental involvement and adolescents' needs for privacy in health care decisions and strategies to allay parental concerns and help them view the need for confidentiality as a normal part of human development. Policy recommendations for confidential care for adolescents are included at the end of the report.

ADOLESCENTS' NEED FOR CONFIDENTIAL HEALTH SERVICES

A major developmental task of adolescence is learning how to make appropriate decisions about education, employment, social relationships, and health behaviors. Physicians can help adolescents to incrementally assume greater responsibility for health behaviors and decisions by providing a context in which the adolescent may candidly discuss concerns, worries, and health-risk behaviors.

Privacy is essential to process. Confidentiality refers to the privileged and private nature of information provided during the health care transaction. It is generally acknowledged to be a cornerstone of the physician-patient relationship and "essential to a patient's trust in a health care provider and to a patient's willingness to supply information candidly for his or her benefit."[6] Exceptions to confidentiality include information required by third parties for billing purposes or when the law requires disclosure (eg, a threat to inflict bodily harm, cases of communicable diseases, gun shot and knife wounds, or child abuse).[7,8(p51)]

Uncertainty about whether health services will be confidential is perceived by both physicians and adolescents as a factor that may lead some adolescents to suppress relevant information or delay or avoid medical visits.[9] Lack of candor makes it harder for the physician to identify and provide appropriate treatment for the adolescent's medical problems. The delay or failure to seek necessary care may result in more serious short- or long-term complications.

Adolescents are more likely to seek necessary medical treatment, particularly for problems of a sensitive nature, if they can do so without their parents' knowledge. A 1982 survey[10] of 180 suburban New York City adolescents found that if parental knowledge were mandatory, only 45% of adolescents would seek medical services for depression, 19% for birth control, 15% for STDs, and 17% for drug use. If assured that medical treatment would be confidential, an additional 12% indicated that they would seek care for depression, 50% more would seek care for STDs, and 49% more would seek care for drug use. The desire for confidential medical care has led some adolescents to use community clinics or school-based health centers rather than seek health services from their primary

From the Council on Scientific Affairs, American Medical Association, Chicago, Ill.

This report was presented at the 1992 House of Delegates Annual Meeting as Report A of the Council on Scientific Affairs. The recommendations were adopted as amended, and the remainder of the report was filed.

This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. This report reflects the scientific literature as of June 1992.

Reprint requests to the Group on Science and Technology, American Medical Association, 515 N State St, Chicago, IL 60610 (Janet E. Gans, PhD).

care physician.[11,12] There is no evidence that adolescents receive inferior care in these settings, but continuity of care from a physician with greater understanding of the family unit and the individual adolescent's need and capabilities may be sacrificed in the process.

Many adolescents fear that physicians will report confidential information to their parents. In a 1982 survey of community clinics in 37 counties, one of four adolescents reported choosing a family planning clinic because they thought that their physicians would inform their parents about the visit. These fears appear to be somewhat exaggerated; 80% of physicians living in those counties reported that they would provide such services to unmarried minors younger than 18 years of age, and 63% would do so without parental consent.[11]

PHYSICIAN SUPPORT FOR CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS

Physician support for adolescent confidential health services depends on the age and maturity of the adolescent, the nature of the presenting problem, and the age and specialty of the physician. A 1983 national survey[13] of adolescent medicine specialists and board-certified pediatricians found that 83% of physicians favor confidential care for 17-year-olds, 66% for 14-year-olds. A 1987 national survey by the American Medical Association (AMA)[14] found that 63% of physicians support confidential health services for 15- to 17-year-olds, and 39% for 12- to 14-year-olds. Between 79% 94% of physicians favor confidential contraceptive services (depending on the age of the adolescent), and 48% to 60% favor confidential care for adolescents reporting illicit drug use.[13] Physicians than the age of 50 years are more likely than older physicians, and obstetrician-gynecologists are more than twice as likely as physicians in other specialties to support the use of confidential health services for adolescents.[15] State statutes regarding confidential services, concerns about liability, and the provision of preventive and diagnostic treatment also affect physician support.[16]

Organized medicine has supported confidential health services for adolescents, both for specific conditions and in terms of general guidelines for the development of public policies. In 1967, the AMA took the position that to stem the incidence and prevalence of STDs, minors needed to receive treatment for suspected STDs without parental notification.[8(p291)] The AMA[17] opposed regulations requiring parental notification for the provision of prescription contraceptives to minors through federally funded programs and urged that "obstacles to the distribution of birth control information, medication, and devices should be removed, and physicians should provide contraceptive services on a confidential basis where legally permissible."[18] The AMA policy states that while consultation with parents or other adults may be beneficial, "physicians should not feel or be compelled to require minors to obtain consent of their parents before deciding whether to undergo an abortion.... [M]inors should ultimately be allowed to decide whether parental involvement [in abortion decisions] is appropriate."[19]

In 1988, the American College of Obstetricians and Gynecologisis, the American Academy of Pediatrics, the American Academy of Family Physicians, and the National Medical Association jointly endorsed policy recommendations on confidentiality to guide the development of public policy.[20] The recommendations state that health professionals should provide the best possible care to adolescents and encourage parental participation in their care when appropriate. They encourage physicians to work with parents to facilitate payment, appointments, and other matters that reflect the confidential nature of arrangements made. They conclude that "ultimately, the health risks to adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed care."[20]

More recently, the AMA National Adolescent Health Coalition[21] prepared a compendium of recommendations on confidential health services for adolescents, which describes the policies of each organization on diverse topics related to confidentiality. Members of the Coalition include specialty societies in medicine, psychiatry, and the allied health professions, public health associations, private foundations, and federal agencies who are active in adolescent health. The compendium was designed to educate health professionals and policymakers about the need for confidential health services for adolescents, to prompt organizations to develop or clarify policy recommendations on this topic, and to enhance adolescent access to health services. Twelve of the 22 membership organizations had policy recommendations supporting confidential health services for adolescents. Half or more of the organizations supported the general need for confidential services, the need for physicians and providers to explain the limits of confidentiality to adolescents and parents, and the need to encourage adolescents to involve parents in medical matters, but not to make parental involvement a barrier to care.

INFORMED CONSENT AS A BARRIER TO CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS

Informed consent means that the individual can understand the diagnosis, the risk and benefits of a proposed procedure or treatment, alternative procedures and treatments and their associated risks, and the consequences of not undergoing the proposed procedure and treatment. The individual must also be able to decide voluntarily whether to proceed with the physician's recommendation.[9] Consent from a person legally entitled to authorize medical care must be obtained before medical care can be given, regardless of age. The traditional legal requirement of parental consent for the health care of minors reflects legal proscriptions against minors entering into binding contracts (which includes the physician-patient relationship) and the presumption that minors lack the developmental capabilities required to make decisions about their health care.[22]

During the second half of this century, the courts and state statutes created exceptions to parental consent requirements for certain categories of minors and certain types of medical services. Adolescents serving in the armed forces or living away from home and managing their own financial affairs are considered emancipated minors and are legally permitted to consent to treatment on the same basis as adults. States also allow mature minors to provide informed consent.[23,24] These are adolescents less than the age of 21 years who, although living at home as dependents, demonstrate the cognitive maturity to understand the risks and benefits of a proposed medical treatment and its alternatives and who can decide voluntarily whether to undergo the treatment.[25,26]

Since the 1960s, states have also developed medical emancipation statutes, which specify the types of medical services to which minors may consent without parental consent or notification. Most states allow minors to consent to pregnancy care (including prenatal and postnatal care, delivery services, and treatment for complications), contraceptive services, treatment for STDs,[27] and alcohol and other drug abuse treatment. Fewer states have statutes permitting minors to consent to inpatient or outpatient mental health counseling and treatment.[23,28] (There are no known cases in which a physician has been successfully sued for providing nonnegligent treatment to a minor aged 15 years or older without parental consent.[23,25,29,30])

The most publicly contested limitation on minors prerogative to consent to care centers on the early termination of pregnancy. At least 38 states require parental consent or notification before a minor may have an elective abortion.[31] These states, however, are required by law to establish a judicial bypass procedure to enable minors to obtain a court order authorizing the termination of pregnancy without first informing their parents.[31] Under precedents established by the Supreme Court, "the Constitution does not recognize any independent interest of the parents in the outcome of the abortion decision. The pregnant minor has a privacy interest which encompasses both independence in decision-making and non-disclosure of intimate information."[31]

The legal need for consent triangulates the adolescent patient–physician relationship by bringing parents or legal guardians into health care decision making. Few would deny that most adolescents would benefit from the advice and counsel of a parent or other adult on important decision affecting their health, and the AMA and several primary care specialty societies support parental involvement, as appropriate.[21] At issue is whether legal requirements that mandate parental involvement have the effect of enhancing parent-adolescent communication or family unity. Proponents of mandatory parental consent, particularly in decisions about adolescent pregnancy, maintain that parents have a right to know and participate in decisions affecting their child's health and well-being.[32] Opponents of these laws maintain that mandatory parental consent can delay or deter adolescents from seeking timely medical care and exacerbate the risks associated with an existing health problem.[32] These laws may endanger adolescents who live in dysfunctional families or who fear hostile or abusive responses from their parents.[22,33]

IMPACT OF MANDATORY PARENTAL CONSENT

Only a handful of studies have examined the impact of mandatory parental consent on adolescents' use of health services. Those studies have focused exclusively on reproductive health services, especially the decision to terminate a pregnancy. Overall, mandatory parental consent does not appear to significantly increase the proportion of adolescents who consult their parents about a pregnancy. For example, in a 1984 study,[34] 65% of adolescents in Minnesota and 62% of adolescents in Wisconsin reported consulting their parents. Minnesota had enacted a mandatory parental consent statute, Wisconsin had not.

Rather than promoting parental involvement, mandatory notification laws appear to have the unintended effect of increasing health risks to the adolescent by delaying the termination of pregnancy or forcing the adolescent into an unwanted birth. After Massachusetts enacted mandatory parental consent statutes in 1981, court proceedings delayed the abortion procedure by an average of 4 to 5 days, with some abortions delayed by nearly 6 weeks.[35] The law had little impact on the number of adolescents who conceived and elected to terminate the pregnancy.[32] However, the number of adolescents leaving the state to terminate a pregnancy climbed steadily in the months following enactment of the law.[36] Of the 477 adolescents in Massachusetts who chose a judicial bypass rather than informing parents, the judge assessed all but nine as mature and authorized them to consent to the procedure. In eight of the nine remaining cases, the judge determined that the abortion was in the minor's best interest. The ninth minor left the state to terminate her pregnancy rather than appeal the decision.[35]

Somewhat similar results were found after Minnesota adopted its parental notification requirement in 1981. The proportion of second-trimester abortions increased 12%; court proceedings delayed the procedure by 1 to 3 weeks.[37] For some adolescents, the length of these delays precluded the termination of the pregnancy.[38] However, the abortion rate and birth rate among 15- to 19-year-olds in Minnesota fell between 1981 and 1983.[39] It is possible that adolescent women took greater precautions to avoid pregnancy after enactment of this law. It is also possible that these trends reflect increased concern about STDs and human immunodeficiency virus infection among adolescents, and/or a greater awareness and availability of birth control following a 20% increase in funding for family planning services in Minnesota during 1980 and 1981.[40] There is little evidence that large numbers of adolescents left Minnesota to terminate a pregnancy in a state without parental notification laws.[34]

Most adolescents (55%)[41] inform parents about their use of reproductive health services, and 61% involve them in decisions about pregnancy.[33,42] Mandatory parental consent and notification laws are unlikely to convince adolescents who choose not to inform parents about these visits to do so. Forty-five percent of unmarried adolescent females attending Planned Parenthood clinics in 10 states reported that they had not informed their parents about the clinic visit. Of these, 80% reported that they would not seek clinic care if their parents had to be told, but fewer than one in 100 said that they would discontinue sexual relations.[41]

In sum, while the intent of mandatory parental consent laws is to enhance family unity, improve parent-child communication, protect adolescents from making deleterious decisions, and reduce abortions, there is limited evidence that the law has these effects. A majority of adolescents who want an abortion consult their parents regardless of statutes mandating consent or notification. The vast majority who elect judicial bypass rather than consult parents are granted authorization to make the decision about the course of the pregnancy. These tend to increase the health risks to the adolescent by delaying medical care. It is unclear whether these findings also characterize the use of medical services for other problems, such as the treatment of drug abuse or mental disorders.

PAYMENT AS A BARRIER TO CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS

Confidential health care for adolescents may be compromised ultimately by the economic realities of medical treatment. Adolescents who rely on their parents' private insurance need to recognize that the insurance claim sent to parents will list the services provided thereby compromising confidentiality. Adolescents living in families receiving Medicaid are also likely to have difficulty obtaining confidential care. Most adolescents cannot enroll in Medicaid without the family's involvement because applicants must provide financial information in order to determine eligibility. In many states the adolescent must show the family's Medicaid card or a Medicaid sticker in order to use the coverage, and these must be obtained through the parent.[25] Some states send parents who receive Medicaid a monthly itemized list of services provided to family members. Although this is meant to deter fraud, it may also prevent some adolescents from seeking needed medical care.[43]

State statutes allowing minors to consent to medical treatment typically hold the adolescent rather than the parent liable for payment.[25,29] Exceptions include emergency treatment or treatment given under court order. However, few adolescents can afford to pay for their own medical care,[44] and few physicians can provide subsidized care on a regular basis.

Health maintenance organizations and some prepaid health plans may be better able to offer confidential services to adolescents because care is provided

without disclosing the nature of the visit in a bill for services. Increased access to low-cost or free community clinics or to school-based clinics would also enhance confidentiality and would be especially helpful for adolescents living in poor and low-income families. However, because most adolescents are covered by private insurance or public insurance (74% and 9%, respectively), it is critical that third-party payers develop a system for listing services that preserves confidentiality for adolescents.

PHYSICIAN ROLE IN THE PROVISION OF CONFIDENTIAL HEALTH SERVICES TO ADOLESCENTS

Confidential health care is sometimes portrayed as a contest of rights between parents and adolescents.[9] In this scenario, the physician may be seen as either moderating or fueling conflict between parents and adolescents. However, confidentiality is better understood as a part of normal adolescent development in which the adolescent learns to me greater responsibility for his or her own health and health care and pursues the growing need for privacy.

Both physicians and parents have a role to play in this process.[45] As the child gains maturity and experience, the degree of confidentiality may also increase. When the physician finds the adolescent capable of autonomous decision making, he or she becomes a full partner in the physician-patient relationship; at this time the physician must determine whether the adolescent is capable of giving informed consent.

At all times, the physician should inform parents and minors about the conditions under which confidential care will be provided and when it will be abrogated. This should include any arrangements for the adolescent to have independent access to health care, including financial arrangements. Many physicians meet separately with adolescents and parents, allowing each to express their concerns independently in a confidential context. Most parents and adolescents are comfortable with this arrangement, particularly those who have an ongoing relationship with a physician.[45]

At times the physician and adolescent may disagree about whether informing parents is in the adolescent's best interest or critical to effective treatment.[26,46] In such cases, the physician can offer to inform the parents (with the adolescent's permission), to be present when parents are informed, or to dis- with the adolescent ways to inform parents on his or her own.[45] The rare occasions for overriding adolescents' objections and informing parents (or others) include suicidal ideation or for immature minors or minors with limited competence.[25]

Primary care physicians and adolescent medicine specialists usually encourage parental involvement believing that most adolescents benefit from the counsel and support of concerned and caring parents. Some problems—hospitalizations or treatment for drug abuse or mental health problems—are difficult or impossible to manage without parental participation. When the parent is part of the problem, or when informing the parent would not be in the patient's best interest, physicians have the authority to provide medical treatment on a confidential basis under a fairly broad set of rules determined by case and statutory law.[25]

Physicians are under no legal obligation to provide a specific service or treatment requested by a minor if it conflicts with their moral principles.[8(p1)] One alternative in such cases is to advise the adolescent about where to go for help and when appropriate, to make a referral.

RECOMMENDATIONS

The AMA remains concerned about the serious health problems facing adolescents and the corresponding imperative that adolescents receive needed medical care. It is important to ensure that confidentiality is consistent with adolescents' developmental and physical needs. Therefore, the Council on Scientific Affairs recommends that the AMA:

1. Reaffirm that confidential care for adolescents is critical to improving their health.

2. Encourage physicians to allow emancipated or mature minors to give informed consent for medical and psychiatric care without parental consent and notification, in conformity with state and federal law.

3. Encourage physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care.

4. Urge physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements).

5. Encourage physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician.

6. Encourage state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis.

7. Urge undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law, and implementation into practice.

8. Encourage health care payers to develop a method of listing of services that preserves confidentiality for adolescents.

9. Encourage state medical societies to evaluate laws on consent and confidential care for adolescents and help eliminate laws that restrict the availability of confidential care.

References

1. Fingerhut LA, Kleinman JC. Trends and current status in childhood mortality: United States, 1900-85. *Vital Health Stat 3*. 1989;No. 26.
2. Johnston LD, O'Malley PM, Bachman JG. *Illicit Drug Use, Smoking, and Drinking by America's High School Students, College Students, and Young Adults: 1975-1987*. Washington, DC: US Dept of Health and Human Services; 1988. Publication ADM 89-1602.
3. Shafer MA, Irwin CE Jr, Sweet RL. Acute salpingitis in the adolescent female. *J Pediatr*. 1982; 100:339-350.
4. Pittman K, Adams G. *Teenage Pregnancy: An Advocate's Guide to the Numbers*. Washington, DC: Children's Defense Fund; 1988.
5. Gans JE, McManus MA, Newacheck PW. *Adolescent Health Care: Use, Costs, and Problems of Access*. Chicago, Ill: American Medical Association; 1991.
6. National Conference of Commissioners on Uniform State Laws. *Uniform Health Care Information Act, Uniform Laws Annotated, Part I*. St Paul, Minn: West Publishing Co; 1988;9:475-520.
7. Council on Ethical and Judicial Affairs. *Current Opinions-1989*. Chicago, Ill: American Medical Association; 1989:section 5.05.
8. Council on Long Range Planning and Development. *AMA Policy Compendium*. Chicago, Ill: American Medical Association; 1990.
9. Hofmann AD. A rational policy toward consent and confidentiality in adolescent health care. *J Adolesc Health Care*. 1980;1:9-17.
10. Marks A, Malizio J, Hoch J, Brody R, Fisher M. Assessment of health needs and willingness to utilize health care resources of adolescents in a suburban population. *J Pediatr*. 1983;102:456-460.
11. Chamie M, Eisman S, Forrest JD, Orr MT, Torres A. Factors affecting adolescents' use of family planning clinics. *Fam Plann Perspect*. 1982;14: 126-139.
12. Mosher WD. *Use of Family Planning Services in the United States: 1982 and 1988*. Hyattsville, Md: National Center for Health Statistics; 1990. Publication PHS 90-1250.
13. Lovett J, Wald M. Physicians' attitudes toward

confidential care for adolescents. *J Pediatr.* 1985; 106:517-521.
14. Harvey LK, Shubat SC. *Physician Opinion on Health Care Issues: 1987.* Chicago, Ill: American Medical Association; 1987.
15. Novack D, Detering B, Arnold R, Forrow L, Ladinsky M, Pezzullo JC. Physicians' attitudes toward using deception to resolve difficult ethical problems. *JAMA.* 1989;261:2980-2985.
16. Resnick MD, Litman TJ, Blum WR. Physician attitudes toward confidentiality of treatment for adolescence: findings from the Upper Midwest Regional Physician Survey. *J Adolesc Health.* 1992; 13;616-622.
17. House of Delegates. *Family Planning.* Chicago, Ill: American Medical Association; June 1971. Report 82.
18. House of Delegates. *Opposition to HHS Regulations on Contraceptive Services to Minors.* Chicago, Ill: American Medical Association; December 1988. Resolution 65.
19. Council on Ethical and Judicial Affairs, American Medical Association. Mandatory parental consent to abortion. *JAMA.* 1993;269:82-86.
20. American College of Obstetricians and Gynecologisis. *ACOG Statement of Policy: Confidentiality in Adolescent Health Care.* Washington, DC: American College of Obstetricians and Gynecologists; 1988.
21. American Medical Association National Coalition on Adolescent Health; Gans J, ed. *Policy Compendium on Confidential Health Services for Adolescents.* Chicago, Ill: American Medical Association; 1993.
22. English A. Legal and ethical concerns. In: McAnarney ER, Kreipe R, Orr DP, Comerci GD, eds. *Textbook of Adolescent Medicine.* Philadelphia, Pa: WB Saunders Co; 1992.
23. Neinstein LS. *Adolescent Health Care: A Practical Guide.* 2nd ed. Baltimore, Md: Urban & Schwarzenberg; 1991.
24. English A. E ing access to health care for teenagers: legal and ethical issues concerning consent and confidentiality. *Youth Law News.* 1985;4-5:22-24.
25. Morrissey JM, Hofmann AD, Thrope JC. *Consent and Confidentiality in the Health Care of Children and Adolescents: A Legal Guide.* New York, NY: Free Press; 1986.
26. Gittler J, Quigley-Rick M, Saks MJ. *Adolescent Health Care Decision-Making: The Law and Public Policy.* New York, NY: Carnegie Corp; 1990.
27. English A. Treating adolescents: legal and ethical consideration. *Med Clin North Am.* 1990;74: 1097-1112.
28. Center for Substance Abuse Prevention. *Legal Issues for Alcohol and Other Drug Use Prevention and Treatment Programs Serving High-Risk Youth.* Washington, DC: Center for Substance Abuse Prevention; 1990. Publication ADM 90-1674.
29. Holder AR. Disclosure and consent problems in pediatrics. *Law Med Health Care.* 1988;16:219-228.
30. Holder AR. Minors' rights to consent to medical care. *JAMA.* 1987;257:3400-3402.
31. Crosby MC, English A. Mandatory parental involvement/judicial bypass laws: do they promote adolescents' health? *J Adolesc Health Care.* 1991; 12:143-147.
32. Donovan P. *Our Daughters' Decisions: The Conflict in State Law on Abortion and Other Issues.* New York, NY: The Alan Guttmacher Institute; 1992.
33. Henshaw SK, Kost K. Parental involvement in minors' abortion decisions. *Fam Plann Perspect.* 1992;24:197-207, 213.
34. Blum RW, Resnick MD, Stark TA. The impact of parental notification law on adolescent abortion decision-making. *Am J Public Health.* 1987;77:619-620.
35. Yates S, Pliner AJ. Judging maturity in the courts: the M husetts c statute. *Am J Public Health.* 1988;78:646-649.
36. Cartoof VG, Klerman LV. Parental co t for abortion: impact of the Massachusetts law. *Am J Public Health.* 1986;76:397-440.
37. Gold RB. *Abortion and Women's Health: A Turning Point for America?* New York, NY: The Alan Guttmacher Institute; 1990.
38. Greenberger MD, Connor K. Parental notice and consent for abortion: out of step with family law principles and policies. *Fam Plann Perspect.* 1991; 23:31-35.
39. Rogers JL, Boruch RF, Stoms GB, DeMoya D. Impact of the Minnesota parental notification on abortion and birth. *Am J Public Health.* 81:294-298.
40. The Alan Guttmacher Institute. Teenage abortions fell after Minnesota imposed parental notification law. *Fam Plann Perspect.* 1991;23:240.
41. Torres A. Does your mother know? *J Plann Perspect.* 1978;10:280-282.
42. Zabin LS, Hirsch MB, Emerson MR, Raymond E. To whom do inner-city minors talk about their pregnancies? adolescents' communication with parents and parent surrogates. *Fam Plann Per* 1992;24:148-154, 173.
43. English A, Tereszkiewicz L. *School-Health Clinics: Legal Issues.* San Francisco, Calif: National Center for Youth Law; 1988.
44. Fisher M, Marks A, Trieller K, et al. Are adolescents able and willing to pay the fee for dential health care? *J Pediatr.* 1985;107:480-483.
45. King N, Cross AW. Children as decisioners: guidelines for pediatricians. *J Pediatr.* 115:10-16.
46. Silber TJ. Justified paternalism in adolescent health care: cases of anorexia nervosa and substance abuse. *J Adolesc Health.* 1989;10:449-453.

INFORMATION / COMMENTS requested

date: 12 March 1996
to: Peter Edelman, Asst Secty for Planning and Evaluation
Jennifer Klein
from: Felicia H. Stewart MD, Deputy Asst Secty for Population Affairs
re: Adolescent Sexuality and Public Policy: A *Liberal* Response
by Lainie Friedman Ross

Overview: This manuscript argues that "specialized consent statutes . . . are an inappropriate ***solution*** to adolescent sexuality." The analysis also notes that "such statutes ***endorse*** deception," and are ***"illiberal*** in that they circumvent parental decision-making authority," and that "recent legislation and court decisions in the United States ***usurp parental power*** on health care issues pertaining to adolescent sexuality and reproduction" [emphasis mine]. The analysis is centered on a hypothetical dilemma, which the author asserts is "***relatively common*** in pediatrics," involving a 14 year old who might seek confidential care from her pediatrician to obtain prescription contraception despite the fact that her family would, because of devout Catholic religious beliefs, prohibit use of contraception, and would not approve of premarital sexual activity.

Comment: Using "loaded" language (see emphases in the preceding paragraph) the analysis misconstrues the origins and reasons for existing statutes, as well as their effects--creating "straw men" to be dispatched. For example, by characterizing such statutes as a "solution" to adolescent sexuality, the author implies that someone believed them to be so. No one I know! Rather, availability of confidential services is but one part of an appropriate set of responses to serious and difficult, multifaceted, public health problems. The statutes and legal precedents involved are not "recent," and these are not new problems. The issues involved have been carefully weighed by many thoughtful, experienced, and deeply concerned people. Confidential health services for adolescents is such an important issue that the AMA Council on Scientific Affairs undertook a comprehensive review in 1992, and concluded that "confidential care for adolescents is critical to improving their health."[1] Similar deliberations have been undertaken, with similar policy recommendations reached, by more than 30 national professional organizations.

The hypothetical case upon which "moral arguments" and conclusions in this analysis are based, also seriously misrepresents the nature of the problems involved.

Contrary to the author's assertion, it is not at all common for a 14 year old to seek confidential contraception care. Half of all teens do not initiate sexual activity before age 17. Among 14 year-olds, although 23% have had intercourse, more than half (60%) have had ***involuntary*** intercourse.[2] So when a 14 year old seeks such health care, whether or not accompanied by a parent, the health issues are far more serious than contraception. In ***most*** cases, the issues of sexual assault or incest must be addressed, and appropriate resources and referrals arranged, and in ***most*** cases there will be, in addition, state reporting requirements related to abuse or neglect. The very fact of sexual

activity at age 14 is so defined in many jurisdictions. Statistics are slightly less severe for teens at age 15 (30% have had intercourse, 40% of those involuntarily),[2] but still a very serious health concern. The clinician's role in caring for very young teens, therefore, is first concerned with the teen's safety and health, and second with helping the teen acquire resources, knowledge and self-knowledge, and skills in negotiation and planning, that can help him or her avoid future exposure to unwanted sexual experiences. This role is not fairly described as "endorsing deception" or "approving or condoning responsible adolescent sexual activity;" it is a possible life-line for rescue in a situation where parental support has already proven to be insufficient.

The policy analysis in this manuscript, based on a highly atypical, hypothetical young teen situation, does not adequately represent the scope of the issues involved for young teens, nor the true dilemmas for mid-age teens, and ignores entirely the largest group involved-- the nearly-adult minors.

Background: The author is a pediatrician, recently turned philosopher (with Ph.D. from Yale anticipated in 1996). She is a member of the Univ. of Chicago, Department of Medicine Faculty. Previous publications listed on the Univ. of Chicago world-wide-web home page include: "Spheres of Political Order" (written with David Schmidtz) forthcoming in *Nomos;* "Justice for Children: The Child as Organ Donor" in *Bioethics* (1994); and "Moral Grounding for the Participation of Children as Organ Donors" in *Journal of Law, Medicine, and Ethics* (1993).

The manuscript (apparently) will be published in *Politics and the Life Sciences,* a refereed but obscure journal. It is not included on the normal journal search lists, but was tracked down with the help of two extraordinary research librarians at the Parklawn reference library. It is published twice yearly for the Association of Politics and Life Sciences, by a British firm, Beechtree Publishing. Telephone information from the publisher indicates that the journal has a circulation of about 1,000, two-thirds of which is in the U.S. Its authors also are mostly from the U.S. We have requested a complimentary copy, and will forward it to you when it arrives.

References:

[1] Anon. Report of the Council on Scientific Affairs: Confidential Health Services for Adolescents, 1992. Reprint request to the Group on Science and Technology, American Medical Association, 515 North State Street, Chicago, Il 60610 (Janet E. Gans, PhD).

[2]Patricia Donovan *et al.* Sex and America's Teenagers. New York: The Alan Guttmacher Institute, 1994.



adolescent health

VOLUME III: CROSSCUTTING ISSUES IN THE DELIVERY OF HEALTH AND RELATED SERVICES






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CONSENT AND CONFIDENTIALITY IN ADOLESCENT HEALTH CARE DECISIONMAKING[1]

Introduction

Who should decide whether an adolescent is provided health services, what health services are provided, and how health services are provided? The adolescent? The adolescent's parents or legal guardian? Health professionals? The state? And who should decide whether adolescents' communications with health professionals and health care records are to be treated as confidential?

The question of how authority for adolescent health care decisionmaking should be allocated has been much debated—and is far from being settled. The body of law that determines how this authority is allocated—including the extent of parental involvement in adolescent health care decisionmaking—is summarized in this chapter. That body of law is large and complicated and is not always clear or consistent, in part because it is an amalgam of decisions of State and Federal courts, statutes passed by Congress and State legislatures, and regulations issued by executive departments and agencies.

The common law rule—to which there are many notable exceptions identified in this chapter—is that parental consent is generally required for the medical or surgical care of a minor child (i.e., a son or daughter who has not reached the age of majority, either age 18 or 19, depending on the State). The rationales for parental consent requirements are several. One rationale is that minors lack the capacity to make their own health care decisions and need to be protected from their own improvident decisionmaking. The legal presumption that minors are incompetent rests at least in part on an assumption of courts and legislators that minors as a class lack the requisite capacity to make health care decisions for themselves. Recently, the factual validity of that assumption has been increasingly criticized on the ground that it inequitably denies minors in middle or late adolescence—many or most of whom may actually have the requisite decisionmaking capacity—the power to make their own decisions about services. Several empirical studies that challenge the legal presumption about the incompetency of minors to make health care decisions are summarized in the second part of this chapter.

It is important to recognize, however, that concerns about adolescents' competency to make decisions are not the only rationale for parental consent requirements. Several other rationales for such requirements are reviewed in the discussion that follows, among them the state's interest and families' interest in encouraging family involvement in minors' lives and health care providers' interest in being able to receive compensation for the services they provide to minors.

How the law should allocate authority for making decisions about adolescent health care has traditionally been a matter for the individual State governments to determine, but the allocation of authority is or can be controlled or influenced to some extent by the Federal Government acting through the Federal courts, Congress, and Federal agencies. If it chose to, Congress could increase the Federal Government's role in the formulation of more uniform or coherent policies pertaining to the allocation of authority for adolescent health care decisionmaking. That and other possibilities are discussed, and a conceptual framework for public policy formulation in allocating authority for adolescent health care decisionmaking is presented, in the concluding section of this chapter.

Law Pertaining to Consent and Confidentiality in Adolescent Health Care Decisions

The large and complicated body of law that determines the allocation of authority for adolescent

[1]This chapter is based on a February 1990 background paper entitled "Adolescent Health Care Decisionmaking: The Law and Public Policy," prepared for OTA's Adolescent Health Project under contract to the Carnegie Council on Adolescent Development by J. Gittler, M. Quigley-Rick, and M.J. Saks. That background paper has been published separately in its entirety, including extensive legal citations, and is available from the Carnegie Council on Adolescent Development, Washington, DC, or from OTA.

health care decisionmaking is summarized below.[2] Much of the law focuses on the nature and extent of parental involvement in adolescent health care decisionmaking, including whether an adolescent's parents must *consent* to the delivery of health services to the adolescent and whether an adolescent's parent must be *notified* of the adolescent's decision to obtain health services or of the adolescent's actual receipt of health services.

As noted in the introduction, the body of law that determines the allocation of authority for adolescent health care decisionmaking is not always clear or consistent, in part because it is an amalgam of principles and rules drawn from different areas of law (e.g., tort law, contract law, family law, and constitutional law) and different jurisdictions, and in part because it consists of decisions of Federal and State courts, statutes passed by Congress and State legislatures, and regulations issued by executive departments and agencies. For at least some adolescents, a lack of information about what services they can or cannot receive without parental consent or notification may be a barrier to their seeking or receiving certain types of health services. For other adolescents, the barrier may be the substance of the laws requiring parental consent or notification rather than confusion about what the law allows.

Parental Consent Requirements

Anglo-American law draws a sharp distinction between adults and minors, and it is well established that minors have fewer rights and more restrictions on their liberty than adults (27,33). It is also well established that parents have a right to care, custody, and control of their minor children (83). Perhaps not surprisingly, therefore, the common law rule is that parental consent is generally required for the medical or surgical care of a minor child.[3] The age of majority is determined by individual States. Currently, the age of majority is set at age 18 in every State but Alaska, Nebraska, and Wyoming, where the age is 19. States can modify the age of majority to confer upon minors rights normally reserved for adults, and five States (Alabama, Kansas, Rhode Island, South Carolina, and Oregon[4]) have enacted statutes that specifically authorize minors who have reached a designated age—ranging from 14 to 16—to consent to health care.

The parental consent requirement reflects the application to minors of the tort law doctrine of informed consent, as well as principles under contract law. As discussed later in this chapter, the legal doctrine of informed consent is based on the premise that every person has the right to determine what is done to his or her own body. The doctrine of informed consent holds, therefore, that physicians and surgeons have a duty to give their adult patients the information necessary for making an informed and voluntary choice concerning medical treatment or surgery; the failure by a physician or surgeon to obtain informed consent from a patient may give rise to a civil liability and an award of damages.[5] In addition, under contract law, the relationship between a doctor and an adult patient is usually considered a contractual relationship. Among the essentials of any contract are competent parties.

Traditionally, minors have been deemed incompetent as a matter of law to give informed consent to medical and surgical care and incompetent to enter into binding contracts, including contracts with physicians and surgeons. Thus, parental consent has been required for provision of health services to minors.

The rationales for parental consent requirements in the area of health care are several. One of the main rationales for the parental consent requirement—based on the assumption that minors lack the requisite capacity to make health care decisions—is the need to *protect minors from their own improvi-*

[2]Although the focus of this OTA Report is on "adolescents" defined as individuals ages 10 to 18, the law regards 10- to 18-year-olds not as "adolescents" but as either "minors" or "adults." Since 18-year-olds are legally considered adults in all but three States, most of the issues about adolescent health care decisionmaking raised in this chapter pertain to adolescents ages 17 and under.

[3]See, for example, *Bonner* v. *Moran*, 75 App. D.C. 156, 126 F.2d 121, 123 (D.C. Cir. 1941); *Rogers* v. *Sells*, 178 Okla. 103, 61 P.2d 1018 (1936); *Browning* v. *Hogan*, 90 W. Va 568, 111 S.E. 492 (1922). See Institute of Judicial Administration and American Bar Association, Juvenile Justice Standards Project, *Standards Relating to Rights of Minors* (47); G.D. Dodson, "Legal Rights of Adolescents: Restrictions on Liberty, Emancipation, and Status Offenses" (33); and R. Bennett, "Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis" (19).

[4]ALA. CODE § 22-8-4 (1984); KAN. STAT. ANN. § 38-123b (1986); R.I. GEN. LAWS § 23-4. 6-1 (1985); S.C. CODE ANN. § 20-7-280 (Law. Co-op. 1985); OR. REV. STAT. § 109.640 (1981).

[5]The law of torts protects persons against unauthorized bodily invasion. Bodily contact with a patient by a physician or surgeon without the patient's consent constitutes technical battery, which is a tort (53).

dent decisionmaking.[6] Accepting for the sake of argument that minors in fact need protection from their own improvident decisionmaking, there remains the question of why *parents* have been legally authorized to make health care decisions on behalf of their minor children. There appear to be two operative premises in this regard: 1) that parents, in contrast to their minor children, possess the intelligence, maturity, and experience needed for adequate and appropriate health care decisionmaking; and 2) that parents usually have an identity of interest with their minor children and will act in their best interests. In at least some situations, parents and their adolescent children do not have an identity of interest, and sometimes their interests may conflict.[7] It is precisely such situations that give rise to concerns that parental consent or notification requirements may create barriers to adolescents' seeking or receiving certain types of health services.

Another rationale for the parental consent requirement—apart from the need to protect minors from their own improvident decisionmaking—is a belief that the parental consent requirement *promotes family autonomy*[8] *and privacy and promotes parental authority*[9] *and control of minor children*. Family autonomy and parental authority, in turn, are often viewed as fostering the stability and cohesiveness of the family as an institution and of individual family units. The U.S. Supreme Court has commented in a series of decisions on the importance of family autonomy and parental authority, and the Court has extended Federal constitutional protection, albeit not absolute protection, to family autonomy and parental authority.[10] The parental consent requirement also seems, at least somewhat, to be designed to protect parents from financial liability arising from the provision of health services, without their consent, to their children and to ensure providers of the availability of a payment source for the services they provide to minors.

Exceptions to the Parental Consent Requirement

Over the years, the number of exceptions to the parental consent requirement applicable to the health care of minors has grown significantly. Exceptions to the parental consent requirement, described below, tend to fall into four categories:

- exceptions arising out of the jurisdiction of juvenile and family courts over abused and neglected minors,
- exceptions related to the status and characteristics of individual minors (e.g., emancipated, independent, or mature minors),

[6]In dealing with issues of consent to health care for minors, State courts and lower Federal courts have consistently expressed concern about the decisionmaking capabilities of minors. In *Bonner* v. *Moran*, 75 App. D.C. 156, 126 F.2d 121, 122 (1941), for example, the court stated: "In deference to common experience, there is general recognition of the fact that many persons by reason of their youth are incapable of intelligent decisions, as a result of which public policy demands legal protection of their personal as well as their property rights." In recent years, the U.S. Supreme Court, in dealing with issues concerning access of minors to contraceptives and abortions and the civil commitment of minors, has similarly expressed concern about the decisionmaking capabilities of minors. For example, in *Parham* v. *J.R.*, 442 U.S. 584, 602, 603 (1978), the court stated: "Most children, even in adolescence, simply are not able to make sound decisions, including their need for medical care or treatment." See also *Bellotti* v. *Baird*, 443 U.S. 622, 633, 640 (1978), reh. denied, 444 U.S. 887 (1979); *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 91 (1976) (Stewart, J., concurring); *Carey* v. *Population Services International*, 431 U.S. 678, 709 (1977) (Powell, J. concurring); *Carey* v. *Population Services International*, supra at 714 (1977) (Stevens, J. concurring).

[7]For a further discussion of how the interests of an adolescent, the adolescent's parents, the state, and health providers may differ, see box 17-B in the concluding section of this chapter.

[8]*Family autonomy* refers to noninterference by the state in the right of families to make important decisions concerning family life and family members. A tradition of family autonomy is deeply imbedded in Anglo-American law and can be traced back to Roman law, the Judeo-Christian tradition, and Anglo-Saxon customary law. Family autonomy is often but not always equated with parental authority (42).

[9]*Parental authority* refers to the deference of the state to the right of parents to make childrearing decisions (42). At common law, minor children were in effect the chattels or property of their parent, who had virtually the unfettered right to rear them as they saw fit. Over time, minor children increasingly have been recognized as having independent rights (45), yet they are still largely subject to the authority of their parents.

[10]In a line of decisions over 50 years, the U.S. Supreme Court has held that parents have a Federal constitutional right to direct the upbringing of their children free from state intervention in the absence of a constitutionally acceptable justification for such intervention. The Court's most notable decisions in this regard are *Meyer* v. *Nebraska*, 262 U.S. 390 (1923); *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925); *Prince* v. *Massachusetts*, 321 U.S. 158 (1944); and *Wisconsin* v. *Yoder* 406 U.S. 205 (1972). See also *Ginsburg* v. *New York* 390 U.S. 629, 634 (1968), reh. denied, 391 U.S. 971 (1973). In another line of decisions, the U.S. Supreme Court has afforded minors some of the same constitutional rights that adults are afforded in areas that do not directly implicate parents' right to direct the upbringing of their children. See, for example, *In re Gault*, 387 U.S. 1 (1967); *Tinker* v. *Des Moines Independent Community School District*, 393 U.S. 503 (1969); and *Goss* v. *Lopez*, 419 U.S., 565 (1975). In recent years, the U.S. Supreme Court has begun to confront conflicts between a parent's asserted right to direct the upbringing of his or her minor child and the minor's assertion of his or her own independent rights and has issued several decisions involving actual or potential parent-child conflicts with respect to the access of minors to contraceptives and abortions and the civil commitment of minors. Taken as a whole, however, the results and rationales of the Supreme Court's decisions do not reflect a coherent approach to such conflicts.

- exceptions for health emergencies, and
- exceptions for specific health problems and services (e.g., services related to sexual activities, drug and alcohol abuse, or mental health).

As noted in the discussion that follows, some of the exceptions apply to certain categories of minors regardless of their age, and others are directed at or affect primarily adolescent minors. For a number of exceptions to parental consent requirements for specific health problems, as will be discussed later, there are now in place parental notification requirements.

Exceptions Arising From Juvenile and Family Courts' Jurisdiction Over Abused and Neglected Minors

In all States, juvenile and family courts have jurisdiction over minors of all ages who have been abused or neglected. Exercising this jurisdiction, juvenile and family courts have traditionally had the power to intervene to secure health services for minors whose parents refuse to consent to the provision of services if the parents' refusal is deemed medical neglect. The basis for judicial intervention under State juvenile and family court acts in such instances is the state's parens patriae power. In many instances where medical neglect is alleged, the parents' refusal to consent to care is based on religious convictions. Judicial intervention typically occurs only when a minor's life is or will be threatened because of lack of care.

Exceptions Related to the Status and Characteristics of Individual Minors

Two major types of exceptions to the parental consent requirement are related to the status and characteristics of individual minors:

- exceptions for "emancipated" minors and "independent" minors, and
- exceptions for "mature" minors.

Exceptions for "Emancipated" and "Independent" Minors—Emancipation is a somewhat murky and confused area of the law,[11] but generally speaking, "emancipated minors" are minors who have been legally freed from the control and authority of their parents. Under the common law doctrine of emancipation, courts—without explicit statutory authorization—may use various factors in determining whether a minor's emancipation has taken place. Emancipation may be found to have occurred in accordance with an express agreement between a minor's parents and the minor or may be implied from the acts of the minor's parents and the minor. The main indicia of emancipation implied from the acts of the parties are a minor's marriage, a minor's induction into the armed services, a minor's establishment of a home away from that of his or her parents, a minors' economic independence from his or her parents, and a minor's age (50). Emancipation under common law may be complete or partial and may or may not result in a minor's having the right to consent to health services.

About half of the States have enacted statutes that provide for court-ordered emancipation of minors or specify that certain designated acts by a minor's parents, a minor, or both constitute emancipation. Some of these statutes explicitly state that emancipation under these statutes removes the disabilities of minority, including the requirement of parental consent to health services. Thus, minors emancipated under these statutes have the right to consent to health services.

A substantial number of States have enacted statutes that authorize minors who have attained varying degrees of *independence* to consent to health services but that do not use the term "emancipation" or "emancipated" minors. Over half of the States have "independent minor" statutes that allow minors who are parents to consent to health care for themselves and/or their children; about half of the States have statutes that allow married minors to consent to health care; and some States have statutes that allow independent minors in other categories (e.g., minors living apart from their parents and managing their own financial affairs, minors in the military, minors who are high school graduates) to consent to health services.

Emancipated minor and independent minor exceptions to the parental consent requirement affect minors who have achieved complete or substantial independence from their parents, so they primarily affect adolescent minors. The focus of these exceptions is the minor's independence, not the minor's capacity to make health care decisions. These

[11]For discussions of the origins and development of emancipation, see H.H. Clark, *The Law of Domestic Relations in the United States* (27); F. Cady, "Emancipation of Minors" (24); and S. Katz, W. Schroeder, and L. Sidman, "Emancipating Our Children—Coming of Age in Legal America" (50).

exceptions seem to reflect legislative judgments that a minor who is not part of a functioning family, or whose parents exercise little or no control over him or her, is in a better position to make health care decisions than the minor's parents.

Exceptions for "Mature" Minors—The "mature minor" exception to the parental consent requirement has been enunciated primarily by courts rather than by State legislatures. This exception was recognized by State courts beginning in the early 1900s. According to one authority, the factors supporting a determination of a minor's maturity for purposes of health care decisionmaking in these decisions are as follows:

> (1) the treatment is undertaken for the benefit of a minor rather than a third party; (2) the particular minor is near the age of majority; (3) the minor is considered to have sufficient mental capacity to understand fully the nature and importance of medical steps proposed; (4) the procedures are characterized as less than "major," not "serious" or not overly "complex" (75).

Recently, the mature minor doctrine has been applied by the U.S. Supreme Court in decisions dealing with the right of a minor to family planning services and abortion services (see discussion below). Only a few States have mature minor statutes. Three States (Arkansas, Mississippi, and New Hampshire[12]) have enacted statutes that explicitly authorize mature minors to consent to health services, and two States (Idaho and Nevada[13]) have enacted statutes that are somewhat ambiguous but could be construed to constitute mature minor consent statutes.

The mature minor exception to the parental consent requirement is based on a rejection of the presumption of minors' incompetency and the underlying assumption that minors as a class lack decisionmaking capacity; this exception allows for individualized determinations of minors' actual decisionmaking capacity. Because it pertains to mature minors, this exception to the parental consent requirement probably most often applies to minors in middle and late adolescence.

Exceptions for Health Emergencies

In health emergencies, medical or surgical care may be furnished to minors without parental consent. The emergency exception to the parental consent requirement was originally enunciated by the courts. More than half of the States now have statutes that codify the exception. Some of the State statutes simply authorize emergency care of a minor without parental consent; others state that a physician or other health professional who treats a minor in an emergency without parental consent is relieved from liability; and still others provide that a minor may consent to emergency care.

Exceptions for Specific Types of Health Services

Exceptions to the parental consent requirement for specific health problems or specific types of services fall into three major categories:

- exceptions for health services related to sexual activities,
- exceptions for health services related to drug and alcohol abuse, and
- exceptions for mental health services.

Exceptions for Health Services Related to Sexual Activities—Exceptions to the parental consent requirement for health services related to sexual activities are of three general types: 1) exceptions for health services related to venereal,[14] sexually transmitted, and infectious diseases and acquired immunodeficiency syndrome (AIDS); 2) exceptions for family planning services and abortion services; and 3) exceptions for pregnancy-related health services.[15]

Exceptions for Health Services Related to Venereal, Sexually Transmitted, and Infectious Diseases and AIDS—Almost all States have enacted legislation that specifically allows minors to consent to or to receive services for a venereal or sexually transmitted disease without parental consent. More

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[12]ARK. CODE ANN. § 20-9-602(7) (1987); MISS. CODE ANN. § 41-41-3(h) (Supp. 1988); N.H. REV. STAT. ANN. § 318-B:12a (1984).

[13]IDAHO CODE § 39-4302 (1985); NEV. REV. STAT. § 129.030(2) (1987). But see NEV. REV. STAT. § 129.030(1) (1987).

[14]In common usage, the term "venereal disease" has been replaced by "sexually transmitted disease" (see ch. 9, "AIDS and Other Sexually Transmitted Diseases: Prevention and Services," in Vol. II. However, because some State statutes use the older term venereal disease, it is included here.

[15]The effectiveness of services related to adolescents' sexual behavior—e.g., services for the prevention and treatment of AIDS and other sexually transmitted diseases, family planning services, and pregnancy-related services—is discussed in Vol. II in ch. 9, "AIDS and Other Sexually Transmitted Diseases: Prevention and Services," and ch. 10, "Pregnancy and Parenting: Prevention and Services."

than two-thirds of the States have enacted legislation that specifically allows minors to obtain without parental consent health services for "venereal disease"; about one-quarter of the States have a statute that allows services without parental consent for "sexually transmitted disease." A few States have a statute that allows minors to obtain services without parental consent for "infectious, contagious, communicable and reportable diseases" (or some variant thereof). None of the State statutes just mentioned expressly covers testing for infection with human immunodeficiency virus (HIV), the virus that causes AIDS, but some of them may cover or could be interpreted to cover HIV testing. A few States have statutes that expressly authorize minors to consent to or to receive HIV testing without parental consent.

Most of the State statutes just mentioned allow minors of any age to consent to services or to receive services for the diseases specified without parental consent, although others specify that minors must be 12 or 14 to consent to these services. The fact that these statutes impose either no age limit or a very low age limit for minors to consent to or to receive services for these diseases without parental consent appears to stem from a legislative recognition that society has a critical interest in facilitating and encouraging access to health services to reduce the spread of disease among its citizens.

Exceptions for Family Planning Services[16] *and Abortion Services*—Restrictions on access to family planning services and abortion services by adolescents are governed by Federal constitutional law as interpreted by the U.S. Supreme Court and the lower Federal courts, and the Supreme Court is the final arbiter of what is constitutionally permissible and impermissible when it comes to State-imposed restrictions—including parental consent and notification requirements—on the provision of family planning services and abortion services to minors.

In the landmark 1965 case *Griswold* v. *Connecticut* [381 U.S. 479 (1965)] and in *Eisenstadt* v. *Baird* [405 U.S. 438 (1972)], the U.S. Supreme Court held that an individual has a constitutionally protected "right to privacy" under the 14th amendment encompassing decisions with respect to the use of contraceptives.[17] In the 1977 case *Carey* v. *Population Services International* [431 U.S. 678 (1977)], the U.S. Supreme Court established that minors as well as adults have a constitutionally protected right to privacy with respect to the use of contraceptives.[18] A little under half of the States have statutes providing that minors may obtain without parental consent what are variously described as contraceptives, birth control services, or services for the prevention of pregnancy. Some of these statutes impose restrictions on minors' obtaining these services without parental consent (e.g., that the minor be of a certain minimum age, be referred from a designated source, possess a certain maturity and intelligence, or be likely to suffer detrimental health consequences if the services are not provided). Many of them explicitly exclude or have been or could be interpreted as excluding abortion from the services that minors may obtain.

In the landmark 1973 decision *Roe* v. *Wade* [410 U.S. 113 (1973)], the U.S. Supreme Court held that the constitutional right to privacy encompassed a woman's decision about whether to have an abortion and invalidated State criminal statutes prohibiting nontherapeutic abortions at any stage of pregnancy. At the same time, however, the Court ruled that a State did have legitimate interests (e.g., in safeguarding maternal health, in maintaining proper medical standards, and in protecting human life) that could justify State regulation of the performance of abortions.[19]

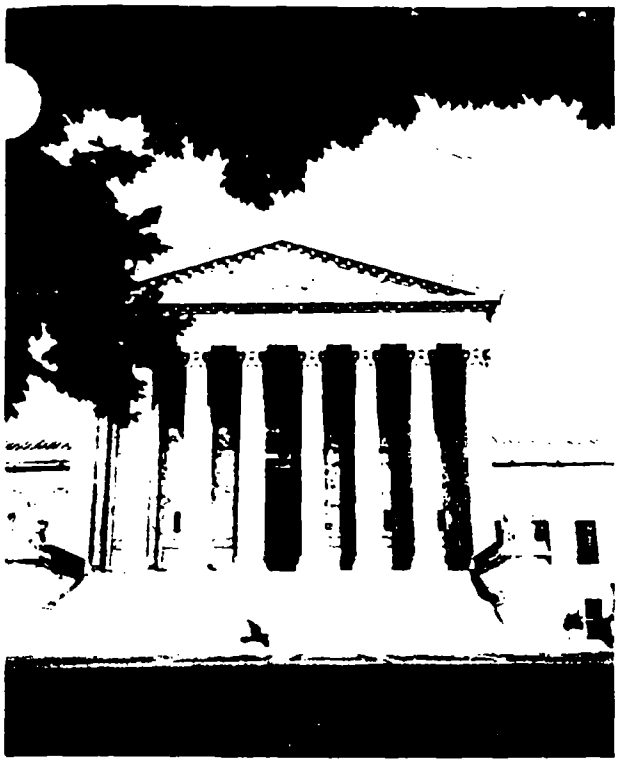
Since 1972, the Supreme Court has issued several decisions that have extended to minors at least some constitutional protections with respect to the right to

[16] *Family planning services* are contraceptives and other birth control services, with the exceptions of sterilization and abortion.

[17] In *Griswold* v. *Connecticut* [381 U.S. 479 (1965)], the U.S. Supreme Court held that State regulation of use of contraceptives by married persons invaded "the zone of privacy created by several constitutional guarantees" and struck down as unconstitutional a State statute prohibiting the use of contraceptives by married persons. In *Eisenstadt* v. *Baird* [405 U.S. 438 (1972)], the Court held that unmarried as well as married persons had a right to privacy with respect to contraceptive use.

[18] In *Carey* v. *Population Services International* [431 U.S. 678 (1977)], the Supreme Court specifically held unconstitutional a State statute prohibiting the sale or distribution of contraceptives to minors. The Court indicated that "State restrictions inhibiting privacy rights are valid only if they serve any significant State interest . . . that is not present in the case of an adult."

[19] The Supreme Court ruled in *Roe* v. *Wade* that during the first trimester of pregnancy, a State may require only that the abortion be performed by a licensed physician; that after the first trimester, a State may "regulate the abortion procedure in ways that are reasonably related to maternal health;" and that once the fetus is "viable," a State may "regulate, even proscribe, abortion except where it is necessary in appropriate medical judgment, for the preservation of life or health of the mother" [410 U.S. at 164-65].



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Laws related to the allocation of authority for decisions about the provision of health services to minors have historically been the province of State legislatures, State courts, and State administrative agencies, but the U.S. Supreme Court decides whether State laws adhere to the requirements of the U.S. Constitution.

have an abortion.[20] The U.S. Supreme Court has not held a parental consent requirement for a minor's abortion to be unconstitutional per se. It has ruled, however, that a minor's parents cannot be given an absolute veto of a minor's decision to undergo an abortion; any parental consent requirement for a minor's abortion must be coupled with the availability of a "judicial bypass" procedure, under which a minor can secure court approval for an abortion if she can demonstrate to the court that she is mature enough to make the abortion decision or that the abortion would be in her best interests. The Court has also indicated that the judicial bypass procedure must ensure a confidential and expeditious proceeding. In the wake of the Supreme Court's *Roe* v. *Wade* decision and related decisions, about one-quarter of the States have enacted statutes requiring parental consent to abortion for minors. Some of these State statutes have been invalidated or are currently being challenged on Federal constitutional grounds, however, so not all of the statutes are currently being enforced.

It is important to emphasize that Federal constitutional law concerning the permissible scope of State regulation of abortion as interpreted by the U.S. Supreme Court is in flux. The Supreme Court's decision in the 1989 case *Webster* v. *Reproductive Health Services* [109 S. Ct. 3040 (1989)] appears to give the States greater leeway in restricting abortions and at the same time casts doubt on the future of *Roe* v. *Wade* and other Supreme Court decisions dealing with abortion. To the extent that *Webster* and future rulings increase States' ability to restrict abortion generally, they may reduce minors' access to abortion—even though the decisions do not directly address the question of parental consent.

Exceptions for Pregnancy-Related Health Services—Over half of the States have statutes specifically authorizing minors to consent to pregnancy-related health services (e.g., testing to determine pregnancy, prenatal care, and delivery services). Since these consent statutes are directed at pregnant minors, they are in effect adolescent consent statutes.

Exceptions for Health Services Related to Drug and/or Alcohol Abuse[21]—All but five States (Alaska, Arkansas, Oregon, Utah, and Wyoming) and the District of Columbia have statutes specifically authorizing minors to consent to drug- and/or alcohol-related health services or to receive such services without parental consent. Two-thirds of the States have statutes covering health services related to both drug and alcohol abuse and dependency; other States have statutes covering health services related to drug abuse or alcohol abuse but not both. The majority of State statutes that allow minors to obtain treatment for drug and alcohol abuse without parental consent do not impose minimum age requirements, although some of them pertain only to minors who have reached a designated age—ranging from 12 to 16 years of age.

[20]Notable Supreme Court decisions dealing with parental consent to a minor's abortion include *Planned Parenthood of Missouri* v. *Danforth* [428 U.S. 52 (1976)], In *Bellotti* v. *Baird* (Bellotti II) [443 U.S. 622 (1979)], *City of Akron* v. *Akron Center for Reproductive Health, Inc.* [462 U.S. 416 (1973)], and *Planned Parenthood Association* v. *Ashcroft* [462 U.S. 476 (1983)].

[21]For a discussion of health services related to drug and alcohol abuse, see ch. 12, "Alcohol, Tobacco, and Drug Abuse: Prevention and Services," in Vol. II.

State statutes that create an exception to the parental consent requirement with respect to services for drug or alcohol abuse would appear to represent an acknowledgment on the part of State legislatures of the seriousness of drug and alcohol abuse problems among adolescent minors. They would also appear to be the product of a concern on the part of State legislatures that minors may not obtain care related to such abuse if they have to secure parental consent for such care, because "communications" between parents and minors regarding alcohol or drug abuse may "be strained or nonexistent" (81).

Exceptions for Mental Health Services[22]—A little under half of the States have statutes that allow some minors to obtain *outpatient* mental health services without parental consent. These statutes typically impose age restrictions and pertain only to adolescent minors. Underlying these statutes appears to be a legislative realization that a parental consent requirement might deter some adolescent minors who have mental health problems from seeking needed treatment because of a reluctance to reveal such problems to their parents.

Inpatient mental health services for minors present special problems in the area of consent. The involuntary commitment of a person to a mental institution or facility results in the deprivation of that person's liberty, so certain safeguards are in place (e.g., substantive criteria for commitment and procedures pertaining to due process) to ensure that such commitment is necessary. For voluntary commitment, however, such safeguards are not mandated, and as a concomitant of the parental consent requirement for the provision of health services to minors, parents have sometimes been allowed to make a "voluntary commitment" of a minor child to a mental institution or facility, regardless of the minor's desire or need for services.

In *Parham* v. *J.R.* [442 U.S. 584 (1979)], the U.S. Supreme Court rejected the contention that an adversary hearing was required to decide whether a minor may be committed by his or her parents in order to protect the minor, but held that the risk of error in the parental decision to commit a minor to a mental health facility was sufficiently great as to call for an inquiry by a neutral fact finder to determine whether the statutory criteria for admission were met. About two-thirds of the States now have statutes that allow parents to make a voluntary commitment to a mental health facility of a minor child. These statutes vary substantially in the safeguards they provide against inappropriate use of hospitalization or institutionalization to manage "troublesome" minor children who do not have severe mental health problems.[23] According to one analysis, "In general, . . . minors are significantly less able than are adults to resist mental hospitalization sought for them by others" (85).

About half of the States have statutes that authorize minors to apply for admission as an inpatient to a mental institution or facility without parental consent. Most of these statutes impose minimum age limits, the most common being 16 years of age or older. Finally, a few States have statutes that require both the minor's consent *and* a parent's consent for inpatient mental health services.

Confidentiality and Parental Notification Requirements

It has long been accepted that the confidentiality of the relationship between a physician and patient as well as of the relationship between other types of health care providers and their patients or clients, is essential to a patient's trust in a health care provider and to a patient's willingness to supply information candidly (68). Courts and legislatures have established a physician-patient privilege to protect the confidentiality of communications between physicians and their patients and have established similar privileges to ensure the confidentiality of communications between other types of health care providers and their patients or clients (29). Furthermore, there is a developing case law imposing liability on physicians for unauthorized disclosure of confidential information about their patients (8) (although all health care professionals are required by law to disclose information in situations where there is a strong societal interest in disclosure—e.g., in the reporting of cases of suspected child abuse to the public child welfare authorities (47)).

[22]Mental health services for adolescents are reviewed in ch. 11, "Mental Health Problems: Prevention and Services," in Vol. II.

[23]Some people are concerned that the rising admission to psychiatric units of private hospitals are indicative of widespread misuse of commitment to control "troublesome" minors (85). See ch. 11, "Mental Health Problems: Prevention and Services," in Vol. II, for further discussion.

By and large, the confidentiality of the relationship between health service providers and minors and the disclosure of confidential information by health service providers to the parents of minors or other third parties are not addressed in case or statutory law. Requirements that parents be notified of a minor's decision to obtain health services or of the minor's actual receipt of health services, however, have in fact become a "legal" issue. In carving out exceptions to the requirement for parental consent to the provision of health services to minors, courts and legislatures have sometimes—though not always—replaced the parental consent requirement with a parental notification requirement.

The justifications for requiring that the parents of minors be notified of the decisions of their minor children to obtain health services are essentially the same as—or at least very similar to—the justifications for requiring that parents consent to health services for minor children. One justification for parental notification requirements is to ensure that parents play an appropriate "guiding role" in counseling their minor children about health care decisions—a role assumed to be needed given the presumed incompetency of minors to make health care decisions based upon minors' assumed lack of decisionmaking capacity.[24] Another major justification is to bolster parental direction and control of their minor children and thereby to maintain the family structure.[25]

Parental Notification Requirements for Health Services Provided to "Emancipated," "Independent," or "Mature" Minors

The prevailing pattern in the many State statutes that authorize "emancipated minors" to obtain health services without parental consent is for these statutes to be silent concerning parental notification; only a few of these statutes contain various kinds of parental notification provisions. The same prevailing pattern is found in States' "independent minor" statutes and "mature minor" statutes.

Parental Notification Requirements for Emergency Health Services

The prevailing pattern in the many State statutes that create an exception to the parental consent requirement in health emergencies is for the statutes to have no provisions concerning parental notification; only a handful of these statutes have some sort of parental notification provisions.

Photo credit: Los Angeles Free Clinic, Project Able

Courts and legislatures seem to regard parental notification requirements as less burdensome for adolescents than parental consent requirements, but it is not clear that adolescents in conflict with their parents make this distinction.

Parental Notification Requirements for Specific Types of Health Services

Many parental notification provisions appear in State statutes that create exceptions to parental consent requirements by allowing minors to consent to health services related to sexual activities, health services for drug and alcohol abuse, or mental health services (see discussion of these exceptions above). Although the legislatures and courts appear to regard the requirement of parental consent as more onerous from the standpoint of an adolescent than the requirement of parental notification, *it is not clear that adolescents distinguish between parental consent and notification requirements.* According to one observer, it is "immaterial to the adolescent just when parents learn (before or after the fact of treatment) or how parents learn (by mandatory consent, by notification, or by inadvertent disclosure through parental reading of the health record)" (43).

[24]See, for example, *H.L.* v. *Matheson*, 450 U.S. 398 (Burger, J.) (Powell, J. concurring); *H.L.* v. *Matheson* 420-25 (Stevens, J. concurring); and B.D. Hofman, "The Spousal Rule: Statutory Resolution and Constitutional Implications—Burdening the Minor's Right of Privacy" (44).

[25]See, for example, M. Boumil, "Dispensing Birth Control in Public Schools: Do Parents Have a Right To Know?" (23).

Notification Requirements for Health Services Related to Sexual Activities—Parental notification requirements related to health services involving sexual activities pertain to the three major categories of services mentioned earlier: 1) health services related to venereal, sexually transmitted, and infectious diseases and acquired immunodeficiency syndrome (AIDS); 2) family planning services and abortion services; and 3) pregnancy-related health services.

Notification Requirements for Health Services for Venereal, Sexually Transmitted, and Infectious Diseases and AIDS—The many State statutes that authorize minors to obtain testing and treatment for venereal, sexually transmitted, or infectious diseases without parental consent generally *do not* require parental notification. A few States have statutes that specifically state that services for these diseases may be furnished to minors without parental notification; nearly one-third of the States have statutes that give health professionals general discretion to notify parents or discretion to notify parents under certain specified circumstances; nearly two-thirds of the States have statutes that contain no parental notification provisions; and one State has a statute that mandates parental notification under limited conditions.

The relatively small number of State statutes that permit minors to be tested and treated without parental consent for infection with HIV (the virus that causes AIDS) generally do not require parental notification. A few States have statutes with provisions giving health professionals general discretion to notify or discretion to notify parents under specified circumstances; one State has a statute that contains no parental notification provision; and one State has a statute requiring confidentiality unless a minor's HIV test results are positive, in which case parental notification is required.

Notification Requirements for Family Planning Services and Abortion Services—Only a few of the State statutes that permit minors to consent to *family planning services* without parental consent have provisions pertaining to parental notification of the minor's application for receipt of such services, and nearly all of these provisions allow but do not compel parental notification. As of mid-1990, the U.S. Supreme Court had not directly addressed the constitutionality of parental notification requirements that involve parents in a minor's decision about obtaining family planning services.

In 1983, the U.S. Department of Health and Human Services unsuccessfully attempted to promulgate Federal regulations *requiring* that family planning clinics receiving Federal funds under Title X of the Public Health Service Act[26] notify parents of unemancipated minor children when contraceptives were prescribed.[27] These regulations—issued pursuant to a congressional amendment to the authorizing statute for the Title X family planning program that provided that "[t]o the extent practical, entities which receive grants or contracts under this subsection shall encourage family participation in projects assisted under this section" [42 U.S.C. § 300(a) (1982)]—aroused a great deal of controversy and were the subject of litigation in the Federal courts. Ultimately, two Federal courts enjoined the Department from implementing the regulations.[28]

Although the issue of parental notification has also generated a great deal of attention in relation to minors' access to *abortions*, the U.S. Supreme Court has not dealt extensively with parental notification in cases involving abortion services for minors. In the 1981 case *H.L.* v. *Matheson* [450 U.S. 398 (1981)], however, the Supreme Court sustained the constitutionality of a State statute requiring a physician to notify "if possible" the parent of a minor upon whom an abortion is to be performed as applied to a minor living with and dependent on her parents; the Court left open the question of whether the statute would be constitutional as applied to emancipated or mature minors.

In *Hodgson* v. *Minnesota* [110 S.Ct. 2926 (1990)], handed down in June 1990, the Supreme Court

[26]For further discussion of the Title X family planning program, see ch. 10, "Pregnancy and Parenting: Prevention and Services," in Vol. II ch. 19, "The Role of Federal Agencies in Adolescent Health," in this volume.

[27]The regulation provided that 10 days after prescribing a contraceptive drug or device for a minor, the family planning clinic must notify the r's parent [45 CFR § 59.5(a)(12)(i)(A)].

[28]The Court of Appeals for the Second Circuit held that the 1981 amendment to Title X did not authorize the regulation mandating parental notification [*New York* v. *Heckler*, 719 F.2d 1191 (2d Cir. 1983)]. The Court found that Congress did not intend to require parental notification but r to encourage parental involvement. The Court of Appeals for the District of Columbia held that the regulation requiring parental notification was inconsistent with congressional intent with respect to Title X [*Planned Parenthood Federation of America* v. *Heckler*, 712 F.2d 650 (D.C. Cir. 1983)].

struck down as unconstitutional a section of a Minnesota statute requiring that both parents of an unemancipated minor be notified before she undergoes an abortion, except under very limited circumstances. However, the Court upheld the constitutionality of a section of the statute providing for the same two-parent notification requirement with the addition of a "judicial bypass" procedure. In a contemporaneous decision, *Ohio* v. *Akron Center for Reproductive Health* [110 S.Ct. 2972 (1990)], the Court upheld the constitutionality of an Ohio statute making it a crime for a physician or other person to perform an abortion on an unmarried, unemancipated minor unless: 1) there was timely notice to one of the minor's parents, her guardian, or custodian; 2) the minor's parents, guardian, or custodian had consented to the abortion; 3) a juvenile court had issued an order authorizing the minor to consent to the abortion, thereby bypassing parental notification for consent; or 4) judicial inaction under certain circumstances constitutes constructive authorization for the minor to consent.

A little under one-quarter of the States have statutes requiring parental notification of a minor's abortion decision. In the wake of the *Webster* ruling, there has been increased debate as to whether parental notification of abortions involving minors should be required,[29] and the Supreme Court's decisions as to the constitutionality of the two State statutes just mentioned may furnish an impetus for additional State legislative activity aimed at requiring parental notification in the case of a minor's decision to have an abortion.

Notification Requirements for Pregnancy-Related Health Services—The many State statutes that authorize minors to obtain pregnancy-related health services without parental consent generally *do not* require parental notification. One State has a statute that explicitly provides that prenatal care may be furnished without parental notification; somewhat under one-third of the States have statutes that have no provisions regarding parental notification; and about one-fourth of the States have statutes that provide for parental notification at the discretion of health professionals.

Notification Requirements for Health Services Related to Drug and/or Alcohol Abuse—The many State statutes that allow minors to obtain health services for drug and/or alcohol abuse without parental consent exhibit considerable variation when it comes to parental notification provisions—and this variation makes generalizations difficult. Some of these State statutes are silent as to parental notification; some of the statutes require that a minor's drug or alcohol abuse treatment be kept confidential under specified circumstances; some of the statutes leave parental notification up to the discretion of the health professional or to the discretion of the health professional under certain specified circumstances; a few State statutes require parental notification attempts; and a few of the statutes require parental notification or require parental notification under certain specified circumstances.

In 1987, the U.S. Department of Health and Human Services issued a final rule for federally funded alcohol and drug abuse programs that *prohibits* such programs from notifying a minor's parent of the minor's application for treatment without the minor's written consent to notification in States where State law permits minors to obtain alcohol or drug abuse treatment without parental consent [42 CFR, Part 2 § 2.14 (1989)]. This prohibition covers, among other things, the disclosure to a minor's parent of patient identifying information for the purpose of obtaining financial reimbursement; however, "these regulations do not prohibit a program from refusing to provide alcohol or drug abuse treatment until a minor consents to the disclosure necessary to obtain reimbursement. . ." [42 CFR, Part 2 § 2.14 (1989)]. In States where State law requires parental consent to alcohol or drug abuse treatment, the rule states that the fact of a minor's application for treatment may be communicated to the minor's parent only if: a) the minor has given written consent; or b) the minor "lacks the capacity for rational choice" regarding such consent (e.g., because of extreme youth or physical condition) and the minor's "situation poses a substantial threat to the physical well-being of the minor or other person" that may be alleviated by parental notification [42 CFR, Part 2 § 2.14 (1989)].

Notification Requirements for Mental Health Services—The many State statutes under which minors can consent to mental health services or

[29]See C. Collins, "Abortion Focus Shifting to Teenagers" (30); New York Times, "Kansas Is Urged To Curb Abortion" (70); New York Times, "Virginia Senators Stall Bill To Curb Abortion" (71).

Photo credit: Joe M. Sanders, American Academy of Pediatrics

Laws requiring parental consent and notification in the provision of health services to adolescents do not affect adolescents' access to services unless there are conflicts or potential conflicts between adolescents, their parents, and health care professionals.

receive mental health services without parental consent vary in terms of parental notification requirements. The majority of State statutes that allow minors to consent to *outpatient* mental health services are silent as to parental notification, and the remainder of statutes specify that mental health treatment should be confidential, specify that notification is at the discretion of health professionals, or mandate parental notification under designated limited conditions. The majority of State statutes that allow minors to consent to *inpatient* mental health services similarly do not have parental notification provisions, and the remainder provide for parental notification at the discretion of health professionals, or provide for notification under certain circumstances. Perhaps not surprisingly, inpatient mental health statutes are more likely than outpatient statutes to require or permit parental notification.

The Impact of Law Requiring Parental Consent and Notification on Minors' Access to Health Services

What is the impact of law requiring parental consent to health services for minors or requiring parental notification of the provision (or intended provision) of health services to minors? More specifically, what is the impact of parental consent and notification requirements on minors' access to health services and on minors' utilization of health services?

Several factors affect the impact of legally mandated parental consent and notification requirements on minors' access to and utilization of health services. One factor is *whether—and if so, to what degree—there are actual or potential conflicts between minors, the parents of minors, and health professionals in the making of health care decisions involving the minor.* As noted earlier, laws requiring parental consent and notification do not become critical, or even relevant, unless there are such conflicts. In some cases, the way a health professional presents information to a minor and the minor's parents and what kind of relationship he or she has with them may have a decisive influence on the nature and extent of such conflict. If a health professional has knowledge, skills, and experience regarding the management of potential conflicts, some conflicts may well be avoided (43,77).

On the other hand, some conflicts between minors, their parents, and health professionals over health care decisions affecting the minor are probably unavoidable. There is some evidence that actual or potential conflicts do occur in a significant number of cases involving decisions about the provision of family planning and abortion services to adolescent minors.[30] What is not known, however, is whether—and if so, to what degree—actual or potential conflicts occur in cases involving decisions about *other* health services that minors, particularly adolescent minors, may want or need.

Another factor that affects the impact of legally mandated parental consent or notification requirements for the delivery of health services to minors is whether—and if so, to what degree—health care providers comply with these requirements in providing health services to minors. Laws might be expected to evoke compliance, carrying with them as they do sanctions for violations and constituting as they do a societal declaration that certain conduct is right or wrong. Clearly, however, laws differ in their effectiveness. Noncompliance with parental consent or notification laws on the part of health professionals might occur because the professionals misunderstand or do not know the legal requirements. Noncompliance might also occur because the legal requirements, at least as applied to particular factual situations, are at odds with the ethical

[30]See, for example, Brief for Petitioners at 16-23 *Hodgson* v. *Minnesota* [853 F.2d 1452 (8th Cir. 1988) (en banc), appeal filed (U.S. Feb. 3, 1 (No. 88-11257), 110 S.Ct. 400 (1989)].

standards as expressed in statements by professional organizations of their profession (see box 17-A) or with their personal ethical values and norms. OTA is unaware of any empirical studies and data concerning compliance and noncompliance with legally mandated parental consent or notification requirements that would permit valid conclusions about the extent of compliance and noncompliance among health service providers.

To the extent that legally mandated parental consent and notification requirements are adhered to by health professionals, the issue arises of whether—and if so, to what degree—such requirements may operate as barriers to adolescents' access to needed health services. As noted earlier, it is not clear that adolescents distinguish between parental consent and notification requirements. With parental consent and notification requirements in place, one possible scenario is that a substantial number of parents of adolescents would frequently and strongly object to the provision to their children of at least some health services—for example, family planning or other services associated with sexual activity, services for substance abuse, and services for mental health problems. A possibly related scenario is that a large number of adolescent minors would be unwilling to reveal to their parents their need for health services—or at least their need for certain services associated with sexual activity, drug or alcohol abuse, or mental health problems—and therefore would delay or be deterred from seeking these services entirely.

Several empirical studies concerning the impact of parental consent and notification requirements indicate that such requirements—at least in the case of family planning and abortion services—do create barriers to adolescents' access to and utilization of services (21,22,25,26,28,78,79,87,88). What cannot be said with certainty, however, is whether the findings of these studies of the impact of parental consent and notification requirements on adolescents' access to family planning and abortion services can be extrapolated to other types of health services.

One other point related to evaluating the impact of parental consent and notification requirements is deserving of mention. Even if the laws in a given jurisdiction do not *require* that a parent consent to health services for a minor and/or that the parent be notified of the provision or intended provision of

Photo credit: March of Dimes Birth Defects Foundation

In the case of family planning and abortion services, studies have found that parental consent and notification requirements pose a significant barrier to adolescents' access to and utilization of services. Quite probably, such requirements also pose similar barriers to adolescents' access to other types of services (e.g., mental health treatment, drug abuse treatment, alcohol abuse treatment).

health services to a minor, *health care providers*—both institutional providers (e.g., hospitals, clinics, and health maintenance organizations) and individual providers—*may as a matter of policy or practice refuse to provide services to minors* without parental consent and/or notification. One of the main reasons that health care providers may refuse to provide services without parental consent is probably financial—i.e., *providers may be concerned that a minor will be unable to pay for services provided and that the minor's parents will not pay for services because they have not consented to or been notified of the*

Box 17-A—Professional Ethical Standards Relevant to Consent and Confidentiality

A central principle of medical ethics is that "a physician may not reveal the confidences entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community" (9). Many organizations of physicians, nurses, psychologists, social workers, and other professionals engaged in providing health services to adolescents have issued or approved professional ethical standards that similarly stress the importance of maintaining confidentiality between the health professional and the patient or client being served but at the same time acknowledge that legal obligations and the welfare of the individual and the community may take precedence over confidentiality (2-4,6,7,9-16,65-67).

Few of the ethical standards issued or approved by organizations of health professionals speak directly to issues of consent and confidentiality as they arise in the provision of health care to *adolescents*. A conference sponsored by the American Academy of Pediatrics in 1981 sought to address that problem. Conference participants from a variety of disciplines agreed that the following principles should govern consent and confidentiality in adolescent health care:

- With respect to adolescence, there exists an enduring need to balance delicately the relative rights and needs of minors to confidential health services with the relative rights and responsibilities of parents toward their offspring.
- Adolescents should have access to needed health services.
- Adolescents, unless fairly adjudged incompetent, should participate in decisions pertaining to their health.
- The concept of "mature minor" and the capacity of that individual to consent is recognized.
- Even when adolescents seek health care on their own consent, they should be encouraged to involve their parents, unless there is compelling reason not to do so. (In that case, often an alternative adult adviser/relative is appropriate.)
- Chronologic age is not a suitable yardstick to determine an adolescent's maturity and capacity to give informed consent. Development criteria are far more telling, as applied on an individual basis.
- Adolescents generally should be entitled to confidentiality in their own health care, and that presumption should be overridden only by good reason.
- Parental notification should be encouraged but not be made mandatory in the provision of adolescent health care, especially inasmuch as the absence of guaranteed confidentiality could deter many young persons from seeking and receiving necessary services.
- Adolescents should have the same right of access to their health care records as do adults unless there is compelling reason to the contrary.
- Disclosure of health data to third parties, such as health insurers, should only be with parents' informed consent and/or that of adolescents if it pertains to care they have received on their own. As a general rule, adolescents should retain the right to consent to such disclosure with or without parental participation, even if the adolescent did not originally consent to the health care, unless there is a compelling reason not to.
- Health providers and third-party repositories periodically should review data collected during an individual's minority to reassess its relevance, expunging data no longer needed.
- To protect adolescents, they should be provided with some record as to where their health information was sent, when it was sent, and for what purpose (5).

In 1989, the American College of Obstetricians and Gynecologists (ACOG) issued a policy statement setting forth the most extensive ethical standards pertaining to consent and confidentiality in adolescent health care to date. The statement, which has since been approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the NAACOG (the Organization for Obstetric, Gynecologic, and Neonatal Nurses), and the National Medical Association, provides as follows:

1. Health professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients.
2. This obligation includes every reasonable effort to encourage the adolescent to involve parents, who support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis.
3. Parents are frequently in a patient relationship with the same providers as their children or have been exercising decisionmaking responsibility for their children with these providers. At the time providers

establish an independent relationship with adolescents as patients, the providers should make this new relationship clear to parents and adolescents with regard to the following elements:

a. The adolescent will have an opportunity for examination and counseling apart from parents, and the same confidentiality will be preserved between the adolescent patient and the provider as between the parent/adult and the provider.
b. The adolescent must understand under what circumstances (e.g., life-threatening emergency) the provider will abrogate this confidentiality.
c. Parents should be encouraged to work out means to facilitate communication regarding appointments, payment, or other matters consistent with the understanding reached about confidentiality and parental support in this transitional period when the adolescent is moving toward self-responsibility for health care.

4. Providers, parents, and adolescents need to be aware of the nature and effect of laws and regulations in their jurisdictions that introduce further constraints on these relationships. Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care (7).

The ACOG policy statement and American Academy of Pediatrics conference principles encourage parental involvement in adolescent health care decisions but do not endorse the current legal requirements of parental consent and notification. The support of health professionals serving adolescents for that statement and principles indicates that many of these professionals are—at least in theory—more willing than most courts or legislatures have been to grant adolescents autonomy in health care decisionmaking and to afford protection to the confidentiality of the relationship between a provider of health services and an adolescent patient or client. Furthermore, at least one empirical study suggests that health professionals are willing to support these ideas in practice (60).

A question that remains is how helpful existing standards in the form of statements by professional organizations are in resolving the kinds of ethical problems that professionals encounter in providing health services to adolescents. The following situations, compiled by a national authority on adolescent medicine, are illustrative of potential conflicts between interests of the adolescent, the adolescent's parents, and the state (77):

- A 16-year-old boy is discovered to have a malignant bone tumor. Appropriate treatment requires amputation of his leg. His parents consent to the surgery but he refuses. He will accept all other forms of treatment but would "rather die with both legs than survive as a cripple!" Do you operate without the consent of the boy? Do you seek a court order against the wishes of the boy?
- A 17-year-old boy is admitted to the intensive care unit with multiple fractures and disorientation. He was the driver of an automobile involved in a collision in which three passengers were killed. As part of the evaluation of his state of consciousness you determine that his blood alcohol level is well above the legal limits for intoxication. Do you share this information with his family in explanation for his confusion? Do you share this information with the authorities who are investigating this fatal accident?
- A 16-year-old girl is brought to care by her mother who is concerned about her daughter's poor school performance and disruptive behavior. In your private interview with the girl, she confides that she is smoking marijuana a few nights each week. The girl feels that her current problems relate to the unrealistic expectations of her mother regarding performance and behavior. She insists that the confidentiality of her interview be respected and that the information about her drug use not be shared with her mother. Do you tell the mother anyway? What if the mother specifically asks, "Is my daughter using drugs?" The mother requests that a portion of the urine sample collected for routine analysis be sent for drug testing. Do you accede to this request?
- A 15-year-old girl returns with her parents to discuss her recently diagnosed pregnancy. Her parents are certain that the only acceptable course of action is to terminate the pregnancy. The girl is adamant in her refusal to consider an abortion. What do you do?
- A 16-year-old girl is brought for evaluation by her mother because of a complaint of abdominal pain. Physical examination and laboratory evaluation reveal a vaginal discharge secondary to gonorrhea. The girl admits to multiple brief intimate relationships over the past few months. She states that her mother would "kill her" if she found out. You know the family and the mother is a bit of a tyrant with a quick temper. What do you tell the mother?

Continued on next page

Box 17-A—Professional Ethical Standards Relevant to Consent and Confidentiality—Continued

- An 18-year-old homosexual male comes in and requests testing for AIDS. His affect is depressed and upon questioning he admits to frequent suicidal ideation and one prior attempt. He is certain "he would kill himself" if he finds out he has AIDS, but must know the results of his testing because not knowing is "driving him crazy." Do you do HIV testing?
- You are caring for a 17-year-old intravenous drug abuser whom you know to be HIV positive. For the very first time he appears to be sincerely motivated to enter into a drug abuse treatment program. He asks that you complete the required preadmission history and examination form but insists that you make no mention of his HIV status. Do you fill out and sign the form omitting reference to his HIV status?
- A recently married 18-year-old with a past history of homosexual activity is found to be HIV positive. He refuses to inform his bride. He is certain she would leave him. Do you tell her?
- You are caring for a 17-year-old who has AIDS secondary to a transfusion. His 16-year-old girl friend is aware of the diagnosis, but they continue to have unprotected intercourse. She "doesn't care"; she "loves him." Do you inform her parents?

Unfortunately, existing ethical standards by professional organizations would appear to give little concrete guidance and direction to adolescent health service providers in resolving many of these problems. Perhaps the limitation of professional standards in giving guidance in actual situations is inevitable given the sui generis nature of most ethical problems. It is very troublesome, however, given the complex dilemmas that the service providers often encounter in serving adolescents.

provision of services.[31] Another reason may be providers' concern that the effectiveness of the services provided will be reduced by lack of parental involvement or belief that the effectiveness of the services provided will be enhanced by parental involvement.

Minors' Competency To Make Health Care Decisions

As noted at the beginning of this chapter, individuals traditionally have been treated as legally competent or incompetent for purposes of health care decisionmaking on the basis of their age rather than a determination of their actual capacity for decisionmaking. As a general rule, the law presumes that adults are competent to consent to health care and that minors are incompetent. The legal presumption that minors as a class are incompetent to consent to health services rests at least in part on the assumption that minors as a class lack the requisite decisionmaking capacity. The legal presumption that adults are competent is rebuttable under some circumstances upon a factual showing of actual lack of decisionmaking capacity; however, the legal presumption that minors are incompetent is not rebuttable by a factual showing of actual presence of decisionmaking capacity in the absence of legislatively or judicially sanctioned rules permitting such a showing.

The factual validity of assumptions that minors lack the requisite capacity to make health care decisions has been increasingly challenged.[32] Accordingly, the presumption that minors are incompetent to make health care decisions has been increasingly subject to criticism on the ground that it inequitably denies minors in middle or late adolescence—some of whom actually have the requisite decisionmaking capacity—the power to make their own determinations about obtaining health services (82). Since assumptions concerning minors' lack of health care decisionmaking capacity seem largely to reflect the intuition of judges and legislators rather than hard evidence, it is important to identify empirical research bearing upon the validity of these assumptions and to evaluate whether such research supports modification or elimination of the pre-

[31]If a parent has consented to health services for his or her minor child, the parent is usually financially liable for the services. If a parent has not consented to health services for the minor child, however, the parent is usually not financially liable unless the services are determined to be "necessary." If the parent is not financially liable, the health care provider may attempt to collect from the minor child, but collection may prove difficult because the minor may have the power to disaffirm the contract for services or may have insufficient financial resources to pay for the services. As noted at the beginning of this chapter, one of the rationales for the parental consent requirement seems to be to assure providers of the availability of a payment source for their services.

[32]See, for example, G. Melton, "Children's Consent: A Problem in Law and Social Science" (61).

sumption that minors are incompetent to make their own health care decisions.

Empirical research bearing on the competency of minors to make health care decisions was reviewed by OTA's contractors and is discussed below. Before turning to that research, however, it is necessary to examine two definitional issues: first, what constitutes *effective legal consent* to health services; and second, what constitutes *legal competency* to make such consent.

Ambiguities in Legal Definitions of Consent and Competency

What Constitutes Effective Legal Consent to Health Services

As alluded to at the beginning of this chapter, the tort law doctrine of informed consent requires physicians and surgeons to obtain from their patients informed consent for medical treatment or surgery; failure to obtain informed consent may give rise to civil liability.[33]

The informed consent doctrine has been developed in judicial opinions and codified by legislation and does not readily lend itself to a concise summary. Nevertheless, one leading tort law authority has summarized the doctrine as follows:

> The informed consent doctrine is based on principles of individual autonomy, and specifically on the premise that every person has the right to determine what shall be done to his own body. Surgeons and other doctors are thus required to provide their patients with sufficient information to permit the patient himself to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgical procedure. Such a disclosure should include the nature of the pertinent ailment or condition, the risks of the proposed treatment or procedure, and the risks of any alternative methods of treatment, including the risks of failing to undergo any treatment at all. Thus, although the procedure is skillfully performed, the doctor may nevertheless be liable for an adverse consequence about which the patient was not adequately informed.
>
> In addressing the perplexing question of whether the patient needed to know about a particular undisclosed risk in order to make an informed decision, the courts often speak in terms of the materiality of the risk: the doctor's duty is to disclose all risks which are "material." The extent of this duty to disclose has traditionally been based upon a professional medical standard—whether physicians customarily inform their patients about the type of risk involved, or whether a reasonable physician would make the disclosure in the circumstance. Since the use of a professional standard paternalistically leaves the right of choice to the medical community, in derogation of the patient's right of self-determination, a number of recent cases have defined the duty in terms of the patient's need to know the information—based on whether a reasonable person in the patient's position would attach significance to the information.
>
> In addition to proving the doctor's failure to provide sufficient information, on whatever standard, the plaintiff must also establish a causal link between the nondisclosure and his harm, by proving that he would not have undergone the treatment had he known of the risk of harm that in fact occurred. . . . [Citations omitted] (53).[34]

Rationales for the informed consent doctrine are to promote the patient's autonomy and protect the patient's right of self-determination (64), to protect patients against depersonalized authoritarian medical treatments, and to encourage rational decisionmaking (59). It is important to note that focus of the doctrine as it has been articulated and applied is on the *duty of health professionals to disclose information* to an individual. The focus has not been on the individual's actual understanding of the information disclosed.

What Constitutes Legal Competency To Make Health Care Decisions

The legal concept of competency has a very long history and is central to existing laws governing health care decisionmaking with respect to adolescents. On the one hand, as noted earlier, the well-established legal requirement that parents must *consent* to the provision of health services for their minor children is partially an outgrowth of the presumption that minors are incompetent (which in turn is based on assumptions of their lack of decisionmaking capacity). To some extent, judicial

[33]To be legally effective, consent to health care services must be both "informed" and also be "voluntary." The concept of voluntariness is not well defined (17).

[34]For discussion of the development of the informed consent doctrine, see P.S. Appelbaum, C.W. Lidz, and A. Meisel, *Informed Consent: Legal Theory and Clinical Practice* (17); for a State-by-State analysis of the application of the informed consent doctrine, see A.J. Rosoff, *Informed Consent: A Guide for Health Care Providers* (73).

and statutory parental *notification* requirements applied to minors are also derived from this presumption and assumption. On the other hand, "mature minor" and some other exceptions to the parental consent requirement, as discussed earlier in this chapter, represent a rejection of the presumption of minors' incompetence (and underlying assumptions of their lack of decisionmaking capacity) as applied to some minors under certain circumstances.

Unfortunately, neither the courts nor the legislatures in this country have furnished much guidance as to the content and meaning of competency in the context of health care decisionmaking. The U.S. Supreme Court has most fully articulated its assumptions concerning the minors' lack of health care decisionmaking capacity (which underlie the presumption of minors' incompetency to make health care decisions) in decisions dealing with minors' rights to obtain contraceptives and abortions without parental involvement and in decisions dealing with the civil commitment of minors by parents (see discussion above). A thread that runs through these Supreme Court decisions is the Court's concern that minor children do not possess the intelligence, maturity, and experience that their parents possess. Another thread that runs through these decisions is the Court's concern that minors are not capable of making informed and voluntary decisions. The Court's specific concerns in this regard are that minors may not understand or appreciate the short-or long-term consequences of their decisions, that they may be susceptible to interpersonal pressures in making decisions, and that they may make unwise decisions detrimental to their welfare.

Courts—and, to a lesser extent, legislatures—have probably come closest to enunciating a *standard* for determining the competency of minors to make health care decisions in connection with exceptions to parental consent requirements for "mature" minors (see discussion above). The standard for judging competency in these cases is essentially whether the minor is capable of understanding the nature and consequences of proposed medical or surgical treatment and procedures. Unfortunately, however, this standard for determining a minor's competency provides little real assistance for its application in particular cases.[35]

Recognizing the need to define with more specificity a criterion for determining whether a person, including an older minor, is competent to make health care decisions, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research noted t three general criteria have been used to determine if a patient lacks capacity to make health care decisions: the outcome of the decision, the status or category of the patient, and the patient's functional ability as a decisionmaker.

> The outcome approach—which the Commission expressly rejects—bases a determination of incapacity primarily on the content of a patient's decision. Under this standard, a patient who makes a health care decision that reflects values not widely held or that rejects conventional wisdom about proper health care is found to be incapacitated.
>
> Using the status approach, certain categories of patients have traditionally been deemed incapable of making treatment decisions without regard to their actual capabilities. Some of these categories of patients—such as the unconscious—correspond closely with actual incapacity. But other patients who are presumed to be incapacitated on the basis of their status may actually be capable of making particular health care decisions. Many older children, for example, can make at least some health decisions, mildly or moderately retarded individuals hold understandable preferences about health care, and the same may be true in varying degrees among psychotic persons.
>
> The third approach to the determination of incapacity focuses on an individual's actual functioning in decisionmaking situations rather than on the individual's status. This approach is particularly germane for children above a certain age variously described as from seven to mid-teens. . . . .
>
> The Commission recommends that determinations of incapacity be guided largely by the f c-tional approach, that individuals not in certain categories (such as under the age of 14, g y retarded, or comatose) should be assumed to p s decisionmaking capacity until they demonstrate otherwise, and that incapacity should be found to exist only when people lack the ability to decisions that promote their well-being in conform-

[35]See, for example, G.B. Melton, "Legal Regulation of Abortion, Unintended Effects" (62).

ity with their own previously expressed values and preferences. [Citations omitted] (72).[36]

The failure of courts and legislatures to furnish much guidance as to the content and meaning of competency in terms of health care decisionmaking has had important implications for the strategies adopted in empirical studies of the capacity of minors to make health care decisions. Because courts have not provided operational definitions of legal standards for minimally competent decisionmaking, researchers have been unable to use an operational definition of competency corresponding to the legal definition. Thus, researchers seeking to test the validity of the law's presumption that adults are competent and minors are incompetent to make health care decisions have had to resort to an alternative strategy—namely, comparing decisionmaking by minors to decisionmaking by adults (i.e., individuals age 18 and over). Since adults are presumed by the law to be competent, adults' decisionmaking capabilities implicitly set the standard against which the decisionmaking capabilities of minors are to be judged. If the decisionmaking of minors and adults were found to be indistinguishable, the argument for lowering the age of legally effective consent would be strengthened, although other considerations would have to be taken into account as well. Virtually all of the empirical research on the competency of minors to make health care decisions reviewed by OTA's contractors recognizes that the standard of comparison is the decisionmaking ability of adults.

Empirical Research on Minors' Competency To Make Health Care Decisions

To review the empirical research on the competency of minors to make health care decisions, OTA's contractors selected a core group of seven empirical studies that address the cognitive development of minors and tested whether minors differ from adults in their ability to make health care decisions (1,18,48,49,55,56,86). Those core studies, which are listed in table 17-1, share the following characteristics:

- they involve health care decisionmaking;
- they involve participants whose ages span or overlap the range of 10 to 18 years;
- they involve comparison groups with at least some subjects legally considered adults—i.e., age 18 or over[37] (although no adult participants in the core studies were older than 25 and most were 21 or younger); and
- they appear to be methodologically adequate.

In addition to the core group of studies, a few other studies that lack one or more of the features just mentioned but nevertheless provide insight into decisionmaking by minors were reviewed (40,51,57, 58,76). Some of these other studies address decisionmaking domains not addressed in the core group of studies (e.g., legal decisionmaking); and some of them deal with the effect on decisionmaking of a variable or variables other than age (e.g., the differential vulnerability of minors and adults to social influence of peers, family, or professionals).

Findings of the Core Group of Empirical Studies on the Age-Competence Relationship in Health Care Decisionmaking

The findings of the core group of seven empirical studies on the age-competence relationship in health care decisionmaking reviewed by OTA's contractors are summarized in table 17-1 and discussed in more detail below. ***These core studies generally found few differences in health care decisionmaking as a function of age for adolescents as young as 14 or 15 years of age.*** It is important to note that most of the core studies did not collect information on decisionmaking by adults older than 25, and most of the core studies did not collect information on decisionmaking by adolescents under age 13 (i.e., ages 10 to 12).

Lewis, 1980—The 1980 study by Lewis compared hypothetical pregnancy decisions for 42 unmarried minors (ages 13 to 17) and young adults (ages 18 to 25) awaiting the results of pregnancy tests in a clinic (55). Those who learned they were pregnant would be faced with the decision whether to have an abortion or deliver a child. All 42

[36]See also L.H. Roth, A. Meisel, and C.W. Lidz, "Tests of Competence To Consent to Treatment" (74). (The various legal, medical and psychiatric tests of competency being utilized may be categorized as: evidencing a choice, "reasonable" outcome of choice, choice based on "rational" reasons, the ability to understand, and actual understanding.)

[37]As noted previously, this OTA Report focuses on individuals ages 10 through 18. Legally, 18-year-olds are considered adults in all but three States (where the age of majority is 19). In the studies comparing decisionmaking capabilities of adults and minors listed in table 17-1, therefore, 18-year-olds are regarded as adults.

Table 17-1—Summary of Seven Core Empirical Studies of the Age-Competency Relationship in Health Care Decisionmaking

Study[a]	Sample	Decision domain	Influence of age on decisionmaking	
			No differences	Differences found
Lewis, 1980	N = 42 Ages 13-17 v. 18-25 Possibly pregnant, unmarried females; diverse socioeconomic statuses; urban California	Pregnancy: knowledge of law, source of advice, reasons for choice	In knowledge of laws; in number of types of people consulted; in advice expected; in consideration of childrearing ability; in hypothetical advice giving.	The 18- to 25-year-olds were more likely to consult a professional; consider their own ability to care for a child. The 13- to 17-year-olds were more likely to consider impact of a child on their parents; to consider bility of deformity; and to perceive decision as externally determined.
Lewis, 1981	N = 108 Ages 12-19 (grades 7-8, 10 and 12) Middle to upper socioeconomic status; 87% expected to attend college; San Francisco	Cosmetic surgery, choice of custodial parent, research: on acne medication, on "mind"	In consulting with peers or parents; in revising attitudes in light of new information.	With increasing age, t was increasing probability of mentioning risks, future consequences, and desirability of consulting an independent specialist, as well as caution against persons with vested interests.
Welthorn and Campbell, 1982	N = 96 Ages 9, 14, 18, 21 Half male, half female; white; middle socioeconomic status; younger groups, Long Island; older groups, Washington, DC	Choice of treatment alternatives for diabetes, epilepsy, enuresis, depression; risks, benefits, etc.	In expression of a decision preference or choice of treatments among 14-, 18-, 21-year-olds; in reasons for choice (except as noted); in factual understanding and appreciation of problems/consequences (except as noted).	The 9-year-olds differed from other groups on treatment choices for depression; they were more likely to choose inpatient treatment. In reasons for choices, 9 olds differed from other groups; 14-year-olds differed on epilepsy. In tual understanding of the condition and appreciation of the consequences, 9-year-olds differed from all others.
Belter and Grisso, 1984	N = 60 Ages 9, 15, 21 All males; predominantly white; middle-class; average to above average IQ	Recognizing and protecting against violations of patients' rights by a professional	In recognition or protection of patients' rights between 15- and 21-year-olds who were briefed about such rights.	The 9-year-olds showed less recognition of patients' rights violations and failed to protect their own rights more often than the other two groups.
Kaser-Boyd et al., 1985	N = 62 Ages 10-13 v. 14-20 Behaviorally disordered, emotionally disturbed, learning disabled; some with, without prior therapy experience; 70% middle socioeconomic status, 20% low-mid, 10% low; mostly white, 16 nonwhite; 67% male; probably LA.	Psychological treatment; risks, benefits	In identifying risks [Author's note: ns were too small in some instances to complete chi-sq]; in 8 benefit dimensions.	Nonsignificant trend for 10- to 13-year-olds to say did not know if risks existed. In benefits, 14- to 20-year-olds thought psychotherapy helped you learn new things. The 14- to 20-year-olds used more abstract concepts in describing benefits.

Table 17-1—Summary of Seven Core Empirical Studies of the Age-Competency Relationship In Health Care Decisionmaking—Continued

Study[a]	Sample	Decision domain	Influence of age on decisionmaking: No differences	Influence of age on decisionmaking: Differences found
Kaser-Boyd et al., 1986	N = 75 Ages 10-19 Adolescents with mild to severe learning and behavioral problems; mostly upper middle socioeconomic status, low to mid socioeconomic status; mostly white, 14 nonwhite; probably LA.	Psychological treatment; risks, benefits, and irrelevant considerations	In distinguishing risks, benefits, and irrelevant considerations; in treatment decision vignettes.	None
Ambuel, 1989	N = 75 Ages 13-21 All females; diverse racial, economic, and religious backgrounds	Broad range of knowledge, affect, decision conflict around unplanned pregnancy	In cognitive or volitional competence (except among females ages 13 to 15 who did not consider abortion an alternative).	Females ages 13 to 15 who did not consider abortion scored lower on the measure of volitional competence and most measures of cognitive competence.

[a]Full citations are listed at the end of this chapter.

SOURCE: Office of Technology Assessment, 1991, adapted from J. Gittler, M. Quigley-Rick, and M.J. Saks, "Adolescent Health Care Decisionmaking: The Law and Public Policy," prepared under contract to the Carnegie Council on Adolescent Development for the Office of Technology Assessment, U.S. Congress, Washington, DC, February 1990.

participants were asked to respond to a hypothetical question seeking advice for a person in that situation.

In terms of the decision as to whether to have a child, this study found that the minors and young adults did not differ from each other in terms of knowledge of relevant laws, number or types of people consulted, the advice anticipated from those consulted, or considerations of childrearing ability in giving advice to another person.

On the other hand, the young adults in the study were more likely than the minors to want to consult an independent professional and more likely to consider their own childrearing abilities in deciding whether or not to have a child themselves. The minors were more likely to consider the impact of their child on their own parents and gave more weight to the likelihood of possible deformity of their baby. Furthermore, the minors tended to perceive the decision as being more externally determined than as being within their own power to make. (This perception may simply reflect the minors' life experience in other domains.)

Lewis, 1981—The 1981 study by Lewis asked students ages 12 to 19 (grades 7-8, 10, and 12) what advice they would give peers who were faced with a variety of choices: cosmetic surgery, choice of custodial parent, a research trial involving acne medication, and research on "the mind" (56). This study found no age-related differences in advice the participants said they would give regarding consultation with peers or parents and found no age-related differences in participants' revisions of attitudes in the light of new information.

On the other hand, this study found that with increasing age from 12 to 19, there was an increasing tendency among participants to mention risks, future consequences, and the desirability of consulting an independent specialist (i.e., a specialist without vested interests in the choice made), and there was an increasing tendency to express caution about the advice of persons with vested interests in the choice made.

Weithorn and Campbell, 1982—The 1982 study by Weithorn and Campbell presented hypothetical treatment dilemmas involving four health problems (diabetes, epilepsy, enuresis, and depression) to participants ages 9, 14, 18, and 21 and asked participants what decisions they would make and the reasons for those decisions (86).

This study found that groups of participants ages 14, 18, and 21 did not differ in their decisions or reasons for decisions. Moreover, the decisions of these participants did not differ from those recommended by health professionals for the problems in question. Groups of participants ages 14, 18, and 21 also did not differ from each other on tests of factual

understanding of the health problems or appreciation of the consequences associated with various options.

The group of 9-year-olds, this study found, did differ in many ways from the older groups. The 9-year-olds were more likely than the older groups to select inpatient treatment for depression. Indeed, the study found an overall trend for younger participants to be accepting of inpatient treatment and older participants to reject it. The 9-year-olds also differed from the older groups in the reasons for their choices of treatment, in factual understanding of the conditions, and in appreciation of consequences.

Belter and Grisso, 1984—The 1984 study by Belter and Grisso studied the ability of 60 middle-class males ages 9, 15, and 21 to recognize a violation of their rights as patients in a simulated counseling session and to take steps to assert and protect their rights against violations by the professional (18). The research procedure involved half the participants at each age level receiving briefings on the rights of patients (e.g., the rights to refuse treatment, to know the reason for referral, to withhold information, to refuse to allow tape recording of the session, and the rights of confidentiality and access to records). In a subsequent session, participants observed a videotaped counseling session and were asked at various points whether or not a right was being violated and, if so, what they would do to protect the right.

The Belter and Grisso study found that 15-year-olds did not differ from 21-year-olds in their scores on the recognition or protection of rights or in the benefit they gained from the briefings about patients' rights. On the other hand, this study found that 9-year-olds showed significantly lower recognition of or asserted protection of rights than did the 15- or 21-year-olds, who did not differ from each other.

Kaser-Boyd et al., 1985—The 1985 study by Kaser-Boyd et al. compared behaviorally disordered, emotionally disturbed, and learning disabled individuals ages 10 to 13 to those ages 14 to 20 in their ability to assess risks and benefits of psychological treatment (48).

This study found that the 10- to 13-year-olds did not differ from the 14- to 20-year-olds in the identification of risks or evaluation of eight benefit dimensions. A serious problem noted by the authors, however, is that in some of these comparisons, the numbers were too small to permit a significance test to be performed. In terms of differences in decisionmaking as a function of age, this study found that participants ages 14 to 20 identified more potential benefits from psychotherapy and expressed the perceived benefits in more abstract terms than participants ages 10 to 13.

Kaser-Boyd et al., 1986—The 1986 study by Kaser-Boyd et al. asked 75 adolescents ages 10 to 19 with mild to severe learning and behavior problems to distinguish among risk and benefit factors, as well as irrelevant considerations, with respect to a hypothetical decision to accept or refuse psychotherapy (49). One might regard the decisionmaking ability of a group of adolescents with problems such as these as immediately suspect, but in fact a group such as this may be the right group of adolescents to be testing, because it is adolescents with problems such as theirs who might actually be asked to decide whether to accept psychotherapy. Although this study does provide comparisons in decisionmaking among younger and older study participants up to 19 years of age, it does not provide comparisons between subjects with and subjects without the problems mentioned.

In any event, this study found no differences in decisionmaking as a function of age. Participants ranging in age from 10 to 19 years of age showed no differences in distinguishing risks, benefits, and irrelevant considerations, or in the psychological treatment decisions they made.

Ambuel, 1989—The 1989 study by Ambuel collected and analyzed data from 75 socioeconomically diverse females ages 13 to 21 who suspected an unplanned pregnancy and were visiting a medical clinic for a pregnancy test (1). This study is noteworthy for combining a real-world setting in which research participants faced a potentially serious and stressful decision with extensive and careful measurement of attitudes, affect, and cognition.

The study found that—apart from females ages 13 to 15 who said they excluded abortion as an option—participants showed no age-related differences in three measures of cognitive competence (thoroughness of consideration of consequences, number of reasons considered, and quality of the

process and content of reasoning about pregnancy) or in a measure of "volitional competence."

Females ages 13 to 15 who did not consider abortion as an option (but no other groups of minors, categorized either by age or attitude toward abortion) had significantly lower scores than adults age 21 and under on every measure of competence except one measure of cognitive competence (the number of reasons considered). This difference suggests that females ages 13 to 15 who regard abortion as a possibility have cognitive and volitional competencies similar to or indistinguishable from those of young adult females, whereas females age 13 and above whose competencies are lower have ruled abortion out and are therefore not likely to seek an abortion anyway.

Findings of Other Studies on the Age-Competence Relationship in Health Care Decisionmaking

The finding of several studies that are not part of the core group discussed above provide some additional insight concerning age-related similarities and differences in health decisionmaking.

Lewis et al., 1977—A 1977 study by Lewis et al. systematically observed the behavior of elementary school children ages 5 to 12 in an innovative program in two Los Angeles schools (58). That program allowed children to decide when a health problem required the attention of the school nurse, to sign themselves out of class to see the nurse, and to choose among treatment options presented to them by the nurse. In short, the program allowed the children the same freedom as adults in making their own health care choices, and the children's choices had real consequences for treatment.

The authors of this study found that children in their school's self-activated health program made sensible (even in adult terms) use of their power to choose. It is interesting to note that the elementary school children in this study are below the age at which we would have any theoretical reason based on developmental psychology to expect equivalence between child and adult decisionmaking.

Lewis et al., 1978—A 1978 study by Lewis et al. invited 213 elementary school children ages 6 to 9, grouped in their classes, to become informed about swine flu vaccine trials and to decide whether or not to volunteer to participate (57). If a child did volunteer, the consent of the child's parents was sought, and if granted, the child did participate in the vaccine trial. Thus, the child's decision had potential real consequences.

This study found very few age-related differences in the ability of classes of children to elicit information about the flu and the vaccine and about potential risks and benefits of participation in a vaccine trial, although one class of 6-year-olds did not elicit all the relevant information it could have. It is important to note that this study really measured group ability—rather than individual ability—to elicit information critical to making the decision to participate in medical research. If, as seems likely, there is significant variation in decisionmaking capacity among individuals *within* age groups, then measuring group ability would tend to minimize differences *between* age groups. In other words, assuming that the percentage of individuals who could think of all the questions to ask increases with age, then any of these groups might *as groups* be able to ask all the right questions and appear equally capable, while in fact important developmental changes were occurring over time (as larger and larger percentages of children in older classes would individually be able to ask the appropriate questions). The basic question before us pertains to the competence of minors as individuals and the information-seeking of individuals that is more typical of the informed consent process in our institutions. Still, it is striking that even in a group of 6-year-olds, there are enough group members that in all but one class all the relevant information was elicited by the children.

Kazdin, 1986—A 1986 study by Kazdin had parents and their severely disturbed children rate the acceptability of different kinds and settings of mental health treatment (51).[38] This study found that parents rated both outpatient treatment and hospitalization as more acceptable than their children did. The parents rated hospitalization higher than outpatient treatment; the children rated them in the reverse order. Furthermore, the strength of treatment was positively correlated with acceptability for parents and negatively correlated for children. According to Kazdin, these differences may very well reflect differences in the meaning of the treatments for

[38]Special problems in the area of consent to mental health services were discussed earlier in this chapter. For a discussion of various mental health treatment settings available to adolescents, see ch. 11, "Mental Health Problems: Prevention and Services," in Vol. II.

parents (e.g., relief) and children (e.g., abandonment).

Grisso, 1981—An important note of caution is raised by a study that addresses not medical decisionmaking by minors but legal decisionmaking—Grisso's 1981 study of juveniles interrogated by police, with particular attention to the decisionmaking of these youths in asserting or waiving their legal rights (39). This study reminds us that minors making decisions in different contexts and different subsets of minors may show important differences in decisionmaking as compared with adults.

This study found that 42 percent of arrested adults chose not to answer police questions but that fewer than 10 percent of arrested juveniles asserted their right to remain silent—and virtually none of the arrested juveniles under age 15 refused to answer police questions.[39] As a group, juveniles under age 15 showed little comprehension of the *Miranda* warning[40]—so little comprehension in fact that their decisions to assert or waive those rights had little meaning. Furthermore, as many as half of the juveniles ages 15 to 16 who had IQs below 80 or who were black or in lower socioeconomic groups also showed little comprehension of their legal rights and the consequences of asserting or waiving their rights. This study found that white juveniles who had greater contact with juvenile courts and police evinced improved understanding of *Miranda* rights, but black juveniles who had such contact evinced poorer understanding. Greater contact with police and courts did, however, lead to greater understanding of the different roles of judges, lawyers, and police.[41]

Findings of Studies on How Variables Other Than Age Affect Adolescents' Health Care Decisionmaking

Variables other than age have important effects on decisionmaking, and several studies involving some of these other variables in the context of health decisionmaking by minors are described below. The studies reviewed here do not permit any definitive conclusions about how variables such as gender, socioeconomic status, race and ethnicity, intellectual skills, experience, condition severity, pressure from peers or family, or skill training affect decisionmaking by minors. They do, however, point to areas in which the gathering of additional data about minors' decisionmaking capacity would probably be useful.

Gender—Only one core study reviewed by OTA's contractors specifically examined effects of gender on decisionmaking. That study, the 1982 study by Weithorn and Campbell, used equal numbers of male and female participants and found no gender differences in decisionmaking in hypothetical tr ment situations (86). Two other studies that examined the effect of gender and were reviewed by OTA's contractors were the 1977 and 1978 studies by Lewis et al. The 1977 study by Lewis et al. reported that the patterns of utilization of health services by elementary school boys and girls (ages 5 to 12) participating in their school's self-activated health program paralleled the utilization patterns of adults—i.e., girls made more use of the services t boys (58). The 1978 study by Lewis et al. reported that elementary school boys and girls ages 6 to 9 did not differ in the questions they asked after being invited to volunteer for swine flu trials, but reported both that boys volunteered less often than girls and that girls more often than boys found themselves unable to make a choice about volunteering.

Socioeconomic Status—None of the core studies reviewed by OTA's contractors examined the effect of socioeconomic status on decisionmaking, but decisionmaking by minors from different socioeconomic groups was compared in one of the other studies they reviewed. That study, the 1977 Lewis et al. study, found that the poorer elementary school children (ages 5 to 12) in their school's self-activated health program made more visits to the school health service than the more affluent children (58). Furthermore, the poorer children saw their health as more in the control of physicians, while the more affluent children saw their health as being more influenced by forces that they themselves could control. None of the other studies OTA's contractors reviewed had enough minors from lower socioeconomic strata to allow conclusions about

[39]The U.S. Supreme Court has found juveniles to be competent to make their own decisions in this context and has held such waiver of constitutional rights by minors to be valid [*Fare* v. *Michael C.*, 442 U.S. 707 (1979)].

[40]The *Miranda* warning is the standard warning given to apprise criminal suspects of their constitutional rights in regard to custodial interrogation by police—they have the right not to answer any questions and the right to the advice and assistance of an attorney.

[41]For a discussion of adolescents in the juvenile justice system, see ch. 13, "Delinquency: Prevention and Services," in Vol. II.

possible differences in decisionmaking related to socioeconomic status.[42]

Race and Ethnicity—Only one of the core studies OTA's contractors reviewed reported on the effect of race or ethnicity on decisionmaking by adolescents. That study, the 1986 Kaser-Boyd et al. study among adolescents with mild to severe learning and behavior problems, reported that white, non-Hispanic adolescents obtained higher scores on the psychological treatment decision vignettes than other participants; but only 14 of the 75 subjects in this study were black or Hispanic (49). The 1977 Lewis et al. study reported that as white elementary school children gained experience in their self-activated health program, they increasingly saw themselves as the decisionmakers, but that the same shift did not occur for the black or Hispanic children (58).

Intellectual Skills—Only one of the core studies OTA's contractors reviewed, the 1986 study by Kaser-Boyd et al., compared participants with different intelligence or a comparable measure of intellectual ability (49). This study found, unsurprisingly, that participants with poor reading comprehension scored less well on the decision tasks. A point made earlier in this discussion was that there seems to be considerable variation in decisionmaking ability of individuals *within* particular age groups. This within-group variation could be due to a variable that is more important to the quality of decisionmaking than age. Intelligence or reading comprehension may very well be that variable, but few data on this topic have been collected.

Experience—Only two of the core studies OTA's contractors reviewed examined the effect of experience on decisionmaking. The 1986 study by Kaser-Boyd et al. found surprisingly that participants with learning and behavioral problems who had had experience with psychotherapy obtained lower scores on the psychological treatment decision vignettes than participants without such experience (49). The researchers advanced several hypotheses to account for this finding. The 1985 study by Kaser-Boyd et al. found that participants with learning, behavioral, and emotional problems who had experience with psychotherapy were more likely than participants who had no experience to assert that psychotherapy had low risks and that participants who were currently referred to therapy saw somewhat more benefits to psychotherapy than participants who were not referred (48).

No other studies of which OTA is aware make comparisons among experienced and inexperienced decisionmakers. One would expect decisionmakers experienced with the decision domain to show some differences from those who are new to the decision domain. Presumably, one advantage that older—especially considerably older—decisionmakers have is experience with the decision task, and presumably some decisions benefit more from such experience than others. More research on this topic would probably be useful.

Condition Severity—Only one of the core studies OTA's contractors reviewed examined the effect of condition severity on competence to decide. This study, the 1986 study by Kaser-Boyd et al., found that participants not currently referred for psychological treatment and participants with moderate behavior problems scored higher on the psychological treatment decision vignettes than participants currently referred for psychological treatment and participants with severe behavior problems, respectively (49).

Two of the other core studies provide a partial answer to the question of whether the severity of a condition that does not impair a decisionmaker's intellectual functioning affects decisionmaking, the 1982 study by Weithorn and Campbell (86) and the 1981 study by Lewis (56). These two studies, which presented to participants several different treatment dilemmas varying in seriousness, reported no systematic differences in decisionmaking as a function of the seriousness of the condition.

Social Influence From Peers, Parents, or Professionals—One issue that often is raised, but seldom studied with care, is the ability of minors to make independent decisions not unduly influenced by peers, parents, or professionals. As far as one can tell, the issue of minors' ability to make decisions without undue influence from peers, parents, or professionals has not even benefited from a thoughtful conceptual analysis of the questions that need to be asked. When is a rejection of information from and about others evidence of independent judgment,

[42]For a further discussion of issues pertaining to the delivery of health and related services to adolescents living in poverty, as well as adolescents in specific cultural subgroups, see ch. 18, "Issues in the Delivery of Services to Selected Groups of Adolescents," in this volume.

and when is it a sign of irrationality? When is sensitivity to the ideas and conduct of others thoughtful open-mindedness, and when is it conformity? Does the tendency toward conformity vary with the context? These and many other questions remain to be answered.

None of the core studies OTA's contractors reviewed examined the relationship between age and conformity to social influence in decisionmaking. Available research on the general relationship of age and conformity to social influence suggests the relationship between age and conformity to social influence is complex. The available research shows inconsistent findings, which may be reconciled by positing that conformity to social influence decreases from ages 7 to 11, then increases from ages 11 to 13, and then begins to decrease after that.[43] A 1988 study by Scherer and Reppucci examined the effects of parental pressure on hypothetical health decisions by adolescents ages 14 and 15 and found that these adolescents yielded greatly to parental pressure (76). The Scherer and Repucci study found that the more consequential the health problem and invasive the treatment choices, the less the 14- and 15-year-olds yielded to parental pressure; the more socially sensitive the condition, the more these adolescents yielded to parental pressure.

Surely the amount of social conformity people exhibit varies widely with the social situation and setting as well as with the individual. In fact, it is at least conceivable that developmental effects on social conformity may actually be overshadowed by situational variables. On the other hand, there may be complex situation-by-development interactions. Studies to examine that possibility have yet to be done.

Skill Training—Only one of the core studies OTA's contractors reviewed examined the effect of skill training on competence to decide. In the 1984 Belter and Grisso study, half the participants at each age level received briefings on patient rights and half did not. This amounts to specific training in one aspect of decisionmaking by patients (18). Unsurprisingly, participants who received briefings showed significantly higher recognition and protection scores than participants who did not. Th 15- and 21-year-olds both derived significant ben fit from the briefing, but the 9-year-olds did n derive any benefit. With the briefings, the 15-yea olds performed indistinguishably from the 21-yea olds in the recognition and protection of their righ as patients.

None of the other core studies OTA's contracto reviewed involved special efforts to teach decisio making skills to minors. Some additional researc has addressed the question of whether decisionmal ing skills can be taught. For example, a 1988 stud by Weinstein has prepared children for psychothe apy by using videotaped modeling (84), and a 198 study by Hammes and Petersen has shown that six grade children can be taught resistance to persuasic and thereby taught to make more independe decisions (41). These studies suggest that even minors *were* found to lack adult-level competence consent—which in general they have not been—might be possible to prepare minors to mal decisions that reflect a heightened level of comp tence.

Implications for Public Policy of Empirical Research on Minors' Competence

The studies that form the core of OTA's review c the age-competence relationship in health ca decisionmaking, though not great in number, c provide at least some empirical support for the id that minors as a class—especially minors age 14 15 through age 17—have the same capacity to m health care decisions as young adults. *These empi cal studies, therefore, challenge the traditional a implicit assumption of the law that minors as a cla are unable to make health care decisions as well adults.* Furthermore, the studies' findings on th point are consistent with a huge body of research c cognitive development generally.[44]

Are the empirical studies reviewed in this chap sufficient to establish that adolescents as a grou ages 14 or 15 and above, are competent to consent their own health care? Probably not. Beyond bei

[43]See P. Costanzo and M. Shaw, "Conformity as a Function of Age Level" (32); and B. Bishop and L. Beckman, "Developmental Conformi (20).

[44]See D. Elkind, "Conceptual Orientation Shifts in Children and Adolescents" (34); J. Flavell, *The Developmental Psychology of Jean Piaget* (and "An Analysis of Cognitive-Developmental Sequences" (37); B. Inhelder and J. Piaget, *The Growth of Logical Thinking From Childhoo Adolescence* (46); D.P. Keating, "Thinking Processes in Adolescence" (52); G.B. Melton, G.P. Koocher, and M.J. Saks, *Children's Competenc Consent* (63); and B.D. Neimark and N. Lewis, "Development of Logical Problem Solving: A One-Year Retest" (69).

Photo credit: U.S. Congress, Office of Technology Assessment

Available empirical research challenges the traditional and implicit assumption of the law that minors as a class are unable to make health care decisions as well as adults.

rather few in number, *the studies reviewed leave gaps in the knowledge ideally needed for the formulation of public policy* pertaining to adolescents' involvement in health care decisionmaking. One limitation of the available studies is that most of them did not examine minors' decisionmaking performance in situations sufficiently real and stressful to see what effects such situations may have on their decisionmaking performance (although the few that did examine this found the same pattern of results as the other studies). Another limitation of the available studies is that they generally compared minors' decisionmaking with the decisionmaking of very young adults rather than with that of adults of various ages. Still another limitation of available studies is that they leave open several important questions about the effects exerted on minors' decisionmaking by factors such as socioeconomic status, ethnicity, social influence, skill training, and experience, and how these might interact with the age-competence relationship found in the generally white middle-class groups studied. It is difficult to know how well one may generalize from the groups studied to the groups not studied.

Two basic responses can be made to the limitations of existing studies of minors' health care decisionmaking capabilities. One would be to carry out studies designed to generate more complete data. The other would be to make judgments as to whether the pattern of findings of existing studies is firm enough to expect them to carry over into untested areas. *Whatever is done, it is important to bear in mind that there is considerable variation among individual adolescents.* Some of the empirical studies reviewed for this chapter *note* the great variation of performance within age groups, but they do not go beyond that. Because of individual variation in decisionmaking capacity among adolescents, some adolescents ages 14 and older do not, in fact, have the requisite capacity to make health care decisions. Even if the average minor of any given age group can make health care decisions as well as the average adult, if the variability is much greater among the minors than it is among adults, then a large absolute number of minors might fall below whatever the standard of competence is.

The problem of individual variation in decisionmaking capacity within an age group can be dealt with in various ways. One way would be for public policymakers to require individualized determinations of competency by courts or even by health professionals. Unfortunately, however, an approach based on individualized determinations would open the door to discriminatory and arbitrary determinations unless there were tests of decisionmaking capacity that were reliable and valid and that could be administered easily—and it is doubtful that there are such tests.[45] Moreover, individualized determinations can be quite expensive in terms of resources.

Another way of dealing with the problem of individual variation in decisionmaking capacity would be for public policymakers to establish a rebuttable legal presumption of competence based on chronological age that could be used by courts to make individualized determinations of competence

[45]Some observers suggest that not one of the usual tests of competence relied on by the law and health professionals—evidencing a choice, reasonableness of outcome of choice, "rational" reasons, ability to understand, actual understanding—is or can ever be used consistently and that changing circumstances and considerations modify the tests that the law or clinicians apply (74).

(31).[46] Thus, for example, public policymakers could establish a legal presumption that any minor age 14 or above is competent to make health care decisions, but could also allow for the use of evidence of an individual's inability to make such decisions to rebut that presumption.[47]

Finally, it must be noted that considerations of minors' health care decisionmaking capacity have not been the sole determinant of the degree of freedom minors have been granted with respect to obtaining health services on their own. As pointed out earlier in this chapter, the presumption that minors are incompetent to make decisions about health care based on assumptions about minors' lack of health care decisionmaking capacity is only one of several rationales—albeit a major rationale—for parental consent and notification requirements. It also must be noted that only some of the recognized exceptions to parental consent and notification requirements are based on a rejection of this legal presumption and underlying assumptions. *In short, the capacity of a minor to make health care decisions may be a necessary but not a sufficient condition for allowing a minor to obtain health services on his or her own. Conversely, the lack of capacity on the part of a minor to make health care decisions may not preclude allowing the minor to obtain health services without parental permission.*

Conclusions and Policy Implications

This chapter began by asking how the law should allocate authority for making decisions about an adolescent's health care among the adolescent, the adolescent's parents, health professionals, and the state. It is important to emphasize that the way in which the law allocates adolescent health care decisionmaking authority does not become critical, or even very relevant, unless the adolescent and one or another of the parties just mentioned are in conflict. As noted earlier, however, potential or actual decisionmaking conflicts can and do sometimes occur. In the case of family planning and abortion services and possibly other types of health services that may be needed or wanted by adolescents, parental consent and notification requirements may sometimes pose barriers to access.

The ultimate responsibility for deciding how the law should allocate authority for making decisions about an adolescent's health care rests with public policymakers—legislators, judges, and administrators of public programs. If public policymakers are to formulate appropriate public policy pertaining to the allocation of authority for adolescent health care decisionmaking, they must balance the interests of adolescents, parents, health care providers, and the state.[48] Balancing these interests is no easy especially when the balancing has to be done in a political environment in which policymakers must rely on value judgments about which there is no consensus. It is at least possible, however, that an analysis of the interests of the various parties involved can serve as a conceptual framework for the development of clearer, more rational, and more consistent policies. Such an analysis is presented in box 17-B.

Laws related to the allocation of authority for decisions about the provision of health services to minors—individuals under age 18 in 47 States and the District of Columbia, and under age 19 in 3 States—have historically been the province of State legislatures, State courts, and State administrative agencies. As noted in this chapter, existing State laws governing parental consent and notification for different types of health services vary widely from State to State, and the laws of a particular State often vary with respect to different types of services or situations. For the most part, therefore, existing State laws do not furnish clear and consistent answers to the question of how authority for minors' health care decisionmaking is allocated.

Given the array of laws and regulations described in this chapter, many adolescents—and perhaps even providers—are probably uncertain about how these laws and regulations pertain to them as individuals. The involvement of the U.S. Supreme Court and lower Federal courts in the allocation of authority for decisions about family planning and abortion services through their power to interpret the

[46]See F.E. Zimring, *The Changing Legal World of Adolescence* (90).

[47]See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions, Volume 1: Report* (72).

[48]See R. Bennett, "Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis" (19); L.S. Ewald, "Medical Decision-Making for Children: An Analysis of Competing Interests" (35); M.S. Wald, "Children's Rights: A Framework for Analysis" (82); Harvard Law Review, "Developments in the Law—The Constitution and the Family" (42); and F.E. Zimring, *The Changing Legal World of Adolescence* (90).

Box 17-B—A Conceptual Framework To Aid Public Policymakers in Formulating Policy Related to the Allocation of Authority for Adolescent Health Care Decisionmaking

A conceptual framework to aid public policymakers in formulating policy related to the allocation of authority for adolescent health care decisionmaking can be supplied by analyzing the interests of the parties who may be involved in such decisionmaking—namely, the adolescent, the adolescent's parents, the health care providers, and the state. The essential issue to be considered in such an analysis is: Does the state have an interest or interests derived from the interests of the adolescent, the adolescent's parents, or health care providers—or does the state have an independent interest—that would justify a particular allocation of authority for adolescent health care decisionmaking via statutes, judicial decisions, or administrative regulations?

Interests of the Adolescent and the State—An adolescent has obvious interests in protecting his or her own life and in maintaining good physical and mental health—interests that translate into an interest in timely access to needed health services. The state, under its parens patriae power, also has an interest in protecting the life and health of the adolescent and thus also has an interest in ensuring the adolescent's access to needed health services. The nature and extent of the adolescent's interest—and by extension the state's interest—in the adolescent's access to health services varies, depending on the type of service and circumstances. Clearly, the interest is greatest in the case of health services that are needed to preserve life (e.g., emergency medical services for a seriously injured or suicidal adolescent) and less in the case of health services that may be viewed as desirable but are not necessary to preserve or even to achieve or maintain health (e.g., cosmetic surgery). In situations where the adolescent's life or health may be at stake, the adolescent's interest in access to services should be paramount in any balancing of interests to arrive at an appropriate allocation of the authority to make decisions concerning the provision of health services to adolescents.

Given the interests of the adolescent and the state in ensuring that the adolescent has access to needed health services, an issue that arises is whether—and if so, to what degree—legally mandated parental consent and/or notification requirements create barriers to adolescents' access to services. Several empirical studies have found that such requirements do create barriers to adolescents' access to and utilization of family planning and abortion services (21,22,25,26,28,78,79,87,88); the applicability of the findings of these studies to other types of services, however, remains unclear. If policymakers are considering the advisability of allowing adolescents to make their own health care decisions, a central concern becomes the competency of adolescents to make appropriate determinations as to their need for services. Some empirical studies, which are reviewed in this chapter, suggest that adolescents ages 14 or 15 and above have the same capacity to make health care decisions as young adults. It is important to bear in mind, however, that these studies have a number of limitations. Furthermore, adolescents within these age groups exhibit individual variation in decisionmaking capacity, and this variation itself has implications for public policy.

Interests of the Adolescent's Parents and the State—Parents and their minor children typically have affectional and other ties, and the parents of most adolescents are likely to have an interest in ensuring that decisions about the provision of health services for their adolescent child will benefit him or her. In some cases, however, an identity of interest between an adolescent and the adolescent's parents cannot be assumed; nor can it be assumed that the parents will always act in the adolescent's best interests in health care decisions affecting the adolescent. Parents have responsibility for the care, support, and rearing of their minor children, and the parents of an adolescent may have an interest in maintaining their authority over the adolescent. The parents also may have a more generalized interest in protecting their family's autonomy and privacy and in promoting their family's stability and cohesiveness.

The state may or may not have an interest in reinforcing parental authority. The state certainly has an interest in having the parents continue to assume responsibility for their adolescent child, however, and if parental authority is reduced, parents may be less willing to assume this responsibility. The state also has an interest in protecting family autonomy and privacy, which are widely valued in American society, but the protection of family autonomy and privacy is not necessarily the same as reinforcing parental authority. The state also has an interest in maintaining family cohesiveness and stability, but this is not necessarily the same as reinforcing parental authority.

Interests of Health Care Providers—The interests of health care providers are seldom discussed or even mentioned in discussions concerning the allocation of authority for adolescent health care decisionmaking. Certainly, however, health care providers can be said to have an interest in providing services to adolescents that

Continued on next page

Box 17-B—A Conceptual Framework To Aid Public Policymakers in Formulating Policy Related to the Allocation of Authority for Adolescent Health Care Decisionmaking—Continued

are consistent with their professional ethics (e.g., standards pertaining to confidentiality) and consistent with accepted professional practices. Providers have an interest in being able to receive compensation for services they provide. Providers also have a more narrow, but nonetheless significant interest, in clear and consistent laws to enable them to avoid unintentional violation of these laws. It is not clear, however, whether or to what degree the state has an interest in promoting or furthering these interests of health care providers.

Independent Interests of the State—Although, to some extent, the state's interests may be derived from and substantially the same as those of the adolescent, the adolescent's parents, and health care providers, the state also has its own independent interests. Thus, the state has a clear independent interest in ensuring that adolescents are tested and treated for sexually transmitted diseases to prevent the spread of those diseases and thereby protect its citizens from these diseases. To the extent that adolescent childbearing results in increased public expenditures for health and human service programs that serve families started when the parents were adolescents (e.g., public programs such as the Medicaid program, the Aid to Families With Dependent Children program, and the Food Stamp Program) and to the extent that adolescent childbearing is associated with negative health, educational, economic, and social consequences for these families,[1] the state may also have an independent interest in ensuring access of adolescents to family planning services and abortion services.

Interests of the Various Parties Depending on the Types of Health Services Involved—The interests of the adolescent, the adolescent's parents, the state, and health care providers may well differ depending on the types of health services involved—and the way the interests are balanced may well differ depending on the types of services involved. Thus, analyzing the interests of the parties concerned may lead to rules regarding the proper allocation of authority for adolescent health care decisionmaking that vary for different types of services. What this means for policymakers is that while one set of rules may appropriately govern the allocation of decisionmaking authority for general medical care, another set of rules may appropriately govern the allocation of decisionmaking authority for family planning services, another set of rules may govern the allocation of this authority for mental health services, and still another set of rules may govern the allocation of this authority for substance abuse treatment and counseling.

[1]Various studies have different findings considering the consequences of adolescent childbearing (38,54,80,89). For a further discussion of this topic, see ch. 10, "Pregnancy and Parenting: Prevention and Services," in Vol. II.

provisions of the U.S. Constitution may very well add to their uncertainties. One way of reducing adolescents' uncertainties, apart from moving laws toward greater uniformity, would be to incorporate information about the legal aspects of access to health services for adolescents in health education courses offered to adolescents in a State. Such information would give adolescents the information they need to make choices about whether or not to seek care.

Responsibility for allocating authority for health care decisionmaking now rests primarily with the State courts and legislatures and Federal courts. If it chose to, however, the U.S. Congress could play a greater role in formulating public policies pertaining to the allocation of authority for adolescent health care decisionmaking. At least in theory, Congress may enact legislation that would have the effect of establishing particular substantive policies in this area at the State and local level.[49]

One way for Congress to take on a larger role in formulating public policies pertaining to the allocation of authority for adolescent health care decisionmaking would be to enact legislation conditioning States' receipt of Federal funds for specified purposes on the States' having statutes or administrative rules and regulations that incorporate particular substantive policies with respect to health care decisionmaking for and by adolescents. To OTA's knowledge, this approach has not been used by Congress in this realm to date.

[49]As noted earlier, the U.S. Supreme Court is the final arbiter of what State laws are permissible and impermissible under the U.S. Constitution.

An alternative way for Congress to expand its role would be to enact legislation that requires federally ed programs that support the provision of health es for adolescents to adopt particular substantive policies with respect to the allocation of authority for adolescent health care decisionmaking. Congress authorizes and appropriates funds for a variety of programs that provide reimbursement or grants for adolescent health services—for example,

- the Medicaid program authorized under Title XIX of the Social Security Act,
- the maternal and child health services block grant programs authorized under Title V of the Social Security Act,
- the family planning services and research program authorized under Title X of the Public Health Service Act, and
- the alcohol, drug abuse, and mental health services block grant program authorized under Title XIX of the Public Health Service Act.[50]

The Federal laws authorizing and appropriating funds for these programs and the regulations and rules issued by the agencies administering these programs at the Federal level generally do not deal directly with questions of whether adolescents must arental consent to participate in the programs, er parents must be notified of adolescents' participation in the programs, or whether health care records and communications between program service providers and adolescents are confidential vis-à-vis their parents.[51] In the absence of explicit directives from Congress or Federal agencies, the administrators of federally funded programs are free—so long as they remain within the parameters imposed by State law and Federal constitutional law—to establish their own policies regarding parental consent and notification requirements and the confidentiality of records and communications involving 1 ors.

If Congress were to legislate in the area of parental consent and notification and confidentiality of communications involving adolescents, it presumably would move laws governing matters such as parental consent and notification toward greater uniformity and coherence. Assuming for the sake of argument that greater uniformity and coherence is desirable, there remains the issue of what substantive policies Congress should adopt. That is a political judgment—some people would undoubtedly support requiring or encouraging parental involvement in decisions concerning health services for adolescents and others would support giving adolescents a substantial measure of autonomy in such decisions. To help guide policymakers in decisions governing the allocation of authority for health care decisionmaking, further empirical research on the decisionmaking capabilities of adolescents and factors that may influence these capabilities (e.g., age, prior experience, situational factors, intelligence) would probably be useful.

Chapter 17 References

1. Ambuel, B., "Developmental Change in Adolescents' Psychological and Legal Competence To Consent to Abortion: An Empirical Study and Quantitative Model of Social Policy," doctoral dissertation, University of Illinois, 1989, *Dissertation Abstracts International* (in press).
2. American Academy of Child and Adolescent Psychiatry, *Code of Ethics* (contains clarification notes) (Washington, DC: 1980).
3. American Academy of Child and Adolescent Psychiatry, "Adolescent Pregnancy and Abortion Policy Statement," Washington, DC, policy statement adopted by the Council 1975 and amended by the Executive Committee, Mar. 19, 1982.
4. American Academy of Pediatrics, Committee on Youth, "A Model Act for Consent of Minors for Health Services," reprinted in *Pediatrics* 51(2):293-96, 1973.
5. American Academy of Pediatrics, *Conference on Consent and Confidentiality in Adolescent Health Care*, R.S. Moore and A.D. Hofmann (eds.) (Elk Grove Village, IL: 1982).
6. American College of Obstetricians and Gynecologists, "Providing Effective Contraception to Minors," Washington, DC, policy statement approved by the Executive Board, May 1971.
7. American College of Obstetricians and Gynecologists, "ACOG Statement of Policy—Confidentiality in Adolescent Health Care," reprinted in *American Academy of Pediatrics News*, April 1989.
8. American Law Reports, "Doctors' Disclosure of Confidential Information," *American Law Reports 4th* 48:668-713 (Rochester, NY: The Lawyer's Co-Operative Publishing Co., 1986).
9. American Medical Association, *Principles of Medical Ethics* (Chicago, IL: 1971).

[50]Some of these Federal programs are discussed in other chapters of this report. Medicaid, for example, is discussed in ch. 16, "Financial Access to Services." The Title X family planning program is discussed in Vol. II in ch. 10, "Pregnancy and Parenting: Prevention and Services." The l and child health services block grant program is discussed to some extent in ch. 9, "AIDS and Other Sexually Transmitted Diseases: Prevention Services." The alcohol, drug abuse, and mental health services block grant program is discussed in ch. 11, "Mental Health Problems: Prevention and Services," and ch. 12, "Alcohol, Tobacco, and Drug Abuse: Prevention and Services." A number of these programs are also discussed in ch. 19, "The Role of Federal Agencies in Adolescent Health," in this volume.

[51]There have been some exceptions, for example, the previously discussed final rule issued by the U.S. Department of Health and Human Services in 1987, which prohibits federally funded alcohol or drug abuse programs from notifying a minor's parent of the minor's application for treatment without the minor's consent but only in States where State law permits minors to obtain alcohol or drug treatment without parental consent [42 CFR, Part 2 2.14 (1).

32-872 0 - 91 - 6 QL 3

10. American Nurses' Association, *Code for Nurses With Interpretive Statements* (Kansas City, MO: 1985).
11. American Psychiatric Association, *Opinions of the Ethics Committee on the Principles of Medical Ethics* (Washington, DC: 1986).
12. American Psychiatric Association, *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (Washington, DC: 1986).
13. American Psychological Association, Committee on Professional Standards, "Specialty Guidelines for the Delivery of Services by School Psychologists," reprinted from *American Psychologist* 36(6):670-81, 1981.
14. American Psychological Association, Division of Child, Youth, and Family Services, Committee on the Civil Commitment of Minors, "A Model Act for the Mental Health Treatment for Minors," Washington, DC, undated.
15. American Psychological Association, Division of Child, Youth, and Family Services, Task Force on Legal Issues, "Position Statement: Standards Regarding Consent for Treatment and Research Involving Children," draft, Washington, DC, 1982.
16. American Psychological Society, "Ethical Principles of Psychologists," reprinted from *American Psychologist* 36(6):633-38, 1981.
17. Appelbaum, P.S., Lidz, C.W., and Meisel, A., *Informed Consent: Legal Theory and Clinical Practice* (New York, NY: Oxford University Press, 1987).
18. Belter, R.W., and Grisso, T., "Children's Recognition of Rights Violations in Counseling," *Professional Psychology: Research and Practice* 15:899-910, 1984.
19. Bennett, R., "Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis," *Virginia Law Review* 62:285-330, 1976.
20. Bishop, B., and Beckman, L., "Developmental Conformity," *Developmental Psychology* 5(3):536, 1971.
21. Blum, R.W., and Resnick, M., "Adolescent Sexual Decision-Making: Contraception, Pregnancy, Abortion, Motherhood," *Pediatric Annals* 11(10):797-805, 1982.
22. Blum, R.W., Resnick, M., and Stark, T., "The Impact of Parental Notification Law on Adolescent Abortion Decision-Making," *American Journal of Public Health* 77(5):619-620, 1987.
23. Boumil, M., "Dispensing Birth Control in Public Schools: Do Parents Have a Right To Know?" *Seton Hall Law Review* 18:356-377, 1988.
24. Cady, F., "Emancipation of Minors," *Connecticut Law Review* 12:62-91, 1979.
25. Cartoof, V.G., and Klerman, L.V., "Parental Consent for Abortion: Impact of the Massachusetts Law," *American Journal of Public Health* 76(4):397-400, 1986.
26. Chamie, M., Eisman, S., Forrest, J.D., et al., "Factors Affecting Adolescents' Use of Family Planning Clinics," *Family Planning Perspectives* 14(3):126-139, 1982.
27. Clark, H.H., Jr., *The Law of Domestic Relations in the United States*, 2d ed. (St. Paul, MN: West Publishing Co., 1988).
28. Clary, F., "Minor Women Obtaining Abortions: A Study of Parental Notification in a Metropolitan Area," *American Journal of Public Health* 72(3):283-285, March 1982.
29. Cleary, E.W., *McCormick on Evidence*, 3d ed. (St. Paul, MN: West Publishing Co., 1984).
30. Collins, C., "Abortion Focus Shifting to Teenagers," *New York Times*, p. 1 (col. 3), Oct. 1, 1989.
31. Comment, "Speaking for a Child: The Role of Independent Counsel for Minors," *California Law Review* 75:681-706, 1987.
32. Costanzo, P., and Shaw, M., "Conformity as a Function of Age Level," *Child Development* 37:967-975, 1966.
33. Dodson, G.D., "Legal Rights of Adolescents: Restrictions on Liberty, Emancipation, and Status Offenses," *Legal Rights of Children*, R.M. Horowitz and H.A. Davidson (eds.) (Colorado Springs, CO: Shepard's/McGraw-Hill, 1984).
34. Elkind, D., "Conceptual Orientation Shifts in Children and Adolescents," *Child Development* 7(3):493-98, 1966.
35. Ewald, L.S., "Medical Decision-Making for Children: An Analysis of Competing Interests," *St. Louis University Law Journal* 25:689-733, 1982.
36. Flavell, J., *The Developmental Psychology of Jean Piaget* (New York, NY: Van Nostrand, 1963).
37. Flavell, J., "An Analysis of Cognitive-Developmental Sequences," *Genetic Monographs* 86:279-289, 1972.
38. Furstenberg, F.F., Brooks-Gunn, J., and Morgan, S.P., "Adolescent Mothers and Their Children in Later Life," *Family Planning Perspectives* 19(142):142-151, 1987.
39. Grisso, T., *Juveniles' Waiver of Rights: Legal and Psychological Competence* (New York, NY: Plenum Press, 1981).
40. Grisso, T., *Evaluating Competencies: Forensic Assessments Instruments* (New York, NY: Plenum Press, 1986).
41. Hammes, M., and Petersen, D., "Teaching Decision-Making Skills to a Sixth Grade Population," *Journal of Drug Education* 16:(3)233-242, 1986.
42. Harvard Law Review, "Developments in the Law—The Constitution and the Family," *Harvard Law Review* 93:1156-1383, 1980.
43. Hofmann, A.D., Children's Hospital of Orange County, Orange, CA, personal communication, August 1989.
44. Hofman, B.D., "The Squeal Rule: Statutory Resolution and Constitutional Implications—Burdening the Minor's Right of Privacy," *Duke Law Journal* 1984:1325-1357, 1984.
45. Horowitz, R.M., "Children's Rights: A Look Backward a Glance Ahead," *Legal Rights of Children*, R.M. Horowitz and H.A. Davidson (eds.) (Colorado Springs, CO: Shepard's/McGraw-Hill, 1984).
46. Inhelder, B., and Piaget, J., *The Growth of Logical Thinking From Childhood to Adolescence* (New York, NY: Basic, 1958).
47. Institute of Judicial Administration and American Bar Association, Juvenile Justice Standards Project, *Standards Relating to Rights of Minors* (Cambridge, MA: Ballinger Publishing Co., 1980).
48. Kaser-Boyd, N., Adelman, H.S., Taylor L., et al., "Minors' Ability To Identify Risks and Benefits of Therapy," *Professional Psychology: Research & Practice* 16(3):411-417, 1985.
49. Kaser-Boyd, N., Adelman, H.S., Taylor L., et al., "Children's Understanding of Risks and Benefits of Psychotherapy," *Journal of Clinical Child Psychology* 15(2):165-171, 1986.
50. Katz, S., Schroeder, W., and Sidman, L., "Emancipating Our Children—Coming of Age in Legal America," *Family Law Quarterly* 7:211-230, 1973.
51. Kazdin, A.E., "Acceptability of Psychotherapy and Hospitalization for Disturbed Children: Parent and Child Perspectives," *Journal of Clinical Child Psychology* 15(4):330-340, 1986.
52. Keating, D.P., "Thinking Processes in Adolescence," *Handbook of Adolescent Psychology*, J. Adelson (ed.) (New York, NY: Wiley, 1980).
53. Keeton, W.P., Dobbs, D.B., Keeton, R.E., et al. (eds.), *Prosser and Keeton on the Law of Torts*, 5th ed. (St. Paul, MN: West Publishing Co., 1984).
54. Lewin, T., "Three Studies Cause Confusion on Impact of Pregnancy," *New York Times*, p. A10 (col. 3), Mar. 7, 1990.
55. Lewis, C.C., "A Comparison of Minors' and Adults' Pregnancy Decisions," *American Journal of Orthopsychiatry* 50(3):446-453, 1980.
56. Lewis, C.C., "How Adolescents Approach Decisions: Changes Over Grades Seven to Twelve and Policy Implications," *Child Development* 52:538-544, 1981.
57. Lewis, C.E., Lewis, M.A., and Ifekwunigue, M., "Informed Consent by Children and Participation in an Influenza Vaccine Trial," *American Journal of Public Health* 68(11):1079-1082, 1978.
58. Lewis, C.E., Lewis, M.A., Lorimer A., et al., "Child-Initiated C The Use of School Nursing Services by Children in an 'Adult-Free' System," *Pediatrics* 60:499-507, 1977.
59. Lidz, C.W., Meisel, A., Zerubavel, E., et al., *Informed Consent: A Study of Decisionmaking in Psychiatry* (New York, NY: The Guilford Press, 1984).

60. Lovett, J., and Wald, M.S., "Physician Attitudes Toward Confidential Care" *Journal of Pediatrics* 106:517-520, 1985.
61. Melton, G., "Children's Consent: A Problem in Law and Social Science," *Children's Competence To Consent*, G. Melton, G. Koocher, and M. Saks (eds.) (New York, NY: Plenum Press, 1983).
62. Melton, G.B., "Legal Regulation of Abortion, Unintended Effects," *American Psychologist* 42:79-83, 1987.
63. Melton, G.B., Koocher, G.P., and Saks, M.J. (eds.), *Children's Competence To Consent* (New York, NY: Plenum Press, 1983).
64. Mnookin, R.H., *Child, Family and State: Problems and Materials on Children and the Law* (Boston, MA: Little, Brown, 1978).
65. National Association of Children's Hospitals and Related Institutions, Inc., "The Pediatric Bill of Rights," Wilmington, DE, endorsed 1974.
66. National Association of Social Workers, *Code of Ethics—Professional Standards* (Silver Spring, MD: 1980).
67. National Association of Social Workers, Provisional Council on Clinical Social Work, *NASW Standards for the Practice of Clinical Social Work—Professional Standards* (Silver Spring, MD: 1989).
68. National Conference of Commissioners on Uniform State Laws, Uniform Health-Care Information Act, *Uniform Laws Annotated, Part I*, 9:475-520 (St. Paul, MN: West Publishing Co., 1988).
69. Neimark, E.D., and Lewis, N., "Development of Logical Problem Solving: A One-Year Retest," *Child Development* 39(2):527-536, 1968.
70. New York Times, "Kansas Is Urged To Curb Abortion," *New York Times*, p. 28 (col. 1), Nov. 9, 1989.
71. New York Times, "Virginia Senators Stall Bill To Curb Abortion," *New York Times*, p. 47 (col. 5), Feb. 11, 1990.
72. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions, Volume 1: Report* (Washington, DC: 1982).
73. Rosoff, A.J., *Informed Consent: A Guide for Health Care Providers* (Rockville, MD: Aspen Systems Corp., 1981).
74. Roth, L.H., Meisel, A., and Lidz, C.W., "Tests of Competence To Consent to Treatment," *American Journal of Psychiatry* 135:279-284, March 1977.
75. Rothenberg, K.H., "Medical Decision-Making for Children," *BioLaw*, J. Childress and R. Gaare (eds.) (Frederick, MD: University Publications of America, 1986).
76. Scherer, D.G., and Reppucci, N.D., "Adolescents' Capacities To Provide Voluntary Informed Consent," *Law and Human Behavior* 12(2):123-141, 1988.
77. Schonberg, S.K., Montefiore Hospital, Bronx, NY, personal communication, July 1989.
78. Torres, A., "Does Your Mother Know . . .?" *Family Planning Perspectives* 10(5):280-282, 1978.
79. Torres, A., Forrest, J.D., and Eisman, S., "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," *Family Planning Perspectives* 12(6):284-292, 1980.
80. U.S. Congress, Library of Congress, Congressional Research Service, *Teenage Pregnancy: Issues and Legislation* (Washington, DC: April 1988).
81. Wadlington, W., "Minors and Health Care: The Age of Consent," *Osgoode Hall Law Review* 11:115-822, 1973.
82. Wald, M., "Children's Rights: A Framework for Analysis," *University of California, Davis Law Review* 12:255-282, 1979.
83. Wardle, L.D., Blakesley, C.L., and Parker, J.Y., *Contemporary Family Law: Principles, Policy, and Practice* (Deerfield, IL: Callaghan, 1988).
84. Weinstein, M., "Preparation of Children for Psychotherapy Through Videotaped Modeling," *Journal of Clinical Child Psychology* 17:131-136, 1988.
85. Weithorn, L.A., "Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates," *Stanford Law Review* 40:773-838, 1988.
86. Weithorn, L.A., and Campbell, S.B., "The Competency of Children and Adolescents To Make Informed Treatment Decisions," *Child Development* 53:1589-1598, 1982.
87. Zabin, L.S., and Clark, S.D., "Why They Delay: A Study of Teenage Family Planning Clinic Patients," *Family Planning Perspectives* 13(5):205-216, 1981.
88. Zabin, L.S., and Clark, S.D., "Institutional Factors Affecting Teenagers' Choice and Reasons for Delay in Attending a Family Planning Clinic," *Family Planning Perspectives* 15(1):25-29, 1983.
89. Zabin, L.S., and Hirsch, M.B., "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status, and Subsequent Pregnancy," *Family Planning Perspectives* 21(6):248-255, 1989.
90. Zimring, F.E., *The Changing Legal World of Adolescence* (New York, NY: Free Press/Macmillan, 1982).

THE WHITE HOUSE

December 22, 1997

Ms. Ann Moore
President
People
Time & Life Building
Rockefeller Center
New York, New York 10020

Dear Ms. Moore:

Thank you for your letter and invitation to participate in your efforts to raise awareness about teen pregnancy. I am grateful for your leadership on this issue and have forwarded a copy of your letter to appropriate members of my staff for consideration. It was good to hear from you again.

With best wishes for a blessed holiday season, I am

Sincerely yours,

Hillary

Hillary Rodham Clinton

cc: Melanne Verveer, Chief of Staff
Marsha Berry, Director of Communications
Patti Solis Doyle, Director of Scheduling

bcc: Jen K Ceiner

I hope we'll be able to work together on this important issue — thanks.

cc: Melanne, Marianna, Jan, Patti

People weekly

Ann S. Moore
President

Time Inc.

People
Time & Life Building
Rockefeller Center
New York, NY 10020

212-522-3970
212-522-7639 Fax

December 10, 1997

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500
ATTN: Pamela Cicetti

Dear Mrs. Clinton:

While I am sorry we couldn't get you to celebrate your 50th birthday with us in New York, I wonder if we could schedule a substitute luncheon in May 1998 on a subject of mutual interest.

I continue to follow the issue of teen pregnancy ever since the President hooked me on The National Campaign to Prevent Teen Pregnancy. The reception you hosted last spring at the White House was a wonderful event for the Campaign and I was quite delighted to learn that Katherine Graham donated her Sara Lee Award to it.

PEOPLE has chosen the Campaign as one of our three year-end charities. I understand my friend, Pat Fili, the President of ABC Daytime, is hosting a briefing on teen pregnancy in the first quarter

All of us, however, need to do more to keep the subject "top of mind" among media leaders, because this is a long, hard problem to solve.

In honor of May being "Teen Pregnancy Prevention Month," I would volunteer, with Teen PEOPLE editor, Christina Ferrari, to assemble the editors of all the major magazines read by pre-teen and teen girls to discuss the teen pregnancy problem and its solutions. I am hoping your schedule will allow you to attend the luncheon and participant on a discussion panel. Your presence at such an event would make it a "must attend" session where we could corral others to join in finding a much needed solution to our children becoming parents before their time.

I will ask someone at The Campaign to Prevent Teen Pregnancy to try and coordinate a date with your office.

Best wishes for a Happy Holiday.

Sincerely,

Ann Moore

ASM:cm

TO: Hillary Rodham Clinton
FROM: Jennifer Klein
DATE: 3/25/96
RE: Teen Pregnancy

You had asked for a critique of the manuscript by Lainie Friedman Ross that Dr. Koop forwarded to you. Attached please find a short critique by Dr. Felicia Stewart, Deputy Assistant Secretary for Population Affairs at HHS.

I have also attached an article by the Council on Scientific Affairs of the American Medical Association on the same subject. Dr. Ross uses this article to support her claim that "most adolescents . . . do discuss these issues with their parents." The article actually concludes that confidential care is critical for adolescents and cites data showing that adolescents are more likely to seek care if they can do so confidentially. It also recommends that physicians involve parents in the medical care of an adolescent patient when it is in the best interest of the patient.

TO: Hillary Rodham Clinton
FROM: Jennifer Klein
DATE: 3/4/96
RE: Dr. Koop's Letter on Lainie Friedman Ross

You had asked me to look into the four questions on the attached post it:

1. You did not receive the manuscript from Lainie Friedman Ross.

2. I agree that Dr. Ross overstates when she cites your articles as part of a "movement that claims that competent children should not be treated differently from their competent adult counterparts." Your 1979 article, "Children's Rights: A Legal Perspective," does argue that "[t]he first thing to be done is to reverse the presumption of incompetency [that has been applied to children] and instead assume all individuals are competent until proven otherwise." However, you do not imply that children determined to be competent should be treated the *same* as adults, but only that they should be given certain given rights and responsibilities. You state that "[t]here are certain children at certain ages in certain circumstances who can and should exercise responsibilities," and that the law should recognize that reality.

   Dr. Ross' article concludes that children should not be able to get prescription contraceptives without parental consent. Your article does say that "[d]ecisions about motherhood and abortion . . . and others where the decision or lack of one will significantly affect the child's future should not be made unilaterally by parents."

3. Janet Abrams is the staff contact for the "National Campaign to Reduce Teenage Pregnancy" which is a private, nonpartisan organization chaired by Dr. Henry Foster. The organization has not included Dr. Ross (in fact, they have never heard of her) but would be happy to consider her.

4. I have asked Felicia Stewart, the head of the Office on Population Affairs, to critique the article for you.

C. EVERETT KOOP, M.D.

February 2, 1996

The Honorable Hillary Rodham Clinton
Office of the First Lady
2nd Floor, West Wing
THE WHITE HOUSE
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Hillary:

I recently was sent a manuscript by the journal, *Polit*
to write a critique. When I read it, I thought that it was sc
permission from the editor to forward it to you. He told n
but I am not sure whether your staff put it in your hands.

In any event, here is Lainie Friedman Ross' piec
Policy." I would like you to be familiar with her point of
was sent to you also asked that you write a critique.

Would Dr. Ross make a good addition to your ad

To Jen —
(1) Did I ever receive a copy of this?
(2) Please see P. 8 where she mentions my articles & I believe overstates. Could you review for me?
(3) Who is liaison for Teen Pregnancy taskforce? Find out if this person has been included + / or considered.
(4) Could someone critique for me? HRC

Sincerely yours,

Chick Koop

C. Everett Koop, M.D.

enclosure

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Adolescent Sexuality and Public Policy: A *Liberal* Response

Lainie Friedman Ross University of Chicago, USA

Abstract. Conflicting U.S. statutes exist governing adolescent sexuality. While parents are allowed to remove their children from sex education, they cannot prevent their children from procuring medical care and contraception without parental awareness or consent. I argue that specialized consent statutes--statutes which empower adolescents to seek confidential reproductive and sexual health care--are an inappropriate solution to adolescent sexuality because (1) they empower individuals whom we otherwise believe are not ready for autonomous decision-making; (2) they endorse deception, which is the wrong message to be sending to our children; and (3) they are illiberal in that they circumvent parental decision-making authority to promote a particular conception of the good life. I argue that we should rescind these statutes and return these decisions to the family.

[Author Profile]

Lainie Ross is Assistant Professor in the Department of Pediatrics and the MacLean Center for Clinical Medical Ethics at the University of Chicago. She is a practicing pediatrician. In November 1995, she successfully defended a dissertation entitled "Health Care Decision Making for Children," and will receive a Ph.D. in Philosophy from Yale University in May 1996. Her main interests are pediatric ethics and ethical issues in genetics. Correspondence should be addressed to Lainie Friedman Ross, M.D., University of Chicago School of Medicine, MacLean Center for Clinical Medical Ethics MC 1057, 5841 S. Maryland Ave., Chicago, IL 60637, USA (E-mail: LROSS@MEDICINE.BSD.UCHICAGO.EDU).

Acknowledgments. I thank Walter Glannon, Ann Dudley Goldblatt, Robert E. Merrill, Jeffrey Oak, Mary Mahowald, Leslie Moore, Jacqueline Peterson, Julie Rothstein, John Ross, David Schmidtz, Sara Swenson, and Joanna Zolkowski-Wynne for reading earlier drafts of this paper. I also thank three referees for *Politics and the Life Sciences* for their thoughtful comments. *Editor's note*: Commentaries and a response by the author will appear in the August 1996 issue of *PLS*.

There is a contradiction between the purported acceptance of diverse lifestyles by our *liberal community*[1] and present-day U.S. policy regarding contraceptives for *minors*.[2] In a liberal community, it is presupposed that adults have a special insight into their own conception of the good life that they can pass on to their children. Yet, recent legislation and court decisions in the United States usurp parental power on health care issues pertaining to adolescent sexuality and reproduction.

Consider the following scenario: The Joneses are devout Catholics. Their third daughter, Jane, is 14 years old. Jane, who has become sexually active with her 18-year-old boyfriend Eric, asks her pediatrician for prescription-requiring oral contraceptives. Jane knows that her parents disapprove of premarital sexual activity, and that birth control is strictly prohibited by their religion. Genuine respect for different values would require that we respect the Jones's decision to raise their daughters according to strict Catholic doctrine. They have simplified this for us by enrolling Jane in a Catholic parochial school that does not teach the students about human sexuality, birth control, and abortion.

We cannot argue that the parents' strict prohibition against premarital sexual activity and sex education is a form of neglect. On the contrary, the Joneses are offering their children a coherent, viable lifestyle--a lifestyle that they believe would be threatened by such education outside the context of marriage. And yet, the Joneses cannot fully shelter their daughters because sexuality is pervasive in the mass media and literature. The Joneses recognize this risk, and expend much energy in monitoring their children's exposure to television programs and movies that address sexuality. Nevertheless, if Jane is truly bent on obtaining the facts about human sexuality, she can go to the public library!

A liberal community is and must be tolerant of various lifestyles. As such, our laws allow parents to remove their children from sex education in the public schools, as well as to send their children to private schools in which sexuality is either intentionally omitted from the curriculum or, if addressed, taught as a moral and not a biological issue. And yet most states also have specific statutes (specialized consent statutes) that allow Jane and her pediatrician to discuss contraceptives and allow for Jane to be given a prescription for birth control pills--all without parental consent, even without parental notification. That the laws are inconsistent in the way that they respect various lifestyles is not surprising: different policies were set by different people with different agenda.

Although Jane Jones is a hypothetical person, realize that patients like Jane are relatively common in pediatrics. And realize that Jane may come to my office alone, or she may come with a parent under some pretense (e.g., back pain) and then announce her real intention (her desire for oral

contraceptives) when her parent leaves the room. In this article, I consider--both from the private doctor-patient relationship and from the public context of the larger liberal community--whether specialized consent statutes are a moral response to Jane and her parents.[3]

Specialized Consent Statutes

In a liberal community, parents have the legal right to raise their children according to their own values, and to make major educational, religious, and social decisions for them. Within the context of health care, parents in a liberal community are presumed to be the child's proxy voice for minor as well as serious conditions.[4] In general, physicians can neither examine nor treat a child without parental consent; if they do, they can be charged with battery and assault. There are two important exceptions. First, physicians can treat a child when a life-threatening emergency exists even if parents are unable or unwilling to give their consent. Second, the state does not require parental permission if it has a substantial compelling interest, such as with universal vaccinations (which it can actually require for all citizens, both children and adults--*Jacobson v. Massachusetts*, 1905).

Nevertheless, all fifty states have specialized consent statutes that--although varying in scope--give adolescents some autonomy to seek and consent independently to the diagnosis and treatment of drug and alcohol abuse, contraceptive counseling, and/or the procurement of contraceptives (Holder, 1985). Some states even allow minors to consent to abortions without disclosure or consent from their parents. The statutes were designed to encourage adolescents to seek health care for problems that they might deny, ignore, or delay if they had to get parental permission.

The purported purpose of the specialized consent statutes is laudable: to encourage early, responsible sexual health care for adolescents. But the empirical data do not support the claim that adolescents will seek medical care for sexual and reproductive issues if they are assured complete confidentiality. Despite the inception of the specialized consent statutes in the 1960s, adolescent pregnancy and sexually transmitted diseases (STDs) are on the rise.[5] And the data suggest that most adolescents (especially those younger than 16 years) do discuss these issues with their parents.[6]

Is this a case in which a few "bad" cases have produced "bad" laws? That is, were the specialized consent statutes written to protect the rare adolescent whose parents might harm or threaten to harm her were they to learn that she had a sexually transmitted disease or that she went to a physician for birth control? Were the statutes written without concern for the vast majority of

parents who are both able and willing to guide their adolescents' medical care and who consider this role integral to their child-rearing rights and responsibilities?

I am deeply troubled by specialized consent statutes and believe they are an inappropriate response by a liberal government. A liberal community must accommodate families that hold a wide spectrum of attitudes toward sexuality, and it must realize that these families may seek to structure the experience of their children according to these values. A truly liberal community would allow the Joneses to prevent Jane from procuring all contraceptives and from aborting a fetus, if conceived. But we do not want adolescents having children. So we allow adolescents to get birth control because we agree with them that they are not ready to be parents, and we are willing to override their parents' role as medical decision-makers in order to prevent what we perceive to be a greater tragedy. That is, the specialized consent statutes support those particular conceptions of the good life that approve--or at least condone--responsible adolescent sexual activity. These statutes allow sexually active adolescents to circumvent parents who belong to subcommunities that discourage or forbid premarital sexual activity by their members. These statutes, then, circumvent parental decision-making authority without parental awareness of being excluded.

To minimize adolescent pregnancy, the specialized consent statutes, allow, if not require, Jane's physician to collude with Jane if she insists upon deceiving her parents.[7] This collusion leads to multiple moral difficulties. First, as Jane's pediatrician, I have developed relationships of trust with both Jane and her parents. What happens when Jane's parents discover the birth control pills? If they confront me and Jane, there is nothing to say but that I believed it was in Jane's best interest. But I have lost their trust, and rightly so. I have also made it clear that I do not respect their religious beliefs; and, since the law stands behind me, my action suggests that members of the larger community also do not respect their religious beliefs. Second, what happens if Jane has a medical complication? A sexually transmitted disease that leaves her infertile? Or an uncommon but serious medical complication from the pill, such as a stroke? How do I explain to Jane's parents that Jane understood and consented to these risks, and that she and I believed that their consent was unnecessary and undesirable, even though they are the parties who will remain responsible for the physical, emotional, and economic hardships that result? And third, what does this mean for Jane herself? She has learned that a physician, an authority figure, is willing to serve as an accomplice in deceiving her parents. What are we teaching our adolescents when they find persons in authority willing to help them deceive their parents? What does it teach these adolescents with regard to the respect owed to any adult, least of all a deceitful doctor or a duped parent?

There is more to our illiberal policy. As the health care system now stands, our classic suburban middle-class adolescent would find it difficult to go to a doctor without her parents' knowledge. The visit is expensive, and to maintain absolute secrecy, the insurance company cannot be billed. Even if the doctor agrees to see the adolescent free of charge, a month's supply of oral contraceptives costs $15-25. And then the nondriving suburban adolescent must get to the doctor's office, which is not accessible by public transportation. In effect, then, the law gives increased confidential access to oral contraceptives only to poor adolescents who live in inner cities, who can go to a hospital clinic, and who can get free care and medicine with their state Medicaid card. So the policy tends to disproportionately disempower welfare parents who are already politically impotent. I wonder whether the laws would be overturned if physicians were treating large numbers of children whose parents had more political clout?

The Failure of Arguments for Specialized Consent

Those who support the specialized consent statutes offer several pragmatic and moral justifications. The first pragmatic position is compelling: Given the fact that adolescents can be and frequently are sexually active even when birth control and other sexual health services are relatively inaccessible, they should be given the opportunity to be responsible for their sexual activity. The pragmatist does not need to concede or refute whether the availability of such services increases the number of sexually active adolescents. Rather, he or she must argue only that the number is sufficiently large, even when such services are unavailable, as to portend a public health crisis. I accept the pragmatist's position thus far. But the argument makes two assumptions that must be fleshed out: (1) that adolescents are competent to make health care decisions, and (2) that a policy that grants adolescents autonomy will achieve greater sexual responsibility than would a policy that requires parental involvement.

Consider if the two assumptions are false. If the first assumption is false--that is, if adolescents are not competent to make health care decisions--then the statutes are misdirected. If adolescents are incapable of giving informed consent in the area of sexual and reproductive health services, then the statutes unfairly hold them responsible for such measures. If the second assumption is false--that is, if granting autonomy to adolescents does not produce greater sexual responsibility--then the argument for extending autonomy fails. Since parents have presumptive responsibility for their minor children, even if the children are competent, legislation should override the parents' responsibility only if it can

be shown that the policies will promote adolescent well-being *significantly better* than a policy based on parental responsibility. The state should not override parental authority on any issue in which the state is only slightly more effective than parents *unless* the state is able and willing to take responsibility for the myriad of other concerns of its adolescent citizens; otherwise, state intervention inadvertently risks undermining parental authority in other realms--realms in which we both need and want enduring parental commitment. Thus, unless granting adolescent autonomy will promote significantly better sexual and reproductive health care for adolescents, the state must defer to parental authority.

Is the first assumption valid? Are adolescents competent to make health care decisions? The data support the claim that adolescents make decisions as competently as adults do in medical case scenarios designed by psychologists (see Grisso and Vierling, 1978; Weithorn and Campbell, 1982). But does this competency necessarily apply to actions in real life? Despite their knowledge regarding auto safety, adolescents account for a disproportionate number of fatal car accidents. And despite their ability to repeat the facts about the transmission of AIDS and other sexually transmitted diseases, adolescents tend to overlook long-term consequences. The result is that adolescents are quickly becoming a high-risk group for sexually transmitted diseases, including AIDS (DiClemente, 1993). Thus, if competency is understood as the ability both to choose *and* to act to promote one's own interests, then the claim that adolescents are competent is not persuasive.

The second assumption--that specialized consent statutes will promote significantly better health care for adolescents in the realm of sexual and reproductive services than if adolescents required parental involvement--is also unpersuasive. Despite the confidentiality assured by specialized consent statutes, adolescents typically delay seeking sexual and reproductive health care for almost one year after they become sexually active (American Academy of Pediatrics, 1990, citing Zabin and Clark, 1981). Of course, if parental involvement would cause adolescents to delay such services indefinitely, then the statutes achieve significantly better results. Proponents of these statutes need to present empirical evidence that adolescents will seek earlier and better care if they are assured complete confidentiality. Since such data do not exist, the presumption ought to be in favor of parental involvement.

A second pragmatic reason to favor adolescent autonomy in sexual and reproductive health care is the concern of domestic violence. The position is that some adolescents seek sexual and reproductive health care without parental knowledge because these adolescents fear potential parental abuse. They fear physical or emotional abuse if their parents were to find out that they are sexually

active. But many of these adolescents who claim to fear such parental actions have never been abused. That is, they believe that their parents would be so outraged that they would harm them even when their parents have never harmed them previously. There are no data to support their fears. Should the law be written to deal with the few potentially unfortunate cases? I would prefer legislation that included parents in procreative decisions for their sexually active children through the age of emancipation. In the rare event that a parent becomes abusive, I would dispose of this case to the system that deals with abused and neglected children.

A third pragmatic reason to support adolescent autonomy is that this position avoids conflict. Some adolescents want to act without their parents' consent because they know that their parents' religious convictions condemn premarital sexual activity and birth control. But why do we permit these adolescents to seek medical help when we do not allow them to get sex education against their parents' beliefs? That is, if parents can remove their children from sex education classes because we supposedly respect their traditional lifestyle, then why do we allow physicians to go behind their backs and prescribe birth control to their daughters? And would anyone suggest that, to avoid conflict, we should not tell parents when their adolescents are failing in school? Surely, poor grades are common and are a major cause of intrafamilial strife. The pragmatic arguments are weak at best. The empirical data that presently exist do not justify the policy.

The moral argument in support of the specialized consent statutes is based on the moral claim that competency should entail autonomy. This claim is the prevailing moral justification for denying physicians the right to act paternalistically towards competent adult patients. However, whether competency is necessary and sufficient to give children the right to make autonomous decisions is more ambiguous. The argument ignores the fact that parents are responsible, not only for responding to the child's *current* identity, needs, and interests, but also for shaping the child's *future* identity, needs, and interests. Granting autonomy to competent children should serve both their current selves and their future identities. Parents must be able to justify restricting a child's present-day autonomy in order to enhance his or her overall or long-term autonomy. I will return to this point below.

The moral argument that competency should entail autonomy depends on two assumptions: (1) that the competency of children is not morally different from the competency of adults, and therefore that competent children and competent adults should be treated similarly; and (2) that competency is necessary and sufficient to justify autonomy. Both of these claims can be refuted.

Let us consider the first assumption. There is a large and growing movement that claims that competent children should not be treated differently from their competent adult counterparts. These

advocates are known as child liberationists, and they are found in both academic circles (see, for example, Cohen, 1980; Harris, 1982) and the White House (see Rodham, 1973, 1979). Child liberationists differ on when children should be emancipated, depending on how they define competency. One group uses a minimum rationality test: as long as an individual has some minimal capacity to get what she wants, she should be deemed competent to make her own decisions. A second group uses a thicker notion of competency that includes the ability to make informed, intelligent, and voluntary decisions that can take into account both short-term and evolving long-term interests.

Laura Purdy offers a compelling argument on why competent children should not be treated the same as their competent adult counterparts. First, she rejects the minimal competency argument on the grounds that society should not use a least common denominator as its standard for competency:

> Even liberationists, after all, lament the mistakes and immorality of adults. It seems to me that instead of asserting children's right to be equally silly and weak, it would be at least as plausible to argue for the overriding importance of helping children develop the self-control and other enabling virtues necessary for living more satisfying and moral lives. (Purdy, 1992:78)[8]

Purdy is in favor of granting *all* competent adults, even minimally competent adults, the right to self-determination on the grounds that the right to make autonomous decisions has intrinsic value. Even if a minimally competent adult might benefit from guidance, the intrinsic value of acting autonomously often outweighs the benefits of guidance. Children, on the other hand, have a great potential for improving their capacity to make decisions that reflect their best interests, and therefore Purdy is willing to restrain present-day decision-making authority in order to enhance overall decision-making authority (Purdy, 1992:55-84).

When children are competent according to the thicker notion of competency, Purdy is still willing to restrict their autonomy. Purdy argues that the knowledge and skills that individuals need for genuine autonomous choice are accumulated only gradually and are developed, in part, by practicing these skills in areas of lesser import (e.g., young children should be free to choose between equally nutritious cereals). Purdy maintains that children, by contrast with their adult counterparts, have a great potential for *improving* their knowledge base and their skills of critical reflection and self-control. By adulthood, however, most individuals will have developed the skills and obtained the necessary background knowledge to use their autonomy to achieve their own goals, and those who have not are not likely to benefit from a longer training period. Thus, at some point an individual must be allowed to live her own life, provided that she has attained some minimal level of competency (Purdy, 1992).[9] For children, on the other hand, we can and should aspire to higher goals.

The second assumption holds that competency is necessary and sufficient to justify autonomy. I believe, for two reasons, that competency is necessary but not sufficient. First, granting autonomy to children may actually be autonomy-restricting over a lifetime, and so we can justify restricting a child's autonomy now to give her greater overall autonomy. An example helps to clarify this point. If Jane enjoys great sexual freedom now, she may suffer several cases of pelvic inflammatory disease, which may cause her to be infertile. This condition may prevent Jane from becoming a parent when she is psychologically prepared to do so. Or she may contract an incurable sexual disease (preferably herpes and not AIDS) that will limit her sexual expression as an adult. Both of these conditions, then, have long-term consequences to which Jane may not give adequate attention during her adolescent years. Thus, we can justify withholding autonomy from adolescents in the short run in order to promote their potential for greater lifetime autonomy in the long run.

Second, I favor continued proxy decision-making authority by the adolescent's parents on the ground that her parents have a valid third-party interest in her development and activities, even after she has achieved a significant level of competency. In general, parental decision-making authority serves both the children and the parents. It serves the needs and interests of the child to have autonomous parents who will help her to become an autonomous individual capable of devising and implementing her own unique life plan. It also serves the adults' interests in having and raising a family according to their own vision of the good life. This freedom does not automatically stop when the child becomes competent. If anything, parents then have the opportunity to try to inculcate their beliefs through rational discourse, instead of through example, bribery, or force. While children are still dependent upon their parents for emotional, economic, and material support, the parents' interest in their children must be balanced against the competent children's interest in acting autonomously. In contrast, the present-day specialized consent statutes give unilateral responsibility to adolescents who can still benefit from adult guidance, and thus deny the parents' enduring interest in educating and guiding their competent children according to their own values.

For Rescinding Specialized Consent Statutes

There are several reasons why we ought to rescind specialized consent statutes. First, these statutes send adolescents the wrong message. They teach adolescents that their decisions regarding sexuality are unrelated to other aspects of their lives. Consider that parents dictate what schools and church their children attend and the activities in which their children may participate, but these same

children have legal sanction to ignore parental discretion in the area of sexuality. Consider that these children cannot consent to a throat culture without parental permission,[10] but they can authorize their physicians to perform a pelvic examination.

Second, specialized consent statutes affirm the adolescents' attitude that their sexuality is solely a private matter. It is not. Adolescent sexual activity has numerous public consequences for which adolescents are ill-prepared to accept responsibility. Adolescents have a responsibility to themselves to delay sexual gratification until they are emotionally and psychologically prepared; they have a responsibility to their partners to practice safe sex; and, finally, they have a responsibility to their community to avoid parenthood until they are both emotionally and financially capable of caring for a child.

Third, our laws give parents decision-making authority for their children because parents are best situated to decide and to act upon what is in their children's best interest, and because parents are financially and socially responsible for them. This is, or ought to be, no less true of their medical care with regard to sexual health issues.

In arguing against specialized consent statutes, I do not deny the need for a public commitment to prevent and treat the unwanted consequences of adolescent sexual activity. In that vein, specialized consent statutes are on the mark: they affirm the community's belief that the cost of unwanted adolescent pregnancy and untreated sexually transmitted diseases is too high. But the implementation of these statutes entails moral hurdles for the ethical physician: collusion against parents, disrespect for parental conceptions of the good, and a disregard for the adolescent's need for further parental guidance.

I am committed to the prevention and treatment of the unwanted consequences of adolescent sexual activity, but I want parents involved in their adolescents' care. When parents are involved, I am able to call the house to discuss laboratory results instead of asking my nurse to pretend to be a classmate and see if the adolescent is available. Similarly, when the parents are not excluded I am able to call the house if an adolescent fails to follow up for her reevaluation after treatment for a sexually transmitted disease. Follow-up is improved when parents are involved because both the parents and the child are looking out for the adolescent's welfare. Parents have a responsibility for the well-being of their children, and they can fulfill that responsibility only if they are aware of their children's needs.[11]

A serious objection to rescinding the specialized consent statutes and requiring parental authorization for prescription-requiring contraceptives is that it is unrealistic: the result is a pregnant

adolescent (and we all know what we think of this option). But the fact is that over one million adolescents become pregnant yearly--and most of these adolescents are unmarried and their pregnancies are unplanned--which suggests to me that the present statutes are not working. A pediatric colleague suggested that I was missing the point.[12] She argued that adolescents get pregnant for many reasons, and not necessarily by mistake. Some hope that a child will strengthen relationships with their boyfriends; some seek legal emancipation from their parents; and others seek a child who will love them unconditionally. She argued that these "selfish" reasons were no less true of adult women. She asked why I condemned one and not the other.

My response is liberal in the classic sense of the term: I do not believe it is my prerogative, nor the prerogative of the liberal community, to decide what is or is not a good reason for having children. However, I do believe that the right to procreate entails responsibilities. Is an adolescent as capable as an adult woman of coping with the emotional, physical, social, and financial costs of a child? The data suggest she is not. For example, adolescent parents are less likely to graduate from high school, which involves significant social and financial costs. But even more worrisome is the impact on their children. Children of adolescent parents often have more behavior problems and are at greater risk for significant morbidity and mortality from accidents. In the long term, they are more likely to be high school dropouts, adolescent delinquents, as well as adolescent parents themselves (Juszczak, 1992).

Presently an adolescent mother is legally emancipated from parental authority and accountability. These adolescent mothers are legally allowed to leave home, get their own apartments, drop out of school, and receive welfare. And they will get additional state support by having a second child. What would the consequences be if adolescent motherhood did not emancipate Jane, but instead legislation held Jane's parents accountable for their grandchild until their own daughter was old enough for emancipation? Or should the Joneses be unwilling to care for their granddaughter, what if the child were to be placed in foster care until her mother was able to take care of her? Would this serve as a deterrent to adolescent pregnancy? My goal is not to penalize adolescents who unwittingly become parents, but to discourage adolescents from viewing parenthood as a means to early independence. I would like to help adolescent parents learn the skills that they will need to care for themselves and their children. They need parenting skills as well as vocational skills. And this requires more, not less, schooling; more, not less, adult guidance.[13]

I told my pediatric colleague that it is she who is missing the point. The liberal community must not be neutral with respect to adolescent pregnancy and parenthood. We must reemphasize the

emotional, physical, and yes, the financial obligations of parenthood. Adolescent sexual activity and pregnancy are not just private moral decisions, and neither physicians nor the community at large should act as if they were. As a pediatrician, I should not pretend that Jane's pregnancy has positive aspects in addition to the negative. Jane, her parents, and I should all anguish over how to deal with this most unfortunate consequence of her sexual activity.

Another objection to rescinding specialized consent statutes is the greater negative impact such action would have on adolescent females versus adolescent males. It was pointed out to me that this article claims to be about adolescents, but it is really only about female adolescents.[14] According to this objection, the specialized consent statutes are a part of the whole package that ensures *all* women the right to procreative freedom and control over their own bodies. To rescind specialized consent statutes would be to diminish women's autonomy in the sexual and reproductive arenas.

This argument fails because it is over-inclusive. Nothing in my proposal detracts from the sexual and reproductive rights that must be guaranteed to all adult women. I believe that adult women *must* have full control over their own bodies--and such empowerment entails public support for family planning clinics, pregnancy-related services including abortion services and prenatal care, rape-counseling programs, and public clinics that treat sexually transmitted diseases and counsel patients regarding HIV. But this commitment does not prevent me from distinguishing between adult women and female adolescents. The independent minor will still be protected under the emancipated minor statutes. My position is only that adolescents who live at home with their families must involve their families in their health care.

I mean no harm to either female or male adolescents by urging rescission of specialized consent statutes. In general, females need more sexual and reproductive health care than males, but that reality involves responsibility as well as privilege, for only females have the capacity to conceive and bear a child. That this biological fact gives female adolescents less sexual freedom as children (and as adults, at least in our contemporary culture) is surely outweighed by the fact that these same individuals have greater reproductive opportunities as adults.[15]

Public Policy Implications

Given my great respect for parental autonomy and family privacy, I favor existing policy that allows parents to remove their children from sex education courses, but I also favor rescinding specialized consent statutes. Sexuality and sexual expression are private matters to be decided upon

by individuals and their intimates, and not to be imposed by the state. This position does not mean that I would encourage parents to exclude their children from sex education classes: liberal institutions other than the family share responsibility for educating our youths. But parents have the right and responsibility to select the means and scope of those other institutions' teachings.

Since I accept the liberal position that adolescent pregnancy and adolescent parenthood are public crises, how can I justify my policy proposals? Morally, I believe that parents should be allowed to remove their children from sex education courses that conflict with their moral beliefs–it is the responsibility and prerogative of parents to teach their children their own values, including their values on sexuality. Parents play a leading role in the formation of their children's sexual identity, their sexual attitudes and mores, and the manner in which they give their sexuality expression. Pragmatically, I would also add, sex education has not worked. Sex education has not been shown to change risky behavior (see, for example, Cromer and Brown, 1992; Durbin et al., 1993; Ku, Sonenstein, and Pleck, 1992).

I am also against prescribing birth control to Jane without parental notification because I am morally uncomfortable with the deceit that it entails. I respect Jane's parents' right to lead a more traditional lifestyle and to inculcate this lifestyle into their children. This is not to deny that Jane's parents have a responsibility to fulfill Jane's basic needs and interests and to help Jane develop into a mature autonomous adult. It is only to deny that her parents are obligated to expose her to a wide range of possible ways of life, or that they must permit her to participate in activities at odds with their moral conception of the good. On the contrary, if parents want to inculcate certain traditional lifestyles–be they Amish, Hasidic, or Catholic–then they need to restrict their children's exposure to their own ways of life. A truly liberal community must tolerate non-liberal but legitimate (i.e., non-abusive, non-neglectful) lifestyles.

Unfortunately, some adolescents who are sexually active are unable or unwilling to discuss their decision with their parents. The public goal of preventing and treating the unwanted consequences of adolescent sexual activity applies to these adolescents as well. A liberal community can devise statutes that keep present-day over-the-counter birth control easily accessible to all individuals, even minors. And, in fact, the Supreme Court held in *Carey v. Population Service International* (1977) that state laws restricting the availability of over-the-counter contraceptives to minors were unconstitutional. I concur with the Court's decision.

How can I justify allowing adolescents to obtain non-prescription birth control without parental notification and yet advocate parental consent for prescription-requiring contraception?[16] To a great

extent my response is pragmatic: a policy that makes over-the-counter birth control easily accessible to all individuals, even minors, is neither an attempt to override parental moral values nor a statement condoning adolescent sexual activity. Rather, the decision to have barrier method birth control available to all adolescents is consequentialist: the costs of denying adolescent sexual activity are unwanted adolescent pregnancy and diseases, which are a larger community burden than we are willing to accept. But my response also has a deontological basis: the adolescent's procurement of over-the-counter contraceptives does not require deception by medical providers and does not entail that medical providers undermine parental authority.

Some have argued that adolescents have a constitutional right to procure prescription-requiring contraception from family planning clinics without parental notification. The proponents base their position on the repeal of the "squeal rule." In 1970, Congress enacted Title X of the Public Health Service Act, which provided for voluntary family planning projects. In 1978, Title X was amended "to encourage family participation." The Department of Health and Human Services promulgated the "squeal rule" in 1981, which sought to require family planning projects that received federal funds to notify a minor's parents within ten days that she had been given contraceptives.

I believe that this interpretation is misguided. In both court cases in which the "squeal rule" was struck down, it was overruled on the ground that the rule was inconsistent with congressional intent (*State of New York v. Heckler*, 1983; *Planned Parenthood Federation of America v. Heckler*, 1983). Neither decision discussed whether parental notification or parental consent requirements violated a minor's constitutional rights.[17] If family privacy and autonomy are the important ideals that the courts have claimed them to be,[18] then we must respect the different lifestyles that different families promote.

Conclusion

Specialized consent statutes were designed to empower adolescents with respect to their sexual identity. But to do this, the statutes permit or even encourage adolescents to circumvent their parents and the guidance they might offer. These statutes also permit physicians to collude with these adolescents. I have argued that the statutes are inconsistent with the respect owed to parents within a liberal community. The liberal response to the unwanted consequences of adolescent sexual activity requires a set of policies consistent with liberal goals and values. I favor laws that allow parents to decide upon the nature of their children's sexual education and laws that require parental involvement

in the procurement of medical care pertaining to adolescent sexual activity. I also favor laws that allow sexually active adolescents who refuse to involve their parents to have access to over-the-counter barrier methods of birth control. These latter laws enable adolescents to avoid the unwanted consequences of their decision without legitimizing disrespect for parental authority by other institutions. It is a liberal community's way of avoiding a lose-lose solution in a no-win situation.

Notes

1. By "liberal community" I refer to a political democracy in which there is limited government and institutional guarantees of basic rights and personal liberties. A liberal community can be either liberal or conservative, depending on where it places the boundaries between the public and private spheres. In general, we tend to think of family and domestic life as private and economic and political spheres as public. The distinction is not so clear-cut, as many feminists have shown (see, for example, Nicholson, 1986; Okin, 1989). Although the dichotomy is too rigid, the distinction is nevertheless important, as we tend to tolerate greater state supervision and intrusion in the public sphere. Whether a liberal community is liberal or conservative depends, in part, on the extent and type of state involvement it tolerates in the different spheres.

2. By "minors" I refer to all individuals under the age of 18, which is the current legal age of emancipation. The specific age at which emancipation should be granted is a political and not a moral question. I do not argue for any particular age. Rather, I believe that the age should be chosen by societal consensus, and may differ in different cultures and different epochs. My arguments are germane regardless of where the line is drawn. (I do favor line-drawing versus a case-by-case evaluation because I know of no value-free standards on which to judge individual cases.)

3. This article does not address the issue of abortion, nor should the reader extrapolate my position on the role of parental consent and/or notification from my arguments regarding contraception and the treatment of sexually transmitted diseases. Although I do not believe that a fetus is a moral person, the fetus does add further complexities to the public and private dimensions of adolescent sexual activity that require a separate analysis. I leave this project for another day.

4. By "parents" I refer to those adults who are intimately involved in their child's upbringing. That is, I use the term morally and not biologically. I would not respect the decision-making authority of uninvolved caretakers regardless of their genetic or gestational relationship to the child. In this hypothetical case, both of Jane's parents are responsible for her upbringing, and *either* parent can be the child's proxy voice. I thank Ann Dudley Goldblatt for asking me to clarify this point.

5. To be accurate, the increased number of pregnancies among adolescents today may be more a reflection of the larger number of adolescents who are sexually active than a rise in the rate of adolescent pregnancy (see DeAngelis et al., 1987). Regarding the data on STDs, see Washington, Sweet, and Shafer, 1987.

6. These data were culled from a variety of studies that were summarized and discussed by the Council on Scientific Affairs of the American Medical Association (1993). Of note, the council's emphasis was to show that other adolescents stated that they would avoid medical care if parental notification were required, but as the authors of a corollary article in the same issue of *JAMA* note: "what adolescents say they will do (i.e., regarding forgoing care) may be different from what they actually do" (Cheng et al., 1993:1406).

7. Technically, the statutes do not require physicians to deceive parents, because physicians are under no legal obligation to provide a specific service or treatment requested by a minor if it conflicts with their moral principles (Council on Long Range Planning and Development, 1990:1). Nevertheless, the point still stands that if the physician confidentially gives Jane the prescription that she requests, then the physician effectively has colluded with Jane in deceiving her parents.

8. Purdy defines "enabling virtues" as "a certain class of skills, habits and goals that . . . help us get what we want," which includes such traits as rationality, diligence, and the desire for excellence (Purdy, 1992:45).

9. Again, this is not to deny that adults can also improve their decision-making ability to better reflect their own interests, but only to acknowledge that at least part of the value of autonomy is in its use. That is, the capacity to make autonomous decisions is valued because it allows one to act according to one's own beliefs and judgments. It acknowledges that at some point an individual must stop preparing for an autonomous life and just live it.

10. I realize that this is also changing under the mature minor statutes which allow "mature" adolescents to consent to much of their own medical care (Sigman and O'Connor, 1991). Nevertheless, this freedom is not commonly sought when the issue is not sexual, reproductive, or psychiatric. Rather, in general, parents are an important influence in their children's decisions, and adolescents tend to seek their support and advice in most other matters (see Hendry et al., 1992). In addition, adolescents are often willing to conform to parental influence (see Scherer and Reppucci, 1988), particularly female adolescents (Gilligan, Lyons, and Hanmer, 1990).

11. In discussions with families regarding adolescent sexual activity, I have met a number of parents who have asked me to prescribe birth control for their children if their children request it, and then to respect their children's confidentiality. Although they hope that their children will be able to discuss these intimate issues with them, they are more concerned with their child's well-being and the avoidance of unwanted consequences. The policy that I propose to replace the specialized consent statutes would in no way prevent parents from giving physicians such pre-approved authorization.

12. I thank Joanna Zolkowski-Wynne for pressing me on this point.

13. In no way do I mean to deny Eric's and his family's responsibility for his and Jane's child. I would endorse a policy that required Eric's financial support and encouraged his social participation. Men as well as women must be responsible for their sexuality. I have focused on the Joneses because I am Jane's pediatrician and I frequently do not know the young man and his family.

14. I thank Sarah Swenson and Leslie Moore for pressing me on this point.

15. Consider, for example, that the single or lesbian woman can procreate by artificial insemination, whereas paid surrogate mothers for single or gay men are often illegal. At the other end of the spectrum, the pregnant woman has the final right to decide whether to carry a

child to term. If abortion were illegal, this part of my argument would be weaker.

16. I thank Robert E. Merrill for insisting that I address this issue directly.

17. This legal issue is discussed by Mnookin and Weisberg, 1989 and Wardle, 1989.

18. See, for example, *Meyer v. Nebraska*, 1923; *Pierce v. Society of Sisters*, 1925; *Wisconsin v. Yoder*, 1972.

References

American Academy of Pediatrics, Committee on Adolescence (1990). "Contraception and Adolescents." *Pediatrics* 86:134-38.

Carey v. Population Service International (1977). 431 U.S. 678.

Cheng, T., J.A. Savageau, A.L. Sattler, and T.G. DeWitt (1993). "Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes among High School Students." *Journal of the American Medical Association* 269:1404-7.

Cohen, H. (1980). *Equal Rights for Children*. Totowa, NJ: Littlefield, Adams.

Council on Long Range Planning and Development (1990). *AMA Policy Compendium*. Chicago, IL: American Medical Association.

Council on Scientific Affairs of the American Medical Association (1993). "Council Report: Confidential Health Services for Adolescents." *Journal of the American Medical Association* 269:1420-24.

Cromer, B.A. and R.T. Brown (1992). "Update on Pregnancy, Condom Use, and Prevalence of Selected Sexually Transmitted Diseases in Adolescents." *Current Opinion in Obstetrics and Gynecology* 4:855-59.

DeAngelis, C., A. Duggan, F. Heald, and D.A. Silvey (1987). "Symposium: Confronting the Crisis of Teenage Pregnancy." *Contemporary Pediatrics* 4:68-90.

DiClemente, R. (1993). "Preventing HIV/AIDS among Adolescents: Schools as Agents of Behavior Change." *Journal of the American Medical Association* 270:760-62.

Durbin, M. et al. (1993). "Factors Associated with Multiple Sex Partners among Junior High School Students." *Journal of Adolescent Health* 14:202-7.

Gilligan, C., N.P. Lyons, and T.J. Hanmer, eds. (1990). *Making Connections: The Relational Worlds of Adolescent Girls at Emma Willard School*. Cambridge, MA: Harvard University Press.

Grisso, T. and L. Vierling (1978). "Minors' Consent to Treatment: A Developmental Perspective." *Professional Psychology* 9:412-27.

Harris, J. (1982). "The Political Status of Children." In K. Graham (ed.), *Contemporary Political Philosophy*. Cambridge, MA: Cambridge University Press.

Hendry, L.B., W. Roberts, A. Glendinning, and J.C. Coleman (1992). "Adolescents' Perception of Significant Individuals in Their Lives." *Journal of Adolescence* 15:255-70.

Holder, A.R. (1985). *Legal Issues in Pediatrics and Adolescent Medicine*. Second edition. New

Haven, CT: Yale University Press.

Jacobson v. Massachusetts (1905). 197 U.S. 11.

Juszczak, L. (1992). "Adolescent Parenthood." In S.B. Friedman, M. Fisher, and S.K. Schonberg (eds.), *Comprehensive Adolescent Health Care*. St Louis, MO: Quality Medical Publishing.

Ku, L.C., F.C. Sonenstein, and J.H. Pleck (1992). "The Association of AIDS Education and Sex Education with Sexual Behavior and Condom Use among Teenage Men." *Family Planning Perspectives* 24:100-106.

Meyer v. Nebraska (1923). 262 U.S. 390.

Mnookin, R.H. and D.K. Weisberg (1989). *Child, Family and State: Problems and Materials on Children and the Law*. Second edition. Boston, MA: Little, Brown.

Nicholson, L. (1986). *Gender and History: The Limits of Social Theory in the Age of the Family*. New York: Columbia University Press.

Okin, S.M. (1989). *Justice, Gender and the Family*. New York: Basic Books.

Pierce v. Society of Sisters (1925). 268 U.S. 510.

Planned Parenthood Federation of America v. Heckler (1983). 712 F.2d 650.

Purdy, L. (1992). *In Their Best Interest: The Case Against Equal Rights for Children*. New York: Cornell University Press.

Rodham, H. (1973). "Children Under the Law." *Harvard Educational Review* 43:487-514.

Rodham, H. (1979). "Children's Rights: A Legal Perspective." In P.A. Vardin and I.N. Brody (eds.), *Children's Rights: Contemporary Perspectives*. New York: Teachers College Press.

Scherer, D.G. and N.D. Reppucci (1988). "Adolescents' Capacities to Provide Voluntary Informed Consent: The Effects of Parental Influence and Medical Dilemmas." *Law and Human Behavior* 12:123-41.

Sigman, G.S. and C. O'Connor (1991). "Exploration for Physicians of the Mature Minor Doctrine." *Journal of Pediatrics* 119:520-25.

State of New York v. Heckler (1983). 719 F.2d 119.

Wardle, L.D. (1989). "Parents' Rights vs. Minors' Rights Regarding the Provision of Contraceptives to Teenagers." *Nebraska Law Review* 68:216-60.

Washington, A.E., R. Sweet, and M-A. Shafer (1987). "Pelvic Inflammatory Disease and Its Sequelae in Adolescents." *Sexually Active Teenagers* 1:66-78.

Weithorn, L. and S. Campbell (1982). "The Competency of Children and Adolescents to Make Informed Treatment Decisions." *Child Development* 53:1589-98.

Wisconsin v. Yoder (1972). 406 U.S. 205.

Zabin, L.S. and S.D. Clark (1981). "Why They Delay: A Study of Teenage Family Planning Clinic Patients." *Family Planning Perspectives* 13:205-17.