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Consent and Confidentiality in Adolescent Health Care by Pediatricians: A Private Practice Viewpoint

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INTRODUCTION

There is growing and continuing controversy, both public and within medical professional groups, in restructuring the ethical and legal basis for physicians providing health care services to the adolescent. The purpose of this article is to stimulate broader discussion by pediatricians, in particular those in private practice, as they enter more actively into the provision of services for this age group.

Analysis and critique of these issues provide a perspective of contrasting and conflicting views regarding the role of pediatricians in providing health care services to the adolescent. A conservative viewpoint, as a counterpoint, is put forth in regard to the emotion-laden psychosexual and psychosocial issues which enmesh the pediatric physician in the care of this age group.

SCOPE OF ISSUE: POINT-COUNTERPOINT

Traditionally, the exercise of the rights of consent and confidentiality for the adolescent have been vested in parents acting in the adolescent's behalf. Recent legal decisions in the specific adolescent health areas of drug abuse, venereal disease, contraception and abortion have awarded legal consent rights to the adolescent while the legal right to confidentiality, i.e., no parental notification, remains at issue.

Proponents of emancipation of adolescents for health care purposes commend guidelines regarding consent and confidentiality which are predicated on three concepts:

1. pragmatic need;
2. cognitive development and psycho-social maturation, i.e., the mature minor;
3. "new" ethical-legal considerations, i.e., the mature minor doctrine.

From these three concepts, four principles governing issues of consent and confidentiality regarding adolescent health care are derived:

1. consent rights: the graduated legal emancipation of minors 12-18 years of age;
2. confidentiality rights; health is pre-eminent and no parental consent and/or notification barriers are to be allowed;
3. an ethical disclaimer: parental assent and/or involvement are desirable and should be encouraged but not legally required;
4. adolescent assent: the right to affirm parental consent and/or parental notification.

In 1973, the American Academy of Pediatrics executive committee published a "Model Act Providing for Consent of Minors to Health Services" based on recommendations of the Council on Child Health.¹ This document has been used as the basis for state and federal legislative proposals, as well as court decisions which have led to full legal rights to consent for the adolescent and the corollary "freedom from liability" for the physician. This represents the doctrine of the limited emancipation of minors for health care purposes.

Recent proposals, in essence, represent recommendations to assure full legal rights of confidentiality, as well, and the removal of all constraints on the adolescent receiving, or the pediatrician providing, health care services to minors aged 12-18 years.² Thus, for health care purposes, the "emancipated minor" is created. The adolescent and the pediatric physician are freed from any ethical or legal liability as to parental consent, assent and/or notification. In my opinion, this would represent the complete emancipation of minors for health care purposes.

Underlying the referenced statement³ and articles⁴ is a basic premise regarding adolescent health care, i.e., parent(s) and families have failed, because by law, no one can exercise the supervision of

minors except the parent(s) unless and until the parent(s) has failed. Hence, professional surrogate or custodial supervision of minors' health care, i.e., no parental consent or notification, represents an assumption that the parent(s)/family have failed. Therefore, the full legal emancipation of all adolescents is necessary in order to meet their health care needs.

Opponents of this point of view believe that it is crucial to support parent(s) and the family as the primary caretaker system for children and adolescents until the age of majority. These opponents acknowledge the surrogate role of the physician/professional as clearly applicable to that relatively small percentage of adolescents who suffer parental/family failure or the adolescent is defined as emancipated for particular reasons of law. However, the proposal to expand emancipation to eliminate consent and/or notification of available and functioning parent(s)/family is considered adversarial and not necessarily in the long-term best health interest of the overwhelming majority of adolescents.

The family tradition historically has enjoyed an important compatibility with the individual tradition because of the family's primary role in preparing children for the responsibility of majority status by helping them develop mature capacities. There are now those who would "liberate" children from the captivity of the family tradition. Hence, it is important to examine the relations among adolescents, family life and individual liberty.

A key concept underlying the policies of protection of minority status is the notion that parents stand in a position of authority and responsibility between the state and the child. Short of "in loco parentis" circumstances, parents have been taught to have not only the constitutionally sanctioned right, but also the heavy responsibility to protect, educate and influence the values of their children, in addition to providing physical and economic care. The state has had no authority to intervene in those cases unless there was no parent competent to act or parental action threatened serious harm. The children's "liberation" theory states that in no case could parents exercise greater authority than could the state.

Mr. Hafen offers clarifying distinctions which might help ensure the future compatibility of the family tradition and the individual tradition.⁵ The constitutional principles applicable to children can be categorized into rights of "protection" and rights of "choice." No minimal intellectual or other capacity is necessary to justify claim to "protection" rights. "Choice" rights, on the other hand, are legal authority to make binding decisions of lasting consequence.

An important relationship exists between the "protection-choice" distinction and the concept of minority status. The denial of "choice" rights during minority is a form of protection against the minor's own immaturity and his/her vulnerability to exploitation by those having

no lasting responsibility for his/her welfare.

Accordingly, in Mr. Hafen's view: "Supervision of the 'choice' rights of minors is the very heart of the custodial rights of parenthood as well as being the rationale for minority status. For most parents, the rights of parenthood leave them no alternative but an assumption of parental responsibility because that responsibility, both by nature and by law, can be assumed by no one else until the parent has failed."⁶

THE ISSUE

Is the parent(s)/family to be deprived of the primary right and primary responsibility for the health care of the adolescent by the state and/or the professional based on the following concepts?

1. **Pragmatic Need:** Parental involvement constitutes a significant barrier to adolescent health care.
2. **Mature Minor Concept:** Contemporary adolescent cognition and psycho-social maturation provide *self-autonomous* decision-making by the adolescent.
3. **Mature Minor Doctrine:** The legal concept of entitlement rights and the "free exercise thereof" from birth — provides for the legal emancipation of all children.

CRITIQUE OF CONCEPTS

Concept 1: Pragmatic Need

The concept of pragmatic need is predicated on the recognition that the "rule" of parental consent and/or notification does not apply all the time to all adolescent health care situations. Since health is pre-eminent, all legal and ethical constraints should be eliminated in order to provide needed adolescent health care.

This represents discarding the "rule" or "principle" because there are exceptions, rather than modifying the "rule" in order to address the exception, i.e., the adolescent whose parent(s)/family is failing. The exception (the situation) becomes the "rule."

Hereby, the adolescent would be assigned full legal and ethical rights to confidentiality (privacy). The physician would be forbidden from notification of parent(s)/family without adolescent assent. Thereby, the pediatrician would lose the right to notify the parent(s)/family even though this was clearly indicated to be in the best interest of the adolescent's health care.

There is no objective evidence that parental involvement (consent and/or notification requirements) constitutes a significant barrier to needed adolescent health care. Neither is there objective evidence that confidential care provides improved health service for the adolescent.

One only needs to catalog the increase in "controversial" behavior/health care problems occurring concurrently with the sexual liberation

movement over the last 15 years, the demise of social and personal moral constraints, and the unfulfilled promise of technologic solutions to the problems of premature sexual activity. Certainly it is worth considering the progressive fragmentation of family life over the same period with the loss of parent(s)/family sanctions and the increase in these particular adolescent health problems. These events would seem to warrant efforts to stabilize rather than to undermine the parent(s)/family role and relationship with the adolescent.

More importantly, the majority of pediatricians are not willing to break the professional/ethical "contract" with the intact parent(s)/family in order to provide confidential health care services to the adolescent. The pediatrician must retain the right to notify the parent(s)/family if such notification is judged to be in the best interest of the adolescent, with or without the adolescent minor's consent or assent.

Recommendations of full emancipation may be germane to adolescent care in clinics in areas of high familial fragmentation and socio-economic dysfunction. It is inappropriate as the group statement of an academy made up primarily of private practitioners serving intact families.

Concept 2: The Mature Minor

The premise that adolescents today are more eminently capable in their decision-making than previous generations, especially with professional counsel, is very doubtful. This is based on "contemporary adolescent cognitive and psycho-social developmental principles."⁷ Also, parents in the vast majority of cases, i.e., private practice, are a lot more capable, responsible and caring in counseling their adolescent decision-maker than proponents of full emancipation are willing to envisage.

A major contention of the proponents is the concept of the mature minor based on accelerated "cognitive development and psycho-social maturation."⁸ At the same time, they acknowledge that determination of the minor's maturity is not an easy matter and "rests on a subjective appraisal" by the professional health care provider.⁹ They concede that young people do need particular guidance and support because of their greater inexperience.

Additional debatable assumptions are made regarding adolescent status and relationships, i.e., (1) the health professionals share the same goals and concerns of the parents; (2) the adolescent is a member of the family, but separate; (3) professionals are ideal role models; and (4) since parents and family are failing our adolescents, we must insert the critical, extraparental adult, i.e., the professional.¹⁰

In point of fact, the logistics of pediatric practice would not allow for the prolonged contacts necessary to achieve insights into a youngster's complex needs and cultural background. It would be presumptuous

tuous for any professional to claim wisdom superior to that of an interested parent in discerning when an adolescent's requests are wise, whimsical, or even self-destructive. Moreover, while it may be presumed that most pediatricians would be highly motivated in providing health care, this cannot be said for all who seek a role in adolescent counseling without parental knowledge or consent.

Is the available parent(s)/family to be judged by the adolescent, the professional, the bureaucrat and the court as too subjective, moralistic and unable to act appropriately in the long-term best interest of the youngster?

Concept 3: The Mature Minor Doctrine

The legal concept of the child or minor's rights perspective is the foundation of the mature minor doctrine. In particular, the newfound "right to privacy" of children represents new legal approaches to all minors based on "entitlement rights" and the free exercise thereof from birth. This movement constitutes an effort to liberate children and adolescents and represents a major departure from legal, ethical and cultural tradition. As such, it must not be merely asserted but rather demonstrated to be superior to tested safeguards.

On this basis, adolescents continue to be provided the notion that their appetites and desires represent a need and, hence, they are "entitled," i.e., have the right to fulfill or actualize self — be sexually active, use drugs, etc. All of this is based on the premise of sexual rights and the right to self-expression because there is no defined morality to sexuality or self-expression, i.e., an amoral, value-free, liberated society. The fact is that these "rights" vitally concern individual responsibility and, therefore, warrant ethical and legal constraints on their exercise. Indeed, it is not merely a matter of choice, any choice, and simply justifying that choice only to self, i.e., SELF-AUTONOMY. Youngsters 12-18 years of age do choose self-injury autonomously.

They need concrete "rights" and "wrongs" to limit them until they are mature enough to make a "good" choice, not just any choice. The immature, inexperienced, vulnerable adolescent needs moral guidance by parent(s)/family. There are "rights" and "wrongs" to be defined which are in the best interests of the adolescent and should be judged as such by the professional, as well as by the parent(s)/family. The responsibility is not only to self (privacy) but to others, i.e., parent(s)/family, society, etc.

The behaviors involved in adolescent health care are labeled "controversial." This understatement is the crux of the conflict evolving between parent(s)/family and the professional providing health care to the adolescent. Premature sexually active behavior with its concomitant health care problems of venereal disease, contraception and abor-

tion, and the often associated drug scene are moral issues and therefore require mature judgment. Whose judgment? Whose morality?

Parents do not have absolute or sovereign "rights" over their children. There is a need for reasonable legal constraints on parent(s)/family—for example, issues involving child abuse. Where is the balance? What are the appropriate limits—limits not only for parent(s)/family, but constraints on adolescents, professionals, bureaucracy and the adversarial system, i.e., the law? For sure, the statement of faith in professionals and the adversary, objective, legal system superseding the necessary legal and ethical commitment to parents and family as an advocacy system is clearly debatable.

IMPLICATIONS: VIEWPOINT

Should we really feel that the professional is the key to the long-term health care of the majority of adolescents who have intact parent(s)/family? Are the law and the professional sharing and supporting the adolescent in his autonomous decision-making, the answer to adolescent health needs? Certainly that is true where parent(s)/family are absent or dysfunctional or the youngster is legally emancipated for specific reasons of law, but not just because the adolescent or his professional surrogate desire no constraints, no value judgment, no moralizing. Why are the professionals and the courts willing to be quite judgmental of the parent(s)/family but unwilling to be judgmental of the adolescent, regarding his obligations? Is the adolescent to act responsibly, yet not have concretely defined limits or constraints (ethical or legal) regarding his choice, even if that choice constitutes self-injury and irresponsibility? Personal moral constraint and family-based sanctions are the primary restraints remaining in remediating irresponsible behavior.

The social services professionals lead the way for us by educating pediatricians to confront parents who abuse their children and define the treatment ideal of supporting and stabilizing the abusing family. Can we do less than caringly confront minors regarding their self-injury? If we judge and moralize regarding parents, why not minors? Hereby the professional responsibilities are in accord with the parents in the context of their family.

The moral confrontation implicit in the above critique is caring in its deepest sense. The professional's primary role and responsibility are as a facilitator to insure communication between the adolescent and parent(s)/family. That is what they both desire and desperately need. Modern parent(s)/family can "hack it" if given help and support.

Perhaps we should also confront the primary cause of the problems of teenage sexuality, i.e., the shattered network of communication among parent(s)/family and their children, which is responsible for increased premature sexual activity and attendant health problems.

Technological measures and professional counseling only suppress the results. As Eunice Kennedy Shriver opined, "If we do not involve our teenagers in moral discourse, if we do not strengthen families, if we do not add a dimension of responsibility and control to sexuality, if we do not care for those who become pregnant, if we can do no more than propose technological solutions to an issue that concerns human life — what does that say about us?"

CONCLUSION

Proposals for full emancipation of adolescents, minors aged 12-18, for health care purposes are based on the false premise that parent(s) and families have failed. Only "some" have failed!

Full emancipation is not valid nor in the best interests of adolescents who have available and functioning parent(s)/family. It may be appropriate when there is parental/family failure or the adolescent is defined as emancipated for specific reasons of law.

There is no adequate evidence that the three concepts of pragmatic need, the mature minor and the mature minor doctrine, from which the principle of full emancipation is derived, are valid. Furthermore, there is no objective evidence that these concepts and principles regarding consent and confidentiality issues would assure improved health care for children and adolescents.

The statement that "health is pre-eminent" is questionable.¹¹ There are many facets to the notion of health, particularly in the areas addressed, that involve personal, social and cultural values, i.e., human behavior. There is much more importance to the human relationships involved in the health care of adolescents than simple license, i.e., full moral, ethical and legal emancipation.

The differences herein expressed notably relate to shared goals and concerns regarding adolescent health. Both viewpoints cherish the goals of healthy, mature, coping, responsible adults, in turn assuring their progeny the same maturity in a just and caring society. The differences, however, are profound as to the means to those ends.

The proposed emancipation, the liberation of adolescents earlier from their parental/family responsibility and moral values, is not the best means for assuring these shared goals. There is a vital need to support the present constraints on the adolescent, the professional, the bureaucracy and the courts on behalf of the adolescent's need to become mature and responsible in the protective environs of the primary caretaker, i.e., the parent(s)/family unit. Primary prevention, i.e., the ideal of responsible (moral) behavior, is necessary for adolescents' health care and their achievement of maturity and independent, responsible freedom earned as a citizen's right and not simply as an entitlement.

PROPOSAL

The principles of adolescent health care require restructuring of the patient-parent-physician relationship at the beginning of adolescence. The primary relationship is with the adolescent patient yet in the context of the parent(s)/family and the community.

An oral contract is to be established which seeks to balance the needs and responsibilities of both the adolescent and the parent(s)/family.

The complexity of the relationships and problems involved requires limited, not absolute, rights. Therefore, an oral agreement is necessary in defining the limits of consent and confidentiality the minor may expect.

In establishing these procedural rights, the physician seeks to do no harm while acting in the best interests of the patient. Adolescent access to health care and respect for the individual require very broad though limited confidentiality rights based on the need for continuing parent(s)/family supervision to protect the minor.

Limitation of consent rights requires consideration of the degree and seriousness of the problem, reversibility, the impact on the parent(s)/family and the community, moral conflicts, economic factors, and the maturity of the minor. I find the determination of maturity by chronological age (state law) to be necessary for legal and practical purposes. Determination by professional evaluation is subjective and often adversarial.

Minors' consent to health care that involves potential injury, i.e., pregnancy, prescribed contraception, abortion, sterilization, drug abuse, running away and suicide warrants parental consent and parents are to be notified unless there are compelling reasons to the contrary, i.e., serious harm for the minor, harm to others, the public health and safety (VD), an emergency, emancipation for specific reasons of law (married, living independently, etc.), or failure of the parent(s)/family.

Based on these considerations, I would recommend the following general rule and procedure for adolescent health care by the pediatrician as a positive alternative.

Adolescent health care that involves potential injury requires parental notification and consent where the parent(s)/family are available and functioning. Therefore, the pediatrician should maintain the right of parental notification and consent preferably, but not necessarily, with the adolescent's assent.

Parental notification and consent are not in the best interests of the adolescent when there is parent(s)/family failure or the adolescent is emancipated for specific reasons of law.

Thus, exceptions to the general principle of parental notification and consent may be justified by the reasonable, responsible exercise of the physician's judgment in the best interests of the adolescent. These

principles are applicable to public clinics as well as to private practice under responsible professional supervision.

Assuming that there is an available and functioning parent(s)/family, the procedures are as follows:

- Sexual abstinence is commended as the ideal for the adolescent.
- Non-prescriptive, publicly available barrier/chemical methods of contraception are safe, effective, inexpensive, accessible, readily utilized and afford adequate contraception when abstinence is rejected. Parental consent and/or confidentiality are not at issue.
- Prescribed contraception, i.e., the IUD and the "pill," and abortion involve potential serious harm and risk for the adolescent and, therefore, warrant parental consent and notification.
- The management of substance abuse in the adolescent is peculiarly dependent upon parent(s)/family involvement and warrants parental notification.
- The treatment of venereal disease is a pragmatic need, and as a public health interest warrants confidentiality or adolescent assent to parental notification.

Conversely, in the circumstance of parent(s)/family failure, the physician may proceed with informed consent of the adolescent and act in the best interests of the adolescent as follows:

- Abstinence remains a suitable ideal to be proffered. Barrier/chemical contraception is advised. Prescribed contraception, i.e., the IUD and the "pill," is an option which involves potential for serious harm and risk that does not require consent but warrants parent(s)/family notification. In my opinion, the abortion option requires parent(s)/family consent and notification. Substance abuse and venereal disease are treated without parent(s)/family consent, and notification is exercised only with adolescent assent.

A summary table follows.

SUMMARY TABLE

Health Care	Functional Parent(s)/Family		Failed Parent(s)/Family	
	Consent	Notification	Consent	Notification
Prescribed Contraception	Yes	Yes	No	Yes
Abortion	Yes	Yes	Yes	Yes
Substance Abuse	No	Yes	No	No
Venereal Disease	No	No	No	No

The risk of suit by the parent(s)/family reasonably judged to have failed, or when the adolescent is emancipated for specific reasons of law, is essentially nil based on case law.

The adolescent, however, has the right to sue in many jurisdictions for a period of two years after maturity, usually until age 23. Therefore, professional liability requires a regard for litigation when harm ensues from medical risk procedures (IUD, "pill," abortion) in the adolescent as with any other patient, whether or not parental consent and notification are obtained.

Legal constraints that would prohibit the physician notifying and involving functioning parent(s)/family in the best interests of the adolescent should be avoided.

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