2.2.2 Confidential Health Care for Minors

Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.

In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.

When an unemancipated minor requests confidential care and the law does not grant the minor decision-making authority for that care, physicians should:

(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:

  (i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;

  (ii) involving the patient's parent/guardian is necessary to avert serious harm to others;

  (iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.

(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.

(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.

(d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).

(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.

(f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.

(g) Consult experts when the patient's decision-making capacity is uncertain.

(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

AMA Principles of Medical Ethics: IV

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 3-A-13 Amendment to E-5.055, Confidential care for minors

CEJA Report G-A-92 Confidential care for minors

CEJA Report 3-A-16 Confidential health care for minors

2.2.2 Confidential Health Care for Minors

Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. *A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits. [new content sets out key ethical values and concerns explicitly.]*

In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.

When an unemancipated minor requests confidential care and the law does not grant the minor decision-making authority for that care, physicians should:

(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:

  (i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;

  (ii) involving the patient's parent/guardian is necessary to avert serious harm to others;

  (iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being. [new content addresses gap in current guidance]

(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.

(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.

(d) *Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements). [new content addresses gap in current guidance]*

(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.

(f) *Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state. [new content addresses gap in current guidance]*

(g) Consult experts when the patient's decision-making capacity is uncertain.

(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

AMA Principles of Medical Ethics: IV

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-13

Subject: Amendment to E-5.055, "Confidential Care for Minors" (Resolution 1-A-12)

Presented by: H. Rex Greene, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William T. Bradley, MD, Chair)

This report is submitted in response to Resolution 1-A-12, "HPV Vaccination for Minors," introduced by the Medical Student Section and referred by the House of Delegates, which asks that "our American Medical Association (AMA) develop and support model state legislation allowing unemancipated minors to consent to HPV vaccination" and was referred to the Council on Ethical and Judicial Affairs (CEJA) by the Board of Trustees for input on the relevant ethical considerations. Based on its review of the ethical analysis that informs current AMA policies, CEJA recommends that Resolution 1 be addressed by amending Opinion E-5.055, "Confidential Care for Minors" to allow minors to consent to measures that not only treat sexually transmitted disease, but also prevent it.

BACKGROUND

Human papillomavirus (HPV) is one the most common sexually transmitted infections (STI) in the world with a lifetime prevalence of 80%, and an estimated 6.2 million new infections occurring each year.[1,2] The Food and Drug Administration has approved several vaccines that are between 93%-100% effective in preventing the strains of HPV that are associated with cancers and genital warts in both males and females.[1] Vaccination can prevent 70% of all cervical cancers as well as vaginal and vulvar cancers in females, 90% of genital warts in both genders, and anal, penile, and oropharyngeal cancers.[1,3] Although HPV vaccines can be administered through age 26, the Center for Disease Control's (CDC) Advisory Committee on Immunization Practices (ACIP) recommends HPV vaccinations in early adolescence, when the best antibody response occurs and before the adolescent becomes sexually active.[4,5] The vaccine can be administered as early as 9 years of age and ACIP recommends HPV vaccination for both adolescent males and females, given the disease burden associated with HPV in both genders.[4,5]

An estimated 24% of parents may object to vaccinating their children against HPV [2]. Parents may not wish to consent to the vaccine on behalf of their children for a variety of reasons: they are conscientious objectors of vaccines generally; they do not feel their child is at risk for acquiring an STI, safety concerns, a lack of knowledge about the vaccine, or perceptions that the vaccine will promote sexual activity prematurely.[2,6,7] Recent data reveals that HPV vaccination of 11 and 12 year old girls is not associated with the clinical markers that suggest increased sexual activity like

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

sexually transmitted disease or pregnancy.[8] The FDA has licensed HPV vaccines as safe and effective, and vaccination has shown only mild side effects like pain, fever, headache, or nausea.[9]

HPV vaccination has been at the center of state legislation over last several years, mainly considering whether states can and should mandate HPV vaccination for minors.[10] With respect to the question of consent, in January 2012, a California law went into effect that explicitly allows minors (ages 12 years and older) to consent not just to treatment and diagnosis of STIs (which the law already permitted), but also to prevention of STIs, including the HPV vaccine, Hepatitis B vaccine, and medications to prevent HIV exposure before or after sexual contact.[11,12]

CURRENT AMA POLICY

AMA Policy H-60.965, "Confidential Health Services for Adolescents," confirms that confidential care for adolescents is critical to improving patient health and that, while parental involvement in children's health should generally be encouraged, parental consent should not act as a barrier to needed medical care.[13] Moreover, H-60.958, "Rights of Minors to Consent for STD/HIV Prevention, Diagnosis, and Treatment," emphasizes the importance of minors being permitted to consent for prevention of STIs, as well as STI treatment and diagnosis.[14] While Opinion E-10.016, "Pediatric Decision-Making," acknowledges that generally parental consent should be sought in the treatment of pediatric patients, parental consent is not always mandatory.[15] For example, Opinion E-2.015, Mandatory Parental Consent to Abortion," ultimately allows minors to consent to abortion without parental involvement when, in the discretion of the minor, parental involvement is not appropriate.[16] Moreover, Opinion E-5.055, "Confidential Care for Minors," provides ethical guidance for physicians in the provision of other types of medical care to minors without parental consent.[17] According to Opinion E-5.055 and its related report, CEJA Report G-A-92, "Confidential Care for Minors," physicians should always permit competent minors to consent to medical care, only notifying parents with the patient's consent.[17,18] For incompetent minors physicians should ordinarily provide certain types of medical services without parental consent if, in the absence of confidentiality, the minor may otherwise fail to receive healthcare that is necessary to prevent serious harm. Such services include contraception, treatment of STI, pregnancy-related care, drug and alcohol abuse or mental health treatment.[17,18]

ETHICAL CONSIDERATIONS

Confidentiality is necessary in the medical encounter to ensure that patients are not reluctant to disclose all relevant health information or to visit the physician for certain sensitive health problems.[18] Confidentiality is of particular importance in minor care, or minors may avoid care that they do not want their parents to learn about.[18] Parents are generally seen as the authority in their children's health, including in making healthcare decisions on behalf of their children, however this relationship changes as the child matures and increasing need for confidentiality emerges.[18] In the vast majority of scenarios, minors will not object to their parents' involvement in their healthcare. Yet some care is private in nature and may be associated with behaviors that the parent would disapprove of, such as use of contraceptives or treatment for drug abuse. While minors should be encouraged to involve their parents in healthcare decisions and such involvement will usually be in line with the best interests of the minor, there are times where it is important to preserve confidentiality in order to ensure that the minor feels safe to seek care that can prevent serious harm.[6,7,18]

As AMA Policy H-60.958 already recognizes, preventing STIs in minors is equally as important as treating them—thus confidentiality is important in either case. Just like treatment for STIs, adolescents may be reluctant to seek care to prevent STIs and include their parents in these decisions for a variety of reasons: a desire to take ownership over their own health as they develop autonomy, or fear of embarrassment, parental disapproval, or parent refusal.[6] Without confidential care, some minors may avoid such preventive measures rather than have their parents find out. If parental consent is required, patients may fail to receive care which is necessary to promote patient health and prevent serious harm. For example, an HPV vaccine allows the prevention of a number of burdensome cancers associated with the disease, and the morbidity and mortality associated with those cancers. Moreover, like treatment for STIs, prevention of STIs may also be time-sensitive (as in the case of the HPV vaccine which minors should ideally receive before reaching age of majority). Preventive measures (like treatment) involve sensitive, private health matters where parental consent may sometimes act as a barrier to important care and thus confidential care should be permitted in preventive STI treatment as it is in treatment and diagnosis. Such preventive measures may include vaccinations against STIs, as well as medicines that minimize exposure to STIs. Like treatment of STIs, physicians should generally provide preventive STI measures to minor patients without requiring parental consent.

Like other services, the physician who is uncomfortable administering the vaccine without parental involvement should inform the patient that care may be available elsewhere.

RECOMMENDATION

Given these considerations, the Council recommends that Opinion E-5.055, "Confidential Care for Minors," be amended by insertion as follows and that the remainder of this report be filed:

> Physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities.
>
> When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections.
>
> Where the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.
>
> When an immature minor requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, measures to prevent sexually transmitted disease, drug and alcohol abuse, or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor

may be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached, according to Opinion 5.05, "Confidentiality." In addition, confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor. (IV)

Modify Current HOD Policy

Fiscal Note: $500

REFERENCES

1. Centers for Disease Control and Prevention. HPV vaccine information for clinicians- fact sheet. Updated July 12, 2012. http://www.cdc.gov/std/hpv/stdfact-hpv-vaccine-hcp.htm. Accessed October 9, 2012.
2. Bosch X, Harper D. Prevention strategies of cervical cancer in the HPV vaccine era. Gynecol Oncol 2006; 103:21–4.
3. The Advisory Committee on Immunization Practices. Recommendations on the Use of Quadrivalent Human Papillomavirus Vaccine in Males — Advisory Committee on Immunization Practices (ACIP), 2011. Published December 23, 2011. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a3.htm. Accessed October 23, 2012.
4. The Advisory Committee on Immunization Practices. FDA Licensure of Bivalent Human Papillomavirus Vaccine (HPV2, Cervarix) for Use in Females and Updated HPV Vaccination Recommendations from the Advisory Committee on Immunization Practices (ACIP). Published May 28, 2010. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a4.htm. Accessed October 9, 2012.
5. The Advisory Committee on Immunization Practices. FDA Licensure of Quadrivalent Human Papillomavirus Vaccine (HPV4, Gardasil) for Use in Males and Guidance from the Advisory Committee on Immunization Practices (ACIP). Published May 28, 2010. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a5.htm. Accessed October 9, 2012.
6. Farrell RM, Rome ES. Adolescents' access and consent to the human pappilomavirus vaccine: a critical aspect for immunization success. *Pediatrics* 2007; 120: 434.
7. Chen DT, Shepherd LL, Becker DM. The HPV vaccine and parental consent. *Virtual Mentor* 2012; 14(1): 5-12. http://virtualmentor.ama-assn.org/2012/01/ccas1-1201.html. Accessed March 7, 2013.
8. Bednarczyk RA, David R, Ault K, Orenstein W, Omer SB. Sexual activity- related outcomes after human papillomavirus vaccination of 11- to 12-year-olds. Pediatrics 2012; published online October 15, 2012. http://pediatrics.aappublications.org/content/early/2012/10/10/peds.2012-1516. Accessed October 23, 2012.
9. Centers for Disease Control and Prevention. Vaccines and preventable diseases: HPV-vaccine-questions & answers. Last updated July 20, 2012. http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm. Accessed October 23, 2012.
10. National Conference of State Legislatures. HPV vaccine: state legislation and statutes. Updated July 2012. http://www.ncsl.org/issues-research/health/hpv-vaccine-state-legislation-and-statutes.aspx. Accessed October 23, 2012.
11. Cal Fam Code § 6926 (2012).
12. California Department of Public Health. Minors, medical care consent: chapter 652 summary of the law. Published January 26, 2012. http://www.cdph.ca.gov/programs/std/Documents/AB-499-Fact-Sheet.pdf. Accessed October 23, 2012.
13. H-60.965 Confidential Health Services for Adolescents.
14. H-60.958 Rights of Minors to Consent for STD/HIV Prevention, Diagnosis, and Treatment.
15. E-10.016, Pediatric Decision-Making.
16. E-2.015, Mandatory Parental Consent to Abortion.
17. E-5.055, Confidential Care for Minors.
18. CEJA Report G-A-92, Confidential Care for Minors.

CEJA Report G – A-92
Confidential Care for Minors

INTRODUCTION

A report of the Council on Scientific Affairs examines the issue of confidential care for adolescents.[1] It focuses on adolescent under-utilization of health care services in the face of increasing rates of health care problems such as drug and alcohol abuse, depression, and sexually transmitted diseases, including HIV disease. The report also examines research indicating that a lack of or perceived lack of confidentiality is a primary factor inhibiting adolescents from seeking medical care. Another report of the Council on Ethical and Judicial Affairs provides an ethical analysis of the issues of parental consent and notification for abortion. [see Report 41] This report of The Council on Ethical and Judicial Affairs will examine the ethical issues related to confidential care for minors in general.

IMPORTANCE OF CONFIDENTIALITY

In the medical encounter, patients necessarily relinquish some privacy when they provide information about their personal health histories and when they undergo a physical examination.[2] (p.329) Because physicians have special access to private information about their patients, they acquire the responsibility for keeping such information confidential. Without an assurance of confidentiality, patients may be reluctant to disclose relevant information or even to consult physicians for certain health problems.[2] (p.3S3) In particular, without confidentiality, minors may be deterred from seeking services that they do not want their parents to learn about (e.g. contraceptive services and treatment for drug or alcohol abuse).[3]

When minors are treated, the issue of confidentiality is complicated. In general, parental participation is an integral element of the physician-patient relationship. Parents often provide much of the medical history and accompany their children during physical exams. In addition, parents generally are responsible for making health care decisions for their children. As children mature and approach adolescence, this physician-patient-parent relationship changes. There is an increasing need for older minors to have a more independent relationship with their physicians, at which point keeping information confidential from the minor's parents becomes an issue.

In the vast majority of situations, minors will not object to parental involvement. The situations where minors (generally adolescents) do have objections usually involve certain types of problems or behaviors that they do not want their parents to learn about, such as sex or drug use. Objections often can be eliminated if the physician ascertains the reasons why the patient is reluctant to involve his or her parents and corrects any misconceptions. For example, an adolescent may fear that his or her parents will not be understanding. The physician can inform the patient that, while parents often initially react with anger or disappointment, they generally are very supportive. Physicians should also try to persuade such patients that they may actually benefit from the involvement of their parents through support and the help of their parents' life experienced

Confidentiality when parental consent need not be obtained

Minors should be permitted to consent to confidential care in two circumstances: 1) the minor is competent, and 2) the minor requests certain confidential services (to be outlined below).

Competent minors

In this analysis, competence, or decision-making capacity, refers to the ability to make specific kinds of decisions.[5] A person's capacity to make one type of decision may be greater or less than his or her capacity to make other decisions, depending on the complexity and consequences of the decision.[2] (p.80),[6] (p.218) For example, a minor may bee competent to choose what school courses to take, but not competent to make a decision to donate a kidney. A determination of competence to make a medical decision must be based on an evaluation of the patient's ability to understand, reason and communicated

While it is true that most minors lack the cognitive capacity to make autonomous health care decisions, experts agree that many older minors are mature enough to make autonomous decisions.[4,7] In fact, research in this area suggests that the process of medical decision-making for adolescents often does not differ from that of adults.[7(pp.37-48),8,9,10] In one recent study, researchers interviewed 75 women, ages 13 to 21, who were visiting a clinic for a pregnancy test because they suspected an unplanned pregnancy. The decision whether to carry the pregnancy to term was examined, and comparisons of the women's decision-making processes were made across the different age groups. Among the women who considered abortion, the researchers found no age-related differences for the three measures of cognitive competence studied (thoroughness of consideration of consequences, number of reasons considered, and content of the reasoning about pregnancy).[10]

On the other hand, the research on the competence of minors is limited in a few respects. The measures for decision-making capacity vary among studies, and it has not been established that the measures used fully assess the decision-making process. Only a few studies examine decision-making in real-life situations; most study the process in the context of hypothetical examples.[7(pp.30-7)] In addition, the susceptibility of minors to the influence of others is a potential barrier to autonomy that has not been thoroughly examined. Children and younger adolescents seem to conform to authority more than adults 4, while middle-stage adolescents (15-16 year olds) tend to rebel against authority and conform to the influence of their peers to a greater extent than adults.[6(p.223)] The strength of these influences may cause minors' decision-making to be less voluntary than adults' decision-making.

There is a general consensus that there are minors who are capable of making autonomous health care decisions.[4] In general, adolescents 14 and above appear mature enough to make decisions about their medical cared However, before the presumption of competence is shifted from age 18 years to a younger age, more research is necessary in the area of medical decision-making by minors. At this time, competence should be evaluated on a case-by-case basis.

Usually, it is clear when a minor is competent to make a particular decision. However, there will be cases where it is not obvious. At this time, there is no generally accepted standard for competence.[4] The minimum levels and means of measuring the capacity to understand, reason and communicate have not been established. As a result, the question of who should evaluate minors' competence is important to this analysis.

Courts make competency determinations in a number of circumstances including the capacity of individual minors to consent to medical treatment (mature minor rule). In addition, their decision-making is subject to many procedural safeguards. On the other hand, physicians are usually in the best position to judge decision-making capacity, since 1) they often have greater knowledge of the patient and his or her parents, and 2) they have experience with the treatment decisions of their patients. Competency evaluations by physicians instead of judges are also less cumbersome

and more private, and thus more accessible to patients. Therefore, competence should be evaluated by physicians in most cases. In difficult cases, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competency determinations should be made only as a last resort.

When a minor is judged to be competent, he or she becomes a fullfledged partner in the physician-patient relationship.[4] In other words, minors who are competent due to their maturity are entitled to the same degree of autonomy and confidentiality as an adult patient. Parental involvement should always be encouraged, but parental consent should not be required for the treatment of mature minors, and information disclosed in the patient-physician interaction must not be disclosed to the parents or another third party without the consent of the minor. Certainly, if the minor wants his or her parents to make health care decisions, the patient should not be forced to make such decisions. As with adults, competent minors may choose to waive their authority to consent and to transfer that authority to others.[6](p.240) Also, the exceptions to confidentiality for adults also apply to competent minors (e.g., gunshot wounds, danger to an identifiable person, and child abuse).[4]

If a physician does not feel comfortable providing a service without parental involvement, and there are alternative confidential services available, the patient may be referred. If no alternative confidential services are available, the physician should provide the service. Competent minors should not be required to waive their right to confidentiality as a condition of receiving medical care.

Provision of certain services

When an immature minor requests specific confidential services, the minor generally should not be granted the authority to consent to treatment. Incompetent persons, as a rule, cannot be relied upon to make decisions that will promote their well-being.[2(p.227)] However, there are exceptions for certain kinds of services. Parental consent ethically need not be obtained before providing contraceptive services, treatment of sexually transmitted diseases, pregnancy-related care (including pregnancy testing, prenatal/postnatal care, and delivery services), drug and alcohol abuse treatment and mental illness treatment to minors who request these services. Due to the private nature of these services and their association with problems or behaviors that parents may disapprove of, adolescents are often so reluctant to involve their parents that they forgo services altogether if parental involvment is required. As a result, the absence of confidentiality may cause adolescents to fail to receive health care that is necessary to prevent serious harm.

When providing these services, physicians should always encourage parental involvement. Physicians should discuss with the patient the benefits to the patient from parental involvement as well as the potential harms from parental non-involvement. However, if the minor still wants confidential services, the physician ordinarily should respect the patient's wishes. Failure to respect the minor's confidentiality may reduce the likelihood that the minor will receive care or seek care in the future, and may consequently increase the risk of health problems for the minor.

If the physician feels uncomfortable providing the service without parental involvement, he or she may refer the minor to another physician or a clinic where the minor can receive confidential services. When the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

Confidentiality when parental consent must be obtained

The goal of medicine is to promote the health of patients. Beyond the requirement that physicians do no harm to their patients (i.e., nonmaleficence), they must use the tools of medicine to benefit their individual patients. Beneficence requires that the interests of one's patient come before the interests of others. Only in rare cases, when there is a greater societal interest at stake, may that interest override the interest of the patient. In the case of minors, the interests of the parents generally coincide with the interests of minors. However, it is important to remember that the primary interests to consider are those of the patient—the minor

Parental involvement will usually be consistent with the interests of the minor (e.g., greater compliance, emotional support), and such involvement should be strongly encouraged. In addition, family unity and the importance of the role of parents in shaping their children's values and character are factors that support parental involvement.

Nevertheless, a degree of confidentiality is often critical to the patient-physician relationship even when the patient is an immature minor. Disclosing sensitive information to parents without the consent of the minor may disrupt the patient's trust in the physician, and may make it less likely that he or she will disclose any similarly private information in the future. In addition, failing to specifically assure the patient of confidentiality (and explain its limits) may also hinder adolescents from disclosing important information about their health. Accordingly, for incompetent minors who are mature enough to be unaccompanied by a parent for their examination, confidentiality of information disclosed during an exam, interview, or in counseling should be ordinarily maintained.[4]

Since parents are responsible forsaking health care decisions for their children, and their decisions must be informed ones, certain information relevant to the health status of their children must be disclosed to them. In addition, there may be instances when it is necessary for physicians to disclose certain information to parents to avert a serious harm to their child. Only information that is essential for the parents to know in order for them to make medical decisions or to avert serious harm should be disclosed against the wishes of the minor. In such circumstances, the physician should inform the patient that his or her parents will be notified, and explain the necessity for the disclosures. Confidential information may always be disclosed to the parents if the minor agrees.

An important consideration to be weighed when deciding whether to breach a minor's confidentiality is that, for seriously dysfunctional parent-child relationships, disclosing sensitive information such as sexual behavior, pregnancy, or drug use to the parents may place the minor in danger. Examples of potential harms to minors include being forced out of their homes, being forced into unwanted marriages, or being physically abused.

When there is reason to believe the minor may be endangered by disclosure to the parents due to a dysfunctional parent-child relationship, the physician should not breach the minor's confidentiality. The physician should also make referrals to counseling services or social services. If there is evidence of child abuse, a report should be made to the appropriate child protection agency.

Factors limiting confidentiality

There are some problems with maintaining confidentiality that are, to a large extent, beyond the control of the physician. For example, minors who live with their parents will probably not be

able to hide the fact that they have been hospitalized An even greater threat to confidentiality involves payment for services. If a minor does not have the personal resources to pay for medical care, and the physician is not willing to provide free or discounted services, it may not be possible to provide services without parental knowledge.[12] Usually, if a minor is covered by his or her parents' insurance, parents must provide insurance information to the physician before treatment, and the services that a minor receives will often be itemized on the parent's insurance statement.

The problem of payment for confidential care may result in physicians and hospitals turning minors away who seek confidential services. When a physician does not provide needed services because the minor cannot afford to pay, the physician has an ethical duty to make a referral, when possible, to another physician or clinic that will provide the needed confidential care despite the patient's inability to pay.

Duty to promote autonomous decision-making

Just as physicians must provide the necessary medical information to patients to increase patients' autonomy in making health care decisions, physicians also have a role in fostering minors' autonomy by promoting their decision-making capacity. Promoting the autonomy of minors enables them to become better health care decision-makers, contributes to the decision-making process, and often benefits the minors psychologically.[13]

The best way to promote minors' decision-making capacity is to involve them in the decision-making process to an extent commensurate with their ability.[4] For example, historical information can be obtained from 4 or 5 year old children and the initial explanation of the medical condition or treatment may be directed to children as young as 6 or 7 years of age.[4] If the physician has a long standing relationship with a minor he or she will be able to gradually increase the minor's participation in medical decision-making over time, at the same time gaining a better understanding of the minor's decision-making capacity.

PHYSICIANS LEGAL REQUIREMENTS IN RELATION TO THEIR ETHICAL DUTIES

The above analysis provides ethical guidelines for the treatment of minors given the current state of knowledge. When the law does not require otherwise, the ethical duties described in this report must direct physicians. However, physicians' legal requirements in many situations, prohibit physicians from acting in accordance with their ethical duties as outlined above.

The ethical analysis is not intended to encourage physicians to violate the law. It should guide lawmakers and judges, and in this respect, physicians should play an active role in changing or repealing laws which violate accepted ethical principles.

Over the years, physicians' legal requirements for treating minors have evolved to be much more compatible with physicians' ethical duties than they were a century ago. The common law rule for the treatment of minors was that any treatment without the parental consent constituted assault and battery.[14] More broadly, parents had an almost absolute right to make all decisions affecting a minor's welfare.[7(pp.1-3),14]

Currently, the rights of minors have been significantly expanded. A number of Supreme Court decisions have established that although minors do not possess all of the constitutional rights of adults, they do have a number of previously unrecognized rights.[15,16,17] In the medicolegal context, legislatures and courts have expanded the right to consent to medical treatment without parental consent for certain categories of minors and for certain medical services.

Along with these exceptions to parental consent, laws have been developed concerning the confidentiality of the physician-patient relationship when the patient is a minor, particularly regarding parental notification. A number of courts and legislatures have replaced parental consent requirements with parental notification requirements.[7(p.14)]

Physicians' legal requirements for treating minors are governed by state statutes, federal funding regulations, and case law including Supreme Court decisions. It should be noted that there has not been a case in the past 25 years in which a parent recovered damages for nonnegligent treatment of a minor age 15 or older without parental consent.[14]

Mature and emancipated minors

Consent

The law recognizes that age 18 is an arbitrary line to draw between those who are and are not capable of consenting to medical treatment, and that there are minors under 18 who, due to their maturity, have the right to make their own medical decisions. This principle is located in the mature minor rule and more indirectly in the common law doctrine of emancipation.

Mature minors' capacity to consent to medical treatment has been recognized in state courts since the early part of this century.[7(p.7)15] In addition, the Supreme Court has also recognized the "mature minor rule" in cases dealing with contraception and termination of pregnancy.[17,19] Currently, a few states have case law addressing the mature minor exception and only a couple states have mature minor statutes.[7(pp.7-8)]

The legal concept of maturity is essentially equivalent to the concept of competence defined in the previous ethical analysis. In this way the law is consistent with physicians' ethical duty to respect treatment decisions of competent minors. Determining maturity on a case-by-case basis is also consistent with the ethical analysis of competence. Furthermore, the determination of maturity is usually left to physicians. However, in the case of the termination of a pregnancy without parental consent or notification, in many states a judge must determine maturity.[7,20]

On the other hand, the criteria for maturity in the courts and in the few mature minor statutes often include factors that go beyond criteria for competence. Often the age of the minor is considered in addition to his or her capacity to make the treatment decision. Generally, minors must be at least 15 years old to be considered mature. Courts and statutes also require in many cases that the treatment be necessary and, except for emergency care, be less than "major" or Serious" and not overly complex.[5(p.7),14,2l,22] Ethically, factors such as whether the treatment is necessary, and the seriousness or complexity of the decision raise the standard for competence. However, it is possible for a minor to be mature enough to make a major or very complex health care decision.

An emancipated minor is one who has become independent from his or her parents, or is no longer subject to parental control. The criteria for emancipation varies from state to state and court to court. Generally, minors are considered emancipated by courts when they no longer live with their parents, are self-supporting, or their parents have surrendered their parental rights and responsibilities. 14 Married minors and minors who have entered active duty in the armed forces have traditionally been considered emancipated.[14] College students living away from home are also often considered emancipated even though they may be financially dependent on their parents.[14]

More recently, state legislatures have enacted emancipated or independent minor statutes. Almost half of the states have statutes which provide that emancipation be determined through a judicial process, and a few states have statutes which allow emancipation to be determined without court involvement.[7(p.6)] Emancipation statutes generally do not specifically state that an emancipated minor may consent to medical treatment without parental consent.[7(p.6)]

A large number of states have statutes that do not refer to emancipation but provide that certain categories of minors considered to be independent from their parents may consent to medical treatment. Minors included in these statutes include those who are parents, married, living apart from their parents and managing their own finances, in the military, or high school graduates .[7(p.6-7)]

Laws allowing minors to consent to medical treatment due to their emancipation or independence do not focus on the capacity of the minors to consent. However, it is likely that in most cases, emancipated minors are competent, since they possess the maturity to live independently of their parents. When emancipated minors are competent, it is ethically justified to provide treatment to them without parental consent or notification. In addition, granting emancipated minors the authority to consent is ethically justified when seeking parental consent may be harmful to the patient, as in the case of a runaway who refuses to disclose the identity and location of his or her parents.

Confidentiality

Statutes codifying the emancipated/independent minor and mature minor exceptions to parental consent rarely address confidentiality or parental notification.[7(p.19-20)] The only law that may direct physicians with respect to confidentiality for mature and emancipated minors is the law that requires confidentiality of patient-physician relationship for adults.[7(p.15)] Therefore, except when there exists a statute which requires parental notification for the treatment of mature or emancipated minors, it is legal to provide services to these minors without notifying their parents. Consequently, due to their ethical duties, physicians must not breach confidentiality for mature or emancipated minors without their consent.

Exceptions for specific services

There are numerous state statutes providing parental consent exceptions for contraceptive services, pregnancy care, and treatment for sexually transmitted disease, drug and alcohol abuse and mental illness. However, many states do not have statutes for all of these services.[7(pp.8-l4)] In addition, many have age and/or maturity requirements and some statutes have parental notification requirements.[7(pp.16-19)] All such requirements violate the Council's ethical guidelines.

RECOMMENDATIONS

1. Physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities.

2. When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minors' reasons for not involving their parents and correcting misconceptions that may be motivating their objections.

3. Where the law does not require otherwise:

    a. Physicians should permit competent minors to consent to medical care and should not notify parents without the patients' consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.

    b. When an immature minor requests contraceptive services, pregnancy related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor may be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

    c. For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached. In addition confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor.

4. When laws violate these ethical standards, physicians should fulfill their legal requirements. However, such laws should be altered to conform with these guidelines. Physicians should play an active role in changing laws that are not in conformity with these standards.

REFERENCES

1. Council on Scientific Affairs. Report A: Confidential health services for adolescents. In: *Proceedings of the House of Delagates of the AM*A. Chicago: AMA, June 1992.

2. Beauchamp TL, Childress JF. *Principles of biomedical ethic*s. *(3rd e*d.) New York: Oxford University Press, 1989.

3. Demetriou E, Kaplan DW. Adolescent contraceptive use and parental notification. *Am J Diseases of Childre*n. 1989;143:1166-1172.

4. King NM, Cross AW. Children as decision makers: guidelines for pediatricians. *J Pediatric*s. 1989;115:10-16.

5. Report D of the Council on Ethical and Judicial Affairs: Decisions to forgo life-sustaining treatment for incompetent patients. *Proceedings of the House of Delegate*s, June 1991.

6. Buchanan AE, Brock DW. *Deciding for others: the ethics of surrogate decision makin*g. Cambridge: Cambridge University Press, 1989.

7. Gittler J, Quigley-Rick M, Sacks MJ. *Adolescent health care decision making: the law and public polic*y. Carnegie Council on Adolescent Development: working papers, New York, 1990.

8. Lewis CG. A comparison of minors' and adults' pregnancy decisions. *Am J Orthopsychiatr*y. 1980;53:446- 53.

9. Weithorn LA, Campbell SB. The competency of children and adolescents to make informed treatment decisions. *Child developmen*t. 1982;53:1589-98.

10. Ambuel B. Rappaport J. Developmental trends in adolescents' psychological and legal competence to consent to abortion. *Law Hum Beha*v. 1992;16:129-154.

11. Leikin S. Minors' assent and dissent to medical treatment. *J of Pediatric*s. 1983;102:169-176.

12. Holder A. Disclosure and consent: problems in pediatrics. *Law, Med & Health Car*e. 1988;16;219-228.

13. Tremper CR, Kelly MP. The mental health rationale for policies fostering minors' autonomy. *International J Law & Psychiatr*y. 1987; 10:111-127.

14. Holder AR. Disclosure and consent problems in pediatrics. *Law, Med. & Health Car*e. 1988;16:219-228.

15. *In re Gaul*t, 387 U.S. 1 (1967).

16. *Tinker v. Des Moines Independent Community School Distric*t, 393 U.S. 503 (1969).

17. *Planned Parenthood of Missouri v. Danfort*h, 428 U.S. 52 (1976).

18. *Bakker v. Welsh* 144 Mich. 632, 108 N.W. 44 (1906).

19. *Bellotti v. Bair*d, 443 U.S. 622 (1981).

20. Strasburger VC, Eisner J, Tilson JQ, Rigg CA, Kulig JW. Teenagers, physicians, and the law in New England. *J Adolescent Med* 1985;6:377-382.

21. Rothenberg KH. *Medical decision making for children. BioLa*w. J Childress, R Goare (Eds.), Frederick, MD: University Publishers of America, 1986.

22. Engum ES. Expanding the minor's right to consent to non-emergency care: a psycho-legal rationale. *J Legal Me*d. 1982:3:557-615.