Ethical Considerations Concerning Adolescents Consulting for Contraceptive Services

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Adolescents increasingly come to physicians' offices for contraceptive care. This raises the issue of parental involvement, often formulated in terms of conflict around the issues of consent and confidentiality. In the past two decades, a new philosophy has emerged that deals with the issues from a perspective of the "civil rights" of adolescents. This concept, referred to as the "mature minor doctrine," allows for parents or the state to represent the minors' interest only as long as the adolescent is not able to do so. The ethical justification for this position is based on the principles of autonomy and beneficence. The legal implications are being developed in state laws which recognize that teenagers should have access to confidential medical care in order to facilitate contraceptive knowledge and prevention of pregnancy.

More than 1 in 10 adolescent girls get pregnant every year. Four out of every 10 of them will get pregnant at least once during their teenage years. Seven million adolescent boys and 5 million adolescent girls are currently sexually active. One fifth of teenage pregnancies occur in the first month of intercourse, and one half of them occur in the first six months of sexual activity. The average teenager is sexually active a year or more before seeking contraceptive advice. One third of those teenagers who consult for birth control say that their reason for delaying the medical visit was that they were afraid their families would find out.[1] The implications and consequences of adolescent pregnancy should be of grave concern to anybody working with teenagers.[2] This article addresses one particular and crucial concern: the ethical considerations involved in the medical care of adolescents who consult for contraceptive services.

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The Problem

When an adolescent girl comes alone, or is brought in by her parents, to the physician's office for health assessment, she becomes the patient, and if responsibility is accepted for her care, the physician has an obligation to her.[3] How can the physician's obligation to the adolescent patient be reconciled with the physician's obligation to her parents? This problem may be best viewed in terms of consent and confidentiality.

Consent and Confidentiality

Consent is a contract between patient and physician. The physician must explain the nature of the treatment proposed as well as the existing alternatives, in return for which the patient will give permission to the physician for treatment. At this point a conflict emerges: In the case of the adolescent, neither a child nor an adult, who should give consent?

Confidentiality deals with the privileged nature of information provided to the physician by the

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adolescent. Accordingly, the medical history and the physical findings cannot be shared with others, including parents, without the adolescent's permission. Here a conflict arises: When adolescents who live at home engage in unprotected intercourse, which may place their health in danger and put them at high risk for pregnancy, should not the parents have a right to know?

The way in which the preceding questions are answered depends to some degree on how society defines children in relationship to their parents. Several approaches have been taken to answer these questions in a consistent fashion.[4]

Historically, the earliest response was to deny all rights to the adolescent. Adolescents therefore could not consent to their health care. Based on the concept of "parental sovereignty," parents assumed a claim of ownership of their children. This doctrine continues to be reflected in court rulings on custody, foster care, and adoption.

In the late 19th century, legal limits were imposed on parental ownership in those circumstances in which the children were considered to be in danger. This doctrine became known as the "child welfare" position and is clearly reflected by child abuse and compulsory education laws.[5]

In spite of their dissimilarity, both of these interpretations have a significant element in common: Adolescents have no rights of their own. Either the parent or the state determines what is to be in their best interest. A serious flaw of both the parental sovereignty doctrine and the child welfare doctrine is that neither distinguishes between the stages of complete dependency that characterize childhood and the autonomy that develops in adolescents. In the past two decades a new philosophy dealing with the issue of the "civil rights" of adolescents emerged, taking into account differences in age and maturity. This approach allows for parents or the state to represent the minors' interest only as long as such minors are not able to represent themselves.

A determining rule is proposed: The level of developmental capacity of the adolescent, rather than any arbitrary legal disposition, should be the deciding factor of competency for consent for treatment. Often referred to as the "mature minor doctrine," this concept is exemplified in recent legislation on freedom of speech in schools and the minor's right to obtain contraceptives. This pivotal idea has been expressed in the legal literature as follows: "A 'mature minor' does make his or her decisions on daily affairs, is mobile, independent, and can manage financial affairs; can initiate own appointments, understands risks, benefits, and informed consent (if anyone does!)."[6] The mature minor doctrine has been congruent with the viewpoint of specialists in child development and has been accepted by the American Academy of Pediatrics.[7] As a societal definition it acknowledges the changes that come with the increasing cognitive competence of teenagers and affirms that they can make rational decisions[8] and therefore are capable of giving informed consent.

The ethical justification for this position is based on two principles: the principle of autonomy, which states that a person should have a say on any action that is going to affect him, and the principle of beneficence, which states that whenever something good can be done for a person, it should be done, or at least no barriers should be placed to attaining that good.

Applied to an adolescent who engages in unprotected intercourse, the principle of autonomy rejects the formulation that the adolescent is being protected when parental consent is requested as a prerequisite for medical care. Instead, it views the insistence on parental consent as a denial of the adolescent's rights as a person separate from his parents. The principle of beneficence clearly lends support to the mature minor doctrine. Many adolescents who need access to medical care in order to get contraceptive care would never consult a physician if the physician required parental consent prior to treatment. Under the same principle it is also easy to see how the confidentiality of the information given by the adolescent can be ethically justified. Lack of confidentiality would constitute a barrier to health care.

Discussion

Some feel that parents have a right to complete information on the health condition of their children. Others fear that, in advocating the acceptance of the adolescent's right to consent, too much power is given to the physician. All of these concerns may be subsumed in another question: May an otherwise dependent adolescent be considered independent in relationship to contraception, especially since there are health risks associated with many contraceptive modalities?

Elimination of mandatory parental consent or mandatory parental notification does not imply that parental involvement is not important. Parental involvement is a recognized part of optimal health care for adolescents.[9] The physician in reality is not in an adversary position toward the parent when he obtains the adolescent's consent and maintains the confidentiality in the relationship (although parents might not perceive it this way). The physician shares the same goal with the adolescent's family: to protect and restore the adolescent's health.

Physicians do encourage their adolescent patients to seek support from their families; they often act as an intermediary during a crisis, and they help to restore the organization of the family they care for. There is also no question that physicians value life above confidentiality and that they will breach confidentiality in cases of dangerous behavior such as an adolescent's refusal to be hospitalized if she suffers from a complication stemming from the use of a contraceptive method. However, whenever such an unusual step must be taken, it is the physician's obligation to inform the patient about the breach of confidentiality and the rationale for it.

The legal implications of ethical considerations such as these become a matter of state law. Most states have laws establishing that minors may give consent for their treatment under specified conditions. Suspicion of pregnancy qualifies in most state legislations. In addition, there are laws that go even further, creating the category of "emancipated minor." Courts determining who fits this category take into account such conditions as "living apart from parents," "having a child," "being a member of the armed forces," and so on, and such criteria vary from state to state. The principle has been tested in the case of a 17-year-old girl who had consented to medical treatment without her parents' knowledge.[10] In spite of good medical results the parents sued the physician on the reasoning that because their daughter was a minor, she could not give consent for treatment and had therefore been treated without valid consent. They lost. The trial court held that the state law insulated the treating physician from liability, a ruling that was subsequently affirmed on appeal.

From the viewpoint of malpractice liability, at present physicians are required to know the condition and circumstances under which their states allow them to treat adolescents without parental consent as well as what constitutes an "emancipated minor" in their jurisdiction. If consultation about possible pregnancy or contraception is not covered by the state law, the physician must determine if the patient fits the "emancipated minor" status. This determination should be documented in the medical record. It is of interest to note that many state laws provide that physicians and health care facilities cannot be held liable for accepting a minor's consent in good faith. Thus, misrepresentation by a minor regarding, for example, the degree of his independence will not invalidate the consent accepted in good faith by the treating physician.

The debate on the adolescent's right to consent and confidentiality is only one component in a larger struggle in moral philosophy. This society stands at the crossroads of a number of different ethical systems. Each is the carrier of a highly particular kind of moral tradition, as evidenced by "parental sovereignty," "child welfare," and "adolescent rights." Of course, when such moral traditions encounter each other, they are to some degree damaged and fragmented in the process. Thus, it comes as no surprise that the confusions of pluralism are often expressed in issues that relate to the status of adolescents. Though this confusion is being clarified through guidelines and by statutory regulations, conscientious reflection by physicians is necessary concerning the nature of their commitments to adolescents and their parents.

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