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Adolescents' Right to Consent to Reproductive Medical Care: Balancing Respect for Families with Public Health Goals

Margaret Moon, MD, MPH

The 16-year-old patient in room A can consent to antiretroviral treatment for HIV, but the 17-year-old in room B needs a parent to consent to management of a gastric ulcer with famotidine. What does it say about our society that adolescents may seek health care independently for reproductive health but not for treatment of everyday medical conditions?

It says that we are a pragmatic people, willing to seek a balance among fairness, respect for families, and critical public health and safety goals.

A bit of history is necessary to gain perspective on the seemingly inconsistent set of standards affecting adolescent patients' rights to consent to care. The legal framework that supports a limited right for adolescents to consent to care has been in place for almost 50 years. In 1967, the Supreme Court emphasized that minors have constitutional rights, albeit limited [1]. Several decisions in the following decade extended and clarified the constitutional rights of minors to due process, free speech, and, finally, privacy rights and access to contraception. The *Carey v. Populations Services International* decision in 1977 made it illegal to prohibit the sale of legal contraceptives to minors and supported minors' right to privacy with regard to decisions about reproduction [2]. A key point in that decision was that sexual maturity, i.e., the capacity to become pregnant, rather than age or marital status, should determine access to contraception.

The social framework for adolescents and reproductive health was undergoing important changes while the legal environment was being redefined. The 1970s were notable for a rise in the average age of marriage, increasing the population of sexually mature but unmarried teens [3]. There was a lessening of the social pressure for pregnant teens to marry [4]. At the same time, abortion became legal. Inevitably, teenage sexual activity was more likely to lead to out-of-wedlock births and abortion. Even more important, public health and epidemiologic data revealed that teenage pregnancy was associated with poor outcomes for mother and baby [5].

Preventing bad outcomes for teens and their offspring was the prevailing impetus behind expansion of confidential care for reproductive health. The public health goal was avoiding or reducing unwanted pregnancy and optimizing treatment of sexually transmitted illnesses. Teenagers had to be willing to access care and seek information. Clinicians needed to be able to engage in open and frank discussions so

that appropriate care was offered. Most experts agreed then, as now, that adolescents would be less likely to seek necessary care for reproductive health issues if they had to involve their parents. To the extent that a requirement for parental involvement creates an obstacle to the provision of necessary care, it is counterproductive.

Most states have passed laws regarding minors' consent for confidential reproductive health services, addiction, and some mental health services [6]. Again, the identification of specific and narrowly defined categories of care to which teens can consent reflects the pragmatic intent behind confidential services. Teens are also able to give consent for emergency medical services when a delay in gaining parental consent would increase the risk of harm.

Although access to confidential services has become a cornerstone of adolescent health care, it is important to recognize that confidentiality is limited. Most states require that confidential care be available [6], but many states offer physicians discretion in limiting confidentiality in pursuit of the best interests of the minor patient [7]. Physicians may be free to disclose information to parents if they feel it is in the best interest of the adolescent patient. Despite promises of confidential care, parents might have full access to their children's medical records. Medical bills may reveal the type of care provided, further limiting confidentiality.

Support for confidential care for adolescents has always been a pragmatic notion, directed toward public health outcomes. It is not a normative statement about the relative value of the autonomy of adolescents and the rights of their parents. Most clinicians, including those most vigorously in support of confidential care, agree that the active involvement of a concerned and capable parent is the best possible situation for sexually active teens. Parents are in the best place to know the emotional needs of their adolescent—they are usually the best bet for consistent love and care and are, unlike minors, presumed to be competent decision makers. Parents also have legal and financial duties to care for minor children. In light of those duties, we honor parents' rights to direct the moral and spiritual upbringing of children—within specific limits. Unfortunately, it is obvious that some teens do not enjoy the support of capable parents. For those teenagers, access to confidential care may be necessary.

If we understand the limited nature of minors' rights to consent to care for specific reproductive and mental health services and their origin as a public health objective, it is a little easier to understand why the 17-year-old in room B may not be able to consent to routine care for a minor illness. While respect for autonomy of the patient is a basic principle of biomedical ethics, its application in the pediatric context is complex. Children are generally not considered to be autonomous, but support for and protection of developing autonomy is a fundamental goal of pediatric practice. Capacity to consent to medical care is a presumption for adults and incapacity is the presumption for minors. (On rare occasions, minors become emancipated by marriage, military service, or financial independence, thereby gaining full rights to consent to care.)

Presumptions are always flawed, and it is particularly absurd to anticipate that capacity magically develops on someone's eighteenth birthday. Ideally, individuals with the capacity to consent would be allowed to do so, no matter what their age. Assessment of capacity, however, is rarely straightforward for adolescents. Capacity to consent requires the abilities to communicate a choice, to understand the options, to reason effectively about those options, and to make an uncoerced decision. The level of capacity required varies with the risk of the choice to be made. The capacities to understand options and to reason effectively are tricky notions and often difficult to test. Life experience and cognitive capacity have significant impact on both. At every stage of adolescence, there is remarkable variability in cognitive development and experience and, correspondingly, variability in capacity to consent.

Adolescent care requires ongoing assessment of the developing level of autonomy and its practical application—capacity for consent. We presume incapacity, always ready to be wrong. The default is to rely on parents to help fill in the gaps in adolescent capacity to consent. Most parents begin to defer to their teenage children as the child's capacity grows. Physicians can support parents and teens in this shift in control, encouraging teens to take an active role in medical communication and decision making and helping parents learn to yield authority. This is the ideal for management of adolescents' medical care, slow and careful development of capacity guided by a supportive parent and an assessing clinician. Asking adolescents to make independent choices about such high-risk issues as sexual behavior, reproductive health, addiction, and mental health is no one's idea of an optimum safety net. It is pragmatic, it is necessary, but it is rarely satisfactory.

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Margaret Moon, MD, MPH, is an assistant professor in the Division of General Pediatrics and Adolescent Medicine at the Johns Hopkins University School of Medicine and a core faculty member at the Johns Hopkins Berman Institute of Bioethics in Baltimore, Maryland, where she is the Freeman Family Scholar in Clinical Ethics.

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