NCC Pediatrics Continuity Clinic Curriculum: **Adolescent Addendum: Confidentiality** ***Faculty Guide***

Overall Goal:
Identify key adolescent health issues and become comfortable interviewing an adolescent.

Overall Outline-Primary Modules:

Adolescent I:	***Adolescent II:***	***Adolescent III:***
Contraception	Dysmenorrhea	Acne
STIs	Amenorrhea	

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Pre-Meeting Preparation:
- HEADSS & CRAFFT screens
- "Achieving a decision making triad in adolescent sexual health care" *(2011)*
- *Excerpt from* "Maryland Minor Consent Laws" *(AAP, 2007)*

Conference Agenda:
- Complete Adolescent Addendum Quiz/ Discussion

Post-Conference: *Board Review Q&A*

Extra Credit:
- AAP Adolescent Health Home: *includes policy statements, patient handouts, etc*
- Maryland Minor Consent & Confidentiality Laws: *also includes info on emancipated minor, HIPAA, kinship care, and reporting of adolescent sexual activity*
- **Consent Laws *by* State- 2012:** *overview from Guttmacher Institute, with links*

The HEADSS Assessment

(Adapted from Goldenring and Cohen, Contemporary Pediatrics, *1998)*

H – Home Environment
· Where do you live? Who lives with you? How does each member get along? Who could you go to if you needed help? · Parent(s) jobs? Recent moves? Run away? New people at home?
E – Education/Employment
· What do you like/not like about school/work? How do you get along with teachers/other students? · What can you do well/what areas would you like to improve on? Grades, suspensions? Changes? · Many young people experience bullying at school – have you ever had to put up with this?
E – Eating/Exercise
· Sometimes when people are stressed they can over eat/under eat. Have you ever experienced either of these? · In general, what is your diet like? In screening more specifically for eating disorders, you may ask about body image, the use of laxatives, diuretics, vomiting or excessive exercise and rigid dietary restrictions to control weight.
A – Activities and Peer Relationships
· **Do you have any stress right now?** With peers? (What do you do for fun? Where? When?) With family? · Sports; exercise? Hobbies? Tell me about the parties you go to? How much TV do you watch? Favorite music?
D – Drugs/Cigarettes/Alcohol
· Many people at your age are starting to experiment with cigarettes/alcohol. Have any of your friends tried these or maybe other drugs like marijuana, IV drugs, etc. How about you, have you tried any? Then ask about the effects of drug or alcohol use on them, and any regrets. How much are they taking, how often, and has frequency increased recently?
S – Sexuality
· **Have you had the sex talk with your parents?** How do you feel about relationships in general/ your own sexuality? · Some people are getting involved in sexual relationships. Have you had a sexual experience with a guy or girl or both? · Number of partners? Contraception? Knowledge about STDs · Has anyone ever touched you in a way that's made you feel uncomfortable or forced you into a sexual relationship?
S – Suicide/Depression/Mood Screen
· How are you feeling at the moment on a scale of 1-10? Do you feel this way often? · What sort of things do you do if you are feeling sad/angry/hurt? **Is there anyone you can talk to?** · Some people who feel really down often feel like hurting themselves. Have you ever tried to hurt yourself or take your own life? What have you tried? What prevented you from doing so? Do you feel the same way now?
S – Safety
· Sun protection, immunization, bullying, carrying weapons, violence at home or in the community.

The CRAFFT Screen © *Children's Hospital Boston, 2009*

If positive substance abuse screen, ask all 6 CRAFFT questions. If negative, ask only CAR question:

1. Have you ever ridden in a CAR driven by someone (including you) who was "high" or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?
4. Do you ever FORGET things you did while using alcohol or drugs?
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?

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Achieving a Decision-Making Triad in Adolescent Sexual Health Care

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INTRODUCTION

Improving the health of adolescents faces many barriers, as evidenced by their declining health indices.[1–4] Preventable, risk-taking behaviors are present among all age groups, but result in the highest rates of morbidity and mortality among teenagers.[1] The pursuit of improved teenage health becomes especially challenging when attempting to positively influence teenage sexual behaviors. Adolescent sexual health care is susceptible to a well-known litany of obstacles, including, but not limited to, the inapplicability of adult treatments and a paucity of biomedical adolescent research,[3,5] difficulty identifying and adapting to teenagers' varying degrees of psychosocial and cognitive development,[1] and access and insurance issues.[6] Compounding all of these, when providers and parents are dealing with sexual health, a lack of privacy and confidentiality can undo many good intentions in offering age appropriate counseling and care.

Case: A 15-year-old girl with dysuria is brought into a suburban pediatric clinic by her mother. She has no cognitive deficits, has had normal intellectual development, and has no history of previous medical problems. Menarche occurred at age 13. The mother indicates that she believes her daughter is sexually active, but the girl has refused to confirm this with her parents. The mother requests that her daughter be tested for sexually transmitted infections (STIs). The daughter privately expresses interest in getting tested for STIs and treatment for dysuria but wishes that her records not be shared with her mother.

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Can the adolescent developmentally consent to her own care?

What are the provider's ethical obligations to uphold confidentiality, and what measures can be taken for provisions of privacy and confidentiality in follow-up care post visit?

What rights, if any, do parents have to access their adolescent's sexual health information?

It is well known that adolescents delay and avoid sexual health care and fail to disclose necessary information regarding their sexual behaviors to providers when their confidentiality and privacy are not assured.[5,7–11] Many states and professional organizations have, correspondingly, revised their laws and policies to encourage waiving parental permission and providing confidential sexual health care to adolescents.[10,12] However, it is not always clear if adolescents are psychosocially, affectively, or cognitively capable of consenting for themselves, or if they are ready to engage in healthy sexual practices. In many ways adolescents are as mature as adults, but despite comparable reasoning ability, their activities tend to be significantly riskier, and their health unnecessarily suffers as a result.[13] Whether confidentiality initiatives can and should be maintained necessitates that parents and providers have an understanding of adolescents desire for confidentiality. This article explores the concepts of confidentiality and consent in the context of teenage behaviors and addresses the complexity of the decision-making triad in adolescent sexual health care.

THE DEVELOPMENTAL ROLE OF CONFIDENTIALITY

Understanding the adolescent developmental process is crucial to understanding the need for confidentiality in sexual health care. Adolescence can be an extremely vulnerable period as cognitive, neural, and behavioral systems are all maturing at different times and at varying paces.[14] This developmental upheaval is even more pronounced because during this period adolescents are also trying to establish a clear sense of self.[15]

During the preadolescence and early adolescence phases, the identity of teenagers is largely defined by the adults in their lives.[14,16] During adolescence, teens slowly begin to separate themselves from their parents and redefine their sense of self based on burgeoning abilities and choices. The push for independence and identity often comes in the form of conflicts with parents.[17] The psychosocial stresses of development and the endocrinological changes associated with the onset of puberty are responsible for the characterization of teenagers as rebellious and oppositional and of teenage behavior as being driven by hormones. However, teenagers typically need to emotionally distance themselves from their parents to become competent, independent adults,[6,18–20] and individuation and autonomy can even be promoted by conflicts with parents.[21] There is

also increasing recognition that the sexual activities of adolescents are not an expression of rebellion, but rather "an expression of personal preference and individuality"[22(p119)] exhibiting their emergent sense of self.

"To share private matters that take place outside the home with mothers and fathers diminishes the sense that such matters are the adolescent's own."[18(p14)] Privacy is extremely crucial for the successful development of a sense of self. With the myriad pressures teens face through their developmental process, including learning a completely new set of social and vocational skills that are in line with their budding identity and future goals,[23] the period of individuation has to be handled tactfully by those adults in a teen's life. Receiving the freedom to practice making their own choices, along with adult support and confidence, allows teenagers to learn in a safe environment how to transition from childhood to adulthood.

The gradual but successful development of a sense of self has far reaching implications for teenage sexual behaviors.[15] The ability to identify a responsible path of action, which is a crucial part of good judgment, requires clarity of identity, self-reliance, and healthy autonomy.[16] Accurately identifying oneself as a sexual being, even if one is not sexually active, is a prerequisite to psychosexual maturity, which is directly correlated with increased planning and effective use of contraception.[5,22] For example, adolescents often underestimate their personal risk of acquiring an STI. Adolescents under this impression are less comfortable speaking with their physician about sexual problems.[3] Adolescents with a less clear sense of self also often suffer from low self-esteem.[23] This puts them at higher sexual risk because they are fearful of parental disapproval or rejection, and they do not disclose information to care providers about their sexual activity.[5] Denial of sexuality entirely is also a typical response for many adolescents,[22] which could be due in part to the difficulty parents experience in seeing their children as sexually capable and the pursuant tendency to treat adolescents as asexual. This all culminates in low rates of parental discussion about sexual matters and parent-driven sex education.[3,19,22,24-25] School-based sex education, educational campaigns by government agencies, and initiatives by national and international health protection agencies are also often inhibited out of fear of overstepping boundaries with parents and violating local and state laws.[3] Lastly, provider-driven sex education rates are low as well, with providers reporting reluctance to speak with adolescents so as not to oppose a parent's wishes.[8] Teenagers are therefore often left to come to terms with their sexual identity alone and to obtain the majority of their sexual education from their peers who may be equally uninformed.[26] Parents, educators, and adolescent care providers need to be aware of the importance of acknowledging adolescent sexuality to contribute to their sense of self as a sexual being[24] and to be certain that teenagers are receiving accurate sex information. This is a prerequisite for effective health care–seeking behavior and family planning, whether it means an awareness of the difficulties in choosing a form of abstinence or informed use of contraception and follow-up care.

Teenagers do not seek sexual health care if confidentiality is not guaranteed, and unfortunately many teens believe their physicians will not keep their information confidential[3,5] or they report that their physicians do not explain clinic or hospital confidentiality policies.[27,28] The Council for Scientific Affairs of the American Medical Association[6] reported that if parental notification were mandated, only 15% of adolescents would seek care for STIs and 19% for birth control. Reddy et al[7] found that 59% of teens already using sexual health care services would discontinue the use of these services and delay testing for STIs or HIV, and only 1% would decide to stop having sexual intercourse. Failure to seek care or delays in care can result in serious, preventable short-term and long-term complications[6] that endanger both the health of the individual and the public.[29]

"Every year, failure to assure confidential contraceptive care costs tens of thousands of adolescent girls their lives, and many more their reproductive and wider health. Denial of services or of confidentiality may be a matter literally of an adolescent girl's death, or severe and enduring injury."[3(p17)] Sexual health emergencies are not limited to only certain subsets of adolescents. In 2009, almost half of all high school students reported they had engaged in sexual intercourse, with 14% reporting having had 4 or more partners. Of those sexually active, more than one-third indicated that the last time they had sexual intercourse they had not used a condom.[25,30] Within the 33 states reporting HIV/AIDS to the Centers for Disease Control (CDC) in 2006, 14% of those diagnosed were between 13 and 24 years of age. Of the almost 19 million new cases of STIs every year, approximately half occur among 15 to 24 year olds.[30,31] When confidentiality is a prerequisite to young people seeking timely health care, it becomes a high priority.[18]

Accordingly, all states allow minors to consent to STI treatment without parental notification, although more than one-third of states give physicians the discretionary power to decide if informing parents is necessary.[6,32] Although providers do often have the option to disclose health information, confidentiality in this case refers to the imperative not to disclose unless it is itself a matter of safety.[31]

The question that researchers, guardians, and care providers have therefore asked over the past half century is how to influence adolescent behaviors to best minimize the health risks that can result from sexual activity. It has been found repeatedly that without confidentiality and privacy, teenagers do not seek care for sexual health, disclose all the information necessary for treatment and prevention, or learn competence in safe practices. A healthy sense of self remains inchoate, and without a sense of self, adolescents continue to engage in risky sexual behaviors. This is an individual and public health hazard. It is paramount that adolescents be given the confidentiality assurances necessary so that they not only seek education and care from trained providers, but also develop the abilities necessary to decide and act as competent adults.

ADOLESCENT CONSENT

The first step to providing confidentiality is allowing teenagers to consent to sexual health care without parental permission. The discussion to this point has been grounded in the need for separation from parents. This is not to ignore the fact that these young persons may not yet be cognitively capable of consenting, and that independence from parents could leave the adolescent without a responsible adult guide. Consent theory posits that only an individual can "consent" to treatment for him or herself because a requirement to consent is the ability to consider all the pertinent information about options[9,13] within the context of the patient's life, to deduct the consequences of those options for the future, and to emotionally and psychologically manage the implications of those options.[6,33] Historically, adolescents have not been thought of as having the capacity to provide consent for themselves.[31] However, research over the past few decades on characteristics related to maturity of judgment, such as identity formation, rational thought, and risk-perception, indicate adolescents have many of the skills necessary to consent but that their utilization is sometimes selective.[16] Responsibility and perspective, for instance, crucial for appreciating the consequences of actions, may be intact but their demonstration depends on the situation and social context.[14,16] Studies have shown that teens use abstract thinking when considering nonanxiety provoking topics such as moral decisions, but relapse to concrete thinking when considering choices regarding sexual behavior.[18] Teenagers in midadolescence to late adolescence are typically able to reason and deduct consequences as well as adults[2,18,31,34] and do perceive the risks of their activities.[35] However they still engage in significantly more risky activities than adults.[14] No single cause can explain this, but the common denominator may be the influence of noncognitive factors, such as teenagers experiencing more difficulty controlling their impulses and weighing the importance of the various factors in the decision differently than adults.[14,16] A teenager may come to the conclusion, for instance, that certain risks are worthwhile if they are valuable for attaining social status. Those teens with a more amorphous sense of self are more susceptible to this kind of social pressure because they tend to have lower self-esteem and rely heavily on peer judgment during introspection.[23] The onset of puberty can also have an indirect impact on the ability to consent because it triggers hormonal fluctuations. These fluctuations can cause unpredictable emotional states that may affect judgment and decision-making.[16]

Clearly there is much going on during adolescence that plays a major role in the capacity to consent; however, it can be noted that this does not make teens very different from adults. Many adults also vacillate between abstract thinking, which allows future perspective, and concrete thinking depending on the context, and some theorists posit that up to 30% of the population never acquires the ability for abstract thought.[36] Deficiencies in understanding are often reported by adults going through a clinical consent process. A study by Williams[37] found that 60% of patients in one public hospital did not understand the basic content of the informed consent form. Adults commonly use heuristics and judgment biases,

such as "ignore important information, rely on seemingly inappropriate decision-making shortcuts, and make non-optimal decisions across a wide array of situations."[35] There are substantial issues with the current consent process for all age groups that physicians need to be aware of, but on top of this, young people need additional guidance due to their lack of experience.[18]

"All 50 states and the District of Columbia explicitly allow a minor to consent to testing and treatment of STIs, except human immunodeficiency virus (HIV) testing or treatment,"[13(p115)] and physicians are called to the very difficult task of making a maturity assessment, within the laws of their state, of the adolescent patient in real time.[10,13,16,31,33] Many physicians and researchers have argued that seeking out education and care is itself a sign of maturity to consent, but for those not in this category,[3,16,18,38] means of facilitating and supporting adolescent consent in sexual health education and care are critical.

SUPPORTING CONSENT

If a teenager is not yet independently capable of consent, assistance from adults is needed for understanding and decision-making. Adolescence is marked by the increasing importance of peers and extraparental adults in teenagers' lives.[18] Partnering adolescents with a nonfamily, adult confidante can create a relationship that is less threatening and therefore conducive to honest conversation.[39] Teenagers do sometimes actively pursue such confidantes,[22] but many resort to silence. Even in situations where teenagers bring adult third parties with them to clinic visits, those third parties often underestimate the concerns and worries of the teenager, and therefore may not be fulfilling the role of guide that the teen needs.[20] Providers are uniquely situated to position themselves as a confidante or to assist in communication between adolescents and other adults in their lives.

It has been found that the comfort of the physician in discussing sexual matters has a direct, positive correlation to the comfort of the adolescent patient in disclosing their activities and also their questions. When physicians initiate conversation about sexual activities and risks at a general health examination, teenage patients become much more willing to communicate about them as well.[5,40] Younger physicians who more recently graduated from medical school and female physicians tend to have higher rates of comfort in screening and educating adolescent patients.[6,41–43] Female patients indicate they are more comfortable talking to a female physician and teens of both sexes are typically more comfortable disclosing activities to their regular physician.[4,5] Assuring these dynamics are in place is by no means a guarantee that teenagers open up, however. Seeing the same physician can also give rise to fears that the doctor feels an obligation to report back to parents due to their ongoing relationship with the family.[11,40] Physicians need to make a concerted effort to assure adolescents of the protections and limitations to their confidentiality policies before any conversation about sexual health.[10,38,43] It is also crucial to confirm that teens are receiving the same information from all clinic staff.[11,44] As

young persons transition from early to late adolescence, trust and comfort in physicians decrease, perhaps because younger adolescents have fewer sexual experiences to keep hidden. Many teens also show more resistance to disclosing when they may have a sexual problem than they do when disclosing general sexual activity.[5] Providers must be aware of how their own age and experience and that of their patients impact disclosure. Being open about sexual matters, physicians can encourage honesty and comfort in patients. This allows the provider to identify gaps in the patient's knowledge and understanding and educate appropriately to support consent.

Information alone, however, is not sufficient. From what is known about the failings of the current consent process, the impact of psychosocial, noncognitive, and emotional factors on decision-making are frequently ignored but are each important aspects of judgment that go beyond cognition.[42] "Mature judgments are the product of an interaction between cognitive and psychosocial factors, with competent decision making potentially undermined by deficiencies in either domain."[16(p251)] The topic of sex can be highly controversial and can cause strong emotions, and individuals' opinions about it are often laden with value.[19] What is needed is not just a focus on cognitive capacity and the provision of information to adolescents, but rather education on how the information is applicable to their lives.[18,22] Structured interviews designed to assess an adolescent's psychosocial function can assist in obtaining this information from patients,[39] as can creatively utilizing resources that adolescents are comfortable with, such as educational computer programs and videos in adolescent-friendly waiting areas.[31]

With a greater understanding of teen experiences and the psychosocial elements that influence thoughts and behaviors, adult mentors can work to balance the values adolescents place on certain activities and consequences before making decisions. They can also provide tailored education and care to the patient. Physicians can facilitate the shift in a doctor-patient relationship from one of guidance-cooperation, where the doctor directs and the patient obeys, to one of mutual participation. The provider's role in this case is to help the patient help himself or herself.[45] Parents and clinics should do what they can to appropriately match patients with providers and impress on physicians the great need for this kind of attention and conversation. In this way parents and providers are not leaving adolescents to make important decisions and to consent to care on their own but are supporting their growing maturity and independence through acknowledging when it is necessary to extend the role of mentor to trained, adult care providers and tailoring the consent process to take into account the unique psychology of near-adult patients.

MAINTAINING CONFIDENTIALITY

In sexual health care of teenagers, the end of the consent process and clinic visit does not mark the end of the steps necessary to protect confidentiality. Communication regarding follow-up care is often required. Receipts or bills

that itemize the care provided may be sent in an unintended fashion to the holders of insurance policies.[6,31] With teenagers this is likely to be their parents.[3] Parents may also have the legal right to request access to their children's medical records.[13] What is critical to adolescents in their willingness to seek education and care is confidentiality, so it is irrelevant whether parents' knowledge comes about via mandatory permission or through parental notification and access to records after care is given.[18] In many states parents have the right to retrieve their children's medical records, and even the Health Insurance Portability and Accountability Act (HIPAA) makes a specific exception to defer to state laws with regard to adolescent confidentiality.[10] In the case where a state has provisions for confidentiality of minor's records, HIPAA does permit adolescents to specify a method of alternate communication for follow-up, and providers should explore how to report procedures in a generalized way or offer nonspecific details in billing invoices.[38] Insurers, however, are not always required to honor such protections unless the teenager can prove that the release of information would result in self-endangerment.[10,13] Clinics and delivery systems should, if necessary, rewrite their confidentiality policies to protect adolescents as much as possible, and physicians, aware of their state's laws, need to consult with adolescents regarding the possibility for parental notification. Ideally formulating a plan for maintaining confidentiality post-visit and providing a referral to a low-cost or school-based clinic with more protective confidentiality rules would diminish the possibility of unintended breaches in confidentiality.[6,11,39,46]

THE DECISION-MAKING TRIAD—PARENTS AND PROVIDERS

One of the primary rights of parents in the process of raising and educating a child is having information about the child's activities.[47,48] Promoting confidentiality in adolescent care seems, at face value, to violate this parental right. Although so far legislative efforts to mandate parental notification for use of some sexual health services have been unsuccessful, each year attempts are made.[29,49,50] In light of the lack of legislative support, what role can parents play in advising their child in the area of sexuality? Providers, correspondingly, often find themselves in the difficult but important role of confidante and mediator between parents and adolescents, and consequently can sometimes be seen as the perpetrator of this violation of rights. Parental dissatisfaction or anger can be a threat to the reputation and economic well-being of a health care provider[3] and, depending on the circumstances, others with whom the physician practices. In this case what role can providers play in the decision-making triad that does not simultaneously harm their interests?

Here, two conditions of the parental right and duty to raising a child must be mentioned. These include, first and foremost, maintenance of good health and, second, successful development of autonomy. As indicated earlier, without

assurances of confidentiality many teens put their health and the health of others at risk by not seeking out information on safe methods of sexual activity or not seeking out care in cases where risky behaviors can lead to problems. One argument, often heard in the federal and state debates on adolescent confidentiality, is that if parental notification were required, rates of sexual activity would decrease based on the assumption that adolescents are embarrassed to have parents find out about their sexual activities; therefore, mandated notification might discourage those activities.[50] In fact, up to 60% of teenagers utilizing sexual health resources indicated their parent(s) already knew about their use of these services.[6,49] Adolescents often report that their parents' values and opinions are important to them.[26] The group in need of attention, though, is those adolescents who have not already discussed their activities with their parents and who report that mandated parental notification only discourages seeking out necessary education and care. It seems clear that in light of the circumstances, health is better maintained through policies of confidentiality.

For the second condition to raising a child, having offspring achieve autonomy is an established, primary goal of most families.[18] The transfer of authority from parents to children is undeniably a difficult one, particularly in early adolescence when teenagers consider themselves to have more authority over their decisions and actions than parents report being willing to grant.[17,40] However, studies of parental attitudes regarding teenagers' use of health clinics and services indicate that parents are not inflexible, and many feel that if their adolescent indicates a desire for it, he or she should be allowed privacy in sexual health care.[6,8,11,50] Adolescents report that they want their physician to provide them with information on sexuality and that their doctor's opinion is at least as important to them as their parents' or best friend's.[5,41] This also allows the provider to be in a position to judge whether and when parents do need to be included in the process. With an honest, initial introduction to the limitations of confidentiality already provided to the patient, providers can collectively determine the best method of informing and involving parents.

It is encouraging to note that being informed of the rationale behind clinic confidentiality policies may sway those parents who do not initially agree adolescents should have the right to consent and confidentiality. In a study conducted by Hutchinson and Stafford, parents were surveyed on their attitudes regarding privacy in health care before and after an educational intervention. Parents were given a handout about the clinic privacy policy and national statistics on adolescent risky behaviors. Before the intervention 35% of parents felt that there were not good reasons for adolescents to have their information kept confidential, whereas only 14% still held this opinion after the intervention.[8] A blanket policy offered to guardians seems to be a good place to begin mitigating the potential for harm to the provider when parent and adolescent interests do not initially match up and is supportive of good parent-child relations going forward.

CONCLUSION

With regard to adolescent sexual education and care, if parents can be involved, everyone benefits.[6,13,18,38,39] When the parental goal of raising a healthy, competent adult can only be met through privacy from parents, allowing other adult figures to perform the role of adviser upholds parental, adolescent, and provider rights and interests. Parents must be informed about the need for privacy and the clinic's policy regarding confidentiality to best respect the parental role and protect the provider's interests. Providers need to be aware of the comfort of their adolescent patients and train themselves to be comfortable initiating conversations on sexual activity and safety. Adolescents should be informed of confidentiality policies and encouraged to be honest about their desire for confidentiality in the health care setting.

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MARYLAND MINOR CONSENT LAWS

Who Can Consent For What Services and Providers' Obligations

MINORS OF **ANY AGE** MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
PREGNANCY	A minor (*i.e.,* a person under the age of 18) has the same capacity as an adult to consent to treatment for or advice about *pregnancy* other than sterilization [Md. Code Ann., Health-Gen. II § 20-102(c)(1)-(5)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information about an abortion [Md. Code Ann., Health-Gen. II § 20-102(f)]
CONTRACEPTION	A minor (*i.e.,* a person under the age of 18) has the same capacity as an adult to consent to treatment for or advice about *contraception other than sterilization* [Md. Code Ann., Health-Gen. II § 20-102(c)(1)-(5)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information about an abortion [Md. Code Ann., Health-Gen. II § 20-102(f)]
DIAGNOSIS AND/OR TREATMENT FOR SEXUALLY TRANSMITTED DISEASES	A minor (*i.e.,* a person under the age of 18) has the same capacity as an adult to consent to treatment for or advice about *venereal disease* [Md. Code Ann., Health-Gen. II § 20-102(c)(1)-(5)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]
AIDS/HIV TESTING AND TREATMENT	A minor (*i.e.,* a person under the age of 18) has the same capacity as an adult to consent to treatment for or advice about *venereal disease* [Md. Code Ann., Health-Gen. II § 20-102(c)(1)-(5)] Voluntary written informed consent of the individual to be tested is required for an HIV test, except in specified circumstances, including at anonymous test sites where an individual may be identified by a number [Md. Reg Code tit. 10, § 18.08.07]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)] A student is not required to disclose his/her status of being infected with HIV to school authorities. The decision whether or not to disclose HIV infection is at the discretion of the parent/guardian on the advice of the infected individual's medical care provider
ABORTION	A physician may not perform an abortion on an unmarried minor unless the physician first gives notice to a parent or guardian of the minor, except as provided with respect to "incomplete notice" and "waiver of notice" [Md. Code Ann., Health-Gen. II § 20-103(a)]	*Waiver of Notice*-No notice required, if, in the professional judgment of the physician… 1. Notice to the parent or guardian may lead to physical or emotional abuse of the minor 2. The minor is mature and capable of giving informed consent to an abortion; or 3. Notification would not be in the best interest of the minor. *Incomplete Notice*-No notice required if: 1. The minor does not live with a parent or guardian; and 2. A reasonable effort to give notice to a parent or guardian is unsuccessful. [Md. Code Ann., Health-Gen. II § 20-103(b)] **A physician is not liable for civil damages or subject to a criminal penalty for a decision under this subsection not to give notice [Md. Code Ann., Health-Gen. II § 20-103(c)] *Notice Prohibited* A physician may not provide notice to a parent or guardian if the minor decides not to have the abortion [Md. Code Ann., Health-Gen. II § 20-103(e)]
EMERGENCY MEDICAL SERVICES/ GENERAL MEDICAL CARE	A minor (*i.e.,* a person under the age of 18) has the same capacity as an adult to consent to medical treatment if, in the judgment of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual [Md. Code Ann., Health-Gen. II § 20-102(b)]	The health care provider shall inform the minor's parent or guardian. The health care provider may treat a patient who is incapable of making an informed decision, without consent, if the treatment is of an emergency nature; the person who is authorized to give consent is not available immediately; and the attending physician determines that there is substantial risk of death or immediate and serious harm to the patient and that the life or health of the patient would be affected adversely by delaying treatment to obtain consent [Md. Code Ann., Health-Gen. II § 5-607]

MARYLAND MINOR CONSENT LAWS

Who Can Consent For What Services and Providers' Obligations

MINORS OF **ANY AGE** MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER
DRUG AND ALCOHOL ABUSE TREATMENT	A minor (*i.e.*, a person under the age of 18) has the same capacity as an adult to consent to treatment for and advice about *drug abuse* and a*lcoholism* [Md. Code Ann., Health-Gen. II § 20-102(c)(1)-(5)] *Psychological treatment for drug abuse or alcoholism* – A minor has the capacity to consent to psychological treatment for drug abuse or alcoholism if, in the judgment of the attending physician or a psychologist, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual [Md. Code Ann., Health-Gen. II § 20-102(d)] *Refusal of treatment.* The capacity of a minor to consent to treatment for drug abuse or alcoholism does not include the capacity to refuse treatment in a certified inpatient alcohol or drug abuse treatment program for which a parent/guardian has given consent [Md. Code Ann., Health-Gen. II § 20-102(c-1)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]
OUTPATIENT MENTAL HEALTH SERVICES	A minor who is 16 years old or older has the same capacity as an adult to consent to *consultation, diagnosis, and treatment of a mental or emotional disorder* by a physician, psychologist, or a clinic [Md. Code Ann., Health-Gen. II § 20-104(a)] The capacity of a minor to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic does not include the capacity to refuse consultation, diagnosis, or treatment for a mental or emotional disorder for which a parent, guardian, or custodian of the minor has given consent.	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]
SEXUAL ASSAULT AND RAPE SERVICES	A minor (*i.e.*, a person under the age of 18) has the same capacity as an adult to consent to: • Physical examination and treatment of injuries • Physical examination to obtain evidence from an alleged rape or sexual offense [Md. Code Ann., Health-Gen. II § 20-102(c)(6)-(7)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]
ADMISSION TO DETENTION CENTER	A minor (*i.e.*, a person under the age of 18) has the same capacity as an adult to consent to: • Initial medical screening and physical examination on and after admission into a detention center [Md. Code Ann., Health-Gen. II § 20-102(c)(8)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]

Source: People's Law Library of Maryland – www.peoples-law.org © Maryland Legal Assistance Network / MLSC, 1999-2006.
Source: Student Services Technical Assistance Guide. Maryland State Department of Education. June 2006 www.marylnadpublicschools.org

Adolescent Addendum-Quiz & Discussion

1. Minors' consent laws permit individuals under 18 years old to consent to certain health care services. **Why do these laws exist?**

A) To derail parents' efforts to control their children's lives
B) To dissuade health care providers from providing any care for teenagers by making it unnecessarily awkward and confusing
C) To remove barriers to care that prevent minors from accessing timely, appropriate care for a variety of sensitive health issues

Removing barriers to care is the primary intent of minor consent laws. This can be overshadowed by parental and provider misgivings or misconceptions about minor consent. It can help to remember this if you feel stuck between the law and what you feel is the best course clinically for your patient.

2. Which of these patients can **consent to their own care** for the issue in question?

A) A 14yo male requesting STI testing
B) A 16yo girl desiring contraception

All states and DC allow all minors to consent to STI services. 46 states and DC allow all or some minors to consent to STI services, the remaining 4 have no specific policy or case law. Note the definition of "minor" can vary, and only certain classes of minors may be covered. In MD, all minors (<18yo) can consent to STI or contraception management. Physicians "may but need not notify" parents over the objection of the teenage patient.

C) A 16yo girl requesting a 1st trimester elective termination of pregnancy

Details of consent for elective abortion vary by state (and can vary by trimester). It's important to know the specific requirements of the state(s) in which your patients live. Tricare does not cover the cost of elective terminations, and these services are not offered in the military health care system. Patients considering this option should be informed of community-based resources. http://www.prochoice.org and http://www.plannedparenthood.org have search tools for local abortion services (*not accessible through firewall*). Planned Parenthood also has teen friendly info about contraception and pregnancy options.

D) A 16yo teen mother requesting IUD placement

Contraception options that are more invasive may not be covered under minor consent laws and thus may require parental consent. In MD, the law states minors may consent for "contraception other than sterilization". There may be separate institutional policy about parental consent for placement procedures for subdermal or IUD contraception.

E) A 16yo male needing drug treatment without his parents' knowledge or involvement

This module centers on navigating consent and confidentiality issues when providing sexual health care, but don't forget that this complexity plays out similarly in other sensitive health areas, like mental health and substance abuse. Strictly speaking, this patient does not require parental consent to receive treatment. However, optimizing his care will likely involve collaboration with parents or other trustworthy adults, and breaking confidentiality may be justified by degree of self-harm or limited capability to progress clinically without parental involvement.

3. **True or False?**

	True	False
Adolescents are unlikely to seek care for sexual health issues if confidentiality and privacy are not assured.	X	
If an adolescent patient is having sex, he/she is capable of consenting for their own medical care. Even if they have the skills necessary to consent independently, adolescents may use them selectively when making decisions. The influence of non-cognitive factors (impulsivity, different priorities, less risk aversion) also makes it difficult for them to be safely, completely independent in their capability to consent. Adults can provide valuable support of understanding and decision making – parents, non-family adult confidantes, healthcare providers.		X
Parents need to know what kind of questions providers may ask their teenager in a private interview. It's useful for both the teen and parent to understand the purpose of confidentiality, and limits of confidentiality and parental consent, prior to the private interview. Parents don't like to be caught by surprise or to feel undermined.	X	
Barriers to education about sexuality and sexual health often exist within families, in school, and in the health care setting. Parents and providers' discomfort level with discussing sexual health or other sensitive health topics can be a barrier to teens' receiving reliable information. In the absence of good (or any) guidance, teens may turn to other, less credible sources.	X	
Maintaining confidentiality interferes with parents' ability to raise their child by inhibiting communication. Confidentiality assurance is necessary to enable independent health seeking/health management behaviors that will be required in adult life. Practicing independence for the first time in clinic is a safer environment for this transition to occur.		X
Even if state law protects a teenager's confidentiality about a particular matter, HIPAA federal law grants guardians access to their health information. In general, HIPAA defers to states' provisions for confidential care of minors. This is more complicated in practice, and it is largely up to providers to maintain policies and practices that will prevent unintended breaches of confidentiality from follow up care, medical or insurance records.		X
Adolescents typically avoid discussing personal issues with their parents because they don't value their opinion. Adolescents tend to report placing high value on parents' values opinions. Communication is often hampered by opposing views, embarrassment, or fear of disapproval or reprobation. Teens also report that their doctor's opinion is just as important as their parents' or peers.		X
In the state of Maryland, it is against the law to disclose health information to parents without the teenager's consent, if this information is related to a health condition for which the teen is medically-emancipated. In MD, physicians *may but are not required to notify* parents of adolescents' health information related to pregnancy, contraception, STI, AIDS/HIV, drug/ETOH abuse, outpatient mental health, sexual assault, care while in a detention center. For abortion service, they *must* notify unless certain waiver criteria are met. For general medical care, they *must* notify unless emergent intervention is required.		X

Adolescent Addendum Board Review:

1. You are seeing a 15-year-old girl for her first health supervision visit to your practice. In explaining your practice's policies, you discuss confidentiality.

Of the following, you are MOST likely to state that
A. adolescents are more likely to seek health care for sensitive issues if they believe that their parents will be informed
B. billing policies of an outpatient or inpatient facility are always confidential in regard to sexually transmitted disease infection testing for adolescents
C. if an adolescent poses a threat to self or others, confidentiality can be broken
D. parents have access to all of an adolescent's health information through the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
E. state laws mandate that adolescents in all states may receive confidential treatment for alcohol and other drug use disorders

2. A 16-year-old girl who attends boarding school in your community comes to your office because she is feeling depressed. You see her alone for the visit, and she relates that she feels suicidal at this time and has a plan to kill herself.

Of the following, the BEST description of your obligation to alert her parents to her situation is
A. no parental notification is necessary because she is a mature minor
B. no parental notification is necessary because she is an emancipated minor
C. parental notification is necessary due to billing issues
D. parental notification is necessary due to her serious threats of self-harm
E. parental notification is prohibited by the Health Insurance Portability and Accountability Act