



ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Adolescents and consent to treatment

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Abstract

Adolescents, defined by WHO as 10 to 19 years old, can give independent consent for reproductive health services if their capacities for understanding have sufficiently evolved. The international Convention on the Rights of the Child, almost universally ratified, limits parental powers, and duties, by adolescents' "evolving capacities" for self-determination. Legal systems may recognize "mature minors" as enjoying adult rights of medical consent, even when consent to sexual relations does not absolve partners of criminal liability; their consent does not make the adolescents offenders. There is usually no chronological "age of consent" for medical care, but a condition of consent, meaning capacity for understanding. Like adults, mature minors enjoy confidentiality and the right to treatment according to their wishes rather than their best interests. Minors incapable of self-determination may grant or deny assent to treatment for which guardians provide consent. Emancipated minors' self-determination may also be recognized, for instance on marriage or default of adults' guardianship.

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1. Introduction

The legal and ethical duties of health service providers to disclose information to their potential patients have become reasonably settled in most countries [1]. Legal requirements address disclosure of such matters as the patient's diagnosis,

prognosis when untreated and treated according to available options, the prospective benefits, risks and uncertainties of each option, and the impact of options on lifestyle, including, where appropriate, on reproductive health. Laws also address related matters, such as duties to protect medical confidentiality, [2] and the human rights framework within which national laws apply [3].

Legal and ethical duties are often not so clear, however, when prospective patients are adolescents. Parents have historical duties to provide their dependent children with necessary therapeutic and

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preventive healthcare services, under civil (that is, non-criminal) and often criminal laws, and duties expressed in religious and ethical principles of parental duty. Adolescents are in transition between childhood dependency and the independence of adulthood. They often struggle to escape the bonds of dependency against parents who distrust their children's capacity to make sound choices and who conscientiously consider their parental duties to continue. Struggles are often particularly intense concerning adolescents' emerging sexuality, and related medical care.

Access to services directly affecting reproductive health can arouse conflict between adolescents and their parents in which health service providers become involved, such as when adolescents request contraceptive products, treatment for sexually transmitted infections (STIs), pregnancy testing, and pregnancy termination. Provision of such services may serve adolescents' interests, but relate to behavior that offends their parents' preferences and values. Some treatments may be difficult to keep confidential when adolescents live with their parents. Those that can be delivered confidentially may present professional dilemmas, such as when parents need to know adolescents' health and medication status because of legal liability to provide dependents with general health care services, and to pay for their treatment.

2. Interests and wishes

When judicial decisions have to be made that affect children, regarding not only their medical care but also their custody and upbringing, courts often apply the criterion of the children's best interests [4]. Widespread practice is embodied in the almost universally accepted international Convention on the Rights of the Child (CRC), which provides in Article 3(1) that "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration." Although courts may receive expert evidence on technical and medical prognostic issues, the common understanding is that, in principle, parents best know where their children's best interests lie. Parents have to be proven, to judicial satisfaction, to be harmful to their children's medical welfare before third parties will be authorized to replace them in determining the children's best interests [5].

In contrast, adults of ordinary mental capacity, including those of modest intellect, enjoy decision-making autonomy regarding their own medi-

cal care. There is almost universal endorsement of the classical proposition that "Every human being of adult years and sound mind has the right to determine what shall be done with his own body." [6] The legal right of medical autonomy is not dependent on education, wisdom, more than usual intelligence, or experience. Adults as informed as they want to be have the right to make decisions for themselves that others, including others who are better educated, trained or experienced and more wise, consider to be erroneous, misguided, or contrary to the decision-maker's best interests.

Adolescents are somewhere between dependent children, who are to be treated according to perceptions of their best interests formed by their parents or those legally authorized to act *in loco parentis* (in the place of parents), and independent adults, who are to be treated according to their wishes. In practice, adolescents whose wishes coincide with health service providers' views of their best interests are more likely to be considered "mature" (see Section 5 below).

Adults and adolescents capable of autonomy must also bear the consequences of choices they make that are not in their best interests, and may frustrate or damage their best interests. Further, they bear moral and sometimes legal responsibility for the effects their choices have on others, such as those they infect with STIs, and the children they intentionally or unintentionally produce.

3. Adolescence

The World Health Organization (WHO) defines "adolescence" as being between the ages of 10 and 19 years [7]. Recognition of adolescence as a distinctive stage of development is relatively recent. The WHO, for instance, defines an overlapping stage of "youth," between 15 and 24 years of age. Legal systems have historically distinguished "infants" and "minors" from adults. Ages of majority, such as 21 or 18 years of age, determine legal capacity for instance to own land and other property, to hold certain offices, and to marry without parental consent. The description "child" can be understood genetically, but has also been given a legal meaning. For instance, the CRC defines a "child" in Article 1 as "every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier," such as by marriage.

Laws also set arbitrary ages, for instance, for mandatory school attendance, purchasing tobacco products and alcohol, driving motor vehicles, voting, and marriage without parental consent. Some

set ages for autonomous medical decision-making, and giving legally effective consent to sexual intercourse. When unmarried female adolescents voluntarily become sexually active, but their consent legally does not relieve their partners of liability under criminal laws on rape, sexual assault or child abuse, the females themselves do not commit or become parties to offences against the laws designed for their protection.

Adolescents' access to protection against suffering or causing unwanted pregnancy, and against STIs including HIV/AIDS, is a significant reproductive health concern that is not resolved by insistence on their abstinence. Service providers may be reluctant to deny care that it is wise for adolescents to seek, but also apprehensive to provide care that may encourage unwise behavior, and that parents oppose. It is no offence against parents, however, to treat their competent children without parental consent or knowledge. Offering care only on the condition that parents be notified risks violation of patient confidentiality. If adolescents are below a locally observed age of medical self-determination, sometimes misdescribed as the "age of consent", their right to medical confidentiality presents a legal and ethical challenge (see Section 9 below).

4. Adolescents' "evolving capacities"

Adolescence, in WHO terms spanning 10 years of age to 19, occupies a period of major physiological, psychological, and social evolution. The 18-year-old person is quite different from the 10-year-old child she or he used to be. The CRC recognizes this by references to "evolving capacities". The concept is introduced as a limitation on parental responsibilities and rights, which may extend to their complete termination. Article 5 of the Convention provides that:

States parties shall respect the responsibilities, rights and duties of parents...to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Emphasis is given to "the exercise by the child," rather than on its behalf by its parents, of the rights identified in the Convention. Article 14 addresses adolescents' right to freedom of thought, conscience and religion, and parental rights and duties to provide direction to a child "in the exercise of his or her right in a manner consistent with the

evolving capacities of the child." The Committee on the Rights of the Child, the international agency that monitors observance of the CRC, stated in 2003 that it "notes with concern that in implementing their obligations under the Convention, states parties have not given sufficient attention to the specific concerns of adolescents as rights holders and to promoting their health and development." [8].

Recognition of adolescents' right of independent conscience and religion is of particular significance to reproductive health, since the definition and widespread acceptance of rights to reproductive health achieved at the UN International Conference on Population and Development, held in 1994 in Cairo, and the UN Fourth International Conference on Women, held in 1995 in Beijing, remain vigorously resisted by some conservative religious forces and institutions. Recognition that adolescents can hold different conscientious and religious convictions from their parents is liable to be threatening to parents anxious to observe the common religious mandate to bring up children in the parents' religious faith.

5. "Mature minors"

Some legal systems express adolescents' evolving capacities for medical and other self-determination in the "mature minor" rule. This has an historical foundation, but takes its present form through a case in which a mother in England challenged governmental guidance to physicians that they could exceptionally prescribe contraceptives to females under 16 years of age who were or were about to become sexually active, and were competent to employ them appropriately. Under the Sexual Offences Act 1956, sexual intercourse with females below 16 years of age is a criminal offence in England.

Mrs. Victoria Gillick challenged the legality of this guidance by requesting a judicial order that physicians under the regulation of her local area health authority not prescribe contraceptives to her daughters aged under 16, nor abort their pregnancies, without her parental approval, which she made clear she would not grant. The trial judge refused the order, finding the guidance lawful in embodying the mature minor rule. The Court of Appeal reversed this finding, due to the criminal nature of intercourse with girls under 16 years of age, and upheld Mrs. Gillick's order. This was unexpected, in showing judicial naïveté about the high incidence of pregnancy, childbirth and abor-

tion among early adolescents in England, and legally doubtful in that parents have no power to deny abortions to daughters whose lives, or physical or mental health, are medically found to be endangered by continuation of pregnancy. On further appeal, the highest court in the country, the House of Lords, reversed this decision, and restored the finding that Mrs. Gillick had no right to the order she requested [9].

The House of Lords' empowerment of an adolescent who is said to be "Gillick competent" has been embraced in Commonwealth countries such as Australia [10] and Canada [11] and increasingly widely beyond. Gillick competence reflects the evolving capacity of a normal child in the progressive transition to adulthood, and to responsibility for the consequences of choices.

Adolescents do not all mature at the same pace, and criteria of maturity may not be uniform among different forms of medical treatment. An adolescent or younger child who has capacity to request and consent to treatment of a wound or fracture suffered in a playground or sporting accident or a brawl, and to dental treatment, may lack capacity to consent to treatment that is more serious or that has wider implications for future options [12] including reproductive health [13]. It can be difficult in law and medicine to decide the capacity of a seriously ill adolescent to balance present needs for treatment against future disabilities [14]. However, an adolescent female who voluntarily engages, or proposes to engage, in sexual relations who requests treatment to prevent pregnancy or STIs may appear to be mature; indeed, the maturity of those who do not request such treatment is more open to doubt. Similarly, a pregnant adolescent who seeks abortion because she is not ready to assume responsibility for a child may be making a mature judgment, even when not appreciating the moral implications of that choice to her parents' satisfaction [15]. An adolescent considered incapable of making this decision for herself may seem no more capable of making decisions for the care and raising of a baby.

6. Emancipated minors

Adolescents achieve mature status by their own development, but they may become self-determining, that is, emancipated, by the acts of their parents or comparable guardians. The most historical form of emancipation occurred when parents consented to the marriage of their dependent children under age to marry without such consent.

Other forms occurred when legal minors left home for military service or to work and become economically self-supporting, or themselves became parents. Another form occurred when parents abandoned their children to their own means of survival. A sad modern form occurs when parents die, for instance from HIV/AIDS, and leave their children without adult care-givers.

When adolescents or younger children become self-reliant due to the acts, defaults or absence of more mature care-givers, they acquire the capacity to make medical decisions for themselves. When adolescents are emancipated but lack maturity to exercise medical judgment on their own behalf, health care providers offering care may ethically be parentalistic. They may go beyond simply informing the adolescents of medical options, and positively urge acceptance of treatments they consider to be in the adolescents' best interests.

Courts in some countries, such as the US [16], have recognized different areas of adolescent emancipation, so that those who remain economically dependent on their parents may be found emancipated in social, political, religious and, for instance, sexual aspects of their lives. They may therefore give consent to medical treatment related to these areas of emancipation independently of parental consent, and knowledge.

7. The "age of consent"

Many criminal laws seek protection of vulnerable children and adolescents against sexual exploitation, and their own sexual precociousness, by making intercourse with them when they are below a given age, such as 16, a punishable offence. Any consent they give, however free and genuine, affords their partners no defence in law. Such children and adolescents have not reached the legal "age of consent", and their sexual partners are convictable of such crimes as rape, sometimes described as "statutory rape."

The "age of consent" concept is sometimes invoked in the law of medical consent, particularly when a statute or court declares an age above which adolescents may be self-determining. However, it is almost invariably a misconception to analogize statutes and judicial declarations that provide such an age to those in criminal law. With very few exceptions, there is no fixed age of consent in medical law [9]. There is only a condition of consent, which is capacity to understand the nature and consequences of treatment options and refusal. Capacity is determined as a matter of law, but strongly guided by medical

assessments. Adolescents below any arbitrary or abstractly set age who have the intellectual and emotional maturity to make an informed decision about whether or not to undertake a particular medical procedure [1] can give legally effective consent to it.

Rigidly set ages below which mature minors legally require parental consent to receive therapeutic or preventative reproductive health services are frequently dysfunctional in that they prejudice adolescents' health and well-being, by creating barriers to care [17]. The law does not require parental consent to treat young victims of serious conditions such as accidents, since there is implied consent under the law of emergency care, reflecting the legal proposition that "peril invites rescue." The implication of consent can be rebutted, of course, such as when competent Jehovah's Witnesses show rejection of blood and blood products [18]. The law encourages emergency care rendered by "Good Samaritans", for instance by relaxing the usual standards of negligence law, and imposing liability only for gross or criminal negligence, meaning mistakes that no reasonable person, under whatever pressure, would make [19].

Denying non-emergency reproductive health care to mature or emancipated adolescents often offends the historical medical ethic to Do No Harm. Denial may leave such adolescents at risk, for instance, of unplanned pregnancy, STIs, unskilled abortion, and parental or other familial violence, especially where punishment of "honor killings" remains unenforced. Laws and professional practices that bar appropriate treatment for adolescent sexuality, in order to serve conservative social goals by reinforcing deterrence of sexual conduct through examples of severe consequences, are also ethically suspect, since they treat adolescents as means of warning.

8. Consent and assent

Adolescents incapable of exercising mature medical judgment are not necessarily excluded from a role in decisions others must make for them. When their own consent would lack legal force, they may nevertheless be entitled to give or withhold their assent. The focus of assent is less on longer term or indirect implications of proposed treatment than on the direct and immediate requirements of treatment options. That is, adolescents may state their willingness or unwillingness to undergo the direct experiences treatment would entail for them. These might include pain, discomfort, or inconvenience. If invasive procedures are an alter-

native to non-invasive, drug-based treatments, for instance, they may express preferences of which account should be taken.

Health service providers may consider that adolescents' refusal of assent should neutralize their parents' consent when voluntary compliance with a treatment regimen is critical to its success. Similarly, adolescents fearful, for instance, of injections, may be medicated by alternative routes, and they may decline internal examinations when other forms of reliable diagnosis exist. Courts have upheld parentally approved treatment over refusals of assent, however, when adolescents face risks to their lives or longer-term health.

When on-going treatment was approved by parents, a time may come when the children can be asked for their assent. When they evolve in capacity to become sufficiently mature for self-determination, their grant or refusal of consent may supersede earlier assent, and may displace choices of their parents. Legal systems differ, however, on whether the decisions of mature minors are an alternative source of consent to that given by their parents,[20] or displace and veto their parents' preferences [21]. It is doubtful, for instance, that doctors or courts would approve abortion of a 15-year-old adolescent on her parents' consent when she refused to assent, unless her life or health were in serious peril.

9. Confidentiality

Highest courts have confirmed that adolescents capable of making their own choices of receiving medical care enjoy the same power as adults to decide whether their confidences may be shared with others, such as their parents, employers or schoolteachers [9]. The legal and ethical challenge for service providers is not determining whether confidentiality should be respected, because in principle it should be, but in determining the practicalities of how it can be. Discussions with adolescents should include the extent to which confidentiality cannot be maintained, such as of continuing pregnancy, and counselling on circumstances in which it should not be maintained. For instance, if adolescents seek contraceptive protection against rape assaults by neighbours, schoolmates, authority figures, or family friends or members, service providers may counsel that those able to provide protection should be alerted, and required to furnish preventive measures that the adolescents cannot secure for themselves.

A compromise of confidentiality may arise when adolescents are dependent on parents or other

guardians to pay for services to which the adolescents can give consent. Service providers may be unable to conceal that gynecological services were rendered, but may have to generalize their nature, or offer bland, non-specific details. Disclosure of drug prescriptions may become necessary if guardians are providing general health care including medications that would be contraindicated for patients taking the prescribed products. Their purpose may be unspecified, although in some cases it may be obvious.

Third-party health service insurers may be billed for specified treatments, but required not to disclose their nature or purpose to parental premium-payers. When private or public health insurance agencies routinely check with insured parties to monitor whether billed services were actually delivered to them or their family members, bills for adolescents' sensitive services should be marked not to be verified with parents or other guardians who are named in insurance agreements. Adolescents should be warned in advance, however, when disclosure to those they want to remain uninformed of the services they seek cannot practically be prevented.

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