



TOOL KIT FOR TEEN CARE
SECOND EDITION

CONFIDENTIALITY IN ADOLESCENT HEALTH CARE



THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

KEY POINTS

- Confidentiality is a major concern in the delivery of health care to all adolescents, but there are special considerations for those who are minors.
- Physicians should address confidentiality issues with every adolescent patient to build a trusting relationship with her and to facilitate a candid discussion regarding her health and health-related behaviors.
- Physicians also should discuss confidentiality issues with the parent(s) or guardian(s) of the adolescent patient. Physicians should encourage their involvement in the patient's health and health care decisions and, when appropriate, facilitate communication between the patient and a parent or guardian.
- Physicians should develop office procedures to maintain adolescent patients' confidentiality. All office staff should be aware of these procedures.
- Physicians should be familiar with state and local laws that affect the rights of minors to receive health care services and to give their own consent for health care.
- Physicians also should be familiar with the federal and state laws that affect confidentiality in the provision of health care to adolescents, including the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.
- The right of a "mature minor" (who is able to give informed consent) to obtain selected medical care, including services related to contraception, pregnancy, sexually transmitted diseases, substance abuse, and mental health, without parental consent has been established in most states.
- A minor's right to obtain an abortion without parental involvement or court involvement is restricted in most states.
- Health care providers should work to ensure that confidential services for adolescents are not compromised by legal and financial constraints.

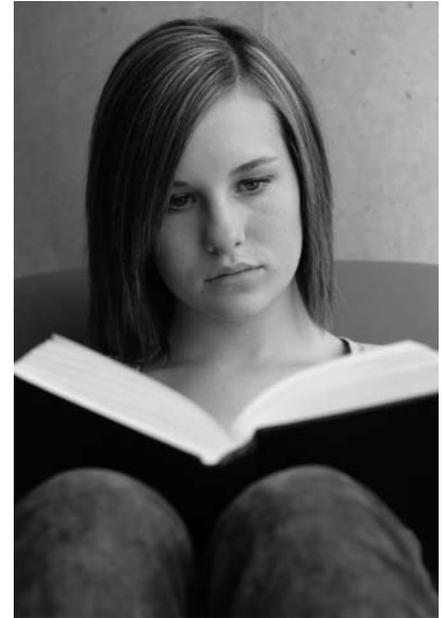
Adolescence is a time of transition from childhood to adulthood and is marked by a number of developmental milestones. For many, this transition is relatively smooth; for others, however, it may be a time of difficulty. Adolescent girls are confronted with numerous challenges and the decisions they make can have both short- and long-term consequences for their health and well-being.

Adolescents are a relatively healthy subgroup of the U.S. population. However, often their behavior puts them at substantial risk for poor health. Behaviorally related morbidities include alcohol and substance abuse; sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV); pregnancy; eating disorders; depression; suicide; violence; and unintentional injury. Because these behaviors can jeopardize an adolescent's development, future opportunities, and even life, any barriers to needed health care services should be identified and removed.

Most adolescents underuse existing health care services. A major obstacle to the delivery of health care to adolescents is their concern about confidentiality. Confidentiality refers to protection of the privileged and private nature of information shared during a health care encounter and other information and records about the encounter (1). Although ensuring confidentiality is relatively simple when providing services to adults, including adolescents aged 18 years or older, providing the same degree of confidentiality protection to adolescents is usually less straightforward. The legal status of a minor and legal requirements for parental consent before the provision of medical services often encumber the physician–patient relationship or place limits on the potential for protection of confidentiality.

Confidentiality also may be compromised by financial considerations because few adolescents are able to pay for medical services themselves and, therefore, may need parental or adult help in arranging payment. Only California allows adolescents to qualify for Medicaid on the basis of their own incomes in limited instances. Most states consider family income and assets when determining eligibility. To supply such information, adolescents will almost certainly need to consult with family members. Explanation of Benefits forms issued by indemnity insurers, managed care organizations, and Medicaid are sent to parent policyholders, which also can compromise the confidentiality of information and, therefore, a minor's access to health care services.

To overcome barriers to confidentiality imposed by legal and financial constraints, physicians should discuss confidentiality with both the adolescent girl and, when appropriate, her parent(s) or guardian(s). Health care providers should be familiar with current state and local statutes on the rights of minors to consent to health care services as well as those federal and state laws that affect confidentiality. It also is important to involve and inform office staff about those policies and procedures that facilitate and ensure confidentiality and about how to avoid unintentional breaches of confiden-





tiality. Finally, when feasible, physicians should work with the political process to eliminate laws unduly restrictive of confidential health services for adolescents.

ADDRESSING CONFIDENTIALITY

Parents should be counseled that it is appropriate for the maturing adolescent girl to assume increasing responsibility for her health and health care. Adolescence is a period of significant change and maturation, and learning to make appropriate health care decisions is a major developmental task. Physicians can assist in this process by providing an environment in which adolescents can candidly discuss their concerns. Adolescents are more likely to develop trusting relationships with their health care providers when the issue of confidentiality has been addressed. A confidential relationship, in turn, facilitates the open disclosure of health histories and risky behaviors. The health and behavioral issues of adolescent patients can then be addressed with nonjudgmental counseling and medical intervention.

Physicians should stress to parents that they share a common goal—the health and well-being of the minor patient. The mutual trust that follows from this common goal will enhance and support the adolescent–physician relationship. The involvement of a concerned adult can contribute to the health and success of an adolescent. Providers should encourage and, when appropriate, facilitate communication between a minor and her parent(s) (2).

Parents and adolescents should be informed, both separately and together, that the information each of them shares with the provider will be treated as confidential. Additionally, they should be informed of any restrictions on the confidential nature of the relationship. For instance, the physician should explain that if the patient discloses any risk of bodily harm to herself or others (1), confidentiality will be breached. Furthermore, state laws may mandate the reporting of physical or sexual abuse of minors.

LEGAL ISSUES

Because the legal status of minors differs from that of adults, physicians who treat minors should be aware of laws that affect the provision of services. The age of majority has been set at 18 years in most states. The following information is an introduction to the laws that address the medical treatment of minors. Providers of health care to adolescents are encouraged to familiarize themselves with federal laws and the laws in their own states to determine when protection of confidentiality is required. When necessary, they should seek appropriate legal advice.

All states require consent for the medical treatment of a minor from an individual legally entitled to authorize such care. Although this usually will

be a parent, other guardians and caretakers, such as foster parents, juvenile courts, social workers, and probation officers, may provide the necessary consent in certain instances.

There are, however, exceptions to this requirement for parental consent. First, in an emergency situation, when immediate treatment is necessary to safeguard the life or health of a minor, parental consent is assumed (3). Second, “emancipated minors” generally are held to be capable of consenting to any medical treatment (3). Such minors may include those who are married, those who are members of the armed forces, and those who live apart from their parents and are financially self-supporting. Third, minors who are themselves the parent of a child may often consent for their own care as well as their child’s care. Fourth, all states and the District of Columbia have statutes allowing minors to consent to at least some specific health care services. These services may include contraceptive services, prenatal care and delivery services, STD services, HIV testing and treatment, treatment of drug and alcohol problems, and outpatient mental health treatment (3). The laws may specify the age at which minors can begin to consent to such care. As of September 2008, all states allow minors to consent to testing and treatment services for STDs. Only the District of Columbia and 21 states explicitly allow all minors to consent to contraceptive services (4). However, in other states, specific groups of minors are explicitly authorized to consent for contraceptive services, and minors, who are able to consent for all services based on their status (eg, married, or living apart from parents), also are allowed to consent for contraceptive services (5). Moreover, both the federal Medicaid statute and the federal Title X Family Planning Program require confidential family planning services to program-eligible minors who seek these services.

Over the past few decades, courts have acknowledged the growing independence of adolescents and the seriousness of their health care needs. Through case law, the right of a “mature minor” to consent to some forms of medical care without prior parental consent has been established and is recognized not only in states in which a mature minor case has been explicitly decided by the courts but in other jurisdictions as well. A mature minor is defined as an adolescent younger than the age of majority who, even if living at home as a dependent, demonstrates the cognitive maturity to give informed consent (1). The capacity to consent will be influenced by the minor’s developmental maturity, prior experience with illness, the gravity of the current illness, and the risks of proposed therapy (1). Although the mature-minor doctrine has been written into statute in only a few states, during the past several decades there have been no reported decisions holding a physician liable solely for failing to obtain parental consent when nonnegligent care was provided to a mature minor (typically at least 15 years old) who had given informed consent (5). When dealing with high-risk health concerns, such as contraception, pregnancy, STDs, and mental health, most states have concluded that the need for confidential services outweighs the reasons for parental notification. When deciding whether or not to accept a mature minor as a patient, individual providers should evaluate their

personal views. If a provider's views on confidentiality restrict the provision of services to a minor, the patient should be referred to another health care provider.

The federal privacy regulations issued under HIPAA, also known as the HIPAA Privacy Rule, provide additional important protection of confidentiality for minors. This rule includes rights for adolescents and grants legal significance to agreements that favor adolescents receiving confidential care. When a minor has the legal right to consent for care and does consent, the HIPAA Privacy Rule allows the minor generally to assume the rights to control access to information and records of their care on the same basis as adults. The minor is treated as an "individual" who can exercise rights under this rule when the minor legally consents to health care such as for treatment of STDs or receives care without parental consent with court approval of care such as in an abortion, or when the parent assents to an agreement of confidentiality between the adolescent and the health care provider. In these cases, the parent does not necessarily have the right to access the minor's protected health information. According to the HIPAA Privacy Rule, the parent's right to do so is determined by "state and other applicable law." However, the minor may request that the parent act as a personal representative and, if she does so, the parent may have access to information (1, 6). State or other applicable laws may give the right to control access to the information to the minor or may grant discretion to a physician.

A minor's right to obtain an abortion without parental consent or notification is one area in which the rights of a minor have been restricted by legislatures and by courts. As of September 2008, 34 states require that a minor either notify or receive consent from one or both parents before obtaining an abortion; 22 states require parental consent only; 10 states require parental notification only; and two states require both parental consent and notification (7). All of the 34 states provide for an alternative process that allows a minor to obtain an abortion without involving a parent, as is constitutionally required (7). This takes place typically in the form of a judicial bypass, which allows minors to seek a court order allowing them to give their own consent without the involvement of a parent (8). The U.S. Supreme Court has ruled that if a minor chooses this option, the judge must allow the minor to give her own consent if she is mature or, if not, must authorize the procedure if it is in the girl's best interest (9).

A MODEL OFFICE VISIT

Physicians should develop office procedures that safeguard their adolescent patients' rights. Furthermore, every member of the office staff must be aware of these procedures and their role in preserving confidentiality. Outlined in Table 1 and described as follows is an initial office visit process that works well when an adolescent girl is accompanied by her parent(s) or guardian(s):

Table 1. An Adolescent Office Visit That Supports Confidentiality

In Consultation With	The Physician Should
Patient and parent(s) or guardian(s)	<ul style="list-style-type: none"> Outline structure of visit Obtain general medical and family history Discuss confidentiality Address parental concerns*
Patient	<ul style="list-style-type: none"> Obtain health history, including risk-taking behaviors Address patient concerns Provide health guidance Address billing issues
Patient†	<ul style="list-style-type: none"> Perform physical examination, as indicated
Patient	<ul style="list-style-type: none"> Summarize findings and recommendations Determine parental involvement Determine method of notification of laboratory results
Patient and parent(s) or guardian(s)	<ul style="list-style-type: none"> Summarize findings and recommendations, as appropriate Provide guidance about adolescent development to parent Address confidentiality issues regarding billing issues

*If the parent wishes to speak with you about her concerns privately, this should be done before the confidential visit with the patient.

†Parent may be present, at patient's discretion

1. The physician initially sees the parent and adolescent patient together to explain the structure of the visit. The reason for the visit and the patient's medical and family history are then reviewed. It is important to direct questions to, and maintain eye contact with, the adolescent patient during this discussion, deferring to the parent or guardian only when supplemental information or clarification is needed.

The issue of confidentiality also should be discussed. Physicians should inform both the adolescent and her parent of the scope of the minor's authority to consent to medical care. Physicians also should reassure them that family communication is encouraged and facilitated and that no attempt is being made to undermine good parent–child relationships. The adolescent should be informed about various reporting requirements and when confidentiality must be breached.

An adjunct to this discussion may be a simple written agreement (see the box on page 7). Such a document recognizes the adolescent's emerging autonomy and at the same time promotes communication between the parent(s) and child. It must be stressed that the agreement is not legally binding. It does, however, acknowledge the importance of confidentiality and outline the expectations of the new adolescent patient–parent–physician relationship. Parents also may be reminded that medical protocols may require pregnancy testing and screens for STDs when the adolescent has

gynecologic concerns or symptoms. The parent(s) or guardian(s) should be asked about any concerns they may have at this time.

2. The parent(s) or guardian(s) should then be excused from the room. This allows for a confidential discussion between the physician and the patient about her health-related behaviors and concerns. The discussion about sexuality, substance use, alcohol, smoking, eating behaviors, violence, depression, relationships, and school performance can be facilitated by adopting an open, relaxed, and nonjudgmental attitude. At this point it is important to distinguish between judging the behavior and judging the individual. Although certain behaviors can clearly be judged as harmful or inappropriate, the adolescent patient should not be judged as “bad.”

Disclosures made during the discussion will determine the need for a physical examination. An internal pelvic examination rarely is necessary during the initial visit, unless indicated by medical history. If a general physical examination is necessary, including a visual breast and genital examination, the patient should be provided with a description of this process and asked if she would like her parent or another individual present.

3. On completion of the physical examination, consultation with the patient should address physical findings and diagnosis and treatment options, if needed. Once a mutually agreed-on treatment plan is established, the adolescent is encouraged to include her parent in treatment planning. Depending on the adolescent’s level of maturity, the nature of the medical problem, the physician’s medical judgment, and legal constraints, parental involvement may be more or less strongly advised and facilitated. A method for reporting confidential laboratory results to the adolescent should be established at this time. Verify how to contact the patient, such as by e-mail, cell phone, or any other phone number provided. If the adolescent agrees to parental input and a conflict in treatment planning develops once the parents are involved, the physician often will have to take the role of arbitrator. Such a conflict may be resolved by determining if the adolescent has the legal right to consent to the services in question.
4. At the conclusion of the consultation the patient, her parent(s), and the physician should meet again. During this meeting, findings and recommendations are discussed, if appropriate. Any remaining concerns also can be addressed and the parent can be offered guidance on adolescent development.
5. Finally, a claim for payment is filed. Maintaining confidentiality for a minor patient often is a problem when billing for office visits and laboratory work for services such as pregnancy and STD testing. Insurance companies and health maintenance organizations may not reimburse for laboratory services described as “indicated routine screening” and may insist that parents receive an itemized bill listing the specific tests. The disclaimer that “these tests are necessary in medical protocols” may be sufficient to satisfy

Confidentiality Agreement Regarding Reproductive Health Care

Parent

I, _____ (parent or guardian), allow

_____ (patient), to enter a confidential patient–physician relationship. I understand that she can make independent health care decisions regarding reproductive health care, but that my input and involvement will be encouraged.

_____ (patient) has permission to schedule appointments and receive confidential reports from this office. I further understand that various laboratory tests may be necessary in medical protocols and accept responsibility for physician charges and laboratory fees.

PARENT OR GUARDIAN

PHYSICIAN

Patient

I, _____ (patient), am entering a confidential physician–patient relationship with

_____ (physician). I will make an effort to communicate with my parent(s) or guardian(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my physician and I establish.

PATIENT

PHYSICIAN

the concerns of some parents. To ensure confidentiality, however, some adolescents may choose to pay for these tests themselves. Some practitioners offer a reduced rate for these tests or refer patients to agencies such as Title X, family planning programs, and public health clinics that charge on a sliding scale according to income. If the service is covered by an insurer with whom the physician has a contract, allowing the patient to pay out of pocket could violate the terms of the contract because she is being denied a covered benefit. Office personnel should be cognizant of the issues of confidentiality with billing, reviewing claims with parents, and reporting laboratory results. Practitioners can familiarize themselves with local resources to inform patients of ways they can obtain the service for the lowest cost.

6. Patient preferences or special circumstances (eg, reading level or learning disabilities) may necessitate a modification of the initial office visit process, and physicians should allow additional time for separate patient and parent interviews. Parents may express specific concerns regarding their daughter's health that may necessitate a separate meeting with parents. Such a meeting often helps to relieve any anxiety parents feel in their new "passive" role. Physicians should reassure parents that they will encourage the adolescent to include her parents in important health decisions. Also, the teen should be made aware of this meeting and assured that patient confidentiality will be maintained. If meeting with the parent alone, the meeting should take place before the visit with the adolescent. If the meeting with the parent takes place after the visit with the adolescent, the adolescent may be concerned that the confidential information she just provided will be shared with the parent.

Although this process may take more time than an adult patient visit, in the long run it should result in fewer telephone calls from parents who do not fully understand their changing role in their adolescent daughter's health care or the nature of confidential services for minors.

CONCLUSION

Confidential health services promote the health and well-being of all adolescents. Legal requirements and financial constraints, however, can present significant barriers to confidential health services for adolescents. Both minors and providers consistently identify concerns about the lack of confidentiality as major obstacles to minors obtaining needed health care. Overcoming the obstacles imposed by such constraints is not difficult. Providers should broach discussions of confidentiality with minor patients and their parents or guardians, familiarize themselves with current federal and state laws affecting confidentiality, and develop office procedures aimed at maintaining confidentiality. Family communication is the desired goal, and health care providers are able to assist in this effort. Confidential care does not preclude

working toward this goal. By showing concern both for a parent's desire to be involved in a daughter's health care decisions and for the minor's growing need for autonomy, physicians can aid in a minor's healthy transition from childhood to adulthood.

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8. The adolescent's right to confidential care when considering abortion. American Academy of Pediatrics. Committee on Adolescence. *Pediatrics* 1996;97:746–51.
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RESOURCES

Publications

The initial reproductive health visit. ACOG Committee Opinion No 335. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2006;107:1215–9.

Advocates for Youth. Adolescent access to confidential health services. Washington, DC: AFY; 1997. Available at: <http://www.advocatesforyouth.org/PUBLICATIONS/iag/confhlth.htm>. Retrieved February 8, 2008.

The following lists are for information purposes only. Referral to these sources and web sites does not imply the endorsement of the American College of Obstetricians and Gynecologists. These lists are not meant to be comprehensive. The exclusion of a source or web site does not reflect the quality of that source or web site. Please note that web sites are subject to change without notice.

Other Resources

American Academy of Family Physicians

Telephone: (913) 906-6000 or (800) 274-2237

Web: www.aafp.org

American Academy of Pediatrics

Telephone: (847) 434-4000

Web: www.aap.org

American Medical Association

Telephone: (800) 621-8335

Web: www.ama-assn.org

Center for Adolescent Health and the Law

Telephone: (919) 968-8850

Web: www.adolescenthealthlaw.org

Go Ask Alice!

Telephone: (212) 854-5453

Web: www.goaskalice.columbia.edu

Guttmacher Institute

State Center

Telephone: (212) 248-1111 or (800) 355-0244

Web: www.guttmacher.org/statecenter

National Women's Health Information Center

Office on Women's Health

Department of Health and Human Services

Telephone: (800) 994-9662

Web: www.4.woman.gov

Society for Adolescent Medicine

Telephone: (816) 224-8010

Web: www.adolescenthealth.org

Teenwire

Planned Parenthood Federation of America

Telephone: (212) 541-7800 or (800) 230-PLAN (7526)

Web: www.teenwire.com