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KEEPING CHILDREN'S SECRETS: CONFIDENTIALITY IN THE PHYSICIAN-PATIENT RELATIONSHIP

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I. INTRODUCTION

"Whatever, in connection with my professional practice or not in connection with it, I see or hear in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."[1]

The importance of maintaining confidentiality in the physician-patient relationship has been recognized since the 4th Century BC

[1] Ludwig Edelstein, THE HIPPOCRATIC OATH: TEXT, TRANSLATION AND INTERPRETATION 3 (1943). The precise words of the Hippocratic Oath are slightly varied in different texts as a result of translation differences. *See* Bernard Friedland, *Physician-Patient Confidentiality*, 15 J. LEGAL MED. 249, 256 (1994).

and remains a fundamental tenet of professional medical ethics. Keeping patients' secrets has been described as one of the most challenging, yet sacred aspects of being a physician.[2] It demonstrates respect for the patient and his or her autonomy-based right to decide with whom to share personal information and build trust, which is essential to good patient care. Studies suggest that individuals who do not believe sensitive medical information about them will be kept confidential are less likely to seek professional help, reveal private information that may be necessary for accurate diagnosis and treatment, or comply with treatment recommendations.[3] Adolescents are particularly vulnerable to these concerns.[4] Thus, physicians who treat pediatric patients are often faced with a difficult decision: do they promise confidentiality to the patient in an effort to build a therapeutic alliance and improve physician-patient communication, or do they breach confidentiality to inform others, usually the patient's parent(s), about the patient's medical condition?

Although many older pediatric patients have the cognitive capacity to understand medical decisions,[5] individuals eighteen years

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2 Kent Sepkowitz, *A Young Doctor's Hardest Lesson: Keep Your Mouth Shut.*, N.Y. TIMES, Dec. 28, 2004, at A8.

3 New genetics may exacerbate the potential risks to medical privacy. Since health insurance would inevitably pay for genetic services, including testing and counseling, genetic information about a particular patient would likely proliferate. In turn, the patient, fearing a "biological 'scarlet letter'" as a result of the genetic databases, would no longer have confidence in the reciprocal promise of confidentiality between physician and patient. Ultimately, the patient may refuse to seek care or, at the very least, refuse to confide. A general demise of the sanctity in the physician-patient relationship may result. Paul A. Lombardo, *Genetic Confidentiality: What's the Big Secret?* SYMPOSIUM, *Genetics and the Law: The Ethical, Legal, and Social Implications of Genetic Technology and Biomedical Ethics*, 3 U. CHI. L. SCH. ROUNDTABLE 589, 593-96 (1996).

4 Research has found that adolescents are sensitive to the assurances of medical confidentiality. These concerns, in turn, influence the adolescents' stated intentions for: (1) considering return visits to the particular physician; (2) discussing sensitive issues with their physicians; and (3) seeking future medical treatment. As stated by C. Ford et al., "Assurances of confidentiality increased the adolescents willing to discuss sensitive issues [with their physicians] . . . from 39% to 46.5% and increased the willingness to seek future health care from fifty-three percent to sixty-seven percent." C.A. Ford et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care: A Randomized Controlled Trial,* 14 (2) JAMA 116, 116-17 (1997).

5 *See generally* T.L. Kuther, *Medical Decision-Making and Minors: Issues of Consent and Assent,* 38, 38-40 (150) ADOLESCENCE, 343, 345-56; K. Toner & R. Schwartz, *Why a Teenager Over Age 14 Should Be Able To Consent, Rather Than Merely Assent, to Participation as a Human Subject of*

of age and younger are generally considered legally incompetent and thus lack decisional authority. Informed consent for medical treatment of a minor must be obtained from a parent or legal guardian.[6] When parental consent is required, medically relevant information must be disclosed to the parents so they can make an informed treatment decision.[7] Not all information revealed by the patient will be necessary for decision-making, leaving physicians with some professional discretion about the extent to which that information is disclosed.[8] Every state recognizes exceptions to the rule that minors are incompetent to make medical decisions and allow pediatric patients, in certain circumstances, to consent to their own medical treatment.[9] The obligation of a physician to maintain or breach patient confidentiality in these circumstances is not always clear. The ability to disclose individually identifiable protected health information (PHI) is limited by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule as well as state laws governing confidentiality in the physician-patient relationship.[10] However, both federal and state laws leave room for physician discretion to determine how best to manage these particularly sensitive situations.[11]

Part II of this article will examine pediatric patients' right to authorize the disclosure of their protected health information to third parties and their parent/guardian's right to access that information under the HIPAA Privacy Rule. Since the Privacy Rule depends largely on the right of minors to consent to treatment under state law, Part III will investigate variability among different states on this issue. Part IV will explore how states legislate confidentiality with pediatric patients, demonstrating that in most situations, physicians

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Research, 3 (4) Am J. Bioeth., 38-40 (2003) (arguing that, given cognitive developments resulting in the ability to comprehend and rationalize, minors should have the ability to make medical decisions).

6 *See generally* David M. Vukadinovich, *Minors' Rights to Conset to Treatment: Navigating the Complexity of State Laws,* 37 J. HEALTH L. 667, 670 (2004).

7 *Id.* at 672.

8 *Id.* at 690.

9 *Id.* at 682-82. *See also infra* Parts II, III.

10 45 C.F.R. § 164.502(g)(3) (2002).

11 45 C.F.R. § 164.502(g)(3)(ii)(C) (2002).

will be required to exercise some professional discretion when deciding whether or not to disclose confidential patient information to parents/guardians. Part V will consider the ethical justifications for conflicting approaches to confidentiality in pediatrics and will conclude with recommendations for the responsible exercise of physician discretion when managing difficult cases regarding confidentiality with pediatric patients.

II. HIPAA PRIVACY RULE

The HIPAA Privacy Rule federally protects individuals' privacy and confidentiality with regard to personal health information. Individuals are permitted to control certain uses and disclosures of their health information.[12] In terms of minors' confidentiality rights, the Privacy Rule mandates a two-step analysis, discussed below.

The first step of the analysis is to determine who has the right to control third party access to the minor's personal health information. For the purposes of this article, a third party is defined as anybody outside the physician-patient-parent/guardian relationship. Presumptively, parents/guardians are considered personal representatives for their minor children.[13] As such, parents/guardians generally have control over their child's personal health information[14] and can authorize disclosures of the minor's protected health information to third parties.[15] However, the Privacy Rule provides two major exceptions to this general principle. First, a parent can agree to a confidential relationship between the minor and the physician.[16] If such a confidential relationship is formed as a result of parental agreement, the parent loses personal representative status, and the right to authorize disclosures to third parties transfers to the minor.[17] Second, the parent loses personal representative status

12 45 C.F.R. § 164.502 (a)(1)(i).

13 45 C.F.R. § 164.502 (g)(2). For a summary of the law in laymen terms, *see* http://www.hhs.gov/ocr/hipaa/guidelines/personalrepresentatives.pdf (last visited Oct. 19, 2007).

14 45 C.F.R. § 164.502(g)(2).

15 45 C.F.R. § 164.502(g)(3) (2002).

16 45 C.F.R. § 164.502(g)(3)(i)(C).

17 *Id.*

when state law (expressed statutorily or through case law) does not require parental consent for medical treatment.[18] When the minor is legally authorized to consent to health treatment the "parent does not control the minor's health care decisions, . . . and [the parent does] not control the protected health information related to that care."[19] The minor has the sole authority to authorize disclosures of her protected health information to third parties.

This does not, however, resolve the question of whether the parent/guardian can access the pediatric patient's personal health information without the patient's consent. The question of whether the parent or child controls the information (i.e., can authorize disclosures to third parties) (Figure 1) must be treated as separate from the question of whether the parent can access the information without the child's consent (Figure 2). The first question turns on whether or not the parent/guardian is the personal representative of the patient. Regardless of how this question is resolved, however, the issue of parental access to the patient's health information depends on state law.[20]

But what happens then when the state law is silent or ambiguous? If the parent is the personal representative, the parent has the right to access the minor's health information in the absence of state law.[21] On the other hand, if the minor controls his or her personal information (i.e., either the parent agreed that the physician may maintain a confidential relationship with the minor, or there is state law permitting the minor to consent to treatment), physician discretion is permitted. That is, if the parent or guardian is not the

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18 45 C.F.R. § 164.502(g)(3)(i)(A).

19 U.S. DEP'T OF HEALTH AND HUMAN SERVS., PRIVACY SUMMARY (2003), http://www.hhs.gov/ocr/hipaa/guidelines/personalrep-resentatives.pdf.

20 *Id.* An example of the two-step analysis is provided in the following statutory language: "If the person seeking treatment . . . for [substance abuse] is a minor, the fact that the minor sought such treatment . . . shall not be reported or disclosed to the parent or legal guardian of the minor without the minor's consent. The minor may give legal consent to the receipt of such treatment and rehabilitation." CONN. GEN. STAT. ANN. §17A-688 (West 2006). **Step One**: Note that the state statute specifically gives the minor the ability to consent to treatment. Thus, the parents lose their personal representative status and the minor effectively controls their own personal health information. **Step Two**: In terms of parental access, the state law expressly prohibits disclosure to the parents without the minor's consent.

21 U.S. DEP'T OF HEALTH AND HUMAN SERVS., PRIVACY SUMMARY (2003), http://www.hhs.gov/ocr/hipaa/guidelines/personalrep-resentatives.pdf.

patient's personal representative and the state law is ambiguous or silent concerning parental access to the patient's health information, then the physician or institution may use discretion to permit or prohibit parental access to the pediatric patient's health information.[22] This discretion should be exercised within the confines of professional judgment.[23]

III. STATE LAW: PEDIATRIC CONSENT

The HIPPA Privacy Rule creates the skeletal framework for informed consent and confidentiality rights with regard to minors. State laws, however, create the contours. As stated previously, when state law permits the minor to consent to treatment, the minor effectively controls his or her personal information under HIPAA. This section explores how various states regard minors' rights to consent to treatment.

There are two situations where minors are given sole authority to consent to medical treatment. The first permits certain minors to consent to treatment by virtue of their status. In this situation, the minor is deemed "emancipated," and he or she is considered an adult for the purpose of medical decision-making.[24] Second, minors who are otherwise unemancipated may have sole decision-making authority in certain contexts, either by virtue of their cognitive maturity (the "mature minor" doctrine) or because the minor seeks treatment for certain medical conditions.[25]

A. Emancipated Minors

State statutes permit certain minors to consent to all medical treatment by virtue of their status as emancipated minors. The minor may be considered emancipated for the purposes of consenting to medical treatment if he or she is married, has obtained court emancipation, served in the armed forces, or is a parent. Though the

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22 *Id.*

23 *Id.*

24 Garry Sigman et al., Position Paper of the Society for Adolescent Medicine, *Confidential Health Care for Adolescent Medicine*, 21 J. ADOLESCENT HEALTH 408, 411 (1997).

25 21 J. ADOLESCENT HEALTH 411-12 (1997).

states vary in terms of what conditions are necessary to effectively emancipate a minor, all states consider at least some of these conditions to be sufficient. For instance, nearly every state explicitly considers the minor emancipated upon marriage or parentage. Approximately twenty percent of the states explicitly consider service in the armed forces effective means of emancipation,[26] the majority of which are the traditionally more conservative southeastern states.[27]

In addition to the emancipation provisions, an unemancipated minor may be deemed "emancipated" if he or she is living separately from his or her parents and is financially independent. Some states, in addition to requiring financial independence, stipulate that the minor must be a certain age for the purpose of consenting to medical treatment.[28] Though these "runaway" provisions are fewer in number than the legal emancipation provisions discussed above, they do exist in about twenty-five percent of all states.[29]

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26 CAL. FAM. CODE § 7002 (West 2004); GA. CODE ANN., § 15-11-201 (West 2006); IND. CODE ANN. 16-36-1-3 (West 2006); ME. REV. STAT. ANN. tit. 22, § 1503 (2004); MASS. GEN. LAWS ANN. ch. 112, § 12F (West 2003); MICH. COMP. LAWS ANN. § 722.4 (West 2002); MINN. STAT. ANN. § 256D.05 (West 2007); N.H. REV. STAT. ANN. § 161-H:1 (1995); TEX. FAM. CODE ANN. § 32.003 (Vernon 2002); VT. STAT. ANN. tit. 12, § 7151 (1995).

27 Texas, Georgia, and Mississippi qualify as conservative, southeastern states which deem military service an effective means of emancipation. California, a state which concededly falls outside of the conservative regime, has also legislatively determined that military service could operate as a means of emancipation. See, e.g., TEX. FAM. CODE ANN. § 32.003 (Vernon 2002).

28 *See, e.g.,* KAN. STAT. ANN. § 38-123b (2000) (sixteen years old); ALASKA STAT. § 09.55.590 (1976) (sixteen years old); CAL. FAM. CODE § 6922 (West 2004) (fifteen years old); COLO. REV. STAT. § 13-22-103 (2005) (fifteen years old); ALA. CODE § 22-8-4 (1971) (fourteen years old); IND. CODE ANN. 16-36-1-3 (West 2006) (fourteen years old); R.I. GEN. LAWS § 23-4.6-1 (1956) (sixteen years old); S.C. CODE ANN. § 20-7-280 (2006) (sixteen years old); TEX. FAM. CODE ANN. § 32.003 (Vernon 2002) (sixteen years old); VT. STAT. ANN. tit. 12, § 7151 (1995)(sixteen years old). The Alabama and Kansas statutes suggest that being fourteen years old is sufficient to warrant emancipation, regardless of the minor's financial dependency. ALA. CODE § 22-8-4 (1971); KAN. STAT. ANN. § 38-123b (2000). Rhode Island and South Carolina will give any minor over the age of sixteen the ability to consent to medical treatment, regardless of financial stability or residence. R.I. GEN. LAWS § 23-4.6-1 (1956); S.C. CODE ANN. § 20-7-280 (2006). The other statutes listed, however, require a finding of financial independence or separate residence from the minor's parents in addition to their reaching the requisite age.

29 ARIZ. REV. STAT. ANN. § 44-132 (1991) (no age requirement); MINN. STAT. ANN. § 244.341 West (2005) (no age requirement); ME. REV. STAT. ANN. tit. 22, § 1503 (2004) (no age requirement); MASS. GEN. LAWS ANN. ch. 112, § 12F (West 2003) (no age requirement); MONT. CODE ANN. 41-1-401(2005) (no age requirement); KAN. STAT. ANN. § 38-123b (2000)

B. Unemancipated Minors Who Can Consent to Certain Types of Treatment

In addition to the provisions that permit emancipated minors to consent to all medical treatment, other state consent laws allow unemancipated minors to consent to certain types of medical treatment.[30] These statutes are contextually tailored, permitting the minor to consent to some types of treatments but not all treatment options.[31] The most common conditions for which parental consent is not required are: diagnosis and treatment for sexually transmitted diseases; diagnosis and treatment for substance abuse; mental health treatment; and family planning (e.g., access to contraceptives and treatments related to pregnancy).

Interestingly, virtually every state permits a minor to seek treatment for sexually transmitted diseases without parental consent.[32] Most of these state statutes are fairly liberal, with only a

(sixteen years old); ALASKA STAT. 09.55.590 (1976) (sixteen years old); CAL. FAM. CODE § 6922 (West 2004) (fifteen years old); COLO. REV. STAT. § 13-22-103 (2005) (fifteen years old); ALA. CODE § 22-8-4 (1971) (fourteen years old); ALASKA STAT. 09.55.590 (1976) (sixteen years old); IND. CODE ANN. 16-36-1-3 (West 2006) (fourteen years old); R.I. GEN. LAWS § 23-4.6-1 (1956) (sixteen years old); S.C. CODE ANN. § 20-7-280 (2006) (sixteen years old); TEX. FAM. CODE ANN. § 32.003 (Vernon 2002) (sixteen years old); VT. STAT. ANN. tit. 12, § 7151 (1995) (sixteen years old).

30 It is important to note the status provisions and the treatment provisions are not necessarily congruous for each particular state. For instance, Texas has a statute granting minors' consent to treatment by virtue of their status. Particularly, financial independence, service in the armed forces, parentage, pregnancy, and any minor at least sixteen years old living separately from his or her parents may consent to treatment. Additionally, Texas has provisions granting minors authority to consent by virtue of the treatment sought. In this respect, minors seeking chemical-dependency treatment, diagnosis or treatment of sexually transmitted diseases, and counseling for suicide ideation or abuse may effectively consent. The result is that a fifteen-year-old male who lives separately from his parents cannot consent to mental health services outside the realm of chemical dependency, suicidal ideation, or abuse unless he can demonstrate that he is financially independent, a parent, or served in the armed forces. TEX. FAM. CODE ANN. § 32.003 (Vernon 2002); TEX. FAM. CODE ANN. § 32.004 (Vernon 2002).

31 There are three exceptionally comprehensive statutes: South Carolina, Tennessee, and Rhode Island. These three statutes permit any minor to consent to any treatment suggested by the physician. Rhode Island and South Carolina require the minor be at least sixteen years old. These are the only states found that do not require the minor to be of a certain status (e.g., pregnant, a runaway, married, etc.) or need a specific type of treatment (e.g., diagnosis of sexually transmitted diseases, mental health services, etc.) S.C. CODE ANN. § 20-7-280 (2006); R.I. GEN. LAWS § 23-4.6-1 (1956); TENN. CODE ANN. § 63-6-229 (West 1995).

32 ALA. CODE § 22-11A-19 (2007); ALASKA STAT. § 25.20.025 (1968); ARIZ. REV. STAT. ANN. § 44-

few states requiring that the minor reach a certain age threshold (typically twelve or fourteen years old).[33]

While approximately half of the states also permit a minor to receive mental health services in the absence of parental consent,[34] the majority of those include an age threshold.[35] Further, the age

132.01 (1991); ARK. CODE ANN. § 20-16-508 (West 2008); A. CAL. FAM. CODE § 6922 (West 2004); COLO. REV. STAT. ANN. § 25-4-402 (West 2007); CONN. GEN. STAT. § 19a-216 (West 2007); DEL. CODE ANN. tit. 13 § 710 (2007); FLA. STAT. ANN. § 384.30 (West 2000); GA. CODE ANN. § 31-17-7 (West 1971); HAW. REV. STAT. § 577A-2 (2007); IND. CODE § 16-36-1-3 (Lexis Nexis 2007); 410 ILL. COMP. STAT. 210/4 (1995); IOWA CODE ANN. § 139A.35 (West 2005); KAN. STAT. ANN. § 65-2892 (2002); KY. REV. STAT. ANN. § 214.185 (West 2005); LA. REV. STAT. ANN. § 40:1065.1 (2007); ME. REV. STAT. ANN. tit. 32 § 3292 (1998 Supp. 2007); MD. CODE ANN., HEALTH – GEN., § 20-102 (West 2006); MASS. GEN. LAWS ANN. ch. 112 § 12F (West 2007), MICH. COMP. LAWS. ANN. § 333.5127 (West 2001); MINN. STAT. ANN. § 144.343 (West 2005); MISS. CODE ANN. § 41-41-13 (West 1995); MO. ANN. STAT. § 431.061 (West 1992 & Supp. 2007); MONT. CODE ANN. § 41-1-402 (2007); NEB. REV. STAT. § 71-504 (West 2007); N.D. CENT. CODE § 14-10-17 (1971); NEV. REV. STAT. ANN. § 129.060 (2006); N. H. REV. STAT. ANN. § 141-C:18 (2008); N.J. STAT. ANN. § 9:17A-4 (West 2006); N.C. GEN. STAT. ANN. § 90-21.5 (West 20007); OHIO REV. CODE ANN. § 3709.241 (West 2008); 35 PA. STAT. ANN. § 521.14a (West 2007); R.I. GEN. LAWS § 23-11-11 (2007); S.D. CODIFIED LAWS § 34-23-17 (2007); VA. CODE ANN. § 54.1-2969 (West 2007).

[33] The states that permit minors twelve years or older to consent to treatment or diagnosis of sexually transmitted diseases include: Alabama, California, Delaware, and Vermont. ALA. CODE § 22-11A-19 (1987); CAL. FAM. CODE § 6926 (West 2004); DEL. CODE ANN. tit. 13 § 710 (1999); VT. STAT. ANN. tit. 18, § 4226 (1975). Washington, North Dakota, and New Hampshire stipulate that the minor must be at least fourteen years of age before he or she can consent to the diagnosis or treatment of sexually transmitted diseases. N.D. CENT. CODE § 14-10-17 (1989); N.H REV. STAT. ANN. § 141-C:18 (1995); WASH. REV. CODE ANN.§70.24.110 (West 2002). The New Jersey statute states that the minor must be at least thirteen years of age. N.J. STAT. ANN. § 9:17A-4 (West 2006). Interestingly, whereas the statutes permitting consent by virtue of the minors' status are all included in one statute, the statutes permitting minors' effective consent to treatment for sexually transmitted diseases generally discuss only sexually transmitted diseases.

[34] ALA. CODE § 22-8-6 (1975); COLO. REV. STAT. ANN. § 27-10-103 (West 2002); CONN. GEN. STAT. ANN. § 19a-14c (West 1995); DEL. CODE ANN. tit. 13 § 710 (2007); FLA. STAT. ANN. § 394.4784 (West 2006); GA. CODE ANN. § 37-3-20 (West 2007); HAW. REV. STAT. § 334-60.1 (1984); 405 ILL. COMP. STAT. ANN. 5/3-502 (West 2000); KY. REV. STAT. ANN. § 214.185 (West 2005); ME. REV. STAT. ANN. tit. 22, § 1502 (2004); MD. CODE ANN. HEALTH-GEN. § 20-104 (West 2007); MINN. STAT. ANN. §253B.04 (West 2007); MO. ANN. STAT. § 632.110 (West 2007); MONT. CODE ANN. § 53-21-112 (2005); N.Y. MENTAL HYG. § 33.21 (McKinney 2007); N.C. GEN. STAT. ANN. § 90-21.5 (West 1971 & Supp. 1985); OHIO REV. CODE ANN. § 5122.04 (West 1988); OKLA. STAT. ANN. tit. 43A, § 5-503 (West 2001); OR. REV. STAT. ANN. § 109.675 (West 2003); 35 PA. STAT. ANN. § 10101.1 (West 2004); S.C. CODE ANN. § 20-7-290 (2007); TENN. CODE ANN. § 63-6-229 (West 1995); TEX. FAMILY CODE ANN. § 32.004 (Vernon 2002); UTAH CODE ANN. § 62A-15-711 (West 2002); VA. CODE ANN. § 54.1-2969 (West 2002); WASH. REV. CODE ANN. § 71.34.500 (West 2005); W. VA. CODE ANN. § 27-5-3 (West 2006).

[35] Colorado and Hawaii require that the minor be at least fifteen years old before he or she can

requirement for receiving mental health services is generally higher than the requisite age for the diagnosis and treatment of sexually transmitted diseases.[36] While the age threshold for the latter group is typically twelve to fourteen, the minor must be fourteen to sixteen to obtain mental health services in the majority of states.[37] Thus, a minor can far more easily consent to diagnosis and treatment of sexually transmitted diseases than consent to mental health services. A possible explanation for this discrepancy may be that minors are generally more reluctant to discuss sexual activity with their parents and may avoid seeking treatment if they believe confidentiality will not be maintained, which could create public health concerns.

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consent to mental health treatment. COLO. REV. STAT. ANN. § 27-10-103 (West 2002); HAW. REV. STAT. § 334-60.1 (1984). Illinois, Minnesota, Maryland, Kentucky, Oklahoma, and Montana require that the minor be at least sixteen years old before he or she can consent to mental health treatment. 405 ILL. COMP. STAT 5/3-502 (West 2000); MD. CODE ANN. HEALTH-GEN. § 20-104 (West 2007); MINN. STAT. ANN. §253B.04 (West 2007); KY. REV. STAT. ANN. § 214.185 (West 2005); OKLA. STAT. ANN. tit. 43A, § 5-503 (West 2001); MONT. CODE ANN. § 53-21-112 (2005). Virginia, Oregon, North Dakota, and Pennsylvania use fourteen years of age as their threshold. VA. CODE ANN. § 54.1-2969 (West 2002); OR. REV. STAT. ANN. § 109.675 (West 2003); N.D. CENT. CODE § 14-10-17 (1971); 35 PA. STAT. ANN. § 10101.1 (West 2004). Washington requires that the minor be at least thirteen before he or she can consent to minor health treatment, although the minor can only consent to outpatient services. WASH. REV. CODE ANN. § 71.34.500 (West 2005). Quite atypically, Georgia, California, and Florida require the minor be at least twelve years old. GA. CODE ANN. § 37-3-20 (West 2007); CAL. FAM. CODE § 6926 (West 2004); FLA. STAT. ANN. § 394.4784 (West 2006). Alabama, Connecticut, Delaware, Maine, Texas, New York, North Carolina, Tennessee, and South Carolina do not stipulate that the minor must be of a certain age before he or she can effectively consent to mental health treatment. ALA. CODE § 22-8-6 (1971); CONN. GEN. STAT. ANN. § 19a-14c (West 2003); DEL. CODE ANN. tit. 13 § 710 (1999) ME. REV. STAT. ANN. tit. 22, § 1502 (2004); TEX. FAM. CODE ANN. § 32.004 (Vernon 2002); N.Y. MENTAL HYG. § 33.21 (Mckinney 2006); N.C. GEN. STAT. ANN. § 90-21.5 (West 1986); TENN. CODE ANN. § 63-6-229 (West 1995); S.C. CODE ANN. § 20-7-290 (2007).

[36] *Id*.

[37] Delaware, for instance, does not have an age requirement. However, the minor can only consent to treatment if he or she is suffering from a disease or injury that, if left untreated, would threaten the minor's health or life. DEL. CODE ANN. tit. 13 § 707 (1999). Similarly, though Connecticut does not have an age stipulation, it does require that, in the event the minor knowingly and voluntarily seeks treatment, the health care provider must use his or her professional judgment in determining whether the parent should be notified or give consent to treatment. CONN. GEN. STAT. ANN. § 19a-14c (West 2003). Additionally, Virginia states that a minor can consent only if the health care provider cannot reach the parents, and the situation is such that a delay would adversely affect the minor. VA. CODE ANN. § 54.1-2969 (West 2002). *See also* N.Y. MENTAL HYG. § 33.21 (McKinney 2006); WASH. REV. CODE ANN. § 71.34.500 (West 2005).; CAL. FAM. CODE § 6924 (West 2001); TEX. FAM. CODE ANN. § 32.004 (Vernon 2002).

In terms of the minors' ability to consent to treatment for substance abuse, nearly forty states permit the minor to consent.[38] Approximately twenty-five percent of these states require the minor to be a certain age before he or she can consent to substance abuse treatment.[39] The age threshold, in contrast to the mental health provisions and the sexually transmitted disease provisions, is considerably variable among the states. [40]

Finally, a few states have provisions regarding a minor's ability to receive information about family planning, including contraceptive information, without parental consent.[41] However,

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38 ALA. CODE § 22-8-6 (1971); ARIZ. REV. STAT. ANN. § 44-133.01 (2007); CAL. FAM. CODE § 6926 (West 2004); COLO. REV. STAT. ANN. § 13-22-102 (West 2005); CONN. GEN. STAT. § 17a-688 (West 2006); DEL. CODE. ANN. tit. 16, § 2210 (2002); FLA. STAT. ANN. § 397.601 (West 2006); GA. CODE ANN. § 37-7-8 (West 1971); HAW. REV. STAT. § 577-26 (1978); 410 ILL. COMP. STAT. 210/4 (1985); IND. CODE § 12-23-12-1 (West 2007); KAN. STAT. ANN. § 65-2892a (2002); KY. REV. STAT. ANN. § 214.185 (West 2005); LA. REV. STAT. ANN. § 40:1096 (2001); ME. REV. STAT. ANN. tit. 32, § 3292 (1998); MD. CODE ANN., HEALTH–GEN., § 20-102 (West 2006); MASS. GEN. LAWS ANN. ch. 112, § 12E (West 2003); MICH. COMP. LAWS ANN. § 333.6121 (West 2001); MINN. STAT. ANN. §253B.04 (West 2007); MISS. CODE ANN. § 41-41-14 (West 1979); MO. ANN. STAT. § 431.061 (West 1992 & Supp. 2007); MONT. CODE ANN. § 41-1-402 (2003); N.D. CENT. CODE § 14-10-17 (1971); NEV. REV. STAT. § 129.050 (2001); N.H. REV. STAT. ANN. § 318-B:12a (1995); N.J. STAT. ANN. § 9:17A-4 (West 2006); N.Y. MENTAL HYG. LAW § 22.11 (McKinney 2002); N.C. GEN. STAT. ANN. § 90-21.5 (West 1986); OHIO REV. CODE ANN. § 3719.012 (West 1982); OKLA. STAT. ANN. tit. 43A, § 5-503 (West 2001); OR. REV. STAT. ANN. § 109.675 (West 2003); 71 PA. STAT. ANN. § 1690.112 (West 1990); S.C. CODE ANN. § 20-7-290 (2007); TENN. CODE ANN. § 63-6-229 (West 1995); TEX. FAM. CODE ANN. § 462.022 (Vernon 2001 & Supp. 2007); VT. STAT. ANN. tit. 18, § 4226 (1971); VA. CODE ANN. § 54.1-2969 (West 2002); W. VA. CODE ANN. § 60-6-23 (West 1977); WIS. STAT. ANN. § 51.47 (West 2003).

39 CAL. FAM. CODE § 6926 (West 2004) (twelve years old); KY. REV. STAT. ANN. § 214.185 (West 2005) (sixteen years old); OKLA. STAT. ANN. tit. 43A, § 5-503 (West 2001) (sixteen years old); WIS. STAT. ANN. § 51.47 (West 2003) (twelve years old); ARIZ. REV. STAT. ANN. § 44-133.01 (2007) (twelve years old); DEL. CODE. ANN. tit. 16, § 2210 (2002) (fourteen years old); 410 ILL. COMP. STAT. 210/4 (1985) (twelve years old); MASS. GEN. LAWS ANN. ch. 112, § 12E (West 2003) (twelve years old); MINN. STAT. ANN. § 253B.04 (West 2007) (sixteen years old); N.D. CENT. CODE § 14-10-17 (1971) (fourteen years old); N.H. REV. STAT. ANN. § 318-B:12a (1995) (twelve years old), 43A OKLA. STAT. ANN. tit. 43A, § 5-503 (West 2001) (sixteen years old); OR. REV. STAT. ANN. § 109.675 (West 2003) (fourteen years old); TEX. FAM. CODE ANN. § 462.022 (Vernon 2001 & Supp. 2007) (sixteen years old); VT. STAT. ANN. tit. 18, § 4226 (1971) (twelve years old); ARIZ. REV. STAT. ANN. § 44-133.01 (2007) (twelve years old).

40 *Id.*

41 ALA. CODE § 22-8-6 (1971); ALASKA STAT. § 25.20.025 (1968); CAL. FAM. CODE § 6925 (West 2004); COLO. REV. STAT. ANN. § 13-22-105 (West 2005); FLA. STAT. ANN. § 381.0051 (West 2007); HAW. REV. STAT. § 577a-2 (1984); IOWA CODE ANN. § 141a.7 (West 2007); KY. REV. STAT. ANN. § 214.185 (West 2005); MD. CODE ANN., HEALTH-GEN. § 20-102 (West 2006); MINN. STAT. ANN. § 144.343 (West. 2005); OR. REV. STAT. ANN. § 109.640 (West 2005); S.C.

generally speaking, the statutory provisions make it far more difficult for a minor to receive information on family planning than it is for minors to consent to mental health services, substance abuse treatment, or treatment for sexually transmitted diseases. For instance, of the few states that explicitly mention pregnancy prevention as a type of treatment that does not require parental consent, several require the minor to be effectively emancipated by virtue of her status.[42] Specifically, these states require the minor to either be married, pregnant, or a parent before she can consent to treatment. Further, some states require the minor to be referred by a clergyman, educational institution, or family planning center before she can obtain contraceptives without parental consent.[43] However, any minor, regardless of age, can receive confidential care and treatment related to family planning at a federally funded family planning clinic without parental consent.[44] Thus, if a physician believes that it would be in the best interest of the patient to receive counseling and/or treatment for birth control, pregnancy, or sexually transmitted diseases without parental involvement, the physician might consider referral to a federally funded family planning clinic, such as Planned Parenthood.

C. The Mature Minor Doctrine

In addition to the statutory provisions granting minors the sole authority to make health care decisions, some states have adopted the common law notion of a "mature minor." The mature minor doctrine grants certain minors the power to enter into valid contracts and, as

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CODE ANN. § 20-7-290 (2007); TENN. CODE ANN. § 68-34-107 (West 1971); VA. CODE ANN. § 54.1-2969 (West 2002).

42 For example, Colorado and Tennessee state that in the absence of pregnancy, parentage, or marriage, the minor must be referred by a physician, clergyman, school, family planning center, or some other state agency before she can obtain birth control services. COLO. REV. STAT. ANN. § 13-22-105 (West 2005); TENN. CODE ANN. § 68-34-107 (West 1971). Florida and Maryland also requires parentage, marriage, or pregnancy before birth control services can be provided. However, the statutes also permit the physician to dispense birth control services if, in the opinion of the physician, the minor may suffer adverse health consequences if such services are not provided. FLA. STAT. ANN. § 381.0051 (West 2007); MD. CODE ANN., HEALTH–GEN., § 20-102 (West 2006).

43 COLO. REV. STAT. ANN. § 13-22-105 (West 2005); TENN. CODE ANN. § 68-34-107 (West 1971).

44 Public Health Service Act, Pub. L. 91-572, § 1008 (codified at 42 U.S.C. § 300a-6 (1970)).

such, permits these minors to obtain medical treatment without parental consent.[45] In determining whether a minor is sufficiently mature, courts consider various factors including the minor's physical age, evidence of maturity, education, and judgment to consent knowingly to medical treatment. In short, the minor must be able to understand and appreciate the nature and consequences of a medical procedure.[46]

Interestingly, the mature minor doctrine is weakening statutorily. While a few states like Arkansas fully embrace the doctrine in all circumstances,[47] the majority of states adopt the mature minor doctrine only in limited circumstances. For instance, New Mexico mentions the mature minor doctrine in the context of withholding or withdrawing life-sustaining treatment only.[48] Additionally, the majority of states discuss requisite maturity in the context of judicial bypass procedures in abortion cases. That is, when it would not be in the best interest of a pediatric patient to obtain parental consent prior to an abortion, and the patient demonstrates sufficient maturity to understand the complexity of the risks and benefits associated with abortion, most states permit a judicial bypass as an alternative to parental consent.[49] In these circumstances, the judge will carefully evaluate the risks and benefits of parental involvement as well as the minor's cognitive maturity in terms of her ability to understand the nature and consequences of her decision, as well as potential alternatives to abortion.[50]

The relatively small number of states that have codified the mature minor doctrine is surprising, given the general acceptance of

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45 Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987).

46 Lacey v. Laird, 166 Ohio St. 12, 139 N.E.2d 25 (Ohio 1956).

47 ARK. CODE ANN. § 20-9-602 (West 1973 & Supp. 2006).

48 "[I]f an unemancipated minor has capacity sufficient to understand the nature of that unemancipated minor's medical condition, the risks and benefits of treatment, and the contemplated decision to withhold or withdraw life-sustaining treatment, that unemancipated minor shall have the authority to withhold or withdraw life-sustaining treatment." N. M. STAT. ANN. § 24-7A-6.1 (West 1978 & Supp. 1997).

49 Belotti v. Baird, 443 U.S. 622, 643-44 (1979); Ann C. Bonny, *Parental Consent and Notification Laws in the Abortion Context: Rejecting the "Maturity" Standard in Judicial Bypass Proceedings*, 11 U.C. Davis J. Juv. L. & Pol'y 311 (2007).

50 *See, e.g.,* Bellotti v. Baird, 443 U.S. 622, 99 S. Ct. 3035 (1979); Planned Parenthood, Sioux Falls Clinic v. Miller, 63 F.3d 1452 (8th Cir. 1995).

the doctrine within the profession. For example, the American Academy of Pediatrics opines, "In cases involving emancipated or mature minors with adequate decision-making capacity . . . physicians should seek informed consent directly from the patients."[51]

IV. STATE LAW: CONFIDENTIALITY AND PEDIATRIC PATIENTS

Despite the fact that every state allows minors to consent to treatment in certain circumstances, most states address confidentiality only in certain contexts and usually afford professional discretion to notify parents of the minor's diagnosis or treatment.[52] These parental notification provisions, where they are found, are typically attached to laws that recognize the minor's right to consent under limited circumstances.[53] Nearly all of the statutes permit the health provider to use his or her discretion as to whether

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51 Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice,* 95(2) PEDIATRICS 314, 317 (1995).

52 There are several statutes that permit the health care provider to use his or her discretion as to whether the parent or guardian of the minor patient should be notified. They are listed immediately below. The specific language of several of these statutes is discussed *infra notes* 54 & 55. ALA. CODE § 22-11A-19 (LexisNexis 1987); KAN. STAT. ANN. § 65-2892 (2002); DEL. CODE ANN. tit. 13 § 710 (1995); MISS. CODE ANN. § 41-41-13 (West 2007); MISS. CODE ANN. § 41-41-14 (West 2007); NEB. REV. STAT. § 71-504 (2007); 71 PA. STAT. ANN. § 1690.112 (West 1990); S.D. CODIFIED LAWS § 34-23-17 (2007); COLO. REV. STAT. ANN. § 25-4-402 (West 2001); COLO. REV. STAT. ANN. § 13-22-102 (West 2007); COLO. REV. STAT. ANN. § 27-10-103 (West 2007); OR. REV. STAT. ANN. § 109.675 (West 2007); KY. REV. STAT. ANN. § 214.185 (West 2005); VA. CODE ANN. § 54.1-2969 (West 2002); GA. CODE ANN. § 31-17-7 (West 1971); ARK. CODE ANN. § 20-16-508 (West 2006); LA. REV. STAT. ANN. § 40:1065.1 (2007); LA. REV. STAT. ANN. § 40:1096 (2007); MASS. GEN. LAWS ANN. ch. 112 § 12F (West 2007); MD. CODE ANN., HEALTH-GEN. § 20-102 (West 2006).

53 Rarely, a parental notification provision is attached to those provisions giving minors the authority to consent to treatment by virtue of their status. However, this was found in five states only. Delaware, for instance, includes pregnancy among the confidentiality provisions: "The physician to whom such consent [for treatment or diagnosis of pregnancy or sexually transmitted diseases] shall be given may, in the sole exercise of his, her, or its discretion, either provide or withhold from the parents or spouse . . . as such physician deems advisable . . . having primary regard for the interests of the minor." DEL. CODE ANN. tit. 13 § 710 (1995). *See also* KY. REV. STAT. ANN. § 214.185 (West 2005). On the other hand, Massachusetts requires confidentiality for all status provisions (i.e., if the minor married, if he or she is a member of the armed forces, if she is possibly pregnant, or if he or she is a "runaway," living separate from his or her parents). ME. REV. STAT. ANN. tit. 32 § 3292 (1999 & Supp. 2007). *See generally* NEV. REV. STAT. § 129.050 (2007).

the parent should be notified of the minor's treatment. These "discretion" provisions use very similar language, typically following one of two patterns.

One type of "discretion" provision explicitly notes that the health care provider may examine the minor patient without the "consent of or notification to" the parent and that there is "no obligation" to inform the parent.[54] The other language pattern, though explicitly permitting the health care provider to use his or her discretion as to parental notification, is less deferential to the minor. This language pattern typically begins by noting that the health care provider is not "obligated" to inform the parent, but then adds language similar to the following: "[S]uch information may be given to the . . . parent . . . without the consent of the minor patient and even over the express refusal of the minor patient to providing of such information."[55] While both provisions explicitly permit the health care provider to use his or her discretion as to parental notification, the former provision seems to implicitly assume confidentiality, whereas the latter provision seems to encourage parental notification. In several states, the "discretion" provision is coupled with a provision

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[54] The Alabama statute is illustrative: With regard to diagnosis or treatment of sexually transmitted diseases, the healthcare provider may, but "shall not be obligated to inform the parent . . . of any such minor as to the treatment needed or given." ALA. CODE § 22-11a-19 (2007). *See also* KAN. STAT. ANN. § 65-2892 (2002); DEL. CODE ANN. tit. 13 § 710 (1999); MISS. CODE ANN. § 41-41-13 (West 2007); MISS. CODE ANN. § 41-41-14 (West 2007); NEB. REV. STAT. § 71-504 (2007); 71 PA. STAT. ANN. § 1690.112 (West 2007); S.D. CODIFIED LAWS § 34-23-17 (2007); COLO. REV. STAT. ANN. § 25-4-402 (West 2007); COLO. REV. STAT. ANN. § 13-22-102 (West 2007); COLO. REV. STAT. ANN. § 27-10-103 (West 2002); OR. REV. STAT. ANN. § 109.675 (West 2003). The Kentucky statute states that a healthcare provider may treat the minor patient for sexually transmitted diseases, addictions, contraception, pregnancy, or childbirth without the consent or notification to the parents. KY. REV. STAT. ANN. § 214.185 (West 2005). Virginia's statute is similar. VA. CODE ANN. § 54.1-2969 (West 2007).

[55] Arkansas's statute typifies this language pattern: "The information [concerning the diagnosis or treatment of sexually transmitted diseases] may be given to or withheld from the spouse, parent, or guardian without the consent and over the express objection of the minor." ARK. CODE ANN. § 31-17-7 (West 1971). *See also* § 20-16-508 GA. CODE ANN. (West 2008); LA. REV. STAT. ANN. § 40:1065.1 (2007); LA. REV. STAT. ANN. § 40:1096 (2007); MASS. GEN. LAWS ANN. ch. 112 § 12F (West 2007). Maryland, in addition to stating that the healthcare may inform the parents without the express consent of or over the express objection of the minor in the context of sexually transmitted diseases, mental services, and substance abuse, also adds that the healthcare provider may inform the parents when the minor seeks pregnancy or contraception information or services. MD. CODE ANN., HEALTH-GEN. § 20-102 (West 2006).

indicating that the express refusal of the minor patient is irrelevant.[56] Despite these curious differences in tone, both patterns have the same effect: they are deferential to the health care provider's discretion.

A. Confidentiality Explicitly Required

The only federal law that requires confidentiality for minors is the Family Planning Act whereby entities may receive federal grants for providing family planning services. The services are provided on a confidential and independent basis.[57]

While most state statutes are either silent or discretionary, some explicitly require either confidentiality or parental notification in certain circumstances. Maine, Massachusetts, and California are the only three states that categorically require confidentiality for minors. Specifically, Maine entitles minors to the same confidentiality rights afforded to adults in circumstances where the minor can legally consent to health care services, with some limited exception.[58] California explicitly permits the minor to access his or her records, and it categorically prohibits parental access to the minor's health records where the minor is able to consent to treatment.[59] Perhaps the most comprehensive statute is Massachusetts, which stipulates that all information and records of the minor are confidential between the minor and the physician.[60]

Other state statutes that require confidentiality are piecemeal and

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56 MD. CODE ANN. HEALTH-GEN. § 20-104 (West 2007); GA. CODE ANN. § 37-7-8 (West 1971); LA. REV. STAT. ANN. § 40:1096 (2001); MICH. COMP. LAWS ANN. § 333.6121 (West 2001); MISS. CODE ANN. § 41-41-14 (West 1979); MD. CODE ANN., HEALTH–GEN. § 20-102 (West 2006); MICH. COMP. LAWS. ANN. § 333.5127 (2001).

57 Public Health Service Act, Pub. L. No. 91-572, § 1008 (codified at 42 U.S.C. § 300a-6 (1970)), *supra* note 44. *See generally* Abigail English & Madlyn Morreale, *A Legal and Policy Framework for Adolescent Health Care: Past, Present, and Future;* 1 HOUS. J. HEALTH L. & POL'Y 63 (2001).

58 Though the statute explicitly gives minors the same confidentiality rights as adults, somewhat paradoxically, the health care provider may notify the parent of the minor's treatment in very limited circumstances. "A health care practitioner or health care provider may notify the parent or guardian of a minor who has sought health care . . . if, in the judgment of the practitioner or provider, failure to inform the parent or guardian would seriously jeopardize the health of the minor or would seriously limit the practitioner's or provider's ability to provide treatment." ME. REV. STAT. ANN. tit. 22, § 1505 (2004).

59 CAL. HEALTH & SAFETY CODE § 123115 (West 2007).

60 MASS. GEN. LAWS ANN. ch. 112 § 12F (West 2007).

less inclusive.[61] For instance, New Hampshire and New Jersey explicitly require confidentiality when the minor consents to substance abuse treatment, but the statutes are silent with regard to confidentiality when the minor consents to treatment for sexually transmitted diseases.[62] Connecticut requires confidentiality when the minor consents to treatment for sexually transmitted diseases or substance abuse, but the Connecticut statute does not discuss confidentiality when the minor consents to mental health treatment.[63]

In some states, not only is confidentiality not protected, but parental notification is explicitly required in certain circumstances.[64] Generally, these statutes provisionally require the health care provider to make an attempt to notify the parents, but a failure to notify the parents does not prohibit authorization of care.[65] These statutes are usually amorphous, providing little guidance to health care providers. For instance, the Nevada statute requires the health

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61 New Jersey's drug and substance abuse statute requires confidentiality between the physician and the patient with regard to substance abuse treatment. N.J. STAT. ANN. § 9:17A-4 (West 2006). Relatedly, although North Carolina's minor consent statutes do not discuss confidentiality between the physician and the minor patient, a separate provision states that a minor patient can consent to the release of confidential information in those circumstances in which he or she can effectively consent to treatment. 10A N.C. ADMIN. CODE 26B.0203 (1996)

62 N.H. REV. STAT. ANN. § 318-B:12a (2008); N.J. STAT. ANN. § 9:17A-4 (West 2006); N.H. REV. STAT. ANN. § 141-C:18 (2008).

63 CONN. GEN. STAT. § 19a-216 (West 2003); CONN. GEN. STAT. § 17a-688 (West 2007); CONN. GEN. STAT. ANN. § 19a-14c (West 2008).

64 The Vermont statute is illustrative. In the event the minor requires immediate hospitalization as the result of substance abuse or sexually transmitted diseases, the healthcare provider must inform the parent. VT. STAT. ANN. tit. 18, § 4226 (1975). It is necessary to contrast the statutes that *require parental notification*, as exemplified in the Vermont statute, from those statutes that merely *encourage parental involvement*. In the latter scenario, parental involvement is merely one component in the decision-making process. That is, for those states that encourage parental involvement, the health care provider should determine whether, given the circumstances, the parent should be involved before treatment is given. For those states that require parental notification, the statutes explicitly state that the physician must notify the parents after treatment has been rendered. For an example of a parental involvement statute, see the Illinois substance abuse statute, "Anyone involved in the furnishing of medical care. . . shall, upon the minor's consent, make reasonable efforts to involve the family of the minor in his or her treatment, if the person furnishing treatment believes that the involvement of the family will not be detrimental to the progress and care of the minor." 410 ILL. COMP. STAT. ANN. 210/4 (West 1995).

65 410 ILL. COMP. STAT. ANN. 210/4 (West 1995); N.J. STAT. ANN. § 9:17A-4 (West 2006); N.Y. MENTAL HYG. LAW § 22.11 (McKinney 2002).

care provider to "make every reasonable effort to report the fact of [the minor's] treatment to the parent . . . within a reasonable time after treatment."[66]

B. Responsible Management of Professional Judgment

In the absence of clear state law, physicians will be required to use their professional judgment to decide whether or not and to what extent to maintain pediatric patients' confidentiality. There is no clear professional consensus on this issue. For example, the American Medical Association (AMA) adopts a more conservative approach to pediatric confidentiality, encouraging parental involvement whenever possible: "When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections."[67] On the other hand, the Society for Adolescent Medicine (SAM) argues that confidentiality is "an essential component of health care for adolescents" and that physicians have a professional obligation to protect patient confidentiality: "Providing confidential care to adolescents is a professional duty deriving from the moral tradition of physicians and the goals of medicine."[68] In light of these professional opinions, how should physicians responsibly manage these ethically challenging cases?

As an important first step, physicians should become well acquainted with relevant state laws regarding pediatric consent and confidentiality. Violation of a statute that either requires or prohibits the disclosure of confidential patient information may result in legal liability. In some limited circumstances, a physician may be willing to take this legal risk in order to engage in what she believes, after critical reflection and, ideally, ethics consultation to be the most ethically justified course of action.

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66 NEV. REV. STAT. § 129.050 (2001).

67 AMA Comm. on Principles of Med. Ethics, Formal Op. E-5.055 (1996) (discussing confidential care for minors).

68 *See generally* C. Ford, et al., *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 J. ADOLESCENT HEALTH 4 (2004).

Physicians should also be aware of the opinions of professional organizations. Although there are some differences between the AMA and the SAM's position on this matter, physicians who clearly violate either of these guidance documents must have good reasons for their departure. This is particularly important in the event of a lawsuit as these statements are often invoked as evidence of established ethical consensus and professional standards of care.

Finally, if physicians have strongly held beliefs about the importance of patient confidentiality, or conversely, about the importance of family involvement in pediatric decision making, then the physician should establish a general policy for managing patient confidentiality and should inform patients and their parents of this policy prior to initiating a physician-patient relationship. Transparency is important so that patients and their parents can make an informed decision when choosing a physician. Physicians who adopt a policy of parental access risk nondisclosure of important sensitive clinical information. However, breaches of confidentiality, when they are not expected, may result in deep distrust of medical professionals, which might discourage minors from seeking professional help and may lead to noncompliance with recommended treatment.

In deciding on a general policy regarding patient confidentiality, physicians ought to consider, weigh and prioritize the patient's developing autonomy and level of maturity, the importance of trust in the therapeutic relationship, the family dynamics, respect for the parent-child relationship and the parents' right to rear their child as they deem appropriate, and the potential consequences (both short-term as well as long-term consequences) of maintaining or breaching confidentiality. Of course, even if physicians adopt a general policy regarding patient confidentiality, there may be circumstances in which deviation from the policy is warranted. Ultimately, the physician must remember that her primary obligation is to the patient and that as a fiduciary of the patient she must seek to protect and promote the patient's health-related interests.