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ETHICS CASE
Teen Pregnancy and Confidentiality
Commentary by Mary A. Ott, MD, MA

Jennifer, 15, is a sophomore at Middlefield High School who has made an office appointment with Dr. Wilson, an ob-gyn, for the first time. During the new patient history, Dr. Wilson asks, "Are you sexually active now, or do you plan to be?"

Jennifer hesitates to answer. Instead, she tells Dr. Wilson that the visit will be charged to her parents' insurance and asks whether what she says will be confidential.

Dr. Wilson replies, "Conversations that teens have with their physicians about matters of sexuality and drug use are kept confidential. We want you to be able to discuss things that are of concern to you and your health without fearing that we will 'tell on you' to you parents or anyone else."

"Whew," Jennifer says. She then tells Dr. Wilson that she recently entered a pact with her friends. Each girl promised the others she would get pregnant within the next year. "And I want you to be my doctor," she concludes.

"My goodness, Jennifer. That is quite a serious pact. We must talk some more about this. We must think about how having a child will influence the rest of your life, and how profound and difficult the consequences of this decision can be, especially at your age. How many of your friends are in this pact?"

Jennifer responds, "Four of them. Our families will help us take care of the kids. We all know that. We just want to go through this together, before we separate and go to college or something."

Commentary
When Adolescents Push the Limits of Confidentiality
Confidential care for adolescents, particularly in the area of reproductive health, is a core tenet of adolescent health care. It is strongly supported in best practices guidelines such as the American Academy of Pediatrics' and the US Maternal and Child Health Bureau's *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* [1], and most major medical professional associations that work with adolescents have issued or endorsed position statements supporting confidential care for adolescents (for example, the American College of Obstetricians and Gynecologists [2], the Society for Adolescent Health and Medicine [3], and the American Medical Association [4]). Confidentiality is the idea that the

personal and health information a patient reveals to a clinician is private and that there are limits on how and when the information can be disclosed to a third party [5]. Adult patients' confidentiality is subject to few restrictions. For adolescents, however, confidentiality is limited, in large part, because of our ethical duty to provide care in their best interests until they have the legal right to make decisions for themselves. The case of Jennifer and Dr. Wilson illustrates the difficulties inherent in navigating confidential care for adolescents.

Arguments In Support of Confidentiality for Adolescents

The ethical arguments supporting confidential care for adolescents are strong and focus on respect for emerging autonomy, recognition of evolving decision making capacity, allowing teens to learn responsibility in health decision making, and improving safety and access to care. Adolescence is a time of intense developmental transition. During adolescence, an individual will move into a peer group, develop intellectually and emotionally, enter the workforce or higher education, and, in many cases, become socially or financially independent. When physicians provide confidential care for adolescents, they are giving them the opportunity to learn how to interact with clinicians and to become responsible for their own health care, and they are respecting and supporting the development of an emerging autonomous self. Research supports this claim: when clinicians discussed sensitive topics with a group of surveyed adolescents, the adolescents reported that the clinicians listened to them and that they felt more engaged in their own health care [6].

Most adolescents have sufficient cognitive capacity and emotional maturity to make many health care decisions. Research suggests that by approximately age 14 to 15 years, adolescents make health-related decisions similar to those that adults make in controlled decision-making situations (see, for example, [7] and [8]). Because of differences in maturation between the cognitive and affective systems, adolescents may have more difficulty in situations with high emotional arousal or peer distraction [8, 9] and may need more decision-making support in these circumstances.

Medical decision-making capacity includes the ability to understand the issue, weigh risks and benefits, appreciate the consequences of choices, and make a voluntary choice based upon understanding of the information [10]. Adults are presumed to have capacity, and, as long as they demonstrate the above four abilities, they are permitted to make their own decisions, even if the clinician disagrees or believes it is not in their best interest [11]. It is important to note that the threshold for decision-making capacity for adults is not very high, and that clinicians do in some cases tolerate decisions they disagree with from adults. In this case, Jennifer demonstrates a somewhat limited understanding of risks, benefits, and consequences related to her plans to become pregnant. This is an area that Dr. Wilson can address through counseling.

Improved safety and access to care are important public health arguments for adolescent confidential care. One randomized controlled trial demonstrated that

adolescents provided with confidentiality assurances are more likely to disclose risk behaviors to their physicians [12]. Such disclosures are necessary for prevention and treatment. Dr. Wilson's statement about confidentiality most likely made Jennifer's disclosure possible and makes it easier for Dr. Wilson to help her. On a public health level, confidentiality has been linked to increased utilization of services, particularly related to contraception and family planning [13]. Research suggests that most parents desire confidential care for their adolescents [14], in large part for safety reasons: if adolescents are not able to tell their parents about risk behaviors, parents would like them to talk to trusted professionals.

Adolescent Confidentiality and the Law

The law underpins adolescents' right to confidential care. The strongest legal support is state health care consent laws, which provide adolescents with the right to consent to and receive confidential care. All 50 states and the District of Columbia (DC) have laws allowing minor adolescents to consent to STD diagnosis and treatment; similarly, 26 states and DC allow minors to consent to receive contraceptive services; and 32 states and DC allow minors to consent to prenatal care [15].

When state law is silent on contraception for minors, constitutional arguments support a minor's right to reproductive privacy and confidential care. The US Supreme Court's *Gault* decision established that minors have constitutional rights [16]. Subsequent cases in federal courts established that a minor's constitutional rights include the right to reproductive privacy, including confidential care [16]. Twenty states allow some or all minor parents to consent to health care for themselves [16]. For Dr. Wilson, the specifics of state laws are important in defining the limits of confidential care for Jennifer.

Limits to Adolescent Confidentiality

Confidentiality is never absolute, particularly for adolescents. Just as we have an ethical obligation to support adolescents' emerging autonomous selves, so we have a (sometimes competing) ethical obligation to protect and act in the best interest of adolescents, who have limited life experiences to help them make judgments. A physician might break confidentiality when he or she has a legal obligation to report, as with child abuse; when the child is a danger to him- or herself, as with an actively suicidal or psychotic adolescent; and when there is a danger to others, as in the case of a homicidal adolescent. Dr. Wilson must decide at what point the benefits of involving Jennifer's parents or authorities would outweigh the harms—to Jennifer or others—of breaking confidentiality. There are no absolutes in this assessment, and these ambiguities are recognized in guidelines such as the AMA *Code of Medical Ethics*, which states that "ultimately clinical judgment, ethical principles, and moral certitude guide decisions about individual cases" [4].

Breaking adolescent confidentiality is something that a physician should take very seriously. The therapeutic alliance with adolescents is particularly fragile, and the resulting mistrust will not be easily repaired [17]. Of particular concern is that an adolescent whose confidentiality is betrayed by a clinician may be less likely to trust

other health care professionals with the confidential information necessary for optimal health care and thus may not seek care for sensitive issues. Breaking confidentiality also sends a signal to the adolescent that the doctor does not respect his or her emerging autonomy or decision-making capacity.

The Art of Adolescent Medicine

Adolescent pregnancy is associated with potentially serious health risks and poor social, educational, and economic outcomes for both adolescent parents and their children [18, 19]. Best practices focus on delay of sexual activity, particularly in younger adolescents, while promoting effective methods of contraception for those adolescents who are or plan to be sexually active. However, unprotected sex is common among adolescents. Nearly half of US high school students have had sex, with less than 60 percent of that group reporting condom use at last sex and less than 30 percent of sexually experienced female students reporting contraceptive use at last sex [20]. While an individual adolescent expressing a desire to become pregnant or disclosing unprotected sex is something a clinician must address (and, ideally, encourage the patient to consider delaying), that does not, in and of itself, rise to a level of harm that would compel Dr. Wilson to break confidentiality.

Dr. Wilson should start with a careful sexual and reproductive history. Has Jennifer ever had sex? What are her sexual practices? Has she ever used contraceptives? Is she engaged in a relationship now? There are also some potentially life-threatening dangers seen in sexually active adolescents that would warrant breaking confidentiality, and Dr. Wilson should assess these more immediate threats, such as whether Jennifer is being coerced by her partner or is involved in sex trafficking.

Dr. Wilson will want to search for a solution that involves both respect for Jennifer's confidentiality and autonomy and the support and services she needs. Using motivational interviewing techniques, Dr. Wilson can inquire further into her plans for becoming pregnant, her commitment to becoming pregnant, and the social and relationship contexts of her decision making. Dr. Wilson may be able to work with Jennifer to delay pregnancy until after a certain date—e.g., graduation from high school, or reaching age 18. If a patient is amenable, clinicians can provide access to long-acting reversible contraceptives (LARCs), which have better continuation rates and lower rates of subsequent pregnancy than other methods.

Another possible solution that allows Dr. Wilson to respect patient confidentiality is encouraging Jennifer to use available resources and talk to others. Has she spoken to her parents or other trusted adults about her desire to become pregnant or how she would care for a child if she became pregnant? Although it can be a very difficult conversation, if the adolescent brings up the topic, many families are willing to discuss sex and adolescent pregnancy, its consequences, and prevention. Is Jennifer willing to speak to a counselor or social worker who could minimally help her prepare for or, ideally, delay a pregnancy?

Finally, Dr. Wilson will need to search for the problem behind the problem. In 2008,

a northeastern city received national media attention about a supposed pregnancy "pact" when 18 young women in one high school became pregnant in a single year [21]. When individual adolescents were interviewed, however, it was found that no pact had led to the pregnancies but rather the usual suspects—high poverty, poor school performance, lack of opportunity, early and consistent dating, lack of adult supervision, limited sex education, and lack of access to effective contraceptives. It is likely that exploring the details of the "pact" will help Dr. Wilson discover modifiable factors that are contributing to Jennifer's desire to become pregnant.

The "pact" is a splashy and newsworthy topic; adolescent pregnancy is an age-old problem whose amelioration will take concerted efforts by communities, schools, families, and medical and health care professionals. Confidentiality is a tool that clinicians can use to engage adolescents in their care and provide access to effective sexual health services, such as long-acting reversible contraceptives. Dr. Wilson's best chance at engaging Jennifer in pregnancy prevention thus lies in building a therapeutic alliance upon the foundation of confidentiality.

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