

# Parental Notification/Consent for Treatment of the Adolescent

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**ABSTRACT:** A continuing debate exists in both law and medicine regarding an adolescent's capacity to make rational, independent decisions. Neuroscience research responds to the question by noting that the area of the brain involved in critical thinking and decision making does not reach full maturity until the early to mid-twenties. For this reason teens typically act impulsively rather than with rational and goal-oriented thought. Relying upon limited data for over a decade, medical organizations have generally maintained that most teens are fully competent to understand the risks and consequences of, and give informed consent to, medical procedures including abortion without parental knowledge, involvement, or consent. The American College of Pediatricians examines the data and challenges this position, emphasizing the important contribution of parents in advising their adolescent children about such life-changing decisions.

The American Academy of Pediatrics (AAP) maintains as continuing policy that "Adolescents who are willing to involve parents in their abortion decisions will likely benefit from adult experience, wisdom, and support." An amici curiae brief submitted to the United States Court of Appeals for the First Circuit seems to agree with the AAP's acknowledgement. Referred to as the Alaska brief, it states: "In almost all cases, adolescent girls do not plan their pregnancies, are shocked by the news that they are pregnant, and consider the resulting situation to be a crisis. Pregnant minor girls need adult guidance in dealing with crisis pregnancies." A majority of state legislatures also agree as thirty-five states require some parental involvement in a minor's decision to have an abortion. To the detriment of most teens, all of these states include a judicial bypass procedure. In addition, six permit a minor to obtain an abortion if a grandparent or other adult relative is involved in the decision; 29 permit it in a medical emergency; and 14 allow for cases of abuse, assault, incest, or neglect.

The aforementioned Alaska brief made an additional and more significant observation: "The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of abortion are not necessarily related." Recently published studies lend

credence to this statement by demonstrating that the area of the brain involved in critical thinking and decision making does not reach full maturity until the early to mid-twenties: "The dorsal lateral prefrontal cortex, important for controlling impulses, is among the latest brain regions to mature without reaching adult dimensions until the early 20s."

As reported by the National Institutes of Mental Health (NIMH) in 2001, advances in MRI image analysis are providing insights into how the brain develops. Dr. Arthur Toga and UCLA colleagues turned the NIMH team's MRI scan data into 4-D time-lapse animations of children's brains "morphing as they grow up." These researchers report a wave of white matter growth that begins at the front of the brain in early childhood, moves posteriorly, and then subsides after puberty. Striking growth spurts can be seen from ages 6 to 13 in areas connecting brain regions specialized for language and understanding spatial relations, the temporal and parietal lobes. They also note this growth drops off sharply after age 12, coinciding with the end of a critical period for learning languages.

While the NIMH adolescent brain development research suggests a wave of brain white matter development that flows from front to back, animal functional brain

imaging and postmortem studies have suggested that gray matter maturation flows in the opposite direction, with the frontal lobes not fully maturing until young adulthood. To confirm this in living humans, the UCLA researchers compared MRI scans of young adults, 23-30 years of age, with those of teens, 12-16 years old. As noted in the NIH report, they looked for signs of myelin, which would imply more mature, efficient connections, within the gray matter. As expected, areas of the frontal lobe showed the largest differences between young adults and teens. As the researchers point out, this increased myelination in the adult frontal cortex likely relates to the maturation of cognitive processing and other "executive" functions.

In a 2003 article examining the criminal culpability of juveniles, Steinberg and Scott argued that juveniles should not be held to the same standards of criminal responsibility as adults because "...adolescents' decision-making capacity is diminished, they are less able to resist coercive influence, and their character is still undergoing change." They concluded, "The uniqueness of immaturity as a mitigating condition argues for a commitment to a legal environment under which most youths are dealt with in a separate justice system and none are eligible for capital punishment."

The US Supreme Court, in its March 1, 2005, ruling on juvenile executions, found it significant that "...juveniles are vulnerable to influence, and susceptible to immature and irresponsible behavior. In light of juveniles' diminished culpability, neither retribution nor deterrence provides adequate justification for imposing the death penalty." Experts in mental health agree with this ruling. As David Sternberg notes, "Psychiatrists across the country, having argued for years that adolescents' brains function differently from those of adults, applauded last month's Supreme Court ruling that abolished juvenile executions." Sternberg adds, "Several organizations, including the American Psychiatric

Association, the American Academy of Child and Adolescent Psychiatry, the American Society of Adolescent Psychiatry, and the National Mental Health Association, have long opposed the death penalty for juvenile offenders." David Fassler, M.D. speaks to the same issue, stating that: "I am pleased and quite happy with the court's decision ... The decision is a reinforcement of what we all know in the psychiatric community—that the brains of adolescents function differently (from those of) adults." And child psychiatrist Cynthia Pfeffer, M.D. concludes, "I think the court took a developmental view, which was very appropriate. From the perspective of development, children and adolescents are not the same as adults regarding neurobiological development."

Clearly, child and adolescent psychiatrists note differences in brain development between adolescents and adults that affect judgment, behavior, impulse control, and decision-making ability. They also point out that teens, with their still-maturing brains, rely more on impulse than rational and goal-oriented thought.

Based on this research-derived data and its implications for adolescent decision-making capacity, there should be no debate regarding parental involvement in a minor's abortion. Prior to the Supreme Court decision on abortion in 1973, parental consent would have been an assumed preliminary to the institution of any medical care involving an underage minor child. It was not until 1975 that the Burger Court, in its decision in *Planned Parenthood v. Danforth*, declared that minors had a constitutional right to privacy and that it was unconstitutional to require parental permission for their abortion procedure. This was, however, subsequently refined in *H.L. v. Matheson* to allow states to require parental notification/consent.

In 1996, the AAP's Committee on Adolescence rendered an opinion which has had dramatic implications for the health care

of female minors. The Committee stated: "Summaries of well-designed research conclude that most minors 14 to 17 years of age are as competent as adults to provide consent to abortion. They are able to understand the risks and benefits of options and to make voluntary, rational, independent decisions." Largely relying on that opinion, State legislators enshrined the concept in law that an adolescent is responsible and competent to consent to her own medical treatment during a pregnancy and to make medical decisions regarding her fetus or newborn. A year earlier, authored by a different committee [Bioethics], the AAP had published similar recommendations regarding those who have decision-making capacity for health care. This earlier statement posited that, "...adolescents, especially those age 14 and older, may have as well developed decisional skills as adults for making informed healthcare decisions." They drew this conclusion while admitting there was "...limited relevant empirical data" dating from 1978 through 1989.

How can a minor not be capable of committing a capital crime due to a lack of decision-making capacity, yet be considered competent in making reproductive decisions, including the procurement of an abortion? Why are parents required to consent to non-reproductive health care decisions of minors but not to reproductive ones? Is it proper for health professionals to usurp parental rights, excepting those cases in which parents are abusive or neglectful? Goldstein and colleagues at Yale University's Child Study Center expressed concern that physicians and others sometimes forget where their responsibilities end, and describe the harm that is done when these professionals presume to ignore parents rights.

When loving parents are involved in their teen's pregnancy, they can help their daughter think about the pregnancy and consider the options of adoption or parenting. If parents fail to dissuade their daughter from procuring an abortion, they can, without moral complicity in the act of

abortion, at least assist in monitoring for complications, assuring that their daughter receives proper post-abortive medical and mental health care.

Furthermore, parental notification prior to an adolescent's abortion provides increased protection against sexual exploitation of minors by adult men. National studies show that two-thirds of adolescent mothers have partners who are 20 years of age or older, with the youngest mothers (those under age 15 years) being about six times more likely to have partners who are over 20. ETR Associates, a research branch of Planned Parenthood, reports that about half of the births to teen mothers involve men ages 20 – 24, and an additional one-sixth are over age 25. These pregnancies are therefore the result of exploitive, abusive, criminal acts.

When a parent is not informed of their adolescent's pregnancy, the adolescent most often involves her partner in making the abortion decision. In one study, 89% of adolescents said their boyfriends were involved in the decision when their parents were not informed, and 76% of the time the boyfriends paid for the abortion. In that study, 2% of the adolescents admitted they were being forced to have sex. All of this information raises the concern that, without parental involvement, adult men may coerce their pregnant adolescent partners to have abortions, perhaps after having previously coerced them to have sexual intercourse.

Opponents of parental involvement in a minor's abortion, including the AAP, in its Position Statement "The Adolescent's Right to Confidential Care When Considering Abortion," argue that parental notification legislation causes a delay in obtaining medical care as well as an increase in the risk of family violence. Although research is limited in these areas, a study in Mississippi did find that "minors, on average, were delayed [in obtaining an abortion] by about 3 days. This delay is marginally statistically significant." What studies reveal regarding the impact of parental involvement laws is

that they reduced the abortion rate for minors. Levine suggests the introduction of these laws may have contributed to the reduction in the frequency of abortions by minors (up to a rate of 15-20%) by increasing the difficulty in obtaining one. Others do not hold the same view.

Family violence is a tragedy and no child or adolescent should ever be subjected to abuse, physical, emotional, or in any other way. Unfortunately, the risk of such abuse or family violence, following parental notification of a planned abortion, has been overestimated and overstated. The AAP misquotes the Henshaw and Kost study to say that “One third of minors who do not inform parents already have experienced family violence and fear it will recur.” In fact, only 1% of adolescents presenting for abortion in the Henshaw & Kost study actually did experience violence, 1% were forced to leave home, and <0.5% reported being beaten (with the important note that the girls could check more than one answer). Elsewhere in the Henshaw article, the author states “...a minimum of 6% of these minors appear to have suffered relatively harmful consequences.” It is tragic that these adolescents have been harmed. If the health professional suspects parental notification or involvement would cause an adolescent to be harmed, then, legal recourse should be taken to remove the pregnant minor from the abusive household.

Legislation mandating or encouraging parent involvement in decisions related to a minor’s pregnancy protects adolescents during a very vulnerable time in their lives. As we learn more about the immaturity of the adolescent brain, especially in the development of the decision making frontal lobes, it is obvious that loving parents must guide their teens in all medical decisions, including decisions regarding pregnancy. Society recognizes this need and encourages, often requires, parents to be a positive resource for their adolescents in matters of health, and other issues of consequence excluding them from a minor’s

decision about abortion cannot therefore be justified.

As Lainie F. Ross notes: “Children need a protected period in which to develop ‘enabling virtues’ – habits, including the habit of self-control, which advance their life-time autonomy and opportunities.” She goes on to say in the same article, “A second reason to limit the child’s present-day autonomy is the fact that the child’s decisions are based on limited world experience and so her decisions are not part of a well-conceived life plan.” Additionally, Forman and Ladd in addressing the “best interest standard” note that where the patient has not achieved decision-making capacity, the dismissal of parents’ values and authority by the health professional and minor compromises parent/child intimacy, impairs the doctor/parent relationship and leads to guilt and anxiety for the child. As Ross so well states: “What are we teaching our adolescents when they find persons in authority willing to help them deceive their parents? What does it teach these adolescents with regard to the respect owed to any adult, least of all a deceitful doctor or a duped parent?”<sup>36</sup>

The American College of Pediatricians advocates for all children, including pregnant minors and their unborn children. Loving parents are in the best position to help their children learn how to make good decisions regarding their health and well-being. Pediatricians can offer expertise concerning decisions involving the child’s health care without undermining parental authority. The existing policy statements of medical organizations which limit parental involvement are based on old and flawed data about the decision-making capacity of minors.

Despite this fact, many still use these policy statements in opposition to parental involvement legislation and in support of a minor’s unfettered right to abortion. Doing so ignores, in addition, the 25-year longitudinal study of 630 young women in

New Zealand. This study found that women who had an abortion between the ages of 15 and 25 were significantly more likely to develop mental health problems post-abortion, including depression, suicidal behaviors, and substance use disorders. This was the case even when accounting for confounding variables, including pre-existing psychological conditions (in direct contrast to the conclusions of the American Psychological Association 2005 report<sup>39</sup>).

One must therefore conclude as previously noted, “Adolescents who are willing to involve parents in their abortion decisions will likely benefit from adult experience, wisdom, and support.” Finally, Ross clearly declares, “...our laws give parents decision-making authority for their children because

parents are best situated to decide and to act upon what is in their children’s best interest, and because parents are financially and socially responsible for them. This is, or ought to be, no less true of their medical care with regard to sexual health issues.” If capital punishment and teen driving laws are being changed based on new brain development data, then we should do the same for laws involving parental notification.

With this background and for the well-being of the patient, the American College of Pediatricians supports all efforts to enact and enforce parental notification/consent requirements for adolescents requiring or contemplating any medical treatment or surgical procedure, including abortion.

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*The American College of Pediatricians is a national medical association of licensed physicians and healthcare professionals who specialize in the care of infants, children, and adolescents. The mission of the College is to enable all children to reach their optimal, physical and emotional health and well-being.*

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