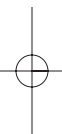
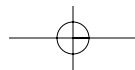
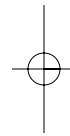
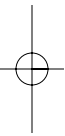


Health Care for Pregnant Adolescents

**A L E G A L G U I D E
F O R H E A L T H C A R E
P R O V I D E R S**





Health Care for Pregnant Adolescents

A LEGAL GUIDE FOR HEALTHCARE PROVIDERS

Anne Dellinger and
Arlene M. Davis

INSTITUTE OF GOVERNMENT
September 14, 2001

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www.adolescentpregnancy.unc.edu

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Preface

THIS GUIDEBOOK FOR HEALTH CARE PROVIDERS is the first in a series explaining the law to pregnant and parenting adolescents, their parents, and the professionals who care for these young women. Nurses, social workers, physicians, and others should be better able to care for these patients if they know what choices are open to patient and provider. While the legal issues discussed are relevant to any minor, the book draws attention to the youngest girls, those under age fifteen, for two reasons: They present the legal issues most starkly, and they are arguably the neediest.

A note about terminology: No single name for pregnant and parenting female adolescents has seemed to us sufficiently accurate and respectful. We use both “girls” and “young women” in order to recognize the considerable differences in age and maturity within the group. Many sources, including the American Academy of Pediatrics’ Committee on Adolescence, are comfortable with the word “girls.” One admirable North Carolina practitioner uses it “to remind myself not to treat them as miniature adults.” Another practitioner, Judith S. Musick, wrote “At 13, 14, 15, and 16 years old they may be mothers, but they are not yet women.”

Robert Coles’ book¹ on teen parents shows the range of views. Its text refers to “woman,” “young woman,” “mother,” “young mother,” and “youths.” One of the book’s photographers, though, almost always writes of “girls,” while the other uses “teenager,” “adolescents,” and “parents.” Most interestingly, when a male teenage subject refers to himself, his mate, and other young parents as “boys and girls,” Coles suggests to him instead that they are “men and women.” The teen father emphatically rejects the suggestion.

Initially, we expected the “right” term to become clear to us, but after years, it has not. We now accept the verbal dilemma as a useful reminder of

1. ROBERT COLES, *THE YOUNGEST PARENTS: TEENAGE PREGNANCY AS IT SHAPES LIVES* (1997).

the ambivalence with which we—and most other adults—view adolescent sexuality and its consequences.

The choice of topics for this book emerged from four kinds of research. First, we reviewed 186 medical records of girls pregnant when under fifteen years of age and 15 medical records, selected at random, of infants born to them. Most of these patients had delivered at a large hospital in North Carolina after receiving prenatal care at a local health department. A smaller number had an abortion performed at the hospital or, in more cases, at a private urban clinic in the state. This review provided information about the medical and social problems affecting these patients both during pregnancy and sometimes for years to come; suggested the nature of their interactions with family members and health care providers; and gave an idea of what legal questions providers most want answered.

Second, we conducted legal research and identified the recommendations of national medical organizations on the care of pregnant adolescents. With one exception we were unable to locate nursing guidelines on the subject, although nurses probably provide more care for pregnant adolescents than do the members of any other health care profession.

Third, we interviewed more than 100 North Carolinians with some knowledge of adolescent pregnancy. They included nurses, nurse practitioners, physicians, and social workers in hospitals, health departments, medical faculties, community outreach programs, nonprofit agencies, and private practice settings; maternity care coordinators; an owner, directors, and staff members of two abortion clinics; a counselor in a pregnancy support center; domestic violence and adoption specialists; judges, attorneys, and prosecutors; several parents of girls who became pregnant as young teens; two court-appointed guardians for such girls; and several adult women who had given birth as minors. To protect their privacy, we made no effort to contact pregnant girls or their partners. However, Arlene Davis, a nurse as well as a lawyer, observed two sessions at a teen prenatal clinic, and we listened for fifteen hours to telephone counselors as they staffed a national abortion referral line.

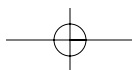
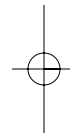
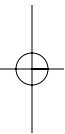
Fourth, we gathered data on facilities, programs, individuals to contact,

written material, and other types of assistance available to adolescents and those who are responsible for them. This information is available at www.adolescentpregnancy.unc.edu and will be supplemented when the other documents are published.

We do not vouch for or endorse any resource; and the book offers information, not legal advice. For legal advice, readers must consult an attorney. In addition, because the law is constantly in flux, readers or their legal advisors must check statutes or regulations that are cited to see whether they have since been repealed or amended as well as any court decision for relevant subsequent decisions.

Besides the generous financial support previously noted, we gratefully acknowledge the valuable contributions of our advisory committee and of many others who reviewed drafts of this publication and those who graciously talked with us or assisted us in other ways. In particular, these institutions kindly agreed to use a draft for six months and suggest improvements: Buncombe, Catawba, Chatham, Guilford, and Warren county health departments; the pediatrics department of Pitt Memorial Hospital in Greenville and the department of adolescent medicine of UNC Hospitals in Chapel Hill; Planned Parenthood of Orange and Durham counties; Raleigh Women's Health Organization; and Teen Health Connection in Charlotte and Wilmington Health Access for Teens.

Anne Dellinger and Arlene M. Davis
September 14, 2001



Introduction

A PREGNANT ADOLESCENT IS a challenging patient. Although she is young, her adult medical condition causes health care providers to consider more than medical issues in caring for her. A primary concern is the legal context for both provider and patient. Who gives consent for this patient? Who is responsible for payment for services? Should authorities be involved? What are the patient's rights? To the extent possible, many providers also concern themselves with the young patient's living situation, health education, and the effect that pregnancy or parenting will have on her future.

This book is intended for nurses, physicians and their assistants, students in those professions, social workers in health settings, health administrators, and educators who care for adolescents. The levels of knowledge about and experience with these patients will vary according to the reader. Some health care providers rarely diagnose or work with a teen or preteen pregnancy; others frequently do. Primary care providers and private practitioners may know a patient over years, treating her for a broad range of conditions. Specialists, on the other hand, and staff in hospitals, clinics, or other institutions, may meet a young woman only once as they provide pregnancy diagnosis, consultation, pregnancy options counseling, abortion, prenatal or postnatal care, contraceptive or adoption counseling, or support services for new mothers. This book discusses many of the legal questions that providers have about the care of pregnant girls as well as some of the questions that these girls commonly ask their providers.

The information we present is of several types. We explain reasonably clear legal requirements, but we also offer an interpretation of less-clear issues, and sometimes venture predictions about unresolved legal questions. We refer to the literature on adolescent pregnancy and relay advice on practice from medical organizations, treatises, and individual providers. In

addition, we make observations based on our interviews and medical record review. Our goals are to make caring for this group of adolescents easier and to ensure that these young patients benefit as much as possible from their contact with providers.

Consent to Treatment for Minors

ABSTRACT

Parents usually control the medical care of minors—if not parents, then custodians, guardians, or other adults in authority. In a few circumstances, minors do not need adult consent: in an emergency; when the minor seeks treatment for certain medical conditions, including pregnancy; when she is consenting to treatment for her own child; or when she is emancipated. Providers need to pay special attention to a minor patient's competence to consent, whether the consent is given voluntarily, and whether the condition is one for which the law lets a minor consent to treatment. It also would be prudent to adopt a policy on minors' care and document these matters in the medical record.

GENERAL RULE THAT PARENTAL CONSENT IS REQUIRED

In North Carolina, minors (people under the age of eighteen) are “subject to the supervision and control of” their parents.¹ As part of supervision, parents must make sure that their children get necessary medical care. Parents who fail to do so can be charged with neglecting the child.² Because parents are responsible for medical care, they usually have the legal right to control the care—arranging for it, consenting to it or not, and paying for it. Another reason why parents consent for minors is that minors cannot enter into binding contracts.

The law in some states considers older minors generally capable of

1. Section 7B-3400 of the North Carolina General Statutes (hereafter G.S.).

2. G.S. 7B-101(15).

making their own medical decisions, but North Carolina law does not. Still, in recent decades the General Assembly has made exceptions to the traditional rule that parents control the medical treatment of minors. The legislature has identified several situations in which a minor may consent for herself, an adult other than the girl's parent may consent for her, or a physician may treat her without consent.

These exceptions are described below. More than one exception may apply to a particular minor, but any applicable exception allows a provider to treat a minor without parental consent.

CONSENT FROM ANOTHER ADULT

In some cases an adult who is not a minor's parent may legally consent to her care. The most common situations in which this is true are the following:

Guardians

A guardian can consent to a minor's medical care as fully as a parent can.³ However, to become a guardian, a person must be so designated by a court. Therefore an adult who will be consenting for a minor's care as her guardian should be asked to show his or her court appointment as guardian as proof of legal authority before any treatment is given. A provider may want to make a copy of the document for the minor's medical record.

Custodians

Custodians have certain rights, although they are not equal to those of parents or guardians. For example, if a minor is in the custody of a local department of social services (DSS), the department's director may consent to some types of treatment, namely, "routine or emergency medical or surgical care or treatment."⁴ Sometimes a DSS director will delegate to foster

3. G.S. 35A-1241(a)(3); 7B-600; 7B-2001.

4. G.S. 7B-903(a)(2)c; 7B-2503(1)c; 7B-2506(1)c.

parents the authority to consent to routine care; but before treating a minor, a provider should verify that the foster parents do in fact have that authority and document it in the minor's medical record. Unless a court has terminated parents' rights, a custodian cannot consent to elective care. It remains the parent's prerogative. (The terms *routine*, *emergency*, and *elective* care are not, to our knowledge, defined in North Carolina statute or regulation.)

When a minor is in the legal or physical custody of DSS and her parents are "unknown, unavailable, or unable to act" for her, the DSS director may also consent to mental health, educational or "other" (presumably this includes medical) evaluations and treatment.⁵

Providers who treat delinquent minors confined to a facility should be aware that the Department of Juvenile Justice may authorize medical and surgical care needed to preserve a minor's life and health,⁶ but only a parent, guardian, or custodian may consent to elective surgery.⁷

People Acting as if They Were Parents

The law allows providers to accept consent for a minor from someone acting as her parent. (The legal term is a person standing *in loco parentis*.) Being *in loco parentis* means taking on informally the rights and duties of a parent, especially the burden of support.⁸ Unfortunately, it is quite difficult to be confident that a person wanting to consent actually is *in loco parentis*. A provider rarely knows who is supporting a child and certainly is in no position to judge whether a particular adult *intends* to act as a parent—or if so, how fully and for how long. Thus providers who accept consent on this ground are advised by the American Academy of Pediatrics (AAP) to "document the situation in the medical record, including attempts to obtain verbal or written consent from a parent."⁹

5. *Id.*

6. G.S. 143B-526.

7. G.S. 148-22.2.

8. *State v. Pittard*, 45 N.C. App. 701, 263 S.E.2d 809 (1980).

9. AMERICAN ACADEMY OF PEDIATRICS, *Consent for Medical Services for Children and Adolescents*, in POLICY REFERENCE GUIDE at 130 (1998) and at www.aap.org.

People Acting for an Absent Parent

North Carolina law lets a parent transfer the power to consent to treatment for a child to someone else when “the parent is unavailable for a period of time by reason of travel or otherwise.”¹⁰ To do so, the parent must have sole or joint custody of the child and transfer his or her authority in writing. No parent, however, may authorize another person to agree to the withholding or withdrawal of life-sustaining procedures for a child.

**ADULT CONSENT NOT NEEDED IN EMERGENCIES
AND CERTAIN OTHER SITUATIONS**

At his or her discretion, a physician may treat¹¹ a minor whose parents are unavailable if

1. despite reasonable efforts the physician cannot reach the proper adult during the time the minor needs treatment; or
2. delaying treatment, in order to seek consent, would endanger the life or seriously worsen the minor’s physical condition; or
3. the minor’s identity is unknown.¹²

When a parent is available but refuses consent, a physician also has alternatives in some circumstances. If a parent refuses to consent to treatment,

10. G.S. 32A-28 through -34.

11. Here “treatment” does not include surgery but is “any medical procedure or treatment, including X rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures employed by or ordered by a physician licensed to practice medicine in the State of North Carolina that is used, employed, or ordered to be used or employed commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in the community where said physician administers treatment to said minor.” G.S. 90-21.2.

12. G.S. 90-21.1.

a physician may ask a judge to order it.¹³ If taking time to ask for a court order would endanger the life of the minor or seriously worsen her physical condition, the physician may provide nonsurgical treatment over a parent's objection and without a court order. In such a case, another North Carolina–licensed physician must agree—before treatment—that it is needed to prevent immediate harm to the minor.¹⁴

The statute that allows physicians to treat in their own discretion in emergency and related circumstances does not say whether they can do so simply to relieve pain. However, that is a reasonable inference. The statute refers to the “time when the minor needs treatment.” This phrasing could cover a period of pain or suffering, even if the problem was not expected to result in immediate harm, a threat to life, or worsening of the minor's physical condition. AAP guidelines suggest that physicians assume an implied parental consent to treatment when a child is suffering or in pain.¹⁵

If a physician wants to perform surgery on a minor in the circumstances listed above, he or she must get a second opinion, if it is feasible to do so.¹⁶ The second opinion is not required in a “rural community” (not defined) or if it is impossible to reach another physician in time.

It should be noted that a physician's decision to treat a minor in an emergency would not justify the treatment of nonemergency conditions at the same time.

Emergency abortion on a minor is treated separately under the law.¹⁷ A physician may perform an abortion when in his or her “best medical judgment . . . based on the facts of the case . . . a medical emergency exists that so complicates the pregnancy as to require an emergency abortion.” A

13. G.S. 7B-3600.

14. G.S. 90-21.1.

15. AMERICAN ACADEMY OF PEDIATRICS, *Consent for Medical Services for Children and Adolescents*, in POLICY REFERENCE GUIDE at 131 (1998) and at www.aap.org.

16. G.S. 90-21.3.

17. G.S. 90-21.9.

physician may perform an abortion over a parent's objection also if the delay in getting a court order would endanger the minor's life or seriously worsen her physical condition. In that instance, though—where a parent has refused to give consent—the physician must get a second opinion, from another North Carolina–licensed physician, that an abortion is needed to prevent immediate harm to the minor.¹⁸

CONSENT FROM THE MINOR ONLY

In North Carolina, as in many other states, a minor may seek care on her own in certain circumstances, namely, when she wants treatment for one of a few specified conditions,¹⁹ when she is consenting to care for her child, or when she is emancipated.

Minors Seeking Care for Certain Conditions

Minors can approach providers independently for contraception, treatment for sexually transmitted diseases (STDs), and prenatal care (although not for abortion).²⁰ They can consent to services for the *prevention, diag-*

18. G.S. 90-21.1(4).

19. The Bush Administration is considering whether to amend new federal guidelines on the privacy of medical records to give parents access to all minors' medical records, which would vitiate these state minors' consent laws. 45 C.F.R. Section 164.502(g) (July 6, 2001).

20. G.S. 90-21.5. The other conditions with respect to which minors may consent to treatment are any other reportable communicable disease, abuse of controlled substances or alcohol, and emotional disturbance. Minors alone may not consent to abortion, sterilization, or nonemergency hospitalization for mental health care. G.S. 90-21.6 through -21.10, described later, require a parent's or other adult's consent to abortion or a judicial waiver of the requirement.

Because minors may consent to diagnosis of reportable communicable diseases, they may consent to HIV testing. Some providers think, to the contrary, that a parent must consent to a minor's HIV testing because G.S. 130A-148(h) provides that, if parents refuse permission for HIV testing, a child may still be tested if "there is a reasonable suspicion that the minor has AIDS virus or HIV infection or that the child has been sexually abused." However, we assume this provision does not apply to a minor who is herself consenting to diagnosis under G.S. 90-21.5.

nosis, and treatment of these and other conditions specified by statute, if the provider is a North Carolina–licensed physician²¹ or is working under such a physician’s direction and supervision or standing orders.²²

Moreover, the law instructs the physician not to notify the minor’s parent about the request for treatment except in unusual circumstances. A physician *must* notify a parent about a minor’s condition if the physician thinks notification may be essential to the minor’s life or health; the physician *may* talk with parents if contacted by them.²³

In weighing whether to notify a parent, providers should consider the minor’s mental and physical health—hints that she may be thinking of suicide, for example, or her refusal to seek treatment for a serious health condition. One county health director, for example, told us that he intended to inform a parent in the case of a family planning patient who took no action for months after receiving a troubling PAP test result. His intention seems reasonable.

Although, according to the statute allowing minors to consent, “[a]ny minor may give effective consent,” a provider should not take *any* literally. In order to give valid consent, a minor, like anyone else, must understand her condition, the alternatives for treating it, and the risks and benefits of treatment or nontreatment. That is, she must be able to give informed consent.

There is no specific age at which adolescents become capable of understanding these matters, and selecting an age arbitrarily seems especially problematic when the health issue is pregnancy. Legal commentators, psychologists, and judges are divided, for example, on whether girls under fifteen should be able to consent to abortion or childbirth. A national commission on consent to treatment recognized that “there is an age, below about 14 years old, at which the traditional presumption of incompetence

21. G.S. 90-21.5(a).

22. Opinion of Attorney General to Ed McClearen, Staff Attorney, Mental Health Study Commission, 47 N.C.A.G. 83 (1977), and Opinion of Attorney General to Margie Rose, M.P.H., Branch Head, Family Planning Branch, Division of Health Services, 47 N.C.A.G. 80 (1977).

23. G.S. 90-21.4(b).

remains sensible.” Still, the commission advised against a generally applied rule for age of consent, thinking it “more reasonable to ask—of any person at any age—‘is *this* person capable of making *this* decision?’”²⁴

The commission described *decisional capacity* as having “sufficient ability to understand a situation and to make a choice in the light of that understanding.”²⁵ Another definition is the ability to understand the situation, weigh the risks and benefits of the choices, compare choices, incorporate her own values in the final decision, and make a decision that is not overly affected by the opinions of others.²⁶

One North Carolina specialist in adolescent medicine uses practical tasks to help form her judgment about a patient’s capacity—for example, whether the patient demonstrates responsibility for her own health by keeping appointments that have been described to her as important. In addition, this provider usually asks a pregnant adolescent to describe in writing what she thinks her life will be like in one year and in five years if she makes one choice or another.²⁷ Simply talking with a patient about her situation and plans can help a provider form an opinion about the patient’s competence to make medical decisions, which may differ from what her parent—or the provider—would choose. If she does not seem competent, the provider should decline to treat on the patient’s request only. However, again, parents should not be told of the request unless the physician thinks notifying them may be essential to the minor’s life or health.

If a provider thinks that a minor patient is able to consent, he or she must

24. PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS* at 122 n.5 (1983).

25. *Id.* at 123.

26. Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents’ Psychological and Legal Competence to Consent to Abortion*, 16 L. & HUM. BEHAV. 129, 132 (1992).

27. Interview with Carol A. Ford, Assistant Professor of Pediatrics and Internal Medicine and Director, UNC Adolescent Medicine Program, Chapel Hill, N.C. (Mar. 3, 1999).

also assess whether the minor's consent is voluntary. Are the pregnant girl's decisions unduly influenced by peers or adults—family, partner, or advisers, including providers? People who have studied adolescents making medical decisions disagree on whether most of them act autonomously.²⁸ Several staff members in North Carolina institutions (hospitals, clinics, and adoption agencies) told us they often fear that the decision made by a young adolescent—whether to give birth, have an abortion, or keep her child—was not truly her own. Naturally, adolescents—especially the youngest—will be influenced by their parents. However, if providers suspect that a minor's consent is coerced, they should, after talking with her alone, tell her that she has a right to decide. If necessary, they should ask the DSS to intervene on her behalf.²⁹ Treatment should be postponed until the issue is resolved and the minor's consent seems to be freely given.

The scope of consent is another important issue when a minor alone is consenting. When providers treat a minor for one of the specified conditions—an STD, for example—they may not also treat clearly unrelated conditions, such as otitis, a laceration or burn, or a sprained ankle. In fact, however, providers may find it hard to decide whether a condition is related, and there are no guidelines on this point.

A Minor Consenting to Her Child's Treatment

When there is no law directly on point concerning a practical matter that has to be settled, lawyers must look to other legal principles for guidance.

28. “[M]inors younger than 14 or 15 years are unlikely to assert themselves well against authority figures, such as physicians or parents. . . . Also, there are significant social class differences that may modify willingness to express preference.” Sanford L. Leikin, *Minors' Assent or Dissent to Medical Treatment*, 102 J. PEDIATRICS 169, 173 (Feb. 1983). But Leikin's views contrast with those of David G. Scherer: “Children [ages 9 and 10] were significantly more likely to defer to parents than either adolescents [14 or 15] or young adults [ages 21 to 25]. Adolescents were more likely to defer to parents than young adults, although this finding only approximated statistical significance.” David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 L. & HUM. BEHAV. 431, 431 (1991).

29. FAY A. ROZOVSKY, *Children's Refusal of Treatment*, in CONSENT TO TREATMENT: A PRACTICAL GUIDE § 5.18, at 358–59 (2d ed. 1990).

As explained above, a parent is responsible for a child's basic needs, including medical care. Thus it is our view that a minor parent *must* be able to consent to her child's treatment because no one else has the responsibility or the authority to do so.

Here is our reasoning. State statute allows an emancipated minor to consent for her child's treatment,³⁰ but very few minor parents are emancipated because only marriage or a court order—not parenting—is evidence of emancipation. (See the section immediately following.) Unless a minor parent who is not emancipated may also consent to her child's treatment, many infants and small children could not be treated. The minor's parents or her partner's parents might seem logical parties to give consent, but their potential support obligation for a grandchild confers no legal right to make decisions. If a minor is not able to carry out a parent's duties, a court can place her child in the custody of another person or of DSS. The guardian or custodian would then be the appropriate person to provide consent. However, unless a guardian or custodian has been named, the minor retains the rights and duties of parenthood. The odd result, in our opinion, is that minor parents can consent to their *children's* treatment even though it is generally believed that an unemancipated minor cannot consent to *her own* treatment outside of the conditions we have noted.

Emancipated Minors

An emancipated minor is one who has the right to transact business as if she were an adult.³¹ *Transacting business* includes consenting to medical care.³² Most people become emancipated automatically by reaching the age of eighteen, after which they are treated as adults for nearly all legal purposes. North Carolina law allows a sixteen- or seventeen-year-old to petition a court for an order of emancipation.³³ That only fifty-three minors filed a pe-

30. G.S. 90-21.5(b).

31. G.S. 7B-3507.

32. G.S. 90-21.5(b).

33. G.S. 7B-3500 to -3509.

tion for emancipation in a recent year,³⁴ however, shows how rarely the procedure is used.

Marriage and serving in the armed forces are the other means of emancipation for someone under eighteen.³⁵ (See the subsection on “Marriage.”) Becoming a parent does not emancipate a minor in North Carolina.³⁶

DOCUMENTING CONSENT AND OTHER MATTERS

Documenting patient consent is always an important legal matter. Although the law does not require different documentation for minor patients, we suggest that providers take extra measures with pregnant adolescents, both to help them and as a precaution against liability.

We recommend that the following information be recorded:

- whether an adult accompanied the minor on the first visit;
- the name of that adult;
- his or her relationship to the minor;
- references to the institution’s policies on care of minors;
- that the minor and adult were interviewed separately;
- that the pregnancy diagnosis and all options were explained to the minor;
- what option(s) she chose and the concerns she raised;

34. The only year for which the number of petitions filed seeking emancipation is known is 1999. Telephone conversation with Patrick Tamer, Statistician, Administrative Office of the Courts, Raleigh, N.C. (Feb. 22, 2000).

35. G.S. 7B-3402. A few adolescents who are emancipated by marriage obtain a divorce before they reach the age of eighteen. Although the law does not mention their status, it is the authors’ opinion that these minors remain emancipated.

36. Some providers will recall that, before 1979 when the emancipation statute was enacted, a minor was judged to be emancipated or not by various criteria of independence. Under this individualized test, young parents were usually treated as emancipated. That is still the case in a number of other states.

- the legal basis for allowing her to consent—for example, “medical emergency,” “treatment of pregnancy,” “minor has court order allowing her to consent to abortion” or “minor and her mother consented to abortion,” or “minor showed certificate of emancipation”;
- the physician’s conclusion about the minor’s decisional capacity and whether her consent was voluntary;
- counseling on STDs, including treatment of the patient and partners and information on prevention; and
- counseling and the patient’s decision on abstinence or contraception after the pregnancy is resolved.

In addition to documenting consent, providers could help a pregnant minor by asking about her living situation; sexual history; and the possibility of abuse, neglect, or a criminal act committed against her. Documentation should include the patient’s age and that of the father of the fetus, whether she is enrolled in school (particularly after a child is born), and what reports or referrals providers have made.

Treatment of Pregnant Minors

ABSTRACT

Informing a pregnant patient about her options (abortion or childbirth; to raise the child or place the child for adoption) is a precondition for informed consent. Minors who bear and raise a child can decide about perinatal care and about the child's care. Minors who continue a pregnancy and place the child for adoption decide about perinatal care and the child's care until their rights are ended by the adoption proceeding. Abortion for a minor requires her written consent and that of a parent or specified other adult, but a judge can waive the adult consent requirement. Providers could help patients by explaining the law on adoption, marriage, and child support; facilitating their return to school; and referring young mothers to resources for parenting.

OPTIONS COUNSELING

Before providers ask for consent to treatment, medical¹ and legal² standards require them to explain the patient's medical condition, the treatments available for it, and the likely results of treatment or nontreatment.³ North Carolina law on informed consent is found both in statute and in court decisions.

1. For example, Standard RI.1.2.1 of the JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS' COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS (2000).

2. G.S. 90-21.13.

3. For a full discussion, see FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE (2d ed. 1990 & Cum. Supp. 1999).

Under the consent statute, a provider sufficiently informs a patient (and thus avoids liability) by acting like his or her fellow practitioners,⁴ that is, by providing enough of an explanation to give a reasonable person a “general understanding of the . . . treatments and of the usual and most frequent risks.”⁵ An alternative test for liability is whether a reasonable person would have consented if advised under the first test.⁶

North Carolina courts occasionally hear allegations from patients who think that they were not fully informed. Although no case has yet to rule directly on liability for not explaining the options for a normal pregnancy,⁷ a decision about unwanted conception may be relevant.⁸ Allegedly a woman’s IUD was removed during surgery, and she was not told, although her doctor knew that she did not want more children. After bearing a healthy child, the woman sued for malpractice, and the state supreme court upheld her right to sue. The justices wrote, “There are many reasons . . . to avoid pregnancy, some of which are matters of personal inclination and some of which are related to health.”⁹ When a patient conceives because of a provider’s mistake, “it is the fact of the pregnancy *as a medical condition* that gives rise to compensable damages and completes the elements for a claim of negligence.”¹⁰ The court views pregnancy as a medical condition that some patients want help from providers to avoid. The case, like the informed con-

4. Specifically, “in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities.” G.S. 90-21.13.

5. *Id.*

6. *Id.*

7. The state supreme court refused to recognize claims by a child born with a genetic defect and his parents. Although conceding that the mother would likely have aborted but for the providers’ inadequate counseling, the court told the child that “even life with genetic defects cannot be an injury in the legal sense.” The court deferred to the General Assembly on the parents’ claim. *Azzolino v. Dingfelder*, 315 N.C. 103, 337 S.E.2d 528 (1985).

8. *Jackson v. Bumgardner*, 318 N.C. 172, 347 S.E.2d 743 (1986).

9. *Id.* at 177, 347 S.E.2d at 746.

10. *Id.* at 181, 347 S.E.2d at 748 (emphasis in opinion).

sent statute, suggests that a provider's failure to counsel a patient about pregnancy options is malpractice.

Other considerations besides state law affect some providers. Most family planning programs in local health departments in North Carolina receive federal funds. Providers who work in federally funded (Title X) family planning programs are bound by federal regulations¹¹ and program guidelines.¹² Whether Title X clinics are to counsel patients about abortion and provide referrals for it¹³ has inspired public controversy and official action for years, involving Congress, the federal courts, and several presidents. Since 1993, when the abortion counseling "gag rule" was suspended,¹⁴ nondirective counseling on the full range of pregnancy options, including abortion counseling and referral, has again been required treatment in Title X programs.¹⁵

In the case of adolescent patients, it is extremely important that their options be explained to them as soon as pregnancy is diagnosed. Typically these young women lack sufficient information about pregnancy, the law, and health systems. They come for care near the deadline for obtaining an abortion and past the time when prenatal care should have begun. In one group of fifty-eight teens, for example, 74 percent of the young women realized they were pregnant only after "someone else suggested the possibility, and half of them did not detect it until the second trimester."¹⁶

11. 42 U.S.C.A. § 300a authorizes the Secretary of the U.S. Department of Health and Human Services to make grants to states for family planning services. The states, in turn, fund local agencies to provide services. Regulations for the operation of these programs are found at 42 C.F.R. § 59.1.

12. BUREAU OF COMMUNITY HEALTH SERVICES, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES (n.d.).

13. 42 C.F.R. § 59.5.

14. Memoranda of President, 58 Fed. Reg. 7,455 (Jan. 22, 1993).

15. Standards of Compliance for Abortion-Related Services in Family Planning Service Projects, 58 Fed. Reg. 7,462 (Feb. 5, 1993), and U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES § 8.6 (n.d.).

16. Kari Sandven & Michael D. Resnick, *Informal Adoption among Black Adolescent Mothers*, 60 AM. J. ORTHOPSYCHIATRY 210, 217 (1990).

A pregnant adolescent should receive private counseling whether or not she is accompanied by another person. Most pregnant girls, especially the youngest, do come with a parent to visit a health facility. Ninety percent of those under fifteen report that one parent knows about the pregnancy; 43 percent report that both parents know.¹⁷ Unless a provider tells them, however, many of these young patients will not realize the extent to which they are entitled to make health care decisions.¹⁸

A pregnant minor's desire for confidentiality must almost always be respected. (For the exceptions under North Carolina law, see the "Minors Seeking Care for Certain Conditions" section, above.) When a minor is accompanied by a parent, medical and nursing association policy statements advise providers to meet separately with the patient to counsel her, to seek the most sensitive information, and to learn how and whether she wants her parent to be involved in her medical care.¹⁹ The American Academy of Pediatricians (AAP) policy is typical. It recommends that the diagnosis of pregnancy be delivered to a minor patient alone and that she should then be urged, particularly if she is a younger adolescent, to involve her parents and partner. While that is best for most patients, the AAP realizes that for some patients, their parent or partner is not a supportive figure. In those instances, the Academy's advice is that "minors should be urged to seek the advice and

17. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA'S TEENAGERS* 49 (1994).

18. Except for abortion, a pregnant girl is fully entitled as long as she is competent. In the case of abortion *she* must consent, but a parent or other specified adult also must consent or a judge must waive the adult consent requirement. On the subject of minors' competence, see Lois A. Weithorn, *Involving Children in Decisions Affecting Their Own Welfare: Guidelines for Professionals*, in *CHILDREN'S COMPETENCE TO CONSENT* at 252 (Gary B. Melton et al. eds., 1983).

19. AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY (ACOG), *Confidentiality in Adolescent Health Care*, ACOG EDUCATIONAL BULLETIN No. 249 (Aug. 1998); ASSOCIATION OF WOMEN'S HEALTH, OBSTETRIC AND NEONATAL NURSES (AWHONN) POSITION STATEMENT: CONFIDENTIALITY IN ADOLESCENT HEALTH CARE (*reaffirmed* 1995); AMERICAN MEDICAL ASSOCIATION, *GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES: RECOMMENDATIONS FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS* (n.d.).

counsel of adults in whom they have confidence. . . . This is especially true for young adolescents, age 12 to 15 years.”²⁰

Providers themselves have options in dealing with pregnant minors, though their options may be limited by conditions of employment or by grants or other requirements. Both state²¹ and federal²² laws allow providers to object on moral, ethical, or religious grounds to participating in abortions. State law *lets* a physician treat a pregnant minor who does not want a parent involved, but it does not *require* a physician to accept her as a patient.²³ However, if a provider is unwilling to explain options or treat the minor, he or she should refer the patient without delay. If the girl has been a patient of the provider, referral may be necessary to avoid a claim of abandonment. The AAP, the American College of Obstetrics and Gynecology (ACOG),²⁴ and the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN)²⁵ also advise referral. AAP states, “The physician needs to respect the adolescent’s personal decision and her legal right to continue or terminate her pregnancy and not impose barriers to health services from another provider. Should a pediatrician choose not to counsel the adolescent patient about sexual matters such as pregnancy and abortion, the patient should be referred to other experienced professionals.”²⁶

20. AMERICAN ACADEMY OF PEDIATRICS (AAP), *Counseling the Adolescent about Pregnancy Options*, in 101 PEDIATRICS 938–40 (1998) and at www.aap.org.

21. G.S. 14-45.1(e), applicable to physicians and nurses.

22. 42 U.S.C.A. § 300a-7, applicable to all health care personnel in federally funded programs.

23. G.S. 90-21.5.

24. ACOG EDUCATIONAL BULLETIN at 3.

25. For women of all ages, AWHONN “supports and promotes a . . . right to accurate and complete information and access to reproductive health services.” AWHONN POSITION STATEMENT: HEALTH CARE DECISION MAKING FOR REPRODUCTIVE CARE (*revised & reaffirmed under new title* Sept. 1999); *see also*, AWOHHN POSITION STATEMENT: NURSES’ RIGHTS AND RESPONSIBILITIES RELATED TO ABORTION AND STERILIZATION (1999) (both are available at <http://www.awhonn.org>).

26. American Academy of Pediatrics, *Counseling the Adolescent about Pregnancy Options*, 101 PEDIATRICS 938–40 and at www.aap.org.

One health department gives each woman who receives a pregnancy diagnosis a written supplement to the oral options counseling. The department's sheet invites the patient to call for further discussion and lists additional resources in three categories: prenatal care and support services; adoption/abortion alternatives/post abortion counseling; and abortion. Each resource's contact information is listed.²⁷

ABORTION

In North Carolina, written consent from the minor is required for abortion. In addition, either an adult from one of several categories must consent in writing or a court must waive the adult consent requirement.²⁸ As has been noted, most minors who are considering abortion, especially those at the youngest ages, do talk with a parent. In North Carolina, as in the United States as a whole, that figure is approximately 90 percent. But for those adolescents who will not or cannot get adult consent, the court process described in this section is an alternative means of gaining permission for abortion. In a year in which 2,287 abortions were performed on minors aged nine through seventeen²⁹ in our state, 233 petitions for waiver of parental consent to abortion were filed.³⁰

Minors generally depend, initially, on health care providers for information about abortion. Many young patients do not know how long into a pregnancy abortion is legally, practically, or medically available; where or how to obtain one; or that if they choose abortion, they will need an eligible adult's consent or must ask a judge to waive that requirement.

27. Catawba County Health Department, patient information sheet revised Jan. 12, 2001.

28. G.S. 90-21.7.

29. STATE CTR. FOR HEALTH STATISTICS, NORTH CAROLINA DEP'T OF HEALTH AND HUMAN SERVICES, NORTH CAROLINA REPORTED PREGNANCIES (1998).

30. ADMINISTRATIVE OFFICE OF THE COURTS, Raleigh, N.C.

Abortion is legal for any woman in North Carolina until the fetus is viable³¹ or through the end of the second trimester (the twenty-fourth week of gestation), whichever comes first. An abortion is legal at any point in pregnancy if “necessary to preserve the life or health of the mother.”³² However, the state of North Carolina licenses clinics³³ and ambulatory surgical facilities³⁴ to offer abortions only through twenty weeks of gestation. Not all licensed facilities offer abortion for that length of time.³⁵ In North Carolina, after twenty weeks of gestation an abortion must be performed in a hospital.³⁶

The requirements for a minor being able to obtain an abortion are described below.

31. In *Roe v. Wade*, 410 U.S. 113 (1973), the U.S. Supreme Court established an unfettered right to choose abortion through the first trimester of pregnancy. Under *Roe*, in the second trimester a state may regulate to protect maternal health, and after viability, a state may forbid abortion except where a woman’s life or health may be at stake. Subsequent U.S. Supreme Court decisions have retreated from *Roe* by allowing states to impose restrictions that the Court does not find unduly burdensome to the exercise of a right to abortion.

Roe is understood to have invalidated G.S. 14-45.1, which permitted abortion only through twenty weeks of gestation. Although the General Assembly has not enacted a new statute, we assume that the legislature wishes to prohibit abortion after viability except, as required by *Roe*, to preserve a woman’s life or health.

32. *Roe v. Wade*, 410 U.S. 113, 164 (1973).

33. 10 NCAC 3E.0101; 0107.

34. 10 NCAC 3Q.0204.

35. For example, the Statesville, North Carolina, telephone book for 1999–2000 listed under “Abortion Services” clinics that offer abortions through twenty weeks, sixteen weeks, fifteen weeks, and fourteen weeks. In addition to different time limits set by facilities, physicians serving a single clinic sometimes have different numbers of weeks through which each is willing to perform abortions. Occasionally, too, a provider declines to perform an abortion on a young woman because of the problems presented by her small or immature uterus.

36. In 1999, North Carolina hospitals reported performing 141 abortions after twenty weeks. These later abortions represented one half of one percent of the 28,136 abortions performed in the state that year.

With a Parent's or Another Adult's Permission

Unless a judge waives this requirement, a provider must have written consent from the minor and from one of the following adults: a custodial parent, a legal guardian or custodian, a parent with whom the girl is living, or a grandparent with whom she has lived for six months immediately before the abortion.³⁷ If the consenting adult is present, informed consent standards would suggest that providers should explain treatment options, risks, and benefits to the adult as well as to the minor patient.³⁸

If the minor is unaccompanied and presents a document as evidence of an appropriate adult's consent, providers may wonder how far they must go to verify it. In the only North Carolina case on this point, the court held that a physician could rely on the minor's word that the signed permission she presented was valid. The state court of appeals ruled that the parental consent statute "contains no requirement, express or implied, that the physician conduct an investigation into the circumstances of a purported written parental consent for an abortion to determine the validity of the writing."³⁹

With Court Waiver of the Adult Consent Requirement

If a minor wants an abortion but no eligible adult is available to consent, or will consent, or if the minor does not want to ask the adult, she may ask a judge to allow her to decide.⁴⁰ (The official name of such a request is a "Petition for Waiver of Parental Consent for Minor's Abortion," which court staff usually call a *waiver petition* or *judicial waiver*. The petition and other forms used in this procedure may be seen and printed from <http://www.aoc.state.nc.us/>.) The judge must grant the request if he or she finds any one of the following to be true:

1. the minor is mature and well-informed enough to make the decision;

37. G.S. 90-21.7(a).

38. G.S. 90-21.13. Informed consent to health care treatment or procedure.

39. *Jackson v. A Woman's Choice*, 130 N.C. App. 590, 594, 503 S.E.2d 422, 425 (1998).

40. G.S. 90-21.7.

2. making the decision herself would be in her best interest; or
3. she is a victim of rape—which would include statutory rape—
—or felonious incest.⁴¹

If a minor wants a waiver, a provider should tell her to contact a district court clerk in a county courthouse for information and assistance.⁴² The minor need not be a North Carolina resident to submit a waiver petition here,⁴³ and if she is a resident of the state, she does not have to file her request in the county where she lives. Any minor may ask for a judicial waiver in any county in the state.⁴⁴

Health care providers could further assist a patient who wants a waiver by explaining the court procedure and by giving her written certification of her pregnancy and the estimated gestational age of the fetus to take to court. Although neither the statute nor the court forms on waiver mention these items, some judges ask for this information. Having it to present to a judge might save the minor a delay that would make it impossible for her to obtain an abortion.

State law requires that a court employee help a young woman prepare her request if she wants help. The court employee will give the young woman the correct forms and help her fill them out.⁴⁵ She is entitled to have, without charge, the assistance of a lawyer and someone else,⁴⁶ or she may proceed on her own.⁴⁷ If she wants a lawyer, the court will find and appoint

41. Felonious incest is that between grandparent and grandchild, parent and child or stepchild or legally adopted child, and brother and sister “of the half or whole blood.” G.S. 14-178.

42. G.S. 90-21.8.

43. G.S. 90-21.8(a).

44. The statute says that a petition may be filed “in the district court where the minor resides or where she is physically present.” G.S. 90-21.7(b).

45. G.S. 90-21.8(b). *See also* JACK COZORT, Rule 1C, RULES OF RECORDKEEPING: JUDICIAL WAIVER OF PARENTAL CONSENT (JW) PROCEEDINGS (Oct. 1, 1995) (hereafter, *Rules of Recordkeeping*).

46. The adult helper who is not a lawyer is called a guardian ad litem, that is, a guardian for purposes of the court proceeding. This could be an adult friend or relative of the minor or someone assigned to help the minor by the clerk of court.

47. G.S. 90-21.8(c). *See also* Rule 1B, *Rules of Recordkeeping*.

one to represent her. Court costs and fees are waived for this procedure, so it costs the minor nothing. The minor's parents are not notified unless she asks that they be. Her identity and the record of the hearing are confidential, except that the court must notify the local department of social services (DSS) if the pregnancy is the result of any type of incest,⁴⁸ abuse, or neglect.⁴⁹ A DSS investigation or its consequences could cause parents to learn of the minor's petition or abortion.

After a waiver petition has been filed, a judge has seven days to decide whether to grant it. Some judges talk with the minor and make a decision the day the petition is filed.⁵⁰ If the judge grants the request, she or he issues an order. The clerk of court then gives the minor a certificate stating that she does not need an adult's consent, which the girl can present to an abortion provider. If the minor's request is denied, she has twenty-four hours to appeal. On appeal, she will be required to present her case anew, to a different judge. Or, since the statute does not limit a minor to a single petition, she could instead begin the process again by filing another petition in a different county or before a different judge.

Payment for Abortion

Payment is an important aspect of abortion for adolescents. Medicaid very rarely covers the procedure. Abortions that qualify for Medicaid reimbursement are those where the pregnancy is the result of rape or incest, or is life-endangering. A North Carolina-licensed physician must fill out and sign a statement to that effect. In 2000, Medicaid paid for three abortions in North Carolina.⁵¹

The state abortion fund, which in the past paid for many procedures, no

48. G.S. 90-21.8(f).

49. G.S. 7B-301.

50. Interview with a North Carolina assistant clerk of court (Apr. 7, 1999).

51. Information from Beth Osborne, N.C. Dep't of Health and Human Services, Division of Medical Assistance, Raleigh, N.C. (Apr. 17, 2001).

longer functions.⁵² However, some private health insurance policies cover a dependent's abortion, and clinics and hospitals sometimes reduce or waive charges—or spread out payments—for those who are unable to pay. (Problems of confidentiality in billing practices are addressed below under “Financial Responsibility for A Minor’s Medical Care.”)

CHILDBIRTH

Although many adolescents choose to end their pregnancies, a majority of them are now giving birth and raising their children. As a result, many health care providers are treating young pregnant patients both pre- and postnatally. A provider may also treat a patient's child and, occasionally, her parent or partner, despite the fact that caring for several members of a family can raise conflicts of interest. For example, as discussed later, a provider would have to report a mother who abused or neglected her child and might urge a girl to report an older or abusive partner's statutory sexual offense or violence. Physicians have different policies on retaining as patients minors who give birth. One pediatrician we interviewed told us that her practice group will no longer treat such a patient but will accept her infant as a patient.

Continuing to treat an adolescent after she becomes a mother is likely to benefit her greatly. A provider who is familiar with a young mother can best assess her needs for personal security, contraception, and protection from STDs and can encourage her to pursue education and employment while she develops parenting skills. The AAP strongly encourages its members to serve this group of patients, stating that “Pediatricians should serve as resources for pregnant teenagers and their infants, the teenager's family, and the father

52. Since 1995, the fund has consisted of \$50,000 available under the same conditions as Medicaid, but the applicant must not be eligible for Medicaid despite her poverty status. 1995 N.C. Sess. Laws ch. 324, sec. 23.27; ch. 507, sec. 23.8A; 1999 N.C. Sess. Laws ch. 237, sec. 11.29. The fund has been almost untouched in recent years.

of the baby to ensure that optimal health care is obtained and appropriate support is provided.”⁵³ In a newly revised policy statement on the subject, the association’s first (of thirteen) recommendations is that “Pediatricians should provide continuity of care and a ‘medical home’ for adolescent parents, as well as for their children.”⁵⁴

Perinatal Care

The law governing the perinatal period is straightforward. As part of the state statutory permission to minors to consent to treatment for pregnancy,⁵⁵ an adolescent can consent for prenatal care, labor and delivery, and postnatal care.

But a minor who gives birth and keeps the child faces medical and financial challenges that must be met while she also learns to function as a parent and resumes schoolwork. Previous pregnancies or other children may add to the difficulties. Nine of the 186 pregnancies in girls under age fifteen that we studied were second pregnancies. At least four girls had a child at home already.

Although most adolescent mothers do well physically, the medical risks of childbirth for them (especially the youngest) and their infants are substantially greater than for adult women.⁵⁶ In addition, these adolescents are disproportionately poor,⁵⁷ usually first-time mothers, and less prepared than

53. AAP COMMITTEE ON ADOLESCENCE, *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS 516–20 (Feb. 1999) and at www.aap.org.

54. *Care of Adolescent Parents and Their Children*,” 107 PEDIATRICS 429–34 (Feb. 2001) and at www.aap.org.

55. G.S. 90-21.5.

56. AAP *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS 516–20 (Feb. 1999) and at www.aap.org, citing L. J. Piccinino & W. D. Mosher, *Trends in Contraception Use in the US: 1982–1995*, 46 FAM. PLAN. PERSP. 4–10 (1998), and A. J. Satin et al., *Maternal Youth and Pregnancy Outcomes: Middle School versus High School Age Groups Compared with Women Beyond the Teen Years*, 171 AM. J. OBSTETRICS & GYNECOLOGY 184–87 (1994).

57. “Poverty is correlated significantly with adolescent pregnancy in the United States. Although 38% of adolescents live in poor or low-income families, 83% of adolescents who give birth and 61% who have abortions are from poor or low-income

older women for parenthood—facts that make a very brief postpartum stay a strain on their personal resources. A short hospital stay for high-risk mothers can cause problems for their infants. The AAP discourages early discharge in a number of circumstances including where the mother is a teen or where there is a “lack of social support, particularly for single, first-time mothers.” For new mothers who present these or other risk factors, the AAP recommends that discharge be delayed until these circumstances “are resolved or a plan to safeguard the infant is in place.”⁵⁸ A 1999 policy statement advises pediatricians to “recommend that adolescent mothers not receive early postpartum discharge so that clinicians can ensure that the mother is capable of caring for her child and has resources available for assistance.”⁵⁹

North Carolina law requires private insurers to cover a forty-eight-hour stay for any mother after a normal vaginal delivery.⁶⁰ If a mother and her physician agree on earlier discharge, the insurer must cover “timely post-delivery” care.⁶¹ Similarly, Medicaid encourages physicians to keep patients postpartum as long as medically necessary. Its reimbursement for normal uncomplicated vaginal delivery is for 1.9 days in hospital. If a minor’s parents’ insurance does not cover her,⁶² she very likely is eligible for Medicaid because only the minor’s income is considered in determining childbirth coverage under Medicaid. As a last resort for pregnant women, a federal statute

families.” *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS at 516–20 and at www.aap.org.

58. *Hospital Stay for Healthy Term Newborns*, 96 PEDIATRICS 788–90 (Oct. 1995, reaffirmed Oct. 1999) and at www.aap.org.

59. Recommendation 6 in AAP COMMITTEE ON ADOLESCENT PREGNANCY, *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS at 516–20 (Feb. 1999) and at www.aap.org.

60. G.S. 58-3-169.

61. G.S. 58-3-169(c).

62. Many insurance policies sold in the state exclude dependents’ coverage for labor and delivery. Telephone conversation with Kim Shepherd, Life and Health Section, N.C. Dep’t of Insurance, Raleigh, N.C. (June 9, 1999).

requires hospitals to treat anyone, regardless of ability to pay, who comes to the hospital in active labor.⁶³

Hospital staff often refer an adolescent mother to North Carolina's Child Services Coordination program, which provides home visits for the first three years of a child's life by a nurse or social worker trained to identify services available for the child. Visits are made at least quarterly and more frequently if needed.

Continued school attendance by young mothers is crucial to the economic well-being of adolescents and their children.⁶⁴ School districts' policies vary greatly in how well they facilitate a new mother's return to school and her gaining credit for the semester or year in which she gives birth. One district grants students an excused absence for up to thirty days before and thirty days after delivery.⁶⁵ Another requires a doctor's letter before excusing absences even for the physical necessities of the postpartum period. Given these differences in both policy and practice, if a physician and patient decide that an absence of more than a day or two is advisable—for bonding, establishing breast-feeding, securing child care, or other reasons—a written statement from the physician to school officials may be essential for the student to have a chance of being allowed to continue working at home for credit.

63. Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, *renamed in 1989* Examination and Treatment for Emergency Medical Conditions and Labor Act.

64. For one of numerous studies reaching this conclusion, see J. Brooks-Gunn & Frank F. Furstenberg, Jr., *Continuity and Change in the Context of Poverty: Adolescent Mothers and Their Children*, in *THE MALLEABILITY OF CHILDREN* at 171–88 (J. Gallagher & C. Ramey, eds. 1989).

65. The “Homebound Instruction” policy of the Alamance–Burlington School System allows for such an absence. Telephone conversation with Jerry Ferguson, Director of Student Support Services (Mar. 13, 2000). Moreover, under the system's “High School Attendance Policy Procedures,” for “[a]bsences resulting from . . . life-altering circumstances of the student, the principal has the authority to exempt the student from the provisions of the individual class attendance policy.”

Surrendering a Newborn

Showing particular concern about young parents,⁶⁶ the General Assembly now lets adults accept temporary custody of infants fewer than seven days old who might otherwise be abandoned. If a parent offers a child and “does not express an intent to return,” a health care provider *must* and other adults *may* take the child.⁶⁷ “[H]ealth care provider” is very broadly defined. Besides emergency medical personnel on duty at a fire or emergency service station, the term means anyone licensed, registered, or certified to practice

medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology, or a hospital or a nursing home; or any other person who is legally responsible for the negligence of such person, hospital or nursing home; or any other person acting at the direction or under the supervision of any of the foregoing person, hospital or nursing home.⁶⁸

The provider must guard the infant’s health and well-being and immediately contact DSS or law enforcement. He or she may ask the parent’s identity and medical history, but must tell parents they are not required to answer. A provider who acts in good faith in performing this legal duty is safe from liability.⁶⁹ For the parent, surrendering a newborn will either be a shield against child abuse charges⁷⁰ or, at the least, a mitigating factor in sentencing.⁷¹

66. Section 6, Session Law 2001-291.

67. G.S. 7B-500. Law enforcement officers and department of social services employees must also accept an infant presented to them.

68. *Id.* The statute incorporates the definition of G.S. 90-21.11.

69. The immunity does not extend to “gross negligence, wanton conduct, or intentional wrongdoing.” *Id.*

70. G.S. 14-318.2.

71. G.S. 14-319.4.

Raising the Child

In 1999, 353 infants were born in North Carolina to girls who became pregnant before the age of fifteen. The total number of babies born to North Carolina minors that year was 5,628.⁷² Nearly all minors who give birth intend to raise the baby. While most will manage, usually with family help, health care providers may have questions about how and whether some young patients can fulfill the responsibility.

Parent's Competence

There is no minimum age for being permitted by law to raise a child, but all parents have a legal duty to give a child the necessities of life (including health care), plus an education, and to keep a child from harm. The failure to carry out these duties can result in civil and criminal penalties⁷³ and cause authorities to terminate a person's parental rights.⁷⁴

Health care providers should assume that a young mother, though not an adult for most legal purposes, has the legal rights of a parent⁷⁵ (and they can help young mothers gather resources for parenting by referring them to DSS or elsewhere). If, however, providers have reason to suspect that the mother, her child, or both, are being abused or neglected, they must contact social services. (See the section on "Abuse, Neglect, Dependency, Sexual Assault" for more information.)

Marriage

State law strongly favors marriage and the legitimacy of children, though the benefit of marriage at a very early age is debatable.⁷⁶ For example, a

72. STATE CTR. FOR HEALTH STATISTICS, NORTH CAROLINA DEP'T OF HEALTH AND HUMAN SERVICES, NORTH CAROLINA REPORTED PREGNANCIES (1999).

73. Article 39, Ch. 14, Protection of Minors, contains criminal statutes. The state court of appeals finds the same duty in civil law. *Coleman v. Cooper*, 89 N.C. App. 188, 366 S.E.2d 2, *discretionary review denied*, 322 N.C. 834, 371 S.E.2d 275 (1988).

74. G.S. Ch. 7B, especially Articles 3, 5, and 11.

75. See the section "A Minor Consenting to Her Child's Treatment," above.

76. According to one source, the policy "subordinates other interests, such as

young woman married before age eighteen is nearly twice as likely to end the marriage as a woman married at age twenty-five or higher.⁷⁷ In North Carolina, people are free to marry at eighteen, when they become adults. Sixteen- and seventeen-year-olds may marry with consent from an appropriate adult; that is, a person having legal custody of them or serving as their guardian.⁷⁸ A fourteen- or fifteen-year-old girl may marry if she (1) is pregnant or has a child by the person she wants to marry and (2) a district court judge authorizes the marriage. Likewise, a fourteen- or fifteen-year-old boy may marry a woman he has impregnated or who is the mother of his child if a judge authorizes the marriage.⁷⁹

A judge may approve a request from an underage person to marry only after finding that the underage party can fulfill the responsibilities of marriage and that marriage would be in her or his best interest. In determining best interest a judge must consider the opinions of the underage person's parents, custodian, guardian, and guardian ad litem (GAL). (The GAL assesses, among other things, "the emotional development, maturity, intellect and understanding" of the youth.)⁸⁰ The marriage law states that "The fact

those of the parents and guardians of the underage applicant [for a marriage license] and the long-term welfare of both the child and its mother." William A. Campbell, *North Carolina Marriage Laws: Some Questions*, 63 *POPULAR GOV'T* 50, 53 (Winter 1998). Another legal writer points out that the Uniform Marriage and Divorce Act, which North Carolina has not adopted, allows no one younger than sixteen to consent to marriage and "expressly rejects pregnancy as an automatic exception to an age requirement" because "marriages entered into under these circumstances are even more vulnerable than other youthful marriages." Suzanne Reynolds, 1 *LEE'S NORTH CAROLINA FAMILY PRACTICE* § 2.8 at 98 (5th ed. 1993). A third source concludes that "[a]dolescent childbearers may not be able to combine school attendance and marriage successfully." Diane Scott-Jones, *Educational Levels of Adolescent Childbearers at First and Second Births*, 99 *AM. J. EDUC.* 461, 477 (Aug. 1991).

77. Matthew D. Bramlett and William D. Mosher, "First Marriage Dissolution, Divorce, and Remarriage: United States." *ADVANCE DATA* (No. 323, May 31, 2001), Centers for Disease Control and Prevention, national Center for Health Statistics, available at <http://www.cdc.gov/nchs/>.

78. G.S. 51-2(a1).

79. G.S. 51-2A.

80. G.S. 51-2A(d).

that the female is pregnant, or has given birth to a child, alone does not establish that the best interest of the underage party will be served by the marriage.”⁸¹

An emancipated minor does not need anyone’s consent to marry, but to obtain a marriage license he or she must file a copy of the certificate of emancipation with the register of deeds.⁸²

Support Obligations of Parents, Grandparents, or Others

Whether parents are married or not, they owe their child financial support until he or she is at least eighteen or is emancipated.⁸³ (*Support* is defined as an amount that satisfies “the reasonable needs of the child for health, education and maintenance” considering the family’s “accustomed standard of living” and total circumstances.)⁸⁴

Establishing paternity is the necessary first step in getting financial support from the father. Most unmarried fathers in North Carolina acknowledge paternity when their child is born, and in most of the remainder of cases, the state’s Child Support Enforcement program is able to establish paternity.⁸⁵ A mother can ask a court to establish paternity.⁸⁶ Such an action can be filed any time until the child is eighteen. In addition to requiring support, a court may order a father to reimburse the mother for expenses related to pregnancy and childbirth and the cost of her legal action against him.⁸⁷

A minor’s parents and her partner’s parents also can be held responsible

81. G.S. 51-2A(a).

82. G.S. 51-2.

83. G.S. 50-13.4.

84. G.S. 50-13.4(c).

85. Fifty-two percent of unmarried fathers acknowledge paternity at the hospital. Paternity is established later for 57 percent of the remaining newborns. Telephone conversation with Barry Berger, Assistant Chief of Program Operations, Child Support Enforcement, Division of Social Services, North Carolina Dep’t of Health and Human Services, Raleigh, N.C. (Mar. 23, 2000).

86. G.S. 49-14.

87. G.S. 110-132.

for child support. The General Assembly requires both sets of grandparents to support a child when one or both parents are unemancipated minors who together do not provide full support for their child.⁸⁸ If another person or an official of an agency, organization, or institution stands *in loco parentis* to the minor parent, that party too can become responsible for support.

Out-of-Home Placement

A parent who feels unable to care for a child should contact DSS. Some departments will accept a child temporarily and let the parent reclaim him or her months later. (A court must review a parent's voluntary placement of her child with DSS within 90 days of the event, and the child may not stay in voluntary placement more than six months unless DSS asks a court to declare the child abused, neglected, or dependent.)⁸⁹ Other departments rarely accept custody unless a parent is willing to give up the child permanently or a court has found the child to be abused, neglected, or dependent. (See the section "Abuse, Neglect, Dependency, Sexual Assault.") An important instrument of social services policy, state and federal, is "permanency planning"; that is, developing "a plan to achieve a safe, permanent home" for a child "within a reasonable period of time."⁹⁰ Toward that goal, departments usually move within months, or at most a year or two, to reunite a family or to arrange for a permanent alternative, which may include termination of parental rights.⁹¹

Adoption

The most permanent arrangement that a parent who cannot raise a child can choose is adoption. Although minors of any age are legally able to offer a child for adoption,⁹² few make this choice—only 2 to 5 percent of

88. G.S. 50-13.4.

89. G.S. 7B-910. The state statute is based on federal requirements intended to secure a permanent home for children as soon as possible.

90. G.S. 7B-907(a).

91. G.S. 7B-907.

92. G.S. 48-3-605(b).

unmarried adolescent mothers.⁹³ Apparently far more teens consider placing their children for adoption than do so—12 percent in one study, even though 89 percent predicted a negative reaction from partner, friends, or family members.⁹⁴

Health care providers may not realize how important their views on adoption are to their adolescent patients. In one study, researchers found that among teens considering adoption, “While the most influential person was the adolescent’s mother, over half of respondents solicited advice [on legal adoption] from a professional—usually a physician or a nurse (the importance of providing counseling in health care facilities seems salient).”⁹⁵ A North Carolina adoption specialist reports that it is “all too common and can be extremely destructive” for a minor who has tentatively decided on adoption to face disapproval from one or more health care providers. According to this source, such interactions occur most frequently during hospitalization for delivery.⁹⁶

The AAP advises members to know state laws on adoption⁹⁷ and to indicate repeatedly to patients during pregnancy that the provider is willing to discuss the subject.⁹⁸ For their legal protection, providers should counsel patients and other parties about adoption for the same fee (no more, no less) they normally charge patients for other counseling. Otherwise they might

93. One source reports 5 percent: JUDITH MUSICK, YOUNG, POOR, AND PREGNANT: THE PSYCHOLOGY OF TEENAGE MOTHERHOOD 18 (1993); another, 3 percent: RICKIE SOLINGER, *Introduction*, in THE ABORTION WARS (1998); and, according to the AAP, 2 to 4 percent: *The Adolescent’s Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746–51 (May 1996) and at www.aap.org.

94. Sandven & Resnick, *supra* note 16 at 217.

95. *Id.* at 220.

96. Telephone conversation with Sandy M. Cook, Director, Children’s Home Society of North Carolina (Mar. 2, 2000).

97. *Issues of Confidentiality in Adoption: The Role of the Pediatrician*, in AAP POLICY REFERENCE GUIDE at 473 and at www.aap.org.

98. *Counseling the Adolescent Concerning Pregnancy Options*, in AAP POLICY REFERENCE GUIDE at 180 and at www.aap.org.

inadvertently violate criminal statutes barring unauthorized persons from various kinds of involvement in adoptions.⁹⁹

Questions and Answers

Below are some of the principal questions that young obstetric patients may have about adoption and brief answers under North Carolina law.

1. Do my parents have to agree to my baby's adoption?

No. Whatever your age, you, rather than your parents, decide whether to let the baby be adopted.¹⁰⁰ By the same token, if your parents want the baby to be adopted and you do not, you do not have to agree.

2. Does the baby's father have to agree to adoption?

The baby's father does have legal rights. He could stop an adoption if you and he married, if he took legal responsibility for the baby in any of a number of ways, supported you or the baby, or was ordered by a court to support the baby.¹⁰¹ He can lose the right to object to adoption, though, by not responding to notice from those hoping to adopt that an adoption is scheduled to take place. Another way for an unmarried father to lose his parental rights is to sign a notarized statement denying that he is the father or indicating that he does not have a legal interest in the baby.¹⁰²

3. If I agree to adoption, could the baby's father or his family adopt the baby?

A father can always try to get custody, whether or not you are trying to have the baby adopted. But you can prevent the father or his family from gaining custody of the child *as a result of* the adoption process. If you choose the

99. G.S. 48-10-101 and -102.

100. G.S. 48-3-605(b).

101. G.S. 48-3-601.

102. G.S. 48-3-603.

person who adopts the baby,¹⁰³ you and that person can agree, in writing, that if the father tries to claim the baby before the adoption, you will take the baby back.¹⁰⁴ If an agency handles the adoption, you can agree to give up the baby only on the condition that the child be adopted by a particular family that has been described to you. (The legal term for setting a condition about who will adopt is *designated relinquishment*.) Be sure that the relinquishment form you sign says that if the adoption does not work out you want to be notified so that you can take the baby back.

4. Can I talk to an adoption agency or a person who wants to adopt my baby and then decide against adoption? What about changing my mind?

Certainly, you can explore placing your child for adoption and decide not to. You have any amount of time you want before deciding, and you have a brief time after agreeing to adoption to change your mind. A mother cannot agree to her baby's adoption until the baby is born, though the baby's father can.¹⁰⁵ Once you sign a consent to adoption, you usually have seven days to change your mind.¹⁰⁶

5. Can I choose the family that will adopt my baby?

Yes. You might choose someone you know, who (unless he or she is a close relative) would have to be investigated before being approved as an adoptive parent. Or you could let an adoption agency or the DSS find a family. If you do not want to name a particular person, you can still say what kind of per-

103. This kind of adoption, if arranged by a baby's parent, is called *direct adoption* (see G.S. 48-3-202) or, if an agency is involved, a *designated agency adoption* [see G.S. 48-3-703a(5)(b)].

104. G.S. 48-3-609(a)(2). Both you and the baby's father might then seek custody. Having previously consented to adoption will not prevent a mother from being awarded custody. G.S. 50-13.2(d).

105. G.S. 48-3-604(a) and (b).

106. G.S. 48-3-608 and -706. In a few circumstances the periods could be shorter or longer.

son or family you would like.¹⁰⁷ Most agencies would let you choose from descriptions or pictures or from meeting a couple already approved for adoption. Whatever way an adoptive parent is selected, though, a court must find that person suitable before it will approve an adoption.¹⁰⁸

6. If I don't choose someone I know or a family described to me, will I ever know anything about the parents?

Most agencies (including social services departments) will tell you about the adopting family and may show you pictures or let you and the adoptive parents speak by phone or meet. If knowing about the family is important to you, ask adoption agencies, before you choose one, how much information they would give you. You might learn the most from asking whether you could read the "home study" done on each possible adoptive family. Agencies are required by law to answer your questions about their process and to place your child with a couple if the agency agrees to let you select one.¹⁰⁹

7. Will I have to pay to have my baby adopted?

No. There are no charges.

8. Can the adoptive parents give me money?

They can pay your ordinary living expenses during pregnancy and for six weeks afterward. They can also pay counseling, medical, and legal fees.¹¹⁰ You can accept this money and still change your mind about letting the baby be adopted. The money is not payment for the baby.¹¹¹

107. G.S. 48-3-201 through 48-3-203.

108. G.S. 48-2-603.

109. G.S. 48-3-203(b).

110. G.S. 48-10-103.

111. It is a crime to give or to take money for a baby. G.S. 48-10-102.

9. Can I visit or hear about my baby as it grows up?

You will have no legal right to do so, not even if you choose the adoptive parents. If they promise that you will be able to contact the child, they might keep the promise, but they do not have to.¹¹²

10. Can the baby find me when he or she is grown?

If your grown child wants to find you, and you want to be found, probably yes. North Carolina has not created a system for adult children and birth parents to contact one another, but there are registries in the United States that match inquiries from birth parents and children.

11. Why should I think about adoption if a relative or friend will keep the baby?

Actually, more than half of all adoptions are by relatives. Letting a friend or relative adopt, rather than just keep your baby, would help that person care for the baby. As an adoptive parent, your relative or friend could much more easily act for and gather resources for the baby—get the baby medical care, enter him or her in school, and apply for health insurance or other benefits, for example. Still, you must understand that *after adoption, the person becomes the baby's parent for all legal purposes.*

12. Are there places I could go for a while, have the baby, and then return home? If so, how can I find one?

Yes. They are called maternity homes, and there are several in North Carolina. One way to locate a maternity home is to ask an adoption agency for information about them. Adoption agencies also have information about state funding that might be available to pay for a maternity home stay.

112. G.S. 48-3-610.

Additional Care Considerations

ABSTRACT

The needs of pregnant minors, especially early adolescents, differ in some ways from those of adult patients. Many minors need advice on abstinence, contraception, and sexually transmitted disease control. State law gives minors a right to confidential care in these areas except in extraordinary circumstances. Providers should watch for evidence that these patients are mistreated by caretakers, partners, or others and, if found, report it if required or discuss the matter with the patient.

TAKING THE HISTORY

Girls who become pregnant at an early age often have been leading more difficult lives than older teens and, certainly, adults.¹ It would be prudent for providers to take particularly careful histories from these patients for legal and medical reasons—to resolve questions about consent to treatment or patient discharge, for instance; and to understand risk factors, the patient's ability to comply with treatment, and the need for patient and family education.

A patient's sexual history can yield important clues about neglect, abuse, and assault, which are known to be associated with early adolescent pregnancy.²

1. JUDITH MUSICK, YOUNG, POOR, AND PREGNANT: THE PSYCHOLOGY OF TEENAGE MOTHERHOOD especially 127–29 (1993). Also, interview with Carol A. Ford, Assistant Professor of Pediatrics and Internal Medicine and Director, UNC Adolescent Medicine Program, Chapel Hill, N.C. (Mar. 3, 1999).

2. M. Jocelyn Elders, *Adolescent Pregnancy and Sexual Abuse*, 280 JAMA 648–49 (Aug. 19, 1998); Harold P. Gershon et al., *The Prevalence of Coercive Sexual Experience among Teenage Mothers*, 4 J. INTERPERSONAL VIOLENCE 204–19 (June 1989).

The AAP recommends that pediatricians “be prepared to obtain a developmentally appropriate sexual history on all adolescent patients.”³

Certain data—age at first intercourse, number and age of partners, screening for STDs, and patient concerns about intercourse or pregnancy—often are missing in the medical records of pregnant adolescents. In one set we reviewed, age at first intercourse was recorded for only thirty-one of fifty girls. The possible value of the missing information can be inferred from what *was* recorded: Two of the thirty-one said they were raped at age seven. A third stated that she began intercourse “voluntarily” (the provider’s word) at age ten. Two more began intercourse at age eleven.

Attending to a young patient’s personal history and social context is appropriate recognition that she is still in part a pediatric patient, that sexual activity at a young age usually is related to maltreatment,⁴ and that pregnancy in early adolescence can be either a cause or effect of psychic distress. Compiling a psychosocial history alerts providers to matters that a pregnant adolescent may want help with, and this in turn improves the chances of good outcomes for her and her child.⁵

Data collection will be easier if staff know the importance of complete history taking for these patients, can allow additional time for it, and will check their assumptions and ask open-ended questions.⁶ For example,

3. Recommendation 2 in *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 *PEDIATRICS* 516–20.

4. “Some 74% of women who had intercourse before age 14 and 60% of those who had sex before age 15 report having had sex involuntarily.” ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA’S TEENAGERS* 22 (1994).

5. Personal communication to Anne Dellinger from Carol A. Ford, Assistant Professor of Internal Medicine and Pediatrics and Director, UNC Adolescent Medicine Program, Chapel Hill, N.C. (Dec. 30, 1999).

6. This statement is based on our observation that the social worker’s note in a medical record often contained the most complete and accurate patient history. Unfortunately, in the facility from which most of our records came, the social work interview usually took place just before discharge, so its results were not available to doctors, nurses, and other staff when they might have acted on them.

“Who lives in your home?” is likely to elicit a more fruitful response than would “Do you live with your mother?” The patient who wants to meet what she believes to be her providers’ expectations may answer “yes” to the latter question even though her grandmother is the head of household and a more constant presence in the girl’s life. Or after answering “yes,” the patient may not mention other household members whose presence could affect her ability to care for a newborn.

CONTRACEPTION

National organizations of providers advise confidential counseling of young patients about responsible sexual behavior, including abstinence, and offering them the means to protect themselves against an unplanned pregnancy beginning at age eleven.⁷ The AAP recommends that pediatricians encourage and support abstinence but also inform teens about contraceptives.⁸ North Carolina law allows minors independent access to contraception.⁹ Family planning clinics including those in local health departments offer services to minors and must, as a condition of state or federal funding, counsel minors “about the importance of discussing birth control needs

7. AMERICAN MEDICAL ASSOCIATION (AMA), GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES (GAPS): RECOMMENDATIONS FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS 1995–99 (hereafter, *GAPS Recommendations*) (www.ama-assn.org). For American Academy of Pediatrics (AAP) recommendations, see *The Adolescent’s Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746–51 (May 1996); *Counseling the Adolescent about Pregnancy Options*, 101 PEDIATRICS 938–40 (May 1998); and AAP Committee on Adolescence, *Contraception and Adolescents*, 104 PEDIATRICS 1161–66 (Nov. 1999). All are available at www.aap.org.

8. *Contraception and Adolescents*, 104 PEDIATRICS 1161–66 (Nov. 1999) and www.aap.org.

9. G.S. 90-21.5.

with parent(s).”¹⁰ Thus minors are strongly encouraged to tell their parents about their contraceptive care but are not required to do so in order to obtain contraception.

Some young obstetric patients do not fully understand reproduction and reproductive health. In that respect, they are typical teens. A 1999 survey of more than one thousand high school students showed widespread ignorance. Most girls did not know about emergency contraception. Of those who were sexually active, 39 percent did not know that they could obtain birth control pills without a parent’s permission and 47 percent did not know that an STD increases the chance of contracting HIV during sex. Yet, the high school students were quite aware that they lacked information. Roughly half of those surveyed—more or less, depending on the item—wanted information on contraception, STDs, HIV, handling the pressure to have sex, and dealing with rape or sexual assault.¹¹

Minors as a group are at high risk for unintended pregnancies, and as many as one-quarter of adolescent girls who conceive have had one or more prior clinic visits resulting in a negative pregnancy test result.¹² Although sexually active teens are using contraception more often and more effectively,¹³ the youngest are the least likely to do so.¹⁴ Moreover contraception

10. DIVISION OF WOMEN’S AND CHILDREN’S HEALTH, NORTH CAROLINA DEP’T OF HEALTH AND HUMAN SERVICES, SUBSECTION 6C, SECTION D: QUALITY ASSURANCE DELIVERABLES, FAMILY PLANNING ADDENDUM TO THE CONSOLIDATED CONTRACT (n.d.).

11. KAISER FAMILY FOUNDATION, KAISER FAMILY FOUNDATION NATIONAL SURVEY OF SECONDARY SCHOOL STUDENTS ABOUT SEXUAL HEALTH ISSUES AND SERVICES (www.kff.org).

12. Such visits can be an opportunity to counsel sexually active teens. See Luella Klein & Felicia Stewart, *Preconception Care*, in ROBERT A. HATCHER ET AL., *CONTRACEPTIVE TECHNOLOGY* at 624–25 (17th revised ed. 1998), citing L. S. Zabin et al., *Adolescents with Negative Pregnancy Tests*, 275 *JAMA* 113–17 (1996).

13. THE ANNIE E. CASEY FOUNDATION, *WHEN TEENS HAVE SEX: ISSUES AND TRENDS* 8–9 (1998).

14. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA’S TEENAGERS* 33 (1994).

fails more often among women who are young, unmarried, low-income, and African American or Latina.¹⁵

STERILIZATION

In only a very few of the records we studied had a minor asked to be sterilized and a physician been willing to consider it.¹⁶ State law does allow married minors to be sterilized—after all, they are emancipated. An unmarried minor, though, may only be sterilized if

- she gives written consent,
- her parent or guardian files a request with a juvenile court, and
- the court finds that the surgery would be in her best interest and
- the court issues an order authorizing a physician to perform the operation.¹⁷

Providers should proceed with considerable caution about liability in this area, however, paying particular attention to assuring that the minor's consent is informed and voluntary. Federal funds cannot be used.¹⁸

15. Markus J. Steiner, *Contraceptive Effectiveness: What Should the Counseling Message Be?* 282 JAMA 1405 (Oct. 20, 1999).

16. In two of the records we reviewed, the patients requested sterilization. One young woman had had four children, the other woman five, before the age of eighteen.

17. G.S. 90-272.

18. Family planning [42 C.F.R. § 50.203(a)] and Medicaid (42 C.F.R. § 441.253) funds cannot be used to sterilize anyone under twenty-one.

SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV

Sexually transmitted diseases (STDs)¹⁹ pose serious health risks for teens in the United States.²⁰ In 1998, among ten- to fourteen-year-old girls, North Carolina recorded 9 cases of syphilis, 254 of gonorrhea, and 536 of chlamydia.²¹ Treatment for an STD was noted in many of the records of early adolescent pregnancies we reviewed. About 20 percent (35 of 186) of the patients had STDs diagnosed during their pregnancy; for another 11 patients, an STD was identified during preparation for an abortion or during labor. These diseases disproportionately affect African-American and Latino youth,²² and in North Carolina a majority of the youngest pregnant group

19. STDs are also referred to as STIs (sexually transmitted infections). STIs and common infections of the genital tract are collectively referred to as reproductive tract infections (RTIs). These RTIs have serious health consequences: tubal occlusion, pregnancy loss and neonatal morbidity, genital cancers, and enhanced HIV-transmission. STDs may include HIV, syphilis, gonorrhea, chlamydia, and the pelvic inflammatory disease that can follow from either of the last two diseases, as well as trichomoniasis, herpes genitalis (HSV), human papillomavirus (HPV), and other conditions. Hepatitis B also may be transmitted through sexual activity. Willard Cates, Jr., *Reproductive Tract Infections*, in ROBERT A. HATCHER ET AL., *CONTRACEPTIVE TECHNOLOGY* at 187–88 (17th revised ed. 1998).

20. Ralph J. DiClemente, *Preventing Sexually Transmitted Infections among Adolescents*, *A Clash of Ideology and Science*, 279 *JAMA* 1574 (May 20, 1998).

21. Telephone conversation with Nannie D. Staggers, State Ctr. for Health Statistics, North Carolina Dep't of Health and Human Services, Raleigh, N.C. (Feb. 21, 2000).

22. Rochelle N. Shain et al., *A Randomized Controlled Trial of Behavioral Intervention to Prevent Sexually Transmitted Disease among Minority Women*, 340 *NEW ENG. J. MED.* at 93 (Jan. 14, 1999). See also John B. Jemmott III et al., *Abstinence and Safer Sex: HIV Risk-Reduction Interventions for African American Adolescents*, 279 *JAMA* 1529 (May 20, 1998); Philip S. Rosenberg et al., *Trends in HIV Incidence among Young Adults in the United States*, 279 *JAMA* 1896–99 (June 17, 1998).

belong to a minority race.²³ The portion that is Latina, while still small, is growing.²⁴

Teens are relatively well informed about HIV transmission, but they are ignorant on some important points and want to know more.²⁵ The AMA recommends talking to adolescent patients annually about STDs and making latex condoms available.²⁶ The AAP strongly emphasizes the danger of HIV transmission to adolescents. The Academy considers it essential that pediatricians counsel all adolescents about HIV infection, the “correct and consistent use of latex condoms” to prevent infection, and the availability of testing. For teens who are sexually active or substance abusers, testing is encouraged.²⁷ Under North Carolina law, a patient must specifically consent to be tested for HIV before a physician may order the test,²⁸ and the patient must be “counseled appropriately” when told of the result.²⁹ Although a patient’s written consent is not required by statute, it would be advisable for liability protection.

23. For girls ages nine to fourteen, the number was 376 of 574 pregnancies reported in 1999. STATE CTR. FOR HEALTH STATISTICS, NORTH CAROLINA DEP’T OF HEALTH AND HUMAN SERVICES, NORTH CAROLINA REPORTED PREGNANCIES (1999).

24. The State Center for Health Statistics does not record pregnancies in a Hispanic or Latina category, but an increase can be inferred from the increase in Hispanic births to mothers of all ages between 1990 (1,752) and 1998 (8,095). Office of State Planning Website: www.ospl.state.nc.us. In 1998, 1,382 children were born to Hispanic adolescents (nineteen and under) in North Carolina. Thirty-eight were born to girls under age fifteen. State Ctr. for Health Statistics, North Carolina Dep’t of Health and Human Services, Raleigh, N.C. (Sept. 15, 1999).

25. KAISER FAMILY FOUNDATION, NATIONAL SURVEY OF TEENS ON HIV/AIDS 2000, www.kff.org.

26. Recommendation 9 in *GAPS Recommendations*, *supra* note 7.

27. AAP COMMITTEES ON PEDIATRIC AIDS AND ON ADOLESCENCE, *Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention*, 107 *Pediatrics* 188–90 (Jan. 2001) and at www.aap.org.

28. G.S. 130A-148(h).

29. G.S. 130A-148(g).

STD testing and counseling are advisable for pregnant teens as well. As in the case of birth control and pregnancy, North Carolina law lets minors ask for medical care for the prevention, diagnosis, and treatment of “venereal diseases and other” reportable communicable diseases. All STDs are venereal³⁰ diseases, and most are also included in the “reportable” category. The state Commission for Health Services decides which diseases are to be reported,³¹ and physicians, diagnostic laboratories, school principals, and child care operators must inform the local health director of each case they encounter.³² Medical facilities may report but are not required to do so.³³ If a reportable disease is diagnosed, state law requires “the attending physician” to teach patients how to prevent its transmission.³⁴

Providers (and everyone else) must keep information and medical records about reportable disease cases confidential.³⁵ Administrators of health care

30. “Venereal. Relating to or resulting from sexual intercourse.” *STEDMAN’S MEDICAL DICTIONARY* (26th ed. 1996).

31. G.S. 130A-134. Currently the list of reportable diseases and conditions includes these possible STDs: AIDS, chancroid, chlamydial infection, gonorrhea, granuloma inguinale, HIV, lymphogranuloma venereum, nongonococcal urethritis, and syphilis. 15A NCAC 19A.0101; Amended Eff. March 1, 1988; Amended Eff. October 1, 1994; February 1, 1990; Temp. Amend. Eff. July 1, 1997; Amended Eff. August 1, 1998; Temp. Amend. Eff. June 1, 2001. *See also* 15A NCAC 19A.0204, Eff. December 1, 1991; Amended Eff. July 1, 1993. Pregnant women must be tested “early in pregnancy” and in the third trimester, and women at “high risk” for exposure to syphilis and gonorrhea must be tested for them again at time of delivery. 15 NCAC 19A.0204(c). Eff. December 1, 1991; Amended Eff. July 1, 1993.

32. Physicians must report if they have “reason to suspect” a case in someone “about whom the physician has been consulted professionally,” G.S. 130A-135. Principals and child care operators must report a suspected case in any person within the school or facility. G.S. 130A-136.

33. G.S. 130A-137.

34. G.S. 130A-144 requires the Commission for Health Services to prescribe control measures, which it does in the state’s administrative code: 15A NCAC 19A.0204—Control Measures—Sexually Transmitted Diseases (1991, *amended* 1993) and 15A NCAC 19A.0202—Control Measures—HIV (1988, *temporary amendment, recodified, or amended* 1989, 1990, 1991, 1992, 1994, 1995).

35. G.S. 130A-143.

facilities should be especially careful not to use billing practices that breach confidentiality. Before releasing communicable disease information, providers must consult the confidentiality statute itself—the summary immediately following is not sufficiently detailed—and they should also seek legal advice. The exceptions to the law, that is, the situations in which information about a reportable disease case might be released, meet one of the following general criteria:

- Data released is nonidentifying statistical information.
- Data is released
 - with the patient’s written consent, or
 - to health care personnel caring for the patient, or
 - for public health purposes, or
 - for judicial or law enforcement purposes, or
 - for research.

ABUSE, NEGLECT, DEPENDENCY, SEXUAL ASSAULT

Nationally, 30 percent of fifteen-year-olds who give birth have been reported to have partners who are six or more years older than they are.³⁶ In North Carolina, having sex with a person who is under age sixteen and four or more years younger is a sexual assault. (Sexual assaults are described more fully at the end of this section.) The older partner commits statutory rape, even though the younger person acquiesces. Then, too, a young girl’s pregnancy might indicate sexual abuse by a parent or caretaker or that she was not properly supervised. Failure to supervise one’s child is legally defined as neglect.³⁷ A parent’s approval of a daughter’s inappropriate sexual relationship also might be considered neglect.

36. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA’S TEENAGERS* 53 (1994).

37. G.S. 7B-101(15).

Be aware that, under the legal definitions, only a parent or other caretaker can abuse or neglect a child. It is this mistreatment or the inability to care for a child—on the part of a caretaker, not other persons—that must be reported to DSS. Of course, if someone does not know *who* is harming a child, he or she should certainly report.

A young girl's pregnancy should always raise questions for providers: Has the patient been sexually assaulted? Neglected or abused? Is she dependent? (*Dependent* is a legal term that does not imply fault on the part of the caretaker. It describes a minor who has "no parent, guardian, or custodian responsible for . . . care or supervision or whose parent, guardian, or custodian is unable to provide for the care or supervision and lacks an appropriate alternative child care arrangement.")³⁸ An adolescent, her baby,³⁹ or both, might be abused, neglected, or dependent. A provider's reasonable suspicion that any of these is true triggers a duty to report.

All providers (in fact, "any person or institution") must report possible abuse, neglect (that is, mistreatment by a *caretaker*), or the dependency of a minor. The process is as follows: A provider with a reasonable suspicion that a young patient's caretakers are harming her or cannot care for her tells what she or he knows or suspects to DSS in the county where the minor "resides or is found."⁴⁰ For the provider's legal protection, he or she should clearly document the date and time of the report, the name of the person to whom it was made, and what information the provider gave. DSS then moves to protect the minor about whom the report was made and, if necessary, other children in the home.⁴¹ If DSS opens an investigation, providers must cooperate with it. A DSS director or representative has the right to see any information, including medical records, that the director

38. G.S. 7B-101(9).

39. One study's major conclusion was that, "Childbearing at an early age was strongly associated with infant homicide, particularly if the mother had given birth previously." Mary Overpeck et al., *Risk Factors for Infant Homicide in the United States*, 339 NEW ENG. J. MED. 1211–16 (Oct. 22, 1998).

40. G.S. 7B-301.

41. G.S. 7B-302(b).

thinks may be relevant to an investigation.⁴² Although a patient might guess where the report came from, DSS does not identify reporters.⁴³ After an investigation, DSS must tell the reporter the outcome of its inquiry.⁴⁴

If a provider fears harm to a minor patient before a report can be made and DSS can investigate, there are other choices. Providers may ask DSS or law enforcement to take the patient into temporary custody,⁴⁵ or seek a court order under a statute allowing a physician or administrator of a medical facility to keep a minor for up to twelve hours.⁴⁶ Among other requirements of the statute, a physician must certify that (1) she has examined the minor (2) the minor may have been abused and (3) the minor should remain for medical treatment or because it is unsafe to return to the parent or guardian. Consult the statute for a full explanation of the process.

As noted earlier, sometimes a provider who suspects that a minor patient is being mistreated will not know *who* is mistreating her or what the person's relationship is to the patient. In our opinion, unless a provider knows that the person who may be harming a minor is *not* a parent or caretaker, the provider should report what is known about the situation to DSS. The DSS director then deals with the matter if it is abuse, neglect, or dependency or, if it is not, conveys the information to the district attorney.⁴⁷

*Reporting Child Abuse and Neglect in North Carolina*⁴⁸ by Janet Mason is a very useful source for providers. It explains essential terms such as

42. G.S. 7B-302(e) & 7B-303. A health provider, administrator or medical record custodian should ask for proper identification from a DSS representative before discussing the patient or family or showing medical records. If DSS needs record information, naturally the representative should be given copies rather than the original.

43. G.S. 7B-302(a).

44. G.S. 7B-302(g).

45. G.S. 7B-500 lets a DSS worker or law enforcement officer take temporary custody "if there are reasonable grounds to believe that a juvenile [a minor] is abused, neglected, or dependent and that the juvenile would be injured or could not be taken into custody if it were first necessary to obtain a court order."

46. G.S. 7B-308.

47. G.S. 7B-307(a).

48. Institute of Government, The University of North Carolina at Chapel Hill (1996).

reasonable suspicion, caretakers, abuse, and neglect, describes the reporting process and its possible resolutions, and offers helpful advice. Mason emphasizes, “*if in doubt, make the report.*”⁴⁹

Medical guidelines support legal requirements to report abuse and neglect. The AMA recommends that every adolescent patient “be asked annually about a history of emotional, physical, and sexual abuse.”⁵⁰ Similarly the AAP urges providers to “be sensitive to the possibility of sexual abuse or incest in the young or developmentally delayed pregnant adolescent.”⁵¹

Sexual involvement between a minor and a caretaker must be reported as child abuse. If a partner is not a caretaker the involvement may be a crime (sexual assault), depending on the ages of the partners, but reporting it probably is not required. Only a few crimes must be reported in North Carolina. Treating physicians and health facilities are required to report illness or injury resulting from firearms, knives, or poison or “grave bodily harm or grave illness if it appears . . . that the wound, injury or illness resulted from a criminal act of violence.” These reports are made to law enforcement authorities.⁵²

Since providers are not required to report sexual assaults, including statutory rape, unless they meet the definition above, what to do is unfortunately both a hard question and a common situation. Difficulties arise from at least three sources. First, some providers will wonder whether any purpose is served if the crime is reported. Immediately after the recent change in state law raising to sixteen the age at which minors can consent to intercourse, prosecutions were rare. Some prosecutors may have shared public perceptions that young girls, like adult women, must take full responsibility for their sexual behavior, or that sex between minors and older people is uncommon. Others perhaps thought convictions unlikely, or that the new penalties for statutory rape and sex involving young teens were too se-

49. *Id.* at 33.

50. Recommendation 21 in *GAPS Recommendations*, *supra* note 7.

51. *Counseling the Adolescent about Pregnancy Options*, 101 *PEDIATRICS* 938–40 (May 1998) and at www.aap.org.

52. G.S. 90-21.20.

vere.⁵³ Second, providers may hesitate to raise the subject of sexual assault because they fear that asking a girl about her partner may drive her away from medical care. Third, providers may realize that they could be liable for violating patient confidentiality by reporting these situations, since reporting sexual assault is not required by law.

On the first point, whether pre- and early-teen sexual activity truly is voluntary, there is considerable evidence that often it is not.⁵⁴ A young female ordinarily has less power and experience than her partner and, in addition, may have been directly coerced. A substantial age difference “may make it hard for the young woman to resist [a partner’s] approaches and even more difficult for her to insist that contraceptives be used to prevent STDs and pregnancy.”⁵⁵ Judith Musick, who researches teen pregnancy and works with teen mothers, states that, while girls may appear to be eager initiators of sex, that “is probably not the case for many girls who become mothers in their teens, and it is surely not the case for those who become pregnant in their very early teens.”⁵⁶ One study found that 61 percent of teen mothers reported at least one coercive sexual experience, almost 30 percent reported coercion by a family member, and more than 50 percent reported coercion by a male friend. Of the males mentioned by study participants, 46 percent

53. *No Convictions under Tougher Statutory Rape Law*, RALEIGH NEWS & OBSERVER, Nov. 26, 1997, at 3A.

54. For example, the U.S. Department of Justice, in a survey of twelve states, including North Carolina, found that a majority of all forcible rape victims were minors and that 38 percent of those minors were under age twelve. Pierre Thomas, *Rape of Girls Is Common, Study Finds: Half of All Victims Are under Age 18*, WASHINGTON POST, June 23, 1994, at A1.

55. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA’S TEENAGERS* 74 (1994). See also David J. Landry & Jacqueline Darroch Forrest, *How Old Are U.S. Fathers?* 27 FAM. PLAN. PERSP. 159, 165 (1995). For a general discussion of the legal context, see SHARON ELSTEIN & NOY DAVIS, ABA CTR. ON CHILDREN AND THE LAW, *SEXUAL RELATIONSHIPS BETWEEN ADULT MALES AND YOUNG TEEN GIRLS: EXPLORING THE LEGAL AND SOCIAL RESPONSES* (1997).

56. JUDITH MUSICK, *YOUNG, POOR, AND PREGNANT: THE PSYCHOLOGY OF TEENAGE MOTHERHOOD* 74 (1993).

were more than ten years older than their partners.⁵⁷ As if in recognition of this problem, prosecution of statutory rape and related offenses has increased in North Carolina lately. There were convictions on thirty-six such charges in 2000.⁵⁸

As to the third point, the safest legal course for providers to take is to encourage a young patient to end a criminal relationship and consider either reporting the crime herself or telling her parents so that they can report it. (Remember that a treating physician who learns of a situation where notifying a minor patient's parents may be "essential to the life or health" of the patient *must* tell her parents.)⁵⁹ All providers should initiate discussions with the young pregnant patient about an inappropriate relationship and, if she is willing, with her parents. Health department providers are required, under the contract between the local department and the State of North Carolina, to try to help minors resist coercive sexual activities.⁶⁰ Providers can also help by knowing and explaining to patients and their families the criminal law on intercourse with minors. The following activities are criminal in North Carolina:

- Intercourse between someone twelve or younger and a person at least four years older is first-degree rape, a crime that carries severe penalties.⁶¹

57. Harold P. Gershon et al., *The Prevalence of Coercive Sexual Experience among Teenage Mothers*, 4 J. INTERPERSONAL VIOLENCE 204 (June 1989).

58. Information from the North Carolina Administrative Office of the Courts, Raleigh, North Carolina, March 6, 2001.

59. G.S. 90-21.4.

60. "All minors will be: (1) offered counseling on how to resist coercive attempts to engage in sexual activities; (2) provided counseling in cases where the minor requests it; and (3) provided counseling and other appropriate services where there is physical evidence or evidence by history that such counseling is indicated." DIVISION OF WOMEN'S AND CHILDREN'S HEALTH, NORTH CAROLINA DEP'T OF HEALTH AND HUMAN SERVICES, SUBSECTION 5D, SECTION D: QUALITY ASSURANCE DELIVERABLES, FAMILY PLANNING ADDENDUM TO THE CONSOLIDATED CONTRACT (n.d.).

61. G.S. 14-27.2.

- If one partner is between thirteen and fifteen and the other is four or more years older, their intercourse is called statutory rape (i.e., intercourse that apparently is consensual but involves a person who is legally too young to consent). Statutory rape is a serious felony, and it carries even greater penalties if one partner is six or more years older than the other.⁶²
- Intercourse “by force and against the will” of one partner, no matter what their ages, is second-degree rape. The force need not be physical; inducing fear can be enough.⁶³
- Regardless of age, incest between grandparent and grandchild; parent and child or stepchild; or brother and sister is a felony,⁶⁴ as is intercourse with a minor residing in a home where the adult partner has the position of a parent.⁶⁵ (If these relationships involved a caretaker they would also be child abuse and as such would have to be reported.)

DOMESTIC VIOLENCE

Pregnant or parenting adolescents are at substantial risk of domestic violence. Women in the United States report partner assaults in alarming numbers,⁶⁶

62. G.S. 14-27.7A.

63. G.S. 14-27.3.

64. G.S. 14-178.

65. G.S. 14-27.7.

66. One of the lower rates reported is that in a study of women presenting for emergency care: 54 percent of women seen in five Denver emergency departments reported having been threatened or injured by an intimate partner at some point in their lives. Twenty-four percent had been injured by their current partner. The study excluded women under age eighteen and those presenting for labor and delivery, which according to other studies may explain the lower incidence of violence reported. Jean Abbott, et al., “Domestic Violence Against Women: Incidence and Prevalence in a Department Population,” 273 JAMA 1763 (June 1995). Men also suffer domestic violence, but researchers conclude, based on frequency, severity, and

and far more violence is thought to occur than is reported.⁶⁷ Moreover, the danger is greater both to adolescent⁶⁸ and to pregnant⁶⁹ women than to women in general. If a pregnant adolescent is abused, there is also the possibility of harm to her pregnancy⁷⁰ and to infants and young children. About half of men who abuse partners also abuse children living in the home.⁷¹

A North Carolina statute defines domestic violence as a (specified) wrongful act against a person—or a minor child living with or in the custody of the person—by someone with whom the person has, or has had, a personal relationship.⁷² Notice that under the definition the partners need not live together. This is important in the case of adolescents because they often are not

fear of injury, that “intimate partner violence should be considered first and foremost a crime against women.” PATRICIA TJADEN and NANCY THOENNES, *EXTENT, NATURE, AND CONSEQUENCES OF INTIMATE PARTNER VIOLENCE*, U.S. Department of Justice: Washington, D.C. 2000, at 55. In a recent year in North Carolina crisis centers received 34,902 calls from a woman and 2,113 from a man. REPORT OF THE NORTH CAROLINA COUNCIL FOR WOMEN’S DOMESTIC VIOLENCE PROGRAM, July 1, 1999, to June 30, 2000.

67. VIOLENCE, position paper of THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, 2000, at www.aafp.org.

68. Twenty-six percent of pregnant teens report physical abuse from partners, and 40 to 60 percent of those young women, depending on the study, say the abuse began or increased with pregnancy. Nancy Worchester, “A More Hidden Crime: Adolescent Battered Women,” THE NETWORK NEWS, NATIONAL WOMEN’S HEALTH NETWORK, July/Aug. 1993 at 4.

69. Isabelle L. Horon and Diana Cheng, *Enhanced Surveillance for Pregnancy-Associated Mortality—Maryland 1993–1998*, 285 JAMA 1455–1459 (March 21, 2001); Constance M. Weimann et al., *Pregnant Adolescents: Experiences and Behaviors Associated with Physical Assault by an Intimate Partner*, 4 MATERNAL AND CHILD HEALTH J. 93101 (2000); and Barbara Parker et al., *Physical and Emotional Abuse In Pregnancy: A Comparison of Adult and Teenage Women*, 42 NURSING RESEARCH 173–77 (1993).

70. MARCH OF DIMES BIRTH DEFECTS FOUNDATION, FACT SHEET: DOMESTIC VIOLENCE & TEEN PREGNANCY (1996).

71. AMERICAN PSYCHOLOGICAL ASSOCIATION, VIOLENCE AND THE FAMILY: REPORT OF THE APA PRESIDENTIAL TASK FORCE ON VIOLENCE AND THE FAMILY. Washington, D.C. (1996) at 80. (Hereafter, APA REPORT).

72. G.S. 50B-1.

married to or living with their partner. In other words, domestic violence does include dating behavior and acts between non-cohabiting sexual partners, as well as behavior between relatives.

What is necessary for domestic violence is that the two parties have a personal relationship, past or present. The relationship can be that of current or former spouses, living with someone of the opposite sex, parent and child or grandparent and grandchild;⁷³ having a child in common, current or former members of the same household, or a current or former dating relationship between members of the opposite sex.⁷⁴ (Again, if the violence emanates from a parent, grandparent, or other caretaker, it is child abuse as well as domestic violence. Every adult who reasonably suspects it has occurred must report it to DSS.)

Domestic violence is often both a crime and a civil injury, and the person injured may seek help from a civil or criminal court or both. Criminal acts that can also be domestic violence include assaults, battery, rape, and other sexual offenses.⁷⁵ Other acts such as stalking, communicating threats, or destruction of property might also qualify. However, statutory rape⁷⁶ is not, by itself, domestic violence, although domestic violence certainly occurs between some older/younger partners.

As explained above, an adolescent who suffers experiences because of domestic violence could report her partner to law enforcement to determine

73. Or a similar relationship, "acting in loco parentis to a minor child." A child of any age may be the victim, but a child must be sixteen or older to be considered the abuser. G.S. 50B-1(b).

74. *Id.*

75. "(1) Attempting to cause bodily injury, or intentionally causing bodily injury; or (2) Placing the aggrieved party or a member of the aggrieved party's family or household in fear of imminent serious bodily injury; or (3) Committing any act defined in G.S. 14-27.2 through G.S. 14-27.7." [These criminal statutes describe first- and second-degree rape; first- and second-degree sexual offense; and intercourse and sexual offenses with certain victims (children in a home where the defendant "has assumed the position of a parent" or students where the defendant is a school staff member.)] G.S. 50B-1(a).

76. Statutory rape is apparently consensual intercourse between a person under sixteen and a person four or more years older. G.S. 14-27.7A.

whether his behavior is criminal. If she cannot afford an attorney, the court might—depending on the nature of the violence—appoint one. Instead of seeking criminal prosecution or in addition to it, she may want a civil protection order.⁷⁷ By means of the order a judge may protect domestic violence victims in various ways. Besides directing someone to stop the abuse and leave his partner alone in future, a judge can regulate the couple's housing, child custody and support, and personal property and require the abuser to pay legal costs and attorneys' fees and even to accept treatment.⁷⁸ Violating a civil protection order is a crime.⁷⁹ Although evidence is conflicting, it appears that the orders are helpful. In one study, six months after obtaining a court order, 65 percent of victims had had no further problem.⁸⁰

Because she is a minor, the adolescent cannot ask the court for an order directly. However, the clerk will appoint a guardian ad litem (GAL), who is often a relative or adult friend, to make the request⁸¹ and will waive court costs if the young woman cannot pay.⁸² She does not have to have a lawyer, and is not entitled to an appointed one.⁸³ If she has no lawyer,⁸⁴ the GAL files the necessary forms, which are available in Spanish and English from

77. G.S. 50B-2 through -4.2.

78. G.S. 50B-3.

79. G.S. 50B-4.1.

80. American Bar Association Commission on Domestic Violence, "*Prevalence*," at www.abanet.org/domviol/stats.html, citing CPOs: THE BENEFITS AND LIMITATIONS FOR VICTIMS OF DOMESTIC VIOLENCE, NATIONAL CENTER FOR STATE COURTS RESEARCH REPORT, 1997.

81. G.S. 1A-1, Rule 17. If the defendant (the alleged abuser) is a minor, he must also be represented by a GAL. The form used in North Carolina courts for the appointment of a GAL in domestic violence actions is AOC-CV-318.

82. G.S. 1-110.

83. JOAN BRANNON, DOMESTIC VIOLENCE IN NORTH CAROLINA, *unpublished manuscript*, Institute of Government (October 2000). In some counties the Legal Services attorneys may assist the adolescent, but in most instances her GAL will have to bring the action without the assistance of a free attorney.

84. Having a lawyer is always best, if possible. Leslye E. Orloff, et al., *With No Place to Turn: Improving Legal Advocacy for Battered Immigrant Women*, 29 FAMILY LAW QUARTERLY 313-29, at 319 (No. 2, Summer 1995).

the clerk of court.⁸⁵ If the minor or her child are in danger, the GAL can ask for emergency relief.⁸⁶ After the alleged abuser is notified, an emergency hearing can be held (usually within ten days of filing a request). If necessary, a GAL may ask that an order (called an *ex parte* order) be issued immediately, that is, before the alleged abuser is notified that his partner has applied for an order.

Law enforcement officers can provide other assistance. A domestic violence victim “may request the assistance of a local law enforcement agency . . . [which] shall respond as soon as practicable.”⁸⁷ An officer may take steps to protect the person and tell her where to find shelter, medical care, counseling and other services. If she asks and “if feasible” the officer may take her to appropriate facilities for care and to her home to remove needed items.⁸⁸

Besides explaining that legal remedies are available, health care providers can help patients by referring them to private agencies. A domestic violence hotline is an important resource for many victims and one that adolescents are especially likely to use. A woman need not be planning to leave her partner in order to call or to use the services of a local program. Calling a crisis line is often a victim’s first positive step toward ending violence.⁸⁹ The national hotline at 1-800-799-SAFE (1-800-799-7233) can refer callers to a local program or shelter. During normal business hours the North Carolina Coalition Against Domestic Violence also refers callers to local programs.⁹⁰

85. G.S. 50B-2(a).

86. G.S. 50B-2(b).

87. G.S. 50B-5.

88. *Id.* If the officer does not help, the woman could ask a magistrate for an *ex parte* domestic violence order [G.S. 50B-2(c1)]. That order can, among other provisions, order an officer to help the woman get personal belongings from her residence.

89. “Many women do return to the abuser many times during the process of ending the abuse.” APA REPORT, at 66.

90. Unless otherwise attributed, the information in this paragraph is from Marie French, Training Specialist, North Carolina Coalition Against Domestic Violence, December 12, 2000. The Coalition is located at 115 Market Street, Suite 400, Durham, North Carolina, (919) 956-9124.

Most local domestic violence programs in North Carolina offer twenty-four-hour hotlines, court advocacy, support groups and shelter for victims. The programs differ, however, and health care providers will want to learn what services are offered locally. Most shelters will accept minors on an emergency basis and work with them to bring about their return to a safe home, placement elsewhere, emancipation, or other appropriate arrangements.

PATIENT'S REASSURANCE AND EDUCATION

To repeat and summarize points made earlier: Young pregnant and parenting women represent a paradox. On the one hand, their condition (pregnancy or motherhood) is adult in nature and their right to deal with it must be respected. On the other hand, as the AAP reminds practitioners, the patient is still an adolescent and often one living in difficult circumstances,⁹¹ appropriately a pediatric patient,⁹² and entitled to broad attention and concern, particularly if she becomes a mother.⁹³ Some pregnant minors do not understand the basic facts of sexual activity or pregnancy. Providers can educate them and may be able to help them reject sexual activity⁹⁴ by telling them directly that they do not have to allow it. Counseling, referring, and supporting pregnant adolescents, especially the youngest among them,⁹⁵ is

91. AAP Committee on Adolescence, *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 *PEDIATRICS* 516–20 (Feb. 1999), in *AAP POLICY REFERENCE GUIDE* at 27 and at www.aap.org.

92. AAP Committee on Child and Adolescent Health, *Age Limits of Pediatrics*, 81 *PEDIATRICS* 736 (May 1988) and at www.aap.org.

93. AAP Committees on Adolescence and on Early Childhood, Adoption, and Dependent Care, *Care of Adolescent Parents and Their Children*, 107 *PEDIATRICS* 429–34 (Feb. 2001) and at www.aap.org.

94. MUSICK, YOUNG, POOR, AND PREGNANT at 85.

95. “[I]t is really the early adolescents who need the most help and counseling [from health care providers], but . . . they are the least likely to report for followup appointments.” Sherry Lynn Marcus Hatcher, *The Adolescent Experience of Pregnancy and Abortion: A Developmental Analysis*, 2 *J. YOUTH & ADOLESCENCE* 53, 72 (1973).

a difficult task for providers but is likely to be of great benefit to their patients and the children they may bear.⁹⁶

CONFIDENTIALITY

Some providers hesitate to offer adolescents independent, confidential access to health services.⁹⁷ However, the professional organizations of health care providers support such access. Numerous medical and nursing groups advise providers to (1) offer adolescents confidential care for sex-related conditions while in most cases strongly encouraging parental involvement; (2) breach an adolescent's confidentiality only in extreme circumstances; and (3) make their policies clear from the beginning to both parents and patients.⁹⁸ On the last point, many providers have told us that they talk with minors at the beginning of treatment about situations where confidential care may be inadvertently revealed through, for example, telephone messages or letters from the provider to patients, billing practices, or the minor's developing side effects from medications prescribed.

96. For the difficulties of working with adolescents and likely gains from offering them services, see Kathleen M. O'Leary et al., *Contacting Pregnant Adolescents: Are We Missing Cues?* SOCIAL CASEWORK: J. CONTEMP. SOC. WORK 297–306 (May 1984).

97. See, for example, Gretchen Fleming et al., *Pediatricians' Views of Access to Health Services for Adolescents*, 15 J. ADOLESCENT HEALTH 473 (1994).

98. The joint recommendation of the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, NAACOG—The Organization for Obstetric, Gynecologic, and Neonatal Nurses, and the National Medical Association is found in *Confidentiality in Adolescent Health Care*, in AAP NEWS (April 1989) and at www.aap.org. The National Association of Social Workers (NASW) holds a similar view, *Adolescent Pregnancy*, in SOCIAL WORK SPEAKS: NASW POLICY STATEMENTS (4th ed. 1997). See also GARRY SIGMAN ET AL., CONFIDENTIAL HEALTH CARE FOR ADOLESCENTS: A POSITION PAPER OF THE SOCIETY FOR ADOLESCENT MEDICINE (www.adolescenthealth.org). The AMA's policy is more limited: Recommendation 3 in *GAPS Recommendations*, *supra* note 7.

As explained earlier, North Carolina law requires physicians who treat pregnant minors to keep their confidence, “unless the situation in the opinion of the attending physician indicates that notification is essential to the life or health of the minor.”⁹⁹ However, if the adult responsible for the minor contacts the physician, he or she may give the adult information.¹⁰⁰

Most health facilities would benefit from adopting a policy on when minors’ care is confidential and informing staff, parents, and patients of the policy.

99. As also noted, the Bush Administration is considering whether to amend federal regulations on medical record privacy to allow parents access to all minors’ medical records. 45 C.F.R. Section 154.502(g) (July 6, 2001).

100. G.S.90-21.4.

Control of a Minor's Records

ABSTRACT

Federal regulations on minors' health records give more control to minors than does North Carolina law. However, the regulations leave state laws in place. Therefore, Article 1A of N.C. General Statutes Chapter 90, Treatment of Minors, remains the law in this state.

In 2001 the United States Department of Health and Human Services issued regulations on the privacy of health information.¹ The regulations allow a minor to control the use of and access to her medical records if she could legally consent, by herself, to the health care that is the subject of the records. The minor alone controls such records even if she and a parent both consented to the care.²

Where a state law exists on parental access to minors' health information—in some twenty-five states—the regulations leave the state's law in place. As explained earlier, North Carolina has laws telling physicians when they may, must, or should not discuss a minor's treatment with a parent³ and, therefore, by inference when the minor alone controls medical records.

1. U.S. DHHS, Standards for Privacy of Individually Identifiable Health Information; Final Rule, 65 F.R. 82798 (December 28, 2000), to be codified as 45 C.F.R. Parts 160 and 164.

2. 65 F.R. 82806, to be codified as 45 C.F.R. Section 164.502(g)(3). (President Bush and Secretary of Health and Human Services Thompson have said that they hope to eliminate this language so as to permit parents access to all medical records of minors.)

3. See section on "Consent from the Minor Only."

Provider's Liability

ABSTRACT

Although legally more complicated than treating adults, treating minors does not seem to expose providers to substantial additional liability. Except for the handling of special consent issues and the required reporting of maltreatment, the usual standards of medical care apply.

TREATING A MINOR WITHOUT PARENTAL CONSENT

Although we know of no North Carolina decisions on the point, the general rule in law is that a provider will be liable for treating a minor without parental consent.¹ The main exceptions (described above) are that a provider may rely on consent from someone the parent has appointed, in writing;² may treat a minor in an emergency;³ and may accept the minor's consent to her own treatment for certain conditions.⁴ Performing an abortion on a minor "with knowledge or reckless disregard" of the fact that she is a minor, and without proper consent, is a misdemeanor.⁵

1. ROBERT E. LEE, 3 NORTH CAROLINA FAMILY LAW § 240.2 (1981). See also Danny R. Veilleux, *Medical Practitioner's Liability for Treatment Given Child without Parent's Consent*, 67 A.L.R. (4th) 511 (1996).

2. G.S. 32A-33.

3. G.S. 90-21.1 & -21.3. The statute also tries to insulate a physician from liability for not treating.

4. G.S. 90-21.5.

5. G.S. 90-21.10.

TREATING A MINOR WITHOUT PARENTAL CONSENT NEGLIGENTLY

Physicians and other providers under their supervision who treat minors under one of the statutory exceptions to parental consent are held to the usual standards of medical treatment. That is, as with any other patient, they could be liable if they did not use methods “commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in [their] community.”⁶

TREATING A MINOR WITHOUT HER CONSENT

Treating a minor at a parent's request, but against her will, is a murky area of the law with very few decisions reported anywhere in the United States. Medical and legal sources advise against it,⁷ however, and it is possible that a provider could be liable for forced treatment of an adolescent.

North Carolina law specifically forbids performing an abortion on a minor without her written consent.

NOT REPORTING ABUSE, NEGLIGENCE, OR DEPENDENCY

Criminal and civil liability could result from not reporting a reasonable suspicion of child abuse, neglect, or dependency. When a state statute does not specify a penalty for violation, as is the case with the abuse reporting law,⁸

6. G.S. 90-21.2. *See also* G.S. 90-21.4(a).

7. AAP Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 *PEDIATRICS* 314–17 (Feb. 1995) and at www.aap.org; FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* 358–59 (2d ed. 1990); and ANGELA R. HOLDER, *LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE* 290–93 (2d ed. 1985) (abortion issue only).

8. G.S. 7B-301.

failure to comply is a misdemeanor. At least two people, a psychologist and a school official, have been prosecuted in North Carolina for failure to report possible mistreatment of a child.⁹

As for civil liability, according to Janet Mason, “[t]hus far, the threat of civil suit has materialized rarely. There are no appellate court decisions in North Carolina—and very few nationally—dealing with civil liability for failing to report child abuse, neglect, or dependency. But that does not mean that a person cannot be civilly liable for failing to report child abuse in North Carolina. The issue simply has not come before the courts in this state. Cases from other states and the literature in this area suggest that the potential for civil liability for failing to report is real.”¹⁰

REPORTING ERRONEOUSLY

Reporters of abuse, neglect, or dependency are protected from liability in most circumstances, even if their reasonable suspicion proves incorrect. The law offers them immunity because acting on suspicion only, which reporters must do, creates a significant risk of error. The state immunity statute aims to save people from legal consequences for honest error. A reporter’s good faith is presumed; that is, in order to recover damages from a reporter, the suing party must prove that the reporter acted from malice or in bad faith. Unless a plaintiff can establish bad motives, anyone who reports, cooperates in a DSS investigation, testifies, or otherwise participates in the statutory process for protecting minors is immune from civil or criminal liability.¹¹

9. JANET MASON, REPORTING CHILD ABUSE AND NEGLECT IN NORTH CAROLINA 43 nn.4 & 5 (1996).

10. *Id.* at 40.

11. G.S. 7B-309, interpreted in *Dobson v. Harris*, 352 N.C. 77, 530 S.E.2d 829 (2000).

**PERFORMING AN ABORTION ON A MINOR WHO PRESENTS
FRAUDULENT PARENTAL CONSENT**

There is one North Carolina case on this point. A physician performed an abortion on a girl who forged a consenting note from her mother. Six months later the girl and her parents sued the physician for assault and battery and infliction of emotional distress for performing an abortion on her without valid consent. The trial court dismissed their complaint, and the court of appeals agreed that the doctor was entitled to rely on the patient's statement that her mother had written the note. The court found that the parental consent law "contains no requirement, express or implied, that the physician conduct an investigation into the circumstances of a purported written parental consent for an abortion to determine the validity of the writing."¹²

12. Jackson v. A Woman's Choice, Inc., 130 N.C. App. 590, 594, 503 S.E.2d 422, 425 (1998).

Financial Responsibility for a Minor's Medical Care

ABSTRACT

Payment for the medical care of pregnant adolescents is a major concern for patients and providers. State and federal programs often cover prenatal care and delivery, contraception, STD treatment, mother and child nutrition, and other needs, but there are few sources of payment for abortion on a minor. Providers whose billing practices do not ensure confidentiality should let their minor patients know this before treatment begins.

It is hard to be sure that a minor patient will be legally responsible for her own bill, and providers should not make that assumption. English, and then U.S. state courts, including those in North Carolina, long ago developed theories on this issue.¹ The basic rules are, first, that parents (or whoever is legally responsible for the minor) must supply or pay others to supply the necessities of life for the minor, and medical care is a necessity. Second, those who provide necessities to a minor cannot collect for their services unless they have a contract with the responsible adult. That rule is meant to prevent minors from being taken advantage of, their families from unknowingly incurring debt, and strangers from making decisions for the minor that properly belong to a parent.

1. For a general discussion, see John D. Hodson, *Infant's Liability for Medical, Dental, or Hospital Services*, 53 A.L.R. (4th) 1249 (1998). Significant North Carolina cases include *Freeman v. Bridger*, 49 N.C. 1 (1856); *Cole v. Wagner*, 197 N.C. 692, 150 S.E. 339 (1929); *Bitting v. Goss*, 203 N.C. 424, 166 S.E. 302 (1932); *In re Peacock*, 261 N.C. 749, 136 S.E.2d 91 (1964); *Lane v. Aetna Casualty & Surety Co.*, 48 N.C. App. 634, 269 S.E.2d 711 (1980); and *Rhodes, Inc. v. Morrow*, 937 F. Supp. 1202 (M.D.N.C. 1996).

For good reasons, an exception to these rules developed, and it can be particularly useful when a minor receives medical services that a parent does not know about. To encourage providers to help minors who are ill or injured, the law sometimes makes minors themselves responsible to providers. In North Carolina, minors have been liable for a bill when the parent was unable or unwilling to pay it or simply because the minor had a source of payment—a damage award for an injury,² for instance, or insurance coverage.³

Although minors may not be able or legally required to pay for care themselves, they may qualify for assistance. For pregnant minors, the regular Medicaid program and Medicaid's "Baby Love" program⁴ pay for prenatal care, labor and delivery, childbirth and parenting classes, maternity care coordination, nutrition therapy, and postpartum home visits. Any minor on Medicaid ("Health Check") or enrolled in the Child Health Insurance Program ("Health Choice")⁵ in North Carolina has contraceptive and STD treatment coverage. Under state law, any person is entitled to certain STD diagnoses and treatment without charge at a local health department.⁶ Health Choice does not cover pregnancy-related care or abortion. However, if minors in Health Choice become pregnant, most qualify for Medicaid because only an adolescent's income, plus that of the father of the pregnancy if he lives with her, are counted. Medicaid covers abortion but only in the case of rape or incest or when the pregnant woman's life is endangered.⁷

2. *In re Peacock*, 261 N.C. 749, 136 S.E.2d 91 (1964).

3. *Rhodes, Inc. v. Morrow*, 937 F. Supp. 1202 (M.D.N.C. 1996).

4. Regular Medicaid enrollees are given a blue card and "Baby Love" enrollees, a pink one. The colors indicate financial eligibility at different income levels and coverage for specific services.

5. Health Choice enrolls North Carolina children with family incomes just above that of Medicaid-eligible families.

6. G.S. 130A-144(e). These diseases are listed at note 19 in the section on "Sexually Transmitted Diseases."

7. Information in this paragraph is based on correspondence with Lynda C. Dixon, State "Baby Love" Program Coordinator, N.C. Dep't of Health and Human Services, Division of Medical Assistance, Raleigh, N.C. (Mar. 2000). For fuller descriptions of

Some private insurance policies pay for dependents' prenatal care and abortions; most cover STD treatment and contraception.

As has been noted, the billing procedures of government agencies and/or private insurance companies may or may not maintain a minor patient's confidentiality. For instance, whereas Medicaid enrollees are not notified about payments that Medicaid has made for services to their dependents, Health Choice enrollees do receive such notices. As a result, a minor could use Medicaid but not Health Choice benefits without her parents becoming aware that she received a medical service.⁸ The American College of Obstetrics and Gynecology (ACOG) sees a connection between the frequent loss of minors' confidentiality as a result of billing procedures and their underutilization of health care.⁹ Other researchers report similar findings.¹⁰ ACOG correctly notes that in order to maintain confidentiality, some minors will pay for tests and treatment themselves, or use only providers who can offer confidential care. The practices of providers and health facilities, including billing practices, should be explained to minor patients at the outset so that they can make these choices, and minors should be referred for confidential care if it is available in the community.

Emancipated minors are adults for the purposes of financial responsibility for services.¹¹ Remember, though, that very few North Carolina minors are emancipated.

When parents refuse consent for treatment and a judge consents in their

these programs, see PAM SILBERMAN, *NORTH CAROLINA PROGRAMS SERVING YOUNG CHILDREN AND THEIR FAMILIES* (Chapel Hill, N.C.: North Carolina Institute of Medicine, 1999).

8. Correspondence with Lynda C. Dixon, *supra* note 7 (Mar. 2000).

9. *Confidentiality in Adolescent Health Care*, ACOG EDUCATIONAL BULLETIN No. 249 (Aug. 1998).

10. Carol A. Ford et al., *Foregone Health Care among Adolescents*, 282 JAMA 2227-34 (Dec. 15, 1999).

11. The emancipation decree gives a minor "the same right to make contracts . . . and to transact business as if [the minor] were an adult." G.S. 7B-3507.

place, the judge may order the parent or “other responsible parties” to pay. If the parent cannot pay, the judge may order the county to do so.¹²

At least some legal immigrants qualify for Medicaid and Health Choice, and receiving those benefits cannot be used to label them a *public charge* for immigration purposes. Noncitizens who do not have legal immigration status in the United States are not eligible for Health Choice or for Medicaid (except for emergency care). However, hospitals must treat anyone with an emergency condition and any woman in active labor or lose the right to Medicare and Medicaid reimbursement.¹³ In addition, federal agencies interpret the Welfare Reform Act¹⁴ to make available the Women's, Infants, and Children's (WIC) supplementary feeding program and federally funded prenatal care and family planning services regardless of a recipient's ability to pay or citizenship status.¹⁵

12. G.S. 7B-3600.

13. The Emergency Medical Treatment and Active Labor Act, colloquially known as the “anti-dumping” law, 42 U.S.C. § 1395dd(a) *et seq.*

14. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

15. For definitions of categories of foreigners in the United States and the government benefits for which they qualify, see articles by Jill D. Moore in the Fall 1999 issue (Vol. 65, No. 1) of *Popular Government* (Chapel Hill, N.C.: Institute of Government, The University of North Carolina at Chapel Hill): “ABCs of Immigration Law and Policy,” “Migrants' Access to Public Benefits,” and “A Guide to Immigrants' Eligibility for Public Benefits in North Carolina.”

