QUICK LESSON ABOUT

Legal Issues...Maintaining Confidentiality: Minors

Issue Description

For a general discussion on the topic of confidentiality see *Quick Lesson on Legal Issues… Maintaining Confidentiality: An Overview* . A related topic is covered in *Quick Lesson on Legal Issues ... Consent and Minors* .

Unsafe sexual behavior, consumption of alcohol and drugs, and interpersonal violence are major problems for adolescents. Proper prevention of, and treatment for, these risky behaviors is vital for adolescent well-being.(7) Without confidentiality (keeping information away from parents or respecting the privacy rights of the patient), their treatment and prevention is difficult(8) especially when parents are not aware of confidentiality requirements.(52) Physicians and other healthcare providers should be ready to follow up on high-risk behaviors when seeing adolescents for other ailments because incomplete care otherwise results.(9) However, physician ignorance of the laws and ethical rules of confidentiality relating to treatment of minors may cause physicians to avoid providing necessary care. Physicians make excuses such as inadequate staffing for failure to provide confidential adolescent care and some even think that they are not bound by the law relating to confidentiality.(10) This ignorance may stem in part from the fact that laws in the United States differ by state.(52)

Issues of consent and confidentiality are two sides of the same coin when dealing with parents or surrogates of minors.(1) Confidentiality is destroyed if the healthcare provider obtains consent from an older minor's parents or surrogate. The consent issue has assumed special importance in connection with teenage abortion, medical advice related to teen sexual activity,(2) and risky behaviors that are a major cause of adolescent mortality.(3) If a minor teenager wishes to conceal medical information from parents the question arises whether the child is competent to consent to the contemplated treatment.(4) In the United Kingdom the child must understand several factors relating to the treatment: what it is, benefits and risks, what will happen without the treatment, and available alternatives.(5) The difficulty arises in establishing whether the child understands the advice given concerning the proposed treatment. Informal testing by two-way conversation is recommended. The younger the child, the more thorough is the testing. The nature of the treatment may also require more thorough testing.(6)

Social workers are sometimes caught in a dilemma when they consider it their duty to divulge information to parents but they fear losing their minor client's trust. They are also subject to federal and state laws regarding minor confidentiality. A decision is difficult in these circumstances. They should review the ethical standards set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) for guidance on their ethical responsibilities. Federal laws and regulations may be applicable; for example, in a drug treatment agency that receives federal funds. State laws and regulations vary considerably throughout the United States. In some states the social worker may use his or her discretion;in other states, disclosure is prohibited. Lastly, their employer may have written policies and procedures that must be followed.(55)

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Many healthcare centers treating adolescents have no policy on confidentiality, resulting in confusion among office staff and doctors who adopt different standards in the same setting.[11] Some parents, healthcare providers, and adolescents also are ignorant of the rules of confidentiality. The key is for the physician to know the rules of confidentiality and to gain the adolescent's trust by sensitively broaching the necessary issues; otherwise adolescents may forgo needed treatment and parents will remain unaware of what happened or is happening to their child.[12] It is those very adolescents that forgo treatment who are more likely to engage in risky conduct and to suffer mental health problems requiring treatment – more so than the adolescents who confide in their physicians.[13] Very few adolescents think that their primary care physician will respect their confidences.[14] Most sexually active girls consulting Planned Parenthood would forgo assistance with contraception if their parents were informed.[15] On the other hand, parents think that they will be fully informed even against their child's wishes, although most of them approve of a doctor's consultation without them present. Those who did not approve of confidentiality changed their minds after written and oral education and were persuaded that it was important for their teenager to communicate openly with the doctor. It turns out that confidential medical services do not damage the parent-child relationship.[16]

Deciding what information should be shared with parents depends on the maturity of the adolescent and his or her capacity to make decisions. Such capacity can vary in different circumstances.[17] It is important to recognize the differences between mental healthcare services and other types of care. With mental healthcare, information is shared with family members due to the very nature of the treatment. Family members are involved with treatment and may be participants. Parents must be informed in order to discharge their parental responsibilities. Furthermore, social welfare agencies, schools, and other child health service agencies may have to be informed in the interests of the child.[18]

Compulsory reporting of child abuse by mental health service providers can present a problem in some circumstances because the law in the United States is inflexible and applicable regardless of the specific circumstances.[19] A 1994 survey canvassed the views of 51 child protective services agencies in the United States, of which 44 responded. Various models of reporting were described in the survey; namely, mandatory reporting, family self-report, conjoint reporting, and discretionary reporting. Forty-threejurisdictions had laws corresponding to the mandatory reporting model,in which reporting of child abuse by mental health service providers to child protective services is compulsory. Twenty-four states also permitted conjoint reporting,in which the mental health service provider and the family jointly meet with child protective services to report the abuse and discuss action to be taken. Although the rules described above are inflexible, most child protective service agencies are reluctant or unable to consider revisions to their policy.[20] The California Supreme Court ruled in the 1976 *Tarasoff* case[21] that social workers and therapists at mental health agencies, and private mental health practitioners, must breach the confidentiality of the information they receive from their clients in certain circumstances. Where the social worker or therapist has reason to believe that the client presents a serious danger of violence to another, including a child, they must warn that person of the danger or take such other steps (such as reporting to the police) as may be reasonably required to protect that person from violence.[22] Since 1976 a surge of lawsuits caused some states to pass legislation limiting the liability of therapists in cases in which they have followed the requirements of the applicable statute. The most difficult issue for a social worker is judging how dangerous a client is. The best way is to focus on the client's history of violence, current mental state, and what is likely to precipitate an attack on a third party.[23] For example, in the United Kingdom, a social worker on a forensic psychiatric team who had worked with Darren Carr, a former live-in babysitter, reported his concerns about Carr to the local child protection team. His report was ignored and Carr later set fire to the house where he had worked, killing a mother and her two children. This was a case where a report was in fact made but was ignored.[24]

When minors in the United Kingdom between the ages of 10 and 18 years are arrested by the police as criminal suspects, a sample of their DNA may be taken and stored in the National DNA Database for future use in crime investigations. Also, minors who have not been arrested may be requested to consent to a sample of their DNA being taken and stored for the same purpose. Concerns have been raised regarding this extensive use of private medical information. New legislation is needed to protect the interests of children in the United Kingdom to preserve the confidentiality of their private DNA information.[53]

An official enquiry was made in the United Kingdom concerning a possible conflict between confidentiality and the need for social workers and physicians to share information. A social worker working in a family practitioner's practice failed to disclose to the physician information regarding a patient's mental condition. The patient received a diagnosis of schizophrenia a year later. The enquiry report commented on the lack of communication between the social worker and the physician.[25]

For a social worker, client records memorialize the client's condition and progress, and serve the sole purpose of facilitating the client's recovery. However, for managed care companies (insurers), confidential client records serve a different purpose: they are used to assess whether the company should pay for therapy and to maximize savings for the company.[26] This applies to minors and adults alike. Private medical information is not well protected by these companies and disclosure of this information to unauthorized recipients occurs.[27]

In the United Kingdom adopted children enjoy the right to ascertain the identity of their birth father (if known) and birth mother. The British Association of Social Workers lobbied for many years to extend a similar right to donor-conceived persons to access information about their genetic origins. This culminated in the Human Fertilization and Embryology Act 1990, which granted them that right. For example, a person may at age 16 ascertain whether he or she is related through donor conception to anyone he or she intends to marry.[28]

Definitions

Separation of powers: An ancient system to curtail governmental powers by dividing the government into several branches, each with its own powers and duties. The U.S. Constitution provides for a Congress (the legislature) to pass laws and to enjoy limited oversight of the Executive Branch headed by the President. The Executive Branch carries out the ministerial functions of government such as law enforcement, defense of the country, health, and regulation of many commercial and other activities conducted in interstate commerce (e.g., agriculture, roads). Lastly, the judicial branch consists of the Supreme Court, federal appeal courts, and district (trial) courts with the power to declare laws passed by Congress (and all state legislatures) as unconstitutional and therefore invalid. The judicial branch also adjudicates cases involving disputes subject to federal law but not state law. The federal government is entirely separate and distinct from state governments. State governments also have three branches, executive (headed by a governor), legislative, and judicial, that are also subject to the separation of powers doctrine.

Risks

Computer technology will seriously affect the confidentiality of minors' medical records in the same way it will affect the confidentiality of adults' records.[29]Electronic health records (EHRs) of minors, and the availability of EHRs through Internet portals, will also increase parental access [58]. The innovation of patient-controlled health records will give parents control of the records of their adolescent children.[30] The problem is exacerbated by the encouragement given to parents to manage their family's records. A proposed solution is to differentiate children 13–18 years old and to restrict parental access to their records. These records will be customized by classifying separate pieces of information as either accessible to parents or not.[31]

For example, a record of a visit for asthma may be accessible to a parent whereas a visit to the doctor for advice concerning contraception will not appear on the adolescent's medical record when a parent accesses it. This result will presumably be achieved by giving each party a different access code. The ultimate goal is to improve teen health by increased access to sound medical advice and assistance.[32]

Units Potentially Involved

Clinics operated by organizations such as Planned Parenthood feature prominently in the quest for confidentiality of children's and adolescents' medical records in regard to reproductive medical advice. Other units such as medical-surgical units in hospitals generally do not provide the type of care that adolescents wish to keep confidential from their parents.

Play therapy was suggested as an appropriate method of counseling for children. In particular, group play therapy may bring about "individual changes through relationship, catharsis, insight, reality testing, and sublimation". However therapists should be aware of confidentiality issues that arise. Not only are participants (excluding therapists) not bound by duties of confidentiality but also children are more likely than adult participants to disclose private information learned during group therapy.[59]

A recommendation was made that older children participate more in formulating policy on how to deal with child abuse by their fathers. These children ("young experts") expressed concern that confidentiality may be breached arising out of their discussions with adults and the use of online social media. Anonymity was suggested as one solution.[60]

Laws and Court Cases

In the area of confidentiality of communications with clients, the relationship between the mental health system, including social work, and the legal system has been described as "an uneasy alliance."[57] Social workers for minors do not wish to disclose confidential communications but sometimes they are ethically and legally compelled to disclose communications to parents or the legal system.

Applicable to both minors and adults, the U.S. Supreme Court ruled in 1996 in *Jaffee v Redmond* [33] that licensed or clinical social workers enjoy an absolute privilege from disclosure of their professional records relating to their clients. This privilege is applicable in federal courts but has limited applicability in state courts, depending on the particular state.[34] "Privilege" should be distinguished from "confidentiality." The latter term means that information given to a social worker or therapist will be used responsibly whereas the former term means that, due to the special status of the information recorded by the social worker, disclosure of the information may not be compelled by a third party or the courts.[35]

In the United States the main law governing confidentiality is the Health Insurance Portability and Accountability Act (HIPAA), effective 2003 (See *Quick Lesson About Legal Issues... Maintaining Confidentiality: an Overview* , referenced above). There are also federal court decisions, especially by the U.S. Supreme Court, and state court cases, laws, and regulations for all 50 states. In regard to consent, state laws are divided into two groups, those based on the status of the minor and those based on the minor's specific needs. On the federal level, despite pressure from interested parties, adolescents can keep contraceptive services confidential from their parents and others under Medicaid rules (as interpreted by federal courts) and under Title X of the Public Health Service Act.[36] This means that parents cannot be advised beforehand (to enable them to provide consent) or afterwards. Rules promulgated by the Clinton administration under HIPAA in December 2000 protected the confidentiality of minors' medical records relating to the particular care that they could lawfully consent to under federal or state law, and in other situations when the parents agreed.[37] The next year, in 2001, the Bush administration reversed this rule and authorized confidentiality only when state laws require it. Where state law is silent, the care provider had to make the decision whether to tell the parents, subject to prevailing rules of medical ethics.[38]

In the Obama administration, as of November 2010, confidentiality of minors' medical records is under the control of the states. For example, for contraceptive services, the physician may, but is not compelled to, inform the minor's parents in Kentucky, Maryland, Minnesota, Montana, Oklahoma, and Oregon. In Delaware and Hawaii this rule applies only to minors younger than 13 and 15 years, respectively.[39] For access to services for sexually transmitted infections, more states adopt the same policy (physician may, but is not compelled to, inform parents).[40]

HIPAA protects confidentiality of minors' health records in the juvenile justice system.[41] Title X of the Public Health Service Act was amended in 1978 to ensure confidentiality of minors' health records. In 1981 a further amendment required recipients of federal funds to "encourage" minors being treated to involve their parents in reproductive healthcare decisions. In 1983, "encourage" was interpreted to mean compulsory notification within 10 days.[42] This interpretation was found to be unconstitutional in the federal court case*Planned Parenthood v Matheson*. The Reagan administration did not appeal this decision to the U.S. Supreme Court, so the decision remained authoritative. In the United Kingdom, as in other countries, confidentiality cannot be respected when healthcare workers are obliged to report information to the authorities if child abuse is suspected or the child suffers from a notifiable disease. The philosophy behind confidentiality can vary from country to country. For example, in the United Kingdom parents are entitled to medical information about their children to enable them to fulfill their parental roles. By contrast, in the United States parents are entitled to the same information as a parental right.[43] In the United Kingdom the Family Law Reform Act 1969 permits adolescents ages 16–18 to be treated without informing their parents but parents may be informed if the adolescent refuses necessary care.[44]

Cases involving breach of confidentiality of minors' medical records are scarce. Most breaches involve disclosing information to parents, who are unlikely to file a lawsuit on behalf of their child. However, organizations such as Planned Parenthood file lawsuits in most jurisdictions in their quest for confidentiality of minors' medical information. One such case is *Planned Parenthood of Indiana v Carter,* [45]in which Planned Parenthood of Indiana (PP) was accused of not reporting 73 cases of child sexual abuse as required by Indiana law. In response, PP filed a lawsuit to prevent the Medicaid Fraud Control Unit of the state of Indiana from gaining unlimited access to minor patients' medical records. PP based its lawsuit on constitutional and other grounds. However, the Medicaid Fraud Control Unit contended that preventing its access to the records would violate the separation of powers doctrine (see *Definitions*, above). The Unit argued that the judicial branch (the court) had no power to interfere with the executive branch in the legitimate execution of its routine duties. The court rejected this argument, holding

that the Medicaid Fraud Control Unit was merely a creation of an Indiana statute and had no powers beyond those expressly granted by the statute. The court held that it was empowered to make a finding whether or not the Medicaid Fraud Control Unit was seeking to exceed powers granted to it under the statute. In the end, the court found that the Unit was not exceeding its powers by investigating the "neglect" of children based on PP's alleged failure to report child abuse as required by Indiana law. PP claimed that the Unit could not take children's medical records because this was prohibited by the privacy right conferred by the 14th Amendment to the U.S. Constitution. The court held that PP had standing (eligibility) to claim privacy rights on behalf of the minors because PP had a close relationship with the minors and the minors were unable to assert their own rights. Also, the minors had a limited constitutional right to privacy in their medical records. After balancing the minors' rights against the Unit's interest in investigating complaints of patient neglect, the court concluded that the minor patients' rights of privacy would be violated by giving up their medical records. Seizing patient records was not the most effective nor the least intrusive means of serving the Unit's interests in investigating complaints of patient neglect. The court suggested that the Unit could refer the investigation to an appropriate criminal investigative or prosecuting authority such as the local prosecutor's office, which would have actual knowledge of whether an abuse report had been made in a particular case. Therefore the court issued an order enjoining (preventing) the Unit from seizing the children's medical records.

In 2003 the Florida Supreme Court held in *North Florida Women's Health and Counseling Services, Inc. v Florida* [(46)] that a Florida statute, the Parental Notice of Abortion Act, 1999 (the Act) was unconstitutional and therefore unenforceable. The Act imposed a direct and significant intrusion on a minor's constitutional right of privacy. The Act required a minor to notify her parents of her intentions before she has an abortion. If she does not want to tell her parents she must convince a court that she is sufficiently mature to make the decision, or if she is immature, that the abortion is nevertheless in her best interests. The Court held that the Act failed to further a compelling State interest and because the Act violated minors' rights of privacy it was invalid. The minor would be forced to disclose to others—that is, her parents, guardians, and sundry court personnel—one of the most intimate aspects of her private life. The Court relied heavily on a previous case *In re T.W.*, 55,1 So.2d 1186 (Fla. 1989) to come to its decision.

The following case[(47)] involved a minor but also applies to adults. In Australia, a 6-year-old boy, Ankur, was born in 1998 with cardiac disease and a defective kidney. He sued his pediatrician, Dr. Richards, for not diagnosing his congenital heart disease until he was 9 months old, thus causing pulmonary hypertension and irreversible damage. Dr. Richards applied to the court for an order that Ankur, a minor, had waived doctor-patientconfidentiality with his pediatric cardiologist, Dr. Sholler, although the latter had already produced medical records in response to Dr. Richards' subpoena. Dr. Richards' aim was to compel Dr. Sholler to be interviewed by defense counsel. Dr. Richards' counsel relied on a Canadian case[(48)] which held that a plaintiff in a medical malpractice lawsuit waives his or her right to doctor-patient confidentiality even with doctors who are not defendants. The judge commented that the Canadian decision had met with a mixed reception in Canada and he relied on another Australian case to rule that doctor-patient privilege had not been waived in the present case as regards the non-party doctors. The only instances when confidentiality is waived are to preserve the life or health of others, where the information concerns dishonesty of the patient, the information is acquired criminally, or privilege is removed under a specific statute. The court held that the present situation did not fall under any of those exceptions. The mere fact that the information may assist a party in civil litigation does not suffice to remove confidentiality. However, all the above does not apply in the lawsuit to doctor-patient confidentiality between the plaintiff and the doctor who is being sued. The defendant doctor must be given the opportunity to defend himself and for this purpose he may use all relevant confidential medical information about the plaintiff. In the end, the court held that the Canadian case did not represent Australian law, and Ankur had not waived doctor-patientconfidentiality with his cardiologist, Dr. Sholler, although Dr. Sholler was obliged to produce Ankur's medical records and testify in court. Also, Ankur had to submit to a medical examination if called upon for purposes of litigation.[(49)]

Recommendations

The Wisconsin Department of Public Instruction issued an undated guide for school social workers on students' rights to confidentiality. The intention of the guide was to "balance minor students' rights to privacy and confidentiality, and their parents' rights, roles and responsibilities in an effort to improve outcomes for both students and families."[(56)]Wisconsin law grants confidentiality to minors at certain ages for some services such as substance abuse treatment and family planning services. However, the Wisconsin Department of Public Instruction does not grant similar legal privileges to its students in schools. The guide also notes that state and federal law permits confidential information to be disclosed in an emergency to protect the safety of students or others. There is a useful list of references to recommendations on ethical standards given by other professional organizations such as the School Social Work Association of America.[(56)]

Position statements have been issued by most U.S. medical organizations such as the American Medical Association, American Academy of Pediatrics, and American Academy of Family Practice.[50] For example, Opinion 2.015 of the American Medical Association recommends that physicians should strongly encourage minors to discuss their pregnancy with their parents. The American Academy of Pediatrics issued a policy statement in 2012 setting forth its recommended standards for health information technology to ensure adolescent privacy. The recommendations cover data concerning health care based on adolescents' status and on the treatment they need. Status: emancipated or mature minor, pregnant or parenting teenager. Nature of treatment: sexually transmitted disease diagnosis and treatment, contraception, pregnancy care, substance abuse counselling and treatment, and mental health care. Although the Academy encourages adolescents to discuss their health issues with parents, the former should control the privacy of their health records and information to the extent the law permits.[54]Physicians should familiarize themselves with the law in their state to ensure that they are complying with their legal obligations.[51]

Recent review of the literature has found no updated research evidence or noteworthy recent legal cases concerning this topic since previous publication on May 15, 2015.

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