

Consent And Confidentiality Issues When Caring For Adolescents

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Abstract

The American Nurses Foundation of the American Nurses Association works with a federally funded program entitled, Partners in Program Planning for Adolescent Health (PIPPAH). These partners are working to improve the health status of America's adolescents. Health care professionals are key to helping parents and other caring adults understand the needs of children as they transition into adolescence. Nurses, numbering 2.7 million, comprise the largest group of health care professionals in the United States.

The purpose of this module is to increase nurses' knowledge of consent and confidentiality issues for those who work with adolescents in order to protect the consent and confidentiality rights of adolescent patients and to increase awareness that not all states define these rights uniformly.

Key Words: adolescent health; consent; confidentiality; emancipated minors; nurses; protection of adolescent rights

Objectives

On completion of this module, the nurse will be able to:

1. Describe why consent and confidentiality issues are of critical importance when providing care to an adolescent population, especially when dealing with chronic illness, mental health, preventable injuries, reproductive and sexual health, substance use and abuse, and violence.
2. Define the elements of consent how the capacity to consent is legally determined.
3. Identify who can consent on behalf of an adolescent.

4. Define confidentiality and identify the legal basis for the protection of the adolescent's right to privacy.
5. Describe the process for seeking legal advice when consent and confidentiality issues impact the treatment of an adolescent.
6. Define the terminology utilized for adolescent consent and confidentiality, rights, and issues.
7. Identify risk management issues for nurses caring for adolescents.

Introduction

The American Nurses Foundation (ANF), supported by the Office of Adolescent Health (OAH) of the Maternal Child Health Bureau (MCHB) and the Health Resources and Services Administration (HRSA), participates in inter-organizational activities focused on the promotion of adolescent health and positive youth development. A resource from the American Bar Association Center on Children and the Law, entitled *Health for Teens in Care : A Judge's Guide*, describes the sensitive areas when consent may be required for care and where confidentiality may not always be possible to maintain. Another resource is the Center for Adolescent Health and the Law document entitled *State Minor Consent Laws: A Summary*. The second addition of this resource was published in May of 2003; ordering information is available at www.cahl.org. This resource would be helpful to nurses who need to understand specific issues that are introduced in this continuing education activity in greater detail or depth.

In order for nurses to provide care to adolescents within the laws of their state, it is important to be aware of consent and confidentiality issues. Nurses must encourage adolescents to involve their parents when making health care decisions. The rights of adolescents differ from adult patients due to consent issues, yet the adolescent's right to confidentiality often mirrors the rights of adults. However, in some states/jurisdictions, confidentiality cannot be protected, as information must be

shared with the adolescent's parents or guardians. It is important for nurses to understand the legal rights of adolescents in the state/jurisdiction where they practice in order to work within the law and to understand if they can maintain confidentiality of the care provided.

The adolescent's rights as well as the parent's ability to access information should be disclosed at the onset of care. In some states reproductive and sexual health issues must be discussed with the parent, where in other jurisdictions the confidentiality of these issues is protected by statutory rights. Health care of an adolescent must be initiated only after having received consent from the parent or guardian, unless the adolescent is an emancipated minor.

Emancipated minors are considered adults and able to consent for their own health care. Criteria for recognizing a minor as emancipated include marriage, military service, or living apart from parents, and being self-supporting. At least 34 states have specific emancipated minor health care consent statutes. In other states, however, minors who meet the criteria for emancipation could also be recognized as able to consent for health care.

Laws are constantly changing to reflect our society's needs. Nurses must constantly update their understanding of the rights of adolescents and advocate for laws that reflect the best interests of adolescents.

Consent and the Capacity to Consent

Legally defensible consent must be obtained from a patient who has been informed of the significant risks and benefits of the proposed treatments and alternative options in language that is understandable and in a setting that diminishes any duress the patient may be feeling. A person is incompetent to consent when the law determines that he/she does not understand the consequences of his/her decision. In order to consent to medical treatment, the patient must have the capacity to understand the implications of the decision he/she is making. In order to understand the consequences of the decision that is being made regarding what treatment will be accepted or

refused, the law requires that the patient have the capacity to understand the consequences of this decision. Generally a person under the age of 18 is not considered to have the life experiences nor cognitive development to comprehend this serious decision-making process. Therefore, the adolescent's parent or guardian must make the decision on behalf of the adolescent as the surrogate decision maker. Hopefully the parents or guardians are discussing this decision with the adolescent and reflecting the adolescent's desires when they perform this legal duty.

If the adolescent is emancipated, he/she does have the capacity to consent. The most common categories in which states have laws allowing minors to consent for health care are minors who are living apart from their parents, minors who are married, minors who are parents, and minors who are pregnant.

Nurses who are involved in receiving consent from patients must remember that only the health care provider who will be treating the patient can legally obtain consent from the adolescent or their parent. Nurses are not educated as physicians and, therefore, cannot explain the significant risks and benefits as well as the potential options of medical treatment to the patient. The nurse can only witness that the patient has signed the consent form. If the nurse has concerns that the patient is signing the consent form without understanding the consequences of the patient's decision, the nurse as the patient advocate, has the duty to inform the health care provider or physician that the patient needs to have clarification regarding the treatment the patient is agreeing to receive. Advance practice nurses and other health care providers can obtain consent for care they are providing.

If treatment is given to an adolescent or any person without consent, the legal charges of assault, or the threat of unwanted touch, and battery, the actual touching, can be asserted. The right to consent to or refuse treatment is a statutory right that is legislated in most jurisdictions. Consent must also be received from the patient or the adolescent's parent at a time when the adolescent and parent have the opportunity to discuss and consider the information they have received. Duress or

undue stress at the time of giving consent can nullify the document. It is not a good idea to receive informed consent from an adolescent and/or the parent after the patient has been sedated for a procedure and cannot think clearly. The argument can be made that the patient was agreeing to the treatment without the mental ability to understand the consequences of the decision being made. An attorney for the patient may be able to demonstrate to a judge or jury that the patient would not have given consent for care if the patient had not been medicated or in duress.

Confidentiality

It is very important for nurses to understand the various confidentiality rights and reporting laws in the state within which they are providing care to adolescents. Privacy is a right afforded to us through our constitutional rights, whereas confidentiality is a means of protecting the privacy of those to whom we provide health care. The Constitution of the United States guarantees the right of privacy to our nation's citizens. However, the right of confidentiality cannot be extended to those who are in need of protection by a parent or guardian because of their youth. Confidentiality rights are most often defined statutorily by states and vary from jurisdiction to jurisdiction. The legal right to consent varies from the protections of confidentiality because the confidentiality of adolescent care information cannot always be guaranteed.

The enactment of the Health Information Privacy and Accountability Act (HIPAA) prevents disclosures of information about a patient to persons who do not have a "right to know" because the patient has not authorized them to know private information or to healthcare providers who do not have a "need to know" in order to benefit the patient's care. Unlawful disclosure is a HIPAA violation and can result in penalties identified under this law. HIPAA applies to all states and jurisdictions because it is a federal law and protects the privacy rights of patients. Adolescent rights remain defined in state statutes even though HIPAA provides privacy protection to adolescents also.

School Health

The Family Educational Rights to Privacy Act (FERPA) is a federal law that impacts school nurses and school health records. This act serves to protect privacy but allows the parents of minors, i.e., those below the age of 18, access to the adolescent's health care record. Many schools have a general consent form signed by parents at the beginning of the school year. This consent allows the nurse to treat the adolescent legally as needs arise. The confidentiality issues still may exist. Consent and confidentiality laws vary among jurisdictions. Federal regulations such as HIPAA and FERPA apply across our nation to all jurisdictions, yet states still enact the legislation with the statutory language that defines informed consent and patients' rights in the individual states. In some states, adolescents have the right to have private information kept confidential. In other states, the parents have the right to be notified when care is sought by an adolescent.

Chronic Illness and Advance Directives

Adolescents who are being treated for a chronic illness may wish to consider having a living will or special medical directive. These instruments instruct health care providers regarding the patient's wishes if the patient is no longer able to speak for him/herself or when health care becomes futile to improving health care status. A surrogate decision maker, such as a parent or guardian, would need to act on behalf of the adolescent if the patient is not yet emancipated. A living will or special medical directive instructions are documents that serve as a contract between the patient and the health care providers. Adolescents do not have the capacity to contract within our legal system.

The creation and utilization of a living will is defined by state statute and usually requires the patient to be in a vegetative or terminal state near death before the living will becomes effective. Special directives give more specific instructions on what care would or would not be desired under various circumstances and do not require statutory guidelines of vegetative or terminal health care status. Living will laws vary from jurisdiction to jurisdiction. It is important for nurses to understand the statutory directions of living wills within the state where they practice nursing.

Surrogate decision makers such as parents and guardians need to discuss with the adolescent what their wishes and desires are regarding treatment at the end of life if these difficult decisions must be made by the surrogate on behalf of the adolescent. The living will or special directive should serve as documentation of the adolescent's desires at the time the document is created. Living wills and special directives can be nullified at any time, verbally or in writing, if patients change their minds about a previously stated direction of treatment. Hopefully, the parent, as the adolescent patient's surrogate decision maker, will honor and support the adolescent patient's wishes. If the patient and parent indicate that the instructions in the living will or special directive are no longer desired, the nurse must document this information and communicate the change in treatment desires or cancellation of consent to the health care providers who need to know in order to legally comply.

Mental Health

Due to social stigma, the privacy protections for mental health care are expanded. Both federal and state regulations offer special protections for the privacy of patients receiving mental health care. It is especially important for nurses to understand federal regulations that apply in every jurisdiction, as well as their state guidelines for maintaining the privacy and confidentiality of adolescent patients receiving mental health care. If the nurse is not aware of the HIPAA regulations, as well as the specific guidelines for mental health care providers, the nurse can easily violate these federal and state guidelines. State laws must meet at least the minimum requirements for privacy protections enacted through HIPAA and can exceed the protections of the federal guidelines. Therefore, nurses must understand the state regulations within the jurisdiction they are practicing. For example, if the adolescent is accompanied by a family member for treatment, and the nurse proceeds to discuss the adolescent's mental health issues without first having received consent from the adolescent to share this information with the family member, a HIPAA or state

privacy/confidentiality violation may have occurred. How nurses handle these situations is important. The adolescent may be uncomfortable asking the family member to leave and the parent may object to having the health care provider and the adolescent meet privately. If the law in the jurisdiction allows the adolescent confidentiality, the nurse must either receive consent from the adolescent to have the family member present during treatment discussions or meet with the patient in a private setting. The parent may be asked to complete documents or other legal forms that need to be signed by the parent or guardian, while at the same time allowing the therapist and adolescent to meet privately. Parents who persist in attending treatment sessions need to have their adolescent's legal rights explained to them.

Reproductive and Sexual Health

An equally sensitive issue between adolescents and parents or guardians is reproductive and sexual health. Adolescents may be hesitant to discuss their need for contraceptives or their concerns about sexual contacts with a parent or guardian present. In some jurisdictions the parents have a legal right to be informed of the adolescent's need for or request for contraceptives. In other jurisdictions, adolescents have their privacy protected, and their communications are held confidential by the nurse and physician. The legal requirements in both of these health care situations need to be understood before the nurse is in the position of having abused a law or state regulation. If the law protects the privacy of the adolescent, the nurse needs to discuss with the parents the nurse's rationale for allowing the adolescent to have a private discussion and the need to keep this information confidential. If the law allows the parent or guardian access to the adolescent's health care information, the nurse needs to discuss this issue with the adolescent in order to maintain a relationship of trust. Adolescents may be less likely to share personal and private information with the nurse if they know that the nurse must disclose this information to their parent or guardian.

Every state allows minors to consent for care related to sexually transmitted disease (STD). Many of the statutes use the term “venereal disease” rather than ‘sexually transmitted disease.’ Some states refer to a specific list of STDs.

At least 34 states allow minors to consent for family planning services or contraceptive services. Even in the absence of such a statute, however, there may be a basis for minors to consent for these services, based on the constitutional right of privacy or if the services are provided at a site funded under the federal Title X Family Planning Program or if the minor is a Medicaid beneficiary.

At least 35 states allow minors to consent to pregnancy-related care. These statutes, however, may specifically exempt abortion. Whether minors may obtain an abortion without parental consent or notification has been the subject of extensive legislation and litigation. Currently minors are able to do so in less than one-third of the states. Nurses are encouraged to seek up-to-date information about the current status of parental notification or consent to abortion for adolescents on both federal and state levels.

Preventable Injuries

Three-fourths of all adolescent deaths occur due to preventable injuries. Legal cases in our nation’s courts have identified that nurses have a duty to teach patients upon discharge from health care facilities and the duty to inform their patients of known and foreseeable risks. Foreseeable risks are those risks we should be able to anticipate and therefore avoid. Nurses who work in community settings need to inform the adolescent population of the consequences of behavior that increases their risk of harm. Nurses in roles of health care teachers and health care providers in community settings must take this responsibility seriously. Preventable injuries are very often related to automobile and sports equipment accidents. However, the risks of sexually transmitted disease for reproductive health nurses and suicide for mental health nurses are also preventable injuries that nurses need to discuss with adolescents. These are foreseeable and known risks during the

adolescent years. The warning signs of depression or manic behavior must be recognized by nurses in order to intervene to prevent the risks of injury associated with these illnesses. The adolescent who has articulated a plan for harming him/herself must be protected and guided to an appropriate health care provider to receive mental health support and treatment. The adolescent who has disclosed sexual activity, must be informed of the risks of sexually transmitted disease and undesired pregnancy. The adolescent who has a driving record which indicates high risk behavior must also be counseled regarding the preventable injuries that are foreseeable due to this high risk activity.

Youth Risk Behavior Statistics

Nurses are providing care to adolescents that is often needed because of the adolescent's high risk lifestyle. Current trends are reflected in the following statistics from the National Youth Risk Survey conducted by the Centers for Communicable Disease:

- Seventy percent of all deaths of persons between the ages of 10-24 were due to automobile crashes and other unintentional injuries, homicide, and suicide.
- Motor vehicle accidents are the third leading cause of death in adolescence. During the 30 days preceding the survey, 18% of students in grades 9 to 12 had not worn a seatbelt when riding in a car driven by someone else. Thirty percent had ridden in a car with a driver who had been drinking alcohol.
- The sexual behavior questions provided through this survey indicated that 47% of the high school students reported they had had sexual intercourse in their lifetime and 34% reported sexual intercourse during the 3 months preceding the survey. Twenty-seven percent had not used a condom during their last sexual intercourse. Four percent of students had been pregnant or had gotten someone pregnant.
- Almost thirty percent of adolescents surveyed felt sad or hopeless for two or more consecutive weeks that stopped them from doing some of their usual activities. Seventeen

percent of adolescents surveyed had made a specific plan to attempt suicide. Nine percent of adolescents surveyed had attempted suicide. The greatest number of attempts were in the 9th and 10th grades.

Substance Abuse

Substance use and abuse should also be viewed by nurses as a preventable injury. Mental health and preventable injuries and other behaviors, such as drug abuse and alcohol use, that place the adolescent's health at risk are closely connected. Problems in one area generally place adolescents at risk for several foreseeable events. For example, it may be foreseeable that a depressed adolescent will drink and drive. Substance use and abuse concerns of nurses must include knowledge of the legal reporting laws in the nurse's jurisdiction. The nurse may not be the actual person who reports known substance abuse to the legal authority, but the nurse is ultimately responsible to inform his/her supervisor or whomever has the legal responsibility for the agency to report this illegal activity. Parental or guardian involvement will also be dictated by state statute detailing whether the adolescent's privacy is protected or whether notification of the parents/guardian is required. The nurse must understand the requirements of these reporting laws including when behavior must be reported. If nurses are required to notify the parents and elect not to do so, the adolescent may later be seriously harmed by their risky behavior because of the lack of intervention. The parents could claim that the nurse withheld information and denied them the opportunity to intervene to protect the adolescent. Parental neglect may become a legal issue if adolescents are not protected from their own high risk behavior.

The National Youth Risk Survey showed that the majority of high risk illegal behaviors begin prior to age 13. Almost 45% students drank alcohol during the previous 30 days. Marijuana use was reported by 40%, cocaine 9%, inhalants (sniffed glue, breathed the contents of aerosol spray cans) 12%, illegal steroids 6%, heroin 3%, methamphetamines 8%, and ecstasy use was reported by 11% of the high school students.

Violence

Finally, a serious area of concern when caring for adolescents is violence. Our society deals with violence in the criminal justice system because of the seriousness of the consequences of violent behavior. When an adolescent is brought to an emergency department with injuries, there are consent issues and parental notification issues. If the adolescent requires immediate treatment to avoid serious harm or death, the emergency room nurses are given legal protection to proceed with this care without parental consent. However, if the adolescent's injuries do not require immediate care, notification of the parent or guardian is necessary to receive consent for treatment of the adolescent. There are also legal reporting requirements when a violent injury must be treated. Nurses must be familiar with reporting laws in their state and follow their employer's procedures and channels of communications for notifying those who must notify the authorities of the violent injury.

- Nationwide, 33% of adolescents had been in a physical fight during the previous 12 months of the survey. Four percent of these students required treatment for their injuries. Thirteen percent of these fights had been on school property.

- Nine percent of adolescents had been threatened or injured with a weapon (gun, knife, or club) on school property during the 30 days preceding the survey. Five percent had missed school because they felt unsafe at school or unsafe on the way to and from school.
- Nine percent of adolescents identified that they were forced to have sexual intercourse when they did not want to.

Seeking Legal Advice

Nurses are not educated as lawyers and should not be expected to understand the legal system and all of its complexity without the support of professional legal advice. It is a good idea to know who can answer legal questions for you on behalf of your agency prior to the need for immediate legal advice. For private agencies, a corporate counsel or attorney is usually available for formal advice on legal issues impacting the agency and its staff. The agency may have policies, procedures, and protocols on how and who can approach the agency's legal counsel with questions, but the nurse should have access to these channels of inquiry. In Veterans Administration (VA) and Public Health Service (PHS) hospitals, there are legal counsels who are well informed on federal health care law that is applied to these federal agencies. Nurses who work in VA or PHS hospitals must rely upon the expertise of these attorneys to inform them of the specific regulations and rights of their patients. VA and PHS patient's legal rights are protected under federal regulations rather than state statutes.

Nurses who work in public facilities such as county and state health departments will rely upon the Attorney General's office for the legal advice they need in order to comply with patient

consent, confidentiality, privacy, and reporting laws. In large public agencies, there may be a legal department or a specific legal counsel identified to address the specific concerns of each division or department. If a nurse or the agency is concerned about an ethical issue that does not appear to be clearly defined in regulations, rules, or law, the nurse and the agency may request a written opinion from the Attorney General's office. An Attorney General's opinion gives legal advice about unclear legal or ethical issues and may be relied upon by the nurse and the agency as they proceed to provide care to patients in the developing legal and ethical areas of care. Nurses need to become informed of the legal resources available prior to a problem arising. If nurses have answers to concerns prior to providing treatment, errors can be prevented. Nurses must also be trained under the HIPAA regulations on how to protect the privacy of patient information. During training sessions, nurses should clarify specific issues related to caring for adolescent patients. If the legal counsel presenting the HIPAA training does not provide an immediate response to the nurses' questions, they can research the issue for the specific rules in that statutory jurisdiction and provide the information they need to practice nursing within the law.

Risk Management for Nurses.

Many nurses struggle with the question of whether they need personal professional liability (malpractice) insurance. Often employers reassure nurses that they are amply covered by the employer's liability insurance coverage. However, if a nurse provides voluntary services outside the scope of their employment or intentionally violates an agency policy or procedure, he/she will not be covered by the employer's liability insurance coverage and would, therefore, be well advised to carry his/her own personal liability insurance coverage. The threat of the "deep pockets", the belief that the nurse has the financial backing to pay a judgment fee, is often shared by nurses. In reality, the patient who becomes a plaintiff will name a nurse as a defendant if the patient believes that the nurse has caused an injury whether or not the nurse has his/her own insurance coverage. It is highly

risky behavior to not carry personal professional liability insurance in today's litigious health care environment. The cost of personal liability insurance for nurses is still remarkably reasonable compared to fees physicians must pay. When a nurse has a personal policy, the nurse's own defense counsel is provided by the insurance company to look out for the nurse's interests, rather than having to rely upon the legal counsel who is protecting the hospital or agency's interest. If the nurse finds himself or herself in a conflict with the employer, the nurse will be very happy to have his/her own legal counsel looking out for his/her special interests.

There are two forms of professional liability (malpractice) insurance coverage available to nurses. The first type of insurance is called a claims made policy and requires that the nurse be covered by the insurance at the time the incident occurs and that the claim is made while the nurse is also still covered by this individual policy. If a nurse desires to change insurance with a claims-made policy, the nurse should consider purchasing tail coverage in order to insure that incidents occurring during the claims-made policy will be covered after the insurance policy is no longer held. Tail coverage can be expensive. The second form and the recommended type of insurance for nurses is called an occurrence policy. Under an occurrence policy the nurse is covered by the insurance protection if the incident occurs while the nurse is insured by the policy. If the plaintiff brings suit after the policy is no longer held, the nurse is still protected by the policy if the injury occurred while the nurse was insured by the occurrence policy. This type of policy does not cause the nurse to have to purchase expensive tail coverage. It can be difficult to determine what type of policy the nurse is being offered. It is wise to clarify in writing with the insurance company whether the policy is a claims-made or occurrence-type policy.

If the nurse has his/her own personal professional liability insurance, he/she is provided with his/her own legal counsel. The nurse can also provide services to persons outside the scope of employment with greater peace of mind that professional actions will be covered by insurance if

they are reasonable and are not excluded from policy conditions. It is very important to understand the terms and conditions of a personal professional liability insurance policy. Timely notification of possible claims as well as other terms and conditions must be closely followed. It is important to be totally honest with the insurance company to avoid losing the coverage through charges of fraud or misrepresentation of actions. Insurance companies estimate their risk determined by the nurse's specific practice setting. If the work setting changes, such as from a medical-surgical unit to an intensive care unit or to obstetrics, notify and update the insurance carrier.

Incident Reports

Incident reports are a risk management tool that enable health care agencies to improve the manner in which health care is provided. Most employers of nurses have policies, procedures, and protocols on how and when to file an incident report. It is especially important that nurses comply with their employer's policies and procedures for notifying risk management and administration of a potential problem. A formal incident report form must always be used when filing an incident report, or this risk management tool may not be protected under the discovery rules of your state. Most jurisdictions still protect these documents from being available to a plaintiff's attorney in order to allow agencies to improve the way care is provided through open and honest internal communications. If the nurse documents in the patient's record that an incident report was filed, the incident report may become available to the plaintiff's attorney through a legal term entitled incorporation by reference. It is important to document in the patient's record the facts of care provided without mentioning that an incident report has been filed. It is also important when creating the incident report to document objective observations and to avoid accusations and opinions about why or who caused the injury. Subjective opinions will not assist risk management

and may cause damage to the agency's case if a legal action results, and the incident report becomes discoverable by the plaintiff's attorney.

Conclusion

Ignorance of the law is no defense to having unknowingly ignored the law. If a reporting requirement exists, nurses must understand the notification and reporting requirements and comply with the language of the law. Providing health care to adolescents becomes more complicated when consent and confidentiality issues are being considered. The nurse is not just working with the adolescent patient but must know who legally has the right to consent on behalf of the adolescent and what the adolescent's rights for confidentiality and privacy of the patient care information are when sharing the information with the parent or guardian. If the adolescent has parents who are divorced, the nurse must assure that the parent who has been identified as the patient's legal guardian, with the legal capacity to consent on behalf of the adolescent, is indeed the parent who is being given the privilege to act as the adolescent's surrogate decision maker. This is just one example of the complications that can arise when caring for persons under the age of 18 who are not emancipated and do not have the capacity to consent on their own behalf.

The Healthy People 2010 twenty-one critical objectives for adolescents and young adults cluster around the six major health areas of chronic illness, mental health, preventable injuries, and reproductive and sexual health, substance use and abuse, and violence. The legal implications for nursing care that is provided to adolescents in all of these six areas of care carry with them the responsibility to understand the adolescent's right to consent or to refuse treatment, and who may act on their behalf. Additionally, nurses must understand the adolescent's right to have their treatment remain confidential or who has the right to have this information disclosed to him/her because of the adolescent's status under the law. Nurses must understand their legal obligations, such as reporting laws, and consent and confidentiality issues when treating adolescent patients. The advice of legal

counsel is important to understanding the various approaches to these issues in different jurisdictions across our country. The federal HIPAA regulations give nation-wide guidance for protection of the right to privacy of patients' medical records. State guidelines also provide guidance on the confidentiality rights of adolescents and the disclosure of this information to parents or guardians.

Author

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References

Howze, Karen A. (2002). *Health for teens in care: A judge's guide*. American Bar Association Center on Children and the Law. [Ordering information is available at

<http://www.abanet.org/child/home2.html>]

English, Abigail and Kennley, Kirsten. (2003). *State minor consent laws: A summary* (2nd Ed.).

Center for Adolescent Health & the Law. May, 2003. [Ordering information is available at

www.cahl.org]

Youth risk behavior surveillance – United States, 2003. Center for Disease Control and Prevention.

Surveillance Summaries, May 21, 2004. Morbidity and Mortality Weekly Report 2004:53

(No. SS-2). <http://www.cdc.gov/mmr/PDF/SS/SS5302.PDF>

Recommended Readings

- Adams, K.E. (2004). Mandatory parental notification: the importance of confidential health care for adolescents. *Journal of American Medical Women's Association*, 59(2), 87-90.
- Bertuglia, J. (2001). Preserving the right to choose: a minor's right to confidential reproductive health care. *Women's Rights Law Report*, 23(1), 63-77.
- Brindis, C. (2002). Advancing the adolescent reproductive health policy agenda: issues for the coming decade. *Journal of Adolescent Health*, 31(6), Supp. O.
- Brindis, C.D., Llewelyn, L., Marie, K., Blum, M., Biggs, A., Maternowska, C. (2003) Meeting the reproductive health care needs of adolescents: California's family planning access, care, and treatment program. *Journal of Adolescent Health*, 32(6), Supp. O.
- Champion, J.D., Shain, R.N., Piper, J. (2004). Minority adolescent women with sexually transmitted diseases and a history of sexual or physical abuse. *Issues in Mental Health Nursing*, 25(3), 293-316.
- Diaz, A., Neal, W.P., Nucci, A.T., Ludmer, P., Bitterman, J., Edwards, S. (2004). Legal and ethical issues facing adolescent health care professionals. *Mount Sinai Journal of Medicine*, 71(3), 181-5.
- Dickey, S.B., Kiefner, J., Beidler, S.M. (2002). Consent and confidentiality issues among school-age children and adolescents. *Journal of School Nursing*, 18(3), 179-86.
- Doswell, W.M., Braxter, B. (2002). Risk-taking behaviors in early adolescent minority women: implications for research and practice. *Journal of Obstetrical, Gynecologic and Neonatal Nursing*, 31(4), 454-61.
- English, A., Ford, C.A. (2004). The HIPAA privacy rule and adolescents: legal questions and clinical challenges. *Perspectives in Sexual and Reproductive Health*, 36(2), 80-6.

- English, A. (2002). The health of adolescent girls: does the law support it?: Current Women's Health Reproduction, 2(6), 442-9.
- Gruskin, S., Plafker, K, Smith-Estelle, A. (2001). Understanding and responding to youth substance abuse: the contribution of a health and human rights framework. *American Journal of Public Health*, 91(12), 1954-1963.
- Kington, Y.S., O'Sullivan, A.L. (2001). The family as a protective asset in adolescent development. *Journal of Holistic Nursing*, 19, 102-126.
- Kirby, D. (2002). Antecedents of adolescent initiation of sex, contraceptive use, and pregnancy. *American Journal of Health Behavior*, 26(6), 473-85.
- Kirby, D., Miller, B.C. (2002). Interventions designed to promote parent-teen communication about sexuality. *New Directions in Child Adolescent Development*, 97, 93-110.
- Klein, J.D., Wilson, K.M. (2002). Delivering quality care: adolescents' discussion of health risks with their providers. *Journal of Adolescents Health*, 30(3), 190-5
- Lederman, R.P., Mian, T.S. (2003). The parent-adolescent relationship education PARE program: a curriculum for prevention of STDs and pregnancy in middle school youth. *Behavioral Medicine*, 29(1), 33-41.
- Levine, P.B. (2003). Parental involvement laws and fertility behavior. *Journal of Health Economics*, 22(5), 861-78.
- Maradiegue, A. (2003). Minor's rights versus parental rights: review of legal issues in adolescent health care. *Journal of Midwifery and Women's Health*, 48(3), 170-7.
- Martyn, K.K., Martin, R. (2003). Adolescent sexual risk assessment. *Journal of Midwifery & Women's Health*, 48(3), 213-219.
- Mays, R.M., Zime, G.D. (2004). Recommending STI vaccination to parents of adolescents: the attitudes of nurse practitioners. *Sexually Transmitted Diseases*, 31(7), 428-32.

Pohlman, K., Schwab, N. (2001). Consent and release. *Journal of School Nursing*, 17(3),162-5.

Renker, P.R. (2002). "Keep a blank face. I need to tell you what has been happening to me."

American Journal of Maternal-Child Nursing,27(2), 109-16.

Wissow, L., Fothergill, K., Forman, J. (2002). Confidentiality for mental health concerns in adolescent primary care. *Bioethics Forum*, 18(3-4), 43-45.