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AIDS and Adolescents

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AIDS AND ADOLESCENTS

RHONDA GAY HARTMAN*

INTRODUCTION

The Acquired Immunodeficiency Syndrome (AIDS) epidemic, due to unique transmission, fatal course, psychosocial implication, and discrimination from social opprobrium, has provided legislative stimulus for policy designed to achieve balance among public health concerns of preventing, treating, and monitoring the disease, and private, decision-making interests.¹ Statutory law requires voluntary informed consent to testing and treatment,² confidentiality protections for testing persons at risk,³ medical judgment to determine who should be tested for Human Immunodeficiency Virus (HIV) infection,⁴ reportage of HIV-positive test results to public health registries,⁵ and health department development of protocol.⁶

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1. *E.g.*, FLA. STAT. ANN. § 381.0037 (West 2002 & Supp. 2004) (declaring a public policy for balancing medical necessity, privacy rights, and harm prevention).

2. *E.g.*, ALA. CODE § 22-11A-51(a) (1997 & Supp. 2003); ARIZ. REV. STAT. ANN. § 36-663(A) & (B)(4) (West 2003 & Supp. 2003); CAL. HEALTH & SAFETY CODE § 120990 (West 1996 & Supp. 2004); DEL. CODE ANN. tit. 16 § 1202(a)-(b) (1999); FLA. STAT. ANN. § 381.004(3) (West 2002 & Supp. 2004); HAW. REV. STAT. ANN. § 325-16(a) (Michie 2000 & Supp. 2003); IND. CODE ANN. § 16-41-6-1(a) (Michie 1993 & Supp. 2003); IOWA CODE ANN. § 141A.8 (West 1997 & Supp. 2004); KY. REV. STAT. ANN. § 214.181(5)(a) (Banks-Baldwin 1992 & Supp. 2003); LA. REV. STAT. ANN. § 40:1300.13(A) (West 2001 & Supp. 2004); ME. REV. STAT. ANN. tit. 5, § 19203-A(1) (West 2002 & Supp. 2003); MASS. GEN. LAWS ANN. ch. 111, § 70F (West 2003 & Supp. 2004); MONT. CODE ANN. § 50-16-1007(1) (2003); NEB. REV. STAT. § 71-531(1) & (2) (1996 & Supp. 2002); N.H. REV. STAT. ANN. § 141-F:5 (1996 & Supp. 2003); N.D. CENT. CODE § 23-07.5-02 (1) & (2) (2002 & Supp. 2003); OHIO REV. CODE ANN. § 3701.242(A) (Anderson 2002 & Supp. 2003); 35 PA. CONS. STAT. ANN. § 7606(b)(1)(ii) (West 2003 & Supp. 2003); R.I. GEN. LAWS § 23-17-31(a) (1996 & Supp. 2002); WASH. REV. CODE ANN. § 70.24.330 (West 2002 & Supp. 2004); W.VA. CODE ANN. § 16-3C-2(a)(4), (c) (Michie 2001 & Supp. 2003).

3. *E.g.*, ARIZ. REV. STAT. ANN. § 36-663(B)(3) (West 2003 & Supp. 2003); FLA. STAT. ANN. § 381.004(3)(a) (West 2002 & Supp. 2004); GA. CODE ANN. § 24-9-47 (1995 & Supp. 2003); HAW. REV. STAT. ANN. § 325-16(c) (Michie 2000 & Supp. 2003); 410 ILL. COMP. STAT. ANN. 305/6 (West 1997 & Supp. 2004); LA. REV. STAT. ANN. § 40:1300.13E (West 2001 & Supp. 2004); ME. REV. STAT. ANN. tit. 5, § 19203 (West 2002 & Supp. 2003); N.Y. PUB. HEALTH LAW § 2782 (McKinney 2002 & Supp. 2004); W.VA. CODE ANN. § 16-3C-3(a)(5) (Michie 2001 & Supp. 2003); WIS. STAT. ANN. § 252.15(5) (2004).

4. *See, e.g.*, ALA. CODE § 22-11A-52 (1997 & Supp. 2003); ARIZ. REV. STAT. ANN. § 36-663(D)(5) (West 2003 & Supp. 2003); FLA. STAT. ANN. § 381.004(3) (West 2002 & Supp. 2004); HAW. REV. STAT. ANN. § 325-16(b)(5)-(6) (Michie 2000 & Supp. 2003); IND. CODE ANN. § 16-41-6-1(b)(1) (Michie 2001 & Supp. 2003); MISS. CODE ANN. § 41-41-16 (2001 & Supp. 2003); MONT. CODE

Statutes that aim to protect public health and safeguard personal privacy interests largely exclude those most at risk for HIV infection and AIDS – adolescents.⁷ Adolescents (fourteen through seventeen) constitute a subset of minors, defined by law as persons under eighteen years and presumed to lack decision-making ability.⁸ This presumption derives from anecdotal assertion about vulnerability and decisional incapacity and is at odds with prevailing social and scientific evidence.⁹ Anecdotal assertion does not legitimize the legal disparity in decision-making stature to substantiate extensive state restriction on adolescent decisional liberty. Adolescent decisional liberty remains unexamined in the context of AIDS. Adolescents have not been the focus of scholarly writing and policy analysis about HIV decision making, yet they merit specialized attention due to their distinction as an HIV-infected group reaching crisis proportion and to the complexities in law related to their decisional ability.

While the disabled legal status of adolescents may explain, in part, their absence from legislative priority, a paradigmatic shift in the progression of AIDS compels policy attention directed toward the unprecedented rise of HIV infection among adolescents mainly attributed to transmission by sexual activity.¹⁰ Complicating this is the long-standing legal supposition that adolescents are

ANN. § 50-16-1007(1)(c)(iii) (2003); N.H. REV. STAT. ANN. § 141-F:5V (1996 & Supp. 2003); OHIO REV. CODE ANN. § 3701.242(E)(5) (Anderson 2002 & Supp. 2003).

5. *E.g.*, ARIZ. REV. STAT. ANN. § 36-663(B)(5) (West 2003 & Supp. 2003); COLO. REV. STAT. ANN. § 25-4-1405(3) (West 2001 & Supp. 2003); FLA. STAT. ANN. § 381.004(3)(e)(5), (15) (West 2002 & Supp. 2004); GA. CODE ANN. § 31-22-9.2(b) (2001); ME. REV. STAT. ANN. tit. 5, § 19203 (West 2002 & Supp. 2003); S.C. CODE ANN. § 44-29-80 (Law. Co-op. 2002 & Supp. 2003).

6. *See, e.g.*, COLO. REV. STAT. ANN. § 25-4-1405(3) (West 2001); FLA. STAT. ANN. § 381.004(8) (West 2002 & Supp. 2004); HAW. REV. STAT. ANN. § 325-16(e) (Michie 2004); KY. REV. STAT. ANN. § 214.181(6) (Banks-Baldwin 1992 & Supp. 2003); LA. REV. STAT. ANN. § 40:1300.16 (West 2001); N.Y. PUB. HEALTH LAW § 2786 (McKinney 2002); W.VA. CODE ANN. § 16-3C-2(e)(2) (Michie 2001 & Supp. 2003).

7. *See* CTRS. FOR DISEASE CONTROL AND PREVENTION, FACTS ABOUT ADOLESCENTS AND HIV/AIDS (March 1998) (noting that as many as 50% of new HIV cases in the U.S. may be people under age 25, and as many as 25% may be people under age 22), *available at* <http://www.thebody.com/cdc/hivteen.html> (last visited June 5, 2004).

8. *Parham v. J.R.*, 442 U.S. 584, 602 (1979); *see generally* Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J. L. & MED. 409 (2002).

9. *See* Marilyn Jacobs Quadrel et al., *Adolescent (In)vulnerability*, 48 AM. PSYCHOLOGIST 102, 111 (1993) (reproving policies “based on anecdotal observations and cultural presumptions about adolescents”); William Gardner & Janna Herman, *Adolescents’ AIDS Risk Taking: A Rational Choice Perspective*, 50 NEW DIRECTIONS FOR CHILD DEV. 17, 19 (1990) (explaining that “contrary to popular belief, there is little evidence that adolescents lack the information-processing capacity to make rational decisions”).

10. *See* Comm. on Pediatric AIDS and Comm. on Adolescence, Am. Acad. Of Pediatrics, *Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention*, 107 PEDIATRICS 188 (2001); Susan G. Millstein, *Risk Factors For AIDS Among Adolescents*, 50 NEW DIRECTIONS FOR CHILD DEV. 3, 4-5 (1990); Catherine Lewis et al., *School-Based Primary Prevention: What is an Effective Program?* 50 NEW DIRECTIONS FOR CHILD DEV. 35, 36 (1990).

incapable of decision making, despite recognition of adolescent decisional autonomy for criminal responsibility,¹¹ tort and contract liability,¹² medical decision making for certain conditions, such as substance abuse and venereal disease,¹³ and in social situations such as marriage or high school graduation.¹⁴

State statutes aimed toward AIDS are virtually silent as to adolescents. Those that mention adolescents routinely require parent notification and consent that obscure privacy protection for access to testing and treatment.¹⁵ State-engineered notification and consent barriers contravene policy objectives for HIV reduction and detract from adolescent decision-making development. By not protecting adolescent privacy in accessing health care, lawmakers miss an important opportunity to advance state *parens patriae* power toward the development of adolescent decision-making ability in the context of HIV. Vigilance by lawmakers is required to remove – rather than erect – barriers to responsible decision making by adolescents in the prevention and reduction of HIV infection and AIDS. A practical, comprehensive approach is needed for charting consistent policy over a range of issues related to adolescent medical decision making for testing and treatment. Indeed, the crisis of HIV infection among adolescents constitutes an opportunity for policymakers to establish a model framework on which laws related to adolescent decision making in health care generally may be based. A significant step toward this end requires close scrutiny of current statutory law in order to identify shortcomings and challenge underlying policy assertions that pose

11. See ARIZ. REV. STAT. ANN. § 8-341(E) (West 1999 & Supp. 2003); 705 ILL. COMP. STAT. ANN. 405/5-101 (West 1999 & Supp. 2004); MD. CODE ANN., CTS. & JUD. PROC. § 3-8A-05 (2002); 42 PA. CONS. STAT. ANN. § 6355 (West 2003 & Supp. 2003); accord 18 U.S.C. § 5032 (2000).

12. See, e.g., CAL. FAM. CODE § 6600 (West 1994); MONT. CODE ANN. § 41-1-201, 305, 306 (2003). For a fuller discussion of adolescent legal autonomy in the context of tort and contract liability, see Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L. J. 1265, 1301-05 (2000).

13. E.g. ARIZ. REV. STAT. ANN. § 44-133.01 (West 2003 & Supp. 2003) (substance abuse); CAL. FAM. CODE §§ 6926, 6929 (West 1994 & Supp. 2004) (substance abuse, STDs); 410 ILL. COMP. STAT. ANN. 210/4-4 (West 1997 & Supp. 2003) (substance abuse, STDs); MD. CODE ANN. HEALTH-GEN. I § 20-102(c) (2000 & Supp. 2003) (substance abuse, STDs); MASS. GEN. LAWS ch. 112, § 12E (West 2003 & Supp. 2004) (substance abuse); PA. STAT. ANN. tit. 35, § 521.14a (West 2003 & Supp. 2003) (STDs); VT. STAT. ANN. tit. 18, § 4226 (2002 & Supp. 2003) (substance abuse and STDs); WYO. STAT. ANN. § 35-4-131 (Michie 2003) (STDs).

14. E.g., KY. REV. STAT. ANN. § 214.185(3) (Banks-Baldwin 1992 & Supp. 2003) (marriage); ME. REV. STAT. ANN. tit. 22, § 1503 (West 2004) (marriage); MD. CODE ANN., FAM. LAW § 2-301(a)(2) (1999 & Supp. 2003) (marriage); MASS. GEN. LAWS ANN. ch. 112, § 12F (West 2003 & Supp. 2004) (marriage or divorce); MONT. CODE ANN. § 41-1-402(2)(a) (2003) (marriage or high school graduation); OKLA. STAT. ANN. tit. 63, § 2602(A)(1) (West 2004) (marriage); PA. STAT. ANN. tit. 35, § 10101 (West 1993 & Supp. 2003) (marriage or high school graduation); R.I. GEN. LAWS § 23-4.6-1 (1996) (marriage); VA. CODE ANN. § 54.1-2969F (Michie 2002 & Supp. 2003) (marriage).

15. See, e.g., CONN. GEN. STAT. ANN. § 19a-592(a) (West 2003); MICH. COMP. LAWS ANN. § 333.5127(2) (West 2001); N.C. GEN. STAT. § 130A-148(h) (2003); N.D. CENT. CODE § 23-07.5-02(2) (2002 & Supp. 2003).

impediments to promoting adolescent health and preventing the spread of HIV infection and AIDS.

Accordingly, Part I discusses statutory law aimed at HIV infection and AIDS while Part II fleshes out deficiencies in this statutory law related to adolescents as a high-risk group that compel increased legislative attention. Part III proposes policy and procedure to enhance risk reduction and disease prevention for adolescents. In so doing, Part III sets forth a framework for analyzing decisional rights of adolescents and state interests compatible with both *parens patriae* and due process.

I. STATUTORY LAW AND POLICY

Although the AIDS epidemic has captured public health and policy attention, nearly half of the states have yet to enact legislation to address HIV testing, treatment, and related issues. One reason may be the social stigma and controversy associated with AIDS that offers a disincentive to lawmakers for developing cohesive policy, delegating instead to state health departments the task of promulgating protocol. Closely allied is an assumption by lawmakers that issues attendant to the AIDS crisis will be effectively dealt with by health departments. States that have enacted statutes aimed at HIV issues elucidate public policy to promote confidential voluntary testing and counseling for HIV infection in order to reduce risk for spread of the disease and increase awareness about treatment and prevention.¹⁶ These statutes typically include provisions for informed consent, testing and counseling that triggers confidentiality, reportage by health care providers to state registries, and dissemination of information for risk-reduction education and disease prevention. Of these states, California, Colorado, Connecticut, Delaware, Michigan, Montana, New Mexico, North Carolina, Ohio, West Virginia, and Wisconsin mention minors.¹⁷

A. Testing and Treatment

States that address HIV infection and AIDS encourage voluntary testing.¹⁸ Prior to testing, providers must engage decisionally-capable persons in a consent

16. See *supra* notes 1-6 and accompanying text.

17. E.g., CAL. HEALTH & SAFETY CODE § 121020(a)(1) (West 1996); COLO. REV. STAT. ANN. § 25-4-1405(6) (West 2001 & Supp. 2003); CONN. GEN. STAT. ANN. § 19a-592 (West 2003); DEL. CODE ANN. tit. 16, § 1202(f) (2003); MICH. COMP. LAWS ANN. § 333.5127 (West 2001); MONT. CODE ANN. § 50-16-1007(8) (2003); N.M. STAT. ANN. § 24-2B-3 (Michie 2000); N.C. GEN. STAT. § 130A-148(h) (2003); OHIO REV. CODE ANN. § 3701.242(B) (Anderson 2002 & Supp. 2003); W.VA. CODE ANN. § 16-3C-2(e)(2) (Michie 2001 & Supp. 2003); WIS. STAT. ANN. § 252.15(2) (West 2004).

18. See, e.g., CONN. GEN. STAT. ANN. § 19a-594 (West 2003); R.I. GEN. LAWS § 23-11-17 (1996 & Supp. 2002) (requiring physicians to offer HIV testing to "all persons" and pre- and post-test counseling to coincide with medical standards).

process. According to Delaware's statutory scheme, that informed consent *shall* include an explanation of the nature of AIDS and manifestations of HIV infection, behaviors known to pose risk for transmission, purposes and potential uses of HIV test results, the manner and extent to which results will be kept confidential, and withdrawal of consent to testing.¹⁹ Yet, the legal disability of minors – despite any actual decision-making capacity that may exist – routinely necessitates parent or guardian consent for most medical testing and treatment, thus proscribing physicians from accepting consent from adolescents.

Despite the disability barrier, some states permit adolescents to consent to medical care for specific conditions such as substance abuse.²⁰ Fewer states afford adolescents legal autonomy for mental health treatment²¹ and for routine medical care, usually with age restrictions.²² Sexually transmitted diseases constitute a condition for which states widely recognize legal autonomy of adolescents in order to encourage testing and treatment.²³ Most STD statutes omit any reference to HIV testing,²⁴ although in practice physicians extend policy underlying these statutes to permit adolescent consent. One plausible explanation may be that the absence of statutory protection for adolescent consent to HIV testing otherwise discourages adolescents from accessing care and education concerning risk reduction and prevention. Critical to physician consideration in allowing

19. DEL. CODE ANN. tit. 16, § 1202(b) (2003).

20. *E.g.*, ARIZ. REV. STAT. ANN. § 44-133.01 (West 2003 & Supp. 2003); CAL. FAM. CODE § 6929(b) (West 1994 & Supp. 2004); GA. CODE ANN. § 37-7-8 (1995); 410 ILL. COMP. STAT. ANN. 210/4 (West 1997 & Supp. 2003); LA. REV. STAT. ANN. § 40:1096(A) (West 2001 & Supp. 2004); MASS. GEN. LAWS ANN. ch. 112, § 12E (West 2003 & Supp. 2004); MICH. COMP. LAWS ANN. § 333.6121(1) (West 2001 & Supp. 2003); MISS. CODE ANN. § 41-41-14 (2001); PA. STAT. ANN. tit. 71, § 1690.112 (West 1990 & Supp. 2003); VT. STAT. ANN. tit. 18, § 4226 (1982); WIS. STAT. § 51.47 (2003).

21. *E.g.*, CAL. FAM. CODE § 6924 (West 1994 & Supp. 2004); CONN. GEN. STAT. § 19a-14c (West 2003); D.C. CODE ANN. § 7-1231.14 (2001 & Supp. 2003); FLA. STAT. ANN. § 394.4784 (West 2002 & Supp. 2004); MONT. CODE ANN. § 53-21-112 (2003); N.Y. MENTAL HYG. LAW § 33.21 (McKinney 2002 & Supp. 2004); OHIO REV. CODE ANN. § 5122.04 (Anderson 2004); PA. STAT. ANN. tit. 50, § 7201 (West 2001); WIS. STAT. ANN. § 51.14 (West 2003 & Supp. 2003).

22. *E.g.*, KAN. STAT. ANN. § 38-123b (2000); R.I. GEN. LAWS § 23-4.6-1 (1996).

23. *E.g.*, ALA. CODE § 22-11A-19 (1997); ALASKA STAT. § 25.20.025(4) (Michie 2002); ARIZ. REV. STAT. ANN. § 44-132.01 (West 2003 & Supp. 2003); COLO. REV. STAT. ANN. § 25-4-402(4) (West 2001 & Supp. 2003); DEL. CODE ANN. tit. 13, § 710 (1999); FLA. STAT. ANN. § 384.30 (West 2002 & Supp. 2004); GA. CODE ANN. § 31-17-7(a) (2001); HAW. REV. STAT. ANN. § 577A-2 (Michie 1999); KY. REV. STAT. ANN. § 214.185(1) (Banks-Baldwin 1992 & Supp. 2003); LA. REV. STAT. ANN. § 40:1065.1(A) (West 2001 & Supp. 2004); ME. REV. STAT. ANN. tit. 22, § 1823 (West 2004); MINN. STAT. ANN. § 144.343(1) (West 1998 & Supp. 2004); MONT. CODE ANN. § 41-1-402(2)(c) (2003); N.J. STAT. ANN. § 9:17A-4 (West 2002 & Supp. 2003); OHIO REV. CODE ANN. § 3709.241 (Anderson 2002 & Supp. 2003); OKLA. STAT. ANN. tit. 63, § 1-532.1 (West 2004); OR. REV. STAT. § 109.610 (2003); PA. STAT. ANN. tit. 35, § 521.14a (West 2003 & Supp. 2003); S.D. CODIFIED LAWS § 34-23-16 (Michie 1994 & Supp. 2003); UTAH CODE ANN. § 26-6-18 (1998); VT. STAT. ANN. tit. 18, § 4226 (1982); VA. CODE ANN. § 54.1-2969E(1) (Michie 2002 & Supp. 2003); W. VA. CODE ANN. § 16-4-10 (Michie 2003). *See also* CAL. FAM. CODE § 6926 (West 1994 & Supp. 2004).

24. *Cf.* MICH. COMP. LAWS ANN. § 333.5127 (West 2001).

adolescent consent is the deterrent effect that parent notification has on health care access that is especially harmful given the increased incidence of HIV infection among adolescents. Actual prevalence of infected adolescents is *underestimated* because many adolescents do not get tested, which is not surprising given adolescent aversion to accessing health care.²⁵ Thus, as with STDs generally, physicians afford adolescents autonomy in order to optimize treatment for a condition with long-term and potentially fatal consequences.²⁶ There is some legal policy support for this medical position. Michigan, for example, includes HIV in statutes recognizing legally-valid consent by adolescents for STD testing and treatment,²⁷ and Wyoming extends legal consent to persons under eighteen for the examination and treatment of *any* STD infection.²⁸

Several states expressly afford physicians latitude for recognizing valid consent by a minor for HIV testing and treatment, provided they exercise independent judgment regarding reasons that parent or guardian involvement vis-à-vis consent requirements would impede testing and/or treatment.²⁹ California and Delaware, however, permit minors who are at least twelve years of age to consent to HIV testing and post-test counseling.³⁰ One state requires parental consent only if the minor is under fourteen years,³¹ while others expand the scope of legally-valid consent by minors without imposing any age restriction.³² Michigan and Ohio, for instance, characterize consent by a minor as valid and binding as if attaining adulthood, thereby alleviating legal concerns of practice liability by physicians who accept consent by a minor, as well as financial liability by

25. Brian L. Wilcox, *Federal Policy and Adolescent AIDS*, 50 NEW DIRECTIONS FOR CHILD DEV. 61, 67 (1990). Noting that increased incidence of adolescent infection is due, in part, to the long incubation period, William G. Buss reasons, "[s]ince the incidence of AIDS in young adults is high and the incubation period for AIDS (the second phase) is long, it must be true that many known cases of AIDS in young adults represent HIV infection that began during teenage years." William G. Buss, *Human Immunodeficiency Virus, the Legal Meaning of "Handicap," and Implications for Public Education Under Federal Law at the Dawn of the Age of the ADA*, 77 IOWA L. REV. 1389, 1400 (1992).

26. See Rhonda Gay Hartman, *Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices*, 8 U. CHI. L. SCH. ROUNDTABLE 87, 111 (2001) (reporting that physicians consider seriousness of medical condition as a factor influencing whether to honor adolescent patient decisions).

27. MICH. COMP. LAWS ANN. § 333.5127 (West 2001).

28. WYO. STAT. ANN. § 35-4-131(a) (Michie 2003).

29. See *infra* notes 35-39 and accompanying text.

30. CAL. HEALTH & SAFETY CODE § 121020(a)(1) (West 1996). Both Delaware and Montana recognize a minor's refusal of HIV testing and/or post-test counseling in addition to consent. DEL. CODE ANN. tit. 16, § 1202(f) (2003); MONT. CODE ANN. § 50-16-1007(8) (2003).

31. WIS. STAT. ANN. § 252.15(2)(a)(4)(a) (West 2004).

32. COLO. REV. STAT. ANN. § 25-4-1405(6) (West 2001 & Supp. 2003); MICH. COMP. LAWS ANN. § 333.5127(1) (West 2001); N.M. STAT. ANN. § 24-2B-3 (Michie 2000); OHIO REV. CODE ANN. § 3701.242(B) (Anderson 2002 & Supp. 2003).

parents.³³ Still, Michigan affords latitude to medical judgment for informing a parent or guardian notwithstanding the minor's express refusal.³⁴

Indicating preference for parental guidance during the minor's consent process, a few states encourage consent by a parent or guardian unless a physician determines and documents that such involvement would discourage the minor from undergoing testing and treatment.³⁵ As a requisite to testing a minor in the absence of a parent, North Carolina obligates physicians to document that they reasonably suspect the minor is infected and that consent by a parent or guardian is not forthcoming.³⁶ Yet, North Carolina does not recognize adolescent legal autonomy. Rather, it authorizes doctors to determine that such testing is medically necessary in the circumstances. Once physicians document medical necessity, they may treat an HIV-infected minor in the absence of parental involvement, although it is unclear whether physicians must document this determination each time the adolescent accesses treatment. HIV infection necessitates continuity of care and treatment by health care providers, conceivably necessitating multiple determinations of medical necessity until the adolescent achieves the age of majority.

B. Notification and Privacy

In states where legislators authorize valid consent by minors for HIV testing, notification to parents or guardians either before or after testing is left to physician judgment as to whether it would thwart treatment altogether or even dissuade an adolescent from accessing or continuing treatment.³⁷ Should a physician document reasons why parental notification would be ineffective, Connecticut, for example, recognizes the minor's consent as legally valid, attaching personal liability to the minor for costs incurred.³⁸ In a similar vein, Michigan delegates a degree of discretion to physicians regarding notification to inform a parent or guardian about an adolescent's HIV testing or treatment. While not obligating physicians to notify parents or guardians, the statute permits physicians to disclose information to them, should a physician adjudge notification

33. MICH. COMP LAWS ANN. § 333.5127(1) (West 2001); OHIO REV. CODE ANN. § 3701.242(B) (Anderson 2002 & Supp. 2003).

34. MICH. COMP LAWS ANN. § 333.5127(2) (West 2001). *Accord* COLO. REV. STAT. ANN. § 25-4-1405(6) (West 2001 & Supp. 2003).

35. *E.g.*, CONN. GEN. STAT. ANN. § 19a-592(a) (West 2003); N.C. Gen. Stat. § 130A-148(h) (2003).

36. N.C. GEN. STAT. § 130A-148(h) (2003).

37. *E.g.*, CONN. GEN. STAT. ANN. § 19a-592(a) (West 2003).

38. CONN. GEN. STAT. ANN. § 19a-592(b) (West 2003).

as appropriate.³⁹ The statute, however, is devoid of factors to guide medical judgment as to the inappropriateness for contacting a parent or guardian.

Notification provisions reflect, in substantial measure, the concern by state legislatures for greater parental involvement with adolescents. Legislative concern for parental involvement is juxtaposed, however, with concern for confidential HIV testing and treatment. Statutes that recognize a minor's consent to HIV testing occasionally include privacy protection, illustrated by Connecticut's statute that mandates confidentiality for consultation, examination, and treatment of a minor for HIV infection.⁴⁰ Implicit to statutory provisions according valid legal consent to minors for HIV testing and treatment is privacy protection for test results and communications, as part of "acceptable medical standards."⁴¹ As a public health contagion, physicians are required to report HIV-positive test results to state registries,⁴² similar to reportage of STDs generally. Should disclosure of HIV-related information exceed reportage requirements, civil and criminal penalties may attach. Unauthorized disclosure of HIV-related information constitutes a misdemeanor of the first degree in Florida and Wisconsin,⁴³ for instance, although it is unclear whether this sanction applies when the privacy violation pertains to a minor. Wisconsin also provides recourse for privacy violations through civil remedies that can include attorney fees and exemplary damages, though once again it is unclear whether such recourse includes minors.⁴⁴ Other states proscribe violations of statutory privacy protections through professional disciplinary action against the health care provider.⁴⁵

C. Pregnancy and Parenthood

Generally, state law affords pregnant adolescents autonomy for health care decision making.⁴⁶ The scope of adolescent legal autonomy includes testing and

39. MICH. COMP. LAWS ANN. § 333.5127(2) (West 2001). *But see* CONN. GEN. STAT. ANN. § 19a-592(a) (West 2003) (requiring confidentiality to the consultation, examination, and treatment of a minor, which shall not be divulged without the minor's consent).

40. CONN. GEN. STAT. ANN. § 19a-592(a) (West 2003).

41. R.I. GEN. LAWS § 23-11-17(c) (1996 & Supp. 2002).

42. *E.g.*, ARIZ. REV. STAT. ANN. § 36-663(B)(5) (West 2003); FLA. STAT. ANN. § 381.004(3)(e)(5), (15) (West 2002 & Supp. 2004); GA. CODE ANN. § 31-22-9.2(b) (2001); ME. REV. STAT. ANN. tit. 5, § 19203 (West 2002); S.C. CODE ANN. § 44-29-80 (Law. Co-op. 2002 & Supp. 2003).

43. FLA. STAT. ANN. § 381.004(6)(a)-(b) (West 2002 & Supp. 2004); WIS. STAT. ANN. § 252.15(9) (West 2004).

44. WIS. STAT. ANN. § 252.15(8) (West 2004). *Accord* HAW. REV. STAT. ANN. § 325-16(d) (Michie 2000 & Supp. 2003).

45. *E.g.*, KY. REV. STAT. ANN. § 214.181(8) (Banks-Baldwin 1992 & Supp. 2003).

46. *E.g.*, FLA. STAT. ANN. § 743.065(1) (West 1996 & Supp. 2004); KAN. STAT. ANN. § 38-123 (2000); N.J. STAT. ANN. § 9:17A-1 (West 2002 & Supp. 2003); VA. CODE ANN. § 54.1-2969G (Michie 2002 & Supp. 2003).

treatment, as well as prenatal care. Legal autonomy for medical care by pregnant adolescents is not restricted by the nature of condition or treatment; *a priori*, valid legal consent by pregnant adolescents extends to HIV testing and treatment. Underscoring policy concerns of transmittal by an infected mother to a fetus of this “serious and unique danger to public health and welfare,”⁴⁷ several state statutes address decisional autonomy of pregnant adolescents regarding HIV tests and treatment.⁴⁸ By respecting a pregnant minor’s confidential consent to testing, subject only to medical providers’ mandatory disclosure requirements to state health departments, these statutes evidence a degree of policymaking attention to promoting risk reduction and disease prevention by adolescents. To this end, a few states require physicians and other health care professionals to provide information to pregnant minors about the benefits of testing for HIV.⁴⁹ Other states merely direct medical providers to advise *every* pregnant woman about HIV testing and counseling,⁵⁰ although adolescent patient care should be targeted given the high-risk status of adolescents for HIV infection and optimum perinatal transmission.

II. LEGISLATIVE DEFICIENCIES

While legislative efforts aimed at formulating and furthering policy concerning HIV infection are laudable, the means to policy advancement is problematic as it relates to adolescents. First, the continuing spread of the disease among adolescents commands heightened attention by policymakers to privacy protections if goals of disease prevention and risk reduction are to be realized. In fact, the actual prevalence of HIV infection among adolescents is unknown because few adolescents access testing, obviating these policy goals. According to researchers, “the prevalence of AIDS in adolescents reflects a cumulative pattern of infection and thus underestimates the current prevalence of infected individuals.”⁵¹ Compounding these concerns is complexity attendant to legal decision-making autonomy by adolescents, which is evidenced by marked variance among state laws. Second, states that provide statutory guidance to health care professionals regarding HIV treatment and AIDS overlook the opportunity to establish coherent policy in the testing and treatment of adolescents to foster public policy generally with respect to HIV/AIDS and especially in the care of

47. FLA. STAT. ANN. § 381.0037 (West 2002 & Supp. 2004); KY. REV. STAT. ANN. § 214.600 (Banks-Baldwin 1992 & Supp. 2003).

48. *See, e.g.*, CONN. GEN. STAT. ANN. § 19a-594a (West 2003); N.J. STAT. ANN. § 26:5C-16 (West 2003).

49. *E.g.*, N.J. STAT. ANN. § 26:5C-16 (West 1996). *Compare with* CONN. GEN. STAT. ANN. § 19a-594a (West 2003) (delegating discretion to the state public health department to develop training programs for health care providers in order to discuss the benefits of HIV testing with those who are pregnant or are parents with newborns).

50. *E.g.*, R.I. GEN. LAWS § 23-13-19(a)-(b) (1996); TENN. CODE ANN. § 68-5-703(a) (2001).

51. Millstein, *supra* note 10, at 3.

adolescents as a high-risk group. In spite of – and to some extent because of – deficiencies, these statutes serve as a cohort for examination in order to flesh out the problems, while identifying points that invite increased attention by both legal policymakers and health care providers in the areas of privacy, protocol development, and personal decision making.

A. Privacy Protections

Protecting patient privacy is a primary responsibility of health care providers. Patient privacy, coterminous to confidentiality, is the touchstone of the patient-physician relationship. Should a physician disclose a patient's private information without consent, adverse action from institutional and professional disciplinary review can result, including sanctions pursuant to state licensure requirements,⁵² common law claims for invasion of privacy and breach of confidentiality,⁵³ and lack of funding for violating federal law enacted to prevent fraud and abuse in the maintenance of patient records.⁵⁴ Inherent to professional responsibility for safeguarding patient information is personal dignity, as well as practice enhancement with patients who are more likely to divulge intimate information and trust providers when they perceive that confidences will be maintained.⁵⁵

Confidentiality is especially important to adolescents, as several researchers have found. One study reports that adolescents regard confidentiality as critical when deciding whether to access health care.⁵⁶ Adolescent perception that physicians will not safeguard confidential communications concerning their condition provides a disincentive for accessing care, which deters testing for HIV. This exacerbates risks associated with HIV infection by delaying treatment, which is detrimental to adolescents because early use of combination regimens of antiretroviral medications can relieve HIV-related symptoms and prolong survival.

52. *E.g.*, DEL. CODE ANN. tit. 24, § 1720(a)(4) (1997); IDAHO CODE § 54-1806A(6) (Michie 2003); 225 ILL. COMP. STAT. ANN. 15/15 (West 1998 & Supp. 2003); IOWA CODE ANN. § 148.6 (West 1997 & Supp. 2004); MASS. GEN. LAWS ANN. ch. 112, § 5 (West 2003 & Supp. 2004); MISS. CODE ANN. 73-25-28 (2000 & Supp. 2003); MONT. CODE ANN. § 37-3-401 (2003); N.H. REV. STAT. ANN. § 329:26 (2003); OHIO REV. CODE ANN. § 4731.22(4) (Anderson 2002 & Supp. 2003); OR. REV. STAT. § 677-141(3) (2003); R.I. GEN. LAWS § 5-37.3-7 (1999); S.D. CODIFIED LAWS § 36-4-29 (Michie 1999 & Supp. 2003).

53. *See Wheeler v. Commissioner of Social Services*, 662 N.Y.S.2d 550, 553 (N.Y. App. Div. 1997).

54. *See generally* Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d (2000 & Supp. 2003).

55. As one state court explained, "[t]he patient whose privacy and sensibilities are safeguarded will be the more likely to reveal information that will result in improvement or cure. This benefits the individual and, in turn, the community and, ultimately, the population." *Wheeler*, 662 N.Y.S.2d at 553.

56. Kenneth R. Ginsburg et al., *Adolescents' Perceptions of Factors Affecting Their Decisions to Seek Health Care*, 273 JAMA 1913, 1917 (1995).

For adolescents who access care, it censures complete candor, creating difficulty for physicians to diagnose conditions and to encourage patient compliance.

The importance of confidentiality in adolescent patient care cannot be underestimated. Physicians protect it, even when there may be question as to legal vulnerability in the event of challenge by a parent or guardian.⁵⁷ While reported cases do not indicate a successful challenge by a parent or guardian to a physician safeguarding adolescent patient confidentiality, they do signal a trend toward supporting providers' attempts to protect adolescent privacy when it collides with parents' interests in obtaining information.⁵⁸ This trend is consistent with the contemporary adolescent-centered approach to parental rights and entitlements, which yield to interests most beneficial to minors.⁵⁹ Competing interests of adolescent confidentiality and parent involvement occasionally converge in statutory provisions that permit physicians to recognize consent by adolescent patients as legally valid, while requiring notification to parents and/or disclosure of information to parents upon their request without adolescent assent.⁶⁰

While it is clear that parent notification requirements derive from policy that seeks to promote family harmony,⁶¹ less clear is what policy should be given priority by physicians when they believe parental involvement poses a barrier to care. By not prioritizing among policy goals in the event of conflict, statutory requirements can compromise care that physicians deem appropriate for their adolescent patients. In fact, many physicians rate family support as a less persuasive justification for disclosing confidential patient information and opt to facilitate adolescent decision making about the degree of parental involvement, concluding that such involvement would be more supportive and sustaining as a result of adolescent amenability.⁶² There is empirical support for this position, as studies suggest adolescent receptiveness to adult involvement when they perceive that adults regard seriously their views and they will, in their own right, consult

57. Hartman, *supra* note 26, at 112-13.

58. Hartman, *supra* note 26, at 115.

59. See generally Marsha Garrison, *Law Making for Baby Making: An Interpretive Approach to the Determination of Legal Parentage*, 113 HARV. L. REV. 835 (2000). In addition to custody, visitation, and support agreements, technological conception arrangements have likewise yielded to minors' best interests. See Joan G. Wexler, *Rethinking the Modification of Child Custody Decrees*, 94 YALE L.J. 757 (1985); Note, *Looking for a Family Resemblance: The Limits of the Functional Approach to the Legal Definition of Family*, 104 HARV. L. REV. 1640 (1991). See also Jhordan C. v. Mary K., 224 Cal. Rptr. 530 (Cal. App. 1986).

60. *E.g.*, CAL. FAM. CODE § 6929(c) (West 1994 & Supp. 2004); MICH. COMP. LAWS ANN. § 333.5127(2) (West 2001). *But see* CONN. GEN. STAT. ANN. § 19a-592(a) (West 2003) (providing that a physician shall not notify the minor's parents if he determines that notification will result in the minor not seeking treatment, or if the minor asks that his/her parents not be notified).

61. See CAL. FAM. CODE § 6929 (West 1994 & Supp. 2004).

62. See Hartman, *supra* note 26, at 113, 124-25.

with a parent.⁶³ Cast in this light, tension in policy aims of adolescent privacy and parent involvement are largely illusory, as physicians may achieve both goals in the absence of parent notification and consent provisions.

Lack of prioritization among policy goals also tends to circumvent existing policy on which these statutes are based. Policy goals of disease prevention and risk reduction may be thwarted when statutes are devoid of express privacy protections that include sanctions for disclosure of information beyond the scope of reporting requirements. Actually, few statutes enacted to prevent the spread of HIV infection include sanctions for health care practitioners who violate confidentiality of HIV-infected patients, aiming to reduce the tendency of discriminatory or derogatory treatment.⁶⁴ Sanctions for privacy violations suggest respect and dignity by policymakers for those persons undergoing HIV testing by deterring vindictive, biased, or arbitrary action toward HIV-infected persons. Sanctions may also alleviate self-inhibitors for those persons considering whether to undergo HIV testing. Yet, statutes that afford legal protection to a minor's consent to HIV testing typically omit any reference to confidentiality.⁶⁵

Because privacy is crucial, state legislators should respond to cues from case law when crafting statutory provisions related to adolescent patient care.⁶⁶ Cases that progress to trial and appellate court decision offer exceptional opportunities for understanding issues attendant to adolescent decision making. Although adolescent decision-making liberty for HIV testing and treatment has yet to be considered by courts, an opinion rendered by the Colorado Court of Appeals is worth examining. In *John Doe v. High-Tech Institute Inc.*,⁶⁷ an adolescent student in a medical assistant training program confided to his instructor that he had tested positive for HIV.⁶⁸ The student asked his instructor to maintain the

63. See Sharon R. Beier et al., *The Potential Role of an Adult Mentor in Influencing High-Risk Behaviors in Adolescents*, 154 ARCHIVES OF PEDIATRICS & ADOLESCENT MED. 327, 330 (2000); Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 L. & HUM. BEHAV. 129, 150-151 (1992).

64. Florida and Wisconsin are notable exceptions. FLA. STAT. ANN. § 381.004(6)(a) (West 2002 & Supp. 2004); WIS. STAT. ANN. § 252.15(9) (West 2004). See also *supra* notes 43-44 and accompanying text.

65. Cf. CONN. GEN. STAT. Ann. § 19a-592 (West 2003) (mandating privacy protection for adolescents by stating that information related to consultation, examination, and treatment of a minor "shall not be divulged without the minor's consent, including the sending of a bill for the services to any person other than the minor until the physician consults with the minor").

66. See Hartman, *supra* note 8, at 433 (stating that court opinions "provide important cues for points that compel research through scientific method to inform and to illuminate understanding by policy-makers"); Rhonda Gay Hartman, *Dying Young: Cues from the Courts*, 158 ARCHIVES OF PEDIATRICS & ADOLESCENT MED. 615 (2004) (discussing a range of issues identified by courts related to adolescent decision making for end-of-life care).

67. 972 P.2d 1060 (Colo. Ct. App. 1998).

68. *Id.* at 1064.

confidentiality of his communication concerning the test result.⁶⁹ Shortly thereafter, the instructor informed the entire class of a mandatory test for rubella, to which students consented with the understanding that the blood test would be used exclusively for that purpose.⁷⁰ Without the student's knowledge or consent, the instructor requested the laboratory to test the student's blood for HIV.⁷¹ The test yielded a positive result, which the lab reported to the public health registry in compliance with state law.⁷²

The student instituted a lawsuit against the college and his instructor, claiming invasion of privacy based on a privacy interest in his blood sample and the information derived from it.⁷³ The defendants took the position that the unauthorized test was minimal, rather than offensive as a privacy intrusion and therefore not cognizable under state law.⁷⁴ The trial court agreed, dismissing the student's claim.⁷⁵ The Colorado Court of Appeals reversed, finding it reasonable and thus cognizable as a legal claim for a person to expect seclusion of medical information obtained from a blood sample.⁷⁶ The appellate court reasoned that, in addition to physical intrusion by extracting a human blood sample, the unauthorized HIV testing of the sample was "sensitive" because it concomitantly involved "strong social stigma" against infected persons.⁷⁷ Accordingly, the Colorado appellate court recognized a heightened need to seclude such "highly personal" information, and that common law privacy protects decision making about HIV testing.⁷⁸

By extending legal protection to adolescents for privacy interests in HIV testing that includes decision making regarding the seclusion of information, appellate courts highlight adolescent privacy interests in medical information as distinct from those of parents, especially when interests clash. In so doing, these decisions represent a shift in socio-legal perception concerning what is most beneficial to adolescents that coincide with the contemporary child-centered legal approach to parent rights and entitlements regarding their children.⁷⁹ *Attorney Ad Litem for D.K. v. Parents of D.K.*⁸⁰ is a paradigmatic example of parent rights and entitlements yielding to adolescent interests. The natural parents of 17-year-old

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Doe v. High Tech Inst., Inc.*, 972 P.2d 1060, 1064 (Colo. Ct. App. 1998).

74. *Id.*

75. *Id.*

76. *Id.* at 1071-72.

77. *Id.* at 1070.

78. *Id.* at 1070-71.

79. See *supra* note 59 and accompanying text.

80. 780 So.2d 301 (Fla. Dist. Ct. App. 2001).

D.K. were in the throes of divorce litigation, precipitated by the mother who believed the father had sexually abused D.K.⁸¹ The state family court ordered psychological counseling sessions due to the ensuing custody dispute.⁸² Both parents sought to access D.K.'s mental health records that reflected discussions with her therapist during the counseling sessions, and the court-appointed guardian *ad litem* filed a motion for a protective order, maintaining that only D.K., not her parents, could waive the privilege to confidential information.⁸³ The trial court denied the motion, finding parental waiver valid.⁸⁴

The Florida appellate court reversed.⁸⁵ Acknowledging the traditional presumption in law that adolescents lack capacity for autonomous decision making, the court reasoned that "not all decisions are removed from a minor," citing Florida statutory and common law examples such as abortion decision making, mental health decision making, and minors' presumed ability to invoke and waive constitutional rights including the privilege against self-incrimination and the right to an attorney.⁸⁶ Recognizing that adolescents possess an emotional maturity and capacity not present in minors under fourteen years, the Florida appellate court ruled that D.K., rather than her parents, was entitled to assert the statutory privilege of confidentiality.⁸⁷ The court limited its ruling to the facts presented, stating that courts should employ a case-by-case approach to determine whether a minor asserting a confidentiality privilege is "sufficiently mature."⁸⁸ Commending to the state legislature "a more comprehensive review of the substantial policy issues" presented by D.K.'s case, the court acknowledged "tension apparent in the law" between the rights and responsibilities of parents and the rights of adolescents.⁸⁹ While underscoring the pivotal role of parents in adolescent life, the court recognized that parents also inhibit minors from seeking or succeeding in treatment.⁹⁰

81. *Id.* at 303.

82. *Id.* at 304.

83. *Id.*

84. *Id.* at 304.

85. *Id.* at 310.

86. *Attorney Ad Litem for D.K. v. Parents of D.K.*, 780 So.2d 301, 305-08 (Fla. Dist. Ct. App. 2001).

87. *Id.*; see also *S.C. v. Guardian Ad Litem*, 845 So.2d 953 (Fla. Dist. Ct. App. 2003) (ruling that a 14-year-old minor possessed a right to assert privilege in the confidential communications with her psychotherapist).

88. *Attorney Ad Litem for D.K.*, 780 So.2d at 308. Maturity is commonly invoked by courts as an indicator for legal protection of adolescent decision making, without sufficiently clarifying or defining it. See Hartman, *supra* note 26, at 105.

89. *Attorney Ad Litem for D.K.*, 780 So.2d at 310.

90. *Id.*

B. Protocol Development

State statutes cede protocol development for HIV testing and treatment to health departments to formulate a precise and detailed set of guidelines.⁹¹ Protocol development enhances the delivery of health services by promoting just and uniform approaches to patient care.⁹² Typically, these provisions encourage health departments to design and implement comprehensive training programs for health care providers that may include instruction on the benefits of HIV testing and related confidentiality.⁹³ In contrast to simply encouraging health department development for protocol, one state mandates “model protocol... for counseling and testing persons for the human immunodeficiency virus... includ[ing] criteria for evaluating a patient’s risk...and for offering...testing, on a voluntary basis” while acceding wide discretion to the state health department for crafting “model protocol.”⁹⁴

Statutory delegation to state health departments for protocol development related to adolescents is problematic for several reasons. First, in the absence of any accompanying provision that creates an incentive to craft protocol, such as funding and time-frame restrictions, it is uncertain whether protocol will actually be promulgated, resulting in an absence of guidelines for HIV testing and treatment. Second, should a health department eventually establish protocol, it is unlikely to address adolescents as a distinct group at risk. Coupled with urgency in reducing HIV infection among adolescents, these reasons question the appropriateness for assigning protocol development to a state instrumentality, rather than developing it through a statutory structure that results from democratic process.

Even assuming protocol promulgation by health departments, the process for protocol development is suspect by lacking assurances for careful and comprehensive consideration of the issues specific to adolescent testing and treatment. State agencies derive authority from statutory structure. Statutes aimed toward HIV infection usually omit testing and treatment for adolescents and limited statutory recognition for adolescent legal decision-making autonomy is

91. *E.g.*, COLO. REV. STAT. ANN. § 25-4-1405(3) (West 2001 & Supp. 2003); FLA. STAT. ANN. § 381.004(8) (West 2002 & Supp. 2004); HAW. REV. STAT. ANN. § 325-16(f) (Michie 2000 & Supp. 2003); KY. REV. STAT. ANN. §214.181(6) (Banks-Baldwin 1992 & Supp. 2003); LA. REV. STAT. ANN. § 40:1300.16 (West 2001 & Supp. 2004); N.Y. PUB. HEALTH LAW § 2786 (McKinney 2002 & Supp. 2004); W.VA. CODE ANN. § 16-3C-2(e)(2) (Michie 2001 & Supp. 2003).

92. For a discussion of protocol necessity in a specific context of medical services, see Rhonda Gay Hartman, *Tripartite Triage Concerns: Issues for Law & Ethics*, 31 CRITICAL CARE MED. SUPP. S358, S359-S360 (May 2003) (advancing reasons why protocol development is essential in the critical care context when prioritizing patients).

93. *E.g.*, COLO. REV. STAT. ANN. § 25-4-1405(2) (West 2001 & Supp. 2003).

94. FLA. STAT. ANN. § 381.004(8) (West 2002 & Supp. 2004). *Accord* TEX. HEALTH & SAFETY CODE ANN. § 85.081(a) (Vernon 2001 & Supp. 2004).

often subject to physician discretion.⁹⁵ Given the disparity in decision-making status premised on the long-standing supposition that adolescents are incapable of decision making, it is unlikely that health department protocol will deal effectively – if at all – with adolescent decisional rights. Department promulgation has not dealt directly with adolescent decision making related to HIV testing and treatment, instead delegating any allowance for adolescent consent to physician judgment. Deferral to physician judgment, however, does not abdicate any regulatory role and should not be seen as a reason to forego the advantage of policy-related standards to guide medical judgment. Regulatory guidance would also provide a framework within which to debate and resolve issues as they arise, including the physician's role in adolescent health care for HIV testing and treatment – particularly the consent process, extent of confidentiality protection, and continuity of care – that remains unexamined and requires thoughtful, sustained attention.

Moreover, the legal presumption that minors, even in adolescence, are incapable of decision making has become a sacrosanct principle, and should be reshaped by democratic means, where legislative history and inferences drawn from recorded deliberations increase confidence that expertise and experience in adolescent patient care will be represented. Although levels of expertise may exist within state health departments, those levels are likely limited to general health policy and are less varied in both expertise and examination of issues attendant to adolescents and their medical decision making. Acknowledging the lack of varied expertise attendant to departments, Oklahoma recommends by statute the convention of a multidisciplinary advisory committee to increase the likelihood that expertise will inform issues.⁹⁶ However, that recommendation is devoid of any measure for ensuring accountability for representation of desired expertise in specific areas.

In contrast, a participatory, legislative process affords greater exposure to those with expertise regarding subtleties in adolescent development and decision making. It also affords opportunities for exposure to knowledge acquisition by a broader range of expertise germane to adolescent ability for decision making and how those abilities should be reflected through a statutory regime furthering risk reduction and disease prevention for HIV infection.⁹⁷ Laws are made by legislatures, and health departments derive authority to promulgate protocol from

95. See *supra* notes 18-28 and accompanying text.

96. See OKLA. STAT. Ann. tit. 63, § 1-502.2D (West 2004).

97. Issues requiring research and a contemplative approach include etiology of adolescent socialization that gives way to health-related risks, social and biological determinants of risky behaviors, and disposition of adolescents to HIV, including how their beliefs about AIDS may differ from those of adults. See generally 50 NEW DIRECTIONS FOR CHILD DEV. (1990) (focusing on adolescents in the AIDS epidemic).

statutory structure; therefore, the most effective forum for advancing adolescent decisional rights is the legislative process.

The openness of legislative hearings and records, moreover, is desirable when issues in adolescent patient care are juxtaposed with an epidemic attached to social stigma and discrimination. Deliberation and debate that provides a basis for statutory enactment should be a product of a majoritarian process that ascribes accountability to the state electorate, as well as to political retribution, and represents a judgment reached by the citizenry through its elected representatives. Especially when decisional rights are at stake, the Supreme Court has lauded the distinct advantage of a legislative process, rather than department subdivision, to sort out state interests that justify regulation.⁹⁸ According to the Court, legislative judgment is the most reliable index for contemporary values and evolving legal norms because it is representative of those elected to draft and study policy issues.⁹⁹ Thus, legislatures, rather than health departments, should formulate legal policy related to decision making in matters of personal importance, including decisions made by adolescents for HIV testing and treatment.

C. Adolescent Decision-making Autonomy

Current legislation aimed toward reducing the risk of HIV infection is also deficient in its treatment – or lack thereof – of adolescent decision-making autonomy. Few state statutes address the scope of legal autonomy afforded to adolescents for accessing health care for HIV. Those that mention minors lack any cohesive approach.¹⁰⁰ Even those statutes that legally protect decision making by adolescents for STD treatment exclude HIV.¹⁰¹ This oversight by legislators in formulating legal policy for adolescent HIV decision making may reasonably be attributed to the prevailing presumption in law that minors are decisionally incapable.

Demarcation for presuming decisional capacity to exercise legal rights – including constitutional guarantees for medical decision making – is eighteen years. This presumptive incapacity differentiates adults' legal decisional rights

98. *See generally*, Lawrence v. Texas, 123 S.Ct. 2472 (2003).

99. *Atkins v. Virginia*, 536 U.S. 304, 312 (2002).

100. *See* DEL. CODE ANN. tit. 16, § 1202(f) (2003) (stating that a minor 12 years of age or older may consent or refuse consent to be subjected to HIV-related testing and counseling); N.C. GEN. STAT. §130A-148(h) (2003) (providing physicians with authority to test a minor, once it is determined that the parents either refuse to give consent and the physician reasonably suspects the minor has HIV or has been sexually abused); N.D. CENT. CODE §23-07.5-02 (2002 & Supp. 2003) (requiring a parent or guardian to consent for HIV testing of a minor); N.M. STAT. ANN. §24-2B-3 (Michie 2000) (recognizing the capacity of minors to give informed consent to HIV testing); WIS. STAT. ANN. §252.15(4)(b) (West 2004) (requiring parent or guardian consent only if the minor is younger than 14 years).

101. *Cf.* MICH. COMP. LAWS ANN. §333.5127 (West 2001).

from those of minors, whether six or sixteen. Research applying both Piagetian and task-related schema reveals that decision-making ability of adolescents far exceeds younger minors and is comparable, in several health care contexts, to young adults.¹⁰² Although more research is required to examine adolescent decision making for HIV and related issues, existing empirical evidence does challenge the validity of legislative adherence to presumptive decision-making inability of adolescents, especially in a context of medical decision making where minors are confronted with physical and psychological difficulties attendant to serious, life-altering conditions.¹⁰³ This evidence also advances the necessity for law-making attention to adolescents in order to devise statutes that accurately reflect their ability and do not subordinate adolescent decision-making liberty to that of adults in identical contexts.

Research that suggests decision-making ability of adolescents challenges the constitutionality of laws that unduly restrict adolescents in their exercise of decisional rights, such as medical decision making. The few state courts that have considered this research invalidated statutes that restrict minors' decision making, concluding that these statutes violate constitutional guarantees of privacy in medical decision making where scientific and social-scientific evidence shows comparable decision-making abilities of adolescents and young adults.¹⁰⁴ Other state courts have afforded legal protection to adolescent autonomy for medical decision making, including refusal of life-sustaining treatment, by adopting a mature minor doctrine and applying criteria of age, experience, and maturity in judgment.¹⁰⁵ Even so, courts have urged state legislators to undertake policy development of adolescent medical decision making.¹⁰⁶

102. Ambuel & Rappaport, *supra* note 63, at 148; Catherine C. Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions*, 50 AM. J. ORTHOPSYCHIATRY 446, 452 (1980); Quadrel et al., *supra* note 9, at 112; David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 LAW & HUM. BEHAV. 431, 445 (1991); Paul V. Trad, *The Ability of Adolescents to Predict Future Outcome*, 28 ADOLESCENCE 533, 550 (1993).

103. See Ambuel & Rappaport, *supra* note 63, at 148; Alfio Maggiolini, et al., *Self-Image of Adolescent Survivors of Long-term Childhood Leukemia*, 22 J. PEDIATRIC HEMATOLOGY/ONCOLOGY 417, 419-20 (2002); David G. Scherer & N. Dickon Reppucci, *Adolescents' Capacities to Provide Voluntary Informed Consent: The Effects of Parental Influence and Medical Dilemmas*, 12 LAW & HUM. BEHAV. 123, 135 (1988).

104. *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797 (Cal. 1997). For a discussion of the case law involving adolescents' competence in abortion decisions, see Preston A. Britner et al., *Evaluating Juveniles' Competence to Make Abortion Decisions: How Social Science Can Inform the Law*, 5 U. CHI. L. SCH. ROUNDTABLE 35 (1998).

105. *Belcher v. Charleston Area Medical Center*, 422 S.E.2d 827 (W.Va. 1992); *In re E.G.*, 549 N.E.2d 322 (Ill. 1989).

106. *In re Application of Long Island Jewish Medical Center*, 557 N.Y.S.2d 239, 243 (N.Y. Sup. Ct. 1990). Courts have also held parents with deeply-held religious conviction liable in the death of adolescents in need of medical care. See *Commonwealth v. Nixon*, 761 A.2d 1151 (Pa. 2000). Available scientific and social-scientific evidence is, however, inconclusive as to whether cognitive development of adolescents raised in a restrictive religious environment is stunted by indoctrination

Reported appellate court opinions that extend legal autonomy to adolescent medical decision making cite to state statutes that compartmentalize adolescent legal autonomy for specific conditions, such as venereal disease¹⁰⁷ and mental health needs,¹⁰⁸ and in certain circumstances, such as homelessness¹⁰⁹ or military enlistment.¹¹⁰ These statutes reflect evolving norms that acknowledge adolescent decision-making ability but lack any underlying cohesive framework for adolescent decisional liberty. Variance among states and inconsistency of statutory law in particular states explicate this. Pennsylvania, for example, authorizes decision making by adolescents for mental health treatment,¹¹¹ substance abuse,¹¹² and STDs,¹¹³ and in situations of marriage or high school graduation¹¹⁴ though not for routine medical care in the absence of these situations. While Pennsylvania fosters adolescent access for mental health treatment, it is only one of a small minority of states that promote this policy through statutory recognition of legally-valid consent by an adolescent.¹¹⁵

The AIDS epidemic emerging among adolescents compels attention by legislators to chart consistent policy over a range of issues responsive to the special needs of this population. Indeed, the crisis of HIV infection among adolescents constitutes an opportunity for state lawmakers to fashion a framework on which laws related to adolescent decision making in health care generally may be based. State statutes affording legal autonomy to adolescents for substance abuse and mental health decision making are indicative of increasing recognition of

when compared to adolescents raised in environments where there is exposure to diverse views. Note, *Children as Believers: Minors' Free Exercise Rights and the Psychology of Religious Development*, 115 HARV. L. REV. 2205 (2002). This point, not yet considered by courts, is worthy of empirical exploration.

107. MICH. COMP. LAWS ANN. § 333.5127 (West 2001).

108. *E.g.*, CAL. FAM. CODE § 6924 (West 1994 & Supp. 2004); COLO. REV. STAT. ANN. § 13-22-101 (West 1997 & Supp. 2003); CONN. GEN. STAT. ANN. § 19a-14c (West 2003); D.C. CODE ANN. § 7-1231.14 (Supp. 2004); FLA. STAT. ANN. § 394.4784 (West 2002); MONT. CODE ANN. § 53-21-112 (2003); N.Y. MENTAL HYG. LAW § 33.21 (McKinney 2002 & Supp. 2004); OHIO REV. CODE ANN. § 5122.04 (Anderson 2004); PA. STAT. ANN. tit. 50 § 7201 (West 2001); WIS. STAT. ANN. § 51.14 (West 2003).

109. *E.g.*, ARIZ. REV. STAT. ANN. § 44-132(A) (West 2003 & Supp. 2003).

110. *E.g.*, ME. REV. STAT. ANN. tit. 22, § 1503 (West 2004); MASS. GEN. LAWS ch. 112, § 12F (2003 & Supp. 2004).

111. PA. STAT. ANN. tit. 50, § 7201 (West 2001).

112. PA. STAT. ANN. tit. 71, § 1690.112 (West 1990 & Supp. 2003).

113. PA. STAT. ANN. tit. 35, § 521.14a (West 2003).

114. PA. STAT. ANN. tit. 35, § 10101 (West 2003).

115. PA. STAT. ANN. tit. 50, § 7201 (West 2003). *See also* CAL. FAM. CODE § 6924(b) (West 1994 & Supp. 2004); COLO. REV. STAT. ANN. §13-22-101 (West 2002 & Supp. 2003); D.C. CODE ANN. § 7-1231.14(b) (2001 & Supp. 2003); FLA. STAT. ANN. § 394.4784 (West 2002 & Supp. 2004); MONT. CODE ANN. § 53-21-112 (2003); N.Y. MENTAL HYG. LAW §33.21(c) (McKinney 2002 & Supp. 2004); WIS. STAT. ANN. § 51.14(h) (West 2003).

adolescent decision-making ability and a departure from rigid adherence to unsupported assumptions.¹¹⁶

III. BIFURCATED LEGISLATIVE ROLE: *PARENS PATRIAE* AND DUE PROCESS

The unprecedented rise in HIV infection among adolescents merits legislative undertaking to retool *parens patriae* toward a cohesive policy framework that both recognizes adolescent decision-making ability and ensures adequate due process. Laws of other nations that afford legal autonomy to adolescents for medical decision making should inform policymakers in this endeavor.¹¹⁷ In developing state *parens patriae* to undergird a comprehensive statutory structure with procedural safeguards, policymakers should draw upon clinical expertise and forge alliances with physicians, who play a vital role in adolescent care and in the AIDS epidemic. Close collaboration is necessary to inform *parens patriae* development and the due process that furthers it.

A. Development of *Parens Patriae*

The United States Supreme Court has identified vulnerability potential, inability for incisive decision making, and a need to ensure a centralized parental role as interests that permit legislators to regulate the rights of minors more extensively than adults under a *parens patriae* power, or the power of the government to promote the health and well-being of citizens. While the Supreme Court has ruled that constitutionally-protected decisional liberty extends to minors, the Court in *Bellotti v. Baird* invoked state interests in adolescent vulnerability, decisional inability, and parental involvement to uphold statutory regulation of adolescent abortion decision making.¹¹⁸ In *Parham v. J.R.*, the Court employed these same interests to find that federal due process was satisfied by scant statutory requirement of parental consent and psychiatric evaluation of a minor prior to involuntary civil commitment.¹¹⁹ Other than anecdotal observation about adolescents generally, the Court in neither case drew upon any evidence to strengthen these interests in application to the decision-making context at issue.

116. See *Atkins v. Virginia*, 536 U.S. 304, 312 (2002) (pinpointing that the “clearest and most reliable objective evidence of contemporary values is the legislation enacted by the country’s legislatures”).

117. See *Lawrence v. Texas*, 123 S.Ct. 2472, 2483 (2003) (stating that government interests in the United States are not necessarily more legitimate, when compared with other countries, in circumscribing personal choice). For a summary of law in other countries, including Australia, Canada, France, and the United Kingdom, that afford legal decision-making autonomy to adolescents for medical care, see Hartman, *supra* note 12, at 1284 n. 84.

118. 443 U.S. 622, 634 (1979) (upholding parental consent provision). See also *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (same); *H.L. v. Matheson*, 450 U.S. 398 (1981) (approving parental notification requirement); *Lambert v. Wicklund*, 520 U.S. 292 (1997) (same).

119. 442 U.S. 584, 624 (1979).

More specifically, the Court failed to differentiate among contexts – medical care, criminal behavior, tortious activity, contractual agreements – when applying these general interests to justify extensive state regulation of minors’ decision making compared with adults. These interests are arbitrary to maintain in the absence of development in a concrete context. Nor did the Court clarify and support the interests with evidence, other than collective conjecture and common knowledge. A problem with common knowledge is that it tends to breed complacency for critical thought and examination, demonstrated by state courts that have reiterated these interests without accompanying analysis in medical contexts to deny recognition for adolescent decision-making liberty.¹²⁰ In addition to slipshod analyses of adolescent decision-making liberty by state courts, cobbled state legislation has resulted. This is demonstrated, in part, by an amalgam of statutes that afford legal autonomy to adolescents for testing and treatment of most STDs but not HIV, and permit adolescents to waive rights in the absence of counsel in criminal proceedings,¹²¹ but not to refuse unwanted medical care for long-term illness,¹²² when studies show that, in a medical care context, adolescents appear as confident, emotionally stable, self-assured, and mature as some adults, whose decision making is afforded legal protection in substantially similar settings.¹²³

By failing to flesh out state interests of vulnerability, decisional inability, parental involvement, the weight assigned these interests when evaluating adolescent ability in a specific context, and that state *parens patriae* authority may be better served by affording adolescents decision-making autonomy, the Supreme Court lessened the potential for adolescent decisional rights development by not requiring critical examination by state courts and legislatures of these interests in a specific context. Ironically, members of the Court have suggested that its assertions should be informed by objective facts and data to the extent possible, admonishing that assertions “should not be, or appear to be, merely the subjective views of individual Justices.”¹²⁴ Anecdotal, subjective assertions that support state interests justifying extensive regulation of adolescent decision-making liberty call into question the legitimacy of these interests in overriding adolescent liberty rights to decide HIV testing and treatment. Notwithstanding this failure by the high

120. See *In re Application of Long Island Jewish Medical Center*, 557 N.Y.S.2d 239 (N.Y. Sup. Ct. 1990).

121. See, e.g., *Fare v. Michael C.*, 442 U.S. 707 (1979); *Ingram v. State*, 918 S.W.2d 724 (Ark. Ct. App. 1996). See also *Hartman*, *supra* note 12, at 1298-1301 (discussing inconsistencies in legal treatment of adolescent rights in juvenile delinquency proceedings).

122. See, e.g., *In re Application of Long Island Jewish Medical Center*, 557 N.Y.S.2d 239 (N.Y. Sup. Ct. 1990) (holding that a non-mature minor cannot refuse a life-saving blood transfusion).

123. *Ambuel & Rappaport*, *supra* note 63, at 148-49; *Scherer*, *supra* note 102, at 444-45.

124. *Atkins v. Virginia*, 536 U.S. 304, 341 (2001) (Scalia, J., dissenting).

Court, the opportunity exists for judicial and legislative development of adolescent decisional liberty in this context.

Since *Bellotti* and *Parham* were decided, however, very few state courts have analyzed these interests with scientific and social-scientific evidence. Courts that have analyzed these interests in light of available evidence have found state restriction of adolescent decisional liberty through parent notification and consent provisions indefensible in areas of medical care and abortion.¹²⁵ It may be argued that adolescent development depends, in important part, on the benefit derived from involved parents who provide insight and guidance during a difficult time. This argument is grounded on the assumption that state-initiated parental involvement heightens this benefit. Yet, adolescents are shown to be capable of communicating preference for adult involvement in their decision-making process; usually it is parents to whom adolescents turn most for emotional support and sustenance, and the quality of the involvement is maximal when adolescents initiate it.¹²⁶

State interests of vulnerability, decisional inability, and parental involvement based on implicit assumptions rather than supporting evidence lessens persuasiveness of these interests. These interests do not legitimize the legal disparity in decision-making stature to substantiate state restriction of adolescent decision-making liberty in an HIV context. In fact, these interests argue against the transferability of traditional state restrictions on minors' decision making for medical care. Particularly in the area of HIV, there is a need for legislative calibration of a comprehensive statutory scheme regarding adolescent decision-making liberty that fosters decisional development through *parens patriae*.

The first interest employed by the Supreme Court to support state restriction of adolescent decisional rights is "peculiar vulnerability."¹²⁷ The Court has never explained what is meant by the talismanic term, let alone clarified it for application by lower courts and legislatures. Vulnerability suggests susceptibility to external influences. While susceptibility to external influences is characteristic of most persons throughout their lives, the concern is the degree of vulnerability. If, for example, one is overly sensitized to the opinions of others, which reduces the resolve to assert one's own choices, the ability to examine facts and evaluate consequences of actions based on personal values may become clouded; thus, vulnerability may impair capable decision making and activate state *parens patriae* in a way to legitimize regulation.

Study of adolescents indicates that, in medical decision making, adolescents are no more susceptible to external influences than are adults in identical situations

125. *E.g.*, *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797 (Cal. 1997).

126. *Ambuel & Rappaport*, *supra* note 63, at 150-51.

127. *Bellotti v. Baird*, 443 U.S. 622, 623, 633 (1979).

and suggests a presence of mind equivalent to young adults.¹²⁸ Additionally, adolescents have demonstrated remarkable levels of confidence and thoughtfulness in their approach to decision making regarding serious illness, such as leukemia, that sustains a solid basis for making other responsible decisions.¹²⁹ It may be argued that vulnerability decreases with years and minors have less years of experience to shape their potential for responsible decision making; however, this argument is not necessarily transferable to health care settings where the nature of the experience, rather than chronological age, appears to be a more reliable indicator of cognitive development and mature judgment.¹³⁰

Disparate legal protection for medical decision making by adults and adolescents is suspect in a health care environment, where vulnerability is common throughout all age groups given diagnoses and diseases that engender perception of helplessness and loss of control. HIV infection as a life-threatening affliction does not translate to higher levels of vulnerability experienced by HIV-infected adolescents than by adults. Although more research is needed, mere assumption that HIV-infected adolescents are more vulnerable than adults when deciding medical care in this context is not defensible. Existing research shows that anecdotal observation about adolescent vulnerability is generally misplaced.¹³¹ It may reasonably be contended that vulnerability results more from an inability to access care for HIV infection rather than from the affliction itself, thereby exacerbating helplessness and loneliness. Vulnerability that impacts decision-making ability is actually reduced when persons are actively engaged in the course of their medical care through unfettered access, affording them a greater sense of self-control and connection with others, which also has been shown to reduce irresponsible decision making and risk-taking behavior.¹³² Thus, state-engineered barriers to care, such as parent notification provisions or no statutory provision that affords legal autonomy to adolescents for HIV testing and treatment, undermine policy objectives for health promotion and disease prevention.

Concern for vulnerability that is thought to impair decisional ability of adolescents to decide medical care segues into the second state interest identified by the Court – decision-making inability. Identified as a separate state interest, it

128. Scherer, *supra* note 102, at 444-45; Scherer & Reppucci, *supra* note 103, at 136.

129. Maggiolini et al., *supra* note 103, at 419-20. *See also* Scherer & Reppucci, *supra* note 103, at 135 (reporting that adolescents “reserv[e] the prerogative to make treatment decisions that have consequential bearing on their lives” while being “mindful of their parents’ wishes and social power”).

130. *See* Hartman, *supra* note 8, at 444-45 (explaining that courts acknowledge experience with illness to be a reliable indicator of maturity).

131. *See* Quadrel et al., *supra* note 9, at 111 (noting that teens see themselves at risk less often than they see others at risk); Scherer & Reppucci, *supra* note 103, at 135 (concluding that adolescents are not intimidated by the gravity or severity of treatment decisions). *See also* Gardner & Herman, *supra* note 9, at 19 (debunking the notion that adolescents “are driven helplessly by external psychic forces”).

132. Beier et al., *supra* note 63, at 330-31; Ginsburg et al., *supra* note 56, at 1918; Scherer, *supra* note 102, at 446.

nonetheless subsumes vulnerability. Despite a legal presumption of decisional inability, studies show adolescent capability of decision making and suggest comparability with the decisional capacity of young adults in identical health care contexts.¹³³ Capacity is an elusive standard that is comprised of ability to understand information, deliberate rationally about information, and communicate concerns and choices. It is also task-specific. The inquiry to determine who possesses capacity is not whether one has achieved the standard ideally, but the degree of divergence in a particular context that merits legal protection.¹³⁴ For example, studies of adolescents confronting unplanned pregnancy suggest maturity in judgment comparable to young adults in the same situation.¹³⁵ According to physicians, adolescents also show mature judgment in primary care settings.¹³⁶ While study of adolescent capability continues as a work in progress, studies collectively suggest a capacity level for this age group compatible with legal recognition for decision making. Prevailing research also suggests cognitive capacity to a remarkable degree for medical decision making regarding serious conditions,¹³⁷ weakening the Supreme Court's sweeping assertion that adolescents lack capacity "for making life's difficult decisions."¹³⁸ Thus, blanket presumptions by lawmakers – in the absence of supporting evidence – that adolescents are incapable of making decisions about HIV infection are untenable.

Parental involvement, as the third interest recognized by the Court to justify extensive state regulation of adolescent decisional rights, is not exclusive to state restriction of those rights. Although parental involvement has been invoked to curb legal recognition for adolescent autonomy to decide medical care, it actually advances the position for affording legal autonomy to adolescents for medical decision making, especially as applied to the context of HIV. The inclusion of parents in an adolescent's decision-making process is a source of support for adolescents as they consider benefits and burdens of choices for HIV infection that present cumbersome, long-term treatment. Not only do adolescents seek out parental involvement and advice in the absence of state imposition for parent

133. See, e.g., Ambuel & Rappaport, *supra* note 63, at 148 (finding "no age-related developmental changes" in decision making capability between adolescents and young adults); Scherer, *supra* note 102, at 445 (observing that older adolescents are comparable to young adults in their reactions to parental influence concerning medical decisions); Lewis, *supra* note 102, at 451 (reporting no major differences in unplanned pregnancy decision making between adolescents and young adults).

134. Hartman, *supra* note 26, at 87-88.

135. See Lewis, *supra* note 102, at 448-49.

136. Hartman, *supra* note 26, at 108.

137. See Ambuel & Rappaport, *supra* note 63, at 148 (stating that study results suggest "that minors remain competent decision makers when facing an emotionally challenging, real-world decision"); Scherer & Reppucci, *supra* note 103, at 135-36 (reporting that adolescents are more likely to resist external influence when the gravity of the decisions presents serious implications for health).

138. *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

notification by providers,¹³⁹ adolescent-initiated involvement is more likely to advance state interests for enhancing their decisional development, concomitant to closeness and companionship that underlie public policy for family harmony. Physicians, who are poised to facilitate meaningful involvement by parents during an adolescent's decision-making process, encourage adolescent-initiated parental involvement.¹⁴⁰ The benefit derived from involved parents who provide insight and guidance during a difficult time is thought indispensable to adolescent development. This position has been grounded on the assumption that state-initiated parental involvement heightens this benefit. However, adolescents demonstrate capacity for communicating preference for adult involvement in their decision-making process, and that involvement is maximal when adolescents initiate it.¹⁴¹

State-imposed requirements of parental involvement through notification and consent provisions tend to deter access to medical care,¹⁴² which is deleterious to HIV-infected adolescents and, in turn, undermine state policy goals for reducing infection and promoting adolescent health. In other words, legislators would more effectively achieve policy aims through statutory provisions that afford decision-making autonomy to adolescents and foster their self-sufficiency. Although it may be contended that provisions according legal autonomy to adolescents would disrupt the parent-child relationship by diminishing parental control, prevailing research shows greater receptiveness to parental involvement by adolescents when exercising autonomy because adolescents, in their own right, will integrate parents into their decision-making process.¹⁴³ Viewed in this light, provisions affording decision-making autonomy to adolescents are compatible with, not contrary to, state policy for parental involvement. These provisions, however, should be informed by clinical practice for incorporating parental involvement. Physicians play an important role in encouraging adolescents to involve parents – to which most adolescents are predisposed – by establishing a caring, comfortable environment to advance adolescent amenability.

By affording adolescents legal autonomy for consent to HIV testing and treatment and assigning responsibility to physicians for counseling about the importance of bringing parents into the adolescent's confidence, Colorado's statute

139. See generally Ambuel & Rappaport, *supra* note 63 (commenting that many minors choose to involve their parents in medical decision making); Beier et al., *supra* note 63 (noting that adolescents identify parents as someone they can turn to for help); Scherer & Reppucci, *supra* note 103 (finding that minors appear mindful of their parents' wishes regarding medical decisions).

140. Hartman, *supra* note 26, at 115.

141. See Ambuel & Rappaport, *supra* note 63, at 150-51.

142. See Comm. on Pediatric AIDS and Comm. on Adolescence, *supra* note 10 (recommending that desire for parental involvement should give way to providing the adolescent treatment); Kenneth R. Ginsburg et al., *Factors Affecting the Decision to Seek Health Care: The Voice of Adolescents*, 100 PEDIATRICS 922 (1997) (discussing adolescents' desire to maintain privacy).

143. See *supra* notes 139-141 and accompanying text.

illustrates how the balance of these interests might be struck and policy objectives for adolescent development and parent involvement harmonized.¹⁴⁴ Statutory assignment of this responsibility to physicians reveals collaboration by lawmakers with medical practitioners in order to ensure that discussion with the adolescent occurs to enrich physician understanding about how to best promote the adolescent's ability to engage responsibly in the decision-making process. Striking the balance of interests in a way that complements rather than compounds state policy objectives also increases the likelihood for continued involvement by the adolescent and those who care about the adolescent, which is crucial in the context of HIV treatment. The ongoing support offered by parents, family members, and health care providers creates incentive for adolescent compliance with continuing care that may be burdensome and lonely. It likewise enhances adolescent adaptability to the challenges ahead.

General assertion of state interests in vulnerability, decisional inability, and parental involvement by courts and legislators fails to adequately override adolescent rights to freely engage in personal medical decision making for HIV and is largely indefensible as a justification to encroach adolescent decision-making liberty. Such sweeping assertion without supporting evidence stands in striking contrast to existing data related to adolescent ability and the importance of recognizing decision-making liberty in the context of HIV. State restriction on adolescent access to HIV testing and treatment, in effect, discourages attempts by adolescents to engage responsibly, perhaps even causing them to disengage from realizing their own ability. This is in contravention of *parens patriae* power to promote adolescent cognitive development. Accordingly, legislative provisions that afford legal autonomy for adolescent medical decision making promote policy objectives of risk reduction and disease prevention, along with the beneficence underlying *parens patriae*, by extending decision-making opportunity to adolescents for meaningful participation in their own well-being.¹⁴⁵ *Parens patriae*, then, should be reshaped by policymakers to extend beyond narrow confines of common knowledge to reflect realistically the norms related to adolescent ability. The reshaping should afford adolescent decisional liberty for HIV testing and treatment that include choices central to personal dignity and autonomy protected by the Due Process Clause.

B. Due Process for Decision Making

While the Supreme Court has retained *parens patriae* for shaping laws governing adolescents, the Court has also required that those laws comport with

144. COLO. REV. STAT. ANN. § 25-4-1405 (6) (West 2001).

145. See *Wisconsin v. Yoder*, 406 U.S. 205, 238-49 (1972) (White, J., concurring) (extolling state interests in developmental ability of minors).

the Due Process Clause.¹⁴⁶ Substantive and procedural components comprise due process. Substantively, the concept of liberty includes privacy in personal decision making, which the Court has extended to health care decision making.¹⁴⁷ Intrinsic to personal decision making is an opportunity to participate meaningfully in decision making and to define one's meaning and existence without undue interference from the state. Personal dignity and fulfillment is found therein, whether adolescent or adult.¹⁴⁸ Procedurally, the state must not deprive a person of this substantive protection for decision making, unless substantial state interests are furthered through regulation. The appropriate inquiry when the state infringes decision making is whether the regulation is necessary and related to state interests, not whether decisional liberty rights are entitled to lesser protection.¹⁴⁹ State regulation of personal decision making must satisfy the rudimentary requirement for fundamental fairness, which the Court deems essential to due process of law and to a just approach.¹⁵⁰ A component to due process is informed choice in decision making among alternative courses of action that is central to personal dignity and autonomy at the core of liberty.¹⁵¹

According to the Supreme Court, decision-making liberty constitutes a sphere for individual control beyond state interference under the Due Process Clause,¹⁵² and includes a right to engage in medical decision making.¹⁵³ Decision making as personal as medical care fulfills the promise of the federal Constitution – whose guarantees are not exclusive to adults – that there is a realm of personal liberty that the government may not contravene.¹⁵⁴ While history and tradition – like the legal supposition that adolescents lack decision-making ability – may be a starting point for consideration in a substantive due process inquiry, it is not the ending point.¹⁵⁵

146. *In re Gault*, 387 U.S. 1, 14 (1967). See also Emily Buss, *The Missed Opportunity in Gault*, 70 U. CHI. L. REV. 39, 49 (2003) (criticizing the Court's decision in *Gault* to advance an argument for greater "commitment to the due process principles of accuracy, dignity, and participation" in juvenile delinquency proceedings).

147. *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 269 n.7 (1990).

148. See *Lawrence v. Texas*, 123 S.Ct. 2472, 2483 (2003) (noting that liberty is an integral part of human freedom).

149. *Cruzan*, 497 U.S. at 279-80.

150. *Schall v. Martin*, 467 U.S. 253, 263 (1984); *McKeiver v. Pennsylvania*, 403 U.S. 528, 543 (1971).

151. *Lawrence*, 123 S.Ct. at 2475. For a position advocating that information is indispensable to the meaningful exercise of liberties for minors, see Catherine J. Ross, *An Emerging Right for Mature Minors to Receive Information*, 2 U. PA. J. CONST. L. 223, 225 (1999) (arguing that "minors possess autonomous liberty interests that cannot be exercised meaningfully without access to information conveying a variety of viewpoints").

152. *Lawrence*, 123 S.Ct. at 2475.

153. *Cruzan*, 497 U.S. at 278 (inferring the "principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment").

154. *Lawrence*, 123 S.Ct. at 2475.

155. *Id.* at 2480.

Decision-making liberty extends to adolescents.¹⁵⁶ Although the Court put forth vulnerability, decisional inability, and parental involvement as interests that may justify government restriction on the exercise of this right by adolescents, these state interests lack both validity and viability for adolescent medical decision making generally and for HIV testing and treatment particularly in the absence of supporting evidence. The relevant inquiry is whether these state interests justify restricting adolescent decisional liberty in the context of HIV infection. This entails an assessment of decisional liberty, state interests, and the weight assigned each interest in this context of care. As previously discussed, baseless assertions of vulnerability, decisional inability, and parental involvement are substantially weakened in this context and untenable to override adolescent rights for HIV decision making. Abstract state interests are by no means absolute to the exclusion or subordination of the decision-making liberty of adolescents – to whom constitutional guarantees extend.¹⁵⁷

While minority status of adolescents does merit an analysis of these interests by lawmakers in specific contexts in order to assess the legitimacy of state intervention, minority status alone does not justify dilution of personal decision-making rights, particularly when state-engineered barriers to health care are deleterious to adolescents as a high-risk group for HIV infection and demeaning to adolescent development. A collateral consequence for state-erected barriers to care is the stigma and secrecy associated with HIV and AIDS that inhibit not just adolescent access to testing and treatment, but also serve only to defeat policy aims for awareness and health care access in order to achieve risk reduction and disease prevention. Thus, adolescent decisional rights should not be subject to lesser constitutional protection afforded adults in a substantially equivalent setting.

State restriction on adolescent consent and confidential access to HIV testing and treatment neither furthers nor substantiates sweeping state concerns for vulnerability, decisional inability and parental involvement. Particularly in this context of medical care, state restriction on decision making, either by parent notification and consent provisions or by legislative silence that effectively maintains the status quo of presumptive decisional inability, undermines the beneficence of *parens patriae* for promoting adolescent health. It forecloses decision-making opportunity for informed choice by adolescents contrary to their best interests. It also undercuts the promise of *parens patriae* to enable

156. *Bellotti v. Baird*, 443 U.S. 622, 650-51 (1979).

157. *Bellotti*, 443 U.S. at 633-35; *In re Gault*, 387 U.S. 1, 12-13 (1967). See also *Kent v. U.S.*, 383 U.S. 541 (1966) (holding that a juvenile hearing must “measure up to the essentials of due process and fair treatment”).

adolescents to assimilate into responsible and confident decision makers into and throughout adulthood.¹⁵⁸

Federal due process protections, as well as parallel procedural protections afforded by state constitutions,¹⁵⁹ advance the position that statutes aimed toward achieving policy objectives related to HIV infection should include provisions that safeguard adolescent confidentiality and consent, unless a state can make a particularized showing that state interests in vulnerability, decisional inability, and parental involvement justify restriction on adolescent decision-making liberty in the context of HIV. Several safeguards, such as confidentiality provisions and requirements that physicians document discussions with adolescents regarding the importance for parent or guardian guidance, could be established to maximize adolescent ability to engage responsibly and to minimize the possible harmful effects of delayed testing and treatment. Sufficient procedural protections are required in order to comport with the concept of fundamental fairness.¹⁶⁰

Legal autonomy for HIV decision making should be afforded to adolescents by statute. Statutory provisions should direct physicians to promote adolescent informed choice among alternate courses of action, as well as involvement of parents or other trusted adults during the informed consent process. This may be accomplished through statutory directive for providers to document discussions with adolescent patients, along with factors to guide physicians for documenting reasons that substantiate noninvolvement by parents. By extending procedural safeguards in decision making to adolescents, the state acknowledges the importance of adolescent decision-making liberty in this context of care and extends the beneficence of its *parens patriae* power by engendering in adolescents the realization of responsible decisional ability to become productive participants in health and self-care. Health care providers, especially physicians on the frontlines dealing with adolescents as a high-risk group, optimize this realization.

Physicians play a vital role in the AIDS epidemic and constitute the core resource for awareness, risk reduction, and disease prevention.¹⁶¹ As a critical source for state exercise of *parens patriae*, legislators should collaborate with physicians for strategies that include curriculum development in schools for achieving state-related objectives about AIDS. Preventive education is chief

158. See *Prince v. Massachusetts*, 321 U.S. 158, 168 (1944) (stating that “[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies”).

159. Discussions of heightened state constitutional protection for liberty rights are found in William J. Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977); Ken Gormley & Rhonda G. Hartman, *Privacy and the States*, 65 TEMP. L. REV. 1279 (1992).

160. *Schall v. Martin*, 467 U.S. 253, 263 (1984); *Virgin Islands ex rel. M.B.*, 122 F.3d 164, 168 (3d Cir. 1997).

161. See generally Comm. on Pediatric AIDS and Comm. on Adolescence, *supra* note 10.

among these objectives.¹⁶² A model for AIDS prevention efforts should include physician participation in school-sponsored programs to educate about etiologies, thereby sensitizing adolescents about risky behaviors that place them in contact with blood-borne pathogens.¹⁶³ Because sexual activity is the primary mode of HIV transmission among adolescents, abstinence should be stressed,¹⁶⁴ along with postponing sexual behavior, safer sexual practices, and the risks and responsibilities of engaging in sexual behavior. Education designed to reach this target audience that includes medical expertise and experience is more likely to effectively debunk myths regarding HIV transmission and dissipate lingering stigma due to adolescent misconceptions about AIDS.¹⁶⁵ Access to health care should constitute another key focus, and should include a range of available resources, which is not insignificant for adolescents who are “notoriously reluctant to use health care services.”¹⁶⁶

Moreover, adolescents comprise the leading demographic for Internet use.¹⁶⁷ Thus, providers’ web pages and on-line availability for questions will prove an effective and efficient way to educate adolescents about issues attendant to HIV infection, along with STDs generally. Physician availability enhances adolescent perception that physicians care about them and enriches their understanding about the benefit of accessing providers to discuss these issues and to undergo testing and evaluation. Not only do out-reach counseling and straightforward communication by physicians advance policy aims of reducing exposure and risk of transmission, they increase connectedness with adolescents, who demonstrate openness to those they believe are genuinely concerned, honest, and knowledgeable in ways from which adolescents may benefit.¹⁶⁸ Adolescent perception of connectedness with providers generates a sense of security and self-confidence that, in turn, shapes self-image and self-identity.¹⁶⁹ This is especially important to adolescent development of skills for overcoming peer pressure and avoiding high-risk activities.

162. See COLO. REV. STAT. ANN. § 25-4-1405(2) (West 2001). See also AIDS Action Comm. of Mass. v. Mass. Bay Transp. Inc., 849 F.Supp. 79 (D. Mass. 1993), *aff’d*, 42 F.3d 1 (1st Cir. 1994) (underscoring importance that minors receive information about the prevention of AIDS).

163. See COLO. REV. STAT. ANN. § 25-4-1405(2) (West 2001). See also Parents United for Better Schools, Inc. v. School Dist. of Philadelphia Bd. of Educ., 148 F.3d 260 (3d Cir. 1998) (condoning implementation of education related to transmission and prevention of HIV infection).

164. Stressing abstinence may, in effect, reinforce self-held belief by adolescents. See Nina Bernstein, *Behind Fall in Pregnancy: A New Teenage Culture of Restraint*, N.Y. TIMES, March 7, 2004, at A1.

165. Millstein, *supra* note 10, at 12-13.

166. Wilcox, *supra* note 25, at 67.

167. See Alan Goldstein & Vikas Bajaj, *Teens Setting Tech Trends—And Firms are Paying Attention*, DALLAS MORNING NEWS, Dec. 1, 2002, at A1.

168. Ginsburg et al., *supra* note 142, at 925-26; Ginsburg et al., *supra* note 56, at 1917.

169. See Beier et al., *supra* note 63, at 331; Ginsburg et al., *supra* note 142, at 929-30; Ginsburg et al., *supra* note 56, at 1917-18.

Aside from information dissemination, physicians could further *parens patriae* through legislative provisions that afford adolescents privacy protection. As studies have shown, when adolescents perceive that providers maintain and safeguard their privacy, they are more likely to access care, seek out providers, and demonstrate amenability to testing and treatment by those they trust.¹⁷⁰ Trust and ease in testing are important in the context of HIV infection because adolescents may internalize fear and anxiety due to social opprobrium against those infected or simply suspected of being informed of HIV infection. Distrust and fear of discrimination in health care decrease the likelihood that adolescents will access testing and candidly disclose to providers risky behaviors. Avoidance in the context of HIV is adverse to adolescent health, given the promise of combination antiviral therapies and clinical prophylaxes that pose a potential for longer, higher quality of life. Escalation in HIV infection among adolescents and the compelling need to identify asymptomatic adolescents at the earliest stages of infection advance the necessity for an activist stance by physicians in safeguarding the privacy of adolescent patients with statutory protection.

Physicians not only recognize that protecting adolescent privacy is essential to effectuating health policy associated with AIDS but also to promoting adolescent overall health and well-being. This is so even when parents or guardians confront physicians with disclosure demands for information pertaining to the adolescent patient.¹⁷¹ Due to their developmental stage, physicians believe that adolescents benefit from confidentiality in ways beyond any benefit accruing to adults.¹⁷² As adolescents progress toward adulthood, their desire to engage in autonomous decision making and to have their decisions respected by others strengthens self-conception, as studies have shown.¹⁷³ Unwanted disclosure has proven destructive to adolescent decisional development and self-image.¹⁷⁴ In the context of HIV, it may be permeably destructive to adolescent self-perception due to the psychosocial implications from residual stigma and discrimination associated with AIDS. Stigma and discrimination imputed to AIDS can lead, in some cases, to serious identity crisis that is not inconsequential to adolescents.

170. Ginsburg et al., *supra* note 56, at 1917-18.

171. See Hartman, *supra* note 26, at 112-13. In fact, physicians protect adolescent confidences in spite of pressure or threats by parents who demand disclosure and despite the lack of statutory safeguards. Hartman, *supra* note 26, at 112-13.

172. See Council on Scientific Affairs, *Confidential Health Services for Adolescents*, 269 JAMA 1420, 1423 (March 17, 1993). See also Ginsburg et al, *supra* note 142, at 929-30 (identifying benefits such as accessing care, divulging personal information, complying with treatment, and perceiving respect).

173. See, e.g., Maggiolini et al., *supra* note 103, at 419; Michael J. Dolgin et al., *Caregivers' Perceptions of Medical Compliance in Adolescents with Cancer*, 7 J. ADOLESCENT HEALTH CARE 22, 26 (1986).

174. See generally Council on Scientific Affairs, *supra* note 172.

Adolescents are among those at highest risk for suicide.¹⁷⁵ Thus, even in the absence of statutory provisions that protect adolescent privacy, physicians concede that they are willing to risk exposure to potential legal challenges by maintaining confidentiality.¹⁷⁶

Protecting adolescent privacy advances the physician's role as a mentor to assist adolescent development for responsible decision making. Mentorship for adolescents has been shown to dramatically decrease behavior that places adolescents at risk for HIV, especially sexual activity.¹⁷⁷ This underscores the utility of mentorship by physicians in risk reduction and prevention of HIV infection among adolescents. Research about mentorship in the lives of adolescents reveals a composite of qualities that a mentor is someone who may be trusted, and cares about the adolescent by showing support and respect.¹⁷⁸ According to researchers, the "mentor must have competence, and know something that the youth does not know, and be able to share that knowledge."¹⁷⁹

Providers, especially physicians, can mentor adolescents by being an inspiration – perhaps even a lifeline – for access to health care and to understand the importance for self-care. In this role, physicians may assist adolescents in nurturing abilities for mature decision making and for thoughtful, individualized approaches to their care, as mentorship is associated with adolescent development.¹⁸⁰ Testing positive for HIV, moreover, entails long-term, continued adherence to treatments that are evolving, as well as "complex, time-consuming, and, at times, demoralizing."¹⁸¹ Physicians contribute considerably to adolescent cognitive development and decision making when the patient must confront the prospect of continuity of care into and possibly throughout adulthood. Research with adolescents who experience disease reveals a "role of central importance" for doctors to cultivate adolescent self-assuredness in facing difficulties and advance into adulthood with "an ability to adapt and to command the outside world with a belief in their own ability to make decisions while maintaining a greater sense of their own limitations."¹⁸²

175. Comm. on Adolescence, Am. Acad. of Pediatrics, *Suicide and Suicide Attempts in Adolescents*, 105 PEDIATRICS 871 (2000). Others at high risk are seniors. See Sharon Parmet, *Suicide in Older Persons*, 291 JAMA 1158 (March 3, 2004).

176. Hartman, *supra* note 26, at 112-13.

177. Beier et al., *supra* note 63, at 330.

178. Beier et al., *supra* note 63, at 330.

179. Beier et al., *supra* note 63, at 330.

180. Beier et al., *supra* note 63, at 330.

181. Kimberly M. Mutcherson, *No Way To Treat A Woman: Creating An Appropriate Standard for Resolving Medical Treatment Disputes Involving HIV-Positive Children*, 25 HARV. WOMEN'S L.J. 221, 275 (2002).

182. Maggiolini et al., *supra* note 103, at 419. Although physicians are uniquely situated for a mentorship role with adolescents, increased training and education of physicians targeted to the specialized needs of patient care, such as HIV, are warranted. See Hartman, *supra* note 26, at 128-29;

Statutes requiring provider notification to parents or guardians regarding adolescent HIV testing or treatment at once obscure the scope of privacy afforded adolescents while marginalizing parental involvement. Although it may be claimed that statutory protection for adolescent privacy threatens parent participation by driving a wedge in the parent-child relationship, thereby causing family discord, there is nothing in the ordinary course of human experience to indicate that adolescents will not seek parental guidance with health care decision making that has potentially serious, long-term effects. In fact, parental involvement has been shown to increase in both extent and quality when adolescents choose to involve their parents, to whom they will most likely turn for support and sustenance.¹⁸³

Additionally, practitioners tend to exercise discretionary judgment and counsel adolescents as to whether parent notification would add anything to the adolescents' best interests or instead detract from adolescent compliance with care.¹⁸⁴ State courts have underscored the importance of safeguarding adolescent confidentiality, as previously discussed,¹⁸⁵ and statutes aimed at HIV testing and treatment typically delegate to physicians the exercise of medical judgment as to whether parent notification and/or consent is warranted in the circumstances.¹⁸⁶ While these provisions vary considerably by state, they commonly omit guidance to physicians in making this judgment that consequently generates physician perception of legal vulnerability.

Adult guidance during adolescent medical decision making is essential to the emergence of mature, responsible judgment by adolescents. Adult guidance may be better achieved when physicians encourage adolescents to involve a trusted adult and confer with the adolescent as to achieving this. Studies suggest that, although adolescents turn to parents for guidance in health care, they experience a greater sense of family support and solidarity, including close collaboration with their doctor, when physicians act as mediators between adolescents and their parents.¹⁸⁷ Thus, physicians should facilitate an adolescent's medical decisional process by offering assistance to adolescents when informing their parents (and partners who may be at risk), thereby providing a supportive setting for disclosure.

Beier et al., *supra* note 63, at 331. Education and training should focus more on how physicians can enhance development of the emerging adult within the adolescents and less on legal liability concerns, especially when no reported case demonstrates a successful legal claim against a doctor for maintaining adolescent confidentiality.

183. Beier et al., *supra* note 63, at 330-31; Ambuel & Rappaport, *supra* note 63, at 150-51; Scherer & Reppucci, *supra* note 103, at 134-35.

184. Hartman, *supra* note 26, at 113, 115. See also Attorney Ad Litem for D.K. v. Parents of D.K., 780 So.2d 301, 310 (Fla. Dist. Ct. App. 2001) (acknowledging that parent involvement can inhibit minors from seeking and succeeding in treatment).

185. See *supra* notes 67-89 and accompanying text.

186. See, e.g., CONN. GEN. STAT. ANN. §19a-592(a) (West 2003).

187. Beier et al., *supra* note 63, at 329, 331.

Statutes should direct – and protect – physicians in facilitating adolescent decision-making processes. This could strengthen adolescent trust in physicians, especially when studies indicate that doctors are not the persons most preferred by adolescents for consult in time of crisis.¹⁸⁸ For example, Colorado squarely states that parent or guardian consent shall not be a prerequisite to the examination and treatment of minors for HIV infection.¹⁸⁹ Connecticut requires the consent of a parent or guardian, unless the physician determines and documents reasons why notification would result in a denial of treatment or the physician adjudges it unlikely that the adolescent will continue treatment *and* the adolescent requests that a parent or guardian not be notified.¹⁹⁰ Other states such as Delaware, Michigan, New Mexico, and Ohio declare that a minor's consent is valid and binding without any parent involvement.¹⁹¹

In the absence of statutory directive, physicians should maintain adolescent confidentiality rather than insist on parent involvement. While physicians may facilitate parent involvement, their principal obligation is to ensure adolescent access to care. In this respect, physicians perform a gate-keeping function by coordinating multidisciplinary support, including links to mental health providers and social services, and securing trust by adolescents that intimate communications will be regarded seriously and respectfully. Physicians contribute to adolescent cognitive development by engaging adolescents in ways that are responsive to their concerns and choices during the decision-making process. As has been the case in other areas of patient care such as end-of-life decision making and advance health care planning, physician practices have influenced and informed statutory law.¹⁹²

Thus, legislators should partner with physicians to shape health policy specifically related to adolescent patient care and to construct a statutory framework that is informed by clinical practice. Partnership between policymakers and health care practitioners should focus on HIV testing and treatment, due not only to policy objectives for risk reduction and disease prevention but principally to the unprecedented rise in HIV infection among adolescents. Expertise and experience with adolescents enable physicians to be powerful policy advocates for informing lawmakers about precise problems and practices in adolescent patient care, along with multidisciplinary resources that should be available to adolescents. Physicians may advance policy objectives by corresponding with legislators about issues in adolescent patient care, by testifying before legislative subcommittees,

188. Beier et al., *supra* note 63, at 329, 331.

189. COLO. REV. STAT. ANN. § 25-4-1405(6) (West 2001).

190. CONN. GEN. STAT. ANN. § 19a-592(a) (West 2003).

191. DEL. CODE ANN. tit. 16, § 1202(f) (2003); MICH. COMP. LAWS ANN. § 333.5127(1) (West 2001); N.M. STAT. ANN. 24-2B-3 (Michie 2000); OHIO REV. CODE ANN. § 3701.242B (Anderson 2002 & Supp. 2003).

192. See CONN. GEN. STAT. ANN. § 19a-592 (West 2003); MICH. COMP. LAWS ANN. § 333.5127(2) (West 2001); N.C. GEN. STAT. § 130A-148(h) (2003).

and by lobbying legislators to devote attention to issues in need of policy development for adolescent medical decision making, including issues in HIV testing and treatment related to this high-risk group.

CONCLUSION

Issues in law and policy take on new urgency as the AIDS epidemic experiences a shift in the rising number of HIV-infected adolescents. State statutes that further a policy agenda for HIV risk reduction and AIDS prevention do not focus on adolescents as a high-risk group. Health policy for promoting HIV testing and treatment for adolescents is virtually nonexistent. In fact, the national AIDS research portfolio does not adequately reflect treatment of adolescent AIDS or the unique questions requiring investigation. Nor has it singled out adolescents to enable states to develop health policy agenda on behalf of youth. This inattention undermines *parens patriae*-based policy objectives, reflected through deficiencies in current statutory law aimed toward HIV prevention that neither address nor afford adequate protection for adolescent decision-making liberty. The unprecedented rise of HIV infection among adolescents affords lawmakers an opportunity to develop a model framework for analyzing adolescent decisional rights and state interests that, when applied to HIV infection, advances the need for adolescent legal decision-making autonomy.

The Supreme Court has identified peculiar vulnerability, decisional inability, and parental involvement as legitimate interests of the state for restricting the decisional autonomy of minors, despite extension of liberty guaranteed by the Due Process Clause to adolescents for freedom to engage in personal decision making. The focus should be whether these state interests for overriding adolescent decisional rights in the context of HIV can be legitimized. Absent overriding state interests, reliance by courts and legislatures on these interests results in an impermissible denial of decision-making liberty in the context of HIV infection that disrupts not only adolescent development for responsible judgment and self-reliance, but contravenes policy objectives for risk reduction and disease prevention. These interests, either individually or collectively, are not supported by existing evidence. Reliance on these interests, therefore, is insufficient to override the exercise of adolescent decisional rights for HIV testing and treatment. Thus, state restriction arguably lacks justification to differentiate adolescents for exercising decision-making liberty for HIV, which should not be within dispensation of adults alone.

Decisional rights in this context suggest that statutory protection for, rather than restriction of, adolescent decision making would actually promote state interests for HIV risk reduction and prevention. It would also enhance state *parens patriae* power by promoting the health and well-being of adolescents. *Parens patriae*, as an elastic and evolving basis for state regulation of minors' rights, should be reshaped by legislators to recognize adolescent decision-making liberty

as part of the AIDS agenda, rather than to its exclusion. By reflecting changing cultural and legal norms, statutes that now afford decisional autonomy to adolescents for mental health, substance abuse, and STD treatment advance this position. However, piecemeal progression of adolescent legal autonomy is inadequate, given the liberty rights at stake.

There is a paucity of definitive statutory law regarding HIV testing and treatment of adolescents. Beneficence associated with *parens patriae* is furthered through statutes that acknowledge adolescent decisional liberty for HIV, while fostering development for decision-making ability. Notwithstanding limited statutory grants of decision-making protection, a comprehensive statutory scheme is needed to afford adolescents the dignity found in personal decision making guaranteed by the Due Process Clause that should be proactive, rather than reactive, to issues concerning adolescents in the AIDS epidemic. Health care practitioners, especially physicians, contribute considerably to achieving this end by partnering with policymakers to ensure statutes that afford legal autonomy to adolescents for HIV infection are informed by clinical practice. These statutes are long overdue, as researchers over a decade ago foresaw the “overwhelming” numbers of HIV-infected adolescents due to legislative oversight.¹⁹³ The time is now for lawmakers to collaborate with physicians to develop sound policy and practice standards responsive to adolescent needs.¹⁹⁴ Concerted efforts by legislators and practitioners in furthering cogent policy goals for decision-making responsibility by adolescents about HIV are essential to facilitating “informed, voluntary, and confidential use of tests designed to detect HIV infection”,¹⁹⁵ to achieving AIDS reduction and prevention for this group most at risk, and ultimately to improving the lives of adolescents.

193. See generally Wilcox, *supra* note 25, at 69 (foreseeing that “the nation seems incapable of recognizing the gravity of the threat posed by adolescent AIDS and HIV infection until the number of victims becomes overwhelming...”).

194. See Robert Steinbrook & Jeffrey M. Drazen, Editorial, *AIDS – Will the Next 20 Years be Different?*, 344 NEW ENG. J. MED. 1781, 1782 (June 7, 2001) (averring that “[t]reating and preventing infection must be viewed in terms of simple morality and humanity, not as an endeavor that is burdened by national and sexual politics, misinformation, stigma, and blame”).

195. See KY. REV. STAT. ANN. § 214.181(1) (Banks-Baldwin 1992 & Supp. 2003).