

MINORS'S RIGHT TO CONFIDENTIALITY IN REPRODUCTIVE HEALTH CHOICES

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ABSTRACT. According to current Romanian Law, minors have the right to decide in the field of reproductive health, after 16 years. „Reproductive health” means the physical, mental and social well-being of human person, in relation to the genital tract, its functions and functioning, not merely the absence of disease or disability (1). What happens, however, when a minor, who is already 16 years old, approach the physician to the school medicine office and asks for contraceptives or gives information to the medical staff, which shows that he/she has sexual activity? More specifically, should medical staff inform parents or legal representatives about these issues? Through the three cases presented in this article, we want to highlight certain situations faced by doctors and nurses who treat minor patients. Our goal is to establish, from the answers given by the majority of the participants in our study, to what extent the opinions of the professionals are in accordance with the Romanian legislation in force and with the principles of medical ethics. The cases analyzed in this article have as a central element the topic of minors' confidentiality in relation with reproductive health issues. Results and analysis of cases of violence on minors will be presented in a next issue of this publication.

KEYWORDS: Minors, Confidentiality rights, Reproductive health

INTRODUCTION

The concept of reproductive health can only exist when the persons involved have their rights recognized. These rights correspond to certain human rights already recognized in national and international human rights law. It is about recognizing the fundamental right of the individual to decide freely and with discernment about the number of children he/she wants, their place of birth and to have the necessary information on sexual and reproductive health. Reproductive health rights are based on the principles of dignity and equality and the right to life (art. 2), as enshrined in the International Convention on Human Rights (1948).

„Reproductive health” means the physical, mental and social well-being of a human person, in relation to the genital tract, its functions and functioning, not merely the absence of disease or disability [1].

While the patients must have the right to confidentiality, the obligation to maintain medical secrecy is imposed on all employees of the medical institution, including students and medical trainees. In the case of a minor, there are legal provisions that allow doctors, in certain circumstances, to take into account the request of the minor, when he/she wants the medical information or treatments to remain strictly confidential, especially not to be brought to the notice of the parents [2].

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These provisions are part of the recognized right of the minor to have his or her privacy respected, established by the United Nations Convention on the Rights of the Child (1989), art. 16: “No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honor and reputation. The child has the right to the protection of the law against such interference or attacks.” and by the Civil Code, art. 71: “Everyone has the right to respect for his private life. No one shall be subjected to interference with his/her privacy, family, home or correspondence, nor to attacks upon his/her honor and residence without his/her consent.” These rights are an important aspect of the autonomy granted to the minor. In practice, exercising this right can put doctors in delicate situations, as the information that must be kept secret can be important for the parents and for the protection of the minor.

ETHICAL PRINCIPLES REGARDING THE TREATMENT OF THE MINOR PATIENT

Medical ethics imposes several universal ethical principles to be applied in clinical medical practice and medical research. They are: autonomy, beneficence, non-maleficence and equity. These principles are guidelines of medical practice and all four must be followed at the same time for the same patient, which is particularly difficult to do in practice. The current, called *principlism*, was proposed in the 1970s in the United States of America and developed in the Anglo-Saxon area, then reaching the European continent. The paradigm of principlism was launched in 1974 by the United States Congress, which implemented *the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research*, in order to recognize certain ethical principles to be observed in the experimentation of human subjects. Subsequently, in 1979, the final document (*The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*) was implemented, which launches the first three generally valid principles in the ethics of scientific re-

search, namely: respect for the autonomy of patients involved, beneficence and justice (equity). Thomas L. Beauchamp together with James F. Childress extend the principles to the whole biomedical field, thus establishing the fundamental principles of bioethics, based on this report, adding a fourth ethical principle: non-maleficence [3].

Any doctor-patient relationship is based on these four fundamental principles of bioethics. In the case of the pediatric patient, this relationship is different, being more of a doctor-patient-parent relationship, and the decisions taken will take into account the rights and obligations of each member of this relationship, respecting them with certain features and challenges.

1. The principle of autonomy

The term “autonomy” comes from the Greek words “auto”, meaning “proper” and “nomos”, meaning “rule”. The principle of autonomy, considered the most important principle of bioethics, refers to the right of the individual to make decisions for himself, implying the obligation of others, in this case the medical staff, to respect whatever the patient decides and not to act against the patient’s will, even if the doctor considers a certain intervention in the patient’s interest (for example, the patient refuses a treatment that could save his/her life) [4]. Autonomy also implies the patient’s right to consultation and information, the obligation of the medical staff being to explain to the patient the situation they find themselves in, the diagnosis and the possible therapeutic interventions, as well as their implications. An autonomous patient decides what he wants to do after being correctly and completely informed about his condition [5].

Also, the state of “autonomy” imposes certain conditions that must be met by the patient: the ability to understand their health status and the procedures to which he may be subjected, including the risks, benefits and alternatives, the ability to make freely decisions about oneself and one’s own interests and, last but not least, the ability to decide clearly what is good for him and his health, given that he is mentally competent [5].

Because autonomy is characteristic for a patient with discernment and decision-making ability, this principle does not usually apply in pediatric practice because it is generally considered that minors do not have the ability to make medically important decisions. This presumption should not be absolute, should not be valid for all cases with minor patients. It is obvious that newborns, infants and young children do not have the necessary skills to decide whether they need a certain medication or medical intervention, but this becomes debatable in adolescents, who, although they do not have the same rights as adults, in general, they understand and judge correctly what is happening and could make rational decisions from a medical point of view. They should be involved in the decision-making process related to their own health. Although all this indicates that it is not an absolute principle in the case of pediatric patients, the principle of autonomy must be adapted to each individual situation, patients, even if they are minors, should be involved in the decision-making process, insofar as their physical, psychic and intellectual development allows this [4].

2. The principle of beneficence

The principle of beneficence is defined as the moral obligation to act only for the good of the patient, including respecting the patient's rights, preventing the worsening of the health status and helping those in danger, in other words, always acting in the interest of the patient [5].

Beneficence can sometimes conflict with autonomy, for example when a discerning patient consciously and informedly refuses a treatment that might do him or her good. In this situation, the doctor tries to convince the patient of the benefits of the treatment and the risks that come with refusing the treatment, but cannot administer it if he does not have the patient's consent, even if the outcome is that the patient dies as a result of his/her decision to refuse treatment. [4].

The notion of "doing good" is rather interpretable, each individual having a different perception of what is good for him, for example, if one person considered it good to prolong his life regardless of its

quality, another person might find this unacceptable, considering that there is no point in living longer if you do not have a certain physical independence. This is clear in the case of an adult who is able to decide what is good for him/her, but in the case of minors who are not able to make decisions for themselves, the decision to do what is good for them involves analyzing the options, risks and benefits, as well as establishing an optimal variant. Most of the time, this fact has a subjective component. In general, these decisions are made by parents in the best interests of the children, but there are cases where the choice of parents is obviously to the detriment of the patient. In these cases, the doctor is compelled to act for the benefit of the patient, having the obligation to turn to certain specialized institutions or to set up a committee of doctors to establish the optimal approach, or, in extreme cases, even to address the court [6].

3. The principle of non-maleficence

This principle, stated by Hippocrates as "*primum non nocere*", complements the principle of beneficence and implies the duty of the physician not to harm, but to anticipate and prevent harm and to improve the present unfavorable conditions [7]. During the exercise of profession, the doctor has a control over the patient, in some situations he may not have the necessary resources to cure him, but he can harm his health at any time. Therefore, the doctor-patient relationship is based on the principles of beneficence and non-maleficence, which impose on the doctor the moral duty and a legal responsibility deriving from the medical act [5].

4. The principle of equity

The principle of equity or justice is defined as fairness in the allocation of the doctor's resources and obligations regarding the patient. This means practicing medicine both on the basis of the principle of non-discrimination (sex, ethnicity, age, religion, sexual orientation, etc.) of those persons receiving medical care and on the basis of the principle of equity. The latter involves the rationalization of each act, aiming at a maximum benefit on the patient, with minimal

risks, as well as the equal division of resources, opportunities and equal rights for each patient.

MINORS' RIGHT TO CONFIDENTIALITY

Although current laws do not establish the complete autonomy of the minor, the medical act involving both the minor patient, the doctor and the medical staff as well as the parents and sometimes even the school staff, it must be taken into account that the right to confidentiality is essential in some situations, being the basis on which the patient - doctor trust is created. Ensuring confidentiality, especially among adolescents, has important implications for ensuring the quality of medical care.

Minors can be divided into two important categories: those who have discernment and those who do not have discernment. Discernment is defined as the ability to understand relevant information about medical treatment and the ability to appreciate the consequences of personal decisions. For those who do not have this ability, we cannot talk about the right to confidentiality, either legally or ethically, their interest being expressed through parents or a legal representative.

Discerning minors, the so-called mature minors, have their right to autonomy and confidentiality largely recognized, although their right is not protected by law as it is in the case of adults. We consider it ethical for this right to be recognized insofar as the patient acts in his own interest [8].

An important proportion among the causes of morbidity and mortality among adolescents are risky sexual behaviors, violence, substance abuse, and psychiatric disorders, such as depression and anxiety, all of which are sensitive topics that need to be treated or prevented, and which must be disclosed to a trusted physician [9].

In recent decades, studies have shown that, in the absence of confidentiality, adolescents do not address the doctor for contraception, screening and treatment of sexually transmitted diseases, signs and symptoms of psychiatric disorders, and if they do go to the doctor, they hide information or do not show up

at subsequent follow-ups. These things compromise the quality of the medical act, the patients in question being deprived of the necessary care to cure or prevent some diseases. Therefore, it is important for the doctor to gain the patient's trust, guarantee his or her secrecy, and at the same time to explain to the family the importance of respecting the minor's privacy [9].

The purpose of ensuring confidentiality in the relationship between adolescent and physician is to remove barriers of communication, to ensure full trust that allows the patient to reveal intimate details, sometimes essential in diagnosis and treatment or in prevention. One of the principles of bioethics, *the beneficence*, is applied in such situations, the doctor making the necessary decisions for the patient's well-being and for providing optimal medical care. At the same time, it reduces the probability of some health problems, such as unwanted pregnancies among adolescents, sexually transmitted infections, substance abuse and depression among young people [9].

In conclusion, in theory, laws and ethical principles indicate the direction to follow, in general, but in practice there are different situations in which obtaining informed consent and maintaining confidentiality, especially in cases of minor patients, come into conflict, and the legal and ethical provisions do not offer concrete solutions, remaining at the discretion of the doctor to adopt the optimal conduct, to adapt to each situation and to do, always, what is good for the patient [10].

THE RIGHT OF MINORS TO REPRODUCTIVE HEALTH - DESCRIPTION OF CASES

1st Case: *16-year-old patient is examined in the school medical office after injuring her left ankle during PE classes. While examining her, you notice an edematous and erythematous ankle with functional impotence and, although the appearance is of a sprain, you recommend an X-ray and an orthopedic examination in order to rule out a fracture and for proper treatment. After a more detailed discussion about her general health, the patient refers to a secondary amenorrhea, thinks she is pregnant and does not want her*

parents to be informed about the matter. In addition, she asks if the x-ray could harm the pregnancy.

Possible answers:

- a. You inform the parents about both medical problems of the minor.
- b. You respect the patient’s confidentiality, you prescribe anti-inflammatory and conservative treatment while also recommending an orthopedic examination.
- c. You inform the parents about the ankle sprain and about the necessity of an orthopedic examination.

2nd Case: 13-year-old patient approaches the nurse in the school medical office during school hours, telling her that she needs a prescription for oral contraceptives for her. Her partner is her fitness instructor, 20 years old. The girl’s parents work abroad, she is living with her maternal grandmother.

Possible answers:

- a. You inform the grandmother and do not write the prescription because you find it inadequate for the patient to have sexual relationships at her age, and the age gap between her and her partner is too big.
- b. You inform the grandmother but also the National Authority for the Protection of the Rights of the Child and Adoption (ANPDCA).
- c. You provide the prescription, being aware that you cannot influence her sexual activity, but you report the case to the competent authorities, because sexual activity with a minor between 13 and 15 years old is considered a crime and is punishable by imprisonment.

3rd case: 17-year-old boy discusses with his family doctor the test results for sexually transmitted diseases, which turned positive for gonococcal infection. He admits he has a stable relationship with a 16-year-old girl.

Possible answers:

- a. You recommend a treatment for the patient and ask for retesting 8 days after finishing the treatment.

- b. You refuse treatment and counseling in the absence of parents or legal representatives.
- c. You recommend a treatment only for the patient, you inform him that his partner should also receive treatment, and you recommend a specialty examination.

RESULTS

The respondents to our study chose, for the first presented case, in proportion of 18% “option b” (which we consider to be correct), 58% “option a” (informing the parents about both conditions), and 24% “option c” (informing the parents only about the sprained ankle) (Image 1).

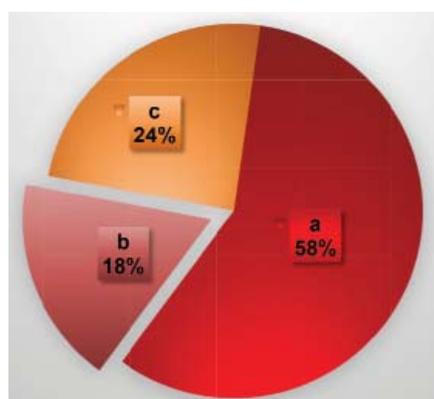


Image 1 - 1st Case - Correct answer “b”

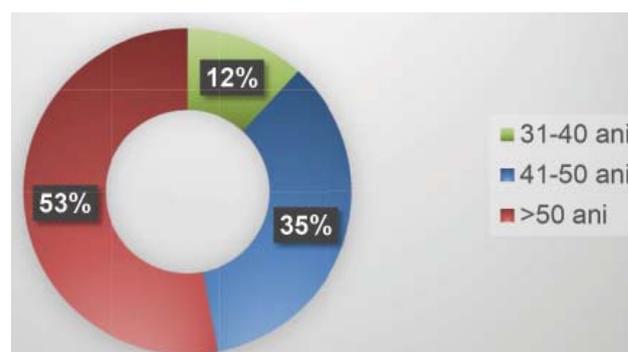


Image 2 - 1st Case - Age distribution of those who answered correctly

From those who answered correctly 32% are nurses, 29% are specialist physicians and 41% are senior medical specialists (Image 3).

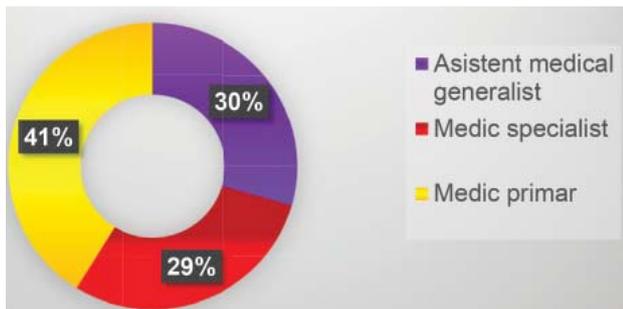


Image 3 - 1st Case - Professional distribution of those who answered correctly

The majority of respondents who answered correctly work in the medical field for more than 5 years (88%), while 12% have a work experience of under 5 years (Image 4).

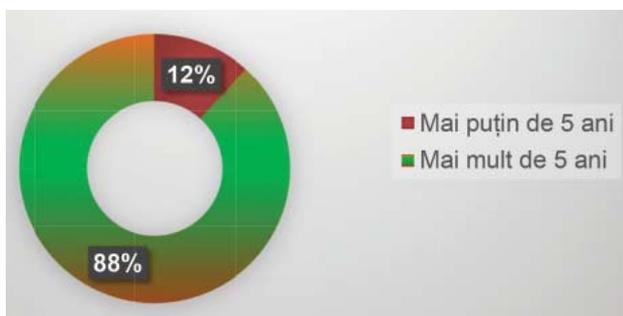


Image 4 - 1st Case - Work experience of those who answered correctly

When analyzing the answers for the second case, we noticed that 24% of the respondents chose “option c”, which we considered to be correct. 53% chose “option b” (informing the grandmother and the ANPDCA), while 23% chose “option a” (informing the grandmother and not prescribing the contraceptives, as the patient is too young to be involved in sexual relationships, and the age gap between her and her partner is too big) (Image 5).

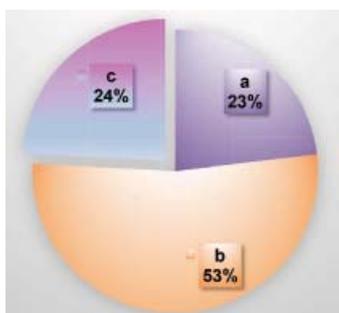


Image 5 - 2nd Case - Correct answer: c

Among the respondents who chose the correct answer, we can observe that 30% are aged between 31 and 40, 35% between 41 and 50, while 35% are over 50 (Image 6).

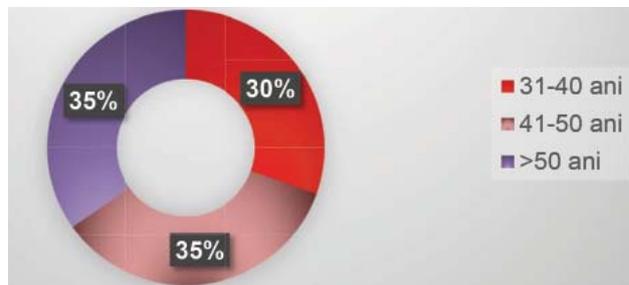


Image 6 - 2nd Case - Age distribution between those who answered correctly

From those who answered correctly 44% are nurses, 30% are specialist physicians and 26% are senior medical specialists (Image 7).

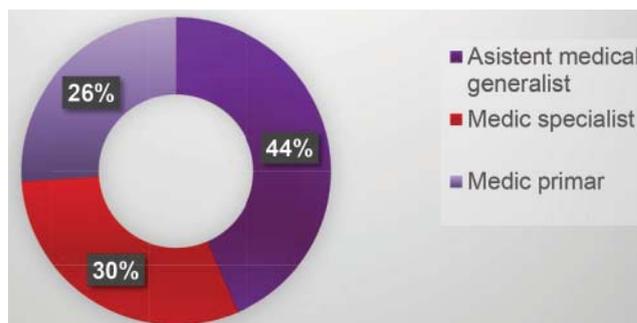


Image 7 - 2nd Case - Professional distribution of those who answered correctly

The majority of respondents who answered correctly work in the medical field for more than 5 years (96%), while 4% have a work experience of under 5 years (Image 8).

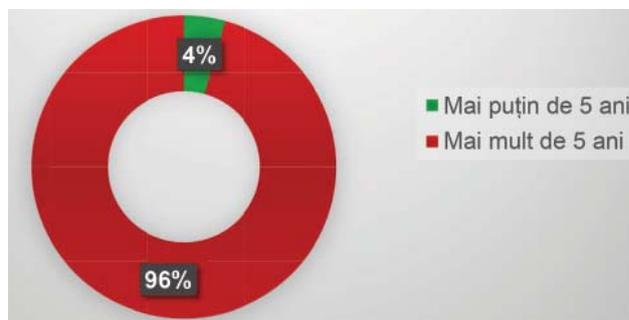


Image 8 - 2nd Case - Work experience of those who answered correctly

In our third scenario we observed that the majority of respondents, 61%, chose “option c”, which we consider to be the correct answer (“*You recommend a treatment only for the patient, you inform him that his partner should also receive treatment, and you recommend a specialty examination*”). 38% chose “option b” (“*You refuse treatment and counseling in the absence of parents or legal representatives.*”) while only 1% chose “option a” (“*You recommend a treatment for the patient and ask for retesting 8 days after finishing the treatment.*”).(Image 9)

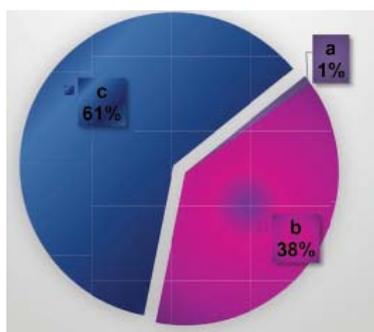


Image 9 - 3rd Case - Correct answer: c

Among the respondents who chose the correct answer, we can observe that 2% are aged 20 to 30, 19% are aged between 31 and 40, 31% between 41 and 50, while 48% are over 50 (Image 10).

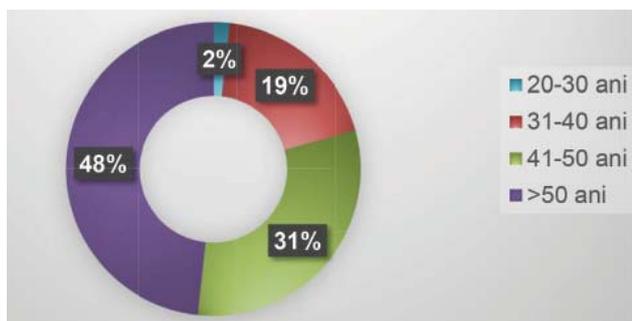


Image 10 - 3rd Case - Age distribution of those who answered correctly

From those who answered correctly 46% are nurses, 26% are specialist physicians and 28% are senior medical specialists (Image 11).

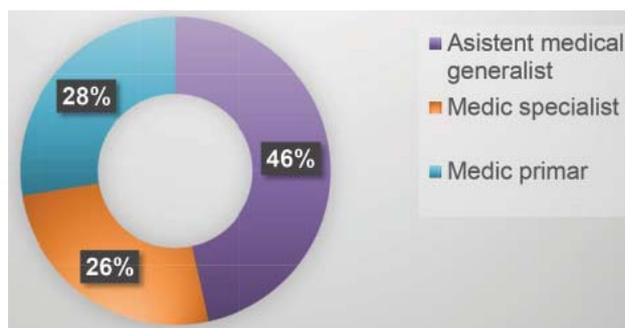


Image 11 - 3rd Case - Professional distribution of those who answered correctly

The majority of respondents who answered correctly work in the medical field for more than 5 years (97%), while 3% have a work experience of under 5 years (Image 12).

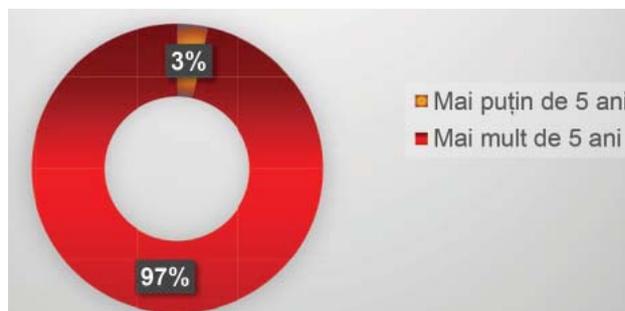


Image 12 - 3rd Case - Work experience of those who answered correctly

DISCUSSIONS

The first case is about a teenager who assumes she is pregnant, being aware that an x-ray could harm the pregnancy. The medical problem for which she seeks medical help (ankle accident) does not necessarily require the notification of the parents, and the alleged pregnancy of a 16-year-old patient does not provide for the obligation to inform the parents, the patient having an age at which the law no longer requires parental consent for issues of a sexual and reproductive nature. The patient has her own right to privacy. Given these considerations, the correct answer is “b” (informing the patient and maintaining her confidentiality). Option “a” meant informing the parents about both conditions of the patient, and option

“c” refers to informing parents only about the accident during PE classes. The correct answer was selected by only 18% of participants, the majority, 58% choosing option “a”, considering that parents should be notified about the girl’s conditions, and 24% chose the answer “c”. (Image 1). It is obvious that, according to Law No. 95/2006 on health care reform (art. 650), the legal age for expressing informed consent is 18 years. Law No. 95 states that minors may express their consent in the absence of their parents or legal representative in the following cases:

a) emergency situations, when the parents or the legal representative cannot be contacted, provided that the minor has discernment and understands the situation he is in;

b) situations related to the diagnosis and / or treatment of sexual disorders, at the request of the minor who must be over 16 years of age [11].

Among the respondents who chose the correct answer, we can observe that 12% are aged between 31 and 40, 35% between 41 and 50, while 53% are over 50 (Image 2). From those who answered correctly 32% are nurses, 29% are specialist physicians and 41% are senior medical specialists (Image 3). The majority of respondents who answered correctly work in the medical field for more than 5 years (88%), while 12% have a work experience of under 5 years (Image 4).

The second scenario raises a legal issue: a minor (13 years old) requesting oral contraceptives, her partner being 20 years old. The doctor has the obligation to report the case to the competent authorities, as it is a crime. The fact that only the girl’s grandmother is informed (option “a”) is not enough, nor is the notification to the National Authority for the Protection of the Rights of the Child and Adoption (ANPDCA) (option “b”). Thus, the correct answer is option “c”, since “sexual intercourse (...) with a minor aged between 13 and 15 is punishable by imprisonment from one to 5 years”, as stipulated by art. 220 paragraph (1) of the New Criminal Code (NCP) [12]. These legal provisions are found in most European criminal law, being one of the provisions of the European Council Convention for the Protection of Children against Sexual Exploitation and Sexual Abuse adopted in 2007 [13]. Even if the minor, at the age of 13, consented to this sexual act, her consent is considered to be obtained

much easier than in the case of an adult. The minor is not considered to be fully familiar with what sexual intercourse entails and what consequences the involvement in such a relationship produces. The legislator presumed this consent to be “flawed”[14]. We note that only 24% of participants chose this option, the majority, 53% choosing option “b”, which involves alerting ANPDCA, and 23% opted for option “a”, considering it necessary and sufficient to notify the girl’s grandmother (Image 5).

Among the respondents who chose the correct answer, we can observe that 30% are aged between 31 and 40, 35% between 41 and 50, while 35% are over 50 (Image 6). From those who answered correctly 44% are nurses, 30% are specialist physicians and 26% are senior medical specialists (Image 7). The majority of respondents who answered correctly work in the medical field for more than 5 years (96%), while 4% have a work experience of under 5 years (Image 8).

The last scenario is of a patient over 16 years of age with a sexually transmitted disease. In this case the doctor can recommend treatment even in the absence of parental consent, as stated by art. 650, lit. b) from Law No. 95/2006 on health care reform [11]. The patient must also be tested and treated for other sexually transmitted infections, while the young man’s partner must be notified and treated, as she may become unknowingly infected and also require testing and treatment. Untreated, gonorrhea can cause serious health problems, such as pelvic inflammatory disease, infertility, and ectopic pregnancy. At the same time, by not treating the partner, the disease can be transmitted back to the initial patient or, in the future, to other partners [15].

The correct answer in this case is “c” and was identified by 61% of participants. Answer “b”, in which the patient is not treated in the absence of parents was chosen by 38% of the study participants, and answer “a”, in which the patient is treated but the partner is not informed, was chosen by 1 % (Image 9). Among the respondents who chose the correct answer, we can observe that 2% are aged 20 to 30, 19% are aged between 31 and 40, 31% between 41 and 50, while 48% are over 50 (Image 10). From those who answered correctly 46% are nurses, 26% are specialist physicians and 28% are senior medical specialists

(Image 11). The majority of respondents who answered correctly work in the medical field for more than 5 years (97%), while 3% have a work experience of under 5 years (Image 12).

CONCLUSIONS

In conclusion, we can say that medical practice involving minor patients, in adolescence, is a complex one that must take into account a number of specific features. These patients have their own rights, based on autonomy, on their ability to understand and discern reality, and on dialogue with the parents or legal representatives. Although legislation and principles have been adopted to guide appropriate behavior with these type of patients, there are still paternalistic views, tensions that arise from education and religion, as well as social and economic pressures. Reproductive and sexual health and the right to one's own choices in this field, especially when it comes to minors aged 16-18, remains a challenge for all actors involved in their education and protection.

Practical implications of the results obtained

From analyzing the results from the answers provided by the medical staff who faces such situations in current practice, we can note that the topic of confidentiality of minor patients is not very familiar, and their choices are made based on personal opinions, social considerations and cultural or work experience of medical staff.

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