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# ELIMINATING PARENTAL CONSENT AND NOTIFICATION FOR ADOLESCENT HIV TESTING: A LEGITIMATE STATUTORY RESPONSE TO THE AIDS EPIDEMIC

*Janine P. Felsman\**

*[T]here may be grounds for concern that the child receives the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children.<sup>1</sup>*

## INTRODUCTION

Our nation's youth are contracting the human immunodeficiency virus ("HIV")<sup>2</sup> at an alarming rate.<sup>3</sup> In the United

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\* Brooklyn Law School Class of 1997.

<sup>1</sup> *Kent v. United States*, 383 U.S. 541, 556 (1966).

<sup>2</sup> The human immunodeficiency virus ("HIV") is responsible for the development of a group of opportunistic diseases or conditions which infect and weaken the body's immune system. CHRIS JENNINGS, UNDERSTANDING AND PREVENTING AIDS 3 (2d ed. 1988). Acquired immune deficiency syndrome ("AIDS") is one stage of HIV infection. JOHN BARTLETT & ANN FINKBEINER, THE GUIDE TO LIVING WITH HIV INFECTION 2, 15-16 (1994). Individuals identified as HIV positive have not necessarily contracted AIDS. *Id.* However, over time the immune system of an HIV-infected individual can become severely weakened and cause the infected individual to contract certain infections and tumors called opportunists or "AIDS-defining diagnoses." *Id.* It is at this latter stage that individuals with HIV are said to have contracted full-blown AIDS. *Id.*

<sup>3</sup> According to the Centers for Disease Control and Prevention ("CDC"), reports of additional males and females between the ages of 13 and 24 who were newly diagnosed with HIV increased by 1604 and 1004, respectively, during the period of July 1, 1994 through June 30, 1995. HIV/AIDS SURVEILLANCE REP., 7 U.S. DEP'T OF HEALTH & HUMAN SERVS. 1, 27 (1995) [hereinafter SURVEILLANCE REP.] (figures as of June 1995). The ratio of male-to-female HIV infection reported among adolescents is much lower than that reported among adults. Society for Adol. Med., *Guide to Adolescent HIV/AIDS Program*

States alone, over 17,000 individuals ages thirteen to twenty-four have already been diagnosed with full-blown AIDS,<sup>4</sup> and at least 11,000 additional individuals within that age group have contracted HIV.<sup>5</sup> Moreover, the teenage population represents one of the

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*Development*, 14 J. ADOL. HEALTH NO. 5, 7S (Supp. July 1993) [hereinafter Society for Adol. Med.] (stating that the national average male-female ratio of adolescents with HIV infection is 3:1 and the adult male-female ratio is 7:1, excluding New York City adults who have a 15:1 ratio). Moreover, the proportion of U.S. adolescent females with AIDS has more than doubled from 14% in 1987 to 32% in 1994. CDC, *Facts About Adolescents and HIV/AIDS*, Dec. 1994, at 1 [hereinafter CDC]. Recent CDC figures indicate that in June 1995, the percentage of adolescent females with AIDS rose again to 34% of the total adolescent AIDS population. See SURVEILLANCE REP., *supra*, at 12.

<sup>4</sup> SURVEILLANCE REP., *supra* note 3, at 12. According to the CDC, reports of additional males and females between the ages of 13 and 24 who were newly diagnosed with full-blown AIDS increased by 1978 and 1014, respectively, between the period of July 1, 1994 and June 30, 1995. SURVEILLANCE REP., *supra* note 3, at 12. In 1991, AIDS rose to "the sixth leading cause of death among young people 15 to 24 years old." SURVEILLANCE REP., *supra* note 3, at 12; Patricia Sweeney et al., *Teenagers at Risk of Human Immunodeficiency Virus Type 1 Infection: Results from Seroprevalence Surveys in the United States*, 149 ARCHIVES OF PEDIATRICS & ADOL. MED. 521, 521 (1992) (citing National Center for Health Statistics, *Advance Report of Final Mortality Statistics 1991*, 42 MONTHLY VITAL STATIS. REP., 21 (1991)).

<sup>5</sup> See SURVEILLANCE REP., *supra* note 3, at 27 (stating figures as of June 1995). It is estimated that an even larger number of adolescents have contracted HIV than CDC statistics indicate because of limitations and biases inherent in such data. See Society for Adol. Med., *supra* note 3, at 5S, 14S (stating that epidemiological criteria used in studies do not accurately capture all adolescent HIV cases because the symptoms and disease progression differ between adults and adolescents). See also CDC, *supra* note 3, at 1 (noting that only "[one] in [five] reported AIDS cases is diagnosed in the 20-29 year age group"). In addition, a long latency period between the time HIV is transmitted and the time AIDS is diagnosed often permits HIV infection to go undiagnosed throughout the teenage years. See Society for Adol. Med., *supra* note 3, at 5S (stating that "AIDS case data represent a snapshot of transmission and diagnostic patterns that are, on average, 11 years old."). See also Sweeney et al., *supra* note 4, at 523 (estimating that over 25% of AIDS victims who have acquired HIV through heterosexual contact acquired the virus between the ages of 13 through 19). Finally, national data compiled by the CDC, as well as basic epidemiologic data available through public health literature, are limited to the study of specific subpopulations of adolescents such as runaways, African Americans, Latin Americans, homosexuals and females. Society for Adol. Med., *supra* note 3, at 5S.

fastest rising groups contracting HIV in the United States.<sup>6</sup> State legislatures must make certain that preventative measures develop more rapidly than the spread of AIDS among the adolescent population because thousands of teenagers will learn that they are HIV positive during the remainder of this decade.<sup>7</sup>

Recognizing that many teenagers engage in behaviors which make them susceptible to contracting HIV,<sup>8</sup> many states have

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As a result, it is difficult to pinpoint the precise number of adolescents presently infected with the HIV disease.

<sup>6</sup> See Soc. for Adol. Med., *supra* note 3, at 1S; YOUTH AND AIDS: IT CAN HAPPEN TO YOU 1 (Staten Island Visiting Nurse Ass'n ed., 1995); Vincent J. Schodolski, *Gay Teens Help Others Fight AIDS*, CHI. TRIB., Sept. 21, 1995, at 24.

<sup>7</sup> See Soc. for Adol. Med., *supra* note 3, at 1S (“[A]dolescents are clearly the next wave of the HIV epidemic.”); Schodolski, *supra* note 6, at 24 (“The number of HIV-infected teenagers doubles every 14 months.”).

<sup>8</sup> See CDC, *supra* note 3, at 2. Activities which indicate an increased risk of HIV infection are referred to as “risk behaviors.” Soc. for Adol. Med., *supra* note 3, at 6S. Activities frequently classified as “risk behaviors” include unprotected sexual intercourse, oral and anal intercourse, intravenous drug use, crack-cocaine use and blood transfusions. Soc. for Adol. Med., *supra* note 3, at 9S-12S. The CDC breaks down high risk behaviors believed to lead to AIDS and HIV infection according to “exposure categories.” See SURVEILLANCE REP., *supra* note 3, at 33. These categories include the following activities: male homosexual contact; intravenous drug use; hemophilia-coagulation disorders; receipt of blood transfusions, blood components or tissue; and heterosexual contact which includes sex with an intravenous drug user, a person with hemophilia, a transfusion recipient with HIV infection, a bisexual male or an HIV-infected person. SURVEILLANCE REP., *supra* note 3, at 27. The most frequently reported means of exposure among adolescent females is heterosexual contact with HIV-infected persons, compared with intravenous drug use among adolescent males. See SURVEILLANCE REP., *supra* note 3, at 27. The transmission routes reportedly differ between adolescents and adults. See Society for Adol. Med., *supra* note 3, at 7S (noting that in 1992, 14% of HIV-infected adolescents between 13 and 19-years-old. For HIV-infected adults, only five percent transmitted the disease through male-female sexual contact).

Although statistics vary demographically, CDC studies of high school seniors indicate that approximately 75% are having sexual intercourse, less than half use condoms consistently and approximately 20% have more than four lifetime sex partners. See CDC, *supra* note 3, at 2. “The mean age of first intercourse is 16 years, although among such urban adolescents the mean age of first intercourse has been reported as low as 12 years.” Society For Adol. Med.,

implemented statutes which allow adolescents to receive HIV testing.<sup>9</sup> However, the parental consent and notification requirements contained in HIV testing statutes vary from state to state.<sup>10</sup>

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*supra* note 3, at 10S. Another study of sexually active teenagers reveals that only 29% of them consistently use condoms. Larry K. Brown et al., *Predictors of Condom Use in Sexually Active Adolescents*, 13 J. ADOL. HEALTH 651, 655 (1992). Of the remaining teenagers in the study, 48% had never used a condom and 23% had inconsistently used condoms. *Id.* Studies show that young men with the most sexual experience are the least likely to use condoms. See Joseph H. Pleck et al., *Patterns of HIV Risk and Preventive Behaviors Among Teenage Men*, 107 PUB. HEALTH REP. 1, 131-33 (1994). In addition to the high-risk sexual behavior of many teenagers, one in 62 high school students have reportedly intravenously injected drugs such as heroin, cocaine, amphetamines and steroids. See CDC, *supra* note 3, at 2.

<sup>9</sup> See, e.g., CONN. GEN. STAT. ANN. § 19a-582(d) (West Supp. 1996) (stating that “[t]he consent of a parent or guardian shall not be a prerequisite to testing of a minor”); FLA. STAT. ch. 384.30 (1993) (stating that the consent of a parent or guardian is not required for examination or treatment of a sexually transmitted disease); MICH. COMP. LAWS ANN. § 333.5127 (West 1992) (allowing minor to consent to treatment for venereal disease or HIV infection); OHIO REV. CODE ANN. § 3701.242 (Baldwin 1991) (requiring minor to give informed consent for HIV testing except if physician “determines the test is necessary for providing diagnosis and treatment” to a test subject). See also *infra* Part I.C (providing further examples of state HIV testing statutes).

Because HIV lives in blood cells, HIV blood tests for the virus itself are 95% accurate. BARTLETT & FINKBEINER, *supra* note 2, at 300. However, an HIV antibody test is most commonly used to detect HIV infection. BARTLETT & FINKBEINER, *supra* note 2, at 300. HIV antibody tests, such as the enzyme-linked immunosorbent assay (“ELISA”) test and the Western Blot test, when combined, are regarded as highly accurate in identifying positive results. *What is Testing’s Role in HIV Prevention?*, HIV PREVENTION: LOOKING BACK, LOOKING AHEAD (Center for AIDS Prevention Studies et al., San Francisco, Cal.), Feb. 1995 [hereinafter CAPS UPDATE] (citing Robert S. Janssen et al., *HIV Infection among Patients in U.S. Acute Care Hospitals: Strategies for Counseling and Testing of Hospital Patients*, 327 NEW ENG. J. MED. 445, 452 (1992)). It is estimated that within six months of infection, 95% of infected individuals test positive using HIV antibody tests. CAPS UPDATE, *supra*, at 1. Moreover, notwithstanding the virus’ relatively long latency period, detection of infection without testing remains extremely difficult because of HIV’s exceptional rate of mutation. JENNINGS, *supra* note 2, at 16 (stating that “HIV mutates at a rate five times faster than [the flu]”).

<sup>10</sup> Compare N.C. GEN. STAT. §§ 130A-148 (1995) (permitting testing without consent when a “parent or guardian has refused to consent to such testing

Laws which do not clearly authorize adolescents to receive HIV testing without parental consent or notification can deter teenagers from determining their HIV status.<sup>11</sup> Even where statutes authorize teenagers to independently consent to HIV testing, teenagers may nevertheless avoid testing if there is a possibility that their parents will be notified of the results.<sup>12</sup> State statutes which effectively preclude adolescents from taking HIV tests burden the right of adolescents to know their HIV status and contribute to the increased rates of HIV transmission among the adolescent population.

Although courts and legislatures have historically avoided encroaching upon parental authority over the health care of minors,<sup>13</sup> rising rates of HIV infection among teenagers compel state legislatures to reconsider traditional policies in an effort to

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and there is reasonable suspicion that the minor has AIDS virus or HIV infection or that the child had been sexually abused") with IOWA CODE ANN. § 141.22(6) (West 1992) (stating that minors can consent to screening or treatment for AIDS and other sexually transmitted diseases, but parent or guardian will then be informed of a positive HIV test). See also *infra* Part I (outlining different statutory approaches to adolescent HIV testing).

<sup>11</sup> Phyllis Arnold, *Betwixt and Between: Adolescents and HIV*, in AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS 41, 60 (1992). See also *infra* Part I (explaining how ambiguous statutes can deter adolescents from seeking HIV testing).

<sup>12</sup> See *infra* Part II.C and accompanying text (explaining how parental involvement can deter teenagers from seeking HIV testing).

<sup>13</sup> See Francis B. McCarthy, *The Confused Constitutional Status and Meaning of Parental Rights*, 22 GA. L. REV. 975, 1017 (1988) (stating that recognition of parental rights is usually justified as either serving the interests of the child, advancing social values or avoiding social inefficiencies). See, e.g., *Bellotti v. Baird*, 443 U.S. 622, 638 (1979) (describing as "deeply rooted in our Nation's history and tradition" the "belief that the parental role implies a substantial measure of authority over one's children"). See also *infra* Part II.A (discussing the Supreme Court's general reluctance to infringe upon the parental right to raise children as they see fit). The law historically treats childhood as an homogeneous status continuing from the age of birth to the age of majority. ANGELA R. HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 124-25 (2d ed. 1985). The age of majority is the age at which the disabilities of minority are removed and the individual legally becomes an adult, free of parental authority and control, and entitled to full decisionmaking authority over his or her own life. *Id.*

reduce the spread of AIDS among the adolescent population.<sup>14</sup> By authorizing confidential HIV testing and counseling for adolescents,<sup>15</sup> states increase the likelihood that they will avoid

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<sup>14</sup> See Deborah J. Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U. L. REV. 739, 742 (1986) (proposing the application of a "reasonable person, unaware of whether he or she were infected with AIDS" standard to determine whether to support legislation aimed at preventing the spread of AIDS).

<sup>15</sup> The issue of confidential *treatment* for HIV-positive adolescents is beyond the scope of this Note. Confidential treatment implicates the resolution of the multifaceted issues of insurance coverage and healthcare reform. Our present healthcare system does not exempt parents from general liability for full payment of necessary medical services supplied to their unemancipated children by third parties. See DONALD T. KRAMER, *LEGAL RIGHTS OF CHILDREN* 646-49 (1994) (discussing how medical providers can collect payment for services provided to minors who were treated without parental consent). Moreover, "[s]tatutes emancipating children solely for purposes of consenting to medical care do not serve to emancipate the child generally, and parents should remain liable for medical care." *Id.* at 648. See Lawrence P. Wilkins, *Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors*, 1975 ARIZ. ST. L.J. 31, 58-59. In a scenario where an adolescent is financially dependent upon his or her parents and the adolescent's doctor is unwilling to provide services to the minor without parental consent due to fear of nonpayment, the availability of confidential HIV testing for the minor is compromised. See KRAMER, *supra*, at 648-49. See generally Michael T. Isbell, *AIDS & Access to Care: Lessons for Health Care Reformers*, 3 CORNELL J.L. & PUB. POL'Y 7, 32 (1993) (discussing the issues involved in providing HIV treatment to individuals under a public health care system).

Confidential testing, as used in this Note, differs from *anonymous* testing because anonymous testing allows for the adolescent's identity not to be recorded by the facility offering the HIV antibody test. Although anonymity is a debatable safeguard, anonymous testing is now being offered through a national network of alternative test sites which have become increasingly popular over the last decade. See CAPS UPDATE, *supra* note 9, at 1. In contrast, confidential testing allows for the recording of the test subject's name, social security number or other identifying mechanism. BARTLETT & FINKBEINER, *supra* note 2, at 309. Although the adolescent's identity may be recorded, access is limited pursuant to state confidentiality laws and regulations. BARTLETT & FINKBEINER, *supra* note 2, at 309.

Despite the fact that confidential testing can give health care providers a means of administering follow-up care and support where necessary, this Note does not advocate diminishing the current privacy provisions established to protect HIV testing subjects. As a matter of medical and social policy,

behaviors which threaten others with transmission.<sup>16</sup> Additionally, confidential testing and counseling can facilitate early treatment of HIV-positive adolescents.<sup>17</sup>

This Note argues that HIV transmission among teenagers decreases when states make confidential HIV testing and counseling freely accessible.<sup>18</sup> Part I describes common law and legislative approaches to parental consent and notification requirements for the health care of minors. Part I also provides a further inquiry into existing statutory approaches to adolescent HIV testing which reveal a lack of legislative consensus. Part II of this Note explores how parental consent and notification requirements negatively

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recordkeeping of adolescent testing ought not breach the confidentiality provisions of state statutes; however, this is not always the practice. See Michael Closen et al., *AIDS: Testing Democracy—Irrational Responses to the Public Health Crisis and the Need for Privacy in Serologic Testing*, 19 J. MARSHALL L. REV. 835, 922 (1992). General breaches in the confidentiality of a positive test result or submission to an HIV test have created widespread public concern because such breaches deter both adolescents and adults from getting tested. Arnold, *supra* note 11, at 50; Closen, *supra*, at 875-77. For a discussion of recent confidentiality concerns and an analysis of protections utilized to maintain confidentiality of HIV-related information, see Roger Doughty, *The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic*, 82 CAL. L. REV. 113 (1994). See also William H.L. Dornette, *Confidentiality Issues*, in AIDS AND THE LAW 371, 371-81 (Wiley Law Publications ed., 2d ed. 1992).

<sup>16</sup> See BARTLETT & FINKBIENER, *supra* note 2, at 311. See also *infra* Part II (establishing a correlation between testing statutes and the prevention of HIV transmission).

<sup>17</sup> See *infra* Part II.C (discussing how early treatment can prolong and enhance the lives of HIV-positive individuals).

<sup>18</sup> See Arnold, *supra* note 11, at 41-42 ("With growing evidence that early treatment of asymptomatic infection is beneficial and that the failure to develop effective preventive strategies for adolescents poses the risk of massive morbidity and mortality in the young adult population, it is important to address the need for HIV testing of teens."). Many groups have endorsed voluntary HIV testing of persons as a means of reducing HIV transmission, including the Committee for the Oversight of AIDS Activities of the Institute of Medicine, the Presidential Commission of the Human Immunodeficiency Virus Epidemic, the Centers for Disease Control and the Canadian National Advisory Committee on AIDS. Frank S. Rhame & Dennis G. Maki, *AIDS Testing Can Control the Spread of AIDS*, reprinted in THE AIDS CRISIS 112, 112 (Bender et al. eds., 1991).



impact an adolescent's decision to ascertain his or her HIV status. Part III considers the constitutional rights and issues presented by HIV testing statutes which authorize minors to independently consent to such testing. The analysis, in turn, weighs the corresponding parental rights, minors' rights and state interests. In an effort to encourage states to adopt more effective legislation, Part III also proposes a model HIV testing statute, merging confidential testing with pre-test and post-test counseling procedures. This Note concludes that confidential testing is a legitimate statutory objective because the states' interests in promoting HIV awareness and reducing HIV transmission outweigh the countervailing right to parental autonomy.

## I. AN EXAMINATION OF MINORS' HEALTH CARE AUTONOMY

Statutes imposing parental consent and notification requirements are often premised on two assumptions: (1) that "parents possess what a child lacks in maturity, experience and capacity for judgment required for making life's difficult decisions,"<sup>19</sup> and (2) that "parents act in the best interests of their child."<sup>20</sup> Although courts and legislatures occasionally determine that minors may make autonomous decisions regarding their own health care,<sup>21</sup> those determinations are generally made on a case-by-case basis.<sup>22</sup>

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<sup>19</sup> *Parham v. J.R.*, 442 U.S. 584, 602 (1979). See *Barnes v. Mississippi*, 992 F.2d 1335, 1339 (5th Cir.) (stating that parental consent and notification requirements guarantee that "someone other than an immature minor and the [medical] provider has a hand in making an important decision that fundamentally affects the minor's health and welfare"), *cert. denied*, 510 U.S. 976 (1993).

<sup>20</sup> *Id.*, 442 U.S. at 604.

<sup>21</sup> *McCarthy*, *supra* note 13, at 977. See, e.g., *Bellotti v. Baird*, 443 U.S. 622, 643 (1979) (holding unconstitutional a Massachusetts statute requiring parental consent to obtain an abortion because it served as "an absolute and possibly arbitrary veto over the decision of the physician and his patient"). See NEV. REV. STAT. § 129.030(2) (1993) (stating that a minor may consent to health care if he or she "understands the nature and purpose of the proposed examination or treatment and its probable outcome, and voluntarily requests it").

<sup>22</sup> The Supreme Court has reasoned that the use of a case-by-case analysis by states when determining the maturity of pregnant minors seeking abortions is

This section examines minors' health care jurisprudence and parental consent and notification provisions with an analysis of how these concepts can be applied to existing HIV testing legislation.

*A. Common Law Exceptions to Parental Consent and Notification*

At common law, minors could not obtain medical care without the express or implied consent of their parents or guardians.<sup>23</sup> The rationale for this approach is based on the assumption that children have not yet developed the cognitive capacity, experience and maturity needed to give meaningful consent to their own

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justified:

The nature of both the State's interest in fostering parental authority and the problem of determining 'maturity' makes clear why the State generally may resort to objective, though inevitably arbitrary, criteria such as age limits [or] marital status . . . for lifting some or all of the legal disabilities of minority. Not only is it difficult to define, let alone determine, maturity, but also the fact that a minor may be very much an adult in some respect does not mean that his or her need and opportunity for growth under parental guidance and discipline have ended.

*Bellotti*, 443 U.S. at 644 n.23. See also McCarthy, *supra* note 13, at 1016-21 (discussing how the subject matter of a decision may affect the ability of a minor to make competent choices).

<sup>23</sup> David L. Shapiro, *Courts, Legislatures and Paternalism*, 74 VA. L. REV. 519, 573 (1988). See, e.g., *Bonner v. Moran*, 126 F.2d 121, 123 (D.C. Cir. 1941) (holding a mother's prior consent necessary to authorize surgery on her 15-year-old son); see also *Fager v. Hundt*, 610 N.E.2d 246, 251 (Ind. 1993) (stating that "the relationship of trust and confidence" between parent and child allows parental knowledge to serve as sufficient notice to the child). A group of legal scholars, commenting on the consensus among states to respect and uphold parental autonomy, state the following:

[W]e have a preference for privacy. To safeguard the right of parents to raise their children as they see fit, free of government intrusion, . . . to safeguard each child's need for continuity. This preference for minimum state intervention . . . is reinforced by our recognition that law is incapable of effectively managing, except in a very gross sense, so delicate and complex a relationship as that between parent and child.

JOSEPH GOLDSTEIN ET AL., *BEYOND THE BEST INTERESTS OF THE CHILD* 7-8 (1979).

health care.<sup>24</sup> Moreover, at common law, parents had an unqualified right to make decisions affecting the child's welfare.<sup>25</sup> Physicians, therefore, often seek parental permission before administering medical services to minors in order to avoid the imposition of liability where a patient has not fully consented to a given medical procedure.<sup>26</sup>

Adolescence, a point midway between childhood and adulthood, has been a problematic area for courts because as children age they become better able to make intelligent and mature decisions for themselves.<sup>27</sup> Thus, a legal dilemma arises in attempting to arrive at the precise point in which adolescent decisionmaking abilities match those of adults.<sup>28</sup> Over time, courts have adopted exceptions to the common law rule of parental consent.<sup>29</sup> For example,

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<sup>24</sup> Arnold, *supra* note 11, at 48; *Developments in the Law—The Constitution and the Family*, 93 HARV. L. REV. 1156, 1219. See, e.g., *Bonner*, 126 F.2d at 122 (“In deference to common experience, there is general recognition of the fact that many persons by reason of their youth are incapable of intelligent decision, as the result of which public policy demands legal protection of their personal as well as their property rights.”).

<sup>25</sup> Arnold, *supra* note 11, at 48-49. Children were considered chattels of their parents. HOLDER, *supra* note 13, at 125. Even if treatment of a minor without parental consent occurred without negligence and led to a satisfactory result, an action for assault and battery could be brought by the parents because minors were deemed unable to consent to the touching involved in the medical care. HOLDER, *supra* note 13, at 125 (holding that blood tests and transfusion from minor, without parental consent, was grounds to award damages to parents) (citing *Zaman v. Schultz*, 19 Pa. D. & C. 309 (Cambria Co. 1933)). It is also believed that the origin of the common law rule, in which minors were considered incompetent to enter into binding contracts, may be attributed to the contractual nature of the doctor-patient relationship. KRAMER, *supra* note 15, at 642 (citing *Rishworth v. Moss*, 159 S.W. 122 (Tex. Civ. App. 1913), *aff'd*, 222 S.W. 225 (Tex. 1920)).

<sup>26</sup> KRAMER, *supra* note 15, at 642. See also *infra* note 40 (explaining the meaning of the “capacity to consent” standard).

<sup>27</sup> Nancy Batterman, *Under Age: A Minor's Right to Consent to Health Care*, 10 TOURO L. REV. 637, 645 (1994).

<sup>28</sup> Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 738-39 (1993).

<sup>29</sup> William Adams, “*But Do You Have to Tell My Parents?*” *The Dilemma for Minors Seeking HIV-Testing and Treatment*, 27 J. MARSHALL L. REV. 493, 499 (1994); Carolyn O'Connor, *Illinois Adolescents' Rights to Confidential*

minors can receive medical treatment without parental consent in an emergency,<sup>30</sup> or if the minor is deemed "emancipated"<sup>31</sup> or "mature."<sup>32</sup> The common law exceptions developed by courts

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*Health Care*, 82 ILL. B.J. 24, 26 (1994).

<sup>30</sup> A medical emergency involves a medical condition which either "endangers the minor's life or threatens permanent impairment if the condition is left untreated." KRAMER, *supra* note 15, at 642. *See, e.g.*, *Tabor v. Scobee*, 254 S.W.2d 474, 476 (Ky. 1951) (prohibiting removal of diseased fallopian tubes during an appendectomy without parental consent because it was not life threatening); *Luka v. Lowrie*, 136 N.W. 1106, 1110 (Mich. 1912) (allowing amputation of minor's infected foot without parental consent).

<sup>31</sup> At common law, an emancipated minor is commonly described as one who is living separate and apart from parents, with or without their consent, self-supporting and managing his or her own financial affairs. KRAMER, *supra* note 15, at 670-74. Courts have also weighed additional factors in determining the emancipation of minors. For example, a Washington appellate court acknowledged that a minor may be deemed emancipated when "intelligence, maturity, training, experience, economic independence, general conduct as an adult, and freedom from the control of parents" are present as indicators. *Smith v. Seibly*, 431 P.2d 719, 722 (Wash. 1967) (finding emancipation on the basis of marriage). *Compare* *Bach v. Long Island Jewish Hosp.*, 149 Misc. 2d 207, 208, 267 N.Y.S.2d 289, 291 (Sup. Ct. 1966) (upholding a 19-year-old's consent to a non-emergency surgical operation where she was emancipated by marriage) *with* *Hamdy v. Hamdy*, 203 A.D.2d 958, 612 N.Y.S.2d 718, 718 (4th Dep't 1994) (stating that an individual may be considered unemancipated if he or she is a full-time student under the age of 21). *See also* *Rich v. Rich*, 871 S.W.2d 618 (Mo. Ct. App. 1994) (holding that a minor is not considered emancipated for purposes of either custody or support if the child, although over age 18, is enrolled in college).

The common law "emancipated minor" doctrine should not be confused with emancipation statutes whereby states allow minors to attain legal adulthood before reaching the age of majority if they meet specific statutory requirements. JAMES M. MORRISSEY ET AL., *CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS* 34 (1986).

<sup>32</sup> The common law "mature minor" doctrine renders a minor, not otherwise emancipated, capable of making an informed and mature decision after consideration of the long-term consequences of that decision. *See* *Batterman*, *supra* note 27, at 653; Leslie A. Fithian, Note, *Forcible Repatriation of Minors: The Competing Rights of Parent and Child*, 37 STAN. L. REV. 187, 208 (1984). A review of long-term consequences usually explores whether it is impractical to obtain parental consent, whether the procedure is relatively uncomplicated and likely to be beneficial to the minor, and whether the minor is sufficiently intelligent and mature to appreciate and understand the nature and consequences

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of the procedure. *See, e.g.*, *Younts v. St. Francis Hosp.*, 469 P.2d 330, 337 (Kan. 1970) (allowing surgery to replace tip of 17-year-old's finger where the parents were unavailable for consent and the patient did not object to the procedure beforehand); *Baird v. Attorney Gen.*, 360 N.E.2d 288, 293 (Mass. 1977) (holding that if a parent or guardian is available, a state may require parental notification where an unmarried minor seeks to obtain judicial consent for a non-emergency abortion).

A mature minor is especially likely to be able to give consent where the medical procedure involves little risk. *See, e.g.*, *Bishop v. Shurly*, 211 N.W. 75, 78 (Mich. 1926) (allowing a minor to contract with a doctor for the performance of a tonsillectomy); *Gulf v. S.I.R. Co.*, 119 So. 501, 502 (Miss. 1928) (allowing minor to consent to vaccination); *Lacey v. Laird*, 139 N.E.2d 25, 26 (Ohio 1956) (allowing minor to consent to cosmetic surgery). The Restatement of the Law of Torts also provides that "[i]f a child . . . is capable of appreciating the nature, extent and consequences of the invasion [of his or her body, then the minor's consent] prevents the invasion from creating liability, [even] though the assent of the parent, guardian, or other person is not obtained . . ." RESTATEMENT (SECOND) OF TORTS §59a (1965).

Where the parents of a 17-year-old female, who were Jehovah's Witnesses, refused to consent to a blood transfusion, the Illinois Supreme Court stated that "[i]f the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions . . . then the mature minor doctrine affords her the common law right to consent to or refuse medical treatment." *In re E.G.*, 549 N.E.2d 322, 327-28 (Ill. 1989). However, the mature minor doctrine does not give minors an absolute right. *Id.* at 328 (reasoning that, even where a minor possesses the requisite degree of maturity, a mature minor's right to refuse life-sustaining medical treatment may be limited by state interests). As a result, a minor's decisionmaking rights are balanced against the state's interests in preserving life, "protecting the interests of third parties," preventing suicide and "maintaining the ethical integrity of the medical profession." *Id.* at 328 (citing *In re Longeway*, 549 N.E.2d 292, 299 (Ill. 1989)). Note, however, that the "mature minor" doctrine is invoked more often when the treatment is for the minor's own benefit than when the treatment is designed to benefit a third party. *See, e.g.*, *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941) (holding that the consent of a 15-year-old boy's parents was necessary where the boy wished to provide his cousin with flesh for a skin graft).

The American Bar Association ("ABA"), along with several state legislatures, has formally adopted the common law mature minor doctrine, thereby permitting an unemancipated minor of sufficient maturity and judgment to consent to treatment without prior parental consent. The ABA section reads as follows:

A minor of [sixteen] or older who has sufficient capacity to understand the nature and consequences of a proposed medical treatment for his

during the last century have set the stage for individual state legislatures to pass statutes governing minors' health care autonomy.<sup>33</sup>

### B. *Statutory Consent and Notification Requirements*

State legislatures have generally retained the common law approach to minors' health care decisions by imposing parental consent and notification requirements.<sup>34</sup> The court often permits state legislatures to override parental authority if necessary to protect the best interests of a child.<sup>35</sup> Lawmakers have gone even further by constructing individual statutes which authorize minors to consent to their own health care under certain conditions<sup>36</sup>

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or her benefit may consent to that treatment on the same terms and conditions as an adult. . . . The brackets around sixteen in Standard [4.6] A. are intended to minimize the significance of the age of the minor, thereby placing the emphasis on the minor's capacity to understand the nature and consequences of the proposed treatment as the essential prerequisite to informed consent to the treatment.

STANDARDS RELATING TO RIGHTS OF MINORS § 4.6 & Commentary (IJA-ABA Joint Comm'n on Juvenile Justice Standards 1980).

<sup>33</sup> See generally KRAMER, *supra* note 15, at 641-61 (discussing "legislative modification" of common law rules governing minors' health care for areas such as drug addiction, pregnancy, contraception and abortion).

<sup>34</sup> See Batterman, *supra* note 27, at 637 (noting that lawmakers, like the judiciary, are "fearful of encroaching upon parental rights").

<sup>35</sup> Wilkins, *supra* note 15, at 59. The early common law absolute right of parents over their children is now limited by state intervention under the theory of protecting the child even where the family is considered a healthy unit. See, e.g., *Washington v. King County Hosp.*, 278 F. Supp. 488, 504 (D.D.C. 1967) (holding constitutional a state statute authorizing physicians and hospitals to sustain blood transfusions for children of Jehovah's Witnesses where the transfusion was done "in the name of their health and welfare"), *aff'd*, 390 U.S. 598 (1968). Under conditions similar to those of an "emergency situation," a doctor may file medical neglect charges against the parent(s) who refuse consent, seek a court order to authorize medical treatment or both. See, e.g., *Custody of a Minor*, 379 N.E.2d 1053, 1066-67 (Mass. 1978) (ordering the custody of a child to vest in the state where it was certain that a child suffering from leukemia would die without chemotherapy treatment).

<sup>36</sup> HOLDER, *supra* note 13, at 129. See MD. CODE ANN., HEALTH-GEN § 20-102 (1996) (providing that when "the life or health of the minor would be

based on the minor's particular status, the minor's particular medical condition or both.<sup>37</sup>

Statutes conditioning consent on the particular status of a minor may be further grouped according to age requirements or "capacity to consent" requirements. Age-based classifications provide that only minors of specified ages may independently authorize a particular medical procedure.<sup>38</sup> Such an approach is widely criticized and debated because age-based classifications may operate as an arbitrary means of determining the minor's ability to provide consent.<sup>39</sup> Alternatively, legislatures may adopt a "capacity to consent" requirement which allows a court or medical provider to weigh maturity criteria when deciding whether parental consent and

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affected adversely by delaying treatment," the minor is deemed to have "the same capacity as an adult to consent to [emergency] treatment").

<sup>37</sup> Batterman, *supra* note 27, at 652. The authority for health care providers to at least treat older minors for their own benefit has gone unchallenged. HOLDER, *supra* note 13, at 133.

<sup>38</sup> KRAMER, *supra* note 15, at 586.

<sup>39</sup> Today, it is largely recognized that age-based classifications do not always accurately reflect the developing capacities of adolescents because maturation is a gradual process and not an instantaneous one. Michael S. Wald, *Children's Rights: A Framework for Analysis*, 12 U.C. DAVIS L. REV. 255, 267-68 (1979). See *Bellotti v. Baird*, 443 U.S. 622, 643 n.23 (1979) (admitting that age limits are "inevitably arbitrary"). Some legal scholars deem age-based classifications inappropriate because an entire class of fully capable minors may be denied access to health care, and adolescents must sometimes make medical decisions regardless of their age. Wald, *supra*, at 268. The Supreme Court, however, is generally not receptive to criticisms of age-based classification. See *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 312 (1976) (upholding, under a rational-basis review, a statute providing 50 as the age of mandatory retirement). See also McCarthy, *supra* note 13, at 1014 (providing an exception where the Supreme Court has addressed age-based classifications in reproductive freedom cases). Enormous variation exists from state to state with respect to the age at which a particular activity is considered appropriate for adolescents. See generally U.S. DEP'T OF HEALTH & HUMAN SERVS., THE LEGAL STATUS OF ADOLESCENTS 43-47 (1981) (summarizing statutes which affect adolescent rights); CAL. HEALTH & SAFETY CODE § 121020(a)(1) (West 1996) (deeming a minor under 12 years of age "not competent" to provide consent for an HIV test).

notification will be necessary in a given case.<sup>40</sup> This approach is likewise vulnerable to legal criticism because of its potential for subjective, incompatible determinations.<sup>41</sup>

Conversely, some legislatures choose to condition a minor's ability to provide consent on the particular health care service sought by the youth, regardless of the minor's age or capacity.<sup>42</sup>

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<sup>40</sup> Kristen J. Brown, *Bellotti v. Baird: The Impropriety of Extending the Invalid Assumptions of Bellotti to Determine the Constitutionality of Pure Notification Statutes*, 18 CAP. U. L. REV. 297, 309 (1989). The "capacity to consent" standard is most commonly invoked in minor's abortion statutes. *Id.* Legislation permitting minors to consent based upon "capacity" merges the ideas of the common law "emancipated minor" and "mature minor" doctrines. Batterman, *supra* note 27, at 653. The "capacity to consent" standard describes the qualities adults are assumed to bring to the decisionmaking process. *See* Batterman, *supra* note 27, at 653. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 20-102(b) (stating that "[a] minor has the same capacity as an adult to consent to medical treatment if, in the judgment of the attending physician, the life or health of the minor would be affected adversely"); MISS. CODE ANN. § 41-41-3(g)-(i) (1991) (allowing a minor to consent to health care when emancipated or when the minor possesses sufficient intelligence to render informed consent, and when consent pertains to pregnancy or childbirth); N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 1994 & Supp. 1996) (permitting minor to consent to health care when the attending physician determines that an emergency exists and delay would otherwise "increase the risk to the person's life or health").

<sup>41</sup> KRAMER, *supra* note 15, at 586-87 (stating that as between courts and legislatures, there are frequently inconsistent outcomes when determining a minor's capacity to consent to a particular activity).

<sup>42</sup> The legislative approach which conditions consent upon a particular medical condition enables states to protect the welfare of children from specific harm by acknowledging that certain conditions are too damaging to society as a whole to remain untreated. *See* ANGELA R. HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 141-42 (1977). Dr. Holder notes that "[t]he consequences of untreated contagious diseases in general and venereal diseases in particular are so enormous both to the child himself and to society in general that common sense would require a physician to take the view that something has to be done and to do it." *Id.* at 142. *See, e.g.*, LA. REV. STAT. ANN. § 40:1095(a) (West 1992) (providing that a minor may consent to medical treatment, without later disaffirmance by a parent or guardian, if the minor "is or believes himself to be afflicted with an illness or disease"); MD. CODE ANN., HEALTH-GEN. § 20-102(c) (outlining specific treatments in which minors can independently consent, including drug abuse, alcoholism, venereal disease,



For example, many state legislatures authorize access to testing and care for venereal and sexually transmitted diseases,<sup>43</sup> alcohol and other substance abuse treatments,<sup>44</sup> condoms<sup>45</sup> and pregnancy care.<sup>46</sup> These laws reflect a legislative policy determination that the benefits of permitting independent access to such health care may serve to outweigh the costs of abrogating parental consent,

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pregnancy, certain forms of contraception and injuries related to a sexual offense).

<sup>43</sup> See, e.g., ALA. CODE § 22-11A-19 (1990) (permitting minor to consent to treatment for diseases designated as "sexually transmitted" by the state board of health); NEB. REV. STAT. § 71-504 (1990) (granting minors the right to be treated for sexually transmitted diseases "without the consent of or notification to the parent, parents, guardian, or any other person having custody of [the minor]"); W. VA. CODE § 16-4-10 (1995) (permitting minor to be treated for venereal disease without parental consent).

<sup>44</sup> See, e.g., GA. CODE ANN. § 37-7-8 (1995) (allowing a minor to consent to treatment for drug abuse "as if the minor had achieved his majority"); N.J. STAT. ANN. § 9:17A-4 (West 1993) (permitting a minor to consent to medical care if the minor is suffering from drug or alcohol dependency).

<sup>45</sup> The Court of Appeals for the Sixth Circuit upheld a Michigan statute permitting minors to receive condoms without parental consent or notification and rejected the parents' constitutional challenge. *Doe v. Irwin*, 615 F.2d 1162, 1169 (6th Cir.), *cert. denied*, 449 U.S. 829 (1980). The distribution of condoms to adolescents by a public family planning center without parental consent was held constitutional because there was no state compulsion on parents to send their children into the clinic. *Id.* at 1168. Instead, the practice was viewed as a valid health service. *Id.* See *Doe v. Pickett*, 480 F. Supp. 1218, 1219 (S.D. W. Va. 1979) (finding against a state agency which denied birth control and family planning services to minors without parental consent).

In contrast, New York's appellate division upheld a trial court decision which invalidated a condom distribution program in the public schools because the program was a "health service" and should, therefore, have required consent from the parents or guardians prior to the distribution. *Alfonso v. Fernandez*, 195 A.D.2d 46, 52, 606 N.Y.S.2d 259, 263 (2d Dep't 1993). The court held that the statute violated the parents' constitutional right to direct the upbringing of their children. *Id.* at 57, 606 N.Y.S.2d at 266. The reviewing court acknowledged the state's compelling interest in controlling AIDS, but determined that the ends did not justify the means. *Id.* at 53, 606 N.Y.S.2d at 263.

<sup>46</sup> See, e.g., MICH. COMP. LAWS ANN. § 333.9132 (West 1992) (stating that a minor may consent to "prenatal and pregnancy related health care" or to health care for her own child); N.J. STAT. ANN. § 9:17A-1 (permitting a minor to consent to health care if the minor is pregnant).

especially in those areas where teenagers would typically avoid appropriate treatment rather than inform their parents of their medical needs.<sup>47</sup>

### C. *Survey of Legislative Approaches to HIV Testing of Minors*

There are several statutory approaches to the HIV testing of minors. Some statutes specifically authorize medical care providers to both administer HIV testing without parental consent and release results to minors without parental notification.<sup>48</sup> Other statutes simply authorize minors to consent to testing for sexually transmitted diseases.<sup>49</sup> Although some courts interpret "sexually transmitted disease" to include HIV or AIDS,<sup>50</sup> in actuality, they are not technically "sexually transmitted" diseases.<sup>51</sup> Ambiguity results when either minors, test providers or courts rely on a narrow reading of such statutes.<sup>52</sup> Even if legislators amend these statutes to explicitly encompass HIV testing, the scope of a minor's rights may nevertheless remain vague in an AIDS setting where "the potential for discrimination is great and assurances of

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<sup>47</sup> Arnold, *supra* note 11, at 49.

<sup>48</sup> See *supra* note 9 (providing examples of state statutes allowing minors to independently consent to HIV testing).

<sup>49</sup> See *supra* note 43 (providing examples of relevant statutes).

<sup>50</sup> See, e.g., Hill v. Evans, No. 91-A-626-N, 1993 WL 595676, at \*4 (M.D. Ala. Oct. 7, 1993) (stating that Alabama state law includes AIDS as a sexually transmitted disease); Doe v. Minneapolis, 693 F. Supp. 774, 777 (Minn. 1988) (ordinance seeking to reduce the spread of contagious diseases caused by "high risk sexual conduct" includes AIDS).

<sup>51</sup> HIV may be transmitted through means other than sexual activity. See *supra* note 8 and accompanying text (listing routes of HIV transmission and HIV exposure categories).

<sup>52</sup> Taunya L. Banks, *Women and AIDS—Racism, Sexism and Classism*, 17 N.Y.U. REV OF L. & SOC. CHANGE 351, 374 (1990). See Tamar Lewin, *Judge Blocks Effort to List AIDS as a Sex Disease*, N.Y. TIMES, Nov. 16, 1988, at B1 (reporting that the New York Health Commissioner has the discretion to refuse to place AIDS on the list of sexually transmitted diseases doctors are authorized to test for without a patient's written consent). But see MICH. COMP. LAWS ANN. § 333.5127 (explicitly stating that a minor may consent to treatment for venereal disease or HIV infection).

confidentiality are essential.”<sup>53</sup> When legislatures simply amend pre-existing venereal disease statutes to incorporate HIV and AIDS, legislatures are, in effect, neglecting the issues specific to HIV within our adolescent population.

Another deficiency within adolescent HIV testing legislation can be found in those statutes which permit minors to independently consent to HIV tests, but remain ambiguous as to the level of confidentiality given to the test and its results.<sup>54</sup> For example, Colorado provides for a minor’s consultation, examination and treatment for HIV infection to remain confidential,<sup>55</sup> but provides optional notification to a parent or legal guardian if the minor is under sixteen years of age or not emancipated.<sup>56</sup>

A final problem among HIV testing statutes is when an adolescent’s ability to independently consent to an HIV test is conditioned upon the particular age or maturity level of the minor.<sup>57</sup> As discussed in Part I, conditioning consent to HIV testing upon a minor’s capacity to provide informed consent,<sup>58</sup> or

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<sup>53</sup> Arnold, *supra* note 11, at 56 (naming regulatory control measures such as isolation and contact tracing as limitations inherent in making HIV-related care available to minors). See, e.g., IOWA CODE ANN. § 141.22(6) (West 1989 & Supp. 1996) (stating that a minor can consent to screening or treatment for AIDS and other sexually transmitted diseases, but that a parent or guardian will then be informed of a positive test result).

<sup>54</sup> See ALA. CODE § 22-11A-19 (stating that a medical provider who gives a minor 12 years of age or older medical treatment for a “sexually transmitted disease” is “not . . . obligated to, inform the parent, parents or guardian of any such minor as to the treatment given or needed”) (emphasis added).

<sup>55</sup> COLO. REV. STAT. § 25-4-1405(6) (1989 & Supp. 1995) (“The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the facility or physician to any person other than the minor.”).

<sup>56</sup> *Id.* In Michigan, a health care provider *may* inform the parent or guardian about the treatment suggested or rendered, but the provider is not obligated to so report. See MICH. COMP. LAWS ANN. § 333.5127(2).

<sup>57</sup> See *supra* Part II.B (discussing how lawmakers have constructed individual statutes which authorize minors to consent to their own health care based on their particular status).

<sup>58</sup> Minors are generally regarded as lacking “capacity to consent” because they are incapable of understanding risks and benefits and of making a truly voluntary decision to consent. WILLIAM L. PROSSER & KEATON, TORTS 118 (5th

the parents' refusal to provide consent,<sup>59</sup> could bar a significant number of teenagers from freely accessing their HIV status due to the arbitrariness or subjectivity of such criteria.<sup>60</sup>

Divergent statutory strategies concerning the health care of minors reveal the dilemma faced by legislatures in determining the proper approach to adolescent HIV testing. By imposing parental consent and notification requirements, the legislature is confronted with two distinct issues. First, parental consent denies minors the right to make autonomous health care decisions.<sup>61</sup> Secondly, parental notification limits the right of adolescents to control the dissemination of information about their personal choice.<sup>62</sup> Legislatures are more likely to eliminate parental consent and notification requirements if states demonstrate that their interests in safeguarding the general welfare surpass the right of parents to be involved in the HIV testing of their children.

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ed. 1984). *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 36-661(2), -663(A) (West 1993 & Supp. 1995) (stating that an HIV test may be given to a test subject "who has capacity to consent or, if the subject lacks capacity to consent, [consent may be given by] a person authorized pursuant to law to consent to health care for that person"); N.Y. PUB. HEALTH LAW § 2780(5) (McKinney 1993) (defining "capacity to consent" to include an individual's ability "to understand and appreciate the nature and consequences of," and "to make an informed decision" concerning, "a proposed disclosure of confidential HIV related information"). Arizona and New York codify a "mature minor" rule by requiring that a test subject give informed consent to the test, and by defining the subject's capacity to consent in terms of his or her ability, "without regard to age," to appreciate and understand the nature and consequences of the proposed procedure and to make an informed decision about it. Arnold *supra* note 11, at 51; *see* N.Y. PUB. HEALTH LAW § 2780(5) ("capacity to consent" [is] determined without regard to the individual's age").

<sup>59</sup> *See, e.g.*, N.C. GEN. STAT. § 130A-148 (1995) (permitting testing—without consent when a "parent or guardian has refused consent to such testing and there is reasonable suspicion that the minor has the AIDS virus or HIV infection or that the child had been sexually abused").

<sup>60</sup> *See supra* note 39 and accompanying text (discussing the overbreadth of statutes invoking age-based classifications).

<sup>61</sup> Arnold *supra* note 11, at 50.

<sup>62</sup> Arnold, *supra* note 11, at 50.

## II. TESTING THE RIGHTS OF PARENTS, THE RIGHTS OF ADOLESCENTS AND THE INTERESTS OF THE STATE

As the level of parental involvement in HIV testing increases, the incentive of adolescents to determine their HIV status decreases.<sup>63</sup> Consequently, the right to know whether or not a minor is HIV positive is significantly restricted. Additionally, the right of parents to know of their child's predisposition for HIV and AIDS is pitted against the state's interest in promoting adolescent responsibility to avoid further HIV transmission. The Supreme Court has provided limited insight into the appropriate guidelines or applicable level of scrutiny when dealing with the tension between the role of the state and the role of parents.<sup>64</sup> Public policy, however, supports balancing the right of minors to have unrestricted access to their HIV status and the state's interest in reducing the number of AIDS-related deaths and illnesses against the countervailing weight of the parental right to supervise the health care of their child.<sup>65</sup>

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<sup>63</sup> See Arnold, *supra* note 11, at 54 (stating that a parental notification requirement for adolescent HIV testing "threatens to render meaningless the minor's independent authority to give consent"); see also *infra* Part II.C (explaining how parental involvement can deter teenagers from seeking medical advice).

<sup>64</sup> Compare *Ginsberg v. New York*, 390 U.S. 629, 639 (1968) (finding a law which prevents the sale of sexually explicit material to minors constitutional because it is rational for legislatures to determine that minors' exposure to such material is harmful and such measures are necessary to support parents in exercising their responsibilities) with *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52, 74-75 (1976) (holding the state's interest in conditioning a minor's abortion on the consent of her parents insufficient to justify a parental consent requirement).

<sup>65</sup> See *supra* Part II.C (arguing the weight of the state's interest in protecting the health and welfare of its citizenry).

### A. *The Right of Parents to Be Involved in HIV Testing*

The U.S. Supreme Court interprets the Due Process Clause of the Fourteenth Amendment<sup>66</sup> as granting parents a fundamental right to oversee the health and welfare of their children.<sup>67</sup> Consequently, state legislatures commonly defer to the liberty rights of parents in the supervision of minors' health care.<sup>68</sup> Although the Supreme Court has not specifically addressed HIV testing statutes

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<sup>66</sup> U.S. CONST. amend. XIV (denying states the power to "deprive any person of life, liberty, or property, without due process of law"). The U.S. Supreme Court has incorporated the Due Process Clause of the Fifth Amendment into the Fourteenth Amendment. *See* U.S. CONST. amend. V (stating that no person "shall be deprived of life, liberty, or property, without due process of law"). As a result, due process guarantees apply equally to state and federal law. *See* *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (holding unconstitutional a state law forbidding the use of contraceptives as an intrusion upon the right to marital privacy); *Pointer v. Texas*, 380 U.S. 400, 400-01 (1965) (holding the Sixth Amendment right of an accused to confront witnesses against him as binding upon the states under the Fourteenth Amendment).

<sup>67</sup> *See, e.g.*, *Parham v. J.R.*, 442 U.S. 584, 603-04 (1979) (holding that parents have a substantive due process right to commit their children to a mental institution); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925) (holding unconstitutional a state law requiring children to attend public schools where the Fourteenth Amendment gives parents a liberty interest in directing their child's education); *Meyer v. Nebraska*, 262 U.S. 390, 401 (1923) (asserting that parents' liberty rights were violated by a state law prohibiting public grade schools from teaching foreign languages).

<sup>68</sup> *Lassiter v. Department of Social Servs.*, 452 U.S. 18, 27 (1981) ("[The Supreme] Court's decisions have by now made plain beyond the need for multiple citation that a parent's desire for and right to 'the companionship, care, custody, and management of his or her children is an important interest that' undeniably warrants deference. . . absent a powerful countervailing interest. . . ." (quoting *Stanley v. Illinois*, 405 U.S. 645, 651 (1972)); *see* *Wisconsin v. Yoder*, 406 U.S. 205, 213-14 (1972) (holding that parents' right to determine their children's upbringing and education outweighs the state's interest in compulsory secondary school education). However, Justice William O. Douglas' dissent in *Yoder* argues that "children themselves have constitutionally protectable interests" and urges the consideration of a child's substantive right to secondary education. *Id.* at 243 (Douglas, J., dissenting).

aimed at minors,<sup>69</sup> decisions addressing parental consent requirements in abortion statutes concerning minors suggest that adolescents require the protection and advice of their family.<sup>70</sup> Justice Lewis Powell Jr., writing for the Court in *Bellotti v. Baird*,<sup>71</sup> argues that “the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing,” justifies parental consent and notification requirements.<sup>72</sup>

By authorizing HIV testing without parental consent and notification, legislatures may keep parents from fulfilling their parental obligations.<sup>73</sup> Without the support of parents, however, the risk of HIV infection can be a psychologically and emotionally

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<sup>69</sup> See generally Michael L. Closen, *The High Court's Fear of AIDS*, N.Y. TIMES, Oct. 26, 1995, at A25 (explaining how the Supreme Court has remained silent on a number of AIDS-related issues). To date, the Supreme Court has reviewed only one AIDS-related case. See *American Nat'l Red Cross v. S.G.*, 505 U.S. 247 (1992). The case involved a lawsuit filed against the American Red Cross by a patient claiming to have received a blood transfusion contaminated with HIV. *Id.* at 248-49. The Court, however, decided the case solely on procedural grounds without addressing any HIV issues. *Id.* at 257 (holding that a federal charter authorizing the Red Cross “to sue and be sued in courts of law and equity, State or Federal, within the jurisdiction of the United States” conferred original federal jurisdiction).

<sup>70</sup> See, e.g., *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502, 520 (1990) (stating that “the family will strive to give a lonely or even terrified minor advice that is both compassionate and mature . . . .”); *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 492 (1983) (holding constitutional a parental consent requirement in Missouri abortion statute because the statute provided a judicial bypass procedure); *H.L. v. Matheson*, 450 U.S. 398, 409 (1981) (holding that “a ‘mere requirement of parental notice’ does not violate the constitutional rights of an immature, dependent minor”); *Bellotti v. Baird*, 443 U.S. 622, 637 (1979) (“The guiding role of parents in the upbringing of their children justifies limitation on the freedom of minors.”); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 90-91 (1976) (Stewart, J., concurring) (“There can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents . . . [because she] . . . may be ill-equipped to make it without mature advice and emotional support.”).

<sup>71</sup> 443 U.S. 622 (1979).

<sup>72</sup> *Id.* at 634.

<sup>73</sup> Wilkins, *supra* note 15, at 78.

stressful ordeal for an adolescent to face alone.<sup>74</sup> Adolescents are particularly prone to experience trauma upon learning that they are HIV positive.<sup>75</sup> Moreover, there exists a risk that after testing, an adolescent may continue to engage in high-risk behaviors or avoid early treatment.<sup>76</sup> Accordingly, parents may express concern that laws eliminating their consent before administering an HIV test and releasing test results to their child bars them from otherwise learning of the high risk activities and propensity for HIV infection particular to their child.<sup>77</sup> Parental guidance and support may therefore be viewed as necessary to mitigate any emotional stress experienced by an adolescent and ensure that adolescents receive treatment and avoid further risk behaviors.<sup>78</sup> Thus, state legislatures might seek a safe retreat and adhere to the common law view that parents, acting in the best interests of children, can serve as a source of support and supervision for at-risk teenagers.<sup>79</sup>

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<sup>74</sup> See Society for Adol. Med., *supra* note 3, at 27.

<sup>75</sup> Jean Fain, *AIDS Poses a Threat to Teenagers*, reprinted in THE AIDS CRISIS, *supra* note 18, at 36, 42. Twenty-one percent of high school students individually surveyed answered they would “commit suicide” when asked what they would do if they tested HIV-positive. *Id.*

<sup>76</sup> See Closen et al., *supra* note 15, at 876 n.177 (“A person told that he or she has [tested positive for HIV] may abandon all hope and all respect for the health of his or her partners by purposefully engaging in unsafe sex.”). *But see infra* Part II.C (explaining how a person tested for HIV is likely to avoid engaging in subsequent high-risk behaviors because they are more aware of the long-term repercussions).

<sup>77</sup> Adams, *supra* note 29, at 497.

<sup>78</sup> See Dornette, *supra* note 15, at 377 (arguing that the seriousness of HIV infection warrants the involvement of a minor’s parents).

<sup>79</sup> See *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children . . . . The law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life’s difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children.

*Id.* at 602-03 (citations omitted).



Debate is sure to ensue where states impose the sole responsibility on parents to communicate the risks of HIV infection to their teenagers and to offset the emotional trauma experienced by adolescents testing positive for HIV. A disenchanting faction of the legal community has sharply criticized the traditional role of parents as primary health care managers.<sup>80</sup> Even the Supreme Court has questioned the efficacy of a doctrine which gives parents complete autonomy over the medical care and treatment of their children.<sup>81</sup> One commentator has proposed that a more appropriate

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<sup>80</sup> James G. Dwyer, *Parents' Religion and Children's Welfare: Debunking the Doctrine of Parents' Rights*, 82 CAL. L. REV. 1371, 1371 (1994) ("The scope, weight, and assignment of parental rights have been the focus of much debate among legal commentators.").

<sup>81</sup> See *Hodgson v. Minnesota*, 497 U.S. 417, 418 (1990) (5-4 decision) ("The State has no legitimate interest in conforming family life to a state-designed ideal by requiring family members to talk together."). Therein, the Supreme Court found a statute requiring two-parent notification for minor-abortion cases, whether or not both wish to be notified or have assumed responsibility for the upbringing of the child, did not reasonably further any legitimate state interest. *Id.* at 418-19. A plurality of the *Hodgson* Court, however, upheld a two-parent notification requirement which included a judicial bypass provision for the pregnant minor. *Id.* Expressing disfavor with what he perceives to be the overriding message of the *Hodgson* decision, Justice Kennedy stated:

It is true that for all too many young women the prospect of two parents, perhaps even one parent, sustaining her with support that is compassionate and committed is an illusion. Statistics on drug and alcohol abuse by parents and documentation of child neglect and mistreatment are but fragments of the evidence showing the tragic reality that becomes day-to-day life for thousands of minors. But the Court errs in serious degree when it commands its own solution to the cruel consequences of individual misconduct, parental failure, and social ills. The legislative authority is entitled to attempt to meet these wrongs by taking reasonable measures to recognize and promote the primacy of the family tie, a concept which this Court now seems intent on declaring a constitutional irrelevance.

*Id.* at 501 (Kennedy, J., dissenting in part). *But see Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 281 (1990) (holding that parents may not suspend their daughter's life-sustaining treatment, stating that "[n]ot all incompetent patients will have loved ones available to serve as surrogate decision-makers . . . . There will, of course, be some unfortunate situations in which family members will not act to protect a patient."). Legal scholars have expressed

level of protection can be provided to children when parents are simply given a "child-rearing *privilege*" in which parents are required to make decisions in accordance with the child's rights as compared to the existing approach where parents make decisions in accordance with their own ideals.<sup>82</sup>

The negative effects of parental involvement to outweigh any positive effects. These statutory requirements tend to create an unfair dilemma for adolescents because the adolescent who seeks parental consent for an HIV test is effectively disclosing that he or she has engaged in high-risk behavior. For many adolescents, avoiding such disclosures to their parents receives priority over taking an HIV test.<sup>83</sup> A significant number of adolescents, therefore, will be estopped from ascertaining their HIV status where legislatures allow for parental involvement.<sup>84</sup>

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difficulty in reconciling the Supreme Court's view of family autonomy in *Hodgson and Cruzan*. Martha Minow, *The Role of Families in Medical Decisions*, 1991 UTAH L. REV. 1, 11 ("The Court appeared to promote family authority when it upheld a state's entitlement to restrict minors' access to abortion, but restrain family authority when it upheld a state's entitlement to block termination of life-support urged by parents." (quoting Anita L. Allen, *Court Disables Disputed Legacy of Privacy Right*, NAT'L L.J., Aug. 13, 1990, at S8, S14)). See *Michael H. v. Gerald D.*, 491 U.S. 110, 139 (1989) (Brennan, J., dissenting) (expressing skepticism of "tradition" as a criterion for identifying a particular liberty interest as protected by the Constitution: "Even if we could agree . . . on the content and significance of particular traditions, we still would be forced to identify the point at which a tradition becomes . . . too obsolete to be relevant any longer."); Rhonda Copelon, *Losing the Negative Right of Privacy: Building Sexual and Reproductive Freedom*, 18 N.Y.U. REV. L. & SOC. CHANGE 15, 36-37 & n.150 (1991) (examining the recent line of Supreme Court cases ruling on notification requirements in minor's abortion statutes and expressing difficulty in predicting future decisions).

<sup>82</sup> Dwyer, *supra* note 80, at 1372 (emphasis added) (proposing that "children's rights, rather than parents' rights, serve as a basis for protecting the legal interests of children").

<sup>83</sup> Forty-seven percent of adolescents tested do not return for the results because they fear lack of confidentiality. Antonia Novello, *Let's Deal with the Reality of Teens and AIDS*, MIAMI HERALD, Oct. 31, 1993, at 5M.

<sup>84</sup> See HOLDER, *supra* note 13, at 267 (stating that "[n]othing in the parent-adolescent relationship is more likely to produce serious conflict than sexual activity by the minor."). "Minors will frequently do without treatment rather than inform their parents about certain medical needs. . . ." KRAMER, *supra* note 15,

State legislatures evaluating HIV testing policies and procedures for minors should assess the utility of parental consent and notification requirements. By allowing parents to participate in adolescent testing decisions, HIV-positive teenagers may continue to engage in high risk behaviors, which inadvertently increases the overall rate of HIV transmission.<sup>85</sup> State legislatures are, therefore, urged to consider the serious ramifications of requiring parental consent and notification when enacting HIV testing statutes because parental involvement can prove deadly for American youth.

*B. The Privacy Right of Minors to Independently Ascertain HIV Status*

As family rights jurisprudence develops, the question of whether minors have individual constitutional rights when the interests of parent and state clash must be clearly resolved by the courts.<sup>86</sup> The Supreme Court has unequivocally held that “neither

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at 644. Dr. Holder states: “It is, of course, better if the physician can persuade the minor to inform his parents . . . but where this is impossible and it appears that without the physician’s promise of confidentiality the youth will probably delay seeking treatment, the youth’s health is paramount to any other consideration.” HOLDER, *supra* note 13, at 130. Admission of possible HIV exposure further incriminates the minor and may require further explanation to their parents about other controversial subjects. See KRAMER, *supra* note 15, at 644 (explaining that minors are also likely to forego treatment than discuss venereal disease, drug or alcohol abuse, pregnancy, contraception and abortion with their parents).

<sup>85</sup> Arnold, *supra* note 11, at 50.

<sup>86</sup> According to one commentator:

The Supreme Court has not articulated any standards for determining whether a minor is mature. . . . The case law of state and federal courts provides no clear guidance on the matter. Reported cases that have dealt with the issue reflect difficulty or ambivalence in interpreting statutory language. . . . While the question arises frequently in the abortion context, there are very few opinions on point because of the constitutional requirement that such proceedings remain confidential. . . . Courts do not typically publish these opinions in the official reporters.

Richard E. Redding, *Children’s Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 753 n.129 (1993).

the Fourteenth Amendment nor the Bill of Rights is for adults alone."<sup>87</sup> However, the Supreme Court confers upon minors full constitutional rights only where the nature of the minor's interest can overcome either the presumption that both the parents' and the state's interests are consistent with the child's best interests or the presumption that the minor is too immature to make an independent, informed decision.<sup>88</sup> The judiciary has become increasingly receptive to considering the rights of minors as independent from those of their parents,<sup>89</sup> most notably in cases involving the privacy rights of minors seeking abortions<sup>90</sup> and contraceptives.<sup>91</sup>

States may, nevertheless, seek to limit the right of adolescents to gain unrestricted access to HIV testing. It may be argued that adolescents have a fundamental right to ascertain their HIV status without state interference because the Supreme Court has reassured

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<sup>87</sup> *In re Gault*, 387 U.S. 1, 13 (1967) (holding that children in juvenile delinquency proceedings are entitled to the due process protections of the Fourteenth Amendment); see *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 96 (1976) ("Minors, as well as adults, are protected by the Constitution and possess constitutional rights."); *Goss v. Lopez*, 419 U.S. 565, 600 (1971) (stating that a student has a procedural due process right to a hearing pending a school suspension); *In re Winship*, 397 U.S. 358, 365-66 (1970) (holding that a 12-year-old child is entitled to the same constitutional burden of proof protections as an adult for criminal law violations); *Tinker v. Des Moines Indep. Comm. Sch. Dist.*, 393 U.S. 503, 506 (1969) (recognizing the right of students to the First Amendment protections of free speech).

<sup>88</sup> Alison M. Brumley, *Parental Control of a Minor's Right to Sue in Federal Court*, 58 U. CHI. L. REV. 333, 339 (1991).

<sup>89</sup> See Wilkins, *supra* note 15, at 37.

<sup>90</sup> See, e.g., *Bellotti v. Baird*, 443 U.S. 622, 633 (1979) (discussing how the Fourteenth Amendment protects minors as well as adults); *Danforth*, 428 U.S. at 74 (stating that parental interest in terminating a minor daughter's pregnancy is not greater than the daughter's right to privacy).

<sup>91</sup> See, e.g., *Carey v. Population Serv. Int'l*, 431 U.S. 678, 693 (1977) (holding unconstitutional a New York statute prohibiting distribution of nonprescriptive contraception to minors under the age of sixteen, stating that "since a State may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptive to minors is *a fortiori* foreclosed"); *Doe v. Irwin*, 615 F.2d 1162, 1166 (6th Cir. 1980) (explaining that minors do possess a constitutional right to privacy).

us that “[c]onstitutional rights do not mature and come into being magically only when one attains the state defined age of majority.”<sup>92</sup> If adolescents were recognized as having a fundamental privacy right to receive confidential HIV testing, state parental consent and notification requirements should certainly be regarded as unconstitutional burdens on minors.<sup>93</sup>

Yet, constitutional precedent holds that states are only required to grant adolescents the freedom to independently provide consent to testing if an adolescent’s privacy right to ascertain his or her HIV status is “virtually coextensive” with that of adults.<sup>94</sup>

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<sup>92</sup> *Danforth*, 428 U.S. at 74.

<sup>93</sup> *See, e.g., Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 441-42 (1983) (holding that a city ordinance requiring parental consent, with regard to second trimester abortions, is unconstitutional because the state imposed procedure was not sufficiently tailored to allow a minor to receive an abortion without undue burden); *Bellotti*, 443 U.S. at 623 (holding that a statute requiring pregnant minors to obtain parental consent or judicial approval places an unconstitutional burden upon seeking abortions). *Cf. Planned Parenthood Ass’n of Kan. City Mo. v. Ashcroft*, 462 U.S. 476, 491 (1983) (noting that a statute requiring parental consent for minors’ abortion is constitutional as long as it includes a provision allowing judicial consent to substitute for parental consent). *See also Carey*, 431 U.S. at 715 (recognizing the state’s disapproval of sexual activity among the adolescent population where the state sought to strictly regulate the distribution of contraceptives to minors, but noting that “an attempt to persuade [adolescents to abstain from sexual activity] by inflicting harm on the listener is an unacceptable means of conveying a message that is otherwise legitimate . . . . It is as though a State decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets”).

<sup>94</sup> Privacy rights of minors in the matters of both abortion and birth control are recognized under the privacy doctrine. The Sixth Circuit has stated the following:

In a series of cases dealing with laws affecting the right to abortion, the Supreme Court has held consistently that a woman’s decisions concerning child-bearing are within the most intimate area of personal privacy. . . . Though the state has somewhat broader authority to regulate the conduct of children than that of adults, minors do possess a constitutionally protected right of privacy.

*Doe*, 615 F.2d at 1166. *See, e.g., Bellotti*, 443 U.S. at 635 (recognizing that “the State is entitled to adjust its legal system to account for children’s vulnerability”); *Carey*, 431 U.S. at 695 n.17 (holding that “in the area of sexual mores, as in other areas, the scope of permissible state regulation is broader as to minors

The Supreme Court has further stated the following:

States validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences. These rulings have been grounded in the recognition that, during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them.<sup>95</sup>

Therefore, state legislatures following Supreme Court precedent may justify quashing a minor's claim to a fundamental right to confidential HIV testing where the decisionmaking rights of minors seeking HIV testing are deemed inferior to that of adults in the same situation.

The position that minors are too vulnerable and immature to provide consent to exercise the right to obtain their HIV status is highly suspect. Recent social research undermines such a conclusion.<sup>96</sup> Notwithstanding past indiscretions which may prompt

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than as to adults"). *Cf. Ginsberg v. New York*, 390 U.S. 629, 638 (1968) (holding that a child's right of access to information under the First Amendment is not coextensive with the rights of an adult).

<sup>95</sup> *Bellotti*, 443 U.S. at 635. *See Hodgson v. Minnesota*, 497 U.S. 417, 482 (1990) (stating that "[t]he law does not give to children many rights given to adults, and provides, in general, that children can exercise the rights they do have only through and with parental consent" (citing *Parham v. J.R.*, 442 U.S. 584, 621 (1979) (Stewart, J., concurring))).

<sup>96</sup> *See* Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 L. & HUM. BEHAV. 129, 147-48 (1992) (asserting that individuals under 18 years of age are no less competent than adults to make health care decisions). An empirical study of pregnant adolescents considering abortion found that minors ages 14 through 17 are similar to adults in cognitive competence and discretion. *Id.* at 148. A determination of a minor's cognitive ability to consent to abortion involves the following factors: (1) understanding the nature and probable consequences of the situation; (2) thoroughly considering the consequences associated with each alternative, including risks and benefits; (3) comparing alternatives based upon evaluation of consequences; (4) integrating personal values and goals; and (5) making voluntary, proactive decisions that are not overly influenced by others. *Id.* at 139. *See generally* JOHN J. CONGER, *ADOLESCENTS AND YOUTH: PSYCHOLOGICAL DEVELOPMENT IN A CHANGING*

adolescents to seek HIV testing, it seems inconsistent to withhold consent from an individual who wishes to take responsibility for past behavior simply because the law holds that adolescents are less mature than adults. An adolescent's effort to ascertain his or her HIV status evinces the level of maturity necessary to confer such a right.

Although it is expected that a parent would not refuse consent for a minor's HIV test,<sup>97</sup> many states ignore the fact that American teenagers continue to engage in behaviors which put them at risk of acquiring HIV.<sup>98</sup> State-imposed obstacles to HIV testing do not necessarily curb an adolescent's participation in risky behaviors.<sup>99</sup> Moreover, if the minor would not naturally seek their parents advice about testing, it is doubtful that parental consent and notification requirements would yield better communication between parent and child.<sup>100</sup>

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WORLD 206-11 (1973) (stating that, in some cases, the intellectual, social and moral development of American youth exceeds that of adults).

<sup>97</sup> Batterman, *supra* note 27, at 648.

<sup>98</sup> See *supra* note 8 and accompanying text (discussing the prevalence of high risk behavior among adolescents).

<sup>99</sup> See *infra* note 125 and accompanying text (explaining why adolescents commonly engage in high-risk behavior).

<sup>100</sup> Adolescents with emotional difficulties engage more frequently in high-risk behaviors than emotionally-stable adolescents. See Ralph J. DiClemente et al., *Prevalence and Correlates of Cutting Behavior: Risk for HIV Transmission*, 30 J. AM. ACAD. CHILD & ADOL. PSYCHIATRY 735, 738 (1991) (identifying a high prevalence of risk behaviors commonly associated with HIV transmission among psychiatrically-hospitalized adolescents who engage in self-mutilation behavior). See also CDC, *supra* note 3, at 1 (reporting that "racial and ethnic minorities are disproportionately affected" by AIDS). Thus, unencumbered HIV testing becomes more important for adolescents belonging to families where channels of communication are blocked. See HOLDER, *supra* note 13, at 122. Regardless of a minor's home life, it has been convincingly argued that parental notification requirements, in general, do not advance open communication between parent and child. See Selina K. Hewitt, *Hodgson v. Minnesota: Chipping Away at Roe v. Wade in the Aftermath of Webster*, 18 PEPP. L. REV. 955, 957-58 (1991) (relating the story of Becky Bell's parents who began to advocate the authorization of minors' abortions without parental notification after their daughter died from infection five days after receiving an illegal abortion).

Adolescents who express an interest in ascertaining their HIV status should be presumed to have the capacity to independently consent to HIV testing. Even where an adolescent's right to make the testing decision is not viewed as "virtually coextensive" with that of an adult, the threat of being HIV positive is not diminished by minority status. As a result, the state is compelled to strike the balance in favor of adolescents who wish to independently determine their HIV status—without express parental permission.

*C. The Compelling Interests of the State In Protecting Adolescent Health*

If courts were to conclude that the privacy rights of minors do not embrace an absolute right to HIV testing, a state could, nevertheless, abrogate parental consent and notification requirements by showing a compelling state interest in promoting confidential HIV testing for minors.<sup>101</sup> Admittedly, the issue of post-testing parental notification of an adolescent's HIV status, especially where test results are positive, is a difficult policy consideration for state legislators. However, permitting adolescents to receive unconditional, confidential HIV testing, without changing the rules based on notification of test results, suggests to teenagers that HIV test providers can be trusted. If a test provider is viewed as a friend, rather than a foe, adolescents are more likely to seek their services. Legislatures should, therefore, consider how increased HIV testing of adolescents benefits the health and welfare of all adolescents, not just those seeking testing, by promoting accountability for one's high-risk behaviors.<sup>102</sup>

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<sup>101</sup> The "right to privacy" under the Due Process Clause of the Fourteenth Amendment has been understood to include "the interest in independence in making certain kinds of important decisions." *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977). However, the Supreme Court has recognized the right of state legislatures to regulate decisions where there is a compelling state interest. *See, e.g., Carey v. Population Serv. Int'l*, 431 U.S. 678, 685 (1977) (noting that "even a burdensome regulation may be validated by a sufficiently compelling state interest"); *Roe v. Wade*, 410 U.S. 113, 154 (1973) (stating that the legislature's "interest in safeguarding health [and] maintaining medical standards" may become "sufficiently compelling" to permit state regulation).

<sup>102</sup> *Society for Adol. Med.*, *supra* note 3, at 16.



The elimination of testing barriers reinforces the adage that "knowledge is power."<sup>103</sup> If adolescents are aware of their HIV status, they are more likely to modify their behaviors.<sup>104</sup> On the other hand, adolescents unaware of their HIV status tend to subscribe to an "it can't happen to me" philosophy,<sup>105</sup> and avoid taking precautionary measures against transmission.<sup>106</sup> Although giving an adolescent more responsibility does not necessarily create a more responsible adolescent, research indicates that adolescents who test negative for HIV are likely to practice safe sex in order to preserve their negative status.<sup>107</sup> In addition, adolescents who learn that they are HIV positive can reduce the chance that the

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<sup>103</sup> Access to an one's HIV status can positively affect the future conduct and lifestyle choices of teenagers. CAPS UPDATE, *supra* note 9, at 3 (citing AGENCY FOR HEALTH CARE POL'Y AND RES., EVALUATION AND MANAGEMENT OF EARLY HIV INFECTION (1994)) [hereinafter AH CPR].

<sup>104</sup> Centers for Disease Control, *Acquired Immunodeficiency Syndrome (AIDS)*, 34 MORBIDITY & MORTALITY WEEKLY REP. 75S, 76S (1985). See Rhame & Maki, *supra* note 18, at 114 (stating that studies indicate that HIV testing appears to reduce unsafe sexual behavior in those infected with HIV and may reduce the incidence of high-risk behavior among those who test negative).

<sup>105</sup> See Society for Adol. Med., *supra* note 3, at 9S-14S (outlining "behaviors that place adolescents at risk for HIV infection").

<sup>106</sup> CAPS UPDATE, *supra* note 9, at 3 (citing AH CPR, *supra* note 103). There are several steps a person may take to avoid HIV transmission to others. BARTLETT & FINKBEINER, *supra* note 2, at 10, 38-42. The best way to avoid transmission is to abstain from sex. BARTLETT & FINKBEINER, *supra* note 2, at 38-40. The next best way is to use condoms and spermicides for all genital contact or to have the kind of sexual contact that does not involve the transferring of semen, vaginal fluids, menstrual blood or blood from one person's body into another's. BARTLETT & FINKBEINER, *supra* note 2, at 40. Females with HIV should avoid getting pregnant because of the risk of transmitting the virus to the fetus. BARTLETT & FINKBEINER, *supra* note 2, at 41-42. The best way for intravenous drug users to avoid transmission is to stop using drugs or, at the very least, stop sharing needles. BARTLETT & FINKBEINER, *supra* note 2, at 40-41.

<sup>107</sup> See Rhame & Maki, *supra* note 18, at 114 (reporting that studies indicate that HIV testing appears to reduce unsafe sexual behavior in those infected with HIV and may reduce the incidence of high risk behavior among those who test negative).

virus will continue to be spread by unprotected sex or other "high-risk behaviors."<sup>108</sup>

Early testing also serves as a means of monitoring changes in the condition of adolescents who have tested positive for HIV. Additionally, early testing increases the likelihood that HIV-positive adolescents will receive necessary treatment before the virus progresses.<sup>109</sup> Adolescents testing positive for HIV infection should have the opportunity to consult with a health care provider as early as possible because recent medical research indicates that treatment of HIV infection, and of selected opportunistic infections, can substantially delay the onset of AIDS, especially in those

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<sup>108</sup> See CAPS UPDATE, *supra* note 9, at 1. See also BARTLETT & FINKBEINER, *supra* note 2, at 302 (stating that the public health message is the same for both infected and non-infected persons). Those individuals aware of their positive HIV status tend to engage in safer sex and safer drug use. See Steven R. Salbu, *HIV Home Testing and the FDA: The Case for Regulatory Restraint*, 46 HASTINGS L.J. 403, 434-35 (1995) (arguing that "increased testing for HIV will diminish the spread of AIDS by diminishing the incidence of new infections").

<sup>109</sup> See CAPS UPDATE, *supra* note 9, at 3 (citing AHCPR, *supra* note 103); Centers for Disease Control, *Special Focus: Surveillance for Sexually Transmitted Diseases*, 42 MORBIDITY & MORTALITY WEEKLY REP. NO. SS-3, Aug. 13, 1993, at 1 [hereinafter Centers for Disease Control]. The CDC cited the unavailability of clinical services convenient to adolescents as a possible cause of the increase of sexually transmitted diseases in the 1980s, noting that:

Care is particularly fragmented for adolescents, and a lack of readily accessible services could have resulted in increases in the amount of time between exposure to an infection, awareness of the symptoms, and diagnosis and treatment. Furthermore, health professionals may not be likely to address issues of sexually transmitted infections or sexuality among adolescents. All these factors could have led to longer periods of untreated infection and consequently to increased transmission of sexually transmitted diseases among adolescents.

Centers for Disease Control, *supra*, at 10.

without symptoms.<sup>110</sup> Early detection of HIV, consequently, helps to prolong and enhance the life of HIV-infected adolescents.

Those state legislators resisting pressure to provide confidential HIV testing to adolescents may rely on several policy arguments. First, legislators might argue that parental involvement alleviates the psychological and emotional trauma adolescents may encounter<sup>111</sup> and decreases the likelihood that, after testing, adolescents would continue to engage in high-risk behaviors or avoid treatment.<sup>112</sup> Secondly, state legislatures adopting such a policy may argue that the interests in supporting confidential HIV testing for adolescents are not as compelling as the interests involved in other health care situations, such as abortion.<sup>113</sup> Finally, even if an adolescent's right to know his or her HIV status is not blocked by parents involved in the testing decision, parents may still play an intrusive role in the testing of a large number of adolescents.<sup>114</sup>

The decision to be tested, however, is at least as pressing as a minor's decision to have an abortion. Delays in testing could create a domino effect with dire consequences due to the lengthy latency

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<sup>110</sup> BARTLETT & FINKBEINER, *supra* note 2, at 302. See William A. Bradford, Jr. & Michelle A. Zavos, *The American Bar Association AIDS Coordinating Committee, The AIDS Epidemic and Health Care Reform*, 27 J. MARSHALL L. REV. 279, 297 (1994) ("Delays in testing result in missed opportunities for treatment which could have prolonged the life span of an HIV-infected individual or prevented the infection of others.").

<sup>111</sup> See *supra* text accompanying note 78 (arguing that parental guidance and support may mitigate the psychological stress associated with HIV testing).

<sup>112</sup> See *supra* text accompanying notes 78-79 (arguing that parents may help their child to seek treatment or to avoid future risk of transmission).

<sup>113</sup> An adolescent's right to receive an abortion cannot be wholly barred by a parent because otherwise, she is denied the right to decide whether to bear or beget a child. *Bellotti v. Baird*, 443 U.S. 622, 642 (1979) ("[T]here are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible [as the abortion decision]."). See *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) ("Just as with the requirement of consent from the spouse, so here, the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision [to terminate a pregnancy].").

<sup>114</sup> Batterman, *supra* note 27, at 648 (recommending that, regardless of whether parents ultimately give consent, legislatures should provide better guidance to courts and health providers regarding the treatment of minors).

period associated with HIV.<sup>115</sup> For example, an unsuspecting HIV-positive adolescent could engage in high-risk behaviors for several years and unknowingly transmit the infection to others.<sup>116</sup>

Although some teenagers may continue to take risks with their health or the health of others,<sup>117</sup> the state must respond to the present rise in HIV infection among adolescents for the benefit of the majority who strive to protect themselves and others. Confidential testing is the state's means of achieving that end.<sup>118</sup> Conversely, parental consent and notification requirements seriously hinder a state's efforts to contain rates of transmission and to facilitate early treatment for infected adolescents.<sup>119</sup> Due to the large number of AIDS deaths,<sup>120</sup> the state's interest in controlling the spread of HIV and mitigating its effect on the adolescent population has, therefore, become compelling.<sup>121</sup>

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<sup>115</sup> Although the latency period varies by individual, the period may last as long as a decade. See CDC, *supra* note 3, at 1 and accompanying text (explaining the average period of time between transmission and the development of symptoms).

<sup>116</sup> See Bradford & Zavos, *supra* note 110, at 282 (arguing that individuals "lacking access to health care and other resources" are disproportionately infected with HIV).

<sup>117</sup> Critics have stated that an adolescent who is aware of his or her negative HIV status will interpret such a status as a green light to engage in further high-risk behaviors. See Fain, *supra* note 75, at 42; see also *supra* note 76 and accompanying text (relating the view that an individual aware of his or her positive status could still continue to partake in high-risk behaviors).

<sup>118</sup> Brenda Almond, *High-Risk Groups Should Be Tested for AIDS*, reprinted in THE AIDS CRISIS, *supra* note 18, at 121, 130; Minow, *supra* note 81, at 150. From the vantage point of the state, confidential HIV testing creates a "participatory," as opposed to a bureaucratic relationship between the minor and the state. Minow, *supra* note 81, at 150.

<sup>119</sup> See *supra* Part II.C (illustrating the benefits early HIV testing can have on the individual adolescent, as well as all others at risk for transmission).

<sup>120</sup> Since its recognition in 1981, AIDS has caused the death of more than 295,000 Americans. SURVEILLANCE REP., *supra* note 3, at 14.

<sup>121</sup> See *supra* note 84 and accompanying text (explaining how parental consent and notification requirements deter adolescents from being tested). Medical science is not hopeful of finding a cure for HIV because it is a virus which infects the cells of the immune system and the brain, and, like the common cold and herpes, a virus cannot be killed without killing the cells it has infected. LYNDA MADARAS, LYNDA MADARAS TALKS TO TEENS ABOUT AIDS

### III. A STATUTORY PROPOSAL: COUNSELING ADOLESCENTS AT HIV TESTING SITES

Despite how compelling a state's interest may be in facilitating adolescents' access to HIV testing, an effective prevention program requires more than simply a test. Adolescents need to be prepared both socially and psychologically to cope effectively with the results of an HIV test.<sup>122</sup> In light of the startling increase in HIV infection among the teenage population,<sup>123</sup> the presumptions inherent in the Supreme Court's endorsement of the parental role in child rearing should be reevaluated in an HIV testing scenario.<sup>124</sup> Unique developmental, social and emotional characteristics make teenagers especially vulnerable to HIV infection and difficult to reach with traditional intervention approaches.<sup>125</sup> State lawmakers committed to reducing HIV

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11 (1988). However, medical science is experimenting with drug treatments which slow the virus' rate of reproduction, thus allowing infected individuals to live normal lifespans. *Id.*; see BARTLETT & FINKBEINER, *supra* note 2, at 189-204 (discussing the availability of approved and experimental drugs and the practice of clinical trials used to combat HIV).

<sup>122</sup> Arnold, *supra* note 11, at 50.

<sup>123</sup> See *supra* INTRODUCTION (discussing the alarming rate in which adolescents are becoming infected with HIV).

<sup>124</sup> See *Bellotti v. Baird*, 443 U.S. 622, 635 (1979) (holding that "the States validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences"). See also *supra* Part I.A (identifying three justifications for parental consent provisions: (1) the vulnerability of children; (2) the inability of children to make mature decisions; and (3) the importance of the parental role in the raising of children).

<sup>125</sup> Arnold, *supra* note 11, at 43. It is estimated that fewer than 10% of U.S. adolescents receive adequate HIV/AIDS education, such as condom distribution programs, despite the fact that 90% of parents support prevention programs. SEX INFORMATION AND EDUCATIONAL COUNCIL OF THE U.S. ("SIECUS"), GUIDELINES FOR COMPREHENSIVE SEXUALITY EDUCATION 1 (1994). Because adolescents are a highly diverse group of individuals with perceptions that vary according to their individual age and upbringing, their identities are frequently developed via experimentation and risk-taking behavior with sex and drugs. Arnold, *supra* note 11, at 43-44. Additionally, teenagers tend to think in present, concrete terms and also tend to dismiss feelings of vulnerability. Arnold, *supra*

infection rates among adolescents should consider drafting confidential HIV testing statutes which address the individual concerns of both parents and teenagers.<sup>126</sup>

By mandating counseling programs for all adolescents seeking an HIV test, states can offer teenagers a source of support and information, that offsets the risks associated with confidential HIV testing.<sup>127</sup> The desire of an adolescent to be tested does not

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note 11, at 44. Finally, teenagers are subject to intense peer pressure which further encourages participation in high-risk behavior. Arnold, *supra* note 11, at 44. Effective prevention strategies must, therefore, be responsive to differences in adolescent development, lifestyle and behavior. Arnold, *supra* note 11, at 44. A man who tested positive for HIV at the age of 17, and ultimately died from AIDS, was quoted as saying: "Everyone always told us to have safe sex, but no one ever told me how." Deborah P. Work & John DeGroot, *Teen-Agers Becoming Latest Prey of AIDS*, SUN SENTINAL, Sept. 15, 1995, at 1A.

<sup>126</sup> See *supra* Part II.A (debating whether adolescents lack a sufficient level of guidance and support where parents are absent from their child's HIV testing decisions). See also *supra* note 125 and accompanying text (explaining that adolescents need reliable information about their risk for HIV transmission). By mandating the administration of counseling to teenagers at HIV-test sites, states may similarly implicate the constitutional right of parents to raise and educate their children. See *Pierce v. Society of Sisters*, 268 U.S. 510, 534 (1925) (acknowledging that "[t]he child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations"); *Meyer v. Nebraska*, 262 U.S. 390, 401 (1923) (holding a statute forbidding the teaching of foreign languages to school children was an unconstitutional exercise of the state's police power because it unreasonably interferes with the right of parents to educate and raise their children). However, the right of minors and the interests of the state regarding counseling are analogous to those involved in testing. Cf. *supra* Parts II.A, II.B (comparing and contrasting the privacy rights of parents with those of minors as they relate to the adolescent HIV testing debate).

<sup>127</sup> Arnold, *supra* note 11, at 50 (stating that the emotional support decreases adolescents' sense of isolation and fatalism); Society for Adol. Med., *supra* note 3, at 21S-30S (discussing the importance of effectively counseling, supporting and educating adolescents during pre- and post-HIV test counseling). See CAPS UPDATE, *supra* note 9, at 4 (describing a program conducted in Rwanda in which the rates of new HIV infections decreased where participants and their sexual partners were provided with a confidential HIV testing and counseling program (citing S. Allen et al., *Confidential HIV Testing and Condom Promotion in Africa*, 268 JAMA 3338-343 (1992)). See also Part II.A (describing the psychological and social effects HIV testing may have on its subjects).

presume that he or she already understands and appreciates the risks and consequences of HIV infection. Accordingly, pre-test and post-test counseling programs must be structured so that states are assured that adolescents will receive age-appropriate counseling as early as possible. Upon review of current testing and counseling legislation,<sup>128</sup> this Note proposes a model approach to adolescent HIV testing—one that is tailored to the unique demands of today's teenage population:

*A. Counseling Procedures Required Prior to Administering an HIV Test to Minors*

1. No HIV test shall be administered to a minor without offering such minor an immediate opportunity to receive face-to-face counseling or a reasonable alternative source of guidance and support.

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<sup>128</sup> States with counseling statutes aim to provide test subjects with an understanding of the test, including its purposes, uses and the meaning of its results, an explanation of the nature of the disease and of the procedures to be followed, information about high-risk and preventive behaviors and efforts to address the emotional and physical consequences. Arnold, *supra* note 11, at 51. See, e.g., CONN. GEN. STAT. ANN. § 19A-582(d) ("At the time of communicating the test result to the subject of the test, a person ordering the performance of an HIV-related test shall provide the subject of the test or the person authorized to consent to health care for the subject with counseling or referrals for counseling"); DEL. CODE ANN. tit. 16, § 1202(b) (1995) (defining informed consent as a "voluntary agreement executed by the subject of the test or the subject's legal guardian" and outlining minimum requirements for obtaining informed consent); MICH. COMP. LAWS ANN. § 333.5133(3) (requiring that providers of HIV tests "distribute to each test subject a pamphlet regarding the HIV test"); WASH. REV. CODE ANN. § 70.24.017(13) (West 1992) (defining "sexually transmitted disease" as that "determined by the board by rule to be sexually transmitted, to be a threat to the public health and welfare, and to be a disease for which a legitimate public interest will be served by providing for regulation and treatment . . . [which includes AIDS and HIV]"). Unique among counseling statutes is Colorado's which requires health care providers to counsel minors about the importance of involving parents in their treatment. See COLO. REV. STAT. § 25-4-1405(6) (stating that test providers "shall counsel the minor on the importance of bringing his parents or guardian into the minor's confidence about the consultation, examination, or treatment" of HIV infection).

2. Such proscribed counseling programs must include, but are not limited to:
  - a. the purpose and meaning of an HIV antibody test, which includes:
    - i. an explanation of the symptoms and progression of HIV infection and AIDS-related illnesses;
    - ii. a description of the testing procedure; and
    - iii. an explanation of possible test results;
  - b. an explanation that testing is voluntary and that consent may be withdrawn at any time;
  - c. risk-assessment and risk-reduction information, stressing behaviors known to reduce the minor's risk of HIV exposure and transmission;
  - d. the benefits of being tested for HIV, including early diagnosis and medical intervention;<sup>129</sup>
  - e. a discussion of common psychological and emotional responses to HIV testing;<sup>130</sup>
  - f. the possibility of additional testing; and
  - g. an explanation of legal considerations involved in HIV testing, including:
    - i. potential discriminatory treatment which may result from a minor's disclosure of HIV-related information,
    - ii. existing legal remedies regarding HIV discrimination and unauthorized disclosure of HIV-related records, and

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<sup>129</sup> Society for Adol. Med., *supra* note 3, at 22-23 (identifying the avoidance of additional HIV infections and the ability to protect others from infection as benefits of testing).

<sup>130</sup> Teenagers considering HIV testing commonly experience fears of infection, death, fears of disclosure, stigmatization and discrimination. See Society for Adol. Med., *supra* note 3, at 22-23. A counselor, describing the reactions of teenagers upon learning they are HIV positive, recounts the following incident: "I had a 12-year-old girl who acted like she was 18—until I told her . . . Then she put her fingers in her mouth and started sucking her thumb." Work & DeGroot, *supra* note 125, at 1A.



- iii. the differences between confidential and anonymous testing.<sup>131</sup>

*B. Counseling Procedures Required Prior to Administering an HIV Test Result to an HIV-Positive Minor*

1. No positive test result may be revealed to a minor upon whom a test was performed unless the minor is either:
  - a. counseled by a trained on-site counselor, or
  - b. referred to a recognized counseling site within the immediate geographic area which offers adolescents services consistent with the information outlined below in subparagraph 2.<sup>132</sup>
2. Pursuant to subparagraph 1, HIV-positive minors must receive information regarding:
  - a. the practical and psychological aspects of living with HIV and AIDS;
  - b. early treatment programs and treatment options;
  - c. the benefits of consulting parents about the minor's HIV status;
  - d. the benefits of locating and informing any individual who may have exposed the minor to HIV infection, and any individual whom the infected minor may have exposed to HIV infection; and
  - e. the availability of public health services which can facilitate locating and counseling any individual described in section 2(d).

States have the authority to mandate pre-test and post-test counseling as legitimate safeguards to ensure that informed consent has been given<sup>133</sup> because medical providers are legally required

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<sup>131</sup> See *supra* note 15 and accompanying text (describing the distinction between anonymous HIV testing and confidential HIV testing).

<sup>132</sup> Adolescent responses to positive test results are wide ranging, including disbelief, panacea, crying, repeating of results, rage, relief, silence, demanding a retest and wanting to leave. Society for Adol. Med., *supra* note 3, at 27. In addition, adolescents often experience self-blame, guilt and feelings of impurity after learning they are HIV positive. Society for Adol. Med., *supra* note 3, at 27.

<sup>133</sup> See Society for Adol. Med., *supra* note 3, at 26. See, e.g., CONN. GEN.

to obtain informed consent from their subjects.<sup>134</sup> The proscribed pre-test counseling programs are designed to educate adolescents about the legal, social and emotional issues involved in HIV testing.<sup>135</sup> Most importantly, pre-test counseling laws will assure state legislators that teenagers seeking testing are emotionally prepared to learn of their HIV status and understand the nature and

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STAT. ANN. § 19A-582(b)-(c) (providing pre-test counseling for “the subject of an HIV-related test, or to a person authorized to consent to health care for the subject . . .”); FLA. STAT. ch. 381.004(3)(c) (1993) (“At the time an HIV test is ordered, the person ordering the test shall schedule a return visit with the test subject for the purpose of disclosing the test results and conducting posttest counseling”); N.Y. COMP. CODES R. & REGS. tit.10, § 63.3(a)(1) (1993) (“Informed consent shall include providing pre-test counseling to the person to be tested”).

<sup>134</sup> See, e.g., CONN. GEN. STAT. § 19a-582(a) (Supp. 1995) (requiring the receipt of informed consent before an HIV-related test may be administered); R.I. GEN. LAWS § 23-6-13 (1989) (requiring written informed consent form before a subject may be tested for HIV). Informed consent forms, provided by the test site, must be read and signed by the test subject prior to testing. Society for Adol. Med., *supra* note 3, at 26. Some test sites use adolescent-specific consent forms instead of standard consent forms. Society for Adol. Med., *supra* note 3, at 26.

<sup>135</sup> BARTLETT & FINKBIENER, *supra* note 2, at 311. MADARAS, *supra* note 121, at 100; Society for Adol. Med., *supra* note 3, at 22-29. For example, New York law provides that:

Pretest counseling shall include: (i) explanations regarding the nature of HIV infection and HIV-related illness, an explanation of the HIV-related test, including a description of the procedure to be followed, meaning of the test results, and the benefits of taking the test, including early diagnosis and medical intervention; (ii) an explanation that discrimination problems may result from disclosure of confidential HIV-related information and that legal protections exist which prohibit discrimination . . . and unauthorized disclosures [under New York law]; (iii) information on preventing exposure or transmission of HIV infection, including behavior which poses a risk of HIV transmission; (iv) an explanation that the test is voluntary, that consent may be withdrawn at any time, and that anonymous testing is available, including the location and telephone numbers of anonymous test sites, and that for the purpose of insurance coverage, confidential, as opposed to anonymous testing is required; and (v) information regarding psychological and emotional consequences of receiving the test result.

N.Y. COMP. CODES R. & REGS. tit.10, § 63.3(a)(1) (1993).

consequences of HIV transmission.<sup>136</sup> Even if an adolescent does not return for his or her test result,<sup>137</sup> the state still benefits by having communicated accurate and reliable risk-reduction information to the adolescent at the pre-test stage.

A reasonable alternative source of counseling, as proposed above, becomes necessary when individualized pre-test counseling proves fiscally unworkable for a state or local government. Consequently, test sites that cannot afford to maintain individual counselors should seek to disseminate the requisite information via either video-taped programs or comprehensive fact sheets.<sup>138</sup> A video or fact sheet that is responsive to teenage questions and concerns can serve as an effective alternative to face-to-face counseling.<sup>139</sup>

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<sup>136</sup> See Society for Adol. Med., *supra* note 3, at 22-26 (identifying risk assessment and risk reduction as integral to an HIV counseling program). Pre-test counseling can prompt adolescents to perform a cost-benefit analysis so he or she approaches the decision to be tested in a thoughtful manner. Adams, *supra* note 29, at 495; Society for Adol. Med., *supra* note 3, at 24. Additionally, pre-test counseling sessions can assist test providers in scheduling return visits for the purpose of disclosing the test results and conducting post-test counseling. See, e.g., FLA. STAT. ch. 381.004(3)(c) (requiring that “[a]t the time an HIV test is ordered, the person ordering the test shall schedule a return visit with the test subject for the purpose of disclosing the test results and conducting posttest counseling . . .”).

<sup>137</sup> See Novello, *supra* note 83 (reporting the return rates of test subjects for their results).

<sup>138</sup> See CDC, *supra* note 3, at 3-4. The CDC National AIDS Clearinghouse offers an array of helpful brochures, fact sheets, posters, videotapes and other resource materials. See CDC NAT’L AIDS CLEARINGHOUSE, CATALOG OF HIV AND AIDS EDUC. AND PREVENTION MATERIALS, 18-23 (suggesting materials which are targeted at the adolescent population and offering the assistance of a “reference specialist” at (800) 458-5231).

<sup>139</sup> See, e.g., CDC NAT’L AIDS CLEARINGHOUSE, *supra* note 138, at 9 (describing “HIV Counseling, Testing and Referral Standards & Guidelines” materials which are “intended for persons and programs who provide HIV counseling, testing, and referral services for persons who are potentially HIV infected . . .”); CDC NAT’L AIDS CLEARINGHOUSE, *supra* note 138, at 2 (offering videotape entitled *Smart Sex, T.V. Special* in which “young people [talk] about sexual relationships and making informed, intelligent choices about safer sex.”).

The post-test counseling provisions proposed above serve to strengthen adolescent support systems and fill gaps which may result from the absence of parental supervision.<sup>140</sup> Because an HIV-positive teenager will inevitably become symptomatic, those who oppose such a confidential testing and counseling law merely advocate the displacement of emotional distress which may accompany a positive test result.<sup>141</sup> Thus, an adolescent HIV testing statute which provides for post-test counseling can help an HIV-positive teenager begin to build a support system<sup>142</sup> and adopt a treatment plan as early as possible.<sup>143</sup>

Post-test counseling requirements may, however, present administrative concerns for test providers. Without financial incentives, it may be impracticable for states to mandate that all test sites furnish trained post-test counselors. The above-proposed statute provides test sites which lack financial resources the option of managing a referral system for HIV-positive teens.<sup>144</sup> A referral

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<sup>140</sup> See Society for Adol. Med., *supra* note 3, at 26-29. Florida provides that:

No test result shall be revealed to the person upon whom the test was performed without affording that person the immediate opportunity for individual, fact-to-face counseling about:

1. The meaning of the test results;
2. The possible need for additional testing;
3. Measures for the prevention of the transmission of [HIV] infection;
4. The availability in the geographic area of any appropriate health care services, including mental health care, and appropriate social and support services;
5. The benefits of locating and counseling any individual by whom the infected individual may have been exposed to [HIV] infection and any individual whom the infected individual may have exposed to such [HIV] infection; and
6. The availability, if any, of the services of public health authorities with respect to locating and counseling any individual described in subparagraph 5.

FLA. STAT. ch. 384.30(3)(e).

<sup>141</sup> Rhame & Maki, *supra* note 18, at 118.

<sup>142</sup> Society for Adol. Med., *supra* note 3, at 28-29.

<sup>143</sup> See Rhame & Maki, *supra* note 18, at 120-23. See also *supra* Part II.C (discussing the benefits of early HIV treatment).

<sup>144</sup> Society for Adol. Med., *supra* note 3, at 9 (discussing that, at the very

system, administered in accord with the above counseling provisions, should nevertheless meet the state's objectives of ensuring that HIV-positive teens receive adequate psychological and medical support services. However, because on-site counselors are preferred,<sup>145</sup> state legislatures must make budgetary allowances for trained counselors to work cooperatively with test providers,<sup>146</sup> especially in areas with high rates of adolescent HIV infection.

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least, test sites should provide a solid referral system for adolescents). *See, e.g.,* CONN. GEN. STAT. ANN. § 19A-582(d) (stating that a person ordering an HIV test "shall provide the subject of the test or the person authorized to consent to health care for the subject with counseling or referrals for counseling . . .").

<sup>145</sup> "For most patients, mere provision of a printed statement of relevant information is not counseling." *Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 448 n.38 (1983) (commenting on counseling in the context of teenage abortion). Counselors can serve as advocates by delivering information to teens in a prompt and uncomplicated fashion. Arnold, *supra* note 11, at 46 (commenting that "even something as seemingly simple as establishing a residence or obtaining necessary documents may prove impossible to an unversed young person"). Counselors can be trained to provide adolescents with a means of coping with their initial emotional responses to learning their positive HIV status. *See* William N. Eskridge, Jr. & Brian D. Weimer, *The Economics Epidemic in an AIDS Perspective*, 61 U. CHI. L. REV. 733, 767 (1994) (advocating the use of intervention programs which increase a teen's ability to engage in safe behaviors rather than "simply providing information" and literature to reduce high risk behavior); Society for Adol. Med., *supra* note 3, at 24S-30S (suggesting ways in which counselors should conduct pre-test and post-test counseling sessions). Moreover, on-site counselors offer HIV-positive adolescents useful information about future transmission and the availability of treatment options before leaving a test site. BARTLETT & FINKBIENER, *supra* note 2, at 311. Finally, a counselor may suggest that an HIV-positive teenager consider notifying their partner(s) or others who a teen believes may have been exposed to the virus. Society for Adol. Med., *supra* note 3, at 27.

<sup>146</sup> Federal programs may provide a source of additional funding for states which need assistance to implement an adolescent HIV testing and counseling program. For example, the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 provides supplemental grants to areas which demonstrate a substantial need for HIV and AIDS-related services, including youth-centered care. 42 U.S.C. § 30ff (1990).

## CONCLUSION

Few topics of discussion are more likely to fall into the communication gap between a parent and a teenager than HIV infection. Although it is unlikely that parents would deny their children consent to be tested for a disease as frightening as HIV, minors may forego HIV testing rather than reveal their high risk behavior to their parents. The privacy protections granted through the United States Constitution strongly support a minor's autonomous right to receive HIV testing. However, even if the judiciary is unwilling to recognize a fundamental right of minors to ascertain their HIV status through confidential testing, legislators may still find that the states' interest in extending confidential HIV testing to minors is compelling enough to prompt the drafting of appropriate legislation. Parental claims of a right to be advised of their child's risk of HIV infection must yield to state statutes drafted to protect the health and welfare of our vulnerable adolescent population.

State legislatures must recognize that teenagers are not immune from contracting HIV and AIDS. This Note urges state lawmakers to pass legislation which combines counseling programs with confidential testing so that HIV information and guidance are readily accessible to all adolescents. Adolescents must be put on equal footing with adults who possess an unabridged freedom to ascertain their HIV status because adolescents, too, need to protect themselves from the deadly grip of the AIDS epidemic.

