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"Doctor, I'm Pregnant and Fifteen--I Can't Tell My Parents--Please Help Me:" Minor Consent, Reproductive Rights, and Ethical Principles for Physicians

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"DOCTOR, I'M PREGNANT AND FIFTEEN— I CAN'T TELL MY PARENTS—PLEASE HELP ME": MINOR CONSENT, REPRODUCTIVE RIGHTS, AND ETHICAL PRINCIPLES FOR PHYSICIANS

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ABSTRACT

The parent-child bond underpins human society, and parents guard their children's lives and health as their own. Basic legal principles require parents to provide care necessary for their minor child's physical, mental, and emotional health, and parental consent is generally required to treat minor patients. But the case of reproductive health—pregnancy and what to do about it—presents difficult issues; adolescents consider themselves young adults, not children, and have an expectation of a certain level of privacy in this most sensitive of health concerns. Medical providers face a quandary: respect a minor's request to privacy, or notify the parents their young daughter is pregnant? The 2009 North Dakota Legislature addressed the issue, passing Senate Bill 2394—codified at N.D.C.C. § 14-10-19. The statute, entitled "Minor's consent for prenatal care and other pregnancy care services," allows a health care provider to provide pregnancy testing and pain management related to pregnancy to a minor without the consent of a parent or guardian. However, the care based on the minor's own consent is limited to prenatal care in the first trimester of pregnancy, and to a single prenatal care visit in the second or third trimester of pregnancy without the consent of a parent or guardian. The statute also requires medical providers to encourage the pregnant minor to involve her parents. The statute serves two policy goals. First, if a minor who is hesitant to involve her parents at the beginning of her pregnancy is assured of confidentiality she will feel able to seek health care earlier in the pregnancy which improves pregnancy outcomes and reduces the incidence of complications. Second, the statute requires medical providers to discuss with their young patients the general benefit of parental involvement, soliciting the minor's reasons for not involving her parents and correcting misconceptions that may be motivating her objections, and may reduce the incidence of abortion. This statute does not authorize a minor to consent to abortion or otherwise supersede the requirements of chapter 14-02.1. The statute has not changed the status

quo, and has not answered the significant constitutional and ethical principles relating to a minor female's right to make such profound decisions regarding her reproductive life. The statute does not eliminate parental involvement, but expands the circumstances under which a medical provider may provide care based on minor consent.

I. INTRODUCTION

Suppose a fifteen-year-old comes to your office seeking medical attention because she fears she is pregnant. She may be afraid to tell her parents, confused about what her future holds, and in need of your care, both physically and emotionally. You may have a child her age, and your empathy could be easily kindled. Your professional instincts take over; you undertake an examination, counsel and console, and ascertain the young woman's initial intentions. You hope the parents of the young woman are stable adults who can be informed and counted on to support their daughter, and you discuss this with your patient. She may be reluctant; she may have real—or simply imagined—reasons to refuse to involve her parents. As a physician, you understand you are ethically bound to confidentiality, an essential element in forming and fostering the physician-patient bond[1]—a sacrosanct bond in our society, unique because physicians help safeguard the most elemental human need: our very health and well-being. And, as you inform her about the medically-indicated courses of action, you and your young patient begin to plan the treatment regimen. At this point, you have agreed to one of the most challenging relationships a physician might undertake: you have in your charge a girl who, in the absence of parental support, seeks your support. You hope this situation can be rectified, but that might not be possible. You are in the middle of a dilemma: How do you balance the competing interests? Do parents not have rights, too? How do you ensure that you comply with the law? What does your conscience tell you to do, if your own reaction to the young woman's plan is not in accord with your principles?

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1. "[P]hysicians are not fungible as to their relationships with patients," Baptist Health v. Murphy, 226 S.W.3d 800, 813 (Ark. 2006), because "[s]trong patient-physician relationships are the underpinning of good medicine, and . . . patients who have long term relationships with their doctors have better outcomes." Murphy v. Baptist Health, No. CV 2004-2002 (Ark. Cir. Ct., Pulaski Cnty., 13th Div., Feb. 27, 2009), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/395/order-for-permanent-injunction.pdf. President Barack Obama emphasized the centrality of physicians to health care, noting in his extemporaneous remarks during his speech to the American Medical Association on June 15, 2009, "I need your help, doctors[.] . . . To most Americans, you are the health care system. We just do what you tell us to do." *President Obama Brings His Health System Reform Proposals to U.S. Physicians*, TEXAS MEDICAL ASSOCIATION (Apr. 9, 2010), http://www.texmed.org/Template.aspx?id=7809.

Prior to the enactment of Senate Bill 2394 by North Dakota's 2009 Legislative Assembly, codified at North Dakota Century Code (N.D.C.C.) section 14-10-19,[2] a physician would have faced a direct quandary: the general parental consent requirement would apply, but ethical rules pointed toward maintaining confidentiality. The new statute provides some cover, authorizing treatment based on minor consent during the first trimester, though limiting treatment based on minor consent to one visit during the second and third trimesters.[3] In addition to discussing the issues that arise from the legislature's enactment of Senate Bill 2394, this article addresses a number of over arching issues involving minors' reproductive rights and ethical principles that govern a physician's conduct in the context of reproductive health.

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2. The statute, entitled "Minor's consent for prenatal care and other pregnancy care services," provides as follows:

> 1. a. A physician or other health care provider may provide pregnancy testing and pain management related to pregnancy to a minor without the consent of a parent or guardian.
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> b. A physician or other health care provider may provide prenatal care to a pregnant minor in the first trimester of pregnancy or may provide a single prenatal care visit in the second or third trimester of pregnancy without the consent of a parent or guardian.
>
> c. A physician or other health care provider may provide prenatal care beyond the first trimester of pregnancy or in addition to the single prenatal care visit in the second or third trimester if, after a good-faith effort, the physician or other health care provider is unable to contact the minor's parent or guardian.
>
> d. The costs incurred by the physician or other health care provider for performing services under this section may not be submitted to a third-party payer without the consent of the minor's parent or guardian.
>
> e. This section does not authorize a minor to consent to abortion or otherwise supersede the requirements of chapter 14-02.1.
>
> 2. If a minor requests confidential services pursuant to subsection 1, the physician or other health care professional shall encourage the minor to involve her parents or guardian. Notwithstanding subsection 1, a physician or other health care professional or a health care facility may not be compelled against their best judgment to treat a minor based on the minor's own consent.
>
> 3. A physician or other health care professional who, pursuant to subsection 1, provides pregnancy care services to a minor may inform the parent or guardian of the minor of any pregnancy care services given or needed if the physician or other health care professional discusses with the minor the reasons for informing the parent or guardian prior to the disclosure and, in the judgment of the physician or other health care professional:
>
> a. Failure to inform the parent or guardian would seriously jeopardize the health of the minor or her unborn child;
>
> b. Surgery or hospitalization is needed; or
>
> c. Informing the parent or guardian would benefit the health of the minor or her unborn child.

N.D. CENT. CODE § 14-10-19 (2009).

3. *Id.* § 14-10-19(1)(b).

II. INFORMED CONSENT FOR MINORS UNDER CURRENT NORTH DAKOTA LAW

While the general contours under which a physician may provide medical care to a minor without parental consent are relatively clear, the legislature has struggled for years with the controversial issue regarding a minor's right to confidentiality. After several failed efforts to pass legislation,[4] Senate Bill 2394 is the 2009 legislature's resolution, however imperfect, of the minor consent to medical care issue. In brief, the statute expands the circumstances under which pregnancy-related health care may be provided based on minor consent.[5] Although the legislation represents a step forward, it simultaneously creates problems. The statute attempts to manage a physician's practice by limiting a minor's right to consent to treatment to one prenatal visit during the second and third trimesters,[6] and the statute prohibits billing the minor's insurer if parental consent is not obtained.[7] This article makes practical suggestions for physicians to resolve the problems created by the new statute.

It is a basic principle that parents are required to provide the care and control necessary for their minor[8] child's physical, mental, and emotional health.[9] But other than N.D.C.C. section 14-10-19, there is no clear and unambiguous language in North Dakota statutes or case law concerning the circumstances under which minors may consent to their own medical treatment without parental consent. Arguably, N.D.C.C. section 23-12-13 generally requires parental consent for minor health care treatment.[10]

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4. *See generally* S.B. 2181, 60th Leg. Assemb. (N.D. 2007); S.B. 2308, 59th Leg. Assemb. (N.D. 2005). Previous bills were introduced in the North Dakota Legislative Assembly in 2005 and 2007, as Senate Bill 2308 and Senate Bill 2181, respectively. S.B. 2181, *supra*; S.B. 2308, *supra*. Though differing in detail, both bills would have authorized minors to consent to care related to pregnancy. S.B. 2181, *supra*; S.B. 2308, *supra*. While the legislation passed easily in the state Senate in both years, the House handily defeated the 2005 bill, and the 2007 version died in a tie vote in the House, 46-46. *See* S.B. 2181, *supra*; S.B. 2308, *supra*.

5. N.D. CENT. CODE § 14-10-19 (2009).

6. *Id.* § 14-10-19(1)(b) (2009).

7. *Id.* § 14-10-19(1)(d).

8. The N.D.C.C. defines a minor as any person under the age of eighteen. *Id.* § 14-10-01.

9. *Id.* § 14-09-22 (providing for a class C felony for failure to provide "proper parental care or control, subsistence, education as required by law, or other care or control necessary for the child's physical, mental, or emotional health, or morals."). There is also general recognition that minors are "members of a special class of citizens who may require additional legal protection." *E.g.*, Olson v. N.D. Dep't of Transp. Dir., 523 N.W.2d 258, 260 (N.D. 1994).

10. *See* § 23-12-13. The N.D.C.C. provides:

> 1. Informed consent for health care for a minor patient or a patient who is determined by a physician to be an incapacitated person, as defined in subsection 2 of section 30.1-26-01, and unable to consent may be obtained from a person authorized to

Under section 23-12-13, North Dakota is consistent with the general common law rule that a physician is liable for treating a minor without the consent of the minor's parents, except in emergency cases in which it was impractical to obtain parental consent, or when any delay would unduly

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consent on behalf of the patient. Persons in the following classes and in the following order of priority may provide informed consent to health care on behalf of the patient:

a. The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions, unless a court of competent jurisdiction specifically authorizes a guardian to make medical decisions for the incapacitated person;

b. The appointed guardian or custodian of the patient, if any;

c. The patient's spouse who has maintained significant contacts with the incapacitated person;

d. Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person;

e. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person;

f. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person;

g. Grandparents of the patient who have maintained significant contacts with the incapacitated person;

h. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person; or

i. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

2. A physician seeking informed consent for proposed health care for a minor patient or a patient who is an incapacitated person and is unable to consent must make reasonable efforts to locate and secure authorization for the health care from a competent person in the first or succeeding class identified in subsection 1. If the physician is unable to locate such person, authorization may be given by any person in the next class in the order of descending priority. A person identified in subsection 1 may not provide informed consent to health care if a person of higher priority has refused to give such authorization.

3. Before any person authorized to provide informed consent pursuant to this section exercises that authority, the person must first determine in good faith that the patient, if not incapacitated, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

4. No person authorized to provide informed consent pursuant to this section may provide consent for sterilization, abortion, or psychosurgery or for admission to a state mental health facility for a period of more than forty-five days without a mental health proceeding or other court order.

5. If a patient who is determined by a physician to be an incapacitated person, or a person interested in the patient's welfare, objects to a determination of incapacity made pursuant to this section, a court hearing pursuant to chapter 30.1-28 must be held to determine the issue of incapacity.

Id. § 23-12-13. This statute stems from the 1991 House Bill 1296, which, as introduced, would have addressed consent to medical treatment only in respect to incapacitated persons. H.B. 1296, 52d Leg. Assemb. (N.D. 1991). The language adding minors to the consent bill appears to have been an afterthought, resulting from a question posed from representatives of the North Dakota Medical Association to the 1991 Senate Human Services and Veteran Affairs Committee as to whether minors were included in the definition of incapacitated persons. Subsequent amendments were made to the bill to clarify this question. *See Hearing on H.B. 1296 Before the S. Human Servs. & Veterans Affairs Comm.*, 52d Leg. Assemb. (N.D. 1991).

endanger the patient's health and life.[11] A second common exception to the parental consent requirement exists for emancipated or mature minors.[12]

Some question whether the legislature improved the law by enacting N.D.C.C. section 14-10-19, arguing that medical providers could advantage themselves of the vagueness of N.D.C.C. section 23-12-13, which does not necessarily require parental consent to such prenatal care.[13] Admittedly, North Dakota's general "minor consent statute" is not a model of clarity, providing that "[i]nformed consent for health care for a minor patient . . . *may* be obtained from a [third] person . . . ."[14] Use of the word "may" indicates the statute does not specifically require informed consent from a third person for a minor patient. And, while the statute requires a physician to make "reasonable efforts" to secure consent, the obligation only applies when the physician "seek[s] informed consent."[15] Although legislative history is not germane unless the statute is deemed ambiguous,[16] N.D.C.C. section 23-12-13 seems ambiguous, and the legislative history suggests that it was intended for North Dakota to follow the general rule that parental

11. § 23-12-13. The N.D.C.C. also provides a "minor may contract for and receive emergency examination, care, or treatment in a life threatening situation without the . . . consent of the minor's parent or guardian." *Id.* § 14-10-17.1. *See* MICHAEL J. DALE ET AL., REPRESENTING THE CHILD CLIENT § 3.02(2)(c)(i) (2008); FAY A. ROZOVSKY, CONSENT TO TREATMENT § 5.01(B)(1)-(2) (4th ed. 2007); Danny R. Veilleux, Annotation, *Medical Practitioner's Liability for Treatment Given Child Without Parent's Consent*, 67 A.L.R.4th 511, 530-34 (1989). Of course, the health emergency must be the minor's—for example, a minor cannot consent to providing blood in an emergency situation for another patient who requires a blood donor. Veilleux, *supra*, § 3, at 523-24.

12. Veilleux, *supra* note 12, at 530-34. North Dakota appears to recognize the common law emancipated minor exception in N.D.C.C. section 14-09-20, which provides that "[t]he authority of a parent ceases" if a court appoints a guardian, if the child marries, or if the child reaches age eighteen. § 14-09-20. Thus, the marriage of a minor would emancipate the minor and presumably constitute an exception to the parental consent requirement for medical care. *See id.* North Dakota also recognizes a court should consider the minor's maturity in determining whether to bypass parental consent requirements in the case of abortion, and state law provides that a married minor may consent on her own behalf. *Id.* § 14-02.1-03.1(1)(b), (5). That some minors achieve maturity at an earlier age than others is a truism recognized by the courts. *See* Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 440 (1983) (noting a state cannot presume the immaturity of female minors under the age of fifteen).

13. *See* § 23-12-13.

14. *Id.* § 23-12-13(1) (emphasis added).

15. *Id.* § 23-12-13(2).

16. *In re* Guardianship and Conservatorship of V.J.V.N., 2008 ND 106, ¶ 10, 750 N.W.2d 462, 465. The North Dakota Supreme Court noted:

> If statutory language is clear and unambiguous, the letter of the statute cannot be disregarded under the pretext of pursuing its spirit, because the Legislature's intent is presumed clear from the face of the statute. N.D.C.C. § 1-02-05. If statutory language is ambiguous, a court may resort to extrinsic aids, including legislative history, to interpret the statute. N.D.C.C. § 1-02-39.

Id. (quoting *In re* Guardianship/Conservatorship of Van Sickle, 2005 ND 69, ¶ 18, 694 N.W.2d 212, 219).

consent is required.[17] Thus, the limited exception to the parental consent requirement in the 2009 legislation creating N.D.C.C. section 14-10-19 is arguably an improvement in the ambiguity of existing law.

Some health care providers also contend the new statute is unnecessary, arguing minors have a constitutional right to privacy that trumps statutes requiring parental consent in matters relating to procreation—for example, abortion and contraceptives. The constitutional right to privacy issue exists, however, regardless of whether the legislature enacted Senate Bill 2394.[18]

What is informed consent? The medical profession has established a strong code of ethics concerning many of the topics addressed in this article. The American Medical Association (AMA) Current Opinion E-8.08 addresses informed consent, providing "[t]he patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice . . . . The physician's obligation is to present the medical facts accurately to the patient . . . and to make recommendations for management in accordance with good medical practice."[19] The ethical opinions recognize that in the case of minors, the information is generally provided to the parents.[20]

Although the AMA opinions provide guidance, North Dakota physicians must comply with the state's informed consent law to avoid liability. The doctrine of informed consent places a duty on "a physician to disclose sufficient information to permit a patient to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgical procedure."[21] So, an informed consent action stands separate from

17. *See* H.B. 1296, *supra* note 10 and accompanying text.

18. *See* discussion *infra* Part VII.

19. AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS WITH ANNOTATIONS § 8.08, at 245-46 (Am. Med. Ass'n 2008-2009 ed. 2008) [hereinafter AMA CURRENT OPINION], *available at* http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/toc.html.

20. *Id.* §§ 5.055, 8.08, at 166-67, 245-46.

21. Flatt v. Kantak, 2004 ND 173, ¶ 6, 687 N.W.2d 208, 211. In *Winkjer v. Herr*, the court noted that while a majority of courts have related a physician's duty of disclosure to a subjective standard of the custom of physicians practicing in the community, a growing number of jurisdictions have adopted an objective standard for measuring the performance of a physician's duty of disclosure based on conduct that is reasonable under the circumstances. 277 N.W.2d 579, 587 (N.D. 1979). In other words, while some jurisdictions measure materiality based on what information a "reasonable doctor" would provide, "[o]thers refuse to cede to the medical profession the decision of what risks ought to be disclosed. Emphasizing that the heart of an informed consent right is patient autonomy, they opt for a 'reasonable patient' standard to determine materiality." Margaret A. Berger & Aaron D. Twercki, *Uncertainty and Informed Choice: Unmasking* Daubert, 104 MICH. L. REV. 257, 271 (2005). In *Jaskoviak v. Gruver*, the court did not explicitly adopt either the subjective or objective standard of disclosure, but rather discussed common ground under both standards:

a claim that the physician was negligent in recommending or performing therapy.[22] An informed consent action assumes no operational negligence but instead focuses on the physician's failure to deliver to the patient information about "available choices for treatment and the material and known risks involved with each treatment."[23] An assessment of the materiality of risk involves: "(1) an examination of the existence and nature of the risk and the probability of its occurrence; and (2) a determination by the trier of fact of whether the risk is the type of harm which a reasonable patient would consider in deciding on medical treatment."[24] Materiality is a "function of the severity of the potential injury and of the likelihood it will occur."[25] Of particular interest to physicians may be special rules that govern informed consent involving prescription drugs—the so-called learned intermediary doctrine, which places on the physician the duty to provide the patient with drug information, absolving the manufacturer of liability.[26] Of course, the duty to warn and the obligation to provide information also apply when caring for minors, though the consent obtained is frequently that of the parent. The informed consent doctrine reappears in the discussion about "conscience clauses."[27]

> In acquiring a patient's informed consent to a medical procedure, a physician should disclose a number of things: It is sometimes said that the physician should disclose the diagnosis, the general nature of the contemplated procedure, the material risks involved in the procedure, the probability of success associated with the procedure, the prognosis if the procedure is not carried out, and the existence and risks of any alternatives to the procedure.

2002 ND 1, ¶¶ 17-19, 638 N.W.2d 1, 8-9 (citations omitted).

22. Berger & Twercki, *supra* note 22, at 270.

23. *Flatt*, ¶¶ 6-8, 687 N.W.2d at 211-12.

24. *Gruver*, ¶¶ 17-19.

25. *Flatt*, ¶¶ 6-8. In sum, "a physician is not required to inform a patient of risks that are so remote as to be negligible even where the consequences may be severe, and is not required to inform the patient of a very minor consequence even though the probability is high." *Id.* ¶ 8.

26. Terence C. Green, *Licking, Sticking, Counting, and Pouring—Is That All Pharmacists Do?*, McKee v. American Home Products, Corp., 24 CREIGHTON L. REV. 1449, 1459 (1991). Traditionally, the law's attempt to disclose to patients the hazards of prescription drugs has operated through a two-pronged duty: first, the manufacturer has a duty to inform the physician about the uses and hazards of its drug; second, the physician has a duty to relate to each of her patients the dangers of using that prescription drug. *Id.* While a thorough discussion of the learned intermediary doctrine is outside the scope of this article, the doctrine, adopted in a majority of jurisdictions, largely absolves drug makers and pharmacies from having a duty to warn customers by recognizing that prescribing physicians bear the primary responsibility to warn patient-consumers of drug interactions and side-effects. *See, e.g.*, Larkin v. Pfizer, Inc., 153 S.W.3d 758, 762 (Ky. 2004) (noting the doctrine is recognized by the Restatement (Third) of Torts: Products Liability in section 6(d)). At least thirty-four states have adopted the learned intermediary doctrine. *Id.* at 767.

27. *See* discussion *infra* Part VI.

III. ADDITIONAL CARE BASED ON MINOR CONSENT

The North Dakota Legislative Assembly's enactment of N.D.C.C. section 14-10-19 expands the circumstances under which pregnancy-related health care may be provided based on minor consent, granting a minor the right to consent to "pregnancy testing and pain management" without parental consent.[28] Despite the clear delineation of the treatments covered—pregnancy testing, pain management, and prenatal care—to ensure there can be no misunderstanding, the legislature further specified the section "does not authorize a minor to consent to abortion or otherwise supersede the requirements of chapter 14-02.1."[29] The statute *requires* physicians and other health care providers to encourage a pregnant minor to involve her parents.[30] By requiring that this discussion between physician and patient take place in the case of prenatal care, the legislation arguably improves upon the current statutory scheme. Further improvements are possible; section 2 of the legislation provides for an interim study of the issue, and the Legislative Council has placed the item on its list of matters "prioritized for study."[31]

N.D.C.C. section 14-10-19 follows the lead of at least thirty-five other states in providing statutory authority for a physician or other health care professional to rely on the consent of a minor for pregnancy-related health care. The statute thus serves two laudable policy goals. First, if a minor who is hesitant to involve her parents at the beginning of her pregnancy is assured of confidentiality, she will feel able to seek health care earlier in the pregnancy to improve pregnancy outcomes, as well as potentially limit the risks and eliminate the cost of additional treatment for complications. Second, by requiring a physician-patient discussion regarding the general benefit of parental involvement—for example, soliciting the minor's reasons for not involving her parents and correcting misconceptions that may be motivating her objections—N.D.C.C. section 14-10-19 might reduce the incidence of abortion.[32]

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28. N.D. CENT. CODE § 14-10-19(1)(a) (2009).

29. *Id.* § 14-10-19(1)(e).

30. *Id.* § 14-10-19(2). The statute uses the words "shall encourage." *Id.* Use of the word "shall" ordinarily means the duty is mandatory. *See* Timm v. Schoenwald, 400 N.W.2d 260, 263 (N.D. 1987). *See also infra* notes 49-50 and accompanying text (noting the AMA Ethics Opinions similarly recognize it is generally beneficial to the minor patient to involve the parents).

31. N.D. Legislative Council, Study Directives and Assignments Made by the Legislative Council for the 2009-10 Interim 2 (March 2, 2010), *available at* http://www.legis.nd.gov/assembly/61-2009/docs/pdf/citation.pdf.

32. Statistics from the North Dakota Department of Health indicate that 194 children were born to a minor parent in 2007, compared to 182 in 2005. In that same year, fifty-two minors aborted their unborn children, compared to thirty-six minors who aborted their unborn children in 2005.

A. THE CARE LIMITATION CREATES POTENTIAL PROBLEMS

As noted, the new minor consent statute authorizes provision of "prenatal care" without parental consent in the first trimester, "or . . . a single prenatal care visit in the second or third trimester."[33] Additional care beyond this may be provided without parental consent only if the health care provider is unable to locate the minor's parent or guardian, despite a "good-faith effort" to do so.[34] This limitation on the physician's ability to provide a minor with pregnancy-related health care based on the minor's own consent raises the first potential problem: affording patient confidentiality and avoiding abandonment of the patient. One practical solution to the legislature's inapt involvement in the physician-patient relationship—limiting the physician's ability to provide care based on minor consent—is to have in place a referral system so the care of the minor patient objecting to disclosure may be readily transferred to another physician. Although the referral system might fracture medical care by requiring a minor to change physician mid-stream, some medical care is preferable to no care, and a referral in compliance with statutory treatment limitations based on minor consent meets the physician's ethical duties and avoids patient abandonment.[35]

What is the tort of abandonment? Once a professional relationship has been created, a physician is legally required to provide the patient treatment unless or until the relationship is properly terminated; improper termination constitutes the tort of abandonment and the risk of malpractice liability for consequential harm.[36] While physicians have an absolute right—they need not provide a reason—to terminate care and treatment of a patient,[37]

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33. *Id.* § 14-10-19(1)(b).

34. *Id.* § 14-10-19(1)(c).

35. *See* AMA CURRENT OPINION, *supra* note 20, § 8.115, at 261. AMA Current Opinion E-8.115, Termination of the Physician-Patient Relationship, formerly included Opinion E-8.11, Neglect of Patients. *See id.* Opinion E-8.115 states, "Physicians have an obligation to support continuity of care for their patients." *Id.* Further, Opinion E-10.01, Fundamental Elements of the Physician-Patient Relationship, provides:

> The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

Id. § 10.01.

36. Ricks v. Budge, 64 P.2d 208, 211-12 (Utah 1937) (holding the failure to satisfy the *duty to notify* the patient when the physician terminates the relationship can result in abandonment liability if the patient suffers an injury as a result of the termination).

37. *See, e.g.*, Grant v. Douglas Women's Clinic, P.C., 580 S.E.2d 532, 534 (Ga. Ct. App. 2003). The court held that although the physician may unilaterally withdraw from treating a patient, the physician must provide reasonable notice of withdrawal to enable the patient to obtain substitute care if the patient desires. *Id.* The court stated whether the physician's chart notation

physicians should be prepared for the courts to examine the manner in which that relationship was terminated.

Once the physician-patient relationship has commenced, treatment generally must continue until: (1) the patient's condition no longer warrants treatment;[38] (2) the physician and patient mutually agree to discontinue treatment by the physician;[39] (3) the patient discharges the physician;[40] or (4) the physician unilaterally withdraws from treatment and gives the patient appropriate notice of his or her intention and an opportunity to secure a competent replacement.[41]

The fourth scenario is the most likely to give rise to litigation; the prudent physician should treat the patient until she has had a reasonable time to find an alternative source of care. "The amount of time necessary [to find a competent replacement] may depend upon such factors as the acuteness of the patient's medical condition, the availability and accessibility of alternative care, and the patient's ability to afford such care."[42] Again, to avoid a case of abandonment, the physician should establish a referral system to another physician to ensure continuity of care for those

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that he had "nothing to add" constituted proper withdrawal was a question of fact for the jury and did not constitute reasonable notice as a matter of law warranting summary judgment in his favor, nor do medical ethics preclude a physician from withdrawing from the physician-patient relationship. *Id.* The prevailing viewpoint is that a physician has the right to refuse on personal *moral grounds* to participate in continuing or foregoing life-sustaining treatment. In exercising this right, however, the physician must transfer the care of the patient to another qualified physician. *See* Conservatorship of Morrison, 253 Cal. Rptr. 530, 534 (Cal. Dist. Ct. App. 1988) (citing ALBERT R. JONSEN ET AL., CLINICAL ETHICS 94 (2d ed. 1986)); *see also* AMA CURRENT OPINION, *supra* note 20, § 8.115 ("While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient . . . sufficiently long in advance of withdrawal to permit another medical attendant to be secured."); *Id.* § 10.01.

38. *Grant,* 580 S.E.2d at 534 (citing Church v. Perales, 39 S.W.3d 149, 164 (Tenn. Ct. App. 2000)); Weiss v. Rojanasathit, 975 S.W.2d 113, 119-120 (Mo. 1998); Brandt v. Grubin, 329 A.2d 82, 87-88 (N.J. Super. Ct. Law Div. 1974); McManus v. Donlin, 127 N.W.2d 22, 28 (Wis. 1964).

39. *See Grant,* 580 S.E.2d at 534 (citing *Church*, 39 S.W.3d at 164); *Weiss*, 975 S.W.2d at 119-120; *Brandt*, 329 A.2d at 87-88; *McManus*, 127 N.W.2d at 28.

40. *See* Estate of Haar v. Ulwelling, 154 P.3d 67, 74 (N.M. Ct. App. 2007) ("[The physician] owed no duty of care to [the patient] after [the patient] missed his appointments and obtained treatment from others."); Knapp v. Eppright, 783 S.W.2d 293, 295 (Tex. App. 1989) ("Appellant's theory of abandonment also does not apply because the evidence shows that [the] appellant terminated the doctor-patient relationship. There can be no abandonment when the patient has voluntarily chosen not to return to her doctor."); Millbaugh v. Gilmore, 285 N.E.2d 19, 21 (Ohio 1972) (holding the physician-patient relationship terminated when the patient missed a scheduled appointment and did not see the physician again, and the relationship did not continue despite the fact the patient later secured a refill of a prescription that was prescribed during the relationship).

41. Scripps Clinic v. Superior Court*,* 134 Cal. Rptr. 2d 101, 109 (2003). A physician can lawfully abandon a patient "only . . . after due notice, and an ample opportunity afforded to secure the presence of other medical attendance." *Id. See also* King v. Zakaria, 634 S.E.2d 444, 448 (Ga. Ct. App. 2006).

42. CALIFORNIA PHYSICIAN'S LEGAL HANDBOOK § 34:35 (2006) (citing *Scripps Clinic,* 134 Cal. Rptr. 2d at 109).

minor patients who require additional care beyond the initial visit and do not consent to parental notice.[43]

B. A SECOND POTENTIAL PROBLEM: COSTS OF CARE CANNOT BE BILLED TO THE PARENT'S INSURER

N.D.C.C. section 14-10-19(1)(d) creates a second dilemma, providing the costs of the care may not be billed to a third-party payor without the consent of the minor's parent or guardian.[44] Because a physician's primary ethical duty is to the patient when it is lawful to provide care based on minor consent, affording this confidentiality takes precedence over the inability to bill the parent's insurer. An issue arises as to whether the minor may disavow a contractual obligation to make payments in this circumstance. Minors may generally disavow otherwise valid contracts,[45] and in North Dakota there are only two exceptions to this rule: first, minors remain obligated "to pay the reasonable value of things necessary for the minor's support,"[46] and; second, minors may not disavow contracts "entered into by the minor under the express authority or direction of a statute."[47] The minor's support exception provided by N.D.C.C. section 14-10-12 might successfully support a provider's right to payments from minors, especially in light of the court-made rule that, where a minor has the right to consent to treatment, he or she is responsible for paying for the treatment and may not disaffirm any contract made with a care provider.[48]

IV. PROTECTING PATIENT CONFIDENTIALITY

As we have seen, physicians have developed a sophisticated code of ethics. First, it is well-known that a physician is ethically required to use sound medical judgment, "holding the best interests of the patient as paramount" and "above obligations to other groups."[49] It is equally clear

43. *See* N.D. CENT. CODE § 14-10-19(1)(b)-(c) (2009). The N.D.C.C. contemplates whether parental notice occurs after the initial visit in the second or third trimester of the pregnancy. *Id.*

44. *Id.* § 14-10-19(d)(1).

45. *Id.* § 14-10-12.

46. *Id*. § 14-10-13.

47. *Id*.

48. *See generally* DALE ET AL., *supra* note 12, § 3.02(c)(v); John D. Hodson, Annotation, *Infant's Liability for Medical, Dental or Hospital Services*, 53 A.L.R.4th 1249, 1256-60, 1278-79 (1987) (courts generally hold that medical, dental, and hospital services are necessaries that may not be disavowed by emancipated minors).

49. AMA CURRENT OPINION, *supra* note 20, § 10.015, at 348. It is clear the minor patient's health is paramount, but her health might be improved by involving the parents over the minor's objections. The N.D.C.C., in a section setting out the physician's right to refuse to treat based on minor consent, contemplates whether a patient's best interests might be served by referring the minor to another physician to rekindle a strong physician-patient relationship. N.D. CENT. CODE § 14-10-19(2) (2009).

that in this collaborative effort to safeguard life and health, physicians "best contribute to this alliance by serving as their patient's advocate and by fostering" patient rights, including both the right to confidentiality and to receive information regarding benefits, risks, and costs of appropriate treatment alternatives.[50]

A. MINOR CONSENT AND CONFIDENTIALITY

By requiring physicians and other providers to encourage the pregnant minor to involve her parents, N.D.C.C. section 14-10-19(2) is consistent with the Ethical Opinion of the AMA's Council on Ethical and Judicial Affairs.[51] Of course, this recognizes that parental involvement is normally beneficial to the minor. Should the minor continue to insist on confidentiality despite the physician's concern that lack of parental involvement is contrary to the minor's best interest, the statute provides a safeguard that health care providers "may not be compelled against their best judgment to treat a minor based on the minor's own consent."[52] This protection of professional judgment is perhaps unnecessary because the statute authorizes a physician or other health care professional to notify the minor's parents if doing so is in the patient's best interest.[53]

In fact, N.D.C.C. section 14-10-19(3) specifically authorizes the physician to notify the minor's parents about the treatment course *despite the minor's objections* if disclosure is in the patient's best interests.[54] The statute fleshes out the circumstances where a physician or other health care professional is authorized to inform the minor's parents or guardians about any health care services given or needed after discussion with the minor: (1) "failure to inform the parent or guardian would seriously jeopardize the health of the minor or her unborn child"; (2) major surgery or prolonged hospitalization is needed; or (3) "[i]nforming the parent or guardian would benefit the health of the minor or her unborn child."[55] Thus, the statute

50. AMA CURRENT OPINION, *supra* note 20, § 10.01, at 341; *see also id.* § 5.05, at 149.

51. *Id.* § 5.055, at 166-67.

52. N.D. CENT. CODE § 14-10-19(2) (2009). At first glance, the language allowing physician withdrawal is suggestive of a "conscience clause." *See* discussion *infra* Part VI. The purpose here is unclear, however, because providing pregnancy-related care does not appear to pose the ethical conundrum that abortion does. Moreover, it is *perhaps* preferable that a physician struggle with the decision of whether to notify the parents over the patient's objections based on the patient's best interest—which should be an unusual circumstance—rather than ignore the issue and withdraw from providing care. The exception, of course, may be in the circumstance where the physician–patient relationship is damaged by the disagreement to the extent that judgment dictates withdrawal will benefit the patient by providing her the opportunity to forge a new and stronger physician-patient relationship.

53. § 14-10-19(3).

54. *Id.* (emphasis added).

55. *Id.*

recognizes the potential complications providers may face in meeting their ethical obligations to safeguard both the minor patient's confidentiality and best interests. It is axiomatic that it is in the patient's best interest to protect her health and the life of her unborn child.[56]

B. GENERAL ETHICAL CONSIDERATIONS IN PROVIDING CARE FOR MINORS

A patient's best interests are not always served by retaining strict confidentiality. A potential conflict is likely to be particularly acute in rendering care to minors. An Ethical Opinion of the Council on Ethical and Judicial Affairs of the AMA notes that "[p]hysicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision making process to a degree commensurate with their abilities."[57] But minors may benefit from parental involvement, and "[w]hen minors request confidential services, physicians should encourage them to involve their parents."[58] Where the issue cannot be resolved, "*unless the law requires otherwise*, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent."[59]

The exceptions are limited. AMA Current Opinion E-5.055 provides, "[c]onfidentiality may be justifiably breached in situations for which confidentiality for adults may be breached."[60] To further complicate matters,

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56. While the patient's best interests are paramount, in the case of pregnancy-related health care—as opposed to abortion—the interests of the unborn child must also be weighed. § 14-10-19(3)(c).

57. AMA CURRENT OPINION, *supra* note 20, § 5.055, at 166-67.

58. *Id.* The physician-patient discussion may prove valuable to the minor. *Id.* As AMA Current Opinion E-5.055 notes, this effort includes ascertaining "the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections." *Id.*

59. *Id.* (emphasis added).

60. AMA CURRENT OPINION, *supra* note 20, § 5.055, at 166. AMA Current Opinion E-5.05 refers to a number of situations in which confidentiality may be breached, such as when a patient threatens to inflict serious bodily harm to another person or to self with reasonable likelihood it will be carried out, and as required by law—for communicable diseases, gunshot and knife wounds, etc.—in which case the patient should be notified of the disclosure. *Id.* § 5.05, at 149. North Dakota, like most states, requires physicians to report suspected child abuse and child neglect:

> Any physician, nurse, dentist, optometrist, medical examiner or coroner, or any other medical or mental health professional . . . having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, shall report the circumstances to the department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity.

N.D. CENT. CODE § 50-25.1-03(1) (2009). The N.D.C.C. definition of a neglected child is similar to that used to define a deprived child in chapter 27-20. *Id.* § 50-25.2-01(11). The N.D.C.C. offers a broad definition of a deprived child, including the all too common situation where the child "[i]s

AMA Current Opinion E-5.055 recognizes a tension that may arise between breach of confidentiality on the one hand, and dereliction of the duty to warn a third person that the patient may constitute a danger on the other.[61] Furthermore, with regard to minors, confidentiality is not required "when necessary to enable the parent to make an informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor."[62] As noted previously, N.D.C.C. section 14-10-19(3) recognizes the "patient's best interest" exception, allowing parental disclosure in such a case.[63]

C. ETHICAL CONSIDERATIONS: PREGNANCY CARE AND MINORS

AMA Current Opinion E-5.055 also provides specific guidance regarding confidentiality concerning the provision of treatment where privacy concerns are understandably heightened—such private and intimate matters as reproduction or mental health.[64] The Opinion recognizes in these private and sensitive matters that parental involvement may be counterproductive, but generally parental involvement is healthy and should be encouraged.[65] In sum, N.D.C.C. section 14-10-19 does not appear to pose any unusual

present in an environment subjecting the child to exposure to a controlled substance . . . ." *See id.* § 27-20-02(8)(g).

61. AMA CURRENT OPINION, *supra* note 20, § 5.055, at 166-67. For example, in the famous California case, *Tarasoff v. Regents of the University of California*, the Supreme Court of California held mental health professionals have a duty to protect individuals who are threatened with bodily harm by the professional's patient. 551 P.2d 334, 345 (Cal. 1976).

62. AMA CURRENT OPINION, *supra* note 20, § 5.055, at 167.

63. N.D. CENT. CODE § 14-10-19(3) (2009).

64. AMA CURRENT OPINION, *supra* note 20, § 5.055, at 166-67.

65. *Id.* The opinion provides:

> When an immature minor requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse, or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor may be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is *ethically justified*. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

Id. (emphasis added). Of course, whether an ethical justification is tantamount to legal justification is another matter. But, because the "breach" is limited to circumstances in which the failure to disclose is likely to pose a health threat to the minor, and the standard of care is to disclose, it seems likely that no liability would result in the circumstance. *See infra* text accompanying note 91.

ethical difficulties. By contrast, the ethical conundrums posed in the abortion debate are significant.[66]

D. HIPAA AND MINOR CONFIDENTIALITY

N.D.C.C. section 14-10-19 grants a minor the right to consent to limited "pregnancy testing and pain management" without the consent of a parent.[67] The Heath Insurance Portability and Accountability Act's (HIPAA)[68] confidentiality protections allow states to grant minors the ability to consent without parental notification; the regulation promulgated to implement HIPAA generally defers to state law.[69] The opposite concern is that in providing a mechanism to notify the parents despite the minor's objections, the statute breaches a minor's right to privacy and confidentiality in conflict with HIPAA regulations. This concern appears to be groundless. Again, HIPAA explicitly defers to state law in this area: "the addition of paragraphs (g)(3)(ii)(A) and (B) of § 164.502, clarify that State and other applicable law governs when such law explicitly requires, permits, or prohibits disclosure of protected health information to a parent."[70] HIPAA does afford minors protection from parental notification in circumstances where the minor might be endangered by such notification, explicitly preempting state laws to the contrary.[71] Nothing in Senate Bill 2394 requires parental notification if such notification would endanger the minor.[72]

V. TORT LITIGATION DUE TO BREACH OF RIGHT TO CONFIDENTIALITY

Professional care organizations have cause to be concerned that notifying the parents without the minor's consent may give rise to a medical

66. *See infra* Parts VI-VII.

67. N.D. CENT. CODE § 14-10-19 (2009).

68. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 42 U.S.C.).

69. *See* 45 C.F.R. § 164.502 (2009).

70. Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53182, 53201 (proposed Aug. 14, 2002) (to be codified at 45 C.F.R. pt. 160, 164).

71. 45 C.F.R. § 164.502 (2009).

72. The N.D.C.C. provides the circumstances in which the health care professional *may* notify the minor's parents about the pregnancy care services without the minor's consent—these include when *failure to inform* would jeopardize the minor's health, when surgery or hospitalization is required, and a general catch-all where informing the parent "would *benefit* the health of the minor or her unborn child." N.D. CENT. CODE § 14-10-19(3) (2009) (emphasis added).

negligence claim.[73] Any negligence claim is comprised of four elements.[74] For example, a plaintiff filing a tort claim alleging medical negligence due to an unauthorized disclosure must show: (1) that the medical professional had a duty[75] of confidentiality to plaintiff; (2) breach of the duty;[76] (3)

73. *See, e.g.*, Goins v. Mercy Ctr. For Health Care Servs., 667 N.E.2d 652, 657 (Ill. App. Ct. 1996) (allowing a tort claim for breach of a confidentiality act against an employer-hospital).

74. VICTOR E. SCHWARTZ ET AL., PROSSER, WADE AND SCHWARTZ'S TORTS: CASES AND MATERIALS 130 (10th ed. 2000). It is settled law there are four elements to a cause of action in negligence: duty, breach, causation, and damage. *Id.* *See infra* notes 96-99 (citing cases specifically recognizing the existence of a cause of action in tort against medical professionals for violation of duty of confidentiality).

75. According to Professor David Owen:

> Few principles are more fundamentally important to modern society than duty. As obligation to oneself and others—to one's family, friends, neighbors, business associates, clients, customers, community, nation, and God—duty is the thread that binds humans to the world, to the communities in which they live. Duty constrains and channels human behavior in a socially responsible way before the fact, and it provides a basis for judging the propriety of behavior thereafter. Duty flows from millennia of social customs, philosophy, and religion. And duty is the overarching concept of the law. Duty is central to the law of torts. Negligence law divides human choices to engage in (or refrain from) foreseeably harmful conduct as proper or improper, and choices are adjudged improper only if they involve a breach of duty. Thus, serving as the foundational element of a negligence claim, duty provides the front door to recovery for the principal cause of action in the law of torts: On the way to possible redress, every negligence claim must pass through the duty portal that bounds the scope of tort recovery for accidental harm.

David Owen, *Duty Rules*, 54 VAND. L. REV. 767, 767-68 (2001). The California Supreme Court, noting that "legal duties are not discoverable facts," and that duty "is not sacrosanct in itself, but a conclusory expression that liability should be imposed for damages done," set out the major factors to balance in determining whether a duty exits:

> The foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved.

Tarasoff v. Regents of the University of California, 551 P.2d 334, 342 (Cal. 1976). The California Supreme Court also noted the "most important" factor is foreseeability, noting generally:

> [A] defendant owes a duty of care to all persons who are foreseeably endangered by his conduct, with respect to all risks which make the conduct unreasonably dangerous . . . . [But] . . . when the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person or to the potential victim. Since the relationship between a therapist and his patient satisfies this requirement, we need not here decide whether foreseeability alone is sufficient to create a duty to exercise reasonable care to protect a potential victim of another's conduct.

Id. at 434-35. (citations omitted). Three of the four elements—duty, causation, and damages—are the object of intense study, with immense literature devoted to each. *See infra* notes 78-80.

76. While duty questions present complicated multi-factorial questions of law, whether a breach occurred is generally a question of fact for the jury. *See, e.g.*, Cox v. Paul, 828 N.E.2d 907, 911-12 (Ind. 2005) ("The question of the breach of a duty is usually one for the trier of fact. However, if any reasonable jury would conclude that a specific standard of care was or was not breached, the question of breach becomes a question of law for the court." (citations omitted)).

causation;[77] and (4) injury—that is, damages.[78] In *Greenwood v. Paracelsus Health Care Corp.*,[79] the court simply restated the negligence elements as requiring a plaintiff to "present evidence establishing the applicable standard of care, a violation of that standard, and a causal relationship between the violation and the harm complained of."[80] The court continued, "Medical malpractice cases typically involve a complex jumble of medical, technical, and ordinary fact questions."[81] A jury might resolve "ordinary fact questions" without reference to expert opinion, but technical and medical questions require expert testimony.[82] Due to "the technical and complicated nature" of medicine, case law generally requires the plaintiff to "establish through expert testimony the degree of care and skill required of a physician, and whether specified acts fall below that standard of care."[83]

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77. The philosophical difficulty of proving causation is notorious and probably insoluble. *See, e.g.*, W. PAGE KEETON ET AL., PROSSER & KEETON ON TORTS § 41, at 236 (5th ed. 1984) (noting causation is a notoriously broad concept—like beauty, it may be in the eye of the beholder: "the fatal tresspass done by Eve was cause of all our woe"), the difficulty exists in practice as well. *See* Berger & Twercki, *supra* note 22, at 261 (noting "safety and efficacy studies done by manufacturers to obtain Food and Drug Administration approval will often provide inadequate data to prove the causal relationship between a toxic agent and the harm suffered by a plaintiff"); Dean J. Haas, *Falling Down on the Job: Workers' Compensation Shifts from a No-Fault to a Worker-Fault Paradigm*, 79 N.D. L. REV. 203, 249-50 (2003) (criticizing the use of a lax causation standard in apportioning benefits under the "aggravation statute," N.D.C.C. section 65-05-15, which reduces benefits when a work injury combines with a pre-existing condition). It is simple and unfair to obtain an Independent Medical Evaluations opinion to apportion cause. *See, e.g.*, Balliet v. N.D. Workmen's Comp. Bureau, 297 N.W.2d 791, 794 (N.D. 1980) ("Putatively, almost every injury could, with sufficient scrutiny, be linked to some pre-existing weakness or susceptibility."). Some argue a more objective standard should be required to reduce a worker's benefits, requiring that the pre-existing condition remained active at the time of the work injury. Haas, *supra*, at 249-50. Proof the pre-existing condition remained active at the time of the work injury simply requires that the pre-existing condition constitutes a permanent impairment, or resulted in permanent work restrictions. *Id.*

78. A huge amount of literature exists on every aspect of damages, from the concrete proof of damages—including economic damages and noneconomic damages, punitive damages, etc.—to the rather esoteric nature of tort that can give rise to damages, which might consist of bodily injury, or more abstract, involving nearly any form of mental distress, such as outrage, humiliation, damage to reputation, and the like. *See generally* Nancy Levit, *Ethereal Torts*, GEO. WASH. L. REV. 136, 137 (1992).

79. 2001 ND 28, 622 N.W.2d 195.

80. *Greenwood,* ¶ 10, 622 N.W.2d at 199 (citations omitted).

81. *Id.* ¶ 16, 622 N.W.2d at 200.

82. *Id.*

83. *Id.* ¶ 13 (citing Bader v. Johnson, 732 N.E.2d 1212, 1217-18 (Ind. 2000)). In North Dakota, N.D.C.C. section 28-01-46 generally requires a plaintiff alleging medical evidence to serve an expert opinion. N.D. CENT. CODE § 28-01-46 (2009). The statute applies before trial, requiring a "preliminary screening," thus "designed to dispose of frivolous or nuisance medical malpractice actions at an early stage of the proceedings." *Greenwood,* ¶ 8, 622 N.W.2d at 199. The *Greenwood* parties devoted "much of their arguments to N.D.C.C. section 28-01-46, *res ipsa loquitur*, and whether the claim "fit under traditional *res ipsa loquitur* concepts [or] within one of the exceptions [to the need to submit an expert opinion] in N.D.C.C. § 28-01-46." *Id.* ¶ 12. The court found it unnecessary to address these issues, concluding the plaintiff had "established a

The question of whether a duty exists is a question of law for the courts.[84] *Greenwood* is illustrative; there, the plaintiff brought a medical malpractice claim against a physician who allegedly left gauze in the plaintiff's ear after surgery, causing injury.[85] As to the first element, the defendant physician admitted the applicable standard of care required removal of the gauze.[86] In sum, the nature of the duty—the standard of care[87]—might be admitted by the defendant physician or provided by the plaintiff's expert, who might rely on general ethical principles, for example,[88] or guided by reference to a statute or regulation—in North Dakota, violation of a statutory or regulatory duty is generally considered evidence of negligence, not negligence *per se*.[89] The *Greenwood* court similarly addressed the defendant physician's argument that breach of the standard of care must be established through expert testimony; while the circumstances might

prima facie case without relying upon *res ipsa loquitur* or upon the exceptions to N.D.C.C. § 28-01-46." *Id.*

84. *See, e.g.*, Long v. Jaszczak, 2004 ND 194, ¶ 12, 688 N.W.2d 173, 177 (noting "[a] plaintiff in an informed-consent case must establish breach of a physician's duty of disclosure, causation, and injury," and "[g]enerally, whether a duty exists is a 'preliminary question of law for the court to decide.'" (citation omitted)).

85. *Greenwood*, ¶ 5, 622 N.W.2d at 198.

86. *Id.* ¶ 13, 622 N.W.2d at 200.

87. It is uncontroverted that due to the special nature of the physician-patient relationship, the physician owes his patients a number of legal duties. *See generally* RESTATEMENT (SECOND) OF TORTS § 874 cmt. a (1979) ("A fiduciary relation exists between two persons when one of them is under a duty to act for or to give advice for the benefit of another upon matters within the scope of that relation."). AMA CURRENT OPINION, *supra* note 20, §§ 5.05, 5.055 (discussing the duty to ensure confidentiality).

88. *See, e.g.*, Ketchup v. Howard, 543 S.E.2d 371, 377 (Ga. Ct. App. 2000) (holding section 8.08 of the AMA Code of Medical Ethics, entitled Informed Consent, provides the relevant standard of care "[b]ecause the AMA is an organization composed of experts in the field of medicine, its code of ethics and the duties of physicians prescribed therein should be understood to reflect the standard of care of the profession on the issue of informed consent"), *overruled by* Blotner v. Doreika, 678 S.E.2d 80, 84 (2009) (holding the common law doctrine of informed consent does not exist in the state, but rather is governed by Georgia statute); *see also* Hall v. Anwar, 774 So. 2d 41, 42 (Fla. Dist. Ct. App. 2000) ("We recognize that some medical standards of care are influenced by medical ethics.").

89. Gonzalez v. Tounjian, 2003 ND 121, ¶ 20, 665 N.W.2d 705, 713; Haider v. Finken, 239 N.W.2d 508, 516 (N.D. 1976) (holding a violation of highway safety statutes is only evidence of negligence for the trier of fact to consider; it does not constitute negligence per se). The California Supreme Court expounded upon the concept of per se negligence, explaining an emergency room physician who failed to report battered child syndrome "will not be heard to say that other members of his profession would not have made such a report," concluding California law requiring the physician to report the child abuse was a statutory duty. *See* Landeros v. Flood, 551 P.2d 389, 394 n.8 (Cal. 1976). This is consistent, broadly speaking, with the principle that "the existence of a statute or ordinance authorizing particular conduct is a factor which militates in favor of the conclusion that [it was done in good faith]." Grossman v. City of Portland, 33 F.3d 1200, 1209 (9th Cir. 1994).

require expert testimony, the claim might simply present an ordinary fact question for the jury.[90]

The common law tort for breach of confidentiality is recognized in most states, generally providing for liability whenever one owes a duty of confidentiality and breaches that duty.[91] Such claims may arise under an alternative contract theory as well.[92] Actions against those who breach confidentiality are nothing new; in fact, remedies for improperly divulging confidential information began to emerge as early as the eighteenth century.[93] In 1920, the Nebraska Supreme Court held that because doctors were "bound [by] professional honor and the ethics of [their] high profession" to maintain patient confidentiality, a "wrongful breach of such confidence, and a betrayal of such trust, would give rise to a civil action for the damages naturally flowing from such wrong."[94] In 1985, the Supreme Court of Massachusetts held a physician owes a patient a duty not to disclose confidential information gained through the physician-patient relationship, and "a violation of that duty gives rise to a cause of action sounding in tort."[95] Throughout the country, recognition of similar torts has since become common.[96] In fact, litigation for a confidentiality breach by a medical professional is relatively straight-forward because the duty of physicians to protect their patients' confidentiality is well known.[97] In sum,

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90. *Greenwood*, ¶15, 622 N.W.2d at 200 (citing N.D. R. EVID. 702). The court explained why, in this case, presenting an expert opinion on the issue of breach wasn't necessary: "[I]t is unclear what the substance of such an expert's testimony would have been . . . . Whether [the physician] actually left gauze in Greenwood's ear was an ordinary fact question for the jury, and an expert's opinion would not have assisted the jury in resolving that question." *Id.*

91. Neil M. Richards & Daniel J. Solove, *Privacy's Other Path: Recovering the Law of Confidentiality*, 96 GEO. L.J. 123, 136 (2007) (explaining the scope of privacy rights that ground the right to confidentiality generally). *See infra* notes 95-99 and accompanying text (discussing the duty of medical professionals to protect their patient's confidentiality).

92. *E.g.*, Horne v. Patton, 287 So. 2d 824, 830 (Ala. 1973). In *Horne*, the court recognized a cause of action for the unauthorized release of medical records, holding the unauthorized disclosure of intimate details of a patient's health may amount to such unwarranted publicizing of one's private affairs, with which the public has no legitimate concern, "as to cause outrage or cause mental suffering, shame or humiliation to a person of ordinary sensibilities." *Id*. The *Horne* court held the unauthorized release of medical records may amount to a breach of an implied contract of confidentiality on the part of the doctor. *Id*. at 832.

93. Richards & Solove, *supra* note 93, at 124.

94. Simonsen v. Swenson, 177 N.W. 831, 832 (Neb. 1920).

95. Alberts v. Devine, 479 N.E.2d 113, 124 (Mass. 1985).

96. Richards & Solove, *supra* note 93, at 158.

97. *See, e.g.*, Randi A.J. v. Long Island Surgi-Center, 842 N.Y.S.2d 558, 565 (N.Y. App. Div. 2007) (holding liability resulted from a nurse calling a twenty-year-old patient's home, providing the patient's mother with sufficient information so the mother could determine her daughter had an abortion (citing Public Health Law § 2803-c(3)(f) ("Every patient shall have the right to have privacy in treatment and in caring for personal needs, confidentiality in the treatment of personal and medical records, and security in storing personal possessions.")); Sloan v. Farmer, 217 S.W.3d 763, 767-68 (Tex. App. 2007) (recognizing the existence of a cause of action in tort against a physician for a violation of the duty of confidentiality that arises from the physician-

the universally recognized duty to protect confidentiality is sufficient to support a tort action under state law for damages resulting from an unauthorized disclosure.[98] Whether disclosure is authorized—for example, to parents—is another issue, also generally left to state law,[99] including claims that may be fashioned as an invasion of privacy tort.[100] Because the statutes

patient relationship, but dismissing the case due to the plaintiff's failure to serve the expert report required in cases alleging medical negligence); Grimminger v. Maitra, 887 A.2d 276, 279-80 (Pa. Super. 2005) (recognizing a distinct cause of action for invasion of privacy and a separate, distinct cause of action for a breach of physician-patient confidentiality); Gracey v. Eaker, 837 So. 2d 348, 353-54 (Fla. 2002) (describing the psychiatrist-patient relationship as that of a fiduciary, the court concluded a civil action for damages arose from the breach of a statutory duty of confidentiality and privacy); Berger v. Sonneland, 26 P.3d 257, 263 (Wash. 2001) (reversing a summary judgment award because a question of fact existed regarding whether the disclosure caused injury, the court held "a tort action exists under [state law] for damages resulting from the unauthorized disclosure of confidential information related to health care and obtained within the physician-patient relationship"). The duty is based on the nature of the relationship, buttressed by universally recognized ethical precepts. According to the ancient Hippocratic Oath, circa 400 B.C.E., "Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." *See also* AMA CURRENT OPINION, *supra* note 20, §§ 5.05, 5.055.

98. Because a statute or general ethical principle is only *evidence of* the existence or absence of a legal duty, the question would be more difficult if different rules point different ways. *See* discussion *supra* note 91. Here, the statutes and ethical principles align—generally, a minor must obtain parental consent to medical treatment. *See* N.D. CENT. CODE §§ 14-10-19, 23-12-13 (2009); AMA CURRENT OPINION, *supra* note 20, §§ 5.05, 5.055. These laws and principles may determine the parameters of the confidentiality standard of care for medical providers who treat minors—in other words, the circumstances under which the general confidentiality rules are waived, with the concordant obligation to disclose to parents.

99. One exception is HIPAA's preemption of any state law that would otherwise require disclosure to parents when such would endanger the health of the minor. *See* 45 C.F.R. § 164.502(g)(5) (2009); *supra* note 73 and accompanying text.

100. The causes of action may include any number of theories involving invasions of privacy. For example, the Second Restatement of Torts sets forth those four distinct categories of invasion of privacy. RESTATEMENT (SECOND) OF TORTS §§ 652B-E (1977). According to the Restatement, "[a]n action for an invasion of privacy is comprised of four distinct torts: (1) intrusion upon seclusion, (2) appropriation of name or likeness, (3) publicity given to a private life, (4) publicity placing the person in a false light." *Id.* § 652B court citations. The tort of breach of physician-patient confidentiality can readily be distinguished from the torts of appropriation of name or likeness, publicity given to a private life, and publicity placing the person in a false light. It will be the rare circumstance where a physician decides to publish, publicize, or appropriate confidential medical information. *See, e.g.*, Doe v. Roe, 400 N.Y.S.2d 668, 671 (N.Y. App. Div. 1977) (recognizing a cause of action against a psychiatrist who breached the duty of confidentiality by publishing his former patient's "thoughts, feelings, and emotions . . . their most intimate personal relationships," in his book, concluding the un-named tort was a kind of violation of privacy). Consequently, there seems to be a substantive distinction between these three categories of privacy liability and the tort of breach of physician-patient confidentiality, with the exception of the rare circumstance where a physician takes the extraordinary measure of publishing a patient's confidential medical information without consent. The final category of privacy invasion plaintiffs consider raising in conjunction with the tort of breach of physician-patient confidentiality is "intrusion upon seclusion." *See* RESTATEMENT (SECOND) OF TORTS § 652B. According to the Second Restatement of Torts, the intrusion upon seclusion tort can be easily distinguished as a substantive matter from the tort of breach of physician-patient confidentiality. *See id.* While an action for breach of physician-patient confidentiality is normally based on a negligence theory, intrusion upon seclusion is a species of intentional tort. Pro Golf Mfg., Inc. v. Tribune Review Newspaper Co., 809 A.2d 243, 248 (Pa. 2002). Each of the privacy torts may be distinguished

and ethical principles generally authorize notice to parents regarding the minor's medical care, it is difficult to envision successful litigation against a physician due to such disclosure.

Additionally, a plaintiff might allege violations of HIPAA regulations as the basis of a suit for breach of confidentiality. Such a plaintiff must address the fact that in enacting HIPAA, Congress did not see fit to bestow a private right of action.[101] But the legislature's failure to create a specific cause of action is not necessarily determinative because the cause of action may also be implied.[102]

Even if a federal cause of action is not implied, however, the HIPAA privacy rule could serve as the basis for a tort suit brought under state law for a violation of the patient's right to confidentiality. How? It is done simply by utilizing the principle that a statute or regulation can serve as evidence of the confidentiality standard.[103] In 2006, HIPAA was invoked as the basis for such privacy standards in two significant cases. In *Sorensen v. Barbuto*,[104] a personal injury plaintiff received treatment from a physician, who subsequently produced the plaintiff's medical records and engaged in ex parte communications with defense counsel in the personal injury suit.[105] The trial court agreed to exclude the physician's testimony.[106] After prevailing in the personal injury action, the plaintiff filed an

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from the tort of breach of confidentiality. *See* Burger v. Blair Med. Assocs., Inc., 928 A.2d 246, 250-51 (Pa. Super. 2007), *aff'd*, 964 A.2d 374 (Pa. 2009) (discussing substantive differences between physician-patient confidentiality breaches and each of the four Restatement theories for invasion of privacy).

101. Under HIPAA, individuals do not have a right to court action. Compliance and Enforcement, 65 Fed. Reg. 82,600, 82,601 (Dec. 28, 2000); *see also* Webb v. Smart Document Solutions, LLC, 499 F.3d 1078, 1082 (9th Cir. 2007). *See generally* HIPAA, 42 U.S.C. §§ 290aa-290ff (2010); *id.* § 290dd-2(a); Fisher v. Yale Univ., No. X10NNHCV044003207S, 2006 WL 1075035, at *3 (Conn. Super. Ct. Apr. 3, 2006) (citing Logan v. Dept. of Veterans Affairs, 357 F. Supp. 2d 149, 155 (D.D.C. 2004)) ("[C]ourts have repeatedly held that Congress did not intend to create a private cause of action under HIPAA.").

102. *See* Trade 'N Post, L.L.C. v. World Duty Free Americas, Inc., 2001 ND 116, ¶ 11, 628 N.W.2d 707, 711 (quoting Cort v. Ash, 422 U.S. 66, 78 (1975)). In *Cort v. Ash*, the Supreme Court stated:

> In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff one of the class for whose especial benefit the statute was enacted, . . . that is, does the statute create a . . . right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? . . . Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?

Cort, 422 U.S. at 78.

103. Gonzalez v. Tounjian, 2003 ND 121, ¶ 20, 665 N.W.2d 705, 713.

104. 143 P.3d 295 (Utah Ct. App. 2006).

105. *Sorensen*, 143 P.3d at 298.

106. *Id.*

action against the physician.[107] The appeals court agreed the duty to not disclose confidential personal information arises out of trust and confidence in the physician-patient relationship, and the court concluded a tortious action may arise from the breach of that confidentiality.[108] While the plaintiffs recognized HIPAA did not create a private right of action, they argued HIPAA's professional confidentiality standards constituted the proper standard of care.[109]

Similarly, in *Acosta v. Byrum,*[110] the court found in the HIPAA rule a basis for determination of the appropriate level of care in relation to the privacy of medical information.[111] While the court recognized the patient could not assert a private right of action under HIPAA, it held the privacy rule may be used to establish an appropriate professional standard for the protection of health care information.[112] In short, just as N.D.C.C. sections 14-10-19 and 23-12-13 are evidence that parental disclosure does not necessarily violate a professional standard to protect the minor patient's confidentiality, the HIPAA confidentiality rule could similarly be used as evidence of the professional standard.

VI. GENERAL ETHICAL CONSIDERATIONS RELATING TO PREGNANCY AND ABORTION

Abortion, more than any other topic, divides the American people; it is not surprising that it engenders profound philosophical and ethical debate. There are significant constitutional and ethical principles relating to a minor female's right to make such significant decisions regarding her reproductive life. First, the basics: AMA Current Opinion E-2.01 states ethical principles "do not prohibit a physician from performing an abortion."[113] Regarding minors, AMA Current Opinion E-2.015 requires physicians to ensure they follow their legal obligations regarding parental involvement and "strongly encourage minors to discuss their pregnancy with their parents."[114] As always, informed consent is crucial.[115] AMA Current

107. *Id.*

108. *Id*. at 300.

109. *Id*. at 299 n.2.

110. 638 S.E.2d 246 (N.C. Ct. App. 2006).

111. *Acosta*, 638 S.E.2d at 253.

112. *Id*. (holding "HIPAA is inapplicable beyond providing evidence of the duty of care owed by Dr. Faber with regards to the privacy of plaintiff's medical records," but through this mechanism the plaintiff provided evidence of one of the necessary elements of negligence). Thus begins what is likely to be a line of civil cases using HIPAA as a standard for the measurement of the duty to maintain health care privacy, similar to the use by plaintiffs' attorneys of the clinical practice guidelines developed and published by the Agency for Health Care Research and Quality.

113. AMA CURRENT OPINION, *supra* note 20, § 2.01, at 4.

114. *Id.* § 2.015, at 5.

Opinion E-2.015 recognizes "[p]hysicians should not feel or be compelled to require minors to involve their parents before deciding whether to undergo an abortion," but the patients should be told "under what circumstances (e.g. life-threatening emergency) the minor's confidentiality will need to be abrogated."[116] But, this opinion does not address the physician's personal ethics—that is, the right to practice medicine in accordance with one's conscience. Of course, this ethical dilemma may not be simple; physicians must consider both their personal conscience and the weighty general duty to provide quality medical care to the public.

One manifestation of the national controversy over abortion is the "conscience clause," which is a statutory provision that allows providers to opt out of providing abortion services.[117] Fierce advocates of patient rights re-label conscience clauses as "refusal clauses."[118] Transcendent moral issues lie at the heart of individual religious beliefs and moral conscience in

115. *Id.*

116. *Id.*

117. *See generally* 1 AM. JUR. 2d *Abortion and Birth Control* § 80 (2010) (indicating a state may constitutionally permit private hospitals, health care facilities, physicians, nurses, and employees to refuse to perform or participate in performing abortions for "ethical, moral, religious, or professional reasons," but may not extend such an institutional "conscience" clause to public hospitals or facilities (citation omitted)).

118. *See, e.g.*, Maureen K. Bailey, *Contraceptive Insurance Mandates and* Catholic Charities v. Superior Court of Sacramento*: Towards a New Understanding of Women's Health*, 9 TEX. REV. L. & POL. 367, 369 n.7 (2005) ("The ACLU refers to these clauses as 'refusal clauses,' a term recently selected by the ACLU for its political purposes" (citing George Gund Foundation, Pro-Choice Resource Center & Reproductive Freedom Project, American Civil Liberties Union, *Conscientious Exemptions and Reproductive Rights*, EXECUTIVE SUMMARY, NATIONAL MEETING (2000))); Heather Rae Skeeles, Note, *Patient Autonomy Versus Religious Freedom: Should State Legislatures Require Catholic Hospitals to Provide Emergency Contraception to Rape Victims*?, 60 WASH. & LEE L. REV. 1007, 1022 n.75 (2003) ("[Religious Refusal laws] offer important protections for health care professionals but may endanger patients" (citing AM. CIVIL LIBERTIES UNION REPROD. FREEDOM PROJECT, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 10 (2002))); *see also* Jason Green, Commentary, *Refusal Clauses and the Weldon Amendment: Inherently Unconstitutional and a Dangerous Precedent,* 26 J. LEGAL MED. 401, 409 (2005); Susan Berke Fogel & Lourdes A. Rivera, *Saving* Roe *Is Not Enough: When Religion Controls Healthcare,* 31 FORDHAM URB. L.J. 725, 727 (2004). In brief, the legal argument is that state conscience clauses "fail the undue burden test by presenting a substantial obstacle for women seeking [such services], particularly if the patient is in a rural area with few or no alternatives." Green, *supra*, at 409 (presenting the argument in connection with providing the emergency contraceptive mifepristone). Many of these commentators also advocate compulsory coverage by all insurers—and increasingly, for compulsory provision by all health care providers—of many of these controversial services and products, especially contraceptives. At least twenty states require employer health insurance plans to include coverage of contraceptives. *See generally* Bailey, *supra,* at 373 n.31. The California Supreme Court has upheld such a provision against attack that compulsory coverage violates the First Amendment rights of the nonprofit employer. *See* Catholic Charities of Sacramento, Inc. v. Superior Court, 85 P.3d 67, 93 n.20 (Cal. 2004), *cert denied*, 543 U.S. 816 (2004). The California court noted, as of that time, at least nineteen other states had enacted similar laws. *Id.*

many aspects of health care, not just abortion.[119] These issues have long engaged the concerns of bioethicists, theologians, and law professors.[120] Perhaps in light of the profound competing values involved in the abortion debate, the AMA has no single statement on conscientious objections, but addresses various facets and issues through a combination of policy documents.[121]

The history of conscience clause statutes is intriguing; this brief overview cannot do it justice. It is a well-settled principle of American law that patients receiving medical care ultimately are autonomous agents, retaining the right to choose what is to be done to their bodies.[122] But, it is

119. These include issues concerning the provision or assisting the provision of many other procedures, medications, and materials, such as: provision of birth control procedures; pharmaceutical abortifacients; assisted reproductive techniques, such as implementing the new technological means to predict or even influence the characteristics of the fetus, including the sex; sex change procedures and therapies; assisted suicide; euthanasia; sterilization; cloning; pre-natal human experimentation; stem cell research; harvesting of fetal and other organs and tissue; organ transplantation; and others.

120. *See generally supra* note 122. *See also* William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine,* 17 J. CONTEMP. HEALTH L. & POL'Y 455 (2001); Gerard V. Bradley, *Beguiled: Free Exercise Exemptions and the Siren Song of Liberalism*, 20 HOFSTRA L. REV. 245 (1991); Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 OR. L. REV. 625 (2003); Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. a Physician's Professional Conscience,* 44 HASTINGS L.J. 1241 (1993); Philip A. Hamburger, *A Constitutional Right of Religious Exemption: An Historical Perspective,* 60 GEO. WASH. L. REV. 915 (1992); Douglas W. Kmiec, *The Original Understanding of the Free Exercise Clause and Religious Diversity,* 59 UMKC L. REV. 591 (1991); Maureen Kramlich, *The Abortion Debate Thirty Years Later: From Choice to Coercion*, 31 FORDHAM URB. L.J. 783 (2004); Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 HARV. L. REV. 1409 (1990); Martha S. Swartz, "*Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL'Y L. & ETHICS 269 (2006); Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177 (1993); Katherine A. White, Note, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights*, 51 STAN. L. REV. 1703 (1999).

121. The most significant of these are AMA Current Opinions E-9.12 and E-10.05. *See* AMA CURRENT OPINION, *supra* note 20, §§ 9.12, 10.05, at 325, 354-55. The first of these is Opinion E-9.12, entitled "Patient-Physician Relationship: Respect for Law and Human Rights." *Id.* § 9.12, at 325 (noting while the creation of the physician-patient is contractual in nature, and both are generally free to decline to create a relationship, "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination"). The second is Opinion E-10.05, "Potential Patients." *Id.* § 10.05, at 354-55 (discussing that unless otherwise addressed, a physician may decline to provide a "specific treatment . . . incompatible with the physician's personal, religious, or moral beliefs").

122. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault."). The paternalistic view that "doctors know best," and so need not involve patients in medical decision-making, has long since become an anachronism. *See generally* John F. Kennedy Mem'l Hosp. v. Heston, 279 A.2d 670, 673 (N.J. 1971) (holding a twenty-two-year-old woman's physician was justified in ordering a life-saving blood transfusion over the patient's surrogate's religion- based objections, the court said, "When the hospital and staff are thus involuntary hosts

equally true that at the beginning of the physician-patient relationship, a physician may, without articulating a reason, lawfully limit the extent and scope of his or her obligation to treat a patient by communicating this intent to the patient.[123] Similarly, in most circumstances, a private hospital may also limit the procedures it offers to its patients.[124] Physicians may have many reasons not to accept prospective patients into their care or to limit their practices to certain areas. The most profound reason may be the physician's exercise of conscience.[125]

In sum, a general consensus recognizing the rights of physicians and hospitals to limit the treatments and procedures they provide has long existed.[126] But, in the aftermath of *Roe v. Wade*,[127] some began to question this right. The underlying theory is that the right to abortion—or other legally permissible procedures or medications that might be subject to conscientious objection—becomes meaningless without physicians or pharmacists who are willing to provide such services.[128] In other words, a patient's very ability to choose these procedures or medications is

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and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards"), *overruled in part by In re* Conroy, 486 A.2d 1209 (N.J. 1985) (overruling *Heston* to the extent the court there attributed more weight to the physician's professional creed than to the patient's privacy rights; the *Conroy* court noted "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law").

123. Giallanza v. Sands, 316 So. 2d 77, 83 (Fla. App. 4th Dist. 1975) (Walden, C.J., dissenting); Brandt v. Grubin, 329 A.2d 82, 88-89 (N.J. 1974); McNamara v. Emmons, 97 P.2d 503, 507 (Cal. App. 4th Dist. 1939); Ricks v. Budge, 64 P.2d 208, 211 (Utah 1937); Childers v. Frye, 158 S.E. 744, 746 (N.C. 1931). Of course, the relationship is a voluntary one—the same rule applies to creation and termination of the relationship. *See supra* note 38.

124. *See, e.g.*, Ham v. Holy Rosary Hosp., 529 P.2d 361, 367 (Mont. 1974) (upholding the hospital's right to refuse to allow sterilization within its facility).

125. The importance of conscience in American life has a long history, crucial to the founding of the country. The powerful influence of respect for rights of conscience on the founders of the American Constitution is well documented. *See, e.g.*, Noah Feldman, *The Intellectual Origins of the Establishment Clause,* 77 N.Y.U. L. REV. 346, 354-72 (2002) (reviewing colonial history of protection of rights of conscience); Harrop A. Freeman, *A Remonstrance for Conscience*, 106 U. PA. L. REV. 806 (1958); Timothy L. Hall, *Roger Williams and the Foundations of Religious Liberty,* 71 B.U. L. REV. 455 (1991); McConnell, *supra* note 124; Aviam Soifer, *Full and Equal Rights of Conscience*, 22 U. HAW. L. REV. 469 (2000). James Madison spoke of the exercise of the conscience as a fundamental right of man. *See* Everson v. Bd. of Educ., 330 U.S. 1, 65-66 (1947) (Rutledge, J., dissenting).

126. A duty commences upon formation of a physician-client relationship. *See generally* Majzoub v. Appling, 95 S.W.3d 432 (Tex. App. 2002) (stating a physician who did not take an affirmative action to treat a patient in order to create a physician-patient relationship owed no duty to the patient).

127. 410 U.S. 113 (1973) (finding a Constitutional right to privacy grounds a woman's right to abortion services). *See infra* notes 185-188 and accompanying text.

128. *See, e.g.*, Lois Uttley & Ronnie Pawlko, *No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States*, MERGERWATCH, 2002, at 47-48, *available at* http://www.mergerwatch.org/pdfs/bp_no_strings.pdf.

dependent upon the existence of a doctor who is willing to facilitate whatever choice the patient makes; this concern is especially keen in rural areas.[129] Consequently, a physician's unwillingness to act in a particular way due to his or her conscience becomes a barrier to a patient's self-realization.

Some argue an underlying broad access theory essentially treats physicians and care providers like a public utility, relegating the significance of moral feelings to the second tier.[130] Most advocates do not go so far, however, suggesting a compromise of the competing interests.[131] Regardless of a physician's ethical beliefs, a patient is entitled to receive the information necessary for informed consent.[132] Some advocates go further,

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129. *See, e.g.*, Susan A. Farrell, *Reframing Social Justice, Feminism and Abortion,* CATHOLICS FOR CHOICE (Spring 2005), http://www.catholicsforchoice.org/conscience/archives/c2004spring_reframingsocialjustice.asp. It is perhaps unnecessary to illustrate the intensity of emotion that abortion issues engender, but the following provides an example:

> The bishops use [the conscience clause] to insist that Catholic hospitals are exempt from federal guidelines to provide women and men with full reproductive services . . . . Who's being discriminated against? No word on women struggling to hold body and soul together as they try to raise families, deal with the possibility of health care problems and try to pay for their own and their children's health care. These religious leaders talk about the conscience rights of institutions, but are dismissive of Catholics who argue for the right of conscience when trying to make decisions about reproductive issues that affect their very lives. Again, this is especially important for poor women. If these hospitals exercise their conscience rights and are the only health care providers available in a given location, women may die.

Id.

130. While suggesting a compromise of competing interests is possible, Professor Wardle's powerful rebuttal to an argument like Farrell's illustrates the passions on the other side of the issue:

> [To] sacrifice individual religious principles and personal rights of conscience for an assumed expedient in patient autonomy undermine the moral basis for the very objective they seek to secure. Such expediency impoverishes and demeans not only the individual health care providers specifically and the medical profession generally, but it weakens the very foundations of our constitutional order. We cannot survive as a Constitutional republic without constantly protecting the rights of conscience of all citizens.

Lynn D. Wardle, *Protection for Rights of Conscience in American Law: First Rights or Last Rites?*, PROTECTION OF CONSCIENCE PROJECT (2006), http://www.consciencelaws.org/issues-legal/legal031.html.

131. Bassett, *supra* note 124, at 565 ("Hospitals' ethical independence must be measured by the informed right and feasibility of choice of those contracting for their services," suggesting that hospitals advertise their religious affiliation and availability of reproductive health services and refrain from monopolization); Swartz, *supra* note 124, at 334-35 (noting that proposed "compromise tactics" to balance an institution's religious beliefs with patient access to health care range from simply requiring a facility to fully disclose services available to an intermediate step of requiring insurance coverage and referrals, or even "encouraging" objectors to consider shifting specialties); White, *supra* note 124, at 1742-45.

132. In this circumstance, the issue is not whether the physician has firm views against a procedure and would refuse to perform it—for example, in a wrongful birth or abortion case—the issue is the patient's right to receive information: the negligence, then, is the failure to inform the parents of a possibly disabling condition of the fetus, availability of genetic testing, etc. *See infra* note 147.

arguing that because patient access to health care is the focus of "medical professionalism," physician "devotion to health care values by placing the goals of individual and public health ahead of other goals"[133] can be applied even in cases of conscientious objection.[134]

In response to *Roe v. Wade*—and apparently to buttress the historical ability to practice medicine in accordance with one's interests and conscience—states and the federal government[135] enacted statutes allowing health care providers to refuse to provide procedures to which they objected on moral or religious grounds.[136] According to the often cited Guttmacher Institute, as of September 1, 2010, some type of conscience clause had been enacted in forty-six states.[137] The North Dakota Legislative Assembly enacted a conscience clause enabling medical providers to refer elsewhere those patients who make end-of-life "health care decisions" regarding withdrawal of treatment.[138] Regarding reproductive health decisions, North

133. Matthew K. Wynia et al., *Medical Professionalism in Society*, 341 NEW ENG. J. MED. 1612, 1612-13 (1999) (presenting the argument in the economic sphere—in the context of market competition and financial self-interest—that physicians must speak out in favor of patient rights even when this conflicts with personal beliefs).

134. Swartz, *supra* note 124, at 346.

135. Relying upon the Church Amendments, the Public Health Service Act, and the Weldon Amendment, the United States Department of Health and Human Services (HHS) affirmed the right of federally-funded health care providers to decline to participate in services to which they object, such as abortion, in a final rule notice published in the Federal Register on December 19, 2008. *See* 73 Fed. Reg. 78072 (Dec. 19, 2008). The regulation was to become effective January 20, 2009, but HHS components were given discretion to phase-in the regulation's written certification requirement by October 1, 2009, the beginning of the 2010 federal fiscal year. The Obama Administration may not be in agreement with the Bush Administration about this issue; HHS issued a notice proposing to rescind the December 19, 2008 final rule stating "it is important to have an opportunity to review this regulation to ensure its consistency with current Administration policy and to reevaluate the necessity for regulations implementing the Church Amendments, Section 245 of the Public Health Service Act, and the Weldon Amendment." 74 Fed. Reg. 10207 (March 10, 2009).

136. *See, e.g.*, OR. REV. STAT. § 127.800 (1994). Enacted by ballot measure in 1994, Oregon's Death with Dignity Act was the country's first law authorizing physician-assisted suicide. *See id.* A specific conscience clause protected the right of refusal by physicians and pharmacists who prefer not to become involved in this process. *Id.* The Act was upheld against the argument that physician-assisted suicide violated the federal Controlled Substances Act, 21 U.S.C. § 801 (2006); the conscience provision was not in question. Gonzales v. Oregon, 546 U.S. 243, 270-75 (2006). Though many of these provisions apply only to certain procedures, such as abortion, in other cases the clauses potentially affect not merely abortion and other aspects of reproductive medicine, but end-of-life care, stem-cell-related technologies, and a host of other issues. Medical ethics even impact state executions. *See* Baze v. Rees, 553 U.S. 35, 66 (2008) (interpreting the Eighth Amendment's prohibition on cruel and unusual punishment, the U.S. Supreme Court commented on the conscience issue in executions, noting medical ethics precluded physician involvement, resulting in postponement of executions in California (citing Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty,* 76 FORDHAM L. REV. 49 (2007))).

137. *State Policies in Brief*, GUTTMACHER INSTITUTE (Sept. 1, 2010), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf. *See also* Wardle, *supra* note 124, at 179-99 (describing and categorizing the various state conscience clauses).

138. N.D. CENT. CODE §§ 23-06.5-09(2), -12(3) (Supp. 2009).

Dakota limits its conscience clause protections on abortion: "[N]o hospital, physician, nurse, hospital employee, nor any other person is under any duty [or] required to participate in the performance of an abortion, if such hospital or person objects to such abortion. No such person or institution may be discriminated against because the person or institution so objects."[139]

Gradually, the exemptions expanded beyond physicians to include other individuals and entities involved in health care, such as nurses, counselors, insurers, and hospitals. Although some statutory refusal rights are predicated on exercise of a religious or moral conscience, others, like North Dakota's, do not refer to religious or moral beliefs at all—though it seems safe to assume that moral beliefs ground most objections to participating in an abortion. Predictably, litigation has followed, and while the complications are many, a few general "rules of the game" might be gleaned. First, it appears the grounds for the medical professional's objections are important—in other words, whether the objections are based on moral or religious conscience or on personal ethics. Closely related is the second generality—that secular and religious institutions can be treated differently. Third, the right of individuals to practice as they see fit might be broader than those of a medical facility.

These generalities are derived by interpreting the particular statutory framework and from broad principles, including balancing the patient's rights to autonomy with the medical practitioner's right to engage his or her conscience. In brief, the patient's right to direct her own medical care generally requires a physician to remedy the knowledge gap between professional and patient by providing the patient with information necessary to make an informed decision about her health care.[140] The principle that patients have a right to direct their medical care is quite broad and applies no less where the medical decision facing the patient is life-threatening.[141]

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139. *Id.* § 23-16-14.

140. *See supra* notes 22-26 and accompanying text. The states are divided as to whether the standard for informed consent is a professional malpractice standard or a patient-oriented "rights" standard, but they agree patient autonomy is the central basis for the doctrine. *See* Ketchup v. Howard, 543 S.E.2d 371, 374, 381-86 (Ga. Ct. App. 2000) (providing, in the appendix, a summary of the other forty-nine state laws or judicial decisions on informed consent).

141. End of life cases famously present the issue in stark terms. *See, e.g.*, Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269-70 (1990). The general principle of patient autonomy also undergirds the so-called "wrongful birth" cases, where a physician is alleged to have negligently failed to diagnose a defect in the fetus or inform the parents of the need for genetic testing, thereby depriving the woman the option of terminating a pregnancy. *See* Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141, 142-43 (2005), *available at* http://www.law.harvard.edu/students/orgs/crcl/vol40_1/hensel.pdf (stating more than half of the jurisdictions have recognized wrongful birth actions). *See also* Willis v. Wu, 607 S.E.2d 63, 65-66 (S.C. 2004) (discussing the difference between wrongful birth, wrongful life, and wrongful pregnancy actions).

First, conscience clauses appear to constitutionally balance a medical provider's right to conscientious objection with patient autonomy, without running afoul of the First Amendment, which simultaneously prohibits the government from prohibiting the free exercise of religion and from establishing a religion.[142] Some health care providers argue that requiring them to provide access to health services to which they have religious-based objections burdens their right to exercise their religion freely.[143] Under the Supreme Court's decision in *Employment Division, Department of Human Resources of Oregon v. Smith*,[144] it does not appear that conscience clauses violate the constitutional guarantee to free exercise of religion because such clauses cannot be used to challenge a neutral law of general applicability.[145] In other words, no matter how much a law burdens religious practices, it is constitutional so long as it does not single out religious behavior for punishment and is not motivated by a desire to interfere with religion.[146]

While the Free Exercise Clause may not protect the rights of religious providers to refuse to provide health care services the government considers necessary to protect public health, neither does the Establishment Clause prohibit governments from enacting conscience clauses. Though the Supreme Court's Establishment Clause jurisprudence has been

142. The First Amendment of the United States Constitution provides, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances." U.S. CONST. amend. I. The First Amendment applies to state governments due to the passage of the Fourteenth Amendment to the U.S. Constitution. Cantwell v. Connecticut, 310 U.S. 296, 303 (1940). The First Amendment applies to state actors; thus, employers are not precluded by the Constitution from engaging employees on the terms the public demands for its goods and services. Of course, in addition to basic constitutional safeguards, various *statutory* schemes protect employees from discrimination that place an undue burden on their religious practices. *See, e.g.*, Civil Rights Act of 1964, 42 U.S.C. §§ 2000e(j), 2000e-2(a) (2006) (prohibiting employers from discriminating against employees on the basis of religion). Many states have similar state laws, but legislative accommodations that accord individuals or entities an exemption from state interference benefit religion and are scrutinized not under the Free Exercise Clause, but under the Establishment Clause. The U.S. Supreme Court has recognized the Constitution demands accommodation by the government in few instances—rather special exceptions for religious practices are generally a matter of legislative choice. *See, e.g.*, Corp. of Presiding Bishop of Church of Latter-Day Saints v. Amos, 483 U.S. 327, 335 (1987) ("It is a permissible legislative purpose to alleviate significant governmental interference with the ability of religious organizations to define and carry out their religious missions."); Hobbie v. Unemployment Appeals Comm'n of Fla., 480 U.S. 136, 144-45 (1987) (citing Wisconsin v. Yoder, 406 U.S. 205 (1972) ("This Court has long recognized that the government may (and sometimes must) accommodate religious practices and that it may do so without violating the Establishment Clause.")).

143. *See* Clark, *supra* note 124, at 649-65 (discussing Free Exercise jurisprudence).

144. 494 U.S. 872 (1990).

145. *Smith*, 494 U.S. at 874-90.

146. *Id.*

characterized as "inconsistent and unprincipled,"[147] the basic principle is that legislative accommodations to religion are reasonable and consistent with the Establishment Clause when they have a secular purpose and do not serve primarily to advance religion or foster an excessive entanglement with religion.[148] In sum, it appears conscience clauses fit "in the room for play in the joints" between the clauses.[149] Most conclude a conscience clause is neither constitutionally mandated by the Free Exercise Clause nor prohibited by the Establishment Clause.[150]

Regarding the first general "rule of the game" that the grounds for the objection are important, there seems to be little doubt the First Amendment encompasses the religious, as opposed to secular, expression of conscience.[151] Though not grounded in science, the First Amendment's distinction between religious and secular conscience serves a purpose. Regarding conscience clauses, the distinction precludes allowing individual practitioners to use their own personal beliefs to determine whether they

147. Stephen G. Gey, *Why is Religion Special?: Reconsidering the Accommodation of Religion Under the Religion Clauses of the First Amendment,* 52 U. PITT. L. REV. 75, 75 (1990) (citation omitted).

148. Lemon v. Kurtzman, 403 U.S. 602, 612-13 (1971); Hobbie v. Unemployment Appeals Comm'n of Fla., 480 U.S. 136, 145 n.11 (1987) (noting the state's award of unemployment benefits to religious observers did not single out a class of persons for favorable treatment and did not endorse religion). Of course, a provision—including a conscience clause—that benefits one religious group, and not others, may run afoul of this injunction. *See, e.g.*, Children's HealthCare is a Legal Duty, Inc. v. Vladeck, 938 F.Supp. 1466, 1486-87 (D. Minn. 1996) (striking down a special exemption from a portion of the Medicare Act granted to Christian Science nursing homes in Minnesota).

149. Cutter v. Wilkinson, 544 U.S. 709, 713 (2005) (citation omitted).

150. *See, e.g.*, White, *supra* note 124, at 1729-30. Conscience clauses do not violate a woman's constitutional reproductive rights. *See* Doe v. Bolton, 410 U.S. 179, 197-98 (1973) ("Further, a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure. These provisions obviously are in the statute in order to afford appropriate protection to the individual and to the denominational hospital.").

151. *See* Feldman, *supra* note 129, at 413 (stating because "protection of dissenters' liberty of conscience formed the motivating force behind the [Establishment] Clause, it follows that the Clause only prohibits government from action that coerces the consciences of religious dissenters"); Freeman, *supra* note 129, at 811-12 (arguing the ultimate dropping of the term "conscience" from the First Amendment resulted from later revisions that were revisions only of language, which all agreed carried out the intent to protect religious conscience); Hamburger, *supra* note 124, at 919-20 (arguing against an interpretation of the Free Exercise clause that exempts individuals from civil laws to which they have objections); McConnell, *supra* note 124, at 1495 (arguing the founders specifically intended to give religious conscience more constitutional protection than rights of conscience generally); Michael W. McConnell, *The Problem of Singling Out Religion*, 50 DEPAUL L. REV. 1, 12 (2000) (arguing the history of the writing of the First Amendment and the differing language used in the various drafts casts doubt on the suggestion of some commentators that the constitutional term "religion" should be broadly interpreted in order to encompass *secular claims* of conscience: "[r]egardless of whether such a broad interpretation would be a good idea, such a step would constitute an amendment, not an interpretation, of the First Amendment, and one that the Framers specifically considered, debated, and ultimately rejected").

will practice their profession, which could potentially create chaos for health care administration and patient care.[152]

The general principle that a distinction exists between religious and secular conscience applies equally to medical facilities—our second related "rule of the game."[153] Examining a conscience objection law protecting private hospitals that have policies against performing abortions, the Alaska Supreme Court, in *Valley Hospital Ass'n v. Mat-Su Coalition,*[154] seemed to find the distinction important, holding a quasi-public hospital could not utilize the state's conscience clause to refuse to offer abortion services.[155] Although the hospital stated its policy "is a matter of conscience," the court held the hospital "is not affiliated with any religion and cannot raise a free exercise claim."[156] The court determined the hospital's policy to be a purely "statutory right" of refusal, while the right to procure an abortion is protected by the broad state constitutional right of privacy.[157] Therefore, utilizing the theory medical providers are akin to a public utility, and concluding the legislature "may not balance statutory rights against constitutional ones," the court struck down the conscience protection law.[158] The court essentially held the right of privacy trumps the moral or ethical policies of the private hospital, relying on the fact the hospital was "organized to serve public interests."[159]

The *Mat-Su* case might have come out differently if the situation had instead involved an individual practitioner—applying our third "rule of the game," that individuals are accorded more rights to exercise conscience than institutions. The idea individuals have more conscientious objection

152. Pierce v. Ortho Pharm. Corp., 417 A.2d 505, 514 (N.J. 1980). In *Thomas v. Review Board of Indiana Employment Security Division*, the Court held that "[o]nly beliefs rooted in religion are protected by the Free Exercise Clause, which, by its terms, gives special protection to the exercise of religion." 450 U.S. 707, 713 (1981). Jurists and scholars have grappled with the difficulty of distinguishing between religious and other beliefs, but "[a] purely rational, philosophical ethical system, regardless of how moral and central to a person's life would appear not to meet the definition" of religion under the Free Exercise Clause. Steven D. Jamar, *Accommodating Religion at Work: A Principled Approach to Title VII and Religious Freedom*, 40 N.Y.L. SCH. L. REV. 719, 751 (1996).

153. Hodgson v. Lawson, 542 F.2d 1350, 1356 (8th Cir. 1976) (per curiam) (holding that Minnesota's conscience clause allowing any "hospital or institution" to refuse to perform abortions could not constitutionally apply to public hospitals); Doe v. Bridgeton Hosp. Ass'n, 366 A.2d 641, 647 (N.J. 1976) (holding that although, on its face, the state's conscience clause applied to all hospitals, the clause did not protect nonsectarian non-profit hospitals).

154. 948 P.2d 963 (Alaska 1997).

155. *Valley Hosp. Ass'n*, 948 P.2d at 972.

156. *Id.* at 972 n.20.

157. *Id.* at 968 (concluding the Alaska Constitution's fundamental right of privacy "provides more protection of individual privacy rights than the United States Constitution").

158. *Id.* at 972.

159. *Id.* at 970-71.

rights than institutions stems from a common sense observation that organizations, though composed of individuals with consciences, might recruit people of different sensibilities. Moreover, context is relevant regarding the greater protections afforded to individuals. Most cases in which courts have upheld the refusal rights of individuals have involved health care professionals who have been discharged or demoted from their employment due to their refusal to participate in a procedure such as abortion. These plaintiffs are easily characterized in a sympathetic light, as victims of religious discrimination. A number of legal theories might be invoked against an employer taking such disciplinary action, such as under Title VII of the Civil Rights Act of 1964,[160] which requires employers to accommodate the religious beliefs of their employees unless such accommodation results in an undue hardship to the employer.[161]

The outcome may be different if the complaining party is a patient injured due to the health care professional's refusal to provide care. For example, in a straight-forward analysis, a Wisconsin Appeals Court rejected the First Amendment "right to conscience" as a defense in a disciplinary proceeding against a pharmacist alleged to have violated the standard of care when he refused to fill or transfer a patient's prescription for an oral contraceptive.[162] The court noted the ordinary standard of care for a pharmacist who exercises a conscientious objection to the dispensing of a prescription simply requires him to "ensure that there is an alternative

160. Civil Rights Act of 1964, 42 U.S.C. §§ 2000e(j), 2000e-2(a) (2006).

161. *See, e.g.*, Shelton v. Univ. of Med. & Dentistry of N.J., 223 F.3d 220, 225-28 (3d Cir. 2000) (finding a hospital not liable to a nurse under Title VII of the Civil Rights Act of 1964 because the hospital had attempted to accommodate the nurse's religious-based objections). Most such employment cases seem to be brought in state courts. *See, e.g.*, Kenny v. Ambulatory Ctr. of Miami, Fla., Inc., 400 So.2d 1262, 1263, 1266-67 (Fla. Dist. Ct. App. 1981) (rejecting the trial court's finding the employer's demotion decision was based on a fiscal necessity, and applying a federal Title VII analysis to Florida's civil rights statute, the court concluded that accommodating the nurse would not have created an undue hardship for the clinic; thus, the nurse was entitled to reinstatement).

162. Noesen v. State Dep't of Regulation & Licensing, Pharmacy Examining Bd., 751 N.W.2d 385, 390 (Wisc. Ct. App. 2008). The court further noted licensing statutes are enacted for the benefit of the public, not the practitioner, and concluded the Administrative Law Judge had not erred in finding the pharmacist had "engaged in practice which constitutes a danger to the health, welfare, or safety of a patient and has practiced in a manner which substantially departs from the standard of care ordinarily exercised by a pharmacist and which harmed or could have harmed a patient, in violation of [Wisconsin Administrative Code] § Phar 10.03(2)." *Id.* The issue arose previously in an employment law case as an unpublished opinion, and the Court of Appeals for the Seventh Circuit rejected the same pharmacist's claim that his firing violated Title VII of the 1964 Civil Rights Act—which requires employers to make reasonable accommodations for its employees' religious beliefs and practices—because it would result in undue hardship to the employer. Noesen v. Med. Staffing Network, Inc., 232 F. App'x 581, 584 (7th Cir. 2007). The employee did not help himself; he believed the employer could reasonably accommodate his demand to avoid any contact with customers who asked to have prescriptions for birth control filled, refusing even to transfer a call. *Id.* at 583.

mechanism for the patient to receive his or her medication, including informing the patient of their options to obtain their prescription," and inform his employer he would not transfer the prescription.[163] By failing to do either, the pharmacist departed from the ordinary standard of care, which could have harmed the patient.[164] After noting "the State has a compelling interest in public health and safety, and that this interest includes ensuring legally prescribed drugs are not improperly withheld from those for whom they have been prescribed,"[165] the court held the pharmacist had not shown his First Amendment right "was burdened by the application of a standard of care."[166] In this case, a more prudent approach—transferring the patient's prescription request to another pharmacist—might have saved the practitioner's right to practice according to conscience; the pharmacist had simply not shown the statutory requirements burdened his First Amendment rights.[167]

Finally, conscience clauses may not protect a medical professional if the exercise of conscience conflicts with other laws. For example, in a California case garnering national attention, a patient sued a physicians' group for violating state anti-discrimination laws due to a physician's refusal to artificially inseminate her because she was involved in a lesbian relationship.[168] While the physician agreed to treat the patient for infertility, the physician clearly stated from the outset she was unwilling to artificially inseminate the patient because of "religious beliefs."[169] The patient concurred with this plan, and the treatment began.[170] Nonetheless, the patient sued, alleging discrimination on the basis of sexual orientation.[171]

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163. *Noesen*, 751 N.W.2d at 389-90.

164. *Id.* at 391-92.

165. *Id.* at 393 n.6 (the defendant pharmacist "concedes that the State has a compelling interest in public health and safety, and that this interest includes ensuring that legally prescribed drugs are not improperly withheld from those for whom they have been prescribed").

166. *Id.* at 393. The court noted "[t]he Wisconsin Constitution offers more expansive protections for freedom of conscience than those offered by the First Amendment." *Id.* at 392. Under Wisconsin precedent:

> The challenger must prove (1) that he or she has a sincerely held religious belief, (2) that is burdened by application of the state law at issue. Upon such a showing, the burden shifts to the state to prove (3) that the law is based in a compelling state interest, (4) which cannot be served by a less restrictive alternative.

Id. Nevertheless, the United States Supreme Court has "never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate." *Id.* at 393 (citation omitted).

167. *Id.* at 393.

168. N. Coast Women's Care Med. Group, Inc. v. San Diego Cnty. Superior Court, 189 P.3d 959, 963 (Cal. 2008).

169. *Id.*

170. *Id.*

171. *Id.* at 964-65.

The physician claimed her rights under the First Amendment, and the corresponding California provision,[172] exempted her from compliance with the antidiscrimination provisions of California's Unruh Civil Rights Act,[173] which prohibits discrimination based on a person's sexual orientation.[174] Citing federal precedent, the court held "the First Amendment's right to the free exercise of religion does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)."[175] Thus, the case was remanded for trial.[176] It does not appear that adding a statutory right of refusal through enactment of a conscience clause would alter this result.

Thus, just as there is a tension between affording confidentiality to the minor patient and parental rights, there is a tension between providing reproductive services demanded by the public and a medical professional's exercise of personal conscience. Senate Bill 2394 does not alter the arguments and issues that stem from North Dakota's conscience clause relating to abortion.

VII. MINORS AND REPRODUCTIVE RIGHTS UNDER THE LAW AND CONSTITUTION

Most of the legislative and court activity regarding minor consent to treatment involves reproductive rights. A majority of states have enacted legislation affording minors the right to consent to reproductive services.[177] While some states have invalidated parental notice statutes on state constitutional grounds,[178] this avenue is less promising in North Dakota because

172. *Id.* at 966-69. The relevant section of California's Constitution provides, "Free exercise and enjoyment of religion without discrimination or preference are guaranteed." CAL. CONST. art. I, § 4.

173. *North Coast*, 189 P.3d at 968 (citing CAL. CIV. CODE § 51 (Deering 2005 & Supp. 2010)).

174. *Id.* at 965.

175. *Id.* at 966 (citing Emp't Div., Ore. Dep't of Human Res. v. Smith, 494 U.S. 872, 879 (1990); Church of Lukumi Babalu Aye, Inc. v. Hialeah, 508 U.S. 520, 531 (1993) ("a law that is neutral and of general applicability need not be justified by a compelling governmental interest even if the law has the incidental effect of burdening a particular religious practice."). Thus, the court concluded, "under the United States Supreme Court's most recent holdings, a religious objector has *no federal constitutional right* to an exemption from a neutral and valid law of general applicability on the ground that compliance with that law is contrary to the objector's religious beliefs." *North Coast*, 189 P.3d at 966.

176. *Id.* at 970.

177. *See generally* DALE ET AL., *supra* note 12, § 3.02(c)(i) (discussing minor consent); ROZOVSKY, *supra* note 12, § 5.02, 5.03 (discussing minor consent).

178. This argument has the most strength when the state constitution recognizes a right to privacy; ten states have such provisions. ALASKA CONST. art. I, § 22; ARIZ. CONST. art. II, § 8; CAL. CONST. art. I, § 1; FLA. CONST. art. I, § 12; HAW. CONST. art. I, §§ 6, 7; ILL. CONST. art. I,

the legislature and North Dakota Supreme Court take a paternalistic view in resolving a potential conflict between parental rights and a minor's privacy rights.[179] Therefore, this section of the article primarily discusses a minor's

§§ 6, 12; LA. CONST. art. I, § 5; MONT. CONST. art. II, § 10; S.C. CONST. art. I, § 10; WASH. CONST. art. I, § 7. California and Florida courts have cited the explicit recognition of the right to privacy as grounds for protecting a minor's right to consent. *See* Am. Acad. of Pediatrics v. Lungren, 940 P.2d 797, 807-08 (Cal. 1997) (noting the California Constitution contains an explicit guarantee to the right of privacy, the court struck down as unconstitutional California's parental consent law, which prohibits abortions for minors without either the consent of one parent or judicial authorization, concluding the judicial bypass did not save the law); Am. Acad. of Pediatrics v. Van De Kamp, 263 Cal. Rptr. 46, 53-55 (Cal. Ct. App. 1989) (enjoining enforcement of California's statute imposing criminal penalties upon persons performing abortions on unemancipated minors without parental consent, based on the state constitutional right to privacy); N. Fla. Women's Health & Counseling Servs., Inc. v. State, 866 So.2d 612, 619-21 (Fla. 2003) (noting the state constitution includes an independent "freestanding Right of Privacy Clause" that protects minors as well as adults, holding the Parental Consent Act imposed a significant restriction on this right, and concluding the state failed to prove the Parental Consent Act furthered a "compelling State interest"). Tennessee has done so under a more general theory. *See* Davis v. Davis, 842 S.W.2d 588, 600-01 (Tenn. 1992) (holding, under the Tennessee Constitution, the right of procreation is "a vital part of an individual's right to privacy," and "a right to procreational autonomy is inherent in our most basic concepts of liberty," which had previously been applied to minors in decisions involving abortion) (citations omitted). Alaska has also taken a broad view of its state's constitutional right to privacy, held by the Alaska Supreme Court to provide more protection than its federal counterpart. *See* Valley Hosp. Ass'n v. Mat-Su Coal. for Choice, 948 P.2d 963, 967-68 (Alaska 1997). Montana also appears to be a likely candidate to extend privacy rights to minors insofar as they make decisions relating to procreation; Montana's Supreme Court noted, "Montana adheres to one of the most stringent protections of its citizens' right to privacy in the United States—exceeding even that provided by the federal constitution." Armstrong v. State, 989 P.2d 364, 373-74 (Mont. 1999).

179. The tension between a minor's privacy rights and parental rights in determining which party has the right to consent to the minor's medical care is undeniable. As noted above, the North Dakota legislature twice defeated minor consent legislation for pregnancy-related care. *See supra* note 3 and accompanying text. Additionally, in contrast to little or no discussion about minor privacy rights, the North Dakota Supreme Court has eloquently expounded the importance of parental rights, stating:

> The rights to conceive and to raise one's children have been deemed essential, basic civil rights of man, and rights far more precious than property rights. It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder. The Due Process Clause provides heightened protection against government interference with certain fundamental rights and liberty interests including the right to direct the education and upbringing of one's children. Choices about marriage, family life, and the upbringing of children are among associational rights sheltered by the Fourteenth Amendment against the State's unwarranted usurpation, disregard, or disrespect. Absent a powerful countervailing interest, a parent's desire for and right to the companionship, care, custody and management of his or her children is an important interest that warrants deference and protection. The history and culture of Western civilization reflect a strong tradition of parental concern for the nature and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition. The liberty guaranteed by the Fourteenth Amendment to the United States Constitution includes the right of the individual to marry, establish a home and bring up children, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men.

Hoff v. Berg, 1999 ND 115, ¶ 8, 595 N.W.2d 285, 288 (citations and internal punctuation omitted). The North Dakota Supreme Court has "often recognized that our North Dakota

rights under the United States Constitution.[180] The U.S. Supreme Court has stated, "If the right of privacy means anything, it is the right of the individual, married or single, to be free of unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[181] Minors, as well as adults, are protected by the Constitution,[182] including the constitutional right to privacy in connection with decisions relating to procreation.[183] Accordingly, legislative enactments are interpreted in light of this crucial constitutional interest.

In brief, although the courts reason the right of privacy regarding this most intimate and essential matter must extend to minors,[184] states may treat minors differently from adults.[185] First, states have a "strong and legitimate interest" in the welfare of its youth, whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights fully.[186] Thus, there is "little doubt" the state has a legitimate interest in encouraging an unmarried minor to seek parental assistance and

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Constitution may afford broader rights than those granted under an equivalent provision of the federal constitution." *In re* K.A.S., 499 N.W.2d 558, 563 (N.D. 1993). Additionally, the court has noted "it is within our power to apply higher constitutional standards than are required of the States by the Federal Constitution." State v. Klodt, 298 N.W.2d 783, 786 (N.D. 1980). However, other than the protection accorded against unreasonable searches and seizures, provided in article I, section 8 of the North Dakota Constitution, "no statutory or constitutional right of privacy . . . has as yet been recognized under the North Dakota Constitution." City of Grand Forks v. Grand Forks Herald, Inc., 307 N.W.2d 572, 579 (N.D. 1981).

180. Under the U.S. Constitution, the right to privacy stems from the concept of liberty bestowed by the Fourteenth Amendment: "No State shall . . . deprive any person of life, liberty, or property, without due process of law . . . ." U.S. CONST. amend. XIV. The U.S. Supreme Court held "the concept of liberty protects those personal rights that are fundamental," such as the right to privacy, "and is not confined to the specific terms of the Bill of Rights." Griswold v. Connecticut, 381 U.S. 479, 486 (1965) (Goldberg, J., concurring). Included in the federal right to privacy is the right of reproductive freedom. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

181. Carey v. Population Servs. Int'l, 431 U.S. 678, 685 (1977) (quoting *Eisenstadt*, 405 U.S. at 453).

182. *Id.* at 692.

183. *Id.* at 693-94 (citing Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74-75 (1976)).

184. Hodgson v. Minnesota, 497 U.S. 417, 434 (1990) (citing Bellotti v. Baird (*Bellotti II*), 443 U.S. 622, 642 (1979)). In *Bellotti II*, the Court stated:

> [T]he potentially severe detriment facing a pregnant woman, is not mitigated by her minority. Indeed, considering her probable education, employment skills, financial resources, and emotional maturity, unwanted motherhood may be exceptionally burdensome for a minor. In addition, the fact of having a child brings with it adult legal responsibility, for parenthood, like attainment of the age of majority, is one of the traditional criteria for the termination of the legal disabilities of minority. In sum, there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible.

Bellotti II, 443 U.S. at 642 (citation omitted).

185. *See generally* ROZOVSKY, *supra* note 12, § 5.03(B)(1) (discussing the right to contraceptives).

186. *Hodgson*, 497 U.S. at 434 (citing *Bellotti II*, 443 U.S. at 634-39).

guidance in making crucial decisions involving procreation.[187] As a counterpart to the responsibilities they have assumed, "[p]arents have an interest in controlling the education and upbringing of their children."[188] Though "biological parentage generally offers a person only an opportunity . . . to develop a relationship with his offspring," the "demonstration of commitment to the child through the assumption of personal, financial, or custodial responsibility may give the natural parent a stake in the relationship with the child rising to the level of a liberty interest."[189] "The family has a privacy interest in the upbringing and education of children . . . which is protected by the Constitution against undue state interference."[190] Unlike legislation affecting adults, in which a state must show a *compelling* state interest to regulate matters that touch upon the right to privacy,[191] laws restricting a minor's right of privacy must demonstrate only a "*significant* state interest."[192]

187. *Id.* at 445 (citation omitted).

188. *Id.* (citations omitted).

189. *Id.* at 446 (citations omitted).

190. *Id.* (citations omitted).

191. For example, many states have enacted legislation imposing ultrasound requirements, "abortion counseling," waiting periods, and the like. *See, e.g.*, OKLA. STAT. tit. 63, § 1-738.3d (2008). *See generally* Emily Bazelon, *Required Viewing: Oklahoma's Gallingly Paternalistic Ultrasound Law*, SLATE (Oct. 22, 2008, 6:30 AM), http://www.slate.com/id/2202765/. The Guttmacher Institute has compiled a list of states that require counseling and/or waiting periods before an abortion may be performed. *See State Policies in Brief: Counseling and Waiting Periods for Abortion*, GUTTMACHER INSTITUTE (Nov. 1, 2010), http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf. North Dakota's 2009 Legislative Assembly amended N.D.C.C. section 14-02.1-04, creating a new subsection, that provides:

> An abortion facility may not perform an abortion on a woman without first offering the woman an opportunity to receive and view at the abortion facility or another facility an active ultrasound of her fetus. The offer and opportunity to receive and view an ultrasound must occur at least twenty-four hours before the abortion is scheduled to be performed. The active ultrasound image must be of a quality consistent with standard medical practice in the community, contain the dimensions of the fetus, and accurately portray the presence of external members and internal organs, including the heartbeat, if present or viewable, of the fetus. The auscultation of the fetal heart tone must be of a quality consistent with standard medical practice in the community. The abortion facility shall document the woman's response to the offer, including the date and time of the offer and the woman's signature attesting to her informed decision.

N.D. CENT. CODE § 14-02.1-04(4) (2009). In a recent opinion, Judge Herman ruled the ultrasound requirement simply requires the facility providing abortion services to provide information about where a pregnant woman can receive the ultrasound and does not require it to purchase the equipment and itself offer the service. MKB Mgmt. Corp. v. Stenehjem, No. 09-09-C-02839 (Cass Co. Dist. Ct. N.D., August 11, 2009). Moreover, the statute does not require a woman to view an ultrasound and listen to the fetal heartbeat, but is intended to provide her with more information. *Id.* Thus, the statute does not place an undue burden on a woman's constitutional rights. *Id.*

192. Carey v. Population Svcs. Int'l, 431 U.S. 678, 693 (1977) ("State restrictions inhibiting privacy rights of minors are valid only if they serve 'any significant state interest . . . that is not present in the case of an adult.'" (citation omitted)).

A. STD'S AND MENTAL HEALTH SERVICES

Minors are most likely to request medical confidentiality regarding private matters, such as sex or mental health matters, including substance abuse. In this regard, North Dakota law provides that any person fourteen years of age or older "may contract for and receive examination, care, or treatment for sexually transmitted disease, alcoholism, or drug abuse without permission, authority, or consent of a parent or guardian."[193] Most states allow minors to consent to such treatment on the theory that minors might not otherwise seek treatment.[194] Moreover, many states have enacted laws protecting minor confidentiality when they seek a wide variety of other mental health services.[195]

B. CONTRACEPTIVES

The general constitutional issues regarding provision of contraceptives and abortion are similar. North Dakota, however, has a detailed scheme governing parental notification in cases where minors seek an abortion. Yet, the state does not specifically address a minor's ability to consent in the case of contraceptives.

1. *Parental Consent*

North Dakota is in the minority, as most states have enacted specific legislation governing minors' rights to access contraceptives.[196] Accordingly, the general parental consent requirements under N.D.C.C. section 23-12-13 apply, tempered by constitutional considerations. In *Carey v. Population Services International*,[197] the United States Supreme Court held that although the Constitution does not protect a fundamental right of access to contraceptives, it does protect individual decisions in matters of childbearing from unjustified intrusion by the state.[198] The *Carey* Court struck down as unconstitutional a New York scheme that only permitted distribution of contraceptives to minors in the case of medical necessity because the law impermissibly "burden[ed] the right to decide whether to bear

193. N.D. CENT. CODE § 14-10-17 (2009).

194. *See* ROZOVSKY, *supra* note 12, § 5.04, at 5-58 to 5-60.

195. *See id.* § 5.05, at 5-60 to 5-76.6.

196. *See* ROZOVSKY, *supra* note 12, § 5.03(B)(3), at 5-36.2 (discussing contraceptive legislation for minors); Danielle M. Costello, *The Right to Make Informed Reproductive-Health-Care Decisions Regardless of Age: Maintaining the Focus on the "I" in "I Want to be One Less*," 8 WISC. L. REV. 987, 1000 (2008) (noting that twenty-one states and the District of Columbia explicitly allow minors to consent to contraceptive services without parental notification).

197. 431 U.S. 678 (1977).

198. *Carey*, 431 U.S. at 687-89.

children."[199] Citing its *Danforth* decision, which recognized the state does not have the constitutional authority to give a third party an absolute veto over an abortion, the *Carey* Court held a blanket provision requiring the consent of parents as a condition for abortion of an unmarried minor unconstitutional:

> Since the 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 contraceptives to minors is a *fortiori* foreclosed. The State's interest in protection of the mental and physical health of the pregnant minor, and in protection of potential life *are clearly more implicated by the abortion decision* than by the decision to use a nonhazardous contraceptive.[200]

An individual's right of privacy does not preclude all state limitations. To reiterate, states may impose more stringent requirements on minors than adults; in the case of adults, the state interest must be *compelling,* and in the case of minors, the state interest must be *significant*. The *Carey* Court found no significant state interest because there "was no medical necessity [asserted by the state] for imposing a medical limitation on the distribution of nonprescription contraceptives to minors."[201] The Court barred delegation of the state's authority to disapprove of minors' sexual behavior to physicians "who may exercise it arbitrarily, either to deny contraceptives to young people, or to undermine the State's policy of discouraging illicit early sexual behavior."[202] The Court noted there are no medical judgments involved in the physician's decision about contraceptives, only "*moral* counseling that can reflect little other than their private views on the morality of premarital sex among the young."[203] *Carey* appears to require a judicial bypass mechanism for minors "sufficiently mature and well-informed" to access contraceptives based on their own consent, but it doesn't address the issue regarding parental notice.

2. *Parental Notification*

Although courts appear to prohibit blanket prohibitions on minor access to contraceptives—judicial bypass of parental consent requirements

199. *Id.* at 697.

200. *Id.* at 694 (emphasis added). In the matter of contraception, state interests to be served by parental notification are not as strong in the abortion issue; nevertheless, narrowly drawn notice provisions are generally upheld. ROZOVSKY, *supra* note 12, § 5.03(B)(2).

201. *Carey*, 431 U.S. at 697.

202. *Id.* at 699.

203. *Id.* at 699 n.24.

must be available—there is no clear rule regarding the closely-related issue of parental notification. Arguably, when minors are treated as though they were adults for purposes of consent, there should be no disclosure to parents. Confidentiality of care is a basic ethical precept and essential to the physician-patient relationship; in the absence of statutory authority, it should not be abridged.[204]

Parental notification without the minor's consent creates ethical and constitutional dilemmas. A minor's right to privacy and the ethical issue of patient confidentiality, which is essential to a bond between physician and patient, are in tension with parental rights and policy arguments that favor parental notification. Parental involvement is normally beneficial to the minor because it ensures both that the parents have an opportunity to provide the physician with the minor's medical history and that minors receive appropriate follow-up care.[205]

In the case of contraceptives, North Dakota law does not provide an answer to the dilemma; physicians must simultaneously balance protecting confidentiality and fostering the physician-patient relationship with concerns for the patient's health—that is, the benefit to a minor patient's health is normally enhanced by parental involvement. Although the courts have noted that in the matter of contraceptives, the state interests to be served by requiring parental notification are not as strong as in the case of abortion,[206] the legislature's resolution of this issue in the context of an abortion may provide useful guidance regarding the physician's obligation to safeguard the minor's privacy rights when providing contraceptives or prenatal care. In the case of abortion, North Dakota law[207] allows a minor to bypass parental notice and consent requirements, provided that she establishes to the court's satisfaction that: (1) she is sufficiently mature and well-informed to make her decision without parental advice and counsel; *or* (2) notwithstanding that the minor is immature or uninformed, the best interests of the minor require confidentiality.[208]

A 2007 case, *Anspach v. City of Philadelphia, Department of Public Health*,[209] provides insight into the general issue surrounding a minor's access to contraceptives, but from the perspective of the *parent's* constitutional rights.[210] A sixteen-year-old, having recently engaged in sexual

204. ROZOVSKY, *supra* note 12, § 5.02(A)(4), at 5-20.1.
205. *Id.* §§ 5.02(A)(4), 5.03(B)(2), at 5-20.1, 5-36.1.
206. *Carey*, 431 U.S. at 694.
207. *See* N.D. CENT CODE § 14-02.1-03.1(2), (5) (2009).
208. *Id.*
209. 503 F.3d 256 (3d Cir. 2007).
210. *Anspach*, 503 F.3d at 262-65.

intercourse, feared she might be pregnant.[211] The minor consulted a medical center and requested a pregnancy test.[212] After being advised pregnancy tests were not being administered that day, she left the facility.[213] She returned shortly thereafter, having been prompted by a friend to ask for the morning-after pill.[214] She spoke with a social worker and a registered nurse about the medication that could prevent pregnancy, and she took the medication as directed.[215] The minor became ill after the second dose and was taken by her father to the emergency room of a nearby hospital.[216]

The parents and minor subsequently filed a lawsuit, asserting a number of claims under state and federal law.[217] The trial court dismissed the federal claims, concluding the parents did not have a constitutional right to notification of a minor's exercise of her reproductive privacy rights.[218] Although the Due Process Clause of the Fourteenth Amendment "protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children," the right is not absolute.[219] Parental interests must be balanced with the child's right to privacy. Moreover, "Courts have recognized the parental liberty interest only where the behavior of the state actor compelled interference in the parent-child relationship."[220]

The parents also argued Pennsylvania law prohibits minors from consenting to any form of treatment unspecified in the Act.[221] The court noted this argument "ignores the well-accepted principle that duties under state law cannot create constitutional rights[,]" thus, state "statutes remain subject to constitutional limitations, including the minor's own privacy rights as well as the state's legitimate interest in the reproductive health of minors."[222] Furthermore, even if such a claim were valid, the plaintiffs had misconstrued state law because the state's Minor's Consent Act "specifically permits minors to 'give effective consent for medical and health services to determine the presence of or treat pregnancy . . . and the consent

211. *Id.* at 259.
212. *Id.*
213. *Id.*
214. *Id.*
215. *Id.*
216. *Id.* at 259-60.
217. *Id.* at 260.
218. *Id.* at 262-64.
219. *Id.* at 262 (citations omitted).
220. *Id.* The court noted, "The real problem alleged by Plaintiffs is not that the state actors *interfered* with the Anspachs as parents; rather, it is that the state actors did not *assist* the Anspachs as parents or affirmatively *foster* the parent/child relationship." *Id.* at 266.
221. *Id.* at 269.
222. *Id.*

of no other person shall be necessary.'"[223] The *Anspach* court distinguished U.S. Supreme Court rulings with respect to notification and abortion, rejecting the claim that parental consent is required unless a court allows the minor to "bypass" the parents.[224] First, the court noted those cases "concern the constitutional limitations on a state to interfere with a minor's right to abortion, rather than a parent's affirmative right to be apprised of a minor's reproductive decisions generally."[225] Second, the *Anspach* court said the case law did not create a constitutional right of parental notification about an abortion, or any other reproductive health decision, but "merely find[s] such notification constitutionally permissible when paired with a judicial bypass provision to protect the minor's health and safety."[226]

The courts, however, have not directly addressed what may be a plausible state interest in requiring parental notification. Professor Rozovsky argues notification of the parents is medically necessary to obtain a good medical history from the parents:

> Perhaps the most interesting medicolegal argument that would have significant weight is the opportunity for parents to provide the minor's physician with essential medical and related information. A minor may not be fully aware of a familial history that makes certain contraceptive medication contraindicated and dangerous. The minor may also have emotional difficulties about which the physician is not aware. Without these types of information the physician may treat a patient without the proper background necessary to recommend a specific form of contraception. This dilemma underlines the tension between the minor's right of privacy and the physician's need for sufficient information. If a minor subsequently suffered an injury due to prescribed contraceptive medication, the physician might be sued for negligent treatment. Such a lawsuit could be successful if the physician had failed to obtain sufficient information on which to base treatment.
>
> The fact that the physician respected the minor's right of privacy and did not contact her parents for further information would *not be* an adequate defense. The right of privacy has nothing to do with an appropriate medical standard of care in the circumstances. When physicians are faced with minor patients about whom they do not have sufficient information, they should refrain from

223. *Id.* (citing 35 PA. CONS. STAT. § 10103 (1970)).
224. *Id.* at 270.
225. *Id.*
226. *Id.*

> dispensing contraceptives known to have dangerous side effects or risks. If a minor is unable to provide the necessary background information, a physician should obtain it from the patient's guardian or parents. Absent statutory law to the contrary, a physician should first seek a minor's consent to consult with her parents. Should the minor refuse permission, the physician should withhold prescribing any medication, turning instead to other contraceptive methods. The minor's reluctance to involve her parents and the physician's respect for the patient's constitutional right of privacy do not justify a departure from accepted standards of practice.[227]

In sum, a blanket prohibition on the ability of a minor to provide legal *consent* to obtain contraceptives without judicial bypass is not likely to pass a constitutional challenge. Additionally, it is clear parental notification statutes are permissible if they provide the appropriate judicial bypass based upon recognized exceptions for a minor's maturity level or best interests.[228] Finally, Rozovsky's argument that medical necessity justifies obtaining the minor's, and potentially familial, medical history from the parents sets out a significant state interest that might justify parental notification statutes even without judicial bypass.[229]

3. *Minor Consent under Federal Law—Family Planning Services Act Title X*

As physicians practicing in this area are aware, there is a line of cases—including in the Eighth Circuit—establishing state parental consent requirements may not be applied to family planning services provided with funds under Title X of the federal Public Health Service Act, which preempts state law.[230] Addressing the concern of physicians that common law tort principles would subject the physician to liability for providing family planning services without parental consent, a federal court said:

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227. ROZOVSKY, *supra* note 12, § 5.03(B)(2), at 5-36.2 (emphasis added).

228. For example, in *Planned Parenthood Ass'n of Utah v. Matheson*, a federal district court invalidated a state law requiring, in all cases, parental *notification* prior to a minor's receiving contraceptives. 582 F. Supp. 1001, 1009 (D. Utah 1983). The court indicated the Utah law failed because it did not provide a mechanism for mature minors, or one for immature minors for whom parental notification was not in their best interests, to obtain contraceptives confidentially. *Id.*

229. Because the courts have not yet determined whether judicial bypass is required for mature minors in abortion cases, the case of contraceptives is even more difficult to predict. This difficulty, of course, flows from the observation that states have a greater interest in regulating abortion than they do in regulating contraceptives.

230. County of St. Charles, Mo. v. Mo. Family Health Council, 107 F.3d 682, 683 (8th Cir. 1997); *see generally* Planned Parenthood Fed'n of Am. v. Heckler, 712 F.2d 650 (D.C. Cir. 1983); Planned Parenthood Ass'n of Utah v. Matheson, 582 F. Supp. 1001 (D. Utah 1983); Doe v. Pickett, 480 F. Supp. 1218 (S.D. W. Va. 1979); T.H. v. Jones, 425 F. Supp. 873 (D. Utah 1975).

> [T]he reluctance of a physician or other service provider [to provide family planning services in the absence of parental consent] is misplaced. There can be no imposition of common law tort liability and especially when the relationship between a physician and a minor patient is protected as a constitutional privacy right.[231]

C. ABORTION: NOTICE AND CONSENT REQUIREMENTS

The constitutional arguments relating to contraceptives are also largely applicable to abortion. North Dakota's Abortion Control Act (ACA)[232] was enacted in light of constitutional norms imposed by the courts. The ACA, therefore, answers the questions regarding parental notification. Senate Bill 2394 is not an "abortion bill" and does not supplement or alter the physician's obligations under the Act to seek parental consent—which obviously means the parents have notice—or ascertain that the minor has obtained an order from the juvenile court for an abortion. The North Dakota Medical Association has long opined the physician's obligation to follow the procedures in the ACA extends to the situation where a prescription for contraceptives terminates pregnancy, rather than prevents pregnancy.[233]

North Dakota law provides a court may authorize an abortion without parental notice or consent if the minor is both "sufficiently mature" and "well-informed with regard to the nature, effects, and possible consequences of both having an abortion and bearing her child . . . ."[234] The law governing provision of abortion services is complex, requiring resolution of the potential conflict between the minor's privacy rights and the parent's

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231. *Doe,* 480 F. Supp. at 1223.

232. N.D. CENT. CODE ch. 14-02.1 (2009).

233. Letter from Bruce Levi, Exec. Dir., N.D. Med. Ass'n, to Dr. Robert E. Grossman, W. River Health Clinics (May 23, 1997) (on file with the N.D. Med. Ass'n); Letter from Murray Sagsveen to Vernon E. Wagner (Nov. 26, 1991). This conclusion follows from the broad definition of abortion, which North Dakota defines as "the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead embryo or fetus." § 14-02.1-02(1). But courts may not give such a broad reading to the statutory definition. In 1994, plaintiffs challenged the definition of "abortion" as unconstitutionally void for vagueness, arguing the definition would subject certain medical procedures such as amniocentesis to the abortion law because those procedures could result in termination of the pregnancy as a consequence. Fargo Women's Health Org. v. Schafer, 18 F.3d 526, 535-36 (8th Cir. 1994). The court rejected the argument as "unduly strained," taking instead a "common sense interpretation" of the statute, concluding that "physicians are fully capable of understanding the . . . [law's] requirements and prohibitions." *Id.* at 535. While the Eighth Circuit's interpretation of the term "abortion" in *Fargo Women's Health* seems to indicate courts may construe that definition narrowly, the scope of the definition and its application to birth control medication or devices is not fully resolved. Because the Abortion Control Act provides both criminal and civil penalties for performance of an abortion without informed consent—including $10,000 in punitive damages and treble actual damages—a prudent physician must be aware of the potential a birth control medication, or device that *terminates* pregnancy, may meet the definition of "abortion" in chapter 14-02.1. *See* § 14-02.1-03.2.

234. § 14-02.1-03.1(2)(a).

constitutional right to make decisions concerning the care, custody, and control of their children. These competing interests and concerns are the genesis for the proposition that states must create a judicial bypass mechanism to parental consent; indeed, much of the litigation concerning a minor's rights and abortion relate to the sufficiency of the bypass.

For a parental consent statute to be constitutional it must contain a bypass procedure that meets four criteria; it must:

> (1) allow the minor to bypass the consent requirement if she establishes that she is mature enough and well enough informed to make the abortion decision independently; (2) allow the minor to bypass the consent requirement if she establishes that the abortion would be in her best interests; (3) ensure the minor's anonymity; and (4) provide for expeditious bypass procedures.[235]

In contrast to parental consent requirements, the U.S. Supreme Court has upheld a parental notification statute, but the Court limited its holding to the particular circumstance of a minor: (a) living with and dependent upon her parents; (b) not emancipated by marriage or otherwise; and, (c) who made no claim or showing as to her maturity or as to her relations with her parents.[236] The Court noted it could not assume that parental notification statutes, when applied to mature minors, would be constitutionally sound.[237] In *Hodgson v. Minnesota*,[238] a five justice majority held Minnesota's two-parent notice requirement, without judicial bypass, was unconstitutional.[239] But, a different five justice majority, with Justice O'Connor joining the majority in each instance, found the constitutional infirmities were eliminated by the statutory inclusion of a judicial bypass procedure.[240]

In *Ohio v. Akron Center for Reproductive Health*,[241] the U.S. Supreme Court reviewed an Ohio statute that made it a crime for a physician to perform an abortion on an unmarried, unemancipated minor, except where there was actual notice to one of the minor's parents or guardians or where the abortion was done in compliance with a judicial bypass procedure.[242] The Court focused on the adequacy of Ohio's judicial bypass procedure and

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235. Lambert v. Wicklund, 520 U.S. 292, 295 (1997) (citing *Bellotti II*, 443 U.S. 622, 643-44 (1979)); Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 511-13 (1990).

236. H.L. v. Matheson, 450 U.S. 398, 407 (1981).

237. *Id.* at 406-07.

238. 497 U.S. 417 (1990).

239. *Hodgson*, 497 U.S. at 437-58.

240. *Id.* at 458-61.

241. 497 U.S. 502 (1990).

242. *Akron Ctr. for Reprod. Health*, 497 U.S. at 507-08.

reiterated its earlier holdings requiring a judicial bypass procedure for parental consent statutes but left open the question of whether due process requires parental notice statutes to contain judicial bypass procedures.[243] Regarding the sufficiency of such judicial bypass to parental notice, it may be enough to note it is a corollary to the greater intrusiveness of consent statutes that a bypass procedure that will suffice for a consent statute will suffice for a notice statute. While the constitutional issue of whether a notice statute must contain a judicial bypass remains unresolved, North Dakota's ACA contains such a bypass mechanism.[244]

Closely related is the issue of whether creation of a judicial bypass is sufficient in itself to ensure the constitutionality of parental consent statutes. The Supreme Court of Alaska has held it is not. The court concluded judicial bypass is not a sufficient safeguard to the minors' privacy rights because the least restrictive alternative is parental notice with judicial bypass, not parental consent with judicial bypass.[245] The court noted the Alaska Constitution's privacy protections are greater than those afforded under the United States Constitution,[246] holding although the state admittedly has a compelling interest in protecting minors by involving parents in such crucial decisions,[247] the legislature had not chosen the least restrictive means.[248]

The court explained the Alaska scheme provides parents a "veto power" over a minor's abortion decisions, and the court's review of statutory schemes around the nation revealed a less restrictive alternative: parental notification.[249] The court commented judicial bypass does not sufficiently "*relieve* [the minor] *of the burden of parental consent*," noting "bypass procedures build in delay that may prove 'detrimental to the physical health of the minor,' particularly for minors in rural Alaska who

243. *Id.* at 510 ("In analyzing this aspect of the dispute, we note that, although our cases have required bypass procedures for parental consent statutes, we have not decided whether parental notice statutes must contain such procedures.").

244. N.D. CENT. CODE ch. 14-02.1 to -03.1 (2009).

245. State v. Planned Parenthood of Alaska, 171 P.3d 577, 585 (Alaska 2007).

246. *Id.* at 581 (citing ALASKA CONST. art. I, § 22, concluding that "its protections [explicitly protecting privacy] are necessarily more robust and 'broader in scope' than those of the implied federal right to privacy").

247. *Id.* at 582 n.29. The court agreed the state's interests were compelling, with the statute aiming to: "(1) ensure that minors make an informed decision on whether to terminate a pregnancy; (2) protect minors from their own immaturity; (3) protect minors' physical and psychological health; (4) protect minors from sexual abuse; and (5) strengthen the parent-child relationship." *Id.*

248. *Id.* at 583-85.

249. *Id.* at 583. The court noted fifteen states have parental notification statutes that simply require parental notification, which is sufficient to allow parents to "actively involve themselves in their minor children's decision-making processes . . . to consult with and guide their daughters through this important decision." *Id.* at 583-84.

'already face logistical obstacles to obtaining an abortion.'"[250] According to the court, Alaska's judicial bypass "will increase these problems, delay the abortion, and increase the probability that the minor may not be able to receive a safe and legal abortion."[251] Moreover, the court concluded, "the inclusion of this judicial bypass procedure does not reduce the restrictiveness of [the Act] relative to a parental notification statute," noting every state to enact a parental notification statute did so in lieu of a consent statute—that is, the notice statutes also provide a form of a judicial bypass procedure.[252] North Dakota courts are not likely to invalidate the State's ACA on such grounds, in light of the fact North Dakota's Constitution—unlike the Alaska Constitution, but like the federal Constitution—does not contain an explicit guarantee of privacy.

Finally, there remains the practical issue regarding the potential tension between medical ethics—the protection of patient confidentiality—and the law. Therefore, while general ethical principles suggest physicians will normally encourage minors to involve their parents, N.D.C.C. section 14-10-19(2) requires this discussion take place in the context of prenatal care.[253] Considering North Dakota law and constitutional requirements, unless the patient agrees, a physician should not notify the parents that the minor patient has sought contraceptives or medical services related to her pregnancy. In order to ensure both continuity of care and facial compliance with the legal requirements in the statute, physicians should establish a referral system so the care of the minor patient objecting to disclosure may be readily transferred to another physician. Regarding abortion, North Dakota does not allow parental notification over a minor's objection unless

250. *Id.* at 584.

251. *Id.*

252. *Id.* The court, holding the state failed to establish that the greater intrusiveness of the consent statute—than that of a notice statute—is necessary to advance its compelling interests, noted the state had not focused on the benefit of parental consent, but rather on the benefit of parental notice: "[I]t has consistently suggested that [the Act's] benefits flow from increased parental communication and involvement in the decision-making process." *Id.* The state eloquently stated this important interest:

> [The Act] protects minors from their own immaturity by increasing "adult supervision"; it protects the physical, emotional, and psychological health of minors, "[p]articularly in the post-abortion context, [by increasing] parental participation . . . for the purposes of monitoring . . . risks"; it ensures that minors give informed consent to the abortion procedure by making it more likely that they will receive "counsel that a doctor cannot give, advice, adapted to her unique family situation, that covers the moral, social and religious aspects of the abortion decision"; it protects minors from sexual abuse since "once appr[]ised of a young girl's pregnancy, parents . . . will ask who impregnated her and will report any sexual abuse"; and it strengthens the parent-child relationship by "increase[ing] parental involvement," "parental consultation," and open and honest communication.

Id.

253. N.D. CENT. CODE § 14-10-19(1)(a) (2009).

the juvenile court finds the minor is not sufficiently mature and well-informed to make her decision alone *and* that parental notice is in the minor's best interest.[254]

D. N.D.C.C. SECTION 14-10-19 DOES NOT RESOLVE THE CONSTITUTIONAL ISSUES CONCERNING MINOR CONSENT FOR PRENATAL CARE

Some providers believe North Dakota's parental consent statutes may unconstitutionally interfere with the minor's privacy rights. North Dakota law, however, was susceptible to challenge on this ground prior to the Legislative Assembly's enactment of N.D.C.C. section 14-10-19. The statute does not alter parental consent requirements; it expands the circumstances under which a physician may provide care based on minor consent.[255] If a physician does not refer a minor patient after the first trimester, and one care visit during the second or third trimester, the statute requires parental notification.[256] While the care limitation based on the minor's own consent might conflict with the patient's constitutional rights, current law already conditions treatment on parental notice; therefore, the constitutional issue exists without regard to the legislature's enactment of N.D.C.C. section 14-10-19. Moreover, whether the Constitution requires a minor have an option to obtain a judicial bypass of parental notice requirements for prenatal care remains an open issue even after the enactment of N.D.C.C. section 14-10-19. Finally, the statute authorizes a physician to notify parents "of any pregnancy care services given or needed if the physician . . . discusses with the minor the reasons for informing the parent . . ." if in the judgment of the physician the "failure to inform the parent . . . would seriously jeopardize the health of the minor of her unborn child; [s]urgery or hospitalization is needed; or [i]nforming the parent . . . would benefit the health of the minor or her unborn child."[257] This is consistent with regulations under HIPAA, which preempts state law in circumstances where the minor may be endangered by parental notification.[258]

254. *Id.*
255. *Id.* § 14-10-19.
256. *Id.*
257. *Id.*
258. 45 C.F.R. § 164.502(g)(5)(i)(B) (2002).

VIII. CONCLUSION

While medical practice is integrally entwined with ethics, economics, and the social and political lives of our society, the day-to-day care of patients weighs heavily on the physician in terms of time and attention. The medical profession is at the center of the health care industry, commanding research, educating students, directing other professionals, managing programs—such as the advancing Comparative Effectiveness regime[259]—running medical facilities, and caring for patients. Physician decisions—overseen perhaps by insurance coverage—determine outcomes, costs, and patient satisfaction. The demand on the practicing physician to shuffle paperwork[260] is perhaps outweighed by the rewards, in which, traditionally, the physician-patient bond is valued and considered as sacrosanct as that between parishioner and priest. Just as these basic facts are often overlooked in the hurly burly of daily life, so too the primary focus here is much narrower, attempting to show the competing interests when the patient is a minor who consults the physician about her pregnancy.

Patients have an expectation of absolute trust and confidentiality. Were it not so, a patient may not fully disclose sensitive history, which could result in misdiagnosis and great harm to the patient. Nurturing and protecting this bond is critical, but competing values come into play when the patient is a minor, where the normal assumption is that failure to involve the parents is potentially harmful to the minor patient. This careful balancing act is most difficult in the case of the minor's reproductive health, where the minor's constitutional expectation of privacy is the greatest.

Your experience with your fifteen-year-old patient has re-confirmed this: your care, comfort, and compassion; your attention to her physical, mental, and emotional needs; and your inquiry and insight into her family dynamics calmed her and gave her optimism that she could broach the subject with her parents. Not all experiences will be quite as successful in

259. The Institute of Medicine of the National Academies issued a report entitled, *Initial National Priorities for Comparative Effectiveness Research*, on June 30, 2009. *See generally* http://www.iom.edu/CMS/3809/63608/71025.aspx (indicating Comparative Effectiveness Research (CER) is "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels"). *Id.* (emphasis omitted).

260. Greater time spent on administrative tasks has been shown to be associated with low physician job satisfaction independent of compensation, financial incentives, and care management restrictions. *See* David Grembowski et al., *Managed Care and Primary Physician Satisfaction,* 16 J. AM. BOARD FAM. PRACT. 383, 383 (2003) ("Sources of physician dissatisfaction include loss of autonomy, increase in administrative burdens, potential loss of patients and income, greater time pressures, and threats of malpractice litigation.").

this regard. If another young woman is not convinced to speak with her family about her pregnancy, you must afford the confidentiality she demands. Nevertheless, you are satisfied your involvement has been positive; having provided her the treatment authorized by statute and having discussed with her the benefits of parental involvement. You know that despite the limited nature of care available based on minor consent, your referral system to another caring physician accomplishes what you are able, fulfilling your legal and ethical obligations. And you hope, as we all do, our society will do better by our youth—our very future—and through education and guidance, the incidence of teen pregnancy will fall.