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REPORT FOLLOWED BY A STATEMENT AND RECOMMENDATIONS

CONFIDENTIALITÉ

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CONFIDENTIAL ACCESS BY ADOLESCENT MINORS TO CARE. REPORT FOLLOWED BY A STATEMENT AND RECOMMENDATIONS

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REPORT

Upon a proposal by the Adolescence Committee.

Committee chairperson
- Ms Véronique Nahoum-Grappe

Members of the Committee:
- Ms Christiane BASSET
- Professor Aimé Charles-Nicolas
- Mr Jean-Marie Faucher
- Mr Paul Hantzberg
- Mr Alain Molla
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INTRODUCTION: PERSPECTIVES ON THE ISSUE

In a letter dated 24th August 1999[1], Ms Dominique Gillot, Secretary of State for Health and Social Action, asked the Conseil national du sida to examine "the different situations that health professionals experience in the context of minors' access to prevention, to diagnosis and to treatments", and to make "recommendations to health professionals on the conduct to adopt" in this respect, "given that the situations studied may be examined in a larger context than that of HIV infection".

The Secretary of State's request arose out of questions asked by professionals at anonymous and free HIV screening centres (known as CDAGs) as to how they should behave in relation to seropositive minors. On one hand, minors can be screened at CDAGs without their parents being present. On the other, by virtue of article 371.2 of the Civil Code regarding parental authority, no therapeutic treatment and care can be given to seropositive minors without the consent of parents. Consequently, health professionals cannot according to the law confidentially treat minors who ask them to do so. Moreover, it appears that the very effectiveness of therapeutic treatment and care of minors requires that it be supported by their parents, and, consequently, requires that "mediation work" be carried out with them, work which is all the more sensitive an issue in that it necessarily concerns, due to the very modes of HIV infection transmission, the practices of minors in very personal areas (heterosexual or homosexual activity, drug addiction).

* * *

In a wider context the problem posed can be redefined as the problem of **minors confidentially accessing care**, or, more precisely, that of the **impossibility for professionals in the health and social apparatuses, due to the obligation of informing parents, of caring for and assisting seropositive minors in a confidential manner who want to receive care and assistance.** The problem evidently concerns the minors, for whom quality therapeutic treatment and care must be provided under the best possible circumstances, as much as it concerns health professionals, who must be able to provide legally-compliant therapeutic treatment and care to their patients.

As the Secretary of State's letter indicates, the source of the existence of the problem is the contradiction between, on one hand, the claim asserted by certain minors to confidential therapeutic treatment and care, and, on the other, the legal principle of parental authority. In order to nuance the issue, it should however firstly be specified that the minors who are likely to assert a claim to confidentiality are also adolescents, and secondly we should remind ourselves of positive law in relation to the link between parental authority and medical secrecy.

- Firstly, certain **adolescent** minors assert a claim to **confidential** (in relation to their parents) anti-HIV treatments.

Health professionals at screening centres are faced with claims for confidentiality as regards care and treatment from adolescent minors whose tests have revealed positive HIV serology. Even though the number of seropositive minors is impossible to quantify in the absence of epidemiological data, the hypothesis can be advanced that such claims are rare in the case of HIV treatment and care. First because minors get themselves screened fairly little – the number of minors who know that they are seropositive is thus notably less than the number of minors affected by HIV infection. Then because it is plausible and desirable that minors

[1] Schedule 3.

who know that they are seropositive do not all want to get access to treatments without their parents knowing. However, regardless of the fact that there are very few of them, these claims deserve to be examined with all the more attention and respect because they concern minors who are also adolescents, and because they can be deemed equivalent with claims to confidentiality in relation to care made necessary by other pathologies.

Minors who are likely to constitute new HIV infection cases – individuals who are sexually active and/or who are injecting drug users – are adolescents and not children. While it is true to say that there is no objective and uniform frontier, and even less a universal one, which separates childhood from adolescence; but there are nevertheless physiological, psychological and social criteria which differentiate children from adolescents, which enable the strictly legal category of "minor" – individuals under the age of 18 – to be nuanced. This point will be developed in the first part of the report.

In other contexts, equivalent claims are expressed by adolescent minors, boys or girls, for instance when they have to deal with other pathologies (such as sexually-transmitted infections and the effects of using psychoactive substances), or when they need to have an abortion. In these situations, certain minors refuse to have their need for care revealed to their parents, in particular because they fear their reproof with respect to the practices which made the care necessary, or else because they believe that such a revelation could damage their health and/or the acknowledged status they have in their families. Requests for confidentiality from minors are in particular sufficiently frequent in the case of abortion that several people – in the close circle of specialists but also beyond it – have called for the legal framework to be adjusted.

Two general characteristics of adolescent minors who ask health professionals that care be confidential must be properly understood now during these preliminary thoughts.

Firstly, the minors do not necessarily suffer from a deficiency in the way they relate to their parents. It is true to say that, in many cases the very claim to confidentiality, especially when it is maintained after discussions with health professionals, is the sign that an adolescent lacks trust in his or her parents, regardless of the reason (disagreement regarding a given practice, opposition on the level of moral convictions and attitudes, emotional deprivation, etc.). It goes without saying that these cases must receive all of the attention and the protection of health professionals as they concern minors who are the most often vulnerable and exposed. But, for a certain number of minors, the claim for confidentiality can be a sign of a desire for privacy in relation to their parents which cannot be unequivocally interpreted in terms of relationship issues between children and parents; the claim can also arise from the wish of the minor to maintain the balance of relationships, their "satisfactory" nature, by hiding a pathology, above all (but not only) when the pathology in question is known to be of short duration and it necessitates short-term care and care which is practically always effective, as is the case for certain sexually-transmitted infections. Seropositive people – whether they are youths or otherwise – who decide to hide their seropositivity in order to protect those around them are numerous. Such a choice can be judged as having little effect or even as being dangerous on a psychological level, but no ethical principles allow us to condemn such behaviour as a rule.

Secondly, the minors are considered to be mature on a psychological level by the professionals they go to see – the feeling of health professionals would not be one of confusion if they did not consider that the minors that they meet have the necessary ability to form their own views and are able to distinguish what is right for themselves from what is not right. The confusion of health professionals arises precisely from the fact that they are convinced that the confidentiality that the adolescent wants is legitimate and useful in the interests of the adolescent himself or herself, on the level of the treatment and care he or she receives but also, in many cases, on the level of his or her familial and social situations.

- Secondly, from a legal point of view, **parental consent** must be obtained by carers on the level of medical secrecy as soon as a minor is concerned.

From the point of view of the hierarchy of legal principles, parental authority takes precedence over medical secrecy. Doctors are of course bound by medical secrecy, which is a general and absolute rule. There is only one legal exception to secrecy, which is that relating to the abuse of, the deprivation of, and sexual abuse perpetrated on minors aged less than fifteen (article 226-14 of the Penal Code). Doctors cannot therefore disclose any information at all to third parties regarding the health of a patient, whether the patient is an adult or a minor.

However, as will be shown in more detail in the first part of the report, no need is felt to distinguish in law between "disclosure to third parties" and "disclosure to parents", because it is evident in legal terms that parents are concerned in relation to the health of their child who is a minor, and that they are consequently not included in third parties. As the Secretary of State's referral letter underlined, protection of minors' health indeed constitutes an attribute of parental authority, according to the terms of article 371-2 of the Civil Code which stipulates that "authority lies with the father and mother to protect a child as regards the latter's safety, health and morality". Nothing legally prevents a child from consulting a doctor alone, but the child cannot be treated by doctors alone[2]. Reciprocally, doctors – bound by medical secrecy – are entitled to hide a consultation by a minor from the minor's parents, but they cannot prescribe care or treatment without their consent – except in cases covered by specific legal provisions, parental authority takes priority over medical secrecy as soon as a diagnosis, care, treatment or hospitalisation takes place.

[2] Ash, 1999. Notes cross-reference the bibliography in schedule 1, at the end of this report.

The legal principle of parental authority thus prohibits health professionals from meeting any requests for confidentiality from minors. From a practical point of view, the professional is in the following no-win situation:

- Either the professional agrees to meet the minor's request, and provides care without notifying the minor's parents, thus placing himself or herself in an illegal situation;

- Or the professional refuses to meet the minor's request, and takes the risk of breaching the trust that the minor placed in him or her; a risk moreover exists that the latter will forego receiving care (if the minor cannot do without the care being confidential).

Furthermore, the professional's no-win situation is different depending on whether the treatment is prescribed over the short term (a few days, for instance) or over the long term (more than one or two weeks, for instance). In the case of prophylactic anti-HIV treatments – treatments which are prescribed for one month following exposure to a risk – it is difficult to provide care to a minor without the minor's parents knowing. Treatment without parents knowing gets very difficult in the case of diagnosed seropositivity, since the treatment must be taken for years and even – given the current state of medical knowledge – for life. Similarly, the no-win situation differs depending on the gravity of the disease which needs to be treated – the medical risk (for instance complications and side-effects), and thus the risk of being held legally liable, is not the same for the health professional depending on whether he or she is treating a benign sexually-transmitted infection or carrying out an abortion by means of an operation with the patient under a general anaesthetic.

The Conseil national du sida, since it believes that the claim expressed by certain adolescent minors to confidential therapeutic care should be taken seriously and that health professionals should be taken out of the no-win situation in which they find themselves, judges it necessary to think about making a change to legislation. The change must both:

- Enable adolescent minors to get access to care without their parents knowing when notification of the parents would risk harming the minor's health or the minor's status in his or her family;

- And clarify the legal liability exposure of doctors and other professionals in the health and socioeducational system, by enabling the former to provide care to adolescent minors and the former to assist adolescent minors with their treatment without them being held liable in principle in relation to the holders of parental authority.

The simplest case scenario to imagine is a situation in which a minor faced with a health problem who goes to consult a care-giver in a voluntary and individual – even isolated – manner, and whose request for confidential care is made in the context of a face-to-face meeting of the care-giver and the care-receiver.

But another case scenario should also be taken into account – that in which safeguarding the health of the minor is part of a necessarily more vast context than that of an initial referral to the courts, arising out of the Order of 21st February 1945 (on child delinquency) or the Act of 4th June 1970 (educational assistance), a context in which the minor will be the subject of other initiatives and checks managed by the children's judge. Yet the intervention of the children's judge means that compliance with confidentiality vis-à-vis parents does not apply, insofar as the judge must hear the latter before making any rulings, and this therefore means information being provided to them. Under the terms of article 1183 of the New Code of Civil Procedure, the intervention of the children's judge indeed obligatorily results in the parents being heard, and thus in information being provided to them.

In practice, it appears that there is no need in any way to act regarding the rules of medical secrecy and client confidentiality, which must be maintained as general and absolute principles. However, there are already a number of exceptions to the principle of parental authority, for instance as regards access to contraception. Though the principle itself cannot be called into question, it is by making its thought process part of the already-traditional legislative current of exceptions to the principle of parental authority that the Conseil national du sida deems it desirable and legitimate that a solution be found to the problem of confidential access for minors to care. The aim of the present report is thus to construct a legal formula for an exception in legislation to the principle of parental authority which prevents – each time that it appears necessary – parental authority from taking precedence over medical secrecy and client confidentiality.

To do so, it will be necessary to devote a first part to an in-depth presentation of the legal and social factors that determine adolescent minors' access to care, before specifying in a second part the possible arrangements regarding such an exception to the principle of parental authority. The main questions to be dealt with concern the extent of the exception: should it be general or specific? Should it apply to all types of care or only to certain types? Should it apply as regards all minors, or as regards those who have reached a certain threshold? But a lot of other questions are raised by the issue at hand, and they are all as vital as these ones. Thus, should confidentiality be automatically granted to minors (for instance depending on the type of care) or should it be granted at the request of the minors? How can possible worsening of the isolation of certain minors be avoided and how can giving others the means not to obtain care be avoided? On a financial level how can access to care be structured, insofar as minors generally use their parents' state health insurance accounts? Far from just being an issue of administrative and financial technicalities, settling this last question will be decisive as regards confidential access by minors to care.

I MINORS AND CARE: LEGAL FRAMEWORK AND SOCIAL NEEDS

This first part presents in detail the existing legal framework and the needs of minors as regards access to care.

A. MINORS AND ACCESS TO CARE: A PROTECTIVE AND THUS RESTRICTIVE LEGAL FRAMEWORK

1. THE PRINCIPLE OF PARENTAL AUTHORITY

Parental authority is a general rule as regards care, which arises out of aforementioned article 371-2 of the Civil Code and the legal incapacity of minors. As Dr Duval-Arnould states, "children have rights as regards their bodies, like any person, but, in principle, they do not exercise them themselves during the time they are minors, due to their legal incapacity; it is their parents or their legal representatives, who are regarded as their initial protectors, who consent to actions carried out on them most commonly with a therapeutic goal"[3].

Traditionally, the law seeks to protect minors against the deemed thoughtlessness of their own decisions, but also against any coercive action that could be carried out against them. The legal incapacity of minors stems from their theoretical incapacity to give enlightened consent, as a result of physical, mental and moral development which is deemed to be insufficient, and/or their relative vulnerability with respect to others. From a paternalistic point of view, incapacity is thus a privilege extended to children, a status grounded in the wish to defend their own interests.

While it protects them from themselves and from people with bad intentions, the legal status of minors has as an immediate downside the effect of prohibiting them from free access to many advantages that adults have access to. Parental consent is indeed obligatory as regards a whole range of acts, amongst which is medical care. In this case minors are subject to the wishes of adults, those of their parents or guardians and those of care providers. The end result of the parental consent requirement as regards access to care and treatment is to limit the choices open to them.

Legal doctrine currently is that parental authority is a set of rights and duties granted to and incumbent upon parents, as opposed to the almost absolute power conferred on fathers through the French law concept of *puissance paternelle* (paternal power) until 1970[4]. This notion is in line with the international Convention on the Rights of the Child, adopted by the General Assembly of the United Nations on 20th November 1989, and ratified on 1st January 1995 by 169 of the 194 UN Member States, including France (which ratified it on 2nd July 1990). By undertaking "to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her", and, to that end, to take "all appropriate legislative and administrative measures" (article 3, point 2), the signatory Member States strengthened the notion of parental authority as a responsibility or a duty, and not simply as possession of rights over a child.

On a general level then, it is parents' responsibility to take care decisions concerning minors, and this applies regardless of their age. More accurately, the consent of one of the parents is required as regards ordinary medical acts, that of both parents as regards major treatment. Parents in particular have a free choice in the area of medical treatment, provided that their choice is in the interests of the child. However, the law imposes obligations on parents (e.g. medical supervision, vaccinations), and prevents them from putting a child's health in danger, for instance by refusing an operation for reasons connected to their beliefs, notably their religious beliefs – if they do so they can be prosecuted for failure to provide assistance to a person in danger (translator's note: this is a crime in France but not in the UK) or manslaughter.

2. NUANCING OF THE PARENTAL POLICY PRINCIPLE

Minors' legal incapacity has however been progressively nuanced, such that parental authority no longer constitutes an absolute power[5]. Three types of nuance can be distinguished: those which entail the involvement of the children's judge; those arising out of practice and those which arise out of legislation.

2.1 THE INTERVENTION OF CHILDREN'S JUDGES

First of all, children's judges are duty-bound to act on behalf of minors in danger. Article 375 of the Civil Code indeed stipulates that "Where the health, security or morality of a non-emancipated minor are imperilled [...] measures of educational assistance may be judicially ordered" (translation source: www.legifrance.gouv.fr). Applicants can in particular be the parents (or one of them), which by definition nullifies the confidentiality issue, but they can also be the person or the structure "of whom/which the child has been placed in the care". In practice, health professionals can therefore notify the public prosecutor's office of minors in danger, which can then refer the case to a children's judge.

In the same order of ideas, article 28 of the Decree of 14th January 1974 on the operating rules of hospital complexes and local hospitals, provides that "when the health or the physical integrity of a minor risks being compromised by the refusal of the legal

[3] Duval-Arnould, 1999.

[4] Act no. 70-459 abolished paternal power and replaced it with parental authority. Translator's note: the *puissance paternelle* concept was first set out in French law in the first Civil Code in 1804.

[5] Duval-Arnould, 1999.

representative of the minor or the fact that it is impossible to obtain the consent of the latter, the doctor managing the structure can refer the case to the public prosecutor's office in order to trigger educational assistance measures enabling him or her to provide the necessary care". This is a case scenario in which the courts intervene to rule upon an apparent refusal of care by parents, a case scenario which implies that the parents have been informed regarding care, and is consequently not one which is covered by the scope of this report.

Regardless of that, a referral to a children's judge, in the context of an educational assistance measure involving a notification made by a doctor to a social worker (or vice-versa), for a health problem regarding which the holders of parental authority are not informed, leads to the latter being heard and to them being informed when the adolescent may have wanted confidentiality to apply; it arises from case law that the interpretation of article 375-1 of the Civil Code, according to which the judge "shall always endeavour to secure the adhesion of the family to the measure contemplated" (translation source: www.legifrance.gouv.fr) is that it represents an obligation for the judge, unless there are extra-ordinary circumstances, to hear the parents before taking an educational assistance measure.

Because it includes the obligation to inform of the measures taken by the parents (the holders of parental authority), the limitation by the children's judge of the absolute power that the parents have over the minor as regards heath issues can thus result in the minor's wish for non-disclosure to his or her parents not being complied with.

It must be added that, as regards abortion, the very principle of intervention by the children's judge on behalf of minors has been contested by lawyers[6]. Some underlined in particular that an abortion does not constitute an educational assistance measure and that only abortions of a therapeutic nature are grounded on the health dangers that pregnancy creates for the health of the mother; others stressed the fact that consent to an abortion constitutes a prerogative which relates to parental authority, and that the children's judge must consequently refuse jurisdiction. In the absence of a legal precedent in the Court of Cassation concerning the jurisdiction of the judge as regards abortion, the practices of judges are very diverse – some refuse jurisdiction, others authorise abortions on the grounds of the minor's psychological balance or on the grounds of her inability to bring up the unborn child, or order a measure by means of which the minor is placed in an establishment or a structure for which parental consent is delegated; the notion of *abus de droit* (abuse of right) has also been used against parents whose refusal to consent was based on their desire to punish their daughters.

While the invention of the children's judge is inconceivable in the case scenario we are examining because it breaks the confidentiality requested by minors, it is also inconceivable because it would be dangerous and wrong to mix up the prerogatives of avoiding putting the child in "danger" and secondly that of "protecting" the child. "Danger" is a fuzzy notion, there are no set criteria for appraising it (except in the minds of the people who employ such criteria), and certain minors who want to get prophylactic AIDS treatment without their parents knowing in all likelihood believe that their health (or less specifically their well-being) would be put in danger – both physically and psychologically – if their parents knew about the risks they had taken and the fact that they could be seropositive. Finally, certain decisions made by children's judges' encourage us not to want them to intervene – in a recent case in which a children's judge did not see it fit to support a minor whose parents wanted her to have an abortion against her will[7].

2.2 NUANCES BROUGHT ABOUT BY PRACTICES

The second type of nuances regards practices, in the absence of specific legal provisions, and may be seen as signifying a development in society's mores – the fact that a minors' wishes are taken into consideration when their state of health necessitates medical care, hospitalisation, or an operation. Consent is not requested, but special attention is paid to providing information to minors, and they are asked to express their opinions. The maturity of minors – therefore their ages – constitutes a condition as regards having the option of carrying out such practices, insofar as health professionals only deem a person to be a participant in matters if they consider that the person has acquired a certain ability to form his or her own views; generally speaking, adolescent minors evidently fall into the category of minors who are capable of forming their own views.

These practices are part of an across-the-board change in our societies, evidence of which moreover can be found in international legislation in article 12-1 of the international Convention on the Rights of the Child, which specifies:

> *"State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and the maturity of the child."*

We shall incidentally have it noted that article 12-1 underlines more accurately the importance of providing the child with "the opportunity to be heard in any judicial and administrative proceedings affecting the child". This aim was also stressed in the report of the working group chaired by Françoise Dekeuwer-Defossez, Rénover le Droit de la Famille: Propositions Pour un Droit Adapté aux Réalités et aux Aspirations de Notre Temps (renewing family law: proposals for legislation in line with the realities

[6] The following developments are sourced from Duval-Arnould, 1999.

[7] Article entitled "Papa, Maman, le Docteur et l'IVG" (dad, mum, the doctor and the abortion), in the French weekly news magazine Nouvel Observateur dated 27th January 2000.

and aspirations of our time) submitted to the Minister for Justice in September 1999. The recommendations were as follows, concerning the rights of the child:

> *"- Lay down as a principle that fathers and mothers involve the child in decisions affecting the child, in consideration of the child's age and degree of maturity;*
>
> *- Remove the capable-of-forming-his-or-her-own-views criteria and assert the possibility of a child being heard regardless of his or her age;*
>
> *- Recognise the right of any child older than thirteen years of age the right to be heard in all proceedings which affect him or her[8]."*

2.3 NUANCES WHICH ARE PART OF LEGISLATION

The second type of nuancing of absolute parental authority has become part of legislation. These legislative exceptions can be categorised on the basis of three types of situation:

2.2.1 They provide for the involvement of minors in decisions made by their parents which affect them;

2.2.2 They give the minor the option of deciding alone;

2.2.3 They provide for the consent of both the minor and of his or her parents.

2.3.1 The involvement of minors in decisions made by their parents which affect them can take the form of a right of veto – the wish of a minor to refuse takes precedence over parental consent.

This is the case as regards in vivo organ donations (article R. 671-3-8 of the Public Heath Code) and blood donations (article L. 666-5 of the Public Health Code) in vivo, and as regards experiments (article L.209-10 of the Public Health Code).

2.3.2 The acts that a minor can carry out in an autonomous manner, where applicable from a certain age, concerning in particular the areas of sexuality, screening, reproduction and maternity.

Fifteen years of age above all constitutes a kind of "sexual majority", since minors aged more than fifteen can consent to sexual relations with a person of their choosing, except if the person in question is a person who has authority over the minor or is an ascendant, without making that person guilty of a criminal offence if that person is an adult (see article 227-25 of the Penal Code). Access to anonymous and free screening centres (CDAGs) is made possible for them precisely because the centres are anonymous and free to access; minors can also get screened and find out their serostatus anonymously and access-free at family planning or education centres (article 50 of Act no. 90-86 of 23rd January 1990). Minors also have confidential access to contraception, by virtue of the Act of 4th December 1974 on State health insurance refunds of purchases of contraceptives, which removed the requirement for the consent of legal representatives of minors to access to such products, and the Act of 31st December 1991 regarding the regulation of births, which amended article 4 of the 1957 Neuwirth Act by authorising family planning and education centres to issue medicine and contraceptive products and objects free-of-charge, on medical prescription, to minors who want to maintain secrecy. Finally, minors can give birth anonymously, abandon their children, acknowledge paternity and maternity, carry out paternity tests, and have parental authority over their children; thus, they can hospitalise them and must consent to medical acts and care as regards them.

2.3.3 Twin consent – the consent of both the minor and of his or her parents – notably concerns the right to marry, and abortions for personal reasons.

This last case merits an in-depth examination, both because the issue of abortion is legally complex, and since it raises in an exemplary manner the issue of confidentiality[9].

Twin consent is a seductive idea on a theoretical level. The main advantage of it is to involve girls in decisions concerning their bodies, without, for all that, giving them full responsibility as regards taking the decision. Moreover, twin consent makes it possible – again on a theoretical level – to protect minors from wrongful use of parental authority.

Implementation of twin consent is nevertheless not less problematical in situations in which a minor and her parents disagree, whether the disagreement is explicit (refusal of the parents when the minor wants to, or vice-versa), or implicit (when the minor does not want to have her parents informed because she anticipates that they will be of the opposite opinion to her). The current solutions to these issues are unsatisfactory, and improvements appear necessary on a legal level.

If we look at abortion on therapeutic grounds, the question is raised on a legal doctrine level of whether the concept of "serious danger" – which is the reason behind this type of abortions – has a psychological dimension due to the age of the person or her personal situation. Furthermore, the spirit of the law seems to indicate clearly that the aim of abortion on therapeutic grounds is

[8] Dekeuwer-Defossez, 1999.

[9] Duval-Arnould, 1999.

not to remedy the refusal to consent of the holder of parental authority. Yet in practice certain care structures often use the ground of serious danger in order to carry out abortions at the request of minors and they do so without the parents' knowledge.

If we look at abortion on personal grounds, twin consent is the source of muddled situations due to an explicit or implicit disagreement between the minor and her parents. We shall not address here the case scenario of a minor who does not want to end her pregnancy whereas her parents want her to do so, insofar as judges in such cases generally rule in favour of the minor, or situations in which parents cannot be contacted (e.g. parents living abroad, the parents of children who have been put in the care of child social assistance structures who have "gone missing") or are not in a position to express their wishes (due to psychological problems). Neither shall we re-examine the situation already outlined concerning explicit disagreement, which leads to the case being referred to a children's judge. We shall only examine case scenarios in which a minor wants a confidential abortion, one carried out without her parents knowing about it.

According to two recent reports drawn up by gynaecologists[10], claims asserted by minors as regards confidentiality notably occur when families cannot agree to an abortion for cultural reasons or due to religious beliefs, when there is a serious conflict between a minor and her parents, when the minor's sexual partner is opposed to the parents being notified, and also when the minor has lost all contact with her parents. Faced with a request for a confidential abortion, health professionals can either refer the case to a children's judge, or seek an extra-legal solution. Yet referring a case to a children's judge – for reasons already detailed – constitutes a breach of the confidentiality requested by the minor. Consequently, a minor cannot legally be granted permission to have an abortion without her parents knowing. Several extra-legal means are in such cases used by health professionals when they believe it legitimate and necessary for the minor to meet her request for confidentiality – consent by a member of the minor's extended family, carrying out the abortion on therapeutic grounds (in particular when the minor states that she became pregnant following non-consensual sexual relations), abortion abroad; moreover, health professionals sometimes pretend to believe that the signature on the parental consent form written by the minor is indeed that of the holder of parental authority.

The recourse by health professionals to extra-legal practices to resolve problems arising out of the refusal of minors to notify their parents cannot be deemed to be a satisfactory state of affairs. Since the idea of not asking for the minor's opinion is excluded, there are three solutions on a legal level – one, minors deciding for themselves only in the case of abortion; two, minors deciding for themselves as regards all medical acts (this is the principle of an age of majority for health matters); and three, an alternative solution to the lack of parents' responsibility.

These three options exist in other countries. In Norway, minors aged above sixteen can consent alone without their parents being informed; in the United States, the Supreme Court has ruled that doctors have the right to carry out an abortion with only the consent of the minor if they believe that the minor in question is sufficiently mature. In Quebec, an age of majority for health matters, which applies as regards all care, was set at fourteen; the former has been set at sixteen in the United Kingdom and in the Netherlands. In Italy, a judge who was referred a case taken by health professionals can hand down a quick ruling (in just three days) on the issue of parents being consulted or not[11].

Some of these options have also been backed by health professionals and political representatives. In a report submitted in 1999, Professor I. Nisand was critical of the legal constraints that the most underprivileged female patients have to deal with. He identified three main problems: the legal timeframe of twelve weeks as regards cases of amenorrhoea; access to abortion by female foreign nationals who cannot prove that they have been resident for more than three months in the country; and the lack of independence for minors, "incontestably the most sensitive"[12] issue. The report underlines the paradoxical nature of legislation which on one hand acknowledges that female minors have a sexuality, legislation which makes contraception available to them free of charge and anonymously, and which grants them parental authority if they choose to continue with their pregnancies, but which – on the other hand – prohibits them from making a choice on their own to have an abortion, a choice which affects their futures, and forces them to make their parents aware that they have a sex life. Considering that "disclosing a pregnancy to parents is totally and utterly impossible in certain families in which culture and religion vigorously prohibit any sexual relations outside of marriage", and dreading that the fear of social rejection – even that they will be banished from their families – will make the adolescent minor to behave in manners that will harm her (e.g. carrying out an abortion on herself, denial as regards her pregnancy, efforts to get money to pay for her abortion), the report concludes that the solution is "affirming that it is the young woman's own right to make a decision regarding an abortion by guaranteeing her that her decision will be confidential" and proposes that abortion be "an opportunity for discussion regarding the introduction of an age of consent of fifteen years of age as regards health matters"[13].

The same proposal was made in Professor M. Uzan's 1998 report entitled "La prévention et la prise en charge des grossesses adolescents" (the prevention and handling of adolescent pregnancies). In its conclusions, the report underlines the fact that a minor is entitled to want to keep her pregnancy secret, and that notification of parents can constitute a genuine danger for the

[10] Uzan, 1998, Nisand, 1999.

[11] World Health Organization, 1989, Uzan, 1998. In Quebec, the independence of children aged above fourteen is a right. But there are certain exceptions this right – an adolescent cannot have an abortion without her parents knowing if they are in hospital for more than twenty-four hours.

[12] Nisand, 1999, pp. 23-25

[13] Nisand, 1999, p. 25 note 67.

minor "under certain cultural circumstances", a problem which requires a legal solution. The report proposes that parental authority remain unchanged as regards minors aged less than fifteen, and pleads in favour of the "freedom to choose" of adolescents aged above fifteen being taken into account more, and proposes that "the pertinence of the concept of an age of majority of sixteen for health matters [be] examined by means of a study".

Finally, at the start of this year, the year 2000, government measures promoted the provision of information to the general public regarding contraception and extended the availability of means of contraception (notably the so-called "morning-after pill", which can now be supplied by school nurses), an extensive public debate is going on regarding changes to be made to legal rules surrounding abortion, and the Socialist Party's Central Office recently came out in favour of removing the requirement for parents' permission as regards minors who want to have an abortion[14].

In conclusion to this mainly legal review, it therefore appears that, while the legal principle of parental authority applies very especially as regards care provided to minors, nonetheless there are a certain number of legal and extra-legal exceptions. Evolutions in society's mores, in the legislator's approach and in the spirit of legal doctrine plead in favour of an extension of the margin of autonomy granted to minors as regards care. However, as things stand, the legal framework prohibits confidential access by minors to care in the name of the minor's best interests, and there are no exceptions to this rule.

B. THE NEEDS OF ADOLESCENT MINORS IN TERMS OF CONFIDENTIAL ACCESS TO CARE: AN IMPORTANT DEMAND

1. DEFINITIONS OF ADOLESCENCE

Adolescence is a fuzzy concept and one which is determined culturally and socially. Although adolescence and puberty cannot be viewed as one and the same thing, very many societies' basis for the passage from childhood to adolescence are the physiological changes which result from puberty (e.g. boys' voices breaking, girls having their first periods), however the criteria regarding the move from adolescence to adulthood vary to a much greater extent in western societies (is the criterion the legal age of majority, or the end of studies, or paid employment, or leaving the parents' household, etc.?). Due mainly to improvements in nutrition, the average age of female puberty has considerably dropped over the last few centuries – it took place at about sixteen years of age in the 18th century, and it now occurs at less than thirteen years of age. As to the average age of male puberty, which is much trickier to establish (is the criterion the fastest rate of growth in terms of height, or a boy's voice breaking, or masturbation?), a recent assessment put it at twenty months later than that of girls, in other words shortly after boys' fifteenth birthdays[16].

Nevertheless, definitions have been drawn up at international level. Thus in 1974 the WHO proposed that adolescence be defined as the period during which:

- The individual passes from the stage at which secondary sexual characteristics first appear to that of sexual maturity;
- Psychological processes and identification mechanisms cease to be those of a child and become those of an adult;
- Individuals go from a state of total socio-economic dependency to a state of relative independence.

When issuing this definition the WHO also noted that a common factor in all societies was the fact that adolescents, while no longer children, are not yet seen as adults.

The three signifiers of transition proposed by the WHO are especially interesting. The first indicates that the child is pubescent – the minor is thus capable of engaging in active sexual and reproductive practices. The second means that the adolescent is becoming an adult on a psychological level – the minor is thus susceptible to adopting some adult practices, in particular addictive practices, by using drugs (legal or illegal ones). The third signifies the start of socio-economic independence (a move from pocket money to work under contract, via small summer jobs) which the adolescent may experience; the adolescent can thus independently buy consumer goods, but also paid services. As latent adults, who voluntarily see themselves as adults, adolescents are thus very prone to and potentially capable of adopting adult practices, without being fully permitted to do so[17].

More recently, in 1998, the World Health Organization (WHO), the United Nations Children's Fund, (UNICEF) and the United Nations Development Programme (UNDP) decided jointly that the term "adolescent" would be used to refer to individuals aged between ten and nineteen years of age, and the term "youths" to people aged between fifteen and twenty-four years of age. The adolescents thus defined make up 20% of the world's population.

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[14] Document entitled "Droit des femmes dans le domaine de la santé" (the rights of women in the area of health) made public on 11th January 2000.

[15] The historian Agnès Thiercé shows that puberty – a physiological event that everybody goes through – almost always leads to social breakdowns, but that it is not the start of a transitional period for all children. Thiercé, 1999.

[16] La Rochebrochard, 1999

[17] A. Thiercé states that, notably for political reasons (the participation of youths in revolutionary movements from 1789), the formula "adolescence = puberty + crisis + supervision", which is still valid today, became established in the middle of the 19th century.

In all cases, the notion of adolescent is in contradiction with the notion of "minor", the upper age for which has been brought down to eighteen in many countries (this occurred in France in 1974), whereas it was traditionally (and is still in many countries) twenty-one. Nevertheless adolescent minors go through several age thresholds in France – while the legal age of majority, which when attained gives an individual all the rights of a citizen, is eighteen, it is however twelve years of age as regards the right to have a bank card, fifteen years of age to have sexual relations with the partner of one's choosing, and sixteen to buy alcohol and to consume alcoholic drinks in bars. On a criminal law level, the age threshold of thirteen is fundamental, since it is at thirteen years of age that minors are deemed to have the ability to form their own views, insofar as under criminal law they are responsible for their acts from that age (article 122-8 of the New Penal Code). Furthermore, a minor aged above fifteen who is accused of a crime is brought before a Criminal Court, and no longer before a Juvenile Court.

The term adolescent thus encompasses both minors and young adults aged nineteen, twenty, or twenty-one. In France studies on young people and adolescents, whether epidemiological studies or in the realm of the social sciences, moreover generally speaking employ the categories "under-fifteens", "aged 15-19" and "aged 15-24". By doing so, they render the legal age threshold of eighteen years of age a minor aspect in the paths taken by adolescents.

The individuals of interest to the Conseil national du sida as regards this report are evidently not adults, even though youths above the age of legal majority cannot, in many cases, obtain care without their parents knowing due to the fact that there treatment is listed on their parents' State health insurance or supplementary health insurance statements. Of interest above all to us here are minors for whom the problem of confidential access to care arises due to the principle of parental authority. However not all minors are affected in the same way by the problem. It is obvious that large differences exist between a child and an adolescent, on a physiological level of course, but also on a psychological level (crises, communication breakdowns, etc.) and sociological level (desire for independence, leaving the parents' household, etc.). It appears of little use at this stage of the report to address the issue of the average age delimiting childhood from adolescence, as regards which it will suffice to place it in the thirteen to sixteen age range. What will be addressed herein by the Conseil national du sida are therefore the problems getting confidential access to care that are faced by adolescent minors, in other words minors aged approximately thirteen to eighteen who are sufficiently mature on a psychological level to steadfastly make a request to a health professional that they be treated without their parents knowing.

2. ADOLESCENT MINORS CONFRONTED WITH HIV INFECTION

Epidemiological data does not enable the numbers of seropositive minors to be ascertained. First of all, given the current position regarding the French HIV epidemiological surveillance apparatus, there is no data for the past two years. Secondly, the majority of structures operating in 1997 and 1998 did not have a separate statistical category for minors[18]. RESORS-VIH (the network of regional observatories for the surveillance of HIV infection screening) used the age categories 5-14 and 15-24, and in 1997, the proportion of 15 to 24-year-olds amongst individuals who had discovered that they were seropositive was reckoned to be 11.3%. The age category used in data collected by RENAVI (the national HIV network) was "less than 20 years old"; between 1989 and 1997, the assessment was that the proportion in this category had stabilised at less than 5% of newly-infected individuals. However, data produced during the course of the operations of anonymous and free screening centres (CDAGs) included a category for people aged less than eighteen. In 1997, 6.7% of tests prescribed by CDAGs that were not carried out in prisons were requested by minors, and the number of positive tests was 0.3 per 1,000; 2.3% of tests carried out in prisons were requested by minors, and the number of positive tests in this case was 3 per 1,000. It should however be noted that the proportion of seropositive tests was markedly higher in the 18-19 age category, since it amounted to 0.9 per 1,000 outside of prisons, and 1.1 per 1,000 in prisons.

Interpretation of this data is tricky, insofar as the 15-24 category is unsuitable (as regards the topic of this report), and insofar as the age categories "less than 18" and "less than 20" do not enable modes of infection to be distinguished, in particular between transmission by sexual means, through the injection of drugs, and infection through mother-to-child transmission. Clearly the number of minors who know that they are seropositive is low. But the question is raised of what is the proportion of minors who know that they are seropositive out of the total number of minors who are actually seropositive.

Yet, several studies appear to show that, generally speaking, minors get screening tests relatively little, despite the fact that they are very aware of the modes of infection[19]. The inquest into the point at which minors become sexually active, based on data from 1994, estimated that 17.5% of girls and 8.5% of boys between 15 and 18 years of age had availed themselves of a screening test[20]. Recent research carried out by Sofres on behalf of Sida Info Service put at almost two-thirds the proportion of young people aged fifteen to twenty-four who were conscious that they had taken a risk as regards sexual relations and who did not take screening tests in the following days; 8% said they did not dare talk about the risk they had taken, and 43% did not want to talk about it.

[18] BEA (Bulletin Epidémiologique Annuel, annual epidemiological update), 1997, pp. 31-37.

[19] Almost all of them know that HIV is transmitted by sexual means or through the sharing of needles. Approximately 10% however believe that HIV can be transmitted during a stay in a hospital in a department in which there is an AIDS patient, in public toilets or by means of mosquito bites. Lagrange, Lhomond, 1997.

[20] Lagrange, Lhomond, 1997.

However, according to the same study, minors tend to better protect themselves and better protect others – most often by using a condom – after they have taken a risk[21]. An overview of the operations of Sida Info Service's freephone number provides information which is relatively consistent with the above data. In the data, which concerns telephone calls, screening indeed appears to be much less of a problem for under-fifteens, since 11.6% of them ask about it, whereas the overall (i.e. across all ages) average of callers who ask about it is 42.6%. Screening however was the main subject of questions from callers aged fifteen to twenty-nine, whose main questions concerned the contact details of screening centres and the reliability and viability of tests[22].

Moreover it must be stressed that a notable proportion of people who proved to have diagnosed cases of AIDS were not aware that they were seropositive three months before the time at which AIDS was diagnosed – this was the case as regards more than 1,000 people in 1995, more than 900 in 1996, and more than 900 again in 1997[23].

Consequently, it is probable that there are quite a few cases of minors who are aware that they are seropositive and do not want their parents find out about it. But the number is all the lower because a certain number of minors are in all likelihood seropositive but are unaware of it – and nothing enables us to know whether or not they would request confidential care if they did know they were seropositive.

Not too high a figure should be put on the number of seropositive minors who stake a claim to confidential care. It is regrettable from epidemiological and public health standpoints that no quantitative estimates of the numbers of minors who do so are available. But numbers are not the main issue with regard to the problem being posed, and this is so for three reasons.

Firstly, the serious nature of such requests should be fully taken into account, as such requests are far from being based on trivial grounds, and relate to genuine suffering, suffering that is genuinely felt in their bodies and suffered as regards their identities by minor adolescents regarding whom it can be feared that they are handicapped in several ways – on the level of family, but also socially, economically and in their studies.

Secondly, the requests are all the more difficult to evaluate in quantitative terms in that they relate to what are the most personal matters for these adolescent minors, and in that the issue is one precisely of respecting this part of them; it is doubtless not easy for them to confide in just anyone when they do not even trust their parents. However, the not-for-profit movement is aware that such situations exist. The not-for-profit organisation Vaincre le Sida thus alerted the Conseil national du sida regarding the situation of young minors who had set out the difficulties they had getting access to care which "met their need for confidentiality". The organisation also underlined the fact that certain minors put back implementation of a care procedure – which they required – and "decided to wait until they reached the age of majority or even the age of twenty in order that they could use their own health insurance cover and not have to use that of their parents". The not-for-profit organisation Act Up more recently informed the Conseil national du sida that during the course of 1999 it received calls from three minors who had taken a risk (unprotected heterosexual relations in one case, unprotected homosexual relations in another, and use of a previously-used syringe in the last one) who sought information on the possibility of obtaining emergency treatment in order to avoid HIV infection without their parents knowing about the treatment. In the three cases, the minors had not yet consulted with their doctors, and did not get back in contact with the organisation. Everything led the organisation to believe and fear that these minors were in great turmoil.

Finally, the claims asserted as regards confidential access to care made by seropositive minors and minors who feared that they are cannot be seen in isolation. They can on the contrary be connected to equivalent claims expressed by minors who need care or treatment following sexual activity (for sexually-transmitted infections, abortions) or use of illegal substances – more especially in relation to hepatitis B and hepatitis C infections – and also following psychological problems. Vaincre le Sida's letter also explicitly referred to requests from minors as to the possibility of getting care without their parents knowing for STDs and also for health problems arising out of the use of illegal substances. Given that, it appears useful to carry out a review of the care needs of minors.

3. THE CARE NEEDS OF ADOLESCENT MINORS AND RISKY PRACTICES

Anti-HIV treatment needs cannot be seen in isolation from care needs as regards sexually-transmitted diseases and care arising out of injected drug use, and also requests for abortions, insofar as it is these types of practices that resulted in the need for care in the first place. The aim of providing the following data is to summarise the risky practices engaged in by adolescent minors.

As regards the sexuality of minors, the main study was carried out in 1994 and the results of it were published in 1997[24].

[21] Sida Info Service, 1999.

[22] Sida Info Service, 1999.

[23] BEH (Bulletin Epidémiologique Hebdomadaire, weekly epidemiological update), 1998, issue no. 37, 15th September.

[24] Lagrange, Lhomond, 1997.

Approximately 45% of adolescents aged 15 to 18 had already had sexual relations with penetration (approximately 47% of boys and 41% of girls), but the figure is 55% (57% of boys and 51% of girls) if you include all of the practices involving the genital organs (caresses, oral sex). By age, the proportions are respectively 20% (sexual activity with penetration) and 30% (all types of sexual activity) for adolescents aged 15, 36% and 48% for those aged 16, and 52% and 63% for those aged 17. The type of educational orientation constitutes a marked differentiating factor as regards the beginnings of sexuality – adolescents taking apprenticeships engage in sexual and genital activity markedly earlier than adolescents who attend technical secondary schools, who themselves engage in activity earlier than adolescents who attend general education secondary schools. As regards sexually-active adolescents, the main results of the research were as follows:

- The sexuality of girls and of boys is characterised by some notable differences: 70% of girls have their first encounter with a partner who is already active, which is true for only 47% of boys; girls more often have an initial sexual partner who is older than them; on average, the emotional and sexual relationship with the first partner lasts longer for girls than for boys; the period of time between the first emotional and sexual relationship and the second is on average shorter for girls than for boys.

- The data regarding homosexuality is difficult to interpret, insofar as adolescence is a period during which peer pressure as to sexual normality is very strong, to the point of making talking about and acknowledging homosexuality difficult. Although 5.7% of boys and 6.5% of girls say that they are attracted in varying degrees to people of the same sex, 1.4% of boys and 1.3% of girls stated that they had engaged in sexual activity at least once with a person of the same sex, and 0.3% of boys and 0.1% of girls stated that they had only engaged in sexual activity with a person of the same sex.

- More than three-quarters of those questioned stated that they had used a condom during their first sexual encounter, and 20% the pill, while 10% did not take any precautions. Moreover, approximately 57% of adolescents who had their first sexual encounter in 1989 stated that they had used a condom, whereas 85% of those who had their first sexual encounter in 1993 did so – the increase in condom use is particularly remarkable, and attests to the fact that in the main adolescents are responsible subjects who respond to prevention messages[25].

- Adolescents who did not use a condom were twice as numerous as those who did use a condom to take an HIV screening test, but in proportions which were still relatively low (18.6% and 8.2% respectively).

- 3.3% of sexually active girls (but 9.9% of girls taking apprenticeships) had been pregnant, of whom 72% had an abortion.

- 15.4% of girls and 2.3% of boys stated that they had been forced to have sexual relations. The proportions were markedly higher for girls taking apprenticeships.

- 16% of boys and 26% of girls had told their parents that they had become sexually active. In 90% of these cases, their parents "reacted well".

This data should be detailed because it provides a fairly accurate and complete "map" of minors' sexuality. It shows first of all that, generally speaking, sexuality is not a subject which is talked about with parents. The research carried out by Sofres for Sida Info Service more than confirms the fact – the main information channels for young people aged 15 to 24 as regards sexuality are peers (friends, brothers and sisters for 65% of those questioned), far ahead of the media (television 45%, magazines and newspapers 36%, radio 19%), and very far ahead of doctors, who themselves ranked ahead of parents (26%). The research institute moreover commented that "sexuality is a major preoccupation and remains a delicate issue, one which is difficult to talk about within family units". Requests for confidential care following sexual activity therefore cannot be seen as anything out of the ordinary. Although they cannot be deemed to be representative, the following statements – taken from a report on the operations of Sida Info Service – shed light on the relations that exist between adolescents and their parents as soon as there is question of sexuality.

> *"I don't know if I was raped or not, because I fainted. Maybe he took advantage of that. I'd like to know if I'm still a virgin. I don't want my father to know. It would be terrible if he found out. Where can I go?"* – A young woman, age not known.

> *"I'm calling because I had sex for the first time at a party. We had drunk a little... it happened very quickly, I didn't have time to go and get a condom. The problem is that my boyfriend told me afterwards that his old girlfriend took a test after they broke up and it was positive... I'm not on the pill either... my mother didn't want me to go on it. Help me."* – A young woman, 16 years old.

> *"My girlfriend is scared she's pregnant. She's more than two weeks late with her period. If it's confirmed, where can she go to have an abortion? Does she need her parents' consent for an abortion? Her parents absolutely can't find out, they'd kill her."* – A young man, 18 years old.

> *"After we broke up, I found out that my ex-boyfriend was seropositive. I took the test as well, I'm seropositive. I don't know what to do any more. I told the nurse who talked about it to the head of the school. Now he's threatening to expel me. He notified my parents who took it very badly. They've stopped speaking to me. They want me to get a job so that I can leave home. They think that I have brought shame on the family. What should I do?"* – A young woman, 19 years old.

Data from the study on adolescents becoming sexually active also indicate that vulnerabilities exist as regards sexuality. Girls' sexuality is generally more stable than that of boys, and they have protected sex more frequently. Yet, it is known that, generally

[25] Same conclusions in Choquet, 1999.

speaking, adolescent girls have much easier access to health professionals than boys, in particular to gynaecologists and to family planning centres, whereas the medical profession – and in particular urologists – is not interested in dealing with male adolescents' sexuality. Moreover, the majority of professionals believe that information provided by mothers is more frequently provided to girls than boys. The type of educational orientation is also a marked differentiating factor, for both boys and girls – adolescents on apprenticeships are sexually more precocious and are more often faced with problems as regards sexual violence and abortion than adolescents receiving a general education. This different level of vulnerability depending on the institution in question moreover increases still further when we look at adolescents in the care of the French **youth** court-ordered welfare service (aged 14 to 21) – 80% of boys and 65% of girls are sexually active (as compared to 45% and 33%), and are sexually active at a younger age; 6% of boys and 34% of girls were victims of sexual violence (as compared to 2% and 7% of adolescents of the same age receiving schooling)[26].

The problems faced by young homosexuals deserve to have light shed on them based on the results of other studies. A recent colloquium underlined the particular vulnerability of young homosexuals in European countries – social vulnerability, linked to a high level of discrimination within families, with the individuals often becoming independent at an earlier age, and greater isolation for youths living away from big towns, but also vulnerability in terms of sexuality, since sexually-transmitted diseases and infection with HIV are increasingly markedly in this grouping[27].

These areas of vulnerability raise the issue of the knowledge these adolescent minors have as regards their bodies and sexuality. At the time of hearings organised by the Conseil national du sida, a person working in a school painted a worrying picture of such knowledge, and according to the person adolescents suffer from a high degree of "emotional and sexual misery" and the misery is all the worse when the school is in an underprivileged area. The misery is apparently due to a large extent to both parents – who relieve themselves of the duty of providing information and expect educational institutions to do it – and to educational institutions – which expect the same thing of parents – failing to play their assigned roles. Knowledge as regards anatomy, sexuality, rules of hygiene, sexually-transmitted diseases, appears deficient to the point that adolescents are exposed to major risks, all the more so in that the model of sexuality tends more and more to be that of pornography. Yet certain experts believe that sexually-transmitted diseases are in the process of becoming the leading diseases that affect children of school-going age; studies have shown a rate of chlamydia infection and genital warts three times higher in adolescent minors than in young adults[28].

Data regarding abortion, too, is far from reassuring, both as regards all women of child-bearing age and adolescent minors. The overall data is as follows[29]:

- 220,000 abortions annually (one abortion for every three births), but approximately 160,000 reported ones, as compared to 250,000 in 1976;
- Out of 100 accidental pregnancies, 53 are due to unprotected sex, 32 to protected sex using an insufficiently-effective method, and 15 to people forgetting to take contraception;
- Out of 100 pregnant women, 36 pregnancies are unwanted, and 22 give rise to an abortion;
- 75% of abortions are carried out before the eighth week, 19% before the fifth week;
- 22% of abortions are carried out by means of the pill RU 486;
- 857 establishments carry out abortions, of which 52% are public and 48% private.

As regards young adults and adolescent minors, the data indicates that:

- 30% of abortions concern individuals aged less than 25;
- 10% concern individuals aged less than 20 – 6,000 abortions carried out on under-18s, 10,000 on individuals aged 18 to 20;
- Between 1985 and 1995 and notably between 1993 and 1995, the number of abortions carried out on minors varied between 5,700 and 6,400 a year;
- The proportion of abortions carried out on pregnant minors is increasing significantly – it was 59.7% in 1985, 64% in 1990 and 71.8% in 1995.
- Adolescent girls are three times more likely than adults to not use any contraception at all (this is the case with regard to around 10% of them) and significantly more of them say the reason for them being pregnant is condom failure (comparable data has been published for Switzerland, the United Kingdom and the United States).

Moreover, a study shows that in 1989 61% of conceptions in minors aged 14 to 15 and 50% in minors aged 16 to 17 result in an abortion, however the proportion is 36% in those aged 18 to 19, and less than 20% in those aged between 20 and 35[30].

[26] PJJ (**Protection Judiciaire** de la Jeunesse, French **youth** court-ordered welfare service) study, 1998.

[27] Faucher, 1999.

[28] Tordjman, 1999.

[29] Nisand, in Le Figaro newspaper dated 11th January 2000, and in Le Quotidien du Médecin dated 12th January 2000.

[30] Blayo, 1997.

All of this data attests to the significant and even increasing vulnerability of adolescent minors from the point of view of access to contraception, and justifies the public awareness campaigns in this regard launched at the start of the year 2000.

From the point of view of the use of psychoactive substances, the preliminary results of a study carried out in France with a view to making comparisons with other European countries indicate a relatively trivialised approach to alcohol and hashish, the potentially disinhibiting effects on sexual practices of which are known[31].

- 49.4% of children aged 11, 66.7% of children aged 13, and 85.9% of children aged 15 have already drunk alcohol; the proportion of those who have been drunk at least once is 5.7% at 11, 15.5% at 13, and 38.1% at 15.

- 16.6% of youths aged 11, 44.5% of youths aged 13, and 65.5% of youths aged 15 have consumed tobacco; with cannabis (the illegal drug most commonly consumed by those questioned during the study), the proportion was 29.2% at 15 years of age.

Other studies have put at less than 1% the proportion of adolescents aged 14 to 19 who are heroin users, and at 1.7% in secondary school pupils aged 15 to 19[32]. The consumption of heroin does not thus appear to be a prevalent danger as far as adolescent minors are concerned. Moreover, the HIV infection prevalence rate is 20% in drug users overall, but is 8% in drug users aged less than 25[33].

Finally, it is impossible not to mention the issue of suicide in adolescent minors and, more widely, in young people. Whereas the mortality rates were 6.5 per 100,000 in boys aged 15 to 24 and 2.7 per 100,000 in girls aged 15 to 24 in 1950-51, they were twice as high in the 1980s and 1990s, varying between 14.5 per 100,000 and 16.1 per 100,000 among boys and between 4.3 per 100,000 and 4.9 per 100,000 among girls between 1982 and 1996[34]. In a society which under the effects of a sustained economic crisis structurally keeps the youngest populations in a situation of dependence with respect to their elders (from the point of view of economic and social independence – access to work, to housing, etc. – and as regards having economic and social duties), the doubling of the suicide mortality rate in two generations constitutes an extremely worrying sign regarding the psychological situations of adolescents, the scale and the seriousness of which could be measured using a wealth of other indicators[35].

In conclusion to this part, it appears obvious that, although the vast majority of adolescent minors have taken on board public health messages as regards protection during sexual intercourse, a certain number of problems remain:

- There is no evidence to suggest that adolescent minors are open enough to public health messages regarding the use of psychotropic substances (legal and illegal);

- A non-negligible proportion (in the order of one in ten) adolescent minors have sexual intercourse without contraception, thus without using condoms; this minority makes one fearful about a rise in the number of new HIV cases, especially in light of the number of pregnancies and abortions in female adolescent minors and the increase in sexually-transmitted diseases in adolescent minors overall;

- Active sexuality is a very personal matter for adolescent minors, who do not voluntarily talk to their parents about it; their use of psychoactive substances is in all likelihood seen as just as personal by adolescent minors;

- Requests for confidentiality take place in a certain number of situations in which a minor needs therapeutic care.

II POSSIBLE SOLUTIONS

The main alternatives on offer entail weighing up, on the one hand, the introduction of a general exception to the legal principle of parental authority, and on the other, the creation of a specific exception to the said principle. Choosing either solution will lead to consequences. One of the consequences, a primordial one, concerns the concept of a threshold. To introduce a general exception which applies as regards all types of care would mean defining an age of majority for health issues which would be lower than the legal age of majority, and this would thus mean setting a threshold. Otherwise, putting in place a specific exception – one which would apply as regards certain types of care or in certain situations as regards care needs – would enable "liberation" from the threshold requirement. But the "liberation" would come at a cost, as introducing a specific exception

[31] BEH, 1999 (Bulletin Epidémiologique Hebdomadaire, weekly epidemiological update), no. 48, 30th November.

[32] Choquet, 1999, MILDT (Mission Interministérielle de Lutte Contre la Drogue et la Toxicomanie, the French Interdepartmental Mission for the Fight against Drugs and Drug Addiction), 1999, p. 15.

[33] Report by F. Lert, J. Emmanuelli and M. Valenciano for the Institut de Veille Sanitaire (IVS, the French National Institute for Public Health Surveillance) and the Institut National de la Santé et de la Recherche Médicale (Inserm, the French Research Centre for Medicine, Science, Health and Society) on drug users who make use of injecting equipment exchange programmes, quoted in Choquet, 1999.

[34] Populations et Sociétés, 1998 (a four-page popular science journal published in French and in English by INED (Institut National d'Etudes Démographiques, the French National Institute for Demographic Studies)).

[35] For instance, one in three adolescents aged 15 to 19 consumed psychotropic substances during the year 1997. After MILDT (Mission Interministérielle de Lutte Contre la Drogue et la Toxicomanie, the French Interdepartmental Mission for the Fight against Drugs and Drug Addiction), 1999.

means foregoing simplicity in relation to the concrete implementation of the rights granted that a threshold system would entail, and, on the contrary, an age threshold would mean putting in place a more complex and more precise practice supervision system.

A. FIRST SOLUTION: SET AN AGE OF MAJORITY FOR HEALTH ISSUES, WITH A THRESHOLD

The first solution consists of introducing a general exception to the legal principle of parental authority, of providing the option for minors who have reached a certain age (the age would have to be decided) of accessing care in an autonomous manner. This solution has a certain number of advantages, but it also has several drawbacks.

1. THE ADVANTAGES OF HAVING AN AGE OF MAJORITY FOR HEALTH ISSUES

First of all, an age threshold would have, just due to the fact of its existence, two advantages which are vital for professionals – it would be simple and clear. Because it would enable them to distinguish in an objective and simple manner the individuals who are entitled to be provided with a service or have a right from those who do not, an age limit would only have the effect of "reassuring" actors in the health and social care system. A person under the legal age of majority already goes through various thresholds, the most important of which concern the ability to form one's own thoughts as regards penal and sexual matters - these were detailed in the first part of this report. It should be noted however that implementation of an age threshold requires that adolescent minors be in a position to prove their ages; yet if the very condition for being able to apply the threshold is a requirement to produce identity papers which enable the ages of minors to be established will also form an obstacle to it being properly applied (in cases where minors do not have papers, regardless of the reason for that).

The recognition of an age of majority for health issues lower than the legal age of majority secondly appears to be founded on the existence of proven differences on many levels (physiological, sociological, psychological) between a child and an adolescent in the current context as regards societal developments. The majority of the experts heard by the Conseil national du sida – and, in addition to them, adolescence specialists – indeed are in agreement when they underline the importance of the drop in the age of puberty in adolescents and the great maturity they show generally. Recognition of an age of majority for health matters can thus be seen as an opportunity to bring the law into line with reality. It goes without saying, given this, that the threshold chosen to grant independence to adolescent minors in relation to access to care should be chosen based on a consensus of specialists and that it should be reviewed regularly using available data.

Third of all, recognition of an age of majority for health matters would, in and of itself, lead to a notable improvement in the health care provided to adolescents. First, adolescent minors who have good relationships with their parents would continue to be cared for with their parents' de facto consent and support. Second, some adolescent minors at least for whom parental authority constitutes an obstacle to access to care could obtain health care in a normal way. Thus, in just as automatic a manner, improvement in the overall health care provided to adolescents is naturally beneficial in public health terms, since access by the greatest number of adolescents to care facilitates better awareness in terms of preventing risky practices.

Fourthly and lastly, the experience of other countries appears to show that the existence of an age of majority for health matters lower than the legal age of majority is possible and advantageous for adolescent minors. Of course cultural difference that exist between from country to country should be taken into consideration. However, the health authorities in Quebec, an entity which is relatively close to France in cultural, economic and social terms, assured the Conseil national du sida that application of the act on health services did not in practice give rise to any particular difficulties from the point of view of care given to minors, and that was also the case as regards anti-HIV treatment. Under the terms of the legislation, the holder of parental authority is entitled to have access to the record of a user who is a minor. *However, an institution shall refuse to give the holder of parental authority access to the record of a user who is a minor where […]* 2) the user is 14 years of age or over and, after being consulted by the institution, refuses to allow his record to be communicated to the holder of parental authority and the institution determines that communication of the record of the user to the holder of parental authority will or could be prejudicial to the health of the user[36].

A second example is adolescents' situation in relation to health care in the Netherlands, where the age of majority for health matters is 16 years of age, and this state of affairs is regarded as exemplary by numerous experts in the field, amongst other things for its consequences on abortion rates. 8.4 adolescents aged between 15 and 19 out of 1,000 have an abortion in the Netherlands, which is half as many as in France, six times less than in Great Britain and ten times less than in the United States.

2. THE DRAWBACKS OF HAVING AN AGE OF MAJORITY FOR HEALTH ISSUES

Recognition of an age of majority for health matters nonetheless poses a certain number of problems. First of all, it seems to the Conseil national du sida and also to every single adolescence expert that, generally speaking, the presence and the support of parents are incontrovertible for an adolescent minor who needs to get care, and that this is also the case from the perspective of

[36] Article 21 (enacted in 1991) of "An Act respecting health services and social services", R.S.Q. (Revised Statutes of Quebec) c. S-4.2.

the minor himself or herself. The objective that the public authorities pursue, both through the measures they take and the standpoints they adopt, is moreover to remobilise and rally parents and remind them of the responsibilities attached to their roles as parents. Reciprocally, the majority of experts heard by the Conseil national du sida underlined the potential dangers inherent in putting too much responsibility on the shoulders of adolescent minors. The main danger concerns a certain number of adolescents who are particularly vulnerable who refuse to receive or to continue treatment.

According to the psychiatrist Philippe Jeammet, "adolescents are sometimes in a place where they feel great confusion and have great difficulties, and, regardless of what they say, their parents mean much more to them than they are prepared to admit. Their disarray often arises out of expectations of their parents that their parents didn't live up to. They ask for secrecy, but don't want complete secrecy, and often do all they can so that the secrecy they say they want is smashed to smithereens." Given that, he continues, [...] adolescents who are in a bad way must be given care against their will. Adults cannot have a hand in adolescents' sabotaging of themselves. Adolescents will argue, they'll moan, but they will obey their parents if the parents are determined. There is a risk that the existence of the age of majority for health matters will reinforce the isolation of adolescents who are doing themselves harm and who won't get treatment, with an "it's my right to have a bad time if I want to" attitude [37].

Second of all, it must be acknowledged that any solution based on the existence of an age threshold brings with it two types of problems – problems regarding exactly what the age should be; and problems in relation to the pernicious effects that arise from it. These problems are necessarily linked, since the choice of a particular age automatically leads to the exclusion of individuals who are not old enough by one day in relation to the age selected. But these problems are especially acute as regards the issue of confidential access to care by adolescents. Firstly, various age thresholds are already in existence as regards law as it applies to minors, which makes choosing hard. Secondly and above all, adolescence constitutes for individuals a period of physical and psychological development, a period of transitions, during which they go through different thresholds in a concrete and singular manner, and quite often experience difficulties.

Given this, what basis can be used for deciding the threshold age of majority for health matters? Setting it at 16 years of age would make it compatible with legal provisions regarding the *couverture maladie universelle* (CMU, universal health coverage) system which recently came into force; but this would also mean excluding the possibility of minors aged less than 16 getting confidential access to care, when certain experts believe that it is at 13 to 14 years of age that many minors become sexually active without being aware of the risks they are taking in terms of their health. The same dilemma applies as regards the other possible thresholds – 15, as it is the age of majority for sex, or 13, since it is the age at which individuals are deemed to be capable of their own views according to criminal law. Reversing the logic behind the choice by basing it on the move from childhood into adolescence does not make the decision any easier, if only because, due to considerations in relation to physiology, a different threshold would have to be set for girls and boys. In terms of logic, all thresholds are, in short, arbitrary; and it is remarkable that none of the experts who got a hearing before the Conseil national du sida felt themselves capable of coming to a decision in favour of such and such an age.

Third of all and lastly, the purpose of this report does not relate to the issue of the independence of minors in general. It is, more specifically, to reflect on solutions which would enable minors who are in the extra-ordinary situation of wanting to receive care without their parents knowing that they are indeed receiving care. Without prohibiting itself from reflecting at a later time on the overall issue of the independence of minors, the Conseil national du sida deems that the solution to the problem of confidential access to care by minors should not be seen in the wider context of the age of majority for health matters.

B. SECOND SOLUTION: AUTHORISATION OF CONFIDENTIAL ACCESS TO CARE BY MINORS SUBJECT TO CONDITIONS, COUPLED WITH A FRAMEWORK OF ETHICAL RECOMMENDATIONS

A second solution would be to put in place a specific legislative exception to parental authority, in other words one which is supported by recommendations and one which depends on circumstances. The exception must first of all depend on circumstances on a legal level, in other words be subject to a set of conditions. It must secondly be structured, i.e. supported by the introduction of recommendations of an ethical nature, which would provide a framework for the practices of health professionals. The implementation of this solution implies finding a suitable method of funding it, changes to the aims of certain structures, and an overhaul of information-provision apparatuses in the areas of sexuality and drug addiction.

1. CONFIDENTIAL ACCESS BY MINORS TO CARE AND TREATMENT MUST FIRST OF ALL BE AUTHORISED SUBJECT TO TWO CONDITIONS

- At the express request of the minor;

- For health problems which, if disclosed to the holders of parental authority, would be likely to be harmful to the minor's state of health and bodily integrity and/or to result in the minor being the subject of opprobrium and discredit within his or her family.

1.1 AT THE EXPLICIT REQUEST OF THE MINOR

[37] Notes on comments he made during his hearing before the Conseil national du sida.

The first condition concerns the form of the request for confidentiality. It is of course necessary, first of all, that an awareness campaign be organised by the public authorities in such a way to make minors aware of the option they have to have such a request met when it is expressed.

In the interaction between the doctor and the adolescent minor, it is preferable to let the minor **spontaneously lay a claim** to confidential access to care. It indeed seems paradoxical to acknowledge a minor's right to stake a claim to confidential care while exposing him or her to the influence of adults. However, the doctor must be able to inform the adolescent minor of the option of getting confidential care, if the doctor finds out during the course of a consultation that the minor is not aware of that option and if disclosing care to the minor's parents could lead him or her no longer wanting to receive care. It shall moreover be seen in the context of considerations of an ethical nature detailed hereinafter that a request for confidentiality should under all circumstances be carefully explored by doctors.

1.2 FOR SPECIFIC HEALTH PROBLEMS

The second condition concerns the type of health problems for which confidentiality could be required. It does not appear desirable that a minor could receive care without his or her parents knowing for any pathology at all. It appears for instance impossible to allow that a health professional agree to provide care to a minor with cancer without the minor's parents knowing. The criteria which enables it to be determined what pathologies should be included furthermore cannot be the seriousness of the pathology – it is known for instance that an abortion, even if it is carried out by means of medication and with support from health professionals, is never a meaningless act for the woman having it; it is nevertheless an event that adolescent minors can want to keep confidential from their parents.

However, it could be thought that confidentiality is requested by the adolescent because the health problem that he or she wants to have treated concerns a **very personal matter**. Such is obviously the case as regards treatments made necessary or desirable by the consequences of sexual activity – sexually-transmitted diseases (regardless of how serious they are) or abortion. But we must also put into this category problems of a psychological order, and also care needs caused by addictive practices (the consumption of illegal substances, but also of alcohol).

The deciding factor concerns the risks run by the adolescent minor should the need for care result in very personal matters being revealed. Notification of parents as to the administering of a treatment to an adolescent minor, thus as to the existence of a pathology or a particular state (pregnancy) can indeed result in **damage** to the health of the child and/or to him or her being the subject of **discredit** within the family, or even being rejected by his or her family. These are the two types of risk on which are grounded requests for confidentiality by adolescent minors.

Damage to health and, less specifically, damage to the adolescent minor's well-being, occurs every time the parents, once notified, are opposed to the treatment being administered. Taking the example already used of a minor who experiences an undesired pregnancy that she wants to terminate for personal reasons, and her parents, for cultural, religious or moral reasons, are vigorously opposed to all forms of abortion, simply disclosing the fact of the pregnancy to her parents could lead to a dispute that could only be settled by means of an intervention by a children's judge given the current legal state of affairs. But making settlement of the dispute between the minor and her parents a legal issue appears all the more undesirable in that doing so will not settle everything and in that doing so does not provide sufficient guarantees as to the subsequent health care provided to the minor.

The notion of **discredit** can be defined by reference to the work of the sociologist Erving Goffman on stigma[38]. A stigma is, in an interaction between two people, any difference which exists between a "virtual" social identity and an "actual" social identity. The former is dependent on the expectations as regards normality of each of the people as to the attributes that the other person should possess; the latter is determined by the attributes that the other person actually possesses. But Goffman distinguishes, amongst people who have a stigma attached to them, those who are "discredited" and those who are "discreditable". Whereas "discredited" individuals (for example blind people) cannot hide their stigma and give themselves the task, in social interaction, to lessen the tension (the illness, particularly) that they inevitably generate, "discreditable" individuals' stigmas are on the contrary not immediately perceptible in social interaction; consequently, the problem which arises for them is to control everything that could reveal it, and harm the quality of the interaction, or harm the very status assigned to them in the interaction.

Evidently, the situation of minors who want to receive care without their parents knowing for a pathology or for a state which arose out of practices which are very personal to them is that of a "discreditable" individual – their sexual or addictive practices are not known to their parents, and the minors' intention is that the practices will not become known to them, through a fear of being subjected to the family's opprobrium, or through a fear of even being excluded from the family circle. For various reasons – cultural, religious and moral – certain parents would change their behaviour with respect to their son or daughter if they learnt, for instance, that he or she was sexually active, homosexual, or a drug addict.

1.3 JUSTIFICATIONS FOR A SPECIFIC EXCEPTION

[38] Goffman, 1975.

The introduction of a legislative exception based on the above circumstances regarding the principle of parental authority appears justified for two main reasons. First of all, its optional nature is suited to the unconventional nature of the situations regarding claims made on confidentiality by adolescent minors. Rather than introducing autonomy as regards access to care for all adolescent minors who have reached a particular age, what is provided is the option for those for whom parental authority could be prejudicial to getting confidential access to care and treatment. It should be stressed that the conditions in no way apply to particular individuals, but to specific situations – the measures proposed do not concern in any way whatsoever particular groups of individuals. The deciding factor as regards the "exceptional nature" of the situations is the family situation of the adolescent minors as perceived by them, especially from the point of view of tolerance that their parents display with respect to the minors' sexual practices (be they homosexual or heterosexual) or their addictive practices. Potentially all minors are susceptible to finding themselves faced with a need or a desire for confidential care, notably for benign pathologies relating to very personal matters.

Second of all, the introduction of such an exception would only constitute part of the evolution of legislation which, since the 1970s, has being limiting the authority of parents with regard to the sexuality of minors. It seems only logical that adolescent minors who have the right to be sexually active (from the age of 15), who can get confidential and in some cases free-of-charge access to various means of contraception and means of having protected sexual intercourse, and who are in a position to obtain screening tests after having had unprotected sexual intercourse, could also in a confidential manner take responsibility for the consequences in terms of health of such practices should they wish to do so.

2. AN EXCEPTION COUPLED WITH RECOMMENDATIONS

Such an exception must also be supported, in other words accompanied by the introduction of recommendations of an ethical nature which act as a framework in relation to the practices of health professionals.

Two recommendations deserve to be emphasised: firstly, the quality of dialogue between doctors – and more widely, between health professionals – and minors, in particular by introducing a reflection time for minors; secondly, the option of involving a counselling adult.

First of all, doctors should pay the utmost attention to the quality of dialogue with minor adolescents. Knowing that they can uphold secrecy as to certain treatments when adolescent minors stake a claim to confidentiality, doctors must assess the wishes of the minor without, however, trying to get minors to change their minds. It would be useful, to achieve this, for doctors to separate the point in time at which they provide information on the treatment from the point in time at which the minor consents to the treatment and the treatment begins, and, unless it is an urgent situation arising as a direct result out of the state or the pathology in question, allow the adolescent minors a few days in order that they think things over with a clear head. If the doctors deem that it is preferable, in the interests of the adolescent minor, not to administer treatment to them on a confidential basis, doctors must direct them to other care structures, however without disclosing the request for confidentiality that has been made to them to parents. In cases of adolescent minors with HIV infections, directing them to multi-disciplinary care (provided by a nurse, a psychologist, and a pharmacist) appears the most appropriate solution.

Second of all, it is desirable for doctors to ask minors to choose a counselling adult who is capable of providing support to them with regard to their treatment. Doctors absolutely must notify minors of their option of choosing a counselling adult, but the former cannot impose this choice on minors, and still less impose a certain adult on them. While the aim of having a counselling adult is to avoid increasing the isolation minors may feel, the claim made on autonomy which, as regards certain minors is inseparable from the claim made on confidentiality, must be respected. The counselling adult cannot be the prescribing doctor himself or herself, nor be from the judicial domain, but can be chosen by minors from within their family sphere or be someone from a professional sphere (not-for-profit organisations, teachers, health and social workers, etc.). Doctors must also be in a position to direct minors to existing structures which are likely to help the minors follow their courses of treatment and provide psychological support. It goes without saying that the counselling adult will not be granted any aspect of parental authority, and that they will not be held legally responsible for the confidential nature of the care given to the minor. His or her role is restricted to assisting the minor, and – to the extent that it is possible to do so – to examining with the minor ways of renewing ties with the minor's parents. In the latter case, the counselling adult can play the role of mediator between the child and the parents. Indeed everything should be done to prevent the adolescent minor from feeling isolated and from "going into hiding" within the family circle.

3. THE NECESSITY OF SUITABLE FINANCIAL AND ADMINISTRATIVE APPARATUSES

The circumstances-dependent and supported exception to the principle of parental authority implies, finally, the existence a certain number of financial and administrative systems.

Specific financial provisions must be made as regards the confidential access of minors to care and treatment. Minors – but also many young people over the age of legal majority – are dependent on their parents in terms of health insurance. Consequently, reimbursements for acts which are made by the Sécurité Sociale (the French national social security system) and/or from supplementary health coverage organisations are likely to break confidentiality, which makes the funding apparatus for acts a vital part of the effective application of the legislative exception proposed herein.

For minors, the principle of free treatment must be seen as preferable, in the name of equality as regards care. In this context, the funding of medical acts and treatment must be examined on two levels.

As regards private practices, retrospective reimbursement for acts carried out by doctors should be funded by means of an agreement between private sector doctors and the Caisse Nationale d'Assurance Maladie (the French national health insurance fund) and/or the State, by using specific treatment forms for instance, which would be forwarded directly to the Caisse by doctors. It must be stressed that using this type of funding system would not result in any additional cost. Firstly, the cost of the health care provided to adolescent minors would be the same as if the care was covered by their parents' health insurance. Secondly, the desirable short-term increase in cost due to the increase in the numbers of adolescent minors accessing care as a result of the confidential nature of the care would be followed by a drop over the medium term and the long term, arising out of an improvement in the state of health of minors, and the expected positive effects in terms of preventing risky practices.

Health care for adolescent minors will secondly be provided by a certain number of HIV-AIDS structures which already operate under the supervision of the State or which have an agreement with the State, which are used to dealing with adolescents on a confidential if not an anonymous basis. These are, given the current position regarding the health and social care apparatus, hospital structures, anonymous and free screening centres ("CDAGs") and family planning centres. But recognition of confidential access by adolescent minors to care should also represent an opportunity to encourage the development of the not-for-profit sector in the direction of provision of health care to adolescent minors. Consequently, the aims of the structures directly concerned by the care in question herein must be extended – insofar as directing people to hospital centres is not always possible, in particular as regards adolescent minors living in small-sized municipal areas, doctors at CDAGs and at family planning centres should be allowed to prescribe treatment (prophylactic and curative treatment against infection by HIV and STDs). What should also be done, moreover, is to facilitate the development of a not-for-profit sector specially accredited to provide health care to adolescent minors. On a general level, facilitating confidential access by minors to treatment implies mobilising the resources of existing institutions, starting with those which already have experience as regards the provision of care to adolescent minors. Furthermore, directing minors to institutions funded by the State is not only preferable due to financial considerations, but also because of the possibility they provide – notably with regard to the most complex treatment – of supervising the adolescent minor's compliance.

Finally, it appears indispensable that deficiencies in terms of information provision be remedied, as they contribute to minors' care needs. Public awareness campaigns on contraception and on the use of drugs have their usefulness. However the provision of information to adolescent minors regarding sexuality but also the use of legal drugs (notably alcohol) and illegal drugs – if one is to judge by the rise in people with multiple drug addictions and the consumption of synthetic drugs – must be entirely re-thought. It is notably more than ever necessary that **all** adolescent minors receive complete, detailed and accurate information on the human body, on the health effects of legal and illegal drugs, on sexuality, on hygiene rules, and on sexually transmitted diseases, in schools and in the form of extra-curricular activities, if required with support from not-for-profit organisations in the relevant subject areas, **as early as possible**.

STATEMENT AND RECOMMENDATIONS

Given the current state of affairs regarding legislation, minors cannot get medical care or treatment without their parents knowing, since health professionals are subjected to the obligation, except in urgent cases, of trying to get the consent of the holders of parental authority beforehand. No health care can therefore be provided to minors legally without parents being notified and consenting. Medical secrecy is subordinate to parental authority as regards care.

However situations arise in which minors request care that is confidential in relation to their parents (and less specifically, in relation to the holders of parental authority) from health professionals. The minors are in fact adolescents who believe that disclosing their pathology or their state to their parents could permanently damage the quality of their relationship with the latter, that doing so could lead to them being the subject of discredit and opprobrium, or that doing so could be harmful to their health. The state or the pathology which forms the ground for the request for confidential care relates most commonly to minors' sexual activity, activity which by definition is a very personal issue for each individual, whether they be adolescents or otherwise, and which activity, in particular for adolescent minors, presents health risks; the pathology from which the request for confidential care arises can however also relate to the consequences of minors using psychoactive substances.

Yet, health professionals deem the adolescent minors who want to get confidential care capable of forming their own views, and deem their request to be legitimate, even considering it to be a bottom-line factor for minors; in short they believe that, in the minors' interests, they should be able to meet these requests. Caught between wanting to provide care and the obligation of complying with the law, health professionals are in a no-win situation. As to the adolescent minors who consider that care must be confidential, the risk exists that they will decide not to get care if the health professionals refuse to accede to their request. The consequences of them doing so would be highly harmful as regards the personal health of such adolescent minors, for their faith in the care system, and ultimately for public health prevention activities.

Although it constitutes the general rule as regards the provision of care to minors, the principle of parental authority has nevertheless over the past thirty or so years been modified by a certain number of exceptions introduced by means of legislation, which precisely concern matters which are very personal to minors, exceptions regarding access to means of contraception, access to screening, and a system of twin consent as regards abortion. On a legal level, minors are also autonomous in relation to sexual activity from the age of 15, and as regards freedom to consult with a health professional. Furthermore, French society has been subject to changes which – without calling into question the principle of parental authority – constitute a trend towards the wishes of minors who are capable of forming their own views being taken into account more. Consequently, it appears that the introduction of a supported legislative exception based on circumstances constitutes an appropriate solution to the problem of confidential access by minors to care.

Given the above, the Conseil national du sida makes the following recommendations.

1. The Conseil national du sida recommends that, by means of a measure introducing a legislative exception to the rule of parental authority, confidentiality of access to care be granted to minors when both of the following conditions are met:

- The minors **make a request** to health professionals for care which is confidential vis-à-vis the holders of parental authority;

- Care is made necessary by a **state** or a **pathology** which arose out of **practices relating to very personal matters**, and the minors believe that if the state or pathology **is disclosed** to the holders of parental authority this would be likely to lead to them being **the subject of discredit and opprobrium**, and could **result in damage to their psychological health and their physical integrity.**

2. The Conseil national du sida recommends that the implementation of this legislative exception specific to the principle of parental authority be **supplemented by recommendations made to health professionals.**

First of all, while the request for confidential care must **come about on the initiative of the minor**, health professionals **must notify** minors of the option of obtaining confidential care each time they find out that a minor is reticent about obtaining care and this relates precisely to the disclosure of a pathology to parents.

Second of all, health professionals **must always get minors** who request confidential care:

- Firstly, **to take time to reflect**, unless it is an urgent situation arising as a direct result of the state or the pathology in question, to ensure that the minors' own requests are made in a resolute manner;

- Secondly, **to choose a counselling adult** who is in a position to **assist** them and **support** them in their care procedures and, where applicable, to act as a **mediator** between them and their parents.

3. The Conseil national du sida recommends firstly that the implementation of this specific and legislative exception to the principle of parental authority, coupled with a framework, guarantees in financial terms that care will be **entirely free of charge for the minors in question**, secondly that **structures be involved which are competent** as regards the pathologies in question and as regards the provision of health care to adolescents (hospital structures, anonymous and free screening centres, family planning and education centres), and lastly that it is achieved through the development of a not-for-profit sector specially accredited to provide health care to adolescents.

4. The Conseil national du sida recommends finally that, with regard to **prevention in the sphere of education and schools**, policies regarding the provision of information to minors regarding the body, sexuality, the use of psychoactive substances (both legal and illegal) be **completely revised** by all actors – both public and not-for-profit actors – in the school, educational, health and social sectors, in order to improve the knowledge of **all** adolescents with regard to these topics and, at the same time, inform them that they have the option of getting certain types of care on a confidential basis.

SCHEDULES

SCHEDULE 1

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SCHEDULE 2

LIST OF IMPORTANT FIGURES HEARD BY THE CONSEIL

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- Professor Philippe Jeammet, Psychiatry Department Head at the Institut Mutualiste de Montsouri;
- Dr Charlotte Melman, Head of the Belleville anonymous free screening centre (CPAG);
- Ms Pierrette Paillas, technical advisor at the Children's Social Assistance Department at the Seine-Saint-Denis Departmental Council;
- Ms Prononce, clinical psychologist at the Children's Social Assistance Department at the Seine-Saint-Denis Departmental Council;
- Dr Catherine Rongières, hospital doctor, Strasbourg;
- Ms Dominique Seran, Assistant Presiding Judge of the Evry Court, responsible for the juvenile court;
- Ms Anne-Sylvie Soudoplatoff, a magistrate at the Direction de la Protection Judiciaire de la Jeunesse (directorate of youth court-ordered welfare) within the Ministry of Justice.

- The Conseil national du sida, moreover, extends its thanks to the not-for-profit organisations Vaincre le Sida, Act Up and Sida Info Service for the information and data they provided to it.

SCHEDULE 3

French Republic

The Secretary of State for Health and Social Action
acting under the authority of the Minister for Employment and Solidarity

24th August 1999

Dear Mr Chairman,

Questions are regularly asked by health professionals in the context of anonymous H.I.V. screening consultations regarding the approach to take with regard to adolescent minors after they have taken a risk, in particular when a positive result is being notified to an adolescent.

The current context – the notable aspects of which are the therapeutic progress made in the response to infection by H.I.V. – entails tasks which must be carried out in short timeframes (assessment of risks, diagnosis as early as possible leading where applicable to emergency treatment after a risk has been confirmed, quick treatment and care should primary infection have taken place, etc.). Yet, therapeutic treatment and care following a screening consultation, without parents being present, are blocked by the principle of the exercise of parental authority set out in article 371-2 of the Civil Code: "authority lies with the father and mother to protect a child as regards the latter's safety, health and morality". Consequently, all therapeutic acts on a child, unless an express special dispensation applies, are dependent upon the parents' consent. Should a minor request confidentiality, it appears however necessary – by means of the provision of effective treatment and care to the youth – that efforts at mediation be carried out in relation to the parents (for instance when the young person is revealing to them that he or she is addicted to drugs or is homosexual).

This is why I would like the Conseil national du sida to examine the various situations health professionals meet with in relation to minors' access to prevention, diagnosis, and treatment, and to endeavour to gather information on the various points of view being expressed in this respect, notably by not-for-profit patient organisations, by experts in the relevant fields, by representatives of the State at decentralised level and by representatives of local authorities, and for it to make recommendations to health professionals regarding the approach to be adopted, given that the situations studied may be examined in a larger context than that of H.I.V. infection alone.

Yours sincerely,

Dominique Gillot.

Mr GASTAUT
President of the Conseil national du sida
25, rue d'Astorg
75008 PARIS, France

ACCESS BY MINORS TO CARE AND CONFIDENTIALITY[39]

Alain Molla

At a time when patients' rights are – at last – going to be recognised by the law after having been the subject of a vast debate under the impulsion of the not-for-profit sector grouped together as the Collectif Interassociatif Sur la Santé (CISS), it is vital to draw attention to the problem of providing care to sick minors and of their right to confidentiality.

On 24th August 1999, the Conseil national du sida (CNS) was referred – opportunely and intelligently – an issue by the Secretary of State, Dominique Gillot: that of the "approach to be taken by health professionals, in the context of anonymous HIV screenings, with regard to minors who consult after having taken a risk, in particular when a positive result is being notified to an adolescent". What she was doing was requesting an opinion from the CNS in full knowledge of the fact that "therapeutic treatment and care following a screening consultation, without parents being present, is blocked by the principle of the exercise of parental authority (article 371-2 of the Civil Code), therapeutic acts on a child are dependent upon the parents' consent [...] [even] should a minor request confidentiality". The referral was an opportunity for the CNS to reflect on the problem of access to care by ill minors and of the connected confidentiality problem, in a larger context than that of solely HIV/AIDS. The diversity of situations that health professionals are faced with in relation to minors is obvious, just as the notion of "minority" (i.e. being under the legal age of majority), a purely legal one, is obviously not very appropriate at all and is a very ambiguous one in the field of public health in relation to the ethical management of the often distressing situations they have to deal with.

Being minor and thus being aged less than 18 years of age can be the case of children, of pre-adolescents, of adolescents and even of adults, depending on infinitely variable physiological, psychological, socio-economic, and cultural sets of circumstances. Being pubescent or not, being mature or not, living in the family home or not, being at school, in secondary school or being unemployed, or else having a paid job, and even being married or otherwise – so many examples which illustrate the infinite variety of minors' situations and the fact that the legal notion of minority is of very little help to the professionals who have to deal with requests for care.

CONVENIENT LEGALLY BUT MEANINGLESS

The legal reference point which consists of being aware that, under 18 years of age, health issues can only be dealt with if parents or guardians are notified and consent (because protecting the health of "children" is indeed one of the main attributes of parental authority according to the Civil Code) has all the appearances of being a convention which is devoid of meaning, even a troublesome convention, and one which is awkward to deal with if minority is accompanied by puberty, maturity, housing outside of the family home and financial independence.

It is understandable given the above that the CNS wanted to carry out its work with the concept of adolescence – which is easier to define than the concept of childhood – as its starting point, in order to reflect on the extent of the autonomy that should be given to adolescent minors confronted with health problems which they – rightly or wrongly – want to hide from their parents. The CNS did not prohibit itself from thinking that their wishes could be legitimate in certain exceptional circumstances, even though it is also valid to believe that ideally a disease should be faced, especially if it is a serious one, with the support of familial love.

EFFORTS TO AVOID THE GRAVE CONSEQUENCES OF ADOLESCENTS OPTING OUT OF CARE

It unfortunately has to be admitted that many adolescents do not get that support or think that their parents are not capable of understanding what is happening to them. In the two cases, the priority is to avoid the minor adolescent's actual or imaginary isolation leading to the grave consequences of him or her opting out of care or discontinuing his or her treatment, solely as a result of a conviction the minor has – rightly or wrongly – that his or her parents are incapable of understanding what the pathology might reveal about a lifestyle which the parents do not know anything about. Revealing to certain parents – at the same time as a disease – the use of drugs or what is often precocious sexual activity, or homosexual activity, is a very difficult thing to do. The adolescents must be spared that difficulty, and their priority energy and initial energy must be put into their treatment through a relationship with care-givers that is full and is founded on trust and does not relate to the fear of their parents' reaction, anxiety about displeasing them, of disappointing them or of hurting them. Thus came into being, as a fundamental right, the notion of very personal issues and their privacy, which cannot be taken away from adolescents who are at an age at which they have a sexuality and are capable of forming their own views. The main priority for the CNS was to come up with criteria which were then to be used as a framework for professionals who had to be relieved of the legal and ethical no-win situation constituted by a rigid rule, namely that of omnipotent parental authority under 18 years of age. Rejecting hypocrisy means asserting clearly, faced with the seropositivity or the STD of an adolescent who is concerned about confidentiality, that

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they will from now on have a choice between, on the one hand, meeting the patient's request for discretion and breaking the law, and, on the other, notifying parents and thus betraying the trust that the minor placed in them, without the health professional even knowing if the disclosure of information will be a factor which will aggravate the pathology that has been discovered.

MINORS' RIGHTS TO PRIVACY AS REGARDS VERY PERSONAL ISSUES

Guaranteeing adolescent minors the confidentiality they want in relation to the holders of parental authority regarding care the minors have to get due to a state or a pathology which arose out of practices relating to very personal matters is a necessity. It is all the more important should notifying parents be likely to make an adolescent the subject of discredit and opprobrium and his or her psychological health or physical integrity is affected as a result. Protecting minors' right to privacy as regards very personal issues must go hand in hand with free care in order that indirect disclosure via parents' health insurance statements be avoided.

FLEXIBLE CRITERIA WHICH ARE APPRAISED BY CARE-GIVERS

These criteria are the criteria which have been selected by the CNS and which have been suggested to the legislator. Their main advantage is that they are flexible and they are subject to concrete appraisal by care-givers, on a case-by-case basis, within the context of a dialogue which begins with minors' staking their claim to confidentiality. This aim of having a flexible system was all the more important in that the CNS rejected the easy option, the – albeit attractive – concept of an "age of majority for health matters" which would have entailed confidentiality being a right above a certain age threshold, with no further criteria applying, and not being possible under it.

Examining the hypothesis for just a moment that an arbitrary and random choice regarding an age threshold is right, for example 15 so that it would be the same as the sexual and judicial age of majority, it appears that a sociological approach to the notion of adolescence would make derisory and unfair the rejection of claims to confidentiality made by minors aged 14 who are just as likely to experience the distress engendered by the health consequences of precocious sexuality as minors aged 16. The high number of requests for abortions on personal grounds (the figure does not include therapeutic cases) on the part of very young minors and their frequent wish to not obtain legally-mandatory consent from their families demonstrates not only that adolescents are precocious sexually and parents are all too often not aware of that, but also the reality of the risk of contracting an STD and the necessity of ensuring an optimal context surrounding treatment and care.

This move as regards the autonomy of adolescent minors, regardless of their age, when the care need concerns very personal matters, is not new. It is part of a coherent tradition, since contraception (Act of 4th December 1974) and access to an anonymous free screening centre (Act of 23rd January 1990) are two situations that minors can already deal with alone without reference to their parents. In a similar vein, legislation on abortion and the – very controversial – requirement for twin consent (parents and child) should evolve along the same lines and on the same basis, in other words with privacy as regards very personal matters as the priority.

INNOVATION AS REGARDS ASSISTANCE AND SUPPORT

The aim is not to exclude parents or to relieve parents of duties, nor to create for adolescent minors an area of solitude as regards dealing with disease and care. Quite the opposite. Identifying situations in which requests for confidentiality are being made should enable motivations to be assessed and allow innovations to be made as regards assistance and care, even as regards mediation in relation to parents.