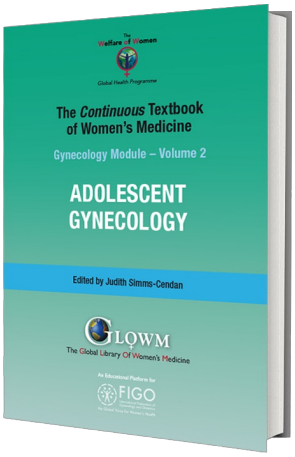
This chapter should be cited as follows:
Hoover K, Lacy B, *Glob Libr Women's Med*
ISSN: 1756-2228; DOI 10.3843/GLOWM.418013

***The Continuous Textbook of Women's Medicine** Series* **– Gynecology Module**
Volume 2
ADOLESCENT GYNECOLOGY
***Volume Editor: Professor Judith Simms-Cendan**, University of Miami, USA*



Chapter

Ethics in Adolescent Gynecology

First published: October 2022

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> "In all actions concerning children, whether undertaken by public or private welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."[1]
>
> *United Nations Conventions on the Rights of the Child*

INTRODUCTION

Adolescent reproductive health is a global concern. Recent statistics from the World Health Organization reflect this with at least 10 million unintended pregnancies occurring each year among adolescent girls aged 15–19. Complications during pregnancy and childbirth are the second leading cause of mortality worldwide in this same age group.[2] Rates of sexually transmitted infection (STI) pose additional public health concern. In the United States approximately half of gonorrhea and chlamydia cases occur in 15–24 year olds.[3] It is estimated in the United States 1 in 4 sexually active adolescent girls

have an STI. Comparably, in the United Kingdom some studies suggest as many as 30–40% of sexually active adolescent girls have a sexually transmitted infection.[4]

As a reproductive health specialist, the gynecologist is uniquely positioned to address such significant concerns. FIGO affirms this sentiment and states, "health professionals, especially gynecologists, should give emphasis to providing young persons' access to education and sexual and reproductive health services."[5] The American College of Obstetricians and Gynecologists (ACOG) recommends an initial reproductive health visit for adolescents between the age of 13 and 15 years.[6] Patient-centered care and shared decision making should be a priority, building on the foundational principles of medical ethics.

The fundamental tenets of ethics in medicine, namely the principles of beneficence and maleficence, autonomy and confidentiality, consent, and assent in the context of adolescent gynecology are discussed below. This chapter continues in addressing specific reproductive health considerations and offers suggestions on how to create space for adolescents seeking reproductive services. While legislation regarding these considerations vary, there are many organizations, national and international, that provide specific recommendations on how to navigate these important matters. These recommendations are acknowledged throughout this chapter and sources providing full text of these guidelines are provided for additional reference.

BENEFICENCE AND NONMALEFICENCE

The ethical concepts of beneficence and nonmaleficence can be traced to the Hippocratic *Oath* circa 400 BC. While the relevance of the Hippocratic *Oath* has been the subject of discussion and debate in contemporary medicine, the core ethical concepts continue to play a significant role in modern medicine. Currently, medical students in nearly all medical schools in the United States, in almost half of medical schools in the United Kingdom, and in the majority of Western medical schools, will recite some form of the Hippocratic *Oath*.[7] Other medical schools use the Geneva Declaration, created by the World Medical Association, which echoes the precept of beneficence and states that among a physician's responsibilities, "a physician shall act in the patient's best interest when providing medical care."[8]

Beneficence is the principle of acting in the benefit of the patient. This value compels the physician to not just avert harm done to a patient, but to act in such a way that promotes the patient's well-being. Nonmaleficence is defined as an obligation on the part of the physician to do no harm to patients. This principle in application requires the physician to weigh the relative merits of treatment against the potential deleterious effects, thereby selecting the best course of action for patients.[9] While the often times sensitive and complex presentations of adolescent gynecology may pose a challenge, the fundamental tenets of beneficence and nonmaleficence are equally applicable in regard to providing care to adolescents.

AUTONOMY AND COMPETENCE

Historically, children were deemed the property of their parents, devoid of independent rights. In the latter half of the 20th century, the concept of a "mature minor" was developed.[10] Developmental research conducted in the 1980s found that many minors reach the level of cognitive development that allows for abstract thinking and complex decision making by mid-adolescence. Indeed, research demonstrates that by age 14 and 15, adolescents have the capacity to make health-related decisions similar to those of adults.[11]

There is no universal agreement among medical organizations that define the age of competence in decision making in adolescent health matters. Competence as it pertains to adolescents has been more extensively evaluated in research than in clinical domain. Evidence has pointed to an emerging level of competence at an age as young as 9 years old.[11] A study conducted from the Netherlands determined that children aged 11.2 years and older were competent to make decisions.[12] Competence may fluctuate depending on the context and it is incumbent on the provider to assess a level of competence after providing comprehensive education in an appropriate environment. It has been proposed that the criteria for assessing competence require that the adolescent be able to understand the nature and intent of a proposed treatment as well as the risks/benefits/alternatives to electing non-treatment. Additionally, it is important that the

adolescent understand how pertinent information applies to them and that they are able to retain said information long enough to make a decision free from coercion.[13]

Numerous international guidelines underscore the importance of actively involving children in decision making regarding their care. The United Nations Convention on the Rights of the Child, signed over 30 years ago, centers the voice of the child as a priority in the child-health matrix. The child's independent rights are reflective of their evolving capacity as they age.[14] This concept is reflected The American Association of Pediatricians position that "patients should participate in decision-making commensurate with their development."[15] The American Medical Association furthers this to say that the involvement of adolescents in their care is "an ethical duty" of physicians.[16] Additionally, FIGO recommends that, "healthcare providers should recognize that adolescents and youths can possess capacity to make substantial life choices for themselves."[5] They continue to state that "chronological age should not determine young persons' rights to make sexual and reproductive health choices for themselves."[5]

CONFIDENTIALITY

Confidentiality in adolescent health care, by definition, is that information about an adolescent's health care that is not disclosed without their permission.[17] It has been demonstrated that adolescents are more inclined to access health care if they have assurance that this care, and what they relay to a provider, is confidential.[18] Conversely, when there is a perceived lack of confidentiality, this presents a barrier to an adolescent utilizing health care effectively.[19] Research has shown that if confidentiality cannot be ensured, adolescents will avoid or stop using health services, are less inclined to use family-planning services for contraception and sexually transmitted infection treatment, and will not be fully forthcoming with providers.[18] An inability to accurately assess risks and behaviors inherently undermines comprehensive and quality care.

In regard to confidentiality, FIGO recommends that "providers should ensure that access to their facilities, and their facilities' waiting and counseling areas and treatment rooms, preserve young persons' confidentiality."[5] Additionally, FIGO states, "adolescents and youths found capable of making treatment and related decisions for themselves should be afforded the medical professional confidentiality that adult patients enjoy, and be made."[5]

The Society for Adolescent Medicine advises the provider clarify and establish the policy of confidentiality at the initial visit. This will foster an atmosphere of trust, allowing for open communication and more accurate assessment of a patient's risk and behaviors. The limitations of confidentiality should be reviewed, including the need to report suspected abuse, suicidality or homicidality, and certain communicable diseases.[20] Additionally, there are limitations on confidentiality within the context of insurance billing, messages relayed through an electronic medical record, and legal mandates in regard to specific services (i.e., abortion). It is prudent for the gynecologist to be aware of the regional legal requirements applicable to their practice. Multiple organizations, among them the WHO, the United Nations Children's Fund, and the American Academy of Pediatrics endorse policies in support of adolescent access to confidential reproductive health services.[17]

Confidentiality is a key component to all of health care, but it is particularly an important element to maintain when caring for the adolescent patient. At times there may be barriers to confidentiality, perceived or real, by the adolescent. Those potential barriers should be addressed by the provider and all questions about confidentiality should be clarified at the outset of the office visit. There are many laws that protect patients with regards to confidentiality. In the United States, HIPPAA provides protection for the adolescent when they are seeking sexual reproductive health services. In most states in the United States adolescents can provide their autonomous consent at age 18.[6] However, this does vary by state and can be younger than this in certain areas.[19] Individualizing the patient's care involves accounting for their developmental stage as well as chronologic age, their ease of access to care, and their ability for compliance.

CONSENT AND ASSENT

Beneficence, nonmaleficence, and respect for autonomy are the underpinning of informed consent. For adolescents, as

with adults, the goals of informed consent are to protect and promote health and engage the family in decision making. While there is no consensus among clinical and research arenas regarding the definition of assent, the most stringent definition requires that a minor meet all elements of an adult informed consent. The elements as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) include a comprehensive review of a proposed treatment, its potential risks, benefits and alternatives, as well as the risks and benefits related to these alternatives, including the option and results of not receiving said treatment. At a minimum, assent should involve the adolescent at a developmentally appropriate level. The provider should review with the patient the expectations of particular treatment, elicit the patient's understanding of the situation, and assess for any undue influence or coercion.[15]

The physician should use age-appropriate language and share information that respects the cognitive ability of the adolescent patient. An effort should be made to solicit the patient's treatment goals and understanding of treatment options. To the extent possible, the parents should be engaged in these discussions as well. Ultimately, gynecologists have an ethical obligation to respect the rights of the adolescent, provided that in doing so does not harm the adolescent as stipulated in the UN Convention on the Rights of the Child.[1]

REPRODUCTIVE HEALTH CONSIDERATIONS FOR ADOLESCENTS

Contraceptive counseling

On a global scale, the adolescent fertility rate has declined over the last two decades. However, the WHO reports the actual number of births to adolescent girls has not decreased due to the large population of young women aged 15–19.[2] It is estimated that 80% of adolescent pregnancies are unintended.[21] The gynecologist has a unique opportunity to counsel adolescents on contraception options, to assess attitudes, knowledge, and beliefs about contraception and to provide anticipatory guidance about sexual activity for the adolescent in the future. When counseling the patient about her options for contraceptive options, it is important for the provider to realize their own biases, self-reflect, and focus on a patient-centered care model involving the patient with their decision making. It is imperative that the provider remove their bias and create an environment that supports open, honest exchange devoid of judgment or coercion.

The gynecologist should be able to review all contraceptive options and be mindful that, barring any contraindication, patient choice should be the primary factor in selection of a particular contraceptive method. It is important that the provider comprehensively review the patient's desires, expectations, and concerns and offer time and space for decision making. The provider should have educational tools, whether in pamphlet form or online, to aid with discussion. There are multiple different formats and tool kits, which can be obtained through different sources, such as the American College of Obstetricians and Gynecologists (ACOG) or the Center for Disease Control (CDC), that are effective for facilitating communication between the adolescent and the provider about options for contraception.[21] There are also modalities online through the US Medical Eligibility Criteria for Contraceptive Use to help the provider select a safe and effective form of contraception for the patient; particularly if they have complex medical problems.[21]

Rates of contraceptive use for females have increased from 2006 to 2010 to 2015 to 2019.[22] Overall use of any contraceptive method has increased to 86%, IUDs and implants have had an uptake from 3% to 15%.[23] There are many misconceptions regarding contraception with adolescents and strategies to mitigate these will be helpful for the provider and patient. There are misperceptions intrauterine devices are associated with an increased risk of infertility, difficulty with insertion, uterine perforation, and expulsion. The data refute these misconceptions and demonstrate that fertility returns fairly rapidly after IUD removal.[23] Successful placement with first attempt reaches a rate of 96% of patients age 13–24 and the overall expulsion rate for women is approximately 6% for all users.[23] Uterine perforation is extremely rare with adolescents and women with rates being similar at approximately 0.1%.[23] It has been studied that IUDs have higher efficacy and continuation rates as well as satisfaction rates than short-term acting contraceptive methods. The Choice study found that 81% of adolescents age 14–19 years of age would continue the use of their LARC method at one year, whereas 44% of the participants continued using short acting contraception.[23]

The physical exam, breast exam, and cervical cytology are not needed to establish contraception for any age. Sharing this with the patient at the outset of the visit may assuage fear or relieve anxiety. Quick-start for all contraception should be considered with the adolescent as well in order to prevent barriers to access.[24,25] Scheduling a short interval follow-up

appointment to aid with compliance is an important element of this introductory visit. Additional recommendations are offered in the ACOG Committee Opinion on the initial reproductive health visit.[26]

Sexually transmitted infections

The prevalence of certain sexually transmitted infections, particularly gonorrhea and chlamydia, are the highest during adolescence.[27] The biologically immature anatomy of the vaginal mucosa of the adolescent can allow for increased susceptibility of sexually transmitted infections and HIV.[28] Human papilloma virus (HPV) is also acquired during adolescence when sexual activity has occurred and can increase risk for cervical cancer in the future.[28] Prevention measures with HPV vaccination can decrease the long-term sequelae.[28] The World Health Organization currently recommends HPV vaccinations to all children at the age of 9.[29]

The provider has an influential roll educating prevention of STIs. If using a highly effective form of contraception, the adolescent is less likely to use barrier protection for STIs.[25] It is of particular importance to advocate dual-use contraception with barrier methods in this group to decrease STI transmission rates. Providing condoms and barrier protection in the clinical office may help ease access for the adolescent obtaining barrier protection.

Both ACOG and FIGO endorse full-scale educational programs to further decrease rates for STI in adolescent pregnancy.[25,27] In the United States, the CDC recommends STI screening, which includes gonorrhea, chlamydia, and HIV testing, for all adolescents seeking testing and offering this testing to all adolescents who are sexually active.[30] In the United States, all minors are allowed to consent for STI services and no parental consent is required for STI care.[30,31] There are some states that require consent for specific services, such as HPV vaccination.[32] The CDC and Guttmacher Institute detail specific state laws and are valuable resources for the provider. Even though the adolescent can consent for STI testing, there are numerous barriers that pose difficulty in accessing testing. Such challenges include transportation, cost, knowledge of where to find testing, confidentiality of the electronic health record, fear of an exam, shame or embarrassment, and provider attitude.[28,33]

Adolescent pregnancy and prenatal care

Adolescent pregnancy is a global health issue. Each year, an estimated 12 million girls age 15 to 19 will give birth and approximately 770,000 are born to mothers less than 15 years old.[34] The leading cause of death for girls age 15 to 19 globally as cited by the World Health Organization is due to complications in pregnancy and childbirth.[34,35] High rates of pre-eclampsia, endometritis, obstructed labor, fistula, and systemic infection are seen in teen pregnancies.[23,35] Additionally, babies born to young mothers often have higher rates of lower birth weight and preterm delivery.[27,35] CDC data shows that infants who are born to teen mothers have an increased risk of death during their first year of life.[36]

Adolescent pregnancy occurs world-wide, but higher rates are seen in lower- and middle-income countries.[34] Poverty and employment opportunities are factors that have been seen to contribute to the adolescent pregnancy rate. In marginalized social situations, marriage and motherhood are valued and are often times views as a means to escape poverty or lower the cost of their family.[28] Adolescents trying to avoid pregnancy have many barriers to contraception, which were discussed earlier. An increase in sexual violence and sex trafficking has added to unintended pregnancy rate. Adolescent pregnancy correlates with lower rates of completing educational opportunities for employment in the future.[27,28]

Discussing the range of options for pregnancy may have significant outcomes for future educational and economic achievement. Providing a clear understanding of termination, parenting, and adoption options to the teen is important. The provider should confirm with the teen who they trust and want to involve in the decision-making discussion. Teens educated through these options in an un-biased fashion have been shown to be happy with the decision of their pregnancy.[37] In the United States, many states have expanded a minor's authority to consent to health care, obtain confidential prenatal care and regular medical visits as well as retaining services for labor and delivery.[38] Although many states require parental consent for abortion services, almost all states allow minors who are parents to have medical decision-making for their child without their own parents' consent.[39] Developing programs to support and educate teens

about sexual health, infant care, and parenting can improve outcomes.

Menstrual equity

Period poverty is defined as a lack of access to clean, absorbent materials to manage menstruation.[40] This also extends to having private and safe places to use menstrual materials. About one-quarter of the world's population does not have access to these elements required to manage a period.[40] Worldwide improvement of menstrual health is gaining policy importance in the United States and a comprehensive Menstrual Equity for All Act is being ushered into legislation.[41] In Scotland, free access to hygiene products is available at all schools, colleges, and universities.[42] Kenya was the first country to abolish a tampon tax. Other countries, which do not tax menstrual hygiene products as luxury items, include the UK, Australia, Uganda, Canada, India, Nicaragua, Malaysia, and Lebanon.[43]

Despite these efforts, there continues to be a disparity in menstrual hygiene equity. Kenyan schoolgirls have reported that competing for resources such as soap and water result in conflict at home.[44] The cost of sanitary pads was a concern for adolescent girls in India, Tanzania, and Uganda. Up to 37% of schoolgirls in Uganda reported using toilet tissue for menstrual management.[45] In many countries, menstruation is viewed as dirty and shameful. Adolescent girls in low- and middle-income countries often hold misconceptions regarding menstruation. In one study, 82% of Nepalese girls felt menstruation was a "curse". Similarly, prior to receiving education on menstruation, 72.4% of school-aged girls in India felt menstrual blood was "impure". Additionally there is shame washing reusable hygiene products in a public spaces.[40] In one study, low- and middle-income countries had 70% of responders saying "we do not have a safe, clean, and private place for menstrual hygiene".[40]

There are decidedly negative consequences of these misconceptions in an emotional, physical, and social capacity. [45] There is evidence that lack of menstrual hygiene contributes to school absences and workplace absenteeism.[40] Wealth is known to be the biggest contributor to menstrual equity.[40] Government programs to enhance access to products and safe places to manage menstruation are necessary.

Providers should continue to educate their patients that menstruation is a normal physiological process their bodies perform. The provider should be cognizant that their patient may struggle with period poverty and help them strategize ways to maintain safe, healthy menstrual care.

Physical and developmentally delayed individuals

In patients with physical disabilities and/or developmental disabilities, menstruation can be a difficult time for the patient and the caregiver. This is especially challenging terrain given the relative lack of consensus guidelines on management for patients with disabilities. That said, it is paramount that health care for these individuals remains comprehensive and ethical where confidentiality and autonomy remain at the forefront. An assessment of a patient's understanding of menstruation, sexuality, and puberty often provides an opportunity for the provider to give cognitively appropriate education to the patient and their caregiver.

When communicating, it is important to direct conversation to the patient, being mindful to accommodate any hearing or speech concerns. If the patient prefers time alone with the provider without a guardian, this should be granted to allow time for questions and concerns to be addressed by the provider. This is also an opportune time to provide level-appropriate education on hygiene, contraception, infection, and abuse protection.

Concern for unintended pregnancy and menstrual hygiene are often worries of the caregiver of a patient with developmental disabilities. In regard to the latter, the goal should be to reduce menstrual flow as complete amenorrhea can be difficult to achieve. Options for suppression should take into account potential desire for contraception, other medications and/or other medical diagnoses. ACOG provides guidance when selecting the best option for purposes of menstrual suppression and contraception.[46]

Of note, the use of endometrial ablation and medication for pre-menarchal suppression are unethical considerations.[46,47] A pelvic exam is rarely needed unless the patient is experiencing refractory abnormal bleeding, if there is a concern for a foreign body, or if there is profuse vaginal discharge. Often these exams may require anesthesia. If there is a concern for sexually transmitted infections, testing can be performed with urine and vaginal swabs and/or

serology. Hysterectomy for the sole purpose of menstrual suppression varies legally state by state and knowing a state's legal statutes is prudent.[47]

Ability to participate in research

The World Health Organization, ACOG, and Society for Adolescent Healthcare all promote ethical guidelines for adolescent research.[48,49,50,51] Researchers should be familiar with federal and institutional regulations surrounding participation with adolescents. Navigating these regulations is often a barrier to including adolescents in research.

The WHO defines an adolescent as an individual in the second decade of life, between the ages of 10 and 19 years old. [50] For research, this poses difficulty as some in this age group are minors and cannot consent and some over the age of 18 and can legally consent on their own. Though minors cannot legally consent, if they are of decision-making capability, informed assent should be acquired. The WHO gives guidance on multiple scenarios on how and when children in difficult living conditions can be approached for research participation.[50] Legal age for minors varies by country. Additionally, certain types of minors can participate in research just as adults would. Those include emancipated minors and mature minors. Emancipated minors are granted legal adulthood by the court system. This is usually through marriage and enlisting in the armed forces.[33,48] Mature minor is a concept that recognizes that a minor is allowed to consent for medical treatment if they are mature enough to understand proposed medical treatment.[33,48,50]

It is important for researchers to understand the principles of autonomy, informed consent, and informed assent. Additionally, there may be specific types of research where waiver for consent is applicable as denoted by an institution's Institutional Review Board.[48] Most commonly accepted waivers for IRB consent are when requiring parental permission is not a reasonable requirement to protect the adolescent, when the waiver would not adversely affect the rights and welfare of the adolescent, or when the study poses no more than a minimal risk to the adolescent.[33,50]Nonetheless, assent is a process that allows the minor to have their voice heard and it allows their willingness to participate in research though not a legal concept is considered an ethically important part for conducting adolescent research.[33,50]

CREATING A SPACE FOR ADOLESCENTS SEEKING REPRODUCTIVE SERVICES

Creating a safe and comfortable space for adolescents seeking reproductive services is paramount. When adolescents perceive a lack of confidential care, they will not seek appropriate medical care.[33] Fostering confidential care will encourage the adolescents to increase discussions around sensitive topics that may affect their mental and physical health. Experts in adolescent medicine suggest giving patients time with a provider away from their guardian to allow the patient time for additional discussion of their interests or concerns.[33] The guardian of the patient should be aware that the conversation is private and disclosure of this conversation would only occur if immediate concern for the patient to harm themselves or others.[33] When seeing an adolescent patient, particularly for the first visit, an outline of the visit should be discussed with the patient and the guardian. There are several workflow models to achieve this effectively, these sites are listed at the conclusion of this chapter. If the patient or guardian is aware before the visit that the patient would be allowed time by themselves, this often eases the anxiety of the adolescent. However, guardians are often apprehensive of this time alone as they have usually been the ones providing their child's history. Taking time before the visit in writing or during the visit to explain why confidential time is important. Designing a safe space to ask questions and build trust will help in assuaging anxiety. The majority of visits will not require physical exam, but if one is needed, ACOG recommends a non-parental chaperone present.[33] The patient should be allowed to decide if they would like their guardian present should a physical exam be needed.

ETHICAL CONSIDERATIONS WITH TECHNOLOGY

Telehealth

Telehealth has emerged as venue to improve access to health care, particularly in underserved areas. However, this option entails legitimate concern for breaches in confidentiality. Telehealth visits are often welcomed by the adolescent due to convenience, however, truly building a safe space is a challenge for the provider. Telehealth visits typically occur

as a video visit where the provider and patient view one another through a computer or cell phone. Although most telehealth visits have a disclaimer regarding privacy at the beginning of the visit, frequently providers will find their patient is in a public or shared space. Alternatively, the guardian may be out of view of the camera but still present and thus not allowing for a complete confidential portion of the visit. Providers should be aware of these circumstances as full disclosure in an interview may not be represented accurately. If there is any concern that the patient is not able to access private space, the provider should consider offering close proximity in-person follow-up with the patient.

Electronic health record

As hospitals and institutions move to complete integration of an electronic health record, patient confidentiality, particularly with adolescents, may be affected. In the year 2022, the United States will be moving to full access of a medical record as defined by the 21st century CURES final act.[33,52] Providers should work with their institution to provide security measures and guard rails to protect confidential portions of the adolescent's visit. It is important that providers are aware of state consent laws and federal confidentiality laws in order to protect the adolescent. Suggestions for recommendations are provided by NASPAG, ACOG, and the Society for Adolescent Health advocating for "confidential" note types, ability to designate notes as confidential, or allow segmented information within the electronic health record.[33,52,53] Patient portals provide electronic access to an individual medical record within a certain health system; however, most minors will be required to allow their parents or their guardian proxy access to their electronic health record. Providers need to be aware that parents or guardians may coerce the adolescent into sharing their log-in information. It is important that the provider is aware of alternative ways to share information with the adolescent if coercion is suspected. There are times when the parent or guardian may be the appropriate proxy into the electronic health record, especially if the adolescent lacks capacity for decision making with severe intellectual or developmental disability.

Other breaches of confidentiality may occur with billing through insurance. An explanation of benefits (EOB) is a form nonuniformly sent by private insurance companies, "explaining" services performed on a certain day. This document often is sent to the patient's household by the insurance company itself and not by the provider. Adolescents need to be aware that some EOB contain itemized statements and though confidentiality is maintained by provider, there may be disclosure of lab results, prescriptions, or diagnoses that is beyond the control of the health care provider. In certain circumstances if this were to occur, the provider may consider a referral to another location that can provide completely confidential care without explanation of benefits being sent.[33,53]

Ethical principle	Principle in practice	Considerations
Consent/assent *As pertains to medical decision making.* *As pertains to participating in research.*	A 15-year-old would like treatment for her genital condylomata. A researcher is interested in determining which social media resource is most influential as a decision-making aid.	The adolescent should be appreciably involved in decision making. Laws and regulations regarding consent vary by region/state/country. Informed consent with a parent or guardian, when possible, should precede a child's participation in research. Assent is not the absence of dissent. Even if not required for legal reasons, the child's assent should be obtained for ethical reasons.
Confidentiality *As pertains to autonomy.* *As pertains to the electronic medical record.*	A 16-year-old reveals that she and her two best friends have made a pact to conceive by the end of the year. A 16-year-old presents to the office while her parents are out of town. She discloses that she recently had unprotected	Utilize confidentiality as a method of engaging with the patient and determining the motivations for this disclosure. Inquire if she has spoken with her parent/guardian, counselor, or other trusted adult. Review who has access to, and would receive notifications of results within, the portal.

Ethical principle	Principle in practice	Considerations
	intercourse and since learned her partner has chlamydia.	Encourage the patient to share this information with parents/guardians while reassuring her that information disclosed in the office will remain confidential.

PRACTICE RECOMMENDATIONS

- **Create an environment that fosters a safe and trusting environment.**
- **Engage the adolescent in shared decision making.**
- **Respect the adolescent's appropriate level of autonomy and capacity for participating in her care.**
- **Be cognizant of regional regulations that pertain to your practice.**
- **Clearly communicate any limitations on confidentiality.**
- **Be mindful to ensure confidentiality is achieved in telehealth appointments.**

CONFLICTS OF INTEREST

The author(s) of this chapter declare that they have no interests that conflict with the contents of the chapter.

RELEVANT CURRENT AND APPROPRIATE GUIDELINES, STATEMENTS AND POLICIES OF PROFESSIONAL ASSOCIATIONS

United Nations Children's Fund Convention on the Rights of the Child – http://www.ohchr.org/en/professionalinterest/pages/crc.aspx
FIGO – https://www.glowm.com/pdf/english%20ethical%20issues%20in%20obstetrics%20and%20gynecology.pdf
WHO – http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf
ACOG – https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-statement/articles/2022/02/patient-centered-contraceptive-counseling.pdf – https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/10/the-initial-reproductive-health-visit#
Guttmacher Institute – https://www.guttmacher.org/global/teens
Center for Disease Control – https://www.cdc.gov/teenpregnancy/health-care-providers
Society for Adolescent Health and Medicine – http://dx.doi.org/10.1016/j.jadohealth.2015.12.009
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