

Cognitus Interruptus: The Courts and Minors' Access to Contraceptives

Brigid Rentoul

In his opinion in *Gillick v. West Norfolk and Wisbech Area Health Authority*,¹ Lord Scarman of the English² House of Lords remarked that "women have obtained by the availability of the pill a choice of lifestyle with a degree of independence and of opportunity undreamed of until this generation"³ He went on to caution wisely that the "law ignores these developments at its peril"⁴ While this is indeed enlightened prose, courts in both the United Kingdom and the United States have been far less rational when faced with the issue of contraceptive services for minors.⁵

Some indication of the number of minors wishing to use methods of birth control is given by statistics of those actually receiving prescription contraceptives.⁶ In the U.S. in 1983, 1.6 million patients under the age of twenty were served by family planning clinics, and almost as many teenagers obtained family planning services from private physicians.⁷ Similar figures for England in 1984 report that

1. *Gillick v. West Norfolk and Wisbech Area Health Authority*, [1985] 3 All E.R. 402 (H.L.).

2. The general practice of those who write about courts in Britain is to use "English law" to refer to the judicial system of England and Wales, leaving out Scotland and Northern Ireland which are largely separate.

3. *Gillick* at 419.

4. *Id.*

5. In the literature, the term "minor" is generally used interchangeably with "youth," "adolescents" and "children." The difference, however, is sometimes significant because, as Professor Wald points out, "semantic differences may reflect real differences in how we perceive young people depending on the issue under consideration." Wald, *Children's Rights: A Framework for Analysis*, 12 U.C. DAVIS L. REV. 255, 265 n.42 (1979).

6. Prescription contraceptives include oral contraceptives ("the pill"), intrauterine devices ("IUDs") and diaphragms. An American study shows that in 1982 73% of teenage women using contraceptives relied on these methods of contraception as opposed to non-prescription methods such as condoms and spermicidal foams and creams; of these, 90% used the pill. 1 RISKING THE FUTURE: ADOLESCENT SEXUALITY, PREGNANCY, AND CHILDBEARING 154 (C.D. Hayes ed. 1987) [hereinafter RISKING THE FUTURE].

7. *Id.* Forty-three percent of the teenage clinic patients were under the age of 18. *Id.* It has also been reported that:

By age 20, most unmarried young men and women are sexually active: over 80 percent of males and over 70 percent of females report that they have had intercourse at least once. . . . While only 5 percent of teenage girls and 17 percent of teenage boys report having had intercourse by their fifteenth birthday, 44 percent

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17,000 minors under age sixteen were taking the pill.⁸ Although these statistics do not indicate the use of non-prescription contraceptives, studies show that only about 60 percent of American teenagers and 90 percent of English teenagers who are sexually active use any contraceptive method with regularity.⁹ These figures are reflected in the teenage pregnancy rates for both countries.¹⁰

On either side of the Atlantic the courts' involvement in the issue of minors' access to contraceptives has come about through debate over whether minors' access to prescription contraceptives should be made conditional on parental consent¹¹ or notification.¹² The main rationale for a consent or notification requirement is that some minors lack the maturity necessary to make rational decisions, and

of girls and 64 percent of boys report that they were sexually active by their eighteenth birthday.

Id. at 41-42.

8. The Times (London), Oct. 18, 1985, at 15, col. 2.

9. RISKING THE FUTURE, *supra* note 6, at 46; Jones, Forrest, Goldman, Henshaw, Lincoln, Rosoff, Westoff & Wulf, *Teenage Pregnancy in Developed Countries: Determinants and Policy Implications*, 17 FAMILY PLANNING PERSP. 53, 57 (1985). The U.S. and U.K. figures given are for 1982 and 1976 respectively.

10. The National Center for Health Statistics predicts that there will be 1.1 million unintended pregnancies among teenagers in 1986. In 1983, the number of births to teens under 20 was just under half a million (499,038), accounting for almost 14% of all births. SELECT COMM. ON CHILDREN, YOUTH, AND FAMILIES, 99TH CONG., 1ST SESS., REPORT ON TEEN PREGNANCY: WHAT IS BEING DONE? A STATE-BY-STATE LOOK (COMM. PRINT 1985) [hereinafter COMMITTEE REPORT ON TEEN PREGNANCY]. See also RISKING THE FUTURE, *supra* note 6, at 5 (it is estimated that 43% of all adolescent girls regardless of marital status will become pregnant at least once before their twentieth birthday); ALAN GUTTMACHER INSTITUTE, 11 MILLION TEENAGERS: WHAT CAN BE DONE ABOUT THE EPIDEMIC OF ADOLESCENT PREGNANCIES IN THE UNITED STATES 10 (1976) ("Each year, more than one million 15-19-year-olds become pregnant, one tenth of all women in this age group. [Two-thirds of these pregnancies are conceived out of wedlock.] In addition, some 30,000 girls younger than 15 get pregnant annually.")

In the U.K. in 1984, 10,000 minors less than sixteen years old became pregnant. The Times (London), Oct. 18, 1985, at 15, col. 4. In 1981, 4.41% of girls aged between 15 and 19 inclusive had a pregnancy [birth rate plus abortion rate]. This should be compared with the equivalent figure of 6.36% in 1971, before birth control became widely available.

11. "Parent" is used to include guardians and those acting in the place of parents.

12. The distinction between a consent requirement and a notification requirement is important in theory, as the U.S. Supreme Court noted in considering parental involvement in abortion decisions. *Bellotti v. Baird*, 443 U.S. 622, 640 (1979). A consent requirement can amount to a parental veto whereas notification seems to recognize the minor's autonomy. In reality, however, the difference is much less significant because any parental involvement is sufficient to deter many minors from seeking contraceptives out of fear that their parents will learn that they are sexually active. See Alan Guttmacher Institute, *What Government Can Do About Teenage Pregnancy*, 4:2 PUBLIC POL'Y ISSUES IN BRIEF, Mar. 1984, at 1, 3. See also *Planned Parenthood Ass'n of Utah [PPAU] v. Matheson*, 582 F. Supp. 1001, 1008 (D. Utah 1983) ("Although the Supreme Court has not confronted the issue directly, it is clear that the rule applicable to parental consent laws also applies to parental notification laws"). This comment will therefore often use "consent" to include both notification and consent.

that parental decisionmaking should therefore be substituted for the judgment of these minors. The difficulty of determining the maturity of a minor with certainty has led to the framing of parental consent requirements in terms of chronological age, using age as a surrogate for maturity.

Given the necessity of striking a balance between individual liberty and the protection of those minors who are unable to make rational decisions, the judiciaries of both the U.S. and the U.K. have been rightly troubled by the mismatch between age and maturity, recognizing that in fact some presumptively immature minors are able to make well-founded independent decisions. An inclination toward self-determination has led the courts to respond to the over-inclusiveness of the age-based method of classification by providing some means whereby a minor can demonstrate her ability to make an independent decision regarding the use of contraceptives. In their preoccupation with ensuring rational decisionmaking, however, both judicial systems have overlooked for the most part the more pressing social problem of the alarmingly high rates of teenage pregnancy. In order to address the problem of teenage pregnancy while providing for the best interests of minors and the wider society, courts in the U.S. and U.K. should ensure that all sexually active minors have access to prescription contraceptives on their own consent.

I. Minors' Access to Prescription Contraceptives

A. The United States Position

1. Federal Statutes

The federal government exerts an influence on minors' access to contraceptives through its funding provisions for family planning services. These provisions are located in four separate programs administered by the Department of Health and Human Services (HHS). Three of the programs were set up by the Social Security Act.¹³ The federal standards provide that none of these is restricted as to age, and consequently a Utah law that attempted to impose a parental consent requirement for the receipt of such services by minors was held unenforceable.¹⁴

13. Social Security Act, 42 U.S.C. § 701 *et seq.* (Maternal and Child Health Services Block Grant), § 1396 *et seq.* (Grants to States for Medical Assistance Programs), § 1397 *et seq.* (Block Grants to States for Social Services) (1982).

14. *T.H. v. Jones*, 425 F. Supp. 873 (D. Utah 1975).

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The fourth and most important of the federal programs is Title X of the Public Health Service Act, added in 1970 to establish a system of federally funded public and non-profit family planning projects.¹⁵ Again, the accompanying federal regulations specifically required that these services must be provided without regard to age.¹⁶ Consequently, when HHS promulgated regulations requiring federally funded family planning clinics to notify the parents of minors to whom contraceptive care was provided, two district courts held them invalid.¹⁷ In December 1985, however, the Senate Labor and Human Resources Committee agreed to allow Title X funds to be used by Utah's health department, despite a Utah statute requiring prior written parental consent before minors may receive publicly funded family planning services.¹⁸

15. 42 U.S.C. § 300(a) *et seq.* (1982). In 1978, § 1001(a) of Title X of the Public Health Service Act was amended to include coverage for "services for adolescents." Pub. L. No. 95-613, 92 Stat. 3093 (1978). This amendment was a response to the concern that "the problems of teenage pregnancy have become critical." H.R. REP. NO. 1191, 95th Cong., 2d Sess. 31 (1978). Three years later, § 1001(a) was amended again, to include a provision encouraging family participation in funded programs. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 570 (1981). Section 1001(a), codified as amended at 42 U.S.C. 300(a) (1982), now reads:

The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents). To the extent practical, entities which receive grants or contracts under this subsection shall encourage family participation in projects assisted under this subsection.

16. Project Grants for Family Planning Services, 42 C.F.R. § 59.5 (1985) reads, in relevant part:

What requirements must be met by a family planning project?

(a) Each project supported under this part must:

...

(4) Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

17. *New York v. Heckler*, 719 F.2d 1191 (2d Cir. 1983) (purporting to enjoin enforcement of the regulation throughout the U.S.); *Planned Parenthood Federation of America v. Heckler*, 712 F.2d 650 (D.C. Cir. 1983). The proposed regulations, intended to be effective in February of 1983, required such clinics to notify an unemancipated minor's parent or guardian within 10 days after the contraceptives were initially prescribed. Notification was to take place by certified mail, return receipt requested, and if notification could not be verified, prescription contraceptives could not be provided to the minor on a subsequent occasion. There were provisions for notice to be waived when it was probable that the parent would inflict "substantial" harm on the minor and in cases of treatment for sexually transmitted diseases. Also, state laws that were stricter than the federal standard would have to be followed, while those authorizing minors to obtain care on their own consent were to be overridden. Finally, fees for services were to be based on the parents' income rather than the minor's. See 4.2 PUBLIC POL'Y ISSUES IN BRIEF, Mar. 1984, at 3; see also *Doe v. Pickett*, 480 F. Supp. 1218, 1220-21 (S.D.W.Va. 1979) (West Virginia's attempt to require parental consent constituted imposition of an additional eligibility requirement and clearly thwarted goals of Title X).

18. This has become known as the "Utah Compromise" because it was insisted upon by Senator Hatch, the Chairman of the Senate Labor and Human Resources Committee,

2. *State Policies*

Where the states are not preempted by federal statutes,¹⁹ the ability of a minor to obtain contraceptives is sometimes governed by the general rule that the age at which one can give effective consent to medical treatment is the age of majority, now eighteen in most states.²⁰ In many states, however, this rule has been almost swallowed by exceptions.²¹ Some states have lowered the age of consent to medical treatment in general by statute²² or have overridden it by legislative or judicial recognition of exceptions in cases of emergency²³ or in cases involving emancipated²⁴ or mature minors.²⁵

With regard to contraceptive services specifically, some state legislatures have affirmed the right of all minors to receive such services on their own consent.²⁶ Other states have statutes providing

as a condition of reauthorization of the Title X program to fiscal 1989. The Committee agreed to authorize the Department of Health and Human Services to spend up to \$600,000 in each of the next four years on a special "demonstration" project in Utah to "test" the impact of the parental consent requirement. WASHINGTON MEMO: A PUBLICATION OF THE ALAN GUTTMACHER INSTITUTE, May 15, 1986 (W-7).

19. The rules against preemption by the federal law are stronger in the area of family law. See *PPAU v. Matheson*, 582 F. Supp. 1001, 1004 n.3.

20. Most states reduced the age of majority from 21 to 18 in 1971 after the enactment of the 26th amendment to the Constitution giving 18-year-olds the right to vote in federal elections. The exceptions are Alabama (19); Colorado (21); Mississippi (21); Nebraska (19); Pennsylvania (21) and Wyoming (19).

21. For a comprehensive table of relevant state laws see J. MORRISSEY, A. HOFMANN & J. THROPE, *CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS: A LEGAL GUIDE* app. at 149-250 (1986).

22. For example, Alabama (14); Kansas (18 in general but 16 if the parents are not immediately available); Louisiana (any minor "who believes himself to be afflicted with an illness or disease"); Oregon (15); and South Carolina (16).

23. While some states have expanded the definition of a medical emergency to include an immediate danger to the life, health or mental well-being of a minor, for example, N.Y. PUB. HEALTH L. § 2504(4) (Consol. 1976 & Supp. 1985), it is unlikely that contraceptive services will be considered emergency treatment.

24. The conditions under which a minor will be recognized as emancipated vary according to state statutes but generally include marriage, living away from home, being self-supporting or being in military service.

25. In Nevada the consent of the parent is not necessary to treat a minor who "understands the nature and purpose of the proposed examination or treatment and its probable outcome, and voluntarily requests it." NEV. REV. STAT. ANN. § 129.030(2) (1986). An Idaho statute provides that "[a]ny person of ordinary intelligence and awareness sufficient for him or her generally to comprehend the need for, the nature of, and the significant risks" inherent in any medical treatment is competent to consent on his or her own behalf. IDAHO CODE § 39-4302 (1985 & Supp. 1986). The crucial criteria in mature minor rulings appear to be that: 1) the treatment was for the benefit of the minor rather than a third party; 2) the minor was near the age of majority, or at least 15, and was considered to have sufficient mental capacity to understand fully the nature and importance of the medical steps proposed; and 3) the medical procedure was not 'major' or 'serious.' A.R. HOLDER, *LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE* 146 (1977).

26. Arkansas, ARK. STAT. ANN. § 82-3104 (1976 & Supp. 1986); California, CAL. WELF. & INST. CODE § 14503 (West 1980 & Supp. 1987); Colorado, COLO. REV. STAT.

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that minors may give consent for contraceptive services but only if they fall within certain statutory categories, such as married minors or those who, in the opinion of the physician, would suffer a health hazard if services were not provided.²⁷ Even in states where a minor may give effective consent, the applicable statute may permit parental notification by the provider.²⁸ Also, in many of the states where minors are not explicitly given the right to consent by statute, there is a *de facto* parental consent requirement since clinics and other services, especially private ones, have considerable discretion in setting office policy.²⁹

§ 25-6-102 (1973 & Supp. 1986); Georgia, GA. CODE ANN. § 31-9-2(a)(5) (1985 & Supp. 1986); Kentucky, KY. REV. STAT. ANN. § 214.185 (Michie 1982 & Supp. 1986); Maryland, MD. HEALTH-GEN. (1982) CODE ANN. § 20-102 (1982 & Supp. 1986); New Mexico, N.M. STAT. ANN. §§ 24-8-3, 24-8-5 (1978 & Supp. 1986); North Carolina, N.C. GEN. STAT. § 90-21.5 (1985); Oregon, OR. REV. STAT. § 109.640 (1985) (15 and over only); South Carolina (no specific statute but the Attorney General has stated that minors aged 16 and over are authorized to procure birth control without the consent of their parents or other persons, 1971-72 Op. Att'y Gen. 213); Tennessee, TENN. CODE ANN. §§ 68-34-104, 68-34-107 (1983 & Supp. 1986); and Virginia, VA. CODE ANN. § 54-325.2(D)(2) (1950 & Supp. 1986).

27. Florida (maternal health and contraceptive information and services of a non-surgical nature may be provided to a minor who is married, or a parent, or pregnant, or who has parental consent, or who may, in the opinion of the physician, suffer probable health hazards if such services are not provided), FLA. STAT. ANN. § 381.382(5)(a) (1986); Idaho (examinations, prescriptions, devices and informational materials regarding the prevention of contraception may be provided to any person who, in the good faith judgment of the physician, is sufficiently intelligent and mature to understand the nature and significance thereof), IDAHO CODE § 18-603 (1979 & Supp. 1986); Illinois (consent of the parent is required unless the minor is married, or a parent, or pregnant, or a serious health hazard would be created without such services, or the minor is referred by a physician, clergyman, or a planned parenthood agency), ILL. STAT. ANN. ch. 111 1/2 para. 4651 (Smith-Hurd 1963 & Supp. 1986); Maine (parental consent is required unless the minor is a parent or married, or may suffer in the professional judgment of a physician probable health hazards if such services are not provided), ME. REV. STAT. ANN. tit. 22, § 1908 (1964 & Supp. 1986); and Mississippi (contraceptives may be furnished to any minor who is a parent, or who is married, or who has the consent of his or her parent or legal guardian, or who has been referred by another physician, a clergyman, family planning clinic, school or state agency), MISS. CODE ANN. § 41-42-7 (1972 & Supp. 1986).

28. See, e.g., HAW. REV. STAT. §§ 577A-2, 3 (1976 & Supp. 1984); MD. HEALTH-GEN. CODE ANN. § 20-102(e) (1982 & Supp. 1986); N.C. GEN. STAT. § 90-21.4(b) (1985) (notification to parents is allowed when essential to the life or health of the minor); and OR. REV. STAT. § 109.650 (1985). The comparable Utah statute, UTAH CODE ANN. §§ 76-7-325, 76-7-321 (1953 & Supp. 1986), was held unconstitutional in *PPAU v. Matheson*, 582 F. Supp. 1001 (D. Utah 1983) because it failed to provide a procedure whereby a mature minor or a minor who could demonstrate that his or her best interests were contrary to parental notification could obtain contraceptives confidentially. Another questionable statute is Kansas' statute which only permits state-established family planning centers to provide contraceptives if the patient is over 18 and is married or has been referred to the center by a person licensed to practice medicine. KAN. STAT. ANN. § 23-501 (1964 & Supp. 1985).

29. A national sample found that only 59% of general and family practitioners would provide contraceptives to minors without parental consent. Orr & Forrest, *The Availabil-*

3. *Judicial Decisions*

The U.S. Supreme Court has held that the use of contraceptives by adults is constitutionally protected as part of the fundamental right to make decisions on matters of child-bearing.³⁰ The right of minors to obtain nonprescription contraceptives was established by the Supreme Court in *Carey v. Population Services International*.³¹ However, because the Court did not consider either parental consent requirements or prescription contraceptives, the constitutionality of requiring parental involvement in the decisions of minors to obtain prescription contraceptives was left unclear.³²

A number of subsequent cases about parental consent requirements, none of which ever reached the Supreme Court, seem to be somewhat less permissive than *Carey v. Population Services International* in their treatment of minors.³³ In *Doe v. Irwin*, for example, although the court held that notifying parents of the distribution of contraceptive devices and medication to unemancipated minors was not constitutionally required, its decision did not rule out the possibility that mandating such notice could be constitutionally permitted.³⁴

The abortion decisions of the Supreme Court provide more guidance on states' ability to require parental involvement in minors'

ity of Reproductive Health Services From U.S. Private Physicians, 17:2 FAMILY PLANNING PERSP. 63 (1985).

30. The first judicial recognition of such protection was in *Griswold v. Connecticut*, 381 U.S. 479 (1965) (Connecticut statute making the use of contraceptives by married couples unlawful was held unconstitutional). The zone of privacy established in *Griswold* was held to encompass unmarried as well as married couples in *Eisenstadt v. Baird*, 405 U.S. 438 (1972). The implications of this right to privacy were clarified in *Carey v. Population Services Int'l*, 431 U.S. 678 (1977), where the court held that, as to adults, restrictions on the distribution of contraceptives had to be justified by a compelling state interest and that the laws must be narrowly drawn to cover only the expressed state interests.

31. Justice Brennan's opinion for the court concluded that a New York statute making it a crime for anyone to sell or distribute contraceptives to those under 16 was unconstitutional because it imposed significant burdens on an individual right to use contraceptives while serving no compelling state interest. 431 U.S. 678, 696.

32. This issue was not before the Court because the state of New York had conceded that physicians were not covered by the law in question and could prescribe such contraceptives for minors of any age. 431 U.S. at 697-98.

33. See, e.g., *Jane Does v. Utah Dep't of Health*, 776 F.2d 253, 256 (10th Cir. 1985) (Title X, though precluding states from imposing parental consent requirements, leaves Utah free to apply its own consent requirements in the use of its own funds); *Planned Parenthood Ass'n of Utah v. Schweiker*, 700 F.2d 710, 720-21 (D.C. Cir. 1983) (referral procedure might allow Utah to impose its own consent requirements while still receiving federal funds); *Doe v. Irwin*, 615 F.2d 1162, 1169 (6th Cir. 1980) ("[I]t is clearly a matter for the state to determine whether a notice requirement is necessary or desirable to achieve the purpose for which the [Tri-County Family Planning Center] was established").

34. 615 F.2d 1162 (6th Cir. 1980).

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decisions to obtain contraceptives. Following *Roe v. Wade*³⁵ many states passed statutes establishing a parental consent requirement before a minor could obtain an abortion. The Supreme Court responded to such legislation by ruling that parental consent may not be required in the case of emancipated or mature minors and that the statutes must provide a "judicial bypass" allowing the pregnant minor to go before the courts to petition for judicial authorization in place of parental consent.³⁶ To obtain such authorization, the minor must show either that she is mature enough to make the decision herself or, if the judge finds that she is not mature, that an abortion would be in her best interests.³⁷ The district court relied on these cases in *Planned Parenthood Association of Utah v. Matheson*, where a Utah statute requiring parental notification prior to the provision of prescription or nonprescription contraceptives to an unmarried minor was held to be not only preempted by Title X but also unconstitutionally overbroad because it failed to distinguish between immature minors and other mature minors or immature minors who could demonstrate that parental notification was not in their best interests.³⁸ Thus it seems that a state "may not impose a blanket parental notification requirement on minors seeking to exercise their constitutionally protected right to decide whether to bear or beget a child by using contraceptives."³⁹ However, the trend of equating birth control decisions with abortion decisions in recent contraceptive access cases⁴⁰ suggests, despite language to the contrary,⁴¹ that a parental consent or notification provision might be constitutional if the state provided a judicial bypass similar to that required in the abortion cases.

35. 410 U.S. 113 (1973).

36. *Bellotti v. Baird*, 443 U.S. 622, 643-44 (1979). It is also clear that parental notification requirements may not be imposed on mature or emancipated minors. *H.L. v. Matheson*, 450 U.S. 398, 406 (1981). While the courts have not yet resolved the issue of whether parental notification statutes must provide a judicial bypass similar to consent statutes, *PPAU v. Matheson* at 1009 suggests such an approach.

37. For an account of how minors demonstrate that an abortion is in their best interests, see Donovan, *Judging Teenagers: How Minors Fare When They Seek Court-Authorized Abortions*, 15 FAMILY PLANNING PERSP. 259 (1983).

38. *PPAU v. Matheson*, 582 F. Supp. 1001.

39. 582 F. Supp. at 1009. See also *Jane Does v. Utah Dep't of Health*, 776 F.2d 253 (1985).

40. See, e.g., *Jane Does v. Utah Dep't of Health*, 776 F.2d 253, 256 (1985), where the court cited an abortion decision in support of an assertion, in dicta, that a requirement of mandatory parental consent for provision of contraceptive services to minors was of dubious constitutionality. The fact that the case cited was an abortion decision was not mentioned.

41. For example, in *Matheson* the court noted in dicta that it did "not intend to imply . . . that a law which provided a means for the minor to demonstrate maturity or best interest contrary to parental involvement would be constitutional." 582 F. Supp. at 1009 n.9.

B. *The United Kingdom Position*

Although the age of majority in Britain is eighteen,⁴² the Family Law Reform Act of 1969 establishes that a minor who has attained the age of sixteen may consent to any "surgical, medical, or dental treatment."⁴³ Where minors under sixteen are concerned, the Act merely says that "[n]othing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted," and thereby preserves any other existing right to consent including any provided by the common law.⁴⁴ Since the common law itself is unclear, the ability of minors under sixteen to consent to medical treatment is not determined by the Act.

The issue of the ability of a minor under sixteen to obtain contraceptives eventually came before the House of Lords in *Gillick v. Wisbech Area Health Authority*, in October 1985. The Department of Health and Social Security's (DHSS) guidance to Local Area Health Authorities,⁴⁵ contained in a circular issued in December 1980, stated that where a person under sixteen asked for contraceptive advice and services the doctor or other professional should urge the minor to involve her parents or guardians, but that in exceptional cases it was up to the physician to decide whether to provide treatment without parental consent.⁴⁶ This guidance was challenged by Mrs. Gillick, the mother of five daughters under the age of sixteen, who sought declarations against her Area Health Authority and the DHSS that the ability to provide contraceptive advice and services without parental consent unlawfully and adversely affected the welfare of her daughters and her own parental rights. The majority of the Lords, having found that there were no statutory provisions that determined their decision, ruled that subject to certain conditions, physicians may legally provide contraceptive counseling and services to minors younger than sixteen without obtaining parental con-

42. Family Law Reform Act, 1969, ch. 46, § 1.

43. Family Law Reform Act, 1969, ch. 46, § 8(1).

44. Family Law Reform Act, 1969, ch. 46, § 8(3).

45. Health Service Notice HN (80) 45. Local Area Health Authorities in the U.K. are responsible for family planning clinics which provide much of the contraceptive treatment in Britain.

46. The exceptional cases cover situations where "the involvement of the parent might dissuade the girl from seeking professional advice at all and, therefore, expose her to the immediate risks of pregnancy and of sexually-transmitted diseases, as well as other long-term physical, psychological and emotional consequences"; where the girl's parents are "unconcerned, entirely unresponsive, or grossly disturbed"; and where the girl is "in the care of local authorities or other voluntary organizations standing in loco parentis." *Id.*

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sent.⁴⁷ The conditions, found in Lord Fraser's judgment,⁴⁸ are somewhat more specific than the guidelines provided by the DHSS and stipulate that the doctor may proceed:

without the parents' consent or even knowledge provided that he is satisfied on the following matters: (1) that the girl (although under sixteen years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.⁴⁹

II. *The Courts' Concerns: A Critique*

In the U.S. and the U.K. the only general restriction on a woman's access to contraceptive services is that some such services must be prescribed by a doctor.⁵⁰ Since adults, therefore, are largely able to make their own decisions about the use of contraceptives, the obvious starting point of the inquiry is to question why minors should be treated any differently. In a political system which attempts to balance individual liberty with protection of minors unable to make decisions for themselves, it seems appropriate to demand a coherent, principled justification for giving any third person a veto over a minor's decision, especially where that decision primarily concerns the minor's own body. Indeed, the U.S. courts have clearly attempted to formulate such a justification in parental consent and notification cases,⁵¹ first identifying the general position and then seeking "a

47. Fraser, Scarman and Bridge, LLJ., with Brandon and Templeman, LLJ., dissenting. Lord Fraser considered and rejected as unhelpful the Family Law Reform Act, 1969, ch. 46, § 8; the Mental Health Act, 1983, ch. 20, § 131; and the Education Act, 1944, ch. 31, § 48. The Lords' decision overruled the Court of Appeal, [1985] 1 All E.R. 533 (C.A.), which had in turn overruled the trial court, [1984] Q.B. 581.

48. *Gillick* at 413.

49. In the wake of *Gillick*, it was suggested that the English Parliament should introduce legislation to make 16 the minimum age of consent for contraceptive services. For example, the headline in *The Guardian* for Feb. 3, 1983, was "Thatcher backs U-turn on under-16 pill". However, it remains to be seen whether the legislature will act on these suggestions.

50. In America there are also financial restrictions, although the four federal programs funding family planning services should ensure that no patient will be denied services because of an inability to pay. See *supra* notes 13, 15.

In Britain, family planning services were incorporated into the National Health Service in 1973 and made available free of charge.

51. *PPAU v. Matheson*, 582 F. Supp. 1001 *passim*; *Doe v. Irwin*, 615 F.2d 1162 *passim*. These cases were settled on questions of statutory interpretation. The constitutional issues, therefore, were never reached.

significant state interest . . . that is not present in the case of the adult"⁵² to justify the greater burden on the privacy of minors. The House of Lords has done likewise, albeit in a less structured fashion.

Historically in both the U.S. and the U.K., the main reason offered for subjecting a minor's decision to a parental consent requirement was the common law's judgment that because minors in general lack full capacity to act in certain matters, they should bear a legal disability as protection against their improvidence and immature judgment as well as against the possibility that they might be exploited by others.⁵³ In addition, it was traditionally the role of the minor's parents to compensate for this incapacity and to give consent on behalf of the minor because parents were assumed to be most likely to act in the best interests of their children.⁵⁴

This traditional analysis has been used in recent court decisions concerning minors' access to contraceptives. These concerns, however, are nowadays perhaps more familiar as issues of informed consent because they have been subsumed by the requirement that a patient must be permitted to exercise a meaningful choice regarding proposed treatment and, therefore, must possess a certain level of understanding.⁵⁵ As a result of this historical influence both the U.S. and U.K. court systems have approached the contraceptive question primarily with the goal of ensuring a rational decisionmaking process. For example, the U.S. courts have accepted the *Danforth*⁵⁶ ruling⁵⁶ that states have a broader authority to regulate the conduct of children than that of adults because children are not possessed of full capacity for individual choice. Similarly, the U.K. courts seem to have accepted the lack of capacity as the main reason for substituting parental consent for the minor's and have framed their decisions in terms of the understanding and intelligence of the child.⁵⁷

52. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 74-75 (1978).

53. See Wald, *supra* note 5, at 256-66.

54. See *Parham v. J.R.*, 442 U.S. 584, 602 (1979) ("The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience and capacity for judgment required for making life's difficult decisions. More important, historically it has been recognized that natural bonds of love and affection lead parents to act in the best interests of their children")

55. See, e.g., J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

56. *Danforth*, 428 U.S. 52 (1978), cited in *PPAU v. Matheson*, 582 F. Supp. 1001, 1007-08 and *Doe v. Irwin*, 615 F.2d 1162, 1166. In *Danforth* the court refers at 74-75 to *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944) and *Ginsberg v. New York*, 390 U.S. 629, 649-50 (1968) as support for this proposition.

57. See *Gillick* at 421 ("The principle is that the parental right of power and control over the person and property of his child exists primarily to enable the parent to dis-

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Given the premise that the justification for the differential treatment of minors is their lack of maturity, policymakers could have decided either that legal capacity should follow actual capacity on a case-by-case basis or that some easily measurable proxy for maturity should be adopted. Where parental consent requirements are involved the latter approach has generally been followed, using chronological age to draw a bright line between those legally presumed to have the capacity to consent and those who lack the requisite maturity and therefore require the substitution of parental consent. Thus the age of majority, or in the U.K. the age of sixteen, has been used to define a group to be accorded special attention.

Although age is no doubt related to maturity, a difficulty arises when one attempts to determine the maturity of a particular individual at a certain age from the average level of maturity at that age because different individuals mature at different rates. This problem is particularly marked during adolescence, when maturity varies widely between individuals depending on physiological changes and life experiences. Parental consent laws based on chronological age are, therefore, arguably underinclusive because they do not include some individuals who, though meeting the age requirement, have yet to develop the necessary maturity, and overinclusive because they do not allow an individual who matures precociously to make such a decision despite her capacity to do so.⁵⁸

Recognizing that many classifications suffer from a similar lack of fit,⁵⁹ the U.S. courts have developed the so-called "rational basis" test under the equal protection clause of the fourteenth amendment in order to determine the bounds of reasonable classification. The courts also employ heightened scrutiny where the classification in-

charge his duty of maintenance, protection and education until he reaches such an age as to be able to look after himself and make his own decisions").

58. See, e.g., Scarman, LJ's opinion in *Gillick*, at 425: "social experience . . . is that many girls are fully able to make sensible decisions about many matters before they reach the age of 16."

It is ironic that the Court in *Doe v. Pickett*, 480 F. Supp. 1218 (S.D.W.Va. 1979), refused to certify a class composed of all individuals under the age of 18 who seek family planning services, in part on the grounds that the court "recognizes that members of a class of minors of child bearing age vary in maturity and their ability to make informed decisions."

59. See J.H. ELY, *DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW* 30 (1980) ("Obviously all unequal treatment by the state cannot be forbidden. Legislation characteristically classifies, distributing certain benefits to, or requiring certain behavior of, some but not others. What's more, such classification typically proceeds on the basis of generalizations that are known to be imperfect. We all order our lives on the basis of such generalizations: without them life would be impossible"). See also Fiss, *Groups and the Equal Protection Clause*, 5 *PHIL. & PUB. AFF.* 107 (1976).

volves a "fundamental right" or "suspect class" and, since contraceptive use has been identified as one aspect of a fundamental right,⁶⁰ decisions concerning parental consent requirements for contraceptive services are subject to this heightened or strict judicial scrutiny.⁶¹ While it is therefore unnecessary for the courts to consider whether or not "youth" constitutes a suspect classification,⁶² the heightened scrutiny caused the courts to query the appropriateness of using age as a proxy for maturity. It was as a result of this reasoning that the U.S. courts hinted at an attempt to ameliorate the overinclusive effects of an age-based classification by using a judicial bypass system like that developed for abortion decisions.⁶³

In England, the majority of the House of Lords also questioned the validity of using age as a surrogate for maturity, concluding that an age-based classification should be rejected or, at least, severely curtailed on public policy grounds.⁶⁴ Lord Fraser, for example, argued that because of "the ordinary experience of mankind, at least in Western Europe in the present century . . . the view that a child's intellectual ability is irrelevant cannot now be accepted."⁶⁵ Although fully aware of the difficulties of determining maturity,⁶⁶ the Lords rejected the Court of Appeal's argument that a fixed age limit was justified by the public interest in the law being certain.⁶⁷ In the view of the majority, as stated by Lord Scarman:

[Certainty] brings with it an inflexibility and rigidity which in some branches of the law can obstruct justice, impede the law's development and stamp upon the law the mark of obsolescence . . . If the law should

60. See *supra* note 30.

61. In *Danforth*, the court held that since "the state has somewhat broader authority to regulate the activities of children than of adults", there must be "a significant state interest . . . that is not present in the case of an adult" to justify the burdens imposed on the minor. *Danforth* at 74-75. See also Note, *The Minor's Right of Privacy: Limitations on State Action After Danforth and Carey*, 77 COLUM. L. REV. 1216, 1232 n.88 (1977) [hereinafter *The Minor's Right of Privacy*].

62. See Tribe, *Childhood, Suspect Classifications and Conclusive Presumptions: 3 Linked Riddles*, 39 LAW AND CONTEMP. PROBS. 35 (1975) (suggesting that childhood might be treated as a "semi-suspect classification" and that "absent compelling justification, age-based, and analogously semi-suspect, lines must be open to rebuttal in settings involving both (1) the deprivation of liberties ordinarily deemed fundamental, and (2) the presence of moral transition — at least if coupled with a self-preserving institutional unresponsiveness").

63. See *supra* text accompanying notes 36-40.

64. *Gillick* at 419.

65. *Id.* at 411.

66. The U.S. courts have also recognized these difficulties. See, e.g., *Bellotti v. Baird*, 443 U.S. 643, n.23.

67. See also Samuels, *Contraceptive Advice and Assistance to a Child Under 16*, 22 MED. SCI. AND LAW 215 (1983) (having an age of majority "is a clear, simple, practical rule, which everybody knows and understands and can apply").

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impose on the process of 'growing up' fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.⁶⁸

Lord Scarman added later in his judgment that "uncertainty is the price which has to be paid to keep the law in line with social experience."⁶⁹ The other major argument against individualized determinations considered by the Lords was that such determinations could invite discrimination and other abuses of discretion and are costly in terms of both time and money.⁷⁰ The court, however, argued that the better course was to regulate the use of discretion rather than to adopt an age-based classification,⁷¹ for, as Lord Scarman stated, "any such general dividing line is sure to produce in some cases injustice, hardship and injury to health,"⁷² which might outweigh the danger of abuse of discretion. The Lords' final decision went beyond that of their U.S. counterparts. Rather than initially assuming the immaturity of all minors below a certain age, the Lords required an individualized determination of maturity in every case, with decisionmaking authority vested in the doctor instead of the courts.⁷³

Although the recognition of the problems of a rigid age-based classification is laudable, the courts in both countries have failed to ensure the equal treatment of minors capable of making independent decisions by requiring proof of maturity before dispensing with parental consent.⁷⁴ Also the means of proving maturity remains problematic because both judicial systems have allocated decision-making responsibility without providing any real guidelines in lieu of age for the determination of maturity. The U.S. courts have merely equated maturity with ability to make an independent deci-

68. *Gillick* at 421.

69. *Id.* at 425. However, Lord Scarman did comment that it would be open to the legislature to intervene in favor of certainty by laying down rigid demarcations after a full consideration of all relevant factors. *Id.* at 421.

70. See, e.g., B. BREST & S. LEVINSON, *PROCESSES OF CONSTITUTIONAL DECISIONMAKING* 816 (1983); Wald, *supra* note 5, at 268 n.55.

71. *Gillick* at 413 (Fraser, L.J.) and 425 (Scarman, L.J.).

72. *Id.* at 425. See also M. FREEMAN, *THE RIGHTS AND WRONGS OF CHILDREN* (1983) ("the danger of discrimination by the decision maker should not lead to the elimination of discretion but to its confinement and control against bias").

73. The House of Lords seems to assume the possibility of judicial review of the doctor's discretion. See *Gillick* at 411 ("It is a question of fact for the judge (or jury) to decide whether a particular child can give effective consent to contraceptive treatment").

74. Not only is it unreasonable to ask someone to go to court to prove his or her ability to exercise a fundamental right, but in practice, poor, minority and rural minors cannot take advantage of the option of going to court and are thus denied the opportunity to prove their maturity. Donovan, *supra* note 37, at 267.

sion.⁷⁵ The Lords have been slightly more precise, emphasizing that maturity also depends on the nature of the particular decision. Lord Fraser stated his opinion that:

[P]rovided the patient . . . is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises.⁷⁶

Lord Scarman talks of the maturity requirement as being satisfied by proof that the minor has a "sufficient understanding and intelligence to enable him or her to understand fully what is proposed."⁷⁷

While these statements do serve to clarify what is meant by maturity, they still leave the decisionmaker with very broad discretion, and, although courts are often called upon to determine states of mind without strict guidelines, U.S. studies of the operation of the "judicial bypass" in abortion decisions have led most U.S. commentators to conclude that "the real intent of such statutes is to make it more difficult for minors to obtain abortions" rather than to provide a means for minors to demonstrate their maturity.⁷⁸ Furthermore, the judicial bypass seems to have allotted to the courts an impossible task for, as Judge Martin of Duluth acknowledged, it is almost absurd to expect a court to determine a minor's maturity in the space of five minutes — the average duration of hearings before his court. Indeed, the judicial bypass laws have unreasonably strained already busy courts and have increased substantially the need for public defenders and guardians ad litem.⁷⁹ The U.K. alternative of requiring the doctor to determine the maturity of the minor seems somewhat more reasonable because the minor already has to go to a doctor for a prescription whereas the U.S. judicial bypass requires a special appearance in court. Doctors are also accustomed to making decisions which go beyond the strict limits of clinical judgment, and are more likely than judges to be familiar with the level of under-

75. *Bellotti* at 643-44.

76. *Gillick* at 409-10. Lord Fraser also talks of the minor having "sufficient understanding and intelligence to know what [contraceptive advice, examination and treatment] involve," but it is unlikely that the intelligence requirement adds anything to the requirement of understanding.

77. *Id.* at 422-23. This encompasses the nature of the advice being given and moral and family questions. *Id.* at 424. Lord Scarman also mentions the requirement that the minor be "capable of making up his or her own mind on the matter requiring decision" and having "sufficient discretion to enable him or her to exercise a wise choice in his or her own interests."

78. Donovan, *supra* note 37, at 267.

79. *Id.*

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standing required to make a decision about the use of contraceptives. The danger remains, however, that minors will be denied contraceptives not because they are immature but as a result of doctors' personal views of the propriety of minors using contraceptives. In addition, the House of Lords' conditions require the doctor to be satisfied that the provision of contraceptives is in the minor's best interests and that her physical or mental health is likely to suffer unless she receives contraceptive advice. The latter requirement is an obstacle that adults do not have to surmount and, therefore, places an unfair burden on minors whom the doctor has already determined to be mature. Furthermore, the additional responsibility may not be welcomed by the medical profession since it would leave them open to malpractice suits and possibly even criminal actions.⁸⁰

III. *Beyond Rational Decisionmaking*

Inasmuch as their decisions have focused on rational decision-making and maturity, the courts in both countries have only squarely addressed the issue of parental involvement in the decisions of *mature* minors to obtain contraceptives. This leaves unanswered the more difficult question of what to do when the minor is judged to be immature and is, therefore, not considered to be the best judge of her own interests. An examination of the position of such immature minors has led both the U.S. and the U.K. courts to recognize that rational decisionmaking is not the only issue involved in questions of minors' access to contraceptives.

One other policy goal supported by, for example, the *Doe v. Irwin* plaintiffs in the U.S. and *Mrs. Gillick* in the U.K., is the preservation of an independent fundamental right of parents to make decisions on behalf of their minor children. The U.S. court acknowledged the existence of this fundamental right but held that it was not constitutionally violated by the absence of a parental consent requirement.⁸¹

80. This concern is probably not of great importance, however, because the discretion the House of Lords advocates giving to the doctor would seem to be no greater than for other medical decisions which have implications going beyond the physical health of the patient. Furthermore, the doctor is highly unlikely to be found guilty of encouraging unlawful sexual intercourse, or of being an accessory to such a crime, because the doctor's probable intention is to provide a palliative against the consequences of the crime and it would be perverse to regard this action as criminal conduct. See *Gillick* at 413-14 (Fraser, L.J.) and 424-25 (Scarman, L.J.).

81. The court's reasoning was that since visiting the birth control clinic was voluntary, the parents remained free to exercise their traditional care, custody and control over their minor children and, thus, there was "no deprivation of the liberty interest of parents in the practice of not notifying them of their children's voluntary decisions to participate in the activities of the Center." *Doe v. Irwin* at 1168; *PPAU v. Matheson* at

In the U.K., while the Court of Appeal accepted the contentions that parents have a parcel of rights in relation to a child in their custody, including the right to completely control the child, and that the parents' decision would be treated as *prima facie* in the child's best interests, the House of Lords made short shrift of these arguments. The Lords instead endorsed Lord Denning's view in *Hewer v. Bryant* that the legal right of the parent to the custody of a child "is a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with a right of control and ends with little more than advice."⁸² The Lords' view that parental rights should be seen as being for the protection of the immature minor and should cease as soon as the minor is deemed to be mature enough to make independent decisions is clearly to be preferred. To find otherwise would be to equate the child with the property of the parent, an attitude which, in the words of Lord Fraser, should be relegated to the status of "a historical curiosity."⁸³ Even where the minor is immature, parents should not be given complete control over the child, and the best interests of the minor should be able to override any parental rights.

In addition, the U.S. courts and literature devote considerable attention to the suggestion that there should be a parental consent requirement, not because the parents will necessarily make a better decision, but because the state has an interest in bolstering parental authority for the sake of "the family" as an institution.⁸⁴ A parental consent requirement has been said to be in the best interests of the family because it respects a private realm of family life which the state should not enter;⁸⁵ or because it enhances parental responsibility for the protection of minors' interests;⁸⁶ or because internal

450-51 (the parents' interests are affected but they must give way to the constitutional rights of mature minors or immature minors whose best interests are contrary to parental involvement).

82. *Gillick* at 412, quoting *Hewer v. Bryant*, [1969] 3 All E.R. 578, 582 (C.A.). Lord Scarman also stated that "the principle of the law . . . is that parental rights are derived from parental duty and exist only so long as they are needed for the protection . . . of the child. *Id.* at 420.

83. *Id.*

84. Professor Wald argues that "[m]ost legal and social policy is based on the beliefs that children lack the capacity to make decisions on their own and that parental control of children is needed to support a stable family system, which is crucial to the well-being of society." He also comments that "the reasons why our family structure is critical to the well-being of the state are rarely articulated." Wald, *supra* note 5, at 259 n.17.

85. The plaintiffs in *Doe v. Irwin* advanced this argument, which was rejected by the court. *Irwin*, 615 F.2d at 1167-68.

86. INST. OF JUD. ADMIN./AM. BAR ASS'N, JUVENILE JUSTICE STANDARDS: STANDARDS RELATING TO RIGHTS OF MINORS 52 (1980).

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decisionmaking promotes family stability and cohesiveness through encouraging family discussion and contributing to the general knowledge of the welfare of family members.⁸⁷

Even assuming the value of the traditional family, the claim that the state has an interest in strengthening the family is circular. It ignores the fact that the family or private sphere is not a natural social institution but one that is itself created by the state,⁸⁸ and a state decision not to regulate the activities of family members is nevertheless a state action regarding the family and is not, therefore, non-intrusive.⁸⁹ The other two claims are empirical and are equally questionable because denying minors the right to make important decisions could very well weaken the family unit.⁹⁰ Furthermore, studies show that forcing a minor to obtain parental consent does not necessarily lead to family involvement and is likely to cause her to have intercourse anyway but without using contraceptives.⁹¹ It has also been argued that rather than enhancing parental authority, "if [the parents'] lack of control is such that intercourse is occurring, it implies either that they are indifferent or that they regard the practice as inevitable or that the situation is beyond their control."⁹² Thus, considerations of the interests of the family as a unit, like considerations of parental interests, are insufficient to provide a basis for a veto over a minor's ability to receive contraceptive services whether or not the minor is mature.

Another obvious and important policy objective, which both the U.K. and U.S. courts have recognized, is the protection of the best

87. *Id.* See also Wald, *supra* note 5, at 280 ("Parents may not be able to perform these roles [of providing help, guidance and support for the child] if they do not know about critical events in the child's life").

88. See Olsen, *The Family and the Market: A Study of Ideology and Legal Reform*, 96 HARV. L. REV. 1497, 1504 *passim* (1983).

89. Minimum state interference only makes sense when the parent and child agree. See *Developments in the Law: The Constitution and the Family*, 93 HARV. L. REV. 1156, 1219 n.137 (1980) [hereinafter *Developments*]. Given the probable distribution of power in the family, a decision in favor of family autonomy amounts to one in favor of parental authority. See Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy*, 88 HARV. L. REV. 1001, at 1013-15 (1974-75).

90. *Developments*, *supra* note 89, at 1220 n.144. A possible alternative would be to encourage minors to bring in their parents voluntarily. See, e.g., Gillick at 413; Title X, *supra* note 15.

91. See *infra* note 97; see also Lord Denning's rather incredible view, acknowledging that a girl might be too afraid to ask for contraception if she believed that her parents might be notified, but that it is more important that her relationship with her family is maintained than that her pregnancy is prevented. Interview with London Weekend Television, reported in *The Guardian*, Dec. 5, 1983, at 3, col. 5.

92. J. MASON & R. MCCALL SMITH, *LAW AND MEDICAL ETHICS* 103 (1983).

interests of the minor.⁹³ It has been argued that a parental consent requirement is in the minor's best interest because, it is claimed, the unconditional supply of contraceptives to minors increases the level of teenage sexual activity. This increase is itself said to be harmful to the psychological and physical well-being of minors.⁹⁴ The argument continues that parents should be involved in the decisionmaking process because they are best placed to enforce abstention. Also, requiring their consent for the provision of contraceptives delays the initiation of sexual intercourse because, rather than involve their parents, minors will not attempt to obtain contraceptives and will forego sexual activity in the face of the threat of pregnancy.

However, studies show that the lack of contraceptive protection is not a significant deterrent against sexual intercourse; "[o]nly one in seven teenagers who attend family planning clinics come for contraceptive help before they initiate intercourse."⁹⁵ Even if the threat of pregnancy did deter minors from sexual activity, U.S. courts have held that states still should not impose a parental consent requirement because it is plainly unreasonable to punish fornication with

93. The danger of a nurturance orientation, however, is that it may actually be a means of maintaining the powerlessness of a group. See, e.g., Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 995 (1984), in relation to the position of women in society. As to minors, because of the social construction of childhood, maturity is mainly dependent on experience and practice. Therefore, making decisions on behalf of an immature minor may retard the ability of that minor to act in a mature and responsible manner.

94. In part this claim relies on the fact that the legislatures in both countries have seen fit to protect female minors by criminalizing sexual intercourse with all females below the age of majority, or some fixed age below that, at least so far as the male participant is concerned. See, e.g., Sexual Offences Act, 1956, ch. 69, §§ 5, 6; Lord Brandon's dissent in *Gillick* at 428-31; N.Y. PENAL LAW §§ 263.00-263.25 (Consol. 1984 & Supp. 1985). However, deference to the criminal laws would require that all minors be denied access to contraceptives whether mature or not, and this conflicts with the courts' position that mature minors should be treated as adults.

Not only is increased sexual activity said to be harmful but contraceptive use itself is claimed to be detrimental to the physically immature. See *Gillick* at 434 (Templeman, L.J., dissenting). However, studies show that "[t]he pill is no more risky in this age group than any other contraceptive method and it affords sexually active teenagers the best protection against the five times greater risks associated with pregnancy and childbirth." 1:3 PUBLIC POL'Y ISSUES IN BRIEF 2 (1981). See also *RISKING THE FUTURE*, *supra* note 6, at 161-62; *BRITISH MEDICAL JOURNAL*, REVIEW OF RELEVANT LITERATURE (Nov. 12, 1983).

95. ALAN GUTTMACHER INSTITUTE, *TEENAGE PREGNANCY: THE PROBLEM THAT HASN'T GONE AWAY* 44 (1981). See also *Carey v. Population Services Int'l*, 431 U.S. 678, at 695-96, 702, 714-15; *Developments*, *supra* note 89, at 1372-73. This issue led to an interesting pair of letters to *The Times* (London). The first, from Lord Devlin, said that "the common law may yet decide whether parents or health authorities are to decide whether to provide those under 16 with the means of sexual promiscuity." In response, Professor Simpson of the University of Kent wrote: "Nature provides the means, and the onset of puberty the inclination" (July 29 and Aug. 1, 1983). See also *Gillick* at 430, 434 (Brandon and Templeman, L.L.J., dissenting).

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the possibility of pregnancy and the birth of an unwanted child.⁹⁶ The gravity of this possibility is demonstrated by other studies showing that a parental consent requirement, while not causing minors to forego sexual activity, would deter them from seeking contraception and would thereby expose minors to the far greater problems of teenage pregnancy.⁹⁷ One of the most important studies in support of this argument is a survey of teenage fertility in thirty-seven developed countries, focusing particularly on the U.S., Canada, Britain, the Netherlands, France and Sweden, which was published by the American Alan Guttmacher Institute (AGI). Of the countries surveyed, the U.S. and the Netherlands were found to have the highest and lowest teenage pregnancy rates respectively, with Britain falling somewhere in the middle. The researchers attributed their findings in part to the lack of confidentiality for teenagers wanting contraceptives in the U.S. compared with Britain, the Netherlands and Sweden, where contraceptive services appear to be most accessible on a confidential basis to minors.⁹⁸ Services in the Dutch clinics are entirely confidential if the minor so requests and, at the time of the survey and prior to the *Gillick* case, complete confidentiality was also the practice in Britain.

Other American studies provide similar evidence that increased access to family planning services reduces the rate of unwanted pregnancy. A study of combined education and family planning services in junior and senior high schools in St. Paul, Minnesota, showed that these programs decreased the rate of unwanted preg-

96. See *Carey v. Population Services Int'l*, 431 U.S. 678 at 715-16 ("It is as though a State decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets") (Stevens, J., concurring). See also *Eisenstadt v. Baird*, 405 U.S. 438, 448 (1972); *Developments*, *supra* note 89, at 1373; *The Minor's Right to Privacy*, *supra* note 61, at 1232-33. If deterrence is the better solution, it would be more appropriate to focus on criminalizing such behavior.

97. "Approximately 1/4 of young teenage patients would not attend family planning clinics if their parents had to be informed. Only 2% of those would forego sexual activity . . ." PPACT INC., FACTSHEET 2 (Jan. 1985). See also *RISKING THE FUTURE*, *supra* note 6, at 159; *Gillick* at 412.

98. Jones, Forrest, Goldman, Henshaw, Lincoln, Rosott, Westoff & Wulf, *supra* note 9, at 57-58. It should be noted that the figures for contraceptive use in the U.K., Netherlands and U.S. were for 1976 (used currently), 1981 (used at last coitus) and 1979 (used at last coitus) respectively, and only covered never-married women. The results were interestingly not correlated with the levels of adolescent sexual activity. *Id.* at 60. Other factors considered were the extent of public health and welfare benefit systems; income distribution; size of the country; homogeneity of the population; influence of conservative religious bodies; school sex education; age of initiation of sexual activity; and cost of contraceptive services. *Id.*

nancy by 56 percent in one school and 23 percent in two others.⁹⁹ Another study reported that during the 1970s "2.6 million unintended adolescent pregnancies were averted" by federally funded family planning programs, with roughly 417,000 of these in 1979 alone.¹⁰⁰

Unwanted pregnancy is acknowledged to be a serious problem for both the mother and her child.¹⁰¹ A 1985 U.S. House of Representatives Select Committee Report found that "teens have higher risk factors for low birthweight infants, infant mortality, inadequate or no prenatal care, school incompleteness, economic self-sufficiency, and having less healthy children."¹⁰² Maternal morbidity and mortality are also considerably greater for teenage mothers.¹⁰³ Teen parents furthermore suffer higher rates of marital instability,¹⁰⁴ and their children are more likely than other children to become teen parents themselves.

In their decisions concerning minors' access to contraceptives, the U.S. and U.K. courts have failed to take account of the evidence that a restrictive attitude to the access of immature minors to contraceptives will not control sexual activity but will increase the incidence of unintended teenage pregnancy. This evidence suggests that a parental consent requirement is not in the best interests of even immature minors. The courts should recognize that although a decision

99. Edwards, Steinman, Arnold & Hakanson, *Adolescent Pregnancy Prevention Services in High School Clinics*, 12 FAMILY PLANNING PERSP. 6-14 (1980).

100. Forrest, Hermalin & Henshaw, *The Impact of Family Planning Clinic Programs on Adolescent Pregnancy*, 13 FAMILY PLANNING PERSP. 109-16 (1981). See also Zabin, *The Impact of Early Use of Prescription Contraceptives on Reducing Premarital Teenage Pregnancies*, 13 FAMILY PLANNING PERSP. 72-74 (1981); J.E. ALLEN & D. BENDER, *MANAGING TEENAGE PREGNANCY: ACCESS TO ABORTION, CONTRACEPTION AND SEX EDUCATION* (1980).

The effect of contraceptive use on pregnancy rates was also recognised by Lord Justice Bridge: "contraception may be the only effective means of avoiding a wholly undesirable pregnancy." *Gillick* at 428.

101. See *Committee Report on Teen Pregnancy*, *supra* note 10, at ix: "Regardless of one's political philosophy, the prospect of one million teenage pregnancies, 400,000 abortions, and one-half million births each year, nearly fifty-five percent of which will be births to unmarried teens, is chilling. The human and fiscal costs to all are unacceptable." Not all teenage pregnancies, however, are unintended. A 1979 U.S. study, for example, reported that 18% of metropolitan-area teenagers who had become premaritally pregnant wanted to become pregnant. Zelnick & Kanter, *Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan Teenagers: 1971-1979*, 12 FAMILY PLANNING PERSP. 230-37 (1980).

102. *Id.* at 1. See also ALAN GUTTMACHER INSTITUTE, *supra* note 95, at 28 (1981) (the "most far reaching consequence of teenage childbearing is the truncation of education among the young parents" which, along with the tendency of teenage mothers to be single parents, generally leads to the child being brought up in a low income household).

103. ALAN GUTTMACHER INSTITUTE, *supra* note 95, at 29.

104. *Committee Report on Teen Pregnancy*, *supra* note 10, at 16.

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to let minors use contraceptives is obviously about enabling them to engage in sexual intercourse without the danger of getting pregnant, the stress should not be on "enabling sexual intercourse" but on "without getting pregnant."¹⁰⁵ Therefore the courts should ensure the access of all minors to contraceptives.

IV. Conclusion

The U.S. and U.K. legislatures and judiciaries should turn their energies to addressing the very real problem of teenage pregnancy. The courts should take into consideration the social, economic and health consequences of unintended teenage pregnancy rather than basing their decisions exclusively or primarily on considerations of individual maturity.¹⁰⁶ Since an increase in the use of contraceptives can reduce the rate of unintended teenage pregnancy, any minor who seeks contraceptive services should be given them without parental involvement.¹⁰⁷ Such an approach would be well within the bounds of the judicial role. The U.S. courts have already recognized that the state's interests may be factored into the constitutional balance and the Supreme Court has ruled that a state has "an independent interest in the well-being of its youth."¹⁰⁸ The U.K. courts have explicitly based the *Gillick* decision on public policy, and there are very good arguments for making the goal of pregnancy prevention a major policy concern. A consideration of unintended teenage pregnancy would not conflict with issues of self-determination or of the best interests of the minor. It would also reintroduce the certainty sacrificed by the courts' attempts to avoid the inequities of age-based determinations, while providing an approach consistent with the goal of equal treatment in the absence of any

105. See *Gillick* at 428-31 (Brandon, L.J., dissenting).

106. Even if the state's overriding interest was in ensuring that minors make well-reasoned childbearing decisions, this argues for making a more extensive educational effort rather than attempting to relieve minors of the opportunity to make the decision. See *supra* note 93 and *The Minor's Right to Privacy*, *supra* note 61, at 1255.

107. This is the solution recommended by the Institute of Judicial Administration and the American Bar Association. See INST. JUD. ADMIN./AM. BAR ASS'N, *supra* note 86, at 72. There are other scholars who argue that immature minors should have the freedom to make their own choices purely out of self-determination concerns. See, e.g., J. HOLT, *ESCAPE FROM CHILDHOOD* 18 (1974); R. FARSON, *BIRTHRIGHTS* 27 (1974).

108. *Ginsberg v. New York*, 390 U.S. 629, 640 (1968). There is also a precedent for ignoring issues of actual or presumed maturity in state statutes permitting treatment for venereal disease and chemical dependency, e.g. N.J. STAT. ANN. § 9:17A-4 (venereal disease); ALA. CODE ANN. tit. 22 § 104(17) (drug and alcohol dependency).

compelling justification for impinging upon the freedom of choice of minors.¹⁰⁹

109. These conclusions have broad implications for the position of minors in society. It would be necessary for policymakers to reassess other instances where minors are treated differently from adults on the basis of their chronological age, where age is used as a surrogate for maturity. Indeed, Lord Fraser used the equal ability of minors regardless of maturity in other areas to support his conclusion regarding contraception. *Gillick* at 409. On the one hand, the fundamental nature of decisions concerning contraception justifies special respect for minors' rights in this area; but, on the other hand, the ability of minors to make decisions to which serious consequences attach argues for greater latitude in less serious matters.