A Minor's Right to Contraceptives

I. INTRODUCTION

> An unwanted pregnancy can be a personal and social disaster for the mother, the child, and the parents and society in general. When the mother is herself a child, the consequences are even more serious. Virtually everyone agrees that the adult woman should have the right of access to contraception; this is her legal right in practically every state. . . . From a behavioral point of view, there is no logical reason why these options actually available to the older woman should be legally denied to minors whose predicament may be even more desperate.[1]

A single minor should have the legally protected right in every state to access to contraceptives without her parents' consent.[2] Increased teenage sexual experience and current patterns of inadequate contraceptive use create an urgent need for comprehensive and enlightened statutory reform. The results of this largely unprotected sexual behavior are reflected in the increasing rates of illegitimacy among teenagers, with disastrous personal and social consequences to both the young woman and her community. Under our present laws abortion has developed as a practical but unreasonable alternative to contraception for the sexually active girl. These pressing medical and social realities will be explored in Part II.

Part III summarizes the four basic types of law which currently govern the availability of contraceptives to minors. Common law doctrines can be codified to give young people access to birth control services without disturbing current legal theory. An analysis of federal legislation and the recent trend of Supreme Court decisions will show that uniform state legislation giving minors a right to contraceptives would probably meet with Congressional and judicial approval.

The model statute proposed by Part IV is an attempt to provide a solution for the social, medical, and legal considerations discussed in

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[1]REPORT OF THE COMMITTEE ON EDUCATION IN FAMILY LIFE, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE MANAGEMENT OF SEXUAL CRISES IN THE MINOR FEMALE [2] (1971) [hereinafter cited as SEXUAL CRISES IN THE MINOR FEMALE]. The opinion is that of the Committee and does not necessarily reflect the policies of the College.

[2]Discussion of sterilization as a method of contraception is beyond the scope of this article.

Parts II and III. The experiences of current pilot programs which provide birth control services to teenagers across the nation, and the recommendations of the health professions, provide a solid basis from which to draft both a statute enabling minors to obtain contraceptives without parental consent and a public health policy designed to implement it effectively.

II. SOCIAL PRIORITIES

A. PATTERNS OF TEENAGE SEXUAL BEHAVIOR

The single minor's need for a legally protected right to contraceptives is indicated by the increase of non-marital sexual activity among progressively younger teenagers. As of 1971, some 28 percent (approximately 2.4 million) of all never-married women between 15 and 19 engaged in sexual intercourse.[3] Single women of age 15 had a 14 percent likelihood of having experienced intercourse; the probability rises to 21 percent at age 16, 27 percent at age 17, 37 percent at age 18, and 46 percent by age 19.[4]

This phenomenon cannot be dismissed as a function of poverty, to be dealt with legislatively in terms of welfare reform alone. What is remarkable about the statistics is the relatively small difference the effect of poverty actually had on the number of girls with such experience.[5] A survey taken by a Marin County, California, high school newspaper revealed that by graduation some 40 percent of the students, all from homes in this wealthy San Francisco suburban area, had engaged in sexual intercourse.[6]

Another factor underlying the urgent need for laws which will provide contraceptives for minors is the alarming ignorance of sexually experienced girls as to the risks of pregnancy and the use of any kind of birth control. In the 15 to 19 year old age group, only 38.3 percent correctly identified their period of greatest fertility.[7] More disturbing was the fact that 15.7 percent of these girls never used contraceptives, 62.9 percent sometimes used them, and only 19.0

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[3]The statistics and conclusions discussed here and below are from an excellent and exhaustive study by Kantner, Zelnick, *Sexual Experience of Young Unmarried Women in the United States*, 4 FAM. PLAN. PERSPECT. 9 (1972) [hereinafter cited as the Kantner-Zelnick Study]. There are some complex racial variables which affect these figures and which are fully discussed in that article.

[4]*Id.* at 9.

[5]*Id.* at 10 Table 1.

[6]Cook, *Sex and the Rich Kids*, San Francisco Chronicle, January 6, 1974, at 1, col. 6.

[7]This breaks down to 23 percent of the 15 year olds, 33 percent of the 16 year olds, 37 percent of the 17 year olds, 51 percent of those 18 and 53 percent of those 19 who *correctly* identified the time of greatest risk of conception. Kantner-Zelnick Study, *supra* note 3 at 17.

percent always did.[8] This ignorance cannot be dismissed as a particularized socio-economic problem either. The Marin high school survey referred to above showed that only 52 percent of its sexually active students used contraceptive protection.[9]

Studies show that contraceptive use is higher among college women.[10] By 1970 almost one-fifth of the health services in colleges and universities prescribed contraceptives for single minors.[11] Although less than 20 percent have a written policy on prescription, a substantial number make referrals to off-campus physicians.[12] Most better-educated girls tend to go to private doctors.[13]

Specific information on the use of public clinics by young people is limited, although estimates run high. In Los Angeles, for example, 30 percent of the patients treated by the Planned Parenthood clinic in one month in 1973 were minors.[14] Statistics indicate that public clinics may be a particularly popular source of birth control services for minors from poverty homes.[15]

What these facts underscore is the need for a legally approved access to birth control for all minors. It is urged that parental consent not be a prerequisite for distribution of contraceptives to sexually active teenagers. Some parents contend that ready availability of

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[8]Use of contraceptives increases with the age of the minor:

PER CENT OF MINORS WHO USE CONTRACEPTIVES

Age	Never Use Them	Sometimes Use Them	Always Use Them
15	31.9	46.0	19.0
16	20.1	57.4	20.0
17	11.9	68.9	16.9
18	12.6	69.0	17.2
19	11.7	63.7	21.6

Kantner, Zelnick, *Contraception and Pregnancy: Experience of Young Unmarried Women in the United States*, 5 FAM. PLAN. PERSPECT., adapted from Table 1 at 22 (1973) [hereinafter cited as *Contraception and Pregnancy*].

[9]*Sex and the Rich Kids, supra* note 6 at 18, col. 1. The article was not clear as to whether males were included in this figure.

[10]*Contraception and Pregnancy, supra* note 8 at 34-35.

[11]Barbato, *Study of Prescription and Dispensing of Contraceptive Medications at Institutions of Higher Education*, 19 J. AM. COLLEGE HEALTH ASS'N 303, 306 (1971). The Association surveyed the trend of distributing contraceptives to college women, and concluded there was an increase in the provision of contraceptives to single minor women from 3.74 percent of the member institutions in 1966 to 34.88 percent of the member institutions in 1970. *Id.* at 306. At the time of the 1970 survey there were 555 Institution members, and the questionnaire was sent to 2003 non-members; there were 513 usable responses representing an enrollment of 3,036,000 students. *Id.* at 303.

[12]*Id.* at 305, 306.

[13]*Contraception and Pregnancy, supra* note 8 at 35.

[14]This is compared to 34 percent in the 19 to 24 year old age group, to 26 percent for those 25 to 34, and to nine percent for 35 to 44 year olds. For that month a total of 3,413 people were treated. Letter from Mike Mochizuki, Clergy Counseling Service for Problem Pregnancies, Planned Parenthood World Population, Los Angeles, October 23, 1973.

[15]*Contraception and Pregnancy, supra* note 8 at 35.

contraceptives will increase sexual promiscuity. Yet studies show that there is no evidence whatsoever that increasing access to contraceptives has affected patterns of sexual intercourse among young people.[16] These parents also argue that the legal provision of contraceptives to their children would usurp their role as parents and would undermine the social and moral education they are entitled to provide at home. However, no statute making available a method of birth control is likely to affect the actions of a teenager who has been imbued with sexual values which are the result of thoughtful and effective parental training at home.

B. SOCIAL COSTS OF ILLEGITIMACY

The profound social costs of illegitimacy are another cogent reason why minors should have legal access to contraceptives upon request. In addition to the possible disastrous personal effects of unprotected intercourse, the serious social consequences of illegitimacy give society a stake in providing contraceptives to its sexually active young.

In the last 25 years there has been a significant increase in the number of illegitimate births to minors, and in the proportion of illegitimate children to legitimate children born nationally. Also, minor mothers now account for a greater proportion of the total number of illegitimate births to any age group.[17]

What the illegitimacy rates do not reflect are the social conse-

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[16] While the incidence of premarital and teen-age sex may or may not be on the increase, there is no evidence that the incidence of premarital or extramarital sex relations is increased by increasing availability of medically prescribed contraception.
Pilpel, Wechsler, *Birth Control, Teenagers and the Law: A New Look, 1971*, 3 FAM. PLAN. PERSPECT. 37 (1971) [hereinafter cited as *Teenagers and the Law*].

[17] Statistics vary. Between 1940-1944 and 1955-1959 there was an increase of 89 percent in the rate of illegitimate births to girls aged 15 to 19. From 1955-1959 to 1968 the increase was another 28 percent. U.S. BUREAU OF THE CENSUS, DEP'T OF COMMERCE, CURRENT POPULATION REPORTS, SERIES P-23, NO. 36, FERTILITY INDICATORS: 1970, SPECIAL STUDIES at 43 Table 25 (April 16, 1971) [hereinafter cited as FERTILITY INDICATORS].

In 1968 alone, 27 percent of all the births to women aged 15 to 19 were illegitimate, and there was an increase in the number of illegitimate births in total population from 3.6 percent annually in the 1940-1944 period to 9.7 percent in 1968. *Id.* at 45, Table 27, 46 Table 26.

Figures have put the number of out-of-wedlock births to girls under 20 at 42,600 in 1940; by 1968 the number had risen to 165,700, or almost half of all live births out-of-wedlock in the U.S. for that year. Girls under 15 comprised 2.1 percent of these pregnancies. Wallace, Gold, Goldstein, Oglesby, *A Study of Services and Needs of Teenage Pregnant Girls in the Large Cities of the United States*, 63 AM. J. PUB. HEALTH 5 (1973) [hereinafter cited as *Needs of Teenage Pregnant Girls*].

Estimates run that two of five illegitimate children are born to teenage mothers. Irwin, *Birth Control for Teenagers*, SEXUAL BEHAVIOR, February 1972 at 41 [hereinafter cited as *Birth Control for Teenagers*].

quences to the young mother. Early school drop-out is endemic when a minor becomes pregnant, whether or not she marries.[18] These girls face such obstacles as:

> long waiting periods after delivery before permission is granted (if it is) to return to school, hostile attitudes on the part of faculty, problems with providing suitable day care for the infant. . . . In short, pregnancy is the major known cause of school drop-outs among girls.[19]

Statistics further suggest that while the total number of children expected by young mothers with higher education is slightly less than the number expected of those who are more poorly educated, the mothers in the latter group are apt to have their children at an earlier age.[20] Early pregnancy precludes returning to school and exacerbates the social and economic consequences of unplanned motherhood. Use of contraceptives would reduce the rate of illegitimacy and would prevent this disruption of young lives.

Another important social consequence of providing contraceptives to minors would be the elimination of maternal risks and deaths associated with pregnancy in young women. Unwanted pregnancy is also cited as a major cause of psychological problems and suicide among teenage girls.[21] The even more onerous costs borne by infants of minors — higher incidence of mortality, prematurity, and intellectual and physical defects[22] — would be avoided if the minor female were legally provided effective birth control assistance.

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[18] In their "Policy Statement of Teenage Sexuality and Family Planning Services to Minors" adopted by the Board of Directors on June 3, 1972, the Planned Parenthood Federation of America lists unwanted pregnancy as a "number one cause among female minors for school drop-outs and prematurely terminated educational attainment."

[19] *School-Age Parents*, EMKO NEWSLETTER, October 1973 at 2, citing the National Alliance Concerned with School-Age Parents.

[20] BIRTH EXPECTATIONS OF YOUNG WOMEN*
AGE 18 to 24, PER THOUSAND

	Less than 4 Years of High School	High School Education	One or More Years of College
Present Births	1465	834	458
Projected Future Births	918	1426	1683
Total	2383	2260	2141

*These statistics are for married women. Presumably the pattern would not be as strong for a single mother.

U.S. BUREAU OF THE CENSUS, DEP'T OF COMMERCE, CURRENT POPULATION REPORTS, SERIES P-20, NO. 254, BIRTH EXPECTATIONS OF AMERICAN WIVES: JUNE 1973 at 7 adapted from Table 3 (October 1973).

[21] Policy Statement of Planned Parenthood, *supra* note 18.

[22] THE REPORT OF THE U.S. COMMISSION ON POPULATION GROWTH AND THE AMERICAN FUTURE, POPULATION AND THE AMERICAN FUTURE 81 (1971).

Pregnancy in minors also has disastrous social consequences leading beyond mother and child, to the young father and to the basic family unit. Those teenagers who do not wish to face the birth of an illegitimate child frequently seek marriage as an escape. Early marriage is a poor solution to both the pregnancy and illegitimacy problems, when it is realized that most of the damage could be avoided by treating the crisis at its source: conception. In 1966, some 42.4 percent of the 15 to 19 year old mothers had children born within eight months of their marriages, and an additional 27.7 percent had their children eight to eleven months after the wedding.[23] The divorce rate of such marriages is disproportionately high.[24]

The minor father is also frequently forced to quit school or limit his education in order to support his young family. Early termination of education by either sex has a long-term destructive effect on the composition of the work force, and frequently increases the need for public assistance. For girls who gave birth to their children within eight months of marriage, 37.5 percent of these new families had an income of less than $3,000 and 60.8 percent lived on less than $4,999 annually.[25]

C. ABORTION: AN UNREASONABLE ALTERNATIVE TO PREGNANCY

From a medical, sociological and legal point of view, it makes no sense that abortion become a more viable solution to unwanted pregnancy than contraception. Despite our current statutory pattern which effectively denies minors legal access to contraceptives, the recent liberalization of abortion laws throughout the country makes

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[23] FERTILITY INDICATORS, *supra* note 17, at 39 Table 23.

[24] The divorce rate for people married when relatively young is approximately twice that of those who marry at an older age. Men who had married by age 21 had a 28 percent rate of marriage failure within 20 years, compared to a 14 percent failure rate for those married after 22. Similarly, 27 percent of women married between 14 and 19 were divorced within 20 years, compared to 15 percent of their counterparts 20 years and older. U.S. BUREAU OF THE CENSUS, DEP'T OF COMMERCE, POPULATION CHARACTERISTICS, SERIES P-20, NO. 223, SOCIAL AND ECONOMIC VARIATIONS IN MARRIAGE, DIVORCE AND REMARRIAGE: 1967 at 1 Table A (October 7, 1971).

Women with children have twice the divorce rate in the first two years of a first marriage than do those without children:

> . . . the high probability of divorce in the first two years of marriage for women with one child is very likely associated with the birth of children before the ninth month of the marriage and the weakness of the marriage ties among many of those who marry because a child was already expected or actually born.

Id. at 3.

[25] FERTILITY INDICATORS, *supra* note 17, at 39 Table 23.

abortion not only a possible legal solution to unwanted pregnancies among minors, but a real and practicable alternative.

In California, for example, the 1971 decision *Ballard v. Anderson*[26] provided that a minor could obtain a therapeutic abortion without the consent of her parents. The court determined that abortion was covered by California Civil Code section 34.5 which provides for minors to receive surgical treatment relating to pregnancy.[27] This decision gives a minor the right to petition the medical committee of the participating hospital for an abortion under the 1967 Therapeutic Abortion Act.[28]

However, the 1973 U.S. Supreme Court decision of *Roe v. Wade*[29] has limited the state's right to regulate a woman's abortion. Theoretically, portions of the California Therapeutic Abortion Act are unconstitutional where they violate the letter of *Wade*. If *Ballard v. Anderson* is read with *Wade*, in California a single minor is subject to no more restrictions than an adult married woman in her quest for an abortion. Until the beginning of the third trimester of pregnancy she would be able to obtain a medical abortion on demand, subject only to provisions protecting her health.

That abortion has been chosen by minors as an alternative to illegitimate birth or early marriage is indicated by statistics. In California, the number of abortions in minors age 10 to 14 rose from 329 in 1969 to 1,166 in 1971. For 15 to 19 year olds this number increased from 4,488 in 1969 to 31,806 in 1971.[30] In 1970, single minor women had three times as many abortions as their married counterparts. The rate that year for unmarried minors reached a high of 952.3 abortions for every 1,000 live births.[31]

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[26] Ballard v. Anderson, 4 Cal. 3d 873, 95 Cal. Rptr. 1, 484 P.2d 1345 (1971).

[27] CAL. CIV. CODE § 34.5 (West 1954).

[28] Cal. Therapeutic Abortion Act, CAL. HEALTH & SAFETY CODE § 25950 *et seq.* (West Supp. 1974). Her petition was still subject to refusal unless the committee of physicians found one or more of the following conditions: (1) there was a substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother; (2) the pregnancy resulted from rape or incest; and, (3) the pregnancy was not beyond its 20th week.

[29] Roe v. Wade, 410 U.S. 113 (1973). Wade held that during the first trimester of pregnancy an abortion can be performed in a licensed physician's office; during the second trimester the state has a sufficiently compelling interest to regulate abortion measures to protect the *health* of the mother; during the third trimester the state has a sufficiently compelling interest to regulate abortion to protect the life of the unborn child.

[30] BUREAU OF MATERNAL AND CHILD HEALTH, DEP'T OF PUBLIC HEALTH, FIFTH ANNUAL REPORT ON THE IMPLEMENTATION OF THE CALIFORNIA THERAPEUTIC ABORTION ACT 8 (1972).

[31] *Id.* at 10 Table 4. The abortion rates have probably increased steadily since the 1971 *Ballard* decision and the 1973 *Wade* case, but current date is not yet available.

III. LEGAL CONSIDERATIONS

A. PATTERNS OF CURRENT STATE LAW

Current legislation neither consistently nor adequately deals with the issue of distribution of contraceptives to minors. Despite the incidence of sexual activity in minors, their high rates of illegitimacy, and their frequent resort to abortion to end pregnancies resulting from unprotected intercourse, few states provide for the distribution of contraceptives to young people.

Statutory treatment on the state level can be divided into four overlapping categories: (1) treatment for veneral disease; (2) treatment of pregnancy-related conditions; (3) publicly-sponsored family planning programs; and, (4) express authorization of distribution of contraceptives to minors.[32]

1. TREATMENT FOR VENEREAL DISEASE

Forty-nine states and the District of Columbia have statutes providing for treatment of venereal disease in minors, generally without parental consent.[33] This liberal trend is indicative of some legislative

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[32] An excellent and comprehensive chart of state law on these issues is found in *Teenagers and the Law, supra* note 16, at 38-42a. Unfortunately, this resource has not been updated since 1971.

[33] Twenty-five states expressly provide that the consent of no other party is necessary when a minor seeks treatment for suspected venereal disease: ALA. CODE tit. 22 § 270 (Supp. 1971); ALAS. STAT. § 09.65.100(a) (1973); ARIZ. REV. STAT. ANN. § 44-132.01 (Supp. 1973); ARK. STAT. ANN. §§ 82-629, 82-630 (Supp. 1973); CAL. CIV. CODE § 34.7 (West Supp. 1974); CONN. GEN. STAT. ANN. § 19-89a (Supp. 1973); FLA. STAT. ANN. § 384.061(a)-(b) (1973); IDAHO CODE § 39-3801 (Supp. 1973); KAN. STAT. ANN. § 65-2892 (1972); MICH. STAT. ANN. § 14.346(1) (Supp. 1974); MINN. STAT. ANN. § 144.343 (Supp. 1974); MONT. REV. CODE § 69-6101 (1970); NEV. REV. STAT. § 441.175 (Supp. 1973); N.J. STAT. ANN. § 9:17A-4 (Supp. 1974); N.H. REV. STAT. ANN. § 141:11-a (Supp. 1973); N.Y. PUB. HEALTH LAW § 2305 (Supp. 1973); N.C. GEN. STAT. § 90-21.5 (Supp. 1973); N.D. CENT. CODE ANN. § 14-10-17 (Supp. 1973); OHIO REV. CODE § 3709.24.1 (Supp. 1972); Ore., ORS 109.610 (1973); PA. STAT. ANN. tit. 35 § 10103 (Supp. 1973); S.D. COMP. LAWS ANN. § 34-23-17 (1972); TEX. FAM. CODE ANN. § 35.03 (Supp. 1973); UTAH CODE ANN. § 26-6-39.1 (Supp. 1973); WASH. REV. CODE ANN. § 70.24.110 (Supp. 1973).

Six more states and the District of Columbia simply provide that a minor has the capacity to consent to treatment for a venereal disease: D.C.C.E. § 6-119j-1 (1973); IND. STAT. ANN. § 35-4411 (Supp. 1973); KY. STAT. ch. 104 § 480 (1970); N.M. STAT. ANN. § 12-34-9 (Supp. 1973); OKLA. STAT. ANN. tit. 63 § 1-532.1 (Supp. 1971); S.C. CODE § 32-565 (Supp. 1973); VA. CODE ANN. § 32-137 (Supp. 1973).

In addition, six states word their statutes so that physicians are relieved of liability for treating minors without parental consent: COLO. REV. STAT. § 41-2-13 (Supp. 1971) (limited to immunity for diagnostic examination); NEB. R.S.S. § 71-1121 (1972); MASS. GEN. LAWS ANN. ch. 111 § 117 (1971), and R.I. GEN. LAWS ANN. § 23-11-11 (1968) (diagnostic examination of minor is not an assault); WYO. STAT. § 35-176 (Supp. 1973); W. VA. CODE ANN. §16-4-10 (1972).

The remaining twelve states allow treatment of minors for venereal disease, with provision for notification of parents or guardians. Hawaii requires the physi-

recognition of the medical and social impact of teenage sexuality. (Few states, however, seem to consider that the distribution of prophylactic contraceptives is a means of treating or preventing venereal disease.) It seems shortsighted to consider illegitimacy and abortion, with their pervasive social repercussions, less important than the spread of communicable disease.

2. *TREATMENT OF PREGNANCY-RELATED CONDITIONS*

Approximately twelve states allow a minor to obtain surgical care relating to a pregnancy.[34] These statutes, however, restrict such treatment to conditions of pregnancy, and generally provide that the minor either be pregnant, be pregnant and a parent, or believe herself to be pregnant. Also, it is not clear whether contraceptives are generally considered to constitute treatment relating to pregnancy.[35]

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cian to inform the spouse, parent, custodian, or guardian if the patient does have the disease; HAWAII REV. STAT. tit. 31 ch. 577A 3 (Supp. 1973). Iowa requires such notification only if it appears the minor might infect members of the family; IOWA CODE ANN. § 140.9 (1972). In Vermont there must be notification if immediate hospitalization is required; VT. STAT. ANN. tit. 18 § 4226 (Supp. 1973). Delaware, Georgia, Illinois, Louisiana, Maine, Maryland, Mississippi, Missouri and Tennessee leave notification to the discretion of the physician. DEL. CODE ANN. tit. 13 § 708(a)(b) (Supp. 1970); GA. CODE ANN. § 74-104.4 (1973); Ill., 91 S.H.A. § 18.4 (Supp. 1973); LA. REV. STAT. § 40:1065.1(c) (Supp. 1974); ME. REV. STAT. ANN. tit. 32 §§ 2606, 3292 (Supp. 1973); MD. CODE ANN. § 43-135 (Supp. 1973); MISS. CODE ANN. § 41-41-13 (1972); Mo., V.A.M.S. §§ 431.061, 431.062 (Supp. 1974); TENN. CODE ANN. § 53-1104 (Supp. 1973).

Wisconsin does not appear to have any statutory provision for treatment of a minor's venereal disease without parental consent.

[34] CAL. CIV. CODE § 34.5 (West 1954); DEL. CODE ANN. tit. 13 § 708 (Supp. 1970); GA. CODE ANN. § 88-2904(f) (Supp. 1973); HAWAII REV. STAT. § 577A-2 (Supp. 1972); Ill., 91 S.H.A. § 18.1 (Supp. 1973); KAN. STAT. ANN. § 38-123 (1973); MINN. STAT. ANN. § 144.343 (Supp. 1974); MONT. REV. CODE § 69-6101 *et seq.* (1970); N.J. STAT. ANN. § 9:17A-1 (Supp. 1974); N.M. STAT. ANN. § 12-34-13 (Supp. 1973); PA. STAT. ANN. tit. 35 § 10103 (Supp. 1973); VA. CODE ANN. § 32-137 (Supp. 1973).

[35] Nor could the general medical treatment statutes on the books in about half the states be construed to allow all minors access to contraceptives:

Only Louisiana, Rhode Island, and South Carolina will allow an unemancipated minor to consent to general medical treatment without parental consent. Louisiana requires the minor to believe himself afflicted with an illness or disease, and Rhode Island and South Carolina require that he be at least 16. LA. REV. STAT. § 40:1095 (Supp. 1974); R.I. GEN. LAWS ANN. § 23-51-1 (Supp. 1973). S.C. CODE § 32-565 (Supp. 1973), *but see* note 40, *infra.*

Arkansas and Mississippi will allow an unemancipated minor sufficiently capable of giving an informed consent to do so. ARK. STAT. ANN. § 82-363 (Supp. 1973); MISS. CODE ANN. § 41-41-3(h) (Supp. 1972). Kansas will provide treatment if parents are not immediately available for consent. KAN. STAT. ANN. § 38-123b (1973).

Approximately 22 states will allow minors who are emancipated, married, a parent, pregnant, or in an emergency situation to consent to medical treatment. These statutes are usually restrictive. ALA. CODE tit. 22 § 104(15)-(22) (Supp. 1971); ARIZ. REV. STAT. ANN. §§ 44-132, 44-133 (1967); ARK. STAT. ANN. § 82-363 (Supp. 1973); CAL. CIV. CODE § 34.6 (West Supp. 1974); COLO. REV. STAT. ANN. § 41-2-13 (Supp. 1971); DEL. CODE ANN. tit. 13 § 707 (Supp.

Dictum in *Ballard v. Anderson*, *supra*, indicates that under California Civil Code section 34.5 contraception would not be treatment relating to a pregnancy, although abortion is.[36]

3. PUBLICLY-SPONSORED FAMILY PLANNING PROGRAMS

Twenty-one states have legislation providing for family planning services. These can be divided into three general subgroups. There are six states which authorize contraceptives and family planning services for any person, or which do not specifically exclude minors.[37] Five states authorize family planning services to adults, minors with one child already, married minors, or minors who file for a marriage license.[38] The third group of states which have family planning legislation authorizes services on the basis of economic status or the dependency of the applicant's children. Ten states allow (or do not exclude) all minors who are present or potential welfare recipients, and/or who have one child already, to receive contraceptives on request.[39]

4. EXPRESS AUTHORIZATION OF DISTRIBUTION OF CONTRACEPTIVES TO MINORS

Eleven states and the District of Columbia expressly allow minors to obtain contraceptives without parental consent. Four of those

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1970); GA. CODE ANN. § 88-2904 (Supp. 1973); Ill., 91 S.H.A. §§ 18.1-18.3 (Supp. 1973); IND. STAT. ANN. §§ 35-4407, 35-4409 (Supp. 1973); KY. REV. STAT. § 214.185 (Supp. 1972); MD. CODE ANN. § 43-135 (Supp. 1973); MINN. STAT. ANN. §§ 144.341-144.347 (Supp. 1974); MISS. CODE ANN. §§ 41-41-3, 41-41-7 (1972); Mo., V.A.M.S. § 431.065 (Supp. 1974); NEV. REV. STAT. § 129.030 (Supp. 1967); N.J. STAT. ANN. § 9.17A-1 (Supp. 1974); N.M. STAT. ANN. § 12-25-1 *et seq.* (Supp. 1973); N.Y. PUB. HEALTH LAW § 2504 (Supp. 1973); N.C. GEN. STAT. § 90.21.1 (1965); Ore., ORS 109.640 (1973); PA. STAT. ANN. tit. 35 § 10101 (Supp. 1973); VA. CODE ANN. § 32-137 (Supp. 1973).

[36] "Medical care aimed at preventing pregnancy is obviously not 'related to her pregnancy', an existing condition, because such care is administered before any pregnancy exists and for the purpose of avoiding the condition of pregnancy." 4 Cal. 3d 873, 882, 95 Cal. Rptr. 1, 7, 484 P.2d 1345, 1351 (1971).

[37] COLO. REV. STAT. § 66-32-2 (Supp. 1971); GA. CODE ANN. § 99-1303 (Supp. 1973); KAN. REV. STAT. § 23-501 (Supp. 1973) (must be over 18 or referred by physician); MISS. GEN. LAWS ch. 531 (1972); NEV. REV. STAT. § 422.235 (1973); WYO. STAT. § 35-508 (Supp. 1973); ALAS. STAT. § 18.05.035 (1969) only provides birth control information to minors.

[38] FLA. STAT. ANN. § 381.382 (1973); HAWAII REV. STAT. § 572-5 (Supp. 1974); MASS. GEN. LAWS ANN. ch. 272 § 21A (1959); TENN. CODE ANN. § 53-4607 (Supp. 1973); VA. CODE ANN. § 20-14.2 (Supp. 1973).

[39] CAL. WELF. & INST. CODE § 10053.2 (West Supp. 1974); IOWA CODE ANN. § 234.21 *et seq.* (1969, Supp. 1974); Ill., by adoption of resolution proposed by Ill. Birth Control Commission (1965); LA. REV. STAT. § 33:7501(g) (Supp. 1974); MICH. STAT. ANN. § 16.414(2) (1968); NEV. REV. STAT. § 422.235 (1973); N.Y. SOC. WELFARE LAW § 131-e (1971); OHIO REV. CODE § 5107.10 (1970); Ore., ORS 435.205 (1973); W. VA. CODE § 16-2B § 2 (1972).

states qualify the eligibility of the minor and several more qualify the method of contraception available.

Eight of these twelve jurisdictions (Colorado, the District of Columbia, Georgia, Kentucky, Oregon, South Carolina, Tennessee, and Virginia) simply give minors access to contraceptives without the consent of their parents.[40]

In addition, two of the eleven states (Illinois and Mississippi) authorize a physician to give contraceptives, on request, to any minor who is married, a parent, pregnant, or who is referred by a party such as a clergyman, family planning clinic, or other physician.[41]

Florida permits a physician to provide non-surgical contraceptives to any minor without parental consent if, in the physician's opinion, the minor may suffer probable health hazards if the services are not provided.[42] Maryland provides that although a minor can consent to treatment for contraceptives, the physician may, at his discretion, inform her parents or guardian.[43]

B. THE NEED FOR LEGISLATIVE ACTION

There is, then, an urgent need for comprehensive legislative action providing minors with access to contraceptives without their parents' consent. A liberal reading of statutory provisions authorizing minors to receive birth control services indicates that only fourteen[44] states and the District of Columbia[45] permit this for most minors, and nine[46] more will only authorize minors who are parents, about to be married, or present or potential welfare recipients to obtain contraceptives from publicly-sponsored family planning programs.[47]

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[40] COLO. REV. STAT. § 91-1-38 (Supp. 1971); DIST. OF COLUMBIA REG. no. 71-27 (1971); GA. CODE ANN. § 88-2904 (Supp. 1973); KY. REV. STAT. § 214.185 (Supp. 1972); Ore., ORS 109.640 (1973); S.C. CODE §§ 32-565, 32-566 (Supp. 1973)("any health services" as interpreted by Att'y Gen. Op. August 23, 1972); TENN. CODE ANN. § 53-4607 (Supp. 1973); VA. CODE ANN. § 32-137 (Supp. 1973).

[41] Ill., 91 S.H.A. § 18.7 (Supp. 1973); Miss. Gen. Laws ch. 531 (1972).

[42] FLA. STAT. ANN. § 381.382(5)(a) (1973).

[43] MD. CODE ANN. §43-135 (Supp. 1973).

[44] Kansas, Nevada, and Wyoming, *see supra* note 37; Colorado, Georgia, Kentucky, Oregon, South Carolina, Tennessee, and Virginia, *see supra* note 40; Illinois and Mississippi, *see supra* note 41; Florida, *see supra* note 42; Maryland, *see supra* note 43.

[45] *See supra* note 40.

[46] Hawaii and Massachusetts, *see supra* note 38; California, Iowa, Louisiana, Michigan, New York, Ohio, and West Virginia, *see supra* note 39.

[47] The number of states authorizing the distribution of contraceptives to minors is not as large as appears from the summary of legislation which provides either family planning programs or express distribution to minors, and inconsistencies are readily visible.

Three (Colorado, Georgia, Mississippi) of the eleven states expressly

The remaining 27 states have taken no clear legislative action allowing minors access to contraceptives without parental consent. Birth control services for the minors of these 27 states, and for the non-qualifying minors in the nine states which base their qualifications on criteria of illegitimate parenthood or poverty, are dependent on case law, interpretation of more general statutes, and public health policy.

One can argue that many of the objectives served by the statutes of the 49 states which allow a minor to be treated for venereal disease would be equally served by allowing her access to contraceptives upon request. The venereal disease statutes aim to protect the health of the minor and to eliminate the social and medical impact of the spread of a communicable disease. They encourage early reporting and treatment of the illness by dispensing with the need for the consent of the minor's parents.

Those statutes which permit a pregnant minor to consent alone to pregnancy-related medical treatment, or an unemancipated minor to consent to general medical treatment,[48] also propose to protect the health of the minor. It seems logical that a statute permitting a minor access to contraceptives without parental consent would similarly encourage her to seek medical services,[49] thereby reducing her own health hazards as well as such social afflictions as illegitimacy and broken families. A farsighted approach to these public health problems would be to insure that a minor's consent alone is sufficient not just to treat her pregnancy, but to prevent it.

The ineffectiveness of current legislation in dealing with the problems of minors and contraceptives has very practical repercussions. On the one hand, a great number of physicians, educational institu-

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authorizing a minor's consent to contraceptives are included in the six which provide family planning services for any person. Three (Florida, Tennessee, Virginia) of the eleven are also three of the five states authorizing family planning services to minors who are parents, married, or about-to-be-married. Thirdly, two (Oregon, Illinois) of the eleven are among the ten states which appear to allow minor welfare recipients and/or parents to receive contraceptives.

[48]The importance of both venereal disease care and provision of contraceptives to minors is underscored in House & Goldsmith, *Planned Parenthood Services for the Young Teenager*, 4 FAM. PLAN. PERSPECT. 27, 28 (1972) [hereinafter cited as *Planned Parenthood Services*]:

> . . . public support of the provision of contraceptive services to sexually active young teenagers is strengthened when venereal disease detection and treatment are included among the services offered to this age group. According to a report from the Venereal Disease Section of the California State Department of Public Health, only one out of four girls being treated at its VD clinics had used any sort of contraceptive. The multiple advantages of combining these two types of medical care are obvious.

[49]Only South Carolina and Mississippi also permit a minor to obtain contraceptives upon request, *see supra* notes 35, 40 and 41.

tions, clinics, clergy, and legislators are uncertain as to the actual status of the law. Physicians and clinics are concerned with their civil and criminal liability when they provide contraceptives to a minor without her parents' consent.[50] On the other hand, some minors have taken advantage of the resulting confusion in state law and have gained haphazard access to contraceptives by being resourceful and persistent. Clear, consistent and comprehensive legislation authorizing minors to obtain birth control services upon their request alone would allow individual members of the medical profession to treat their minor patients on ethical and medical considerations alone, not legal guesswork. It would also promote the health and safety of young women by insuring reputable treatment and prescription, sound advice on the use and effectiveness of various devices, and regular follow-up care.

C. LEGAL OBSTACLES

Two major legal doctrines are invoked against granting minors the legal right to contraceptives without parental consent. Both, however, can accommodate such legislation without doing violence to underlying legal theory.

1. COMMON LAW INCAPACITY TO CONTRACT

The minor's common law incapacity to enter into a binding contract reasonably has deterred hospitals, clinics, and physicians from providing medical services to her if she does not have her parents' consent. Statutes have whittled away this rule either by providing that emancipated minors have an adult capacity to contract, or by prohibiting a minor from disaffirming a certain type of contract. Where medical treatment is concerned, legislatures typically formulate these exceptions in one or more of six ways:[51] (1) statutes which provide an order of persons or agencies which must consent in the event of unavailability of parents; (2) exceptions under the emergency rule; (3) codification of the mature minor rule; (4) emancipation statutes which delimit the right of certain qualified minors to obtain treatment; (5) statutes which exculpate the physician from liability; and, (6) statutes providing for the treatment of certain illnesses of conditions or promoting certain purposes. In this latter category are included treatment of venereal disease, treatment re-

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[50] For two excellent articles elucidating the dilemma of the physician under current California law, *see* Article, *Birth Control and the Liability of Physicians and Pharmacists*, 6 U.C.D.L. REV. 255 (1973); Kavanaugh, *Minors and Contraceptives: The Physician's Right to Assist Unmarried Minors in California*, 23 HASTINGS L.J. 1486 (1972).

[51] Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOODE HALL L.J. 115, 120-122 (1973).

lated to pregnancy, and the family planning programs. Authorization of distribution of birth control devices to minors would be such a qualifying statute.

There appears to be no reason why a legally protected right to contraceptives cannot be easily assimilated into one of these current exceptions.

Under the emancipation theory, an emancipated minor of 15 achieves adult capacity to contract for medical treatment in California.[52] Emancipation of minors can variously result from marriage, living independently of parents, or serving in the armed services.[53] Some states have achieved this same result by having the age of majority for contracting for medical services depend upon the type of treatment sought.[54] There seems to be no theoretical obstacle either to lowering the age of majority for purposes of contracting for contraceptive services, or to qualifying a minor as emancipated for those purposes if she is sexually mature or active. The only practical difficulty with the latter approach would be in defining a particular minor as sexually mature or active within the meaning of the statute.

Many states encourage health treatment of young people by expressly forbidding a minor to disaffirm any contract for medical services. Under California Civil Code section 34.7, for example, no minor of at least 12 can disaffirm any contract for the treatment of a communicable disease.[55] A minor may also have treatment relating to her pregnancy without parental consent, and the contract is not subject to disaffirmance.[56] Similarly, it would be legally consistent to forbid a minor to disaffirm any contract for contraceptive services.[57]

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[52] CAL. CIV. CODE § 34.6 (West Supp. 1974).

[53] CAL. CIV. CODE § 34 (West 1954). For definitions of emancipation, *see generally* 165 A.L.R. 723 (1946), 20 A.L.R.2d 1414 (1951), and 32 A.L.R.3d 1055 (1970).

[54] *See* discussion on treatment of venereal disease and pregnancy related conditions, *supra* notes 33-35 and accompanying text.

[55] CAL. CIV. CODE § 34.7 (West Supp. 1974).

[56] CAL. CIV. CODE § 34.5 (West 1954).

[57] Although the medical profession would receive financial protection for contraceptive services provided to minors under either an emancipation or disaffirmance statute, the physician might still be liable under tort or criminal theories.

Also, since the minor's parents or guardians may also be liable on the contract there is an equitable issue in binding them to a medical contract to which they did not consent and of which they do not approve. *See* County of Alameda v. Kaiser, 238 Cal. App. 2d 815, 48 Cal. Rptr. 343 (1965), where a parent was held liable for cost of treatment because the minor had not become emancipated *for the purpose of paying his medical bills. See also* 32 A.L.R.3d 1055 (1970).

For these two reasons a statute only forbidding a minor to disaffirm a contract for contraceptive services would be an undesirable and ineffective means of providing access to birth control devices without parental consent. The argument is mentioned in this article primarily to show that existing

2. POLICE POWER: PUBLIC HEALTH AND WELFARE

The state police power to regulate matters pertaining to the health and welfare of its citizens is frequently invoked as authority for current statutes prohibiting minors access to contraceptives. This authority, however, can be as validly exercised to permit birth control services to minors, once the desirability of such legislation is recognized.

a. Health

By analogy to legislation for the control of communicable diseases, one could argue that the state similarly has the police power to encourage minors to use contraceptives by eliminating any need for parental consent or any qualifications for eligibility status. The majority of state laws permitting minors to consent to treatment for venereal disease have dispensed with parental permission in furtherance of the state interest of encouraging voluntary submission to treatment for communicable diseases. A statute giving minors access to contraceptives without parental consent would further the substantial state interest in decreasing the incidence of divorce, abortions, illegitimacy, poverty, marriage dissolutions, and early termination of education.

b. Welfare

Many states have given minors access to contraceptives upon request pursuant to articulated welfare policies. The provisions of these codes allow minor welfare recipients, minor parents, or minors adjudged wards of the court,[58] to obtain birth control information and devices without parental consent. This is a commendable attempt to recognize and control the major welfare problems of illegitimacy, poverty, and chronic delinquency.

What the statutes do not provide is a means to prevent the first pregnancy, the first judgment of delinquency, or the first application for welfare which results from unprotected sexual conduct and the birth of a child. A more effective, efficient, and economical way of attacking the welfare problem at one of its sources would be to allow all minors unrestricted access to contraceptives.

D. FEDERAL LAW

Congress has moved more swiftly and directly than state legislatures in developing a comprehensive program which would allow minors access to contraceptives upon request.

The 1972 amendments to the Social Security Act[59] expressly

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legal doctrines can easily accommodate this principle.

[58] CAL. WELF. & INST. CODE §§ 520, 521 (West Supp. 1974).

[59] Act of October 30, 1972, Pub. L. No. 92-603 § 299E, 86 Stat.

provide that minors who are sexually active are eligible for federally subsidized family planning services:[60]

> For family planning services this means social, educational, and medical services to enable appropriate individuals (including minors who can be considered to be sexually active) to limit voluntarily the family size or space the children or reduce the incidence of births out-of-wedlock. Such services include printed materials, group discussions, and individual interviews which provide information about and discussion of family planning; medical contraceptive services and supplies. . . . Such services must be offered and be provided promptly (directly or under arrangements with others) to all eligible individuals voluntarily requesting them.[61]

Whereas Congress indicates by its language that a minor need not be married in order to qualify for assistance, there is question as to whether the minor must have the consent of his parent or guardian. The United States Code states that such services must be provided to all eligible persons voluntarily requesting them.[62] Although eligibility under this section is keyed to eligibility for aid to families with dependent children,[63] the provision does state that the purpose of the program is to provide for development of state child welfare services which are designed to prevent, remedy, or assist in the solution of problems which may result in the neglect or delinquency of children.[64] Arguably the distribution of contraceptives to all minors without parental consent would aid in the prevention of the delinquency of an unmarried mother; it would certainly work to eliminate neglected illegitimate children.

The Code does provide, however, that the medical assistance envisioned be given to those who are eligible under the administering state program.[65] It is as yet too early to determine whether the states will require parental consent as a qualification for eligibility.[66] Short of a broad judicial interpretation of this section or a constitutional decision prohibiting laws requiring such consent, it probably is safe to assume that the states will apply their current policy on the necessity of parental consent for contraceptives to the federally subsidized programs.

1329-1362, *amending* 42 U.S.C. §§603, 1396 (1969).

[60] It should be emphasized that state implementation of any family planning services is purely voluntary.

[61] 38 FED. REG. 30075 (October 31, 1973).

[62] 42 U.S.C. §602(a)(15) (Supp. 1974).

[63] 42 U.S.C. §602(a)(14) (Supp. 1974); §606(b) (1969).

[64] 42 U.S.C. §602(a)(14) (Supp. 1974); §625 (1969).

[65] 42 U.S.C. §1396d(a)(4)(c) (Supp. 1974).

[66] Letter from John A. Svahn, Acting Commissioner, Social and Rehabilitative Service, Community Services Administration, Department of Health, Education and Welfare, November 8, 1973.

E. CONSTITUTIONAL LAW

Recent Supreme Court decisions indicate that statutes authorizing distribution of contraceptives to minors without parental consent would be constitutional. Such legislation is likely to withstand challenges both to the state's interference with the parents' First Amendment rights to freedom of religious expression, and to its interference with parental control of the child's education and upbringing.

Parents with religious objections to birth control could argue that a statute allowing a minor legally to escape their authority by her use of contraceptives devices interferes with their rights to control her religious upbringing. The Supreme Court has held that only those state "interests of the highest order and those not otherwise served can overbalance legitimate claims to the free exercise of religion."[67] The burden on the state to prove an interest of such magnitude would be nearly insurmountable. The 1972 *Wisconsin v. Yoder* decision determined that a state interest in compulsory education for all children did not outweigh the right of Amish parents to control their children's religious upbringing by forbidding their attendance at school. The Amish sect was therefore excluded from the jurisdiction of the statute.[68] Similarly, it is doubtful a state interest in reducing either illegitimacy or abortion would be sufficiently important to mandate interference with the exercise of religious freedom by objecting parents.

Yoder, however, can be distinguished from the constitutional challenge of a statute permitting minors access to contraceptives. The Court in *Yoder* was careful to point out that the Amish religious beliefs were directly in conflict with the compulsory nature of the statute. A law providing only for voluntary use of contraceptives without parental consent would not mandate a conflict between the action of the minor and his parents' religious views.[69]

A statute authorizing distribution of contraceptives to minors without parental consent could also withstand the constitutional challenge that the state has interfered with the parents' rights to educate their children:

> Constitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic in the structure of our society . . .[70]

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[67]Wisconsin v. Yoder, 406 U.S. 205, 215 (1972).
[68]406 U.S. 205 (1972).
[69]The problem of a child's voluntary disobedience of family dictates is an internal disciplinary problem, and, in extreme cases, a problem for the juvenile courts. It is suggested that if a minor were denied access to contraceptives under the proposed statutes *because* his parents had religious objections to his use of birth control devices, the state would be unconstitutionally applying the statute on the basis of religious discrimination.
[70]Ginsberg v. New York, 390 U.S. 629, 639 (1968).

Despite the heavy weight given this parental prerogative, the conflicting doctrine of *parens patriae* upholds the right of the state to interfere with raising a child either on behalf of the child or of the state. In this country the doctrine of *parens patriae* includes two distinguishable ideas:

> The state ought to protect all who cannot protect themselves, and this duty requires protection of infants from their parents and others who may harm them; the state may compel infants and their parents to act in ways most beneficial to society.[71]

It is the latter principle which justifies statutes which remove such diverse subjects as obscenity, treatment for venereal disease, and education from exclusively parental control:

> Parents are ordinarly intrusted [*sic*] with [education] because it can seldom be in better hands; but where they are incompetent or corrupt, what is there to prevent the public from withdrawing their faculties, held, as they obviously are, at its sufferance? The right of parental control is a natural, but not an unalienable one. It is not excepted by the declaration of rights out of the subjects of ordinary legislation; and it consequently remains subject to the ordinary legislative power which, if wantonly or inconveniently used, would soon be constitutionally restricted, but the competency of which as the government is constituted, cannot be doubted.[72]

The Supreme Court has updated this constitutional limitation on legislation for the benefit of child and society in *Ginsberg v. U.S.*: there legislation reflecting New York's interest in protecting the welfare of children was held constitutional so long as there was a rational relationship between the means employed by the statute and the welfare of the minor.[73]

A statute giving minors access to contraceptives without parental consent would meet the *Ginsberg* test of constitutionality. The legislative objectives would be the protection of the minor from the possible health hazards of young motherhood and abortion, and from the social consequences of early marriage, termination of edu-

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[71] Kleinfeld, *The Balance of Power Among Infants, Their Parents and the State*, 5 FAM. L.Q. 64, 107 (1971).

[72] *Ex Parte* Crouse, 4 Wharton 9, 11 (Pa. 1839).

[73] 390 U.S. 629, 641 (1968).

". . . [O]ne can well distinguish laws which do not impose a morality on children, but which support the right of parents to deal with the morals of their children as they see fit." Henkin, *Morals and the Constitution: The Sin of Obscenity*, 63 COL. L. REV. 391, 413 n. 68 (1963) cited in Ginsberg v. New York, 390 U.S. 629, 639-40 n. 7 (1963). With the exception of certain religious objections, use of contraceptives is not immoral in itself. Parental objections to the morality of a statute giving minors access to birth control services are based on the fear that this statute will encourage illicit behavior. However, it should be emphasized that no studies show that increased access to contraceptives has increased the incidence of sexual activity, *supra* note 16. The statute leaves entirely within the control of parents the education of the minor's sexual values.

cation, and poverty. The objectives would also include the social interests of reducing illegitimacy, poverty and the need for public assistance. These objectives reflect the valid state interest, independent of parental concern, in the welfare of its young people. Legislation allowing sexually active minors access to contraceptives rationally serves these objectives by protecting the young person from the problems at their source: unwanted pregnancy.[74]

IV. PROPOSALS

A. SUMMARY

1. REALITIES

Increasing teenage sexual activity, a burgeoning illegitimacy rate among minors, and an increasing resort to abortion as a solution to unwanted pregnancies, have illustrated the pressing social need for eliminating these problems at their source by providing minors with contraceptives upon request. A review of existing state law has shown that few legislatures have provided young people with such birth control services. As a result, the medical profession is faced with a conflict between medical and ethical priorities and the threat of liability for treating these young people. Some determined teenagers can find contraceptives, but their use of them is frequently ill-informed and medically uncontrolled.

2. THEORIES

Common law doctrines of emancipation and the police power of the state to legislate for the health and welfare of its citizens can be codified to provide minors access to contraceptives without parental consent. Congress has encouraged the development of such a comprehensive program through the grant of federal subsidies under the Social Security Act. Supreme Court decisions indicate that a statute authorizing birth control services to minors upon request would be constitutional.

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[74] It is difficult to see how a state can employ any other means as effectively to achieve these certainly valid legislative objectives. An attempt to mold the sexual behavior of minors usurps parental functions:

> It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.

Prince v. Massachusetts, 321 U.S. 158, 166 (1944) *citing* Pierce v. Society of Sisters, 268 U.S. 510 (1925). Given the fact of widespread unprotected sexual intercourse among teenagers, the only recourse left to the state is to protect society from the failure of these parents to provide socially and sexually responsible young people.

3. PROPOSALS

In light of the foregoing considerations, this article has stressed a two-fold proposition to legislatures: (1) that all minors have the right of access to contraceptives; and, (2) that such right not be restricted by the need for parental consent.

A review of current pilot birth control programs for teenagers and a summary of the position of the health professions will indicate how this proposal should be drafted.

B. IMPLEMENTATION

The results of pilot birth control programs and teen sex clinics indicate that easy access and low cost are important factors in effective contraceptive assistance. Experimental health and birth control clinics in this country are very popular with young people and are gradually being integrated into, and accepted by, their communities. Although these public clinics have proven to be an effective outlet for birth control services to minors,[75] restrictive state laws are wasting this valuable social resource. For instance, of all 153 Planned Parenthood Affiliates nationwide, 49 percent of those clinics located in states whose laws are ambiguous as to the sufficiency of a minor's consent alone for contraceptive treatment refuse birth control services to these young people. In contrast, 96 percent of the Affiliates provide contraceptives in states which expressly deem a minor's consent adequate.[76]

Private health clinics are also meeting with excellent youth and community acceptance. Baltimore's Sinai Hospital Adolescent Family Life Service was the first hospital-offered comprehensive teen clinic where girls could be counseled on sexual activity and receive contraceptives without parental consent.[77] Comparable hospital projects have been established or are being planned in Ann Arbor, Topeka, Cleveland, and New York City.[78] Similarly some universities are opening to minor non-students free clinics ordinarly available only to coeds.[79]

There is also expanding involvement of public health agencies in providing contraceptive services to minors. Such progressive depart-

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[75] San Francisco's Center has been the Planned Parenthood trailblazer and is remarkably successful. For the first time in that city's history the illegitimacy birth rate to adolescents has decreased. *Birth Control for Teenagers, supra* note 17, at 44.

[76] *Planned Parenthood Services, supra* note 48, at 31.

[77] *Birth Control for Teenagers, supra* note 17, at 44. Maryland does not require parental consent, but does allow the physician to inform the parents at his discretion. 43 MD. CODE ANN. § 135 (1971).

[78] *Birth Control for Teenagers, supra* note 17, at 44.

[79] University of Minnesota and Ohio State University. *Birth Control for Teenagers, supra* note 17, at 44.

ments include the Seattle-King County (Washington) Department of Public Health and the Los Angeles Health Department Youth Clinics.[80] These agencies should become even more effective as the Social Security Act, as amended in 1972, filters more funds to the contraceptive programs.

The success of these public clinics, private hospital services, and public health department programs indicates several channels through which state legislation authorizing such services to minors could be implemented. Publicity, accessibility, and low cost are critical to the effectiveness of such a legislative policy.

C. PROFESSIONAL RECOMMENDATIONS

The health professions strongly advise that the individual physician have the discretion to give contraceptives to minors upon their request. The majority of the professional medical organizations have solidly supported distribution of contraceptives to minors even without parental consent, although the choice would be left to the individual physician. The American Medical Association recommends that:

> consistent with responsible preventive medicine and in the interest of reducing the incidence of teenage pregnancy . . . the teenage girl whose sexual behavior exposes her to possible conception have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs.[81]

A similar statement has been adopted by the American Academy of Pediatrics, the American Academy of General Practice, and the American College of Obstetricians and Gynecologists.[82]

The A.M.A. further instructs its members that those physicians who choose to provide such birth control services should: (1) attempt to obtain parental consent where possible; (2) consider the case history and the total situation of the patient; (3) reflect in the medical record that health hazards of pregnancy would be greater than those of birth control, if an "emergency" exists; (4) require the minor to sign a consent form indicating her understanding of the

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[80] *Planned Parenthood Services, supra* note 48, at 31.

[81] Teenage Pregnancy, Proceedings of the House of Delegates, American Medical Association 55, 56 (June 20-24, 1971) [hereinafter cited as A.M.A.].

It is interesting to note that the American Academy of Pediatrics also drafted a Model Act Providing for the Consent of Minors for Health Services which provides under § 3(1)-(3) that no minor who is not pregnant, has never been married, has never had a child, or who is not emancipated or graduated from high school can consent to such treatment for contraceptives. 24 JUV. JUSTICE 60, 61 (1973).

[82] A.M.A., *supra* note 81, at 56.

situation; and, (5) insist on follow-up care if necessary.[83]

The Committee on Education in Family Life of the American College of Obstetricians and Gynecologists,[84] the American Public Health Association,[85] and the Planned Parenthood Federation,[86] have adopted stronger statements advising physicians of their duty to provide services to minors on the basis of need alone. For example:

> The physician must make his own judgment of his patient's maturity and act on it at his discretion. Situations occur in which parents, by their irresponsibility or lack of understanding, or in spite of their sincere efforts to maintain effective communication, become so alienated from their children that other responsible members of the community may have to act in their stead. The physician should be free to do this when the occasion requires it, and our laws should be amended to permit it . . . Another appropriate course of action may be to refer the girl to the care and guidance of a family counseling or youth counseling service.[87]

This slight difference of position in the medical profession is academic and overlooks the inherent weighing action in any discretionary medical judgment. A statute which simply frees physicians from civil, criminal, and financial liability for distributing contraceptives to minors will allow for individual differences in professional and ethical judgments, and yet maintain easy access to such services.

D. MODEL STATUTE

Legislation authorizing minors to obtain contraceptives should be two-fold:

1. ENABLING STATUTE

The proposed statute should enable physicians, at their own discretion, to prescribe contraceptives to minors without need for parental consent. Treatment should be confidential. The current Tennessee Code section 53-4607 is a good basic law:

> Contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, or a parent, or married, or who has the consent of his or her parent or legal guardian, or who has

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[83] *Id.*

[84] SEXUAL CRISES IN THE MINOR FEMALE, *supra* note 1.

[85] "The American Public Health Association recommends therefore that college health services offer confidential medical consultation and service on birth control methods, on the diagnosis of pregnancy, and on the diagnosis and treatment of venereal disease." Resolutions Adopted by the Governing Council of the American Public Health Association, Group D — Social Factors, Nov. 15, 1972.

[86] Order #8829/1172, Code #1.2, adopted by the membership, October 26, 1972.

[87] SEXUAL CRISES IN THE MINOR FEMALE, *supra* note 1, at [3].

> been referred for such service by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information.[88]

A model code would need two additional provisions:

> The consent of the parent or guardian shall not be necessary in order to authorize this medical care. A minor is deemed to have the full legal capacity and privileges of an adult when requesting or receiving treatment under this section.

The first statement makes explicit the notion in the Tennessee statute that a minor may obtain birth control services upon his request alone. The second statement insures that the minor will have adult privileges of confidentiality for his treatment, and that his contract for services will not be subject to the infirmities of minority status.

2. POLICY IMPLEMENTATION

The proposed enabling statute does not solve the problems of low cost, easy accessibility, and publicity necessary to encourage sexually active young people to use contraceptives. By creating, in conjunction with the enabling statute, a comprehensive health and welfare policy expressly designed to promote birth control services, the state can make faster progress in its battle against illegitimacy and poverty. Suggested avenues for implementation of such a policy would be through the types of existing public health programs, and public and private clinics, discussed above. Federal subsidies are available if the state expenditures conform with the requirements of the Social Security Act.

V. CONCLUSION

A statute defining the rights of minors to birth control services upon request, and limiting the liability of physicians, must be accompanied by legislative action providing these young people with access to such services through comprehensive public health programs. These two provisions must be enacted together if society is successfully to alleviate the serious problems of illegitimacy, abortion, young and unstable marriage, early termination of education, and poverty, due to the increasing and unprotected sexual activity of its young people.

Elizabeth Jordan

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[88]TENN. CODE ANN. § 53-4607 (Supp. 1973).