ÉTUDES

MEDICAL CONFIDENTIALITY AND INTERFAMILY CONFLICTS REGARDING THE MEDICAL CARE OF ADOLESCENTS: LEGAL FRAMEWORK AND COMPARATIVE LAW OBSERVATIONS

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I. INTRODUCTION

1. The adolescents’ medical care, medical confidentiality and privacy

The term ‘adolescence’ does not capture the biological characteristics of a particular category of individuals, but implies the way in which society refers to the young individuals. Moreover, the adolescents do not constitute a homogeneous group because their maturity degree varies. The World Health Organization (WHO) defines as adolescents the young individuals between eleven and nineteen (11-19) years old1. According to the WHO, adolescents face serious problems related to their bodily and mental health2. Among them, the most significant are those connected with the adolescents’ sexual behavior, which sometimes leads to undesirable pregnancy3 and sexually transmitted diseases such as HIV/AIDS4.

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1 See World Health Organization, Adolescent health: <www.who.int/topics/adolescent_health> [19 May 2011].
2 Ibid.
4 See K. Dehne & G. Riedner, Sexually transmitted infections among adolescents: The need for adequate health services, Reproductive Health Matters May 2001 (9) 177.
Nowadays, the theoretical debate concerning the medical problems, which adolescents face, has been intensified, not only because the comprehension of the problems in question is difficult, but also because the legal framework concerning their medical care is either scarce or anachronistic. Regardless of these difficulties, there are basically three reasons for which the adolescents’ medical care constitutes a major issue in the modern societies. Firstly because medical choices made during the period of adolescence determine the identity of adolescents at their adulthood and have a serious impact on their future life. Secondly, because such choices can be directly damaging for the public health and bear repercussions for the society as a whole. Thirdly, because the above-mentioned choices influence the role of the family by affecting not only the interests of its individual members but the family itself as a unit.

Pregnancy during the period of adolescence constitutes a typical example of these problems. As the WHO underlines, women, which become mothers during their adolescence have difficulties in completing their education while they also face serious medical complications during gestation and child birth. These problems are intensified due to the special feature of adolescence as a ‘middle stage’ of the individual’s process of maturation. Nevertheless, whereas adolescents have more self-confidence as well as mentally and bodily maturity in comparison to children, yet they do not possess the social status or financial ability of adults, in order to be able to face autonomously the repercussions of personal choices such as those related to pregnancy and maternity.

In order to face these problems, social policies should be undertaken and legislative regulation should be adopted by the State. The institutions providing for public health services must be well informed on the adolescents’ legal regime as well as on how to protect their rights towards their doctor and their parents. The fact that the number of doctors specializing in the mental and bodily health problems of the adolescents is quite limited is extremely problematic. Accordingly, the adolescents’ financial dependence on their parents renders their medical care difficult, because doctors are forced, in order to ensure their fees, to put the interests of par-

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6 Ibid.
7 See supra note 3.
8 See Maradiegue, *supra* note 5.
ents in priority in relation to those of their children, who are to be cured. Moreover, seldomly the adolescents avoid to seek medical help, fearing that their health problem which relates to their sexual choices or their psychological condition will not be treated with the necessary sympathy and understanding by their parents\(^9\).

Furthermore, the adolescents’ autonomy to control their medical choices and care pose a series of complex problems\(^10\). In particular, the free circulation of contraceptives as well as the legal recognition of the women’s right to abortion has posed the following two questions: do adolescents have the legal capacity to proceed in medical procedures concerning birth control or make choices such as the termination of a pregnancy without the consent of their parents? Is the doctor obliged to preserve information on the sexual life of adolescents as confidential not only towards third parties but also towards their parents? While most parents believe that the decisions concerning the above mentioned issues lay in their sphere of influence, adolescents on the contrary feel the need to decide autonomously about these issues.

2. Aim of the study – Plan

The present paper examines these problems seen from a comparative law perspective. Its aim is to shed light to the following questions: a) what is the international, supranational and national legal framework of medical confidentiality and what is the way in which it functions in the case of adolescents, b) does there an adolescents’ right to medical confidentiality exist at the first place and towards whom such a right can be addressed? Can such a right be addressed towards third parties only or can it also protect the adolescents towards their parents? c) Under which circumstances do adolescents have the right to seek medical care without their parents’ consent?

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\(^10\) The percentage of first sexual contact in adolescence is higher in the Northern than Southern Europe. Sexual contact among fifteen year-old girls varies significantly from one country to the other. It reaches 12% in Slovakia and 38% in Denmark and Bulgaria. In England, Scotland and Ukraine 1/3 of fifteen year-old girls have experienced sexual contact, compared to 1/5 in Croatia, Czech, Estonia, Hungary, Latvia, Lithuania, Poland and Spain. See World Health Organization, Sexual and Reproductive Health, Regional Office for Europe, <www.euro/who.int/en-what-we-do/health-topics/Life-stages> [19 May 2011].
II. ADOLESCENTS AND MEDICAL CONFIDENTIALITY

1. The notion of medical confidentiality and the importance of its legal protection

The concept of confidentiality is related with the necessity of respect for privacy, that is to say the non-disclosure of personal information, as well as with the relation of confidence between two parties, the transmitter and the recipient of such information. Moreover, the concept of confidentiality has a legal meaning. Consequently, it is distinguished from the concept of secrecy, which, although it commits third parties in a moral duty of non-disclosure, nevertheless, it does not oblige them in the terms of a professionally established relationship of trust. The term ‘medical confidentiality’ reflects the doctor’s obligation not to arbitrarily reveal any information acquired due to his/her professional status and while exercising his/her medical duties, and is connected to the health, life or even more generally to the situation of the individual being treated. On the other hand, the term ‘medical confidentiality’ expresses the corresponding right of the patient to lawfully claim the protection of her personal information.

The oath of Hippocrates of the 4th Century BC is the first source of the concept of confidentiality as an oath of silence, by this meaning as a moral engagement and obligation of the doctor and alongside as a right of the patient. The Hippocratic oath is nowadays a text of international recognition and has intense effect in the international and national codes of moral and medical ethics. Most of these texts have deontological, ethical character. Shortly, they are self-regulation texts, codes of values of medical practice. However, the medical confidentiality obligation can only become effective when it is guaranteed by legislative provisions that impose penal or civil liability sanctions.

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12 According to which, she who undertakes medicine should swear under oath that: “For everything that I may hear or find out during or even outside treatment, which is related to men’s lives and which should not be publicly known, I should be silent considering it as confidential” (authors’ translation from ancient Greek).

13 Such rules in the Greek legal order are the following: Art. 371 of the Greek Penal Code concerning penal sanctions for breaching the duty of professional confidentiality;
The ethical and legislative regulations guarantying medical confidentiality reflect the *rule of silence*, which aims to serve the interests and needs of the patient, protecting not only his/her privacy (according to the internationally known term) but also his/her relationship of trust with his/her doctor, so as to completely entrust the latter with all the personal information needed in order to effectively provide the patient with the necessary medical care, thus the treatment of the patient’s specific health problems. Consequently, the reasons for which the legal order should protect medical confidentiality as a fundamental value for the individual’s autonomy and dignity are the following:

a) The protection of confidentiality is firstly connected with the right to privacy and personal data, which are guaranteed in the Greek legal order by Art. 9 §1 and 9A of the Greek Constitution, as well with the principle of human dignity and the right to personality as they are both established in the Greek Constitution (Art. 2 §1, 5 §1) and the Greek Civil Code (Art. 57). The international and European normative framework along with the national legal orders also provide with adequate protection. In the texts in question, the consolidation of medical confidentiality is equally combined with the protection of the ‘sensitive’ personal information of the individual, such are those connected with his health, and with the guarantees that derive from the protection of the individual’s dignity and personality as well as from the protection of private and familial life.

b) The second reason, which renders medical confidentiality a value, that should be legally protected, is directly based on the previous one. Firstly, the privacy of any personal information concerning the patient’s health is provided in order to protect him/her from unwanted and likely discriminations or even from social seclusion and stigmatization, especially as far as sexually transmitted diseases are concerned. Further-
more, if the disclosure of personal information on the patient’s health takes place without consent, it can limit autonomy regarding the choices concerning medical care and this way it may endanger mental and bodily health, making him/her refrain from being treated, taking medication and medical care\textsuperscript{16}. Moreover, in the same framework, the protection of confidentiality guarantees that the doctor will be able to practice more effectively her duties.

c) Moreover, the patient, who does not know if, when and to what extent someone is aware of his/her health problems cannot fully trust his/her doctor, thus endangering the protection of his/her health. Consequently, the foundation of confidentiality ensures the growth of relations of confidence between the doctor and the patient\textsuperscript{17} and enables this way the provision of medical care to the latter.

d) However, the aim of the legal protection of medical confidentiality is not only to protect the private interests of patient and doctor. Furthermore, one of its goals is to protect the public interest, namely the public health. The foundation of relations of confidence between doctor and patient initiates the individuals to resort more and more to the public health services, thus promoting public health as a public, common value; as society’s public good. The above mentioned function of medical confidentiality is presented indeed as of particular importance so much for the protection of public health from sexually transmitted illnesses, such as for example HIV/AIDS, as for the unhindered access of patients and most of all adolescents to the public health services\textsuperscript{18}.

In the end, it should be noted that in the Greek legal order the protection of medical confidentiality is a principle deriving from the constitutional protection of the individual’s dignity and personality (articles 2 §1, 5 §1). For this reason, medical confidentiality is protected independently from the legal capacity of the patient. In other words, the dead and individuals

\textsuperscript{16} See Papazisi, \textit{supra} note 11, 173-174.

\textsuperscript{17} See in this framework Art. 8 §§1 and 2 of the Code of Medical Deontology (Law 3418/2005), which acknowledges that: “1. A doctor’s contact to her patient should be proper and adequate to her science and to the mission of her service. 2. The doctor provides for the development of relationships of mutual trust and respect between her and the patient. She listens to her patients, she treats them with respect and understanding and she respects their opinions, their privacy and dignity” (authors’ translation).

\textsuperscript{18} See Papazisi, \textit{supra} note 11, 169.
who had been deprived of legal capacity or whose legal capacity had been restricted\textsuperscript{19} as well as minors, whose fundamental rights are protected by supranational conventions and national constitutions and legislations, enjoy a right to medical confidentiality\textsuperscript{20}.

\textbf{2. The adolescents’ rights of private life and medical confidentiality}

\textbf{2.1. Supranational and constitutional legal framework}

The Convention of the United Nations on the ‘Rights of the Child’ (known as UNCRC, CRC or CROC) is the most important supranational text on the protection of the rights of minors\textsuperscript{21}. It should be noted at this point that, in the supranational and national legislative texts there is no discrimination between an adolescent and a child since, as the Convention explicitly provides, each person under the age of eighteen is considered to be a child, unless his/her national legal order provides with a different age limit\textsuperscript{22}. This Convention, which includes 54 articles in total, protecting the individual, political, social, economic and cultural rights of chil-

\textsuperscript{19} According to Art. 1666 ff. of the Greek Civil Code.

\textsuperscript{20} See in this framework Art. 13 §6 of the Code of Medical Deontology (Law 3418/2005), in which it is acknowledged that: “The obligation of preserving medical confidentiality remains valid even after the patient’s death” (authors’ translation).

\textsuperscript{21} The Convention was opened for signature on 20 November 1989. It entered into force on 2 September 1990 and has been ratified by 194 states in total, among which Greece (Law 2101/1992, GG A 192). See Ch. Bourloyanni-Vraila & E. Petroula (eds), \textit{International conventions on rights binding upon Greece} (Athens 2002) 211. The Convention has been signed but not ratified by the USA and Somalia. Implementation is supervised by the Committee of the Rights of Child which consists of member-State representatives. The member States should present annual reports regarding compliance to the Convention. Since 25 November 2000 two optional Protocols have been added to the Convention, which restrict children participation in armed conflicts, as well as children trafficking, prostitution and pornography. See P. Naskou-Peraki (ed.), \textit{The International Convention on the rights of the child and national jurisdiction} (Athens/Komotini 2002) [in Greek].

\textsuperscript{22} See Art. 1 of the Convention on the Rights of Child: “For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier”. Nevertheless the use of the term ‘adolescent’ is extremely important in practice and thus it is adopted by the present paper, firstly because it is during the period of adolescence that many national legal orders acknowledge to minors partial rights of medical confidentiality and consent in medical choices. Moreover, it is in the period of adolescence as it has been noted in the introduction, where the problems of the minors’ autonomy regarding her medical care are becoming especially intense.
children, acknowledges under Art. 16 the right to the protection of the child’s right to privacy, meaning his/her autonomy to determine his/her way of life, as well as his/her right for the protection of his/her family, home and confidentiality of personal communication. According to the entire Convention, apart from Art. 16, a child is a subject of the legal order with a right to self-determination and not a property of the family or the society, to whom it belongs, which needs special protection and help in order to be able to determine her personality and identity with self-sufficiency and freedom.

In the European level, the European Convention of Human Rights (ECHR), which establishes under Art. 8 §1 the right to respect for private life is of particular importance for the protection of the adolescents’ private life. Despite the fact that the protection of the Convention does not appear to have the children as its special recipients, the European Court on Human Rights (ECtHR) interpreting its text as a ‘living instrument’, has developed, with the Gaskin decision as well as with its subsequent jurisprudence, a case law which has ensured a special protective legal framework for the children. The right to respect for private life, moreover, as guaranteed by the Convention, has been enriched by the case law of the ECtHR in such a way, thus including in its content the protection of individual privacy, personality and autonomy in the decision-making process, bodily and mental integrity and dignity. The ECtHR, examining the Plon case, has clearly ruled over the issues concerning the sensitive character of information regarding health and the connection of these issues with the protection of privacy. Moreover, as far as children are concerned,

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23 See Art. 16 of the Convention on the rights of the child: “No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence, or to unlawful attacks on his or her honor and reputation”. See also Art. 17 of the International Covenant on civil and political rights where the protection of privacy is also acknowledged by a similar phrasing. See Bourloyanni-Vraila, supra note 21, 34.

24 See Arts. 2 and 3 regulating obligations that the family and public organizations bear as far as the child’s social protection is concerned aiming to guarantee his/her ‘prosperity, protection and care’; see also Arts. 6-8 protecting the child’s rights to life, name and identity.

25 “Everyone has the right to respect for his private and family life, his home and his correspondence”.

26 See Mareckx versus Belgium (13 June 1979).

27 Gaskin versus UK (7 July 1989). See also Stubbings & Others versus UK (22 October 1996); Mikulic versus Croatia (7 February 2002).

28 Plon versus France (18 May 2004).
the ECtHR has accepted in the Olsson case\(^{29}\), that the contracting States allocate a wide margin of discretion with regard to the cases that concern their care. However, at the same time it considered as interventions in the privacy of children that influence their physical or mental integrity in an undesirable manner\(^{30}\), issues of medical care, such as the obligatory vaccination, the orthodontics treatment, the reception of radiographs, as well as medical tests\(^{31}\).

The children also need special, supra-legislative protection at a national-constitutional level. Particularly, in the Greek legal order, the Constitution of 1975\(^{32}\) especially as it has been revised in 2001, provides a complex network for the child’s protection with regard to its autonomy, privacy, personality and dignity. The epicenter of this protection is considered to be Art. 21 §1 of the Greek Constitution, which protects childhood. However, the protection of the child’s medical confidentiality and autonomy in making choices concerning her medical care and health may be established in the Greek Constitution under Art. 9 §1 that guarantees the protection of private and familial life, Art. 2 §1 which guarantees the protection of human dignity, Art. 5 §1 which protects the free development of the individual’s personality, and finally in the new, guaranteed with the 2001 constitutional revision, Art. 9A, which establishes the right of the protection of personal data. The protection provided by other European legal-constitutional orders can be considered as adequate. Thus, the Italian Constitution (1948) includes under Art. 31 §1 an explicit provision on the protection of childhood and youth, the Spanish Constitution (1978) under Art. 39 establishes not only the protection of childhood but also the equality between children that have been born inside or outside wedlock, while the German Basic Law (1949) recognizes under Art. 6 the importance of the protection of the child’s prosperity, as well as the dignity of the individual and the right to personality, under Arts. 1 and 2 accordingly\(^{33}\).

\(^{29}\) Olsson versus Sweden (30 October 1992).

\(^{30}\) Costello-Roberts versus U K (25 March 1993).

\(^{31}\) Application no. 10435/83 (12 July 1978) 14 DR 31.

\(^{32}\) See A. Manessis, The realization of the constitutional protection of minors in the common law in Annals J. Deliyanni, part IV (Thessaloniki 1992) 240.

\(^{33}\) For a comparative analysis see M. Naldini, Family in Mediterranean welfare states (London 2003) 107 ff.
2.2. National legislative framework

A minor’s right for respect of her medical confidentiality can be established in the above mentioned constitutional and international provisions, in combination with other provisions of the common legislator. In the Greek legal order, such provisions are on one hand Art. 13 of the Code of Medical Deontology (CMD) (Law 3418/2005) specifically regulating the subject of medical confidentiality. And on the other hand, Art. 57 of the Greek Civil Code establishing the right to personality which is *inter alia* also applied in cases where a violation or infringement of private and familial life takes place. This last provision allows the person whose right to personality has been violated to bring an action before the civil courts and claim the waive of the violation and its omission in the future as well as for compensation for pecuniary and non-pecuniary damage, according to the law of torts (Art. 914 of the Greek Civil Code). Moreover, if the breach of confidence occurred with oblique intent, meaning that a doctor has consciously revealed confidential medical information, criminal action might be brought forward by the minor against the doctor under Art. 371 ff., of the Greek Penal Code.

In any case, the duty of maintaining medical confidentiality is not an absolute one. It is subject to exceptions that are set forth under Art. 13 §§ 3 and 4 of the CMD, as well as under Art. 371 §4 of the Greek Penal Code in the following cases. Firstly, when the waive of confidentiality is a prerequisite for the exercise of the medical profession, as it occurs for example when the doctor discloses confidential information with regard to the patient’s condition to his/her assistant or to a colleague that helps him/her in providing medical care to the patient. Secondly, when the will of the contracting parties does exist, that is to say when the patient exempts beforehand the doctor from her duty of confidentiality or subsequently consents to its breach. And thirdly, when the necessity to waive the duty of confidentiality is based on reasons of higher legal interest, such as the danger of transmitting the disease and the endangerment of public health or the danger of committing criminal offences.

Finally, it should be noted that the minor cannot bring by himself a civil or penal action against the doctor arising from the infringement of medical confidentiality. The claims in question can be brought before the Court only by the legal representative of the minor, i.e. the parents, who usually bear the parental responsibility and the custody. The question posed however, is what will happen if the minor has asked the doctor not to notify his/her parents of the information regarding his/her health?
III. THE CONFLICT OF THE ADOLESCENTS’ RIGHT TO MEDICAL CONFIDENTIALITY WITH THE FUNCTIONAL FAMILIAL RIGHT OF THEIR PARENTS

1. Presenting the problem

The answer to the previous question depends firstly on whether law establishes the minor’s right to decide autonomously about the medical procedure which he/she is to undergo, without the consent of his/her legal representative and more precisely his/her parents that have the parental responsibility and custody. Indeed, if the minor has this right, the doctor is not under the obligation to notify the parents on the information regarding her health; to breach, in other words, the minor’s medical confidentiality. On the contrary, if the law does not establish such a right for the minor, the right to medical confidentiality will not extend to her parents. Consequently, the doctor will be under the obligation to disclose to the latter any information related with the health of their child, in order for them to realize her condition and consent to the medical procedure necessary for her health.

2. The comparative law approach to the problem

In German legal theory and jurisprudence, the opinion that the consent of the patient regarding the performance of a medical procedure (§§182-183 of the German Civil Code) does not constitute a legal act and therefore is not directly subject to the provisions regulating the individual’s legal capacity of a person, has prevailed. The relevant legal provisions are simply applied as guiding lines of this consent. Thus, even a legally incapable individual can be considered as legally capable to consent to certain medical procedures provided that she has the maturity and ability to perceive their nature, their aim, as well as the dangers resulting from them.

The ratio of this legal solution is based on the protection of the personality of mature minors. According to its supporters\(^{35}\), the adolescents, that have a certain maturity and can distinguish the probable dangers and the consequences of their actions, must have the right to decide autonomously about certain harmless medical procedures connected with their exterior appearance or with their sexual life, thus medical procedures which fall into the very core of their intimaey. Abortion, the prescription of contraceptive medicines and the placement of contraceptive or odontologist mechanisms constitute some characteristic examples of such procedures\(^{36}\).

Adequate solutions have also been supported in the United Kingdom as well as in the USA. The effort to establish, in these countries, an adolescent’s right to medical confidentiality has been connected with the granting to the minors of a right to a ‘partial’ autonomy regarding their health and medical care decisions\(^{37}\). This ‘partial’ autonomy, distinguishes in these legal orders adolescents from children, a distinction based either on the criterion of maturity (United Kingdom) or emancipation (USA).

In the United Kingdom, the basic legislation protecting adolescents’ medical confidentiality is the Family Reform Act of 1969, which establishes for ‘mature minors’, i.e. individuals aged 16 to 18, the same rights with the adults as far as their legal claims to medical confidentiality and consent to the performance of medical procedures are concerned\(^{38}\).

In any case, the concept of ‘mature minor’ was conceived in the United Kingdom in the *Gillick* decision\(^{39}\). The famous case on the one hand recognized the doctor’s obligation to maintain medical confidentiality regarding information that concern minors between the ages of 16 to 18 not only against third parties, but also against their parents. And on the other hand,

\(^{35}\) *See supra* note 32.


\(^{37}\) *See* Maradiegue, *supra* note 5, 172-173.

\(^{38}\) *See* Part 8(1) of the Family Law Reform Act of 1969: “the consent of a minor who has attained the age of sixteen years old to any surgical, medical or dental treatment […] shall be as effective as it would be if he were of full age: and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian”. *See* also K. Boele-Woelk, B. Braat & I. Curry-Sumner (eds), *European family law in action: parental responsibilities* (Antwerp/Oxford 2005) 67.

\(^{39}\) *See Gillick versus West Norfolk and Wisbech Area Authority* [986] *AC* 112, [986] *AC* 112.
it excluded from the protective scope of the above mentioned regulations infants, as well as individuals considered by law as incompetent.

Nevertheless, it should be noted that the protection of medical confidentiality in the United Kingdom was strengthened when the Human Rights Act (HRA) of 1998 was enacted implementing the European Convention of Human Rights in the English legal order. Since then, Art. 8 of the ECHR protecting private and family life functioned in the English legal order as a ‘constitutional’ background of the legislative and jurisprudence rules that regulated medical confidentiality. In the framework of this development, recent English case law and more particularly the decision in *R versus Plymouth City Council* expanded the protection of confidentiality right to adults who are legally incompetent, as well as to infants. It was held though that this protection is in effect only against third parties and not against the parents or the legal representatives of these individuals.

Moreover, since the Human Rights Act came into force, in the English legal system an effort has been made in order to strengthen the sanctions imposed in the cases of a violation of the Art. 8 HRA, which protects private life and medical confidentiality. Of course, contrary to American case law and theory, that established the tort of privacy, violations of the above mentioned provision were neither under the English legislation nor by the English courts subject to tort law. This means that instead of establishing a tort of privacy (as a distinguishable tort) in cases of violation of private life, as acknowledged by Art. 8 HRA, the English courts kept applying the rules of equity concerning the breach of confidence,

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40 Both the ECtHR and the English Courts have acknowledged the fact that medical information fall into the protective penumbra of Art. 8 of ECHR and of HRA. See ECtHR, *Z versus Finland* (25 February 1997), as well as the decision of the High Court of Justice, QB Division, *R versus Secretary of State for the Home Department, ex. P. Amnesty International (No 3)* (15 February 2000) [unreported] which is commented by J.M. Loughrey, Medical information, confidentiality and a child’s right to privacy, *Legal Studies* 2003 (23), 516 note 39. See *idem*, The confidentiality of medical records: informational autonomy, patient privacy and the Law, *Northern Ireland Legal Quarterly* 2005 (56) 293, 300-301.

41 See [2002] 1WLR 2583.


adapted however in such a way as to provide for a proportional compensation to be ordered to the injured\footnote{See Loughrey, supra note 40, 307-308.}. 

Furthermore, in the USA, the rights of adolescents were strengthened in the \textit{Gault} case by the US Supreme Court\footnote{See 387 U.S. 1 (1967).}, which underlined that “neither the Fourteenth amendment nor the due process clause refer exclusively to adults”. However, the special regulations concerning the autonomy of adolescents in the decision-making process that relates with their medical care and confidentiality involve the Federal legislation, the States legislation as well as the case law. Today, most American States have enacted laws in order to establish an adolescent’s right to consent to the decisions regarding medical care, in the framework of particular cases and under special criteria. From a medical deontology viewpoint, the most important texts that have been adopted in this sector are: the ‘Position Paper on Confidential Health Care: Society for Adolescent Medicine’ (1997), the ‘American Academy of Pediatrics Policy on Confidentiality in Adolescent Health Care Act’ (1989) and the ‘Health Insurance Portability and Accountability Act’ (2002)\footnote{See S. Lawrence\textendash J.P. Wood, Informed consent to the medical treatment of minors: law and practice, \textit{Health Matrix: Journal of Law-Medicine} 2000 (10) 141; H. Boonstra \& E. Nash, \textit{Minors and the right to consent to health care} (2000), <www.agi-usa.org> [19 May 2011].}. 

In general terms, so much the Federal as well as the States legislation in the USA require the parents’ consent before the minor is to be submitted to medical treatment or receive medical care. There are nevertheless exceptions to this general rule. Among these exceptions we should refer, on the one hand, to urgent cases in which the life and health of the minor are at risk\footnote{See S. Elliston, \textit{Best interests of the child in healthcare} (London/New York 2007) 153.} and on the other hand to the special legislative regulations of certain States, that allow the minors to consent, without the parallel consent of their parents, to special sectors of medical care and treatment, such as the reception of contraceptive medicines, the diagnosis and treatment of transmitted diseases, the examination and treatment after sexual attack or rape, the advisory support and treatment of alcoholism and mental diseases, as well as the medical care in the framework of pregnancy and childbirth\footnote{See R. Gillon, Medical ethics: four principles plus attention to scope, \textit{British Medical Journal} 1994 (309) 186.}. Finally, quite few States recognize to some certain categories of minors
enjoying a special legal status, the right to consent to medical procedures without the opinion of their parents to be taken into account. Among these minors are: the emancipated and married minors, the minors that have completed their military service or live separately from their parents and in certain States the ‘mature minors’\textsuperscript{50}.

Moreover, the US Federal and State legislation as well as the case law regarding medical confidentiality have created a system of balancing between the adolescent’s moral right to his/her autonomy, on the one side, and the doctor’s moral obligation, on the other, to breach medical confidentiality in particular cases, in which it is not possible to maintain the duty to confidentiality\textsuperscript{51}. These are cases in which, the adolescent poses a serious danger to him/her or the health of others as well as cases in which the doctor suspects the sexual or physical abuse of a child or adolescent, and therefore has the legal obligation to report the fact to the competent authorities. In such cases, medical confidentiality cannot be considered to be an absolute value. Moreover, in some cases the relevant legislation deems the parents’ right to know the medical status of their child as a doctor’s legal duty, even if finally the medical decision will be based on the consent of the adolescent herself. In the end, as a general rule the USA legislative framework establishes the doctor’s duty to inform the minor in those cases in which he/she is forced to breach medical confidentiality due to certain legal or ethical obligations\textsuperscript{52}.

Finally, in France on the 4\textsuperscript{th} of March 2002 were enacted two laws regarding parental responsibility and public health\textsuperscript{53} that strengthened the equality between parents and children in familial relations, giving in certain cases the precedence to the child’s autonomy\textsuperscript{54}. The new content of the article 371-1 of the French Civil Code, as revised by the first of two
laws that amended provisions concerning parental assiduity, now states that “children participate along with their parents in the decisions that concern them based on their age and their degree of maturity”. Moreover, Art. L 1111-1 of the French Code of Public Health (Code de la Santé Publique) provides that “minors have the right to be informed about their health status and participate in the decisions that concern them in a way adjusted to their level of maturity”\textsuperscript{55}. The child’s autonomy over his/her parents in forming decisions stems from article L 5134-1 of the French Code of Public Health that recognizes the child’s right to decide autonomously for issues related with sexual choices, such as abortion, the use of contraception, of pills and even of emergency contraception (known as the norlevo pill)\textsuperscript{56}.


\textsuperscript{55} See Art. L 1111-1 of the French Code of Public Health (Code de la santé publique) which provides: «Les mineurs ont le droit de recevoir une information sur leur état de santé et de participer à la prise de décision les concernant d’une manière adaptée à leur degré de maturité».

\textsuperscript{56} See Art. L 5134-1 of the French Code of Public Health (Code de la santé publique) which provides: «I- Le consentement des titulaires de l’autorité parentale ou, le cas échéant, du représentant légal n’est pas requis pour la prescription, la délivrance ou l’administration de contraceptifs aux personnes mineures. La délivrance aux mineures des médicaments ayant pour but la contraception d’urgence et qui ne sont pas soumis à prescription médicale obligatoire s’effectue à titre gratuit dans les pharmacies selon des conditions définies par décret. Dans les établissements d’enseignement du second degré, si un médecin, une sage-femme ou un centre de planification ou d’éducation familiale n’est pas immédiatement accessible, les infirmiers peuvent, à titre exceptionnel et en application d’un protocole national déterminé par décret, dans les cas d’urgence et de détresse caractérisés, administrer aux élèves mineures et majeures une contraception d’urgence. Ils s’assurent de l’accompagnement psychologique de l’élève et veillent à la mise en œuvre d’un suivi médical. II- Les contraceptifs intra-utérins ainsi que les diaphragmes et les capes ne peuvent être délivrés que sur prescription d’un médecin ou d’une sage-femme et uniquement en pharmacie ou dans les centres de planification ou d’éducation familiale mentionnés à l’article L. 2311-4. La première pose du diaphragme ou de la cape doit être faite par un médecin ou une sage-femme. L’insertion des contraceptifs intra-utérins ne peut être pratiquée que par un médecin ou une sage-femme. Elle est faite soit au lieu d’exercice du praticien, soit dans un établissement de santé ou dans un centre de soins agréé. III- Les sages-femmes sont habilitées à prescrire les contraceptifs locaux et les contraceptifs hormonaux. La surveillance et le suivi biologique sont assurés par le médecin traitant. Dans les services de médecine de prévention des universités, la délivrance de médicaments ayant pour but la contraception, et notamment la contraception d’urgence, s’effectue dans des conditions définies par décret. Ces services s’assurent de l’accompagnement psychologique de l’étudiant et veillent à la mise en œuvre d’un suivi médical». 
In France, according to previous legislative arrangements, the provision of contraceptive pills to minors was possible only in family planning centers. Nowadays, however, under the new legislative framework, contraceptive pills as well as emergency contraception can be provided to adolescents without the consent of their parents even by drugstores, or the doctors and nurses, who are employed in the schools of the secondary education. Furthermore, the adolescents’ right to medical confidentiality is recognized, in case of abortion, even against their parents, provided that the former are accompanied by some other adult, who confirms the exclusion of the parents from the whole process. Doctors moreover are free to hospitalize a minor even without the consent of his/her parents, if they consider it necessary in order to protect his/her health and the minor himself/herself clearly rejects any communication with his/her parents.

57 See Neirinck, supra note 54.
58 See Art. L 2212-7 of the French Code of Public Health (code de la santé publique) which provides that: «Si la femme est mineure non émancipée, le consentement de l’un des titulaires de l’autorité parentale ou, le cas échéant, du représentant légal est recueilli. Ce consentement est joint à la demande qu’elle présente au médecin en dehors de la présence de toute autre personne. Si la femme mineure non émancipée désire garder le secret, le médecin doit s’efforcer, dans l’intérêt de celle-ci, d’obtenir son consentement pour que le ou les titulaires de l’autorité parentale ou, le cas échéant, le représentant légal soient consultés ou doit vérifier que cette démarche a été faite lors de l’entretien mentionné à l’article L. 2212-4. Si la mineure ne veut pas effectuer cette démarche ou si le consentement n’est pas obtenu, l’interruption volontaire de grossesse ainsi que les actes médicaux et les soins qui lui sont liés peuvent être pratiqués à la demande de l’intéressée, présentée dans les conditions prévues au premier alinéa. Dans ce cas, la mineure se fait accompagner dans sa démarche par la personne majeure de son choix. Après l’intervention, une deuxième consultation, ayant notamment pour but une nouvelle information sur la contraception, est obligatoirement proposée aux mineures.»
59 See passage 6 of the Art. L. 1111-4 of the French Code of Public Health (Code de la santé publique) which provides that: «Le consentement du mineur ou du majeur sous tutelle
Finally, in the same framework, the minor may prohibit the access of parents to the minor’s medical file. In this last case, the mediation of the doctor is necessary in order for the minor itself to access the file60.

3. The approach to the problem by the Greek legal order

The above mentioned comparative observations result in the conclusion that in countries as the United Kingdom, the USA, France and Germany, mature minors do not need the consent of their parents in order to undergo medical procedures related with their intimacy. Moreover, the doctor is under the obligation to maintain medical confidentiality and inform parents that the minor is to undergo these procedures. In our country, the legal theory has supported the above mentioned opinion61. However, the new Code of Medical Deontology (CMD) that has been ratified by Law 3418/200562 distanced itself considerably from this argument63.

More precisely, the first section of Art. 12 §2, passage b, aa’ of the CMD64 regulating the conditions of the patient’s valid consent, explicitly
provides that, in the case of a minor patient, consent is given by the individuals that bear the parental responsibility and custody. In this case, the minor may simply express his/her opinion, provided that the doctor considers that he/she has the age and the related intellectual and sentimental maturity of comprehending the situation of his/her health, the content of the medical procedure and its results or dangers. The Greek legislator’s intention to connect capacity to the consent to medical procedures with the patient’s legal capacity leads to the explicit exclusion of mature minors from their right to decide autonomously for any medical procedures related with their core of personality and intimacy.

While, however, this rule is formulated with clarity under the first section of Art. 12 §2, passage b, aa΄ of the CMD it is completely unjustifiably repeated, also under the third section of the same provision65 that concerns only certain medical procedures recorded under Art. 11 §3 of the CMD66. Such procedures are more specifically, transplantations, techniques of medically-assisted human reproduction, sex-change operations as well as aesthetic and cosmetic ones. According to the third section of Art. 12 §2, passage b, aa΄ of the CMD, in order for a minor to undergo these procedures, it is necessary for those having the parental responsibility and assiduity to give their consent.

As a part of the Greek theory has underlined67, this last regulation is incoherent to the previous one and needs to be corrected via interpretation. Two alternative interpretative proposals have been formulated in order to serve this aim. The first proposal considers the regulation of the third section of Art. 12 §2, passage b, aa΄ of the CMD as unnecessary and therefore, deems as applicable the general rule of the first section of the same provision. This rule as we have mentioned, prioritizes the parents’ functional right to consent to each medical procedure, which their underage child is to undergo, independently of the maturity of the latter68. The second interpretative proposal leads to a diametrically opposite solution as it considers

65 Where in the third passage of Art. 12 §2, passage b, aa΄, it is regulated that: “In the case of paragraph 3 of Art. 11 the consent of those having the parental assiduity of the minor, is necessary”.
66 Especially in Art. 11 §3 it is regulated that: “Special care must be given in the information related to special medical operations, such as transplants, techniques of medically assisted human reproduction, sex-change operations, esthetic or cosmetic operations”.
67 See Foundedaki, supra note 63, 74-75.
that parental consent is required only for the medical procedures, to which
the third section of 12 §2, passage b, aa΄ of the CMD refers. That is to say,
only transplantations, techniques of medically assisted human reproduction,
sex-change operations as well as aesthetic and cosmetic ones. On the
contrary, the minor’s consent to all other medical procedures is a sufficient
prerequisite, provided that she has the maturity to appreciate their gravity,
as well as the repercussions that they may have on her health69.

This second solution is a contra legem interpretation of Art. 12 §2, pas-
sage b, aa΄ of the CMD. It has been supported however that it can be
acceptable because it respects the personality and autonomy of minors70.
It is harmonized, moreover, with the modern tendencies of the legal orders
in Europe and the USA71 with the provisions of the European Convention
on Human Rights and the Biomedicine (Convention of Oviedo), which
was ratified in our country with Law 2619/1998. The above mentioned
Convention does not apply the general provisions of legal capacity to the
incompetent persons’ consent to medical procedures72. And, finally, it is
harmonized with the human rights perceptions as expressed in the field of
international law and more specifically by the International Convention of
UN on the ‘Rights of the Child’, which protects under Art. 16 the private
life of minors.

Based on the textual interpretation and preparatory work of the above
mentioned legislative provision, it is clear that its aim is not only to pre-
vent possible violations of the child’s right to privacy initiated by the pub-
lic administration or generally by the organs of the State73. Moreover, the
objective of the provision is to impose on the State the obligation to adopt
positive measures in order to protect this right against infringements initi-
ated by any individual, the parents of the child included74. Consequently,
the State and namely the legislator and the courts owe to harmonize the
child’s right to private life with his/her parents’ functional rights and more
specifically with their right to assiduity, which encompasses the parents’
power to decide about the issues of the medical care of their child.

69 See Foundedaki, supra note 59, 74-75.
70 Ibid.
71 See supra note 54.
72 See Foundedaki, supra note 63, 74-75.
73 See K. Gogos, Art. 16: respect for privacy in P. Peraki, The International Convention
on the rights of the child, supra note 21, 158 [in Greek].
74 Ibid.
Doctrine underlines that, in such an evaluation, the child’s degree of maturity and the existence of special reasons that justify control over his/her medical choices such as the family’s justified interests, should always be balanced with his/her autonomy and his/her rights to privacy, personality and dignity\textsuperscript{75}. The conclusions drawn from the comparative law approach regarding the notion of the ‘mature’ or ‘emancipated’ minor (UK and USA) and the ‘adult escort’ that substitutes the parents in the abortion process in France, is that in order for this delicate balance to function flexible \textit{standards} should be introduced by the legislators and the courts\textsuperscript{76}. These \textit{standards} are in fact flexible criteria, which are applied \textit{ad hoc}, in the frame of certain circumstances, ensuring the necessary balance between the protection of health, the privacy and the interests of the child on the one hand and the preservation of the family’s unity and interests on the other.

IV. CONCLUSIONS

Based on the above mentioned analysis, it is clear that the need for protecting medical confidentiality supports the acknowledgement of a relevant right not only for adults but also for minors and more specifically adolescents, who are considered to be individuals of an intermediate maturity. The recognition of such a right is also harmonized with the supranational, international and European protection of the child as well as with the corresponding legislative regulations of other legal orders, such as the French, British, German and American, as analyzed above. This approach has the advantage of recognizing to the adolescents the protection of their autonomy in forming any decisions related with their health and medical care, thus contributing in their recognition as subjects of the legal order who have the rights to the protection of their privacy, personality and dignity, as the adults do.

However, the protection of the adolescents’ right to medical confidentiality does not minimize the need to protect other rights and interests. The need to balance between those opposing rights requires flexible answers from the legislator and mainly from the judge, which has to resolve the relative conflicts in court. Thus, the protection of the family, the exercise of rights of parental responsibility and the protection of public health may be balanced with and limit the adolescents’ right to the protection of medi-

\textsuperscript{75} \textit{Ibid.}

\textsuperscript{76} \textit{See supra} note 54.
cal confidentiality. These balances are extremely delicate. Therefore they should always take place in the framework of specific cases aiming in finding the right equilibrium among the public interest, the family unity and solidarity and the children’s autonomy. In order to resolve such balances in the most just and effective manner, a modern legislative framework is needed, orientated to the international protection of the child and mainly the adolescent as an autonomous subject of the legal order, even if not yet a self-sufficient personality. In any case finally, the protection of the adolescents’ medical confidentiality should not lead to the alienation of the members of the family, neither to the creation of ‘families without children’ but on the contrary of families with respect to their children and their rights.