MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2181

2007 SENATE HUMAN SERVICES

SB 2181

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2181

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 16, 2007

Recorder Job Number: # 1184

Committee Clerk Signature Mary K Monson

Minutes:

Senator Judy Lee, Chairperson of the Senate Human Services Committee brought the committee to order.

Attendance was taken indicating all members of the committee present.

Senator Lee opened the hearing on SB 2181 relating to consent for certain health care services provided to minors.

Senator Karen Krebsbach from District 40, prime sponsor of SB 2181 introduced the bill (See attachment #1.)

Bruce Levi representing the North Dakota Medical Association testified in support of SB 2181 (See attachment # 2). He further added that SB 2181 does follow the ethics of medical practice (See the ethical opinion of AMA Code of Medical Ethics included in Attachment # 2.) He also presented a brief review of each subsection of the bill (also included with attachment # 2.)

Senator Dick Dever stated the bill refers to cases when a minor can consent to services if the parents of the minor are not acting in the best interest of the minor. He then asked if the minor is not doing what is in its own best interest can a parent legally force the minor to do what is best.

Bruce Levi responded that the bill is designed not only for those instances when the parents are not acting in the best interest of the child, but for the larger part is when minors ask for confidential services. The bill sets up the legal environment especially for the medical personnel that are now subject to law that says they cannot provide services without the consent of parents.

Dr. Shari Orser, obstetrician-gynecologist testified in support of SB 2181 on her own behalf (See attachment # 3.)

Senator Dever questioned how often minors are left on their own to make medical decisions.

Dr. Orser answered that it is not very often but there are circumstances where a minor is in labor and there is no parent available. Or she has had a pregnant teenager come to her office for care and because of the law she had to refuse her services and unfortunately never saw her again. She further stated she would like to prevent those kinds of situations.

Senator Robert Erbele asked how the paperwork would be handled as far as insurance and other documentation if the bill is passed into law.

Bruce Levi answered the bill does not create a perfect situation as there are issues of disclosure of information and situations will probably be handled on a case by case basis.

Senator Lee asked Rod St.Aubyn of Blue Cross/Blue Shield, if a minor can on her own apply for a "CHIP" if she is pregnant.

Rod St.Aubyn responded he was not sure about a "CHIP", but there are student plans that can be applied for. BCBS has adopted a policy where members would receive services in every state under a parent's plan. The law allows states to be more strident than a standard HIPAA policy. BCBS policy allows children 12 years and up with a separate EOB (Explanation of Benefits) and have many complaints from parents. There is a consent authorization form that minors can sign that allows parents access to that information.

Kathy Perkerewicz a certified obstetrician-gynecologist testified in support of SB 2181 on her own behalf (See attachment # 4).

Senator Joan Heckaman asked if a minor seeks prenatal care does the bill extend to include social work services.

Kathy Perkerewicz confirmed the bill discusses mental health services to include services of a social worker.

Senator Lee asked for further supporting testimony and hearing none asked for opposing testimony and neutral testimony of SB 2181. She further asked the committee if they had any questions of Mr. Mullen of the Attorney General's office. Hearing none closed the hearing on SB 2181.

Senator Heckaman requested background information on the discussion held in the House from two years ago when a similar bill was killed.

Senator Lee recalled that there was one person who felt parents should be included from the beginning.

Discussion was held regarding the history of the bill in the last session.

Bruce Levi added that the difference between the two bills was that last session the senate bill included an immunity clause and contained a section that created confusion relating to financial responsibility. This bill recognizes the ethical obligation which was not in the last session's bill.

Senator Dever added that 32 % of births in North Dakota in 2005 were out of wedlock births and 25 % or 600 of those were teens. (See attachment # 5)

Senator John Warner added that a premature or low birth weight of less than 5 pounds has a hospital cost of approximately $37,000.00 plus the additional cost of the hospital stay.

Senator Lee added there is a wide range of professionals and interest groups that support SB 2181 because they realize the benefits for the young mother and the baby. Being there is no opposition to the bill would also indicate its importance.

Senator Dever made a motion for a Do Pass of SB 2181.

Senator Warner seconded the motion.

Roll call vote 6-0-0. Passed.

Senator Warner will carry SB 2181.

Date: 1-16-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2181

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Sen. Dever Seconded By Sen. Warner

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Warner

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2181: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2181 was placed on the Eleventh order on the calendar.

2007 HOUSE HUMAN SERVICES

SB 2181

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2181

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 13, 2007

Recorder Job Number: 4982

Committee Clerk Signature Judy Schock

Minutes:

Chairman Price: We will open the hearing on SB 2181.

Senator Karen Krebsbach, with District 40 Minot, ND: See attached testimony.

Senator Dick Dever, District 32, Bismarck, ND: See attached testimony.

Representative Kathy Hawken, District 46: I was pleased when asked to be a part of this bill. It is so very important that our young women have prenatal care. My daughter would not have had her twins had it not been for prenatal care. There are young women who are scared and who do not know what to do. We have many times talked about how important the life of a baby is. We want them to be born alive and born healthy. This is not a bill to get between children and parents. It has nothing to do with terminating pregnancies, but it has everything to do with healthy babies.

Dr, Jerry Obritsch, practicing OBGYN at Mid Dakota Clinic Center for Women: I have been doing this for the past 15 years. This is a very important bill. This bill is very important for me as a practicing OBGYN, because it effects what I do in my carrier. While having a young woman laboring the discussion of control of pain came up. Unfortunately her Mom made the statement that she was unable to consent to an epidural because she wanted her daughter to feel the pain of what it is like to do something that was wrong in her opinion. This

was very discouraging to me as a practicing OBGYN, because I know what an epidural can do to relieve pain in labor. This is one of the most painful situations in medicine the other having kidney stones pass. Another patient I had in Standing Rock, she was 15 years old living at home with her Mom. While laboring her Mom went back home to gather things as they left with nothing. In the course of her being away the patient became very active in labor and asked for pain relief. We should have obtained a consent from her Mom. I knew the Mom and if she had been there I would have easily obtained the consent for the epidural. She said you know I would have consented to it. I said I could not because of the way the laws are. The concerns with this bill are about is taking away parental right and consent of a minor daughter. I share those concerns; I am the Father of 4 children. I believe that 99% of parents care for their daughters and want the best outcome for them regarding a healthy pregnancy, and a healthy baby. We work with them to try and obtain consent of their parents. However there is some times this is not the case, and our hands become tied as practicing obstetrician.

Representative Damschen: The example you shared about the pain medication, does this bill allow the physician to administer medication with out the consent of the parent, even when the parent was informed? Are you aware of documentation of young Mothers to be not getting prenatal care?

Dr. Obritsch: It would allow us to gain the consent to do so. I have no documentation of how many Mothers who are minors.

Chairman Price: When the Mother returned home to pick up belongings what would have happened if the baby had gone into distress? In an emergency situation are you able to act?

Dr. Obritsch: Yes, in an emergency we can do what Is needed to do. That is not part of this bill it goes beyond that. When ever a patient sees a physician, we would have a patient physician relationship. In essence it becomes a contract, a bonding time.

Shari Orser, obstetrician-gynecologist of Medcenter One Health Systems: See attached testimony, and attached statistics. In other situations like treatment for STD, the minor can make an agreement with the business office to pay for the care herself. BC will tell you they sent the bill to the person who received the treatment, so parents don't receive the explanation of benefit. I also have articles that were published last year in contemporary OBGYN that talks about adolescent patients and confidentiality, and how to take care of these people.

Chairman Price: In your practice when you have a young woman come to you are you able to do anything, as far as determining a pregnancy or suggesting vitamins. I

Dr Orser: No, at this point in time we are not. I have had to turn young women away because they came in and had no consent of a parent. If the bill were to pass we would be able to do lab work, testing for STD's and provide her with a prescription for prenatal vitamins, or samples. We would talk with them and try to encourage them to talk with their parents to get them involved.

Bruce Levi, executive director of ND Medical Association: See attached testimony, and medical ethics, Minnesota stats, and Montana code annotated.

Representative Damschen: Once a minor as for example she's responsible for making decisions concerning medication. Is it consistent to take that right away from an adult parent? Is it consistent than for us to pass legislation that takes that authority away from and adult parent? From testimony we are not only taking the right of the parent informed away, we would also take away the authority of the decision making for the other parent. We are granting that authority to the physician. I am uncomfortable with the things in this bill

Mr. Levi: The way the frame work is set up in the law now what you say is true. A minor parent does have a new born child; they can make these decisions for the new born child. I think that is the point of the bill. There are situations to protect the unborn child. I think the

health of the unborn child and the minor mother becomes a balance with the health care if provided. I think the bill does deal with different kinds of situations. The bill is to protect the pregnant minor , who needs particular care .

Represenatative Conrad: A young woman has a child and has to make adult decisions about that child, than she needs to be treated a s an adult as she prepares to give birth to that child.

Mr. Levi: Our own abortion control act involves the maturity. The minor need all the information.

Representative Porter: If we are saying that the minor should be able to make this decision and have these treatments. Why don't we than relieve the parents of the financial responsibility at the same time? Why don't we put it all on the patient?

Mr. Levi: I believe last session we tried to include some language to deal with the financial situation. What we did this session is not address the financial implication other than suggest to provide that the minor could contract for that. That is a respect for the dialog of respect for the need for confidentiality. The bill does not address specifically other than allowing the minor to enter into some sort of special relationship and work out the details with how the care will be paid. There are statutes in ND dealing with minors and disaffirming contracts.

Rep. Porter: So in essence we are taking away the parents rights to be involved, but not thir right to pay the bill? If the concern is to allow physicians to get the first or a couple pre natal visit going and have the discussion, getting the right diet and vitamins and risk behaviors associated with the patient. Why don't we limit than, to the first visit?

Mr. Levi: I think it would depend on the specific situation. Every situation is different. The minor may not yet be ready to involve the parents at any particular stage during the preganancy even beyond the first12 weeks. I think it is more than the first initial visit. The prenatal care is a process through out the pregnancy, and that is important.

Audrey Cleary: I am here in support of the bill. See attached testimony. Not all children have the perfect relationship with their children. I also would like to see the Doctors not charge for the first visit.

Chairman Price: We just passed a bill for funds for alternatives to abortion to organizations around the state. Are you fearful that they could loose their opportunity to council expectant mothers on alternatives to abortion?

Ms. Cleary: Yes, we also encourage them to tell their parents. Sometimes our volunteers will go with them.

Tom Freier. Representing the ND Family Alliance: See attached testimony. I am in opposition to SB 2181.

Representative Conrad: If we were to go with this and some of the testimony young women never had prenatal care and came in only for the delivery. Should we than prosecute those parents who are neglect to the medical care of their children? Prenatal care is not provided to these young women and the parents are responsible and it is not happening so who? We don't want to give it to the young women.

Mr. Freier: I am not an attorney and If don't know if to that extent that could be done. I can tell you Family Alliance I am not in favor of not having prenatal care I believe we are reaching to the most extreme cases and looking at it other than the immediate issue is. This does not happen in every pregnancy.

Representative Kaldor: Assuming you would want every pregnancy carried to term if possible. Wouldn't you want minors in particular who are pregnant to have prenatal care as early as possible? Isn't it in keeping with your organizations philosophy that every child is important and in those unfortunate circumstances as you even described in you t testimony,

not every family is perfect. In those unfortunate circumstances isn't it worth it to do a little more than is necessary to insure protection of that baby?

Mr. Freier: Yes, obviously as I said in this room the initial and on going prenatal care should be available for everyone that becomes pregnant. Back to the bill is one issue and a parental issue. We do want to extend that protection to everyone. I think we cannot remove parental. Those individual's you more than likely are referencing are ones that parental (could not understand).

Rep. Kaldor: There are a couple things in the bill that relate to this issue that actually the physician is supposed to encourage the child. This is part of that process, a minor that becomes pregnant probably not very likely to tell her parents. They are probably not the first people they are going to tell, even in good families. Wouldn't it be more beneficial to encourage that process rather than force it?

Mr Freier: Just by encouraging, I don't know that, that is something that can't be done right now. I would hope that the provider would encourage with out this bill.

Chairman Price: Dr. Orser just said they can not treat patients. They can not see her about the pregnancy with out permission. So how can they encourage? :

Mr. Freier: The fact is a matter of contention. Some sort of narrowly crafted legislation that deals with that point alone as opposed to a draft of this bill that goes all the way to the removal of the parental involvement.

Representative Potter: In your testimony you said it removes the parent right and obligation in this instance. I would like to know what exactly you think is the parent obligation?

Mr Freier: Our duties and obligations are very important all the way from when we take care of that young person to education guidance direction all the way through their lives. The family unit is the unit we all come back to. To remove one part that is very important as this is during

a time of crises is really saying the other things are okay and important , but this one you don't have to confide in me, we don't have to be involved. We are responsible for our children.

Rep. Potter: Since it is part of your testimony, whether it is philosophical, I was thinking that you were talking for the family alliance and I heard you say the obligation is nurturing and financial. Those were the two I heard.

Mr. Freier: I don't know that I could give you a whole listing on what the parent's duties to raise their kids and educate them, and be consistent with them.

Representative Schneider: In the case of incest resulting in preganancy. Does the family alliance still support parental consent? If you wanted to let the world know it was your father or grandfather or to put them in jail you could do that. I don't think that is reality in life. Some times you want to put things behind you

Mr. Freier: Family alliance has always been for life, all life not matter the situation or occurrences. I think the status of the parent should still be respected. I believe we have services available through out our human services division and social services. I know there would be an opportunity here to prevail themselves to a service. We would come back to the alliance to keep parents involved.

Chairman Pride: The over all good in this bill the unborn child. We have a third of the babies born on Medicaid, we are asked to support the children that are born with problems because they didn't get prenatal care, a drug abuse Mom, and all sorts of other things. Granted some are genetic. We are 28th in the nation for infant mortality. We have high record of low birth with babies. A lot of it goes back to the prenatal care. Our fear is for the unborn child. As a parent or grandparent would I rather know y grandchild is going to be born healthy or find out two months later that I am going to be a grandma? This is about the unborn child.

Mr. Freier: This is not an easy question or easy situation. Maybe it is more so educational. I think what I heard you say was the prenatal care for that unborn and if in fact for the individuals that are not aware of what can transpire.

Rep. Damschen: I don't think there is a debate here about prenatal care, but however two examples referred to in previous testimony that Representative Kaldor referred to. I don't remember testimony there were actual complications resulting from the lack of prenatal care. Back to Rep. Conrad's question about being responsible, could the Dr. be prosecuted or the parents. Who is responsible?

Mr. Heier: Not being an attorney again, I don't know.

Rep. Porter: On page 2 of the bill, we really have not gotten into the discussion on some of the things that are also allowed under the bill. Sub section b concerns me. I don't know if we have a definition of prolonged hospitalization, but if some ones child needs to be hospitalized than by passing this law it can happen with out the notification of parents. The child could be gone for three days. The parent would have no idea where the child id and still be perfectly legal under this bill. I am not sure what is meant by major, and I know times have changed through medical care and there is a lot of invasive procedures that are done on an out patient basis. A child could have a surgical procedure done and the parents never notified. Are those concerns valid? The examples used could go beyond prenatal care once again.

Mr. Heier: You are correct in stating that the definition of what has occurred with all of a,b,and c is rather vague. We would not be certain what may occur, and once again that does remove the ability of that parent.

Janne Myrdal, representing Women for America of ND: See attached testimony: This is a detersive bill; I think it could be written better. We would support amendment s to clarify the bill. We have 1046 members, and we are about 26 years old.

Representative Dan Ruby, District 38: I felt compelled to come and testify in opposition. As a parent of 10 children I could have a PHD in parenthood, which does not make a perfect parent. I have dealt with this as a young man I understand the full emotions. It was a life changing time in my life. My oldest daughter has come to me with the same situation. She is older than I was, so both end of the spectrum. One who has been through it and one as a parent. For two sessions at least now we are dealing with this mother who denied the epidural. The parent rights are already quite substantial under the HIPPA laws. Either fix the bill or can it.

Bill Schuch, see attached testimony and power structure of the bill, and the second attached parental disempowerment in ND: This is not a medical matter it is a family crises. There is too much going on behind parents back. The problem with this is ir is a broadly framed bill. The parents have a right to know. They can not exercise there responsibilities if they don't know. There needs to be another approach to this.

Representative Potter: I agree with most everything you say. The parents right to guide, and nurture, and their duty. In today's world there are so many parents that aren't. We read about it and see it on TV daily. I am not quite sure what we do with families that are not there for their kids.

Mr. Schuch: Yes, there are a lot of cases of abuse, and neglect, and a parent does not have that right. It is not nearly as common as you get the idea from the news. The vast majorities of the parents care, and want to be involved, and be in charge of their children.

Representative Jim Kasper: District 46 Fargo: I have the following observation that I would ask the committee to consider. Line 18 this bill is putting those people in place of the parent. Some one is going to help that minor make a decision, but this bill is saying the physician or health care providers is in a better position than the parent. In most cases the parent loves the

child, and not aware of any problems. Who is liable if that physician or health care provider gives that young minor the wrong advice? Whether it is to carry the child, abort the child, or adopt the child. It is the responsibility of the parent to take care of that child. Observe the word minor. The definition of minor is someone who is young, immature in the perspective of making difficult decisions. This is a big deal; it is probably one of the biggest in a minor's life. Our family structure is what makes our nation great. Every bad thing we hear in the news or news paper, there is hundreds of good things happening which we never hear about.

Michel Hove: I am a parent. He talks about medical costs in another state about his son related to lines 13, 14, and 19 about parent becoming aware.

Becky Ness , health care professional: See attached testimony.

Mike Motschenbacher, I am here as a concerned parent. See attached testimony.

Vice Chair Pietsch: We will close the hearing on SB 2181

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2181

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 19, 2007

Recorder Job Number: 5267

Committee Clerk Signature	Judy Schock

Minutes:

Chairman Price: Take out SB 2181 for discussion.

Representative Porter: Brings proposed amendments. See attached. I took the concerns from the a\hearing and I worked with Mr. Levi from the Medical Association. We cam up with this amendment that was a narrower scope of what would be allowed. It still doesn't go as far as the ND Family Alliance would like to see it. The suggestion to me was a specific number of prenatal visits, which was one. The rest they were okay with. They are opposed to this amendment without a limiting factor on prenatal care.

Representative Potter asks for him to explain line 9 and what a condition means.

Bruce Levi, with Medical Association: We did assist in developing the recommendations. The intent behind the amendments was to focus on those particular situations that were used as examples in presentations. If a minor comes in at the point of labor and delivery, you are probably looking at an emergency situation at that point, and there is another law that applies to minor consent for emergency care. 14-10-17 that deals with emergency care for all situations involved in a minor.

Representative Porter: Some felt the pain relief didn't go far enough, and it should be spelled out. Pain relief is also healing relief. If things were to effect the unborn child it would go under the emergency code.

Representative Conrad asks Mr. Levi to explain line 3.

Chairman Price: I will let you review the amendment and we will take action later.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2181

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 20, 2007

Recorder Job Number: 5333

Committee Clerk Signature Shirley K Olmstead

Minutes:

Chairman Price asked the committee to continue the discussion on SB 2181.

Representative Porter went over the proposed amendments that are attached. Based on the discussions yesterday, as we looked this over from .0103 to this version (.0105) on these amendments. See attached proposed amendments marked as Item #1. I will tell you upfront that it must be really good amendment because neither side really likes it very well. I know that Representative Damschen has another amendment and we can discuss this after he has presented his amendment.

Representative Conrad asked why it was 2 prenatal visits instead of 3.

Representative Porter said the third visit takes place in weeks 16 to 18. It was looked at that the patient would already be showing so the parental notification on this is up for grabs. The discussion was of course from the medical association having an unlimited to the family alliance side wanting just one so we picked two as the starting point for discussion. There was a sheet provided by Mr. Levi. See attached sheet marked as Item #2. This is an event structure for routine prenatal care. The first four visits are a month apart.

Representative Conrad asked if he had considered number 5 or 6 or the issues there.

Representative Porter said no.

Representative Conrad said if we want to help these young women and girls then we want this to be relevant to the experience in their lives. This isn't like what you would do with cows or something.

Representative Kaldor said his question was regarding the same issue. If the patient comes for a screening or comes in earlier than that period of time, what about a circumstance where they come in after week one or within a week after exception. What would visit 2 consist of? I am assuming that would be visit one.

Representative Porter said if that would happen, that would be considered visit one. The chances of that happening within 7 days of fertilization would probably be slim. If it did happen, that would constitute visit one. Visit two would be between 10 and 12 weeks. Then between 13 and 16 weeks in order to have visit 3, the parents would have to be informed.

Representative Kaldor asked if this was per pregnancy or per physician. They could go to another doctor on the third visit.

Representative Porter said there is nothing in here as a tracking mechanism. The doctors would have knowledge inside the group of doctors that the first two visits had already taken place, but there is no tracking mechanism that wouldn't send the patient across the street and that physician may not have the knowledge that the first two visits took place. I don't know how you would do that. The only thing that may happen would be if there were some risk factors that were at the first initial visit of the first physician and asked for the medical records and realized that they had seen another physician twice before. If everything was normal the patient could certainly go the entire pregnancy by moving to another doctor every two visits.

Representative Conrad said if you look at visit 4 on this routine prenatal care, the family issues are in visit 4. I think this would make more sense than saying 2 visits. I don't mind all these amendments except for defining the numbers because I think that is irrelevant.

Representative Hofstad said that he thought it was relative. We heard in testimony that the main thing is getting the young women off on the right start and it is that initial that helps them that their diet is correct, and their lifestyle is correct.

Representative Conrad said if you look at the list all of those issues are dealt with in different visits. They do not do all these things in one visit. If they were all handled in one visit, our insurance wouldn't pay for all the visits.

Representative Weisz said they don't need their parents for medical care and there is no data produced to show they are not getting care. They are not getting prenatal care because they are afraid to tell their parents.

Chairman Price said she would play the devils advocate and say based on the number of parents that take their kids for abortion, they are going to want to be informed as well so they can get them to the clinic in the first trimester.

Representative Damschen presented his amendments. He said basically what this does is that it says they can go to the first appointment and then the physician will notify the parents.

Representative Porter asked him to clarify that it was one prenatal care visit and whether the patient comes back or not again there is a notification or upon the second visit there is a notification.

Representative Damschen said he never looked at that from that perspective. He said he would read it that they would have to inform the parents.

Representative Conrad said she would move the amendment made by Representative Porter with the change from 2 visits to 4 prenatal visits.

Representative Kaldor seconded the motion.

Representative Uglem said his understanding of this is that the first appointment determines the pregnancy. There is no counseling and the child is in shock and worried. By the second

appointment she is coming to her senses and at that point the doctor can get through to her in advising her about changing her lifestyle like no smoking, no drugs, or no drinking and encourage her to contact her parents. There we have the contact and the counseling with two appointments and that would be a good compromise in my opinion between no appointments and opening it wide open.

Representative Porter said he would hope they would resist the motion and go back to the original intent of the amendment with 2 appointments. If there is a need for further change of the number that it can be done after the rest of the amendment is adopted.

Representative Conrad said she thought the outline looks pretty thorough to her. She wanted to be sure that the conversation happens. It may be that she is not able to listen and process. I would like the doctor to have the chance for her to come back and to have the time and it looks like this is what they consider to be the steps. They are not talking about classes or family until the 4th routine situation. I would like to give these young girls a chance to be prepared for their parent's reaction to this.

Representative Damschen said another concern is even after the first visit and the girl finds out that she is pregnant, what will she do if her parents aren't notified. What is her reaction going to be and I am guessing it could be pretty extreme in some cases. I think we could be endangering her life because of her reaction to the situation.

Representative Porter said this comment was in regards to the routine prenatal care list. He said that using counseling and intervention section, in section 2 we are saying that the parents need to be notified so waiting for visit 4 would not happen. It would happen on the first visit according to the way this amendment fits into the bill.

Representative Kaldor said he has problems with any of the restrictions as to how many visits before the consent is taken away from the minor. It is possible that the physician could

convince the minor on the first visit that their parents need to know about this. If the child says that her parents will kill her if they find out she is pregnant, I think it would be beneficial for the doctor to have more time to investigate about the circumstances that child is in before they deny that child the consent and basically compels them to tell their parents. Our goal here is to make sure the unborn child is given the best chance. We could be ignoring what the circumstances really are with their parents. That does bother me a great deal.

Chairman Price said he didn't think they would even get to the first visit under the current law because the physician can't even see them.

Representative Uglem said that he wanted to point out that the routine prenatal care list is a normal planned pregnancy and things will be different with an unplanned pregnancy.

Representative Damschen said isn't the bill for the doctor going to come to the parents anyway and is that a good way for them to find out. Are we asking the medical providers to withhold the billing? I guess we are thinking about young girls in a bad family situation but it happens to young girls with good parents as well and those that have good relationships with their parents. I think it may be harder for one of those girls to tell their parents because they will know it will be hurtful to their parents. I think we can drive a wedge in that family relationship when we allow this young girl to go to the doctor without her parents consent. I think one time is certainly better than unrestricted visits.

Chairman Price asked if they were ready to vote on the amendment 0105 with the change from 2 to 4 visits. A voice vote was taken and the motion failed.

Representative Porter made a motion for the amendment 0105 as printed.

Representative Schneider seconded the motion.

Chairman Price asked for discussion. Hearing none, a voice vote was taken. It was too close to call so the clerk called the roll. Let the record show 7 yes, 5 no with all present. The motion carried.

Representative Uglem made a motion for a do pass as amended.

Representative Schneider seconded the motion.

Chairman Price asked for further discussion.

Representative Damschen said he had heard the question of the day on KFYR radio and it was about this very bill. The overwhelming response what that they do not think it is a good ideal for young girls to see their doctors without their parents consent. The amendment helps.

Representative Potter said whether it was the radio consensus or not, she was in favor of the bill and I think it is best for the mother and it is definitely best for the unborn child to get in and get medical help, physical and mental combined.

Representative Porter said in light of the testimony that they received in the hearings on this bill, they did strike a balance for both the proponents and opponents of the measure. I don't know if there is piece of legislation that would make both sides happy in this issue. In the course of the action I think we have done our job in finding a balance in a very delicate situation.

Representative Damschen said he wanted to remind them that the discussion was never whether it was wise to get prenatal care. It is not his opinion either. My problem is encouraging a division in the family.

Chairman Price asked for any other discussion. Hearing none, she asked the clerk to call the roll on a **do pass as amended on SB 2181**. Let the record show 9 yes, 3 no with all present.

Representative Porter will carry this bill to the floor.

78267.0104
Title.

Prepared by the Legislative Council staff

March 19, 2007

PROPOSED AMENDMENTS TO SENATE BILL NO. 2181

Page 1, line 7, replace "and contract for" with "to" and replace "medical, mental, and" with "one prenatal care visit"

Page 1, line 8, remove "other health care services" and remove "and"

Page 1, remove line 9

Page 1, line 10, remove "required"

Page 1, remove lines 12 through 17

Page 1, line 18, replace "3." with "2."

Page 1, line 19, replace "may" with "shall"

Page 1, line 20, replace "if the physician or other health" with an underscored period

Page 1, remove lines 21 through 23

Page 2, remove lines 1 through 5

Renumber accordingly

Date: 3/20
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES SB. 2181 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move Amendments w/ Change 2-4

Motion Made By Rep. Conrad Seconded By Rep. Kaldor

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman			Kari L Conrad		
Vonnie Pietsch – Vice Chairman			Lee Kaldor		
Chuck Damschen			Louise Potter		
Patrick R. Hatlestad			Jasper Schneider		
Curt Hofstad					
Todd Porter					
Gerry Uglem					
Robin Weisz					

Total (Yes) "Click here to type Yes Vote" No "Click here to type No Vote"

Absent

Floor Assignment Rep.

If the vote is on an amendment, briefly indicate intent: Dales

Prepared by the Legislative Council staff for
Representative Porter
March 20, 2007

House Amendments to SB 2181 (78267.0105) - Human Services Committee 03/20/2007

Page 1, line 2, replace "certain health" with "prenatal care and other pregnancy"

Page 1, line 6, replace "**certain health**" with "**prenatal care and other pregnancy**"

Page 1, line 7, replace "medical, mental, and" with "pregnancy testing, two prenatal visits, and pain management related to pregnancy"

Page 1, remove line 8

Page 1, line 9, remove "conditions associated with pregnancy"

Page 1, line 12, replace "to determine the presence of or to treat" with "pursuant to subsection 1, the physician or other health care professional shall encourage the minor"

Page 1, remove line 13

Page 1, line 14, remove "encouraged"

Page 1, line 16, replace "its" with "their"

Page 1, line 19, replace "health" with "pregnancy" and replace "may" with "shall"

Page 1, line 20, replace the first "health" with "pregnancy"

House Amendments to SB 2181 (78267.0105) - Human Services Committee 03/20/2007

Page 2, line 2, after "minor" insert "or her unborn child"

Page 2, line 3, replace "Major surgery" with "Surgery" and remove "prolonged"

Page 2, line 4, replace "minor's physical and" with "health of the minor or her unborn child."

Page 2, remove line 5

Renumber accordingly

Date: 3/20
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES 2181 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move DIOT as printed

Motion Made By Rep. Porter Seconded By Rep. Schneider

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad		✓
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor		✓
Chuck Damschen		✓	Louise Potter		✓
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz		✓			

Total (Yes) "Click here to type Yes Vote" 7 No "Click here to type No Vote" 5

Absent

Floor Assignment Rep.

If the vote is on an amendment, briefly indicate intent:

Date: 3/20
Roll Call Vote #: 3

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES SB 2181 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do pass As Amended

Motion Made By Rep. Uglem Seconded By Rep. Schneider

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen		✓	Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad		✓			
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz		✓			

Total (Yes) 9 No 3

Absent 6

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2181: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (9 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). SB 2181 was placed on the Sixth order on the calendar.

Page 1, line 2, replace "certain health" with "prenatal care and other pregnancy"

Page 1, line 6, replace "**certain health**" with "**prenatal care and other pregnancy**"

Page 1, line 7, replace "medical, mental, and" with "pregnancy testing, two prenatal visits, and pain management related to pregnancy"

Page 1, remove line 8

Page 1, line 9, remove "conditions associated with pregnancy"

Page 1, line 12, replace "to determine the presence of or to treat" with "pursuant to subsection 1, the physician or other health care professional shall encourage the minor"

Page 1, remove line 13

Page 1, line 14, remove "encouraged"

Page 1, line 16, replace "its" with "their"

Page 1, line 19, replace "health" with "pregnancy" and replace "may" with "shall"

Page 1, line 20, replace the first "health" with "pregnancy"

Page 2, line 2, after "minor" insert "or her unborn child"

Page 2, line 3, replace "Major surgery" with "Surgery" and remove "prolonged"

Page 2, line 4, replace "minor's physical and" with "health of the minor or her unborn child."

Page 2, remove line 5

Renumber accordingly

2007 TESTIMONY

SB 2181

Attachment #1

Sen. Karen Krebsbach

SB 2181
Senate Human Services Committee
January 16, 2007

There are several instances for which we as legislators have included language in the ND Century Code authorizing minors to consent for health care services. Those services include examination, care and treatment for alcoholism, drug abuse and sexually transmitted diseases, as well as emergency medical services. These are situations in which the public policy is to encourage young people to access medical services, rather than discourage them from seeking the appropriate help they need.

Senate Bill 2181 would recognize that this same kind of situation arises often with respect to a young person who finds herself pregnant – that as a matter of public policy we ought to encourage that young person to seek appropriate prenatal care and other health care for her and her unborn child. Physicians have an ethical duty to involve their minor patients in the medical decision-making process to a degree commensurate with their abilities. At the same time, if a minor patient asks for confidential services, physicians are ethically bound to encourage the minor to involve their parents. More clarity is needed, however, on the legal role of the physician in working with young people who seek confidential pregnancy-related health care services for themselves and their unborn children.

I introduced Senate Bill 2181 at the request of a number of health care organizations seeking this clarity, including the North Dakota Chapter of the American College of Obstetricians and Gynecologists, the North Dakota OB-GYN Society, the North Dakota Medical Association, and the North Dakota Healthcare Association representing hospitals. Senate Bill 2181 would authorize a minor to consent for pregnancy-related care, but not abortion services which are covered by another law, as well as identify situations in which the physician or other health professional may inform the minor's parents or guardian. I introduced a similar bill last session which passed the Senate almost unanimously but was defeated in the House.

Senate Bill 2181 strikes an appropriate balance – a balance that recognizes the need to encourage young people to seek the medical care they need for themselves and an unborn child.

Thank you Senator Lee and members of the Committee. There are representatives of various organizations here to describe more fully the rationale and scope of the bill, and answer questions you have.

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Testimony in Support of Senate Bill No. 2181
Senate Human Services Committee
January 16, 2007

Madam Chairman Lee and Committee members, I'm Bruce Levi representing the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota's physicians, residents and medical students. With me today is Dr. Shari Orser. Dr. Orser has been actively involved in the North Dakota OB-GYN Society and also serves as the President of the North Dakota Medical Association. Dr. Orser will testify on her own behalf as an obstetrician-gynecologist.

The North Dakota Medical Association strongly supports SB 2181. I was also asked to note that the state's hospitals through the North Dakota Healthcare Association also support SB 2181.

SB 2181 would follow the lead of at least thirty-four other states in providing statutory authority for a physician or other health care professional to rely on the consent of a minor for pregnancy-related health care. SB 2181 is actually a hybrid of the Minnesota and Montana statutes.

Under current North Dakota law, if a pregnant minor seeks confidential prenatal care from a physician or other health professional, that care may not be provided without the consent of a parent or the guardian of the pregnant minor. Often, the pregnant minor will not seek appropriate prenatal care for herself and her unborn child if she has not yet told her parents about the pregnancy, or there may even be situations in which the parents of the pregnant minor know of the pregnancy but are not acting in the best interest of the minor and her unborn child.

When confidentiality is a barrier to a pregnant minor seeking care, the health consequences can be significant:

> Pregnant teens are the least likely to of all age groups to get early and regular health care and are at greater risk of complications such as premature labor, anemia, and hypertension. Like many adults, a pregnant teenager often has poor eating habits; she may diet, neglect to take a daily prenatal vitamin, or smoke and take drugs – further

increasing the risk of having a low-birthweight infant (less than 5 ½ lb) or one born with other health problems. A low-birthweight infant is 20 times more likely than one of normal weight to die in the first year of life. *Contemporary OB/GYN, May 2006.*

The purpose of SB 2181 is to create an appropriate legal environment for physicians to address the myriad of situations that confront them when a pregnant minor comes to them asking for confidential care. The bill is also necessary to ensure that pregnant minors receive appropriate prenatal care to protect their unborn child and ensure a safe and successful delivery. The bill also recognizes the appropriate role of the minor's parents or guardian in contributing to a successful health care outcome for their pregnant child.

In summary, SB 2181 would authorize a minor to consent and contract for medical, mental, and other healthcare services to determine the presence of or to treat pregnancy and conditions associated with pregnancy. At the same time, the bill recognizes the ethical imperative for physicians that they encourage the minor to involve her parents or guardian. A physician or other healthcare professional would not be compelled against their best judgment to treat a minor based on the minor's own consent. In addition, a physician or other healthcare professional would be authorized under the bill to inform the parent or the guardian of the minor of any health care services given or needed after discussion with the minor under various circumstances.

The purpose of the bill is not to diminish the general legal rights of parents to make health care decisions for their minor children. The bill does not say that physicians are to rely solely on the consent of a minor in every situation involving a request for pregnancy-related care. In most instances the parents of the minor are in fact involved and acting in the best interests of their child and her unborn child. And the bill does not authorize a minor to consent to abortion.

When a young person comes to a physician asking for confidential medical care, physicians are ethically bound to encourage that young person to involve his or her parents or guardian. States have traditionally recognized the right of parents to make health care decisions on their children's behalf on the presumption that before reaching the age of majority, young people lack the experience and judgment to make fully informed decisions. In North Dakota, the Legislative Assembly in 1991 enacted a third-party consent statute [NDCC 23-12-13] that suggests as a general proposition that a minor does not have capacity to provide informed consent for health care.

Nevertheless, there have long been exceptions to the rule that minors lack capacity to provide consent for health care. In North Dakota, our statutes recognize the ability of

minors to make decisions in a number of contexts, without the consent of a parent or guardian:

- NDCC Section 14-10-17: Examination, care, and treatment for sexually transmitted disease, alcoholism, or drug abuse
- NDCC Section 14-10-17.1: Examination, care, or treatment in a life-threatening situation

Concern about confidentiality is often a major obstacle to the delivery of health care to minors. Access to confidential services is often essential, because many minors will not seek care if they have to inform a parent or have their parents' consent. These laws encourage young people to seek the health care services they need and enable them to talk candidly with their physician or other health professional. If access to confidential health care is not an option, these young people simply may not seek the care they need for themselves and their unborn child.

SB 2181 follows the ethics of medical practice. The American Medical Association Code of Medical Ethics addresses the issue of confidential care for minors, and a copy of the ethics opinion is included as an attachment to my written testimony. I will briefly review the bill.

Subsection 1: The language in subsection 1 provides authorization for a minor to consent for pregnancy-related services, as derived from Minnesota law [Minn. Stat. 144.343]. Subsection 1 uses the Minnesota terminology "medical, mental, or other health services to determine the presence of or to treat pregnancy and conditions associated with pregnancy" in describing the services to which a minor may consent. The consent of no other person is required. The authorization does not include abortion services, which are governed by the state's Abortion Control Act [NDCC 14-02.1]. The Abortion Control Act provides for specific consent and notification requirements that would not be affected by this legislation.

Subsection 2: The first sentence in subsection 2 is derived from the American Medical Association Code of Medical Ethics (E-5.055). That language recognizes that as a general proposition if a minor requests confidential services to determine the presence of or to treat pregnancy and conditions associated with pregnancy, the minor should be encouraged to involve her parents or guardian. The subsection also states specifically that a physician could not be compelled against their best judgment to treat a minor based on the minor's own consent. That language in subsection 2 is derived from Montana law [Mont. Code Ann. 41-1-407]. This provision provides the necessary medical discretion to allow the physician or other health professional to work within the ethical guidelines that address confidential

care for minors, considering such factors as the maturity of the minor and the circumstances surrounding the minor's request for confidential medical care.

Subsection 3: The language in subsection 3 authorizes disclosure to parents or guardian in under certain circumstances deemed appropriate in the physician's or other health professional's judgment, but only if the physician or other health care professional discusses with the minor the reasons for informing the parent or guardian before the disclosure. This prior discussion requirement is consistent with the AMA Ethics Code. The circumstances that may result in disclosure to the parent or guardian include:

- Failure to inform the parent or guardian would seriously jeopardize the health of the minor (serious jeopardy standard recognized in AMA Ethics Code, Minnesota and Montana);
- Major surgery or prolonged hospitalization is needed (Mont. Code Ann. 41-1-403); or
- Informing the parent or guardian would benefit the minor's physical and mental health (Mont. Code Ann. 41-1-403).

NDMA urges you to support SB 2181 with a "do pass" recommendation.

I will attempt to answer any questions you have. Dr. Orser also has prepared testimony and can answer your questions from her experience in providing medical care to pregnant minors.

E-5.055 Confidential Care for Minors
AMA Code of Medical Ethics
Physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities.
When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections.

Where the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.

When an immature minor requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse, or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor may be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached, according to Opinion 5.05, "Confidentiality." In addition, confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor. (IV) Issued June 1994 based on the report "Confidential Care for Minors," adopted June 1992; Updated June 1996.

Attachment #3

Testimony in Support of Senate Bill 2181
Senate Human Services Committee
January 16, 2007

Senator Lee and members of the Human Services Committee,

For the record my name is Shari Orser, an obstetrician-gynecologist. I am an employee of Medcenter One Health Systems, but today I am testifying on my own behalf.

I believe this bill is vitally important. It offers confidentiality to assure that needed care is given to the minor in those unfortunate circumstances where the parents do not necessarily have the best interest of the minor in mind. This is especially important when young women are pregnant in order to assure the best possible outcome for the newborn child and the mother.

In surveys minors and providers consistently identify concerns about lack of confidentiality as a barrier to obtaining health care. Minors who are pregnant, have STD's, abuse drugs and alcohol, or have emotional problems may avoid seeking health care if they must inform their parents.

Our best opportunity for optimal pregnancy outcomes is to begin prenatal care early. Statistics from the State Department of Health indicate that on average 40% of teenage mothers start prenatal visits late. Many minors do not present for prenatal care until the mid-to-late second trimester, often when they can no longer conceal the pregnancy from their parents. This significantly delays the opportunity for treatment with folic acid, providing

iron for anemia, counseling about healthy diet, discussion of other high risk behaviors such as smoking, alcohol and drug use, early treatment of STD's and identification of other risk factors for poor outcome. Some minors do not even come in until they are already in labor and have not received any prenatal care. In either situation, the health of both the mother and child is put in jeopardy.

Accessing care late in a pregnancy is a risk factor for early delivery and babies that are born too early, result in 60% of infant morbidity and mortality. The cost of one day in our NICU (Neonatal Intensive Care Unit) is substantial. If minors are assured of confidentiality they will feel able to seek health care earlier in the pregnancy and would improve pregnancy outcomes as well as potentially limit the risks and eliminate the cost of additional treatment for complications.

When minors know their confidentiality will be respected, they will be able to develop a relationship of trust with the health care provider and in turn the health care provider will be able to encourage the minor to seek parental involvement or facilitate discussions with the minor and the parent if needed.

We would like to believe that all parents are loving and have only their child's best interest at heart, but the sad truth is that that is not always the case.

I am aware of a situation in which a parent refused to consent to an epidural for her 16-year-old daughter. She felt that since her child got herself into the situation, she deserved to

endure the pain of labor. This bill would enable the minor and her physician to determine the best course of treatment and prevent this sort of abuse of parental authority. In some cases parental involvement is just not to a minors benefit.

I believe this bill is important to the health and well-being of young mothers and their children and would urge you to support SB 2181 with a "Do pass" recommendation.

Thank you for the opportunity to testify today. I would be happy to answer any questions you may have.

2005 ND RESIDENT BIRTHS FOR SELECTED AGE GROUP OF MOTHERS BY TRIMESTER PRENATAL CARE BEGAN

AGE OF MOTHER	FIRST TRIMESTER	SECOND TRIMESTER	THIRD TRIMESTER	NOT STATED	NO PRENATAL CARE	TOTAL
13 AND 14 YEAR OLDS	2	2	1	1	0	6
15 AND 16 YEAR OLDS	41	21	7	3	1	73
17 YEAR OLDS	67	26	6	4	0	103
18 AND 19 YEAR OLDS	349	110	20	3	2	484
TOTAL	459	159	34	11	3	666

Senate protects the unborn

By DR. SHARI ORSER
Bismarck

Contrary to William Schuh's letter (Feb. 27, "Senate stripped parents of rights"), members of the North Dakota Senate had not "lost their minds" when they unanimously approved Senate Bill 2181. As physicians, we commend the Senate for appropriately addressing a complex and difficult concern for protecting the unborn child of a pregnant minor.

The bill ensures that appropriate prenatal care is provided as early in her pregnancy as possible, and it respects parents' concern and appropriate responsibility for the health of their child and unborn grandchild.

In the vast majority of situations, minors who come to us for care do involve their parents. In some situations, however, adolescents may not be ready to involve their parents for any number of reasons.

Since the 1970s, the law in our state has allowed minors to consent for their own medical care for drug and alcohol abuse, sexually-transmitted diseases and emergency care.

The motivation behind these laws, then and now, is to encourage minors to receive the care they need — even if, for whatever reason, the minor is not ready or unable to involve his or her parents.

We face a real problem as physicians when a pregnant minor in crisis comes to us seeking care but is not ready to tell her parents.

We encourage her to involve her parents, but she may still refuse. What can we do? Under current law, we have only one option — we must refuse to provide her the prenatal care she and her unborn child need and send her on her way.

If a minor who is hesitant to involve her parents is assured of confidentiality, she will feel able to seek health care earlier in her pregnancy to improve pregnancy outcomes, limit the risks and eliminate the cost of additional treatment for complications.

At the same time, we physicians can encourage the minor to involve her parents. This includes making efforts to obtain her reasons for not involving her parents and correcting misconceptions that may be motivating her objections.

Letters to the editor

The Tribune welcomes letters to the editor. Writers must include their address and both day and night telephone numbers. This information will be used only for verifying the letter and will not be printed. We cannot verify letters via 800 or similar toll-free numbers. We will verify letters via North Dakota exchanges. Letters of 300-350 words, or briefer, will get preference. All letters are subject to editing for clarity, length, style, grammar and taste. No more than two letters per month, please. The letters column is intended primarily for discussion of public issues, so we discourage letters of thanks and appreciation. Mail letters to the Bismarck Tribune, Letters to the Editor, P.O. Box 5516, Bismarck, N.D. 58506, or fax them to 701-223-2063. E-mail may be sent to letters@bismarcktribune.com. Any e-mail attachments must be ASCII text files.8266.

There are negative consequences in any pregnancy if there is no prenatal care or late prenatal care. Adolescent girls are more likely to experience pregnancy complications and give birth to low-weight babies than older women.

Statistics from the North Dakota Department of Health show that, on average, 40 percent of pregnant minors, whether their parents are involved or not, start prenatal visits late.

Some pregnant minors do not even come in for medical care until they are already in labor, with no prenatal care. Some minors do not come in at all and deliver their babies in unsafe places.

SB2181 is based on laws in Montana and Minnesota. If a minor comes to a physician seeking confidential pregnancy care, the bill would authorize a minor to consent and contract for pregnancy care, but a physician would not be compelled against their best judgment to treat a minor based on the minor's own consent.

The bill recognizes the ethical imperative for physicians to encourage the minor to involve her parents. In addition, a physician would be allowed to inform the minor's parents of any health care services given or needed if complications in the pregnancy arise.

SB2181 is about providing access to early prenatal care that ensures the best possible outcome for the unborn child. It would not allow a minor to consent to an abortion or consent to other means to end her pregnancy or even to birth control.

We believe SB2181 would create an environment that provides the best potential for a reluctant minor to involve her parents and to keep her baby and not seek an abortion, which a pregnant minor can now seek without parental consent through juvenile court. For many pregnant minors, without SB2181 abortion becomes the path of least resistance.

SB2181 has been carefully written to address an important need in health care, protecting the health of the unborn child without unduly infringing upon parental rights.

(Dr. Orser is president of the North Dakota Medical Association. The letter also was signed by Dr. Jerry Obritsch, section chair of the North Dakota section of the American College of Obstetricians and Gynecologists; Dr. Todd Twogood, president of the North Dakota Academy of Pediatrics; and Dr. Charles Breen, president of the North Dakota Academy of Family Physicians. The first three are from Bismarck. The last mentioned is from Hillsboro. — Editor)

Adolescent patients and their confidentiality: Staying within legal bounds

By Stephanie L. Anderson, MD, JD, Judith Schaechter, MD, and Jeffrey P. Brosco, MD, PHD

Jim Shive

What right does a teenager have to confidential health care? What influence does HIPAA have on that right? How you apply the answers in your practice could determine whether an adolescent seeks health services—or forgoes necessary care.

A 15-year-old girl (we'll call her "Cindy") comes to your office with an atypical chief complaint: "I want to talk to the doctor." With her mother outside in the waiting room, she tells you that she is sexually active and missed her last period. She's concerned that she might be pregnant. And she doesn't want her mother to know.

For some teenagers, the hardest part of being pregnant, or thinking that they are, is telling their parents. If a physician cannot assure confidentiality about pregnancy (or about any other sensitive health issue), an adolescent may refrain from obtaining health care to keep her parents from learning of her condition.[1,2] Adolescents are more likely to seek care in a setting in which they believe their privacy will be maintained, but state and federal regulations, ultimately, determine the degree of privacy that a patient is afforded.

Despite the 1978 recommendations by the Task Force on Pediatric Education to improve training for adolescent health care, many pediatricians and ob/gyns continue to lack confidence in their ability to address adolescent issues and often do not provide comprehensive care to this age group.[3,4] A study of the availability of adolescent health services and of confidentiality in primary care practices in the Washington, D.C., metropolitan area found that pediatric practices were less likely than family medicine and internal medicine practices to offer adolescents services such as contraception and pregnancy testing.[5] They were also less likely than family medicine practices to offer adolescents confidential care.[5] Pediatricians participating in the survey commonly cited lack of equipment and expertise, inadequate staffing, and low patient demand as reasons for not

DR. ANDERSON is Research Assistant Professor of Pediatrics; DR. SCHAECHTER is Assistant Professor of Clinical Pediatrics, Division of Adolescent Medicine; and DR. BROSCO is Associate Professor of Clinical Pediatrics, and Director, Clinical Services, Mailman Center for Child Development, all with the University of Miami School of Medicine. The authors have nothing to disclose in regard to affiliations with, or financial interests in, any organization that may have an interest in any part of this article. (This article originally appeared in *Contemporary Pediatrics*.)

offering the services. While ob/gyns routinely offer contraception and pregnancy testing, they too are often not familiar with the issues of confidentiality that are so critical to success in treating teens.

Although the teen birth rate has declined steadily since 1991, about 800,000 teenagers become pregnant each year, and about 400,000 give birth.[6] When confidentiality is a barrier to a pregnant minor seeking care, the health consequences can be significant.[7] Pregnant teens are the least likely of all age groups to get early and regular health care and are at greater risk of complications such as premature labor, anemia, and hypertension.[8] Like many adults, a pregnant teenager often has poor eating habits; she may diet, neglect to take a daily prenatal vitamin, or smoke and take drugs—further increasing the risk of having a low-birthweight infant (less than 5½ lb) or one born with other health problems. A low-birthweight infant is 20 times more likely than one of normal weight to die in the first year of life.[9]

The physician who is approached by an adolescent in a scenario like the one involving Cindy can make the clinical diagnosis easily enough. The challenge arises in responding to the adolescent's request for confidentiality. Understanding the rights of the adolescent patient and applying them appropriately in the primary care setting can reduce a barrier to care in this population.

Confidentiality and the adolescent patient

- Adolescents are more likely to seek care in a setting where they believe their privacy will be maintained.
- Laws vary state to state regarding the adolescent's right to confidentiality; clinicians are, therefore, obligated to understand the law in the state in which they practice.
- [State law that specifically addresses disclosure of a minor's personal health information to a parent or guardian generally preempts confidentiality rules under the federal Health Insurance Portability and Accountability Act (HIPAA), regardless of whether that law prohibits, mandates, or allows discretion about disclosure.]
- HIPAA allows the physician discretion in deciding whether to disclose or withhold confidential information, regardless of state law, when she or he believes there is an imminent threat to a minor or other person.
- Physicians who are committed to providing comprehensive health care to adolescents should have a written policy regarding confidentiality and teenagers and should review this policy with patients and their parents.

What are the rights of an adolescent to confidential health care?

The Society of Adolescent Medicine (SAM) and the American College of Obstetricians and Gynecologists (ACOG) have called for health providers to make their patients aware of the requirements of confidential care and to strike the often difficult balance between maintaining an adolescent's confidences and involving responsible adults when necessary.[10,11]

In general, an individual's right to control information about her health care is linked to that person's right to consent to the care itself. As a rule, children younger than 18 years are not allowed to consent to medical treatment; their parents (or legal guardian) make all medical decisions and, therefore, generally have the right to access the health information that results from that treatment.

That rule notwithstanding, public policy for more than three decades has reflected the understanding that many minors will not seek health services if they must first inform their parents. All 50 states have enacted legislation that entitles adolescents to consent to treatment, without parents' knowledge, to one or more "medically emancipated" conditions (Table 1). For example, [27 states explicitly allow minors to consent to contraceptive services without their parents' consent or knowledge. The laws vary from state to state and are, sometimes, complicated. Laws regarding HIV, for example, may involve more stringent privacy rules.]

"Medically emancipated conditions" should not be confused with

the term "emancipated minor." State law provides for a legal proceeding that allows a person under the age of majority (18 years in most states) to petition the court for the full rights of an adult—i.e., become an emancipated minor. This granting of adult rights is based on the maturity of the minor and the minor's need for adult status. Conditions that make it inappropriate for the minor's parents to retain control over the minor may include marriage or service in the armed forces.

When state law does not require consent of a parent or guardian for medically emancipated conditions, the consenting minor, not the parent, controls the health-care decisions and access to health information related to that care. Therefore, [a minor seeking treatment for an emancipated condition has three options:]

- Consent to treatment and withhold medical information pertaining to the emancipated condition from her parents. The physician may not disclose such information to the family without the minor's permission.
- Involve a parent in these health decisions, yet retain the right to control the health information. Here, the minor has the benefit of a parent's counsel and advice, but still ultimately makes the health-care decisions and thus controls the resulting information.
- Have the parent continue to control all the health-care decisions and the resulting health information.

TABLE 1

Some conditions commonly considered "medically emancipated"

- Contraception (counseling and prescription)
- Pregnancy and prenatal care
- Sexually transmitted infections
- Human immunodeficiency virus infection
- Substance abuse
- Mental health disorders
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- Pelvic examination (a minor may consent to examination for diagnosis or treatment)
- Other infectious diseases that require a report to a public health authority

For a list of each state's laws, consult the Web site Laws of the fifty States, District of Columbia and Puerto Rico Governing the Emancipation of Minors: http://www.law.cornell.edu/topics/Table_Emancipation.htm

Where state law does not require disclosure to parents, the parents may agree beforehand to a confidential relationship between the minor child and the physician for medical conditions not included on the state's list of emancipated conditions. The child would then be able to consent to treatment for an injury sustained at or away from school, for example, or for symptoms of an illness that the child fears might upset his parent. In this case the parent relinquishes access to health information related to that confidential relationship, giving the child an even higher level of privacy than provided by state law. In states where disclosure to parents is mandatory, however, such physician-parent-patient agreements would generally not be permitted.

Because laws regarding an adolescent's right to confidentiality vary by state, clinicians are obligated to understand the law in the state where they practice medicine. Ob/gyns may find help in this regard from ACOG, specialists in adolescent medicine, or the state bar association.

How does HIPAA affect the adolescent's right to confidentiality?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal act that came into final form in August 2002, is intended to assure that patients' private health information is kept confidential and that information disclosed for purposes other than health care is minimal.

Much like state law, the principle underlying disclosure under HIPAA is that, if a person has the right to make a health-care decision (i.e., to consent to treatment), she has the right to control information that results from that decision. HIPAA recognizes that parents generally have the right to make health-care decisions for their child and, therefore, to control the so-called protected health information (PHI) associated with those decisions. In those situations

where state law allows a minor to consent to a particular health service, and the minor does so, HIPAA generally allows the minor to control the PHI associated with that service or treatment.

However, when state law specifically addresses disclosure of a minor's PHI to a parent or guardian, state law preempts HIPAA, regardless of whether that law prohibits, mandates, or allows discretion about a disclosure.[12] [If, for example, state law requires parental notification of a minor's health information (such as about abortion), HIPAA does not protect adolescent confidentiality. But HIPAA does allow the treating physician discretion to *deny* the parent access to a minor's PHI (even where state law would dictate disclosure) when, in the physician's judgment, such access constitutes an imminent threat to the minor or another person.] Similarly, when state law prohibits disclosure of PHI to a parent without the minor's consent, HIPAA nonetheless allows the provider discretion to disclose if she believes that doing so will prevent or diminish an imminent threat to the minor or another person.

When state law is silent or unclear regarding control or disclosure of an adolescent's PHI for medially emancipated conditions, the default under HIPAA is for maintaining confidentiality. Again, in situations in which the physician believes that an imminent threat to the minor or another person can be diminished or prevented, she may disclose PHI.[13] In the absence of such a threat, HIPAA does not allow a provider to disclose without the minor's permission.

When a patient trusts her physician, she is less likely to delay medical care and more likely to seek reliable health information.

Cindy is in the 10th grade, doing well in school, and hopes to become a police officer someday. She usually has menstrual bleeding every 28 days, and her period was due 3 weeks ago. She has had some nausea in the mornings but no other complaints. She notes that her boyfriend, a 16-year-old high school track star, usually uses a condom. They plan to get married someday. Her physical examination is within normal limits.

You have known the patient's mother for some years. She is a schoolteacher who has been very diligent in taking care of her daughter. You have not met the girl's father, but he has seemed like a reasonable person when you've talked to him on the telephone in the past. Your patient says that her parents are "very religious" and worries that they will throw her out of the house if they find out she's pregnant.

What is the next step?

For some adolescents, the threat of being "thrown out of the house" is a real one, and many teenagers are subject to physical or emotional abuse by a parent or an intimate partner. Indeed, in studies, as many as a third of pregnant adolescents report being abused during pregnancy.[14,15]

In Cindy's case, the physician correctly asks her why she fears telling her parents. Based on her response and his knowledge of her parents, he should next try to discuss with her how likely it is that her parents will be unhelpful.

Testing is also warranted. In addition to conducting a urine pregnancy test, screening for sexually transmitted infections (STIs) is appropriate in cases of suspected pregnancy.[16] Nearly half of all high school students have had sex, and 20% of 12th graders have had four or more sexual partners.[17] Each year, 2.5 million teenagers acquire an STI, and many of them remain asymptomatic.[18] Girls 15 to 19 years of age have the highest rates of gonorrhea among women of all age groups, and, because of their increased cervical ectopy, teens are

at increased risk of *Chlamydia trachomatis* infection, the most common sexually transmitted bacterial disease.[19] Even a subclinical STI can progress to pelvic inflammatory disease, with its high complication rate of infertility, chronic pelvic pain, and tubal pregnancy.[20]

Chlamydia and gonorrhea can be tested for simultaneously. Nucleic acid amplification tests (NAAT) or nucleic acid probe testing can be used on swabs from the urethra or the endocervix. As *C trachomatis* is an obligate intracellular bacteria, it is important that epithelial cells rather than exudates comprise the sample; vaginal swabs are not recommended. NAAT assays can also be used on first void urine samples, with sensitivity only slightly less than samples obtained from the cervix or urethra, but with the advantage of patient comfort and ease of collection.[21]

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Some sexually active teenagers should be screened for cervical cancer with Pap testing. The sexually transmitted human papillomavirus is found in the cervix of 15% to 38% of sexually active adolescent girls and has been implicated as an etiologic agent in 90% of cervical cancers.[22] Recently updated recommendations suggest that screening begin within 3 years of sexual debut, or by 21 years of age in a woman who has delayed first sexual intercourse. Standard Pap testing should occur annually, although newer, liquid-based preparations may allow for testing every other year.[23]

What is the difference between confidential testing and anonymous testing?

With **confidential testing**, the individual's name and test results are recorded by the testing center, and access to this information is limited to the patient, health personnel, and, in most states, the health department. However, a signed records-release for notification of a personal physician often makes the information a part of the medical record and, therefore, potentially accessible to other health workers, insurers, or employers. Filing a claim for health insurance may also reveal HIV status. Some states have mandatory partner notification laws, which may or may not require that the name of the patient be disclosed to the notified partner.

In contrast, with **anonymous testing**, the person being tested does not provide his (or her) name to the testing center, and only he has access to the test results. Release of results to other providers and referral for services is not possible. Most, but not all, states provide for anonymous testing.

The CDC has a phone line (1-800-CDC-INFO) that provides information on HIV and AIDS in English and Spanish, as well as referrals to testing sites, clinics, counselors, legal services, health departments, support groups, and service agencies throughout the US.

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Although you, as the health-care provider, have some control over the medical record, parents are entitled to review the details of health insurance billing if they are financially responsible for the care rendered. Adolescents who seek health care either without insurance or outside their parents' insurance plan will likely face unaffordably high payments, which may force them to forgo care.

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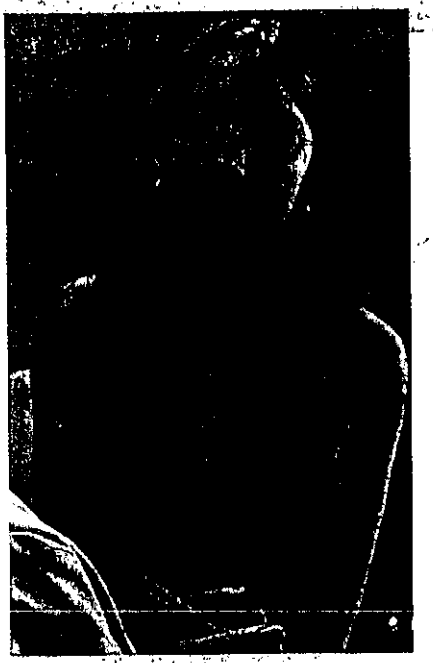

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Physicians who are committed to providing comprehensive health care to adolescents can minimize problems related to billing by having a written policy regarding confidentiality and teenagers. They can review this policy and the challenges of providing confidential health care with patients and their parents during pre-teen well-child visits—before such services may be needed.

[Focus the discussion on helping the parent understand the benefits of a confidentiality agreement:] The teenager may seek more preventive health education and will have a safe, accurate, and trusted source of health information in addition to the parent. It is important that the parent understand that you are not usurping parental authority but rather working for the shared goals of health, safety, and wise decision-making on the part of the adolescent. While parents may initially feel they are being asked to relinquish control, many will eventually understand that such an approach can help their child. Some parents may even be willing to make agreements about payment for services, with access to any medical information being controlled by the minor child. Parents can authorize health insurance payment without seeing the diagnosis or the lab tests that were ordered.

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testing after you explain that the billing records will reveal that such testing was performed.

What will you tell her mother?

Many parents are eager for the physician to discuss topics such as sexual activity and drug use with their teenager. They readily agree that confidentiality is an important aspect of good health care and counseling. But most parents also feel strongly that they have a right to know about important events in their child's life. As discussed, most state laws provide parents with the right to know about all health conditions except in very specific situations such as pregnancy and infection with a STI.

In this case, the law provides Cindy with the right to confidential health care regarding her possible pregnancy. This holds true even if the parents ask direct questions, such as ["Is my daughter pregnant?" The key to responding to such questions is understanding that you do not have to answer "Yes" or "No." Indeed, lying to the parents will destroy your credibility with them and provide a poor example for the adolescent patient.] Instead, you can remind the parent of the office's policy on confidentiality and that the parents agreed to such a plan. You can explain that it is your expert medical opinion that protecting the patient's confidentiality is in their daughter's best interests. You can encourage parents to discuss their concerns with their daughter.

Before speaking to the parent, ask the patient what she would like you to say to the parent. This provides an opportunity for you to make it clear that you will not lie to the parent. It also provides the patient with some time to think about what she will say, now that she is clearly informed of what you intend to share (and not share) with the parents.

It is important that the parent understand that you are not usurping parental authority but rather working for the shared goals of health, safety, and wise decision-making for the teen.

The pregnancy test is positive. Cindy is crying, but she does not want to disclose the results to her parents. You comfort her and ask if she has someone to confide in, such as clergy, extended family, or close family friends. She says she can talk with her aunt, and she promises not to hurt herself. You remind her about the dangers of drinking and smoking to the fetus. You briefly describe her options (adoption, raising the child, termination of pregnancy) and schedule a follow-up appointment for the next day for further discussion.

Her mother has learned from previous visits that you will not disclose confidential information, but she is visibly worried. You remind her about the importance of confidentiality, and you reassure her that your role is to provide the best health care to her daughter.

When and how do you discuss options for the pregnant adolescent?

Adolescents who are pregnant may choose to complete the pregnancy and raise the baby, complete the pregnancy and give the baby to a family wanting to raise a child, or terminate the pregnancy. Some experts recommend discussing these options with the patient before doing the pregnancy test.[24,25] For the adolescent who turns out not to be pregnant, a discussion before the results are known emphasizes the real risks of unprotected sexual intercourse. For the adolescent who has just learned she is pregnant, the news is likely to evoke extreme emotion, making it difficult to understand the medical options. Subsequent visits may be necessary.

Some ob/gyns may be uncomfortable discussing options available to pregnant teenagers. Nonetheless, it is essential that patients have full medical information and understand the risks and benefits of each course of action. An ob/gyn who is unwilling or incapable of providing appropriate counseling should refer the patient to another provider or specialist. Ob/gyns who do discuss all options with their patients should note that most states require parental notification for minors who seek an abortion, though the

constitutional status of such laws is in question. [Thirty-one states require the notification and input of at least one parent in a minor's decision about having an abortion. All states provide a mechanism for the minor to apply for a judicial bypass when they do not want their parents to know about their decision.]

The next day Cindy returns with her mother and her aunt. She tells you that she is afraid to tell her parents, but understands that they will know sooner or later. She asks you to tell her mother.

With Cindy and the aunt present, you explain to the mother what has happened. She suspected that her daughter was in some kind of trouble, and she is obviously upset. She is relieved, however, to know the truth, and reassures her daughter that her parents will not abandon her. You suggest that a member of the clergy or a family counselor may be helpful as the family faces upcoming challenges. You make a note in the chart to follow up by telephone in 1 week.

Optimizing adolescent health

Providers who care for adolescents must recognize and respond to issues that lie at the intersection of medicine, law, and ethics. Respecting an adolescent's right to privacy reduces one barrier to care. (In addition to concern over lack of confidentiality, barriers to adequate health care for adolescents include costs, transportation, inconvenient office hours, and the inability to consent to care.) When a patient trusts her physician, she is less likely to delay medical care and more likely to seek reliable health information, both of which ultimately improve health. A physician who protects a patient's confidentiality also contributes to her safety by being sensitive to potential harm in her environment and by helping the adolescent negotiate the particular course she chooses.

Adolescent health concerns, such as pregnancy, can be emotionally difficult for patients, families, and providers. ACOG, The American Academy of Pediatrics, the American Medical Association, and the Society of Adolescent Medicine, and have established guidelines to help providers who care for this special group navigate the challenges they are likely to encounter.[16,24,25]

Providers must also be aware of state laws that govern issues of emancipation, consent, and privacy for adolescents who have not reached the age of majority. HIPAA does not compel a higher standard of privacy for minors than what is mandated by states, but it does allow physicians discretion—to disclose or to prevent disclosure—when there is an imminent threat to the minor or another person. □

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Attachment #4

Senate Bill 2181

My name is Kathy Perkerewicz. I am a board certified obstetrician/gynecologist. I am employed with MedCenter One Health Systems. However, I am here today as a private citizen.

I am here in support of Senate Bill 2181. Early and consistent prenatal care is vital for optimal pregnancy outcomes. I believe that some minors do not seek prenatal care because they do not want their parents to know they are pregnant. The reason they may not want to involve their parents is varied. Senate Bill 2181 would eliminate the need for parental consent to receive care. I strongly believe this would enable some teens to come into prenatal care earlier.

Teen pregnancies are at higher risk for complications such as gestational hypertension and pre-eclampsia. By getting early and consistent prenatal care, this risk is reduced.

While we hope that parents have the best interest of their own child in mind, there are unfortunately situations where this is not the case. A teenager may feel that they are at risk of physical abuse, or that they may be kicked out of the house if they disclose to their parents that they are pregnant. This bill would allow them to seek prenatal care, and hopefully tell their parents when they are ready.

Most teenage pregnancies are not intended pregnancies. By allowing the minor to seek care on their own we allow them to gain some control over their own life. I think this is important as they have only a few short months to learn and prepare to become a parent. By allowing them the comfort of being free to seek care, they likely will be open to the education provided by the medical community during prenatal visits.

I applaud you for presenting this bill and recommend a 'do pass' vote. Thank you for your time.

SB 2181

2005 NORTH DAKOTA RESIDENT TEEN AND OUT OF WEDLOCK BIRTH AND PREGNANCY DATA

TEEN	NUMBER	RATIO	RATE
BIRTHS	668	79.70	25.83
PREGNANCIES	829	88.69	32.06

OUT OF WEDLOCK	NUMBER	RATIO
BIRTHS	2698	321.92
PREGNANCIES	3419	365.7

NORTH DAKOTA TOTAL	NUMBER	RATE
BIRTHS	8381	13.05
PREGNANCIES	93.47	14.77

*RATES ARE CALCULATED BASED ON TEEN FEMALE POPULATION
*RATIOS ARE CALCULATED BASED ON NUMBER OF LIVE BIRTHS

SOURCE: VITAL RECORDS, NORTH DAKOTA DEPARTMENT OF HEALTH

Attachment # 5

Sen. Karen Krebsbach

SB 2181
House Human Services Committee
March 13, 2007
9:00 a.m.

There are several instances for which we as legislators have included language in the ND Century Code authorizing minors to consent for health care services. Those services include the examination, care and treatment for alcoholism, drug abuse and sexually transmitted diseases, as well as emergency medical services. These are situations in which the public policy is to encourage young people to access medical services, rather than discourage them from seeking the appropriate help they need.

Senate Bill 2181 would recognize that this same kind of situation arises often with respect to a young person who finds herself pregnant and is not yet ready to involve her parents – that as a matter of public policy we ought to encourage that young person to seek appropriate prenatal care and other health care for her and her unborn child. If a minor patient asks for confidential services, physicians are ethically bound to encourage the minor to involve their parents. More clarity is needed, however, on the legal environment for physicians and other health professionals in working with young people who seek pregnancy-related health care services for themselves and their unborn children.

I introduced Senate Bill 2181 at the request of a number of health care organizations seeking this clarity, including the North Dakota Chapter of the American College of Obstetricians and Gynecologists, the North Dakota OB-GYN Society, the North Dakota Medical Association, and the North Dakota Healthcare Association representing hospitals. Senate Bill 2181 would authorize a minor to consent and contract for prenatal care and other pregnancy-related care, but not abortion services which are covered by another law, as well as identify difficult situations in which the physician or other health

professional may inform the minor's parents or guardian even if the minor is not ready to involve them. I introduced a similar bill last session which passed the Senate almost unanimously but was defeated in the House. SB 2181 passed the Senate by a vote of 46-0.

Senate Bill 2181 strikes an appropriate balance – a balance that recognizes the need to encourage young people to seek the medical care they need for themselves and their unborn child, as well as to encourage them to involve their parents.

Thank you Representative Price and members of the Committee. There are representatives of various organizations here to describe more fully the rationale and scope of the bill, and answer questions you have.

Testimony on SB 2181
Senator Dick Dever

Madam Chair, members of the committee, for the record I am Dick Dever, Senator from District 32 here in Bismarck.

When this bill was heard in the Senate, it was about minors getting the prenatal care that I think you and I would agree is very important. There was no opposition to the bill.

When the newspaper article came out about the bill, it was about keeping secrets from parents. Several people reacted, including friends of mine who asked me to come here today and ask you to kill this bill.

I stand before you with my hat in my hand to say that I believe there is a problem and this is a solution. If you have a better solution, or if you can make this bill a better solution, I would encourage you to seek that out.

I would like to share with you four different conversations I have had recently.

My daughter-in-law is an RN. For about three years, she worked in a NICU, first at Meritcare in Fargo, and more recently at St. Alexius here in Bismarck. Following the birth of my granddaughter, Michelle continues to work an occasional shift, and works two days a week as a school nurse. My son, Justin, asked her if she sometimes deals with babies whose grandparents denied the mother the ability to get prenatal care. She said that she has not seen girls who were denied care, but that she sees babies of mothers who did not get care because they were afraid to tell their parents. NICU, by the way, stands for Neonatal Intensive Care Unit.

Some legislators have visited with me about the bill and what they would do if their daughter was in a similar situation. Madam Chair, I can tell you what I did do. It was a little over five years ago when Heather told me. You don't really prepare yourself for that moment. It is said that life is 10% what happens to you and 90% how you react to it.

There was no point at that time in being judgmental. I stayed calm and talked with her about her future and the responsibilities that lay before her. She and her mother made an appointment with a doctor and prenatal care began. Our granddaughter, Lily, was born healthy on Heather's eighteenth birthday.

I don't see anything in this bill that would have changed that relationship.

It was interesting that in the week or two before and after the birth, there were social workers visiting with Heather about different programs the government has in place. Her response was, "It wasn't the government's fault."

She and Lily continued to live with us for the first three years of Lily's life, and then Heather got married. That's what family is for.

After we became aware of Heather's pregnancy, the biological father asked to meet with me and his father. One of his first comments was, "I want you to know that I do not intend to marry Heather at this time." I said, "I guarantee you that you are not going to marry Heather at this time."

He got a little irritated and he said, "If you interfere with my parental rights, I will sue you for everything you've got!"

I said, "You know sometimes when people talk about their rights, I like to substitute the word responsibility, and it's interesting how often that fits." It was one the last times we saw him.

Some people would say this bill is about rights. I would submit that it is about responsibilities. The question is how do teen mothers get the care they need when their parents abdicate the responsibility to get it for them?

I visited with a High School guidance counselor a couple of weeks ago. He said that when girls come to him and discuss their pregnancy, he always encourages them to tell their parents. He offers to be with them when they do. He said that in every case they do. I asked him if he would be able to tell the parents if the girl said no. He said that he would be forbidden by confidentiality laws from telling the parents.

This bill is about getting girls in front of professionals who would facilitate a conversation with the parents.

I would encourage your support of this bill or of a better solution if you know of one.

With that Madam Chair, I would be happy to respond to any questions.

Testimony in Support of Senate Bill 2181
House Human Services Committee
March 13, 2007

Madam Chairman Price and members of the Human Services Committee,

For the record my name is Shari Orser, an obstetrician-gynecologist. I am an employee of Medcenter One Health Systems, but today I am testifying on my own behalf.

I believe this bill is vitally important. It offers confidentiality to assure that needed care is given to the minor in those unfortunate circumstances where the minor may not be ready to involve her parents or her parents do not necessarily have her best interests in mind. This is especially important when young women are pregnant in order to assure the best possible outcome for the newborn child and the mother.

In surveys minors and providers consistently identify concerns about lack of confidentiality as a barrier to obtaining health care. Minors who are pregnant, have STD's, abuse drugs and alcohol, or have emotional problems may avoid seeking health care if they must inform their parents.

Our best opportunity for optimal pregnancy outcomes is to begin prenatal care early. Statistics from the State Department of Health indicate that on average 40% of teenage mothers start prenatal visits late (statistics attached). Many minors do not present for prenatal care until the mid-to-late second trimester, often when they can no longer conceal the pregnancy from their parents. This significantly delays the opportunity for treatment with

folic acid, providing iron for anemia, counseling about healthy diet, discussion of other high risk behaviors such as smoking, alcohol and drug use, early treatment of STD's and identification of other risk factors for poor outcome. Some minors do not even come in until they are already in labor and have not received any prenatal care. In either situation, the health of both the mother and child is put in jeopardy.

Accessing care late in a pregnancy is a risk factor for early delivery and babies that are born too early, result in 60% of infant morbidity and mortality. The cost of one day in our NICU (Neonatal Intensive Care Unit) is substantial. If minors are assured of confidentiality they will feel able to seek health care earlier in the pregnancy and would improve pregnancy outcomes as well as potentially limit the risks and eliminate the cost of additional treatment for complications.

When minors know their confidentiality will be respected, they will be able to develop a relationship of trust with the health care provider and in turn the health care provider will be able to encourage the minor to seek parental involvement or facilitate discussions with the minor and the parent if needed.

We would like to believe that all parents are loving and have only their child's best interest at heart, but the sad truth is that that is not always the case.

I am aware of a situation in which a parent refused to consent to an epidural for her 16-year-old daughter. She felt that since her child got herself into the situation, she deserved to

endure the pain of labor. This bill would enable the minor and her physician to determine the best course of treatment and prevent this sort of abuse of parental authority. In some cases parental involvement is just not to a minors benefit.

I believe this bill is important to the health and well-being of young mothers and their children and would urge you to support SB 2181 with a "Do Pass" recommendation.

Thank you for the opportunity to testify today. I would be happy to answer any questions you may have.

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Testimony in Support of Senate Bill No. 2181
House Human Services Committee
March 13, 2007

Madam Chairman Price and Committee members, I'm Bruce Levi representing the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota's physicians, residents and medical students. With me today is Dr. Shari Orser. Dr. Orser has been actively involved in the North Dakota OB-GYN Society and also serves as the President of the North Dakota Medical Association. Dr. Orser will testify on her own behalf as an obstetrician-gynecologist here in Bismarck.

The North Dakota Medical Association strongly supports SB 2181, as do a number of other physician professional organizations including the ND Section of the American College of Obstetricians and Gynecologists, the ND Academy of Pediatrics, and the ND Academy of Family Physicians. I was also requested to note support on behalf of other organizations, including the North Dakota Healthcare Association, the North Dakota Nurses Association, and the North Dakota Counseling Association.

As a member of the medical profession, a physician is required to recognize responsibility to patients first and foremost. Standards of conduct adopted as Principles of Medical Ethics by the American Medical Association prescribe that physicians be dedicated to providing competent medical care, with compassion and respect for human dignity and rights; that physicians respect the law and recognize a responsibility to seek changes in those laws that are contrary to the best interests of the patient; that physicians safeguard patient confidences and privacy within the constraints of the law; and that physicians support access to medical care for all people.

SB 2181 is about fulfilling these ethical imperatives by creating an appropriate legal environment for providing access by a pregnant minor to prenatal care and other pregnancy care that ensures the best possible outcome for her unborn child, when that pregnant minor is not yet ready to involve her parents or guardian.

SB 2181 follows a principled approach that strikes a proper balance between ensuring access of the minor mother and her unborn child to the health care they need, and supporting the appropriate role of parents to be involved in and direct the health care provided to their children.

Under current North Dakota law [NDCC 23-12-13], if a pregnant minor seeks confidential prenatal care from a physician or other health professional, that care may not be provided without the consent of the minor's parent or guardian. As such, physicians face a real problem when a pregnant minor in crisis comes seeking health care, but is not yet ready or willing to tell her parents. A physician can encourage her to involve her parents, and is ethically bound to encourage the minor to do so, but she may still refuse. Under current law, physicians have only one option – they must refuse to provide her the prenatal care or other pregnancy care she and her unborn child need, and send her on her way.

Ironically, the law provides that once the child is born, the minor has the capacity to make health care decisions for her newborn child, no matter the minor's age.

When confidentiality is a barrier to a pregnant minor seeking care, the health consequences can be significant as the pregnant minor may not seek appropriate prenatal care for herself and her unborn child:

> Pregnant teens are the least likely to of all age groups to get early and regular health care and are at greater risk of complications such as premature labor, anemia, and hypertension. Like many adults, a pregnant teenager often has poor eating habits; she may diet, neglect to take a daily prenatal vitamin, or smoke and take drugs – further increasing the risk of having a low-birthweight infant (less than 5 ½ lb) or one born with other health problems. A low-birthweight infant is 20 times more likely than one of normal weight to die in the first year of life. *Contemporary OB/GYN, May 2006.*

SB 2181 is about creating an appropriate legal environment for physicians to address this situation. It is akin to efforts made in the past by the Legislative Assembly to address other difficult situations involving young children – situations that require some form of intervention to protect the life and health of the child. For example, the "Baby Moses" law adopted in 2001 [NDCC 50-25.1-15] allows the parent of an infant child to abandon that child at a hospital in an unharmed condition. While none of us would condone a parent abandoning their child, these situations were occurring and the Legislative Assembly agreed there was a need for an alternative to parents abandoning children in unsafe places. That environment was created to protect the infant child. SB 2181 is designed to protect the unborn child.

For over thirty years in North Dakota, our statutes have recognized the ability of minors to make some health care decisions without the consent of a parent or guardian:

- NDCC Section 14-10-17: Examination, care, and treatment for sexually transmitted disease, alcoholism, or drug abuse of minors age fourteen and older

- NDCC Section 14-10-17.1: Examination, care, or treatment in a life-threatening situation involving any minor

The first law was enacted in 1971 to allow minors to contract and consent for care for venereal disease. In 1973, the law was expanded to drug abuse. And in 1977, the law was made to apply to alcoholism and emergency care.

The motivation behind these laws, then in the 1970s and now in SB 2181, is to create an environment that assures that minors receive the care they need – even if, for whatever reason, the minor is not ready or unable to involve his or her parents.

SB 2181 would follow the lead of at least thirty-four other states in providing statutory authority for a physician or other health care professional to rely on the consent of a minor for pregnancy-related health care. SB 2181 is actually a hybrid of statutes from Minnesota and Montana, and copies of those statutes are attached.

In summary, SB 2181 would authorize a minor to consent and contract for medical, mental, and other healthcare services to determine the presence of or to treat pregnancy and conditions associated with pregnancy. The bill does not authorize a minor to consent to abortion. A physician or other healthcare professional would not be compelled against their best judgment to treat a minor based on the minor's own consent. The bill also recognizes the ethical imperative for physicians that they encourage the minor to involve her parents or guardian.

The bill recognizes that the pregnant minor's decisions cannot threaten her own health or the health and life of the unborn child. A physician or other healthcare professional would be authorized under the bill to inform the minor's parents or guardian about any health care services given or needed after discussion with the minor, if (1) failure to inform the parent or guardian would seriously jeopardize the health of the minor, (2) major surgery or prolonged hospitalization is needed, or (3) informing the parent or guardian would benefit the minor's physical and mental health.

Medical ethics require that when a young person comes to a physician asking for confidential medical care, physicians should encourage that young person to involve his or her parents or guardian. The American Medical Association Code of Medical Ethics addresses the issue of confidential care for minors, and a copy of the ethics opinion is included as an attachment to my written testimony.

If a minor who is hesitant to involve her parents at the beginning of her pregnancy is assured of confidentiality she will feel able to seek health care earlier in her

pregnancy to improve pregnancy outcomes, as well as potentially limit the risks and eliminate the cost of additional treatment for complications. At the same time, physicians can encourage the pregnant minor to involve her parents. This includes making efforts to obtain the minor's reasons for not involving her parents and correcting misconceptions that may be motivating her objections.

SB 2181 encourages pregnant minors who are not ready to involve their parents to choose childbirth and not seek an abortion, which a pregnant minor can now seek without parental consent through juvenile court. For pregnant minors, without SB 2181, abortion could become the path of least resistance. Statistics from the ND Department of Health indicate that 182 children were born from a minor parent in 2005. In that same year, 36 minors aborted their unborn child.

The purpose of the bill is not to diminish the role of parents in raising their children. The bill does not say that physicians are to rely solely on the consent of a minor in every situation involving a request for pregnancy-related care. In most instances the parents of the minor are in fact involved and acting in the best interests of their child and her unborn child.

In conclusion, concern about confidentiality is often a major obstacle to the delivery of health care to minors. Access to confidential services is often essential, because many minors will not seek care for themselves or their unborn child if they are not ready to inform a parent or have their parents' consent. These laws encourage young people to seek the health care services they need and enable them to talk candidly with their physician or other health professional. <u>They help build a relationship – a relationship in most cases that works in favor of, not against, involving parents.</u>

A brief review of the bill follows:

<u>Subsection 1</u>: The language in subsection 1 provides authorization for a minor to consent for pregnancy-related services, as derived from Minnesota law [Minn. Stat. 144.343]. Subsection 1 uses the Minnesota terminology "medical, mental, or other health services to determine the presence of or to treat pregnancy and conditions associated with pregnancy" in describing the services to which a minor may consent. The consent of no other person is required. The authorization does not include abortion services, which are governed by the state's Abortion Control Act [NDCC 14-02.1]. The Abortion Control Act provides for specific consent and notification requirements that would not be affected by this legislation.

Subsection 2: The first sentence in subsection 2 is derived from the American Medical Association Code of Medical Ethics (E-5.055). That language recognizes that as a general proposition if a minor requests confidential services to determine the presence of or to treat pregnancy and conditions associated with pregnancy, the minor should be encouraged to involve her parents or guardian. The subsection also states specifically that a physician can not be compelled against their best judgment to treat a minor based on the minor's own consent. That language in subsection 2 is derived from Montana law [Mont. Code Ann. 41-1-407]. This provision provides the necessary medical discretion to allow the physician or other health professional to work within the ethical guidelines that address confidential care for minors, considering such factors as the maturity of the minor and the circumstances surrounding the minor's request for confidential medical care.

Subsection 3: The language in subsection 3 authorizes disclosure to parents or guardian under certain circumstances deemed appropriate in the physician's or other health professional's judgment, but only if the physician or other health care professional discusses with the minor the reasons for informing the parent or guardian before the disclosure. This prior discussion requirement is consistent with the AMA Ethics Code. The circumstances that may result in disclosure to the parent or guardian include:

- Failure to inform the parent or guardian would seriously jeopardize the health of the minor (serious jeopardy standard recognized in AMA Ethics Code, Minnesota and Montana);
- Major surgery or prolonged hospitalization is needed (Mont. Code Ann. 41-1-403); or
- Informing the parent or guardian would benefit the minor's physical and mental health (Mont. Code Ann. 41-1-403).

NDMA urges you to support SB 2181 with a "Do Pass" recommendation.

I will attempt to answer any questions you have. Dr. Orser has prepared testimony and can answer your questions from her experience in providing medical care to pregnant minors.

E-5.055 Confidential Care for Minors
AMA Code of Medical Ethics
Physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities. When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving their parents and correcting misconceptions that may be motivating their objections.

Where the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.

When an immature minor requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse, or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor may be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached, according to Opinion 5.05, "Confidentiality." In addition, confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor. (IV) Issued June 1994 based on the report "Confidential Care for Minors," adopted June 1992; Updated June 1996.

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144.343, Minnesota Statutes 2006

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144.343 PREGNANCY, VENEREAL DISEASE, ALCOHOL OR DRUG ABUSE, ABORTION.

Subdivision 1. **Minor's consent valid.** Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

Subd. 2. **Notification concerning abortion.** Notwithstanding the provisions of section 13.02, subdivision 8, no abortion operation shall be performed upon an unemancipated minor or upon a woman for whom a guardian has been appointed pursuant to sections 524.5-101 to 524.5-502 because of a finding of incapacity, until at least 48 hours after written notice of the pending operation has been delivered in the manner specified in subdivisions 2 to 4.

(a) The notice shall be addressed to the parent at the usual place of abode of the parent and delivered personally to the parent by the physician or an agent.

In lieu of the delivery required by clause (a), notice shall be made by certified mail addressed to the parent at the usual place of abode of the parent with return receipt requested and restricted delivery to the addressee which means postal employee can only deliver the mail to the authorized addressee. Time of delivery shall be deemed to occur at 12 o'clock noon on the next day on which regular mail delivery takes place, subsequent to mailing.

Subd. 3. **Parent, abortion; definitions.** For purposes of this section, "parent" means both parents of the pregnant woman if they are both living, one parent of the pregnant woman if only one is living or if the second one cannot be located through reasonably diligent effort, or the guardian or conservator if the pregnant woman has one.

For purposes of this section, "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the fetus and "fetus" means any individual human organism from fertilization until birth.

Subd. 4. **Limitations.** No notice shall be required under this section if:

(a) The attending physician certifies in the pregnant woman's medical record that the abortion is necessary to prevent the woman's death and there is insufficient time to provide the required notice; or

(b) The abortion is authorized in writing by the person or persons who are entitled to notice; or

(c) The pregnant minor woman declares that she is a victim of sexual abuse, neglect, or physical abuse as defined in section 626.556. Notice of that declaration shall be made to the proper authorities as provided in section 626.556, subdivision 3.

Subd. 5. **Penalty.** Performance of an abortion in violation of this section shall be a

Montana Code Annotated 2005

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41-1-402. Validity of consent of minor for health services. (1) This part does not limit the right of an emancipated minor to consent to the provision of health services or to control access to protected health care information under applicable law.

(2) The consent to the provision of health services and to control access to protected health care information by a health care facility or to the performance of health services by a health professional may be given by a minor who professes or is found to meet any of the following descriptions:

(a) a minor who professes to be or to have been married or to have had a child or graduated from high school;

(b) a minor who professes to be or is found to be separated from the minor's parent, parents, or legal guardian for whatever reason and is providing self-support by whatever means;

(c) a minor who professes or is found to be pregnant or afflicted with any reportable communicable disease, including a sexually transmitted disease, or drug and substance abuse, including alcohol. This self-consent applies only to the prevention, diagnosis, and treatment of those conditions specified in this subsection. The self-consent in the case of pregnancy, a sexually transmitted disease, or drug and substance abuse also obliges the health professional, if the health professional accepts the responsibility for treatment, to counsel the minor or to refer the minor to another health professional for counseling.

(d) a minor who needs emergency care, including transfusions, without which the minor's health will be jeopardized. If emergency care is rendered, the parent, parents, or legal guardian must be informed as soon as practical except under circumstances mentioned in this subsection (2).

(3) A minor who has had a child may give effective consent to health service for the child.

(4) A minor may give consent for health care for the minor's spouse if the spouse is unable to give consent by reason of physical or mental incapacity.

History: En. Sec. 1, Ch. 189, L. 1969; amd. Sec. 1, Ch. 312, L. 1974; amd. Sec. 23, Ch. 100, L. 1977; R.C.M. 1947, 69-6101; amd. Sec. 14, Ch. 440, L. 1989; amd. Sec. 188, Ch. 42, L. 1997; amd. Sec. 2, Ch. 396, L. 2003.

Provided by Montana Legislative Services

Montana Code Annotated 2005

41-1-403. Release of information by health professional. (1) Except with regard to an emancipated minor, a health professional may inform the parent, custodian, or guardian of a minor in the circumstances enumerated in 41-1-402 of any treatment given or needed when:

(a) in the judgment of the health professional, severe complications are present or anticipated;

(b) major surgery or prolonged hospitalization is needed;

(c) failure to inform the parent, parents, or legal guardian would seriously jeopardize the safety and health of the minor patient, younger siblings, or the public;

(d) informing them would benefit the minor's physical and mental health and family harmony; or

(e) the health professional or health care facility providing treatment desires a third-party commitment to pay for services rendered or to be rendered.

(2) Notification or disclosure to the parent, parents, or legal guardian by the health professional may not constitute libel or slander, a violation of the right of privacy, a violation of the rule of privileged communication, or any other legal basis of liability. If the minor is found not to be pregnant or not afflicted with a sexually transmitted disease or not suffering from drug abuse or substance abuse, including alcohol, then information with respect to any appointment, examination, test, or other health procedure may not be given to the parent, parents, or legal guardian, if they have not already been informed as permitted in this part, without the consent of the minor.

History: En. Sec. 2, Ch. 189, L. 1969; amd. Sec. 2, Ch. 312, L. 1974; R.C.M. 1947, 69-6102; amd. Sec. 15, Ch. 440, L. 1989; amd. Sec. 3, Ch. 96, L. 2003.

Provided by Montana Legislative Services

Montana Code Annotated 2005

41-1-407. Immunity and responsibility of psychologist, physician, or health care facility. (1) No physician, surgeon, dentist, or health or mental health care facility may be compelled against their best judgment to treat a minor on his own consent.

(2) Nothing contained in this section shall be construed to relieve any physician, surgeon, dentist, or health or mental health care facility from liability for negligence in the diagnosis and treatment rendered such minor.

(3) In any case arising under the provisions of 41-1-406, the physician or licensed psychologist who provides the psychiatric or psychological counseling services shall incur no civil or criminal liability by reason of having provided the counseling services, but such immunity shall not apply to any negligent acts or omissions.

History: (1), (2)En. Sec. 5, Ch. 189, L. 1969; amd. Sec. 5, Ch. 312, L. 1974; Sec. 69-6105, R.C.M. 1947; (3)En. Sec. 2, Ch. 315, L. 1971; Sec. 69-6107, R.C.M. 1947; R.C.M. 1947, 69-6105, 69-6107.

Provided by Montana Legislative Services

Chairman Price and members of the Human Services Committee,

My name is Audrey Cleary and I am here this morning to testify on SB 2181 because I am concerned about the loss of confidentiality that may happen if this bill is not passed. I do not see it as taking away the rights of the parents.

For 25 years I was a volunteer for Birthright, an organization of volunteers who helped young women who were faced with an unplanned pregnancy. We assured them that they could trust us to be confidential. Always we encouraged them to tell their parents but that was something they had to do. Unfortunately, often they are not ready to do that for several months.

The Bismarck Birthright is no longer available but there are other pregnancy care centers that may be compromised because young women will be afraid to take advantage of their services. These young women should be able to have some early prenatal care. This is important for the young woman and for her unborn child.

In a perfect world, every young woman would be able to talk to her parents, especially her mother, if she should become pregnant. Unfortunately, not every young woman has that kind of relationship with her parents. We cannot legislate that. It is up to parents to teach sexuality and the risks associated with being sexually active and to encourage their children to come to them when they have problems.

I would hope that doctors would provide these initial services "free of charge". Please vote YES for SB 2181. Thank you.

North Dakota
FAMILY
ALLIANCE
DEDICATED TO STRENGTHENING FAMILIES

A Trusted Voice

Tom D Freier
EXECUTIVE DIRECTOR

Madame Chairman, and members of the House Human Services Committee, thank you for hearing my testimony.

I am Tom Freier, and I represent the North Dakota FamilyAlliance.

I am here to stand in opposition of SB 2181. The bill removes the parent's right and obligation to guide the medical care of their minor daughter in a period of pregnancy crisis.

While the intentions of SB 2181 may be well meaning, I believe the effect may be just the opposite. By removing parental involvement in the medical care of a minor, it only causes a greater communication problem. It condones circumvention of that parental involvement, and replaces it with that of non parental adults in the medical profession. This model is in direct contradiction of a healthy family unit. The eventual responsibility, obligation, and decision making rest with the parents, and should not be removed or diminished.

It appears this bill is taking a minority of the cases and trying to craft a law to not only deal with those, but all parents and all minors. By presumption, all parents do not need to be notified. Instead of dealing with the lack of communication, it is endorsing it. It is, in fact, providing as an option to those minors who have a good relationship with their parents, the option to withhold information from their parents.

The North Dakota FamilyAlliance believes in the family. While not every family is perfect, it is still the best environment for these issues to be discussed. As unfortunate as this situation may be, and as uncomfortable as the discussion may seem, the long term opportunities for a strengthened relationship are great.

This bill does not offer a solution to the problem. It does not improve the relationship between the minor and parents and may well lead to a greater deteoration of that relationship. In fact, if our concern is for the emotional and physical well being of our minors, we need to strengthen parental involvement.

We ask the committee to place Do Not Pass on SB 2181.

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Beverly LaHaye
Chairman

Concerned Women for America of North Dakota stands in opposition to SB 2181.

A. The intent of SB 2181 is not clear. From conversations with the sponsors of this bill I have gathered that prenatal care of a minor's unborn child is the intent of SB 2181. In the testimony of the sponsors of SB 2181, given to the Senate Human Services Committee, we find the words "prenatal" and "unborn child", however these phrases are not used nor addressed in this bill. The only issue addressed in this bill is consent of a minor for medical care in cases of pregnancy. Why is prenatal and postnatal care not addressed directly in SB 2181? This legislation opens wide the door for medical treatment of a minor who may be pregnant but never even mentions the care of the unborn child. The second intent of SB 2181 is stated to be clarification for the medical community as it relates to a minor and the possibility of a pregnancy. However, again, it does not give any clarification other than that the consent for treatment comes only from the minor herself and states that the medical personnel may "encourage" the minor to notify parents or guardians. There is no requirement here that parents be involved in this decision-making process; the bill says "may encourage" not "shall".

B. Does the care for the life of the unborn supersede the God- given authority of a parent over a minor? CWA fully supports the value of the life of all unborn children, and we believe that they should receive the most excellent care the medical community can provide in order for the unborn child to be born healthy. However, there is NO reason that this cannot be accomplished with the full consent and involvement of the parents and/or guardian of a pregnant minor. There are always going to be "hard cases" where a minor does not have responsible parental supervision or instances where a minor makes unwise decisions. Can these few cases justify a broad sweeping law set in place that removes parental authority from all parents and that allows for the exploitation and exposure of a minor to treatment and values that may conflict with parental authority and rights?

CONCERNED WOMEN FOR AMERICA
OF NORTH DAKOTA

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Beverly LaHaye
Chairman

C. The question that remains after reviewing SB 2181 is again the intent of the bill. If pre and postnatal care are the concerns, then let us see a bill introduced that addresses those issues. As the State Director of CWA, representing more than 1000 members in ND and also as a parent, I cannot abdicate my God-given responsibility and authority over my children, nor do I think it is right of this body of lawmakers to do so for the parents of ND. I do not think it is wise nor should it be lawful to allow a minor to be exposed to unknown courses of medical treatment, be it due to pregnancy or any other medically-related conditions. It occurs to me, after more than 20 years of working with teen pregnancies that the medical consent laws are treated very differently when related to pregnancy than to all other medical issues that may face a minor. This should not be the case.

I applaud and respect the lawmakers and the medical professionals who have the well being of the minor and her unborn child at the heart of this debate. CWA of ND ask that you would not step over the rights of ND parents in order to accomplish this, but write a bill that respects both the unborn, the minor and her parents and/or guardians. Do not let hard cases cause us to establish bad laws.

Janne Myrdal
State Director, CWA of ND.

CONCERNED WOMEN FOR AMERICA
OF NORTH DAKOTA

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Testimony to the House Human Services Committee
Submitted by W.M. Schuh on March 13, 2007

Honorable Members of the House Human Services Committee

PLEASE VOTE DO NOT PASS ON SB 2181

Senate bill 2181, addressing medical care for teen pregnancy, is one of the most dangerous and destructive bills for the family, and for the rights of parents to guide the development of their children that this legislature had considered in many years.

- **The language of this bill strips parents of their authority to guide the medical care of their minor daughters in a period of pregnancy crisis.**

- Ostensibly it is a measure to circumvent decisions of "bad" parents. But **it has no objective way of determining what a "bad parent" is.**

In reality its' power grant strips ALL parents of the authority for decisions concerning their child's medical care in a key crisis situation and turns it over to non parental adults in the medical profession. In doing so it utterly destroys the meaning of "minority" under a parent or legal guardian. While stripping power from parents, the bill is laced with patronizing and meaningless statements regarding parental "involvement" which have no legal significance, no compelling standard, no penalty and no power. They only serve as fluff to disguise the power transfer.

- The power kernel of the bill is in Section 1.1, which states that:

A minor may provide consent and contract for and receive medical, mental, and other health care services to determine the presence of or to treat pregnancy and conditions associated with pregnancy, and the consent of no other person is required.

- **A minor. Any minor! can provide *their own consent* for medical care without any parental control, consent or guidance, or even consultation whatsoever!** The parents, ALL PARENTS , both good and bad, are totally out of the loop.

There is no age limit. Your 16-year old, 14-year old, 12-year old daughter...need not tell their parents. They can provide their own consent for medical care and totally circumvent parents!

- **According to this language, the children can "*contract*" on their own!** Since when can a minor engage a contract without parental permission? Where else can they do so?

- **There is no fiscal note. The parents and their insurance will be billed.** Yet, they are not consulted concerning their own minor children.

- **Under SB 2181 an irresponsible unemancipated minors can legally contract for their parents.** Parents have no right to know what is going on with their own minor daughter, no right to have a say on the course of care, no authority whatsoever! Only the obligation to be saddled with the invoice. **SB 2181 utterly destroys the meaning of legal guardianship.**

- **All language related to parental power or involvement is meaningless fluff.**

SB 2181 states: *"the minor should be encouraged to involve her parents or guardian."*

***"should be"* means the medical service is not obligated. *"Encouraged"* means that the child is not obligated.** There is no requirement, no standard, and no penalty. In legal terms this is utterly meaningless! There is no obligation to the parent at all

SB 2181 states: *"a physician or other health care professional or a health care facility may not be compelled against its best judgment to treat a minor based on the minor's own consent."*

Note that the health care provider is absolved of all responsibility to accept the "contract". The provider is thoroughly empowered and protected. **Only the parent is stripped.**

SB 2181 states: that the health care professional:

" may inform the parent or guardian of the minor.... if the physician or other health care professional discusses with the minor the reasons for informing...."

the word ***may*** **has no legal force whatsoever.** There is no legal requirement that they tell parents anything. ***"if the physician or other health care professional discusses with the minor"* means that the child, not the parent, MUST be consulted.**

SB 2181 states (The parent *may* be told if):

"in the judgment of the physician or other health care professional:
(a) Failure to inform the parent or guardian would seriously jeopardize the health of the minor;
(b) Major surgery or prolonged hospitalization is needed;
(c) Informing the parent or guardian would benefit the minor's physical and mental health.

***"in the judgment"* means that it is ENTIRELY up to the health care providers and what they wants to reveal.** They are not compelled by law or penalty to inform or consult the parent **even if** the child is jeopardized, requires hospitalization, or if the the minors physical or mental health would be served.

- SB 2181 **teaches minors that parents are powerless.**
- It **sends a broad message to teens that all parents cannot be trusted and can be used and manipulated.**
- **Those that would consult parents will not because of this bill.** It lowers the bar.
- Those inclined to be promiscuous will know all about this before they are even sexually active. Minors will know that their **parents are not in control, that they are not legitimate authorities, and that state law has said so.**
- SB 2181 is a dangerous nail in coffin of the family.
- **None of the claimed benefits justify the social problems that it will perpetrate.**

A BRIEF HISTORY OF PARENTAL DISEMPOWERMENT IN NORTH DAKOTA

W.M. Schuh

The Right to Guide Children

The right to exercise our obligations to raise, guide and protect our children is the most fundamental right in any decent society. The natural relationship between parent and child is most suited to the protection of the child. In recent years this right is under constant attack.

The Typical Form of Attack on Parental Authority

(1) A social problem is defined by the worst case scenario.

(2) A law or social system to solve that problem, and based on the assumption that parents are absent or incompetent is applied not to the narrow case, but to all.

(3) Responsible parents are marginalized and undercut and separated from substantive control of their children.

Recent History

- (Late 1980s and early 1990s) The Carnegie Middle School (Turning Points) and Starting Points which propose to guide the education of preschoolers in the home asserted that parents were to be excluded from their private relationship with the child. For example, after proposing that it is important that adolescents have another "non parent" adult to guide them, Turning Points states that:

> "Parents should understand that communications between advisors and students are confidential and that advisors are not free to pass along information they receive from students." (Turning Points, p68)

And after describing conditions for school-based health care, Turning Points states that:

> "Clinic staff members make it clear from the very beginning that any information shared with them will not be shared with other adults, unless it indicates a student may take an action harmful to himself or herself, and then the student is informed first." (Turning Points p63).

- (Early 1990s - Federal Education Law) Under Title IV, Sec. 1018 CONTRACEPTIVE DEVICES of Goals 2000 it is stated that :

> "The Department of Health and Human Services and the Department of Education shall ensure that all federally funded programs which provide for the distribution of contraceptive devices to unemancipated minors develop procedures to encourage, to the extent practical, family participation in such programs. "

Please observe that there is nothing here about respecting parental values or wishes. The law only directs the school to try to bring the parent along with its viewpoint " as much as possible",

- In 1995 SB 2410 stated that any counselor could form a confidential relationship with a child (without parental consent) and the parent could be told nothing without the consent of the child. After initial amendment this bill allowed police and Health officials to be told. ONLY PARENTS were excluded from knowing what was going on with their child. Ostensibly intended to protect children in cases of sexual abuse, this broad bill was very similar to SB 2181 in that it virtually destroyed parental authority and the privileged relationship of parent and child. It was eventually modified to apply only in abused adult resource centers. When thus limited to the narrow case, it ceased to be a general problem for family integrity.

- In 1995 SB 2042 would have mandated and funded basic health services in schools (the 1995 school nurse bill proposed by the League of Women Voters). Michael Petit of the Child Welfare League, who served as the State paid consultant in preparation for the bill described the role of the school nurse as:

> "I think that relative to this question of teenage pregnancy there are really two things. One is not getting pregnant at first. I think that some of these kids, they need someone to talk to that can give the information about choices in their lives... So I think that a school nurse in my mind should emerge as a person that is used as a friendly source of information, both in terms of addressing sexuality of the individual kid, and also in addressing the subject of contraceptives. I've said the C word, and I'll say it again. At some point we have to recognize that there is a causal relationship between teenage pregnancy and teenage sex. *(laughter ripples through the room)*". League of Women Voters forum Bismarck, November, 1994, *transcribed from videotape*).

SB 2042 was amended to forbid dispensing contraceptives in the school. This caveat amendment was similar to the abortion caveat now in SB 2181. In a meeting of health and education officials (observed and recorded by a mother) they were laughing about how the nurse would circumvent this amendment by referring the students to District Health services for contraceptives.

In testimony before the Senate Health Committee then Senator Yokhim (sp?) asked one of the recorded attendees directly if they had stated their intention of referring. She lied.

The bill failed, but contraceptives are being dispensed to minors at District Health services without parental knowledge and consent.

- (Late 1990s and early 2000s) Opening of teen health clinics. Radio and television interviews constantly claim that "parents have to understand that we have a confidential relationship with the adolescent." In other words, the reproductive health, is severed from the parents and their guidance. The health provider is taking over.

- (Early 2000s) HIPPA is passed. Places walls of "privacy" within families - between parents and children and between spouses. Says that parents have know right to know what is

going on.

- (2007) SB 2181 says parents not only have no right to know and guide. The children can contract on their own and send them the bill.

Examples of the Consequences of Parental Marginalization

- At Park River High School in 1989, when two "guest speakers" (medical students) brought a life-size erect crystal model of a penis into the classroom and demonstrated the fitting of condoms for students. Parents were neither consulted nor notified. Guest speakers later justified their actions to outraged parents by stating that they had "stressed abstinence" (Walsh County Press, November 20, 1989).

- At Hazen High School in 1989, where a State Health Department speaker offered to help the students set up secret accounts to obtain contraceptives without parental knowledge. According to one student:

> The speaker went on to tell us where various health clinics in the state are, and that these clinics can help us to set up secret accounts so our parents will not find out if we should need treatment or supplies of any kind.... Then, pulling a silver dollar condom from his pocket ant treating sex as a toy, ... he threw the 'coin' (the joke condom) into our audience saying that it should be used soon because they don't keep forever." (Bismarck Tribune, March 21 1989).

- Parents of a high school girl directed a dermatologist who was treating their daughter for acne that they did not want their daughter to be given a contraceptive injection to use a drug treatment for acne. The physician acknowledge their objection as though it would be followed. When the daughter came home from treatment, she had been given the contraceptive injection against the express directions of the parents. If the injection was required by label, the physician should have resorted to a different treatment.

- In Fargo a school counselor referred a minor girl and her eighteen-year-old boyfriend to a reproductive clinic, without parental knowledge and consent. One year later, the girl was pregnant and the boy was charged with having sex with a minor. The parents were left with the mess. (Source is the attorney retained by the parents seeking legal regress).

- On March of 1996 all sixth-grade girls in J.T. Lambert School in Pocono, Pennsylvania were forced to "partially undress, bend and compromise and submit to a genital examination by medical staff in the school, without prior warning, without parental consent, and over the pleas of the girls to be excused and to call their parents.
" (World, August 17, 1996).

There have been plenty of examples of medical atrocities based on eugenics.

- An earlier example. In the 1930s some counties in southern states would forcibly remove children deemed to be "unintelligent" from their families, institutionalize them and forcibly sterilize them.

Some Rules of Thumb for Legislation

1. All authorities are imperfect. A global transfer of power from parents to another authority will only subject children to the imperfections of that new authority.

2. Legislation dealing with the parent-child relationship must be narrowly crafted to deal with the specific abusive case, so as not to restrict or disempower all parents and destroy the family.

3. Improvements can be made with narrowly crafted legislation. No legislation will solve all problems.

4. SB 2181 is not narrowly crafted. It is a marginalizing bill in the worst sense.

Questions for Legislators

Do you want to live in a society wherein other non parental parties who may not share your values, your knowledge of your children and their needs and personalities, and your comfort zone with respect to risk can interfere personnally, psychologically, and medically with your children and grand children without your permission or guidance? Even if you personally are comfortable with SB 2181, what is the long-term ramification of this principle of allowed interference with respect to your right as a parent to guide your own children? And where might it lead in another case?

Testimony in opposition of Senate Bill 2181

Tuesday, March 13, 2007
(Human Services Committee)

Madam Chair and members of this committee, my name is Becky Ness. I am not a lobbyist; I am not a health care professional; but merely a concerned parent of this state. When I first heard about this bill and its passage in the Senate I have to tell you I was totally shocked. That is when I began educating myself on the bill and what it all entailed. After that, I started to talk to parents, parents who are teachers, parents who work in various medical fields, parents who stay at home, parents who are professionals. When I told them about the bill, I continually heard the same response, "You've got to be kidding me, this is not right. Why are our parental rights constantly being attacked and trying to be taken away from us?" That is when I knew I was not the only parent thinking this way.

While I agree that it is of utmost importance that girls should be seen at the earliest possible time in their pregnancy for responsible prenatal care, I disagree that this bill will fix the problem of young, minor girls currently not seeking early prenatal care. Second, I believe that there is a greater problem looming in our society and until we, as a society, are willing to step forth and say something about it, passage of this bill will only rip away at the integrity of the family unit. For those who disagree, I would ask why in the bill, does it give the girl choices, the doctor or medical facility choices and the parent absolutely NO choices whatsoever? It completely removes the parent from the equation and in an indirect manner makes a statement to the pregnant minor girl that she can make a better decision without her parents, when clearly this is not true. In the few instances where there is a bad relationship already between the girl and her parents, well I would really have to wonder, even with the medical community "encouraging" the girl to tell her parents, would she? And in these particular family situations a bill like this is likely to only enrage the parents further when they find out their daughter is pregnant solely because they received a bill from the doctor or medical facility who saw her.

Furthermore, when the parent tries to contact the facility to find out what they are being billed for they will not be given information because of HIPPA laws, instead they will just be expected to pay the bill and not ask questions.

Instead of removing the parents from this equation, I ask this committee, the state of North Dakota and society at large, "Why can't we do better?" In an age where we parents are constantly being told to talk to our kids about underage drinking and to not use drugs, why aren't parents ever encouraged to talk to our kids about sex? Why can't there be a cooperative effort between the medical industry, the education system and parents to all work together to teach our kids about sex and its dangers. Many people might laugh at this idea saying that some kids will choose to have sex anyway. Well, the same can be said for kids drinking and doing drugs; however, as a society we don't ever give up on trying to educate our kids about the dangers of alcohol and drugs – so why is sex any different? Can we all agree that kids have enough to worry about during their teen years, whether or not they pass their math test, or make the cheerleading squad or pass their driver's test that they should be encouraged to abstain from sexual activity? And as far as "safe-sex" goes, it simply is NOT safe. If it were, we would not be having pregnant teens, we would not be seeing an increase in the numbers of HPV cases, and we would not be seeing teens have abortions or in the event they decide to keep the baby, the staggering number of single mothers having to raise these children without the baby's father. I ask you what part of pregnancy, HPV, abortion or single moms raising their kids is "SAFE"?

As a parent of two girls and a boy, I started at an early age to always be open and honest with my children so that when they are older and start to have questions or concerns about sex, drugs and/or alcohol they will feel like they can come to me or at least not be embarrassed if I bring it up to them and we can communicate with one another what is the best situation for them. It is my personal opinion, and the opinion of many other parents that I spoke with, that this bill, if passed, would undermine all of the hard work and communication that I've spent with my kids in that it would give them the "legal right" to basically go behind their parent's back. In a society where we have laws restricting kids from getting tattoos, body piercing, and their driver's licenses without the consent of the parent, why then would we feel compelled to give away the parental authority on such a serious matter as this.

I've come here today as a competent, willing, loving and responsible parent to tell you that I take my job of parenting seriously and I beg you to not take this parental authority away from me. Thank you.

Mr. Chairman, representatives…

Thank you for your time today. My name is Mike Motschenbacher. I am not here as a lobbyist, I am not here representing a group, I am here as a concerned parent.

1st of all, I would like to compliment you on the job you have done and thank you for the service you do for our state. It is greatly appreciated.

Today I am standing before you to request that you vote NO on this bill. I realize that the bill has been written to help with the health of unborn children, which I have no problem with. However, to pass a bill that completely strips parents of the rights to know what is happening with their minor child is completely unacceptable.

I have testified before with success in front of your committee on bills that I think the legislature should not be involved in. This is another of those bills. This is an issue that needs to be addressed at the family level and not at the state level. I know there are some cases of upset parents, unnecessary punishment, and others but the bottom line is YOU CANNOT CREATE A LAW TO PROTECT EVERYONE!

It is very unfortunate that we do have incidences that lead to the daughters not telling their parents about an unwanted pregnancy. However, they are just that… incidences! This has not become a problem at this point that needs to be addressed by the legislature. The incidences are few and far between.

My other concern is where this will end. What will stop boys from coming in for addiction treatment and not want to tell their parents about it. If you pass a bill like this, you will find yourselves session after session having other groups being requested to be added to this bill and in the long run, the parents will not know anything that their children are doing.

Let's do a positive thing this legislature and leave parenting to parents like it should be.

Thanks again for your time and I encourage you to vote No on this bill.

Health Care Guideline:
Routine Prenatal Care

Item 2

INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

Tenth Edition
August 2006

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Nancy Jaeckels
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Facilitator
Linda Setterlund, MA
ICSI

These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.

Event [1]	Preconception Visit [2]	Visit 1 [3] [**] 6-8 weeks	Visit 2 10-12 weeks	Visit 3 16-18 weeks	Visit 4 22 weeks
Screening Maneuvers	Risk profiles [4] Height and weight/BMI [5] Blood pressure [6] History and physical [7] Cholesterol & HDL [2] Cervical cancer screening [2] Rubella/rubeola [8] Varicella [9] Domestic abuse [10]	Risk profiles [4] GC/Chlamydia [4] Height and weight/BMI [5] Blood pressure [6] History and physical [7*] Rubella [8] Varicella [9] Domestic abuse [10] Hemoglobin [15] ABO/Rh/Ab [16] Syphilis [17] Urine culture [18] HIV [19] [Blood lead screening [20]] [VBAC [21]] Hepatitis B S Ag [25]	Weight [5] Blood pressure [6] Fetal heart tones [27] Fetal aneuploidy screening [23]	Weight [5] Blood pressure [6] Fetal heart tones [27] Fetal aneuploidy screening [23] OB Ultrasound (optional) [28] Fundal height [29] [Cervical assessment [30]]	Weight [5] Blood pressure [6] Fetal heart tones [27] Fundal height [29] [Cervical assessment [30]]
Counseling Education Intervention	Preterm labor education and prevention [11] Substance use [2] Nutrition & weight [2] Domestic abuse [10] List of medications, herbal supplements, vitamins [12] Accurate recording of menstrual dates [13]	Preterm labor education and prevention [11] Prenatal & lifestyle education [22] • Physical activity • Nutrition • Warning signs • Course of care • Physiology of pregnancy • Follow-up of modifiable risk factors Discuss fetal aneuploidy screening [23]	Preterm labor education and prevention [11] Prenatal & lifestyle education [22] • Fetal growth • Review labs from visit 1 • Breastfeeding • Physiology of pregnancy • Follow-up of modifiable risk factors	Preterm labor education and prevention [11] Prenatal & lifestyle education [22] • Physiology of pregnancy • Second trimester growth • Quickening • Follow-up of modifiable risk factors	Preterm labor education and prevention [11] Prenatal & lifestyle education [22] • Classes • Family issues • Length of stay • Gestational diabetes mellitus [32] (GDM) • Follow-up of modifiable risk factors • [RhoGam [16]]
Immunization & Chemoprophylaxis	Tetanus booster [3] Rubella/MMR [4] [Varicella/VZIG [9]] Hepatitis B Vaccine [7,25] Folic acid supplement [14]	Tetanus booster [3] Nutritional supplements [24] Influenza [26] [Varicella/VZIG [9]]		[Progesterone [31]]	

Event	Visit 5 28 weeks	Visit 6 32 weeks	Visit 7 36 weeks	Visit 8-11 38-41 weeks
Screening Maneuvers	Preterm labor risk [4] Weight [5] Blood pressure [6] Fetal heart tones [27] Fundal height [29] [Cervical assessment [30]] Gestational diabetes mellitus (GDM) [32] Domestic abuse [10] [Rh antibody status [16]] [Hepatitis B Ag [25]] [GC/Chlamydia [4]]	Weight [5] Blood pressure [6] Fetal heart tones [27] Fundal height [29]	Weight [5] Blood pressure [6] Fetal heart tones [27] Fundal height [29] Cervix exam [34] Confirm fetal position [35] Culture for group B streptococcus [36]	Weight [5] Blood pressure [6] Fetal heart tones [27] Fundal height [29] Cervix exam [34]
Counseling Education Intervention	Preterm labor education and prevention [11] Prenatal & lifestyle education [22] • Work • Physiology of pregnancy • Preregistration • Fetal growth • Follow-up modifiable risk factors Awareness of fetal movement [33]	Preterm labor education and prevention [11] Prenatal & lifestyle education [22] • Travel • Sexuality • Pediatric care • Episiotomy • Follow-up of modifiable risk factors Labor & Delivery Issues Warning signs/pregnancy-induced hypertension [VBAC [21]]	Prenatal & lifestyle education [22] • Postpartum care • Management of late pregnancy symptoms • Contraception • When to call provider • Discussion of postpartum depression • Follow-up of modifiable risk factors	Prenatal & lifestyle education [22] • Postpartum vaccinations • Infant CPR • Post-term management • Follow-up of modifiable risk factors Labor & delivery update
Immunization & Chemoprophylaxis	[ABO/Rh/Ab [16]] [RhoGAM [16]]			

Numbers refer to specific annotations.

[Bracketed] items refer to high risk groups only.

* It is acceptable for the history and physical and laboratory tests listed under Visit 1 to be deferred to Visit 2 with the agreement of both the patient and the provider.

** Should also include all subjects listed for the preconception visit if none occurred.

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