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Consenting to invasive contraceptives: an ethical analysis of adolescent decision-making authority for long-acting reversible contraception

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Abstract

Since USA constitutional precedent established in 1976, adolescents have increasingly been afforded the right to access contraception without first obtaining parental consent or authorisation. There is general agreement this is ethically permissible. However, long-acting reversible contraception (LARC) methods have only recently been prescribed to the adolescent population. They are currently the most effective forms of contraception available and have high compliance and satisfaction rates. Yet unlike other contraceptives, LARCs are associated with special procedural risks because they must be inserted and removed by trained healthcare providers. It is unclear whether the unique invasive nature of LARC changes the traditional ethical calculus of permitting adolescent decision-making in the realm of contraception. To answer this question, we review the risk–benefit profile of adolescent LARC use. Traditional justifications for permitting adolescent contraception decision-making authority are then considered in the context of LARCs. Finally, analogous reasoning is used to evaluate potential differences between permitting adolescents to consent for LARC procedures versus for emergency and pregnancy termination procedures. Ultimately, we argue that the invasive nature of LARCs does not override adolescents' unique and compelling need for safe and effective forms of contraception. In fact, LARCs may oftentimes be in the best interest of adolescent patients who wish to prevent unintended pregnancy. We advocate for the specific enumeration of adolescents' ability to consent to both LARC insertion and removal procedures within state policies. Given the provider-dependent nature of LARCs and the stigma regarding adolescent sexuality, special political and procedural safeguards to protect adolescent autonomy are warranted.

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INTRODUCTION

Improved contraceptive technologies have afforded users enhanced abilities to control their fertility. Of the many contraceptive options available in the USA, the long-acting reversible contraception (LARC) methods are the most effective.¹ These include intrauterine devices (IUDs), which are effective for 3–10 years, and subdermal implants, which are effective for 3 years.² Use of LARCs by adolescents has increased from 1% in 2005 to 7% in 2013.¹ Adolescents using LARCs have higher rates of satisfaction and continuation than those using short-acting contraceptives such as the pill, patch and shot.³ There are nonetheless unique procedural risks associated with LARCs because they must be inserted and removed by a trained healthcare provider. Ultimately, however, LARCs have a favourable risk–benefit profile and adolescents may uniquely benefit from LARCs.³

Parents typically maintain decision-making authority over their minor's medical decisions in the USA.⁴ Yet, as a result of a constitutional precedent established in 1976, adolescents have increasingly been afforded the 'limited right to privacy' to access contraception without first obtaining parental consent or authorisation.⁴⁵ There is general agreement that this provision of contraception to adolescents without parental consent is ethically defensible,³⁴ and it is currently expressed in many state policies.⁶ However, adolescents are generally not permitted to consent (but should assent) to invasive procedures, absent an emergency indication in which consent is presumed. As LARCs have only recently been prescribed to the adolescent population, it is unclear whether consideration of the unique invasive nature of LARCs changes this ethical and policy calculus.

We argue that the invasive nature of LARCs does not over-ride adolescents' unique and compelling need for safe and effective forms of contraception in the USA. In fact, LARCs may oftentimes be in the best interest of adolescent patients who wish to prevent unintended pregnancy. We advocate for the specific enumeration of adolescents' ability to consent to both LARC insertion and removal within USA state policies. Furthermore, special political and procedural safeguards to protect the autonomy interests of adolescent patients are warranted given the provider-dependent nature of LARCs and the stigma regarding adolescent sexuality.

LARC BACKGROUND

LARCs are the most effective forms of contraception available.¹⁷ While only 1/1000 women become pregnant within the first year of typical IUD use, 9/100 women using oral contraceptive pills and 18/100 women using only male condoms will become pregnant within 1 year of typical use.⁸ Overall, adolescents are twice as likely as women over age 21 to become unintentionally pregnant while using short-acting methods.⁹ Because adolescents may have tendencies to transition into and out of relationships as well as be inconsistent recipients of preventative healthcare services,¹⁰¹¹ the 'forgettable', user-independent nature of LARCs may make them the most developmentally appropriate forms of contraception. Accordingly, rates of both satisfaction and continuation are higher among adolescents that select LARCs than those who select short-acting methods.⁷⁸¹²¹³

However, there are risks involved with LARC devices. Insertion and removal procedures confer the typical procedural risks of bleeding and infection. Specific risks include uterine perforation (with IUDs), haematoma and local skin irritation (with implants).^{14–16} The incidence of experiencing these risks is <1%.¹⁷ As with all medications, LARCs also have the potential for side effects. Bleeding changes due to LARCs are more commonly reported than other side effects. Compared with the adult populations who report an expulsion rate of 2%–10% during the first year, adolescents may report a slightly higher expulsion rate of 5%–22%.² Nonetheless, LARCs are ultimately safe for adolescent use and pose fewer risks of harm to adolescents than short-acting methods.³ It is due to this favourable risk versus benefit calculus that the American Academy of Pediatrics (AAP), American Congress of Obstetricians and Gynecologists (ACOG), Centers for Disease Control and Prevention (CDC), and Society of Family Planning (SFP) all state that LARCs are ‘essential contraception options for adolescents.’⁷

PAEDIATRIC DECISION-MAKING AUTHORITY FOR CONTRACEPTION

Some adolescents are comfortable with the involvement of their parents. The family planning wishes of a minor with decision-making capacity may oftentimes coincide with the values and wishes of their parents.⁴ Indeed, parental—especially maternal—attitudes have been found to be a strong determinant of contraceptive choice among adolescents.⁷ Providers should consider the role, beliefs, attitudes and involvement of parents before engaging in contraceptive counselling sessions with their adolescent patients.⁸

However, not every adolescent desires to involve their parent. It has been demonstrated that mandatory contraception parental consent notification laws threaten to deter adolescent sexual health-seeking behaviours in the USA.⁴ Therefore, the precedent regarding limiting parental decision-making in the realm of adolescent contraception is oftentimes justified on public health grounds.⁴ Accordingly, 21 states and the District of Columbia allow minors to consent to contraception.⁶ In the remaining states, only certain groups of minors (such as those who are married or legally emancipated) are allowed to consent.⁶ Four states lack any policy.⁶

The principle of autonomy can also be used to justify affording those adolescents with sufficient decision-making capacity to consent to contraception with decision-making authority.¹⁸ Unlike in other paediatric medical circumstances, the responsibility for both adolescent pregnancy and childbirth disproportionately falls on the shoulders of the adolescent themselves—not on those of their parents. This reality is formally recognised in states where minors who become pregnant and/or are parents are legally emancipated.¹⁸ Salter specifically states that:

...in most states, minors who are married, have a child, or are emancipated from their parents are correspondingly accorded medical decision-making authority. Again, this cannot be because a person is necessarily accorded the requisite capacities for mature decision-making the moment he or she marries or gets pregnant. Instead, the reasoning that justifies this exception relies far more heavily on the ‘responsibility’ justification.¹⁸

Affording adolescents decision-making authority regarding contraception grants them increased control over their bodies, futures, family lives and family roles.

The sensitive nature of sexual healthcare is relevant to discussions regarding adolescent access to contraception. Partially because adolescent sexuality is stigmatised in the USA, many adolescents can and do elect to engage in sexual activities without first obtaining parental permission. A more practical approach of harm reduction is therefore warranted: if adolescents have the ability to participate in sexual intercourse without parental consent, they should have the ability to minimise risks of harm by accessing contraception without parental consent. By acknowledging the bodily autonomy rights of adolescents, potential harms done to adolescents as they discover their emerging sexuality are minimised. Prioritising bodily autonomy rights recognises the uniquely personal, sensitive and stigmatised nature of sexual and reproductive healthcare as well as addresses the presumptive primacy of procreative liberty.¹⁹

LARC PAEDIATRIC DECISION-MAKING AUTHORITY

It is unclear whether existing USA state laws regarding adolescent contraception use in general are currently being applied to adolescent LARC use policies, as well. Presumably, in the 21 states and the District of Columbia where minors can consent to contraception, they are able to consent to LARC. However, in states in which such law does not exist, more variation may be present as laws that allow for adolescents to consent for sexual health may be heterogeneously extrapolated to some forms of contraception but not LARCs. Thus, given the lack of clarity regarding policy, the unique procedural risks of LARCs warrant further consideration. That is, does the invasive nature of LARCs versus other forms of contraception over-ride the generally accepted ability of adolescents to consent to such contraceptive services? And further, what are the similarities and differences between LARC-related procedures and other procedures for which adolescents are currently permitted to consent?

The above considerations of public health benefit, autonomy, stigmatisation of adolescent sexuality and harm reduction apply when considering LARCs for adolescents. Out of all forms of contraception, LARCs are most likely to provide adolescents control over their futures. While non-maleficence requires that individuals refrain from actions that cause harm, the procedural risks, side effect profile and risk of expulsion associated with the invasive nature of LARCs should be weighed against the potential harms of *not* providing LARCs. These potential harms include the increased risks of unintended teen pregnancy associated with both use of short-acting contraceptive methods and with use of no contraceptive methods, as well as the medical risks associated with short-acting contraception such as the increased risk of thrombosis in an oestrogen-containing contraceptive pill/oral contraceptives. Therefore, given LARCs' increased effectiveness, safety, compliance and satisfaction rates, granting adolescents the authority to give informed consent to LARCs seems a logical, practical and ethical extension of their recognised ability to consent to traditional short-acting contraception prescription.

There is precedent for permitting adolescents to consent to other invasive procedures without parental consent in the USA. Specific instances include pregnancy terminations with a judicial waiver and emergency surgeries. Arguments granting adolescents decision-making authority in these circumstances, but not for LARCs, must therefore demonstrate meaningful differences between these types of procedures.

The first possible difference could be that of time-sensitivity. Both emergency surgeries and termination procedures have an element of urgency, where meaningful harms could be inflicted onto patients if procedures are delayed. Desiring a LARC insertion procedure, in this sense, would not qualify as an emergent need. However, LARC insertion is still time-sensitive. Even though no harm would *immediately* be caused to the patient as a result of not having an IUD or implant, meaningful harms *may* occur if insertion procedures are postponed. Namely, the patient may become pregnant as a result of using a less-effective form of pregnancy prevention. For adolescent patients specifically, the consequences associated with unwanted, unintended pregnancy may be higher than those posed to adult patients. It is due to this risk that the ACOG and the CDC recommend same-day LARC insertion.²⁰²¹ Requiring parental consent may serve as a barrier to this same-day provision for a time-sensitive medical need.

Another relevant consideration is that while both termination procedures and some emergency surgeries such as appendectomies intervene to *physically remove* a potential harm from a patient's body, LARC insertion procedures require healthcare providers to *physically add* an item to a patient's body. However, the distinction of adding or removing something is not ethically significant in and of itself, as well established ethically and legally vis-à-vis the discussion surrounding life-sustaining treatment. Furthermore, this distinction also breaks down because it places ethical significance on the mechanical processes involved in performing invasive surgical procedures rather than on the actual intentions behind physicians' and patients' decisions to engage in these procedures. Specifically, healthcare providers are motivated by an intent to benefit their patients, including in instances when the patient's well-being is threatened. Patients consent to all of these procedures because they seek medical assistance. The physician's handling of an appendix, fetus or subdermal implant, therefore, whether moving it into or out of a patient's body, is merely one of the many consequences of the physician's beneficent pursuit to improve their patient's well-being. Ultimately, neither the intentions motivating these procedures nor the consequences of these procedures appear to reveal evidence that the granting of adolescents decision-making authority to consent to LARC procedures is more problematic than doing this for other invasive procedures.

Another potential difference involves the element of reversibility. Unlike termination or most surgical procedures where results are irreversible, the contraceptive effects of LARCs are—by definition—reversible. Indeed, fertility is restored quickly after removal of both IUDs and implants.¹⁷ If anything, out of all invasive procedures, the argument for granting adolescent decision-making authority is stronger in the case of LARC procedures because the contraceptive effects of LARCs are reversible.

A final consideration is one of cost. As procedures and devices tend to cost more than medications, a reasonable argument can be made that those likely paying for such expenses (ie, parents) should be aware of the service provided and cost. However, due to the USA Affordable Care Act (ACA), LARCs are generally provided without any cost-sharing to the patient, negating this consideration.

Therefore, in circumstances of family planning, adolescents' bodily autonomy and prima facie rights to autonomous decision-making warrant special consideration. The invasive nature of LARCs does not change this ethical calculus when compared either to other forms of contraception or other surgeries. Adolescents with decision-making capacity should therefore be permitted to give their informed consent to all forms of contraception currently available in the USA, including LARCs.

SPECIAL CONSIDERATIONS

LARC removal

Unlike with short-acting contraceptive methods, the invasive nature of LARC mandates that patients rely on trained healthcare providers for both insertion and removal. While LARCs are currently recommended as first-line contraception for adolescents, they may not represent the perfect method for every adolescent.²² Adolescents may change their mind regarding a previously-placed LARC either due to side effects or a desire to parent. Teen pregnancy is not inherently unacceptable and should not be stigmatised or shamed.²² The substantial power dynamics at play between trained healthcare providers and adolescent patients further point to the need for truly dynamic, interactive and informative contraceptive counselling sessions.

LARC removal can become disproportionately problematic for adolescents, as they are more likely to have difficulties accessing preventive healthcare services and are less likely to afford the cost of removal procedures in the USA. While LARC removal is generally covered under the ACA, not all insurance plans have consistently extended coverage.²³ Thus, healthcare providers should discuss the logistics surrounding both LARC insertion and removal procedures during contraceptive counselling sessions. These discussions may protect patient reproductive autonomy.²³ Provider conceptions of teenage pregnancy and adolescent sexuality should not result in the paternalistic overriding of any adolescent's desire to either use or stop using any family planning method.

While it has been argued that 'financial guarantees of removal must be extended at the time of insertion' for LARCs in the USA,²⁴ we qualify this statement as an obligation of the USA health system rather than of individual providers. If this is not feasible from the standpoint of the health system, provider-dependent forms of contraception such as LARCs should not be advertised to patients as 'reversible.'

Evolving policy considerations

Support of the ability of an adolescent to consent to LARCs without parental involvement in the USA is not practically meaningful if adolescents cannot actually exercise that ability. Existing LARC barriers for adolescents in terms of access have been detailed in the

literature.⁷ States with more permissive adolescent contraception laws have been shown to have higher rates of contraception, and specifically, LARC use by adolescents.⁹ Accordingly, we advocate for all states to specifically enumerate and enforce adolescent's ability to consent to insertion and removal of LARCs.

Novel to this discussion is the Trump Administration's removal of the ACA contraception mandate, affording employers increased ability to refuse to offer contraception coverage in their private insurance plans. This policy threatens access to both LARC placement and removal procedures. Adolescents may be disproportionately impacted given their potential inability to pay out-of-pocket for medical procedures.

Ongoing political discussions regarding continuation of funding for Title X clinics such as Planned Parenthood also threaten adolescent access to effective and affordable contraception. Title X facilities should continue to provide the full range of contraceptive options, including LARCs, at free or reduced prices in private and confidential settings, without parental consent requirements.⁷ In fact, LARC use among teens who accessed Title X services increased between 2005 and 2013 from 0.4% to 7.1%.²⁵ Title X facilities must be permitted to continue to provide equitable, comprehensive contraceptive coverage to adolescents without parental consent requirements. Their funding should be supported.

CONCLUSION

The invasive nature of LARCs does not change the precedent that adolescents be afforded the right to access contraception in confidential and private means in the USA. In many instances, LARCs may be in the best interest of adolescent patients. While parental concerns are relevant and oftentimes valued by adolescents, we argue that the invasive nature of LARCs does not supersede the autonomy rights of adolescents with sufficient decision-making capacity. Furthermore, access to timely, affordable and safe removal procedures must be ensured. Current threats to contraception access in the USA, including considerations to decrease funding to Title X clinics, jeopardise the health, well-being and autonomy of adolescents.

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