SPA Spring 2014 PBLD

Title: When there's consent without assent: What should the anesthesiologist do when the adolescent refuses, mom says 'yes' to emergency surgery?

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Goals:

1) Discuss the legal implications of obtaining assent and consent
2) Discuss the options for obtaining consensus when a parent and a patient disagree about proceeding
3) Discuss the resources available during adversarial preoperative situations.

Case Description:
Tony, a 16-year-old boy, presents with a mandibular fracture from a fight at juvenile detention. He is a resident of a group home, but his mother has legal custody.

Questions: What precautions would you take for a patient recently in detention? What special perioperative issues might these patients have? Would you order any additional lab work? (drug screen, infectious disease?)

Case History (continued): Preoperatively, he gets into a physical fight with his mother. He is then placed in handcuffs by security.

Questions: What steps should you take when violence occurs in the preoperative setting? How would you ensure the safety and comfort of other patients? Was it right to place the patient into handcuffs? What if the mother had instigated the fight? What resources would be available if 'hospital security' could not deal with a rapidly escalating situation? How much time would it take for additional resources to arrive?

Case History (continued): Tony, who continues restrained by handcuffs, is refusing surgery, but his mother insists that the mandibular repair proceed.

Questions: Should the handcuffs be removed? Is there anything you could say to the patient to try to gain his assent and cooperation? At what age is assent needed? Is it ethical to proceed without the patient's assent? Does he need to cooperate with jaw immobilization after the surgery for the surgery to be of any value? How should the surgeon be involved in the discussion? What do you think are Tony's reasons for refusing surgery? Have you previously encountered the concept of a 'mature minor' (when a person under age 18 is able to give or refuse consent because he or she has an understanding of the illness or injury and of the consequences of treatment, non-treatment, and alternatives)? Does Tony meet the mature minor standard? Have you encountered other cases in which the patient refuses medical treatment which the parents consent to? Did the patient meet the 'mature minor' standard in those cases? How would you proceed if the roles were reversed, i.e. the mother was refusing the surgery and the patient wanted to go ahead?

Case History (continued): Your resident wants to explain the anesthetic plan to the patient and his mother, but he is unsure of how to induce a combative 'full-sized' patient.

Questions: If you proceeded without assent, how would you induce the patient? What is the most ethical way of doing so?

Case History (continued): The surgical resident says 'this case is an emergency, there is vascular compromise, and we need to go to the operating room immediately'.

Questions: Would the urgency/necessity of the surgery affect your decision to proceed? Would it affect the ethical principles in this case?

Case History (continued): You examine the patient yourself, and you don't see any evidence of vascular compromise. You speak with the attending surgeon, who disagrees with his resident's opinion, and says that the surgery, although beneficial, is not essential, and that the procedure can be delayed. You and the attending surgeon explain to the patient and his mother that you will not proceed, due to the patient's lack of assent. At this point, the mother, who is still insisting that the procedure be done, verbally threatens the attending surgeon.

Questions: What is the best course of action? Would you discharge the patient with his mother? Under what circumstances would you obtain a psychiatric consult (for the mother or patient)? Even if mother and patient finally agree to proceed, would it be useful to delay for a day or two so that the decision can be made in a less charged environment?

Discussion:

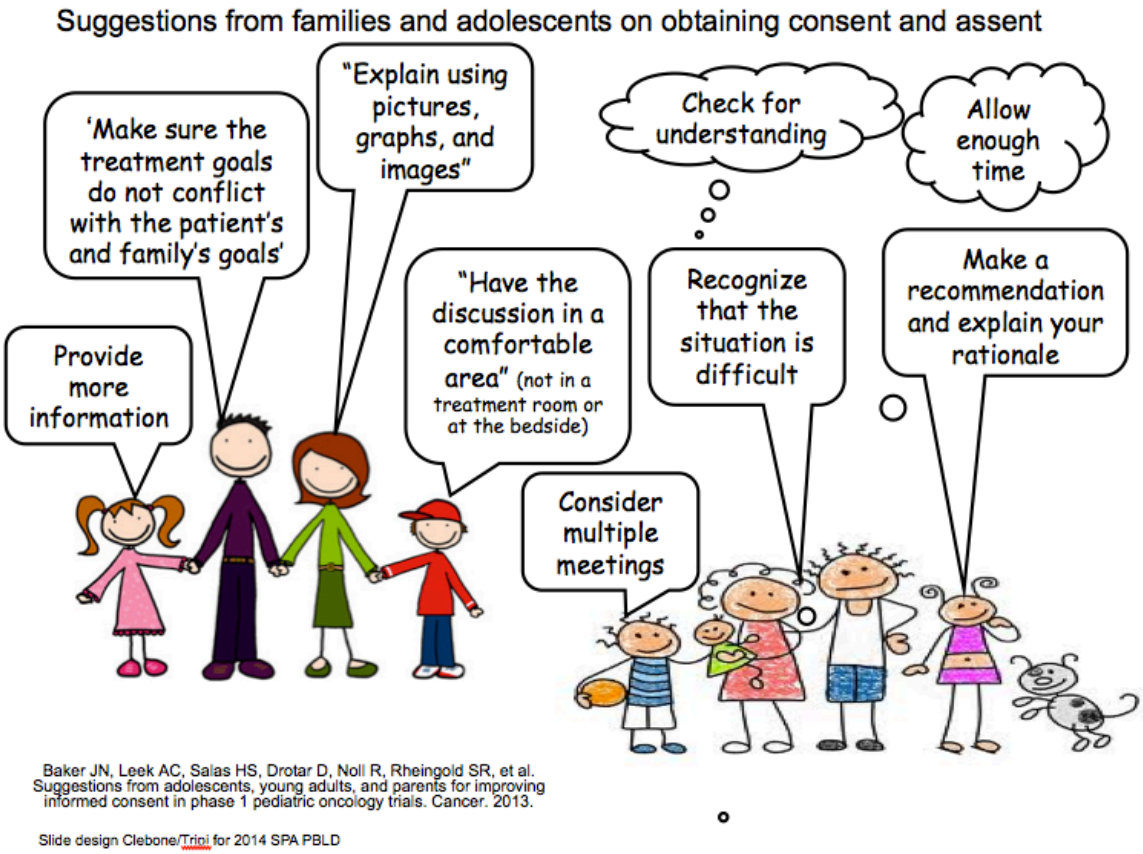
Mature Minor

According to the emerging concept of a 'mature minor' the right to grant or refuse informed consent should be granted to the adolescent or pre-adolescent who is able to understand the risks and benefits of the procedure in question, which emerges around age 14 (1). For example, the Society for Adolescent Health and Medicine supports laws that would allow minors to consent to vaccination without parental presence (2). In the case presented in this PBLD, conflicting needs exist: a beneficial procedure versus the "adolescent's emerging autonomy, values, and personhood" (1). It should be determined whether a particular choice is 'consistent' with the patient's 'wishes and hopes for a particular outcome rather than fear and immaturity' (1). It may be helpful to enlist a psychologist to help the clinician make this assessment. It was also highlighted by Gilmour that the patient is 'the one who will have to live with the consequences, whichever course of treatment is pursued' (1). Children are a vulnerable population, and protecting them must be balanced with honoring their autonomy (1).

How to negotiate

One study looked at improving the consent and assent process for a different situation, phase I cancer trials in 14-21 year olds (3). Providing additional information was the key suggestion made by parents and patients, specifically, about risks, benefits, goals, and options. Details of the plan, such as length of inpatient stay and tests needed, as well as information on how other patients had done was considered helpful (3). Explanations in multiple formats, such as pictures, videos, and graphs were also requested (3). In the case presented here, since an immediate decision was not required, perhaps some of these techniques could be used after the mother and patient had time to 'cool down'.
(See figure 1)

Figure 1:



State By State:

The following state-by-state references are provided from an article by Coleman, et. al., in the journal 'Pediatrics'(4). Some references refer to a law that came into being by statute, and can thus be broadly applied, and some refer to a law that was made by judicial decision (e.g. for a specific case), and thus has narrower applicability (e.g. if the patient in the judicial case in question was 17 years old, the ruling cannot necessarily be applied to a 16 year old) (4). It was Coleman's opinion that many of these statutes were designed not to encourage autonomy of the adolescent, but to limit the liability of health care workers in cases in which a parent was unavailable (4).

Alabama By statute, Alabama provides that minors aged >=14 have consent authority. No separate evaluation of maturity is required to trigger the exception. Al. Stat. Ann. 22-8-4

Alaska By statute, Alaska provides that minors regardless of age are able lawfully to consent to medical treatment when their parent is either unavailable or unwilling to consent. Ak. Stat. Ann. 25.20.025

Arkansas By statute, Arkansas provides that minors who are capable of meeting the informed consent standard have consent authority. No particular age or separate evaluation of maturity is required to trigger the exception. Ar. Stat. Ann. 20-9-602(7)

Delaware By statute, Delaware provides that minors regardless of age are able lawfully to consent to medical treatment where reasonable efforts have been made first to obtain parental consent. De. Stat. Ann. 707(b)(5)

Idaho By statute, Idaho provides that minors who are capable of meeting the informed consent standard have consent authority. No particular age or separate evaluation of maturity is required to trigger the exception. Id. Stat. Ann. 39-4503

Illinois By judicial decision, Illinois provides that a mature minor who is capable of meeting the informed consent standard has consent authority both to accept and to refuse treatment. Case-by-case evaluations of maturity are required as a threshold matter. In cases of conflict, the courts require "clear and convincing evidence" of maturity. However, because of the state's interests in life and relevant third parties, even a mature minor's informed and voluntary decision to refuse treatment against the wishes of her parent(s) may be ignored. In re E.G., 549 N.E.2d 322 (1989)

Kansas By statute, Kansas provides that minors aged >=16 have consent authority but only in circumstances where no parent is immediately available. Kansas Statutes 38-123b. Additionally, Kansas by judicial decision provides that a mature minor who is capable of meeting the informed consent standard has

consent authority. Case-by-case evaluations of maturity are required as a threshold matter. Younts v. St. Francis Hospital and School of Nursing, Inc. 469 P.2d 330 (1970). The decision in Younts has been affirmed on multiple occasions by the state's attorney general. Opinions Nos. 2003-35; 1992-71; 1991-49

Louisiana By statute and opinion of the state's attorney general, Louisiana allows any minor to consent to any treatment she or he believes to be necessary. La. Stat. Ann. 40:1095; 76 Op. Att'y Gen. 454 (Mar. 30, 1976)

Maine By judicial decision, Maine provides that a mature minor's preaccident statements indicating a wish never to be kept in a persistent vegetative state may be determinative of the decision whether to withdraw life support. In re Chad Eric Swan, 569 A.2d 1202 (1990). A subsequent decision emphasized the "exceptional circumstances" to which this very limited exception applies. Connolly v. Board of Social
Work Licensure, 791 A.2d 125 (2002)

Massachusetts By judicial decision, Massachusetts provides that a mature minor who is capable of meeting the informed consent standard has consent authority, but only in circumstances where the minor's
"best interests . . . will be served by not notifying his or her parents of intended medical treatment." Baird v. Attorney General, 360 N.E.2d 288 (1977). Mature minors close to the age of majority who are religiously motivated may also have the right to refuse medical treatment. In re Rena, 705 N.E.2d 1155
(1999)

Montana By statute, Montana provides that minors who have graduated from high school have consent authority. Mont. Stat. Ann. 41-1- 402

Nevada By statute, Nevada provides that minors who are capable of meeting the informed consent standard have consent authority but only in circumstances in which the health care worker believes that she or he is "in danger of suffering a serious health hazard if health care services are not provided." Nev. Stat. Ann. 129.030

Oregon By statute, Oregon provides that minors aged >= 15 have consent authority. Or. Stat. Ann. 109.640. This statute may not apply to protect the right of mature minors to refuse treatment. In re
Connor, 140 P.3d 1167 (2006)

Pennsylvania By statute, Pennsylvania provides that minors aged =>18 and high school graduates have consent authority. 35 Pa. Cons. Stat. Ann. 10101

S. Carolina By statute, South Carolina provides that minors aged >=16 can consent to all medical treatment except "operations." SC Stat. Ann. 65-3-340. A different state statute provides that a licensed
health worker may provide any necessary medical treatment to any child (regardless of age) without consent. SC Stat. Ann. 63-5-530. This provision, which appears to be a version of the
traditional emergency exception, also distinguishes "operations."

Tennessee By judicial decision, Tennessee provides that mature minors who are capable of meeting the informed consent standard have consent authority. Applying tort law's traditional rule of sevens,
the state's courts further presume that minors aged 7 to 13 are not mature and that minors aged 14 to 18 are. Both presumptions are rebuttable. Cardwell v. Bechtol, 724 S.W.2d 739 (1987). The decision in Cardwell was affirmed by the state's attorney general in 2003. Tenn. Op. Att'y Gen. No. 03-087

W. Virginia By judicial decision, West Virginia provides that mature minors who are capable of meeting the informed consent standard have consent authority. Belcher v. Charleston Area Medical Center, 422 S.E.2d 827 (1992). Belcher cites Tennessee's decision in Cardwell, but rejects Cardwell's reliance on the
rule of sevens.

References:

1. Gilmour J, Harrison C, Asadi L, Cohen MH, Vohra S. Treating teens: considerations when adolescents want to use complementary and alternative medicine. Pediatrics. 2011;128 Suppl 4:S161-6.
2. Adolescent consent for vaccination: a position paper of the society for adolescent health and medicine. J Adolesc Health. 2013;53(4):550-3.
3. Baker JN, Leek AC, Salas HS, Drotar D, Noll R, Rheingold SR, et al. Suggestions from adolescents, young adults, and parents for improving informed consent in phase 1 pediatric oncology trials. Cancer. 2013.
4. Coleman DL, Rosoff PM. The legal authority of mature minors to consent to general medical treatment. Pediatrics. 2013;131(4):786-93.