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**Lifespan  
Risk Management**

167 Point Street  
Suite 170  
Providence, RI 02903

tel: (401) 444-8273  
fax: (401) 444-8963

## Consent Issues Regarding Minors

—by Jeffrey Wishik, MD, JD

*“Every human being of adult years and sound mind has a right to determine what shall be done with his own body”*

—Justice Benjamin Cardozo<sup>1</sup>

This widely cited statement by the eminent jurist Cardozo is generally regarded as the cornerstone of the traditional approach to consent in medical practice. Rhode Island and Massachusetts statutes establish eighteen years as the age of consent.<sup>2</sup> At that age, an individual can give consent and is entitled to confidential treatment — even if he or she is living with parents who are paying the bills. Needless to say, the physician may be placed in an uncomfortable position between a parent accustomed to making decisions for a child and the new “adult” who insists that the parent not be involved. This might be avoided by starting to involve the minor in decision-making at a younger age while encouraging parents to allow greater autonomy and privacy. In fact, this is the recommended approach of the American Academy of Pediatrics — obtaining patient assent and parental informed permission for younger children.<sup>3</sup>

The general rule is that parents have the power to consent for minor children. (Other caregivers cannot give consent unless they have parental authorization, preferably in writing.) However, physicians must be wary of parents attempting to force treatment — such as psychiatric hospitalization — on their children for punitive purposes even though Massachusetts law, for example, does give a parent or legal guardian the authority to admit a minor to a mental health facility.<sup>4</sup> Also, additional state and federal laws extend the right to consent to certain minors based either on their legal status or the existence of particular medical conditions. Thus, parents may not hold absolute power when it comes to providing consent.

For example, most clinicians are probably already aware of the exception for medical emergencies. Legally, courts find implied consent in these situations, similar to the rationale allowing treatment of comatose adults. That is, the court presumes that if the parent or guardian had known of the imminent risk to the child’s health, treatment would have been authorized. The emergency must be an existing condition, not merely a potential one, but it need not be life threatening. Certainly, treatment should not be delayed if waiting for consent poses a clear risk to the child’s well being. Furthermore, a Massachusetts statute does protect clinicians who treat minors without consent in emergency situations.<sup>5</sup>

“Mature minors” may also have the right to provide their own consent. Both the definition of maturity and the extent of this right vary from state to state.

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In Rhode Island, married persons and anyone sixteen years or older may consent to “routine emergency medical or surgical care.”<sup>6</sup> The statute does not define the seemingly incongruous phrase “routine emergency.” Presumably, treatment

from or to have come in contact with any disease defined as dangerous to the public health . . . .”<sup>7</sup>

This Massachusetts statute explicitly excludes consent for abortion and sterilization except by married, widowed or divorced minors. It also protects the clinician who relies in good-faith upon a minor’s representation that he is able to consent to treatment under this statute from civil or criminal liability for failing to obtain parental consent. Under Massachusetts Department of Social Services regulations there is a rebuttal

presumption that minors 14 years or older are “mature.”<sup>8</sup>

Emancipation is another exception to the rule of parental consent based upon the minor’s legal status. In some jurisdictions, emancipation occurs automatically through marriage or active military service; in others, a statute specifies requirements. The Massachusetts statute excerpted above contains criteria for emancipation. Rhode Island does not have a statute defining emancipation. Instead, a judge must rule on a minor’s petition for emancipation, making the decision based upon the individual’s circumstances, needs and maturity. Physicians should remember that the mature minor and emancipation exceptions depend on whether legal standards of capacity for consent have been met. It is not the physician’s judgment that is determinative.

Public health and social policy concerns have led to laws in every

state that allow minors to receive treatment without parental consent for specified conditions. Family planning, substance abuse and infectious diseases are the usual areas covered. Thus, in Rhode Island minors may consent to “testing, examination and/or treatment for any reportable communicable disease.”<sup>9</sup> The covered conditions include HIV, sexually transmitted diseases, tuberculosis and a wide range of other infections or infestations.<sup>10</sup> The situation in Massachusetts is less clear. In a statute providing for establishment of clinics for treatment of venereal diseases there is a provision that “physical examination and treatment by a registered physician or surgeon upon the person of a minor who voluntarily appears therefor, shall not constitute an assault or assault and battery upon said person.”<sup>11</sup> This seems to indicate that such minors are capable of giving legal consent for this treatment.

Many states permit minors to receive substance abuse treatment without parental consent or notification. Thus, in Massachusetts, minors “twelve years of age or older . . . found to be drug dependent by two or more physicians” may consent to treatment.<sup>12</sup> If a minor refuses to allow parental contact, Rhode Island law allows noninvasive and noncustodial treatment for substance abuse and chemical dependency. However, during treatment the statute urges the clinician to attempt to obtain the minor’s permission to contact the parents.<sup>13</sup> However, federal statutes and regulations may supercede the state laws. If a treatment program receives any direct or indirect federal assistance its clients —

Interestingly, this law can lead to the unusual situation where fifteen year-old single parents would not be able to provide their own consent for emergencies, but could provide it for their children.

for broken bones, lacerations, infections and the like are covered. On the other hand, organ transplantation probably would not be deemed “routine.” Interestingly, this law can lead to the unusual situation where fifteen year-old single parents would not be able to provide their own consent for emergencies, but could provide it for their children.

Massachusetts has an even broader approach:

“Any minor may give consent to his medical or dental care at the time such care is sought if (i) he is married, widowed, divorced; or (ii) he is the parent of a child, in which case he may also give consent to medical or dental care of the child; or (iii) he is a member of any of the Armed Forces; or (iv) she is pregnant or believes itself to be pregnant; or (v) he is living separate and apart from his parents or legal guardian, and is managing his own financial affairs; or (vi) he reasonably believes himself to be suffering

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including minors — are guaranteed strict confidentiality.<sup>14</sup> Evaluation, treatment and counseling are covered; confidentiality applies from the moment the client applies for or even inquires about the program. The federal law and its implementing regulations do not mention “consent.” However, by requiring strict confidentiality the law implicitly grants the power of consent to the minor.

The federal family planning services grant program, Title X, also covers “unemancipated minors who wish to receive services on a confidential basis,”<sup>15</sup> without regard to age or marital status.<sup>16</sup> Contraceptives may be distributed to minors under Title X without parental consent or notification. Efforts to require parental notification by a federally funded program have been denied by the courts.<sup>17</sup> Note, however, that abortion services are not covered by

**Problems can arise if the parents disagree about a medical course of action. Particularly when dealing with elective treatment the physician should avoid seeking consent from one parent after the other has denied it.**

Title X. Rhode Island requires parental consent for a minor’s abortion unless an appropriate court either finds her to be emancipated or determines that other statutory exceptions to notification are present.<sup>18</sup> Massachusetts Department of Social Services rules grant minors in care or custody the power

to consent for family planning, drug dependency, pregnancy and sexually transmitted disease treatment, but not for abortion.<sup>19</sup>

Divorce raises other problems for the treating physician. Generally, only one parent’s consent is needed for treatment. It is possible for a divorce decree to specify which parent has the power to consent to a minor’s treatment. However, in the typical joint custody arrangement both parents have this power, regardless which parent has physical custody of the child. Problems can arise if the parents disagree about a medical course of action. Particularly when dealing with elective treatment the physician should avoid seeking consent from one parent after the other has denied it. If the dispute cannot be resolved easily, the physician may need to delay non-emergent care until the parents find a solution or bring the matter to court.

If one parent has sole legal custody the other cannot provide consent. Unfortunately, without a copy of the divorce decree or custody agreement the physician can incorrectly assume that the parent purportedly giving consent has that right. Therefore, physicians caring for minors should inquire

about custody and consent. If need be, copies of divorce decrees can be placed in the child’s medical chart. Similarly, a custodial parent should be asked to provide written proxy consent either for the noncustodial parent or other caretakers. This facilitates necessary but non-

emergent treatment of the child when the custodial parent is unavailable. Consent statutes can be quite complex and compliance can sometimes be difficult. By anticipating consent problems the clinician should be able to avoid or minimize these difficulties.

*Portions of this article by Jeffrey Wishik, MD, JD, originally appeared in Medicine & Health/Rhode Island, 1999, vol. 82, no. 11, p. 415.*

## References:

- 1 *Schoendorff v. Society of New York Hospital*, 105 NE 92, 93 (1914).
- 2 *Rhode Island General Laws (R.I.G.L.)* § 15-12-1; *General Laws of Massachusetts (Mass. Gen. L.)* ch. 231, § 85P.
- 3 *Committee on Bioethics, “Informed Consent, Parental Permission, and Assent in Pediatric Practice,”* *Pediatrics*: 95, 314-317 (1995).
- 4 *Mass. Gen. L. ch. 123*, § 10 (a).
- 5 *Mass. Gen. L. ch. 112*, § 12F.
- 6 *R.I.G.L. § 23-4.6-1*.
- 7 *Mass. Gen. L. ch. 112*, § 12F.
- 8 *Mass. Regs. Code tit. 110*, § 2.00.
- 9 *R.I.G.L. § 23-8-1.1*.
- 10 *Department of Health Rules and Regulations Pertaining to the Reporting of Communicable, Environmental and Occupational Diseases (R23-5-6, 10, 11, 23-24.6-CD/ERD) (R23-24.5 ASB) (1996)*. See, *Parts II - VI, disease categories I - V*.
- 11 *Mass. Gen. L. ch. 111*, § 117.
- 12 *Mass. Gen. L. ch. 112*, § 12E.
- 13 *R.I.G.L. § 14-5-4*.
- 14 *United States Code, Title 42, 290dd-2 (1992) and implementing regulations 42 Code of Federal Regulations (C.F.R.) 2.12(e)*.
- 15 *42 C.F.R. 59.2*.
- 16 *42 C.F.R. 59.5(a)(4)*.
- 17 See, e.g., *Planned Parenthood Federation, Inc. v. Heckler*, 712 F.2d 650 (D.C. Cir. 1983).
- 18 *R.I.G.L. § 23-4.7-6*.
- 19 *Mass. Regs. Code tit. 110*, § 11.



# Lessons Learned

*The purpose of this section is to share summaries of closed cases that have occurred in the New England area and represent real life issues that provide proactive risk management educational opportunities. The cases used may come from Lifespan affiliates, or other institutions or practices, but should have some relevance to situations that you may encounter.*

—by John F. Dolan of Rice, Dolan & Kershaw

## Case, Damages, Liability:

The plaintiff brought an action against a hospital alleging assault and battery for performing a peritoneal lavage in the ER without the plaintiff's consent. At trial the Hospital offered to prove that the plaintiff was severely intoxicated while in the ER and because a medical emergency required the performance of the procedure, consent was implied. The trial judge rejected the Hospital's multiple offers of proof and instructed the jury that the defendant Hospital had the burden of proving that the plaintiff was "of unsound mind" in order to perform the lavage without consent.

The plaintiff had consumed considerable liquor in the afternoon and evening and after leaving the drinking establishment was a passenger in his drinking companion's car when it was hit by an oncoming vehicle. The plaintiff was not wearing a seat belt at the time of the accident. Rescue personnel arrived at the accident scene and transported the plaintiff to the Hospital. He was unable to sign the Emergency Room general consent form for treatment. He was admitted to a trauma room where blood was drawn, x-rays were taken, and a catheter was inserted to check for blood in the plaintiff's urine. The blood alcohol level was .233 and the urinalysis revealed blood in the

urine. The plaintiff sustained lacerations over his right eye, on the bridge of his nose and on the right side of his forehead. He also suffered bruised ribs. The plaintiff refused a peritoneal lavage and a security guard was necessary to restrain him. He was strapped to a gurney, administered anesthesia through a syringe and the lavage was performed. (The lavage revealed that the patient did have some bleeding in the abdomen, however, it was not of a sufficiently high level to justify taking him to the operating room and performing a laparotomy). After the lavage, the patient was admitted to the Hospital but left the following morning "Against Medical Advice."

In defense the Hospital offered to prove through an ER physician expert that the high blood alcohol level and the circumstances of the accident triggered a medical emergency and that the mechanism of injury indicated the possibility of internal injuries. Furthermore, the ER expert would testify that when a trauma victim is intoxicated, doctors cannot rely on the usual physical examination and medical history to evaluate the extent of injury. The patient's judgment is impaired to the point that the patient is unable to sense pain accurately, and because an abdominal injury is potentially life threatening, prompt action is required to avert the possibility of a sudden drop in blood pressure and to prevent the patient's lapse into an irretrievable condition.

The Hospital also offered to prove through an expert pharmacologist the effect of a 0.233 blood alcohol level on impairing judgment and reasoning of a person of plaintiff's height and weight.

Finally, the Hospital offered to prove through its ER physician that the Hospital had an established protocol based upon National Standards concerning peritoneal lavage and informed consent. A non-consensual lavage was warranted if two factors are present. First, one must consider if the mechanism of the accident is of a kind that is likely to cause internal injuries such as a car accident or a fall from a height. Second, a lavage is needed if a patient's mental status is impaired by drugs, alcohol or any injury to the head such that the patient cannot sense or report symptoms of internal bleeding.

The trial justice ruled that all of this offered testimony was inadmissible because the Hospital had the burden of proving that the plaintiff was of "unsound mind."

The trial justice instructed the jury over objection by the Hospital in part as follows:

"So, those are the two elements that are necessary for you to look at; the hospital having to show you by a fair preponderance of the evidence that when that procedure was performed, the patient was not of sound mind and there simply was not a reasonable time to get somebody's

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approval. The concept being a person of unsound mind is not capable of giving consent. A person who is of sound mind is not rendered of unsound mind by reason of intoxication. A person who is of sound mind when sober does not become an individual of unsound mind because he is intoxicated. A person's judgment may be impaired by intoxica-

tion. But the impairment of judgment by intoxication does not render a person of unsound mind."

After a jury verdict for the plaintiff, the Hospital appealed to the Rhode Island Supreme Court. The Supreme Court found the trial justice to be in error and that a finding of "unsound mind" is not a prerequisite to determine that a patient lacks the ability

to make decisions regarding medical treatment. The Supreme Court held that the medical capacity to give consent to a surgical procedure is the same as that required to enter into a contract. The test for mental capacity to consent to medical treatment is whether the patient has sufficient mind to reasonably understand the condition, the nature and effect of the proposed treatment and the attendant risks in pursuing the treatment and not pursuing the treatment. The Supreme Court further held that intoxication is a condition that may impair an otherwise competent patient's capacity to consent or to object to medical treatment. Lastly, the Supreme Court held that expert testimony as offered by the Hospital is needed concerning the existence of an emergency and that expert testimony is admissible to inform the jury on the effects of intoxication.

## Risk Management Q&A

**Q** When should I submit an incident report? Sometimes I'm just not sure if what has occurred warrants it.

**A** The quick and easy answer is when in doubt, fill one out. All of the affiliates have specific policies regarding Incident Reporting in the Administrative Manuals. In general, any event that is not consistent with the routine care of the patient should be reported, even if there was no harm to the patient. For example, if a fall is prevented when a patient is eased to the floor, or the wrong medication is almost administered to the patient, you should file an incident report.

Whenever there is significant patient injury, the Risk Management Department should also be notified by telephone/beeper immediately. If equipment is involved, the equipment should be removed from service and sequestered until Risk Management has been consulted.

There are several reasons for prompt reporting of incidents. The Risk Management Department trends and distributes summaries of information so that appropriate improvements can be made in processes and staff education. The information also allows Risk Management to fulfill requirements of prompt reporting to state and federal agencies. Prompt reporting of potential liability events allows the Risk Manager to gather information quickly and assist in mitigating any untoward consequences.

Please remember that the incident report should not be placed in the patient's record and copies should not be distributed to departments other than Risk Management. The event should, however, be objectively documented in the patient's record.

For questions about incident reporting or to schedule an in-service for your staff, please call your affiliate Risk Management Department.

## Risk Management Issues:

The ER physician should not rely solely on the blood alcohol level in making treatment decisions. The physician should document the manifestations of the intoxication particularly those related to mental capacity such as confusion, slurred speech, inability to sign name, combativeness, etc. The physician should also document the reasons for the needed emergency interventions and the results of efforts that have been made to contact a relative for possible consent.

# Lifespan Risk Services

## *Continuing Ed*

### "The Risk of Consultations"

**Monday, October 1, 2001 from noon to 1 pm**

Presenters: Seth Bowerman, Esq., of Bowerman, Taylor & Guertin and Joseph Melino, Claims Adjuster, Lifespan Risk Services

Location: Collis Conference Room, Hasbro Children's Hospital

Today whether requesting a consultation or consulting on a patient, there are inherent risks involved in the consultation process. This program will identify those risks and assist participants in developing practices which will help to avoid the pitfalls associated with consultations.

Pre-registration is required by calling 1-617-636-6579

Lifespan is accredited by the Rhode Island Medical Society to sponsor intrastate continuing medical education for physicians.

Lifespan designates each of these education activities for a maximum of 1 hour in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours or credit that he/she actually spent in the education activity.

*Insights* is published quarterly by Lifespan Risk Management department. Submissions and ideas are welcome and may be submitted to Rosemary Silvia via e-mail: [rsilvia@lifespan.org](mailto:rsilvia@lifespan.org) or fax: (401) 845-1065.

*editorial committee chairperson:* Rosemary Silvia

*committee members:* Paul Adler, Joan Flynn, Virginia Fleming, Kathy Lavalley, Joseph Melino and Roland C. Loranger

*design:* Ellen Watt/IGN

Lifespan  
Risk Management  
167 Point Street  
Suite 170  
Providence, RI 02903



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