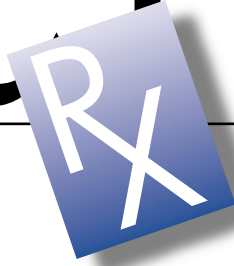




DOCTORS



Volume 11, No. 1

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A Letter from the Chair of the Board

Dear Colleague:

Health care providers who treat patients who are minors find themselves faced with a variety of legal and ethical issues associated with the consent process. While we recognize that laws on this subject are varied, this newsletter will help provide you with a general approach to many of the common consent questions that you face in everyday practice.

The newsletter will also address new guidelines from the Centers for Disease Control on the issue of hand hygiene in general, and the use of alcohol hand rubs in particular, as a further step towards combating infection in the health care setting.

*D. Ted Lewers, M.D.
Chair of the Board*

Medical Mutual Liability Insurance Society of Maryland

A Minor Confusion Can Cause Major Problems

A 15-year-old girl goes to her Family Practitioner's office requesting a pregnancy test, but doesn't want her parents to know. However, she uses Dad's Blue Cross card for payment. Mom calls when she gets the EOB and wants to know why her daughter was in the doctor's office. What do you tell mom? Did the minor have capacity to give consent for the pregnancy test?

Informed consent is a process vital to the physician-patient relationship. It stems from the legal and ethical rights of patients to determine what happens to their bodies and from the ethical duty of physicians to involve patients in their own health care.

The most important goal of informed consent is that the patient be given the opportunity to be an informed participant in health care decision-making. The informed consent process should include a discussion of the following principles:

- The nature of the proposed treatment or procedure
- The risks and benefits of the proposed treatment or procedure
- Reasonable alternatives to the treatment and their accompanying risks and benefits
- The risk of not receiving or undergoing a treatment or procedure

In order for the patient's consent to be valid, he/she must be considered competent to make the decision at hand and the consent must be voluntary. Patient comprehension is just as important as the information that the physician is providing. To help effectuate delivery of this information, the informed consent discussion should be carried out in terms easily understood by a layperson and the patient's understanding checked along the way.

Continued on next page



States have traditionally recognized the right of parents to make health care decisions on behalf of their children on the presumption that someone who has not yet reached the age of majority (age 18 in most states, including those located in our region – MD, VA, DC & DE) lacks the experience and judgment required to make fully informed decisions. However, unlike adults who may make their own treatment decisions regardless of the consequences to themselves, parents do not have the legal right to accept or refuse treatment for their minor children regardless of the consequences to that child. Even if the parents are motivated by sincere personal or religious convictions, the law does not give them the liberty to allow their children to suffer harm for lack of necessary medical treatment.

Another situation where physicians can treat minor patients without parental consent is the medical emergency – when there is no time to obtain parental consent and any delay in treatment would cause harm to the minor child. Most state laws are similar on this issue, but some differ as to the definition of "medical emergency". Maryland law provides the following:

A health care provider may treat a patient who is incapable of making an informed decision, without consent, if:

- 1) The treatment is of an emergency medical nature;
- 2) A person who is authorized to give the consent is not available immediately; and
- 3) The attending physician determines that:
 - (i) There is a substantial risk of death or immediate and serious harm to the patient; and
 - (ii) With a reasonable degree of medical certainty, the life or health of the patient would be affected adversely by delaying treatment to obtain consent.

In Virginia, an emergency situation is defined as "a delay that may adversely affect a minor's recovery" and health care providers are granted immunity from liability for failing to obtain consent to such medical or surgical treatment when no parent or authorized person is available.

However, a minor who is age fourteen or older (and physically able to consent) must consent to the emergency medical or surgical treatment. When a parent cannot be located, a judge in the juvenile and domestic relations court is given authority to consent to medical and surgical treatment.

We believe that the New York case of *Jackovach v Yocom* 237 N.W.444 (1931) is consistent with current Maryland and Virginia law regarding minors and emergencies and illustrates a situation in which a clear emergency for a minor abolishes the need for parental informed consent. In the Jackovach case, a 17-year-old boy was severely injured when he jumped from a moving train. The boy suffered a crushed elbow joint and a 2-to-3 inch scalp laceration from which he was bleeding profusely. While the boy was under anesthesia for closure of the scalp wound, the physicians determined that the boy's arm needed to be amputated because of the immediate danger it posed to his life. After the arm was amputated, the boy and his parents filed suit against the physicians based on the theory that the procedure was performed without their informed consent. In holding for the defendant physicians, the court noted that the physicians were faced with the decision of bringing the patient out from under anesthesia only to obtain consent from the patient and his parents for the amputation. Returning the patient to consciousness for this time would have subjected him to greater risk of shock because of a necessary second anesthesia induction. The court held that in the face of this life-threatening emergency, the physicians acted appropriately.

Along similar lines, states generally allow a qualified immunity for physicians who treat children in the school setting during regular school hours for emergency treatment.

Other exceptions to the rule of parental authority exist when a minor is "emancipated". Again, most states agree on the concept, but may differ as to the definition of what qualifies as emancipation. While there are descriptions of the various rights of the emancipated minor in Maryland law, there is no specific definition of "emancipated" per se. What it does say is that a minor has the same capacity as an adult to consent to medical treatment if the minor:

Doctors RX

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Risk Management Questions	ext. 224
Main Fax	410-785-2631
Claims Department Fax	410-785-1670
Web Site	www.weinsuredocs.com



- 1) Is married; or
- 2) Is the parent of a child

A minor in Virginia who has reached the age of sixteen may be emancipated through formal legal proceedings where a court finds:

- 1) The minor has entered into a valid marriage, whether or not the marriage has been terminated by dissolution; or
- 2) The minor is on active duty with any of the armed forces of the United States of America; or
- 3) The minor willingly lives separate and apart from the parents or guardian, with the consent or acquiescence of the parents or guardian, and that the minor is or is capable of supporting himself and competently managing his own financial affairs.

The emancipated minor is treated as an adult under Virginia law, and can consent to medical, dental or psychiatric care without the input of his parents or guardian.

Parental authority also gradually diminishes as the child's capacity to make responsible decisions increases. The courts in some states have adopted what is known as the mature minor rule that allows an otherwise un-emancipated minor to consent to treatment if they are mature enough to understand the full significance of the proposed treatment without consulting the minor's parents or obtaining their permission. This can also come into play when a parent wants a particular treatment/procedure and the minor refuses. This remains a gray area in medicine and physicians will need to use their judgment based on the maturity level of the minor and the medical situation you are presented with.

Most states have established laws allowing minors to consent to health care related to sexual activity, substance abuse and mental health care. Both Maryland and Virginia have similar statutes with the exception of the following: A pregnant minor in Virginia can give consent for herself and her child to medical care related to the delivery of her child and for the duration of the related hospitalization. After delivery however, the minor mother has the authority to give consent for medical care for her child, but not for herself.

These types of changes were brought on in part by Supreme Court rulings extending the constitutional right to privacy to a minor's decision to obtain contraceptives or to have an abortion. They also reflect the fear of policymakers that many minors would not seek medical services they might otherwise need if they have to seek parental consent.

Problems may arise when a minor's parents are divorced and custody issues come into play. If parents share joint custody of the minor child, they both have the right to make health care decisions for the child. In a joint custody situation, either parent can make health care decisions alone unless there is a court order stipulating that both parents are required to give consent for any treatment. If that is the case and the parents cannot come to a joint decision as to treatment, the courts may have to get involved to make the decision for them. If one parent has sole legal custody, that parent alone has the right to make health care decisions for their child. Court orders detailing these arrangements should be included in the child's chart so that there is no confusion regarding who may give consent.

In response to whether or not a non-custodial parent may have access to their child's medical, dental and educational records, Maryland law holds that, unless otherwise ordered by a court, access may not be denied to a parent because the parent does not have physical custody of the child. Once again, if there is any doubt, look to any court orders for guidance and for any limitations on access. In Virginia, any parents, regardless of whether he or she has custody of a child, is entitled to inspect academic and medical records of a minor child. A court may limit this access for good cause shown. However, a custodial parent may not prohibit an estranged parent from reviewing the medical records of their child.

Persons who have been appointed as legal guardians have the same authority to consent to medical treatment for a minor as the parent. Stepparents do not unless they have legally adopted the child or have been designated as a legal guardian for the child. When a child lives in an institutional setting or in foster care, the natural parents may or may not have the legal right to consent to medical care for their child. Again, the emergency exception would apply here as in other situations.

Many offices have parents or legal guardians sign a statement indicating who may consent for them in the event that they are not available to provide consent for treatment. Additionally, it would be prudent to have the parent or legal guardian sign a consent form at the first treatment in a series of treatments so that the minor patient can continue to be treated even if they come to the office unaccompanied by the parent or guardian. If, however, the treatment plan should change, a new consent should be obtained from the parents or guardian.

The answer to the opening hypothetical? In both Maryland and Virginia, a minor patient has the capacity to consent to the pregnancy test. As for disclosure of information to the minor's parents, a Maryland physician may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information about an abortion. So...it's a physician judgment-call.

Virginia law is less clear. Whether a parent has a right to this information where a minor has sought the treatment without the parent's knowledge yet the minor wishes for the parent to pay the professional fee remains unanswered. The physician should discuss this with the minor before any treatment is rendered.

Conclusion

It is important, particularly when treating a minor patient, for physicians to be aware of the many legal issues involved so that they can give appropriate treatment without the additional risk of legal liability. For additional information, please see the American Academy of Pediatrics Policy Statement on Informed Consent, Parental Permission, and Assent in Pediatric Practice (RE 9510) which can be accessed at: www.aap.org/policy/0062.html. Additional guidance can be found from the AMA's policy E-5.055 "Confidential Care for Minors". For answers to specific questions you might have regarding minor consent, call the Risk Management Services Department at 800-492-0193.



CME Test Questions

Instructions for CME Participation

CME Accreditation Statement — MEDICAL MUTUAL Liability Insurance Society, which is affiliated with Professionals Advocate, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. MEDICAL MUTUAL designates this educational activity for a maximum of one hour in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Instructions—to receive credit, please follow these instructions:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading to the address or fax number provided below:
Med•Lantic Management Services, Inc.
225 International Circle
P.O. Box 8016
Hunt Valley, Maryland 21030
Attention: Risk Management Services Dept.
3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the Doctors RX. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: June 27, 2003
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you. Please allow three weeks to receive your certificate.

1. No minor need be involved in the informed consent process.
A. True B. False
2. State laws broadening the authority of a minor to consent are based in part on the fear that minors would not seek advice/treatment for certain services if parents would be notified.
A. True B. False
3. Stepparents have the authority to consent to treatment for their stepchildren.
A. True B. False
4. Physicians may not notify a minor's parents regarding treatment for substance abuse.
A. True B. False
5. A non-custodial parent may make health care decisions for their child.
A. True B. False
6. Denying medical care to a child is not within a parent's right of freedom of religion.
A. True B. False
7. The CDC's new guidelines on hand hygiene eliminates the need for soap and water.
A. True B. False
8. The use of proper hand hygiene does not obviate the need for gloves.
A. True B. False
9. The most important goal of informed consent is to get consent forms signed.
A. True B. False
10. Courts generally take the side of the parent when they refuse medical treatment for their child.
A. True B. False



CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent three times each year to the insured physicians of MEDICAL MUTUAL/Professionals Advocate. Its mission and educational purpose is to identify current health care related risk management issues and provide physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:

- 1) gain information on topics of particular importance to them as physicians,
- 2) assess the newsletter's value to them as practicing physicians, and
- 3) assess how this information may influence their own practices.

CME Objectives for Minor Consent/CDC Guidelines

Educational Objective: To provide an overview of the legal issues surrounding the area of minor consent and to address questions that arise in the practice setting.

To provide information on the latest CDC guidelines concerning hand hygiene.

Strongly Agree					Strongly Disagree
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Part I. Educational Value:

5 4 3 2 1

I learned something new that was important.

I verified some important information.

I plan to seek more information on this topic.

This information is likely to have an impact on my practice.

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____



Centers for Disease Control — On Hand Hygiene

The CDC has released guidelines to improve adherence to hand hygiene in health care settings. In addition to traditional hand washing with soap and water, the CDC is recommending the use of alcohol-based hand rubs by health care personnel for patient care because they address some of the obstacles that health care professionals face when taking care of patients.

Alcohol-based hand rubs significantly reduce the number of microorganisms on skin, are fast acting and cause less skin irritation. They also take less time to use than traditional hand washing. In an eight-hour shift, an estimated one hour of an ICU nurse's time will be saved by using an alcohol-based hand rub.

Hand washing with soap and water remains a sensible strategy for hand hygiene in non-health care settings and is recommended by the CDC and other experts.

When health care personnel's hands are visibly soiled, they should continue to wash with soap and water.

The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 – 80 percent, prevent cross-contamination and protect patients and health care personnel from infection. Hand rubs should be used before and after each patient just as gloves should be changed before and after each patient.

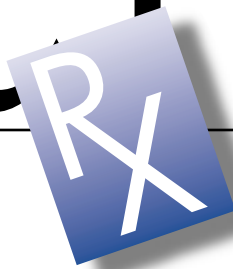
Whether you hand wash or use alcohol-based hand rubs, improved adherence to hand hygiene has been shown to terminate outbreaks in health care facilities, reduce transmission of anti-microbial resistant organisms, and reduce overall infection rates.

For more information on this and other CDC guidelines, visit www.cdc.gov



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