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ETHICS CASES
Can a Minor Refuse Assent for Emergency Care?
Commentary by Philip J. Rettig, MD

Dr. McKinney is working in the emergency department when an ambulance arrives with a frantic 12-year-old-girl, Micah, and her 8-year-old sister, Gracie. The paramedic quickly reports that the girls were home alone when Gracie found Micah sitting on the bathroom floor screaming and "covered in blood." No one has yet been able to contact the girls' parents. Micah is so frantic that she is unable to give Dr. McKinney any medical history.

After a rapid assessment, it is clear to Dr. McKinney that Micah is having profuse vaginal bleeding. However, he does not yet know the reason for the bleeding, and no one knows if the young girl was assaulted or suffered some injury. Alternatively, she could have a bleeding disorder of some sort. He knows that, in either case, a severe laceration or other injury could result in life-threatening bleeding, and decides that a vaginal exam is critically necessary for Micah's care. Recognizing that the Emergency Medical Treatment and Active Labor Act (EMTALA) protects his right to treat Micah without parental consent because of her life-threatening problem, he begins to try to examine her. She screams, "Don't you look down there, I don't want that! Stop it!" as she kicks and yells.

Dr. McKinney normally likes to seek the assent of young patients prior to any invasive exam, and Micah has clearly refused to provide her assent. However, he retains legal authority to perform this important exam, and begins to question the best way to proceed, as the exam will be impossible to perform on an uncooperative 12-year-old.

Commentary
Dr. McKinney is following several decades of best practices in caring for older children and adolescents in his "seek[ing] the assent of young patients prior to any invasive exam."

Since the American Academy of Pediatrics Committee on Bioethics' publication in 1995 of its policy statement "Informed Consent, Parental Permission, and Assent in Pediatric Practice" [1], there has been increasing recognition that minor children have the right to exercise a limited autonomy by being involved in and agreeing to decisions about the medical care they may receive. Advances in developmental psychology and appreciation for human rights for children have coalesced to support the current paradigm that children and adolescents clearly have the right to provide assent and, in some cases, independent full consent to medical care for themselves

years before the achievement of legal majority. Studies of cognitive development and of processes of hypothetical medical decision making have shown that youth from ages 14 or 15 differ little from young adults in their early 20s in how they make treatment decisions [2, 3].

Informed consent has three major elements: a medical decision should be made knowingly (i.e., "informed"), reasonably (.i.e., "competently") and voluntarily (i.e., "free of coercion") [3, 4]. Current practice allows such decision making by "mature minors," even though only three states recognize the "mature minor doctrine" formally by statute. Additionally, certain classes of minors may consent if they qualify as "emancipated" by virtue of being in the armed forces, being married, being themselves parents, or living apart and independent of parental financial and social support. Finally, minors may consent to services in certain categories of medical conditions, including care for sexually transmitted diseases, pregnancy and related conditions, and substance abuse or mental health problems. The minimum age for such categorical consent varies considerably among the states. The right to consent by mature minors applies not only to routine care or minor procedures, but most importantly to vital decisions about end-of-life care, resuscitation status, and institution of palliative care [5].

A rough rule of "7s" has evolved as a guide to whether assent or informed consent should be sought from minor patients both in clinical research and in routine medical care. Children and youth from 7 to 14 years of age should be asked to assent to care and receive basic information about the proposed care, its risks, and potential benefits. For youth ages 15 to 18 years, the process should be very similar to seeking informed consent from young adults of legal age [1], even if ultimate legal decision-making rights are reserved to parent or legal guardian.

Assent for care from older children and younger teens should include developmentally appropriate explanation of the patient's condition, facts about the proposed testing or treatments, clinical insight into the patient's understanding of and willingness to receive the proposed care, and expression of agreement or refusal of the proposed care. Assent to care should always include the option of refusal.

In this case, Micah has forcefully and unequivocally refused a genital exam which might optimize evaluation of her profuse vaginal bleeding. While she has the right to refuse assent for her care, her awareness of the possible severity of her bleeding, of the need for prompt evaluation, and then for appropriate treatment is clouded by her fear, embarrassment, uncertainty, and the worry that she'll get in trouble if she lets the doctor perform the exam.

Micah's almost hysterical response to Dr. McKinney's attempt to proceed with appropriate evaluation cannot be considered an "informed" or "competent" refusal. To try to proceed with an exam meant in part to rule out any genital trauma as the cause of her bleeding would necessitate an equally traumatic, at least psychologically, second assault and potentially do her great emotional harm.

Given that Micah has exercised her autonomy in refusing to agree to this exam, what can Dr. McKinney do to fulfill the principles of beneficence and nonmaleficence in a timely manner? Beneficence demands that he stabilize his patient hemodynamically, identify the cause of the bleeding, and institute optimal medical or surgical therapy. Nonmaleficence requires that he not traumatize Micah physically or psychologically in his attempts to treat her and that he not fail to act appropriately to diagnose and to treat her bleeding.

It is legal in every state to provide emergency medical care to a minor without parental consent. Minors may consent to emergency care if they have the capacity to do so. However, assent for emergency care is no more required than is parental permission. Under federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates initial evaluation (a medical screening exam) and treatment for all patients presenting to an emergency department with an emergency medical condition. Neither parental nor patient consent or assent is needed for such care. Provision of appropriate care is mandated "up to and including surgical intervention or transfer…if needed" [6].

Legally and ethically, Dr. McKinney should render that evaluation and care which he deems most appropriate. But how exactly should he go about it?

If possible, a rapid and separate evaluation of Micah's presenting problem and clinical status from a second ED physician should be sought immediately; this will help assure the appropriateness of what might otherwise be considered an invasive exam. With a consensus that, with this inadequate history, vaginal trauma, accidental or intentional, might be the cause of the profuse bleeding, plans should be made for an emergent exam under anesthesia.

If the cause of bleeding is a vaginal laceration or uncontrolled uterine hemorrhage, either surgical repair or vaginal packing may be necessary. These can be done only under anesthesia, so the appropriate procedure is to do the exam under anesthesia. The minimal risk of general anesthesia is far outweighed by the potential benefit that a comprehensive and timely vaginal exam will provide in optimizing Micah's care. Micah should be told that she needs to go to the operating room and be put to sleep so the bleeding source can be found and then treated. Her assent to this approach should be sought. If she does not assent, then sedating her and appropriately anesthetizing her without her assent would be appropriate both legally and ethically.

Afterword

Several additional comments should be made about this case in addition to offering a possible approach to the clinical dilemma it describes.

Although new-onset profuse vaginal bleeding in a 12-year-old girl may be due either to accidental trauma, such as a straddle injury, or a sexual assault, the most common cause is an unusually heavy initial menses. When this bleeding is abnormal in

volume or duration, it is often evidence of a congenital bleeding disorder.

If Micah's condition is in fact caused by a bleeding disorder, ideally, she should have been educated by her parents that she needs to inform any doctor that she "bleeds easily" or "doesn't clot right." Alternatively, she might have a medical alert bracelet or necklace stating her diagnosis. Future improved electronic health records which contain summary problem lists and medication lists and which are more widely accessible might allow all regional EDs access to vital information in such a case.

Finally, one would hope that any 12-year-old girl would have been prepared for her first menses and told what to expect and what to tell a doctor or nurse if she started bleeding heavily, especially if she also has a known bleeding disorder.

References

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