

# Adolescents, Informed Consent and Confidentiality:

## A Case Study

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### Abstract

Issues related to informed consent and confidentiality often arise in the emergency care setting. When the patient is an adolescent further complexities are introduced, especially when the desires of the adolescent are different from those of the parent. Understanding when an adolescent can give informed consent and what the limits of confidentiality are will assist medical personnel in providing the most appropriate care. These concepts are elucidated with a specific case.

**Key Words:** Informed consent, confidentiality, emergencies, adolescents.

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IN MID-SUMMER, a 14-year-old youth was brought to the pediatric emergency department by his mother, for evaluation for altered mental status. The mother returned from work to find her son acting strangely. She had last seen him the previous evening and there were no problems or complaints at that time. Earlier in the week the child had sustained several mosquito bites. The child was now at times lethargic and at other times agitated. There were two episodes of vomiting. There was no history of fever, trauma, medications or known ingestions. The medical history was negative. The social history was significant for a high-achieving honor student who came from a very financially successful household. Physical examination revealed a drowsy and disoriented athletic male. The vital signs were temperature of 37.8° Celsius, heart rate of 107 beats per minute, respiratory rate of 20 per minute and blood pressure of 123/87 mm Hg. The general physical examination was unremarkable. The neurologic examination revealed a disoriented teenager with ataxia, brisk reflexes throughout, re-

active pupils and intact cranial nerves II through XII. A bedside glucose test and pulse oximetry were both normal. Given the ongoing epidemic of West Nile virus at the time of presentation, the mother was convinced that the child had contracted the insect-borne disease because of the combination of mosquito bites and altered mental status. The mother was absolutely insistent that a spinal tap (lumbar puncture) be performed immediately, to evaluate for the possibility of West Nile virus.

The patient's pediatrician was also concerned and requested a full and thorough evaluation. An intravenous line was started and routine blood evaluations were ordered. The patient seemed at times to be more lucid, but at other times was again disoriented. When interviewed alone, he denied having West Nile virus, but he agreed to tell the physician why he believed this to be the case, but only if his parents were not told. The physician explained that all information given by the patient would be kept in strict confidence. Because of the assurance of confidentiality, the patient disclosed that he had bought a large amount of dextromethorphan on the Internet and had taken it with his friends after school.

Dextromethorphan ingestion, even in large quantities, generally does not require anything but supportive care. The mother, not knowing about the ingestion of this drug, continued to be insistent that further tests be performed, including a spinal tap.

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The case brings up a number of issues for consideration by the clinician treating the patient. There is the practical question of what to do with the patient and what if anything to tell the mother. In order for the physician to determine the most appropriate course, thoughtful consideration should be given to a number of questions:

1. Can this fourteen-year-old give informed consent for his own treatment or lack thereof?
2. Is the patient either a mature minor or an emancipated minor?
3. Is it important for the clinician to tell the truth, and if so to whom? The patient? The mother? The patient's pediatrician?
4. Is the information given by the patient to be held in strict confidence?
5. Finally, given the conflicting duties, should the physician:
  - a. act in the best interests of the patient?
  - b. respect patient autonomy?
  - c. tell the truth?
  - d. keep patient confidentiality?

Each of these questions will be dealt with individually. In the following discussion, arguments are drawn from both ethics and the law. While similar and interrelated, these two disciplines may lead the physician in divergent directions in specific situations (1).

#### **Can This Fourteen-Year-Old Give Informed Consent for His Own Treatment or Lack Thereof?**

While informed consent is a generally accepted doctrine in the treatment of patients in most situations, it is not always possible to adequately explain and discuss the full range of possibilities in an emergency setting. Unconscious patients, those who are severely intoxicated, and those with conditions that are immediately life-threatening are examples of patients for whom proper informed consent is not possible. In the treatment of minors, emergency care is not typically withheld if there is no guardian or parent present to give consent for treatment (2). The definition of "emergency care" may include not only life-threatening illnesses, but also the treatment of pain and interventions that have the potential to prevent disability (3). A minor (defined as less than eighteen years of age in most states) cannot give consent, informed or otherwise, in most medical situations (some of the exceptions are detailed below). However, parental consent is not typically necessary either, at least in the initial evaluation and stabilization of a minor. The Committee on Bioethics of the American Academy of Pediatrics has gone on record as saying that "the

doctrine of 'informed' consent has only very limited direct application in pediatrics" (4).

Federal regulations, generally cited as Consolidated Omnibus Budget Reconciliation Act / Emergency Medical Treatment and Active Labor Act (COBRA/EMTALA) regulations, specify that a medical screening examination be performed, including any necessary stabilization, for all patients presenting for emergency care. And this must be done regardless of all other factors, including the age of the patient and ability to pay for the medical care provided (5). The medical screening examination was performed for the patient under discussion in accordance with these guidelines.

#### **Is the Patient Either a Mature Minor or an Emancipated Minor?**

Exceptions to informed consent can be classified under three headings:

1. The treatment of certain specific conditions. Many states allow minors to seek medical care for the treatment of certain conditions, including sexually transmitted disease, pregnancy or drug/alcohol abuse (4, 6).
2. The treatment of "mature minors." Under certain situations, minors can be considered mature and able to consent for treatment without the involvement of a parent or guardian. A few states allow minors, generally at least 14 years of age, who are thought to have adequate maturity and reasoning capability, to consent for their own health in general (3, 5). This consent would generally be adequate for conditions the treatments of which, by their nature, have small degrees of risk (7). And the adolescent must be able to understand the risks and benefits of the various treatment possibilities (8).
3. The treatment of "emancipated minors." These are adolescents who do not live at home and are self-supporting, are married, are pregnant or have a child of their own, are enlisted in the military, or have been declared emancipated by the court (4).

The patient presented in this case would not fulfill the criteria of any of the above exceptions to informed consent. But if he had come in seeking help for his drug problem, he could have received care without the involvement or consent of a parent.

#### **Is It Important for the Clinician to Tell the Truth, and If So to Whom? The Patient? The Mother? The Patient's Pediatrician?**

Although today most physicians would regard telling the truth to patients as important, this has

not always been the case (9). It was not uncommon in the past for physicians to withhold relevant information about a patient's prognosis, especially if that prognosis was poor. Certain cultures may value and expect the truth from their physicians more than others (10). Historically, paternalism has at times been more important than truth telling and respect for patient autonomy. Presently, telling the truth and involving patients (including children) in their own health care are often considered important principles (11).

In the current case, the physician cannot tell the truth to both the child and the parent. The promise of confidentiality that the provider gave the teenager comes into conflict with the necessity of giving the patient appropriate medical care. The physician must decide which is more important, keeping the promise of confidentiality to the patient, or providing proper medical care to the patient, which would necessarily entail breaking that promise and telling the mother the truth.

#### **Is the Information Given by the Patient to Be Held in Strict Confidence?**

As stated earlier, adolescents seeking treatment for certain conditions, such as sexually transmitted disease, pregnancy or drug/alcohol abuse, can do so without involving the parent or guardian. Physician-patient communications in those settings would be confidential. Thus, if the parent of a teenager with lower abdominal pain secondary to a sexually transmitted infection asks the physician what is wrong with their child, the physician would be bound by confidentiality and could not inform the parent of the patient's condition without the consent of the patient. It is often prudent in those types of situations to strongly encourage the adolescent to involve the parent or guardian, in order to enlist their emotional and other types of support. It has been suggested that if physicians assure confidentiality to adolescents, the adolescents will be more likely to discuss sensitive topics more openly (12). This seems to be true in the case presented.

The American Medical Association agrees with the importance of confidential health care to the well-being of adolescents. They go so far as to say, "When in the opinion of the physician, parental involvement would not be beneficial, parental consent should not be a barrier to care.... The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician" (13).

If the adolescent is not offered confidential care, there is fear that he or she will be less likely

to seek health care in the future when the need arises, with potentially harmful consequences (14).

In the case presented, the physician has promised confidentiality. The only way to maintain this confidentiality would be to have the patient undergo a spinal tap. The immediate risks and discomfort of doing this unnecessary procedure need to be weighed against the potential for future avoidance of medical care. Given those choices, it is likely that the physician will have to break the promise of confidentiality to the adolescent.

#### **Finally, Given the Conflicting Duties, What Should the Physician Do: Act in the Best Interests of the Patient? Respect Patient Autonomy? Tell the Truth? Keep Patient Confidentiality?**

Given the conflicting duties facing the physician, a decision had to be made as to the relative importance of confidentiality versus proper medical care. Weddle has suggested that the necessity of confidentiality between the physician and the patient is age dependent. For adults, respect for autonomy necessitates confidentiality in the doctor-patient relationship. For young children, the well-being of the child is assumed to be primarily the concern of the parent, so confidentiality between the child patient and the physician may not be essential to ensure optimal patient care. Adolescents, in this view, fall somewhere in between, and decisions on confidentiality need to be made on a case-by-case basis (6).

#### **Postscript**

The physician in this case chose to break confidentiality and tell the parent of the ingestion of dextromethorphan. Informing the parent of the adolescent's drug use may lead to potential intervention in the patient's burgeoning substance abuse problem. Initially, the patient was extremely angry and upset. Eventually, by the time of discharge, the patient admitted that taking the dextromethorphan (and using the parent's credit card to pay for it) had broken the trust that his parents had in him.

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