Legal and Ethical Considerations on Consent for Minors

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Legal/Ethical Foundations for Professional Nursing

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About the Author:
Christina Fogleman is a native of Olathe, Kansas. While at the KU School of Nursing she received a Clinical Excellence Award for her work in her Medical Surgical clinical courses and Honorable Mention for Clinical Excellence in the Foundations clinical course. She has accepted an invitation to join Delta Chapter – Sigma Theta Tau International, Nursing's' Honor Society. She will graduate with distinction in the top 10% of her class. After graduation she plans to begin her career on the Neuroscience Progressive Care Unit at The University of Kansas Hospital. Her long range plans include returning to school to pursue a masters or doctoral degree in nursing. She is also looking forward to using her nursing knowledge and ability to make a positive impact in the lives of her patients, co-workers, friends, and family. She wishes to acknowledge her faith in God for "giving me the talents I have", along with her family and friends for "the support they continuously provide to me in order to succeed in my current endeavors".

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Introduction

People considered of minor age are a vulnerable group. Minors are viewed by society as having little autonomy and are largely controlled by the wishes of their parents or legal guardians. This lack of autonomy is due to society's view that adolescents have a limited knowledge and experience base. Many times this deems them unfit to participate in self-determination. When minors enter the health care arena a problem is presented about who is best suited to determine which procedures and treatments the minor receives.

Healthcare providers must obtain consent before performing any procedure or providing treatment to an individual. The defining lines of consent begin to gray when a child shows competency and understanding of a treatment or procedure and has different wishes than their guardians. This raises many legal and ethical dilemmas for healthcare providers who must determine which decision to uphold. This paper will examine the definition of a minor and the legal and ethical challenges associated with who has permission to give consent for a child of minor age.

Review of Literature

Legal challenges

In the United States, individual states hold the power to determine the age at which a child is no longer a minor. For the majority of states, this age is eighteen years old, stating that anyone younger than eighteen must have parental or guardian consent before any type of medical therapy is performed. Exceptions to this law apply when there is an emergency and no guardian is present, the child has been emancipated or fits within the mature minor criteria, there is a court order to initiate or proceed with therapy, or the law recognizes the minor as having the ability to

consent to therapy. Further exceptions include situations where minors would be more willing to seek medical care and assistance if parents or guardians were not involved. These situations include the diagnosis and treatment of certain infectious diseases, drug addiction, obtaining contraception, and treatment during a pregnancy (Guido, 2006).

The exception criterion of a mature minor is a stumbling block for many parents, practitioners, and children. A mature minor is defined as an older adolescent who can demonstrate maturity and decision making skills to the healthcare provider through conversations pertaining to the anticipated treatment options. This is different than the definition of a legal minor which is anyone under the legal age of eighteen. Once it is determined that an adolescent is a mature minor, a practitioner may treat the minor without parental consent on procedures which fall within mainstream medical treatment and have minimal risk. This exception is based on common law and is used to defend practitioners in non-negligent cases (Berlan & Bravender, 2009). This exception allows increased autonomy for children before the age of eighteen that prove themselves able to fully comprehend the risks and benefits of a treatment or procedure. The added autonomy will help an adolescent voice their wishes and concerns, and become more in control of their treatment. When one refuses treatment and healthcare providers go against that person's wishes, the right to autonomy is disrespected and true paternalism is displayed. This puts the nurse in a legal and ethical dilemma because it is the nurse's responsibility to advocate for the patient and assess whose rights they are trying to uphold (Vasey, 2008). A parent's role is not negated with a mature minor, but rather there is a greater need

Ethical Challenges

In the treatment of a minor patient, the family becomes the patient. At times, this family system forgets to include the minor child who is the subject of the treatment. It is the nurse's moral and ethical obligation to respect and advocate for the child so the child is included in the communication and decision making process. Minors in the United States are raised to abide by their parents' and authority figures' decisions. When decisions are being made regarding treatment, minors might agree only because they fear what might happen if they were to oppose their parents' decisions (Allen & Marshall, 2008).

Allowing children to have a voice in their own care allows them to feel in control of their situation and has many therapeutic benefits for the child. The child that is able to express their wants and needs, will feel more like a person with rights and less anxious about their current situation (Batson, 2008). Obtaining consent from the child and parent has both clinical and legal implications. From a clinical perspective, a procedure will be more accepted if there is cooperation from the patient. From a legal perspective, it becomes a defense against crime and tort of trespass (Griffith, 2008). For healthcare providers a controversy arises when parents intentionally fail to disclose information to their children about treatment. In some pediatric HIV and AIDS cases, parents intentionally keep troubling information from their child about how the disease was transferred or the process it will take. This allows for a great disruption in the flow of care for the child by remaining silent when children benefit from open discussions about their illness and treatment options (Allen & Marshall, 2008). Parent's that feel disclosure is not the best option, may need to have additional support and counseling from nurses or other health care providers to understand the profound benefits that communication has in the treatment process.

Adolescents are at the age of curiosity and defiance. A teenager needs to feel safe when disclosing risk taking behavior and mental health needs with health care providers. By providing

a place where confidentiality is upheld, adolescents will be more apt to share important information (Berlan & Bravender, 2009). In order to obtain confidentiality with a minor, there are situations outlined where parental or guardian consent is not necessary. Many adolescents that are sexually active seek reproductive services that provide birth control, condoms, and other contraceptive items. Numerous teenagers have reported that they would stop using contraception and seeking medical advice if their parents were notified. Although parents do not like to have information withheld when medical professionals are working with their children, many parents view confidential time between healthcare provider and minor as necessary to obtain the best care. For those that are initially opposed to confidentiality, it has been shown that their opinions can be changed if written material and education is provided to explain the importance of confidential time (Berlan & Bravender, 2009).

New advances in technology are opening up a realm of possibilities for confidentiality. A new program to allow patients easier access to their medical records is the patient-controlled health record. This medical record is a comprehensive record of all health care interactions over a life time. While the patient-controlled health record is controlled by parents for very young children, it has different privacy options for the various developmental periods of a child's life. Each data field of the record is controlled by access codes to determine if the minor, parent, or both can view the content. Even with these technological advances, adolescents continue to voice fears over how their confidential information will be kept confidential. Consequently, parents voice fears over being kept out of the loop with their child's care (Berlan & Bravender, 2009).

Conclusion

The majority of states uphold that a person eighteen years and older has the right to consent. There are specific exception criteria where children under the age of eighteen are

allowed to consent for themselves such as the diagnosis and treatment of certain infectious diseases, drug addiction, obtaining contraception, and treatment during a pregnancy. Because people differ greatly with various levels of competence, maturity, and behaviors; the lines which are drawn for consent become very gray. Due to this variability, nurses and other healthcare providers are placed in a position with potential for legal and ethical dilemmas.

Consent must be obtained before any procedure or treatment is performed, presenting great challenges for nurses. In order to address these challenges, a nurse must be educated on the different exceptions for consent. Adhering to these exceptions will allow the nurse to give the most comprehensive care and serve as a true patient advocate. Knowing the current ethical and legal requirements on consent for minors, will help nurses provide the best of care to minor patients and their families. Additionally, remaining current and providing quality care can serve as a defense if a nurse is placed in a lawsuit position over consent. The nurse must also educate patients and families on their options with consent and facilitate communication in order to arrive at the option that is best for the patient. For a nursing student, the review of credible sources regarding consent for minors provides a foundation of current practice and familiarity with the various outcomes that may be achieved regarding who provides consent.

References

Allen, D. & Marshall, E. S. (2008). Children with HIV/AIDS: A vulnerable population with unique needs for palliative care. *Journal of Hospice and Palliative Nursing, 10*(6), 362-363.

Batson, J. (2008). Healthcare decisions: A review of children's involvement. *Paediatric Nursing, 20*(3), 24-25.

Berlan, E. D. & Bravender, T. (2009). Confidentiality, consent, and caring for the adolescent patient. *Current Opinion in Pediatrics, 21*(4), 451-455.

Griffith, R. (2008). Consent and children: The law for children under sixteen. *British Journal of School Nursing, 03*(06), 281.

Guido, G. W. (2006). *Legal & ethical issues in nursing* (4th ed.). Upper Saddle River, New Jersey: Pearson Education, Inc.

Vasey, J. (2009). Consent & refusal: Selective respect for a young person's autonomy. *Journal of Community Nursing, 23*(4), 32-33.