

Adolescent Confidentiality: Balancing Provider Responsibilities and Patient Rights

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Presentation for CT-AAP by:

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Overview

- The program covers the basic outline of legal considerations for providers who treat children and adolescents
- Case studies will be used to explore how to implement these considerations in practice
- Q&A will follow

Consent for Care

- Persons with legal capacity for decision making control are permitted to make their own healthcare decisions
- General rule is that minors do not have capacity to make legal decisions, so parents control healthcare decisions for their children but there are many exceptions that return control to the minor.

Minors

- In Connecticut a minor is defined as someone under the age of 18, unless a law gives a different age to apply for limited circumstances.
- Usually a natural or adopted parent has decision-making powers, but courts can reassign that to DCF, guardian, other appointees
- Step-parents do not have independent authority
- Non-custodial parents still have rights, unless court has restricted these rights
- Foster parents rarely have decision-making authority over foster children

Mandatory Child Abuse and Neglect Reporting

- Each healthcare must report, as soon as practicable (no later than 12 hours) to DCF (or the police) if, in the ordinary course of employment or profession the provider has reasonable cause to suspect or believe any child under 18 years old has been:
 - abused or neglected (includes maltreatment, malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment)
 - has a non-accidental injury at variance with history given
 - is placed at imminent risk of serious harm
 - Oral report followed by written report. DCF has authority to follow up and obtain any information it deems necessary for the child and his/her siblings.
- Age of consent for sexual activity is 16, but decision to report 13, 14 and 15 year old as abused or neglected due to sexual molestation or exploitation is NOT tied directly to statutory rape laws (but 12 or younger should be reported)

Statutory Exceptions

- But – sometimes the minor controls instead of the parent. Connecticut law expressly allows minor to control decisions for:
 - Venereal disease/STDs
 - No notice to parents, bill must go only to minor
 - 12 y.o. or under = mandatory DCF abuse & neglect report
 - Substance abuse treatment
 - State and federal laws allow minor to consent
 - HIV testing and care
 - For testing, minor controls
 - For treatment, minor controls only if physician documents why parent is not being involved (e.g., to avoid patient elopement from care)
 - For their own children

Abortion Counseling and Decision-making

- Generally, the choice to have an abortion prior to viability of the fetus is solely controlled by the pregnant woman in consultation with and her physician (per federal case law), but states are permitted to add requirements on minors making a choice about abortion.
- Connecticut DOES NOT require parental consent, but instead for a minor may consent without a parent, but several counseling steps must be met:
 - For abortion minor is specially defined: person less than 16 years of age
 - Requires counseling before minor can consent. Counseling includes a laundry list of items, including:
 - Letting minor know it is her choice, and she can change her mind if she wishes, and give opportunity for her to ask questions
 - Explaining alternative choices and services available
 - Must discuss possibility of involving minor's parents or other family members
 - Minor signs form that counseling elements were met
 - Provider signs off on form
 - In emergency, counseling and form not required

Statutory Exceptions: Mental Healthcare

- These are instances where Connecticut law expressly grants (some) rights to minors over their own healthcare decisions, under certain circumstances - Outpatient mental healthcare (Sixth session rule):
 - Only applies to psychiatrist, psychologist, social worker, marriage and family therapist
 - notifying parent would cause minor to avoid care
 - clinically indicated and failure to treat would be detrimental
 - minor voluntarily seeking care; minor is mature enough to consent
 - Provider must document the decision (reassess after six session)
 - Minor financially responsible (not parent)
 - NO MEDS prescribed! (otherwise doesn't fit the rule)

Statutory Exceptions: Mental Healthcare

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 - 16 & 17 year olds are treated as if adults
 - 14 & 15 year olds can give voluntary consent to sign in (parents need to be contacted w/in five days)

Non-Statutory Reasons Minors Control Their Own Healthcare Decisions

- Contraception/family planning. Two sources of legal authority that give minors control over their own reproductive care (in addition to abortion):
 - Case law has developed over several decades
 - Federal grant program and other payer programs require patients are given confidentiality (including minors)

Emancipation

- Two ways a minor can be emancipated in Connecticut:
 - Common law, where minor is essentially taking care of himself/herself
 - By court order
- Rare that someone is emancipated
 - If emancipated, child control medical decisions
 - Minor not parent is liable for payment for care

Ethical Treatment Considerations

- Minors do not have right in Connecticut to have an advance directive for end of life decisions
- Religious objections are generally honored unless the child's health and safety put in jeopardy, in which case state/court may step in
- Court is the proper place to determine who controls the decision (child, parent, state) and what is in the best interest of the child when there is disagreement and the law is not clear

Record Access and Retention

- The power to authorize disclosure of records generally belongs to the person who controls the medical decision-making
- Copying charges limited to \$.65 per page, plus first class postage
- Retention time frames are the same regardless of patient's age (very unlike other states – because our statute of limitations is not extended for minors)
 - 7 years last date of care
 - 10 years for most facilities

Policy Decisions and Fitting Laws Together

- In your practice setting, particularly facilities, it is important to know and follow the policies
- Often laws and regulations have been weighed out against risks of non-compliance
- HIPAA and other system issues are often handled through policies and protocols

Ethical and Professional Considerations

- AMA, AAP, AAFP and other similar organizations share the same perspective: where law does not require otherwise, physicians who treat minors must involve minors in decision-making process commensurate with abilities of the minor.
- Numerous studies confirm that 66-75% of minors would be at risk of not accessing necessary health services if they did not feel the care could be kept confidential

Access to Treatment

- It is important to assess whether a minor will still seek treatment when parents are involved
- Mature minor theory has not been confirmed as part of Connecticut's common law, but is often relied upon. Case-by-case in many situations:
 - Is the minor able to understand the situation and make meaningful decisions
 - As a matter of professional judgment, can you justify it, and if so, document the decisions

Application of Legal Considerations

CASE STUDIES