

Consent Issues for Minors in Florida

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A 17-year-old University of Florida student is rushed to the Shands emergency room with acute lower, abdominal pain. The Emergency Department physician determines she has appendicitis and will need surgery. Although the student is living independently and for all intent and purposes is an adult, at 17 is the student still legally a minor, thereby requiring parental consent for treatment? The hospitals within the University of Florida Health System and the faculty and staff practicing therein face unique issues daily. The issue of whether medical consent is required when minors need treatment can pose challenges to health care providers whether the patient is a college student or an infant residing with a non-custodial relative. There are situations when non-custodial parents can consent for minors and when minors can consent for themselves. It's important for health care providers to understand the unique consent issues as they relate to patients under the age of 18.

A minor is any person under the age of 18 who is not married and has not been emancipated.¹ A minor over the age of 16 can be emancipated either by a judge or common law. A judicial emancipation occurs when a minor, his/her legal guardian or an independent representative petitions the court asking for the individual to be declared independent and be viewed as an adult in the eyes of the law.² A



minor can also be considered emancipated if she has "[broken] the bonds of subjection of the child to the parent," which may include living independently, supporting herself, maintaining a job for self support and being liable for her own debts.³ A minor is not considered emancipated merely by giv-

ing birth and becoming a parent.⁴ However, a minor who is married or has been married is given the same legal status⁵ as an adult in the eyes of the law.⁶ Therefore, an unmarried, unemancipated minor is unable to consent to most medical treatment.

Natural parents, adoptive parents, legal custodians and legal guardians have the power to consent when minors need medical care.⁷ But, what happens when a parent or legal guardian is not available? Florida Statutes prescribe a list of individuals (in priority order) who can consent to non-surgical "ordinary medical care and treatment."⁸ If a parent is not available, then the physician can first look to a step-parent, then a grandparent, adult sibling, or adult aunt or uncle.⁹ If the child is in the custody of the Department of Children and Families or the Department of Juvenile Justice, then the caseworker, probation office or the administrator of the state residential facility where the individual resides can consent to medical treatment when the parent or guardian cannot be reached.¹⁰ Although the minor may be residing with relatives or a foster family, these individuals do not have the capacity to consent to either surgical procedures or general anesthesia because it is not considered ordinary medical care. Ordinary medical care and treatment includes medical or dental examinations, blood testing, preventative care, immunizations, tuberculin testing and well child care. Ordinary medical care does not consist of surgery, anything requiring general anesthesia, provision of psychotropic medications or other extraordinary procedures.¹¹ Finally, anyone who has power of attorney to provide medical consent for a minor, executed after July 1, 2001, can consent to medical care as well as surgery and general anesthesia.¹²

If a physician or other health care provider needs to provide care that was not consented to by either a parent or guardian, it is essential to document in the medical record details about the attempts to contact a parent, along with the reason consent was provided by someone other than a parent. Moreover, a parent should be advised of medical treatment as soon as possible.¹³

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While there are legal requirements addressing who can or cannot consent to treatment for minors -- and what they can consent to -- there are times when parental consent is unnecessary. Specifically, a *physician* is permitted to provide care to minors without parental consent in emergent situations.¹⁴ Situations are considered emergent when a minor has been in an accident or when a minor is suffering from an acute event wherein a delay in the provision of care would endanger the health or well being of the minor.¹⁵ Nevertheless, prior to providing care there must be



an attempt to contact the parent at home or work (if a parent can be identified).¹⁶ Once again, the reason consent was not obtained must be documented in the record, and there must be a statement by *the attending physician* that the treatment was medically necessary for the patient's well being. A parent should also be notified of the care provided as soon as

possible.¹⁷

There are times when a minor is permitted to consent to medical care for himself/herself. A 17-year-old may consent to blood donations so long as a parent has not objected in writing.¹⁸ Any minor can consent to examination and treatment for sexually transmitted diseases.¹⁹ Moreover, health care providers cannot divulge any information regarding sexually transmissible diseases including sending a bill to a parent or billing insurance, which may reveal the treatment provided.²⁰

Mental health for minors is placed in a special category. Minors 13 years of age and older do not need parental consent to obtain mental health diagnostic or evaluative services by a *mental health professional*. The purpose of the evaluation should be to determine the severity of the minor's issue and the potential for harm to the individual or others if additional help is not provided.²¹ Despite the authority to evaluate a minor, a mental health professional does not have the authorization to prescribe medication, use somatic methods, make

use of aversive stimuli or employ substantial deprivation.²² The minor can also receive crisis intervention services including psychotherapy, group therapy, group therapy or other verbal therapy.²³ If the minor has more than two visits in a one week period for either evaluative or therapeutic services, then parental consent is required for additional care.²⁴ Mental health professionals may choose to provide the evaluative or crisis care to minors, but they are not statutorily required to do so. The minor is responsible for payment for these services if the parent is not involved in the request for care.²⁵

Reproductive care and services for minors also receive special legal treatment. An unwed pregnant minor can consent to *any* medical care provided by her physician so long as it is related to her pregnancy.²⁶ She can also consent to *any* medical services for her child provided by a physician.²⁷ The physician does not have to involve the minor's parent for a medical procedure involving her pregnancy or her existing child. This includes making life or death decisions such as the removal of life support.²⁸ This creates an interesting situation in which a 16-year-old mother could consent to a surgical procedure such as a hernia repair for her child, but not for herself. This is because the hernia repair would not be related to her pregnancy. Minors who are married, pregnant or have had a child can receive maternal health and contraceptive services of a non-surgical nature from a physician or through the Department of Health. (The insertion of an IUD or other nonpermanent internal contraceptive device is not considered surgery.)²⁹ A physician can also provide these services if he/she believes the minor will suffer probable health hazards without the services.³⁰ Therefore, a sexually active, non-pregnant minor who has not previously had a child cannot obtain birth control without a parent's permission unless she would suffer a "health hazard" without it. It is unclear exactly what the law considers to be a health hazard. A pregnant minor, however, cannot consent to an abortion without parental notification in most instances.³¹

Florida requires a physician to contact a pregnant minor's parents in person or by telephone

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at least 48 hours prior to the termination of a pregnancy.³² If the physician reaches the parent by phone, the parent's name and phone number should be recorded in the medical record. A referring physician can also perform parental notification, but the physician performing the abortion must get a written statement certifying notice was completed. If the physician is unable to reach a parent, 72 hours prior to the abortion, then a certified letter must be mailed to the parent's last known address with the physician's name and the name and address of the facility where the abortion is scheduled to occur. A copy of the letter should be put in the patient's medical record.³³ Thus, as a practical matter, a physician should attempt to contact a minor's parent(s) at least 72 hours prior to a scheduled abortion just in case the parent cannot be reached. Notice is not required in an emergent situation, but once again the physician must document in the record the reason the circumstances are emergent.³⁴ Notice is also unnecessary when the court has granted a waiver of the notice requirement, a parent has waived the notice requirement, the minor is/was married, or the minor "has a minor child dependent upon her."³⁵ Previously giving birth is not sufficient to fall into the exception for having a dependent child.³⁶

There are a myriad of conditions, circumstances, exceptions and prohibitions governing the issue of medical treatment and minors. When health care professionals are unsure about what rules do or do not apply in a specific case, seeking legal counsel best serves all involved: the patient, the family or guardian, the facility and the physician.

- ¹Fla. Stat. §743.07 (2006)
²Fla. Stat. §743.015 (2006)
³*Ison v. Florida Sanitarium and Benevolent Association*, 302 So. 2d 200, 201 (4th D.C.A. 1974).
⁴*Doerrfeld v. Konz*, 524 So.2d 1115, 1117 (2nd D.C.A. 1988)
⁵For the purposes of medical consent issues
⁶Fla. Stat. §743.01(2006).
⁷Fla. Stat. §743.0645 (2006).
⁸*Department of Children and Family Services v. G.M.*, 816 So.2d 30, 831 (5th D.C.A. 2002).
⁹Fla. Stat. §743.0645(2) (2006).
¹⁰Fla. Stat. §743.0645(3) (2006).
¹¹Fla. Stat. §743.0645(2)(a) (2006); *Department of Children and Family Services v. G.M.*, 816 So.2d 830, 831 (5th D.C.A. 2002).
¹²Fla. Stat. §743.0645(2)(a) (2006).
¹³Fla. Stat. §743.0645(4) (2006).
¹⁴Fla. Stat. §743.0645 (2006).
¹⁵Fla. Stat. §743.064 (2006).
¹⁶Fla. Stat. §743.064(2) (2006).
¹⁷Fla. Stat. §743.064(3) (2006).
¹⁸Fla. Stat. §743.06 (2006).
¹⁹Fla. Stat. §384.30(1) (2006).
²⁰Fla. Stat. §384.30 (2006).
²¹Fla. Stat. §394.4784(1) (2006).
²²Fla. Stat. §394.4784(1) (2006).
²³Fla. Stat. §394.4784(2) (2006).
²⁴Fla. Stat. §394.4784(1) (2006).
²⁵Fla. Stat. §394.4784(3) (2006).
²⁶Fla. Stat. §743.065(1) (2006).
²⁷Fla. Stat. §743.065 (2)(2006)
²⁸*North Florida Women's Health and Counseling Services, Inc., et. al. v. State of Florida*, 866 So. 2d 612, 622 (Fla. 2003).
²⁹Fla. Stat. §381.0051 (2006).
³⁰Fla. Stat. §381.0051(a)(5) (2006).
³¹Fla. Stat. §390.01114 (2006).
³²*Id.*
³³Fla. Stat. §390.01114(3) (2006).
³⁴Fla. Stat. §390.01114(3) (2006).
³⁵Fla. Stat. §390.01114(3)(b) (2006).
³⁶*Bittinger, Ann. Legal Hurdles to Leap to Get Medical Treatment for Children*, 80 Fla. B. J. 24. (2006).

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Medication Safety-High Priority

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Efforts to reduce adverse drug events have steadily intensified over the last several years. Continuing high profile cases such as the 3 infant deaths at an Indianapolis hospital last September due to a heparin overdose and Institute of Medicine (IOM) studies such as the now famous 1999 "To Err is Human: Building a Safer Health System" and more recent July 2006 study "Preventing Medication Errors" has propelled safety efforts by hospitals and regulatory agencies.

The July 2006 IOM report, "Preventing Medication Errors", conservatively estimates that 400,000 preventable drug-related injuries occur each year in hospitals resulting in \$3.5 billion in extra medical costs. While errors can occur during any step of the medication process, (selection and procurement, storage, ordering and transcribing, preparing and dispensing and administration), the above study found that most errors occur during prescribing and administration. Recommendations included improving communication between patients and health care providers by encouraging patients to take a more active role in their medication moni-



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toring; utilizing information technology to reduce transcription errors, legibility issues and provide quick access to patient data such as allergies; and improve the labeling and packaging of medications to prevent errors associated with look-alike/ sound-alike drugs.

JCAHO's medication standards for hospitals cover all aspects of the medication use process and a brief overview of key areas are outlined below along with medication specific national patient safety goals. Since some of these are open to interpretation, please contact your hospital pharmacy department for specifics should you have questions.

A) Patient specific information is readily accessible to those involved in the medication management system:

- 1) Anyone who orders, dispenses or administers medications, must have access to the following information when needed:
 - i) Patients age, sex, current medications
 - ii) Diagnosis, co-morbidities
 - iii) Lab values
 - iv) Allergies
 - v) Height and weight
 - vi) Pregnancy and lactation status

B) Medications are properly and safely stored throughout the hospital

- 1) Medications are stored under the proper conditions (i.e., refrigerated)
- 2) Controlled substances are properly secure; records are kept to detect any diversion
- 3) Look-a-like and sound-a-like drugs are identified and risks are minimized
- 4) Medications are provided in ready to use form (i.e., unit dose)
- 5) Periodic inspection of nursing units is conducted to ensure medications are stored properly

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C) Medication orders are written clearly and transcribed accurately

- 1) Medication orders are legible, written as generic versus brand-name when possible
- 2) Somewhere in the patient's chart, there must be an Indication for use for all medication
- 3) Hospital must have policies on all potential types of medication orders, (i.e., PRN orders, standing orders, hold orders, automatic stop orders, resume orders, range orders, taper orders, etc.)
- 4) Blanket orders (i.e., resume all previous medications) **are not** acceptable

D) All prescriptions or medication orders are reviewed for appropriateness

- 1) Before dispensing, removal from floor stock, or removal from an automated storage and distribution device, a pharmacist reviews all prescription or medication orders unless a physician, physician's assistant, or ARNP controls the ordering, preparation, and administration of the medication; or in urgent situations when the resulting delay would harm the patient, including situations in which the patient experiences a sudden change in clinical status (for example, new onset of nausea).
- 2) Each facility must determine what they will accept as "urgent situations" and which drugs can then be obtained by a nurse, without a pharmacist review.
 - i) The reason for this "over-ride" must be documented in the patient's medical record.
 - ii) Over-rides must be minimized.

E) Medications are prepared safely

- 1) When an on-site, licensed pharmacy is available, only the pharmacy compounds or admixtures all sterile medication, intravenous admixtures, or other drugs except in emergencies or when not feasible (when the products stability is short)
- 2) When mixed on a nursing unit, the nursing unit must maintain a clean, uncluttered, and func-

tionally separate area for product preparation

F) Medications are safely and accurately administered

- 1) The patient is positively identified using two identifiers (excludes use of patient's room number)
- 2) The prescriber is notified in the event of an adverse drug reaction or medication error
- 3) Documentation that medications are administered at proper time, proper dose
- 4) That the patient is advised of any significant adverse drug reactions

G) The effects of medication on patients are monitored

- 1) Each patient's response to his or her medication is monitored according to the individual needs of that patient which includes the patient's response to the medication
- 2) One must gather the patient's own perception about side effects, referring to information from the patient's medical record, laboratory results, and clinical responses to medication

National Patient Safety Goals that involve the Medication Use System:

A) Goal: Improve the safety of using medications.

- 1) Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- 2) Standardize and limit the number of drug concentrations available in the organization.
- 3) Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

B) Goal: Accurately and completely reconcile medications across the continuum of care.

- 1) For full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
- 2) A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

C) Goal: Improve the effectiveness of communication among caregivers.

- 1) For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- 2) Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization. (See Shands Core policy 2.53 for a list of banned abbreviations.)

Finally, it is important **before** administering any medication, to verify the **5 Rights**:

1.) Right Patient, 2.) Right Medication, 3.) Right Dose, 4.) Right Time, and 5.) Right Route

Congratulations Teams!



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