ETHICS ON CALL

Family Dynamics: Working with Parents and Teens in the ED

By Dr. Mary Bhalla

The patient is a 15-year-old female named Tiffany, presenting with her mother. The chief complaint is "wants tested." The mother explains that Tiffany lied to her about spending the night at a friend's house the night before and had instead gone to a party. Tiffany's mother wants her tested for drugs, alcohol, and to see if she has been having sexual intercourse. Tiffany sits fully dressed with her arms crossed and a defiant look on her face. She is refusing to speak with me or to be examined. She does allow the nurse to obtain her vital signs, which are normal. The mother states that Tiffany has no significant past medical history nor any previous suspicion of substance abuse. To the mother's knowledge, Tiffany has never been pregnant and has never had a gynecologic evaluation.

The Ethical Issues

There are several ethical issues at play in this situation: One is the issue of a minor refusing evaluation when her guardian is insisting on one; another is the request for an emergency physician to perform potentially unnecessary tests or examinations; a third is the use of emergency medicine resources for a non-emergent visit that is, in truth, a problem of family dynamics.

Issue One: Determining if an Emergent Medical Issue Is Occurring

The first issue for the emergency medicine physician is to act in accordance to the Emergency Medical Treatment and Active Labor Act (EMTALA) and establish whether an emergent medical condition is occurring. When dealing with a minor, a physician must also ensure the patient is safe and is not being exploited (i.e., sexual abuse or human trafficking).

If the patient has no complaints, denies being injured or in pain, has normal vital signs, is not under the influence of drugs or alcohol, and appears to have decision-making capacity, then it is unlikely that a life threatening situation is present. The question then becomes whether this patient has decision-making capacity. In most states, minors are allowed to seek medical care for the treatment of sexually transmissible infections (STI), sexual health, birth control, and the treatment for drug and alcohol abuse. The question is whether they can refuse treatment or evaluation for these conditions. One assumes that if a minor seeks treatment for one of these conditions that they will comply with treatment that is in his or her best interest, but that may not be the case. Forcing a teenager to undergo life-saving treatments may be necessary, but would have to be under the direction of the hospital ethics board and potentially a court order. In this case there is no evidence that a substance-abuse problem or sexually transmitted infection is present.

Issue Two: Dealing with Parental Requests

The next ethical issue is the mother's request for testing for drugs, alcohol, and sexual intercourse, despite there being no evidence that an emergent medical condition stemming from these activities is present. It is not uncommon for patients to request laboratory tests or imaging that does not exist or

are inappropriate for the emergency department to perform Although alcohol and illicit substance testing is important for the evaluation of a patient with an altered level of consciousness, there is no indication that routine testing is cost-effective.

Although there is no test or exam for "sexual activity," from a public standpoint, pregnancy and STI testing can be done in the emergency department; however, there must be a follow-up plan in place for those patients who are not treated or will not be present for their results. When performing screening tests in the emergency department, the use of resources to collect and run these tests must be weighed against the needs of the population as a whole and those of the patients in imminent need of emergent care. There also must be a compelling reason to test a minor who is refusing evaluation.

Issue Three: Using the ED for Non-Emergency Medical Concerns

The final issue is the use of emergency department resources for a problem of family dynamics rather than from an emergent medical condition. This makes us question the definition of an "emergency." Will the patient die if she is not treated today? Unlikely. Will she suffer morbidity if an emergent medical condition is not treated today? Unlikely. Will she suffer morbidity if her social situation is not addressed? Possibly.

Although in emergency medicine it is satisfying to save a life by performing a procedure or giving a medication, it is often our counseling that makes a long-term impact on a patient's health: Talking them out of an inappropriate antibiotic; talking them into getting an outpatient colonoscopy; discussing safe sexual practices; giving them advice on substance abuse treatment centers or prenatal smoking cessation. We do no harm when we give patients our time and attention rather than a medical intervention. It would be easy, in this case, to tell the mother that there is no emergency and walk out of the room, but the compassionate intervention would be to sit down and have a discussion.

Case Resolution

Tiffany agreed to speak with me alone without her mother present. Tiffany admitted to me that she had tried marijuana and alcohol before, but did not use either regularly because she does not like the way they make her feel. She stated that she has only had sexual relations with a female her own age, so it is not possible for her to be pregnant. She stated that her periods have been regular and she has not had any pelvic pain or discharge. Tiffany fears telling her mother that she has a girlfriend because she is not sure how her mother will receive her homosexuality. She admited to sometimes thinking about running away but does not have a specific plan for doing so. Tiffany asked that I not disclose her sexual orientation to her mother. I agreed.

We discussed substance abuse avoidance strategies and safe sexual practice. I invited her mother back into the room. I explained that I did not see any indication that Tiffany needed to be tested for substance abuse or STI. I expressed my concern about their ability to have an open, trusting relationship and referred them for family counseling.

About the Author:
(Mary) Colleen Bhalla, MD, is the associate research director of the Summa Akron City Hospital Department of Emergency Medicine, an associate professor at Northeast Ohio Medical University and a member of the SAEM Ethics Committee. Her passions include teaching evidence-based medicine, modeling compassionate healthcare delivery for all patients, and advocating for vulnerable populations. As a member of the Ethics Committee she works to promote the open discussion of complicated patient and societal problems, with a focus on autonomy, justice, beneficence, and non-maleficence in the backdrop of altruism from the healthcare provider.