InFocus

Pediatric Patients Leaving Against Medical Advice

By James R. Roberts, MD

Part 4 in a Series

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Dr. Roberts has disclosed that he is a member of the Speakers Bureau for Merck Pharmaceuticals. All other faculty and staff in a position to control the content of this CME activity have disclosed that they and their spouses/life partners (if any) have no financial relationships with, or financial interests in, any commercial companies pertaining to this educational activity.

Learning Objectives: After participating in this CME activity, the physician should be better able to:

1. Differentiate potential medical outcomes for children whose parents remove them from the ED AMA.
2. Create a profile of pediatric ED presentations that are likely to predict that parents will remove their children AMA.
3. Prepare a plan to discourage parents from prematurely removing their children from the ED.

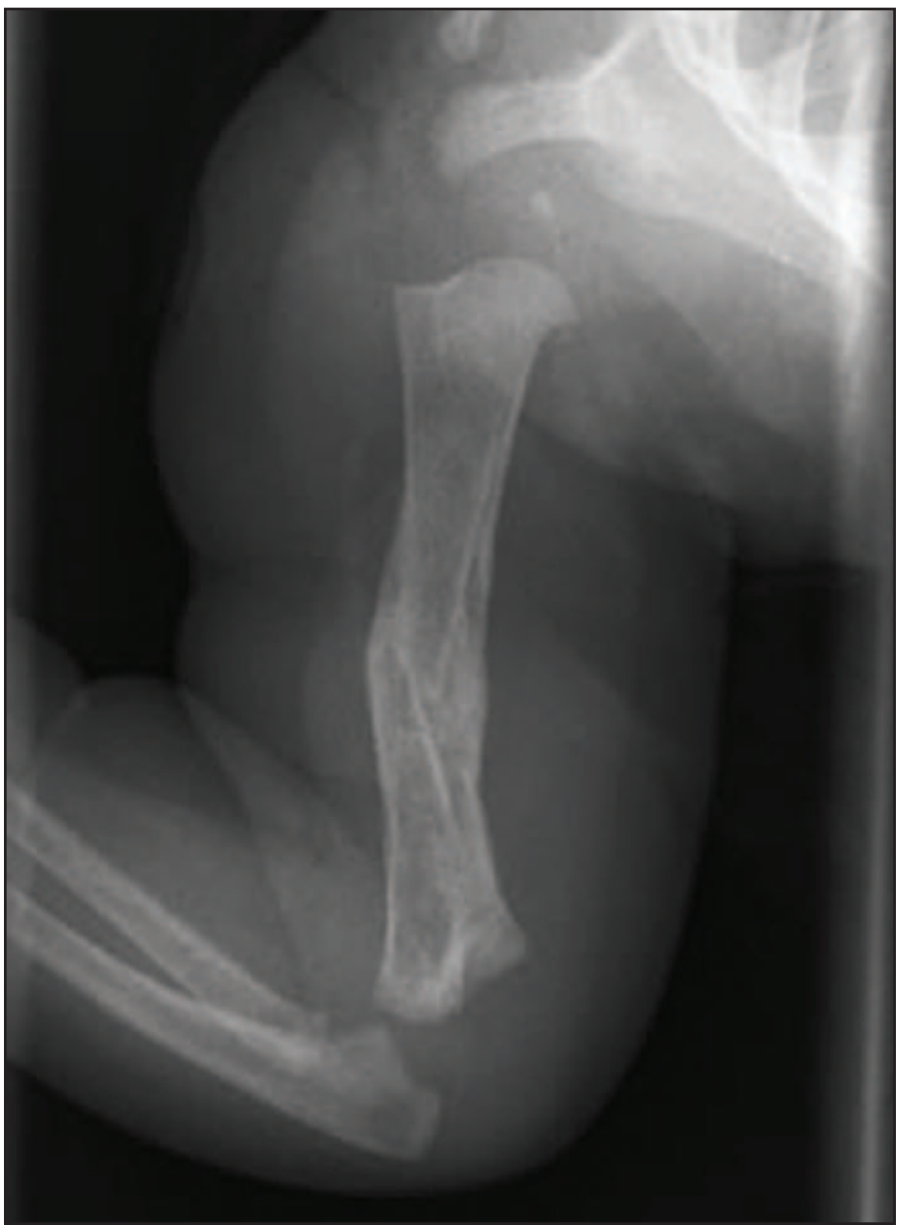
When it comes to adults who opt to leave the ED against medical advice (AMA), patient autonomy generally supersedes physician recommendations. The only requirement for a patient to leave the ED abruptly and to refuse evaluation or treatment is being mentally competent after being adequately apprised of the risks. A properly executed AMA form may offer some protection to the physician and hospital but not blanket immunity if an adverse event occurs. Patients who leave AMA are at higher risk for untoward events and subsequent hospital admission, with an overall increased cost to all.

This month's column tackles the unpleasant issue of children who are prematurely taken out of the ED by their parents. While the public might be somewhat sympathetic to a physician who does his best to keep a recalcitrant adult in the ED, particularly one that merely has a potential medical issue, emotions run high when a child is involved. You don't want to be on the wrong end of a medical disaster involving a child who was plucked from the ED by his parents, with subsequent allegations that they were not fully informed of the medical issues or risks. After reading this article, emergency physicians should be better able to differentiate potential medical outcomes for children whose parents remove them from the ED AMA, create a profile of those parents most likely to leave AMA, and prepare a plan to discourage parents who want to prematurely remove their children from the ED.

Predictors of Pediatric Emergency Patients Discharged Against Medical Advice
Reinke DA, et al
Clin Pediatr
2009;48(3):263

This is one of a few articles in the medical literature that specifically deals with pediatric patients removed AMA from the ED by their parents. It's a five-year retrospective chart review from St. Louis Children's Hospital profiling parents who left AMA and the outcome of their actions. All children were evaluated by a physician or nurse practitioner, and parents removed their children from the ED before therapy was completed.

Subjects were excluded if they were not fully evaluated or left without notifying the staff (elopement). The authors compared 188 routinely discharged controls with 94 children removed AMA. The most frequent chief complaints were abdominal pain, upper respiratory infection, otitis media, asthma, trauma, or fever. There were no differences in the sex, race or ethnicity, or insurance status of the child between those who left and those who stayed. Time of arrival, time to be seen, and day of arrival were similar compared with controls. There was also no difference between AMA versus routine disposition based on age, mode of arrival, mother or father in attendance, or the use of a medical consultant. As one might suspect, chart documentation was poor.



This healed spiral fracture in a young child should conjure up suspicion for distant child abuse, especially when the parents seem to have no coherent explanation for it and other old fractures coincidently found on a skeletal survey. But this child has occult osteogenesis imperfecta. If not previously diagnosed, the findings likely would be reported as suspected child abuse by any competent clinician. There has been litigation against medical personnel for labeling this rare brittle bone process as abuse, wreaking all sorts of havoc on the family when child protective services is likewise flummoxed. Of course, litigation also occurs when child abuse is not reported.

About a quarter of the patients returned to the ED within 15 days, three times the rate of those routinely discharged. The medical complaint was similar in 96 percent of returnees, and the admission rate at the second visit was about 25 percent, not significantly different from controls. Adolescents over 15, especially those who self-registered, left more often. Those urgently triaged and those with a URI or otitis, tended to stay for complete evaluation, possibly because the workup was more expeditious. Patients with more severe illness or with complex medical problems were at higher risk for AMA discharge. Abdominal pain was a predictor of AMA, possibly because the workup is time-consuming, complex, and may require consultation and yield nonspecific diagnoses. It's not surprising that adolescents who self-registered with symptoms of sexually related infections did not stick around, likely due to concerns about their parents finding out.

There also was a consistent failure to document alternative therapy following

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AMA discharge. The authors subsequently revised their AMA form to address parental knowledge of the diagnosis, proposed management, alternative therapies, risk of no treatment, and specific follow-up instructions. Focusing on adolescents and patients with more complex medical problems may decrease the incidence of pediatric AMA.

Comment: There is minimal specific information in this article. Other than focusing one's efforts on better documentation, and perhaps realizing that self-registered teenagers are problematic, the authors offer little clairvoyance. One can readily understand the reticence of teenagers with STD symptoms to stay in the ED, but adolescents who arrived alone were considered competent adults, and parents were not contacted, an unfortunate fallout of the restrictive HIPAA laws.

It is universally suggested to document specific medical risks of leaving on the AMA form. Because many patients left prior to diagnostic testing, it's difficult to identify clearly such specific risks other than to disclose that the diagnosis was "uncertain."

"You could die" is a common warning, but it's a bit tricky to chart that a child could die if he leaves AMA, and then justify why you allowed him to go. Things are more clear-cut when the child is obviously gravely ill, and reasonable parents can often sense impending doom. Parents who remove children who may be ill or who have vague or nonspecific symptoms can pose a dilemma for all, especially for the child who has no say in the matter. Abdominal pain can be caused by appendicitis, a disease that can kill. No standards seem to exist other than recognizing parental autonomy and informed consent.

Hopefully, common sense by all parties will prevail, and health care professionals will eschew the good-riddance approach. But an outraged, sleep-deprived, hostile, intolerant, and occasionally intoxicated parent is tough. At 4 a.m., the desire to leave is great, especially when parents conclude that the ED visit was not really necessary, and is taking too long for a seemingly minor illness. Giving acetaminophen in triage can make a lot of fussy kids look a whole lot better, and sympathetic nurses can give assurances that prompt an exit.

What do doctors think? One study asked board certified EPs to comment on a hypothetical situation in which a mother wanted to remove a febrile infant from the ED. (*West J EM* 2002; 3[3]:51.) The mother does not appear intoxicated or confused, but she is upset and angry about nursing issues. (This is the time for the calm, cool physician to step in, and do some schmoozing and apologizing, even if it hurts.) In this scenario, the child's illness quotient is not clear. Thirty-two percent of the 700 board certified EPs surveyed said they would allow the mother to leave, and take no further action. About 32 percent said they would request an AMA form prior to leaving, 19 percent stated they would allow the mother to leave but report the case to child protective services, and 17 percent said they would call security to prevent the mother from leaving.

Obviously, no standards exist, but clearly these physicians support parental autonomy to make decisions about their child's health issues. It is also clear most would not restrain or take custody of the child, particularly when there was no evidence of parental neglect or abuse, an obviously serious illness, or an unstable patient. I wonder how many actually would carry out restraint or report child abuse in real life. It's easier in a survey, but I strongly doubt that most physicians would be so aggressive.

In today's vaccinated world, most fevers are benign, and febrile children are everyday denizens of the ED. Most do well with minimal intervention. It's not surprising that the surveyed clinicians usually allowed unencumbered egress of the child from the ED. Of course, waiting time is always an issue; there's not much anyone can do about that. No one wants to wait, even for expert medical care for a child. Walk-in clinics and even drugstores are experiencing a boom in business. Not surprisingly, their results for minor problems are similar to prestigious children's hospitals and a whole lot cheaper and faster.

Another study created a patient profile based on 223 pediatric patients who left AMA, finding that those who left were not critically ill and usually did well. (*Ann Emerg Med* 1986; 15[6]:717.) Only three percent were subsequently hospitalized. Most cases occurred on weekends between 4 p.m.

Child Abuse or a Rare Medical Condition?

A patient with osteogenesis imperfecta is literally the poster child for cases wrongly suspected to be child abuse, a potential minefield for physicians. Unexplained or multiple fractures in a child usually raise a red flag for clinicians, but OI can be clandestine and clinically mild. Medical personnel have been prosecuted for erroneously reporting child abuse in children with OI. Watch out for this one, and look for the blue sclera and other signs and symptoms: connective tissue injuries, bruising, below-average height for age, loose joints, muscle weakness, mild scoliosis, a somewhat triangular face, brittle teeth, and hearing loss.

The Osteogenesis Imperfecta Foundation (www.oif.org) offers the following cautionary tale:

"A child is brought into the emergency room with a fractured leg. The parents are unable to explain how the leg fractured. X-rays reveal several other fractures in various stages of healing. The parents say they did not know about these fractures, and cannot explain what might have caused them. Hospital personnel call child welfare services to report a suspected case of child abuse. The child is taken away from the parents, and placed in foster care.

"Scenes like this occur in emergency rooms every day. But in this case, the cause of the fractures is not child abuse. It is osteogenesis imperfecta, or OI. OI is a genetic disorder characterized by bones that break easily — often from little or no apparent cause. A person with OI may sustain just a few or as many as several hundred fractures in a lifetime."

For a review of cases thought to be child abuse, see "The Mistaken Diagnosis of Child Abuse: A Three-Year USAF Medical Center Analysis and Literature Review." *Mil Med 1995;160(1):15.*

Reader Feedback: Readers are invited to ask specific questions and offer personal experiences, comments, or observations on InFocus topics. Literature references are appreciated. Pertinent responses will be published in a future issue. Please send comments to emn@lww.com. Dr. Roberts requests feedback on this month's column, especially personal experiences with successes, failures, and technique.

Dr. Roberts: Thank you for an interesting review of patients who leave against medical advice. What do you think is the right approach to handle the following theoretical situation? A young woman presents to the ED, 28 weeks pregnant with abdominal pain and vaginal bleeding. The emergency physician plans to admit her, but despite a long conversation with the OB-GYN resident, social worker, and others, she decides to leave for personal reasons. The physician has documented her good mental capacity, risks, benefits, and options.

What if this woman presents later in the same ED, requiring an emergency C-section with a bad outcome for the newborn? In this case, should the ED have allowed her to leave? Does the unborn child have any legal rights? Should the emergency physician call Child Protective Services? — ***Giora Winnik, MD, New York***

Dr. Roberts responds: This is a tough one and above my pay grade, but perhaps a reader has more insight and would wish to comment. You forgot to mention that this will likely occur at 2 a.m. on a weekend. My first take is that the mother, if properly informed and deemed competent to make a decision about her own health and the well being of her fetus, would fall into the same category as a parent with a live infant who wants to remove her child against advice. She would be allowed to, but it would not be that difficult to conjure up something that might convince me that she was not competent. If there were documented fetal distress, hypotension, or open cervical os, perhaps one could invoke child protection parameters, but are you going to force her into an emergency C-section, tocolytics, or a blood transfusion? I would certainly try to get help from the hospital attorney and the woman's family. I suspect she has the right to make a bad, albeit informed, decision, but this should be the best chart you have ever documented. I would call child protective services for advice, but they will likely waffle, just like I did on this answer. This is yet another example where the physician has potential liability no matter how he proceeds. Finally, I will remind you that the mother is allowed to abort a fetus, and not be charged with child abuse so go reconcile that one.

and midnight, with more patients on welfare and without alternative health care. Most children presented with minor trauma and minor illnesses, and more than half of those leaving did not seek additional care. Sixteen percent went to another ED, and half were well in 48 hours. When contacted, most parents said they had waited too long (60%) or the medical complaint had spontaneously resolved (10%), but transportation issues, anger, and misunderstood instructions also were reasons cited. In about five percent of patients, a nurse allayed parents' concerns prior to physician evaluation. Since 1986, waiting times have not decreased, but the authors don't offer recommendations except to work faster and try to communicate better.

A study at Children's Hospital of Boston found that children leaving AMA accounted for 2.5 percent of visits. (*Ann Emerg Med* 2008;52[6]:599.) The authors said an urban location, self-pay insurance, less acute medical problems, arrival times, and race and ethnicity were factors associated with leaving AMA. Again, no suggestion was made on how to address the issues.

Comment: No one has an easy answer for why parents take their children from the ED before a complete evaluation. While there are understandable reasons for this, the EP is often on the wrong end of the situation. Who has resources these days to speed things up? Not only do EPs have to placate irate parents and apologize for lab inefficiencies and tardy consultants, they have to smooth over interpersonal problems with clerks, nurses, technicians, and interns. We continually make snap judgments about a child's potential illness with minimal data. Some AMA discharges of an obviously well child can be sanctioned with nothing more than reading the complaint and vital signs (always read the nursing notes), coupled with a quick perusal of the child, and followed by the requisite paperwork.

If done properly, the AMA paperwork takes longer than the clinical interaction, another sad commentary on today's legal climate. Infants with fever rarely have life-threatening illnesses, and one is often prompted to act on a gut feeling of whether a child has a serious bacterial illness requiring further evaluation. If the child is in extremis, his vital signs abysmal, or the chief complaint potentially disastrous, difficult decisions must be made. No one would allow a parent to take a child from the ED when a lumbar puncture demonstrated bacterial meningitis, and would even marshal court orders and security guards and be willing to risk threats of child abuse. The more vexing problem is whether to intervene when you are not sure about the seriousness of the child's condition. There is, unfortunately, physician peril from simply trying to do the right thing.

A crack developer of cool games for the iPhone by day, Matt Roberts is just another distraught and exhausted parent of Liam, a cranky febrile 3-month-old, in the ED at 3 a.m. Statistically, the infant probably only has a benign URI, but prolonged waits are the norm, albeit the bane of all, and quality evaluations take even more time. Parents have the autonomy and right to refuse testing, treatment, and even admission of their children as long as they are competent and properly informed of the relevant issues and consequences. A quick evaluation should allow the prescient clinician to make conclusions that will be beneficial to all. Special attention to those about to depart goes a long way in allowing cooler heads to prevail. One cannot simply cite child abuse statutes for no good reason, and overestimating the danger to a legal entity can get you into trouble with the courts. The physician is clearly between a rock and a hard place with this one. Pay very close attention to the paperwork (AKA squeaky-clean charting) if this child leaves AMA.

As with adults, the American College of Emergency Physicians' guidelines accord parents autonomy over the medical care of their children. If you want to get really steamed, read the *EMN* article detailing a case where an EP was sued for performing a lumbar puncture on a child with suspected meningitis against the wishes of the mother. (http://bit.ly/EPconsent.) Amazingly, this legal action was supported by Center for Individual Rights in Washington, D.C. (Check out the center's web site for a real eye-opener on dubious personal rights organizations: www.cir-usa.org/mission_new.html.) This case is still in the legal system. I find this litigation totally appalling, and just plain stupid, but it's yet another situation where the EP can't win.

I have never called a security guard to take an ill child away from parents wanting to leave AMA, but would if there were obvious child abuse or a known life-threatening medical condition. This falls under the category of "What would you rather defend?" While you might think you are totally protected from litigation when you report suspected child abuse, think again. It's all in the eye of the beholder. Leaving AMA with your child does not equal child abuse. A physician should rarely be the surrogate for an ill child when the parents are in the room. A retrospective analysis, however, is a powerful tool, and a bad outcome is often taken as per se evidence of physician misconduct.

In the long run, parents need to take responsibility for their child's welfare, and cannot blame physicians for their own hasty mistakes or poor judgment. Guilt is powerful, however, and often parental guilt is lessened with attempts to blame the physician. The best one can do is to try to diffuse any hostile situations from the onset, let common sense prevail, and use all the warm-and-fuzzy techniques we have learned in dealing with adults who want to make foolish decisions. Pristine documentation should convey your gargantuan efforts. Unfortunately, the last thing one attends to in a stressful case is the paperwork, and it is rarely pristine enough for the court three years later. Even when the documentation is airtight, you can spend your vacation trying to convince a jury that your written story is more believable than the parent's recollection of what they were told prior to unfortunate post-ED events. Good luck if your AMA form isn't up to par.

Although state laws allow parents to control health issues affecting their children, physicians are empowered to intercede in cases of obvious child abuse or neglect. Parents' rights, including religious beliefs, do not include the right to deny life-sustaining medical care for their children. State laws differ; some require a second physician to reach the same conclusion as the one attempting to take control of a child's care. If the condition is not obviously serious or life-threatening, the courts do not readily agree with well meaning physicians. Most courts allow parents to refuse medical treatment if there is no life-threat or potential for serious impairment. Herein lies the conundrum. Without a period of observation or certain tests, it's merely an educated guess that a child has a serious or a life-threatening illness. Under these circumstances, there is no agreed-upon standard of care.

Be extremely careful when evoking child abuse laws. They are ostensibly designed to allow health care professionals to bypass parental foibles and halt abusive behavior, but they do not offer blanket immunity. Physicians are mandated to report suspected child abuse, and are legally at risk for not doing so. Child protective services have to prove or disprove our suspicions. While the party line is that we are assured legal immunity for reporting abuse, don't be that naïve. If you exaggerate or overestimate potential child abuse to make your point, you can be liable for repercussions from the accused caretaker who may claim all sorts of distress from your seemingly altruistic actions.

Munchausen Syndrome by Proxy
Jani S, et al
Int J Psychiatry Med
1992;22(4):343

This fascinating report examined possible Munchausen syndrome by proxy (MSP) in children discharged AMA or transferred from the University of Maryland. Amazingly, there were MSP characteristics in 64 percent of the AMA discharges and eight percent of transfers, and none in regular controls. It is difficult to believe that physicians also must consider that parents are not just irrational or have unrealistic expectations for medical care; we also have to intuit that they might just be psychotic themselves or trying to harm their children via this bizarre syndrome.

Between a Rock and a Hard Place: When Parents Refuse Treatment for their Children in the ED
McDonnell WM
ED Legal Letter
2008;19(6):66

This erudite and informative article gives a more legal slant to the conundrum of children being removed from

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the ED AMA by their parents. It's peppered with case law references, and although discouraging, it's an easy read. The article should be studied in detail in journal club.

The author, a pediatric emergency physician and lawyer, reiterates that courts recognize a strong public interest in allowing parents to make reasonable medical decisions on behalf of their children (citing nothing less than the 14th Amendment to the U.S. Constitution). The operative word here is "reasonable," and that's in the eye of the reviewer, and it's often a retrospective eye at that. The rock and the hard place is the potentially conflicting issue of child welfare and parental autonomy. Physician obligations and parental rights can conflict, especially in a stressful ED where little rapport has been established in an already charged scenario of long waiting times, hostile counterparts, and ill children.

Case law confirms that a patient or parent must agree to evaluation prior to any physical contact. Failure to do so exposes the physician to potential claims of assault and battery. Of course, federal law (EMTALA) also requires that physicians provide an appropriate examination and stabilizing treatment to all. It's easy when the patient is incompetent or unconscious, but less clear when dealing with only potentially ill children. Even critically ill patients have the right to refuse medical care. And that's not only end-of-life decisions but also refusing admission or further treatment for severe asthma. How's that for an example of the quintessential gray area?

To make things even more complicated, the principle of *parens patriae* (parent of the country) deems the state to have an interest in the welfare of all adults and children. This concept is not a mechanism for the physician but for the state to override parental rights. It might help with feeding tubes and chemotherapy, but it is of minimal practical guidance at midnight when the parents want to take their febrile child home before the EP has a chance to evaluate the patient fully.

One must be careful when trying to protect the child through child abuse laws. Child abuse has only to be suspected, not proven, by physicians, who are liable if they don't report child abuse and if they exaggerate medical risk to institute care against parental wishes. It is not only the child, but also the physician who can get squashed between that rock and that hard place. EMN

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September 2010
Questions:

1. What is the most likely outcome of a child with suspected URI symptoms who is removed AMA from the ED prior to complete evaluation?
   - ○ A. The child will likely do well without further evaluation.
   - ○ B. About 30 percent will return in one week with pneumonia.
   - ○ C. Many parents will institute harmful therapy on their own.
   - ○ D. The child will usually be returned to the same ED in 24 hours.

2. Which of the following pediatric patient scenarios describes a situation in which parents will likely *not* remove their child AMA from the ED?
   - ○ A. The child has an undiagnosed head injury from a motor vehicle crash.
   - ○ B. The child is not seriously ill, but has undiagnosed recurrent abdominal pain.
   - ○ C. The child has no pediatrician, and arrives at midnight with vague complaints.
   - ○ D. The child has symptoms of an upper respiratory infection, and has been waiting for a chest x-ray for more than four hours.

3. The parents of a febrile but well appearing 2-year-old want to leave the ED before the physician completes the child's evaluation. What is the most reasonable response from the physician?
   - ○ A. Call security to restrain the parents, and order a chest x-ray.
   - ○ B. Call social services after filing child abuse forms, and begin a workup.
   - ○ C. Call the grandmother and pediatrician, and consider the possibility of child abuse.
   - ○ D. Document that the parents were completely informed and competent, and allow them to leave.

4. How do American case law and the American College of Emergency Physicians' guidelines view parents who want to take their child from the ED against medical advice?
   - ○ A. Physicians have the ultimate right to overrule parental wishes in all cases.
   - ○ B. Any physician can become the surrogate parent if the child appears ill.
   - ○ C. The autonomy of parents to decide medical care for their children is strongly supported.
   - ○ D. Child abuse should be considered and documented in all AMA cases to ensure follow-up.

5. What best describes the medicolegal outcome when children are treated against the wishes of their parents?
   - ○ A. Courts will not allow litigation against physicians based on Good Samaritan laws.
   - ○ B. Litigation can proceed against any physician and hospital for forcing medical care.
   - ○ C. If the child is ultimately shown to have no medical problems, physicians are automatically liable for assault and battery.
   - ○ D. If the child has osteogenesis imperfecta, child abuse charges cannot be filed for broken bones.

Directions
Your successful completion of this activity includes evaluating it. Please indicate your responses below filling in the blanks or by darkening the circles with a pencil or pen.

Please rate your confidence in your ability to achieve the following objectives, both before this activity and after it: 1 (minimally) to 5 (completely)

	Pre 1	2	3	4	5	Post 1	2	3	4	5
Differentiate medical outcomes for children whose parents remove them from the ED AMA.	○	○	○	○	○	○	○	○	○	○
Create a profile of parents most likely to remove their children AMA.	○	○	○	○	○	○	○	○	○	○
Prepare a plan to discourage parents from prematurely removing their children from the ED.	○	○	○	○	○	○	○	○	○	○

Please indicate how well the activity met your expectations: 1 (minimally) to 5 (completely)

	1	2	3	4	5
Was effective in meeting the educational objectives	○	○	○	○	○
Content was useful and relevant to my practice	○	○	○	○	○

Please address the practical application of this activity below
How many of your patients may be affected by what you learned from this activity? _____

Do you expect that the information you learned during this activity will help you improve your skill or judgment within the next 6 months? (1-Definitely will not change, 5-Definitely will change) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

How will you apply what you learned from this activity? (Mark all that apply.)
- ○ In diagnosing patients
- ○ In monitoring patients
- ○ In educating students and colleagues
- ○ To confirm current practice
- ○ For maintaining board certification
- ○ In making treatment decisions
- ○ As a foundation to learn more
- ○ In educating patients and their caregivers
- ○ As part of a quality/performance improvement project
- ○ For maintaining licensure

Please complete these overall activity assessment questions.
Did you perceive any bias for or against any commercial products or devices? Yes ○ No ○
If yes, please explain: _____

Compared with other educational activities in which you have participated over the past year, how would you rate this activity? (1-Needs serious improvement, 5-A model of its kind) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

Future activities concerning this subject are necessary. (1-Strongly disagree, 5-Strongly agree) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

My biggest clinical challenges related to this topic are: _____

Please use the space below to provide any additional information that will help the activity planners and faculty evaluate this activity.
_____
_____

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