

Evaluation and Treatment of Minors ***Policy Resource and Education Document (PREP)***

This policy resource and education paper (PREP) is an explication of the policy statement
“Evaluation and Treatment of Minors”

Abstract:

Many minors, defined as patients under the legal age of majority (typically 18 years of age), present to emergency departments (EDs) without parents or guardians, raising the question as to who can consent to the treatment of these patients. The Emergency Medical Treatment and Labor Act mandates that all patients presenting to EDs, including minors, receive a medical screening examination to determine if an emergency medical condition (EMC) exists and requires treatment and stabilization of these EMCs. This document also addresses current federal and state legal implications of providing emergency care to minors, as well as guidance in obtaining consent, maintaining confidentiality, and addressing refusal of care.

INTRODUCTION

There are approximately 130 million visits annually to emergency departments (EDs) in the United States,¹ with more than 29 million of these visits for patients 18 years of age or younger.² Children and adolescents may present to the ED without a parent or guardian. In one large study, 45% of adolescents with nontrivial head injury arrive without a guardian to provide consent for medical evaluation and treatment.¹⁵ Adolescents may arrive in the ED without parents or guardians because they developed health concerns that they hope to keep confidential from their guardian(s), including sexual activity, substance abuse, interpersonal violence, or mental health symptoms.

The initial medical screening examination of an unaccompanied minor is required by federal statute, and stabilization of an EMC should occur without delay in situations in which parental consent cannot be obtained.³⁻⁵ Although further care for minors beyond emergency screening and stabilization requires legal consent, exceptions to this rule exist.

This document serves to update the 2018 American College of Emergency Physicians Policy Resource and Education Paper regarding evaluation and treatment of minors in the ED.⁶ This update serves as an overview of general medicolegal issues pertaining to the evaluation and treatment of minors. The main discussion builds on the prior document, in large part removing state specific examples which are prone to rapid change. The role of consent for research in minor patients and minors in custody is beyond the scope of this discussion. Similarly, human trafficking and child abuse will not be discussed in this document. This document is to provide general concepts and considerations and is not meant to serve as a legal reference or legal advice.

FEDERAL AND STATE LAWS

Federal Law

The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 mandates that any individual, regardless of age, presenting to a dedicated, federally funded ED be offered a medical screening examination (MSE) and treatment of an emergency medical condition (EMC).⁷ Although an unfunded mandate, EMTALA remains an overarching federal law that supersedes state law. The Centers for Medicare & Medicaid Services State Operations Manual specifically states that a minor may request emergency evaluation and treatment.⁴ Therefore, hospital personnel should not delay the medical screening examination or delay treatment of an EMC while waiting for consent from a parent or guardian.³⁻⁵

If an EMC is discovered and consent cannot be obtained, the hospital must provide treatment, stabilization, and even transfer for definitive care while trying to contact the family or guardian.⁵ This recommendation follows the legal concepts of the “emergency exception rule” or the “doctrine of implied consent,” which assumes that were a guardian present, they would consent to treatment in the best interest of the child. If an emergency medical condition is not identified, EMTALA no longer applies, and the decision to treat an unaccompanied minor should be informed by state laws that guide minors’ authority to provide legal consent.

State Law

Every state has enacted statutes to allow minors to consent for medical care, but the circumstances in which a minor can consent to their own treatment vary widely among states. This variability comes from two primary categories: the minor’s legal status and the medical condition for which they seek care.

Legal Status

Legal emancipation is the most easily recognized manner to identify a minor as the decision maker regarding their medical care. Although definitions vary amongst states and territories, in general, emancipation is a legal mechanism for a minor to free themselves from parental guardianship, giving them control over their decisions despite being below the age of majority. Most states describe specific requirements for emancipation and once receiving court declaration of emancipation, minors may consent for health care.

The mature minor doctrine, which has been adopted in various forms in some states, allows minors of a certain age, commonly aged 12 years or older, who demonstrate understanding of medical evaluation and treatment, to provide consent without obtaining previous emancipation (with some state-specific limitations on consent for certain conditions, even for mature minors).⁸ If the treating clinician judges the patient to be of appropriate age and maturity to understand the concepts of evaluation and treatment, the minor may provide legal consent. In states without these laws, and in which no other qualifying law grants the minor the legal right, parental or guardian consent for treatment of nonemergency medical conditions remains the standard.⁹⁻¹⁰

Medical Condition

Laws granting authority to minors to legally consent for care for specific medical conditions vary widely among states. Commonly considered conditions include mental health concerns, substance

abuse, and reproductive health concerns such as pregnancy or sexually transmitted infections. Given the unique nuances of each state's laws, legal variability, and constant evolution of these laws, physicians should be aware of their own state's specific statutes.

CONSENT

The American Academy of Pediatrics Committee on Bioethics refers to several key concepts in the development of the parent, legal guardian, patient or legal surrogate's understanding and decision making in regard to medical care.¹¹ Provisions include information about the following:

- Nature of the illness or condition
- Proposed diagnostic steps and/or treatments and the probability of their success
- The potential risk, benefits, and uncertainties of the proposed treatment and alternative treatments, including the option of no treatment other than comfort measures
- Assessment of patient and surrogate understanding and medical decision-making capacity, including assurance of time for questions by patient and surrogate
- Ensure that there is voluntary agreement with the plan

Who Can Provide Consent?

Although a medical screening examination or treatment of an EMC must not be delayed, legal permission for care of a minor should be first obtained from the guardian(s) if possible. While there is growing evidence that adolescents' decision-making ability approaches adult levels by the mid-teens,¹² the doctrine of parental consent remains the default in modern American law.¹³ Generally speaking, consent for treatment recognizes the autonomy of the patient with appropriate capacity and legal empowerment to allow medical evaluation and treatment.¹¹ The age of majority based on state law as well as state-based and condition-based special circumstances are considered within this definition. Parents and custodial guardians or legal surrogates acting in the best interest of a minor may provide consent for medical evaluation and treatment. Generally, the physician should seek assent from the minor patient for permission for medical evaluation and treatment.

Surrogate Decision Makers

Consent by proxy is the process by which a parent or guardian legally delegates to a surrogate decision maker the legal right to consent to medical treatment for a minor. Consent by proxy forms can facilitate treatment for minors currently not under care of guardians. This is common for children at school or summer camps but is not commonly used when a child is cared for by extended family or other surrogate caregivers. If a surrogate caregiver has been given authority to make decisions for a minor, the physician should review documentation, specifically assessing the scope of authorized medical services, limitations in decision making, and time frame during which this authority is valid. State law may require notarization of the signatures of involved parties and documents.

If at any time the physician doubts that the parent, legal guardian, or surrogate decision maker has the capacity to provide consent for care for any reason (including but not limited to lack of intellectual maturity, intoxication, unclear legal standing, or barriers to understanding the information necessary to make decisions for the patient), the physician should seek other routes for consent for nonemergency care, such as obtaining telephone consent with a witness listening to the conversation.¹⁴

Situations in which minor patients may present without legal guardians include:

- Younger children accompanied by older siblings or other relatives, family friends, day care, or school personnel
- Adolescents driving themselves or brought by friends or coworkers
- Runaway youth
- Immigrant children without accompanying legal guardians
- Children separated from their parents or guardians during disasters¹⁶

When an EMC is treated without formal consent, the facts and circumstances should be documented in the patient record, as well as why instituting immediate treatment was felt to be in the best interests of the minor. Because it would be reasonably expected that parents or legal guardians would have provided consent for care had they been present, ED physician should move forward with emergency treatment by presuming implied consent.¹⁷⁻¹⁸ If a MSE determines there is no EMC and the minor is not legally authorized to consent, nonemergency care should be delayed until a parent or guardian can be contacted to provide legal consent. Otherwise, the physician may be vulnerable to legal action.¹⁴

REFUSAL OF CARE AND DISSENT

The American College of Emergency Physicians supports the delivery of patient- and family-centered care, with several tenets core to the discussion of both consent and dissent. When providing patient- and family-centered care when discussing consent, the emergency physician should 1) promote patient dignity, comfort, and autonomy; 2) recognize the patient and family as key decision makers in the patient's medical care; and 3) acknowledge the interdependence of child and parent, as well as the pediatric patient's evolving independence.¹⁹ When disagreements occur between patients, parents, and physicians, significant challenges arise. Various components play into these conflicts, frequently leading to refusal of care due to poor communication.²⁰ Specific components of productive communication should include assessment of the patient's and parent's understanding of the patient's medical status, investigations about why patients or parents wish to refuse care, explanation of the proposed plan of action, and documentation of this communication.²¹ The principles of shared decision making (i.e., when clinicians and patients make decisions together, using the best available evidence while respecting the patient's autonomy and preferences)²² are crucial in these discussions.

When Minors Dissent

For patients who possess the ability to independently provide consent through the mechanisms described above, refusal of recommended care is relatively straightforward. The determination of a minor's ability to consent to care also confers the right of the minor to refuse recommended treatment, as establishing the capacity of the minor to consent to care also carries the presumption that patients can refuse care; both determinations require a clearly documented assessment that the child has the capacity to understand the risks, benefits, and alternatives of a proposed treatment.

In circumstances in which minors do not have the ability to independently provide consent, refusal of care by the patient is significantly more complicated. This is particularly challenging when a patient has a reasonable understanding of the issues. Physicians are encouraged to respect the patient's opinions and to explore issues and facilitate discussion with the patient and the parent or guardian when their views are in disagreement with the goal of creating a solution that is acceptable to all parties, which ideally includes patient assent.²³ This discussion may require input from the primary care physician or relevant subspecialists or external mediators, such as a social worker or an ethics team. The circumstances in which the minor can refuse care vary from state to state.

Parent and Guardian Dissent

Parents will occasionally refuse recommended care for a minor. This becomes more challenging when parents disagree regarding a course of treatment. Disagreements between separated or divorced parents compound this decision making even further, frequently requiring legal involvement.

Generally, a parent is allowed to make decisions for his or her children, with the presumption that the decisions are in the best interests of the child. However, parental authority is not absolute, and when parents make decisions that place children at significant risk of harm, intervention by governmental agencies (eg, child welfare agencies, law enforcement) may be necessary over the objections of the parent. This is particularly true when there is a concern for child neglect or maltreatment. Parents are also unable to refuse care if they are intoxicated or otherwise impaired, as they lack decision making capacity.

Furthermore, the American Academy of Pediatrics strongly argues against the refusal of clearly beneficial medical care because of religious objections and cites rulings from the United States Supreme Court: “The right to practice religion freely does not include the right to expose the community or the child to communicable disease or the latter to ill-health or death.”²⁴⁻²⁵ For example, courts in the United States have repeatedly ruled that Jehovah’s Witnesses cannot refuse lifesaving blood transfusions on behalf of their children.²⁶ A court order may be required to compel compliance with recommended treatment. When these issues are considered, actions such as engaging hospital administration and legal support, and performing an expedited ethics consultation, may be valuable.

CONFIDENTIALITY

Confidentiality and the Law

The concept of privacy that is most closely related to the idea of confidentiality is that of informational privacy, or prevention of disclosure of personal information.²⁷ Health care interactions invariably require transmission of personal information among multiple parties, and parties involved in the transmission of this information have a duty to protect against unauthorized disclosure of this information. Respect for patient privacy and confidentiality is a valued professional responsibility of all emergency physicians,²⁸ and particularly important for adolescent patients who seek care in the ED. Adolescents are more likely to seek and follow-up for care and disclose sensitive information if the clinician addresses confidentiality in the visit.²⁹⁻³¹ Alternatively, without assurances of confidentiality, adolescents may forgo care.^{9,32}

Although this moral imperative to preserve patient confidentiality is codified in codes of ethics of various professional organizations and state laws,⁹ the primary legal foundation for patient and health care confidentiality is the Health Insurance Portability and Accountability Act (HIPAA).³³ The HIPAA Privacy Rule requires explicit consent for most uses or disclosure of protected health information. Violation of this duty can lead to disruption of the therapeutic alliance between the patient and caregiver and can lead to legal penalties.^{34,35}

HIPAA generally allows the parent to have access to the records of his or her minor child. However, exceptions to this exist and may be guided by state and other applicable law(s).³⁶ For example, federal law supports adolescents’ freedom to confidentially seek family planning services through Title X of the Public Health Service Act.³⁷ As a result, in all states minors of any age may consent for and receive confidential family planning services at Title X–funded sites. When confidentiality is not otherwise protected, minors are generally afforded confidentiality protections when:

- A minor has consented for the care and the consent of the parent is not required by state or other applicable law;
- A minor obtains care at the direction of a court;
- A parent agrees that a physician and minor may have a confidential relationship³⁸

Confidentiality is an important, but not absolute, principle.³⁹ For all adult and minor patients, confidentiality may be overridden by stronger conflicting considerations, which include duties to protect the patient and others from harm, as well as duties to obey the law and protect the public health. Although minors may presume that the interactions with physicians will be confidential, they must be made aware of obligations in which confidential information may need to be disclosed to comply with legal or ethical requirements (eg, suicidal ideation).

When minors request confidential services, physicians should encourage them to involve their parents or guardians; this may require ascertaining why the minor does not want parental involvement.^{40,41} If the minor still chooses not to disclose information, the clinician needs to determine how much confidentiality protection a minor can be given while ensuring the safety of the minor. State law varies, but when a minor can consent to treatment as an emancipated individual, he or she is afforded the same confidentiality protections as adult patients.

Generally, these requests for confidentiality should be respected. The American Medical Association recommends that physicians not notify the parents or guardians of a competent minor without the patient's consent.⁴⁰ Furthermore, there should be a means of communicating follow-up information in a confidential manner to the patient on discharge from the ED. This is critical to disclosing sensitive test results, such as the results of sexually transmitted infection testing.

In circumstances in which lack of parental involvement may result in serious harm to the patient, disclosure may be ethically justified, and the minor should be informed of the rationale for doing so.⁴⁰ Furthermore, in certain situations (eg, when the minor needs to be hospitalized) in which confidentiality cannot be accomplished by any reasonable accommodations, parental disclosure may need to occur. Again, agreement from the adolescent patient should be obtained whenever possible.²⁷ It is imperative that the emergency physician be familiar with the applicable state laws pertaining to his or her practice locale. The Alan Guttmacher Institute maintains a current listing of reproductive health services to which an adolescent can consent.⁴²

For minors who are unable to independently consent for treatment and do not have issues that fall under the statutory protections described above, the protection of confidentiality is more challenging. If the minor is unwilling to voluntarily disclose information to the parent or guardian, disclosure becomes more controversial.²⁷ HIPAA allows considerable clinician latitude in this regard, and the Department of Health and Human Services, the governmental agency that oversees the administration and enforcement of HIPAA, states that if "state and other law is silent concerning parental access to the minor's protected health information, a covered entity has discretion to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment".³³

Reimbursement Challenges to Confidentiality

Most insured minors are listed as dependents and have insurance coverage under a primary policyholder, typically a parent. A major threat to confidentiality exists with respect to billing and payment. This occurs in part because confidentiality frequently conflicts with the desire for financial transparency. Typically, most insurance companies send an Explanation of Benefits (EOB) form to

the primary policyholder, describing the financial details of services rendered, and most states require that notice be sent when claims are denied.⁴³ Furthermore, insurance companies typically communicate with the policyholder about any billing questions instead of directly with dependents. Proposed solutions include not requiring health plans to send an EOB when no balance is due, applying a generic current procedural terminology (CPT) code to sensitive services or creating a CPT code to suppress EOBs for confidential or sensitive services, and requiring health plans to honor patients' requests for confidential communications from all individuals obtaining sensitive services.⁴⁴ Several states have already made insurance law modifications that allow for the opportunity to redirect EOBs with confidential communication to the patient instead of the payer.⁴⁵

As with many issues about confidentiality, regulations with respect to communications with insurance companies vary from state to state.⁴⁶ Recognizing this challenge, 31% of teens receiving care in family planning clinics do not use insurance to pay for services because of fear of someone discovering they received treatment through billing or benefit reporting.⁴⁷ Adolescents whose privacy is ensured by their physicians are more likely to share sensitive information and seek treatment if needed.³⁰ Federal law states that a health plan must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of protected health information from the health plan by alternative means or at alternative locations, if the individual clearly states that the disclosure of all or part of that information could endanger the individual.³³ Developing opportunities that address confidentiality include Medicaid's good-cause exception which allows patients to provide a "good cause exception" to not bill the third party payer, innovative management of reporting EOB and other communications as described above, restrictions on disclosure of sensitive information, and statutes or provisions that protect confidentiality for minors that are insured as dependents.⁴⁸

Electronic Health Records and Confidentiality

Another issue affecting adolescent confidentiality is the electronic health record. In addition to facilitating information exchange among physicians, the electronic health record allows easier access by patients to review their medical records. However, this increase in accessibility poses challenges to the protection of information that minors may wish to keep confidential from their parents. Adolescents may have sensitive medical needs, such as STI screening or treatment, mental health concerns, or substance use-related symptoms. Concerns about confidentiality of care may impact their decision to obtain medical evaluation, disclose substance use to physicians, or return for follow-up.^{29,30,49,50} Electronic health record technology does not routinely support confidentiality protections for adolescent patients.⁵¹ Because legal definitions for age and ability to consent vary from state to state, electronic health records need to become compliant with federal and state law specifically excluding information sharing with parents or guardians when requested by minor patients. The American Academy of Pediatrics policy "Standards for Health Information Technology to Ensure Adolescent Privacy" specifically recommends protecting adolescent confidentiality, especially when legally mandated by state or federal law.⁵² Solutions to electronic health record confidentiality concerns involve both functionality adaptations by electronic health record vendors and modifications of policies and process issues by health care institutions.⁵²⁻⁵⁴ Furthermore, attention should be given to the protection of parents' health information in electronic health records (eg, family genetic history, psychiatric illness) that currently may be accessible by minors. This is not a surprising concern because the issue of the rights of children to know parental health history is unsettled.⁵⁵ If the electronic health record system does not allow adequate confidentiality protection, both the minor and parents should be informed of this.^{53,56}

Patient-controlled health records and patient "portals" have become commonplace, with parents

controlling access until the patient is aged 18 years, clearly compromising confidentiality. There is variability in institutional policies regarding adolescent access to patient portal information including prioritization of adolescent confidentiality, parent access only, or a combination of parental and adolescent access.⁵⁶ Differentiating between young children, adolescents, and adults, and allowing variable access may address the concern of compromising adolescent confidentiality.^{51,53,57}

21st Century Cures Act

The 21st Century Cures Act Final Rule came into effect March 2020, and went into full effect April 5, 2021, which governs multiple aspects of health information technology. The aim of the Final Rule is to increase access and exchange of electronic health information for patients.⁵⁸ Although the benefits of the Final Act may include an increase in guardian engagement in a child's health and empower adolescent patients to co-manage or independently manage their healthcare needs, there is also a potential unintended consequence of jeopardizing confidential care for adolescent patients.

The Final Rule also prohibits information blocking, defined as an action that interferes with access, exchange, or use of health information excluding scenarios allowed by law or covered by a specific exception prohibiting health care institutions from blocking patients' access to their medical information.⁵⁹ Breach of this rule may come with heavy financial penalties.⁶⁰ Consequently, institutions may feel pressure to allow access of all patient information, without consideration to sensitive adolescent care.⁶⁰ To help medical institutions and physicians navigate the complexities of adolescent confidentiality after the Final Rule, the North American Society for Pediatric and Adolescent Gynecology and Society for Adolescent Health and Medicine have created a joint statement providing recommendations of how best to advocate for health care privacy for adolescents. These recommendations include increasing physicians' knowledge of specific state and federal laws around protection of adolescent confidentiality, advocacy for and consideration of separate access to information for patients and parents, advocacy for confidential note types for sensitive medical information, and educating patients, families, and medical staff about confidentiality and information access.⁵⁸

CONCLUSION

Emergency clinicians should not delay performing medical screening examinations or treating emergency medical conditions in minors because of an inability to obtain immediate consent. This is consistent with federal law and is in the best interest of the patient. In many situations, adolescents may legally provide consent for medical treatment for their own treatment. Physicians should be familiar with their state regulations. When parents or guardians refusing to consent for evaluation and treatment of an emergency condition in a minor are not believed to be acting in the best interest of the patient, legal interventions should be considered to compel appropriate treatment. When a minor is treated in the ED independent of a parent or guardian, confidentiality should be respected. Emergency physicians should work with third-party payers and electronic health record vendors to help develop mechanisms to meet this aim.

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