

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 patients under the age of majority present to emergency departments (EDs) without parents or guardians. This may create concern in regard to evaluation of these patients without formal consent to treat. The Emergency Medical Treatment and Labor Act mandates that all patients presenting to EDs receive a medical screening examination and does not exclude these minors. Standards for who can provide consent for a patient vary from state to state and address important issues such as consent by parent surrogates, as well as adolescent emancipation, reproductive health, mental health, and substance use. This document 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. [*Ann Emerg Med.* 2018;71:225-232.]

INTRODUCTION

There are more than 136 million visits annually to emergency departments (EDs) in the United States, with more than 29 million of these visits for patients younger than the age of majority or aged 18 years.¹ Children and adolescents may present to the ED without a parent or guardian for several reasons. Furthermore, adolescents may develop health concerns related to behaviors that parents and guardians disapprove of or are uncomfortable with, including sexual activity, substance abuse, interpersonal violence, or mental illness. The initial medical screening examination of an unaccompanied minor is required by federal statute, and stabilization of an emergency medical condition should occur without delay in situations in which parental consent cannot be obtained.²⁻⁴ Providers must recognize that providing care without a complete awareness of the patient’s problems, medications, or allergies may place the provider at risk of medical error. Although further care for minors beyond emergency screening and stabilization requires legal consent, exceptions to this rule exist.

This document serves to update the 1993 American College of Emergency Physicians Policy Resource and Education Paper in regard to evaluation and treatment of minors in the ED.⁵ The main advances discussed build on the original document as listed in Figure 1. The role of consent to research for minor patients is beyond the scope of this discussion.

Figure 1. Updates to 1993 American College of Emergency Physicians Policy Resource and Education Paper.⁵

EMTALA and the role of federal law in delivering medical care to minors
Categories of conditions that minors may consent for, with state examples
Electronic health records and challenges to confidentiality
Legal aspects of refusal of care on the part of the minor or the parent or guardian
Resources defining state-by-state guidelines about common legal statute

LEGAL ISSUES IN REGARD TO TREATMENT OF AN UNACCOMPANIED MINOR

Federal Law

ED practitioners are bound by an ethical and moral duty to provide emergency treatment to safeguard life, even in the absence of consent.⁶ Federal law supports this in the form of the Emergency Medical Treatment and Labor Act (EMTALA) of 1986 that mandates that any individual presenting to an ED in a hospital receiving federal funding be offered a medical screening examination.⁷ EMTALA is a federal law that supersedes state law. Specifically stated in the Centers for Medicare & Medicaid Services State Operations Manual, a minor may request emergency evaluation and treatment.² The participating hospital must conduct a medical screening examination to determine whether an emergency medical condition exists while making every attempt to obtain consent. Hospital personnel should not delay the medical screening examination or delay treatment of an emergency medical condition by waiting for consent.²⁻⁴ State laws generally define an emergency as “any threat to the minor’s life or health.”⁸ If an emergency medical condition is discovered and consent cannot be obtained, the hospital must provide treatment, stabilization, and even transfer for definitive care while staff are trying to contact the family or guardian.³ This is known as the “emergency exception rule” or “doctrine of implied consent,” which assumes that were a guardian present, he or she 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 consent based on 2 categories: the status of the minor and the condition for which they seek care.

State Law and Legal Status

In regard to status, legal emancipation and mature minor doctrines grant minors the right to seek health care independent of parental consent, yet these laws vary from state to state and are wide ranging. In New York, for example, a minor is considered legally emancipated if he or she is married, in the armed services, or financially independent, or if the parent has failed to fulfill parental support obligations.⁹ In Alabama, any minor who is aged 14 years or older, has graduated from high school, is married, has been married and is divorced, or is pregnant may give effective consent to any legally authorized medical, dental, health, or mental health services for himself or herself.¹⁰ In most states, laws support a pregnant minor’s right to consent to the performance of services relating to her

pregnancy or for her child.¹¹ In Pennsylvania, a minor who has borne a child, or who is or has been married, may consent to medical treatment for her child or herself.¹² In a few states, laws support consent for care for their children, but not for themselves, further complicating the issue.

The mature minor doctrine, which has been adopted in various forms in some states, allows a minor of a certain age, commonly aged 12 years or older, who demonstrates understanding of medical evaluation and treatment, to provide consent without seeking previous emancipation.¹³ 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, parent or guardian consent for treatment of nonemergency medical conditions remains the standard.^{14,15}

State Law and Medical Condition

State laws commonly protect minors' authority to consent for specific medical conditions. These may include mental health concerns, substance abuse, and reproductive health concerns such as pregnancy or sexually transmitted infections. The Guttmacher Institute maintains data on state-specific law about a minor's legal ability to consent for sexual and reproductive care and at what age he or she can do so. Tables describing each state's laws in regard to minors' consent for contraceptive services, sexually transmitted infection services, and medical care for a minor's child are available.¹⁶ Notably, each state determines whether and at what age minors can consent to substance abuse treatment, mental health care, and other common adolescent concerns, and commonly authorize some, most, or all minors to consent for these conditions. A detailed resource addressing the laws of all 50 states was published in 2010 by the Center for Adolescent Health & the Law.¹¹ However, given the unique nuances of each state's law, legal variability, and constant evolution of these laws, providers should be aware of their state's specific current statutes.

CONSENT

Legal permission for treatment should be obtained if at all possible, without delaying a medical screening examination and treating an emergency medical condition. The American Academy of Pediatrics Committee on Bioethics refers to several key concepts to be included in the development of the patient's or surrogate's understanding and decision making in regard to medical care¹⁷:

1. The medical provider must provide information in easily understandable terms.
2. The medical provider must assess the patient's understanding.
3. The medical provider must assess the capacity of the patient or surrogate to make decisions.
4. There must be assurance that the patient or surrogate has freedom to choose among alternatives.

Who Can Provide Consent?

Generally speaking, consent for treatment recognizes the autonomy of the patient with appropriate capacity and legal empowerment to allow medical evaluation and treatment.¹⁷ Age of majority based on state law and state-based special circumstances as above are considered within this definition. Parents or other custodial guardians acting in the best interest of the child may provide consent for medical evaluation and treatment. Assent from the minor patient for permission for medical evaluation and treatment should also be sought in these circumstances.

Children and adolescents may present without guardians for many reasons. As an example, 45% of adolescents with nontrivial head injury present without a guardian to legally provide consent for medical evaluation and treatment,¹⁸ creating a barrier to care. Relatives, family friends, and day care or school personnel may accompany younger children to the ED. Adolescents may be brought by friends or drive themselves and may be considered mature minors. As of 2016, there were more than 1.3 million runaway youths,¹⁹ who may have no available guardian or other resources for medical care. In Florida, a health care provider may accept a written certificate as proof of the minor's status as an unaccompanied homeless youth to consent to medical, dental, psychological, substance abuse, and surgical diagnosis and treatment, including preventive care.²⁰ Immigrant children living in the United States commonly do not have legal guardians.²¹ During disasters, children may also present unaccompanied by guardians.²² When an emergency medical condition is treated without formal consent, the facts and circumstances should be documented in the patient record, as well as how substantial delay may lead to suboptimal or poor outcomes, and why instituting immediate treatment would be deemed to be in the best interests of the minor. Because it would be reasonably expected that parents or legal guardians would have consented had they been present, ED practitioners should move forward with emergency treatment by presuming implied consent.^{8,23} After a medical screening examination is performed, if there is no emergency medical condition identified 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 practitioner may be vulnerable to legal action.²⁴ The availability of cell telephones, now owned by more than 90% of US adults, may allow rapid telephone consent to be obtained, obviating the need for significant delay.²⁵

The legal process by which a parent or guardian delegates to a surrogate decisionmaker the legal right to consent to medical treatment for a minor is called consent by proxy. Consent by proxy forms can facilitate treatment for minors currently not under care of guardians. This is common for children at school or summer camp 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 medical provider 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.²⁴

If at any time the medical provider doubts that the patient, parent, legal guardian, or surrogate decisionmaker 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 medical provider should seek other routes for consent for nonemergency care, such as obtaining telephone consent with a witness listening to the conversation.²⁴

Minor Patients in the Justice System

When a minor patient is involved with the juvenile justice system, there are state laws that dictate who can provide consent for medical care. In California, the courts may remove this right from the parent or guardian.²⁶ In Pennsylvania, the detention center must obtain written consent from the minor's parent or legal guardian to obtain routine care and separate written consent for each instance of nonroutine treatment,²⁷ recognizing that no parental or legal guardian consent is needed in an emergency situation in which delay to obtain consent "would increase risk to the minor's life or health."^{28,29} This definition affords the well-meaning physician broad legal protection to act in the best interest of any minor patient, whether the condition be truly dangerous or a more minor situation such as significant pain from injury or minor bacterial infection that may significantly affect the

patient or lead to more serious consequences. State laws often govern legal consent for routine and nonroutine medical needs for minors in the foster care system.³⁰

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.³¹ 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,³² and without assurances of confidentiality, adolescents may forgo care.^{14,33}

Although this moral imperative to preserve patient confidentiality is codified in codes of ethics of various professional organizations and state laws,¹⁴ the primary legal foundation for patient and health care confidentiality is the Health Insurance Portability and Accountability Act (HIPAA).³⁴ 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.^{35,36}

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. An excellent review of the topic has been written by English and Ford, “The HIPAA Privacy Rule and Adolescents: Legal Questions and Clinical Challenges.”³⁷ Some confidentiality protections are afforded to mature minors, and emergency providers should clearly document the criteria used to judge adolescents as such. Federal law supports adolescents’ freedom to confidentially seek family planning services through Title X of the Public Health Service Act.³⁸ 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:

1. A minor has consented for the care and the consent of the parent is not required by state or other applicable law;
2. A minor obtains care at the direction of a court;
3. A parent agrees that a health care provider and minor may have a confidential relationship.³⁹

Confidentiality is an important, but not absolute, principle.⁴⁰ 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 the confidentiality of their interactions with health care providers, they must be made aware of obligations in which confidential information may need to be disclosed to comply with legal or ethical requirements. Examples may include suicidal ideation, intravenous drug use, or pregnancy in a young patient.

When minors request confidential services, physicians should encourage them to involve their parents or guardians, which includes making efforts to ascertain why the minor does not want parental involvement.^{41,42} If the minor still chooses not to disclose information, the clinician needs to determine how much confidentiality protection a minor can be given to ensure 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.⁴¹ Furthermore, there should be a means of communicating follow-up information in a confidential manner to the patient on discharge from the ED.

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.⁴¹ 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.³¹ It is imperative that the emergency clinician be familiar with the applicable state and federal laws pertaining to his or her practice locale.

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.³¹ 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."³⁴

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 form to the primary policyholder, describing the financial details of services rendered, and most states require that notice be sent when claims are denied.^{43,44} Furthermore, insurance companies typically communicate with the policyholder in regard to billing questions instead of directly with dependents. In response to these concerns, more than half of Title X facilities do not bill at all for patients who have requested confidentiality, and some states and insurance companies do not send an Explanation of Benefits form when no balance is due or send one directly to a location specified by the patient.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's discovering they received treatment through billing or benefit reporting.⁴⁷ Adolescents whose privacy is ensured by their providers are more likely to share sensitive information and seek treatment if needed.⁴⁸ 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."⁴⁹ According to the Guttmacher Institute, 11 states have provisions to protect dependent minors' confidentiality by limiting communications to the policy holder, directing communication to the patient when specifically requested, or by directly billing limited Medicaid programs developed for

minors for family planning services.⁵⁰ As examples, California has incorporated this concept into state law, including communication of sensitive topics, as well as those that could endanger the patient,⁵¹ and Texas Medicaid specifically protects insurance reporting in regard to family planning for title programs.⁵² Developing opportunities that address confidentiality include Medicaid's good-cause exception, innovative management of reporting explanations of benefit and other communications, and restrictions on disclosure.⁴⁴

Electronic Health Records and Confidentiality

Another issue affecting adolescent confidentiality is the electronic health record. In addition to facilitating information exchange among providers, the electronic health record allows easier access by patients to review their medical records. This increasing accessibility poses challenges to the protection of information minors may wish to keep confidential from their parents. Current electronic health record technology does not routinely support confidentiality protections for adolescent patients.⁵³ 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.⁵⁴ Solutions to electronic health record confidentiality concerns will likely involve both functionality adaptations by electronic health record vendors and modifications of policies and process issues by health care institutions.⁵⁴⁻⁵⁶ 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 the minors. This is not a surprising concern because the issue of the rights of children to know parental health history is unsettled.⁵⁷ If the electronic health record system does not allow adequate confidentiality protection, both the minor and parents should be informed of this.⁵⁵

Patient-controlled health records and patient "portals" have become commonplace, with parents controlling access until the patient is aged 18 years, clearly compromising confidentiality. Differentiating between young children, adolescents, and adults and allowing variable access may address this concern.^{53,55,58} Health systems are using and studying confidential adolescent-specific portals, reporting high usage from patients.⁵⁹

REFUSAL OF CARE AND DISSENT

Disagreements between patients, family, and providers pose significant challenges. Various components play into these conflicts, but refusal of care frequently arises from poor communication.⁶⁰ 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.⁶¹ The principles of shared decision making (ie, when clinicians and patients make decisions together, using the best available evidence while respecting the patient's autonomy and preferences)⁶² are crucial in these discussions.

Figure 2. Elements of documentation for refusal of care.⁶¹

Performance of the medical screening evaluation
Decisionmaking capacity of the patient, parent, or guardian
Discussion of treatment offered
Discussion of risks and benefits of treatment or no treatment
Reason for refusal of care
Efforts at negotiating ongoing care, including alternative treatments
Steps taken to secure written refusal
Follow-up plan

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. The determination of 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. Figure 2 suggests elements to document when faced with refusal of care.⁶¹

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. Providers 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.⁶³ 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. 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, such that 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."^{64,65} For example, courts in the United States have repeatedly ruled that Jehovah's Witnesses cannot refuse lifesaving blood transfusions on behalf of their children.⁶⁶ A court order may be required to compel compliance

with recommended treatment. When these issues are considered, engaging hospital administration and legal support, and performing expedited ethics consultation at the time of treatment, will be a valuable asset.

CONCLUSION

Emergency clinicians should not delay performing a medical screening examination or treating an emergency medical condition in a minor patient for consent reasons. 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 without consent of a parent or legal guardian. Providers 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 intervention should be considered to allow care to be provided. When a minor is treated in the ED independent of a parent or guardian, confidentiality should be respected. Emergency physicians and providers should work with third-party payers and electronic health record vendors to help develop mechanisms to meet this aim.

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