

EVALUATION AND TREATMENT OF MINORS

Policy Resource and Education Document

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INTRODUCTION

There are over 136 million visits annually to emergency departments in the United States, with over 29 million of these visits for patients less than the age of majority or 18 years of age.¹ Commonly these patients do not have a parent or guardian on initial presentation to the Emergency Department (ED). As many as 45% of adolescents with nontrivial head injury initially present without a formal guardian to legally provide permission, or consent, for medical evaluation and treatment², creating a barrier to care. 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 health 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 where parental consent cannot be obtained. While further care for minors beyond emergency screening and stabilization requires consent or guardian consent, exceptions to this rule exist.

This document serves to update the 1993 American College of Emergency Physicians policy resource and education paper regarding evaluation and treatment of minors in the emergency department.³ The role of consent to research for minor patients is beyond the scope of this discussion.

LEGAL ISSUES REGARDING TREATMENT OF AN UNACCOMPANIED MINOR

Federal Law

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 mandates that any individual presenting to an emergency department in a hospital receiving federal funding must be offered a medical screening examination (MSE).⁴ Specifically stated in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual, a minor may request emergency evaluation and treatment. The participating hospital must conduct a MSE to determine if an emergency medical condition exists, while making every attempt to obtain consent. Hospital personnel should not delay the MSE, nor delay treatment of an emergency medical condition (EMC), by waiting for consent.^{5,6,7} State laws generally define an emergency as “any threat to the minor’s life or health”.⁸ When an EMC is identified, consent is not necessary for initiating treatment. This is known as the “emergency exception rule” or “doctrine of implied consent”, which assumes that were a guardian present, they would consent to treatment in the best interest of the child. As EMTALA is a federal law, it supersedes state law. Therefore, a hospital must perform a MSE on any minor requesting examination or treatment. If an EMC is discovered and consent cannot be obtained, the hospital must provide treatment, stabilization, and even transfer for definitive care.⁶ If an EMC is not identified, EMTALA no longer applies, and the decision to treat an unaccompanied minor should be informed by considerations discussed in the next section.

State Law

Several conditions exist allowing minors to provide consent for medical treatment. The first authorizes minors to consent for treatment for specific categories of illness, which may include mental health concerns, substance abuse, and sexual health concerns. Notably, each state sets its own age at which minors may consent to substance abuse and mental health treatment, so providers must be familiar with the laws in their states. The Guttmacher Institute maintains current data on state specific law requiring minor’s legal ability to consent for care.⁹ The second condition, legal emancipation, grants minors the right to seek health care independent of parental consent, yet these laws vary from state to state as well. In New York, for example, a minor is considered legally emancipated if he or she is married, in the armed services, is financially independent, or if the parent has failed to fulfill parental support obligations.¹⁰ Similarly, the mature minor doctrine adopted in varying forms in some states, allows a minor of a certain age who demonstrates understanding of medical evaluation and treatment, to provide consent without seeking prior emancipation.¹¹ 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 those states without mature minor laws, parent or guardian consent for treatment of non-EMCs remains the standard.^{12,13} Finally, in some states a minor who has borne a child, or who is or has been married, may consent to medical treatment for their child or themselves.¹⁴

CONSENT

Legal permission for treatment should be obtained if at all possible, without delaying a MSE and treating an EMC. 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 regarding medical care:¹⁵

- 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) 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 for medical evaluation and treatment.¹⁵ Age of majority based on state law, state-based special circumstances such as sexual health and pregnancy, mental health, and drug related concerns as well as legal emancipation 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.

Commonly children present to the ED without a legal guardian. In 2002, there were over 1.6 million runaway youth¹⁶ who may have no other resources for medical care. Immigrant children living in the United States without legal guardians are not uncommon.¹⁷ During disasters children may also present unaccompanied by guardians.¹⁸ Additionally, minor patients transported from schools or day care. Children who can drive themselves or who are transported to the ED by extended family or family friends may present without legal guardians. After a MSE is performed, if there is no EMC identified, non-emergent 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.¹⁹

The legal process by which a parent or guardian delegates to a surrogate decision maker the legal right to consent to medical treatment for a minor is called consent by proxy. Consent by proxy forms can facilitate care 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 care givers. If a surrogate care giver 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.¹⁹

If at any time the medical provider doubts the patient, 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 medical provider should seek other routes for consent for non-emergent care.¹⁹

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.²⁰ 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 non-routine treatment²¹ recognizing that no parental or legal guardian consent is needed in an emergent situation where delay to obtain consent "would increase risk to the minor's life or health".^{22,23} State laws also may govern legal consent for routine and non-routine medical needs for minors in the foster care system.²⁴

CONFIDENTIALITY

The concept of privacy that is most closely related to the idea of confidentiality is that of informational privacy, that is, the prevention of disclosure of personal information.²⁵ 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,²⁶ and without assurances of confidentiality, adolescents may forgo care.^{12,27}

While this moral imperative to preserve patient confidentiality is codified in code of ethics of various professional organizations, the primary legal foundation for patient and health care confidentiality is the Health Insurance Portability and Accountability Act (HIPAA). 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.^{28,29}

HIPAA generally allows the parent to have access to the records of his or her minor child. However, exceptions to this exist. Specifically, minors are 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 relationship³⁰

Confidentiality is an important, but not absolute, principle.³¹ 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. While minors may presume the confidentiality of their interactions with health care providers, they must be made aware of these obligations where confidentiality may need to be violated.

When minors request confidential services, physicians should encourage minors to involve their parents or guardians, which includes making efforts to ascertain why the minor does not want parental involvement.^{32,33} If the minor still chooses not to disclose information, the clinician needs to determine how much confidentiality protection a minor can be given. State law varies, but generally, when a minor can consent to treatment because they are emancipated they are afforded the same confidentiality protections as adult patients. Some confidentiality protections are also 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 through Title X of the Public Health Service Act that established a guarantee of confidential care for adolescent girls seeking family planning services.³⁴ As a result, in all states adolescent females may consent for and receive confidential family planning services at Title X-funded sites.

Generally, these requests for confidentiality should be respected. The American Medical Association recommends that physicians should not notify the parents or guardians of a competent minor without the patient's consent.³² Furthermore, there should be a means of communicating follow-up information in a confidential manner to the patient upon discharge from the ED.

In circumstances that, without parental involvement the situation 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.³² Furthermore, in certain situations (e.g., when the minor needs to be hospitalized) where confidentiality cannot be accomplished by any reasonable accommodations, parental disclosure may need to occur. Again, consent from the adolescent patient should be obtained whenever possible.²⁵ It is imperative that the emergency clinician be familiar with the applicable state and federal laws pertaining to his or her practice locale.

For those minors who are unable to independently consent for treatment and do not have issues that fall under the statutory protections as described above, the protection of confidentiality is more challenging. If the minor is unwilling to voluntarily disclose information, to the parents or guardian, disclosure become more controversial.²⁵ HIPPA allows for considerable clinician latitude in this regard, and the Department of Health and Human Services, the governmental agency which oversees the administration and enforcement of

HIPAA, states that if “[S]tate 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.”³⁵

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, which describes the financial details of services rendered.³⁶ Furthermore, insurance companies typically communicate with the policyholder regarding billing questions instead of direct communications with any dependents. In response to these concerns, some states and insurance companies do not send an EOB when no balance is due, or send EOBs directly to a location specified by the patient. As with many issues regarding confidentiality, regulations with respect to communications with insurance companies vary from state to state.³⁷ Recognizing this, 31% of teens receiving care in family planning clinics do not use insurance to pay for services because of fear of someone finding out they received treatment through billing or benefit reporting to the parent or guardian.³⁸ Those adolescents whose privacy is ensured by their providers are more likely to share sensitive information and seek treatment if needed.³⁹ According to the Guttmacher Institute, eleven 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.⁴⁰

Another relatively new issue with respect to adolescent confidentiality is the electronic health record (EHR). In addition to facilitating information exchange among providers, the EHR 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 EHR technology does not routinely support consent and confidentiality protections for adolescent patients.⁴¹ As legal definitions for age and ability to consent vary from state to state, EHRs need to become compliant with federal law as above, as well as individual state confidentiality law, specifically excluding information sharing with parents or guardians when requested by minor patients. The AAP policy “Standards for Health Information Technology to Ensure Adolescent Privacy” make specific recommendations to protect adolescent confidentiality, especially when legally mandated by state or federal law.⁴² Solutions to EHR confidentiality concerns will likely need to involve both functionality adaptations by EHR vendors and modifications of policies and process issues by health care institutions.^{42,43,44} Furthermore, more attention should be given to the protection of parents’ health information in EHR (e.g., family genetic history, psychiatric illness) which currently may be accessible by the minors. Perhaps this is not a surprising concern, as the rights of children to know parental health history is unsettled.⁴⁵ If the EHR system does not allow for adequate confidentiality protection, both the minor and parents should be informed of this.⁴¹ Unique approaches dealing with health information technology may address these concerns. Patient-controlled health records and patient “portals” have become commonplace with parents controlling

access until the patient becomes 18, clearly compromising confidentiality. Differentiating between young children, adolescents and adults and allowing variable access may address this concern.^{41,43,47}

REFUSAL OF CARE AND DISSENT

Disagreements between patients, family, and providers pose significant challenges. Various components play into these conflicts, but refusal of care very frequently arises from problems arising from poor communication.⁴⁸ It is strongly preferable to prevent these conflicts with better communication rather than having to resolve concerns revolving around the ability of a minor to provide consent and parental involvement. Specific components of this communication should include assessment of the patient and parents understanding of the patient's medical status, investigations as to why patients and/or parents wish to refuse care, explanation of the proposed plan of action, and documentation of this communication.⁴⁹ The principles of shared decision-making (i.e., a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences)⁵⁰ are crucial in these discussions.

For those patients who have been determined to 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. That is, the determination of the capacity of the minor to consent to care also carries the presumption that patients can also refuse care; both determinations require a clearly documented assessment that that 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. Providers are encouraged to respect the patient's opinions and to explore issues and facilitate discussion with the patient and the parent when their views are in disagreement with the goal of creating a solution that is acceptable to all parties, which ideally includes patient assent.⁵¹ 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.

Parents will occasionally refuse recommended care for a minor. Generally, a parent is allowed to make decisions for their children, with the presumption that their decisions are in the best interests of child. However, parental authority is not absolute, and when parents make decisions that place children at significant risk of harm, intervention by governmental agencies (e.g., 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. 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.”^{52,53} Refusal of care in any of these above circumstances may warrant reporting to child protective services for suspected medical neglect.

CONCLUSION

Emergency clinicians should not delay performing a MSE or treating an EMC 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 a parent or legal guardian. Providers should be familiar with their state regulations as these vary. When parents or guardians refusing to consent for evaluation and treatment of an emergent condition in a minor are not felt 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 EMR vendors to help develop mechanisms to meet this aim.

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