PEDIATRICS/POLICY RESOURCE AND EDUCATION PAPER

Evaluation and Treatment of Minors

Lee Benjamin, MD*; Paul Ishimine, MD; Madeline Joseph, MD; Sanjay Mehta, MD, MEd

*Corresponding Author. E-mail: Lbenjamin@epmg.com, Twitter: @Lsbenjamin.

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. 2017;■:1-8.]

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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.

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

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

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

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 decisionmaking in regard to medical care[17]:

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