AMERICAN ACADEMY OF PEDIATRICS

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Pediatric Emergency Medicine

Consent for Emergency Medical Services for Children and Adolescents

ABSTRACT. Pediatric patients frequently seek medical treatment in the emergency department (ED) unaccompanied by a legal guardian. Current state and federal laws and medical ethics recommendations support the ED treatment of minors with an identified emergency medical condition, regardless of consent issues. Financial reimbursement should not limit the minor patient's access to emergency medical care or result in a breach of patient confidentiality. Every clinic, office practice, and ED should develop policies and guidelines regarding consent for the treatment of minors. The physician should document all discussions of consent and attempt to seek consent for treatment from the family or legal guardian and assent from the pediatric patient. Appropriate medical care for the pediatric patient with an urgent or emergent condition should never be withheld or delayed because of problems with obtaining consent. ***This statement has been endorsed by the American College of Surgeons, the Society of Pediatric Nurses, the Society of Critical Care Medicine, the American College of Emergency Physicians, the Emergency Nurses Association, and the National Association of EMS Physicians.***

ABBREVIATIONS. ED, emergency department; AAP, American Academy of Pediatrics; EMTALA, Emergency Medical Treatment and Active Labor Act; MSE, medical screening examination; EMC, emergency medical condition.

BACKGROUND

Under US common law, parental consent generally is required for the medical treatment of minor children. However, a number of well-recognized exceptions to this "general rule" have been outlined in common and statutory law to allow for the treatment of minors without parental consent in situations that frequently occur in emergency departments (EDs).[1–14] In fact, every state has enacted minor consent statutes addressing some or all of these exceptions to the "general rule" (Table 1).[15,16] Since publication of the American Academy of Pediatrics (AAP) policy statement "Consent for Medical Services for Children and Adolescents" in 1993,[17] a number of social, legal, and medical ethics considerations that directly impact the policy have developed. These considerations are addressed with this revision. *This statement has been endorsed by the American College of Surgeons, the Society of Pediatric Nurses, the Society of Critical Care Medicine, the American College of Emergency Physicians, the Emergency Nurses Association, and the National Association of EMS Physicians.*

In 1991, Treloar et al[18] conducted a survey on the use of emergency services by unaccompanied minors and found that approximately 2% to 3% of all children seeking treatment in the ED were not accompanied by a parent or legal guardian. Although no recent studies have addressed this issue, the percentage of "unaccompanied" pediatric patients seeking treatment in the ED (by themselves or with child care providers, teachers, older siblings, divorced noncustodial parents, grandparents, foster parents, and state social service workers, among others) has likely increased. A 1993 policy statement from the AAP on consent noted that "fewer than one third of children live in two-parent families in which only the father works outside the home."[17] According to the US Department of Labor, today only 13% of families fit this "traditional model."[19] Currently, both parents work outside the home in 61% of families, and 60% of mothers of children younger than 6 years are in the workforce, leaving an estimated 19.3 million families of children younger than 14 years with work-related child care requirements.[19] Because more children are being supervised outside the traditional framework of family, more children also are likely to be brought to the ED for treatment in absence of a legal guardian.

Common and statutory law generally has supported the physician or health care professional in providing emergency care for children in the ED without the consent of a parent or guardian. In addition, current federal law under the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates a medical screening examination (MSE) for every patient seeking treatment in an ED of any hospital that participates in programs that receive federal funding, regardless of consent or reimbursement issues.[20–23] EMTALA preempts conflicting or inconsistent state laws, essentially rendering the problem of obtaining consent for the emergency treatment of minors a nonissue at participating hospitals.[23] The purpose of the MSE is to determine whether an emergency medical condition (EMC) exists, as defined by EMTALA, that may require the use of extensive ED resources, including laboratory

TABLE 1. Types of Minor Consent Statutes or Rules of Common Law That Allow for the Medical Treatment of a Minor Patient Without Parental Consent[7,9,12,14–16]

Legal Exceptions to Informed Consent Requirement	Medical Care Setting
The "emergency" exception	Minor seeks emergency medical care.
The "emancipated minor" exception	Minor is self-reliant or independent: • Married • In military service • Emancipated by court ruling • Financially independent and living apart from parents In some states, college students, runaways, pregnant minors, or minor mothers also may be included.
The "mature minor" exception	Minor is capable of providing informed consent to the proposed medical or surgical treatment—generally a minor 14 y or older who is sufficiently mature and possesses the intelligence to understand and appreciate the benefits, risks, and alternatives of the proposed treatment and who is able to make a voluntary and rational choice. (In determining whether the mature minor exception applies, the physician must consider the nature and degree of risk of the proposed treatment and whether the proposed treatment is for the minor's benefit, is necessary or elective, and is complex.)
Exceptions based on specific medical condition	Minor seeks: • Mental health services • Pregnancy and contraceptive services • Testing or treatment for human immunodeficiency virus infection or acquired immunodeficiency syndrome • Sexually transmitted or communicable disease testing and treatment • Drug or alcohol dependency counseling and treatment • Care for crime-related injury

testing, radiographic imaging, and subspecialty consultation as needed for diagnosis. In addition to life- or limb-threatening conditions, the legal definition of an EMC may include conditions with severe pain or conditions with the potential for serious impairment or dysfunction if left untreated.[14,22,23] If an EMC is identified, EMTALA mandates therapy up to and including surgical intervention or transfer to a more appropriate facility for stabilization if needed. If an EMC is not identified, EMTALA regulations no longer apply, and the physician or health care professional generally should seek proper consent before further care is provided. If the MSE or treatment for an EMC is refused, the ED should document the offer of appropriate evaluation and care, the discussion of the risks and benefits, and the competence of the individual revoking the request for care.[23] Although the ED should attempt to contact the unaccompanied patient's parent or legal guardian to seek consent for treatment, the performance of the MSE and the stabilization of the patient with an identified EMC must not be delayed.[23] In his comprehensive reference on EMTALA, Bitterman stated, "Thus, under federal law, a minor can be examined, treated, stabilized, and even transferred to another hospital for emergency care without consent ever being obtained from the parent or legal guardian. Such care would not only be in the patient's best interest but also required by federal law."[23] Because the treatment of fractures, infections, and other conditions may broadly be considered as the prevention of disabling complications or EMCs requiring therapy, many centers currently treat all children arriving in the ED, "even if unaccompanied by a parent or caretaker."[24]

Current medical ethics recommendations also appear to support the ED treatment of unaccompanied minors.[25–28] A recent policy statement from the AAP Committee on Bioethics outlined the 3-way interaction among the physician's responsibility (independent of consent issues) to treat the patient, the parent's or other legal guardian's "proxy" to provide "informed permission" for treatment of a minor child, and the right of the child to give (or refuse) "informed assent" for his or her own care, when appropriate.[28] This statement shifts some of the decision-making responsibility and rights to the child (as appropriate for the child's level of maturity and understanding[29]) and to the physician. Although medical care for an emergency condition may need to proceed without prior assent or permission, the physician should seek consensus from the patient or family as soon as possible. If a conflict over consent or assent for treatment develops, to resolve the conflict the physician may need to evaluate the patient's emotional and intellectual maturity and understanding, the severity of the medical condition, the risks and benefits of treatment, the potential to defer therapy, and the basis for the refusal of treatment.[14,28] In some cases the physician may need to involve the court or social service agencies to proceed with treatment against patient or parental will.[14,28]

Financial reimbursement for the ED treatment of the unaccompanied minor may affect access to appropriate medical care and patient confidentiality. Adolescents usually are covered by their family's insurance or by Medicaid, but they may not have coverage for unaccompanied care, and they may not have the resources to pay for care themselves.[15] As mentioned previously, EMTALA requires that an MSE be provided without consideration of reimbursement issues. Although state and federal programs exist to pay for children's health care needs,[15] uncompensated charges may result from the EMTALA requirement of treatment for all without regard to payment. The ED should ensure that the

financial issues surrounding a patient's treatment do not result in a breach of patient confidentiality, particularly if an unintended parental notification may result from the receipt of an itemized medical bill.[15,24] The physician should discuss these ramifications of unaccompanied care with the minor patient as appropriate for the patient's level of maturity and understanding and seek assent from the patient for parental involvement, as may be required by patient privacy laws in some states, or honor the patient's wish for confidential care.[15,24]

Society expects that reasonable and appropriate medical treatment will be provided to the minor patient in emergent and urgent care settings. Physicians would still be well served medically and legally to follow the advice of a 1991 editorial on consent: "Act like the patient is someone you care about. Act like you have the courage and intelligence to tell the difference between necessary and unnecessary care and testing, and that you have done for the patient what you would have done for your own family member."[30]

RECOMMENDATIONS

1. Appropriate medical care for the pediatric patient with an urgent or emergent condition should never be withheld or delayed because of problems with obtaining consent.
2. The physician or health care professional should be familiar with EMTALA federal regulations and state laws concerning consent for the treatment of minors.
3. Every clinic, office practice, and ED should develop written policies and guidelines that conform with federal and state laws regarding consent for the treatment of minors, including specific guidelines on financial billing, parental notification, and patient confidentiality for the unaccompanied minor.
4. The physician or health care professional should document in the patient medical record all discussions of consent or assent, including the identity of the person providing consent or permission for treatment (the patient or parent or another adult acting on the parent's behalf), an assessment of the maturity and understanding of the pediatric patient, and the efforts made to obtain consent from the patient's legal guardian, if unavailable.
5. The physician or health care professional should always seek consent or assent for medical care from the pediatric patient as appropriate for the patient's development, age, and understanding.

REFERENCES

1. Bissett-Johnson A, Ferguson P. Consent to medical treatment by older children in English and Scottish law. *J Contemp Health Law Policy.* 1996;12:449–473
2. Bernet W. The noncustodial parent and medical treatment. *Bull Am Acad Psychiatry Law.* 1993;21:357–364
3. Dickenson D. Children's informed consent to treatment: is the law an ass? *J Med Ethics.* 1994;20:205–206, 222
4. Henry PF. Judicial review of treatment consent issues for minors. *Nurse Pract Forum.* 1992;3:54–55
5. Neinstein LS. Consent and confidentiality laws for minors in the western United States. *West J Med.* 1987;147:218–224
6. Nypaver MM, Linakis JG, Klein BL. In the absence of consent. *Pediatr Emerg Care.* 1995;11:192–195
7. Holder AR. Disclosure and consent problems in pediatrics. *Law Med Health Care.* 1988;16:219–228
8. Rice MM. Medicolegal issues in pediatric and adolescent emergencies. *Emerg Med Clin North Am.* 1991;9:677–695
9. Sigman GS, O'Connor C. Exploration for physicians of the mature minor doctrine. *J Pediatr.* 1991;119:520–525
10. Siegel DM. Consent and refusal of treatment. *Emerg Med Clin North Am.* 1993;11:833–840
11. Sullivan DJ. Minors and emergency medicine. *Emerg Med Clin North Am.* 1993;11:841–851
12. Veilleux JD, Danny R. Medical practitioner's liability for treatment given child without parent's consent. *Am Law Rep.* 1989;67:511–534
13. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Legal aspects of the provision of emergency care. In: Seidel JS, Knapp JF, eds. *Childhood Emergencies in the Office, Hospital, and Community.* 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2000:257–276
14. Tsai AK, Schafermeyer RW, Kalifon D, Barkin RM, Lumpkin JR, Smith EE III. Evaluation and treatment of minors: reference on consent. *Ann Emerg Med.* 1993;22:1211–1217
15. English A, Simmons PS. Legal issues in reproductive health care for adolescents. *Adolesc Med.* 1999;10:181–194, v
16. English A, Boburg E, Hersh CL, Morreale MC, Stinnett A. *State Minor Consent Statutes: A Summary.* 2nd ed. Chapel Hill, NC: Center for Adolescent Health and the Law; 2002
17. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Consent for medical services for children and adolescents. *Pediatrics.* 1993;92:290–291
18. Treloar DJ, Peterson E, Randall J, Lucid W. Use of emergency services by unaccompanied minors. *Ann Emerg Med.* 1991;20:297–301
19. US Department of Labor. Work-related child care statistics. Available at: http://www.dol.gov/dol/wb/childcare/ccstats.htm. Accessed May 16, 2002
20. Emergency Medical Treatment and Labor Act. 42 USC §1395dd (1986)
21. Solloway M. *EMSC White Paper Series: EMTALA and the Prudent Layperson in Emergency Medical Services for Children.* Washington, DC: Emergency Medical Services for Children (EMSC) National Resource Center; 2000:1–11
22. American Academy of Pediatrics, Task Force on Interhospital Transport. Appendix B. EMTALA: an overview. In: MacDonald MG, Ginzberg HM, eds. *Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients.* 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 1999:179–183
23. Bitterman RA. The Medical Screening Examination Requirement. In: Bitterman RA, ed. *EMTALA: Providing Emergency Care under Federal Law.* Dallas, TX: American College of Emergency Physicians; 2000:23–65

24. Jacobstein CR, Baren JM. Emergency department treatment of minors. *Emerg Med Clin North Am.* 1999;17:341–352, x
25. Bartholome WG. A new understanding of consent in pediatric practice: consent, parental permission, and child assent. *Pediatr Ann.* 1989;18: 262–265
26. Bartholome WG. Informed consent, parental permission, and assent in pediatric practice [letter]. *Pediatrics.* 1995;96(5 Pt 1):981–982
27. Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. *J Child Fam Nurs.* 1998;1:57–61
28. American Academy of Pediatrics, Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. *Pediatrics.* 1995;95:314–317
29. King NM, Cross AW. Children as decision makers: guidelines for pediatricians. *J Pediatr.* 1989;115:10–16
30. Henry GL. Common sense. *Ann Emerg Med.* 1991;20:319–320

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