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Consent for Minors

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Well-intentioned healthcare providers often mistakenly assume that persons under age 18 (minors) may consent to their own healthcare. Treatment of a minor without proper consent may expose the practitioner to tort liability for lack of informed consent or battery in addition to limiting the practitioner's ability to receive payment for the care. The following summarizes the current rules for minor consents in Idaho.

General Rule: Obtain Consent from Parent or Surrogate Decision Maker. I.C. § 39-3503 sets forth the general standard for determining whether a person is competent to consent to their own healthcare:

> Any person who comprehends the need for, the nature of and the significant risks ordinarily inherent in any contemplated hospital, medical, dental, surgical or other health care, treatment or procedure is competent to consent thereto on his or her own behalf.

(Emphasis added). Although the reference to "any person" would suggest that sufficiently mature minors may consent to their own healthcare, the next code section, 39-4504, states:

> Consent for the furnishing of … health care … to any person … who is a minor may be given or refused in the order of priority set forth hereafter…
> (a) The court appointed guardian of such person;
> …
> (e) A parent of such person;
> (f) The person named in a delegation of parental authority executed pursuant to section 15-5-104, Idaho Code;
> (g) Any relative of such person who represents himself or herself to be an appropriate, responsible person to act under the circumstances;
> (h) Any other competent individual representing himself or herself to be responsible for the health care of such person; or
> (i) If the person presents a medical emergency or there is a substantial likelihood of his or her life or health being seriously endangered by withholding or delay in the rendering of such … health care … , the attending health care provider may, in his or her discretion, authorize and/or provide such health care, as he or she deems appropriate…

(Emphasis added). Given the specific reference to minors in section 39-3504, unless and until the statute is changed or a court provides a contrary interpretation, the more conservative approach is to assume that a minor may not consent to their own healthcare unless (i) the minor is emancipated, or (ii) another statute authorizes the minor to consent or allows treatment without consent as discussed below.

Exceptions. Minors may consent to their own care in the following situations:

1. If the minor is emancipated. Although there do not appear to be any Idaho cases and few statutes on point, minors will likely be deemed to be emancipated and competent to consent to their own healthcare if: (i) a court has entered an order that declares the minor to be emancipated[1]; (ii) the minor is married or has been married[2]; (iii) the minor is serving in the active military[3]; or (iv) the minor has rejected the parent-child relationship, is living on their own, and is self-supporting.[4]

Contrary to common belief, pregnancy does not appear to be an emancipating event under Idaho law. The Idaho legislature has declared that "[t]he capacity to become pregnant and the capacity for mature judgment concerning the wisdom of bearing a child or of having an abortion are not necessarily related…."[5] Accordingly, Idaho's abortion statute generally requires parental consent before an abortion may be performed on a minor unless certain emergency or judicial bypass conditions are satisfied.[6] Consent would not be necessary if pregnancy were an emancipating event. I.C. § 18-609A specifically refers to a "pregnant unemancipated minor" which would not exist if pregnancy were an emancipating event. Although these sections arise in the context of abortion, it is reasonable to assume that the same principle applies in other healthcare settings, i.e., pregnancy is not an emancipating event.

2. If a statute grants the minor authority to consent for their own care. Several statutes allow minors to consent to their own care or otherwise protect practitioners who treat minors. For example, (i) minors age 14 may consent to their own treatment for certain infectious or communicable disease[7]; (ii) minors age 14 may consent to their own hospitalization or treatment at mental health centers for mental illness[8]; (iii) minors age 17 may consent to donate blood in a voluntary, noncompensatory blood program[9]; (iv) minors may consent to their own treatment or rehab for drug abuse[10]; (v) physicians and certain other licensed practitioners may provide examinations, prescriptions, devices and informational materials regarding contraception if the physician deems the patient to have sufficient intelligence and maturity to understand the nature and significance of the treatment[11]; and (vi) according to Interpretive Guidelines issued by CMS, EMTALA allows minors to consent to their own emergency medical screening examination and, if an emergency condition is detected, stabilizing treatment by hospitals.[12]

3. Maybe if the minor is mature enough to understand and appreciate the consequences of their decision under I.C. § 39-4503. In many states, minors may consent to their own care if they have sufficient maturity and understanding to appreciate the consequences of their healthcare decisions. This "mature minor" doctrine is premised on the fundamental right of mentally competent persons to make their own healthcare decisions and the recognition that a person's eighteenth birthday is a relatively arbitrary date on which to base a person's competency to make such decision.

It is not clear whether Idaho would adopt the mature minor doctrine; however, there is a strong argument that the mature minor doctrine already exists in Idaho. As noted above, I.C. § 39-4503 states that "any person" who "comprehends the need for, the nature of, and the significant risks ordinarily inherent" in any healthcare is competent to consent. In 2006 and 2007, the legislature specifically rejected proposed amendments that would have limited the general consent statute to "any adult person". And as discussed above, several Idaho statutes recognize that sufficiently mature minors may consent to their care in certain contexts.[13] Nevertheless, there are no reported Idaho cases applying section 39-4503 to minors or otherwise adopting the "mature minor" doctrine, and section 39-4504 expressly identifies the surrogates who may consent for minors. If a practitioner decides to rely on the "mature minor" doctrine, they are doing so at their own risk. At the very least, the practitioner should carefully consider and document appropriate factors relevant to their decision, including (i) the age of the minor (e.g., the decision is more easily justified if the minor is close to age 18); (ii) the maturity and intelligence of the minor; and (iii) the nature of the treatment (e.g., minors may be able to consent to less serious care, but may lack maturity to make major decisions).

Additional Considerations. The decision to allow minors to consent to their own health care may have unanticipated consequences. In such cases, for example, HIPAA may preclude practitioners from disclosing information to parents without the minors' consent or, at the very least, without giving the minor patient the chance to object to such disclosure.[14] This may also make it more difficult to collect for the care rendered to the minor patient (especially if the care is not necessary) because minors generally lack the capacity to enter binding contracts.

Conclusion. In most cases, practitioners should require parental consent before treating minors. In exceptional cases where they choose to rely on the minor's consent, practitioners should (i) ensure they have a valid basis for an exception; (ii) document the facts that justify the exception; and (iii) consider the unintended effects of their decision, including the increased limits on their ability to communicate with or collect from the parents and guardians.

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[1]*See* I.C. § 16-2403(1).

[2]*See* I.C. § 16-2403(1), 18-604(3), and 66-402(6); *see also id*. at 32-101(3) and 15-1-201(15).

[3]*See* I.C. § 18-604(3).

[4]*See* I.C. § 66-402(6); *see also Ireland v. Ireland*, 123 Idaho 955, 855 P.2d 40 (1993), *and Embree v. Embree*, 85 Idaho 443, 380 P.2d 216 (1963).

[5]I.C. § 18-602(d).

[6]I.C. § 18-609A.

[7]I.C. § 39-3801; *see also* IDAPA 16.02.10.015.11(c).

[8]I.C. § 66-318.

[9]I.C. § 39-3701.

[10]I.C. § 37-3102.

[11]I.C. § 18-604.

[12]CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 60, 07-16-10)

[13]I.C. § 18-603 and 18-609A(2)(a).

[14]*See* 45 C.F.R. 164.504(g) and 164.510.

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