Kim Stanger

Partner
208.383.3913
Boise
kcstanger@hollandhart.com

Consent for Treatment of Minors in Idaho

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NOTE: The information in this article may be outdated and updates to this information are covered in a subsequent article, which can be found here.

In Idaho, persons under the age of 18 ("minors") may consent to their own healthcare in only limited circumstances.[1]

General Rule: Obtain Consent from Parent or Surrogate Decision Maker. Idaho Code § 39-4503 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 health care services 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, § 39-4504(1), states:

> Consent for the furnishing of health care services to any person … **who is a minor** may be given or refused in the order of priority set forth hereafter; provided however, that the surrogate decision-maker shall have sufficient comprehension as required to consent to his or her own health care services pursuant to … section 39-4503…
>
> (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 [I.C. § 15-5-104];
> (g) Any relative of such person;
> (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 health care services to such person …, the attending health care

> provider may, in his or her discretion, authorize or provide such health care services, as he or she deems appropriate…

(Emphasis added). Given the specific reference to minors in § 39-4504, unless and until the statute is changed or an Idaho 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:

1. A court has entered an order that declares the minor to be emancipated.[2]
2. The minor is married or has been married.[3]
3. The minor is serving in the active military.[4]
4. The minor has rejected the parent-child relationship, is living on their own, and is self-supporting.[5]

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….".[6] Accordingly, Idaho's abortion statute generally requires parental consent before a legal abortion may be performed on a minor unless certain emergency or judicial bypass conditions are satisfied.[7] Consent would not be necessary if pregnancy were an emancipating event. Idaho Code § 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 itself is not an emancipating event. However, several statutes may allow a pregnant minor to consent to certain types of care as discussed below.

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:

1. Under Idaho law, 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.[8] In addition, HHS has taken the position that minors may receive family planning services from Title X projects without parental consent.[9] Such services may include patient education and

counseling concerning family planning, contraception, basic infertility services, pregnancy diagnosis and counseling, cervical and breast cancer screening, and sexually transmitted disease ("STD") and HIV prevention education, testing and referral, but not abortion.[10] According to the federal Office of Population Affairs, Title X program staff may not notify parents or guardians before or after the minor has requested and/or received Title X family planning services.[11] Note, however, that in December 2022, a federal court in Texas held that HHS's Title X exception does not preempt contrary state laws requiring parental consent and notification.[12] The case is currently on appeal to the Fifth Circuit.

2. Healthcare providers may render necessary emergency care when the patient is unable, or there is no authorized personal representative available, to consent.[13] According to CMS Interpretive Guidelines, EMTALA allows minors to consent to their own emergency medical screening examination and, if an emergency condition is detected, stabilizing treatment by hospitals, at least until parents or guardians may be contacted.[14]

3. Minors aged 14 may consent to their own treatment for certain infectious, contagious, or communicable diseases that are required to be reported to the local health officer, including STDs.[15] The parents are not liable for the cost of such care.[16]

4. Minors aged 14 may consent to their own hospitalization or treatment at certain facilities for mental illness.[17] The facility must notify the parents.[18] "Facility" is defined as "any public or private hospital, …institution, mental health center, or other organization designated in accordance with rules adopted by the board of health and welfare as equipped to initially hold, evaluate, rehabilitate, or provide care or treatment, or both, for the mentally ill."[19] It is not clear the extent to which this statute would apply to a minor's request to receive mental health care outside of a facility as defined in the statute. Minors generally require parental consent to access mental health services from Health and Welfare.[20] Psychosurgery and electroconvulsive therapy may not be performed on a minor without a court order; parental consent is insufficient.[21]

5. Minors aged 16 or older may consent to their own treatment or rehab for drug abuse by a physician.[22] If the minor is aged 16 or older, the fact that the minor sought treatment or that he or she is receiving such treatment may not be disclosed to the parents or guardian without the patient's consent.[23] The practitioner must counsel the patient as to the benefits of involving his parents or legal guardian in his treatment or rehabilitation.[24] If the treatment is being provided by a federally assisted substance use disorder program. additional rules may apply as set forth in 42 C.F.R. part 2.

6. Minors aged 17 may consent to donate blood in a voluntary, non-compensatory blood program.[25]

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.

It is not clear whether or to what extent a court would adopt the mature minor doctrine in Idaho. On the one hand, 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 Idaho legislature rejected proposed amendments that would have limited the general consent statute to "any adult person". Several Idaho statutes recognize that sufficiently mature minors may consent to their care in certain contexts.[26] On the other hand, there are no reported Idaho cases applying § 39-4503 to minors or otherwise adopting the "mature minor" doctrine; § 39-4504 expressly identifies the surrogates who may consent for minors; and, as discussed above, the Idaho legislature has apparently felt the need to identify specific statutory situations in which minors may consent to their own care. In addition, the United States Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* rejected a constitutional right of privacy that has been a basis for allowing minors to make certain decisions concerning their own reproductive health.[27]

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.*, the courts have been more deferential in cases involving reproductive rights; and minors may be able to consent to less serious care, but may lack maturity to make major decisions).

Unintended Consequences. The decision to allow minors to consent to their own health care may have unanticipated consequences. For example, minors generally lack capacity to contract;[28] accordingly, with limited exceptions, unemancipated minors may generally disaffirm the contract, thereby limiting the practitioner's ability to get paid for their medical services.[29] In addition, if a practitioner determines that the minor may consent to their own healthcare, the parents or guardians are no longer the personal representatives for purposes of HIPAA;[30] consequently, HIPAA limits the ability of practitioners to disclose information to parents or guardians without obtaining the minor's consent

to disclosure.[31] Although HIPAA generally allows the practitioner to use or disclose protected health information for payment purposes without the patient's authorization, such uses or disclosures must be limited to the minimum necessary.[32] Thus, practitioners must carefully limit how and what information they disclose to parents or guardians in such cases.

Conclusion. In most cases, practitioners should require parental consent before treating minors in Idaho. In exceptional cases where they choose to rely on the minor's consent, practitioners should (i) ensure they have a statutorily or court-approved basis for doing so; (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 patient, parents and guardians.

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[1] 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. For more information concerning general consent law, see our Legal Update here.

[2] I.C. § 16-2403(1).

[3] *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).

[4] *See* I.C. § 18-604(3).

[5] *See* I.C. §§ 66-402(6) and 32-104; *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).

[6] I.C. § 18-602(d).

[7] I.C. § 18-609A.

[8] I.C. § 18-604.

[9] 42 U.S.C. § 300 *et seq*.; 42 C.F.R § 59.5.

[10] 42 C.F.R § 59.5(a); *see also* Program Requirements for Title X Funded Family Planning Projects, available at https://www.hhs.gov/opa/sites/default/files/ogc-cleared-final-april.pdf.

[11] 42 C.F.R § 59.11; OPA Program Policy Notice 2014-01, available at https://www.hhs.gov/opa/sites/default/files/ppn2014-01-001.pdf.

[12] *Deandra v. Becerra,* No. 2:2020cv00092 (N.D. Tex. 2022).

[13] I.C. §§ 39-3801 and 56-1015; *see also id.* at § 16-2422(1).

[14] CMS State Operations Manual App. V—Interpretive Guidelines—Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 07-19-19) at Tag A2406.

[15] I.C. § 39-3801; *see also* IDAPA 16.02.10.050.

[16] I.C. § 39-3801.

[17] I.C. § 66-318(b).

[18] *Id.*

[19] I.C. § 66-317(6).

[20] *See, e.g.,* I.C. § 16-2422.

[21] *Id.*

[22] I.C. § 37-3102; IDAPA 16.05.01.250.02.

[23] *Id.*

[24] *Id.*

[25] I.C. § 39-3701.

[26] *See, e.g.*, I.C. §§ 18-603 and 18-609A(2)(a).

[27] 497 U.S. ___ (2022).

[28] I.C. §§ 29-101 and 32-101.

[29] I.C. § 32-103; *see also id.* at §§ 32-104 and 32-105.

[30] 45 CFR §§ 164.504(g).

[31] See 45 CFR §§ 164.502(a) and 164.510(b).

[32] 45 CFR §§ 164.506 and 164.514(d).
