Coates' Canons Blog: New Law: Consenting to Medical Treatment for a Child Placed in the Custody of County Department

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Through S.L. 2015-136, “An Act to Make Various Changes to the Juvenile Laws Pertaining to Abuse, Neglect, and Dependency,” the General Assembly enacted G.S. 7B-505.1 and G.S. 7B-903.1(e).These two new statutes address medical decision-making authority for a child who is placed in the custody of a county department through an order entered in an abuse, neglect, and dependency action. These new laws apply to all abuse, neglect, and dependency actions that were pending on or filed after October 1, 2015.

Custody Ordered to a County Department

The court may order the child into a county department’s custody at two different stages in the abuse, neglect, and dependency action: nonsecure custody and/or disposition.

An order for **nonsecure custody** is a temporary custody order that is entered by the court to protect a child when specific statutory criteria are met. G.S. 7B-503. The order is entered before the court holds the adjudicatory hearing to determine if the child is abused, neglected, or dependent. G.S. 7B-502, –506(a). The order for nonsecure custody must state who the child will be placed with or who has responsibility for the child’s placement. G.S. 7B-505. When a county department seeks an order for nonsecure custody, the court must first consider “release of the juvenile to the juvenile’s parent, relative, guardian, custodian, or other responsible adult.” G.S. 7B-503(a). If nonsecure custody is not granted to one of these individuals, the court may order the child in nonsecure custody with the county department. G.S. 7B-505(a).

If the child is adjudicated abused, neglected, or dependent, the court proceeds to an initial dispositional hearing. G.S. 7B-901(a). One of the issues the court decides at **disposition** is custody of the child. G.S. 7B-903. Dispositional orders will be entered throughout the proceeding, including after each review and permanency planning hearing. G.S. 7B-905, -906.1, -906.2. At disposition, custody may be ordered to a parent, guardian, custodian, or county department. G.S. 7B-903. A county department with custody of the child has placement responsibility for the child. G.S. 7B-505(a), –507(a)(4), -903(a)(6). A department may place the child in a licensed foster home.

Routine and Emergency Care and Evaluations in “Exigent Circumstances”

The new G.S. 7B-505.1 applies when a child is placed in the custody of a county department. *See also*, G.S. 7B-903.1(e). The statute explicitly allows the director, or the department social worker as the director’s representative, to arrange for and consent to the child’s

- routine medical and dental care;
- emergency medical, surgical, or mental health care; and
- testing and evaluation in exigent circumstances.

G.S. 7B-505.1(a), –101(10).

None of the terms above are defined in the Juvenile Code and lead to the following questions: what is routine care; what is emergency care; and what constitutes exigent circumstances? Until the statutory language or case law addresses these questions, the answers are subject to interpretation.

Routine Care

Although specifically referred to in G.S. 7B-505.1(a)(1), “routine care” is not defined. One can look to sources outside of the North Carolina General Statutes, such as the American Academy of Pediatrics or the Early Periodic Screening Diagnostic and Treatment program under Medicaid, for guidance. One type of care that is widely recognized as routine is the well-child visit, which involves a variety of evaluations: measurements (height, weight, and blood pressure); a check of vital functions; vision, hearing, dental, developmental, and lead screening; a physical examination; and up-to-date immunizations. 42 C.F.R. 441.56(b), *see also* healthychildren.org.

What about a “sick visit” when a child is taken to a medical provider because of an illness or injury, such as an ear infection or knee pain? Is a “sick visit” routine? Routine means “a regular course of procedure.” Merriam-Webster Dictionary. A routine practice for a parent of a sick child probably includes scheduling a “sick visit” with the child’s medical provider and following the course of recommended treatment. Not all “sick visits” will be routine. Depending on the illness or injury, the care may constitute emergency care, or the treatment may require “informed consent” as the term is used in G.S 7B-505.1(c) from the child’s parent, guardian, or custodian, or from the county department when it has obtained a court order authorizing it to consent to the child’s treatment.

What happens when a child is diagnosed with a chronic condition (e.g., diabetes, a seizure disorder, or cancer) that requires a specific treatment? Because the treatment for that condition is not routine to all children, the treatment is probably not routine care for purposes of consent pursuant to G.S. 7B-505.1(a)(1) even though the treatment for a specific condition is commonly accepted in the medical community.

Based on the wording of the statute, routine care probably excludes mental health treatment. “Mental health” is explicitly included in the language allowing for emergency treatment (G.S. 7B-505.1(a)(2)) and for treatment that requires a court order authorizing the county department provide consent for the child’s care (G.S. 7B-505.1(c)(1) & (6)). The language used in G.S. 7B-505.1(a)(1) limits “routine” care to medical and dental treatment and is silent about mental health treatment.

As part of “routine care,” a medical provider may determine the child requires a referral to another provider for evaluation and/or treatment (e.g. a specialist or mental health evaluation). G.S. 7B-505.1 does not prohibit the referral of a child patient to another medical provider but instead addresses who is authorized to consent to the child’s evaluation and/or treatment provided by that specialist.

What is Emergency Treatment?

Emergency care is referenced in G.S. 7B-505.1(a)(2) but is not defined. Various sources provide guidance for how one may interpret emergency treatment. For example, G.S. 90-21.1 authorizes a medical provider to treat a child without the consent of a parent, guardian, or person acting in loco parentis to the child when the necessity for immediate treatment is so apparent that a delay would endanger the child’s life or seriously worsen the child’s condition. It is important to note that G.S. 7B-505.1 does not prohibit a medical provider from providing emergency treatment in situations described by G.S. 90-21.1.

Additional guidance for interpreting emergency treatment is provided by the federal Medicaid regulations, which define an “emergency medical condition” and “emergency services.” 42 C.F.R. 438.114(a). Emergency services are furnished to an individual by a medical provider when needed to evaluate or stabilize an emergency medical condition. An emergency medical condition involves acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following

- placing the person’s health (and if pregnant, the woman or her unborn child) in serious jeopardy,
- serious impairment of bodily functions, or
- serious dysfunction of any bodily organ or part.

What are exigent circumstances?

Exigent means requiring immediate attention. Merriam-Webster Dictionary. Treatment in exigent circumstances is limited to testing or evaluation, and therefore, differs from emergency medical, surgical, psychiatric, psychological or mental health care. The statute does not identify any tests or evaluations that a county department may consent to because of exigent circumstances.

A Child Medical Evaluation (CME)

An evaluation in exigent circumstances is not a **Child Medical Evaluation (CME)**. A CME is specifically addressed by G.S. 7B-505.1 which authorizes a county department to consent to a child's CME by court order. The county department may obtain a court order authorizing it to consent to the child's CME:

1. at the initial request for nonsecure custody; the order must contain written findings of the department's "compelling interest" in having the child evaluated before the first hearing on the need for continued nonsecure custody (G.S. 7B-505.1(b)); or
2. after a hearing on the need for continued nonsecure custody or at disposition; the order must include findings by clear and convincing evidence that the CME is in the child's best interests. G.S. 7B-505.1(c).

If a county department is consenting to the child's CME, the medical provider will need to see the court order that authorizes the department to consent to the child's evaluation. Without this court order, the child's parent, guardian, or custodian must consent to the CME. G.S. 7B-505.1(c)(4). Note, a department does not need to wait until it obtains a court order to schedule the CME. The department may schedule the CME for a date that follows a hearing that will determine who has the authority to consent to the CME.

Medical Care that Is neither Routine nor an Emergency

The general rule for a child who requires non-routine or non-emergency medical care and who is in the custody of a county department is that the child's parent, guardian, or custodian must consent. G.S. 7B-505.1(c), -903.1(e). The exception to this general rule is when, after a hearing, the court authorizes the county department to consent to the child's treatment. The **court order** must find by clear and convincing evidence that the non-routine or non-emergency treatment or evaluation is in the child's best interests. G.S. 7B-505.1.

Maintaining a parent's right to make decisions for his or her child recognizes the state policy of having child welfare workers partner with parents when making decisions regarding the child. NC DHHS DSS Child Welfare Services Manual, 1201, V.A. "Parents of children in foster care placement retain many of their rights." NC DHHS DSS Child Welfare Services Manual, 1201, V.F. A parent has a paramount constitutional right to care, custody, and control of his or her child, although this right is not absolute. *Price v. Howard,* 346 N.C. 68 (1997). A parent's constitutional right may be forfeited when the parent is unfit or has acted inconsistently with his or her constitutional right. *Id.* The new G.S. 7B-505.1(c) recognizes both the parent's right and ability to lose that right.

A court's finding by clear and convincing evidence that it is in the child's best interests that a county department consent to treatment is not the equivalent of a finding that the parent has forfeited his or her constitutional right. Although the statute does not prohibit the court from finding that the parent has acted inconsistently with his or her constitutional right, that finding is not required. It is possible that a parent may agree it is in the child's best interests that the department consent to all or some of the child's medical care while the child is placed outside of the parent's home.

G.S. 7B-505.1(c) identifies a **non-exhaustive list of specific treatments** that require the county department to obtain a court order authorizing it to consent:

- Prescriptions for psychotropic medications.
- Participation in clinical trials.
- Immunizations when it is known that the parent has as bona fide religious objection to the standard schedule of immunizations
- Surgical, medical, dental, psychiatric, psychological, or mental health tests, care, or treatment that require informed consent.

A good practice is to have the court order designate the treatments that have been found to be in the child's best interests for the department to consent to and the treatment decisions that remain with the parent, guardian, or custodian. For example, the court may determine that it is in the child's best interests that the department consent to the child's counseling, especially when abuse in the home will be discussed, but that the parent retains the right to consent to the child's surgery.

Although childhood immunizations are routine and required by law (G.S. 130A-152), a parent may object because of a **bona fide religious belief**. G.S. 130A- 157. If a parent is known to have a bona fide religious objection to immunization, then for purposes of this law, immunizations may not be treated as routine. G.S. 7B-505.1(c)(3) requires a hearing. The court must determine whether the parent's objection is based on a bona fide religious belief, whether the parent has a right to make that objection or has forfeited his or her right, and whether the immunization is in the child's best interests. *See In re Stratton*, 153 N.C. App. 428 (2002).

In setting out the type of care that requires parental consent or court authorization, G.S. 7B-505.1(c) refers to care that **requires "informed consent."** The use of this term is confusing because informed consent is needed for all medical care, including routine care. Criteria for "informed consent" is identified in G.S. 90-21.13(a)(2), although it is not clear if this criteria is what was intended by the language in G.S. 7B-505.1(c)(5) & (6). Informed consent is voluntarily given by a patient, or a person authorized to consent for a patient, to a health care provider for a specific treatment after the provider has explained the procedure or treatment such that a reasonable person is able to have a general understanding of the treatment, including the most frequent risks and hazards of that treatment. G.S. 90-21.13(a)(2). To give meaning to the language in G.S. 7B-505.1(c), care, treatment or tests that require informed consent could mean non-routine and non-emergency procedures that require specific written informed consent, such as surgery, chemotherapy, a hospital admission, or a specific psychiatric therapy.

Psychotropic medications are explicitly identified as treatment that requires a court order for the department to consent. If a child is prescribed a psychotropic medication at the time he or she is placed in a department's custody, questions of who has authority to call in for and pick up prescription refills may arise. Not refilling an existing prescription has the effect of making a medical decision to discontinue treatment. A good practice is to have the court address this issue at the first hearing on the need for continued nonsecure custody. A court may decide the parent should consent to whether the child remains on psychotropic medication while the department has the authority to call in to the medical provider and pick up prescription refills. When the issue of psychotropic medication for a child is first raised after the child is placed in a department's custody, the department will need to obtain a court order to consent to that prescription; otherwise, the decision remains with the child's parent, guardian, or custodian.

Non-psychotropic medications are not specifically addressed in G.S. 7B-505.1(c). The authority to consent to a prescription medication for treatment of a physical condition (e.g. a seizure disorder, acne, or a viral or bacterial infection) may depend on whether that treatment is considered "routine" or "emergency." Non-routine and non-emergency treatment requires parental consent or court order. There is a spectrum of medications and side effects that may affect how the treatment is classified. For example, an adolescent with acne may be treated with a prescription topical ointment that is considered routine, although in the absence of a definition of routine, we do not know for sure. Another adolescent may need a prescription for isotretinoin (a.k.a. the now-defunct brand name Accutane), which requires specific written informed consent, triggering the need for parental consent or a court order. And a third adolescent may need a prescription for long-term antibiotic therapy. Where does that fall?

When a dispute or uncertainty about who has the authority to consent to specific medical care for the child arises, the county department or respondent parent, guardian, or custodian may want to raise it as an issue for the court to decide. This decision may be particularly important for a child with a chronic health condition. The court will have to decide how to classify the treatment (routine or non-routine) when determining which section of G.S. 7B-505.1 applies. A party should be prepared to introduce evidence from a medical provider that can explain the treatment so that the court may base its decision on competent evidence.

Delegated Medical Decision Making Authority

The medical consent statute does not include language that permits a county department with the authority to consent to a child's medical care to delegate that authority to someone else, such as a foster parent. Although the medical consent for

a minor statute allows a person standing in loco parentis to a child to consent to the child's treatment (G.S. 90-21.1), a foster parent does not stand in loco parentis to a child. *Liner v. Brown*, 117 N.C. App. 44 (1994).

The court may delegate part of a department's decision making authority to another individual. G.S. 7B-903.1(a). It is unclear if the decision-making authority that may be delegated by a court order applies to all the provisions of G.S. 7B-903.1 or to subsection (a) only. Subsection (a) identifies decisions that are generally made by a child's custodian whereas subsection (e) identifies medical decision-making.

Health Care to Which the Minor Consents

Although not addressed in the Juvenile Code, a physician may accept a minor's consent for medical services for the prevention, diagnosis and treatment of

- a sexually transmitted or reportable communicable disease (*See* S. 130A-135),
- pregnancy,
- abuse of alcohol or controlled substances, or
- emotional disturbance.

G.S. 90-21.5.

A minor's ability to consent to these specified medical services is not affected by an order that places the minor in a department's custody. The medical provider may accept the minor's consent without additionally seeking the consent of the minor's parent, guardian, or custodian, including a county department.

Additionally, North Carolina law specifically addresses the right of an unemancipated pregnant minor to consent to an abortion. Written informed consent to the minor's abortion must be provided by both the minor and her parent with legal custody or with whom she lives, her legal guardian or custodian, or her grandparent if she has been living with the grandparent for at least 6 months immediately before the minor's consent is given. G.S. 90-21.7, *see also* G.S. 90-21.87. Consent from any of the specified persons is considered "parental consent" for purposes of this statute. A minor may petition for a judicial waiver of "parental consent" in a district court in which she is physically present. G.S. 90-21.8. The minor is not required to seek the consent of one of the designated persons. *Id*. The court must order the waiver if it finds that the minor is mature and well-informed enough to make the decision on her own, that it is in her best interests to not require "parental consent," or that she is a victim of rape or felonious incest. G.S. 90-21.7(b), 90-21.8(e). The court proceeding, including the minor's identity, is confidential. G.S. 90-21.8. A county department with legal custody of the pregnant minor may be considered a legal custodian who is authorized to consent to her abortion. However, it seems clear that abortion falls under G.S. 7B-505.1(c)(5), as a medical procedure requiring written informed consent. The department would need to obtain a court order authorizing it to consent to the procedure, which conflicts with the confidentiality provisions set forth in G.S.90-21.8. When read together, a department with custody of a pregnant minor should not provide consent as a legal custodian (G.S. 90-21.7) and should not seek the court's authorization under G.S. 7B-505.1(c). The pregnant minor may decide to obtain the consent of another person identified in G.S. 90-21.7 or petition for a judicial waiver of the "parental consent" requirement.

What Do You Think?

Other interpretations are possible. Share your thoughts on what constitutes routine care, emergency treatment, exigent circumstances, and informed consent in the comments below.

Links

- www.ncleg.net/EnactedLegislation/SessionLaws/PDF/2015-2016/SL2015-136.pdf
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-503.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-502.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-506.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-505.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-905.html

- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-906.1.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-101.html
- www.law.cornell.edu/cfr/text/42/441.56
- www.healthychildren.org/English/family-life/health-management/Pages/Routine-Doctor-Visits-For-School-Age-Children.aspx
- www.merriam-webster.com/dictionary/routine
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.1.html
- www.law.cornell.edu/cfr/text/42/438.114
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- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-152.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-157.html
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- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.13.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-135.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.5.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.7.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.87.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.8.html