Consenting to Medical Treatment for a Child Placed in the Custody of County Department, Part II: Non-routine and Non-emergency Medical Care

Part I introduced the new G.S. 7B-505.1 and 7B-903.1(e) and discussed the county department's statutory authority to consent to a child's

- routine medical and dental care;
- emergency medical, surgical, or mental health care;
- testing and evaluation in exigent circumstances, and
- a Child Medical Evaluation (CME).

What about 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. 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) provides 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(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 a 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) in 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 to provide informed consent for the procedure, which conflicts with the confidentiality provisions set forth in G.S.90-21.8. When read together, a county 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 it means to require informed consent in the comments below.