

## Health Professionals and Hospitals

### Reporting

Child abuse and neglect often are identified for the first time when a child is taken to a medical facility for diagnosis or treatment. As discussed in Chapter 2, the very first child abuse reporting laws were designed largely to override doctor–patient confidentiality and allow doctors to disclose information about children they saw who were abused. Although reporting laws have expanded to cover many other professionals—and, in North Carolina, to cover everyone—health care professionals continue to be a key source of reports of child abuse, neglect, and dependency.

### Professional Ethics and Reporting Responsibilities<sup>1</sup>

Health care professionals sometimes confront very difficult issues when trying to honor both their statutory duty to report suspected abuse, neglect, and dependency and their professional ethic of confidentiality. Confidentiality refers to the ethical mandate to protect patient and client privacy, and it is considered a cornerstone of the professional, therapeutic relationship. Conflicts may occur, for example, when a psychotherapist becomes aware that a young client or

patient has been victimized or that an adult client or patient may have harmed a child.

Although the statutory requirement to report supersedes confidentiality, the ethical codes of psychologists, physicians, counselors, social workers, and others require that professionals not exceed the reporting that is required by law. Health care professionals, therefore, are sensitive to the fine points of the meaning of key terms like “caretaker,” “abuse,” “neglect,” and “serious physical injury.” A health or mental health professional who exceeds his or her reporting responsibilities, thereby violating a patient’s or client’s confidentiality without statutory authority to do so, risks being sanctioned for an ethics violation within his or her profession.

Health care professionals should contact the ethics bodies of their professional associations or their licensing boards for guidance when conflicts between the duty to report and the obligation to respect confidentiality are difficult to resolve. In keeping with the doctrine of informed consent for the provision of professional services, these

professionals also should make clients and patients aware of the exceptions to confidentiality as part of the process of contracting for evaluation and treatment.

Even when it is clear that there is no duty to report to social services—for example, because the person who harmed a child is not a parent, guardian, custodian, or caretaker—health care professionals should consider whether they have an ethical duty to take other action to protect clients, patients, or others from serious and foreseeable harm. Finally, health care professionals who have been trained in other states need to become familiar with the North Carolina statutes. Reporting laws, although universal, differ dramatically from state to state in their specific provisions and definitions.

## Emergency Custody in Abuse Cases

### PROCEDURES

When someone brings a child to a medical facility for diagnosis or treatment, and someone there has cause to suspect that the child has been abused, that person must make a report to the department of social services. If necessary, a social worker from the county department of social services or a law enforcement officer may assume immediate temporary custody of the child without a court order.<sup>2</sup> Then the department of social services may file a petition and seek a court order for continued custody. Occasionally, however, a parent may attempt to take the child from the medical facility before a social worker or law enforcement officer is available.

In that situation, a physician or an administrator of the facility can keep physical custody of the child and provide necessary treatment by following these procedures:<sup>3</sup>

1. *Certify need to retain custody.*  
A physician who examines the child certifies in writing that
  - the child should remain at the facility for medical treatment, or
  - based on the medical evaluation, it is unsafe for the child to return to the parent, guardian, custodian, or caretaker.
2. *Obtain judicial authority.*  
The physician or administrator contacts and receives authorization (most likely by telephone) from the chief district court judge (or someone the judge has designated to act in his or her place) to retain physical custody of the child in the facility.<sup>4</sup> The date and time that the physician or administrator receives judicial authorization to retain custody must be noted on the physician's written certification.
3. *Notify director of social services.*  
Immediately after receiving judicial authority to retain custody, the physician or administrator (or someone that person designates) notifies the director of the department of social services in the county in which the facility is located. The director will treat the notification as a report of suspected abuse and begin an investigation.
4. *Distribute copies of certification.*  
A copy of the certification is given to the child's parent, guardian, custodian, or caretaker. Copies also are placed in the child's medical and court records.

These procedures are not likely to work well unless both judges and medical professionals are familiar with them before

an emergency arises. Medical professionals and facilities need to know

- whom, if anyone, the chief district court judge has designated to act in his or her place in these cases;
- who the chief district court judge is, and how to contact him or her and any designees; and
- whether forms to facilitate the required documentation are available locally—from the court, the medical facility, or the social services department—or need to be developed.

It is important to remember that these procedures apply only in cases of suspected abuse, not in cases in which a child's neglect or dependency is the cause for the medical professional's concern. Even in abuse cases the procedure is not mandatory. The physician or administrator may make the required report to social services about the suspected abuse and rely on a law enforcement officer or social worker to assume temporary custody of the child if that is called for.

#### TIME LIMITS

Using this procedure, the child can be kept in the facility without the parent's consent or a court order for no more than twelve hours. The department of social services, however, may file a juvenile court petition and obtain a nonsecure custody order authorizing continued custody, as long as it is able to do so within the twelve-hour period. (This period is twenty-four hours if any part of the twelve-hour period falls on a weekend or holiday.) The social services department must file a petition within the twelve (or twenty-four) hours if its preliminary investigation shows that

1. in the certifying physician's opinion, the child needs medical treatment to cure or alleviate physical distress or to prevent the child from suffering serious physical injury; and
2. in the physician's opinion, the child should remain in the custody of the facility for at least twelve hours; and
3. the parent, guardian, custodian, or caretaker either cannot be reached or will not consent to the child's treatment in the facility.

#### FILING A PETITION

If the case meets the criteria described above, the social services director (or the director's representative) must file a petition, and it will be heard in juvenile court like any other juvenile petition alleging abuse. Only the social services director and the certifying physician, together, can voluntarily dismiss the petition.

If the case does not meet the criteria described above and the social services director decides not to file a petition, the physician or administrator may ask the prosecutor to review the director's decision, as in other reports of abuse, neglect, or dependency. (See "Review Process," in Chapter 11.)

#### COST OF TREATMENT

Finally, if the court determines that the medical treatment the child received was necessary and appropriate, the court may charge the cost of the treatment to the child's parents, guardian, custodian, or caretaker. If the parents are not able to pay, however, the court may charge the costs of the treatment to the county of the child's residence.

## Consent for Emergency Medical Treatment<sup>5</sup>

Depriving a child of necessary medical care is a form of neglect. A physician who believes that a parent is refusing to consent to necessary medical treatment for a child must report that situation to the county department of social services.

A physician may use an additional procedure set out in the Juvenile Code when he or she is barred by the parent's refusal to consent from rendering necessary treatment to a child in an emergency. The physician may ask a district court judge to authorize the treatment. The procedure is as follows:

1. The physician signs a statement (or, in an acute emergency, makes an oral statement to the judge) setting out
  - the needed treatment and the nature of the emergency, and
  - the parent's refusal to consent to the treatment, and
  - the impossibility of contacting a second physician for a concurring opinion on the need for treatment in time to prevent immediate harm to the child.<sup>6</sup>
2. A judge examines the physician's written statement (or considers the physician's oral statement) and finds
  - that it complies with the statute, and
  - that the proposed treatment is necessary to prevent immediate harm to the child.
3. The judge issues written authorization for the proposed treatment or, in an acute emergency, authorizes treatment in person or by telephone.
4. If either the physician's statement or the judge's authorization is oral, it is reduced to writing

as soon as possible. The judge's written authorization for treatment should be issued in duplicate:

- one copy for the treating physician, and
  - one copy to be attached to the physician's written statement and filed as a juvenile proceeding in the office of the clerk of superior court.
5. After a judge authorizes treatment in this manner, and after proper notice, the judge conducts a hearing on the question of payment for the treatment, with two possible results:
    - the judge may order the parent or other responsible parties to pay for the treatment, or
    - if the judge finds that the parent is not able to pay, the judge may order that the costs of the treatment be charged to the county.

## Child Medical/Mental Health Evaluation Program<sup>7</sup>

A thorough investigation and evaluation of suspected abuse or neglect often requires the assistance of a medical or mental health professional.<sup>8</sup> The state Division of Social Services administers the Child Medical/Mental Health Evaluation Program through a contractual arrangement with the Department of Pediatrics at the University of North Carolina at Chapel Hill. The program provides medical and psychological assessments to help county social services departments make decisions in connection with investigations of abuse and neglect cases. (It does not include treatment services.) The program's services are provided by a network of local physicians and mental health examiners and are available to every county.<sup>9</sup>

The program has contributed to improved understanding and coordination between social services and medical professionals, more accurate and timely evaluations of children who may be abused or neglected, better testimony and evidence to establish abuse and neglect in cases that go to court, and increased skills and awareness among large numbers of professionals who are involved in these cases.

The program's staff at the University of North Carolina at Chapel Hill provide training for participating medical and mental health providers and also participate frequently in training for social workers, law enforcement officers, and judges.

## Notes to Chapter 15

1. This section is adapted from comments submitted to the author by William V. Burlingame, Ph.D., Clinical Professor of Psychology, The University of North Carolina at Chapel Hill, 3 January 2001.

2. G.S. 7B-500. Ordinarily a child may not be taken into custody without a court order. In order to assume custody immediately the social worker or officer must have reasonable grounds to believe that the child is abused, neglected, or dependent and that the child would be injured or could not be taken into custody if it were necessary to obtain a court order first.

3. G.S. 7B-308. Medical professionals may find, or believe, that it is easier and takes no longer to get a law enforcement officer or a social services worker on the scene than to use the procedures described here. The evolution of this law is interesting. In the early 1970s, former G.S. 110-118(d) gave the physician authority on his or her own to retain temporary physical custody of the child in this cir-

cumstance. It put the burden on the parents to seek a court hearing if they objected. A 1975 amendment added a requirement that the physician who retained custody of a child ask social services to file a petition and seek a court order for temporary custody. In 1977, another amendment added authority for the medical facility to render necessary medical treatment to the child. The requirement that the physician get authorization from a district court judge to retain custody of the child appeared first in the 1979 rewrite of the Juvenile Code, and it has been in the law since then.

4. It seems clear from the wording of the statute that this authority must be sought on a case-by-case basis and that a chief district court judge should not, for example, attempt to use an administrative order or other means to give a facility or physician blanket authority. On the other hand, the statute authorizes the chief district court judge to designate someone to act in his or her place in regard to this procedure and does not limit whom the judge may designate.

5. G.S. 7B-3600.

6. See G.S. 90-21.1, which addresses when a physician may treat a minor without the consent of the parent.

7. The manual issued by the State Division of Social Services contains a detailed description of the Child Medical/Mental Health Evaluation Program and its procedures. North Carolina Division of Social Services, *Children's Services Manual*, Ch. VIII (Protective Services), § 1422. Retrieved 10 April 2003 from <http://info.dhhs.state.nc.us/olm/manuals/dss/>.

8. See *In re Browning*, 124 N.C. App. 190, 476 S.E.2d 465 (1996) (parent's objection to his children's being evaluated, although based in part on his religious beliefs, was not a lawful excuse for interfering with a social services investigation).

9. A medical or mental health professional who wants information about participating in the program should write to the Child Medical Evaluation Program, Division of Community Pediatrics, CB# 3415, The University of North Carolina at Chapel Hill, Chapel Hill, N.C. 27599-3415; telephone (919) 843-9365; or send a fax to (919) 843-9368.

