UNC SCHOOL OF GOVERNMENT

HEALTH LAW BULLETIN NO. 92 | JANUARY 2024

Consent to Care for Minor Patients: An Update on the Legal Landscape after S.L. 2023-106, Part III

Kirsten E. Leloudis

CONTENTS

Kirsten E. Leloudis is an assistant professor of public law and government specializing in public health law.

The author extends special thanks to Jill Moore, Sara DePasquale, Kristi Nickodem, Obed Pasha, Phil Dixon, and Jacqui Greene for their thoughtful feedback and to the many other attorneys and public health practitioners who so generously shared their time and expertise to better assist her in understanding the consent-to-care topic.

Introduction

On August 16, 2023, Session Law (S.L.) 2023-106 was passed after a legislative override of Governor Cooper's veto.[1] Part I of the session law establishes a "Parents' Bill of Rights" and Part II outlines new requirements related to parents' involvement in their child's education. Part III of the session law, which is the focus of this bulletin, amends Chapter 90, Article 1A of the North Carolina General Statutes (hereinafter G.S.), which addresses the provision of health care services to minors. Specifically, the session law creates a new Part 3 of Article 1A titled "Parental Consent for Treatment," which is codified at G.S. 90-21.10A, -21.10B, and -21.10C. These new statutes became effective on December 1, 2023, and are hereinafter collectively referred to as the "New Parental Consent Law."

This bulletin aims to help people who are responsible for the health, care, and wellbeing of minors—local health department (LHD) staff, school nurses, local department of social services (DSS) employees, private health care providers, Department of Juvenile Justice (DJJ) staff, attorneys, parents, and minors themselves—better understand what did and did not change following the passage of the New Parental Consent Law. For those who provide health services directly to minor patients, this bulletin also delivers an in-depth discussion of health care practitioners' responsibilities under the New Parental Consent Law for obtaining consent as well as a "Frequently Asked Questions" section written in a question-and-answer format.

Overview of the New Parental Consent Law

The New Parental Consent Law requires health care practitioners and health care facilities to obtain written or other documented parental consent prior to providing treatment to a minor patient.[2] The law provides definitions for the terms "health care facility," "health care practitioner," "minor," "parent," and "treatment" that will apply throughout G.S. Chapter 90, Article 1A after December 1, 2023.[3] The law also establishes specific penalties for health care practitioners and other persons who violate the requirements of the New Parental Consent Law.[4]

Newly Defined Terms

The new G.S. 90-21.10A provides definitions for the terms "health care facility," "health care practitioner," "minor," "parent," and "treatment." The new definitions for each of these terms are as follows:

Health care facility: "[a] health care facility, licensed under Chapter 131E or 122C of the General Statutes, where health care services are provided to patients, including:

a. An agent or employee of the health care facility that is licensed, certified, or otherwise authorized to provide health care services.
b. The officers and directors of a health care facility."[5]

1. *See* S.B. 49, Gen. Assemb., 2023 Sess. (N.C. 2023); Veto message and objections from Roy Cooper, Governor, State of North Carolina, to Carl Ford, Presiding Officer, N.C. Senate, and Erin Paré, Presiding Officer, N.C. House of Representatives (July 5, 2023).
2. G.S. 90-21.10B(a), (b).
3. G.S. 90-21.10A.
4. G.S. 90-21.10C.
5. G.S. 90-21.10A(3).

This definition does not include LHDs, as they are not licensed under G.S. Chapter 131E or 122C. Although an LHD does not meet the definition of a "health care facility" under the New Parental Consent Law, it likely employs staff who meet the definition of "health care practitioners" under that law and who will therefore be subject to the law's requirements.

Health care practitioner: "[a]n individual who is licensed, certified, or otherwise authorized under this Chapter [90], Chapter 90B, Chapter 90C, or Chapter 115C of the General Statutes to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program, or an agent or employee of that individual."[6]

There are more than forty categories of professionals who are licensed, certified, or otherwise authorized under G.S. Chapters 90, 90B, and 90C.[7] The reference to G.S. Chapter 115C is likely intended to include "teachers, including substitute teachers, teacher assistants, student teachers, or any other public school employee[s]" who are authorized pursuant to G.S. 115C-375.1 to administer certain medications prescribed by a doctor and upon written request of a student's parents, to deliver emergency health care, and to perform first aid or other lifesaving techniques for students.

Minor: "[a]ny person under the age of 18 who has not been married or has not been emancipated pursuant to Article 35 of Chapter 7B of the General Statutes."[8]

Parent: "[a] minor's parent, guardian, or person standing *in loco parentis*. A person standing *in loco parentis* is a person who has assumed parental responsibilities, including support and maintenance of the minor."[9] The question of who meets the definition of a "parent" is addressed in further detail in a later section of this bulletin.

Treatment: means "[a]ny medical procedure or treatment, including X-rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures employed by or ordered by a health care practitioner, that is used, employed, or ordered to be used or employed commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in the community where the health care practitioner administers treatment to the minor child."[10] Types of care that do not fit this definition of "treatment" are discussed in further detail in a later section of this bulletin.

---

6. G.S. 90-21.10A(4).

7. The following professionals are licensed, certified, or authorized to carry out their work under G.S. Chapter 90: physicians, physician assistants, anesthesiologist assistants, nurse practitioners, dentists, pharmacists, pharmacy technicians, certain alcohol and drug counselors, optometrists, chiropractors, nurses, medication aides, nurse aides, midwives, veterinarians, podiatrists, funeral services professionals, dental hygienists, dispensing opticians, marriage and family therapy providers, occupational therapists, physical therapists, psychologists, nursing home administrators, assisted living administrators, speech and language pathologists, audiologists, licensed clinic mental health counselors, dietitians and nutritionists, fee-based practicing pastoral counselors, acupuncturists, industrial hygienists, athletic trainers, massage and bodywork therapists, respiratory care practitioners, certain "safety professionals," perfusionists, registered polysomnography technologists, and behavioral analysts and technicians. Some of these professionals—for example, veterinarians—do not "provide health care services" to humans and therefore are probably not subject to the New Parental Consent Law. G.S. Chapter 90B governs the licensure of social workers, and Chapter 90C governs the licensure of recreational therapists.

8. G.S. 90-21.10A(5).

9. G.S. 90-21.10A(6).

10. G.S. 90-21.10A(7).

What Does the New Parental Consent Law Require?

Subsection (a) of the new G.S. 90-21.10B prohibits a health care practitioner from providing, soliciting, or arranging treatment for a minor without first obtaining written or documented consent from the minor's parent. The law does not define what it means to provide, solicit, or arrange treatment, but this language could extend to the delivery ("provid[ing]") of health care services and the coordination ("solicit[ing]" or "arrang[ing]") of referrals for health care. Similarly, subsection (b) of this new law prohibits a health care facility from allowing treatment to be performed on a minor in its facilities without first obtaining written or documented parental consent.

Subsection (c) of the new G.S. 90-21.10B explains that the parental consent requirements set out in subsections (a) and (b) do not apply to services provided to a minor by clinical laboratories unless those services are rendered during a direct encounter with the minor at the laboratory facility. This exception would cover North Carolina's many clinical laboratories that (1) provide laboratory services under contract and as a vendor to other health care providers but (2) do not see or provide care directly to patients in their own facilities.

Penalties

The new G.S. 90-21.10C establishes penalties for health care practitioners and any "other person[s]" who violate the parental consent requirements set out under G.S. 90-21.10B. The term "other person" is not defined, but it may include agents, employees, officers, and directors of health care facilities, as defined under the new G.S. 90-21.10A(3). Any health care practitioner or "other person" who violates the new parental consent requirements is subject to disciplinary action by the board that licensed, certified, or otherwise authorized the health care practitioner/"other person" to provide treatment and a fine of up to $5,000.

It is not yet known what types of disciplinary actions or how large a fine (up to $5,000) a board will impose on any member who violates the New Parental Consent Law. For "other persons," some of whom may not be licensed, certified, or otherwise authorized by a board to provide treatment, it is unclear what the penalty for violating the new law would be and to whom the potential fine described in G.S. 90-21.10C would be paid. The penalties apply only to violations that occur on or after December 1, 2023, which is the effective date of the New Parental Consent Law.

What Has Changed as a Result of the New Parental Consent Law?

Prior to the passage of the new law, parental consent was still often necessary to provide health care services to minor patients. Before the new law, the need for parental consent could be read into existing statutes that outline when parental consent is *not* required. For example, G.S. 90-21.1 describes a limited set of urgent or emergency situations in which a physician may provide care to a minor patient without first obtaining parental consent. The implication is that care provided outside of the situations described in G.S. 90-21.1 would require prior parental consent, unless some other exception applies.

Although the general requirement to obtain parental consent before treating a minor (unless an exception applies) is not new, the codification of that requirement and the terminology used in the New Parental Consent Law have raised questions for public health practitioners, health care providers, schools, attorneys, parents, minors, and many others. For example, the definition of "health care practitioner" in the New Parental Consent Law extends the law's requirements to categories of professionals who may not have historically thought of themselves as health

care providers. Additionally, the expansive definition of "treatment" has generated questions about whether certain services that are not typically considered health care may now constitute "treatment" and require advance parental consent. The remainder of this bulletin focuses on addressing some of these key questions and concerns.

When Parental Consent Is Not Required

After the passage of the New Parental Consent Law, there continue to be at least six situations in which care may be provided to a minor patient without the prior consent of a parent. Four of these six situations are specifically carved out from the requirements of the New Parental Consent Law. The first two subsections of the new G.S. 90-21.10B include the following caveat: "Except as otherwise provided in this Article [1A] or by a court order [. . .]."[11] This means that care can continue to be provided to a minor without advance parental consent as permitted under G.S. 90, Article 1A, which includes the urgent or emergency situations described at G.S. 90-21.1, when a minor consents to care on their own under G.S. 90-21.5 and when care is provided under G.S. 90-21.7. Care may also be provided without parental consent when a court order authorizes a DSS director to consent to care for a child who is in DSS custody. The remaining two situations in which prior parental consent is not necessary include when care is provided to a minor by certain public school employees under G.S. 115C-375.1 or when another person consents to a minor's care pursuant to a valid health care power of attorney.

These six situations where care may be lawfully provided to a minor without prior parental consent are discussed in greater detail in the remainder of this section. They are also summarized alongside the requirements of the New Parental Consent Law in a table in Appendix A to this bulletin.

Minor's Consent

In North Carolina, minors have the legal capacity to consent to receiving certain health services without the concurrent consent of a parent, guardian, or person standing *in loco parentis*. This authority is derived from G.S. 90-21.5, which is often referred to as "North Carolina's minor's consent law." North Carolina is not unique in allowing minors to access specific health services on their own consent. All fifty states and the District of Columbia permit minors to consent to health services for sexually transmitted infections (STIs), and numerous states allow certain minors to consent to other health services such as immunizations, dental care, contraceptives, prenatal care, substance use treatment, and mental health care.[12]

Under North Carolina's minor's consent law, a minor has the legal capacity to consent to medical health services for the prevention, diagnosis, and treatment of venereal and other reportable diseases; pregnancy; abuse of controlled substances or alcohol; and emotional

11. G.S. 90-21.10B(a),(b).

12. *Policy, Planning, and Strategic Communication*, "State Laws that Enable a Minor to Provide Informed Consent to Receive HIV and STD Services," U.S. Ctrs. for Disease Control & Prevention (last reviewed Oct. 25, 2022). Marianne Sharko et al., State-by-State Variability in Adolescent Privacy Laws, 149 Pediatrics, no. 6, May 9, 2022.

disturbance. However, a minor's consent alone is not sufficient to authorize the minor's receipt of an abortion or sterilization or the non-emergency admission of the minor to a twenty-four-hour facility for substance use or behavioral health services.[13]

G.S. 90-21.4 establishes protections for information about health services that are provided to minors under G.S. 90-21.5(a). It also establishes civil and criminal immunity for physicians who deliver care to minors in accordance with North Carolina's minor's consent law. The immunity granted to physicians under G.S. 90-21.4(a) may also extend to other health care providers working under a physician's supervision and orders.[14]

G.S. 90-21.5(a) applies only to *unemancipated* minors (who will be referred to simply as "minors" for the purpose of this publication). Emancipated minors' legal capacity to consent to medical health services for themselves and their children is set out in G.S. 90-21.5(b). In North Carolina, a minor who is 16 or 17 years of age may be emancipated by a court or by marriage.[15] Emancipation is uncommon, and a minor who is seeking to access health services on their own consent and who claims to be emancipated should be able to provide proof of emancipation.[16]

Additionally, the law only grants a minor the *legal capacity* to consent to the types of health services described in the statute. A minor must still demonstrate the *decisional capacity* (sometimes called "competence") to consent to care. G.S. 90-21.5(a) does not establish a minimum age at which minors are endowed with the legal capacity to consent, which means that minors should be presumed to have the legal capacity necessary to consent to receive the health services described in G.S. 90-21.5(a). In contrast, a minor's decisional capacity is not presumed and must be assessed on a case-by-case basis.

Urgent or Emergency Care Provided by a Physician

There are certain urgent and emergency situations in which obtaining prior parental consent to treatment of a minor may be impractical or impede the timely delivery of care, resulting in harm to the minor or even death. A North Carolina statute, G.S. 90-21.1, identifies four situations in which a physician may provide treatment to a minor patient without first obtaining parental consent:

- The minor's parent, guardian, or person standing *in loco parentis* (PILP) cannot be contacted or located with reasonable diligence within the timeframe in which the minor needs to receive the treatment.

13. Health care professionals should be aware of an exception to the minor's consent law, set out at G.S. 90-21.5(a1), which requires written parental consent before administering a vaccine that is only available under an Emergency Use Authorization (EUA) and that has not been approved by the U.S. Food and Drug Administration. This change to the minor's consent law went into effect on August 20, 2021, and applies only to vaccines that are under an EUA (and not to any other product, such as personal protective equipment, that may be subject to an EUA). For more information on G.S. 90-21.5(a1), please see this blog post: Kirsten Leloudis, *An Update on Minor's Consent: Changes to the Law and Implications for COVID-19, Mpox, and Beyond*, Coates' Canons NC Local Government Law blog (Jan. 12, 2023).

14. Infants & Incompetents; Health Servs.; Physicians; Fam. Plan. Servs. Rendered to Minors by Nurse Pracs. or Physicians Assistants, 47 N.C. Op. Att'y Gen. 80 (Oct. 4, 1977).

15. *See* G.S. 7B-3507 (emancipation by court order) and 7B-3509 (emancipation via marriage). In 2021, S.L. 2021-119 raised the minimum age for marriage from 14 years old to 16 years old.

16. *See* Sara DePasquale, *Juvenile Emancipations*, On the Civil Side: A UNC Sch. of Gov't Blog (Dec. 16, 2015).

- The minor's identity is not known or the need for immediate treatment is so apparent that delaying treatment in order to first obtain consent would endanger the minor's life.
- An effort to contact the minor's parent, guardian, or PILP would delay treatment and seriously worsen the minor's physical condition.
- The minor's parent, guardian, or PILP refuses to consent to the care and the need for immediate treatment of the minor is so apparent that the delay required to obtain a court order would endanger the minor's life or seriously worsen the minor's physical condition, provided that a second physician licensed to practice in North Carolina agrees that the care to be provided is necessary to prevent immediate harm to the minor.

For the purpose of G.S. 90-21.1, "treatment" is defined to include "any medical procedure or treatment, including X rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures employed by or ordered by a physician licensed to practice medicine in the State of North Carolina that is used, employed, or ordered to be used or employed commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in the community where said physician administers treatment to said minor."[17]

Although G.S. 90-21.1 only mentions physicians, the definition of "treatment" applicable to that statute includes care that is "ordered by a physician."[18] As a result, other health care practitioners are also authorized under G.S. 90-21.1 to provide urgent or emergency care to a minor patient without parental consent when they do so under the direction and orders of a physician. When the care to be provided to a minor under G.S. 90-21.1 involves a surgical procedure, additional requirements for obtaining the second opinion of another physician licensed to practice in North Carolina must be met.[19]

First Aid, Emergency Care, and Lifesaving Techniques Provided by Certain Public School Employees

When the New Parental Consent Law was passed, there were questions about whether the requirement to obtain parental consent before providing treatment to a minor would be in tension with G.S. 115C-375.1, which allows certain public school employees to deliver emergency health care and perform first aid or other lifesaving techniques to students. Specifically, the concern was that the new G.S. 90-21.10B would require advance parental consent in these situations, which could impede the timely delivery of first aid, emergency care, or lifesaving techniques. This issue was resolved by Section 7.81.(c) of S.L. 2023-134, which amended the opening sentence in G.S. 115C-375.1 to read: "Notwithstanding G.S. 90-21.10B, [. . .]." As a result of this change, public school employees, including teachers and school nurses, are not required under G.S. 90-21.10B to obtain parental consent before administering first aid, emergency care, or other lifesaving techniques to minor students in accordance with G.S. 115C-375.1.

17. G.S. 90-21.2.
18. *Id.*
19. G.S. 90-21.3

Consent by the DSS Director for a Minor in DSS Custody

After DSS files a petition alleging that a minor[20] is abused, neglected, or dependent, DSS may seek a nonsecure custody order, which is a temporary order that places the minor in DSS's custody. Under G.S. 7B-503, nonsecure custody is ordered in certain situations when the minor's health and safety are at risk, including but not limited to situations where the minor has been abandoned or is at substantial risk of physical injury or sexual abuse due to conditions created by the child's parent, guardian, custodian, or caretaker.

When a minor is placed in the nonsecure custody of DSS, G.S. 7B-505.1 authorizes the DSS director to give consent for the minor to receive routine and emergency care, as well as testing and evaluation in exigent circumstances.[21] Additionally, the court order granting nonsecure custody can authorize the DSS director to consent to non-emergency and non-routine medical care for the minor. In these situations, consent may be given directly by the DSS director or (as is more often the case) by a DSS social worker acting as the DSS director's authorized representative.[22]

If a minor is ultimately found by a court to have been abused, neglected, and/or dependent, then the court will enter disposition orders. The disposition orders may require that the minor be placed in the custody of DSS.[23] When this happens, the same law—G.S. 7B-505.1—applies.[24] While a foster parent or a relative with whom a minor is living while in DSS custody may bring the child to a medical appointment, it is still the DSS director (or a DSS social worker acting as the DSS director's authorized representative) who must consent to the minor's health care.

Although the definition of "parent" under the new G.S. 90-21.10A(6) does not include the DSS director, the new law does not abrogate the DSS director's authority to consent to treatment of a minor under G.S. 7B-505.1 and 7B-903.1(e). The requirements in the New Parental Consent Law for a health care practitioner or facility to obtain parental consent include the following caveat: "Except as otherwise provided in this Article [1A] or by court order [. . .]."[25] Only a court order can grant DSS custody of a minor. As a result, a DSS director's authority to consent to certain care for a minor in DSS custody is not made void by the New Parental Consent Law.

---

20. The statutes that govern abuse, neglect, and dependency proceedings by DSS use the term "juvenile" rather than the term "minor." The definition for a "juvenile" under G.S. 7B-101(14) is almost identical to the definition of "minor" under the new G.S. 90-21.10A(5), except that a "juvenile" can also include someone who is under the age of 18 and a member of the Armed Forces of the United States.

21. For a more in-depth discussion of the types of care that a DSS director may consent to under G.S. 7B-505.1, please see the following blog post by my School of Government colleague Sara DePasquale: *New Law: Consenting to Medical Treatment for a Child Placed in the Custody of County Department*, Coates' Canons NC Local Government Law blog (Nov. 6, 2015).

22. G.S. 108A-14(b).

23. G.S. 7B-903(a)(6).

24. G.S. 7B-903.1(e).

25. G.S. 90-21.10B(a), (b).

Consent by a Non-Parent Pursuant to a Health Care Power of Attorney

In 1993, the legislature enacted G.S. Chapter 32A, Article 4,[26] which permits a custodial parent to "grant an agent full power and authority to consent to and authorize health care for [a] minor child to the same extent that a custodial parent could give such consent and authorization."[27] A "custodial parent" is defined as a parent with sole or joint legal custody of their minor child.[28]

When might a parent delegate their authority to consent to care to an agent under the Minors' HCPOA Law? Here are a few examples:

- A child is staying with grandparents for several weeks while the parent travels. The parent authorizes the grandparents under the Minors' HCPOA Law to consent to care for the child during those weeks while the parent is out of town and unavailable.
- A parent is unable to take a child to a well-child appointment, so an adult sibling takes the child instead. The parent authorizes the adult sibling to give consent for the well-child visit for the younger child.
- A child is spending the summer at a sleepaway camp that is out of town. The child's parents authorize the summer camp director to consent to types of care that the parents anticipate the child could need while away at camp, such as treatment for poison ivy or strep throat.

Under the Minors' HCPOA Law, a parent who delegates their authority to consent for their minor child's health care must (1) be at least 18 years old or be an emancipated minor, (2) have the decisional capacity necessary to (a) give consent for care and (b) delegate that authority to give consent, and (3) be a "custodial" parent with sole or joint legal custody.[29] A natural or adoptive parent has legal custody of their child unless their parental rights have been terminated or limited by a court order. Therefore, a natural or adoptive parent can be a custodial parent who may delegate their consenting authority to another person under the Minors' HCPOA Law (subject to any court orders to the contrary).

The document used to memorialize a custodial parent's delegation of their consenting authority for their minor child to an agent is called an "authorization."[30] An authorization template is available at G.S. 32A-34. However, an authorization does not have to perfectly mirror the template found in the statute and is valid so long as it (1) is in writing, (2) is signed and acknowledged by the custodial parent before a notary public, and (3) otherwise substantially meets the requirements of the Minors' HCPOA Law.[31] An authorization may be broad or narrow in scope. When an authorization has limitations—for example, the custodial parent is only allowing the agent to consent to certain types of treatments for the minor or the authorization

26. For the purpose of this bulletin, G.S. Chapter 32A, Article 4 is hereinafter referred to as the "Minors' Health Care Power of Attorney (HCPOA) Law."

27. G.S. 32A-31(a). G.S. 32A-28(b) states that the Minors' HCPOA Law establishes a "nonexclusive method" for a parent to authorize an agent to consent to health care for the parent's minor child.

28. G.S. 32A-29(3).

29. G.S. 32A-30.

30. G.S. 32A-29(2).

31. *Id.*

is only in effect for a specific period of time—then those limitations should be written out in the authorization.[32] State law prohibits an authorization from being used to empower an agent to withhold or withdraw life-sustaining care from a minor.[33]

An authorization can be revoked under any of the processes described in G.S. 32A-32. Physicians, dentists, and other health care providers who deliver care based on a good-faith reliance on an authorization are immune from certain liability under G.S. 32A-33. Any health care practitioner or facility that accepts the consent of an agent to provide treatment to a minor should make a copy of the authorization document to include in the minor patient's record. Health care practitioners and facilities are encouraged to consult with legal counsel, malpractice insurers, and licensing boards, as appropriate, to determine additional best practices.[34]

Consent from a Grandparent or Judicial Waiver for an Abortion

G.S. Chapter 90, Article 1A, Part 2 establishes the process for obtaining consent to an abortion for a minor patient. The law requires that a physician or a physician's agent performing the procedure on a minor patient obtain the written consent of both the minor and one of the following four types of persons (hereinafter "Consenting Adults"): (1) the minor's custodial parent, (2) the minor's legal guardian or legal custodian, (3) a parent with whom the minor is living, or (4) a grandparent with whom the minor has been living for six months or longer immediately preceding the date of the minor's written consent to the abortion.[35] Alternatively, a pregnant minor may ask that the requirement to obtain consent from a Consenting Adult be waived by a judge. To do this, the minor must file a petition in district court in the judicial district where the minor resides or is physically present.[36] The court may only grant the minor's petition for waiver if the court determines that (1) the minor is mature and well-informed enough to consent to the abortion on their own, (2) it would be in the minor's best interests that consent from a Consenting Adult not be required, or (3) the minor is a survivor of rape or felonious incest.[37]

Just like an adult patient, a minor who receives abortion services—regardless of whether a Consenting Adult agrees to the procedure or a judicial waiver is granted—must meet the additional requirements for an abortion set out at G.S. Chapter 90, Article 1I.

When Parental Consent Is Required

To comply with the New Parental Consent Law, health professionals must be able to determine when the law's consent requirement is triggered—that is, when is a health care practitioner or health care facility providing "treatment" to a minor and therefore required to obtain parental consent before delivering care? Furthermore, health care professionals must know who satisfies

32. *See* G.S. 32A-31.

33. G.S. 32A-31(c).

34. Health care practitioners should also keep in mind that an authorization document is solely evidence of an agent's legal authority to consent to treatment for a minor. The authorization is not documentation that the consent process was completed with the agent and that the agent's consent to a specific treatment was, in fact, given.

35. G.S. 90-21.7(a).

36. G.S. 90-21.7(b).

37. G.S. 90-21.8(e).

the definition of a "parent" under the law and is therefore authorized to give consent, as well as the methods of memorializing parental consent that are acceptable under the New Parental Consent Law. At first blush, the answers to these queries may seem obvious; however, a closer read of the New Parental Consent Law's definitions and requirements suggests that bringing all these pieces together to implement the new law can be a complex undertaking.

Origins of the Definition of "Treatment"

The term "treatment" is sometimes colloquially used to refer to health care services that are provided in response to a particular diagnosis, condition, or set of symptoms.[38] When used this way, "treatment" is understood to be different from "prevention" and "diagnosis"—services that often *precede* treatment. This use of the term "treatment" shows up in some of our state's laws, including G.S. 90-21.5, North Carolina's minor's consent statute. Here, "prevention, diagnosis, and treatment" are set out as distinct (albeit interrelated) types of medical health services. However, this way of thinking about "treatment" is difficult to square with the definition used in the new law. For example, under the new G.S. 90-21.10A, "treatment" is specifically defined to include diagnostic services ("x-rays" and "laboratory or other diagnostic procedures") rather than contemplated as a separate type of care.

The notion that "treatment" might include other types of care, such as diagnostic services, is further supported if we look back at where the definition of "treatment" appears to have come from: an older North Carolina statute that establishes when care can be provided to a minor without prior parental consent in certain urgent and emergency situations.[39] The definition of "treatment" in the new G.S. 90-21.10A closely mirrors the definition of "treatment" found under G.S. 90-21.2, which reads: "The word 'treatment' as used in G.S. 90-21.1 is hereby defined to mean any medical procedure or treatment, including X rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures employed by or ordered by a physician licensed to practice medicine in the State of North Carolina that is used, employed, or ordered to be used or employed commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in the community where said physician administers treatment to said minor."

When this definition of "treatment" in G.S. 90-21.2 was added to North Carolina's laws in 1965, it served to clarify the types of care that a physician could provide under G.S. 90-21.1 to a minor *without* parental consent. G.S. 90-21.1 describes four situations in which treatment can be provided to a minor without the consent of a parent because the consent cannot be timely obtained without delaying care and threatening the child's health or life. As a result, the types of care that fall under "treatment" as defined at G.S. 90-21.2 are already limited to those services that might be necessary in urgent or emergency situations. This context also helps explain why "treatment" was defined under G.S. 90-21.2 to include health services such as x-rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures. While these services may not all immediately come to mind as types of "treatment," they are types of care that may be necessary in an urgent or emergency situation.

The definition of "treatment" from G.S. 90-21.2 appears to have been used in the new G.S. 90-21.10A, with one key change to the text: the term "physician" was replaced with "health care practitioner." This expanded the types of care that could be considered "treatment"

38. *See Treatment*, Merriam-Webster Dictionary Online (last accessed Oct. 29, 2023).
39. G.S. 90-21.1, -21.2.

from just those that are ordered or employed by a physician to those that could be ordered or employed by more than forty types of health professionals. Additionally, when the definition of "treatment" in G.S. 90-21.2 was carried over into the new G.S. 90-21.10A, the term was being used in a different context—not to delineate the services that can be provided without parental consent solely in urgent and emergency circumstances but, rather, to describe a much larger universe of services that may be provided in a multitude of situations, from the less common and more complex (e.g., surgeries or appointments with a specialist to manage a child's chronic condition) to the more frequent and mundane (e.g., trips to the school nurse's office because of an upset stomach or a student athlete's post-practice appointment with the school athletic trainer).

In short, even though the definition of "treatment" in the new G.S. 90-21.10A is almost identical to the definition of the term in G.S. 90-21.2, the replacement of "physician" with "health care practitioner" and the difference in context have significant impact. Under G.S. 90-21.10A in the New Parental Consent Law, "treatment" is a much broader term that encompasses many more types of health services than it does in G.S. 90-21.2. As a result, it becomes critical to distinguish the types of care that do *not* qualify as "treatment" under the New Parental Consent Law.

Care and Services That Are Not Considered "Treatment" under the New Parental Consent Law

Despite the expansive definition of "treatment" under the new law, there are some likely exclusions, and some services are more readily distinguishable from "treatment" than others. This includes, but is not necessarily limited to, the following: (1) services that are not required to be ordered or performed by a "health care practitioner" and (2) pre-school and school health screenings. These two types of services that do not constitute "treatment" are discussed further below.

The New Parental Consent Law's definition of "treatment" only includes care and services that are ordered or employed by a "health care practitioner," as that term is defined in the new G.S. 90-21.10A. Therefore, care and services that can be provided by lay persons—that is, care and services that do not have to be ordered or carried out by someone who is licensed, certified, or authorized as a health care practitioner—are not "treatment" requiring advance parental consent under the new law. This could include, for example, peer-to-peer tobacco-cessation coaching, which is often provided by trained volunteers or staff who are not required to be health care practitioners. Other examples could include work performed by doulas or community health educators, which may require training but not licensure, certification, or authorization as a health care practitioner. These types of services are not "treatment" even if they *happen* to be provided by a health care practitioner (e.g., a nurse practitioner who volunteers his time as a peer tobacco-cessation coach).

What about pre-school and school health screenings? Health screenings generally do not prevent, diagnose, or treat a disease or illness; rather, they enable early detection of a potential health concern, such as a vision or hearing difference. When a screening identifies a potential concern, children and their families have the option to pursue follow-up services, which may include diagnostic testing or treatment. A child's health concern that is detected earlier may be easier to treat, which may translate into better health outcomes for that child.[40] According to

40. *See Your Child's Sight: Getting Your Child Vision-Ready for School*, "Vision Screenings and Eye Exams," Prevent Blindness N.C. (last accessed Oct. 16, 2023); *Hearing Loss in Children*, "Screening and Diagnosis of Hearing Loss," U.S. Ctrs. for Disease Control & Prevention (last reviewed Aug. 7, 2023).

the American Academy of Pediatrics, pre-school- and school-age children are routinely offered health screenings for common health conditions, such as vision or hearing changes and dental caries (cavities).[41]

In some instances, health screenings do not have to be ordered or performed by health care practitioners and can instead be carried out by trained lay staff and volunteers. For example, in North Carolina, children's vision screenings may be performed by volunteers who are trained and certified by Prevent Blindness North Carolina, and certain hearing screenings can be provided by "unlicensed persons" who have received appropriate training.[42] Dental screenings, although typically provided by public health dental hygienists (a type of health care practitioner), are considered educational and preventive services that are "not clinical procedures."[43]

Although health screenings do not constitute "treatment" under the new law, health screenings offered in North Carolina public schools may be subject to S.L. 2023-106, Part II, Section 2.(a), which amends G.S. Chapter 115C and addresses certain services provided in the public school setting. Under the new G.S. 115C-76.45(a), the governing body of a public school unit must adopt procedures for notifying parents, at the beginning of each school year, of the "means for the parent to consent" to a health service or the use of a health screening form for the parent's child. This means that public schools must have a procedure for notifying parents of the process for opting in or opting out (as applicable) of any health screenings that may be offered at the school.

Who Is a "Parent" Who Can Give Consent?

The New Parental Consent Law defines a "parent" as "[a] minor's parent, guardian, or person standing *in loco parentis* [(PILP)]."[44] A minor's parent could be a "natural" parent, which is a minor's biological parent whose parental rights related to healthcare decision making have not been limited or terminated by a custody or court order. A parent could also be an adoptive parent, including a stepparent who has completed the legal adoption process. A guardian is someone who has been appointed to the role of the minor's guardian of a person or general guardian by a court in accordance with G.S. Chapter 35A, Article 6; G.S. Chapter 7B, Article 6; or G.S. 7B-2001. A guardian is different from someone who has been awarded legal custody of a child in a custody proceeding and who would be referred to as a "legal custodian" or "custodian."[45]

The new law defines a PILP as "a person who has assumed parental responsibilities, including support and maintenance of [a] minor."[46] The North Carolina Court of Appeals has also previously weighed in on the question of what it means to be a PILP. In a 1974 case, *Shook v. Peavy*, the court stated that a PILP is someone "who has assumed the status and obligations of a parent without a formal adoption."[47] In 1985, in *State v. Pittard*, the court expounded on that definition by explaining that a person does not stand *in loco parentis* "from the mere placing

41. *Ages & Stages*, "Health Screenings at School," Am. Acad. of Pediatrics, HealthyChildren.org (last updated Nov. 21, 2015).

42. For vision screenings, see G.S. 130A-440.1(a); for hearing screenings, see Title 21, Chapter 64, Section .0212(c) of the North Carolina Administrative Code (hereinafter N.C.A.C.).

43. 21 N.C.A.C. 16W, § .0103.

44. G.S. 90-21.10A(6).

45. *See, e.g.*, G.S. 7B-101(8). *Compare with* G.S. 35A-1202(7), (10).

46. G.S. 90-21.10A(6).

47. 23 N.C. App. 230, 232 (1974) (quoting 67 C.J.S. *Parent and Child* § 71, p. 803).

of a child in the temporary care of other persons by a parent or guardian of such child. This relationship is established only when the person with whom the child is placed intends to assume the status of a parent by taking on the obligations incidental to the parental relationship, particularly that of support and maintenance."[48] Almost a decade later, in *Liner v. Brown*, the court of appeals further stated that whether someone is a PILP is a "question of intent 'to assume parental status' and depends on all the facts and circumstances" of the case.[49] The court in *Liner* then referenced *Hush v. Devilbliss Co.*,[50] a 1977 Michigan case, noting that case's finding that "intent to assume parental status can be inferred from parties' acts and declarations."[51]

Unlike an adult or government agency (such as DSS) that has been granted guardianship or custody of a minor by a court, a PILP will not have official paperwork that documents their PILP relationship to the minor child. Whether or not someone is a PILP to a child will depend on the unique facts of the situation, which means that these determinations must be made on a case-by-case basis. Asking questions about who cares for the minor, and the extent and nature of that care, may help providers get information that is helpful for determining whether someone is a PILP. For example, a health care provider might ask questions including, but not limited to, the following inquiries: With whom does the child live? Who provides financial support for the child (buying groceries, paying for health insurance, making sure the child has clothes, etc.)? Who attends to the child's daily needs, such as preparing meals? Who ensures that the child attends school? When a health care provider determines that an adult is a PILP to a child, the provider should document that determination for their organization's records.

The Consent Process

The New Parental Consent Law requires that the consent for treatment that is given by a minor's parent be "written or documented."[52] It is important for health care practitioners and facilities to remember that consent is a *process*, not merely the collection of a signature or the receipt of a verbal "yes."[53] The consent process is an exchange between the provider and the patient (or their representative) that includes, but is not limited to, a discussion of the risks, benefits, and alternatives to a particular treatment.[54] It is this exchange that allows the consent to be "informed." Health care practitioners and facilities that are unsure of the standards for informed consent should contact legal counsel, malpractice insurers, and licensing boards, as appropriate, for guidance.

The New Parental Consent Law does not change the standards or laws that govern the informed-consent process; rather, it requires that the outcome of a consent process (a parent agreeing to give consent for treatment of their minor child) be memorialized, either in writing or by some other form of documentation.

48. 45 N.C. App. 701, 703 (1980) (citing *Shook*).
49. 117 N.C. App. 44, 49 (1994).
50. 77 Mich. App. 639 (1977).
51. *Liner*, 117 N.C. App. at 49 (citing *Hush*).
52. G.S. 90-21.10B(a), (b).
53. *See* Fay A. Rozovsky, Consent to Treatment: A Practical Guide § 2.01[A] (5th ed. 2020).
54. *Id. See also* G.S. 90-21.13; Am. Med. Ass'n Code of Med. Ethics, Op. 2.1.1, Informed Consent (last accessed Jan. 3, 2024).

Written Consent

The New Parental Consent Law does not include a definition of "written" consent. In accordance with the rules of statutory construction, the word "written" may be "construed to include printing, engraving, lithographing, and any other mode of representing words and letters [. . .]."[55] This could include, for example, a typed form—either printed in hard-copy format or available online through a patient portal—that recites topics addressed during the consent process (risks, benefits, alternatives, etc.) and includes a place for the parent (or the DSS director or the agent authorized under the Minors' HCPOA Law) to sign. A written consent could also be a form developed by a government agency, such as DSS Form 1812, General Authorization for Treatment and Medication, that has been created to give practitioners a standardized method for documenting consent. Some practitioners and facilities also use written checklists. As the consent process proceeds and each required element of the informed-consent process is completed, a step in the list is checked off. The parent (or the DSS director or the agent authorized under the Minors' HCPOA Law) typically signs the checklist once the consent process has been completed.

Since the passage of the New Parental Consent Law, many health care practitioners and facilities have asked how they should treat a handwritten or typed-up consent "note" that appears to have been signed by a minor's parent and that is presented by the minor or a non-parent adult without the parent present. This situation presents several challenges. First, the health care practitioner or facility should ensure that the informed-consent process for the treatment described in the note has actually been completed with the consenting parent. Second, health care practitioners and facilities may understandably have concerns about their obligations to verify the validity of such a note.

There is very little law to guide health care practitioners with concerns about verifying consent notes, except for a 1998 North Carolina Court of Appeals case called *Jackson v. A Woman's Choice, Inc.*[56] There, a physician provided an abortion to a minor patient who presented a handwritten consent note that had allegedly been written and signed by the minor's parent. The note had actually been forged by the minor. The minor patient and her parents later sued the physician for battery and infliction of emotional distress. On appeal, the court held that when a "health care provider is presented with an apparently valid written parental consent and is thereby deceived into performing an abortion procedure upon a minor, the unknowing and unintentional failure to obtain actual parental consent is not a violation of the statute" that required written parental consent for the abortion.[57]

The favorable outcome for the physician in *Jackson* does not ensure that practitioners who act on a seemingly valid consent note and provide care will not face consequences under the New Parental Consent Law. There are key differences between the law that required written parental consent in *Jackson* and the New Parental Consent Law. In the case of *Jackson*, a state law established penalties for anyone who "intentionally and knowingly" provided an abortion to a minor in violation of G.S. Chapter 90, Article 1A, Part 2, including by failing to obtain the

55. G.S. 12-3(10).

56. Note: The Superior Court decision in this case, dated September 8, 1997, is unpublished.

57. *Jackson v. A Woman's Choice, Inc.*, 130 N.C. App. 590, 595 (1998), *aff'g* unpublished Wake County Superior Court order.

In 2011, the state's "Woman's Right to Know Act" established new consent requirements for patients of all ages (minors or adults) seeking an abortion. As a result, a handwritten note would not be acceptable documentation of consent for an abortion these days. *See* G.S. Chapter 90, Art. 1I.

required parental consent.[58] In contrast, the provision of the New Parental Consent Law that establishes penalties for violating the parental consent requirements imposes strict liability—which means that a health care practitioner or facility can be found in violation of the parental consent requirements regardless of their intent or their (erroneous) belief that a forged consent note was legitimate. Health care practitioners and facilities that are presented with consent notes allegedly signed by a minor's parent may wish to consult with legal counsel before providing treatment to the minor patient, particularly if they are unable to separately confirm that the parent did give consent for the care.

Documented Consent

The New Parental Consent Law allows a parent's consent to treatment of their minor child to be documented in a manner other than in writing, though the law does not provide a definition of "documented consent." One common example, however, may be found in a health care provider's documentation of consent in a minor patient's health record. Here, the consent process has been completed and the parent's consent might be given orally (rather than being memorialized by the signing of a written document). The health care practitioner then documents in the minor patient's record that the consent process was completed and that the parent gave consent.

The New Parental Consent Law does not appear to prohibit oral consent given by a parent over the phone and then documented in a minor patient's record by a health care practitioner. However, the appropriateness of this approach will depend on various factors, including, but not limited to, the standard of care, the health care practitioner's confidence that the person on the phone is a parent, and the nature of the treatment to be provided.

Written v. Documented Consent

The New Parental Consent Law requires that the consent be written "or" documented and does not appear to give preference to one approach over the other.[59] However, there may be situations where written consent is required by law or is considered best practice. For example, G.S. 90-21.5(a1) requires that a health care provider obtain "written consent" from a parent or legal guardian before administering to a minor a vaccine that is still under an emergency use authorization (EUA). Similarly, a federal law that applies to hospitals participating in Medicare requires that a "properly executed informed consent form for the operation" be saved in a patient's record prior to surgery, except in emergencies.[60]

58. G.S. 90-21.10.
59. G.S. 90-21.10B(a), (b).
60. 42 C.F.R. § 482.51.

Frequently Asked Questions (FAQs)

Question (Q) 1: *How has the North Carolina minor's consent law been changed by the New Parental Consent Law?*

Answer (A) 1: North Carolina's minor's consent statute, G.S. 90-21.5, is intact and has not been changed by the New Parental Consent Law. The new G.S. 90-21.10B(a) and (b) both begin with the same phrase: "Except as otherwise provided in this Article [1A] [. . .]." North Carolina's minor's consent statute is located in G.S. Chapter 90, Article 1A and is therefore not affected by the parental consent requirements in the new G.S. 90-21.10B.

Q 2: *A 16-year-old pregnant patient is receiving prenatal care at a local clinic. The minor has decisional capacity and consented to the prenatal care on her own under North Carolina's minor's consent law, G.S. 90-21.5. During a prenatal care appointment, the minor's care team discovers that the minor has developed high blood pressure, which may increase her risk of preterm labor and eclampsia. Is the care team required to obtain consent from the minor's parent before they can offer her treatment for her hypertension?*

A 2: No. Under the North Carolina minor's consent statute, a minor with decisional capacity may consent to the prevention, diagnosis, and treatment of pregnancy. The North Carolina Office of the Attorney General has previously stated that a minor may consent to certain health services that are "necessary for the proper medical management of pregnancy [. . .]."[61] Assuming that treatment of hypertension is necessary to manage the minor's pregnancy, the minor could consent to that treatment as an extension of her prenatal care. Although a health care provider could encourage the minor patient to involve her parent in her pregnancy-related care and decisions, the provider is not required to obtain parental consent in this situation before offering the minor treatment for her hypertension.

Q 3: *Is a suicide risk assessment that is administered in a school setting a type of treatment that requires advance parental consent under the New Parental Consent Law when the assessment can be administered by school employees who do not meet the definition of a "health care practitioner" under the new law?*

A 3: No. A suicide risk assessment that can be administered by a lay person—meaning there is no requirement that the person delivering the assessment be a "health care practitioner" as defined under G.S. 90-21.10A—is not "treatment" for the purposes of the New Parental Consent Law. As a result, the requirements of the New Parental Consent Law would not extend to a suicide risk assessment administered by a lay school employee to a minor in the school setting.

61. Health; Consent for Sickle Cell Testing by a Minor, 53 N.C. Op. Att'y Gen. 83 (Mar. 14, 1984).

Appendix A. Consent and Common Pathways for Providing Care to Minors

The following table, "Consent and Common Pathways for Providing Care to Minors," summarizes and compares the six situations where prior parental consent is not required to provide care to a minor patient alongside the requirements of the New Parental Consent Law. This table addresses some of the most common pathways for providing care to minor patients and is not an exhaustive list of the ways that consent can be given or that care can be delivered to a minor.

Pathway for Providing Care	Description of Associated Consent Requirement(s)	Statutory Citation
Minor's Consent		
• Minor consents to own care	A minor with decisional capacity may give consent to a physician (or provider working under the direction of a physician) for the prevention, diagnosis, or treatment of conditions specified in the statute.	G.S. 90-21.5(a)
Urgent/Emergency Care		
• Care provided by physicians	A physician (or provider working under the direction of a physician) may provide care to a minor in certain time-sensitive situations specified in the statute without first obtaining parental consent.	G.S. 90-21.1
• Care provided by school employees	Public school employees authorized by their local board of education may provide first aid, emergency care, and life-saving techniques to a minor without first obtaining parental consent.	G.S. 115C-375.1
Non-Parent Authorized to Consent to Care		
• DSS director consents for minor's care	The DSS director (or their designee) may consent to routine and emergency care, as well as testing and evaluation in exigent circumstances, for a minor in DSS custody. The DSS director (or designee) may also consent to other care as set out in a court order.	G.S. 7B-505.1
• Parent authorizes non-parent to consent using an HCPOA	A "custodial parent" may delegate their consenting authority to another person using a health care power of attorney (HCPOA). An HCPOA can be broad or narrow in scope and may be time-limited. *Note:* This is not the exclusive method for a parent to delegate consenting authority to a non-parent.	G.S. Chapter 32A, Article 4
Abortion Services		
• Parent and some grandparents may consent • Consent requirement may be waived	In addition to a parent, a grandparent with whom a minor has been living for six months can consent to an abortion for the minor. Alternatively, a court may waive the requirement for parental consent to an abortion in limited circumstances. The minor patient must also consent to the abortion. Requirements set out in G.S. Chapter 90, Art. 1I must also still be met.	G.S. 90-21.7, -21.8
Parental Consent		
• Parent consents to "treatment"	A parent (a natural or adoptive parent whose rights have not been limited or terminated by a custody or court order, a legal guardian, or a person standing *in loco parentis*) consents to care for a minor that meets the statutory definition of "treatment." Consent must be memorialized in writing or otherwise documented.	G.S. 90-21.10A, -21.10B, -21.10C