Principles of Consent & Advance Health Care Directives

CHA Webinar
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Welcome & Program Overview

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Continuing Education Offered for this Program

- **Compliance** — The Compliance Certification Board (CCB) has approved this event for up to 2.4 CCB CEUs.
- **Health Care Executives** — CHA is authorized to award 2 hours of preapproved ACHE Qualified Education Credit (non-ACHE) for this program toward the advancement or recertification in the American College of Healthcare Executives.
- **Health Information** — This program has been approved for 2 continuing education unit(s) for use in fulfilling the continuing education requirements of the American Health Information Management Association (AHIMA).
- **Legal** — This activity has been approved for 2 hours of MCLE credit.
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Continuing Education Requirements

Full attendance, completion of online survey, and attestation of attendance is required to receive CEs for this webinar. CEs are complimentary for registrant. If additional participants under the same registration would like to be awarded CEs, a fee of $20 per person, will apply. Post-event survey will be sent to registrant and provide information on how to apply online for additional CEs.
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What We Will Discuss Today

- Patient Rights
- Simple vs. Informed Consent
- Informed Consent Content
- The Joint Commission (TJC), CMS Requirements
- Informed Consent Process
- Emergencies
- Capacity vs. Competency
- Choosing a Surrogate
- The Unrepresented Patient
- Informed Refusal

Informed Consent 101…

- Common Law (judge-made law): Every competent adult has the fundamental right of self-determination
- A person unable to exercise this right (minors or incompetent adults), has the right to be represented by another person
Those Pesky Fundamentals…

- If the nature of the treatment is involved or complicated, “informed consent” is necessary.
- The patient’s consent should be meaningful (risks and benefits, alternatives and their risks and benefits).
- All procedures require consent — but they may not have to be “informed consent”.

“Simple” vs. “Informed Consent”

**Simple:** Conditions of Admissions
- Applies to simple, common procedures with remote risks, e.g., blood screen.
- Signed Conditions of Admission sufficient for administration of Ativan and echocardiogram.

**Informed:** Additional process required
- Cobbs v. Grant (1972) 8 Cal 3d 22

**No consent = Battery (Intentional tort)**
- E.g., wrong surgery or exceeds scope of consent.
**“Simple” vs. “Informed Consent”**

**Federal Court:** Battery must involve an intent to injure  
» Ditto v. McCurdy (2007) 510 F 3d 1070

**California: Determination of “Battery”:**  
will be a question of fact  
- Jury must determine if wrong level disc surgery is a “substantially different surgery”  

**Withholding a material risk or material information** may be fraud, conversion and intentional infliction of emotional distress  

**Consented-to treatment and more:** this may be wrongful conduct and the basis for claim of fraud, conversion and intentional infliction of emotional distress  
Consent for Simple Procedures

- Typical ways consent for “simple” procedures is obtained:
  - Patient agrees to have blood taken
  - Patient takes the medicine
  - Patient agrees to go to radiology for the X-ray
- Typical documentation: just the general authorization given in the conditions of admission

When Informed Consent is Required

- “Informed consent” is shorthand for a process that involves giving the patient information so the patient can make an informed decision — to accept or reject treatment
- Informed consent is required:
  - When the procedure involves material risks that are not commonly understood
  - When required by statute
Informed Consent Basic Principles

Patients have the right to:
- Know health status, diagnosis, prognosis
- Be involved in care planning, treatment and discharge planning
- Decide when to accept and when to reject recommended care
- Receive the information needed to allow them to make informed decisions

Informed Consent: Consent Discussion

Discussion needs to include:
- Nature and purpose of procedure
- Likelihood of benefits, risks, complications and side effects of procedure and its alternatives
- Possible alternative methods of treatment (include the risks of not receiving treatment)
- Potential problems during recuperation
Informed Consent — Content: What Information is Sufficient?

- That information which MD should know would be considered significant by a reasonable person in the patient’s position
- Supplemented by patient’s unique concerns/condition (as known or should be known by MD)

Informed Consent: Content

- Communicate and document significant risks, “including, but not limited to …”
  - Loss of life
  - Loss of limb, limb function
  - Risk of stroke, brain injury, nerve function
  - Potential for hemorrhage, blood clots
  - Potential for allergic reaction
- Utilize interpreter services if any doubt of patient’s ability to speak/comprehend English
Informed Consent: Content

- At a minimum, a physician must disclose a known risk of death or serious bodily harm and explain the complications that can occur, and
- Such additional information as a skilled practitioner of good standing would provide under similar circumstances
  » *Arato v. Avedon (1993) 5 Cal 4th*

Informed Consent: Content:

- No obligation to inform a patient about a test or treatment if neither is recommended
- No duty to advise patient of unapproved treatment
- No duty to divulge a “small or remote” risk
The consent process is complicated by:

- The vast array of work flows of physicians, clinics, and hospitals
- Some physicians under-appreciate the obligation
- TJC does not give a lot of detail
- Worry and concern by hospital staff about liability and hesitancy to become involved in the process

The consent process is managed by the physician and verified by the hospital

- There isn’t always one-stop shopping — the form is part of the process; a note about the process is separate — TJC allows this
- Discussion occurs outside hospital — how does form get to the hospital?
- What about the electronic record? Scanning the form? How about interpreters?
- What about supplemental patient information sheets?
Role of the Doctor in the Process

- Doctor has the responsibility to give the patient the information so the patient can decide
- When two or more doctors are involved, either they can divide the responsibility or the hospital policy can allocate responsibility
  - Surgeon and anesthesiologists
  - Internist and radiology

The Process of Informed Consent

Informed consent is a process that includes:

- A discussion with the patient/family by the physician performing the procedure
- Documentation of the decision to consent to treatment or refuse treatment
  - Physician documentation: e.g., progress note evidencing discussion of risks, benefits and alternatives
  - Hospital documentation: completion of consent form
  - Witnessing of form by hospital personnel
There are Many Ways to Write a Progress Note About Consent

- Must be done before surgery
- Can be done in a summary or detailed way
- Consider augmenting consent process with patient handouts for frequently done surgeries
- The more distance between the consent process and the surgery the better

The Regulators

The Joint Commission & CMS Requirements
TJC’s goal of the informed consent process:

“To establish a mutual understanding between the patient and the licensed independent practitioner or other licensed practitioners with limited privileges who provides the care, treatment and services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences and helps the patient to participate fully in decisions about his or her care, treatment and services”

Standard RI.01.03.01 (2010)

TJC requires that the informed consent (IC) process comply with hospital policy which should describe:

- Which procedures require IC (no requirement of laundry list)
- The process used to obtain IC
- How IC is to be documented (TJC says documentation can be “in a form, progress note, or elsewhere in the record”)
- Rules about surrogates giving consent
- Exceptions to IC requirement
- New 2010 requirement that IC process occur prior to surgery (Note: use of Universal Protocol is a good way to ensure this)
Consent Process: The Joint Commission Requirements (cont.)

TJC requires that the IC process include the following discussion points:
- Nature of treatment and services
- Potential benefits, risks or side effects, including potential recuperation problems
- Likelihood of achieving goals
- Reasonable alternatives
- The relevant risks, benefits and side effects of alternatives, including the possible results of not receiving care

Informed Consent — CMS Conditions of Participation

- Medical record must contain a document recording the patient’s informed consent for those procedures requiring such consent
- The Medical Staff By-Laws should address which procedures require informed consent (surgery requires IC)
- Is it a list or a list of categories?
- Form must be signed and dated by patient or representative
Consent Process:
CMS Conditions of Participation

CMS requires that consent form contain at least:
- Name of hospital where treatment will take place
- Name of specific procedure to be performed
- Name of responsible practitioner
- Statement that procedure has been explained and anticipated benefits, material risks and alternative therapies have been explained
- Signature of patient or patient’s representative
- Date and time the form is signed by the patient

Consent Process:
CMS Conditions of Participation

CMS requirement related to explanation of risks benefits and alternatives:
- Material risks should include risks with a high degree of likelihood, but a low degree of severity as well as those with a very low degree of likelihood, but a high degree of severity
- Hospitals are free to delegate this duty to the responsible practitioner
Consent Process: CMS Conditions of Participation

CMS’s optional suggestions for a “well-designed consent form”:

- Name of practitioner who conducted IC discussion
- Date, time and signature of witness to patient’s signature
- Listing of material risks discussed
- Statement that other practitioners will be performing tasks (required in first draft — ultimately taken out)
- Statement that non-physician practitioners who are participating in procedure will stay within scope of practice

Informed Consent Process

Is this an adequate note evidencing consent discussion?
Informed Consent Process

How about this one?

Can a Consent Form Be Stale?

- There are no strict rules governing how far in advance of the procedure can or should occur. How the physician obtains IC is within his/her discretion.
- As a general rule:
  - The discussion should occur with sufficient time allowed for the patient to consider his/her decision — several weeks might not be unreasonable.
  - Common sense, reasonableness and good judgment should apply.
  - If the patient evidences doubt or confusion, hospital personnel are to contact physician to resolve issue.
Has Anything Changed?

- If the patient’s health has taken a turn for the worse since surgery was originally contemplated, the patient and doctor should discuss the planned procedure in light of any changes in the benefits or risks, or alternatives
- Without documentation, it is almost impossible to prove the further discussion happened

Witnessing Consent Form

- There are no specific witnessing requirements by either TJC or CMS
- CHA recommends that one person serve as a witness to the patient’s signature
- No need to notarize consent form
Witnessing Consent Form

- TJC will ask about witnessing and it is important for staff to know who can witness based on hospital policy
- Typical hospital personnel who act as witnesses are admitting staff, RNs, and LVNs
- Is anyone else allowed to be the witness?
  - Residents?
  - Physicians participating in the surgery?
  - Family members?
  - Interpreters?

Other Issues

- Should we attach labels discussing risks, benefits and alternatives to consent forms?
- Can you get consent over the phone?
- Can you use a fax signature on a form?
- What can we do when incompetent patients arrive in pre-op without any surrogate and no consent?
- Any special standards for research?
Consent: Exceptions and Special Circumstances

Exceptions to Consent:
- Emergency
  - Impracticable to obtain consent
  - Patient mentally incapacitated
  - No authorized representative who can consent
  - Hospitals must make reasonable efforts to contact patient representative (Probate Code Section 4716)
  - If prior refusal, and emergency subsequently results, the emergency exception may not apply
  - Business and Professions Code section 2397 provides immunity
- Patient request for non-disclosure

Two Physicians and Emergencies

An unconscious man who had fallen while hiking was brought to our ER. He needs emergency brain surgery to evacuate a hematoma. He had no ID and we had no way to find his family. Can we do emergency surgery? Two doctors are ready to sign.
Two Physicians and Emergencies (cont.)

First let’s define emergency: when a patient will suffer permanent harm or severe pain without treatment, the patient is incompetent to give consent and there is no surrogate available to make the decision.

- Second, there is no legal requirement that the physician consult with a 2nd physician to confirm the existence of an emergency
  - However, such consultation may be required by hospital or medical staff policy
  - If no policy requires confirmation, a physician has the discretion to decide if consultation is necessary before the physician proceeds with emergency care in the absence of consent from the patient
But Can’t Two Physicians Just Give Consent?

- The myth that will not die:
  - That two physicians can sign the consent
  - Any two physicians will do — even the surgeon and his assistant
  - They can consent to elective, non-emergency surgery for incompetent patients who do not have a surrogate decision-maker

- So the answer is: NO!!

Missing Consent in the OR

**The patient is in the OR and we just discovered there is no consent form on the chart!**

- This needs to be evaluated on case-by-case basis:
  - Look for evidence of consent discussion in medical record or physician clinic chart
  - Obtain consent from surrogate
  - Do no harm to the patient

- A good Universal Protocol would help reduce the risk. Go beyond The Joint Commission National Patient Safety Goal and include verification of consent form as part of pre-procedure process
Changing the Procedure

The consent form says appendectomy, but the surgeon wants to do a hysterectomy. Do we need a new consent form?

- Options:
  - Redo entire consent form
  - Less desirable: Make change and have all initial and witness changes
- NOTE: Avoid a situation where the consent form has a patient signature, but also a change in the procedure that is not initialed or witnessed, e.g., changing the level on a spine surgery — The Joint Commission recent observation.

New Finding During Surgery

In the middle of surgery, the doctor discovered an unexpected problem that he wants to fix now. Can he?

- Case-by-case evaluation taking into account:
  - Is the finding related to original procedure?
  - Was it a complication or finding inherent to the procedure?
    - “Law will deem a patient to have consented to a touching that, although not literally covered by the patient express consent, involves complications inherent to the procedure” — Kaplan v. Mamelak (2008) 162 Cal. App. 4th 637
  - Is there an available surrogate who could consent?
  - Is the action required an emergency?
Case Example: Pressure from Patient to Assume the Risk

- Attorney patient with severe back pain reports to the hospital for surgery by orthopedic surgeon
  - Anesthesiologist reviewed case the night before and realized that the patient had not stopped a medication per guidelines and could be at risk for bleeding
    - Cardiology consult says ok to proceed
    - Anesthesiologist does not wish to proceed
- Patient threatens lawsuit, agrees to sign “hold harmless, assumption of the risk” and threatens to report the physician to the medical board for abandonment
- What should the hospital do?

Determining Competency vs. Capacity

What is the difference between “competency” and “capacity?”
Competency

- Competence generally considered a legal category
- Only courts can declare a person to be legally incompetent and take away the person’s power to make decisions
- Courts can declare a person competent to make health care decisions, but not financial ones

Legal Mental Capacity
(Probate §810)

Judicial Determination of Mental Capacity

- There is a rebuttable presumption affecting the burden of proof that all persons have the capacity to make decisions and to be responsible for their acts or decisions
- A person who has a mental or physical disorder may still be capable of contracting, conveying, marrying, making medical decisions, executing wills or trusts, and performing other actions
Evidentiary Tests for Determining Sound Mind (Probate §813)

- Basic questions — can the person:
  - Respond knowingly and intelligently to queries about that medical treatment?
  - Participate in that treatment decision by means of a rational thought process?
  - Understand the minimum basic medical treatment information with respect to that treatment?

Minimum Medical Information Patients Must Understand (Probate §813)

A. The nature and seriousness of the illness, disorder, or defect that the person has
B. The nature of the medical treatment that is being recommended by the person’s health care providers
C. The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person’s health care providers, and the consequences of lack of treatment
D. The nature, risks, and benefits of any reasonable alternatives
Capacity

- A person who has not been adjudicated incompetent by a court may nevertheless lack capacity to make health care decisions (to be determined by physician (Probate Code Section 4658))
- The incapacity may be temporary (e.g., patient is unconscious or confused due to meds) or more long lasting
- The same standards used by a court to determine whether a person is competent should be used by a physician to determine if a person has the capacity to make health care decisions

Presumption

- The presumption is that patients are capable of making health care decisions
- The fact the family or physician may disagree with a patient’s choice does not render the patient incapable of making the decision
- Psychiatric confirmation is not required (capacity determined by treating physician), but can be helpful when there is doubt, e.g., the patient may be depressed about the medical news and the depression is interfering with the patient’s capacity to make the decision
Factors to Consider

- Medication
- Emotional turmoil
- Pain
- Mental disorder

The Patient Without Capacity or Unrepresented Patient

- Use Ethics Committee
- CMA-CHA policy on Unrepresented Patients (
  Consent Manual, Appendix 2-D)
- Be guided by CMA-CHA Policy on Selection of Health Care Surrogates with the Assistance of Health Care Professionals (Consent Manual, Appendix 2-C)
  - Discusses suggested sources of information
  - Discusses characteristics of surrogate
  - Discusses duties of physician and other health care professionals
Capacity/Competency Documentation

- If the patient has been declared incompetent by a court, the orders should be obtained and included in the chart.
- If the physician has determined a patient lacks capacity, that determination and any factors supporting the determination should be documented.
- If the patient is unrepresented, document process for decision making.

Surrogates: The Basic Options

California Law:

- **General**: The right of a patient lacking capacity survives to the extent that a surrogate decision maker is recognized as having authority to make decisions on behalf of the patient.
  
  » *Barber v. Superior Court* 147 Cal App 3d 1006
Surrogates: The Basic Options

California Law:

- **Conservators:**
  - May or may not make health care decisions depending on scope of authority and patient’s capacity status
  - There are restrictions on conservator’s authority — no placement in mental facility, no consent for experimental drugs, no convulsive treatment
  - For withdrawal of life-sustaining treatment, must prove by clear and convincing evidence that the conservatee wished to refuse care. (Other surrogates’ standard is by preponderance of evidence)

Surrogates: The Basic Options

California Law:

- **Court petition to:**
  - Determine that a patient has capacity to make health care decisions
  - Determine that patient lacks capacity and to order a specific treatment or to designate a person to make a health care decision
  - Such a petition should be utilized only if there is a probability that the patient’s condition, if not treated, will become life endangering or pose a serious threat to the patient’s physical or mental health (Probate Code § 3200 et seq)
California Law:

- **Applying for Temporary or Permanent Conservatorship** — not always viable if:
  - Patient’s care cannot be postponed
  - Patient’s lack of capacity is temporary
  - Patient objects to conservatorship

California Law:

- **Public Guardian application** if:
  - Patient appears to require a guardian or conservator
  - It appears that no one else is qualified or willing to act
  - Appointment would be in best interests of the person

(Note: Not usually the best choice)
Use of Family and Others as Surrogates

The Barber and Cobbs cases provide the best guidance:

- **Cobbs**: “If the patient is a minor or incompetent, the authority to consent is transferred to the patient’s legal guardian or closest available family member”

- **Barber**: Court supported use of wife and children and acknowledged that the law does not specify that only court-appointed surrogates can make decisions

AMA Ethical Opinion 2.20 on Withholding or Withdrawing Life-Sustaining Treatment:

- … Without an AD … the patient’s family should become the surrogate … family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates …
Use of Family and Others as Surrogates

Domestic Partners:
- **Registered Domestic Partners:** Have the same authority (and limitations) as a spouse to make health care decisions for each other
- **Hospital Policy:** Any hospital policy regarding proof requirements should apply equally to spouses and registered domestic partners
- **Note:** Non-registered domestic partner may qualify as a surrogate

Selection of a Surrogate

**A practical suggestion for definition of surrogate for your hospital policy:**
- “A surrogate decision maker can be an agent appointed in an advance health care directive or a durable power of attorney for health care, a court appointed conservator of the person, a family member, domestic partner or persons with whom the patient is closely associated.”
Selection of a Surrogate

In selecting family surrogate, consider which family member:

- Is most familiar with the patient’s values and medical decision-making desires
- Would be most affected by the treatment
- Has expressed a concern or interest in the patient’s welfare

Barber v. Superior Court

Selection of Surrogates — CMA Model Policy

Selection of Surrogates — CMA Model Policy:

- In the absence of a selected or appointed surrogate, physicians may identify a surrogate who appears after a good faith inquiry, to be best able to function in this capacity. Input from the following may be helpful:
  - Family and friends of the patient
  - Other health care professionals
  - Institutional committees
  - Social workers
  - Chaplains
Selection of Surrogates — CMA Model Policy

Relevant factors in selecting a surrogate:

- Familiarity with patient’s personal values
- Demonstrated care and concern for the patient
- Degree of regular contact with the patient before and during the patient’s illness
- Availability to visit the patient

Selection of Surrogates — CMA Model Policy (cont.)

- Availability to engage with health care professionals
- Ability to understand medical condition
- Ability to assume duties of surrogate
- Previous designation of surrogate, whose authority has expired
Selection of Surrogates —
CMA Model Policy

Duties of Surrogate

- Same duties as other surrogates
- Under these circumstances it is important that the surrogate be willing to obtain information about patient’s known values and beliefs from patient’s friends and family
- Surrogate will be asked to assist in communications with relatives and associates of the patient as they are necessary for good medical care

NOTE: Agreement by a potential surrogate with the treatment recommendations of the physician or other health care professional should not be a criterion used in the selection of a surrogate.
Selection of Surrogates

Hospital should not rely on family members if:

- The relative’s decision-making capacity or motives are suspect
- There is a serious question whether the patient would consent
- Another close relative objects to the medical treatment

Selection of Surrogates (cont.)

A HIPAA nugget more protective of the patient —
A physician’s right to not treat a person as a personal representative if the physician has a reasonable belief that:

- The patient has been subjected to domestic violence, abuse or neglect by that person, or
- Treating that person as the personal representative could endanger the patient, and
- In the exercise of professional judgment, the physician decides it is not in the patient’s best interest to treat the person as the patient’s personal representative

45 C.F.R Section 164.502 (g)(5)
Unrepresented Patients

- How often do we have patients who have no one to speak for them?
  - No family
  - No friends
- The law is anything but helpful on how we manage basic consent for these patients
- The concept of a model policy was developed by CHA-CMA-Alliance for Catholic Health Care

The Unrepresented Patient — CHA/CMA/Alliance Model Policy for Acute Care Hospitals

Purpose of the Policy

- Provide a process for making ethically and medically appropriate treatment decisions on behalf of persons who lack decision making capacity and who have no appropriate surrogate decision-maker
- Provide guidance in the absence of clear cut legal guidelines that cover these circumstances
- Found in Consent Manual, Appendix 2-D
Policy involves use of multi-disciplinary team with the following members:
- Attending physician
- Nurse familiar with the patient
- Social worker familiar with the patient
- Chair or vice-chair of ethics committee
- Non-medical (community) member of ethics committee
- As available, consulting clinicians and pastoral care staff

Policy acknowledges that team membership will vary depending on nature and structure of the institution

Duties of the Multi-Disciplinary Team:
- Review diagnosis and prognosis for accuracy
- Determine appropriate goals of care by weighing the following:
  - Previously expressed wishes, if any
  - Relief of suffering and pain
  - Preservation or improvement of function
  - Recovery of cognitive functions
  - Quality and extent of life sustained
  - Degree of intrusiveness, risk or discomfort of treatment
  - Cultural or religious beliefs, to the extent known
- Establish a care plan with a determination of appropriate level of care, including categories or types of procedures and treatment
The Unrepresented Patient — CHA/CMA/Alliance Model Policy for Acute Care Hospitals (cont.)

Guiding Principles

- No bias based on patient demographics
- Team will be decision maker with same rights and responsibilities as agent
- Team must assure itself that medical decision is based on:
  - Sound medical advice and
  - Patient’s best interests and values

Guiding Principles

- If all members of team agree, care will be provided or treatment will be withheld or withdrawn
- If all members of team do not agree on the care plan, team will confer with the ethics committee or other resources to explore disagreement and facilitate resolution
Guiding Principles

- If continued disagreement:
  - Current treatments will be continued and any other medically necessary treatments provided until court resolution or disagreement otherwise resolved
  - NOTE: Court-imposed remedies should be sought only in extreme circumstances and as a last resort

Exceptional circumstances requiring consultation with legal counsel:

- Patient’s condition result of criminal act
- Patient’s condition caused or aggravated by a medical accident
- The patient is pregnant
- The patient is the parent with sole custody or responsible for support of a minor child
The Unrepresented Patient — CHA/CMA/Alliance Model Policy for Acute Care Hospitals (cont.)

Documentation of the following:
- Findings used to determine patient’s lack of capacity
- Findings that no surrogate available
- Attempts to locate surrogate
- Basis for treatment decision
- Ethics committee involvement

Informed Refusal — The Flip Side of Informed Consent

- A patient’s refusal to accept or pursue medical treatment should be informed
- Physician has a duty to advise of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure
- Document refusal of all medical tests and procedures
- Includes refusal to see a specialist
Informed Refusal — The Flip Side of Informed Consent

- An adult patient with capacity has the right to refuse any and all forms of medical treatment
- An adult does not have the right to deny life-sustaining treatment for his or her child

Law Enforcement, Patient Rights and Hospital Response

Physicians/hospital personnel should perform medical evaluations or procedures requested by law enforcement only if:
- Patient/legal representative consents
- Medical emergency exists and patient does not object
- Blood rest requested pursuant to Vehicle Code Section 23612 and patient does not forcibly resist
- Non-invasive medical evaluation is requested to determine if it is medically safe to incarcerate the person
Also …

- Medical evaluation or procedure is requested pursuant to law enforcement’s authority to conduct constitutionally permissible searches
- Requested pursuant to a valid court order
- Request involves collection and release of evidence of rape or other sexual assault from an alleged victim

Recommendations …

- Get requests in writing
- Discharge information to law enforcement permissible only in limited circumstances — Consent Manual, p. 6.6
- Develop policy/procedure
Thank you

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Lois Richardson, JD is vice president of privacy and legal publications/education at the California Hospital Association (CHA). Lois is responsible for all privacy related issues at CHA and for the development, writing and editing of CHA’s legal publications. Her noteworthy publications include the highly-regarded Consent Manual and the California Health Information Privacy Manual, which addresses both state and federal laws regarding the use and disclosure of health information. Additionally, she is the executive director for the California Society for Healthcare Attorneys.
Advance Health Care Directives: What Health Care Providers Need to Know

Lois Richardson, JD
California Hospital Association

How Would You Respond?

Polling Question 1
How Would You Respond?

Polling Question 2

How Would You Respond?

Polling Question 3
Informed Consent 101 …

• Common Law (judge-made law): Every competent adult has the fundamental right of self-determination
• A person unable to exercise this right (minors or incompetent adults), has the right to be represented by another person

Who May Complete an AD?

An adult having capacity may execute an advance health care directive or similar document
Two Parts of AD

An AD may contain either or both:

- A power of attorney for health care, which authorizes another person (the “agent”) to make health care decisions on behalf of the patient
- A health care instruction

Health Care Decisions Law
(Probate Code Sections 4600-4805)

- Requirements for executing a written advance health care directive
- Requirements for an oral designation of a surrogate decision-maker
- How an advance health care directive should be implemented by providers
Valid Advance Directive Has…

- Date of execution
- Signature of patient (or patient’s name written by another adult in patient’s presence and at patient’s direction)
- Signature of notary or witnesses
  *(Consent Manual, p. 3.4 describes requirements)*
- If patient is in SNF, signature of patient advocate or ombudsman

Valid Electronic Advance Directive

- Dated
- Signature of patient
- Acknowledged by a notary (not witnesses)
- If a digital signature, must meet additional requirements
Out-of-state advance directives valid in California if valid in that state/jurisdiction or meet California requirements

Advance directives of military and dependents valid

Unless stated otherwise, valid indefinitely

Oral Designation of a Surrogate Decision-Maker

Patient must personally inform supervising health care provider

 Promptly recorded in medical record

 Effective only during course of treatment/illness/stay, or 60 days — whichever is shorter
If patient has designated an agent in an advance directive and later makes an oral designation of a surrogate decision-maker, the surrogate is the appropriate decision-maker for the applicable time period.

The surrogate decision-maker and the agent must make decisions in accordance with the patient’s individual health care instructions and any other wishes of the patient, if known.
Who Can Not Be An Agent or Surrogate Decision-Maker?

- Supervising health care provider
- Employee* of institution where patient is receiving care
- Operator or employee* of a community care facility or residential care facility where patient receives care
- Patient’s conservator unless patient represented by an attorney

*Does not apply to employees related by blood, marriage, or adoption or registered domestic partners.

Effect of Divorce

- Valid AD, agent is spouse
- Parties have since divorced
- Designation of spouse as agent is revoked by operation of law
- Unless remarried
- Note: Patient can orally designate ex-spouse
POLST can complement an advance directive

- Converts the patient’s wishes into a physician’s order, signed by the physician and patient/legal representative
- Encourages communication between providers and patients — patients can make better-informed decisions
- Does NOT provide for the designation of a surrogate decision-maker
POLST is Not an Advance Directive …

- POLST is a physician order
- POLST is usually more specific regarding end-of-life treatment
- POLST may be modified by legal representative in consultation with MD after patient loses capacity
- POLST does not include space for patient’s wishes regarding autopsy, organ donation

POLST: CMS Perspective

Federal interpretation of Conditions of Participation (CoP) requires that patient treatment provided by a hospital must be ordered by physicians who are on staff and privileged at that hospital
As a Health Care Provider You Should …

- Request a copy of the AD/POLST and place in medical record
- Review the document to see if it meets the requirements
- Comply with an individual health care instruction of the patient
- Comply with a health care decision for the patient made by a person authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity

Health Care Providers May Decline to Comply …

- For reasons of conscience, communicated to patient/decision-maker
- Contrary to generally accepted standards; requests medically ineffective care
- Provide continuing care until transfer
- Or — patient with capacity changes mind
Difficult Situations …

- Agent makes decisions contrary to patient’s instruction
- Agent and family disagree about patient’s care
- Patient has no advance directive and family or caregivers disagree
- “Dead patients do not sue, but families do” — supervising provider disregards advance directive in response to family demands

And Now, Let’s Revisit Our Original Questions …

Polling Question 1
Circumstances Requiring Special Consent

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California Hospital Association

References: Consent Manual

- Minors = Chapter 2
- Special procedures = Chapter 4
- Mental health patients = Chapter 12
No … I Don’t Want It!

Minors and Consent — The Basics

- Parents have a legal obligation to provide necessities of life for minors, including medical care — and right to control care until 18 years old
- Some exceptions: status of minor, nature of treatment sought
- Refer to CHA’s “Medical Treatment of Minors,” Consent Manual, Appendix 2-B
Under California law, minors may obtain medical treatment regardless of parental consent when:

- The minor is legally considered “emancipated”
- The minor is seeking treatment for statutorily-specified medical need
- Minor must also have capacity
Emancipation

- By court order
- Self-sufficient (15 or older, living apart, managing own finances)
- Active duty U.S. military
- Married or previously married
- Note: parenthood is NOT an emancipating event!

Statutorily-Specified Medical Need

- Treatment or prevention of pregnancy, including contraception and abortion
- Diagnosis, treatment of communicable reportable disease
- Prevention of STD (HPV vaccine)
- Rape, sexual assault treatment, evidentiary exam (must attempt to contact parents unless they are believed to be perpetrator)
• Outpatient mental health treatment or drug/alcohol treatment if 12 years or older (parent must be given opportunity to participate unless therapist deems this inappropriate)

Remember!

- A minor has a privacy right in health information whenever the minor has the legal right to consent
- So … no disclosure to the parent allowed!
The person legally responsible for a minor is generally responsible for the minor’s financial obligations, BUT not for health care or related services to which the minor may legally consent.

- (THINK pregnancy, family planning, abortion, sexual assault, reportable communicable diseases, substance abuse, mental health outpatient treatment)

### Additional Considerations

- Married parents
- Divorced parents
- Stepparents
- Adopted minors
- Minors born “out of wedlock”
- Registered domestic partner parents
- Multiple parents
- Guardians
- Third-party consent
- Neighbors, sitters
- Minor parents
- Abandoned minors
- Parents otherwise unavailable
- Minors in custody
Blood Transfusions

- Advisable to view as a complex procedure requiring informed consent by MD
- If transfusion is a reasonably foreseeable possibility, patients should be given “A Patient’s Guide to Blood Transfusion,” Paul Gann Blood Safety Act by:
  - Physician or podiatrist
  - NP, CNM, or PA IF that person is authorized to order a blood transfusion

Sterilization

- Special informed consent requirements for elective sterilizations (not a side effect of an otherwise necessary medical procedure)
- Additional requirements when treatment costs reimbursed by Medi-Cal or other federally-funded programs — also, patients cannot be “mentally incompetent” or voluntarily committed to a facility
- See Consent Manual, p. 4.2 (waiting periods, forms, etc.)
Hysterectomies
- Not reimbursed under Medi-Cal or other federally-funded programs if performed as an elective sterilization
- Specific physician requirements, consent form or written statement forms required
- See Consent Manual, p. 4.9
  (hospital role, emergencies, etc.)

Vaccines
- Federal law requires health care providers to furnish written vaccine information to a patient/legal representative before administering specified vaccines
- Required documentation in medical record
- Competent adult may refuse — also may refuse for minor — THINK informed refusal!
- See Consent Manual, p. 4.18
  (list, documentation)

- Health care practitioner must verbally inform patient that telehealth may be used
- Obtain verbal consent
- Document the verbal consent
- N/A to DCR inmates
- Medi-Cal patient: teleophthalmology or teledermatology by store and forward: notify patient of right to receive interactive communication with distant provider

Tricky Consent Situations …

And a Few More …

See Consent Manual:
- Abortions — p. 4.12
- Re-use of hemodialysis filters — p. 4.14
- Mandatory patient information: breast or prostate cancer treatment; GYN or prostate exams — p. 4.16
- Mandatory consultation — mastectomy patient length of stay — p. 4.17
- Silicon implants and collagen injections — p. 4.18
- Antipsychotic medications — pg. 4.21
- Psychosurgery — pg. 4.25
And More …

See *Consent Manual*:

- Convulsive therapy and insulin coma treatment — p. 4.27
- Mandatory consultation — outpatient and discharge medications — p. 4.31
- Implantation of cells, tissue and organs — p. 4.33
- Assisted reproduction procedures — p. 4.34
- Mandatory patient information: severe chronic intractable pain — p. 4.37
- Dental restorative materials — p. 4.37

And More …

See *Consent Manual*:

- Proposition 65 — p. 4.37
- Pelvic examination on an anesthetized or unconscious female — p. 4.39
- Needles/syringes without a prescription — p. 4.39
- Transplantation: Informed consent for donors and recipients — p. 4.40
- Research — chapter 7
- HIV testing — p. 23.4
And More …

- Fetal ultrasound for keepsake purposes — p. 10.3
- VBAC w/midwife — p. 10.1
- WHEW!

See list at very beginning of Consent Manual

Mental Health Patients — Consent Dilemmas

- Voluntary patient and can leave unless danger to self/others (W&I 5150 / H&S 1799.111)
- Involuntary patients retain right to refuse meds, unless court ruling
- Minor inpatients: parents must consent
- Minor outpatients, 12 and older: minor must consent
Mental Health Patients — Consent Dilemmas

• Is the patient under a conservatorship?
• What type? (LPS/Probate see p. 2.3)
• Has the patient/conservatee been adjudicated to lack the capacity to make health care decisions
• Obtain copy of conservatorship paper; review for specific language regarding patient’s capacity or lack thereof

W & I Code Section 5325 lists certain patient rights for all mental health patients — Consent Manual p.13.1 – 13.2

- Key “consent” rights
  □ Refuse convulsive treatment
  □ Refuse psychosurgery

Restraint and seclusion

- Denial of rights is deemed to have occurred
- Document restraint and seclusion and any other denied right
Restraint and seclusion (cont.)

- Federal (CoPs) = Restraint or seclusion may be imposed only to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at earliest possible time
- Chapter 5, *Mental Health Law Manual*

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**Thank You**

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Questions

Online questions:
Type your question in the Q & A box, hit enter

Phone questions:
To ask a question hit *1
To remove a question hit *2

Principles of Consent & Advance Directives

A handbook on patient consent for treatment and other health care decisions

- Includes first five chapters of Consent Manual
- Covers: principles of consent, who may give consent, procedures that require special consent, advance health care directives, refusal of treatment, the POLST form, and end-of-life issues
- Helpful reference guide for staff
- Useful for staff compliance training

Visit www.calhospital.org/consent-principles
Related Publications

Consent Manual  Mental Health Law  Minors and Health Care Law  EMTALA

To learn more about CHA’s Publications, or to place an order, visit www.calhospital.org/publications

Upcoming Programs

- **Minors Health Care — The Basics of Consent, Privacy and More Webinar**
  *October 29, 2014*
- **Labor and Employment Law Seminars**
  *November 5, Glendale; November 13, Sacramento*
- **EMTALA Webinar**
  *November 14, 2014*
- **Behavioral Health Care Symposium**
  *December 8 – 9, Redondo Beach*
Thank You and Evaluation

Thank you for participating in today’s seminar. An online evaluation will be sent to you shortly.

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.