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Printed in the United States of America.
Welcome to the 2016 edition of the *Minors & Health Care Law* manual — the only comprehensive guide to consent for minors and related health care law in California.

The California Hospital Association publishes this manual for use by the health care community as they assist minor patients and their parents or other caregivers in making informed decisions about their medical care. The manual takes complicated laws and explains them in clear and concise language. The *Minors & Health Care Law* manual tells you exactly what the law requires and what you need to do to comply.

The manual can be used by a wide range of personnel: administrators, risk managers, pediatric staff, health information and admissions staff, privacy officers, health care attorneys, physicians and nurses, emergency room staff, clinic managers, social workers, quality managers and others within a hospital or health care facility. It also is a useful tool for those who develop health care policy and provide counsel to health care facilities.

This edition of *Minors & Health Care Law* reflects changes in state and federal legislation, regulations and judicial decisions through April 2016.

The manual includes a CD with more than 40 forms (many in Spanish) and several posters required by law. For your convenience, the English version of the forms and other appendixes can also be found at the back of the manual.

We are pleased to publish this manual as a service to our members and others. We hope you find it useful.

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Information contained in the *Minors & Health Care Law* manual should not be construed as legal advice or used to resolve legal problems by health care facilities or practitioners without consulting legal counsel. Because the information included here is general, it may not apply to your individual legal or factual circumstances. A health care facility may want to accept all or some of the *Minors & Health Care Law* manual as part of its standard operating policy. If so, the hospital or health facility’s legal counsel and its board of trustees should review such policies prior to implementation.
QUICK REFERENCE GUIDE

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INTRODUCTION

Historically, decisions regarding whether to provide medical treatment to a minor were made exclusively by the child’s parents. Physicians and other providers of care were rarely confused about who needed to be consulted prior to providing necessary care. Usually, it was not a difficult task locating a parent to obtain the consent necessary to proceed with treatment. In recent years, the changing nature of the family and family law has complicated the question of who is legally authorized to provide consent for treatment of a minor. Health practitioners with minor patients are frequently faced with the need to document consent from separated or divorced parents, stepparents, foster parents, grandparents, guardians or other responsible adults.

The rights of minors with regard to their medical treatment and medical confidentiality must be seen in the context of the contemporary parent-child relationship. While the parents are generally presumed to have legal authority to act on their child’s behalf, the law recognizes the rights of minors independent of their parents.

Caution must be exercised, however, for this evolutionary movement toward recognition of minors’ rights has not produced a consistent body of law. Judicial decisions address specific cases or disputes and do not provide a comprehensive scheme for consideration of these issues. Legislation also tends to address these issues in a piecemeal fashion. Taken together, the law concerning the rights of minors has not produced a coherent resource for resolving the numerous situations that hospitals, clinics, physicians, child protective agencies, schools and others face in their efforts to provide appropriate care to minors.

When additional information is desired regarding matters discussed in this handbook, readers are encouraged to consult their legal counsel.
WHERE TO FIND LAWS REFERENCED IN THE MANUAL

All of the laws discussed in the *Minors & Health Care Law* manual can be found on the Internet.

I. FEDERAL LAW

A federal statute is written by a United States Senator or Representative. It is voted on by the United States Senate and the House of Representatives, and then signed by the President. A federal statute is referenced like this: 42 U.S.C. Section 1395. “U.S.C.” stands for “United States Code.” Federal statutes may be found at www.gpo.gov/fdsys or at www.law.cornell.edu.

A federal regulation is written by a federal agency such as the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration. The proposed regulation is published in the *Federal Register*, along with an explanation (called the “preamble”) of the regulation, so that the general public and lobbyists may comment on it. The federal agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. The final regulation is also published in the *Federal Register*. A federal regulation is referenced like this: 42 C.F.R. Section 482.1 or 42 C.F.R. Part 2. “C.F.R.” stands for “Code of Federal Regulations.” Federal regulations may be found at www.gpo.gov/fdsys or at www.ecfr.gov. The preamble, however, is only published in the *Federal Register* and not in the Code of Federal Regulations. The *Federal Register* may be found at www.gpo.gov/fdsys or at www.federalregister.gov.

The Centers for Medicare & Medicaid Services publishes its *Interpretive Guidelines* for surveyors on the internet. They may be found at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo. There are several appendices that hospitals will find useful, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

A federal law must be obeyed throughout the United States, including in California, unless the federal law expressly states otherwise. As a general rule, if a federal law conflicts with a state law, the federal law prevails, unless the federal law expressly states otherwise.

If there is no conflict, such as when one law is stricter but they don’t actually conflict with each other, both laws generally must be followed. For example, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal law states that providers must conform to whichever provision of federal or state law provides patients with greater privacy protection or gives them greater access to their medical information (see chapter 15).

II. STATE LAW

A state statute is written by a California Senator or Assembly Member. It is voted on by the California Senate and Assembly, and then signed by the Governor. A state statute is referenced like this: Civil Code Section 56 or Health and Safety Code Section 819. State statutes may be found at www.leginfo.legislature.ca.gov/faces/home.xhtml. Proposed laws (Assembly Bills and Senate Bills) may also be found at this website.

A state regulation is written by a state agency such as the California Department of Public Health or the California Department of Managed Health Care. A short description of the proposed regulation is published in the California Regulatory Notice Register, more commonly called the *Z Register*, so that the general public and lobbyists may request a copy of the exact text of the proposed regulation and comment on it. The state agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. A notice that the final regulation has been officially adopted is also published in the *Z Register*. The *Z Register* may be found at www.oal.ca.gov/notice_register.htm.

A state regulation is referenced like this: Title 22, C.C.R., Section 70707. “C.C.R.” stands for “California Code of Regulations.” State regulations may be found at www.calregs.com.

A state law must be obeyed in California only. As a general rule, if a California law conflicts with a federal law, the federal law prevails, unless the federal law expressly states otherwise. (If there is no conflict, such as when one law is stricter but they don’t actually conflict with each other, both laws generally must be followed.)
State and federal laws grant patients certain rights. Foremost among these is the right for a competent adult to make his or her health care decisions. Minors, however, do not always have the right to make their own health care decisions. Whether they have the right to make their own health care decisions depends upon their age, their demonstrated independence, and the type of health care services they are seeking. If they do not have the right to make their own health care decisions, these decisions will be made by a responsible adult acting in accordance with their best interests.

A minor is an individual who is under 18 years of age [Family Code Section 6500].

This chapter discusses the basic principles of consent, including when consent is necessary, the difference between “simple” consent and informed consent, how consent may be obtained, penalties for failure to obtain consent, and special issues regarding consent for minors.

I. WHY CONSENT IS NECESSARY

Every competent adult has the fundamental right of self-determination over his or her body and property. Individuals who are unable to exercise this right, such as minors and incompetent adults, have the right to be represented by a parent or another person who will protect their interests and preserve their basic rights. (See chapter 2 regarding appropriate legal representatives for minor patients.)

A. THE PATIENT’S RIGHT TO CONSENT TO, OR REFUSE, MEDICAL TREATMENT

A person does not give up the right to control what is done with his or her body and property when seeking care at a hospital. Indeed, a physician has both a legal and an ethical duty to obtain the patient’s consent, or the consent of the parent or other legal representative, to medical treatment.

Failure to obtain the proper consent to treatment in accordance with applicable legal standards may result in a charge of battery, professional negligence (malpractice), and/or unprofessional conduct against the physician, nurses, or other health care providers, for even the simplest of procedures.

If the nature of the treatment involved is complicated, the recognition of the patient’s right to self-determination may require that “informed” consent be obtained. [Cobbs v. Grant, 8 Cal. 3d 229 (1972)] The distinction between “simple” consent and “informed” consent is described in III. “Informed Consent,” page 1.5.

FAILURE TO OBTAIN CONSENT: BATTERY

“Battery” is defined legally as an intentional touching of a person in a harmful or offensive manner without his or her consent. Consequently, a claim of battery may be made against a physician or other health care provider who performs a medical procedure on a patient without the proper consent. A battery may also arise if the patient (or legal representative) consents to a particular procedure and the provider either exceeds the scope of the consent or performs a different procedure for which consent was not obtained. It is important to note that no wrongful intent need be present; a physician may sincerely intend to aid the patient, but still be liable for committing a battery. A medical procedure may be considered to be a “harmful touching” (a battery) even if it is performed competently with no adverse outcome.

FAILURE TO OBTAIN INFORMED CONSENT: MALPRACTICE

A patient’s right to decide whether or not to submit to medical treatment establishes the physician’s corresponding duty to inform the patient (or legal representative) about the recommended care so that the patient’s decision is meaningful. The physician’s duty of disclosure arises from the fiduciary quality of the physician-patient relationship, which is based upon the patient’s dependence on the physician’s specialized knowledge. [Cobbs v. Grant, supra, at 242]

A physician who fails to adequately disclose the nature of the procedure and its risks and alternatives may be liable for negligence (malpractice). In Cobbs v. Grant, the California Supreme Court established guidelines regarding the physician’s duty of disclosure that are explained at length in III. “Informed Consent,” page 1.5. If the recommended treatment involves the performance of a “complicated” procedure, a physician must explain the nature of the treatment, the risks, possible complications, and expected benefits or effects of the treatment, as well as the alternatives to the treatment and their risks and benefits. The physician must also inform the patient (or legal representative) of any potentially conflicting interests he or she may have, such as research or financial interests. Informed consent is not required for the performance of “simple and common” procedures, where the related risks are commonly understood.

INFORMED REFUSAL

The California Supreme Court has specifically ruled that the physician’s duty of disclosure includes the responsibility to
inform the patient (or legal representative) of the risks of refusing to undergo a simple and common procedure that has been recommended [Truman v. Thomas, 27 Cal.3d 285 (1980)] (see III. “When a Patient or Legal Representative Refuses Treatment,” page 6.1). In the Truman case, the court held that the defendant doctor breached his duty to his patient by failing to inform her of the risks resulting from her failure to authorize and undergo a Pap smear test. The court stated:

If a patient indicates that he or she is going to decline a risk free test or treatment, then the doctor has the additional duty of advising of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure … If the recommended test or treatment is itself risky, the physician should always explain the potential consequences of declining to follow the recommended course of action. [Id. at 292]

Consequently, depending upon the type of procedure involved, a physician may be liable for professional negligence (malpractice) if he or she fails to secure the patient’s (or legal representative’s) “informed refusal.”

B. THE PATIENT’S RIGHT TO CONSENT TO HOSPITAL SERVICES

The patient’s personal and property rights may also be affected by certain activities conducted by the hospital and its personnel (as distinct from activities conducted by the physician). Examples include the release of patient-identifiable information, the transfer of a patient to another health facility, and the submission of patient claims to arbitration.

Although a hospital is not subject to the physician’s fiduciary duty to the patient and is not directly responsible for obtaining informed consent to medical treatment, the hospital is responsible for the care of its patients and for obtaining their consent, or the consent of their legal representatives, to those hospital activities, which, without such consent, would impinge on patients’ rights. Examples of hospital activities that require consent (although not necessarily informed consent) include routine blood tests, chest X-rays and nursing services. Consent to these activities is included in the model “Conditions of Admission” form (CHA Form 8-1).

A hospital’s failure to obtain the proper consent may raise allegations of battery (as discussed above), false imprisonment (as discussed below) and possibly other charges.

FALSE IMPRISONMENT

Obtaining consent to hospitalization will help protect the hospital and physician from the charge that they falsely imprisoned the patient, that is, compelled the patient to remain in the hospital against his or her will. (See also chapter 5 regarding involuntary mental health evaluation and treatment, and chapter 6, VI. “Leaving the Hospital Against Medical Advice,” page 6.5.)

In summary, the proper consent to medical treatment and hospital services is necessary because, as a general rule, without such consent, the physician and the hospital have no authority to subject the patient to medical treatment or hospitalization and related services. Failure to obtain the consent of the patient or the patient’s legal representative may violate the patient’s common law rights discussed above as well as other patients’ rights established by state and federal laws.

II. WHEN CONSENT IS NECESSARY

The general rules for determining when consent is required are presented below. Subsequent chapters address the requirements that apply in specific situations.

A. GENERAL RULE

The hospital may not permit any treatment, without the risk of liability, unless the patient, or a person legally authorized to act on the patient’s behalf, has consented to the treatment. The consent may be simple or informed (see B. "Identifying Procedures That Require Informed Consent," page 1.6). The exceptions to this general rule are described below. (See also chapter 5 regarding involuntary mental health evaluation and treatment.)

B. EMERGENCY TREATMENT EXCEPTION

STATEMENT OF PRINCIPLE

Treatment of a medical emergency may be provided without consent where the provider reasonably believes that a medical procedure should be undertaken immediately and that there is insufficient time to obtain the consent of the patient or of a person authorized to consent for the patient. The law implies consent in these circumstances on the theory that if the patient were able, or if a qualified legal representative were present, the consent would be given. This exception applies to minors as well as to adult patients.

The location of the patient is not relevant to the determination of whether the patient has a medical emergency. A patient may be in the emergency department, yet may not have a medical emergency that obviates the necessity to obtain consent. Similarly, the patient may be located in a medical/surgical unit or outpatient department and develop a medical emergency that requires treatment to be provided without consent.

California law defines a medical emergency for certain purposes, such as the provision of immunity to physicians...
who provide treatment in emergency situations [Business and Professions Code Section 2397(c)(2) and (3)], the rendering of care to incompetent adults without court authorization [Probate Code Section 3210(b)], and the rendering of care to minors in custody of the juvenile court [Welfare and Institutions Code Sections 369(d)]. According to these statutes, a medical emergency exists when:

1. Immediate services are required for the alleviation of severe pain; or
2. Immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed and treated.

**LIMITATIONS**

It is important to note that only the emergency condition may be treated. Treatment that exceeds the necessary response to the emergency condition may not be rendered without consent from someone authorized to consent to treatment on a non-emergency basis.

As a general rule, if a patient or the patient’s legal representative has validly exercised his or her right to refuse particular medical treatment (see chapter 6), the treatment may not be provided. Since the emergency treatment exception is based on the theory of implied consent, it is not applicable when a patient (or legal representative) has validly refused medical treatment, and the emergency arises from the fact that treatment was not given. However, if the medical emergency is the result of a condition or injury that is not specifically related to the condition or injury for which the patient previously refused treatment, the emergency treatment exception generally applies.

If evidence exists to indicate that the patient (or the patient’s legal representative) would refuse the treatment — such as a wallet card stating that the patient is a Jehovah’s Witness and refuses blood products — legal counsel should be consulted. (See chapter 6 regarding refusal of treatment.)

**IMMUNITY FROM LIABILITY**

The emergency treatment exception has been recognized in several statutes that provide immunity to a physician who does not inform a patient (or legal representative) and obtain consent to treatment under certain emergency circumstances. Business and Professions Code Section 2397 provides that a physician is not liable for civil damages for injury or death caused in an emergency situation occurring in his or her office or in a hospital on account of a failure to inform a patient of the possible consequences of a medical procedure where the failure to inform is caused by any of the following:

1. The patient was unconscious.
2. The medical procedure was undertaken without the consent of the patient because the physician reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient.
3. A medical procedure was performed on a person legally incapable of giving consent, and the physician reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give such consent for the patient.

This law is applicable only to actions for damages for injuries or death arising because of a physician’s failure to inform, and not to actions for damages arising because of a physician’s negligence in rendering or failing to render treatment. Business and Professions Code Section 1627.7 provides similar protections for dentists.

In addition, Health and Safety Code Section 1317 provides immunity from liability for an act or omission (which includes the failure to obtain consent) that occurs while a rescue team established by a licensed health facility (or operated by the state or federal government, a county, or the Regents of the University of California) attempts to resuscitate a person who is in immediate danger of loss of life or serious injury or illness, if the rescue team acts in good faith. This immunity extends to the facility, its officers, staff, and employees, including members of the rescue team.

**RECOMMENDED PROCEDURE FOR PROVIDING CARE PURSUANT TO THE EMERGENCY MEDICAL TREATMENT EXCEPTION**

**Determination of Existence and Nature of Emergency**

The physician must initially determine whether the patient has the capacity to give consent, since the emergency exception applies only when consent cannot be given. In addition, the scope of the emergency must be determined, and any treatment provided must be limited to that necessary to alleviate the severe pain, or to prevent the patient’s severe disability or death. The treatment provided may be a matter of first aid, temporary medical care in lieu of surgery, or actual surgical procedures. However, only the emergency medical condition may be treated under this exception, since it is the existence of the emergency condition that establishes the implied consent.

**Consultation**

There is no legal requirement that the physician consult a second physician to confirm the existence of an emergency. However, such consultation may be required by hospital or medical staff policy. Otherwise, it is a matter of discretion.
for the treating physician to determine if consultation is advisable to confirm the existence of the emergency.

**Otherwise Obtaining Consent**

The possibility of obtaining the necessary consent from the patient or legal representative should be assessed and weighed against the possibility that a delay in treatment in order to secure such consent would result in the patient's severe disability or death, or continuing severe pain. If a delay in treatment for purposes of obtaining consent would not jeopardize the condition of the patient, treatment must be delayed and consent obtained pursuant to the guidelines contained in this manual.

**Documentation in the Medical Record**

The medical determination that an emergency exists should be carefully documented by the physician (e.g., “The immediate treatment of the patient is necessary because ...”). The physician does not sign a consent form on behalf of the patient. Such consent is implied by law from the existence of the emergency.

If the physician has obtained a consultation, the consulting physician should similarly document his or her findings and opinion in the patient’s medical record.

**C. EXCEPTION FOR X-RAYS TO DIAGNOSE CHILD ABUSE**

A physician may take skeletal X-rays of a child without the consent of the child’s parent or guardian to diagnose possible child abuse or neglect and to determine the extent of the child abuse or neglect. (See V. “Consent for Abuse-Related Exams,” page 8.6, for further information.)

**D. EXCEPTION FOR ILLNESS OR INJURY AT SCHOOL**

When a minor is ill or injured during regular school hours, reasonable medical treatment may be provided without parental consent if the minor’s parent(s) or guardian cannot be reached. This does not apply if the parent(s) or guardian has filed with the school district a written objection to any medical treatment other than first aid. [Education Code Section 49407] Treatment is limited to medical treatment that is “reasonable” under the circumstances. This does not include procedures involving significant risk or invasiveness.

The law provides immunity from liability to a school district, officer of a school district, school principal, physician or hospital treating any child in any school in any district. It is not clear whether this law also applies where minors attending private schools are treated.

Before relying on this statute, however, a provider should attempt to contact parents and determine whether a written objection has been filed with the school (or the school district). Schools typically have on file the name and telephone number of a student’s parent or guardian authorized to consent to medical treatment for the student.

**E. OTHER CIRCUMSTANCES IN WHICH A PHYSICIAN IS NOT REQUIRED TO OBTAIN INFORMED CONSENT**

**CIRCUMSTANCES**

In Cobbs v. Grant, discussed above, the court noted two special circumstances in which a physician is not required to disclose all of the information that is required to secure the patient’s informed consent.

First, the court indicated that a physician need not disclose the risks of the recommended treatment when the patient has requested that he or she not be so informed.

Second, a physician is not required to disclose information to the patient if such disclosure would seriously harm, rather than benefit, the patient. In this regard, the court explained:

> A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence that the doctor relied upon facts which would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment. [Cobbs v. Grant, 8 Cal.3d at 245-246]

This second exception to the physician’s duty of disclosure is commonly known as the “therapeutic privilege.”

Neither exception should be relied upon by the physician unless it is extremely clear that the facts and circumstances of the case justify invoking it. The court stated that these two exceptions constitute situations in which a physician who fails to make the disclosure required by law may defend his or her actions, and specified that any such defense “must be consistent with what has been termed the ‘fiducial qualities’ of the physician-patient relationship.”

The physician’s decision to not disclose information will be measured in terms of what “a reasonable person” would have done, not what another physician would have done. Also, the court’s discussion about the exceptions generally referred to the disclosure of information about the potential risks of the recommended procedure and did not specifically state that a physician may be justified in not disclosing other information, such as that pertaining to the diagnosis, the nature of the recommended treatment, its expected benefits or effects, alternatives and any potentially conflicting interests of the physician (such as research or financial interests).

The use of these two exceptions should be very rare in the case of adult patients with capacity to make health care decisions. It is not clear that either exception is available in
the case of a patient, including a minor, who lacks the ability to consent to his/her own care. If the parent, guardian, or other legal representative who ordinarily would make health care decisions for the patient requests not to be given certain information, or is not able to emotionally handle the information, legal counsel should be consulted. In such situations, it should be determined whether a different decision maker would be appropriate.

**PROCEDURE**

If the physician determines that the patient specifically asked to not receive information about the proposed procedure or treatment, or that the “therapeutic privilege” applies, the physician should fully document in the patient’s medical record the facts that resulted in this conclusion. The physician should also document what, if any, information was disclosed to the patient. It may be appropriate for the physician to discuss the information that was not disclosed to the patient with the patient’s closest available relative (if the patient consents to the release of medical information to, and the involvement of, the relative) and secure that person’s approval for proceeding with the procedure in view of this full disclosure. The physician should document in the patient’s medical record the nature and results of any such consultation with the patient’s family.

The hospital’s role is to verify, by checking the documentation in the medical record, that the physician’s failure to disclose information resulted from a determination that one of the two exceptions applied. The hospital may wish to refer such cases to hospital administration, risk management, or legal counsel for review prior to beginning the procedure.

### III. INFORMED CONSENT

#### A. ELEMENTS OF INFORMED CONSENT

As discussed above, the California Supreme Court held in *Cobbs v. Grant*, that a patient or legal representative must give “informed consent” prior to certain medical treatment. The court stated that in order to give informed consent, the patient or legal representative must be informed of:

1. The nature of the procedure;
2. The risks, complications, and expected benefits or effects of the procedure;
3. Any alternatives to the treatment and their risks and benefits.

In addition, a later court held that the patient or legal representative must also be informed of any potentially conflicting interest the physician may have (such as research or financial interests). [*Moore v. Regents of the University of California*, 51 Cal.3d 120 (1990), cert. den., 499 U.S. 936 (1991)]

The *Cobbs* court explained that:

> The scope of the physician’s communications to the patient, then, must be measured by the patient’s need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient’s decision. [*Cobbs v. Grant*, supra, 8 Cal.3d 229, 245]

In a subsequent case, the court clarified its definition of “material information” as follows:

> [T]hat which the physician knows or should know would be regarded as significant by a reasonable person in the patient’s position when deciding to accept or reject the recommended procedure…To be material, a fact must also be one that is not commonly appreciated. . . . If the physician knows or should know of a patient’s unique concern or lack of familiarity with medical procedures, this may expand the scope of required disclosure. [*Truman v. Thomas*, 27 Cal.3d 285, 291 (1980)]

The Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoP) *Interpretive Guidelines* (Tag A-0466) state that material risks could 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 high degree of severity. The *Interpretive Guidelines* also state that hospitals are free to delegate to the responsible practitioner (the physician), who uses the available clinical evidence as informed by the practitioner’s professional judgment, the determination of which material risks, benefits and alternatives will be discussed with the patient. The *Interpretive Guidelines* can be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html, then Publication 100-07 *State Operations Manual*, then “Appendices Table of Contents.” Appendix A (hospitals) is listed first.

For some procedures and treatments, the law requires the physician to give additional specified information. Some of these treatments include sterilization, hysterectomy, vaccines, antipsychotic medications, reuse of hemodialysis filters, and electroconvulsive therapy. (See chapter 5 of CHA’s Consent Manual for additional information about these procedures.)

A physician need not inform a patient about treatment that cannot legally be administered in California [*Schiff v. Prados*, 92 Cal.App.4th 692 (2001)]. A physician must inform a patient about alternative treatments only to the extent that it is required for competent practice within the medical community. [*Vandi v. Permanente Medical Group*, 7 Cal.App.4th 1064 (1992)] For example, a physician need not discuss coffee enemas with patients.
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"S" denotes that the form is provided in English and Spanish. Spanish forms can be found on the enclosed CD.