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Welcome to the 2017 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 2017.

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.
## INTRODUCTION

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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.
# The Basic Principles of Consent

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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.)

**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.

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:

That 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.

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.

In certain circumstances the patient’s physician is not required to disclose all information which would otherwise be required to be given to the patient to secure the patient’s informed consent. These circumstances are discussed in E. “Other Circumstances in Which a Physician is Not Required to Obtain Informed Consent,” page 1.4.

In other circumstances, the law requires that specified information be given to the patient. These circumstances are discussed in chapter 5.

B. Identifying Procedures That Require Informed Consent

“Informed” consent, as distinguished from “simple” consent, is not required for all medical treatments. The Cobbs court held that treatments or procedures that are “complicated” require that informed consent (as described above) be obtained. Procedures that are “simple and common” do not require informed consent (although they still require consent, usually obtained in the “Conditions of Admission” form (CHA Form 8-1)). The court stated that a physician is not expected to explain risks that are commonly understood to be remote. The performance of a blood count was cited as an example of a simple and common procedure.

The determination of which procedures are “complicated” and, therefore, require informed consent, is medical in nature. It is the position of CMS that medical staff policies should address which procedures and treatments require written informed consent. (See Hospital Interpretive Guidelines, Tag A-0466.) The medical staff bylaws themselves would not seem to be the best place for this information. The rules and regulations or a policy and procedure would seem to be better choices. However it is done, it should be appropriately documented and approved by the medical staff executive committee. The medical staff may wish to adopt a somewhat generic rule, requiring informed consent for any procedure performed in the operating room, cath lab, lithotripsy center, etc., and for radiology or cardiology procedures involving contrast material, for radiation therapy, etc. Each procedure need not be separately listed. Procedures for which the law specifically requires informed consent should also be included (see chapters 5 and 10 of CHA’s Consent Manual for details). To determine whether a procedure is “simple and common” or “complicated,” the medical staff may wish to consider whether the average layperson would understand the nature of the procedure and its risks and benefits.

C. The Role of the Physician in Obtaining Informed Consent

It is the physician’s responsibility to obtain informed consent. Generally, the physician who performs the procedure is responsible for obtaining the patient’s consent. If a nonphysician will perform the procedure, then the ordering physician is responsible for obtaining consent. If more than one doctor is involved, they can determine together which one will obtain consent, or hospital policy may determine which physician will obtain consent. Hospital personnel should not be involved in providing the information necessary to secure the patient’s (or legal representative’s) informed consent or responding to questions concerning the procedure. The duty to provide this information and obtain informed consent is the exclusive duty of the treating physician.

PROCESS BY WHICH PHYSICIAN INFORMS PATIENT

Verbal discussion, written information, audio and video recordings are typical methods by which physicians may impart the information to the patient or legal representative necessary to obtain informed consent.

Although the physician may use written materials or audio or video recordings to provide information to the patient and/or the legal representative, it is recommended that the physician always give a personal explanation of the procedure or treatment, its possible complications, risks and alternatives. Such verbal discussion gives the patient or legal representative the opportunity (as required by the legal doctrine of informed consent) to ask questions about
the information presented by the physician. Consent given after a discussion with the physician and the opportunity for inquiry is more likely to be truly “informed.”

Physicians frequently develop patient information sheets that contain some or all of the information that must be given in order to secure informed consent. These information sheets may be an important part of the informed consent process since they give the information in a written form which can be reviewed later by the patient or legal representative. However, the use of the hospital’s name or the distribution of such information sheets by hospital personnel might cause a patient or legal representative to conclude that the hospital employs the physician and/or is responsible for the physician’s provision of medical services, including the physician’s duty to provide information about the procedure. Thus, any written information sheets, audio or video recordings, etc. which contain medical information that a physician is responsible for giving to secure informed consent should be designated as the physician’s information. If the information contains the hospital’s name or that of any hospital department, and hospital personnel are involved in distributing such information, describing the procedure to the patient or legal representative, or responding to questions concerning the procedure or the information, this could easily suggest that the physician is a hospital agent or otherwise confuse a patient or legal representative regarding the legal responsibility for obtaining informed consent. For these reasons, such involvement by the hospital or its staff is strongly discouraged. If a hospital chooses to distribute such information or put the hospital’s name on information sheets, etc., it should be clearly noted that the form or information is being provided by the hospital as a courtesy and that the information should be reviewed with the patient’s physician. It should also clearly state that the physician is not the employee or agent of the hospital (if that is the case).

**INFORMED CONSENT FORMS THAT CONTAIN MEDICAL INFORMATION**

Some physicians prefer to use an “informed consent” form that contains within it the medical information the patient or legal representative must be provided. This procedure promotes complete disclosure and allows patients and their legal representatives to study the information. While such forms should not be prepared or distributed by hospital personnel for the reasons discussed above, forms may be used by hospitals to verify and document that informed consent was given by each patient (or legal representative).

A physician who prepares an informed consent form that contains the medical information which must be provided may use as a guide the “Informed Consent to Surgery or Special Procedure” form (CHA Form 1-2). The physician should include medical information regarding the name of the procedure(s), nature of the treatment, its expected benefits or effects, its possible risks and complications, and any alternatives to the proposed treatment and their possible risks and complications. The physician should also include any potentially conflicting interests, such as research or financial interests. Usually it is not possible to include all information relevant to a particular patient’s condition on a written form; accordingly, the form must either be supplemented through verbal discussions and/or by written additions containing the information. For example, the risks of a simple appendectomy will differ depending upon whether the patient is a young, healthy person; a pregnant woman; or diabetic patient. A standardized list of risks may be used, but must be supplemented with any additional information pertinent to the particular patient.

These forms are helpful only if they are understood by the patient. Therefore, it is extremely important for the medical information included in the forms to be written in clear, simple, and easily understood terms. This is especially important if the form is designed to be read by the pediatric patient as well as by the parents or other legal representatives. In addition, it is essential that the forms clearly state that the patient or legal representative should ask any and all questions he or she may have concerning the proposed treatment.

Also, some physicians may ask the patient or legal representative to respond to questions such as: “Have you been given all the information you desire about the proposed treatment?” or “Do you understand the nature of the proposed treatment, its expected benefits and the possible risks and complications?” However, if this type of question is included in a consent form, the physician must verify it has been answered affirmatively on the form; otherwise, it will have established in the document that the patient or legal representative did not give informed consent. The format provided in CHA Form 1-2 does not include such questions; rather, it requires the patient or legal representative to acknowledge receipt of the relevant information.

**PHYSICIAN DOCUMENTATION**

It is recommended that the physician carefully document in the hospital medical record a discussion was held with the patient and/or legal representative and that informed consent was obtained. This documentation can be accomplished in a variety of ways — through a certification on the consent form itself (see the certifications on the “Consent to Surgery or Special Procedure” form (CHA Form 1-1)), through a progress note in the patient’s
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These documents are provided in English in the back of the manual. All forms can be found on the CD that accompanies the Minors & Health Care Law manual, including Spanish versions, when available. “S” denotes that the form is provided in English and Spanish.

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* Indicates forms that are new or revised in this edition.