Decision Making for Unrepresented Patients
Webinar
October 13, 2015
CHA Webinar

Welcome
Liz Mekjavich
California Hospital Association
Continuing Education Requirements

Full attendance, completion of online survey, and attestation of attendance is required to receive CEs for this webinar. CEs are complimentary and available for registrant. Post-event survey will be sent this afternoon. Please fill out the survey – we value your input on our programs.

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**Nursing** — Provider approved by the California Board of Registered Nursing, CEP 11924, for 2.4 Contact Hours.

**Risk Manager** — This meeting has been approved for a total of 2.0 contact hours of Continuing Education Credit toward fulfillment of the requirements of ASHRM designations of FASHRM (Fellow) and DFASHRM (Distinguished Fellow) and towards CPHRM renewal.
Lois Richardson is CHA’s vice president of privacy and education/publications. In addition to her current role, Ms. Richardson has served as CHA’s legal resource for the past 19 years, primarily as legal counsel. She is the author of numerous CHA publications, including the Consent Manual, California Hospital Compliance Manual, California Health Information Privacy Manual and Mental Health Law. Ms. Richardson is also the executive director for the California Society for Healthcare Attorneys.
Faculty

Susan Penney is director of risk management for the University of California, San Francisco (UCSF) clinical enterprise, including UCSF’s Medical Center and Medical Group, San Francisco General Hospital, UCSF Benioff Children’s Hospital Oakland and UCSF Fresno. Previously, Ms. Penney served as legal counsel for the California Medical Association and as an attorney in private practice.

Decision Making for Unrepresented Patients
What We Will Discuss Today

- Review of consent principles – why, when and how
- Who can consent for patients lacking capacity?
- The dilemma of the represented patient
- Interdisciplinary team consent (IDT) and the CHA/CMA/Alliance model policy
- Recent Superior Court case regarding consent for unrepresented patients
- Options

Consent Basics

- Common Law (judge-made law): Every **competent adult** has the fundamental right of self-determination
- A person unable to exercise this right (a minor or incompetent adult) has the right to be represented by another person
“Simple” vs. “Informed” Consent

- All procedures require consent — but they may not have to be “informed consent”
- **If** the nature of the treatment is involved or complicated, “informed consent” is necessary
- Failure to obtain consent can give rise to lawsuit for battery and/or malpractice; CDPH licensing deficiency

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: the general authorization given in the Conditions of Admission form
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
- Not just a form
- Informed consent is required:
  - When the procedure involves material risks that are not commonly understood
  - When required by statute/regulation
  - Centers for Medicare & Medicaid Services requires medical staff to have a list

Elements of Informed Consent

Discussion must include:
- Nature and purpose of procedure
- Risks, benefits, 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
- Potentially conflicting research or financial interests
The Process of Obtaining Informed Consent

After discussion, document the patient’s 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 (usually optional)

Exceptions

Exceptions to consent requirement:
- Emergency
- Patient request for non-disclosure
- Therapeutic privilege

See Consent Manual, p. 1.2 – 1.4
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 discussion and refusal of all medical tests and procedures, including life-sustaining treatment

CDPH – Title 22, California Code of Regulations

- General acute care hospital: Prior to nonemergency surgery, the anesthesiologist (or general surgeon if a general anesthetic will not be administered) must ascertain that a written informed consent is in the medical record (Section 70223(d)(3))
Skilled nursing facility: Ordering/performing practitioner must obtain consent for administration of psychotherapeutic drug or physical restraint, or prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function (Section 72528) (e.g., urinary catheter)

- Facility must verify documentation in medical record prior to administering treatment
- Same exceptions as on slide 16

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!!
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 competent to make financial ones
### Legal Mental Capacity
(Probate Code § 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 Code § 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 Code § 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

- Presumption: 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
Competency/Capacity Documentation

- If the patient has been declared incompetent by a court, a copy of the court order should be obtained and put in the chart
- If the physician has determined a patient lacks capacity, that determination and factors supporting the determination should be documented

Changing Charlie

- Charlie has been in your hospital for about two weeks and due to an infection, he needs a below the knee amputation
- The physician attending decides to obtain a psych consult to determine if the patient has capacity to consent or refuse the surgery
- Psych says that he does not have capacity and there is a note in the chart
- The patient is refusing surgery
Changing Charlie

- A week later, the patient is still in the hospital
- Your social worker has worked extensively with the patient and believes that he understands the risks of not having surgery
- The surgeon speaks to the patient, but expresses the concern that he is bound by the psych evaluation
- Surgery is not performed

Polling Questions
Who Decides? – Potential Decision Makers

Potential Decision Makers

Hierarchy:

- Patient with capacity
- Orally designated surrogate
  
  *(Consent Manual, p. 3.4)*
- Agent under Durable Power of Attorney for Health Care/Advance Directive
- Conservator or other court-appointed person
- Closest available relative
- IDT: GACH vs. SNF
Post-Death Decisions

- Quick note: different decision-makers for post-death decisions (not discussed today; see chart or Consent Manual, chapter 11):
  - Autopsy
  - Anatomical gifts
  - Disposition of remains

Standard for All Decision Makers

- In accordance with the patient’s health care instruction, if any
- In accordance with the patient’s wishes, if known
- Otherwise, in the best interests of the patient
Potential Decision Makers

Orally designated surrogate – what is this?
- Patient must personally inform supervising health care provider
- Promptly document designation in medical record
- Effective only during course of treatment/illness/stay, or 60 days — whichever is shorter
- OK to be proactive!

Potential Decision Makers

Agent under DPAHC or Advance Directive
- 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
- For details, see chapter 3 of Consent Manual
Potential Decision Makers

Conservator: Probate Code (not Lanterman-Petris-Short Act)

- May or may not be able to 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 health 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)

Potential Decision Makers

Family and friends — 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 approved the use of wife and children; acknowledged that the law does not specify that only court-appointed surrogates can make decisions
Potential Decision Makers

Domestic Partners:
- Registered Domestic Partners have the same authority (and limitations) as a spouse to make health care decisions for each other
- Non-registered domestic partner may qualify as a surrogate

Use of Family and Others as Surrogates

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 …
Potential Definition 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 Decision Maker

If more than one person is involved in the patient’s care who wishes to be the decision maker, consider who:

- 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 a Decision Maker: CMA Model Policy

CMA Model Policy, “Policy on Selection of Health Care Surrogates with the Assistance of Health Care Professionals” (Consent Manual Appendix 2-C – included in handouts)

- 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.
- Policy discusses:
  - Suggested sources of information
  - Characteristics of surrogate
  - Duties of physician and other health care professionals

Selection of a Decision Maker: CMA Model Policy

Suggested sources of information:

- Family and friends of the patient
- Other health care professionals
- Institutional committees (i.e., Ethics)
- Social workers
- Chaplains
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

- 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
Duties of Surrogate

- Same responsibilities/limitations as agents or other surrogates
- 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 friends 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 a Decision Maker

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

Polling Question — Surrogates
Final Thought on Surrogate Rights

- 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 acute care hospitals manage basic consent for these patients
- However, statute applicable in SNF setting: Health & Safety Code Section 1418.8
- The concept of a model policy was developed by CHA-CMA-Alliance for Catholic Health Care (Alliance)
Unrepresented Patients

2006 Study:
- 16% of patients in ICUs are unrepresented
- 3-5% of patients in SNFs are unrepresented
- 5.5% of patients who die in hospitals are unrepresented

Three groups of unrepresented:
- Homeless or mentally ill who have lost contact with family or friends
- Patients who are alone by choice
- Elderly who have outlived family and friends

Background of Health & Safety Code section 1418.8

- Passed in 1992
- Purpose was to:
  - Provide a process for providing care to nursing home patients who lacked capacity to consent and
  - Who also did not have anyone to provide consent for them
  - The Legislature recognized the need to provide such medical treatment without the delay of securing a ruling from a court under the Probate Code sections 3200 and 3201
Legislative History of Health Care Decisions Law

Health and Safety Code section 1418.8 is consistent with the legislative history of the Health Care Decisions Law:

“In the absence of controversy, a court is normally not the proper forum in which to make health care decisions.”

Probate Code §4650

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, “Health Care Decisions for Unrepresented Patients” – however, now updated (see handouts)
Preliminary Step

- Determine that the patient is, in fact, “unrepresented”
  - Examine personal effects accompanying the patient (purse, wallet, etc.)
  - Examine any medical records related to the patient (SNF or acute)
  - Review any report made by EMT/police
  - Attempt to contact identified
  - Contact Secretary of State if AD wallet card
- Document (Probate Code Section 4717)
- Social media??

The Unrepresented Patient—CHA/CMA/Alliance Model Policy for Acute Care Hospitals (cont.)

- Policy tracks Health & Safety Code Section 1418.8, which allows an interdisciplinary team (IDT) in a skilled nursing facility to consent on behalf of an unrepresented patient
- IDT includes 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 Interdisciplinary 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

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 (cont.)

- If continued disagreement, current treatments will be continued and any other medically necessary treatments provided until court resolution or disagreement otherwise resolved
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

Document the following:

- Findings used to determine patient’s lack of capacity
- Attempts to locate surrogate
- Findings that no surrogate available
- Basis for treatment decision (e.g., IDT, ethics committee involvement)
Polling Question

CANHR v. Chapman

California Advocates for Nursing Home Reform (CANHR) vs. Ron Chapman, as Director of the California Department of Public Health

- Superior Court for the State of California, County of Alameda, June 2, 2015
- CANHR argued that Health & Safety Code Section 1418.8 is unconstitutional - lack of due process prior to depriving a patient of life, liberty, or property interest
- Many patient examples in complaint
Background of Health & Safety Code section 1418.8

- Passed in 1992
- Purpose was to:
  - Provide a process for providing care to nursing home patients who lacked capacity to consent and
  - Who also did not have anyone to provide consent for them
  - The Legislature recognized the need to provide such medical treatment without the delay of securing a ruling from a court under the Probate Code sections 3200 and 3201

CANHR v. Chapman: Patient Discussion: Gloria

- 63-year-old Gloria was determined to lack capacity — she claims she was not told until she tried to leave the facility with another patient — case turns on the assumption that Gloria was not told of the physician’s determination of her capacity and medical treatment plan
- Gloria also wanted to attend a picnic with another resident, but was told that her physician would need to clear her to attend
- What would have happened if the facility had allowed her to leave and she was injured?
CANHR v. Chapman

CANHR argued that H&S 1418.8 does not comport with due process because it fails to require that the patient be notified of the following:

1. The patient has been determined incapacitated;
2. It has been determined that the patient lacks a surrogate decision maker;
3. Medical intervention has been prescribed; and
4. The patient has the opportunity to seek judicial review of the above determinations.

THE COURT AGREED

CANHR v. Chapman

The court discussed the minor burden of requiring notice:

- The only burden to facilities is adopting a process of how the physician informs the patient
- The burden on the courts is minimal because if the patients lack capacity, then they are unlikely to seek review
- However, at least the patients will be afforded their rights
CANHR v. Chapman

- CANHR also argued that H&S 1418.8 is unconstitutional because it does not always require a patient representative on the IDT (only required “when practicable”)
- This would be a family member or friend who is unable/unwilling to take full responsibility for decision making, but willing to serve as part of the IDT – or possibly a patient advocate, lawyer, other
- **THE COURT DID NOT AGREE** – in this case, anyway. CANHR did not prove that having a patient rep was “practicable” in the case before it. However, the court clearly expects a patient representative on the IDT if possible. If not, document why not.

What CANHR Wanted, But Also Did Not Get

- CANHR also argued that H&S 1418.8 violates due process because it
  - Does not require adequate representation at the determination of capacity
  - Permits a medical decision as to the legal decision of decisional capacity and
  - Fails to require a neutral decision maker in all aspects of the process
The Court’s Review of a Prior Case  
*Rains v. Belshe*

- The Court reviewed the *Rains* case that held that:
  - Adversarial hearing was not required following a physician’s determination of lack of capacity as to do so would not only be cumbersome to thousands of patients, but presumes bias, if not dishonesty on the part of the physician
  - *Rains* argued the law is fair because it allows appeal
  - The Court in *Chapman* thinks the *Rains* court presumed there was notice to the patient to trigger the right to appeal

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**CANHR v. Chapman**

- CANHR argued that H&S 1418.8 is unconstitutional to authorize the administration of antipsychotic drugs.
- **THE COURT AGREED** – because no procedural safeguard such as either (1) a judicial finding of incompetency or (2) an independent review process (an independent physician review)
The Court reviewed the relevant law related to prisoners and the mentally ill where there are due process rights related to psychotropic drugs and concluded that H&S 1418.8 must not have meant to include these drugs as it is not routine health care.

Therefore, CDPH may not permit patients to be treated with antipsychotic drugs under this law.

The court indicates that compliance with Probate Code 3200 is required, except in emergencies.

Does this mean CDPH must cite SNFs?
CANHR v. Chapman

- CANHR also argued that H&S 1418.8 does not allow the physician/IDT to make end of life decisions, including creating/changing POLSTs, because that law only refers to medical interventions and not forbearance of treatment
- THE COURT AGREED

The court agreed because the law doesn’t require a judicial determination of the patient’s lack of capacity or that the patient’s wishes be taken into account when making health care decisions. The judge was also concerned that the law is not limited to making end of life decisions for patients who are terminally ill, comatose or in a persistent vegetative state and have not left instructions
- What about hospice?
- What about aid-in-dying drugs?
CANHR v. Chapman — What About Other Laws?

- The opinion did not discuss other aspects of the Health Care Decisions law that discusses the following of patient instructions and best interests.
- The court also did not address the rights of a physician related to POLST that allows for a change in the POLST if:
  - A physician has conducted an evaluation of the patient and has issued a new order. If possible, the physician should consult with the patient or the patient’s legally recognized health care decision-maker. The new order must be consistent with the most current information available about the patient’s health status and goals of care.

Implications

- Usually, Superior Court case only binding on the parties. But here, defendant is the State of California.
- Appeal status.
- Each party has drafted an order/judgement — the state presuming continued use of 1418.8 with corrections and CAHNR presuming complete elimination of the statute.
- SNFs advised by their trade association to consider transferring unrepresented patients to emergency department if they need treatment requiring informed consent.
- SNFs reluctant to accept unrepresented patients from hospitals if they may need antipsychotics, hospice, etc.
- What does this mean for the model policy in acute care settings?
- Government vs. private.
Suggestions

- Make sure your policy requires notification to patient that:
  - Patient has been determined to lack capacity
  - Patient has no decision maker
  - Medical intervention has been prescribed
  - The patient has a right to seek judicial review
  - FORM?

- Include a patient representative on your interdisciplinary team
- Look at your administration of psychotherapeutic/antipsychotic drugs policy
- Make sure your policies state that patient’s wishes and best interest will be considered
- Have early care plan discussions and documentation of same
- Make sure efforts to find a surrogate are documented
- Train your physicians on capacity determination

Suggestions

- Make sure your policies are clear on not providing medically ineffective care to patients
- Focus on executing both an Advance Directive and POLST
Your materials include an updated model policy and a checklist for you to use in revising your policy, to meet court-identified deficiencies.

- Work with your risk management department and in-house or outside counsel.
Application for public guardian/conservator if:

- Patient appears to require a guardian or conservator
- It appears that no one else is qualified and willing to act
- Appointment would be in the best interests of the person

The public guardian shall apply for appointment as guardian or conservator of the person, the estate, or the person and estate, if there is an imminent threat to the person’s health or safety or the person’s estate.

The public guardian may apply for appointment as guardian or conservator of the person, the estate, or the person and estate in all other cases.

Timeliness issues
(Probate Code Section 2920)
Other Options – Public Guardian

Public guardian/conservator
- SF County: talk to the Hospital Council of Northern and Central California
- LA County: talk to the Hospital Association of Southern California
- Others: talk to your regional hospital association and/or county

Other Options – Superior Court Order

- A patient, relative, hospital or physician can petition the Superior Court under Probate Code Section 3200 et seq. for:
  - A determination that a patient has capacity to make health care decisions
  - A determination that a patient lacks capacity, and to order specified treatment or designate someone else to decide
  - Court will appoint an attorney if the patient doesn’t have one
The petition must include (to the extent known):

- The condition of the patient’s health that requires treatment
- The recommended treatment
- The threat to the patient’s condition if care is delayed or denied by the court
- The predictable or probable outcome of the recommended treatment
- The medically available alternatives, if any
- The efforts made to obtain consent from the patient

- The name of the person to be designated to give consent on behalf of the patient
- The names and addresses of the persons listed in Probate Code Section 1821(b) (spouse and certain relatives)
- The deficit or deficits in the patient’s mental functions listed in Probate Code Section 811(a) that are impaired, and an identification of a link between the deficits and the patient’s inability to respond knowingly and intelligently to queries about the recommended health care or inability to participate in a decision about the recommended health care by means of a rational thought process (Section 811(a) includes factors such as alertness and attention, information processing ability, thought processes, ability to modulate mood and affect)
Other Options – Superior Court Order

- Must give copies of petition and time/place of hearing to:
  - Patient, patient’s attorney, and the agent under the patient’s power of attorney for health care, if any (personal service)
  - Patient’s relatives named in the petition, if any (mail)
  - Must give notice at least 15 days before hearing, unless court, for good cause, shortens or waives notice

Other Options – Superior Court Order

- The court may order specified treatment or designate a decision maker if:
  - The existing or continuing condition of the patient’s health requires the recommended health care.
  - If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical or mental health of the patient.
  - In determining whether the patient’s mental functioning is so severely impaired that the patient lacks the capacity to make health care decisions, the court may consider the frequency, severity, and duration of periods of impairment.
Other Options – Superior Court Order

The court may authorize withholding or withdrawing artificial nutrition and hydration and all other forms of health care and designate another person to do so if:

- The recommended health care is in accordance with the patient’s best interest, taking into consideration the patient’s personal values to the extent known to the petitioner.
- The patient is unable to consent to the recommended health care.

Consider having an attorney draft a template and P&P, then attach a declaration for each patient
Consider meeting with presiding judge or designee at your local superior court – discuss process, timeliness
Other Options – Temporary or Permanent Conservator

Probate Code Section 1820

- Any interested person can file a petition
- Petition must specify the proposed conservator and state why a conservatorship is necessary
- Notify patient, relatives – no provision for shortening notice timeframe
- Probate Court investigator

Required supplemental info, including:

- Inability of patient to provide for his/her own physical health, food, clothing, and shelter
- Location of patient’s residence and whether she can live there while under conservatorship
- Why alternatives to conservatorship are not available
- Health or social services provided to the proposed conservatee during the preceding year, if known
- Inability of patient to manage financial resources, or to resist fraud or undue influence
Future Updates

- Final order
- Appeal?
- Legislation

Other Options – Temporary or Permanent Conservator

- Not a quick or easy option. Not always viable if:
  - Patient’s care cannot be delayed
  - Patient’s lack of capacity is temporary
  - Patient objects to conservatorship
  - Who will pay the conservator?
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
Upcoming Programs

- Hospital Quality Institute Conference
  November 11 – 13, Sacramento
- End of Life Option Act Webinar
  November 19, Virtual
- Behavioral Health Care Symposium
  December 7 – 9, 2015, Riverside
- Post-Acute Care Annual Conference
  February 10-12, 2016, Redondo Beach
- Consent and Related Health Care Law Seminars
  Seven programs statewide, April – May, 2016

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
To learn more about CHA’s Publications, or to place an order, visit [www.calhospital.org/publications](http://www.calhospital.org/publications)

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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.