Consent Rules —
Mental Capacity, Non-Consent, Minors, 5150 Patients

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Or … “Consent in a Nutshell”

- Saying Yes
- Saying No
- Saying something we disagree with

- Easy, clear law \(\Leftrightarrow\) \(\Leftrightarrow\) \(\Leftrightarrow\) not clear at all
Issues We’ll Cover

- Consent and decision-making capacity: Who can consent?
  - Legal capacity // Physical capacity // Mental capacity
- Who determines capacity?
  - Medical (physical) vs. Mental Health Care
- Saying “no” – documenting non-consent and AMA
- Exception to Consent Rule: 5150’s/Involuntary MH
- Putting our knowledge to the test:
  - Tough calls, including 5150 vs. EMTALA in our EDs
First things first …
Why This Topic?

- **Mortality**
  - 1932 study by Benjamin Malzberg, New York epidemiologist: people with mental illness died, on average, 14-18 years earlier than otherwise similar people in the general population.
  - 2006 US Study – mortality gap persists today and may have widened to 13-20 years; mostly owing to medical conditions such as cancer and cardiovascular disease, not accidents and suicide.
  - Is one of the reasons refusal of care given by individuals who lack capacity?
Why This Topic? (cont.)

- Liberty
  - Balance between liberty and forced care is not easy to reach, and there is no “pure” measure of capacity
  - “Some patients will later curse us for not providing needed treatment, while others will sue us for battery”

- Diagnostic limitations
  - “We’re stuck … not knowing when the illness is deadly versus something we can work with …”
  - A patient with a chronic condition may not be in imminent danger, until they are … and then it is too late
“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 or incompetent adults, have the right to be represented by another who will protect their interests and preserve their basic rights.”

— page 1.1 of the CHA Consent Manual
Consent Basics

- Medical and mental health care requires permission ("consent") from patient; if they can’t provide it, then it must come from someone legally authorized to consent on their behalf.

- If procedure is complicated, we must get “informed consent” (Cobbs v. Grant (1972) 8 Cal.3d 229) (i.e., making sure we first educate patient about risks, benefits, alternatives to proposed treatment or procedure).

  - In an emergency when patient can’t give consent in a timely fashion, and there is no one else, “implied consent” permits us to provide care in order to save life/limb (see CA Business & Professions Code 2397).
Consent Basics (cont.)

- Providing care without proper consent can lead to a battery, false imprisonment or malpractice lawsuit, and may pose a compliance issue.

- For example, consent is needed in the ED for:
  1) the EMTALA medical screening exam (incl. dx procedures),
  2) stabilizing treatment, and
  3) transfer/mode of transfer.
Consent Basics (cont.)

So, a very important thing to know is:

WHO CAN GIVE CONSENT?
Who Can Say “Yes”?
Who Can Give Consent?

Person must have:

A. Legal capacity, and

B. Physical capacity, and

C. Mental capacity.
Legal Capacity

- **Adult** (aged 18 or older)
- **Minor** may have statutory “legal capacity” based upon:
  - Who they are *(status)* or
  - What medical care they seek *(sensitive services)*
Minors with Capacity
Status of Minor = Treat as Adult

- **Emancipated** (all care) – treat as adult
  - Married (or divorced/annulled)
  - Active duty U.S. military
  - Court order (14 and older)

- “Self-sufficient minor” (medical/dental care) – treat as adult, but ok to notify/bill the parent
  - 15 or older, **and**
  - Living separate and apart from parent, **and**
  - Managing own finances
Sensitive Services (minors can consent, but only to certain care)

- Any age
  - Sexual assault or rape
  - Prevention or treatment of pregnancy
- 12 and older
  - Dx and tx of infectious reportable conditions
  - Prevention, dx and tx of sexually-transmitted diseases
  - Outpatient mental health/substance use disorder counseling
    - Involve parent, unless inappropriate
    - Does not include medications, ECT, surgery or inpatient care
Physical Capacity

- Physical capacity
  1. Patient is conscious
  2. Patient is able to communicate a decision re: consent to care
Physical Capacity — No
Physical Capacity – Examples

- **Physical capacity - YES**
  - Trauma victim who is awake and talking
  - Patient contemplating procedure who needs a translator or who is hearing impaired
  - Person seeking mental health treatment
  - Person with cultural communication issues that need to be understood (e.g., nodding may indicate disagreement and silence may mean acceptance)

- **Physical capacity - NO**
  - Patient who is unconscious

- **Physical capacity question: EASY!**
Legal capacity and physical capacity must co-exist with mental capacity in order for patient to be able to consent.

What is mental capacity? One definition:

Person can understand the nature and consequences of a decision, including the significant risks, benefits and alternatives, and can make a decision.
Defining Mental Capacity

- MacArthur Test – widely used capacity-measurement tool (1983, Paul Appelbaum, Columbia University psychiatrist)

Patient must be able to:

1. Communicate a choice
2. Understand relevant information
3. Demonstrate appreciation of situation and its consequences, and
4. Reason about treatment options
Defining Mental Capacity (cont.)

- **California Health Care Decisions Law** – Probate Code 4600 et seq.
- **Probate Code 4609:**

  “Capacity” means a person’s ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives.
Defining Mental Capacity (cont.)

- *Riese v. St. Mary’s Hospital* (to be discussed in more detail later in slides); Court held:

  Competence to consent to drug treatment (in the case of an involuntary mental health patient) can be defined by three factors:

1. Whether patient is aware of their situation
2. Whether patient is able to understand benefits, risks, alternatives to proposed medication
3. Whether patient is able to understand and evaluate information given to them for informed consent
Who Decides Capacity Issues?
Who Determines Legal, Physical and Mental Capacity Before Providing Medical (Physical Health) Care?

- Capacity question is seen as a “clinical decision”
  - **Primary physician** should determine that patient has legal, physical and mental capacity to consent (Probate 4658)
  - If patient has no designated physician with primary responsibility for his/her health care, then any physician may undertake that responsibility (Probate 4631)
Determining Capacity (Physical Health Care) (cont.)

- Physician may consider same things a Probate Judge would look at:
  - Does patient respond knowingly and intelligently to queries about the proposed medical treatment?
  - Can patient participate in the treatment decision by means of a rational thought process?
  - Does patient understand the nature and seriousness of the illness, proposed treatment, degree and duration of the benefits/risks of accepting the recommended treatment or any of its alternatives?
Determining Capacity (Physical Health Care) (cont.)

- Examples where patient may be found to lack capacity to give consent to physical health care
  - Patient is asleep or in a coma
  - Patient has dementia
  - Patient is awake, but woozy, and still under the influence of anesthetic drugs (temporary incapacity)
  - Patient is in excruciating pain/shock/other distress
Who Decides Capacity Before Providing Mental Health Care?
Who Determines That Patient has Legal, Physical and Mental Capacity to Consent to Mental Health Care?

- **Legal Capacity** – same as for physical health care
- **Physical Capacity** – same as for physical health care
- **Mental Capacity** — **NOT** the same as for physical health care!

The law does NOT leave it up to the health care provider to decide that a person has mental capacity to say “yes” or “no” to mental health care.
Determining Capacity to Consent to Mental Health Care (cont.)

... it is presumed by the law!

- W&I 5331 – No person may be presumed to be incompetent because he or she has been evaluated or treated for a mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received

- Reality: if patient agrees, and says “yes” to recommended care, we usually “conclude” they have mental capacity and end our inquiry there
Reason for presumption of capacity?

- History of mistreatment of mentally ill patients (LPS Act specifically called out the need for protections and enumerated “rights” of the mentally ill)
- Lack of clarity or agreement when interventions should be forced (i.e., differing opinions as to when a behavior has become too unconventional, risky or dangerous)
- Right to be left alone vs. society’s desire to protect people from self-neglect (e.g., over or under-eating, use of substances, dangerous hobbies, membership in a cult, etc.)
Case-Law Basis for “Different” Rule in Determining Capacity When Providing Mental Health Care


- Court held:
  - Involuntary patient must not be given anti-psychotic meds without their informed consent unless:
    1) it’s an emergency, or
    2) there has been a court determination that patient is incompetent to give informed consent for medication
Argument against “presumption” of capacity and the need for a hearing if doctor wanted to “force meds”

“… concerns of both the California Psychiatric Association (CPA) and the California Alliance for the Mentally Ill (CAMI) were that patients would have to suffer a delay in getting treatment because of a delay in having judicial hearings after admission, or would be denied treatment altogether because they would be considered competent although psychotic.”
Concern about delays caused by *Riese*:

“… This later concern is similar to the arguments made in other right to refuse treatment cases, i.e., that, in the interest of civil liberties, patients would be allowed to ‘rot with their rights on.’”

Concerns Following Riese (cont.)

- Also, there was confusion whether Riese also applied to “assenting” patients who were likely incompetent, or had fluctuating competence, or was Riese only for non-consenting patients?
- (Did Riese mean ALL patients needed a hearing re: competency or just those who said “no”?)
1991 – California legislature added Welfare & Institutions Code section 5332 to codify and clarify *Riese*:

- Antipsychotic medication (as defined in section 5008(l)) may be given to an involuntary patient if the patient does not refuse it following disclosure of right to refuse, as well information necessary to the informed consent process (no need to go to court)
But, if involuntary patient refuses mental health medications, we cannot look at the fact that they are on an involuntary hold, or our own opinion that they lack mental capacity, and turn to a surrogate decision-maker to get consent – we must go to court.

(The only exception to that “rule” is an emergency, and then medication can only be forced long enough to take care of the immediate emergency (W&I 5332(e)))
Summary: Determining Capacity to Consent to Mental Health Care

- Court must decide whether patient lacks capacity if patient refuses meds
- Court order not needed if patient accepts recommended meds.

W&I 5332(b) - If any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, and for whom antipsychotic medication has been prescribed, orally refuses or gives other indication of refusal of treatment with that medication, the medication shall be administered only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment in a hearing held for that purpose.
Saying “No”
Non-Consent and AMA

- He who says “yes” can say “no”
  - Frustrating for provider when patients refuse offered care that provider thinks is appropriate or necessary (and, frankly, wouldn’t be reimbursed unless it was appropriate or necessary!)
  - The more dangerous the “no” the more likely (and appropriate) that the provider will question a patient’s mental capacity
- Saying “no” or disagreeing with physician’s recommended treatment plan does not mean patient lacks capacity!

- But, if patient’s refusal seems extremely ill-advised, provider should look more closely at capacity/ability to understand consequences of the non-consent

- Ask yourself, “have you really explained benefits of “yes” and consequences of “no” clearly enough to the patient?”
Documenting Non-Consent and AMA

- Always document “informed refusal” when patient non-consents
  - If there is any question, establish in your charting that the patient has legal, physical and mental capacity (if they didn’t, you would have found a surrogate decision maker)
  - The more dangerous the “no” the more you should chart!
Documenting Non-Consent and AMA (cont.)

- Train staff to chart:

  “Patient was informed of consequences of...
  - not getting lab work done as ordered
  - not wearing brace as directed
  - not proceeding with surgical removal of foreign body...”
Documenting AMA (cont.)

- When patient wants to leave hospital “against medical advice” be sure to document informed refusal AND make discharge as safe as possible

“Patient was informed of consequences of leaving hospital before vital signs stabilize...” (“...before doctor can assess lab results and treat for possible sepsis”)
Dealing with Non-Consent and AMA (cont.)

- Old approach – “It’s a free country, good luck finding the front door” (dismay, and sometimes anger)

- New approach – “You’re the boss; how can we help make this as safe as possible? And, please come back if you change your mind.” (We still want you to be safe and get well)

- If we can work with the patient to mitigate the risks of the decision to leave, we can improve the likelihood of good outcome
5150’s and Other Involuntary Mental Health Tx (Exception to the Right to Say “No”)

- Conflict between personal rights vs. society’s concerns about dangerousness → complex legal framework dealing with refusal of necessary mental health care
- Different from physical health rules re: “No”
- Takes away patient’s right to say “No” in a very narrow set of circumstances:
LPS Act (W&I Code 5150, 5250, 5260, 5270.15, 5325.2 et seq.)

- Involuntary inpatient evaluation and treatment (72 hours, 2 weeks, longer)

- Even if person has legal, physical and mental capacity, law permits evaluation and treatment without patient’s consent, and against their wishes
5150 Exception to Right to Say “No” (cont.)

- **Laura’s Law** (AB 1421; W&I 5345 et seq.) – assisted (involuntary) outpatient treatment or “AOT”

- **Health & Safety Code 1799.111** – hospital can “lock the door” for up to 24 hours if patient meets 5150 criteria (immunity from liability for false imprisonment)
Putting Our Knowledge to the Test: Tough Calls and Unresolved Issues
What Do You Think?

Does patient have capacity to give informed consent? What would you do?

- Patient brought to ED by buddy after barely missing an attempted cannon-ball jump off the roof into the pool at 4th of July party – his head is bloody and he is obviously very, very drunk. As soon as physician approaches he says “get the @#$&* away from me, I’m leaving!”
Pt. mid-40’s transported to ED from homeless shelter in obvious physical distress. Clear for drugs/alcohol, and agreeable to dx work-up. Dx: possible sepsis.

MD wants to admit with IV antibiotics started immediately. Pt. refuses and states she has been using homeopathic tx with improvement. Refuses sepsis dx, and explains magnetic imbalance of hormones/cosmos is the problem. She is actually quite knowledgeable about anatomy and physiology and at some point pulls out her Nurse Practitioner license from her backpack.

Pt. agrees to treatment so long as it deals with yin/yang imbalance but refuses to consent to antibiotics (she adds, “they are overprescribed and the reason that the end of the earth is near”). You believe that she will likely die without IV tx.
Patient in her late 60s self-presents at health clinic with swelling in throat and difficulty swallowing.

Diagnosis is esophageal cancer, but it is treatable with chemotherapy with good outcomes. Patient states, “I can’t have chemo because it will harm my unborn baby.”
August Kittens
Three Months Later at Thanksgiving
What Do You Think?

- Should a mental health crisis worker be called to “5150” a patient who is refusing life-saving surgery to remove her spleen?

- What about a stroke patient who wants to leave the ED because the wait is too long?
What Do You Think?

- If a 5150 patient has been brought to the ED for medical clearance and refuses to consent to the “appropriate transfer” for stabilizing treatment at a locked designated LPS facility, does it violate EMTALA to force the transfer?
- Whose responsibility is it to arrange for the EMTALA hand-off to the “higher level of care”? County mental health or hospital ED staff?
What Do You Think?

- Can you force diagnostic laboratory testing on a patient who has been brought in “on a hold” who needs medical clearance prior to transfer to PHF but is refusing blood draw?
What Do You Think?

- If “he who says ‘yes’ can say ‘no’” what about a teen-ager whose parent brings her in for outpatient counseling for her (obvious) eating disorder who says “no” under minor consent laws?
Further Reading

- Appelbaum PS, Roth LH, Patients Who Refuse Treatment in Medical Hospitals, JAMA, 1983, 250: 1296-1301

- Appelbaum, PS, Assessment of Patients’ Competence to Consent to Treatment, New England Journal of Medicine, 2007; 357: 1834-1840

- Rosenbaum, MD, Liberty vs. Need – Our Struggle to Care for People with Serious Mental Illness, New England Journal of Medicine, October 13, 2016; 375: 1490-1495

- Rosenbaum, MD, Closing the Mortality Gap – Mental Illness and Medical Care, New England Journal of Medicine, October 20, 2016; 375: 1585-1589
Questions?
Thank you

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