

MATERIALS FOR PATIENTS' RIGHTS ADVOCACY TRAINING 2008

CONSENT: HOW IT APPLIES IN THE MENTAL HEALTH SERVICE
SYSTEM

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CASE LIST

I. General Theories of Informed Consent

A. History of Informed Consent

Union Pacific R. Co. v. Botsford, 141 U.S. 250 (1891)

As early as 1891 the Supreme Court observed that: “No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.” *Id.* at 251.

Schloendorff v. Society of New York Hospital, 211 N.Y. 125 (N.Y. 1914)

Justice Cardozo, while on the Court of Appeals of New York, described the doctrine of informed consent as: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.” *Id.* at 129-130.

Cruzan by Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261

(1990)

Since 1914, the doctrine of informed consent has become “firmly entrenched in American Tort law.” *Id.* at 269.

B. What is Informed Consent?

1 Am. Law Med. Malp. § 4:1 (2006)

“Informed consent is when a person autonomously authorizes a physician to undertake diagnostic or therapeutic interventions for himself or herself. In this view, the patient understands that he or she is taking responsibility for the decision, while empowering someone else, the physician, to implement it. Not any agreement to a course of medical treatment qualifies as informed consent, however. There are three fundamental requirements for valid informed consent: disclosure, understanding and voluntariness. Crucial information relevant to the decision must be disclosed, usually by the physician, to the patient. The patient must understand the information and its implications for his or her interests and life goals. Finally, the patient must make a voluntary decision (i.e., one without coercion or manipulation by the physician). It is a mistake to view informed consent as an event, such as the signing of a form. Informed consent is viewed more accurately as a process that evolves over the course of diagnosis and treatment.”

Id.

II. Exceptions to Informed Consent

Cobbs v. Grant, 8 Cal. 3d 229 (Cal. 1972)

“A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent.” *Id.* at 243.

A. Medical Emergency

Cobbs v. Grant, 8 Cal. 3d 229 (Cal. 1972)

“[T]he law provides that in an emergency consent is implied” *Id.*
at 243.

1 Am. Law Med. Malp. § 4:1 (2006)

“The [medical emergency] exception to the rule concerning consent is based on the notion that the average person would readily agree to treatment if confronted with a life or health-threatening event. Such an emergency exists when all of the following are present: (1) The patient has a life- or health-threatening condition requiring immediate care. (2) The patient is incapable of participating in the consent process. (3) There is no time to obtain consent from a duly authorized representative.”

Id.

B. Minors

1. General Rule

Cobbs v. Grant, 8 Cal. 3d 229 (Cal. 1972)

“[I]f the patient is a minor . . . the authority to consent is transferred to the patient's legal guardian or closest available relative.” *Id.* at 244.

American Academy of Pediatrics v. Lungren, 16 Cal. 4th 307 (Cal. 1997)

“The requirement that medical care be provided to a minor only with the consent of the minor's parent or guardian remains the general rule, both in California and throughout the United States.” *Id.* at 315.

2. Medical Emancipation Statutes

American Academy of Pediatrics v. Lungren, 16 Cal. 4th 307 (Cal. 1997)

“Over the past half-century . . . a number of significant statutory developments in California have modified the general rule relating to the provision of medical care to minors. One development involves the Legislature's enactment of a number of discrete, so-called "medical emancipation" statutes, each of which has designated a general category of minors who—although not legally emancipated for all purposes—nonetheless are authorized to obtain medical, surgical, or hospital care in all contexts, without parental consent....In addition to this first category of what might be characterized as "*general* medical emancipation" statutes, California has adopted a considerable number of additional statutory provisions that fall within a second category of what might be termed "*limited* medical emancipation" statutes, i.e., statutes that authorize minors, without parental consent, to obtain medical care only *for specific, designated conditions*, without authorizing the minor to consent to medical care for other medical needs.”

Id. at 315-316.

3. Constitutional Issues in Abortion Cases

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833

(1992)

“Except in a medical emergency, an unemancipated young woman under 18 may not obtain an abortion unless she and one of her parents (or guardian) provides informed consent If neither a parent nor a guardian provides consent, a court may authorize the performance of an abortion upon a determination that the young woman is mature and capable of giving informed consent and has in fact given her informed consent, or that an abortion would be in her best interests.”

Id. at 899.

“Our cases establish, and we reaffirm today, that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure.” *Id.* at 899.

“[I]n our view, the one-parent consent requirement and judicial bypass procedure are constitutional.” *Id.* at 899.

American Academy of Pediatrics v. Lungren, 16 Cal. 4th 307 (Cal. 1997)

The California Supreme court held that the state statute requiring a pregnant minor to secure parental consent or judicial authorization before obtaining abortion “violates the right of privacy guaranteed by article I, section 1, of the California Constitution.” *Id.* at 314.

The California Supreme court explained:

‘[W]ith respect to the specific constitutional right at issue in this case--*the constitutional right of privacy*--there is a clear and substantial difference in the applicable language of the federal and state Constitutions. The federal Constitution contains no provision expressly setting forth or guaranteeing a constitutional right of privacy; the recent federal cases recognizing and protecting an individual's privacy interest in the area of reproductive rights have found such a right *implied* within the more general constitutional protection of liberty embodied in the Fifth and Fourteenth Amendments. The California Constitution, by contrast, contains in article I, section 1, an *explicit* guarantee of the right of privacy.’
Id. at 326 (citation omitted).

“Article I, section 1, provides: “All people are by nature free and independent and have inalienable rights. Among these are enjoying and

defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, *and privacy*." (Italics added.)" *Id.* at 326 n.13.

"[T]he state Constitution has been interpreted to provide greater protection of a woman's right of choice than that provided by the federal Constitution as interpreted by the United States Supreme Court." *Id.* at 326.

C. Lack of Competency

1. Mental Health System

Cal. Welf. & Inst. Code Ann. § 5331 (West 2006)

"No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received." *Id.*

Riese v. St. Mary's Hospital & Medical Center, 209 Cal. App. 3d 1303 (Cal. App. 1st Dist. 1987)

"If an involuntary patient is judicially determined to possess the capacity to give informed consent to the use of antipsychotic drugs and

refuses to do so, the patient may not be required to undergo the treatment.”

Id. at 1323.

“[T]he task for the court is . . . to determine whether a patient refusing medication is competent to do so despite his or her mental illness. The determination of this capacity “is uniquely a judicial, not a medical function.”” *Id.* at 1321 (citation omitted).

“Judicial determination of the specific competency to consent to drug treatment should focus primarily upon three factors: (a) whether the patient is aware of his or her situation . . . ; (b) whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention . . . ; and (c) whether the patient is able to understand and to knowingly and intelligently evaluate the information required to be given patients whose informed consent is sought.” *Id.* at 1322-1323.

2. Criminal Justice System

Keyhea v. Rushen, 178 Cal. App. 3d 526 (Cal. App. 1st Dist. 1986)

“[S]tate prisoners, like nonprisoners under the LPS statutory scheme, are entitled to a judicial determination of their competency to refuse treatment before they can be subjected to long-term involuntary psychotropic medication.” *Id.* at 542.

In re Qawi, 32 Cal. 4th 1 (Cal. 2004)

‘[A]n MDO can be compelled to be treated with antipsychotic medication under the following non emergency circumstances: (1) he is determined by a court to be incompetent to refuse medical treatment; (2) the MDO is determined by a court to be a danger to others within the meaning of Welfare and Institutions Code section 5300. An MDO's right to refuse such medication may also be limited pursuant to State Department of Mental Health regulations modifying the MDO's rights as is necessary in order to provide for the reasonable security of the inpatient facility in which the patient is being held. A determination that a patient is incompetent to refuse medical treatment, or is dangerous within the meaning of section 5300, may be adjudicated at the time at which he or she is committed or recommitted as an MDO, or within the commitment period.’
Id. at 27-28 (footnotes omitted).

III. End of Life Issues

77 C.J.S Right to Die §§ 27-30 (2006)

“Courts have developed the subjective, substitute judgment, and best interests standards for end-of-life medical decision making, although some courts have blended the standards.” *Id.* § 27.

“The subjective standard allows a decision maker to withhold or withdraw life-sustaining treatment on an incompetent individual's behalf if

the person, prior to incompetency, made a prior clear statement regarding his or her end-of-life medical treatment wishes.” *Id.* § 28.

“Under the substituted judgment standard, a decision maker will attempt to determine the decision an incompetent person would have made if he or she were competent relating to end-of-life treatment, based on either the individual's prior expressions or on several other factors.” *Id.* § 29.

“Under the best interests test, a decision maker will focus on what is in the patient's current best interests by applying various factors.” *Id.* § 30.

Conservatorship of Wendland, 26 Cal. 4th 519 (Cal. 2001)

“[D]ecisions made by conservators typically derive their authority from . . . the *parens patriae* power of the state to protect incompetent persons.” *Id.* at 535.

“[A] conservator is appointed by the court because the conservatee “has been adjudicated to lack the capacity to make health care decisions.” *Id.* at 535 (citation omitted).

“[T]he right to an appropriate decision by a court-appointed conservator does not necessarily equate with the conservatee's right to refuse treatment, or obviously take precedence over the conservatee's right to life or the state's interest in preserving life.” *Id.* at 537.

“[T]he superior court correctly required the conservator to prove, by clear and convincing evidence, either that the conservatee wished to refuse life-sustaining treatment or that to withhold such treatment would have been in his best interest; lacking such evidence, the superior court correctly denied the conservator’s request for permission to withdraw artificial hydration and nutrition.” *Id.* at 554-555

Cal. Prob. Code Ann. § 2355(a) (West 2006)

California probate code section 2355(a) defines the powers and duties of the conservator:

‘(a) If the conservatee has been adjudicated to lack the capacity to make health care decisions, the conservator has the exclusive authority to make health care decisions for the conservatee that the conservator in good faith based on medical advice determines to be necessary. The conservator shall make health care decisions for the conservatee in accordance with the conservatee’s individual health care instructions, if any, and other wishes to the extent known to the conservator. Otherwise, the conservator shall make the decision in accordance with the conservator’s determination of the conservatee’s best interest. In determining the conservatee’s best interest, the conservator shall consider the conservatee’s personal values to the extent known to the conservator. The conservator may require the conservatee to receive the health care, whether or not the conservatee objects. In this case, the health care decision of the conservator alone is sufficient and no person is liable because the health care is administered to the conservatee without the conservatee’s consent.’

Id.