The doctrine of informed consent requires that an individual be adequately informed of the risks and benefits of any medical intervention, including hospitalization, medications, and other interventions. In order to give informed consent, the patient must be able to understand the proposed treatment, its risks and benefits, be able to reasonably weigh the risks and benefits, and be able to communicate his or her decision to the provider of care. Substituted judgment issues arise when an individual chooses not to act on his own behalf or is deemed incapable of acting on his own behalf. Several mechanisms are available to provide for substituted judgment.

**VOLUNTARY MECHANISMS**

**Powers of Attorney**

The power of attorney is a legal instrument that makes one person or legal entity an agent who acts for and on behalf of the party granting the power of attorney. The agent is obligated to act in a fiduciary capacity, meaning that he must act in the best interests of the granting party and cannot use his authority to benefit himself. Until relatively recently, the power of attorney was not a useful tool in the context of medical care because it was presumed to become invalid upon the incapacity of the grantor. A more recent innovation, the durable power of attorney, has dealt with this problem. Authorized by statute in most jurisdictions, the durable power persists even when the granting party is incapacitated. Such a power of attorney must be in writing, appropriately authenticated, clearly state that it remains in effect despite the grantor’s incapacity, and define the areas in which the agent is authorized to act. Durable powers may be either general or limited. A general power grants the agent all authority that the grantor possesses. Limited powers specifically enumerate either specific powers or restriction on powers of the agent. A well-drafted health care durable power should also include guidance for the agent on various aspects of treatment, including such items as CPR, antibiotics, pain control, enteral and parenteral nutrition, and long term life support. Ideally, every patient should have such a document prepared with the assistance of a knowledgeable attorney. Another variant of the power of attorney is the “springing” durable power. Some individuals are uncomfortable with granting a power of attorney until it is absolutely necessary, and have specified that the powers are granted only upon the occurrence of certain conditions, thus the power “springs” into existence. Physicians may be called upon to attest to the occurrence of those conditions. Such documents are unwieldy and create additional uncertainty, but are still being drafted by some legal practitioners.

Unfortunately, the health care durable power has certain limitations. A power of attorney may always be revoked by the grantor, and in California, under code section 2440, a patient, even if incompetent, who objects to a treatment authorized by his agent, may not be treated against his will. Whether or not such an objection revokes the power of attorney remains unclear. In the view of some advocates, even a delirious patient who removes his G-tube or IV is considered to be refusing that treatment. Further, in California, the durable power is limited to medical decision making. Commitment to a mental health treatment facility and use of psychotropic medications (antipsychotics and anti-depressants) to treat mental (not medical) illnesses is not within the scope of authority of a medical durable power.

**INVOLUNTARY SUBSTITUTED JUDGMENT**

**The Medical Emergency Exception**

An individual who presents or is brought to a medical facility for treatment and is or becomes incapable of providing informed consent is deemed to have granted implied consent to the medical treatment necessary to stabi-
lize his or her condition and to prevent further harm. The scope of this exception is broad, and will generally protect a caregiver from legal liability for actions in good faith. However, the caregiver has a duty to diligently seek out any family members or others who may hold a durable power of attorney as soon as a patient is stabilized. In many jurisdictions, there is a statutory scheme that determines which family member is to act as the substituted decision-maker if no durable power exists. One should be wary of situations where family conflicts are apparent, or situations in which there are incentives, financial or otherwise that may influence the family member. The most vocal family member is not necessarily the one who has the legal responsibility. In the absence of a power of attorney or a statutorily suitable willing and able family member (or in other questionable cases), a caregiver may petition the superior court under Probate Code section 3200 for treatment authorization.

One of the roles of the consulting psychiatrist is to assess a patient’s competency to give informed consent, and to assist the treatment team in the necessary formalities to obtain appropriate substituted judgment in the event that a patient is not competent.

**Non-emergent Medical Care**

As discussed above, a court petition is one method for obtaining consent for medical treatment. However, this is unwieldy and expensive both to the hospital and to the court system. Consequently, systems have been established for appointment of conservators by the courts who can, once appointed, give continued consent for medical treatment. The doctrine of informed consent still applies, and the same discussion and formalities should be observed with the conservator as would be observed with the patient. The conservator is obliged to act in what he believes to be the best interests of the patient in making his or her decision regarding treatment, taking into account what he or she knows of the patient’s preferences.

There are two types of conservatorships, probate and LPS. A probate conservator is appointed by a probate court, and may be given various levels of authority. A limited conservatorship is created when an individual is competent to act in some areas but not in others. The conservatorship grant will specifically state what powers are retained by the individual. Probate conservatorships cover the person, the estate, or both. The conservator for the person is authorized to make decisions concerning the person’s medical treatment, living situation, etc. The conservator of the estate is authorized to make decisions regarding disposition of the person’s assets and income. A probate conservator of the person may consent to medical, but not psychiatric care. The LPS conservatorship is named for the Lanterman, Petris, Short Act, named for the legislative authors of one of the statutes which regulates mental health care in California.

There are six important differences between an LPS and a probate conservatorship. First, only an LPS conservator can make mental health decisions, such as petition the court for an involuntary commitment or involuntary medication. Second, an LPS conservatorship requires proof beyond a reasonable doubt (95%-some would say 99%), compared to clear and convincing evidence (75%). Third, a court may establish a probate conservatorship if a person is unable to provide for his or her basic needs, or is unable to manage finances or resist fraud. The LPS further requires that the inability to provide for food, shelter, or clothing result from a mental disorder or alcoholism. Fourth, if a person already has a probate conservator of the estate or person, the court may appoint an LPS conservator of the person only. If the two conservators disagree, the clinician must follow the direction of the LPS conservator. Fifth, a probate conservatorship lasts indefinitely, but is reviewed by the probate court every two years, while an LPS conservatorship lasts for only one year, but may be renewed if the conservator petitions the court for renewal. Such renewal requires the written opinions of two physicians or qualified psychologists to the effect that the conservate is still gravely disabled as a result of a mental disorder. Finally, a probate conservatorship may be requested by any interested party other than a creditor, while an LPS conservatorship may only be recommended by a professional person in charge of an agency providing comprehensive evaluation or of a facility providing intensive treatment. If the county conservatorship investigator agrees, he or she will then petition the Superior Court.

Inasmuch as the process of instituting an LPS conservatorship is time consuming, a temporary conservatorship may be granted upon recommendation of the conservatorship investigator. The temporary conservatorship, or “T-Con” lasts 30 days, allowing time for gathering of data to support the 1-year conservatorship. As part of the LPS conservatorship process, the conservator may request that he or she be authorized to consent to routine medical care, routine psychiatric care, and routine psychotropic medications as part of his appointment. Authority for extraordinary care, such as surgery or electro- shock therapy requires specific authorization from the court, and may require additional supporting evidence of necessity.

In the event that a patient disagrees with the appointment of an LPS conservator, he or she may request a jury trial. If the patient is being held involuntarily pursuant to the conservatorship process, he or she may ask for a writ of habeas corpus. The writ of habeas corpus, which dates to the time of the magna carta, requires that any government entity or private facility acting under color of government authority justify to a court of law that they have adequate legal justification for involuntarily detaining a person. In California the standard or proof for such challenges requires the government to prove beyond a reasonable doubt that the conservatorship or the involuntary commitment by the
conservator is justified.

Emergency Mental Health Treatment

Because the process of LPS conservatorship is so complicated, it is clearly not suited to emergent mental health problems. However, courts and legislatures have been unwilling to grant the mental health system the broad authority to treat emergencies that the rest of the medical care system enjoys. In California, a highly formalized system is statutorily defined. It restricts provision of emergency treatment to three categories of problems, danger to self, danger to others, and grave disability. Grave disability is defined as the inability to provide for one’s own basic needs, specifically food, clothing and shelter. The courts have rather narrowly construed grave disability such that any reasonable plan, such as going to a homeless shelter and a soup kitchen, together with the ability to explain how to get there is sufficient to negate grave disability. If family or friends will provide for the basic needs, that also will negate grave disability. However, there is a presumption that such support will not be forthcoming unless its availability is attested to in writing by the potential providers.

Each category has a different set of rules but all begin with a 72 hour mental health hold, nicknamed the “5150” for the code section that authorizes it. The hold may be placed by a police officer, staff of an evaluation facility, and such others as authorized by the county. There is no mechanism for challenging the hold prior to its expiration, and the statute prohibits lawsuits against those who place the hold acting in good faith and adhering to the statutory requirements. Individuals whose emergency condition have not resolved by the end of the 72 hours may be certified for continued involuntary hospitalization for 14 days. Nicknamed the “5250” for its code section, the grounds are the same as for the 5150, but the certification must be signed by two licensed professionals, preferably two physicians, but one psychiatrist and a registered nurse fulfill the requirement if two physicians are unavailable. Prior to the 14-day certification, a patient must be offered the opportunity to accept treatment voluntarily. The 14-day hold may be challenged by the patient, and an opportunity for a hearing must be provided within 4 days of the start of the 14-day certification. Once a patient has requested a hearing, the patient may not be transferred out of the county until after the hearing is completed. The hearing may be held at the institution or at the county courthouse at the choice of the individual. The individual is entitled to be represented by a patient rights advocate, and to present evidence in his or her behalf. The evidentiary standard is more probable than not. The patient may appeal an adverse decision by requesting a writ of habeas corpus, which must be heard by a judge within two days of the request. The patient is entitled to representation by an attorney.

To be certified for danger to self, an individual must remain a danger to himself during the 72-hour hold. If the patient threatened or attempted to take his own life during the 72 hour or 14 day hold, or if the original hold was for suicidal behavior (including threats, but not thoughts alone), an additional 14 day period of involuntary detention may be granted under section 5260 of the code.

To be certified for danger to others, the patient must pose a demonstrated danger of inflicting substantial physical harm on others. If a patient continues to pose such a danger to others a 180-day hold may be granted under section 5300 of the code. To obtain the 180-day hold the danger must be based on actual infliction, attempt, or serious threat of harm. The hold may be renewed for successive 180-day periods if an attempt, infliction, or serious threat is made during the previous 180-day period. Any request for the 180-day hold must be reviewed in court, and a lawyer must be provided. The patient may request a jury trial, which must be granted within 10 days. The standard of proof is beyond reasonable doubt.

To be certified for grave disability, the patient must be unable to provide for basic needs as discussed under the LPS conservatorship provisions. If the patient remains gravely disabled after the 14-day certification, a statutory provision exists for an additional 30-day hold at the option of the county. However, most counties have opted instead to move to an LPS conservatorship in these instances.

Involuntary Medication

The courts and legislature have also limited the power of mental health providers to administer medications to involuntary patients. This limitation was initially delineated in the case of Riese v. St. Mary’s Hospital in 1987, and has since been codified in statutory form. Under this doctrine, a patient may be given medications involuntarily only in an emergency, narrowly defined as a situation in which treatment is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent. If this definition is not met, the clinician may request an administrative hearing to determine the patient’s competency to refuse medications. The hearing must be held at the facility within 24 hours of filing the petition. The patient is entitled to representation by an attorney or patient’s rights advocate. Only if the patient is legally incompetent will the petition be granted. A person may be gravely disabled and still be legally competent. The standard for competency is the ability to understand the risks and benefits of treatment, to reasonably balance those risks and benefits, and to communicate his decision to the caregiver.

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