Section IV: DECISION MAKERS IN CONSENT SITUATIONS

1-23. CONSENT FOR ONESELF

a. The Consent Giver. As a general rule, consent for treatment must be obtained from competent adults and, in some states, emancipated and/or mature minors. Soldiers and military family members are also under this adult consent provision (with soldiers age 17 or older considered mature minors).

<table>
<thead>
<tr>
<th>CONSENT FOR ONESELF</th>
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<tbody>
<tr>
<td>• Competent adult.</td>
</tr>
<tr>
<td>• Emancipated minor (some states).</td>
</tr>
<tr>
<td>• Mature minor (some states).</td>
</tr>
</tbody>
</table>

Figure 1-17. Consent for treatment is generally obtained from adults and, in some states, emancipated and/or mature minors, provided they are competent and capable of giving an informed consent.

b. Competence. Competence (or incompetence) is a legal determination made by a judge for any number of reasons, for example, competence to handle one’s financial affairs, to make health care decisions. A competent adult is one who has not been declared incompetent by a court and who has adequate mental capacity (decision-making capability).

<table>
<thead>
<tr>
<th>CRITERIA FOR COMPETENCE</th>
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<tbody>
<tr>
<td>The individual must have:</td>
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<tr>
<td>• An understanding of the information.</td>
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<tr>
<td>• An ability to communicate.</td>
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<tr>
<td>• A knowledge of the consequences of one’s own decision(s).</td>
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</table>

Figure 1-18. A patient declared incompetent to handle his or her own financial matters might still be competent to make health care decisions.
**COMPETENT (FOR CONSENT PURPOSES):** having the mental capacity to understand information, to deliberate according to values, to weigh the consequences of one's own decisions, and to communicate one's wishes; a legal determination.

**CHOOSING A MEDICALLY UNSOUND COURSE OF ACTION: THE SUBJECTIVE BEST INTEREST STANDARD**

Choosing a medically unsound course of action that would lead to death does not demonstrate incompetence. In *Lane vs. Candura* (Mass., 1978), the court found a woman to be competent to refuse the amputation of her gangrenous leg even though her train of thought sometimes wandered, her sense of time was distorted, and she was confused on some matters. The court found that since the individual understood the alternatives and the consequences of her decision, she was competent to make her own health care decisions.

The law provides little guidance in defining competence for the purposes of consent, although there are some basic criteria. (See above.) No state statutes define the mental status required to consent to treatment, and there are few reported cases on which to base outcomes. The few cases available indicate that the courts are reluctant to deprive a patient the right to consent, to second-guess the patient's best interests, or to judge the appropriateness of the reasons for a patient's decisions. There are two standards for determining a patient's best interests: the objective and the subjective standards. (See figure below.) Under the objective standard, it is the medically sound course of action that is considered to be in the patient's best interests. Under the subjective standard, allowance is made for the patient who might choose another course of action. Choosing a medically unsound course of action may not be grounds for adjudicating incompetence, provided that the patient understands the available alternatives and their consequences.

**PATIENT'S BEST INTEREST**

**OBJECTIVE STANDARD**

If gangrene develops in the leg, it is in the patient's best interest to amputate the limb.

**SUBJECTIVE STANDARD**

The patient considering amputation is a dancer who cannot imagine life without dancing.

It is not in the patient's best interest, as she sees it, to opt for amputation of the limb.

Figure 1-19. The consent laws allow for both an objective and a subjective standard of the patient's best interests.
c. If the Physician Has Doubts. If the physician has doubts as to the patient's mental capacity, a consultation from another physician with the appropriate expertise should be obtained. It should be someone who is not treating the patient. If, for example, the physician suspects mental retardation, mental illness, or disorders that affect brain function, he or she can consult a psychiatrist or other appropriate specialists. If drugs or infection clouds the patient’s judgment, an attempt should be made to remove the impediment to decision making. Such a patient is not considered incompetent, rather judgment is considered to be temporarily impaired.

<table>
<thead>
<tr>
<th>TEMPORARY JUDGMENT-IMPAIRING CONDITIONS</th>
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<tbody>
<tr>
<td>• Drugs.</td>
</tr>
<tr>
<td>• Intoxication.</td>
</tr>
<tr>
<td>• Anxiety, depression.</td>
</tr>
<tr>
<td>• Unfamiliar hospital setting.</td>
</tr>
<tr>
<td>• Absence of supportive family.</td>
</tr>
<tr>
<td>• Anticipation of surgery.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>PHYSICAL CONDITIONS ASSOCIATED WITH ALTERED MENTAL STATES.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Infection.</td>
</tr>
<tr>
<td>• Metabolic disorders.</td>
</tr>
<tr>
<td>• Tumors.</td>
</tr>
<tr>
<td>• Trauma.</td>
</tr>
<tr>
<td>• Medication.</td>
</tr>
<tr>
<td>• Nutritional deficiencies.</td>
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</table>

Figure 1-20. If a temporary judgment-impairing condition exists and the patient's condition is not life-threatening, the physician must wait until the temporary condition is overcome before seeking the patient's consent for treatment.

1-24. INCOMPETENT ADULTS

a. A Legal Determination. Based on the physician's determination of mental incapacity, the judge will determine whether or not the patient is competent to give consent. The degree of understanding required in order for a patient to be declared competent will depend on the nature of the procedure to be performed, and the level of consent needed. As stated earlier, there are no clear guidelines defining competence apart from the ability to weigh alternatives. The determination of competence will ultimately depend on what satisfies the judge. (A person who is incapable of understanding alternatives is considered incompetent.)

incompetent (for consent purposes): lacking the mental capacity to make rational decisions or to conduct one’s personal affairs; a legal determination.
b. **Categories of Incompetence.** A person who is incompetent has impaired reasoning power. The individual lacks mental capacities, such as understanding, reasoning, and emotional stability. Such individuals lack sufficient mental capacity to appreciate the nature and consequences of their own decisions. There are a number of subcategories of incompetence that reflect the underlying cause of incompetence, i.e., the mentally ill, the mentally retarded, those with brain function disorders, the unconscious patient, and those adjudicated to be incompetent by a court for such purposes as making a contract or will, standing trial, being a parent, or giving consent.

c. **Competence in Other Areas Irrelevant.** The patient's competence to make other types of decisions (financial, business transactions, and so forth) is not relevant to the issue of competence for medical consent purposes. A patient found incompetent for other types of decision-making may still have the mental capacity to make health care decisions.

d. **Mental Capacity.** In day-to-day, bedside consent situations, it is the physician who makes the determination as to the patient's mental capacity (decision-making capability). Competence is *assumed* unless called into question by the physician's determination of mental incapacity.

**mental capacity:** the ability to make decisions and weigh alternatives; a clinical determination made by the physician.

<table>
<thead>
<tr>
<th>COMPETENT PATIENTS</th>
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<tbody>
<tr>
<td>- Understand alternatives and the consequences of their own decisions.</td>
</tr>
<tr>
<td>- May be in a mental institution. (A medically irrational decision leading to death may be acceptable, if the above criteria are met.)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>INCOMPETENT PATIENTS</th>
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</thead>
<tbody>
<tr>
<td>- Mentally ill.</td>
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<tr>
<td>- Mentally retarded.</td>
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<tr>
<td>- Brain-function disordered.</td>
</tr>
<tr>
<td>- Unconscious.</td>
</tr>
<tr>
<td>- Mentally ill.</td>
</tr>
<tr>
<td>- Mentally retarded.</td>
</tr>
<tr>
<td>- Brain-function disordered.</td>
</tr>
<tr>
<td>- Unconscious.</td>
</tr>
<tr>
<td>- Adjudicated incompetent by a court.</td>
</tr>
</tbody>
</table>

Figure 1-21. What distinguishes a competent patient from an incompetent one is the ability to understand alternatives and the consequences of one's own decision(s).
In those cases in which the court is called upon to adjudicate competence for the purposes of consent, the judge relies on the physician's clinical assessment as to the patient's mental capacity as a point of reference.

e. Temporarily Impaired Judgment. As stated earlier, temporary conditions causing impaired judgment, that is, depression, anxiety, effects of medication, physical conditions causing altered mental states, etc., are not grounds for mental incapacity. The patient's judgment may be clouded, for example, by drugs or infection. If the patient's condition is not life threatening, the physician is obligated to help the patient overcome these conditions before providing the information needed to obtain informed consent.

f. Medicolegal Decisions for Mentally Incapacitated Persons. If the physician is convinced that the patient is mentally incapacitated, there are several options available. If the patient's condition is not life-threatening, the physician may hold off on treatment, and seek psychiatric or other help (chaplain, social services). If the condition is life-threatening, the physician may provide treatment based on implied consent and applicable state laws covering such patients, i.e., patients suffering from mental disease and those who are a danger to themselves or others. The physician or hospital administrator can seek authorization from the courts to treat the incapacitated person.

g. Substitute Consent. If a person is judged incompetent, a guardian is appointed to make decisions on the patient's behalf. The guardian's authority may be limited to a particular domain, such as business affairs, financial matters, or health care. (Laws concerning competence and guardianship vary by state.) When someone else has to provide substitute consent, the physician's responsibility to furnish all relevant information needed for decision-making is not eliminated. The surrogate decision maker (the legal guardian, the next of kin, or possibly the physician) acting on behalf of the patient is entitled to the same information that the patient would have needed to make an informed decision. Thus, the autonomy of the incompetent patient is, in some sense, preserved. A guardian, who has legal authority to make most of the decisions regarding the incompetent person’s care, usually provides substitute consent. If there is no guardian assigned, then the representative of the incompetent adult, perhaps a close relative makes decisions concerning patient care. (Some patients with inadequate mental capacity have never been determined to be incompetent by a court, so they do not have guardians.)

<table>
<thead>
<tr>
<th>SUBSTITUTE CONSENT IS AN INFORMED CONSENT INVOLVING</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Disclosure.</td>
</tr>
<tr>
<td>• Express consent.</td>
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</table>

Figure 1-22. A guardian with legal authority or a close relative who makes decisions on behalf of the incompetent patient usually gives substitute consent.
Dr. Christine Castle, a prominent medical ethicist and chief of internal medicine at the University of Chicago Medical Center, believes that the application of ethical principles to health care in the last 10 years has helped resolve moral problems more equitably. At the same time, however, there are cases in which following the ethical rule hasn’t always meant the best results for the patient. Dr. Castle cites a substitute consent case encountered by her own staff. The patient, a 78-year-old woman, was brought to the clinic for deteriorating mental function. Until that time, the woman had been relatively active, participating in senior center activities. She lived with her second husband, a man with failing health who was relatively housebound. Surprisingly, the woman was diagnosed as having syphilis. The mental symptoms associated with late syphilis had to be treated with penicillin. Following correct substitute consent procedure; the patient's daughter was advised of her mother’s condition. The daughter, horrified to learn that her mother had a sexually transmitted disease, kept trying to imagine how she might have gotten it. Ultimately, she decided to place her mother in a nursing home rather than care for her in her own home, as she’d originally intended. Despite the best efforts of the health care team, the estrangement among daughter, patient, and spouse could not be resolved. And, in the end, the patient showed only slight improvement. The staff's concern as to how they might have better handled the case led to an article in a professional journal. The article generated 25 letters from physicians who, in confronting similar cases, had opted to give the elderly patient the medication without advising the family. Dr. Castle believes that these physicians transgressed the ethical principle because they were looking for the optimum results for their patients. And, she concludes that we may have to rearticulate some of the ethical principles or find new ways of solving problems, in some cases.

1-25. CONSENT FOR/BY MINORS

a. When the Parent's or the Guardian's Consent Is Needed. State law governs local definitions as to who is a minor. Generally, consent of the parent or the guardian consent should be obtained before treatment is given to a minor. (Depending on the state, a minor may be someone under the age of 16, 17, or 18.) The consent of the parent or guardian is not needed in: 1) an emergency; 2) situations in which the consent of the minor is sufficient (some states allow minors to consent to receive birth control counseling and prescriptions or treatment for sexually transmitted diseases without parental knowledge); or 3) when a court order or other legal authorization is obtained (where the parents’ personal beliefs stand in the way of treating a child for a life-threatening condition).
b. **Emergency Care.** Consent is implied in medical emergencies where there is an immediate threat to life or health, unless the health care provider has reason to believe that consent would be refused by the parent or guardian. In such a case, court authorization should be sought.

<table>
<thead>
<tr>
<th>EXCEPTIONS TO PARENTAL CONSENT FOR MINORS</th>
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</thead>
<tbody>
<tr>
<td>• An emergency (consent implied).</td>
</tr>
<tr>
<td>• When the consent of a minor is sufficient (emancipated/mature minors).</td>
</tr>
<tr>
<td>• Under court order.</td>
</tr>
</tbody>
</table>

Figure 1-23. Situations in which parental consent for a minor is not needed.

c. **Emancipated Minors.** Those who have assumed the life-style and responsibilities of adult status may consent to their own medical care. As a general rule, minors are emancipated when they are no longer subject to parental control or regulation, and are not supported by their parents. As a rule, a minor may be considered emancipated if he or she is married, a parent, or financially self-supporting and living away from home. The local Judge Advocate General (JAG) office can provide the specific rules for a given locale.

**emancipated minor:** a minor who has assumed the life-style and responsibilities of adult status and is not supported by either parent.

1. Self-supporting minors living away from home can give consent for themselves.

2. Married minors can give consent for themselves. If unable to give consent, the spouse may give consent. (But, in some states, the spouse must be an adult.)

3. Minor parents may give consent for their children.

<table>
<thead>
<tr>
<th>THREE TYPES OF EMMANCIPATED MINOR</th>
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</thead>
<tbody>
<tr>
<td>• Self-supporting and living away from home.</td>
</tr>
<tr>
<td>• Married minor.</td>
</tr>
<tr>
<td>• Minor parent.</td>
</tr>
</tbody>
</table>

Figure 1-24. Emancipated minors can give consent for themselves and their offspring.
Army policy is to follow state law as to when consent is not needed. The local JAG office should be consulted to determine the specific rule for a given location. If there is no applicable state or Federal law, Army policy is to seek the consent of the minor, giving special attention to the minor's maturity, age, and level of intelligence. Even in cases where the minor's consent alone is not legally sufficient, the minor's consent will be obtained along with that of the parent whenever the minor is able to understand the significance of a proposed procedure.

**ARMY CONSENT POLICY**

- Follows state law on exceptions to parental consent.
- Risks and alternatives are reviewed with mature, intelligent minor, even if parental consent is required.

Figure 1-25. The Army follows the local state laws on consent.

d. **Mature Minors.** In many states, mature minors (generally age 15 or older) may consent to some medical care because of minor treatment statutes empowering older minors to consent to medical treatment. The state law may allow the mature minor to consent, though not yet of age, based on such factors as the maturity of the minor, the nature of the procedure, and the benefit, if any, to the child. Many states have special laws concerning minor consent to sexually-transmitted disease and substance abuse treatment that have no age limits. Army policy, however, is to rely on the mature minor exception only as a last resort if the parents cannot be contacted. As a practical matter, whenever major medical treatment is proposed for a mature child, good medical and legal practice is to discuss with the child, as well as with the parents, the nature and purpose of the treatment, its risks, and any alternatives. In general, when treating any minor, parental involvement is to be encouraged. When a mature minor refuses to permit parental involvement, the provider can provide necessary care without substantial risk, unless there is likelihood of harm to the minor. When there is likelihood of such harm, it is advisable to involve the parents, unless state law specifically forbids parental notification.

**MATURE MINOR LAW**

- Permits consent by mature intelligent minors, in some cases.
- Applies generally to minors age 15 or older.

**ARMY POLICY**

- Consent by the mature minor as a last resort, if parents cannot be reached.

Figure 1-26. Mature minor laws exist in many jurisdictions.

MD0067 1-55
TO WHAT EXTENT IS AN OLDER CHILD’S CONSENT NEEDED IN ADDITION TO A PARENT’S?

A question that is not currently dealt with in the law is the extent to which an older child’s consent is required in addition to that of the parents. Can parents force a mature child to undergo treatment over his or her own objections? Lifesaving procedures can clearly be forced, but elective procedures are more problematic. It is good medical practice to discuss elements of disclosure with both the parents and the mature child. The state law may allow the mature minor to give consent, although not yet the age of majority based on such factors as: maturity, the nature of the procedure, and the benefit, if any, to the child. This generally applies to minors over age 15, but may also be applicable to those who are younger, based on the circumstances.

e. Parental or Guardian Consent. Either parent can give legally effective consent, except when there is legal separation or divorce. While it is not necessary to determine the wishes of the other parent, when it is known that the other parent objects, either the procedure should not be performed or court authorization should be obtained.

CONSENT FOR MINORS

CONSENT OF PARENT (GUARDIAN OR TEMPORARY CUSTODIAN)

- For minors underage 17*.

PARENTAL CONSENT NOT REQUIRED

- In an emergency.
- If a court order is obtained.
- For emancipated minors (married, a parent, or self-supporting and living away from home).
- The Army follows the state law as to when parental consent is not needed.

CONDITIONS FOR MINOR CONSENT FOR ONESELF

- Age 18.
- Emancipated minor.
- Mature minor. (For the Army, a last resort if parents can’t be reached.)

*Under age 18 in some states and under 16 in others.

Figure 1-27. Army policy is to obtain the minor’s consent even when parental consent is required.
f. **Babysitters.** Based on legal authorization or special power of attorney, a minor (or any other person) serving as temporary custodian of a minor may give consent for examination and treatment in an emergency.

1-26. **CONSENT FROM OTHER THAN PATIENT**

   a. **Order of Substitute Consent.** When a patient cannot give consent, the next of kin may provide substitute consent. The general order of preference for such consent, which may vary slightly from state to state, is as follows: a spouse, a parent (for a child), an adult child (for a parent), an uncle, an aunt, and a grandparent. A JAG advisor can provide the order of preference for consent for the particular state in which you are practicing.

   b. **Spousal Consent.** Spousal consent is needed if a married patient is unconscious or otherwise unable to consent. As stated earlier, it is also needed when a physician chooses to exercise therapeutic privilege, withholding information from the patient that may adversely affect treatment.

<table>
<thead>
<tr>
<th>ORDER OF SUBSTITUTE CONSENT (GENERALLY)</th>
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<tbody>
<tr>
<td>• A spouse.</td>
</tr>
<tr>
<td>• A parent (for a child).</td>
</tr>
<tr>
<td>• An adult child (for a parent).</td>
</tr>
<tr>
<td>• An uncle.</td>
</tr>
<tr>
<td>• An aunt.</td>
</tr>
<tr>
<td>• A grandparent.</td>
</tr>
</tbody>
</table>

Figure 1-28. The order of consent may vary slightly by state.

*Continue with Exercises, Section IV*
EXERCISES, LESSON I, SECTION IV

It is recommended that you work the following exercises (1 through 20) before beginning the next lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MATCHING. For exercises 1 through 6, match the term in the left-hand column with the appropriate definition in the right-hand column. Enter the appropriate letter in the space provided. (Note: There are two different definitions of an emancipated minor to identify, and there is an extra definition that will not be selected.)

_____ 1. Minor.   a. A minor who lives away from his or her parents and is self-supporting.
_____ 2. Mature minor.  b. Can give consent for his or her own child.
_____ 3. Minor parent.  c. Underage individual aged 16, 17, or 18 depending on the state.
_____ 4. Emancipated minor. d. A minor who is married or a parent.
_____ 5. Emancipated minor. e. Automatically considered incompetent.
_____ 6. Good medical practice.  f. An older minor who can give consent in some states. For the Army, only a last resort if the parents can't be reached.

   g. Discussing medical alternatives with both parent and child.

MULTIPLE-CHOICE. Select the ONE response (a, b, c, or d) that BEST completes the statement or BEST answers the question.

7. Generally, consent to treatment for oneself is obtained from:
   a. Upstanding citizens and pillars of the community.
   b. Individuals with inadequate mental capacity.
   c. Competent adults and, in some states, emancipated and/or mature minors.
   d. Well-educated adults and minors.
8. A competent person is one:
   a. Who makes medically rational decisions.
   b. Who understands alternatives and the consequences of his or her own decisions.
   c. Who has an accurate conception of time and shows no signs of confusion.
   d. Whose train of thought does not wander.

9. If in doubt as to the patient's mental capacity, the physician should:
   a. Reevaluate the patient.
   b. Obtain affidavits regarding mental stability from the next of kin and the last physician who treated the patient.
   c. Exercise therapeutic privilege and obtain a patient waiver.
   d. Consult a psychiatrist or other appropriate specialist.

10. Substitute consent must involve:
    a. Disclosure and express consent by the patient.
    b. All immediate family members.
    c. Informed consent by a surrogate decision maker.
    d. A guardian or conservator with legal authority.

11. Parental consent is generally required:
    a. In an emergency.
    b. For emancipated and mature minors.
    c. When a court order designates a guardian.
    d. For minors.

12. Army policy regarding mature minors is to:
    a. Follow state law.
    b. Rely on the minor's consent only if the parents cannot be reached.
    c. Seek consent from minors who are age 15 or older.
    d. Use maturity, but not intelligence, as the criterion.
13. If the parents are divorced or separated, and it is known that one or the other parent objects to a procedure proposed for their child, either the procedure should not be done or:

   a. A court authorization should be obtained.
   b. Mature-minor rules should be applied.
   c. The child should be treated as an emancipated minor.
   d. A guardian should be appointed.

14. Mental capacity is generally determined by the:

   a. Hospital ethics committee.
   b. Courts.
   c. Next of kin.
   d. Physician.

15. It is advisable to involve parents in mature-minor decisions, especially when __________________________unless the state law expressly forbids it.

   a. There is a likelihood of harm to the patient.
   b. Substance abuse is involved.
   c. Sexually transmitted diseases are diagnosed.
   d. Dealing with the termination of pregnancies.

16. A married adult man, involved in an auto accident, is brought to the hospital in an unconscious state. Who would health care providers be most likely to call first to obtain substitute consent?

   a. The patient's adult child.
   b. His spouse.
   c. His sister or brother.
   d. His boss.
17. Which of the following individuals would **NOT** be considered incompetent for consent purposes?

a. A mentally ill, mentally retarded, or brain-function disordered patient.
b. An unconscious patient.
c. A drugged or intoxicated patient.
d. A patient who has been adjudicated incompetent for consent purposes.

18. Which of the following is **NOT** an emancipated minor?

a. A minor who is self-supporting and living away from his or her parents.
b. A mature 17-year-old.
c. A minor who is a parent.
d. A married minor.

19. Which of the following criteria is **NOT** applicable to mental incapacity for consent purposes?

a. It is a legal determination made by the judge.
b. The physician determines the decision-making capability of the patient at the bedside.
c. The judge relies on the physician's clinical assessment of mental capacity in adjudicating competence.
d. It refers to a condition that cannot be overcome.

20. Which of the following criteria is **NOT** applicable to situations in which the patient is suffering from temporarily impaired, good judgment?

a. The physician must help the patient overcome the condition causing impaired judgment if the patient's medical condition is not life-threatening.
b. Disclosure requirements still apply.
c. Depression, anxiety, intoxication, a drugged state, and certain medical physical conditions can cause impaired judgment.
d. It is the same as mental incapacity.

**Check Your Answers on Next Page**
SOLUTIONS TO EXERCISES, LESSON 1, SECTION IV

1. c (para 1-25a)
2. f (para 1-25d)
3. b (para 1-25c)
4 -5. a and d, in any order (para 1-25c)
6. g (para 1-25d)
7. c (para 1-23a)
8. b (para 1-23b; figure 1-18)
9. d (para 1-23c)
10. c (para 1-24g)
11. d (para 1-25a)
12. b (para 1-25d)
13. a (para 1-25e)
14. d (para 1-23c)
15. a (para 1-25d)
16. b (para 1-26b)
17. c (paras 1-24b, 1-24e, & figure 1-21)
18. b (para 1-25c)
19. a (para 1-23c)
20. d (para 1-23c & figure 1-20)