GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

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TITLE: INFORMED CONSENT FOR TREATMENT AND PROCEDURES				
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PURPOSE:

The purpose of this document is to provide information necessary to obtain and document informed consent from a patient/surrogate decision maker in advance of all medical/surgical interventions. This policy document is divided into four sections: (1) Overview and Basic Consent Requirements, (2) Consent to Treatment of a Minor, (3) Telephone Consent for Treatment/Procedures, and (4) Refusal of Consent or Treatment.

SECTION ONE: OVERVIEW AND BASIC CONSENT REQUIREMENTS

POLICY:

In accordance with local and federal law, prior to providing care, treatment, or services, informed consent must be obtained from the patient or the person with the right to provide consent on behalf of the patient (e.g., parent in the case of a minor patient or surrogate decision maker for an incapacitated patient), in that person's preferred language. The informed consent process includes a discussion about the potential benefits, risks, and side effects of the patient's proposed care, treatment, and services, as well as any reasonable alternatives (including not receiving the proposed care); the likelihood of the patient achieving his or her goals; and any potential complications that might occur during recuperation.

Guam Memorial Hospital Authority (GMHA) respects the diverse cultural needs, preferences, and expectations of the patients and families it serves to the extent reasonably possible while appropriately managing available resources and without compromising the quality of health care delivered.

DEFINITIONS:

Informed Consent: A process accomplished by a dialogue between the clinician and patient/surrogate decision makers during which the patient/surrogate decision maker is given information and an opportunity to ask questions. The dialogue culminates in the understanding by the patient/surrogate decision maker of the risks, benefits, and alternatives to the procedure under discussion and leads to a decision by the patient/surrogate decision maker.

There are three (3) components of Informed Consent:

1. Competence – the individual must have the capacity to either give or withhold their consent;
2. Sufficient Information - that capacity must be exercised on the basis of sufficient information;
3. Voluntary Choice – the process must be conducted in the absence of coercion so the individual can make a voluntary choice.

Express Consent: Oral or written consent given by a competent person or authorized representative for an incapacitated patient.

Implied Consent: Consent may be inferred from the patient's actions or behavior (e.g., extending their arm for a blood draw). Implied consent is rarely documented and may be relied upon for care, treatment or service that is routine and does not involve significant risk(s).

Decision-making Capacity: The ability to understand and appreciate the nature and consequences of a decision regarding medical treatment and the ability to reach an informed decision in the matter.

Attending Physician: The physician with primary responsibility for a patient's treatment and care.

Adult: Generally, a person 18 years of age or older, or a person under 18 years of age who has had the disabilities of minority removed (i.e., has been legally emancipated by a court).

Minor (or child): A person under the age of 18 who has not been legally emancipated by a court.

Emancipated Minor: A person under the age of 18 who is legally emancipated by the courts and able to provide consent for their own treatment.

Parent: Includes the child's biological mother and father (including a man adjudicated to be the biological father), or adoptive mother or father, but not a parent with whom the parent-child relationship has been legally terminated.

Legal Guardian: An individual or public agency appointed for a temporary, fixed, or indefinite term by order of the court located in the county in which the patient resides.

Managing Conservator: A parent, competent adult, authorized or licensed child placing agency appointed by a court to provide the place where the minor will live and receive daily care.

Possessory Conservator: One or more court-appointed person(s) with court approved possession of the child during specified times and conditions.

Incompetent Person: An incompetent person includes minors under the age of 18 years, an incapacitated person who exhibits symptoms of remaining incapacitated, or a person found legally incompetent by a court whether due to mental illness or pursuant to 10 GCA §3801.

If a person who suffers from a mental illness, disability or other medical condition that makes him/her incapable of making decisions that affect his/her health and general welfare is identified by a physician or mental health professional, but there are legal documents or information declaring said person mentally competent, GMHA will identify that person as "potentially being incompetent" until a court finds him or her legally "incompetent".

Incapacitated: Lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits, risks, complications and reasonable alternatives to any proposed treatment.

Surrogate Decision Maker: The parent/guardian of a minor child (under the age of 18 years); closest relative of an adult patient lacking decision making capacity; the legal proxy designated in a Health or Medical Power of Attorney; or the court appointed guardian of a judicially declared incompetent patient.

Health or Medical Power of Attorney: A legal form that allows an individual to empower another with decisions regarding his/her healthcare and medical treatment. A health or medical power of attorney becomes active when a patient is unable to make decisions or consciously communicate intentions regarding his/her healthcare and medical treatment.

Urgently/Emergently Required Medical Treatment: A medical treatment, procedure or intervention to prevent, alleviate, or reverse a condition or symptoms that, in the absence of immediate medical attention, reasonably could result in jeopardy of the patient's health, serious impairment of the patient's bodily functions, or serious dysfunction of any bodily organ or part. *Example: The administration of blood or blood components.*

I. GENERAL CONSENT:

A. When informed consent is required and implied consent is not enough: Informed consent must be obtained for all procedures listed in Attachment I.

B. If a patient's medical condition changes after a consent form for a specific medical or surgical procedure has been signed, and the change in the patient's medical status results in an increased or additional risk associated with the planned procedure or treatment, a new informed consent discussion and consent form must be completed before the specific medical or surgical procedure may be performed unless the treatment or care is being provided emergently.

C. Discussion and Education

Adult patients (or, when appropriate, their surrogate decision-makers) must receive from their attending physician information regarding the risks and benefits of a proposed treatment and/or procedure. The physician performing the procedure may authorize an Advanced Practice Nurse to obtain informed consent from the patient if, in the physician's clinical judgment, the Advanced Practice Nurse has the requisite skills and training to do so. In all such situations, the physician performing the procedure must be available to answer any questions the patient may have that the Advanced Practice Nurse is unable to answer. The physician performing the procedure is ultimately responsible for ensuring that the patient understands the nature of their condition and the proposed treatment regimen or procedure to be performed. Obtaining informed consent also allows the patient to fully participate in their care. In the case of a patient or surrogate decision-maker who is Limited English Proficient, discussion and consent should occur in their preferred language. Except in emergencies, this information may include, but is not limited to:

1. The patient's diagnosis, if known;
2. The general nature and purpose of the procedure or treatment, including its risks and benefits and whether it is experimental;
3. The name(s) of the person(s) performing the procedure or administering the treatment;
4. The benefits, risks, discomforts, side effects, complications, and potential problems related to recuperation associated with the procedure or treatment;
5. The likelihood of success;
6. The patient's prognosis and risks and benefits of not receiving or undergoing a treatment or procedure; and
7. Reasonable alternatives (regardless of their cost or the extent to which treatment options are covered by health insurance), including the risks, benefits,

discomforts, side effects, complications, and potential problems related to the alternatives.

D. Written Consent

1. A Disclosure and Consent for Medical and Surgical Procedures form must be used to document consent if:

   a. The procedure or treatment is included in Attachment I;
   b. The procedure requires the administration of general, spinal, epidural, or regional anesthesia, other than local infiltration;
   c. The procedure (invasive or non-invasive) involves more than a slight risk of harm to the patient's body structure (i.e., a risk is more than slight if its disclosure would be material to a reasonable patient's decision whether to accept or reject a treatment option); or
   d. The procedure is experimental.

2. Consent forms must be signed by the patient (or person providing consent on behalf of the patient) and a third-party witness.

E. General Consent for Hospital Treatment

General written consent for diagnosis and routine hospital services must be obtained upon each patient's admission to a GMHA (i.e., upon admission to the Emergency Department for 3 hours or longer; to Ambulatory Surgery for 1 day; or as an inpatient for an indefinite stay).

II. REVOCATION OF CONSENT

A. Unless revoked orally or in writing, written general consent is effective for the duration of the patient's hospitalization, and written informed consent is effective until the listed procedure(s) has been performed, unless the patient's condition has changed such that the risks and/or benefits of the treatment or procedure have changed.

B. GMHA acknowledges the rights of the patient to refuse consent, delay consent, seek further information, limit the scope of consent, and/or ask for a chaperone, where authorized by hospital policy.

C. The patient/surrogate decision maker has the right to withdraw consent at any time.

D. The patient's/surrogate decision maker's withdrawal of consent is required to be documented in the patient's medical record.

E. Questions posed by the patient/surrogate decision maker will be answered honestly, and information necessary for them to make an informed decision will not be withheld unless there is a specific reason to withhold it. In all cases where information is withheld, the reasons for this will be recorded in the patient's medical record.

F. The person who would have been carrying out the procedure will make sure that all issues around the withdrawal of consent have been fully explained to the patient/surrogate decision maker to enable them to fully understand what may happen if the treatment / operation is not carried out. (The person discussing this must be fully qualified and knowledgeable about the procedure itself and the associated risks).

G. The scope of the authority provided by the patient/surrogate decision maker will not be exceeded unless in a medical emergency. Patients can withdraw consent during a procedure – but if stopping the procedure at that point would genuinely put the life of the patient at risk, the practitioner may be entitled to continue until this risk no longer applies.

III. INCAPACITATED PATIENTS

A. Adults and emancipated minors are presumed to be competent to make their own medical decisions as patients. However, if a patient becomes comatose, incapacitated, or otherwise mentally or physically incapable of communication, an adult surrogate decision-maker may consent to medical treatment on the patient's behalf.

B. If a patient has not designated an individual to act as their surrogate decision-maker (for example by medical power of attorney or written declaration), an adult from the following list, in descending order of priority, who has decision-making capacity, is available after a reasonably diligent inquiry, and is willing to consent to medical treatment on behalf of the patient, may act as the patient's surrogate decision-maker:

1. Patient's spouse;
2. An adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker;
3. A majority of the patient's reasonably available adult children;
4. Patient's parent (s);
5. The individual clearly identified to act for the patient (before the patient's incapacity), the patient's nearest living relative, or a member of the clergy.

C. Any dispute as to the right of an individual to act as a surrogate decision-maker may only be resolved by a court having jurisdiction.

D. Any decision by a surrogate decision-maker must be based on knowledge of what the patient would desire, if known.

E. A surrogate decision-maker may not, under any circumstance, consent to the appointment of another surrogate decision-maker.

F. A surrogate decision-maker's consent to medical treatment that is not made in person shall be reduced to writing in the patient's medical record, signed by the attending physician receiving the consent, and countersigned in the patient's medical record or on an informed consent form by the surrogate decision-maker as soon as possible.

IV. EMERGENCY SITUATIONS

A. If a patient's condition precludes obtaining consent, express consent for emergency care of an individual is not required if:

1. The individual is:
   a. Unconscious or unable to communicate because of an injury, accident, or illness; and
   b. Suffering from what reasonably appears to be a life-threatening injury or illness.

2. A court of record orders the treatment of an individual who is in an imminent emergency to prevent the individual's serious bodily injury or loss of life; or

3. The individual is a minor who is suffering from what reasonably appears to be a life-threatening injury or illness and whose parents, managing or possessory conservator, or guardian is not present.

4. In the event that an incapacitated adult or minor patient's status deteriorates to the point that death or irreparable harm will result unless the urgent/emergent medical care is instituted immediately, two physicians can determine the need for emergency care. Prior to commencing such care, the physician should inform the patient's reasonably available family that the care will be provided despite their objections, if any.

V. DOCUMENTATION OF INFORMED CONSENT

A. The consent forms will become part of the patient's permanent medical record.

B. In addition to the signed consent form, the attending physician should document the informed consent process in the medical record,

C. Additional Documentation for Incapacitated Patients

1 If the patient is incapacitated, the attending physician must document in the patient's medical record:

a. The patient's comatose state, incapacity, or other mental or physical inability to communicate;
b. The proposed medical treatment;
c. The efforts made to contact persons eligible to serve as the patient's surrogate decision maker;
d. The date and time consent was given, if a surrogate decision-maker consents to medical treatment on behalf of the patient; and
e. The attending physician's signature.

VI. CONSENT FORMS

The hospital's consent forms are available for view, download, and printing on its official website: www.gmha.org.

SECTION TWO: CONSENT TO TREATMENT OF A MINOR

I. POLICY

This section provides guidance relating to who may consent on behalf of a minor, and when a minor may consent on their own behalf, to receive medical treatment from GMHA providers. In accordance with Guam law and GMHA policy, informed consent for medical treatment of a minor will be obtained before treatment begins.

Generally, minors do not have the legal capacity to consent for medical treatment. Under Guam law, parents have a duty to provide medical care for their children, and therefore, parents are given the explicit right to consent to such treatment. As a general rule, GMHA must obtain consent from a minor's parent prior to providing medical treatment. This duty includes the right to access the minor's medical records in accordance with federal and local law and GMHA policy.

This section of this policy does not apply to minors who have been legally emancipated. Legally emancipated minors have the same rights as adults.

GMHA respects the diverse cultural needs, preferences, and expectations of the patients and families it serves to the extent reasonably possible while appropriately managing available resources and without compromising the quality of health care delivered.

II. AUTHORITY OF PARENTS AND/OR CONSERVATORS TO CONSENT ON MINOR'S BEHALF

A. Consent for treatment of a minor may be given by a minor's parent (or conservator, when applicable).

B. Divorced Parents

1. Managing Conservator(s): In a custody suit, the court may appoint a sole managing conservator or may appoint joint managing conservators.

2. Possessory Conservator(s): If a managing conservator is appointed, the court may appoint one or more possessory conservators. The court will specify the rights and duties of a person appointed as a possessory conservator.

3. Guam law provides that, unless limited by a court order, a parent appointed as conservator (managing or possessory) of a minor has, at all times, the following rights:

   a. The right of access to medical, dental, psychological, and educational records of a minor;
   b. The right to consult with a physician, dentist, or psychologist of the minor;
   c. The right to be designated on the minor's records as a person to be notified in case of emergency; and
   d. The right to give consent for any emergency health care, including surgical procedures.

4. Sole or joint managing conservator parent(s) have all the rights listed above and may give consent for a minor's non-emergency invasive surgical procedure and may consent to psychological or psychiatric treatment of a minor, unless limited by a court order.

5. Non-Parent Conservators:
   a. Non-Parent Sole Managing Conservator: Non-parent sole managing conservators have the right to provide consent for the minor to receive medical, psychiatric, psychological, dental, and surgical treatment and to have access to the minor's medical record.

   b. Non-Parent Joint Managing Conservator: Non-parent joint managing conservators have the same rights as a parent joint managing conservator including access to the medical records of the minor, unless this right is limited by a court order.

III. AUTHORITY OF NON-PARENTS TO CONSENT ON BEHALF OF A MINOR

A. The following individuals may consent to health care treatment of a minor (other than immunization) when a parent or conservator cannot be contacted, and the parent or conservator has not provided express notice to the contrary:

1. A grandparent of the minor;
2. An adult brother or sister of the minor;
3. An adult aunt or uncle of the minor;
4. An educational institution in which the minor is enrolled that has received written authorization to consent from a person having the right to consent;
5. An adult who has actual care, control, and possession of the minor and has written authorization to consent from a person having the right to consent;
6. A court having jurisdiction over a suit affecting the parent-child relationship of which the minor is the subject;
7. An adult responsible for the actual care, control, and possession of a minor under the jurisdiction of a juvenile court or committed by a juvenile court to the care of an agency of the state or county; or
8. A peace officer who has lawfully taken custody of a minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.

B. Obtaining Consent from a Non-Parent

1. If a non-parent consents to the treatment of a minor, the consent must be in writing and include:

   a. The name of the minor;
   b. The name of one or both parents, if known, and the name of any managing conservator of the minor;
   c. The name of the person giving consent and their relationship to the minor;
   d. A statement of the nature of the treatment to be given; and
   e. The date the treatment is to begin.

IV. CONSENT BY MINOR

A. Medical and Surgical Treatment: A minor may provide consent for medical and surgical treatment of himself/herself if the minor:

1. Is on active duty with the armed services of the United States of America;
2. Is 16 years of age or older and resides separate and apart from his or her parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of such residence; and, is managing his or her own financial affairs, regardless of the source of the income;
3. Consents to the diagnosis and treatment of any infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Department of Public Health and Social Services;
4. Is unmarried and pregnant, and consents to hospital, medical, or surgical treatment, other than abortion, related to her pregnancy;
5. Consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use;
6. Is unmarried, is the parent of a child, and has actual custody of his or her child and consents to the medical, dental, psychological, or surgical treatment of that child.

B. Confidentiality and Access to Medical Records **when** a Minor Consents to Treatment

1. Sensitive communication and assurance of confidentiality are critical to ensuring access to care for minors, especially adolescent minors. If a provider agrees to treat a minor confidentially based on the minor's consent in accordance with this policy, the provider should not initiate communication with the minor's parent or guardian to discuss issues related to the treatment. *See* 19 GCA Section 1111(b) in Attachment II.

2. If a parent, guardian, or other person claiming to be the personal representative of a minor requests access to a minor's medical or billing records, or to speak with a healthcare provider relating to treatment provided with the minor's consent in accordance with this policy, contact the Hospital Risk Management Program Officer/HIPAA Compliance Officer. *See* 19 GCA Section 1111(c) – information regarding provision of medical care and services to minor cannot be disclosed without specific consent from minor patient (in Attachment II).

D. Compensation of Services

A parent, managing conservator, or guardian who has not consented to medical treatment on behalf of a minor is not obligated to compensate a medical provider or the hospital for such services. *See* 19 GCA Section 1111(d) in Attachment II.

SECTION THREE: TELEPHONE CONSENT FOR TREATMENT/PROCEDURES

I. POLICY

Telephone consent may be obtained when a surrogate decision-maker (or parent or legal guardian, in the case of a minor patient) is not physically present and it is not possible to obtain a signed consent by fax or email. Telephone consent should only be used as a "last resort" and is not recommended as a routine practice.

II. PROCEDURE

A. Consent (or refusal to provide consent) for medical treatment that is not made in person must be recorded in the patient's medical record, signed by GMHA's staff member receiving the consent or refusal, and then countersigned in the patient's medical record or on a consent form by the individual who provided (or refused) consent as soon as possible.

B. If it is necessary to obtain telephone consent, the following procedure should be followed:

1. When telephone contact is first made, the physician should inform the individual of the identity of any third parties (preferably another health care professional, such as a physician or nurse) who is also participating on the telephone call. The physician should then ask the individual who will potentially provide consent:

   a. to identify himself/herself and describe his/her relationship to the patient in order to verify his/her authority to provide consent;
   b. verify that he/she is at least 18 years old or is an emancipated minor; and
   c. confirm whether he/she understands the nature and purpose of the phone call discussing consent for treatment, and the consequence(s) of their decision regarding whether the treatment may be provided.

2. The patient's condition, treatment plan, complications, risks and benefits of the treatment, as well as any alternative treatment should be outlined and all questions answered.

   a. To the extent reasonably possible, telephone consent should be substantively the same as the written consent (i.e., the person providing consent should be read the same information as if they had the consent form in front of them, including a discussion about the potential benefits, risks and side effects of the patient's proposed care, treatment, and services, as well as any reasonable alternatives (including not receiving the proposed care); the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.)

   b. It should be explained to the individual providing consent that any consent decision should be made in accordance with what the patient wanted, not what the individual giving consent may want (e.g., ask if the patient had ever discussed a similar treatment and if so, what treatment the patient had requested, along with any other information that might help verify when the patient made the statement).

3. Once all questions have been answered, there must be a specific request for consent to the treatment or procedure.

4. Consent (or refusal) should be reduced to writing in the patient's medical record and signed by the staff member(s) receiving consent. An informed consent form should also be signed by the person providing consent on behalf of the patient if possible, and the form then placed or scanned into the patient's medical record thereafter.

SECTION FOUR: REFUSAL OF CONSENT OR TREATMENT

I. POLICY

Health care is provided at the request of, and for the benefit of, the patient. When a refusal of medical treatment occurs, specifically refusal of urgently/emergently required treatment for non-terminally ill conditions, this may sometimes place the hospital and attending physicians in a position which restricts their ability to provide the best care possible and to control treatment properly. When it becomes apparent that there is a refusal of consent/treatment, these guidelines are meant to proactively assist the health care team in ensuring the protection of both the patient and the hospital. GMHA respects the diverse cultural needs, preferences, and expectations of the patients and families it serves to the extent reasonably possible while appropriately managing available resources and without compromising the quality of health care delivered. A refusal will be respected and honored when provided by the patient or the patient's legally authorized representative as listed in the following chart.

	Refusal for Non-Urgent/Non-Emergent Medical Treatment	**Refusal for Urgent/Emergent Medical Treatment**
Adult Patient with decision-making capacity	The patient's refusal will be respected.	The patient's refusal will be respected. However, Legal Counsel should be contacted if the patient: • refuses treatment for a condition which endangers self or others (e.g.,

		a patient with active TB or a suicidal/homicidal patient) • is pregnant with a viable fetus, and the refusal of treatment endangers the fetus; or • is a single parent of a minor dependent child, and the refusal may result in death, leaving the child a ward of the government.
Incapacitated Adult Patient	The refusal of the following persons will be respected in order of priority*: 1) agent named in a Medical Power of Attorney, unless the court limits the agent's authority and appoints a guardian. 2) legal guardian 3) surrogate decision-maker	The refusal of the following persons will be respected in order of priority: 1) agent in Medical Power Of Attorney*, unless the court limits the agent's authority and appoints a guardian. 2) a court of record through a court order.**
Minor Patient	The refusal of the patient's parent/conservator/guardian will be respected	The refusal will only be respected if from a court of record through a court order. **

*A refusal made by an agent named in a medical power of attorney, guardian, or surrogate decision-maker is ineffective if the adult patient objects, regardless of the adult patient's competency at the time of the objection.

**Person/agency appointed cannot consent to or refuse medical care unless the court's order expressly authorizes any such decision.

III. PROCEDURE

A. The following steps are to be followed when GMHA is notified of a refusal of consent/treatment.

Responsibility Action	Responsibility Action
Health care team member	1. Informs the attending physician of the refusal.
Attending physician	1. Discusses the circumstances of the refusal with the patient or his/her representative to include: • the diagnosis • the explanation of the proposed treatment • the consequences of the refusal 2. Determines if the refusal is effective and should be respected. *Note: If **an agent identified** in a medical power of attorney is the source of refusal, review the medical power of attorney to determine whether the patient a) has granted the agent broad decision-making authority or limited decision-making authority; b) has referenced urgent/emergent treatments in general or specifically the administration of blood/blood components. If the source is **a guardian identified in a court order**, review the court order to determine if the court order expressly*

	authorizes the guardian to consent to and/or refuse care. These documents should be copied and placed in the patient's medical record. 3. Obtains appropriate signature on the "Refusal to Permit Recommended Procedures" form. If the refusal is for the administration of blood/blood components, obtains the appropriate signature on the "Refusal to Permit Blood Transfusion/Release of All Claims" form. 4. If the refusal is not made by an appropriate authorizing source and the condition requires urgent/emergent medical treatment, notifies the Social Services Department to assist in obtaining an authorized representative. 5. Documents all of the above information into the patient's medical record.
Social Services Department	1. Notifies the appropriate local agency and provides the following information: • patient's name, age, diagnosis, and proposed treatment plan; • that the patient is a minor or an incapacitated adult; • medically requires urgent/emergent medical treatment; • a statement that the refusal will lead to death or serious harm to the patient. 2. Documents all of the above information into the patient's medical record.

B. Documentation of Guardianship Process

1. The attending physician will document in the patient's medical record:

   a. local agency contacted;
   b. the name and title of the individual representing that agency;
   c. that the individual is authorized to speak for the agency;
   d. whether or not the agency will take temporary guardianship over the patient; and,
   e. if yes, whether or not the agency will consent to or refuse the urgently/emergently required medical treatment, including administration of blood/blood components.

2. The Social Worker will obtain copies of any court documents generated in the process of obtaining a Patient Representative and place these in the patient's medical record as soon as possible.

C. Unable to Obtain Guardianship

If the appropriate local agency declines to take temporary guardianship over the patient, the attending physician should contact the Hospital Administrator On-Call, who will

consult with the Hospital Risk Management Program Officer regarding the possibility of a petition for an attorney ad litem for the patient.

D. Rendering Emergency Care

In the event that the incapacitated adult or minor patient's status deteriorates to the point that death or irreparable harm will result unless the urgent/emergent medical care is instituted immediately, two physicians can determine the need for emergency care. Prior to commencing such care, the physician should inform the patient's reasonably available family that the care will be provided despite their objections.

E. Offender Patients

Refusals made by patients under the care and custody of either the Guam Police Department or the Department of Corrections are not absolute and, in all cases, will be weighed against legitimate interests, including the security and orderly operation of the correctional facility. Such decisions made by an offender patient shall be communicated to the Agency Head of those institutions.

REFERENCES:

Centers for Medicare and Medicaid (CMS) Patients' Rights Condition of Participation 42 CFR 482.13(b)(2)

The Joint Commission. Rights and Responsibilities of the Individual. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Chicago, IL: The Joint Commission.

RELATED POLICY:

Policy No. A-RI200, *Patient's Rights and Responsibilities*, of the GMHA Administrative Manual.

RESCISSION:

Policy No. A-RI300, *Informed Consent Process*, of the GMHA Administrative Manual made effective April 2013.

ATTACHMENT:

I. INTERVENTIONS REQUIRING WRITTEN INFORMED CONSENT
II. 19 GUAM CODE ANNOTATED SECTION 1111

ATTACHMENT I

Consent should be obtained for all major therapeutic and diagnostic procedures where disclosure of significant medical information, including major risks involved, would assist a patient in making an intelligent decision whether to undergo the proposed procedure. Such procedures include (this list is *not* all-inclusive):

1. Surgical Procedures (not including simple laceration repair or minor dermatological procedures performed in an out-patient setting);
2. Experimental procedures or treatments;
3. Abortions;
4. Testing for human immunodeficiency virus (HIV)
5. Blood and blood product use (including blood donation and autologous and other blood transfusions);
6. Neuroleptic medication when prescribed for the treatment of mental illness or mental retardation (but not when prescribed for other purposes);
7. Any medical treatment necessary to preserve the life or health of a patient;
8. Cancer chemotherapy
9. Radiation therapy;
10. Invasive medical imaging;
11. Major radiologic and/or imaging procedures involving the use of contrast media;
12. Procedures involving moderate to deep sedation where there is a risk of loss of protective reflexes (Note that a separate anesthesia-specific consent form is required);
13. Circumcisions;
14. Sterilization (Federal and local regulations require additional documentation for consent for sterilization);
15. Surgical or other invasive procedures are those involving a skin incision or puncture including, but not limited to: open surgical procedures, percutaneous aspiration, selected injections, biopsy, percutaneous cardiac and vascular diagnostic or interventional procedures, laparoscopies, endoscopies, and excluding venipuncture or intravenous therapy. Specific examples of other invasive procedures for which written informed consent is required are as follows:
    a. Injections of any substances into a joint space or body cavity;
    b. Percutaneous aspiration of body fluids through the skin (e.g., arthrocentesis, lumbar puncture, paracentesis, thoracentesis, suprapubic catherization);
    c. Biopsy (e.g., breast, liver, muscle, kidney, genitourinary, prostate, bladder, skin);
    d. Cardiac procedures (e.g. cardiac catheterization, cardiac pacemaker implantation, angioplasty, stent implantation, intra-aortic balloon catheter insertion);
    e. Central vascular access device insertion (e.g. Swan-Ganz catheter, percutaneous intravascular catheter (PIC) lines, Hickman catheter);
    f. Electrocautery of skin lesion;
    g. Endoscopy (e.g. colonoscopy, bronschoscopy, esophagogastric endoscopy, cystoscopy, Percutaneous Endoscopic Gastrostomy (PEG), and J-tube placements, nephrostomy tube placements);
    h. Laparoscopic surgical procedures (e.g. laparoscopic cholecystectomy, laparoscopic nephrectomy);
    i. Invasive radiology procedures (e.g. angiography, angioplasty, percutaneous biopsy);
    j. Laser therapy (e.g. eye, ear, nose and throat (EENT));
    k. Dermatology Procedures (biopsy, excision and deep cryotherapy for malignant lesions – excluding cryotherapy for benign lesions;
    l. Invasive ophthalmic procedures;
    m. Oral surgical procedures including tooth extraction and gingival biopsy;
    n. Skin or wound debridement performed in the operating room; and
    o. Extracorporeal and peritoneal dialysis.

ATTACHMENT II: *19 GCA Section 1111*

§ 1111. Legal Capacity of Minor Regarding Medical Care.

(a) **Definitions.** For the purpose of this Chapter, the following terms shall be defined as follows:

(1) *Minor* shall be any person under the age of eighteen (18).

(2) *Parent* means the natural and the legal parent and any guardian, custodian or step-parent acting in loco parentis.

(3) *Medical care and services* mean the diagnostic examination, prescription and administration of medication and other items in the treatment of sexually transmitted diseases, the HIV virus, or AIDS, pregnancy and substance abuse. It shall not include surgery or any treatment to induce abortion.

(4) *Substance abuse* means any excessive use or misuse of substances that lead to intoxication, psychiatric disorder, physical disease, social dysfunction associated with dependency and damage to health, social or vocational adjustment.

(5) *Sexually transmitted disease* means any disease that is transmitted through sexual contact.

(b) **Consent Valid**. The consent to the provision of medical care and service by public and private hospitals or public or private clinics, or the performance of medical care and services by a physician licensed to practice medicine or osteopathy, when executed by a female minor who is or professes to be pregnant, or by a minor who is or professes to be afflicted with or is concerned with being afflicted with a sexually transmitted disease, the HIV virus, or AIDS, or by a minor who suffers or professes to suffer from a substance abuse shall be valid and binding as if the minor had achieved his or her majority as the case may be; that is, a female minor who is or professes to be pregnant, or a minor who is or professes to be afflicted with or is concerned with being afflicted with a sexually transmitted disease, the HIV virus, or AIDS, or a minor who suffers or professes to suffer from substance abuse, or a minor who requests, shall be deemed to have and shall have the same legal capacity to act, and the same legal obligations with regard to the giving of such consent to the provision of medical care and services by such hospitals and such clinics, and such physicians as a person of full legal age and capacity, the infancy of the minor and any contrary provision of law notwithstanding, and such consent shall not be subject to later disaffirmance by reason of such minority, and the consent of no other person or persons (including, but not limited to a spouse or parent) shall be necessary in order to authorize the provision of medical care or services by such hospitals and such clinics and by such physicians to the minor.

(c) **Providing Information**. Public and private hospitals, or public and private clinics or physicians licensed to practice medicine or osteopathy, shall not inform the spouse or parent of any minor patient of the provision of medical care and services to the minor or disclose any information pertaining to such care and services without the specific consent of the minor patient to whom such medical care and services have been provided under this Chapter.

(d) **Financial Responsibility**. A minor who consents to the provision of medical care and services shall thereby assume financial responsibility for the costs of such medical care and services. Notwithstanding any other law to the contrary, parents, governmental agencies or third party payers whose consent has not been obtained or who have no prior knowledge that the minor has consented to the provision of such medical care and services, shall not be liable for the costs incurred by virtue of the minor's consent.

(e) **Patient Counseling**. The treatment of sexually transmitted diseases, the HIV virus, or AIDS, pregnancy and substance abuse, shall include individual counseling for each minor patient by a qualified person. Such counseling shall seek to open the lines of communication between parent and child.

(f) This Act shall take effect immediately.

SOURCE: CC § 37A enacted by P.L. 13-020:2 (May 23, 1975). Subsection (a)(3) amended by P.L. 22-084:2 (Mar. 3, 1994). Subsection (a)(5) added by P.L. 22-084:5 (Mar. 3, 1994). Subsection (b) amended by P.L. 22-084:3 (Mar. 3, 1994). Subsection (e) amended by P.L. 22-084:4 (Mar. 3, 1994).