INFORMED CONSENT

An In-Service Seminar Presented to
The Greenville Hospital System
By
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INFORMED CONSENT IN SOUTH CAROLINA

A. Consent Generally – At common law, consent is required before a person may lawfully “touch” another person. Touching without consent constitutes the intentional tort of battery. Since most medical procedures involve touching, consent is required before a procedure may lawfully take place. There are limited exceptions to this requirement noted below.

Informed Consent is consent given by a patient after receiving adequate information from a health care provider concerning the patient’s medical condition, range of possible treatment, and alternative options.

B. Legal Standard – In South Carolina, *Hook v. Rothstein* establishes the standard for informed consent. The patient must be informed of:

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“Those communications a reasonable medical practitioner in the same branch of medicine would make under the same or similar circumstances”

To prove liability for lack of informed consent, patient must show a causal connection between the physician’s failure to obtain informed consent and the patient’s injury. *This connection exists only if a person in the patient’s position would have refused treatment had he/she been told of the risk that resulted in the injury.*

How long is consent valid? There are no statutory rules. Great care should be taken to ensure that the conditions stated in the legal standard above are still met if some time has passed since the patient gave consent. If any of the above factors have changed, or if sufficient time has passed that a reasonable person would not remember the details from the conversation about consent, new informed consent should be obtained.

C. Hospital and Physician Obligations –

The hospital is charged with ensuring that procedures are performed with the informed consent of the patient. **It is the physician’s duty to obtain the consent!** Hospital forms are merely an affirmation that physician has already obtained the informed consent.

If staff has reason to believe a physician has not obtained informed consent, patient should not sign the hospital consent until the physician has properly obtained informed consent.
Hospital liability arises not from lack of informed consent, but from negligence in allowing a procedure to occur without proper consent. Physician liability can arise independently for failure to obtain informed consent of patient to the procedure.

HCFA Conditions of Participation for Hospitals – The newly revised COP’s for hospitals participating in the Medicare program require that patients have the right to participate in the development and implementation of their care plan. (Making informed decisions regarding their care) Under this new regulation, patients have the right to:

1. be informed of their health status;
2. be involved in care planning and treatment;
3. request or refuse treatment;
4. formulate advance directives;
5. have practitioners and staff provide care that is consistent with these directives, and
6. have a family member or representative and his or her own physicians notified promptly upon their admission to the hospital, even if the physicians are not on staff at the hospital or are located in another town.

It is inconsistent with this regulation to notify a competent patient’s relatives or others of the patient’s status and refuse or neglect to tell the patient about his status.

D. Adults

1. **Consent Under the Adult Health Care Consent Act** (S.C. Code § 44-66-10, et. seq.)

   The Act applies to adults (18 and over) and to minors who are married or judicially emancipated.

   The Act creates a legal “safe harbor” for providers who are seeking informed consent from someone other than the patient. This means that providers who follow the statutory framework are not subject to civil or criminal liability or disciplinary action on account of their reliance on the consent given by a surrogate. Providers may still face liability for providing care in a negligent manner (malpractice).

   The Act applies only if patient is “unable to consent” under the statute, meaning:

   a. patient cannot appreciate the **nature and implications** of his condition and **proposed care**;

   b. cannot make a **reasoned decision** concerning proposed care; or
c. cannot communicate his decision concerning proposed care in an unambiguous manner.

“Inability to consent” is determined:

a. by 2 licensed physicians, each of whom have examined the patient, or
b. in an emergency by a physician who certifies in writing that the delay in getting two doctors would be detrimental to the patient’s health.

Those certifying inability to consent must give opinion re:

a. cause and nature of the patient’s inability to consent;
b. extent of the patient’s inability to consent (i.e. all decisions, some more complex decisions); and
c. probable duration of the condition giving rise to the inability to consent.

Finding of inability to consent allows a “surrogate” to consent on patient’s behalf to health care procedures.

“Health care” means a procedure to diagnose or treat human disease, ailment, defect, abnormality, or complaint, whether of a physical or mental origin. Also includes the provision of intermediate or skilled nursing care, rehabilitation services and placement in a facility providing this type of care.

Order of priority for selecting surrogate decision-makers:

1. guardian appointed by Probate Court, if within scope of appointment;
2. attorney-in-fact (agent) appointed by patient under a health care power of attorney, if within scope of agency;
3. anyone otherwise given authority by statute;
4. spouse (unless divorced, signed written property or marital settlement agreement, or legally separated);
5. parent or adult child;
6. adult sibling or grandchild, or grandparent;
7. any other relative (blood or marriage) who physician reasonably believes has a close personal relationship with patient;
8. a person given authority to make health care decisions under a statutory provision placing them in last priority (refer to mental retardation discussion, supra).

**Special Rules and Traps for the Unwary:**

Be careful about “common-law” spouse. To be common-law spouse, must be evidence of parties living together and holding themselves out as a married couple. Statements such as “we were going to get married next summer” negate common-law marriage. Cohabitation does not equal common-law marriage. Ask how long couple has been living as husband and wife, or do you consider yourselves married. Common-law spouse equals “spouse” under #4 above.

A surrogate is not required to act if he or she is unwilling to make decisions on the patient’s behalf (can pass to another surrogate).

A provider cannot give priority to a surrogate if the patient, while competent, told provider he/she did not want that person involved in decisions related to health care.

A provider cannot render treatment – even with the surrogate’s consent or insistence – that the provider knows is against patient’s religious beliefs or that is contrary to the patient’s prior unambiguous or uncontradicted instructions. Example: Jehovah’s Witness with directive concerning blood or other patient with written instructions about health care found during admission.

The surrogate must make decisions for the patient based on patient’s wishes, to extent those can be determined. If the patient’s wishes cannot be determined, the surrogate must make decisions in keeping with the patient’s best interests.

**Remember: The surrogate has right to consent OR withhold (refuse) consent to health care on the patient’s behalf!**

2. **Consent under the SC Health Care Power of Attorney Law** (S.C. Code § 62-5-504)

A health care power of attorney is a type of “durable” power of attorney, meaning it survives the incompetency of the maker (the principal).

The instrument must be signed, dated and witnessed by 2 people. It does not have to be registered with the County RMC.

The two witnesses must be at least 18 years old, legally competent, and must certify in writing that they are not related to principal, not directly financially responsible for principal, not entitled to estate on death, not life
insurance beneficiary, not agent or successor agent, and are not creditors of the principal’s estate.

As to health care providers:

a. only one witness can be employee of health care facility; and

b. attending physician or employee or spouse thereof (unless the employee or spouse is also a relative of the patient) **cannot** be a witness.

A durable health care power of attorney is effective only upon and during the incapacity of the patient. Incapacity determined exactly as under Adult Health Care Consent Act, with these minor differences:

a. two persons must make certification of incapacity, one must be physician or in emergency, another health care professional responsible for the patient’s care; and

b. certification must state cause and nature of incapacity, its extent, and its probable duration; and

c. if certification does not state incompetence is permanent or of an extended duration, further certification is needed in regard to the categories of health care decisions the patient is unable to make during the period of incompetence.

The standard form durable health care power of attorney includes options for organ donation, preferences regarding artificial life support (“living will” language), and hydration-tube feeding.

If the agent appointed under the durable health care power of attorney is unavailable, switch to the next surrogate with priority under the Adult Health Care Consent Act.

Health care providers MUST follow agent’s directives unless:

a. patient is pregnant – life-sustaining procedures cannot be withdrawn or withheld during pregnancy; agent may make other obstetric and health care decisions; or

b. provider believes the agent’s decision is inconsistent with the health care power of attorney (outside the document’s scope of authority) – Provider may petition the probate court for order determining agent’s authority to give directive; or

c. patient has a Living Will – living will has priority where it applies (life-sustaining procedures where patient has a terminal condition).
A durable health care power of attorney can be revoked by:

a. the written or oral statement of the patient OR the patient’s actions constituting notice to agent or to provider responsible for patient’s care of the [patient’s specific intent to revoke; or

b. the patient’s execution of a subsequent health care power of attorney or subsequent durable power of attorney stating intent to revoke or being inconsistent with prior power of attorney.

Special Rules and Traps for the Unwary:

SC has a form approved by the State Legislature. If a patient’s health care power of attorney not in approved form, it must be substantially similar, meaning the instrument must have language stating the powers given by the principal to the agent survive incompetency, AND that agent specifically has authority to make health care decisions. Some general powers of attorney – particularly those limited to financial decision-making and real property transfers are insufficient for this purpose.

If hospital is made aware of revocation, it must immediately record the revocation in the chart and notify the agent, the attending physician, and all other providers responsible for patient’s care.

Like the Adult Health Care Consent Act, the durable health care power of attorney statute provides immunity for those providing care in good faith reliance on the agent’s decisions. The immunity applies to civil and criminal actions, as well as disciplinary action by licensing boards.

Transfer – If provider refuses to follow agent’s directives, must transfer to provider who will.

Conscience Clause – Provider must make a reasonable effort to comply with directive to withhold or withdraw life-sustaining treatment without participation of employee who does not wish to participate.

Living Wills (S. C. Code § 44-77-10 et.seq) – These advance directives apply only when the patient has a “terminal condition” and the issue is whether “life-sustaining treatment” will be administered or withheld. These documents constitute advance consent or refusal to consent to that treatment based on operation of law.

“Terminal condition” means an incurable or irreversible condition that within reasonable medical judgment could cause death within a reasonably short period of time if life-sustaining procedures are not used.
“Life-sustaining procedures” means any medical procedures or intervention which would only serve to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not the procedures are utilized. Life sustaining procedures do not include the administration of medication or other treatment for comfort care or the alleviation of pain.

There is a statutory form for living wills in South Carolina. Other documents may be treated as a living will if they are in substantially similar form to the statutory form.

For purposes of consent, these end of life directives instruct providers to not provide life-sustaining procedures and constitute a refusal to consent. Be aware however, that under these forms a patient must affirmatively state that they do not want artificial nutrition and hydration. If they do not indicate their preference, artificial nutrition and hydration must be provided if medically appropriate.

E. **Minors** – if less than 18 years of age, parents or legal guardian must consent to any procedure except:

1. **Necessary Services.** Health services of any kind may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional medical judgment of the provider legally authorized to perform the service, the service is deemed necessary. If the necessary service involves an operation, the operation may only be performed without consent if the operation is essential to the life of the minor in the opinion of the physician performing the operation and, if available, a consultant physician. (S.C. Code § 20-7-290)

2. **Minors 16 or Older.** A minor 16 or older may consent to any health services unless the service is an operation. Operations require parental consent or may be performed without consent if the operation is essential to the life of the minor in the opinion of the physician performing the operation and, if available, a consultant physician. (S.C. Code § 20-7-280).

3. **Married minors and their spouses.** Married minors may consent to diagnostic, therapeutic, surgical or postmortem procedures, regardless of their age. (S.C. Code § 20-7-270) If the minor is unable to consent, the minor’s spouse, regardless of age, has the legal authority to consent to treatment for the minor. If the minor is unable to consent and the minor’s spouse is unavailable, then necessary care may be provided without consent, as can essential surgical care; other treatment decisions should be made by the legal surrogate determined in accordance with Adult Healthcare Consent Act. In special situations where neither the minor nor the minor’s spouse will consent to necessary treatment, Risk Management should be contacted immediately to assist in formulating an appropriate medical response.
4. **Children Born to Minors.** Minors may consent to health services for their children. (S.C. Code § 20-7-300) If the child is legitimate, either parent’s consent will suffice. If the child is illegitimate, only the mother may consent.

5. **Parents Withholding Necessary Care.** Parents may not withhold consent to medical care for their minor children in a manner that endangers the health and welfare of a minor child. The child abuse reporting statutes allow DSS to indicate such a case for medical neglect. Where consent is withheld for religious reasons or other reasons reflecting an exercise of judgment by the parent as to the best interest of the child, the Children’s Code also permits DSS to petition the Family Court for an order finding that care is necessary to prevent death or permanent harm to the child. **NOTE:** In instances where care is, in the provider’s opinion, “necessary” the law also permits the provider to act without consent. The minor patient’s parent should be advised of the provider’s treatment decision and advised that the provider intends to render medically necessary care over the parent’s objection.

6. **Minors Under the Care or Custody of a Non-Parent.** If the child is under the care or custody of a non-parent (e.g. foster parent, DSS caseworker, DMH caregiver, Shriner’s inpatient), the minor patient’s chart should reflect the non-parent’s legal authority to consent for the child. This could be met by confirming the legal custodial or guardianship status of the non-parent (e.g. contacting a DSS caseworker or the Family Court to establish the foster parent’s legal custody), or obtaining a copy of an authorization signed by the patient’s parent or guardian.

**F. Guardianship / Incapacity**

An adult incapacitated person or anyone interested in his welfare can petition the Probate Court for a finding of incapacity and the appointment of a guardian.

Once a petition is filed, the Probate Court:

1. sends a visitor to the patient’s residence to observe conditions and report back to the Court;
2. sets a hearing on the issue of incapacity and, unless the patient has chosen his own counsel, appoints counsel to represent him;
3. the patient is examined by two physicians, one of whom is court appointed; these physicians submit written reports to the Court;
4. the Court will give notice to the patient, his spouse, parents and/or children (or if none are found, his closest adult relative), the person to be appointed guardian and (if applicable) the person currently serving as the patient’s attorney-in-fact, conservator or custodian.
The Court may appoint a guardian as requested if it is satisfied that the patient is incapacitated and that the appointment is necessary or desirable as a means of providing continuing care and supervision for the incapacitated person.

Any competent person or an institution may be appointed guardian of an incapacitated person. Subject to good cause disqualification by the Probate Court, the following persons have priority for appointment as guardian:

1. a person nominated by the incapacitated patient;
2. a person serving as the patient’s agent under a durable health care power of attorney;
3. the patient’s spouse (the common law spouse has the burden of proving that status to the Court);
4. the patient’s adult child;
5. the patient’s parent, including someone nominated in a deceased parent’s will to care for their incapacitated child;
6. another relative of the patient; or
7. someone nominated by the person who is caring for the patient or paying benefits to the patient.

The Court may create a limited guardianship by limiting the powers conferred upon the guardian.

In an emergency the Court may appoint a temporary guardian upon a physician’s certification that the person is incapacitated and in need of immediate attention. The Probate Court itself may act as a temporary guardian when no person appears to have authority to act for the patient or two or more persons authorized to act for the patient disagree on care to be provided and a physician certifies the patient is incapacitated and that an emergency exists.

The Probate Court may relieve a guardian when the Court finds the appointed guardian or temporary guardian is not effectively performing his duties. A temporary replacement guardian may be appointed if the patient needs immediate attention.

G. Mentally Retarded / Mental Health Patients

1. **Adult Patients in SCDDSN Residential Program.** The ability of each client that resides in a SCDDSN facility to consent to or refuse major medical treatment must be evaluated by the provider prior to rendering service. The Adult Healthcare Consent Act standard for “ability to consent” is applicable in making this determination. “Major medical treatment” is defined to include “a medical, surgical, or diagnostic intervention or procedure proposed for a person with mental retardation or a related disability, where a general anesthetic is used or which involves a significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation, or having a significant recovery period. It does not include routine diagnosis or treatment such
as the administration of medications or nutrition or the extractions of bodily fluids for analysis or dental care performed with a local anesthetic or a nonpermanent procedure designed for the prevention of pregnancy.” (SC Code of Laws, §44-26-10(10).

2. **Minor SCDDSN Clients.** Health care decisions are made for minors who are clients of SCDDSN by the following persons in the following order of priority:

   a. legal guardian;
   b. parent;
   c. grandparent or adult sibling;
   d. other relative by blood or marriage who the provider believes has a close personal relationship with the minor patient;
   e. any other person believed to have a close personal relationship with the minor patient;
   f. an authorized designee of the SCDDSN.

   If persons of equal priority disagree over whether certain care should be provided to the minor patient, the provider or any other person interested in the minor's care may petition the Probate Court for an order determining what care will be provided, or for an order appointing a temporary or permanent guardian.

   In an emergency a minor client of SCDDSN may receive medically necessary care without consent.

3. **Adult Patients of DMH (Non-Residential, Non-Committed).** A Department of Mental Health patient in need of electro-convulsive therapy or major medical treatment must be examined first by a qualified physician to determine if the patient is able to consent. The patient’s ability to consent must be determined consistent with the procedure outlined in the Adult Health Care Consent Act, and must be documented in the patient’s chart. “Major medical treatment” is defined to include a medical, surgical, or diagnostic intervention or procedure where a general anesthetic is used or which involves significant invasions of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation, or having a significant recovery period. It does not include a routine diagnosis or treatment such as the administration of medications or the extraction of bodily fluids for analysis, dental care performed with local anesthetic, or the withdrawal or discontinuance of medical treatment which is sustaining life functions.” (SC Code of Laws, §44-22-10(8).

   Where the DMH patient is determined unable to consent, decisions concerning the need for treatment may be made in accordance with the same priorities established for surrogates under the Adult Health Care Consent Act. (SC Code of Laws, §44-22-40)
If surrogates of equal priority disagree over whether certain care should be provided to the DMH patient, the provider or any other person interested in the patient’s care may petition the Probate Court for an order determining what care will be provided, or for an order appointing a temporary or permanent guardian.

4. **Adult Patients Committed to Department of Mental Health Facilities.** Competent DMH facility inpatients may not receive treatment or medication in the absence of their express and informed consent in writing, except (a) treatment during an emergency situation if the treatment is pursuant to physician order, or (b) as permitted by court order. DMH facility inpatients or their legal guardians may refuse treatment not recognized as standard psychiatric treatment, and may also refuse electro-convulsive therapy, aversive reinforcement conditioning, or other unusual or hazardous treatment procedures. If the patient’s attending physician decides electro-convulsive treatment is necessary, he must enter a statement of the reasons for such treatment in the patient’s record. If the patient is unable to consent to the treatment, permission must be sought from a surrogate as described in Section 3, *supra* concerning DMH patients generally.

**H. DNR Orders**

DNR Orders constitute the corollary of informed consent – they are informed refusal. DNR Orders should only be entered following a discussion with the patient where the standards of *Hook v. Rothstein* are covered, **BY A PHYSICIAN**, and the record is fully documented that this conversation has occurred.

For patients who are unable to consent, and there is no written document from the patient such as a Living Will or Health Care Power of Attorney, the provider is best advised to follow the Adult Health Care Consent Act to enter a DNR Order because of the immunity provisions available to physicians, staff, and the hospital under the Act.

If the provider cannot locate a surrogate with priority, great care should be exercised in entering a DNR Order on a patient who is unable to consent. Here, the record should be fully documented **BY THE PHYSICIAN** as to why the order was entered in the absence of informed refusal on medically reasonable grounds.

**I. Oral or Written Advance Directives**

Sometimes patients will state their intentions about some care, such as life-sustaining procedures to their caregivers or in written documents kept at home or on their person. These statements amount to directives about care that can have legal import. The statements can concern care that a patient does not want to receive, as well as care a patient does want to receive. These statements should be documented in the record as to date, time, circumstances of the statement, and whether the information has been communicated to the attending physician and nursing staff.
Any ambiguity these statements present in terms of the patient’s present medical condition or treatment plan should be resolved immediately with the patient.

J. **DNR Orders During EMS Transport**

The SC Legislature has enacted a provision allowing a patient to have a DNR order that will travel with the patient during transport by EMS services. These orders are available ONLY from a physician. The patient MUST have a terminal condition as defined in the Death with Dignity Act and the order only applies to resuscitative measures. Once the patient arrives in the ER or other endpoint of transport, the order is no longer effective.

K. **Advance Directives From Other States**

Sometimes a patient will present who has a document executed in another state that contains directions about preferred medical treatment under certain circumstances. In general, these documents are to be given full effect under South Carolina law if they are valid in the state where they were drawn.

Care should be taken to look for items such as missing signatures on witness blocks or blocks designed for the patient to sign, as well as reading the document to be sure that the particular class of procedure to be performed is contemplated by the document. Additionally, if the document purports to be a power of attorney, you should inspect the document to be sure the agent has in fact been given authority in the document to make health care decisions on behalf of the patient.

L. **Patients Under Conscious Sedation**

Patients under conscious sedation can potentially give consent if they meet the general standard of being able to communicate in a clear and unambiguous manner about their course of treatment. This is not likely. Every precaution should be taken to ensure that a patient has consented to a proposed procedure before conscious sedation or other anesthetic procedures are begun.

M. **Patients on PCA Pain Management**

Patients receiving PCA pain management should be evaluated at the time of proposed treatment to determine whether they are capable of giving consent. The standard set forth in the Adult Health Care Consent Act, supra Section D.1, should be used to determine the patient’s then current ability to consent. If the inability to consent arises due to the effects of the pain medication, the provider should assess whether the treatment can be delayed until such time as the patient is capable of giving consent. If the treatment cannot be so delayed, the Act should be followed in determining a surrogate decision-maker and obtaining consent from that individual.
N. Abortion and Sterilization

General rule is that a pregnant woman's consent is required in every case where she is capable of giving consent.

If the woman is adjudicated by the Probate Court as mentally incompetent, consent must be obtained from her spouse or her legal guardian. If unmarried, consent must be obtained from one parent or a legal guardian.

If the woman is a minor (legally incapable of giving consent to an “operation”), consent of the minor plus one of the following persons must be obtained:

1. one parent;
2. a legal guardian;
3. a grandparent;
4. any person standing in loco parentis to the minor for a period of not less than 60 days (must sign affidavit indicating nature and length of relationship with minor).

EXCEPTION #1: Competent, emancipated minor can give informed written consent on own.

EXCEPTION #2: Minor can seek court order to obtain abortion without consent of parent or legal guardian; patient should consult DSS or personal legal counsel for assistance.

Consent requirement may be waived for any patient if:

1. physician determines there is a medical emergency involving the life of the woman or grave physical injury to the woman; or
2. pregnancy is the result of incest; in which case physician performing abortion must report incest to DSS or law enforcement agency in county where woman resides or is found. Failure to report is a violation of the child abuse reporting law.

Failure to obtain consent is prima facie evidence of interference with family relations in a civil suit. Punitive damages can be awarded if case involves a minor.

Physician or other professional counseling a minor or discussing the issue of abortion must fully inform her of the consent procedures outlined above, and must make certain additional disclosures under new South Carolina "Women's Right to Know Act" (effective January, 1995):

1. The physician must inform the patient of "the probable gestational age of the embryo or fetus at the time the abortion is to be performed";
2. The physician or an allied health professional working with the physician must inform the patient of the procedure to be involved;

3. The woman must be presented with two booklets prepared by the State of South Carolina regarding fetal development and agencies that offer alternatives to abortion. This information can be mailed to the patient as long as she signs the form described below; AND

4. The woman must sign a form containing specific language prescribed by the Act. She must certify that the information and booklets described above were furnished to her at least an hour before the abortion was performed.

5. If the patient is an unemancipated minor, then the information must be furnished to and the certification must be signed by the minor's parent, legal guardian, grandparent or any person who has been standing in loco parentis to the minor for at least sixty (60) days.

6. If the patient is under adjudication of mental incompetency, the information must be furnished and offered respectively to her spouse or a legal guardian if she is married, if she is not married from one parent or a legal guardian. The spouse, legal guardian, or parent as appropriate must make the required certification.

7. The facility in which the abortion is performed maintains the signed certification for three years.

O. STERILIZATION

1. Federally Funded Sterilization

Elective Sterilization: The "Sterilization for Medicaid Recipients" consent form must be submitted with every billing for services related to an elective sterilization.

Consent Form Requirements: For Medicaid financial coverage of elective sterilization for male or female, the following requirements must be met:

a. The individual must have reached her 21st birthday at the time the consent form is signed.

b. The individual cannot be institutionalized or mentally incompetent.

c. The individual must voluntarily give informed consent. An individual has given informed consent only if an offer has been made to allow a witness of the recipient's choice to be present during the consent interview. A copy of the consent form must be given to the individual. Additionally, all topics covered in the consent form must be discussed orally between the individual and the person obtaining the consent.
Informed Consent may not be obtained while the individual to be sterilized is:

a. in active labor or childbirth;
b. seeking to obtain or obtaining an abortion; or
c. under the influence of alcohol or other substances that affect the individual's state of awareness.

Waiting Period. At least 30 days, but not more than 180 days, must pass between the signing of the informed consent and the date of the sterilization procedure, subject to exceptions in cases of emergency.

The required consent form must be signed and dated by:

a. (Part I) The individual to be sterilized.
b. (Part II) The interpreter, if one was provided.  
   NOTE: Parts I and II must be signed on the same date.
c. (Part III) The person who obtained consent. NOTE: Must be signed prior to surgery.
d. (Part IV) The physician who performed the procedure. NOTE: Must be signed after procedure is completed.

2. **Medically Necessary Sterilization:** For medically necessary sterilization the consent form is not required.

3. **Minors and Mentally Incompetent Patients:** The Hospital does not perform non-therapeutic sterilization on minors and persons who are mentally incompetent. Cases involving the therapeutic sterilization of a minor or mentally incompetent patient require consent of the parent or legal guardian, or an order from the Family or Probate Court. In the event judicial consent cannot be obtained due to time constraints, the attending surgeon must consult with another physician to document that the procedure is essential to the health and life of the patient; a statement to this effect must be recorded in the child's medical record.

**P. ORGAN DONATION**

Written consent must be obtained from the next-of-kin before organ or tissue donation can occur if the decedent has not indicated whether he wishes to donate his organs and/or tissue.

S.C. Uniform Anatomical Gift Act provides that any individual of sound mind and eighteen years of age or more may give all or any part of his body, the gift to take effect upon death. If a deceased patient has made an inter vivos gift of all or any part of his body either by will or by other written document (including an organ donation card), next-of-kin consent is not necessary. A copy of the document indicating the gift should be made part of the patient's medical record.
In the absence of a pre-death gift by the decedent, next-of-kin that may consent to organ or tissue donation are, in order of priority:

1. An agent under a health care power of attorney (if within the scope of the agent's powers);
2. the patient's spouse;
3. the patient's adult son or daughter;
4. either parent of the patient;
5. any of the patient's adult siblings;
6. the patient's guardian;
7. any other person authorized or under obligation to dispose of the body, which might include grandparents, uncles and aunts, or cousins.

If the hospital or other donee of the organ(s) has actual notice of contrary intentions by the decedent, or that a member of the same or a prior class opposes a gift by a member of a class of next-of-kin, the gift cannot be accepted. In addition, a donor may amend or revoke a gift in the manner set forth in the Uniform Anatomical Gift Act. (S.C. Code § 44-43-370)

If a death is under the jurisdiction of the medical examiner or coroner, written or verbal permission must be obtained from that office before organ or tissue recovery commences.

If a deceased person has left no directions for organ donation, before harvesting organs following an autopsy, the party allowed to consent must give "informed consent" after a face to face meeting with a physician, or if the person is unavailable for a face-to-face meeting, after a recorded telephonic communication with a physician. The medical record should contain careful documentation of these events. (S.C. Code § 44-43-720)

In all instances the consent to organ donation should specify clearly which organs and/or tissues are being donated. It should be clear to the person consenting to the donation what is involved in the donation procedure (i.e. removal of bones for bone marrow donation). The original signed consent form should be included as part of the donor's medical record.

According to State law, a statement concerning whether a family is approached concerning organ or tissue donation and the reasons leading to that decision, as well as the disposition of any referral to an OPO and that organization's acceptance or rejection of the donor must be documented in the medical record of any patient who is identified by the Hospital as a potential organ or tissue donor. (S.C. Code of Laws, § 44-43-1000)
The Hospital Nursing Administrative Coordinator is responsible according to Hospital policy for assuring that proper consent and documentation is obtained for all organs or tissues to be procured.

A patient with a health care power of attorney can give his agent power to make anatomic gifts.