CONSENT BY FACSIMILE

Facsimiles are widely used for the transmission of documents from one point to another. As with other instances in which original documents are not available or personal contact is not possible, it is important to verify the identity of the person sending the facsimile transmission. If this can be done, then facsimile reproductions may be useful in the consent process.

If a facsimile is being used because the person who gives consent is not available at the hospital, then direct discussion by telephone with the person who gives consent should generally be possible and the discussion above, under "Consent by Telephone," applies. A facsimile can then be used by the patient's physician to transmit written information to the person who gives consent, and by the person who gives consent to send written verification of the consent given. Whenever possible, it is advisable to have the original of all signed consents sent to the hospital later. Messages, directions, or consent forms received by the hospital via facsimile should be handled as important business records and should be placed, together with transmittal cover sheets, in the patient's medical record. Care should be taken to ensure that confidential information transmitted in this manner is handled appropriately. Hospitals should develop policies in this regard.

V. SECURING CONSENT WHEN COMMUNICATION BARRIERS EXIST

If a patient or his or her legal representative cannot communicate with the physician because of language or communication barriers, the physician, with the hospital's assistance, should arrange for an interpreter. The interpreter's responsibilities will include translating the information regarding the recommended medical treatment that the patient or the patient's legal representative needs to receive before deciding whether to give consent, as well as instructions regarding medical care.

Similarly, vital documents, including consent forms, presented by hospital staff to a patient must be written in a language that the patient can understand or translated into such a language.

It is important for patients to be able to communicate with their health care providers. A hospital's failure to provide a competent interpreter, or to translate consent forms or other important documents, may result in misunderstandings, and increases the chance of a patient safety incident or medical error. Some limited English speaking patients in California have filed lawsuits alleging lack of informed consent because they did not understand the discussions with their health care providers and the consent forms they signed.

Hospitals are required to identify and document a patient's primary language *(see "Other Requirements," page 1.13)*, and should thoroughly document the provision of interpreter and translation services. If a limited English speaking patient chooses not to have an interpreter (because the patient believes he or she understands English sufficiently), the hospital should document the offer to provide an interpreter and the patient's decision.

A. STATE LAW REQUIREMENTS

Health and Safety Code Section 1259 requires licensed general acute care hospitals to adopt and annually review a policy for providing language assistance services to patients with "language or communication barriers" (as defined below). To the extent possible, the policy must provide for the use of "interpreters" (as defined below) whenever a language or communication barrier exists. Interpreters must be available, either on the premises or by telephone, 24 hours a day to the extent possible. A patient may, after being informed of the availability of the interpreter service, choose to use a family member or friend instead.

In addition to the above statute, hospital licensing regulations require that if language or communication barriers exist between hospital staff and a significant number of patients, arrangements must be made for interpreters or for the use of other mechanisms to insure adequate communications between patients and personnel [Title 22, California Code of Regulations, Sections 70721 (general acute care hospitals) and 71521 (acute psychiatric hospitals)].

DEFINITIONS

"Language or communication barriers" means:

1. With respect to spoken language, barriers that are experienced by individuals who are limited English speaking or non-English speaking individuals who speak the same primary language and who comprise at least 5 percent of the population of the geographical area served by the hospital or of the actual patient population of the hospital. (In cases of dispute, CDPH will determine whether the 5 percent population standard applies to a given hospital.)
2. With respect to sign language, barriers that are experienced by individuals who are deaf and whose primary language is sign language.

"Interpreter" means someone fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language. Interpreters must have the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages. Interpreters may include members of the medical or professional staff.

a copy of the "Informed Consent to Surgery or Special Procedure" (CHA Form 1-2), and a copy of a consent to arbitration form *(see IX. "Arbitration," page 8.10)* always be given to the patient.

A copy of any other form signed by the patient should be given upon request. Preferably, the patient's copy should be given to the patient at the time of signing, but in no event later than the time of discharge.

D. CONSENT BY TELEPHONE, EMAIL AND FACSIMILE

Consent for medical or surgical treatment should be obtained by telephone, email or facsimile only if the person(s) having the legal ability to consent for the patient is not otherwise available. If a telephone, email or facsimile is used, the responsible physician must, to the extent possible, provide the patient's legal representative with the information the physician would disclose if the person were present. Consent given by telephone, email or facsimile may be less beneficial in situations where informed consent is required.

CONSENT BY TELEPHONE

Physician Responsibility

The physician should follow the standard protocol for obtaining consent for the medical treatment. Depending upon the type of treatment to be provided, the physician may be required to discuss the nature of the treatment, its risks and benefits, alternatives and their risks and benefits, the consequences of refusing the treatment, and any potentially conflicting interests the physician may have (such as research or financial interests).

Hospital Responsibility

If the physician states that he or she has obtained consent to treat the patient, hospital personnel should verify that the patient's legal representative and physician have discussed the patient's condition and the recommended treatment and that the patient's legal representative has, in fact, given consent. If the treatment requires informed consent, hospital personnel should verify that the patient's representative has given informed consent *(see CHA Form 1-1, "Consent to Surgery or Special Procedure")*. However, hospital employees should not attempt to answer any questions concerning the nature of the treatment or its risks, benefits, and alternatives. These questions should be answered only by the responsible physician *(see C. "The Role of the Physician in Obtaining Informed Consent," page 1.6)*.

In addition to verifying consent to treatment, hospital personnel should also obtain the legal representative's agreement to the "Conditions of Admission" form (CHA Form 8-1) as discussed in chapter 8. *(See V. "Procedure for Completing the "Conditions of Admission" Form," page 8.5.)*

The telephone discussion between the patient's legal representative and a responsible hospital employee should be witnessed by a second responsible hospital employee. The exact time and nature of the consent should be carefully documented. The patient's legal representative must be informed that two hospital employees are on the phone. Both of the hospital employees who participate in obtaining the consent to the "Conditions of Admission" and verifying the consent to medical treatment should sign and date the documentation of the phone call and any forms involved, and all such documents should be placed in the patient's medical record.

NOTE: Steps should then be taken to confirm the consent by facsimile, email or by letter whenever possible. Such confirmation should be in the following general form and should contain the name of the person giving the consent and his or her relationship to the patient. A copy of the facsimile, email or letter should be attached to the "Conditions of Admission" form and placed in the patient's medical record.

> Confirm oral permission to treat [patient's name] given [date] on basis of discussion with [physician's name(s)].

CONSENT BY EMAIL

In limited situations, email may be a means of communicating with the person who is legally able to consent for a patient.

Consent for basic hospital services and medical treatment that do not require informed consent may be obtained by requesting an email in the following general form, followed by the name of the person giving consent and his or her relationship to the patient.

> I hereby grant permission to provide hospital services and medical treatment for [patient's name].

If informed consent is required, the responsible physician should make the request for consent by sending a message stating, to the extent practical, the reason for and nature of the treatment, the risks and benefits, the alternatives, and any potentially conflicting interests the physician may have (such as research or financial interests).

The consent should be made in the following general form, followed by the name of the person giving consent and his or her relationship to the patient.

> I hereby grant permission to treat [patient's name] on the basis of the email message from [physician's name] on [date].

A copy of the email should be attached to the "Conditions of Admission" form and placed in the patient's medical record.

REQUIRED POLICY

On or before July 1, 2016, and every January 1 thereafter, a hospital must send to the California Department of Public Health (CDPH) a copy of its updated policy and must include a description of its efforts to ensure adequate and speedy communication between patients with language or communication barriers and staff. This information should be sent to the local district office. CDPH will post these policies on its website.

REQUIRED NOTICES

Hospitals must develop and post in conspicuous locations notices that list the languages for which interpreter services are available and that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter, CDPH's telephone numbers where complaints may be filed concerning interpreter service problems (including a T.D.D. number for the hearing impaired) and the local address and phone number of CDPH's office. At a minimum, these notices must be posted in the emergency room, the admitting area, the entrance, and in outpatient areas.

WEBSITE REQUIREMENTS

On or before July 1, 2016, and every January 1 thereafter, hospitals must post their policy for providing language assistance services as well as a notice of availability of language assistance services on their web site. The notice must be in English and in the other languages most commonly spoken in the hospital's service area. The hospital must post the notice in the language of individuals who meet the definition of having a language barrier; however, a hospital is not required to make the notice available in more than five languages other than English.

OTHER REQUIREMENTS

Affected hospitals must:

1. Identify and record a patient's primary language and dialect in the patient medical record, and, if desired, on the hospital bracelet, bedside notice, or nursing card. [Health and Safety Code Sections 1259(c)(4) and 123147]
2. Prepare and maintain a list of interpreters who have been identified as proficient in sign language and in the languages of the population of the geographical area served by the hospital.
3. Notify employees of the hospital's commitment to provide interpreters to all patients who request them.
4. Review all standardized written forms, waivers, documents, and informational materials available to patients upon admission to determine which to translate into languages other than English.
5. Consider providing its nonbilingual staff with standardized picture and phrase sheets for use in routine communications with patients who have language or communication barriers.
6. Consider developing community liaison groups to enable the hospital and the limited English speaking and deaf communities to ensure the adequacy of the interpreter services.

Health and Safety Code Section 1259 states that noncompliance with its provisions is reportable to licensing authorities.

B. FEDERAL LAW REQUIREMENTS

Federal law requires hospitals (among other entities) that receive federal financial assistance (such as Medicare, Medicaid, grants or training funds) to take certain steps to ensure meaningful access for individuals with physical, cultural or linguistical barriers. Coverage extends to a provider's entire program or activity, i.e., to all parts of a provider's operations. This is true even if only one part of the provider receives the federal assistance.

Health care providers who do not receive federal financial assistance need not comply with these guidelines. Providers who receive only Medicare Part B funds also need not comply.

HEARING, VISION OR SPEECH IMPAIRMENT

Under the Rehabilitation Act of 1973, hospitals must provide interpreters and other aids for persons with hearing, vision or speech impairments, where necessary to afford such persons an equal opportunity to benefit from the hospital's services [45 C.F.R. Section 84.52(d)]. Hospitals must specifically establish a procedure for effective communication with hearing impaired persons for the purpose of providing emergency health care [45 C.F.R. Section 84.52(c)].

In addition, the United States Department of Justice (DOJ) has published regulations pursuant to Title III of the Americans with Disabilities Act (ADA) regarding auxiliary aids and services for persons who are disabled, including (but not limited to) persons with vision, hearing or speech impairments [28 C.F.R. Sections 36.303, 36.306 and 36.307]. The purpose of Title III of the ADA is to prevent discrimination on the basis of disability by places of public accommodation, including state and local governments, businesses, nonprofit organizations, and hospitals. The DOJ operates an information line to answer questions about the ADA at 800-514-0301.

This section of the manual focuses on the requirements regarding auxiliary aids and services for persons with impaired hearing or vision. These rules apply with respect to companions, such as family members, as well as to patients.

The ADA regulations apply to all hospital programs and services, including emergency room care, inpatient and outpatient services, surgery, clinics, educational classes, cafeteria and gift shop. Wherever patients, family members, companions or members of the public are interacting with hospital staff, the hospital is required to provide effective communication. For example, if a hospital offers a class on preparing for labor and birth to expectant parents, and a father needs a sign language interpreter in order to meaningfully participate, then the hospital must provide one. In addition, hospitals must provide auxiliary aids to allow family members to participate in treatment conferences. Hospitals should evaluate each situation on a case-by-case basis to determine patient and companion needs as well as the hospital's obligation, if any.

Hospitals may not charge patients or other persons a fee for interpreter services or other communication aids and services.

General Rule

A place of public accommodation, which includes a hospital, must take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently from other people because of the absence of auxiliary aids and services, unless:

1. The hospital can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered; or
2. The hospital can demonstrate that taking those steps would result in an undue burden, i.e., significant difficulty or expense.

If provision of a particular auxiliary aid or service would result in a fundamental alteration or an undue burden, the hospital must provide an alternative auxiliary aid or service, if one exists, that would not result in an alteration or burden but would nevertheless ensure that, to the maximum extent possible, disabled individuals receive the goods, services, facilities, privileges, advantages, or accommodations offered.

The law does not require a hospital to alter its inventory to include accessible or special goods that are designed for disabled persons. However, a hospital must order accessible or special goods at the request of a disabled person if, in the normal course of its operation, it makes special orders on request for unstocked goods, and if the accessible or special goods can be obtained from a supplier with whom the hospital customarily does business. (Examples of accessible or special goods include items such as Brailled versions of books, books on audio cassettes, closed-captioned video tapes, special sizes or lines of clothing, and special foods to meet particular dietary needs.)

Definitions

The term **"auxiliary aids and services"** includes:

1. Qualified interpreters on-site or through video remote interpreting (VRI) services; notetakers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;
2. Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;
3. Acquisition or modification of equipment or devices; and
4. Other similar services and actions.

"Companion" means a family member, friend, or associate of an individual seeking access to, or participating in, the goods, services, facilities, privileges, advantages, or accommodations of a public accommodation, who, along with such individual, is an appropriate person with whom the public accommodation should communicate.

Effective Communication

Hospitals must furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. This includes an obligation to provide effective communication to companions who are individuals with disabilities.

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with:

1. The method of communication used by the individual;
2. The nature, length, and complexity of the communication involved; and
3. The context in which the communication is taking place.