

Issues in Discharge Planning Risk Management

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I. Summary.

An increasingly aged population, combined with increases to longevity made possible by medical miracles, will continuously increase the ranks of patients who no longer need acute medical care, but who cannot care for themselves upon discharge.

In January, 2011, the first of the children born from the sea of returned WWII service people will turn 65. The majority will be eligible for Medicare and each of them will be potentially eligible for Medicaid by reason of their age.

Fractured social family systems, including increased divorces, geographically dispersed family care-givers, adult children with twin household incomes, decreased savings rates, and increased consumer debt, will continuously limit home based discharge options.

Discharge problems increase hospital costs and pressure on the social worker to discharge patients.

The social worker and hospital face malpractice liability for negligent discharges, which are discharges in which a failure to adhere to the reasonable practice in the community causes injury to the patient.

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II. Demographics = Destiny.

Table 1: Life Expectancy for Social Security¹				
Year Cohort Turned 65	Percentage of Population Surviving from Age 21 to Age 65		Average Remaining Life Expectancy for Those Surviving to Age 65	
	Male	Female	Male	Female
1940	53.9	60.6	12.7	14.7
1950	56.2	65.5	13.1	16.2
1960	60.1	71.3	13.2	17.4
1970	63.7	76.9	13.8	18.6
1980	67.8	80.9	14.6	19.1
1990	72.3	83.6	15.3	19.6

Table 2: Americans Age 65 or Older 1880-1990	
Year	Number of Americans Age 65 or Older
1880	1.7 million

¹ **Life Expectancy for Social Security**, <http://www.ssa.gov/history/lifeexpect.html>. The Social Security Administration states that this is an historical table and may not reflect current policies or procedures.

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1890	2.4 million
1900	3.0 million
1910	3.9 million
1920	4.9 million
1930	6.7 million
1940	9.0 million
1950	12.7 million
1960	17.2 million
1970	20.9 million
1980	26.1 million
1990	31.9 million
2000	34.9 million

I. The U.S. population age 65 and over is expected to double in size within the next 25 years.

A. By 2030, almost 1-out-of-5 Americans — some 72 million people — will be 65 years or older.²

² [65+ in the United States: 2005](http://www.census.gov/prod/2006pubs/p23-209.pdf) [PDF], was commissioned by the National Institute on Aging (NIA), a component of the National Institutes of Health (<http://www.census.gov/prod/2006pubs/p23-209.pdf>).

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B. The longevity of older Americans is increasing.

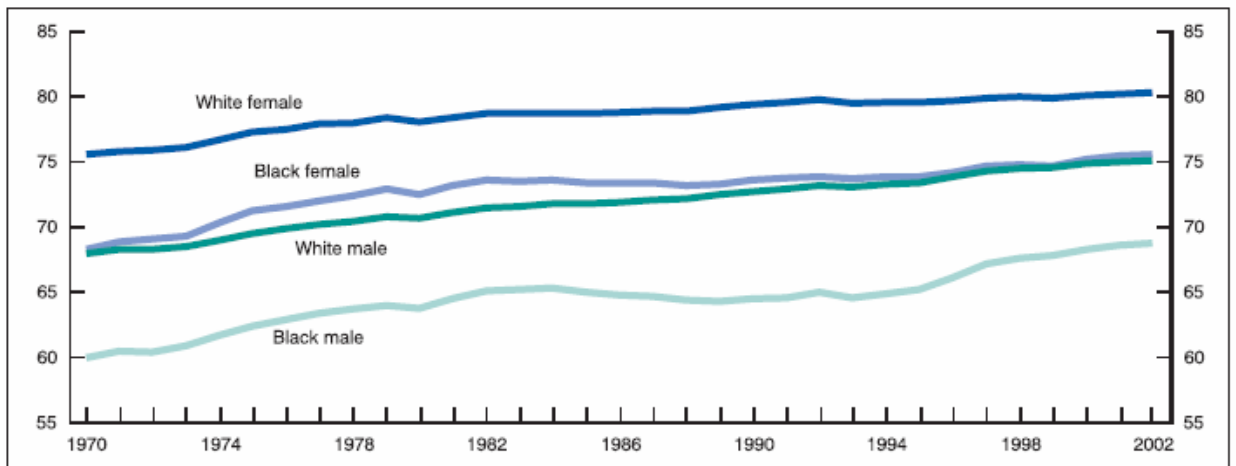


Figure 1. Life expectancy at birth by race and sex: 1970–2002

(Data: United States Life Tables, Volume 53, Number 6, 2002. Elizabeth Arias, Ph.D., Division of Vital Statistics, Centers for Disease Control of the United States)³

C. Longevity accompanies chronic medical conditions requiring care.

1. Many are disabled and suffer from chronic conditions. The proportion with a disability fell significantly from 26.2 percent in 1982 to 19.7 percent in 1999.
2. But 14 million people age 65 and older reported some level of disability in Census 2000, mostly linked to a high prevalence of chronic conditions such as heart disease or arthritis.
3. The age group 85 and older is now the fastest growing segment of the U.S. population.

D. The medical costs at the end of life are enormous.

³ <http://www.cdc.gov/nchs/fastats/lifexpec.htm>.

Table 4: Spending in Last Calendar Year of Life

Medicare Spending				
Beneficiaries	Total Spending	Hospice Care	Hospital Inpatient Care	All Other Services*
Used hospice	\$19,950	\$4,186	\$9,257	\$6,506
Did not use hospice	\$17,790	\$0	\$11,188	\$6,602
All Payer Spending				
Used hospice	\$27,202	\$4,186	\$10,618	\$12,398
Did not use hospice	\$26,047	\$0	\$12,292	\$13,755

* Includes services provided to hospice patients by nonhospice-affiliated physicians.

Note: Excludes Medicare beneficiaries in managed care.

Source: Urban Institute analysis of 1995–1998 MCBS Cost and Use Files.

E. While the financial circumstances of older people have improved dramatically since the 1960’s, there are wide variations in income and wealth and median wealth is not enough to take care of incapacitated people for their projected life expectancy in retirement.

1. The proportion of people aged 65 and older in poverty decreased from 35 percent in 1959 to 10 percent in 2003, mostly attributed to the support of Social Security.
2. In 2000, the poorest fifth of senior households had a net worth of \$3,500 (\$44,346 including home equity) and the wealthiest had \$328,432 (\$449,800 including home equity).

Table 4-10.

Median Net Worth and Median Net Worth Excluding Home Equity for Households by Age of Householder and Monthly Household Income Quintile: 2000

Households and net worth income quintile ¹	Total	Under 35	35 to 44	45 to 54	55 to 64	65 and over			
						Total	65 to 69	70 to 74	75 and over
All households									
(In thousands)	104,644	22,362	24,717	21,347	14,139	22,079	5,634	5,710	10,735
Median net worth	\$55,000	\$7,240	\$44,275	\$83,150	\$112,048	\$108,885	\$114,050	\$120,000	\$100,100
Excluding home equity	\$13,473	\$3,300	\$13,100	\$23,525	\$32,304	\$23,369	\$27,588	\$31,400	\$19,025
Lowest Quintile									
Households (in thousands)	20,937	4,322	3,333	2,827	2,574	7,882	1,497	1,758	4,626
Median net worth	\$7,398	\$500	\$1,510	\$5,896	\$21,000	\$44,346	\$32,000	\$43,230	\$46,266
Excluding home equity	\$1,025	\$0	\$500	\$600	\$1,500	\$3,500	\$2,900	\$2,885	\$4,000
Second Quintile									
Households (in thousands)	20,937	4,944	3,888	2,958	2,648	6,498	1,498	1,721	3,290
Median net worth	\$26,950	\$2,950	\$7,556	\$24,750	\$51,875	\$114,425	\$104,800	\$113,893	\$116,166
Excluding home equity	\$6,349	\$1,500	\$2,500	\$4,750	\$10,150	\$29,532	\$22,332	\$31,513	\$31,269
Third Quintile									
Households (in thousands)	20,913	5,269	5,090	4,030	2,721	3,803	1,174	1,161	1,467
Median net worth	\$44,400	\$8,238	\$30,703	\$56,642	\$100,700	\$192,500	\$155,319	\$201,563	\$226,263
Excluding home equity	\$12,333	\$3,550	\$8,500	\$12,725	\$29,210	\$78,213	\$52,550	\$84,900	\$100,900
Fourth Quintile									
Households (in thousands)	20,935	4,609	6,010	5,096	2,898	2,334	855	640	839
Median net worth	\$78,001	\$19,664	\$64,450	\$101,301	\$157,775	\$284,565	\$222,918	\$312,877	\$322,785
Excluding home equity	\$26,988	\$8,775	\$24,647	\$35,098	\$64,750	\$124,733	\$93,950	\$148,792	\$134,123
Highest Quintile									
Households (in thousands)	20,923	3,219	6,395	6,435	3,311	1,563	610	430	522
Median net worth	\$185,500	\$57,254	\$149,887	\$225,399	\$316,542	\$499,015	\$449,800	\$452,992	\$569,000
Excluding home equity	\$98,510	\$29,850	\$82,235	\$123,621	\$182,430	\$328,432	\$237,925	\$272,681	\$414,369

¹ Quintile upper limits for 2000 were: lowest quintile—\$1,304; second quintile—\$2,426; third quintile—\$3,813; fourth quintile—\$5,988.

Note: The reference population for these data is the civilian noninstitutionalized population.

Source: U.S. Census Bureau, 2003a. For full citation, see references at end of chapter.

(Chart, 65+ in the United States: 2005, December, 2005)⁴

F. Family trends for care-giving: “Will you still need me, will you still feed me, when I’m sixty-four?”

1. Divorce is on the rise, and some researchers suggest that fewer children and more stepchildren may change the availability of family support in the future for people at older ages.

a. 1960, only 1.6 percent of older men and 1.5 percent of women age 65 and older were divorced;

⁴ At <http://www.census.gov/prod/2006pubs/p23-209.pdf>.

- b. 2003, 7 percent of older men and 8.6 percent of older women were divorced and had not remarried. The trend may be continuing: in 2003, among people in their early 60s, 12.2 percent of men and 15.9 percent of women were divorced.
- 2. Increased consumer debt and educational inflation require more families to be two income households, reducing the ability of children to care for their parents.

II. Malpractice Liability for Negligent Discharge.

- A. “The term ‘malpractice’ is defined in Code § 8.01-581.1 as ‘any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.’” *Alcoy v. Valley Nursing Homes, Inc.*, 272 Va. 37, 42, 630 S.E.2d 301, ___ (2006)
- B. “In a medical malpractice action, ‘a plaintiff must establish not only that a defendant violated the applicable standard of care, and therefore was negligent, the plaintiff must also sustain the burden of showing that the negligent acts constituted a proximate cause of the injury or death.’ *Bryan v. Burt*, 254 Va. 28, 34, 486 S.E.2d 536, 539-40 (1997); *see also King v. Sowers*, 252 Va. 71, 76, 471 S.E.2d 481, 484 (1996) (‘[t]he relevant issue . . . is whether the treatment [Page 138] rendered violated the applicable standard of care and whether any such breach of the standard of care was a proximate cause of the plaintiff’s injury’).” *Bitar v. Rahman*, 272 Va. 130, 137-138, 630 S.E.2d 319, ___ (2006)
- C. Regulatory Requirement for Discharge Planning Sets Parameters of the Hospital’s Duty: 42 C.F.R. Sec. 482.43, Condition of participation: Discharge planning.⁵

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

⁵ The federal standard is the minimum standard; it is not exclusive and will not necessarily comply with the requirement for voluntary accreditation; see, e.g., *Crosswalk of JCAHO Standards and Palliative Care – with PC Policies, Procedures and Assessment Tools*, http://www.capc.org/support-from-capc/capc_publications/JCAHO-crosswalk.pdf.

(a) Standard: Identification of patients in need of discharge planning. *The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.*⁶

(b) Standard: Discharge planning evaluation. (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post- hospital services and of the availability of the services.

(4) *The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.*⁷

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in

⁶ *Emphasis added in present work.*

⁷ *Emphasis added in present work.*

the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

(c) Standard: Discharge plan. (1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

(3) The hospital must arrange for the initial implementation of the patient's discharge plan.

(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

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(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and posthospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of posthospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

(d) Standard: Transfer or referral. *The hospital must transfer or refer patients, along with necessary medical information, to appropriate*

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*facilities, agencies, or outpatient services, as needed, for followup or ancillary care.*⁸

(e) Standard: Reassessment. The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

III. Virginia Case Law Regarding Wrongful Discharge Resulting In Injury to Patient.⁹

A. “Decedent, who had a 20-year history of depression and substance abuse, was admitted to a facility under the care of the defendant psychiatrist. Shortly after the defendant's progress notes reflected that decedent had reached maximum hospitalization insurance benefits, decedent was discharged from the facility. The decedent went to the apartment of his estranged wife, barricaded himself in a bathroom, and after police were summoned, and several hours transpired, was shot to death attacking the officers with a large knife. Decedent's personal representative filed a wrongful death action alleging that the discharge violated the applicable standard of care. At trial the jury returned its verdict in favor of the plaintiff and awarded \$1,304,456 in damages. The verdict included responses to jury interrogatories in which the jury expressly stated that it found decedent to have been of unsound mind at the time of his death, and that the defendant doctor's negligence was a proximate cause of the death. The trial court confirmed the jury's verdict, reduced the award to reflect the statutory medical malpractice recovery cap, and give credit for settlements with another defendant, and entered judgment. The defendant doctor appealed.

1. Hospital course.

⁸ *Emphasis* added in present work.

⁹ There is a statutory duty on the part of mental health workers to protect third parties from expressed threats by patients, along with a statutory immunity for specified acts in execution of the duty. See Va. Code § [54.1-2400.1](#). *Mental health service providers; duty to protect third parties; immunity.*, (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2400.1>). Cf. *Walker's Adm. v. Simmons*, 13 Cir. LM603 (2002); *Head v. Inova Health Care Services*, 19 Cir. L189605 (2001);

- a. May 5, 1994: Tyler admitted to Dominion Hospital. Dr. Molchon determined that, once stabilized through inpatient treatment, Tyler would benefit from placement in a “structured residential situation.”
- b. May 10, 1994: Tyler discharged from Dominion Hospital. Tyler subsequently failed to keep a psychiatric outpatient appointment scheduled for him on Dr. Molchon's orders.
- c. May 14, 1994: Tyler attempted suicide and admitted to Fairfax Hospital, then transferred to Dominion Hospital on May 16, 1994, under Dr. Molchon's care, with admitting diagnosis of “[d]epression . . . most likely major depression . . . [a]lcohol dependence . . . [p]robable personality disorder of mixed type . . . overdose of multiple medications and self-inflicted lacerations of both wrists.”
- d. May 18, 1994: Progress notes: “I think that it is *absolutely necessary* for [Tyler] to have a structured living situation after discharge.” (Emphasis added). The following day, Molchon noted “continuing suicidal ideation but [had] no fixed plan at this time. . . . The problem is that without a structured living situation . . . it is unlikely that [Tyler] will be able to maintain sobriety for more than a few days at most. If he drinks, *he will be a very high suicidal risk* (as demonstrated by recent attempt).” (Emphasis added).
- e. May 23, 1994: , Dr. Molchon determined that Tyler “clinically no longer in need” of hospitalization, but acknowledged that the “[p]roblem now is finding an adequately structured living situation since without this he would be at risk for relapse into drinking.”
- f. May 24, 1994: Tyler again expressed his concern that he was “not ready” to leave the hospital and his fear that he would relapse into alcohol abuse and again attempt suicide. Referring to this statement, Molchon's progress notes state: “My assessment of situation is that [Tyler] is using hospital[ization] inappropriately [and] is using the spectre of further suicide attempts [and] relapse” to avoid being discharged. However, noting Tyler's history of suicide attempts, Molchon decided to seek a second opinion as to Tyler's “readiness for [discharge].”

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- g. May 26, 1994: Molchon's progress notes reflect his view that Tyler's "[treatment] plan is at stalemate." Tyler's social worker at Dominion Hospital arranged for Tyler to have a pre-admission interview at the Northern Virginia Mental Health Institute (NVMHI). However, Molchon cancelled Tyler's pass to leave the hospital to attend this interview, apparently out of concern that the two or three day waiting period for admission to NVMHI was incompatible with his plan to discharge Tyler as soon as possible and because Molchon did not "believe . . . that [Tyler] is [a] danger to self/or others" so as to meet the requirements for admission to NVMHI.
 - h. May 27, 1994: Tyler's social worker arranged for him to have a pre-admission interview on June 3, 1994 for residential treatment at one of two facilities operated by Loudoun County Mental Health Services. The social worker advised Tyler that, in the interim between his discharge and this interview, he could seek assistance through an emergency services telephone line and that he should attend Alcoholics Anonymous meetings. Tyler indicated to the social worker that he might "sleep in his van" following discharge. Molchon's progress notes for that day indicate that Tyler had "reached MHB," meaning that he had reached the "maximum hospital benefit" provided by his insurance coverage and directed that he should be "discharg[ed] tomorrow — follow up plan as described above," apparently referring to the social worker's notes. Molchon had no further contact with Tyler after May 27, 1994.
 - i. May 29, 1994: Tyler was discharged from Dominion Hospital on the order of Molchon's partner, who was on call for Molchon during the Memorial Day holiday weekend.
 - j. May 30, 1994: Tyler became distraught, indicated to his wife that he wanted to be readmitted to Dominion Hospital, saying that he did not "feel safe." Tyler's wife contacted the hospital and CMG, Tyler's medical insurance carrier, but was advised that Tyler was not eligible for further inpatient treatment. Tyler became agitated and attempted to cut his wrists with a knife. He then barricaded himself in the bathroom. He was later shot to death by police officers after he rushed at them with the knife. His B.A.C. was .18 when he died.
2. The Supreme Court held that "the evidence showed that Molchon was acutely aware of Tyler's suicidal tendencies and the likelihood that he would suffer a relapse if he were not

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properly supervised upon his discharge from Dominion Hospital. This evidence alone raised a jury question whether Molchon's allowing Tyler to be discharged was a proximate cause of his suicide less than 48 hours later. Accordingly, we hold that the trial court did not err in overruling Molchon's motion to strike the plaintiffs' evidence on this ground.”

Molchon v. Tyler, 262 Va. 175, 177-179; 182, 546 S.E.2d 691, ___ (2001).

IV. Risk Management for Incapacitated Patients.

A. Family Surrogacy.

1. Express advance directive (medical power of attorney), [Va. Code § 54.1-2984](#).
 - a. “If the declarant appoints an agent in an advance directive, that agent shall have the authority to make health care decisions for the declarant as specified in the advance directive if the declarant is determined to be incapable of making an informed decision and shall have decision-making priority over any individuals authorized under § [54.1-2986](#) to make health care decisions for the declarant. In no case shall the agent refuse or fail to honor the declarant's wishes in relation to anatomical gifts or organ, tissue or eye donation.”
 - b. Form, [Va. Code § 54.1-2984](#).
2. Implied Family Surrogacy, [Va. Code § 54.1-2986](#).
 - a. Available when no express advance directive.
 - b. Priority of service.
 - i. A guardian or committee for the patient. This does not require such appointment in order that a treatment decision can be made under this section.
 - ii. The patient's spouse except where a divorce action has been filed and the divorce is not final.

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- iii. An adult child of the patient.¹⁰
 - iv. A parent of the patient.¹¹
 - v. An adult brother or sister of the patient.
 - vi. Any other relative of the patient in the descending order of blood relationship.
- c. Conflicts within class.

If two or more of the persons listed in the same class in subdivisions iii. through vi. with equal decision-making priority inform the attending physician that they disagree as to a particular treatment decision, the attending physician may rely on the authorization of a majority of the reasonably available members of that class.

- d. Conflicts are subject to court intervention.
- e. Consult the statute for specific findings the attending physician must make as a condition precedent to action by an implied surrogate.¹²

B. Direct Judicial Surrogacy for Medical Treatment.

1. Emergency.

- a. Transporting the incapacitated patient to the hospital, § [37.2-1103](#). *Emergency custody orders for adult persons who are incapable of making an informed decision as a result of physical injury or illness.*

[37.2-1103](#). Emergency custody orders for adult persons who are incapable of making an informed decision as a result of physical injury or illness.

A. Based upon the opinion of a licensed physician that an adult person is incapable of making an informed decision as a result of a physical injury or illness and that the medical standard of care indicates that testing, observation, and

¹⁰ *Caveat*: when the adult child is disabled himself.

¹¹ *Id.*

¹² See particularly § D, relating to the requirement of a second opinion.

treatment are necessary to prevent imminent and irreversible harm, a magistrate may issue, for good cause shown, an emergency custody order for the adult person to be taken into custody and transported to a hospital emergency room for testing, observation, or treatment.

B. Prior to issuance of an emergency custody order pursuant to this section, the magistrate shall ascertain that there is no legally authorized person available to give consent to necessary treatment for the adult person and that the adult person (i) is incapable of making an informed decision regarding obtaining necessary treatment, (ii) has refused transport to obtain such necessary treatment, (iii) has indicated an intention to resist such transport, and (iv) is unlikely to become capable of making an informed decision regarding obtaining necessary treatment within the time required for such decision.

C. An opinion by the licensed physician that an adult person is incapable of making an informed decision as a result of physical injury or illness shall only be rendered after the licensed physician has communicated electronically or personally with the emergency medical services personnel on the scene and has attempted to communicate electronically or personally with the adult person to obtain information and medical data concerning the cause of the adult person's incapacity, has attempted to obtain consent from the adult person, and has failed to obtain consent.

D. If there is a change in the person's condition, the emergency medical services personnel shall contact the licensed physician. If at any time the licensed physician determines that a person subject to an order under this subsection has become capable of making and communicating an informed decision, the physician shall rely on the person's decision on whether to consent to further observation, testing, or treatment.

E. Upon reaching the emergency room, the person shall be evaluated by a licensed physician. If the physician determines that the person meets the requirements of § [37.2-1104](#), the physician may apply for a temporary detention order pursuant to that that section. If the physician determines that the person does not meet the requirements of § [37.2-1104](#), the person shall be released from custody immediately. The person shall remain in custody until this evaluation is performed, but in no event shall the period of custody under this section exceed four hours.

F. The law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city or town in which he serves to any point in the Commonwealth for the purpose of executing an emergency custody order pursuant to this section. Nothing herein shall preclude a law-enforcement officer from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

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G. If an emergency custody order is not executed within four hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any magistrate thereof.

- b. Emergency treatment of the incapacitated patient in the hospital, § [37.2-1104](#),
Temporary detention in hospital for testing, observation or treatment.

Upon the advice of a licensed physician who has attempted to obtain consent and upon a finding of probable cause to believe that an adult person within the court's or a magistrate's jurisdiction is incapable of making an informed decision regarding treatment of a physical or mental disorder or is incapable of communicating such a decision due to a physical or mental disorder and that the medical standard of care calls for testing, observation, or treatment of the disorder within the next 24 hours to prevent death, disability, or a serious irreversible condition, the court or, if the court is unavailable, a magistrate may issue an order authorizing temporary detention of the person by a hospital emergency room or other appropriate facility and authorizing such testing, observation, or treatment. The detention may not be for a period exceeding 24 hours, unless extended by the court as part of an order authorizing treatment under § [37.2-1101](#). If, before completion of authorized testing, observation, or treatment, the physician determines that a person subject to an order under this subsection has become capable of making and communicating an informed decision, the physician shall rely on the person's decision on whether to consent to further testing, observation, or treatment. If, before issuance of an order under this subsection or during its period of effectiveness, the physician learns of an objection by a member of the person's immediate family to the testing, observation, or treatment, he shall so notify the court or magistrate, who shall consider the objection in determining whether to issue, modify, or terminate the order.

2. Non Emergency Treatment And Withdrawal or Termination Of Treatment,¹³ Va.
Code § [37.2-1101](#). *Judicial authorization of treatment.*

A. An appropriate circuit court or district court judge or special justice may authorize treatment for a mental or physical disorder on behalf of an adult person, in accordance with this section, if it finds upon clear and convincing evidence that (i) the person is either incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder and (ii) the proposed treatment is in the best interest of the person.

¹³ “‘Treatment’ includes the provision, *withholding, or withdrawal* of a specific treatment or course of treatment upon a showing that the requirements of subsection G of § [37.2-1101](#) have been met.” [Va. Code § 37.2-1100](#).
Emphasis added in present work.

....

G. Prior to authorizing treatment pursuant to this section, the court shall find:

1. That there is no legally authorized representative available to give consent;
2. That the person for whom treatment is sought is incapable of making an informed decision regarding treatment or is physically or mentally incapable of communicating such a decision;
3. That the person who is the subject of the petition is unlikely to become capable of making an informed decision or of communicating an informed decision within the time required for decision; and
4. That the proposed treatment is in the best interest of the person and is medically and ethically appropriate with respect to (i) the medical diagnosis and prognosis and (ii) any other information provided by the attending physician of the person for whom treatment is sought. However, the court shall not authorize a proposed treatment that is proven by a preponderance of the evidence to be contrary to the person's religious beliefs or basic values, unless the treatment is necessary to prevent death or a serious irreversible condition. The court shall take into consideration the right of the person to rely on nonmedical, remedial treatment in the practice of religion in lieu of medical treatment.

....

C. Civil Commitment, Va. Code § 37.2-800 *et seq.*¹⁴

- a. Available for demented patients who are substantially unable to care for themselves or an imminent danger to themselves.
 - b. Patient may be discharged by court order or ordered to a specific out-patient regime of treatment, and the hospital is required to discharge the patient in accordance with the order.
2. Limited Guardianship / Conservatorship, Va. Code § [37.2-1000 et seq.](#)
- a. Available for patient who is proven to be “incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential

¹⁴ See <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+TOC370200000080000000000000>; Majette, *Civil Commitment and Surrogate Medical Consent In Virginia: 2006*,

requirements for his health, care, safety, or therapeutic needs without the assistance or protection of a guardian or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator.”¹⁵

- b. Powers of guardian are broad and carry substantial personal liability unless limited in the court’s order of appointment. [Va. Code § 37.2-1020](#).

A. A guardian stands in a fiduciary relationship to the incapacitated person for whom he was appointed guardian and may be held personally liable for a breach of any fiduciary duty to the incapacitated person. A guardian shall not be liable for the acts of the incapacitated person, unless the guardian is personally negligent. A guardian shall not be required to expend personal funds on behalf of the incapacitated person.

B. A guardian's duties and authority shall not extend to decisions addressed in a valid advance directive or durable power of attorney previously executed by the incapacitated person. A guardian may seek court authorization to revoke, suspend, or otherwise modify a durable power of attorney, as provided by § [11-9.1](#). Notwithstanding the provisions of the Health Care Decisions Act (§ 54.1- 2981 et seq.) and in accordance with the procedures of § [37.2-1012](#), a guardian may seek court authorization to modify the designation of an agent under an advance directive, but the modification shall not in any way affect the incapacitated person's directives concerning the provision or refusal of specific medical treatments or procedures.

C. A guardian shall maintain sufficient contact with the incapacitated person to know of his capabilities, limitations, needs, and opportunities. The guardian shall visit the incapacitated person as often as necessary.

D. A guardian shall be required to seek prior court authorization to change the incapacitated person's residence to another state, to terminate or consent to a termination of the person's parental rights, or to initiate a change in the person's marital status.

E. A guardian shall, to the extent feasible, encourage the incapacitated person to participate in decisions, to act on his own behalf, and to develop or regain the capacity to manage personal affairs. A guardian, in making decisions, shall consider the expressed desires and personal values of the incapacitated person to

<http://mysite.verizon.net/shawn.majette/documents/primer.htm>.

¹⁵ [Va. Code § 37.2-1000](#).

the extent known and shall otherwise act in the incapacitated person's best interest and exercise reasonable care, diligence, and prudence.

- c. Powers of guardian are broad and carry substantial personal liability.
 - i. This liability discourages family members from becoming guardian / conservator.
 - ii. Counsel for the guardian can insist that the liability be limited by conditioning service as a limited guardian with suitable limitations of duties and liabilities in the Court's order of appointment.
 - 1. A "[l]imited guardian' means a person appointed by the court who has only those responsibilities for the personal affairs of an incapacitated person as specified in the order of appointment."¹⁶
 - iii. Language used in the writer's practice defines the scope of duties and liability for the guardian such that the liability is completely discharged by admission of the patient to any licensed assisted living facility or medical care facility.
 - iv. In unusual cases, the writer has presented sketches of orders to extend the liability limitation to residence in specified family situations.
 - v. Example of typical limiting language.

1. Court finding:

"The exclusive powers and the sole duties and responsibilities of the guardian appointed by this order, are limited to the following and none other under any provision of law:

A. to have access to and obtain, and to provide authorization to third parties to access and obtain, all medical records and information pertaining to **Sucha Niceperson**, including protected health information as defined by the Health Insurance Portability and

¹⁶ Va. Code § [37.2-1000](#). Definitions.

Accountability Act of 1996 (HIPAA) and substance abuse records and information protected by reference to the Public Health Service Act, including references to such records appearing at 42 U.S.C. 290ee-3 and 42 U.S.C. 290dd-3, and including but not limited to all psychotherapy notes and alcohol or substance abuse treatment records relating to **Sucha Niceperson**, in existence now or at any time in the future, to which end and for all purposes of HIPAA the guardian shall be considered a “personal representative;” and

B. the power and sole discretion to exercise complete custody and control over the person of **Sucha Niceperson**, but only as necessary or helpful to provide for her admission or retention, even if contrary to her expressed wishes, to any nursing facility, convalescent home, continuing care retirement community, assisted living facility, private home (including the home of **Sucha Niceperson**, or the home of any willing member of her family), or any other residential or therapeutic placement, including any facility which is not licensed to care for more than three unrelated adults. The sole duty of the guardian which corresponds to the power conferred in this subparagraph may be fully and completely discharged by the exercise of such power to admit, or retain admission, of **Sucha Niceperson** to or in any nursing facility or assisted living facility licensed by the Commonwealth of Virginia, without personal liability on the part of the guardian for the expense of **Sucha Niceperson** in any such facility, and without personal liability on the part of the guardian for any act or omission by **Sucha Niceperson**, or any injury which may occur to **Sucha Niceperson**, once admitted to any nursing facility or assisted living facility licensed by the Commonwealth of Virginia; and

C. the power and sole discretion to consent, withhold consent, suspend consent, or terminate consent as to medical procedures affecting **Sucha Niceperson**. The sole duty of the guardian which corresponds to the power conferred in this subparagraph may be fully and completely discharged if, before the guardian consents, withholds consent, suspends consent, or terminates consent, the guardian makes a good faith effort to ascertain the risks and benefits of and alternatives to the procedures or treatment, or termination or withdrawal of such treatment, and the religious beliefs and basic values of **Sucha Niceperson**, and informs **Sucha Niceperson**, to the extent deemed reasonable by the guardian at the time of the execution of the power conferred in this subparagraph such power, of the proposed treatment; but to the extent that the religious beliefs, basic values, and preferences of **Sucha Niceperson** are unknown or unclear to the guardian, then the guardian shall have no liability to any person if the guardian acts in the best interest of **Sucha**

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Niceperson as such guardian shall in such guardian's discretion alone determine; and

D. the power but not the duty to delegate to any willing person, or to otherwise direct and provide for, the interment, cremation, or other disposition of the mortal remains of **Sucha Niceperson** at death, including but not limited to the whole or partial donation of her remains to any bona fide medical institution for transplantation or for the general or special advancement of medical science. To the extent which the guardian chooses to exercise the power conferred in this subparagraph, any duty hereunder may be fully and completely discharged by requesting that the conservator or other person charged with responsibility for the assets of **Sucha Niceperson** transfer her assets under the control of the conservator into an irrevocable trust designated solely for burial of **Sucha Niceperson**, or by requesting that the conservator execute a pre-need funeral contract or purchase a burial insurance policy for the benefit of **Sucha Niceperson**; and

E. completion and filing of the report as required by *Va. Code* §37.2-1021, to the extent the same is applicable to the limited duties imposed upon the guardian herein.”

2. Court's Order:

....

that the rights of **Sucha Niceperson** with respect to her person, property and estate are hereby limited in accordance with the specific findings above, and not otherwise; and

that **Gilly Guardian** is appointed as the limited guardian for the person of **Sucha Niceperson** with the powers and duties set forth above, and none other, for the time period provided above, and not otherwise, in the absence of further order of this Court;

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