

Chapter 2C:

Consent to

Healthcare–Decision-

Making for

Incompetent Patients

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For reference purposes, this chapter was prepared from laws, cases, and materials selected by the authors, which were available as of March 15, 2006.

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Roger Chase, JD, served as an editor to a previous version of this chapter.

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2C.1 Decision-Making for Incompetent Adults: Terminology

The terminology surrounding the area of health care decision-making for incompetent patients is remarkably imprecise. What follows are the technical definitions of various related terms, but it should be understood that health care professionals, lawyers, and judges tend to use terms such as capacity and competence, and incapacity and incompetence, interchangeably.¹

2C.1.1 Decision-Making Capacity

A person who has decision-making capacity has the ability, physically and mentally, to make informed medical decisions. While the term *decision-making capacity* technically refers to a factual status rather than a legal one, it is frequently used synonymously with the term *competence*.

2C.1.2 Competence

Competence refers to the legal status of a person who has the degree of decision-making capacity legally required to make medical decisions. Under the law of Washington, persons who are eighteen years of age or older are adults and, as such, have the legal competence to make decisions regarding their bodies.² Adults are presumed to be legally competent to make decisions, including medical decisions.³ This presumption of competence requires deference to an adult's decisions with regard to medical care absent substantial factual evidence of decision-making incapacity or a legal determination of incompetency. Competence, based on decision-making capacity, is a prerequisite to a person's ability to make a legally binding decision about medical treatment.⁴

2C.1.3 Incapacity

An individual who is incapacitated lacks the ability, either physically, mentally, or both to make informed medical decisions. The term *incapacity* technically refers to a factual status of a person who has not been the subject of a judicial proceeding, but it is frequently used interchangeably with the term *incompetence*.

2C.1.4 Incompetence

Incompetence denotes the legal status of a person who has been determined, through judicial proceedings, to lack the degree of decision-making capacity, legally required to make medical decisions.⁵ Although the determination of incompetency technically requires a judicial proceeding, persons who lack medical decision-making capacity but have not been adjudicated incompetent, are commonly referred to as incompetent. Minors, even without an adjudication of incompetency, are *de jure* incompetent to make medical decisions for themselves.⁶

¹ The following definitions are drawn from Alan Meisel & Kathy Cerminara, *The Right to Die: The Law of End-of-Life Decision Making* 3-15—3-24 (3d ed. 2004).

² RCW 26.28.015(5).

³ *Grannum v. Berard*, 70 Wn.2d 304, 307, 422 P.2d 812, 25 A.L.R.3d 1434 (1967).

⁴ *Grannum*, 70 Wn.2d at 307.

⁵ Meisel & Cerminara, *supra* note 1, at 3-16.

⁶ RCW 26.28.010. *See also* RCW 11.88.010(d) (stating that a person may be determined incapacitated if he or she is under the age of majority).

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2C.2 Determination of Decision-Making Capacity

2C.2.1 Clinical Determination of Incapacity

The fact that an individual has not been declared incompetent in a court of law does not mean that the individual is competent to consent to health care.⁷ In fact, most individuals who lack medical decision-making capacity have never gone through an adjudicatory process and been declared legally incompetent. It is thus incumbent upon health care practitioners to clinically assess their patients' capacity to make informed health care decisions. If a clinician determines that a patient lacks decision-making capacity, the clinician must then turn to a surrogate decision-maker, most often a family member, for informed consent.⁸

2C.2.1.1 Standards for Clinical Determination of Incapacity

Decision-making capacity operates on a continuum—from comatose individuals, who obviously lack the physical and mental capacity to make informed decisions about health care, to mentally intact individuals who obviously have the ability to understand their health care options and give informed consent. Because clinical decisions with regard to incapacity are so rarely challenged in court, the standards by which these decisions are made, or should be made, are not entirely clear. The Washington courts have stated that the determination of capacity to consent is dependent upon the facts and circumstances of each particular case.⁹ For example, in one case a physician asserted that a patient's decision-making capacity was evidenced by the fact that, over a five-year period, the patient always kept appointments, dressed and acted appropriately, sought necessary medical attention, and made decisions about her medical care independently.¹⁰

Mental illness, mental retardation, insanity, and involuntary civil commitment for the treatment of mental illness are concepts that bear some relationship to incapacity, but they are not synonymous with it. A person with a mental disability or mental illness is not necessarily incompetent to make medical decisions. Similarly, individuals who are intoxicated, delirious, delusional, or stuporous are not automatically lacking in decision-making capacity, particularly if these mental states are temporary or fluctuate with periods of lucidity. What is relevant to a determination of competence or incompetence is the practical effect that a mental illness has on a person's capacity to make informed medical decisions.

2C.2.2 Adjudication of Incompetency—Guardianship Proceedings

The Washington legislature has recognized that incapacitated individuals may not be able to effectively exercise their rights under the law unless they have the assistance of a guardian, and have provided for a process through which a guardian can be appointed.¹¹ In addition, the legislature has recognized that an individual may be incapacitated as to some aspects of his or her life but not others, and so has provided for a limited guardianship where the guardian's power extends only to specific areas, which may include health care decision-making.¹²

⁷ *Morinaga v. Vue*, 85 Wn. App. 822, 830, 935 P.2d 637 (1997) (stating that a plain reading of RCW 7.70.065 indicates that a person need not be declared legally incompetent to be incompetent to make health care decisions).

⁸ See RCW 7.70.065, which prioritizes surrogate decision-makers.

⁹ *Grannum*, 70 Wn.2d at 307.

¹⁰ *Morinaga*, 85 Wn. App. at 827.

¹¹ RCW 11.88.005.

¹² RCW 11.88.010(2).

2C.2.2.1 Standards for Judicial Determination of Incompetency

Under the guardianship statute, the determination of incapacity is a legal decision, not a medical one, and is based on evidence of “management insufficiencies” over a period of time with regard to person or estate.¹³ For purposes of giving informed consent for health care, the statute defines an incompetent individual as one who is incompetent by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental capacity of managing property or caring for self; or incapacitated as defined in RCW 11.88.010(a) (a significant risk of personal harm based upon a demonstrated inability to adequately provide for nutrition, health, housing, or physical safety), (b) (significant risk of financial harm based upon a demonstrated inability to adequately manage property or financial affairs), or (d) (under the age of majority).¹⁴

2C.2.2.2 Guardianship Petition

The superior court of each county has the power to appoint guardians for the persons and/or estates of incapacitated individuals,¹⁵ and any person or entity may petition for the appointment of a guardian or limited guardian of an alleged incapacitated person.¹⁶ The petition process requires the following:

- A petition must be filed with the appropriate superior court, which, among other things, states the nature and degree of the alleged incapacity, the names and addresses of relatives by blood or marriage of the alleged incapacitated person, the reason why appointment of a guardian is sought and the interest of the petitioner in the appointment, the name and address of the person the petitioner asks to be appointed as guardian, the specific areas of assistance requested and the limitation of rights that should be included in any limited guardianship, whether the petitioner is proposing a specific individual to act as guardian *ad litem*, and if so, why the individual is proposed.¹⁷
- Upon receipt of the petition for appointment of a guardian, the court must appoint a guardian *ad litem* from a court-maintained registry to represent the best interests of the alleged incapacitated person.¹⁸ The guardian *ad litem* must be free of influence and have the requisite knowledge, training, or experience to perform the statutory duties.¹⁹ The statutory duties include investigating the circumstances surrounding the petition and providing the court with a comprehensive written report recommending whether a guardian or limited guardian should be appointed.²⁰ In addition, while the petition is pending, the guardian *ad litem* is authorized to consent to emergency, life-saving medical procedures.²¹
- Within five court days of the filing of the petition, notice that a guardianship proceeding has been commenced and a copy of the petition must be personally served upon the alleged incapacitated person and the guardian *ad litem*.²² The notice must be in substantially the form prescribed by statute, and must include a clear and easily readable statement of the alleged incapacitated person’s legal rights that may be transferred to a guardian, the right to counsel, and the right to a jury trial.²³

¹³ RCW 11.88.010(1)(c).

¹⁴ RCW 11.88.010(1)(e).

¹⁵ RCW 11.88.010(1).

¹⁶ RCW 11.88.030(1).

¹⁷ RCW 11.88.030(1)(a)-(l).

¹⁸ RCW 11.88.090(3) & (4)(a).

¹⁹ RCW 11.88.090(3)(a-b).

²⁰ RCW 11.88.090(5).

²¹ RCW 11.88.090(8).

²² RCW 11.88.030(4)(a).

²³ RCW 11.88.030(4)(b).

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2C.2.2.3 Adjudicatory Hearing

The following statutory process is required to adjudicate an individual as incompetent:

- Notice of a hearing must be served on the alleged incapacitated person, the guardian ad litem, and other interested individuals at least ten days prior to the hearing on the petition.²⁴
- The alleged incapacitated individual must be present at the final hearing on the petition unless the court waives this requirement for good cause.²⁵ Alternatively, the court may conduct the hearing in the presence of the alleged incapacitated person by holding the hearing at that person's place of residence.²⁶
- At the hearing, the alleged incapacitated person is entitled to counsel of his or her choosing who shall act as an advocate of the client, testify and present evidence, and request and receive a jury trial on the issue of incapacity. The standard of proof, whether the case is before a judge or jury, is that of clear, cogent, and convincing evidence of incapacity.²⁷
- The court must be presented with a written report from a licensed physician or psychologist selected by the guardian ad litem who has expertise in the type of disorder or incapacity at issue. The physician, psychologist, or advanced registered nurse practitioner must have personally examined and interviewed the alleged incapacitated individual, and the report must summarize the relevant findings as to the individual's condition and specific needs.²⁸
- The court's decision on the guardianship petition must be based on specific findings as to the capacities, conditions, and needs of the alleged incapacitated person.²⁹ A court-appointed guardian is under the control of the court,³⁰ and has numerous statutory duties, including the duty to file timely reports on the status of the incapacitated person.³¹

2C.3 Decision-Making for Incompetent Individuals

Incompetent individuals do not lose their rights to autonomy and self-determination merely because they are incompetent.³² In Washington, there are two mechanisms for effectuating an incompetent individual's right to make health care decisions: the advance directive and surrogate decision-making, which can take several forms.

2C.3.1 Advance Directives

2C.3.1.1 Definition

An advance directive (also sometimes called a "living will") is a legal mechanism through which a competent individual may execute a document that specifies the circumstances under which he/she would want medical treatment withheld or withdrawn should the patient be incompetent to make that decision at some point in the future. It is a legal directive to others about how to make health care decisions for the patient in advance if the need arises to actually make such decisions. Advance directives are governed by state statutes that vary tremendously in terms of the formalities of execution, the triggering medical

²⁴ RCW 11.88.040.

²⁵ Such waiver is frequently granted in uncontested guardianships when the parties (including the guardian *ad litem*) agree that the alleged incapacitated person is not capable of meaningful participation.

²⁶ RCW 11.88.040.

²⁷ RCW 11.88.045(1)-(3). *See also Gramum*, 70 Wn.2d at 307.

²⁸ RCW 11.88.045(4).

²⁹ RCW 11.88.095(1).

³⁰ RCW 11.92.010.

³¹ RCW 11.92.043(2).

³² *In re Colyer*, 99 Wn.2d 114, 124, 660 P.2d 738 (1983).

conditions (e.g., terminal illness, irreversible coma, persistent vegetative state), and the treatments that can be withheld or withdrawn.

2C.3.1.2 Patient Self-Determination Act

The Patient Self-Determination Act became law as part of the Federal Omnibus Budget Reconciliation Act of 1990.³³ The Act was intended to increase the role that advance directives and durable powers of attorney play in medical decision making. The statute applies to hospitals, skilled nursing facilities, home health agencies, hospice programs, and HMOs that receive Medicare or Medicaid funding, and requires that covered entities provide each patient at the time of admission with information concerning:

- An individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning . . . medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . ; and
- The written policies of the provider or organization respecting the implementation of such rights.³⁴

In addition, covered entities must document in each patient's record whether the patient has signed an advance directive, assure that state law is followed in the institution, and provide education for the staff and public on advance directives and durable powers of attorney.³⁵

2C.3.1.3 Washington's Natural Death Act

Washington's Natural Death Act permits adults who are competent to execute an advance directive, which directs the withholding or withdrawal of life-sustaining treatment in the future.³⁶ The advance directive thus provides a legal mechanism for individuals to have their treatment decisions effectuated at the point that they become incompetent to make those decisions. However, the utility of the advance directive is limited because it does not come into effect unless the incompetent individual has been diagnosed with a terminal condition or permanent unconscious condition. In addition, the Natural Death Act is designed to allow individuals to direct in advance only the withholding or withdrawal of life-sustaining treatment; it does not provide for individuals to make non-end-of-life medical decisions in advance.³⁷

The specific statutory requirements are as follows:

- The individual executing the advance directive must be an adult who has the capacity to make health care decisions at the time of execution;³⁸
- The directive must be in writing and signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who have no interest in the declarer's estate;³⁹ and
- The directive cannot be given effect unless the diagnosis of a terminal condition has been made in writing by the attending physician, or the diagnosis of a permanent unconscious condition has been made in writing by two physicians, one of whom is the patient's attending physician.⁴⁰

³³ Public Law 101-508; 42 U.S.C. § 1395cc(a).

³⁴ 42 U.S.C. § 1395cc(f)(1)(A).

³⁵ 42 U.S.C. § 1395cc(f)(1)(B)-(E).

³⁶ RCW 70.122. In 1992, the legislature amended the Act to specifically include artificial nutrition and hydration as a form of life-sustaining treatment that could be withheld or withdrawn. *See* RCW 70.122.020(5) and 70.122.030.

³⁷ RCW 70.122.010-.030.

³⁸ RCW 70.122.030(1).

³⁹ RCW 70.122.030(1). A witness may not be the attending physician or employee of the physician or health care facility. RCW 70.122.030(1).

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The Natural Death Act provides that physicians and health care providers who in good faith withhold or withdraw life-sustaining treatment from a qualified patient pursuant to an advance directive are immune from legal liability, unless they are otherwise negligent.⁴¹ There is no legal obligation on the part of nurses, physicians, or other health care practitioners to participate in the withholding or withdrawing of treatment, but the attending physician and health facility, if they are aware of the existence of the advance directive, have an obligation to inform the patient of any policy or practice that would preclude the honoring of the directive.⁴²

2C.3.1.4 Mental Health Advance Directives

In 2003, the Washington legislature enacted a statute authorizing mental health advance directives⁴³ in order to effectuate an individual's right to control decisions relating to his or her mental health care during periods when the patient lacks capacity to make those decisions. Under the statute, mental health advance directives may include, among other decisions, the principal's preferences and instructions for mental health treatment, consent to specific types of mental health treatment, refusal to consent to specific types of treatment, and consent to admission to and retention in a facility for mental health treatment for up to 14 days.⁴⁴

The specific statutory requirements are as follows:

- The individual executing the mental health advance directive must be an adult with decision-making capacity;⁴⁵
- The directive must be in writing, signed by the principal, and witnessed in writing by at least two adults who can attest to the principal's identity and capacity;⁴⁶ and
- The directive must designate whether the principal wishes to be able to revoke the directive during any period of incapacity or wishes to be unable to revoke the directive during any period of incapacity.⁴⁷

The mental health advance directive is to follow substantially the form provided in the statute,⁴⁸ and may include appointment of an agent pursuant to RCW 11.94 to make mental health treatment decisions on the

⁴⁰ RCW 70.122.020(8).

⁴¹ RCW 70.122.051.

⁴² RCW 70.122.060(2), (4).

⁴³ See RCW 71.32.

⁴⁴ RCW 71.32.050(3).

⁴⁵ RCW 71.32.050(1).

⁴⁶ RCW 71.32.060(1)(a), (c), (e). The witnesses may not be a person designated to make health care decisions on the principal's behalf; a health care provider directly involved with the provision of care to the patient; an owner, operator, or employee of a health care or long-term care facility in which the principal is a patient or resident; a person who is related by blood, marriage, or adoption to the person; an incapacitated person; or someone who would benefit financially if the principal undergoes mental health treatment. RCW 71.32.090.

⁴⁷ RCW 71.32.060(1)(d).

⁴⁸ See RCW 71.32.260.

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principal's behalf,⁴⁹ and/or the principal's nomination of a guardian or limited guardian as provided in RCW 11.94.010 for consideration by the court in the event guardianship proceedings are commenced.⁵⁰

2C.3.2 Statutory Authorization for Surrogate Decision-Making

Most individuals have not executed advance directives under the Natural Death Act. In the absence of an advance directive, medical decisions for an incompetent person are made by a surrogate decision-maker. In Washington, the persons authorized to make medical decisions on behalf of an incompetent individual are the following (in order of priority):

- The appointed guardian of the patient, if any;
- The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
- The patient's spouse;
- Children of the patient who are at least eighteen years of age;
- Parents of the patient; and
- Adult brothers and sisters of the patient.⁵¹

As indicated by the second statutory class listed above, an individual may execute, while competent, a durable power of attorney for health care. The effect of this instrument is to authorize the attorney-in-fact to provide informed consent for health care decisions on the principal's (incompetent individual's) behalf.⁵² The attorney-in-fact is second only to a court-appointed guardian in decision-making priority under Washington's informed consent statute.⁵³

The surrogate decision-making statute specifies that a health care provider who is seeking informed consent for an incompetent patient, and who has been unsuccessful in locating and obtaining authorization from a competent person in the first or succeeding class, may seek consent from any person in the next class in the order of descending priority.⁵⁴ However, a person who has lower priority may not consent if a person of higher priority has refused, and a person in the same class with two or more individuals may not give informed consent unless the decision is unanimous.⁵⁵

While the statute dictates a rather rigid hierarchy for surrogate decision-making, in practice, health care providers naturally turn to family members and loved ones to make medical decisions for incompetent patients. The statutory designation of decision-making priority plausibly has the most effect in situations where the family members, loved ones, and health care providers cannot reach agreement on the appropriate treatment choice.

⁴⁹ RCW 71.32.050(3)(g). The agent's mental health treatment decisions must be consistent with the instructions and preferences expressed in the directive, or if not expressed, as otherwise known to the agent. If the principal's instructions or preferences are not known, the agent is to make a decision that is in the best interests of the principal. RCW 71.32.100(4).

⁵⁰ RCW 71.32.050(3)(h).

⁵¹ RC 7.70.065(1).

⁵² RCW 11.94.010(3).

⁵³ See RCW 7.70.065(1)(a).

⁵⁴ RCW 7.70.065(1)(b).

⁵⁵ RCW 7.70.065(1)(b)(i-ii).

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2C.3.3 Role of the Guardian in Medical Decision-Making For Incompetent Individuals

A court-appointed guardian has the legal right and responsibility to make medical decisions for the incompetent individual, and has priority over the other surrogate decision-makers under Washington's informed consent statute.⁵⁶ In the case of a limited guardianship, the limited guardian may make medical decisions for the incompetent individual where the power to make medical decisions is specifically authorized in the court's order, or where the power is not specifically excluded.⁵⁷

2C.3.3.1 General Powers

Consistent with RCW 7.70.065, a guardian is legally empowered to provide informed consent for health care for the incapacitated individual.⁵⁸ In doing so, the guardian is charged with asserting the incapacitated individual's rights and best interests.⁵⁹ As a surrogated decision-maker, the guardian is to make health care decisions through the use of the substituted judgment or best interests standards, as described above. In addition, an individual's advance directive may specify that a guardian or other surrogated decision-maker is to be guided by the directive and any other clear expressions of his or her desires.⁶⁰ Even in the absence of such language, an advance directive may be useful in determining what treatment choices the individual would have made if competent.

2C.3.3.2 Standby Guardian

The person appointed by the court as guardian or limited guardian must file a notice with the court designating a standby guardian or limited guardian.⁶¹ In the event that informed consent for a necessary medical procedure is needed and the guardian or limited guardian cannot be located within four hours of the need for consent arising, the standby guardian or limited guardian may give informed consent.⁶²

2C.3.3.3 Limitations on Power

The guardianship statute prohibits guardians from authorizing certain therapies or procedures. For example, if a guardian believes the incapacitated individual requires involuntary civil commitment for mental health treatment, the statutory procedures for involuntary commitment must be followed.⁶³ In addition, if the guardian believes any of the following procedures are necessary for the proper care of the incompetent person, the guardian must petition the court for an order authorizing the treatment or therapy:

- Therapy or other procedures which induce convulsions;
- Surgery solely for the purpose of psychosurgery; and
- Other psychiatric or mental health procedures that restrict physical freedom of movement, or the rights set forth in RCW 71.05.370.⁶⁴

In construing this statute, the Supreme Court of Washington stated that the intent of the statutory limitations is to require court approval before the guardian may consent to highly invasive, irreversible

⁵⁶ RCW 7.70.065(1).

⁵⁷ RCW 11.88.095(3).

⁵⁸ RC 11.92.043(5).

⁵⁹ RCW 11.92.043(4).

⁶⁰ RCW 70.122.030(1)(b).

⁶¹ RCW 11.88.125(1).

⁶² RCW 11.92.043(5); *see also* RCW 11.88.125(3) (granting authority to the standby guardian to give informed consent as authorized in RCW 11.92.040).

⁶³ RCW 11.92.043(5).

⁶⁴ RCW 11.92.043(5)(a-c).

medical treatment that would seriously affect the incompetent person's bodily integrity.⁶⁵ This leaves open the possibility that judicial authorization may be required before a guardian may consent to other invasive, irreversible procedures even though the procedures are not on the statutory list.⁶⁶ In addition, before an incompetent person may be sterilized, a guardian *ad litem* must be appointed to represent the incompetent person's wishes and a court order must be obtained.⁶⁷

2C.3.4 Durable Power of Attorney for Health Care

An individual may execute, while competent, a durable power of attorney for health care. The effect of this instrument is to authorize the attorney-in-fact to provide informed consent for health care decisions on the principal's behalf.⁶⁸ Under Washington's surrogate decision-making statute, the attorney-in-fact is second only to a court-appointed guardian in decision-making priority.⁶⁹

2C.3.4.1 Statutory Requirements

The durable power of attorney for health care must be in writing and contain language to the effect that the power of attorney becomes effective upon the disability or incapacity of the principal, or that it remains effective during the disability or incapacity of the principal.⁷⁰ The principal's physicians, the physicians' employees, and the owners, administrators, and employees of the health care facility where the principal resides or receives care are ineligible to act as the principal's attorney-in-fact, unless he or she is the spouse or adult child or brother or sister of the principal.⁷¹ The principal may grant the attorney-in-fact the authority to make all health care related decisions, or the principal may limit the attorney-in-fact's authority by specifically defining the powers of the agent with regard to various categories of medical decisions.

2C.3.4.2 Limitations on Power

The durable power of attorney for health care has identical statutory limitations to those described above for court-appointed guardians (see section 2.17.3.3).⁷² Thus, an attorney-in-fact must seek a court order and may not independently authorize therapy, procedures that induce convulsions, or surgery solely for the purpose of psychosurgery, sterilizations, etc.

2C.3.4.3 Relationship Between the Durable Power of Attorney and Advance Directive

The execution of a durable power of attorney for health care is arguably more useful than an advance directive in the event of the principal's incompetency because, unlike the advance directive, it is not limited to circumstances where the individual is terminal or in a permanent unconscious condition, nor is it limited to the withholding or withdrawal of life-sustaining treatment. The durable power of attorney and advance directive can work together, but both documents should be specific with regard to the relationship between the two. For example, the durable power of attorney can be drafted to include specific instructions contained within the advance directive. Likewise, the advance directive can include a statement that directs

⁶⁵ *In re Ingram*, 102 Wn.2d at 837.

⁶⁶ *But see In re Colyer*, 99 Wn.2d at 129 (stated that these statutory limitations on a guardian's power must be narrowly construed). When in doubt, a guardian may always petition the court for specific authority to consent to a particular treatment. This is a particularly good idea when there is disagreement among close family members.

⁶⁷ *In re Hayes*, 93 Wn.2d 228, 238, 608 P.2d 635 (1980).

⁶⁸ RCW 11.94.010(3).

⁶⁹ See RCW 7.70.065(1)(a)(i-ii).

⁷⁰ RCW 11.94.010.

⁷¹ RCW 11.94.010(3).

⁷² RCW 11.94.010(3) (incorporating the limitation on power to consent contained within RCW 11.92.043(5)).

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the attorney-in-fact to follow or be guided by the instructions in the advance directive. Even in the absence of such specific language, an advance directive may always be used for guidance by the attorney-in-fact in making substituted judgment for the incompetent individual.

2C.3.4.4 Relationship Between the Durable Power of Attorney and Guardianship Proceedings

A principal may nominate, by a durable power of attorney, the guardian or limited guardian of his or her estate or person for the court's consideration if guardianship proceedings are subsequently commenced. If the principal has done so, the court is required to make its appointment in accordance with the principal's most recent nomination in a durable power of attorney, except for good cause or disqualification.⁷³ If there is an existing medical power of attorney and the court appoints a guardian, the court must make a specific finding of fact as to the continuing validity of the medical power of attorney.⁷⁴ If the court determines that the power of attorney shall continue, the attorney-in-fact must account to the guardian rather than the principal.⁷⁵

2C.3.5 Standards and Procedures for Surrogate Decision-making

2C.3.5.1 Substituted Judgment Standard

A surrogate decision-maker must use the doctrine of substituted judgment in consenting to or refusing health care on behalf of an incompetent individual. The standard applies to all medical decisions, whether they involve the discontinuation of life-sustaining treatment or a choice between alternate medical treatments.⁷⁶ In each case, the substituted judgment standard requires that the surrogate decision-maker (whether a guardian, attorney-in-fact with authority to make health care decisions, family member, or the court) determine whether the patient, if competent, would have consented to the proposed health care.⁷⁷ The surrogate should consider all relevant factors that would influence the patient's medical treatment decisions, including:

- The person's prior statements regarding medical treatment;⁷⁸
- The person's express wishes, even if made while the individual is incompetent;
- The patient's religious or moral views regarding medical care or the dying process;
- The person's prognosis if no treatment is given;
- The prognosis if one treatment is chosen over another;
- The risk of adverse side effects from the proposed treatment;
- The intrusiveness or severity of the proposed treatment;
- The ability of the patient to cooperate and assist with post-treatment therapy; and
- The wishes of family and friends, if those wishes would have influenced the patient.⁷⁹

⁷³ RCW 11.94.010(1).

⁷⁴ RCW 11.88.095(5).

⁷⁵ RCW 11.94.010(1).

⁷⁶ *In re Ingram*, 102 Wn.2d 827, 839, 689 P.2d 1363 (1984).

⁷⁷ RCW 7.70.065(1)(c). *See also In re Colyer*, 99 Wn.2d at 137 (holding that life-sustaining treatment may be withdrawn if it is the guardian's judgment that the patient, if competent, would have chosen to withdraw treatment).

⁷⁸ The weight to be given to prior statements depends upon the age and maturity of the person, the context of the statements, and the connection between the statements and the patient's condition. *In re Grant*, 109 Wn.2d 545, 567, 747 P.2d 445 (1987).

⁷⁹ *In re Ingram*, 102 Wn.2d at 840.

The Washington Supreme Court has specifically stated that judicial intervention is not generally required when a surrogate decision-maker exercises substituted judgment to make a treatment decision for an incompetent individual.⁸⁰ If the substituted judgment is made in a clinical setting, it will likely be acted upon unless family members or health care providers strongly disagree with the decision.

2C.3.5.1 Best-Interests Standard

When a surrogate decision-maker cannot in good faith ascertain whether the patient, if competent, would have consented to the proposed health care, he or she must determine that the medical treatment is in the patient's best interests before giving consent.⁸¹ Where the person has never been competent, the substituted judgment standard is arguably meaningless, and so the best-interests standard is used instead.⁸² Factors that should be considered by the surrogate decision-maker in determining whether medical treatment is in the best interests of the incompetent individual include:

- The patient's present level of physical, sensory, emotional, and cognitive functioning;
- The various treatment options and the risks, side effects, and benefits of each of the options;
- The life expectancy and prognosis for recovery with and without treatment;
- The degree of physical pain resulting from the medical condition, treatment, or termination of treatment; and
- The degree of dependency and loss of dignity resulting from the medical condition and treatment.⁸³

2C.3.5.3 Judicial Intervention in the Decision-Making Process

Any participant in health care decision-making for an incompetent individual, whether a guardian, attorney-in-fact with authority to make health care decisions, a physician or hospital, or family member may petition the court for intervention in the medical decision-making process.⁸⁴ This occurs most often when family members or health care providers cannot agree on a course of action, particularly with regard to life-sustaining treatment, or where the court is statutorily required to authorize treatment for an incompetent individual. As part of the judicial proceeding, the court will appoint a guardian *ad litem* to ascertain whether the patient, if competent, would have consented to or refused the medical treatment in question.⁸⁵

2C.3.5.4 Withdrawal of Life-Sustaining Treatment

Judicial intervention, including the appointment of a guardian, is not routinely required even if the treatment decision is to discontinue life-sustaining treatment for a terminally ill or permanently unconscious individual.⁸⁶ However, the Washington Supreme Court has stated that additional safeguards should be present before a decision is made to withdraw treatment in circumstances where the incompetent individual did not execute, while competent, an advance directive and/or durable power of attorney for health care. The safeguards include a requirement that a "prognosis board," consisting of the attending physician and at least two disinterested physicians, unanimously concur that the patient's condition is incurable and there is no reasonable probability that the individual will return to a sapient state.⁸⁷ In addition, the immediate family, the treating physician, and the prognosis board must all agree that

⁸⁰ *In re Colyer*, 99 Wn.2d at 127-28.

⁸¹ RCW 7.70.065(1)(c). *See also In re Grant*, 109 Wn.2d at 567-68.

⁸² *See In re Hamlin*, 102 Wn.2d 810, 814-15, 689 P.2d 1372 (1984).

⁸³ *In re Grant*, 109 Wn.2d at 568.

⁸⁴ *In re Colyer*, 99 Wn.2d at 136.

⁸⁵ *In re Hamlin*, 102 Wn.2d at 816-17.

⁸⁶ *In re Colyer*, 99 Wn.2d at 127-28; *In re Grant*, 109 Wn.2d at 565-67.

⁸⁷ *In re Colyer*, 99 Wn.2d at 135, 137.

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withdrawal of life-sustaining treatment is appropriate.⁸⁸ When the incompetent individual has no family, the same standard applies but a guardian must be appointed to represent the patient's rights and interests.⁸⁹ If the individual is not terminally ill or permanently unconscious, or if the above safeguards are not met, judicial intervention should be sought before life-sustaining treatment is withdrawn from an incompetent individual who has not previously executed an advance directive or durable power of attorney for health care.

Withdrawal of Artificial Nutrition and Hydration. In the case of *In re Grant*, the Washington Supreme Court held that life-sustaining treatment may be withheld from terminally ill, incompetent individuals as long as certain safeguards are in place, but the court then excepted artificial nutrition and hydration from the medical treatments that can be withheld or withdrawn.⁹⁰ The viability of that holding has since been called into question by the fact that in 1990, in the case of *Cruzan v. Director, Missouri Dep't of Health*, at least five Justices of the United States Supreme Court took the position that artificial nutrition and hydration is no different from other types of life-sustaining medical treatment.⁹¹ In addition, Washington's Natural Death Act was amended in 1992 to specifically provide that artificial nutrition and hydration is a life-sustaining treatment that may be withheld or withdrawn.⁹² While the Natural Death Act does not directly apply in circumstances where the incompetent individual does not have an advance directive, the Act does reflect the definitional choice that is consistent with the modern trend in other states and would likely be followed by the Washington courts.

The State's Interests. In cases where the court is called upon to decide whether life-sustaining treatment should be withheld or withdrawn from an incompetent patient, an additional element is added to the substituted judgment or best interest analysis: the court weighs that determination against any countervailing state interests.⁹³ The countervailing state interests the court considers are: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.⁹⁴ As a practical matter, courts rarely find that these state interests outweigh an individual's right to self-determination as reflected as substituted judgment. In the *Colyer* case, the court did indicate that the state's interest in preserving life is greater where the proposed treatment offers a possible cure for the individual, as opposed to merely prolonging life.⁹⁵

⁸⁸ *In re Hamlin*, 102 Wn.2d at 819.

⁸⁹ *In re Hamlin*, 102 Wn.2d at 820.

⁹⁰ *In re Grant*, 109 Wn.2d at 570-81. The majority originally reached the conclusion that withdrawal of nutrition and hydration was appropriate. But, some months later, Justice Durham removed her vote from the "majority" opinion and aligned herself with Justice Andersen's partial dissent. See *In re Grant*, 757 P.2d 534 (1988). As a result, five justices held that withdrawal of nutrition and hydration from an incompetent individual was not permissible.

⁹¹ 497 U.S. 261 (1990).

⁹² See RCW 70.122.020(5) and 70.122.030.

⁹³ *In re Ingram*, 102 Wn.2d at 842.

⁹⁴ *In re Colyer*, 99 Wn.2d at 122.

⁹⁵ *In re Colyer*, 99 Wn.2d at 122.

2C.3.6 Special Considerations

2C.3.6.1 Nursing Home Residents

Resident rights regulations entitle residents of nursing homes in the State of Washington to specific rights relating to decision-making, including rights related to health care decision-making.⁹⁶ In general, the resident rights regulations ensure that nursing homes respect the decision-making authority of their residents, or in the case of incapacity, that a nursing home is aware of the identity of the surrogate decision-maker and the scope of authority granted to that person. The regulations provide that upon admission, the nursing home must determine:

- Whether the resident has appointed another person to make health care decisions;
- Whether the resident has created any advance directive (which includes power of attorney, health care directive, code/no code order, anatomical gifts, etc.) or other legal document that establishes a surrogate decision-maker in the future; and
- If the resident is not making decisions, who has the authority for surrogate decision-making and the scope of the authority.⁹⁷

In fulfilling its duty, the nursing home must seek copies of any legal documents that establish the surrogate decision-maker's authority and document in the resident's clinical record the surrogate's name, address, and scope of authority, and the location of the legal documents within the facility.⁹⁸ A nursing home may not require a resident to have an advance directive or condition care on the basis of whether or not the resident has executed an advance directive.⁹⁹

The resident rights regulations entitle the resident to a presumption of decision-making authority, which can be overcome if a court has established a guardianship, the resident has made a voluntary appointment of a surrogate decision-maker, a surrogate has been established by a legal document, or the facility has determined that the resident is an incapacitated individual, as defined by RCW 11.88.010 and WAC 388-97-065(3)(a) (regarding the demonstrated inability to make decisions over time, creating a significant risk of personal harm).¹⁰⁰ If the resident has been adjudicated by a court to be incompetent, the court-appointed guardian is the surrogate decision-maker.¹⁰¹ If the resident has been determined to be incapacitated, but has not been adjudicated as incompetent, the surrogated decision-maker is established through either a legal document, such as a durable power of attorney for health care, or by state law, including the priority list of surrogate decision-makers contained within RCW 7.70.065.¹⁰² When a nursing home has consulted a surrogate decision-maker to exercise the resident's rights, the nursing home must inform the resident of that fact and provide the resident with the information and opportunity to participate in decision-making to the greatest extent possible.¹⁰³ Finally, if at some point the resident regains decision-making capacity, the

⁹⁶ See, e.g., WAC 388-97-055 (resident health care decision making); WAC 388-97-060 (informed consent); WAC 388-97-065 (advance directives); and WAC 388-97-07005 (notice of rights and services, including list of rights).

⁹⁷ WAC 388-97-055(1).

⁹⁸ WAC 388-97-055(3)(a-b).

⁹⁹ WAC 388-97-065(3)(b).

¹⁰⁰ WAC 388-97-055(6).

¹⁰¹ WAC 388-97-055(4)(b).

¹⁰² WAC 388-97-055(4)(c).

¹⁰³ WAC 388-97-055(8)(a-b).

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nursing home must cease to rely on the surrogate decision-maker unless a court order or the resident directs otherwise.¹⁰⁴

2C.3.6.2 Children (See Chapter 2A.7.1.2 and 2A.8.2 re Minors and Chapter 2B.2 re Consent/Refusals for Categories of Individuals.)

The age of majority in Washington is eighteen.¹⁰⁵ Individuals under the age of eighteen generally lack the legal competency to make their own health care decisions, so a parent or legal guardian must give consent. If the minor's parents are married, either parent may give consent to medical treatment,¹⁰⁶ but consent from both parents should be obtained if circumstances permit. In the case of consent for medical care for children, a number of exception and special statutory provisions apply, depending upon the custody and status of the minor and the type of care at issue (e.g., sexually transmitted diseases, abortion, mental health treatment, alcoholism, drug addiction, and treatment for sexually transmitted diseases). Chapters 2A and 2B should be consulted for a complete discussion of the issues regarding consent for minors.

2C.3.6.3 Medical Emergencies (See Chapter 2A.9.1 re Medical Emergencies.)

Actual informed consent for medical treatment is not required in the event of an emergency; consent is implied under the law. Pursuant to RCW 7.70.050, "If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied."¹⁰⁷ This statutory provision is applicable both in circumstances where the individual was legally incompetent to make decisions prior to the medical emergency (e.g., a minor or someone adjudicated incompetent) and where the individual has been rendered incapacitated by the health care emergency.

¹⁰⁴ WAC 388-97-055(9)(b).

¹⁰⁵ RCW 26.28.010.

¹⁰⁶ RCW 26.16.125 (equal rights and responsibilities of parents).

¹⁰⁷ RCW 7.70.050(4).