

Washington Health Law Manual – Fourth Edition
Washington State Society of Healthcare Attorneys (WSSHA)

Chapter 1: Consent to Healthcare–Special Consent Rules

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For reference purposes, this chapter was prepared from laws, cases, and materials which were available as of July 12, 2020.

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1.1 Chapter Summary

This chapter details special consent rules on over thirty different topics. Special consent rules are defined as situations requiring focused consideration on who is the decision-maker and on what are the unique concerns for certain diagnosis or treatment. After evaluating these special issues, the general consent rules, discussed in the chapter on General Consent Rules, usually apply. Each topic is written in self-contained sections that highlight the issue of health care consent. The topics are meant to operate as quick reference tools and are clustered into three major segments: (1) special decision-makers for certain categories of individuals, (2) special consent issues for select specific diagnosis or treatment, and (3) ancillary situations with consent concerns.

Related areas that are not covered in this chapter include the general consent rules (discussed in the chapter on General Consent Rules) and authorization to release health care information, which is usually the corollary to discussions of informed consent. Issues relating to decision-making for incompetent patients are detailed in the chapter on Decision-Making for Incompetent Patients. While comments on mental health, sexually transmitted diseases, reproduction, death, and experimental treatments are limited to the topic of consent issues, other aspects of these areas may be discussed in other chapters of this manual.

1.2 Consents/Refusals for Categories of Individuals

A major segment of special consent rules deals with the myriad of categories of parental figures who may consent for children’s health care. This section touches upon fourteen common areas dealing with minor children as well as two categories that also involve adults.

RCW 7.70.065, which lists in descending priority the persons authorized to provide informed consent for patients who are not competent was revised in 2005 to create a separate section and list applicable to minor children.¹ It was revised again in 2019 to expand the list of potential surrogates for adults to include adult grandchildren, adult nieces and nephews, adult aunts and uncles, and close friends who meet additional statutory requirements.² For the adult list, individuals in the same class must be unanimous in their decision before any person on behalf of that class may give authorization for health care.³ “Parents of the minor patient”, as the second listed class for the minor children list, following higher priority classes for appointed guardian, may be qualified by other statutes for certain parents.⁴

Further, a health care provider may rely upon the representation of a parent that he or she is authorized to consent to health care for a minor child regardless of marital or custodial status or agreement, order, or decree.⁵ Although the statutes provide that civil or criminal liability may not

¹ S.H.B. 1281.

² RCW 7.70.065(1)(a)(vii-x).

³ RCW 7.70.065(1)(b)(ii). The requirement for unanimous agreement between surrogates in the same class has generally been interpreted to apply only to those members who are available and communicating on an issue. RCW 7.70.065 has not been interpreted to require a health care provider to perform a rigorous independent investigation as to the existence of other possible members of a class who have not been in contact for health care decision-making. The provider may accept the representations of the available surrogates. However, independent investigation is still a good idea in the case of conflict over serious care decisions.

⁴ Authority of both parents may not apply when health care decision-making authority has been granted to only one parent pursuant to RCW 26.09.184(4)(a); 26.09.187(2); 26.09.194(2)(c).

⁵ RCW 70.02.130. This statute is redundant in part with new sections RCW 7.70.065(2)(b-d), which give immunity for reliance on representations of a “person” rather than a “parent”.

be incurred by a health care provider for this reliance when consent is required, consider other implications that exist. These implications become more apparent when the health care to be rendered is more than a routine office visit and includes significant decision-making related to chemotherapy or other high-risk treatment, involved surgery, research therapy, critical management of a new chronic illness, or withholding or withdrawing of life-sustaining treatment.

1.2.1 Children of Married/Separated Parents

When parents are married, both have custody of their minor child so that either the mother or the father may consent to the child’s health care.⁶ The rights and responsibilities of the parents of a minor child are equal.⁷ Even though parents are separated and living apart, they continue to share custody in the absence of a court order modifying their rights.⁸

A health care provider who has notice that the parents are in conflict may choose to hold a patient care conference to facilitate a resolution of their differences. If resolution is not achieved, then the health care provider should tell the parents to reach an agreement about the child’s health care or to obtain a court order authorizing the treatment or non-treatment.

1.2.2 Children of Divorced Parents

If parents are legally separated or divorced, the parent who has the “decision-making authority” for health care may provide consent for their minor child. In dissolution cases filed as of January 1, 1988, the temporary or permanent “parenting plan” designates whether one or both parents have this “decision-making authority”.⁹ Absent possession of decision-making authority, a parent may not make any decision for the child other than those relating to day-to-day or emergency care which is to be made by the parent with whom the child is currently spending residential time.¹⁰

In cases filed before 1988, the divorce “decree” states whether one or both parents have “legal custody” of the child.¹¹ The former term “legal custody” included the authority to consent to health care and is to be distinguished from the term “residential or physical custody”. Custodial designation intends long-term continuity for children, with a strong presumption in favor of retaining that custodian, and if modification is sought, a heavy burden exists to show a substantial change in circumstances and a need to protect the best interests of the child.¹²

When the parenting plan designates health care decision-making to be “sole”, the consent of that parent is required.¹³ If the parenting plan instead designates decision-making or custody

⁶ RCW 26.16.125.

⁷ *In re Welfare of Hudson*, 13 Wn. 2d 673, 693, 126 P.2d 765, 775 (1942).

⁸ *State v. LaCaze*, 95 Wn. 2d 760, 763, 630 P.2d 436, 438 (1981).

⁹ RCW 26.09.184(4)(a); 26.09.194(2)(c).

¹⁰ *Id.*

¹¹ RCW 26.09.909.

¹² RCW 26.09.260. *In re Marriage of Shryock*, 76 Wn. App. 848, 850-851, 888 P.2d 750 (1995). See also *Denise Taddeo-Smith v. James Myron Smith*, Docket No. 55097-7-1 (2004) (“[t]he statutory policy favoring the finality of custodial decrees would be defeated if modification of custody was allowed under” circumstances where a custodial parent severely injured in an auto accident called upon the non-custodial parent to temporarily care for their children”).

¹³ 26.09.194(2)(c); RCW 26.09.184(5); See also 26.09.194(2) both parents are presumed to have decision making power over day to day and emergency situations

to be “mutual” or “joint”, the consent of either parent is sufficient. The health care provider is not required to obtain consent from both of the separated or divorced parents or to assure their mutual or joint agreement to the health care.¹⁴ The provider also need not obtain a copy of the parenting plan, but may rely upon the representation of a parent that he or she possesses the health care decision-making authority.¹⁵

If a health care provider has notice, however, that the parents are in conflict regarding either the terms of the parenting plan or divorce decree, or the giving of consent to specific health care, the provider should obtain a copy of the parenting plan or divorce decree for interpretation. If the authority or custody is deemed to be mutual or joint or not allocated, and the parents continue to be unable to resolve their differences, they should be told to either reach an agreement or to obtain a court order authorizing the treatment or non-treatment. If treatment, such as ongoing counseling sessions or a medication regime or a surgical procedure, has been started at the time of receipt of notice of opposition to it by the other parent, it should be brought to a clinically appropriate conclusion and not interrupted to the detriment of the patient.

Two points of law operate despite the entry of a parenting plan: (1) regardless of the allocation of decision-making authority for health care, either parent may consent to emergency health care;¹⁶ and (2) upon the death of the divorced custodial parent, the non-custodial parent’s right of custody revives automatically without any court action.¹⁷ A non-parent, however, may obtain a court order of custody under RCW 26.10.030 to the exclusion of the surviving parent if placing a child with an otherwise fit parent would be detrimental to the child.¹⁸

1.2.3 Children Born to Unmarried Parents

When the parents of a minor child have not been married, the natural mother alone may consent to health care for their child unless the natural father has established a parent-child relationship under Chapter 26.26A RCW.¹⁹ A court order regarding the parent and child relationship shall be determinative for all purposes including health care decision-making authority to consent

¹⁴ RCW 7.70.065(2).

¹⁵ RCW 70.02.130.

¹⁶ RCW 26.09.184(4); 26.09.194(2)(c).

¹⁷ RCW 26.16.125. *In re Welfare of Frank*, 41 Wn.2d 294, 297, 248 P.2d 553, 554 (1952).

¹⁸ *In re Custody of Shields*, 120 Wn. App. 108, 123-124, 84 P.3d 905 (2004), *petition for review granted en banc* 155 Wn.2d 1007 (2005) (court affirmed granting of custody of a 11-year-old boy to his step-mother of six years upon the death of his custodial father after a determination that, although the natural mother is fit, the boy being in her custody “will continue to cause actual detriment to [the boy], which will adversely affect his growth and development.”) *See also In re Custody of Nunn*, 103 Wn. App. 871, 14 P.3d 175 (2000) (court reversed granting of custody to the aunt whose allegations about the mother’s unfitness were unfounded in a petition for non-parental custody upon the death of the custodial father).

¹⁹ RCW 26.26A.100. There are six (6) ways that a man may establish a parent-child relationship: presumption, acknowledgement, adjudication, adoption, assisted reproduction, and surrogate parentage contract. This section addresses the first three. *See Nguyen v. INS*, 533 U.S. 53, 121 S.Ct. 2053, 178 A.L.R. Fed. 587 (2001) (8 U.S.C. section 1409(a) requires a father who is a U.S. citizen to take affirmative steps before his child born abroad and out-of-wedlock may acquire his nationality status).

for his child.²⁰ This court order may or may not be a “parenting plan”, as a parenting plan is not required for paternity actions.²¹

For the father who has had a determination of paternity, the health care provider should be assured that an order granting custody or health care decision-making exists and not rely merely on the listing of the father’s name on the child’s birth certificate. If the father has been granted authority for health care decision-making, a copy of the court order should be placed in the child’s medical records.

1.2.4 Children of Surrogate Parentage Contracts

Consent to health care for neonates resulting from assisted reproduction is given by the individuals established to be the parents. The State of Washington recognizes surrogate parentage contracts and looks to the contractual terms to establish the parentage of the child born from the arrangements.²² If the surrogate parentage contract is unenforceable under the Uniform Parentage Act, however, the parent-child relationship for the birth is determined by the court consistent with the intent of the parties at the time the agreement was executed.²³

The mother-child relationship is established as to a child born of assisted reproduction if the mother is the intended parent of the child pursuant to a valid surrogate parentage contract.²⁴ Alternatively, the ovum donor or surrogate gestation carrier may indicate her intention to be legally bound as mother of the child born through assisted reproduction by filing an affidavit and physician’s certificate with the registrar of vital statistics within ten (10) days of the child’s birth.²⁵ Absent a valid contract or filing within ten (10) days, state statute reverts to the woman having given birth to the child as being the legal mother.²⁶

The father-child relationship is established as to a child born of assisted reproduction if the father is the intended parent of the child pursuant to a valid surrogate parentage contract.²⁷

²⁰ RCW 26.26B.020 , 26.26B.090,

²¹ RCW 26.26B.020. *See Murphy v. Miller*, 85 Wn. App. 345, 348, 932 P.2d 722 (1997) (court refused to enforce parents’ agreement to have joint custody and affirmed originally ordered parenting plan denying joint custody to father).

²² RCW 26.26A.700 through 26.26A.785.A “surrogate parentage contract” is defined as an agreement in which a female, not married to the sperm donor, agrees to conceive a child through natural or artificial insemination. It also is defined as an agreement in which a female agrees to be implanted with an embryo not genetically related to her. In both instances, the female agrees to voluntarily relinquish her parental rights to the child. RCW 26.26A.100

²³ RCW 26.26A.755(2). *See State ex re. D.R.M. v. Wood*, 109 Wn. App. 182, 34 P.3d 887 (2001) (court affirmed finding that a lesbian who did not adopt a child conceived as a result of artificial insemination of the biological mother who was her former partner is not a parent under the Uniform Parentage Act.)

²⁴ 26.26A.700 through 26.26A.785

²⁵ *See Carvin v. Britain*, 121 Wn. App. 460, 89 P.3d 271 (2004), *affirmed in part, reversed in part* by 155 Wn.2d 679 (2005) (court stated that the 2002 Uniform Parentage Act does not provide a method “for determining parentage of the same sex domestic partner of a biological parent of a child conceived by artificial insemination,” but recognized a common law right to status as a *de facto* parent). RCW 26.26A.610 speaks to birth mother’s rights, see also RCW 26.26A.615, 26.26A.605

²⁶ RCW 26.26A.100(1) provides that “[A parent-child relationship is established between an individual and a child if: (1) The individual gives birth to the child, except as otherwise provided in RCW [26.26A.700](#) through [26.26A.785](#);

²⁷ RCW 26.26A,740(1)

Alternatively, the father may be established by his having consented to assisted reproduction by his wife that resulted in that child’s birth.²⁸

1.2.5 Children of Non-Parental Custodians

When a non-parent has secured a court order granting non-parental custody of a minor child, only that individual may consent to the health care for the child.²⁹ The typical court order grants “full custody” which encompasses authority to consent to health care including surgery and anesthesia. But because provision exists for the ordering of specific limitations, the health care provider may need to obtain a copy of the order to determine the scope of the custodian’s authority to make health care decisions. Despite this non-parental authority to consent for health care, one or both parents may continue to be involved with their child. Either or both parents may be the financial guarantor(s), having been required to maintain health insurance coverage for the child in the court order.³⁰ Each parent retains full access to the medical records of the child unless a court order states differently.³¹ Parents may be present during the rendering of health care if they retain rights of visitation with their child or if the non-parental custodian approves visitation.³²

During the non-parental custody proceeding, the consent of the child with mental capacity age twelve (12) and older is required for a health care provider to release information from medical, psychiatric, and other expert persons who have served the child.³³ The consent of the parent or child’s custodian is not required. The Washington Supreme Court has deemed it to be against public policy for a father to give the lifetime care and custody of his toddler child to the grandparents in a written agreement, which had not been made the basis of legal adoption.³⁴ Likewise, it is unlawful for a person or agency to transfer or to assume the permanent care and custody of a child, unless permitted otherwise by a court order or statute.³⁵

Often grandparents and step-parents are the individuals who obtain non-parental custody of a minor child. Grandparents and step-parents may seek this or another appropriate judicial order if they desire to obtain rights to their grandchildren or step-children as “others with an ongoing relationship with the child”.³⁶ Washington state law does not otherwise legally recognize

²⁸ RCW 26.26A,740(1)

²⁹ RCW 26.10.170.

³⁰ RCW 26.10.060.

³¹ RCW 26.10.150.

³² RCW 26.10.160.

³³ RCW 26.10.130.

³⁴ *In re Application of Smith*, 118 Wn. 1, 202 P. 243 (1921).

³⁵ RCW 26.33.370.

³⁶ The United States Supreme Court affirmed a state court decision finding that Washington’s non-parental visitation statute RCW 26.10.160(3) was unconstitutional as applied in the case as it interfered with parents’ fundamental rights to rear their children. *In re Custody of Smith*, 137 Wn. 2d 1, 15, 969 P.2d 21 (1998), *aff’d sub nom., Troxel v. Granville*, 530 U.S. 57, 120 S.Ct. 2054 (2000). Justice O’Connor wrote “The liberty interest at issue in this case—the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by this Court.” She also wrote “[T]here is a presumption that fi parents act in the best interests of their children,” and the problem is that the state superior court “gave no special weight at all to [the mother’s] determination of her daughters’ best interests” but substituted its own, placing the burden of disproving best interests on the mother. The Washington Supreme Court likewise viewed the Constitution to permit a State to interfere with the right of parents to rear their children only to prevent harm or potential harm to a child and RCW 26.10.160(3) to be unconstitutional in that it requires no threshold showing of

grandparents or step-parents to have specific rights in relation to their grandchildren or step-children.³⁷

1.2.6 Children with Kinship Caregivers

A competent adult who is a relative responsible for the health care of a minor patient is authorized to give informed consent to medical care.³⁸ It is sufficient that the kin represent himself or herself to be a relative responsible for the health care of the child. The provider or facility may rely on this representation so long as there is no actual notice of the falsity of the statements.

To secure immunity from civil or criminal suit or from professional action, the provider or facility needs to require a declaration signed and dated under penalty of perjury that the individual is a relative responsible for the child's health care.³⁹ This kinship declaration is effective for up to six (6) months.

1.2.7 Children in Shelter Care/Foster Homes

Dependency is designed to help protect children, to help parents alleviate problems, and to reunite families.⁴⁰ When a minor child is placed in shelter care including a foster home, the court order for placement specifies the agency or individual who has the authority to consent for that child's health care.⁴¹ This authority typically extends only to routine medical, dental, and psychological examination and care. The natural parents do not in addition have to give their consent to these types of health care. A question arises as to whether inpatient admissions are considered "routine" care that does not require the consent of the natural parents. The health care provider may give health care information and patient education to the natural parents,⁴² if present, as well as to the foster parents,⁴³ as both sets of parents may be providers of the child's home health care.

Elective or necessary non-emergency surgical care including anesthesia, on the other hand, requires either a natural parent's informed consent or a court order authorizing the health care

harm. It also viewed the Washington visitation statute to sweep too broadly, disregarding that "[p]arents have a right to limit visitation of their children with third persons".

³⁷ RCW 26.11.020 allows for relatives to petition for visitation when a significant relationship has been shown to exist.

³⁸ RCW 7.70.065(2)(a)(v). In 2005, the State legislature created this new section to the informed consent statute in order to assist children who are in the care of kin to be able to more easily access appropriate medical services.

³⁹ RCW 7.70.065(2)(d).

⁴⁰ *In re A.W.*, 53 Wn. App. 22, 765 P.2d 307 (1988), *rev. denied*, 112 Wn. 2d 1017 (1989).

⁴¹ RCW 13.34.060(3)

⁴² Dependency is "a preliminary, remedial, non-adversary proceeding" that does not permanently deprive a parent of any rights. *In re Welfare of Key*, 119 Wn. 2d 600, 609, 836 P.2d 200, 205 (1992), *cert. denied*, 507 U.S. 927, 113 S.Ct. 1302, 122 L.Ed.2d 691 (1993).

⁴³ Foster parents have limited rights as to the child. "During dependency proceedings, the interests of the foster parents must give way to the paramount interests of the natural parents." *In re Welfare of Coverdell*, 39 Wn. App. 887, 891, 696 P.2d 1241, 1244 (1984), *rev. denied*, 102 Wn. 2d 1009 (1984). Neither statute nor caselaw give foster parents a right to intervene in dependency proceedings, and foster parents do not have a liberty interest in a continued relationship with their foster children. *In re Dependency of J.H.*, 117 Wn. 2d 460, 476, 815 P.2d 1380 (1991).

provider to perform the procedures on a minor child in dependency.⁴⁴ Surgery and anesthesia are not routine health care and may have significant risks, including unexpected death, to a minor child. These procedures require the informed participation and approval of parents who have not had their parental rights terminated.

The typical order also allows the agency or individual to authorize all necessary emergency care for a minor child, although local court rules may impose restrictions. For example, King County court rules require the agency to first secure the consent of the child’s natural parents, if they are available, for emergency care.⁴⁵ The language of this local rule imposes the duty upon the agency and not on the health care provider. It follows that when an agency provides consent in these emergency situations, it would be reasonable for the health care provider to assume that the agency has complied with local rules and internal regulations and to rely upon the consent.

1.2.8 Dependent Children with Court-Appointed Guardians

When the court establishes a dependency guardianship⁴⁶ for a child, the named guardian typically assumes custody of the minor child on a temporary basis. “Guardianship is not permanent, nor is it irreversible, and it does not sever all rights of the parent in the child”.⁴⁷ The granting of a dependency guardianship order automatically includes the authority to consent to necessary health and surgical care for the child unless the court specifies otherwise in the order.⁴⁸ Even though there is no statutory limitation, it may be advisable for a health care provider to request the dependency guardian to obtain a court order for those therapies which are specifically limited in chapters 11.92 RCW guardianship statutes.⁴⁹

It is common for dependency guardians or foster parents to be unclear about their designation in relation to the dependent child. Another area of possible confusion is whether the “guardianship” is one for dependency as set forth under RCW chapter 13 or for incapacity (which includes being of minor age) purposes under RCW chapter 11.⁵⁰ It is also possible for a minor child to have two guardianship orders. The best practice is for the health care provider to obtain a copy of the latest order, as well as related pertinent orders to clarify the designation of the substitute parental figure and the scope of health care decision-making authority.

⁴⁴ *In re Welfare of Hudson*, 13 Wn.2d 673, 681-82, 126 P.2d 765 (1942) (juvenile court could not supersede mom’s decision not to amputate her daughter’s deformed arm for fear that child might not survive the operation as fit parents have the constitutional right to custody and control of their minor children).

⁴⁵ LJuCR 3.8(e)(4).

⁴⁶ *In re Dependency of F.S.*, 81 Wn. App. 264, 270, 913 P.2d 844 (1996) (court held that due process requires the preponderance of the evidence standard in establishing a dependency guardianship).

⁴⁷ *Id.* at 269.

⁴⁸ RCW 13.34.232.

⁴⁹ RCW 11.92.043(1)(f)(i) –(iii)

⁵⁰ See RCW 13.34.030 Definitions; (5) “Dependency guardian”; (10) “Guardian”.

1.2.9 Children of Terminated Parental Relationships

When a natural parent's rights are terminated under the Juvenile Court Act,⁵¹ he or she loses all authority to consent to health care and all rights to visitation.⁵² The entry of a valid termination order severs the relationship between parent and child and “constitutes a final, unassailable determination that such permanent termination is in the best interest of the child”.⁵³ When conflict arises between competing petitions for guardianship and termination, the court has considered the best interests of the child with the primary consideration being permanency for the child.⁵⁴ The termination order typically grants custody to a custodian, for example, DSHS or a licensed child-placing agency, or parental custody remains with the other parent, as the parent-child relationship may be terminated as to one parent and not the other. The custodian or the remaining natural parent has the authority to consent to necessary surgical and other medical treatment.

Likewise, termination of parental rights under the Adoption Act⁵⁵ divests that parent of all rights in relation to the minor child, including those to make health care decisions and, more often than not, to have visitation.⁵⁶ Courts cut off a parent's right to withdraw consent to adoption once a fixed decree of termination is entered, even if the adoption is not final.⁵⁷ The agency or individual named in the temporary custody order for adoption, as designated in the termination order, may provide consent for the health care of the adoptive child.

1.2.10 Children in Pre-Adoption Process

Prior to the entry of an order of relinquishment for adoption,⁵⁸ a relinquishing parent with legal custody of the minor child being placed for adoption has the authority to consent to health care. During at least the first forty-eight (48) hours of an infant's birth, if health care is necessary, the health care provider needs to seek consent from the birth mother or her husband, if married. If the infant is an “Indian child”, more stringent federal requirements apply (see 1.12.14

⁵¹ Chapter 13.34RCW. See *Santosky v. Kramer*, 455 U.S. 745, 102 S.Ct. 1388, 71 L.Ed.2d 599 (1982) (Court held that due process requires at least clear and convincing evidence before a state may sever completely and irrevocably the rights of parents in their natural child). See *Welfare of A.T.*, 109 Wn. App. 709, 34 P.3d 1246 (2001) (court vacated termination of biological father's parental rights as “aggravated circumstance” was not present).

⁵² RCW 13.34.200, 13.34.210.

⁵³ *In re Dependency of G.C.B.*, 73 Wn. App. 708, 717, 870 P.2d 1037, 1043 (1994), *rev.denied*, 124 Wn. 2d 1019, 881 P.2d 254 (1994) (court dismissed the mother's adoption petition as she had no standing to do so once her parental rights had been terminated in a dependency proceeding).

⁵⁴ *In re Dependency of Solomon Yeshema*, 123 Wn. App. 244, 98 P.3d 89 (2004). See also *In re Dependency of K.S.C.*, 137 Wn. 2d 918, 976 P.2d 113 (1999) (in absence of petition for guardianship, court need not consider that option; if petition is filed, inquiry is whether statutory requirements are satisfied).

⁵⁵ Chapter 26.33 RCW.

⁵⁶ RCW 26.33.130. See *In re Adoption of Baby Girl K.*, 26 Wn. App. 897, 900-902, 615 P.2d 1310, 1312-14 (1980), *rev.denied*, 95 Wn. 2d 1003 (1981) (court refused to allow birth mother to revoke her written surrender of her baby to an adoption agency). But see *In re Custody of R.R.B.*, 108 Wn. App. 602, 31 P.3d 1212 (2001) (court affirmed award of custody to natural father as against the adoptive parents, holding that adoption statutes do not prevent biological parent from bringing a non-parental custody action).

⁵⁷ *In re Adoption of Crews*, 118 Wn.2d 561, 571, 825 P.2d 305, 311 (1992). But see *In re A.S.*, 65 Wn. App. 631, 829 P.2d 791 (1992) (relinquishment order vacated based on showing of fraud).

⁵⁸ RCW 26.33.090.

below). Only upon the entry of the relinquishment order may the individual or agency, appointed as legal guardian and awarded custody of the child, authorize health care.

It is insufficient to rely upon consent to adoption by the mother or other parent and those to assume custody by the prospective adoptive parent or agency as being the authorization for health care decision-making. Only a court order or statute may grant this custodial authority.⁵⁹ An adoptive parent achieves permanent custody only under a decree of adoption.⁶⁰ That individual may consent to all health care of the minor adoptive child and is entitled to “a complete medical report containing all . . . information concerning the mental, physical, and sensory handicaps of the child.”⁶¹

A relinquishing parent may retain rights of contact with the child, as open adoption agreements are recognized in Washington.⁶² The specific circumstances usually do not extend to grandparent visitation in an adoption.⁶³

1.2.11 Newborn Transferred to Emergency Department or Fire Station

A parent of a newborn may transfer a newborn, who is less than seventy-two (72) hours old, to a qualified person at a hospital emergency department or a fire station.⁶⁴ The parent need not provide any identifying information and may be asked to provide the family medical history of the parents and newborn. The qualified person should represent to the parent that he or she will “summon appropriate resources to meet the newborn’s immediate needs.” This constitutes statutory authorization for the hospital to provide necessary health care. The person will also notify Child Protective Services (CPS) within twenty-four (24) hours, and CPS in turn will assume custody of the newborn within twenty-four (24) hours.

1.2.12 Emancipated and Mature Minors

In the State of Washington, an individual is deemed to be of full age at eighteen (18) years for the purpose of making health care decisions.⁶⁵ That person may make health care decisions as well for his or her natural born and adopted children. When a person under the age of eighteen (18) years is married to an individual of full age, that minor person is also deemed to be of full age.⁶⁶

⁵⁹ RCW 26.33.370 provides that it is unlawful and a gross misdemeanor for persons to attempt to transfer the permanent care and custody of a child by other means. See *In re Smith*, 118 Wn. 1, 202 P. 243 (1921) (court deemed an agreement by a father giving the care and custody of his infant child to the grandparents, which had not been made the basis of legal adoption, to be void as against public policy).

⁶⁰ RCW 26.33.260.

⁶¹ RCW 26.33.350. See *Morris v. DSHS*, Court of Appeals Div. 1, Docket No. 47964-4-I (2003) (unpublished opinion).

⁶² RCW 26.33.295.

⁶³ *In re Custody of B.S.Z.-S.*, 74 Wn. App. 727, 732, 875 P.2d 693, 696 (1994). In a case that goes counter to the trend in other states, the court held that a biological grandmother had no standing to petition for visitation with her grandchild, who once had a continuing relationship with her, when her ex-husband and his new wife adopted the grandchild.

⁶⁴ RCW 13.34.360. The legislature enacted this section “to increase the likelihood that pregnant women will provide their newborns with adequate health care during the first few days of their lives.” 2002 c 331 section 1.

⁶⁵ RCW 26.28.015(5).

⁶⁶ RCW 26.28.020.

If the patient is a minor and is authorized to consent to health care without parental consent under a federal or state law, emancipation or mature minor status is not also required. Examples of certain types of medical treatment include those for sexually transmitted diseases, mental health, and alcohol or drug addiction. These specific situations are covered elsewhere in this chapter as well in other chapters of this manual.

Under the common law, a minor child was able to provide informed consent for his or her own health care if he or she was determined by a physician to be a “mature minor”. The Washington Supreme Court has listed the factors that should be considered in determining whether a minor is emancipated for the purposes of making health care decisions.⁶⁷ These factors include age, intelligence, maturity, training, experience, economic independence, and freedom from parental control. The physician obtaining informed consent from a minor child needs to ask questions to determine capacity to understand the proposed medical treatment and to weigh the Court’s factors. Documentation should be sufficient to show the maturity of the minor. If the child is determined to be too immature to make health care decisions, then consent needs to be obtained from, in order of priority, appointed guardian or legal custodian, authorized decision-maker if out-of-home placement, or the parents.⁶⁸

A minor child at least sixteen (16) years of age and residing in the State of Washington may petition the court for a determination of emancipation status.⁶⁹ This status includes the right to provide informed consent for health care.⁷⁰ Documentation of this legal status by the health care provider may include obtaining a copy of the child’s Washington driver’s license or identification card which designates emancipation. A copy of the court order is also appropriate documentation to place in the medical chart. Consider, however, the effects of this legislation on the common law determination of maturity. Parameters, such as the minimum age, may be gauged against the statutory requirement, which for age is sixteen (16) years, such that a younger age may not be deemed to signify sufficient maturity. It will be easier for parents or guardians to prevail on challenges to non-statutory determinations of emancipation.

1.2.13 Children of Minor Parents

Parents may make health care decisions for their children. If, however, the parent is a minor and is deemed by the health care provider to be too immature and unable to make responsible health care decisions for his or her child, it may be necessary to contact Child Protective Services. A legal guardian may need to be appointed for the child patient.⁷¹ The parents of the minor parent, as the patient’s grandparents, do not have the right to consent to the health care of their grandchild unless they have obtained a court order of custodianship or guardianship.

⁶⁷ *Smith v. Seibly*, 72 Wn. 2d 16, 21, 431 P.2d 719, 723 (1967).

⁶⁸ RCW 7.70.065(2)(a).

⁶⁹ RCW 13.64.010.

⁷⁰ RCW 13.64.060(1)(h).

⁷¹ *See Benoy v. Simons*, 66 Wn. App. 56, 63, 831 P.2d 167, 171 (1992), *rev. denied*, 120 Wn. 2d 1014, 844 P.2d 435 (1992) (serious doubts existed about the 16-year old mother’s ability to make responsible health care decisions for her infant son who was on life support systems).

1.2.14 Indian (Native American) Children

Health care providers should be aware that the Indian Child Welfare Act of 1978 (ICWA),⁷² mandates that Indian children⁷³ be handled in accordance with special federal requirements. Providers should seek legal advice on situations where court orders of Indian tribes may be the authority identifying the custodian who may give health care consent for an Indian child. Situations include when the patient is the subject of dependency proceedings or in the pre-adoption process.

In any voluntary or involuntary state court placement proceeding⁷⁴ regarding an Indian child, the Indian custodian of the child and the Indian child's tribe have a right to intervene in the proceeding.⁷⁵ Washington statutes incorporate the requirements of ICWA into proceedings for non-parental child custody,⁷⁶ dependency and termination of parent-child relationship,⁷⁷ and adoption.⁷⁸ ICWA does not apply to the custody provisions of a divorce decree or to delinquency proceedings where custody remains with one of the parents.⁷⁹

⁷² 25 U.S.C. sec. 1901-1963 (1988). The federal safeguards are to prevent the unilateral separation of Native American children from their culture.

⁷³ Caselaw has addressed who is an "Indian child" under ICWA. *Dependency of A.L.W.*, 108 Wn. App. 664, 672, 32 P.3d 297 (2001) (tribe's determination is conclusive evidence that a child is an "Indian child"); *In re Adoption of M*, 66 Wn. App. 475, 832 P.2d 518 (1992) (an "Indian child" is one who is eligible for membership in an Indian tribe and the biological child of an Indian tribe member); *In re Adoption of Crews*, 60 Wn. App. 202, 803 P.2d 24 (1991) *affirmed*, 118 Wn.2d 561, 573, 825 P.2d 305, 312 (1992) (neither the adoption agency nor the court has a duty to investigate a child's Indian ancestry based upon sparse information provided by the parents).

⁷⁴ *Dependency of E.S.*, 92 Wn. App. 762, 769, 964 P.2d 404 (1998) (ICWA does not divest a state court of jurisdiction over Indian children who live off the reservation, but authorizes concurrent jurisdiction with a preference for trial court jurisdiction).

⁷⁵ 25 U.S.C. § 1911(c),(d). Congress based this right of intervention on its finding that there is no resource more vital to the continued existence and integrity of Indian tribes than their children, and these children should be protected. *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30, 35, 109 S.Ct. 1597, 104 L.Ed.2d 29 (1989).

⁷⁶ RCW 26.10.034. *See In re S.B.R.*, 43 Wn. App. 622, 625, 719 P.2d 154, 155-56, (1986) *rev. denied*, 108 Wn. 2d 1009 (1986) (court was without jurisdiction to hold non-parental custody proceeding, divesting natural parents of custody based on unfitness, until child's Indian tribe received notice and was permitted to intervene). *In re Interest of Mahaney*, 105 Wn. App. 391, 20 P.3d 437 (2001), *reversed*, 146 Wn. 2d 878, 51 P.3d 776 (2002) (court properly applied best interests test which is not replaced by ICWA in granting non-parental custody to non-Indian grandmother).

⁷⁷ RCW 13.34.040, 070, 132, and 200. *See In re Welfare of M.S.S.*, 86 Wn. App. 127, 134, 936 P.2d 36 (1997) *rev. denied*, 133 Wn. 2d 1008, 943 P.2d 663 (1997) (remand ordered to show whether ICWA notice requirements were met in a petition to invalidate a termination of parental rights). *See Dependency of A.M.*, 106 Wn. App. 123, 135, 22 P.3d 828 (2001) (§ 1912(d) findings must be established by clear, cogent, and convincing evidence).

⁷⁸ RCW 26.33.040, .090, .160. *Dependency of M.D.*, 110 Wn. App. 524, 537, 42 P.3d 424 (2002) (court interpreted RCW 26.33.160(4) to not give an Indian parent the right to revoke a consent to adoption after the entry of a final order of termination).

⁷⁹ 25 U.S.C. § 1903(1).

1.2.15 Developmentally Disabled Individuals

The legal representative⁸⁰ of the developmentally disabled individual⁸¹ is authorized to provide consent to health care. If there is more than one legal representative, the priority is according to the application of RCW 7.70.065. An individual need not be declared incompetent in a court of law to be deemed to lack capacity to make health care decisions, and developmental disabilities can be the basis for deeming an individual to lack capacity to provide informed consent to health care.

If a developmentally disabled minor or adult resides in a residential habitation center,⁸² the Secretary of DSHS has custody and control of all medical, educational, therapeutic, and dietetic treatment.⁸³ The Secretary has the statutory obligation to obtain the consent of or to make efforts to find the parent or guardian of a developmentally disabled resident when surgery is to be performed.⁸⁴ The required surgical consent is not necessary if the Secretary's reasonable effort to locate the decision-maker has failed, and the attending physician certifies the health of the resident to be jeopardized unless the surgery is performed.⁸⁵ This duty to obtain consent or an exception being upon the Secretary, it follows that when the Secretary provides authorization to the health care provider, it would be reasonable to assume that compliance with the statute has occurred.

Legal protections apply during the provision of health care to developmentally disabled individuals. Persons who are developmentally disabled may not be detained for mental health evaluation and treatment or judicially committed solely by reason of that condition, unless that condition causes grave disability or as a result of a mental disorder, a likelihood of serious harm exists.⁸⁶ Adult developmentally disabled persons, as vulnerable adults, are afforded the protection of the reporting and investigation statutes. Additionally, a female diagnosed with developmental disability may not be a surrogate mother.⁸⁷

1.2.16 Individuals in Custody

State statutes and regulations address the rendering of health care to persons in the custody of law enforcement agencies. If an examination, treatment, or procedure requires informed consent for persons in the community, it must likewise be obtained for prisoners.⁸⁸ For these

⁸⁰ RCW 71A.10.020(8). "Legal representative" is defined as a parent of a minor child, the legal guardian, the limited guardian if the subject matter is within the scope of authority, an attorney-at-law, an attorney-in-fact, or any other person who is authorized by law to act for another person.

⁸¹ RCW 71A.10.020(5); RCW 13.34.030(7). "Developmental disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition which originates before age eighteen (18), is expected to continue indefinitely, and which constitutes a substantial handicap.

⁸² Examples of these centers include Lakeland Village, Rainier School, Yakima Valley School, and Fircrest School.

⁸³ RCW 71A.20.050(2).

⁸⁴ RCW 71A.10.030(3). The parent whose child resides in a residential habitation center is not deprived of any parental rights except as provided by statute or regulation for the orderly operation of such facility.

⁸⁵ RCW 71A.20.050(2).

⁸⁶ RCW 71.05.040.

⁸⁷ RCW 26.26.220.

⁸⁸ WAC 289-20-160(1); WAC 289-20-260(1)(a). The legislative intent is that all jail inmates receive appropriate emergency and necessary medical care. RCW 70.48.130.

individuals in custody, mandatory custodial care standards set forth the minimum legal requirements relating to prisoner health and apply to individuals in holding, detention, and correctional facilities.⁸⁹ For minors in custody,⁹⁰ the informed consent of the parent or legal custodian applies as required by law.⁹¹ The administrator of the juvenile court or authorized staff may consent to the health and dental care of a juvenile detained at or sentenced to a detention facility except if informed of objections to the treatment by the parent or guardian.⁹² Chapter 72.05 RCW provisions do not limit the rights of parents and guardians to provide any medical treatment permitted by law.⁹³

Prisoners in detention and correctional facilities may be given medical treatment against their will in specified circumstances.⁹⁴ Care may be rendered as needed to prevent the spread of communicable disease.⁹⁵ RCW 70.24.340(1)(a), for example, provides an exception to the consent requirement in the nonconsensual HIV testing of a sexual offender.⁹⁶ Care may also be rendered to prevent imminent danger to the prisoner's life with necessity to follow Chapter 71.05 RCW addressing mental illness in cases of involuntary commitment or involuntary treatment of mentally ill individuals.

1.3 Consents/ Refusals for Specific Diagnosis or Treatment

Another segment of special consent rules deals with certain diagnosis or treatment requiring focused consideration on unique concerns. After addressing these concerns, the general consent rules, discussed in the chapter on General Consent Rules, usually apply. These specific diagnoses or treatments typically deal with reproductive and mental health care. The rules that are presented in this section differ vastly, ranging from younger age of consent for minor children to broader protection for the mentally ill to mandatory procedures to effectuate state policies in preventing certain diseases.

1.3.1 Sexually Transmitted Disease

An individual fourteen (14) years of age and older may consent to health care, including hospitalization and surgery, for any actual or suspected sexually transmitted disease (STD).⁹⁷

⁸⁹ WAC 289-20-100 through WAC 289-20-290. *See Estelle v. Gamble*, 429 U.S. 97, 97 S.Ct. 285 (1976) (“deliberate indifference to serious medical needs of prisoners” by prison doctors or guards, not present in the case, would constitute cruel and unusual punishment prohibited by the Eighth Amendment).

⁹⁰ The court and the facility may handle prisoners who are both minors and adults. In RCW 72.05.020, “juvenile” is defined as a person under the age of twenty-one (21) years who has been sentenced to a term of confinement under the supervision of the department under RCW 13.40.185. In RCW 13.04.011, “juvenile” is defined as an individual under the age of eighteen (18) years. In RCW 13.40.020, “juvenile” is defined as an individual under the age of eighteen (18) who has not been previously transferred to adult court or is under adult court jurisdiction. In RCW 13.40.020, “juvenile offender” means any juvenile found by juvenile court to have committed an offense, including one age eighteen (18) years or older over whom jurisdiction has been extended under RCW 13.40.300.

⁹¹ WAC 289-20-260(1)(c).

⁹² RCW 13.04.047.(3)

⁹³ RCW 72.05.200.

⁹⁴ WAC 289-20-260(1)(b).

⁹⁵ RCW 70.24.360 and WAC 246-100-206 address HIV testing and counseling of jail detainees. RCW 70.24.370 addresses HIV testing and counseling of correction facility inmates.

⁹⁶ *In re Matter of Juveniles A,B,C,D,E*, 121 Wn. 2d 80, 90, 847 P.2d 455, 463 (1993) (statute applies to juvenile offenders).

⁹⁷ RCW 70.24.110.

The consent of a parent or legal guardian for STD health care for a minor fourteen (14) years of age and older is not required, but when not obtained, the non-consenting parent or guardian is not responsible for payment of costs related to the care. Treatment of a sexually transmitted disease at any age must include instruction on communicability as appropriate to each patient.⁹⁸

Several exceptions allow for testing for sexually transmitted diseases without requirement for consent. In certain limited circumstances, a state or local health officer with reason to believe that a person has a sexually transmitted disease and is engaging in conduct dangerous to public health may issue orders for medical examination, testing, and counseling.⁹⁹ Another exception is that, in caring for a pregnant woman, the physician is required to test for one form of sexually transmitted disease, syphilis, during the first examination.¹⁰⁰ A third exception is that the health care provider must ensure the installation of an approved prophylactic ophthalmic agent into the conjunctival sacs of a newborn infant within established timeframes to prevent gonococcal or chlamydial ophthalmia neonatorum.¹⁰¹

Human immunodeficiency virus (HIV) is considered a special sexually transmitted disease that requires a documented consent specifically identifying the HIV test to be performed, evaluation of risk factors, provision of information about HIV, and recommend and offer or refer for pre-test counseling.¹⁰² A minor patient fourteen (14) years of age and older may consent to HIV testing without his or her parent's additional consent. Consent for HIV testing of an incompetent patient should be obtained from his or her legal representative in accordance with RCW 7.70.065. An exception to the consent requirement is the mandatory HIV testing and counseling of persons convicted of a sexual offense, prostitution or related offense, and drug offenses associated with the use of hypodermic needles.¹⁰³

1.3.2 Sterilization

Informed consent by a competent adult for voluntary sterilization should follow the general consent rules for surgery and may recite the risk that pregnancy may occur despite the procedure.¹⁰⁴ An emancipated minor likewise may consent to a sterilization procedure.¹⁰⁵ If the procedure involves Medicaid funding, federal regulations apply, including a special informed consent form, that patients be mentally competent and twenty-one (21) years of age or older, and a thirty (30)-day waiting period.¹⁰⁶

⁹⁸ WAC 246-100-202. (1)(b)(i)

⁹⁹ WAC 246-100-203.

¹⁰⁰ RCW 70.24.090.

¹⁰¹ WAC 246-100-202(1)(e).

¹⁰² WAC 246-100-207(6)(a).

¹⁰³ RCW 70.24.340(1). *In re Matter of Juveniles A,B,C,D,E*, 121 Wn. 2d 80, 90, 847 P.2d 455, 463 (1993) (court applied statute to juvenile offenders). The result is also achieved under current RCW 13.04.011 and RCW 9.94A.030 which define "conviction" to include juvenile "adjudication".

¹⁰⁴ Patients should also be cautioned against any reliance on the potential reversibility of a procedure such as a vasectomy. In the event of an unsuccessful sterilization operation with resultant pregnancy and birth, public policy prohibits the parents' recovery of the costs of child-rearing and education. *McKernan v. Aasheim*, 102 Wn. 2d 411, 687 P.2d 850 (1984).

¹⁰⁵ *Smith v. Seibly*, 72 Wn. 2d 16, 21, 431 P.2d 719, 723 (1967).

¹⁰⁶ 42 CFR sec. 441.253,.254,.257,.258. Federal funds are not available for sterilization of mentally incompetent or institutionalized individuals.

An adult with developmental disability may be deemed incompetent to consent to sterilization even if not declared to be legally incompetent.¹⁰⁷ A court order is required to authorize the sterilization of a mentally incompetent person whether adult or minor.¹⁰⁸ A guardian *ad litem* must assume an adversarial role and ensure that the patient's substantial rights of privacy and to procreate are not waived.¹⁰⁹ If sterilization is a known risk rather than the direct goal of a procedure, the health care provider should still consider whether to seek a court order of authorization. Informed consent for an incompetent patient is further addressed in the chapter on Decision-Making for Incompetent Patients.

RCW 9.92.100 provides that the court may direct that sterilization be performed for habitual criminals and certain sex offenders. One would question the continuing validity of this statute. If challenged today, it may be deemed unconstitutional based upon the patient's interest in the right to privacy with respect to personal reproductive decisions.¹¹⁰ Related case law likewise is dated.¹¹¹

1.3.3 Abortion

A female patient may consent or refuse to consent to have a physician terminate her pregnancy prior to viability of her fetus or to protect her life or health.¹¹² For a minor child, the consent of a parent or guardian cannot be required.¹¹³ Neither can the consent of the spouse be required for a married woman.¹¹⁴

Two other statutory provisions relate to abortions. A person or private medical facility may object to participation in the performance of an abortion.¹¹⁵ An infant who is born alive in the course of an abortion procedure has the statutory right to medical treatment.¹¹⁶ If the mother refuses to consent to necessary care, Child Protective Services may need to be involved.

1.3.4 Assisted Reproduction

The State of Washington permits surrogate parentage contracts for assisted reproduction, which includes intrauterine insemination, egg donation, embryo donation, in vitro fertilization with transfer of embryos, and intraocyttoplasmic sperm injection.¹¹⁷ Statutes specify requirements for consent from the involved parties.¹¹⁸ The physician must certify the date of

¹⁰⁷ *Morinaga v. Vue*, 85 Wn. App. 822, 829, 935 P.2d 637 (1997).

¹⁰⁸ *In re Hayes*, 93 Wn. 2d 228, 234, 608 P.2d 635 (1980).

¹⁰⁹ *In re Guardianship of K.M.*, 62 Wn. App. 811, 818, 816 P.2d 71, 73-79 (1991).

¹¹⁰ RCW 9.92.100(1).

¹¹¹ *See State v. Feilen*, 70 Wn. 65, 71, 126 P.75 (1912) (procedure of vasectomy is not a cruel punishment where care and skill are required, without physical torture, suffering, or pain.); *Buck v. Bell*, 274 U.S. 200, 47 S.Ct. 584 (1927) (Court upheld constitutionality of eugenic sterilization law that provides adequate procedural safeguards).

¹¹² RCW 9.02.110.

¹¹³ *State v. Koome*, 84 Wn. 2d 901, 530 P.2d 260 (1975); *Bellotti v. Baird*, 443 U.S. 622, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979), *rev. denied*, 444 U.S. 887, 100 S.Ct. 185, 62 L.Ed.2d 121 (1979).

¹¹⁴ *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976); *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992).

¹¹⁵ RCW 9.02.150.

¹¹⁶ RCW 18.71.240.

¹¹⁷ RCW 26.26A.010(4).

¹¹⁸ The statutes on this topic reside within the Uniform Parentage Act, Chapter 26.26A RCW.

the ovum harvest, the medical procedures, the parties' signatures, and the intended parties pursuant to agreement.¹¹⁹ An unemancipated minor female or a female diagnosed with mental retardation, mental illness, or developmental disability may not be the surrogate mother in a surrogate parentage contract.¹²⁰

Statutes provide contingencies in the event of dissolution of marriage or the death of a spouse. If marriage dissolution occurs prior to assisted reproduction, the former spouse may revoke his or her consent.¹²¹ The former spouse must consent in a record if assisted reproduction is to occur after a divorce. A spouse who dies should have consented in a record that he would be a parent of a child resulting from assisted reproduction that occurs after his death.¹²²

1.3.5 Genetic Testing

All individuals licensed or certified to provide prenatal care or to practice medicine must provide educational materials regarding the use and availability of prenatal tests to all pregnant women in their care within the time limits prescribed by state rules.¹²³ As standards of medical necessity, WAC 246-680-020 sets forth the following types of screening and diagnostic tests performed during pregnancy:

- Maternal serum alpha-fetoprotein screening;
- Maternal hepatitis B surface antigen (BHsAg);
- Prenatal ultrasonography;
- Amniocentesis;
- Chorionic villus sampling;
- Fluorescent in-situ hybridization (FISH);
- Percutaneous umbilical cord blood sampling; and
- Prenatal tissue biopsy.

Pre-procedure genetic counseling for the above tests means individual counseling involving a health care provider or a qualified genetic counselor under the direction of a physician, and a pregnant woman with or without family members present, to discuss the purposes, risks, accuracy, and limitations of prenatal testing procedure and to aid in decision-making. Post-procedure genetic counseling for these tests is to discuss the meaning of the results of the prenatal testing done and subsequent testing or procedures available.¹²⁴

A regional genetics clinic or a physician, on behalf of a patient, may request cytogenetic¹²⁵ studies to establish or rule out an abnormality in chromosomal number or structure. One type

¹¹⁹ RCW 26.26A.810

¹²⁰ RCW 26.26A.705

¹²¹ RCW 26.26A.625. *See Marriage of Litowitz*, 102 Wn. App. 934, 942, 10 P.3d 1086 (2000), *reversed*, 146 Wn.2d 514, 48 P.3d 261 (2002) (Court reversed decision awarding two pre-embryos upon divorce to the husband who was progenitor and deemed to have a constitutional right not to procreate, instead looking to the terms of the cryopreservation contract for the remedy).

¹²² RCW 26.26A.635

¹²³ RCW 70.54.220; WAC 246-680-001.

¹²⁴ WAC 246-680-010(4)(h) and (i).

¹²⁵ "Cytogenetics" means the hereditary components of cells in the form of chromosomes. Viable cells for cytogenetic analysis may be obtained from blood, bone marrow, skin, solid tissues, or body fluids

of testing is that of parental chromosomes using a procedure to remove blood or other tissue from one or both parents in order to perform laboratory analysis to establish chromosome constitution of the parents.¹²⁶

In the area of pre-symptomatic DNA testing for adults without symptoms of a genetic disease that has no known medical treatment that can slow or prevent it, the main benefit is psychological. The decision of an adult to be tested for this disease is very personal, and often paternalistic criteria are required to ensure that the individual considers knowledge on the quality of life. Testing is generally not offered to pre-symptomatic children under the age of legal consent (age 18).

1.3.6 Newborn Screening

The policy of the State of Washington in imposing screening tests for newborn infants is to detect congenital disorders and to prevent heritable disorders from leading to developmental disabilities or physical defects.¹²⁷ Early testing and prompt follow-up allow diagnosis and treatment before significant, irreversible damage occurs.

Hospitals providing obstetrical delivery services or neonatal care must obtain a blood specimen from each newborn infant prior to discharge from the hospital, or if not yet discharged, no later than five (5) days of age, to screen newborn infants for certain congenital disorders:¹²⁸

- Phenylketonuria (PKU);
- Congenital hypothyroidism;
- Congenital adrenal hyperplasia;
- Hemoglobinopathies;
- Biotinidase deficiency;
- Galactosemia;
- Homocystinuria;
- Maple syrup urine disease; and
- Medium chain acyl-coA dehydrogenase deficiency.

Parents and responsible parties may refuse testing because of religious tenets and practices.¹²⁹ They must designate their refusal of the newborn metabolic screening on a specific Department of Health (DOH) form.

Another state policy is to detect and prevent disorders resulting from maternal use of alcohol and drugs. The DOH and medical professionals are developing screening criteria to identify

(including amniotic fluid). Abnormalities in the number or structure of chromosomes are associated with physical malformations, impaired reproduction, mental deficiency, mental illness, or aberrant behavior.

¹²⁶ See *Pelton v. Tri-State Memorial Hosp.*, 66 Wn. App. 350, 831 P.2d 1147 (1992) (in a medical negligence action alleging that a child's neurological condition was caused by birth trauma, three cytogenetic tests all revealed a chromosomal defect 9p22 with one-third of cases resulting from a parental translocation).

¹²⁷ RCW 70.83.010; WAC 246-650-001.

¹²⁸ RCW 70.83.020; WAC 246-650-020(2)(a). Five disorders were added on June 1, 2004.

¹²⁹ RCW 70.83.020; WAC 246-650-020(1)(a)(iv).

pregnant and lactating women addicted to alcohol or drugs and at risk of producing a drug-affected baby.¹³⁰

1.3.7 Voluntary Mental Health Treatment

An individual age thirteen (13) years or older may consent to voluntary outpatient mental health treatment without need for parental consent in addition.¹³¹ Outpatient treatment of a minor under the age of thirteen (13) requires the consent of a parent.

An adult may be voluntarily admitted for inpatient treatment and must be released immediately upon request.¹³² A minor thirteen (13) years and older may admit himself or herself without parental consent if the professional person in charge of the treatment facility concurs and procedural steps are followed.¹³³ That minor may give a notice, which must be written and show discernible intent, of intent to leave at anytime. The minor must be discharged by the second judicial day following receipt of the notice.¹³⁴

A minor under the age of eighteen (18) may be voluntarily admitted for inpatient treatment by application of the parent and without the minor's consent.¹³⁵ That minor admitted under parental request may not be discharged solely on the minor's request.¹³⁶ Upon written request of the parent, any minor under the age of thirteen (13) must be discharged immediately from inpatient treatment.¹³⁷

An adult with capacity may execute a mental health advance directive which provides advance consent to or refusal of mental health treatment.¹³⁸ This document becomes effective during periods of the patient's incapacity.¹³⁹

1.3.8 Involuntary Mental Health Commitment

Persons suffering from a behavioral health disorder may not be involuntarily committed for treatment except in accordance with statutes.¹⁴⁰ The applicable laws were substantially impacted by legislation passed in 2019.¹⁴¹ Because the revisions were not all immediately effective, careful attention should be given when considering involuntary commitment.

For criminal defendants, Washington courts may issue an order requiring evaluation and treatment not exceeding ninety (90) days pending criminal trial or sentencing.¹⁴²

¹³⁰ RCW 70.83E.020. *See Welfare of A.T.*, 109 Wn. App. 709, 34 3.Pd 1246 (2001) (one-day-old newborn baby born at home tested positive for cocaine).

¹³¹ RCW 71.34.530.

¹³² RCW 71.05.050.

¹³³ RCW 71.34.500;.510; *see Parham v. J.R.*, 442 U.S. 584, 99 S.Ct. 2493 (1979).

¹³⁴ RCW 71.34.520

¹³⁵ RCW 71.34.600.

¹³⁶ RCW 71.34.600(5). *Compare State ex re. T.B. v. CPC Fairfax Hosp.*, 129 Wn. 2d 439, 918 P.2d 497 (1996).

¹³⁷ RCW 71.34.650(4).

¹³⁸ Chapter 71.32 RCW.

¹³⁹ RCW 71.32.110;.130. These sections describe determination of capacity and reevaluation of capacity.

¹⁴⁰ Chapters 10.77 RCW,71.05 RCW,71.06 RCW, and 71.34 RCW.

¹⁴¹ SB 5720-S2.SL.

¹⁴² RCW 71.05.030.

For adults who are not criminal defendants, the initial consideration is whether the professional staff of an agency or a hospital regards a patient as presenting an “imminent likelihood of serious harm to self or others”, or is “gravely disabled as a result of a behavioral disorder.”¹⁴³ “Imminent likelihood of serious harm to self or others” and “gravely disabled as a result of a behavioral disorder” are terms of art defined by statute.¹⁴⁴ The 2019 legislation, however, provided that the definition in effect corresponds to the occurrence of certain conditions, namely that the single-bed certifications fall below 200 for three (3) consecutive months.¹⁴⁵ This is considered unlikely to occur in the near future. Still, care should be taken in considering the term in effect when consulting this Chapter or the statute itself.

When a patient the professional staff of an agency or a hospital regards a patient as presenting an imminent likelihood of serious harm to self or others, or is gravely disabled as a result of a behavioral disorder, the patient may be detained for a sufficient time to notify the county Designated Crisis Responder (DCRs were formerly referred to MHPs) to authorize custody or transfer for evaluation and treatment.¹⁴⁶ If the patient has been voluntarily admitted and requests release, the maximum time of detention in ordinary circumstances should be no later than the next judicial day. If the patient was brought to an emergency room and refuses admission, the maximum time of detention after medical clearance is six (6) hours to allow time for the DCRs to come to the hospital to perform an evaluation.¹⁴⁷ Until December 31, 2020, a DCR can place a 72-hour hold on a gravely disabled patient.¹⁴⁸ As of January 1, 2021, this period is expanded to 120 hours (5 days).¹⁴⁹ No patient may be involuntarily held beyond that time period without a court order granted pursuant to Chapter 71.05 RCW. Within the initial hold (72 or 120 hour), the petitioner may seek a 14-day hold.¹⁵⁰ There is no requirement to wait 72 to 120 hours before seeking a 14-day commitment order. After a 14-day hold, a 90-day hold may be sought if the patient still meets criteria.

If the patient is a minor thirteen (13) years or older, detainment may be for up to twelve (12) hours to enable a DCR to evaluate the minor and commence initial detention proceedings if deemed indicated.¹⁵¹ The professional person at the facility should have determined that the minor, as a result of a mental disorder, presents a likelihood of serious harm or is gravely disabled, inpatient treatment is required, and the minor is unwilling to consent to voluntary admission.¹⁵² Again the phrases “likelihood of serious harm” and “gravely disabled” are terms of art, and their statutory definitions should be consulted.¹⁵³ Peace officers may also bring minors to evaluation and treatment facilities and ask that they be held for up to eight (8) hours if the minor has been arrested.¹⁵⁴ The facility must make reasonable attempts to contact the

¹⁴³ RCW 71.05.050(3).

¹⁴⁴ RCW 71.05.020.

¹⁴⁵ SB 5720 SL Sec. 110.

¹⁴⁶ RCW 71.05.050(3).

¹⁴⁷ RCW 71.05.050(3).

¹⁴⁸ RCW 71.05.150(1).

¹⁴⁹ RCW 71.05.150(1).

¹⁵⁰ RCW 71.05.230.

¹⁵¹ RCW 71.34.710(2). Note that this law is scheduled to change effective July 1, 2026.

¹⁵² RCW 71.34.710.

¹⁵³ RCW 71.34.020(14), (18).

¹⁵⁴ RCW 71.34.365(1).

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requesting officer during this time to inform them the minor is not approved for admission or is being released so as to enable the officer to return and take the minor back in to custody.¹⁵⁵

The 2019 legislation provided that DCRs may interview a person by real-time video, provided that a licensed health care professional or professional person is present to assist.¹⁵⁶ In response to the COVID-19 pandemic, the Health Care Authority issued guidance that use of video was permissible prior to the date established by statute, of June 11, 2020.¹⁵⁷

The new statutory structure describes the rights of both adults and minors. For adults, all hospitals that provide services under the Involuntary Treatment Act to adults must post a list of the rights defined by law, with the 2019 statute adding the right to individualized care and adequate treatment; to discuss treatment plans and decisions with professional persons; and, to not be denied access to treatment by spiritual means in accordance with the tenets and practices of a religion.¹⁵⁸ The right to treatment by spiritual means was also added for minors, along with those rights already established and clearly listed by statute.¹⁵⁹ Facilities should consider additional requirements, such as informing adult detainees of their rights, and/or posting copies of rights in a prominent place.¹⁶⁰

A person found to be gravely disabled or presenting a likelihood of serious harm as a result of a behavioral health disorder has a right to refuse antipsychotic medications unless certain emergency circumstances exist.¹⁶¹ Different layers of approval exist: (a) attempt to obtain informed consent from patient, (b) short-term treatment up to thirty (30) days if concurring medical opinion approves medication, (c) periodic review by the medical director up to the hearing, and d) review of emergency decision within twenty-four (24) hours.¹⁶² If an antipsychotic medication is given against a patient's wishes, documentation must be made in the medical records of the physician's attempt to obtain informed consent and the reason why the antipsychotic medication is being administered over the patient's refusal of consent.¹⁶³ Through the 2019 legislation, the authority to compel medications was extended to minors by reference to the adult statute.¹⁶⁴ In proceedings related to compelling medication, privileges between patients and professional staff are waived, limited to the records or testimony relevant to evaluation of the detained person.¹⁶⁵ Waiver of privilege in broader contexts is a matter of the court's discretion.¹⁶⁶

¹⁵⁵ RCW 71.34.365(1).

¹⁵⁶ RCW 71.05.150.

¹⁵⁷ Note that the Supreme Court, at least temporarily, issued an order relaxing the requirement of a professional's presence if the facility and DCR together determined the presence was not necessary. *See* Washington Supreme Court's April 29, 2020 Civil Commitment Order.

¹⁵⁸ RCW 71.05.217.

¹⁵⁹ RCW 71.34.355.

¹⁶⁰ RCW 71.05.217; RCW 71.34.355.

¹⁶¹ RCW 71.05.215(1).

¹⁶² Requirements for the hearing are detailed at RCW 71.05.217(j)(i)-(vi).

¹⁶³ RCW 71.05.215(2)(e). *See Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028 (1990).

¹⁶⁴ RCW 71.34.355(1)(j).

¹⁶⁵ RCW 71.05.217(7); RCW 71.34.355(2).

¹⁶⁶ RCW 71.05.217(7); RCW 71.34.355(2).

No evaluation and treatment facility or professional person or attending staff may be civilly or criminally liable for performing statutory duties with regard to the decision to admit, release, administer antipsychotic medications, or detain a person. These duties need to be performed in good faith and without gross negligence.¹⁶⁷ This exemption does not relieve a person from giving the required notices, or the duty to warn or to take reasonable precautions to protect others from violent behavior where the patient has communicated an actual threat of violence against a reasonably identified victim.¹⁶⁸

1.3.9 Chemical Dependency

Chapter 70.96A RCW, addressing treatment for chemical dependency, has been repealed. However, aspects of that Chapter have been recodified in the Community Mental Health Services Act.¹⁶⁹

Statutory authority exists for the involuntary commitment of persons incapacitated by chemical dependency.¹⁷⁰ Persons who are impaired by chronic alcoholism or drug abuse may not be detained for evaluation and treatment or be judicially committed solely by reason of that condition, unless that condition causes grave disability or as a result of a mental disorder, poses a likelihood of serious harm to self or others.¹⁷¹

Recognizing the problems caused by the use of alcohol and other drugs during pregnancy, the state legislature has promoted the increased use of alcohol and drug treatment services by women before, during, and after pregnancy.¹⁷² One significant effect on babies is the manifestation of fetal alcohol syndrome.¹⁷³

1.3.10 Blood Alcohol and Drug Testing

Every person who operates a motor vehicle in the State of Washington is deemed to have given implied consent to the testing of his or her breath or blood to determine the alcoholic content or presence of any drug.¹⁷⁴ A person may refuse the breath or blood test, but this refusal has legal consequences¹⁷⁵ and may not later be withdrawn or negated.¹⁷⁶ A person who is dead,

¹⁶⁷ RCW 71.05.120(1).

¹⁶⁸ RCW 71.05.120(3). But see also *Volk v. DeMeerleer*, 187 Wn. 2d 241, 386 P.3d 254 (2016), which expanded potential tort liability for care providers by extending the duty to warn beyond the long-standing practice of requiring a warning only in cases where actual threat of violence had been made against a reasonably identifiable victim.

¹⁶⁹ Chapter 71.34 RCW.

¹⁷⁰ Repealed. See *Recovery Northwest v. Thorslund*, 70 Wn. App. 146, 851 P.2d 1259 (1993), *rev. denied*, 123 Wn. 2d 1022, 875 P.2d 636 (1994) (standard for involuntary commitment in statute violates federal due process).

¹⁷¹ RCW 71.05.520. *In re Treatment of L.G.*, 78 Wn. App. 420, 897 P.2d 1275 (1995).

¹⁷² RCW 70.83C.005.

¹⁷³ See *McKinney v. State*, 134 Wn. 2d 388, 950 P.2d 461 (1998) (adoptive parents would not have adopted child had they been told about the extent of her problems including fetal alcohol syndrome).

¹⁷⁴ RCW 46.20.308(1). There is a second statute on implied consent to alcohol testing that deals specifically with persons under the age of twenty-one (21) who drive or are in physical control of a motor vehicle. RCW 46.61.503. The legal age for consumption of alcohol is 21 years in the State of Washington. RCW 66.44.270. See *Houser v. State*, 85 Wn.2d 803, 540 P.2d 412 (1975), *overruled on other grounds* in *State v. Smith*, 93 Wn.2d 329, 610 P.2d 869 (1980).

¹⁷⁵ *Nettles v. Department of Licensing*, 73 Wn. App. 730, 732, 870 P.2d 1002, 1003-04 (1994).

¹⁷⁶ *Department of Licensing v. Lax*, 125 Wn. 2d 818, 825, 888 P.2d 1190, 1193 (1995) (driver's consent to blood test twelve minutes after initial refusal was untimely reconsideration of initial refusal).

unconscious, or in a condition incapable of refusal is deemed not to have withdrawn the implied consent. For certain arrests, a breath or blood test may be administered without the consent of the individual arrested.¹⁷⁷

The withdrawal of blood for the purpose of determining its alcoholic content may be performed only by a physician, a registered nurse, a licensed practical nurse, a nursing assistant, a physician assistant, a first responder, an emergency medical technician, a health care assistant, or trained technician.¹⁷⁸ These health care providers, as well as a hospital or duly licensed clinical laboratory, will not incur civil or criminal liability as a result of the act of withdrawing blood when directed by a law enforcement officer.¹⁷⁹

A health care provider is not required to comply with the request for blood alcohol or drug testing. A provider who chooses to do so would be wise to obtain the request in writing of the officer or that of the driver patient, if applicable. The officer should be required to certify that the request is based upon the patient's being in the legally authorized condition of being (a) unconscious, (b) under arrest for vehicular homicide, (c) under arrest for vehicular assault, or (d) under arrest for driving under the influence of intoxicating liquor or drugs resulting in an accident, in which there is a reasonable likelihood that another person may die of injuries.

The Court of Appeals, Division I, has held that the physician-patient privilege of RCW 5.60.060(4) did not apply to a blood sample or any record or report of a blood sample taken at a hospital from a driver for purposes of treatment rather than at the request of police following an arrest...¹⁸⁰ It reasoned that the public's safety interest outweighed the benefits of the physician-patient privilege. A driver may also be deemed to have waived any privilege related to information contained in the medical records related to sobriety and injuries.

1.3.11 Blood Products

A competent adult patient may refuse treatment with blood products including whole blood transfusion, platelets, plasma, or other fractionated blood products. A competent adult patient may refuse to permit a blood transfusion or use of another blood product, even if it leads to death.¹⁸¹ The court has held that a written release of the liability of others from the consequences of the refusal, made knowingly and voluntarily, is valid and does not violate public policy.¹⁸² That release, however, does not shield those released from liability for their own negligence in treating the patient.¹⁸³

When the patient is a child, the parent or custodian may refuse to permit a blood transfusion if it does not endanger life or threaten to result in serious impairment of bodily functions. If refusal of the transfusion, however, will likely result in a child's death or lead to serious impairment of a child's health, the provider should notify the proper state authority in order

¹⁷⁷ RCW 46.20.308(3).

¹⁷⁸ RCW 46.61.506(5).

¹⁷⁹ RCW 46.61.508. These providers may still be found liable for use of improper procedures or failing to exercise the required standard of care.

¹⁸⁰ *State v. Smith*, 84 Wn. App. 813, 822, 929 P.2d 1191 (1997).

¹⁸¹ *Shorter v. Drury*, 103 Wn. 2d 645, 695 P.2d 116 (1985), *cert. denied*, 474 U.S. 827, 106 S.Ct. 86 (1985).

¹⁸² *Id.* at 651-652, 695 P.2d at 120.

¹⁸³ *Id.* at 650-653, 695 P.2d at 119-21.

that a petition may be made to the court for an order declaring the child to be dependent and permitting the use of blood and blood products.¹⁸⁴ Emergency implied consent may apply and is discussed in the chapter on General Consent Rules.

The transfusion of blood and blood products is considered a service by the health care provider not covered by any implied warranty under the Uniform Commercial Code. No civil liability may incur as a result of the provision of blood, except for willful or negligent conduct in relation to the contracting of hepatitis, malaria, and acquired immune deficiency disease.¹⁸⁵ While it is the duty of the physician ordering the blood transfusion to obtain informed consent from the patient, the doctrine of corporate negligence does not encompass a claim for lack of informed consent against a hospital, blood bank, or other corporate entity.¹⁸⁶

1.3.12 Childhood Immunization

The National Childhood Vaccine Injury Act (NCVIA),¹⁸⁷ requires that health care providers administering any vaccine provide a copy of the Vaccine Information Statement (VIS), which covers benefits and risks of the vaccine, to the adult custodian or parent of a minor child receiving the vaccine.¹⁸⁸ Informed consent requirements are based on State law, and the topic is detailed in the Chapter on General Consent Rules. Signatures of the parents indicating that they have read and understand the vaccine materials are required when a government contract is involved. The American Academy of Pediatrics provides detailed up-to-date information on immunizations.¹⁸⁹

The State of Washington requires childcare centers, preschools, and schools to establish requirements for full immunization of children attending childcare and preschool through grade twelve (12).¹⁹⁰ Full immunization means having received age-appropriate vaccines as enumerated in the National Immunization Guidelines.¹⁹¹ Exemptions based on medical reasons must be documented on the certificate of immunization status (CIS) form provided by DOH with a signature of a licensed medical doctor, doctor of osteopathy, doctor of naturopathy, physician assistant, or nurse practitioner practicing within the limits of the

¹⁸⁴ RCW 13.34.030(5); 13.34.040. *See Jehovah's Witnesses in State of Washington v. King County Hospital Unit No. 1 (Harborview)*, 278 F.Supp. 488, 505 (W.D.Wash. 1967), *affirmed en banc*, 390 U.S. 598, 88 S.Ct. 1260, 20 L.Ed.2d 158 (1968), *rev.denied*, 391 U.S. 961, 88 S.Ct. 1834 (1968) (juvenile court act statutes empowering superior court judges to declare children to be dependent for purpose of authorizing blood transfusions against expressed objections of parents are not invalid under the U.S. Constitution).

¹⁸⁵ RCW 70.54.120. *See Garvey v. St. Elizabeth Hospital*, 103 Wn. 2d 756, 697 P.2d 248 (1985) (provider of blood may obtain blood from a supplier who properly maintains donor records in order to be immune from warranty and strict liability).

¹⁸⁶ *Howell v. Blood Bank*, 114 Wn. 2d 42, 56, 785 P.2d 815, 822 (1990).

¹⁸⁷ 42 U.S.C. § 300aa-1 *et seq.*; *See Gonzales v. Cowen*, 76 Wn. App. 277, 884 P.2d 19 (1994) (NCVIA award given to surviving mother but not father who had not established paternity before child's death).

¹⁸⁸ *See Shalala v. Whitecotton*, 514 U.S. 268, 115 S.Ct. 1477 (1995) (requirement of no symptoms of injury prior to vaccination in order to make out a *prima facie* case).

¹⁸⁹ American Academy of Pediatrics, Committee on Infectious Diseases, *2003 Red Book: Report of the Committee on Infectious Diseases* (26th Ed.); <http://www.cispimmunize.org/> .

¹⁹⁰ RCW 28A.210.140.

¹⁹¹ WAC 246-105-030 “vaccine-preventable diseases children must be protected against for full immunization” and/or WAC 246-105-040 “Requirements based on national immunization guidelines”

medical or nurse practice acts. Exemptions for religious, philosophical, or personal objections are permitted when indicated by the parent on the CIS form with signature.¹⁹²

1.4 Consents/Refusals for Special Situations

A third segment of special consent rules deals with common health care situations that are ancillary to the primary medical treatment rendered. Special consent rules are defined as situations requiring focused consideration, after which some of the general consent rules, discussed in the chapter on General Consent Rules, may apply. This section touches upon seven areas that require some form of consent in relation to the dead body, photography, human experimentation, departure from the emergency department, and student athletes.

1.4.1 Autopsy

Typically, the immediate family of the deceased individual does not have a right to either consent to or refuse an autopsy to be performed by a Medical Examiner.¹⁹³ The prosecuting attorney, if there is no coroner in the county, may cause the performance of an autopsy.¹⁹⁴ Patient deaths involving one of the circumstances listed in RCW 68.50.010 are under the jurisdiction of the Medical Examiner who may perform an autopsy. Circumstances include:

- Sudden death when in apparent good health without medical attendance within the thirty-six hours preceding death;
- Death apparently caused by unnatural or unlawful means; or under suspicious circumstances; or resulted from unknown or obscure causes;
- Death occurred within one year following an accident;
- Death caused by any violence whatsoever;
- Death apparently resulted from drowning, hanging, burns, electrocution, gunshot wounds, stabs or cuts, lightning, starvation, radiation, exposure, alcoholism, narcotics or other addictions, tetanus, strangulations, suffocation or smothering;
- Death due to a violent contagious disease which may be a public health hazard; and
- Death resulted from alleged rape, carnal knowledge, or sodomy.

Next of kin are required to provide consents for donation of body parts or tissue for use in research.¹⁹⁵

The Medical Examiners of the various counties may have policies and procedures that clarify the statutory circumstances requiring the performance of autopsies. For example, the current manual for King County discusses in “Chapter II, Establishing a Hospital Death as a Medical Examiner’s Case” the reporting requirements for deaths occurring in the emergency room and the operating room. When a health care facility death does not fall under the jurisdiction of the Medical Examiner, autopsy may be performed at the premortem direction or will of the

¹⁹² WAC 246-105-050(1)(b)(iii)(E)

¹⁹³ *But see Ryan v. Zornes*, 34 Wn. App. 63, 658 P.2d 1281 (1983) (a coroner may have assumed the obligation of performing an autopsy).

¹⁹⁴ RCW 68.50.108.

¹⁹⁵ *See Robinette Amaker v. King County, Stanley Medical Research Institute*, Pierce Co. Cause No. 05-2-11014-2 (medical examiner’s office provided 255 brains from bodies of schizophrenic or bipolar people to a nonprofit research laboratory, allegedly without her consent).

deceased.¹⁹⁶ A patient may consult in advance with a physician regarding autopsy in the event of his or her death. It follows that the deceased on a premortem basis should also be able to refuse the performance of autopsy.

In the absence of a premortem refusal by the deceased, an immediate family member or other individual may consent to the performance of an autopsy according to the order of priority set forth in RCW 68.50.101:

- The surviving spouse;
- Any child of the decedent who is eighteen years of age or older;
- One of the parents of the decedent;
- Any adult brother or sister of the decedent;
- A person who was guardian of the decedent at the time of death; and
- Any other person or agency authorized or under an obligation to dispose of the remains of the decedent.

The health care provider should make a reasonable effort to locate and secure authorization from a competent person in the first or succeeding class, and if no such person is available, may obtain authorization from any person in the next class. Note that this list is different from the substitute decision-maker list of RCW 7.70.065. The preferred practice is for a health care provider to document the authorization as well as the refusal of an autopsy. If the autopsy is requested to be limited, then that limitation should also be documented.

State law provides that a party, by showing just cause, may obtain a court order authorizing an autopsy as well as the release of results.¹⁹⁷ If a party is able to secure an order for autopsy, the health care provider should obtain a copy of the court order and place it in the medical records.

1.4.2 Anatomical Gifts

An individual at least eighteen (18) years of age may authorize or limit or refuse to make an anatomical gift.¹⁹⁸ A guardian and a power of attorney may also authorize an anatomical gift.¹⁹⁹ Likewise, an individual under the age of eighteen (18), who is either emancipated or at least fifteen and a half years of age, may do so.²⁰⁰ If the donor is an unemancipated minor below the age of fifteen and a half, a gift may be made if the document of gift is also signed by either a parent or a guardian of the minor donor.²⁰¹ If the document is signed by the minor donor but not the parent or guardian, then it should not be considered valid until the donor reaches the age of eighteen (18).

The presumption in Washington State is that no anatomical gift has been made unless there is a specific consent. It is not necessary that there be an affirmative refusal. If a donor cannot sign a document of gift, it must be signed by another individual and by two witnesses, all of

¹⁹⁶ RCW 68.50.100.

¹⁹⁷ RCW 68.50.102.

¹⁹⁸ RCW 68.64.030

¹⁹⁹ RCW 68.64.030(2) and (4).

²⁰⁰ RCW 68.64.030(1)(a) and (b).

²⁰¹ RCW 68.64.030(3) provides “the anatomical gift made pursuant to this subsection shall cease to be valid once the donor becomes either an emancipated minor or an adult”

whom have signed at the direction of and in the presence of the donor and of each other and state that it has been so signed.²⁰² A copy of the document of gift signed by the donor should be placed in the medical records.

If a patient did not have a document of gift or leave contrary indications of refusal, then an individual may authorize an anatomical gift on behalf of a patient according to the order or priority set forth in RCW 68.50.550:²⁰³

- The appointed guardian of the person of the decedent at the time of death;
- The individual, if any, to whom the decedent had given a durable power of attorney that encompassed the authority to make health care decisions;
- The spouse of the decedent;
- The son or daughter of the decedent who is at least eighteen years of age;
- Either parent of the decedent;
- A brother or sister of the decedent who is at least eighteen years of age; and
- A grandparent of the decedent.

However, a care provider may not accept an anatomical gift if the provider knows that the gift is opposed by another member of the same class as the person providing consent, or by a person in a prior class.²⁰⁴ Authorization on behalf of a minor child is obtained following this same format.

A donor may amend or revoke the anatomical gift not made by will before death by (a) a signed statement, (b) an oral statement made in the presence of two individuals, (c) any oral or other form of communication made during a terminal illness or injury, or (d) the delivery of a signed statement to a specified donee to whom a document of gift had been delivered.²⁰⁵ If an anatomical gift is made by will, the donor may in addition amend or revoke the gift in the manner provided for amendment and revocation of wills. A gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of anyone else. As a practical matter, although it is not required, a health care provider may obtain the signature of a substitute decision-maker to avoid disputes. A document of anatomical gift that is made by a surrogate decision-maker may be revoked by a member of the same or a prior class only if procedures for removal of body parts have not begun and if the health care provider removing the body part knows of the revocation.²⁰⁶

1.4.3 Photographs and Videotapes

Consent for the taking and use of photographs and videotapes of patients for diagnosis, care and treatment, and medical education may be inserted as part of the general consent for care

²⁰² RCW 68.64.040(2)(a)

²⁰³ RCW 68.64.170 provides for immunity to persons and entities, including Northwest Tissue Center, that facilitate organ and tissue donation or attempt in good faith to do so. “Good faith means an ‘honest belief, the absence of malice, and the absence of design to defraud or to seek an unconscionable advantage.’” *Sattler v. N.W. Tissue Ctr.*, 110 Wn. App. 689, 42 P.3d 440 (2002).

²⁰⁴ RCW 68.50.570(3).

²⁰⁵ RCW 68.64.050

²⁰⁶ RCW 68.64.090(3)

form, or obtained on a separate form.²⁰⁷ When the patient or family seeks to audiotape or videotape conversations regarding the provision of health care, health care providers and other staff have the right to have the patient or family obtain their consent before doing so.²⁰⁸ Health care providers also have the right to limit the circumstances under which elective videotaping of a patient is performed.²⁰⁹

Regarding certain cases of Munchausen Syndrome by Proxy (MSBP), surveillance by video camera may be the optimal method of documenting and diagnosing this serious and potentially lethal form of child abuse where the parent or caregiver deliberately fabricates history of symptoms, causing the child to be regarded as ill. The child may then be subjected by the health care provider relying on the false information to extensive testing and unnecessary invasive procedures. If consent for care has been obtained on a form with a videotaping for diagnosis clause, surveillance to diagnose MSBP is included.²¹⁰ Signing a consent form evidences the parent's intent that relevant medical information be disclosed to the health care provider, thus undercutting any sense of expectation of privacy of these acts within the facility.

1.4.4 Human Subjects Research

Federal regulations govern informed consent issues involving human experimentation.²¹¹ Informed consent for research on human subjects needs to be documented on a written consent form approved by the Institutional Review Board (IRB) with jurisdiction and signed by the subject or the subject's legally authorized representative.²¹² The use of an exculpatory agreement, which releases a medical researcher from liability for negligent conduct that occurs in the course of medical research, violates public policy.²¹³ Additional protective requirements apply to fetuses and pregnant women, human in vitro fertilization, prisoners, and children as subjects in medical research.²¹⁴ Individuals with mental illness constitute another vulnerable group addressed in case law.²¹⁵

Unique provisions apply to research involving minor children. The assent of children research subjects may be necessary for particular protocols. For other studies, the permission of both parents may be necessary when involving a child, unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent has legal responsibility for

²⁰⁷ Joint Commission on Accreditation of Healthcare Organizations standard RI.2.50 requires that consent be obtained for recording or filming made for purposes other than identification, diagnosis, or treatment of patients.

²⁰⁸ See RCW 9.73.030 (Washington Privacy Act).

²⁰⁹ See *In re Matter of Betty Jean Simmons*, 112 A.D.2d 806, 492 N.Y.S.2d 308 (A.D. 4 Dept. 1985).

²¹⁰ See, Mark Epstein, et. al., "Munchausen Syndrome by Proxy: Considerations in Diagnosis and Confirmation by Video Surveillance", *Pediatrics*, Vol. 80, No. 2, August 1987, pp. 220-224.

²¹¹ 21 CFR § 50.20, 50.25, 50.27; 45 CFR § 46.116.

²¹² 45 CFR § 46.117.

²¹³ *Vodopest v. MacGregor*, 128 Wn. 2d 840, 862, 913 P.2d 779 (1996).

²¹⁴ 45 CFR § 46, Subparts B, C, D.

²¹⁵ See *State of Washington, on the Relation of Carroll, v. Junker*, 79 Wn. 2d 12, 482 P.2d 775 (1971) (permanent injunction against court order granting examination of 189 current mental illness court files by law professor and two students for class research project without written consent of patients or legal representatives). See also *Robinette Amaker v. King County, Stanley Medical Research Institute, Pierce Co.* Cause No. 05-2-11014-2 (2005) (claim that Medical Examiner removed her brother's brain for research on schizophrenic or bipolar people without her consent).

the care and custody of the child. If the child is a ward of the state or an agency, an advocate must be appointed in addition to any other individual acting on behalf of the child as a guardian.²¹⁶

1.4.5 Leaving Against Medical Advice (See chapter on General Consent Rules regarding medical hold)

When a competent adult patient or a parent on behalf of a minor child patient seeks to leave the health care facility against medical advice, he or she should be informed of the risks of discontinuing medical treatment and be asked to sign an acknowledgment of receipt of this information. If the patient or parent refuses to sign, the health care provider should document the information given. The provider should try to arrange appropriate discharge planning given the decision to terminate care prematurely.

If there is reasonable cause to believe that discontinuation of health care presents an imminent danger to a minor child's safety, the physician or the health care facility should activate the medical hold provisions of RCW 26.44.056.²¹⁷ Notification should be made as soon as possible, and in no case longer than seventy-two (72) hours, to the appropriate law enforcement agency or child protective services. If a parent recklessly causes great or substantial bodily harm to a child by withholding health care, a basic necessity of life, he or she may be charged with criminal maltreatment.²¹⁸

1.4.6 Transfer from an Emergency Department

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended by the Omnibus Budget Reconciliation Acts (OBRA), includes the Emergency Medicine Treatment and Active Labor Act (EMTALA) applies to hospitals with emergency departments that participate in the Medicare program.²¹⁹ A parallel state law has been enacted in Washington.²²⁰ The Act intends to protect patients who come to an emergency room from being transferred to another hospital before receiving appropriate care. The Act thus requires hospitals to provide a medical screening examination to determine if an emergency medical condition exists. If such condition does exist, the hospital must provide treatment to stabilize the condition or provide for an appropriate transfer of the patient to another medical facility. An unstable patient may not be transferred unless the patient or an individual on behalf of the patient requests a transfer in writing, or unless a physician or qualified medical person signs a certification stating that the benefits of a transfer outweigh the risks. Requirements cover informed refusals of treatment or transfers, patient and physician authorizations, records to accompany a transfer, and the agreement of the receiving hospital.²²¹

1.4.7 Student Athletes

The parent or legal representative with health care decision-making authority for a minor may in writing permit, in the event of unanticipated illness or injury during a sports event, another

²¹⁶ 45 CFR § 46.408, 46.409.

²¹⁷ See *Miles v. Child Protective Servs.*, 102 Wn. App. 142, 6 P.3d 112 (2000).

²¹⁸ RCW 9A.42.020; 9A.42.030.

²¹⁹ 42 U.S.C. § 1395dd.

²²⁰ RCW 70.170.060(2) (state anti-dumping statute).

²²¹ 42 CFR § 489.24.

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competent adult to consent to necessary and appropriate health care for that child.²²² The health care provider should nevertheless make a good faith effort to contact the parent or representative and document the attempt in the medical record.²²³ It would be inadvisable for the provider to accept consent from anyone other than the individual with actual authority for certain health care that entails high risk treatment, involved surgery, research therapy, significant management of a new chronic illness, or withholding or withdrawing of life-sustaining treatment.

Student athletes may provide written consent to random drug testing as a condition of participating in sports.²²⁴ Students as athletes have a decreased expectation of privacy, submitting to preseason physical exams, communal undress, insurance coverage, and a higher degree of regulation. Schools have a compelling interest to deter drug use by schoolchildren with its substantial physical risk to athletes.²²⁵

Commonly, sports participation forms require students and parents to sign releases exculpating the school district and others from liability for its future negligent conduct during public school athletic events. These releases of all potential claims as a condition of student participation in school-related athletics violate public policy and are invalid in the State of Washington.²²⁶ What constitutes athletic “activity” has been broadly interpreted to include driving in private cars to an end-of-the year pizza party following a regularly scheduled track team practice for purposes of WIAA and school insurance policy coverage.²²⁷

²²² RCW 7.70.065(2)(a)(iv). This section enacted in 2005 lists in order of descending priority who may consent for the minor: the appointed guardian or legal custodian, an out-of-home placement court authorization, the parents, the individual to whom the minor’s parent has given a signed authorization to make health care decisions, and kin caregiver responsible for child’s health care.

²²³ Foreign exchange and 1-20 VISA students would not have readily available parents and have been deemed eligible to participate in WIAA varsity sports. *Fusato v. WIAA*, 93 Wn. App. 762, 970 P.2d 774 (1999).

²²⁴ *York v. Wahkiakum Sch. Dist. No. 200*, 110 Wn. App. 383, 40 P.3d 1198 (2002).

²²⁵ *Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 665, 115 S.Ct. 2386 (1995) (student athlete drug policy authorizing random urinalysis drug testing of students participating in athletic programs is constitutional under the Fourth and Fourteenth Amendments).

²²⁶ *Wagenblast v. Odessa School Dist.*, 110 Wn. 2d 845, 758 P.2d 968, 85 A.L.R.4th 331 (1988), 102 Harv. L. Rev. 729 (1989). In addition, parents do not have the authority to release a third party for future negligent injury to their child. *Scott v. Pacific West Mt. Resort*, 119 Wn. 2d 484, 834 P.2d 6 (1992).

²²⁷ *Odessa v. Insurance Co. of America*, 57 Wn. App. 893, 791 P.2d 237 (1990), *rev. dismissed*, 115 Wn. 2d 1022 (1990).