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

# Chapter 2: Consent to Healthcare–Decision-Making for Incompetent Patients

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***Author's Note: This updated chapter draws heavily upon the prior 2007 edition written by Annette Clark, MD, JD, Dean of Seattle University School of Law. Many sections remain either unchanged or essentially the same as Dr. Clark's original text, with minor updates.



For reference purposes, this chapter was prepared from laws, cases, and materials selected by the authors, which were available as of February 26, 2019.

# Biographies

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Heath Fox has a health law practice at Fox Ballard, PLLC emphasizing medical negligence litigation, professional licensing, health law advising, long-term care and guardianship. He has successfully represented health care providers and organizations in jury trials involving allegations of wrongful death, brain injury, spinal injury and paralysis, surgical complications, and guardianship. He is admitted to practice in the State of Washington, the State of Oregon, the State of Alaska, U.S. District Court for the Western and Eastern Districts of Washington, and the Ninth Circuit Court of Appeals. He has served as an adjunct professor of law and part-time lecturer at Seattle University School of Law and the University of Washington School of Law, respectively, teaching health law topics. He is a frequent speaker on health law issues for attorneys, health care providers, hospital social workers and risk managers. He is a board member of the Washington Medical-Legal Partnership. He is also an active member and past President of the Washington Health Care Risk Management Society.

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# Chapter Outline

## 1.1 Decision-Making for Incompetent Adults: Terminology

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

### 1.1.1 Decision-Making Capacity

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

### 1.1.2 Competence

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

### 1.1.3 Incapacity

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

### 1.1.4 Incompetence

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

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

2 RCW 26.28.015(5).

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

4 *Grannum*, 70 Wn.2d at 307.

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

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

## 1.2 Determination of Decision-Making Capacity

### 1.2.1 Clinical Determination of Incapacity

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

#### 1.2.1.1 Standards for Clinical Determination of Incapacity

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

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

### 1.2.2 Adjudication of Incompetency—Guardianship Proceedings

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

#### 1.2.2.1 Standards for Judicial Determination of Incompetency

Under the guardianship statute, the determination of incapacity is a legal decision, not a medical one, and is based on evidence of "management insufficiencies" over a period of time with regard to person or estate.[13]

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

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

9 *Grannum*, 70 Wn.2d at 307.

10 *Morinaga*, 85 Wn. App. at 827.

11 RCW 11.88.005.

12 RCW 11.88.010(2).

13 RCW 11.88.010(1)(c).

For purposes of giving informed consent for health care, the statute defines an incompetent individual as one who is incompetent by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental capacity of managing property or caring for self; or incapacitated as defined in RCW 11.88.010(a) (a significant risk of personal harm based upon a demonstrated inability to adequately provide for nutrition, health, housing, or physical safety), (b) (significant risk of financial harm based upon a demonstrated inability to adequately manage property or financial affairs), or (d) (under the age of majority).[14]

#### 1.2.2.2 Guardianship Petition

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

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

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14 RCW 11.88.010(1)(e).
15 RCW 11.88.010(1).
16 RCW 11.88.030(1).
17 RCW 11.88.030(1)(a)-(l).
18 RCW 11.88.090(3) & (4)(a). The court may deviate from its standard appointment process from its GAL registry for good cause shown. In medically complex cases, it may be prudent to seek the appointment of a knowledgeable and experienced GAL, so long as that individual is truly disinterested and otherwise qualified. The court will need to enter findings justifying the deviation from the standard GAL selection process.
19 RCW 11.88.090(3)(a-b).
20 RCW 11.88.090(5).
21 RCW 11.88.090(8). The authority to consent to emergency life-saving care is commensurate with the implied consent for emergency care under RCW 7.70.050(4). Thus, the appointment of a GAL is not normally, by itself, the solution to a problem arising in the health care context where a surrogate decision-maker is required. In non-emergency situations where urgent medical decisions must be made for an alleged incapacitated person, and no legal surrogate can be found, the court may need to either grant expanded authority to the GAL to make interim decisions, directly authorize injunctive relief, or expedite the appointment of a guardian in order to protect the alleged incapacitated individual.

and the guardian *ad litem*.[22] The notice must be in substantially the form prescribed by statute, and must include a clear and easily readable statement of the alleged incapacitated person's legal rights that may be transferred to a guardian, the right to counsel, and the right to a jury trial.[23]

#### 1.2.2.3 Adjudicatory Hearing

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

- Notice of a hearing must be served on the alleged incapacitated person, the guardian ad litem, and other interested individuals at least ten days prior to the hearing on the petition.[24]
- The alleged incapacitated individual must be present at the final hearing on the petition unless the court waives this requirement for good cause.[25] Alternatively, the court may conduct the hearing in the presence of the alleged incapacitated person by holding the hearing at that person's place of residence.[26]
- At the hearing, the alleged incapacitated person is entitled to counsel of his or her choosing who shall act as an advocate of the client, testify and present evidence, and request and receive a jury trial on the issue of incapacity. The standard of proof, whether the case is before a judge or jury, is that of clear, cogent, and convincing evidence of incapacity.[27]
- The court must be presented with a written report from a licensed physician or psychologist selected by the guardian ad litem who has expertise in the type of disorder or incapacity at issue. The physician, psychologist, or advanced registered nurse practitioner must have personally examined and interviewed the alleged incapacitated individual, and the report must summarize the relevant findings as to the individual's condition and specific needs.[28] The alleged incapacitated person may present his/her own medical/psychological report(s) if the guardianship action is contested.
- The court's decision on the guardianship petition must be based on specific findings as to the capacities, conditions, and needs of the alleged incapacitated person.[29]
- The alleged incapacitated person has the right to a jury trial if requested.[30]
- A court-appointed guardian is under the control of the court,[31] and has numerous statutory duties, including the duty to file timely reports on the status of the incapacitated person.[32] Those reports normally include a care plan and an inventory of the estate. Guardians may also be removed and/or replaced if they fail to meet their duties.[33]

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22 RCW 11.88.030(5)(a).
23 RCW 11.88.030(5)(b).
24 RCW 11.88.040.
25 Such waiver is frequently granted in uncontested guardianships when the parties (including the guardian *ad litem*) agree that the alleged incapacitated person is not capable of meaningful participation.
26 RCW 11.88.040. When the alleged incapacitated person wishes to participate at the hearing but is physically unable to attend in court, the judge or commissioner may hold the hearing in a hospital room or other outside location. Some courts will also allow the alleged incapacitated person to participate by telephone.
27 RCW 11.88.045(1)-(3). *See also Grannum*, 70 Wn.2d at 307.
28 RCW 11.88.045(4).
29 RCW 11.88.095(1).
30 RCW 11.88.045(3).
31 RCW 11.92.010.
32 RCW 11.92.043(2).
33 RCW 11.88.120.

## 1.3 Decision-Making for Incompetent Individuals

Incompetent individuals do not lose their rights to autonomy and self-determination merely because they are incompetent.[34] In Washington, there are two mechanisms for effectuating an incompetent individual's right to make health care decisions: the advance directive and surrogate decision-making, which can take several forms.

### 1.3.1 Advance Directives

#### 1.3.1.1 Definition

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

#### 1.3.1.2 Patient Self-Determination Act

The Patient Self-Determination Act became law as part of the Federal Omnibus Budget Reconciliation Act of 1990.[35] The Act was intended to increase the role that advance directives and durable powers of attorney play in medical decision making. The statute applies to hospitals, skilled nursing facilities, home health agencies, hospice programs, and HMOs that receive Medicare or Medicaid funding, and requires that covered entities provide each patient at the time of admission with information concerning:

- An individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning . . . medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . ; and
- The written policies of the provider or organization respecting the implementation of such rights.[36]

In addition, covered entities must document in each patient's record whether the patient has signed an advance directive, assure that state law is followed in the institution, and provide education for the staff and public on advance directives and durable powers of attorney.[37]

#### 1.3.1.3 Washington's Natural Death Act

Washington's Natural Death Act permits adults who are competent to execute an advance directive, which directs the withholding or withdrawal of life-sustaining treatment in the future.[38] The advance directive thus provides a legal mechanism for individuals to have their treatment decisions effectuated at the point that they become incompetent to make those decisions. However, the utility of the advance directive is limited because it does not come into effect unless the incompetent individual has been diagnosed with a terminal condition or permanent unconscious condition. In addition, the Natural Death Act is designed to

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34 *In re Colyer*, 99 Wn.2d 114, 124, 660 P.2d 738 (1983).
35 Public Law 101-508; 42 U.S.C. § 1395cc(a).
36 42 U.S.C. § 1395cc(f)(1)(A).
37 42 U.S.C. § 1395cc(f)(1)(B)-(E).
38 RCW 70.122. In 1992, the legislature amended the Act to specifically include artificial nutrition and hydration as a form of life-sustaining treatment that could be withheld or withdrawn. *See* RCW 70.122.020(5) and 70.122.030.

allow individuals to direct in advance only the withholding or withdrawal of life-sustaining treatment; it does not provide for individuals to make non-end-of-life medical decisions in advance.[39]

The specific statutory requirements are as follows:

- The individual executing the advance directive must be an adult who has the capacity to make health care decisions at the time of execution;[40]
- The directive must be in writing and signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who have no interest in the declarer's estate;[41] and
- The directive cannot be given effect unless the diagnosis of a terminal condition has been made in writing by the attending physician, or the diagnosis of a permanent unconscious condition has been made in writing by two physicians, one of whom is the patient's attending physician.[42]

The Natural Death Act provides that physicians and health care providers who in good faith withhold or withdraw life-sustaining treatment from a qualified patient pursuant to an advance directive are immune from legal liability, unless they are otherwise negligent.[43] There is no legal obligation on the part of nurses, physicians, or other health care practitioners to participate in the withholding or withdrawing of treatment, but the attending physician and health facility, if they are aware of the existence of the advance directive, have an obligation to inform the patient of any policy or practice that would preclude the honoring of the directive.[44]

The Natural Death Act should not be confused with the more recent Death with Dignity Act,[45] which provides a structure for physician-assisted suicide in Washington. The Death with Dignity Act can only be utilized by those who retain decisional capacity, and it cannot be used by a surrogate decision-maker on behalf of someone who lacks capacity.[46]

#### 1.3.1.4 Mental Health Advance Directives

In 2003, the Washington legislature enacted a statute authorizing mental health advance directives[47]in order to effectuate an individual's right to control decisions relating to his or her mental health care during periods when the patient lacks capacity to make those decisions. Under the statute, mental health advance directives may include, among other decisions, the principal's preferences and instructions for mental health treatment, consent to specific types of mental health treatment, refusal to consent to specific types of treatment, and consent to admission to and retention in a facility for mental health treatment for up to 14 days.[48]

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39 RCW 70.122.010-.030.
40 RCW 70.122.030(1).
41 RCW 70.122.030(1). A witness may not be the attending physician or employee of the physician or health care facility. RCW 70.122.030(1).
42 RCW 70.122.020(8).
43 RCW 70.122.051(2).
44 RCW 70.122.060(2), (4).
45 Chapter 70.245 RCW
46 RCW 7.245.010, 020, 070; RCW 11.125.420.
47 See RCW 71.32.
48 RCW 71.32.050(3).

The specific statutory requirements are as follows:

- The individual executing the mental health advance directive must be an adult with decision-making capacity;[49]
- The directive must be in writing, signed by the principal, and witnessed in writing by at least two adults who can attest to the principal's identity and capacity;[50] and
- The directive must designate whether the principal wishes to be able to revoke the directive during any period of incapacity or wishes to be unable to revoke the directive during any period of incapacity.[51]

The mental health advance directive is to follow substantially the form provided in the statute,[52] and may include appointment of an agent pursuant to chapter 11.125 RCW to make mental health treatment decision's on the principal's behalf,[53] and/or the principal's nomination of a guardian or limited guardian as provided in chapter 11.125 RCW for consideration by the court in the event guardianship proceedings are commenced.[54]

### 1.3.2 Statutory Authorization for Surrogate Decision-Making

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

- The appointed guardian of the patient, if any;
- The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
- The patient's spouse;
- Children of the patient who are at least eighteen years of age;
- Parents of the patient; and
- Adult brothers and sisters of the patient.[55]

Amendments to RCW 7.70.065 taking effect July 28, 2019,[56] greatly expand the list of potential surrogate decision-makers in continuing descending priority as follows:

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49 RCW 71.32.050(1).

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

51 RCW 71.32.060(1)(d).

52 *See* RCW 71.32.260.

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

54 RCW 71.32.050(3)(h).

55 RCW 7.70.065(1).

56 *See* House Bill 1175, enacted during the 2019 Regular Session and signed by Governor Inslee.

- Adult grandchildren of the patient who are familiar with the patient;
- Adult nieces and nephews of the patient who are familiar with the patient;
- Adult aunts and uncles of the patient who are familiar with the patient; and
- An adult who: (I) Has exhibited special care and concern for the patient; 13 (II) Is familiar with the patient's personal values; (III) Is reasonably available to make health care decisions; (IV) Is not any of the following: A physician to the patient or 16 an employee of the physician; the owner, administrator, or employee of a health care facility, nursing home, or long-term care facility where the patient resides or receives care; or a person who receives compensation to provide care to the patient; and (V) Provides a declaration meeting certain statutory requirements.[57]

As indicated above, an individual may execute, while competent, a durable power of attorney for health care. The effect of this instrument is to authorize the attorney-in-fact to provide informed consent for health care decisions on the principal's (incompetent individual's) behalf.[58] The attorney-in-fact is second only to a court-appointed guardian in decision-making priority under Washington's informed consent statute.[59]

The surrogate decision-making statute specifies that a health care provider who is seeking informed consent for an incompetent patient, and who has been unsuccessful in locating and obtaining authorization from a competent person in the first or succeeding class, may seek consent from any person in the next class in the order of descending priority.[60] However, a person who has lower priority may not consent if a person of higher priority has refused, and a person in the same class with two or more individuals may not give informed consent unless the decision is unanimous.[61]

While the statute dictates a rather rigid hierarchy for surrogate decision-making, in practice, health care providers naturally turn to family members and loved ones to make medical decisions for incompetent patients. The statutory surrogates who are present and/or available may be relied upon when reasonable efforts to contact individuals at a higher level of priority are unsuccessful. The statutory designation of decision-making priority plausibly has the most effect in situations where the family members, loved ones, and health care providers cannot reach agreement on the appropriate treatment choice. In the case of an intractable disagreement between

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[57] RCW 7.70.065(a)(x)(B) states: "An adult who meets the requirements of (a)(x)(A) of this subsection shall provide a declaration, which is effective for up to six months from the date of the declaration, signed and dated under penalty of perjury pursuant to RCW 9A.72.085, that recites facts and circumstances demonstrating that he or she is familiar with the patient and that he or she: (I) Meets the requirements of (a)(x)(A) of this subsection; (II) Is a close friend of the patient; (III) Is willing and able to become involved in the patient's health care; (IV) Has maintained such regular contact with the patient as to be familiar with the patient's activities, health, personal values, and morals; and (V) Is not aware of a person in a higher priority class willing and able to provide informed consent to health care on behalf of the patient.

[58] RCW 11.125.400

[59] *See* RCW 7.70.065(1)(a).

[60] RCW 7.70.065(1)(b).

[61] RCW 7.70.065(1)(b)(i-ii).

surrogates on the same level on the hierarchy, particularly when serious health care decisions must be made, court intervention may be required to resolve the conflict.[62]

The 2019 expansion of the previously allowed list of surrogates is expected to facilitate care and avoid problems arising from the lack of a legal surrogate. One consequence from having a broader pool of potential legal surrogates will likely include increased risk of conflict among potential surrogates. Care providers will also likely face more situations in which a potential legal surrogate wishes to direct care that may be contrary to medical advice. Institutions should be encouraged to develop guidance for dealing with these situations, as well as templates for surrogate declarations. Health care providers may, but are not required, to rely on the representations made by a potential surrogate declaration, and they have qualified statutory immunity for such reliance.[63]

### 1.3.3 Role of the Guardian in Medical Decision-Making For Incompetent Individuals

A court-appointed guardian has the legal right and responsibility to make medical decisions for the incompetent individual, and has priority over the other surrogate decision-makers under Washington's informed consent statute.[64] In the case of a limited guardianship, the limited guardian may make medical decisions for the incompetent individual where the power to make medical decisions is specifically authorized in the court's order, or where the power is not specifically excluded.[65]

#### 1.3.3.1 General Powers

Consistent with RCW 7.70.065, a guardian is legally empowered to provide informed consent for health care for the incapacitated individual.[66] In doing so, the guardian is charged with asserting the incapacitated individual's rights and best interests.[67] As a surrogated decision-maker, the guardian is to make health care decisions through the use of the substituted judgment or best interests standards, as described above. In addition, an individual's advance directive may specify that a guardian or other surrogated decision-maker is to be guided by the directive and any other clear expressions of his or her desires.[68] Even in the absence of such language, an advance directive may be useful in determining what treatment choices the individual would have made if competent.

#### 1.3.3.2 Standby Guardian

The person appointed by the court as guardian or limited guardian must file a notice with the court designating a standby guardian or limited guardian.[69] In the event that informed consent for a necessary

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62 Court intervention should be a last resort, after all other options have been tried and/or considered, including family care conferences, social work and/or spiritual care involvement, ethics consultations, etc.

63 RCW 7.70.065(a)(x)(C)

64 RCW 7.70.065(1). Guardianships from other states are generally treated the same in Washington as a guardian who has been appointed in a Washington guardianship action. The role of the health care provider does not require an affirmative duty to explore foreign dockets to verify the validity of a putative guardian's status.

65 RCW 11.88.095(3).

66 RC 11.92.043(1)(f).

67 RCW 11.92.043(1)(e).

68 RCW 70.122.030(1)(b).

69 RCW 11.88.125(1).

medical procedure is needed and the guardian or limited guardian cannot be located within four hours of the need for consent arising, the standby guardian or limited guardian may give informed consent.[70]

#### 1.3.3.3 Limitations on Power

The guardianship statute prohibits guardians from authorizing certain therapies or procedures. For example, if a guardian believes the incapacitated individual requires involuntary civil commitment for mental health treatment, the statutory procedures for involuntary commitment must be followed.[71] In addition, if the guardian believes any of the following procedures are necessary for the proper care of the incompetent person, the guardian must petition the court for an order authorizing the treatment or therapy:

- Therapy or other procedures which induce convulsions;
- Surgery solely for the purpose of psychosurgery; and
- Other psychiatric or mental health procedures that restrict physical freedom of movement, or the rights set forth in RCW 71.05.370.[72]

In construing this statute, the Supreme Court of Washington stated that the intent of the statutory limitations is to require court approval before the guardian may consent to highly invasive, irreversible medical treatment that would seriously affect the incompetent person's bodily integrity.[73] This leaves open the possibility that judicial authorization may be required before a guardian may consent to other invasive, irreversible procedures even though the procedures are not on the statutory list.[74] For example, certain infections can become life threatening unless the infected limb is amputated. In a situation like that, a guardian may elect to petition the court for instruction rather than consent to surgery without clear guidance from the court. In addition, before an incompetent person may be sterilized, a guardian *ad litem* must be appointed to represent the incompetent person's wishes and a court order must be obtained.[75]

For cases where electro-convulsive therapy (ECT) is indicated for a patient who cannot provide informed consent, court authorization is required, even if a full guardian has already been appointed.[76]

### 1.3.4 Durable Power of Attorney for Health Care

An individual may execute, while competent, a durable power of attorney for health care. The effect of this instrument is to authorize the attorney-in-fact to provide informed consent for health care decisions on the principal's behalf.[77] Under Washington's surrogate decision-making statute, the attorney-in-fact is second only to a court-appointed guardian in decision-making priority.[78]

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70 RCW 11.92.043(1)(f); *see also* RCW 11.88.125(4) (granting authority to the standby guardian to give informed consent as authorized in RCW 11.92.040).

71 RCW 11.92.043(1)(f).

72 RCW 11.92.043(5)(a-c).

73 *In re Ingram*, 102 Wn.2d at 837.

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

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

76 RCW 11.92.043(1)(f); see also *In re Schuoler*, 106 Wn.2d 500, 723 P.2d 1103 (1986), which sets out procedural and due process requirements for court-authorized ECT for a person who lacks capacity to provide consent.

77 RCW 11.125.400.

78 *See* RCW 7.70.065(1)(a)(i-ii).

#### 1.3.4.1 Statutory Requirements

In Washington, a durable power of attorney for health care must be in writing, be signed by the principal, and the signature must be acknowledged by either a notary or by two witnesses who satisfy the statutory criteria.[79] To function after the principle become incapacitated, it must contain language to the effect that the power of attorney becomes effective upon the disability or incapacity of the principal, or that it remains effective during the disability or incapacity of the principal.[80] The principal's physicians, the physicians' employees, and the owners, administrators, and employees of the health care facility where the principal resides or receives care are ineligible to act as the principal's attorney-in-fact, unless he or she is the spouse or adult child or brother or sister of the principal.[81] The principal may grant the attorney-in-fact the authority to make all health care related decisions, or the principal may limit the attorney-in-fact's authority by specifically defining the powers of the agent with regard to various categories of medical decisions.

#### 1.3.4.2 Limitations on Power

The durable power of attorney for health care has identical statutory limitations to those described above for court-appointed guardians (see section 2.17.3.3).[82] Thus, an attorney-in-fact must seek a court order and may not independently authorize therapy or procedures that induce convulsions, or surgery solely for the purpose of psychosurgery, sterilizations, etc. Also, a person serving as durable power of attorney cannot designate someone else to serve as power of attorney unless that other person is identified as an alternate power of attorney in the power of attorney document.[83] The durable power of attorney is revocable by the principal at any time, unless the durable power of attorney document expressly conditions such revocation.[84]

#### 1.3.4.3 Relationship Between the Durable Power of Attorney and Advance Directive

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

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79 RCW 11.125.050(1).
80 RCW 11.125.040.
81 RCW 11.125.400(3).
82 RCW 11.125.400(3) (incorporating the limitation on power to consent contained within RCW 11.92.043(5)).
83 RCW 11.125.140(8)
84 The right of the principal to revoke at will a power of attorney can be problematic when the principal suffers from dementia, paranoia, or some other condition that may impair the ability of the principal to appreciate the need for help. In such cases, an express set of conditions for revocation of the power of attorney can be very helpful to prevent confusion about who may make decisions. For example, the power of attorney document could include a requirement for written notice from the principal regarding an intent to terminate the power of attorney arrangement.

If it appears that the decisions made by the durable power of attorney are in conflict with guidance found in an advance directive, an interested party may file a court petition requesting that the court construe the power of attorney, direct the agent to act or refrain from acting, or provide other relief as necessary.[85]

#### 1.3.4.4 Relationship Between the Durable Power of Attorney and Guardianship Proceedings

A principal may nominate, by a durable power of attorney, the guardian or limited guardian of his or her estate or person for the court's consideration if guardianship proceedings are subsequently commenced. If the principal has done so, the court is required to make its appointment in accordance with the principal's most recent nomination in a durable power of attorney, except for good cause or disqualification.[86] If there is an existing medical power of attorney and the court appoints a guardian, the court must make a specific finding of fact as to the continuing validity of the medical power of attorney.[87] If the court determines that the power of attorney shall continue, the attorney-in-fact must account to the guardian rather than the principal. Most often, the court will terminate all prior power of attorney arrangements if a guardian is appointed.[88]

### 1.3.5 Standards and Procedures for Surrogate Decision-making

#### 1.3.5.1 Substituted Judgment Standard

A surrogate decision-maker must use the doctrine of substituted judgment in consenting to or refusing health care on behalf of an incompetent individual. The standard applies to all medical decisions, whether they involve the discontinuation of life-sustaining treatment or a choice between alternate medical treatments.[89] In each case, the substituted judgment standard requires that the surrogate decision-maker (whether a guardian, attorney-in-fact with authority to make health care decisions, family member, or the court) determine whether the patient, if competent, would have consented to the proposed health care.[90] The surrogate should consider all relevant factors that would influence the patient's medical treatment decisions, including:

- The person's prior statements regarding medical treatment;[91]
- The person's express wishes, even if made while the individual is incompetent;
- The patient's religious or moral views regarding medical care or the dying process;
- The person's prognosis if no treatment is given;
- The prognosis if one treatment is chosen over another;
- The risk of adverse side effects from the proposed treatment;
- The intrusiveness or severity of the proposed treatment;
- The ability of the patient to cooperate and assist with post-treatment therapy; and
- The wishes of family and friends, if those wishes would have influenced the patient.[92]

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85 RCW 11.125.160(2).
86 RCW 11.125.080(1).
87 RCW 11.88.095(5).
88 RCW 11.125.080(2).
89 *In re Ingram*, 102 Wn.2d 827, 839, 689 P.2d 1363 (1984).
90 RCW 7.70.065(1)(c). *See also In re Colyer*, 99 Wn.2d at 137 (holding that life-sustaining treatment may be withdrawn if it is the guardian's judgment that the patient, if competent, would have chosen to withdraw treatment).
91 The weight to be given to prior statements depends upon the age and maturity of the person, the context of the statements, and the connection between the statements and the patient's condition. *In re Grant*, 109 Wn.2d 545, 567, 747 P.2d 445 (1987).
92 *In re Ingram*, 102 Wn.2d at 840.

The Washington Supreme Court has specifically stated that judicial intervention is not generally required when a surrogate decision-maker exercises substituted judgment to make a treatment decision for an incompetent individual.[93] If the substituted judgment is made in a clinical setting, it will likely be acted upon unless family members or health care providers strongly disagree with the decision.

#### 1.3.5.1 Best-Interests Standard

When a surrogate decision-maker cannot in good faith ascertain whether the patient, if competent, would have consented to the proposed health care, he or she must determine that the medical treatment is in the patient's best interests before giving consent.[94] Where the person has never been competent, the substituted judgment standard is arguably meaningless, and so the best-interests standard is used instead.[95] Factors that should be considered by the surrogate decision-maker in determining whether medial treatment is in the best interests of the incompetent individual include:

- The patient's present level of physical, sensory, emotional, and cognitive functioning;
- The various treatment options and the risks, side effects, and benefits of each of the options;
- The life expectancy and prognosis for recovery with and without treatment;
- The degree of physical pain resulting from the medical condition, treatment, or termination of treatment; and
- The degree of dependency and loss of dignity resulting from the medical condition and treatment.[96]

#### 1.3.5.3 Judicial Intervention in the Decision-Making Process

Any participant in health care decision-making for an incompetent individual, whether a guardian, attorney-in-fact with authority to make health care decisions, a physician or hospital, or family member may petition the court for intervention in the medical decision-making process.[97] This occurs most often when family members or health care providers cannot agree on a course of action, particularly with regard to life-sustaining treatment, or where the court is statutorily required to authorize treatment for an incompetent individual. However, a growing number of patients require judicial intervention in the decision-making process because they have no family and no existing legal surrogate. As part of the judicial proceeding, the court will appoint a guardian *ad litem* to ascertain whether the patient, if competent, would have consented to or refused the medical treatment in question.[98]

#### 1.3.5.4 Withdrawal of Life-Sustaining Treatment

Judicial intervention, including the appointment of a guardian, is not routinely required even if the treatment decision is to discontinue life-sustaining treatment for a terminally ill or permanently unconscious individual.[99] However, the Washington Supreme Court has stated that additional safeguards should be present before a decision is made to withdraw treatment in circumstances where the incompetent individual did not execute, while competent, an advance directive and/or durable power of attorney for health care. The safeguards include a requirement that a "prognosis board," consisting of the attending

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93 *In re Colyer*, 99 Wn.2d at 127-28.
94 RCW 7.70.065(1)(c). *See also In re Grant*, 109 Wn.2d at 567-68.
95 *See In re Hamlin*, 102 Wn.2d 810, 814-15, 689 P.2d 1372 (1984).
96 *In re Grant*, 109 Wn.2d at 568.
97 *In re Colyer*, 99 Wn.2d at 136.
98 *In re Hamlin*, 102 Wn.2d at 816-17.
99 *In re Colyer*, 99 Wn.2d at 127-28; *In re Grant*, 109 Wn.2d at 565-67.

physician and at least two disinterested physicians, unanimously concur that the patient's condition is incurable and there is no reasonable probability that the individual will return to a sapient state.[100] In addition, the immediate family, the treating physician, and the prognosis board must all agree that withdrawal of life-sustaining treatment is appropriate.[101] When the incompetent individual has no family, the same standard applies but a guardian must be appointed to represent the patient's rights and interests.[102] If the individual is not terminally ill or permanently unconscious, or if the above safeguards are not met, judicial intervention should be sought before life-sustaining treatment is withdrawn from an incompetent individual who has not previously executed an advance directive or durable power of attorney for health care.

Withdrawal of Artificial Nutrition and Hydration. In the case of *In re Grant*, the Washington Supreme Court held that life-sustaining treatment may be withheld from terminally ill, incompetent individuals as long as certain safeguards are in place, but the court then excepted artificial nutrition and hydration from the medical treatments that can be withheld or withdrawn.[103] In 1990, in the case of *Cruzan v. Director, Missouri Dep't of Health*, at least five Justices of the United States Supreme Court took the position that artificial nutrition and hydration is no different from other types of life-sustaining medical treatment.[104] In addition, Washington's Natural Death Act was amended in 1992 to specifically provide that artificial nutrition and hydration is a life-sustaining treatment that may be withheld or withdrawn.[105] While the Natural Death Act does not directly apply in circumstances where the incompetent individual does not have an advance directive, the Act does reflect the definitional choice that is consistent with the modern trend in other states and would likely be followed by the Washington courts.

The State's Interests. In cases where the court is called upon to decide whether life-sustaining treatment should be withheld or withdrawn from an incompetent patient, an additional element is added to the substituted judgment or best interest analysis: the court weighs that determination against any countervailing state interests.[106] The countervailing state interests the court considers are: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.[107] As a practical matter, courts rarely find that these state interests outweigh an individual's right to self-determination as reflected as substituted judgment. In the Colyer case, the court did indicate that the state's interest in preserving life is greater where the proposed treatment offers a possible cure for the individual, as opposed to merely prolonging life.[108]

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100 *In re Colyer*, 99 Wn.2d at 135, 137.
101 *In re Hamlin*, 102 Wn.2d at 819.
102 *In re Hamlin*, 102 Wn.2d at 820.
103 *In re Grant*, 109 Wn.2d at 570-81. The majority originally reached the conclusion that withdrawal of nutrition and hydration was appropriate. But, some months later, Justice Durham removed her vote from the "majority" opinion and aligned herself with Justice Andersen's partial dissent. *See In re Grant*, 757 P.2d 534 (1988). As a result, five justices held that withdrawal of nutrition and hydration from an incompetent individual was not permissible.
104 497 U.S. 261 (1990).
105 *See* RCW 70.122.020(5) and 70.122.030.
106 *In re Ingram*, 102 Wn.2d at 842.
107 *In re Colyer*, 99 Wn.2d at 122.
108 *In re Colyer*, 99 Wn.2d at 122.

### 1.3.6 Special Considerations

#### 1.3.6.1 Nursing Home Residents

Resident rights regulations entitle residents of nursing homes in the State of Washington to specific rights relating to decision-making, including rights related to health care decision-making.[109] In general, the resident rights regulations ensure that nursing homes respect the decision-making authority of their residents, or in the case of incapacity, that a nursing home is aware of the identity of the surrogate decision-maker and the scope of authority granted to that person. The regulations provide that upon admission, the nursing home must determine:

- Whether the resident has appointed another person to make health care decisions;
- Whether the resident has created any advance directive (which includes power of attorney, health care directive, code/no code order, anatomical gifts, etc.) or other legal document that establishes a surrogate decision-maker in the future; and
- If the resident is not making decisions, who has the authority for surrogate decision-making and the scope of the authority.[110]

In fulfilling its duty, the nursing home must seek copies of any legal documents that establish the surrogate decision-maker's authority and document in the resident's clinical record the surrogate's name, address, and scope of authority, and the location of the legal documents within the facility.[111] A nursing home may not require a resident to have an advance directive or condition care on the basis of whether or not the resident has executed an advance directive.[112]

The resident rights regulations entitle the resident to a presumption of decision-making authority, which can be overcome if a court has established a guardianship, the resident has made a voluntary appointment of a surrogate decision-maker, a surrogate has been established by a legal document, or the facility has determined that the resident is an incapacitated individual, as defined by RCW 11.88.010 and WAC 388-97-0240(5)(a) (regarding the demonstrated inability to make decisions over time, creating a significant risk of personal harm).[113] If the resident has been adjudicated by a court to be incompetent, the court-appointed guardian is the surrogate decision-maker.[114] If the resident has been determined to be incapacitated, but has not been adjudicated as incompetent, the surrogated decision-maker is established through either a legal document, such as a durable power of attorney for health care, or by state law, including the priority list of surrogate decision-makers contained within RCW 7.70.065.[115] When a nursing home has consulted a surrogate decision-maker to exercise the resident's rights, the nursing home must inform the resident of that fact and provide the resident with the information and opportunity to participate in decision-making to the greatest extent possible.[116] Finally, if at some point the resident regains decision-making capacity, the

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109 *See, e.g.,* WAC 388-97-0240 (resident health care decision making); WAC 388-97-0260 (informed consent); WAC 388-97-0280 (advance directives); and WAC 388-97-0300 (notice of rights and services, including list of rights). *See also* RCW 74.42.040 (resident rights regarding medical condition, care, and treatment).

110 WAC 388-97-0240(1).

111 WAC 388-97-0240(3)(a-b).

112 WAC 388-97-0280(2)(b).

113 WAC 388-97-0240(5).

114 WAC 388-97-0240(4)(b).

115 WAC 388-97-0240(4)(c).

116 WAC 388-97-0240(8)(a-b).

nursing home must cease to rely on the surrogate decision-maker unless a court order or the resident directs otherwise.[117]

**1.3.6.2 Children (See also Chapter on General Consent Rules re Minors and Chapter on Special Consent Rules re Consent/Refusals for Categories of Individuals.)**

The age of majority in Washington is eighteen.[118] Individuals under the age of eighteen generally lack the legal competency to make their own health care decisions, so a parent or legal guardian must give consent.[119] If the minor's parents are married, either parent may give consent to medical treatment,[120] but consent from both parents should be obtained if circumstances permit. In the case of consent for medical care for children, a number of exceptions and special statutory provisions apply, depending upon the custody and status of the minor and the type of care at issue (e.g., sexually transmitted diseases, abortion, mental health treatment, alcoholism, drug addiction, and treatment for sexually transmitted diseases). Parts A and B of this chapter should be consulted for a complete discussion of the issues regarding consent for minors.

**1.3.6.3 Medical Emergencies (See Chapter on General Consent Rules re Medical Emergencies.)**

Actual informed consent for medical treatment is not required in the event of an emergency; consent is implied under the law. Pursuant to RCW 7.70.050, "If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied."[121] The word « emergency » is not further defined. This statutory provision is applicable both in circumstances where the individual was legally incompetent to make decisions prior to the medical emergency (e.g., a minor or someone adjudicated incompetent) and where the individual has been rendered incapacitated by the health care emergency.

The implied consent for emergency care should not knowingly be used to override any previously expressed care decisions that are known by the care providers at the time of the emergency. For example, first responders are trained to look on the door of a patient's home refrigerator for a POLST form that would indicate the patient's wishes regarding code status. [122] Similarly, if a patient codes in a hospital ICU after the patient had previously communicated certain wishes for care, those wishes should be honored.[123] If patient wishes are known, they should be honored to the greatest extent possible, even in the absence of a properly executed advance directive. It is a good idea to document patient goals of care and care preferences, when known, to facilitate the provision of care consistent with those preferences.

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117 WAC 388-97-0240(9)(b).
118 RCW 26.28.010.
119 *But see* Chapter on Special Consent Rules for exceptions to this rule allowing minors of a certain age to provide their own consent for certain kinds of treatment.
120 RCW 26.16.125 (equal rights and responsibilities of parents).
121 RCW 7.70.050(4).
122 RCW 43.70.480
123 A best practice is to document a patient's care preferences when they are expressed verbally.

#### 1.3.6.4 Urgent Issues

People who lack decisional capacity can have urgent health issues that do not rise to the level of a true medical emergency. This creates a dilemma for patients and care providers if no legal surrogate can be found, because there is no implied consent for care in the absence of a medical emergency, yet the patient may have fairly urgent needs that must somehow be addressed. For example, a patient who suffers a stroke may initially get an endotracheal tube placed on an emergent basis to keep the patient alive. A nasogastric tube might also by placed to keep the patient alive. However, if such ventilatory and nutritional support are required for a longer period of time, the standard of care would be to switch to a PEG tube for optimal nutrition and a tracheostomy tube for better long-term ventililalatory support. Such procedures might not be considered by physicians to be true medical emergencies because the existing endotracheal tube and nasogastric tube will keep the patient alive despite being suboptimal. Yet the PEG and tracheostomy tubes are still needed by the patient. Another example is a patient with a gangrenous foot who may need a procedure for debridement/amputation in order to promote healing and prevent sepsis. This invasive, irreversible procedure cannot be provided without consent. Yet the longer the debridement or amputation is postponed, the greater the risk of life-threatening harm to the patient from sepsis. Situations like this can put the patient and the care team in a perilous position if the patient is not able to make an informed decision and there is no legal surrogate who can make a decision on behalf of the patient.

Ideally, urgent problems can be resolved before they become true medical emergencies. Options for resolution of these difficult issues may include :

A thorough search for legal surrogate decision-makers who meets the criteria set forth in RCW 7.70.065.

A search for input from individuals who would not qualify as surrogates under RCW 7.70.065, but who have insight into the patient's wishes.

A review of prior records to look for guidance regarding the patient's wishes.

Careful evaluation of the patient's capacity to see if the patient may have lucid moments such that the proposed care can be understood by the patient and patient goals and preferences can be communicated during a lucid moment.

Legal action to appoint a surrogate decision-maker under Chapter 11.88 RCW, or to clarify a power of attorney's authority under Chaper 11.125 RCW.

Legal action to seek court authorization for care, or direction from the court for specific decisions.[124]

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[124] This kind of action may be initiated in multiple ways, but is most often done in the context of a Chapter 11.88 RCW guardianship action. During the pendency of the action, the GAL is authorized by RCW 11.88.010(9) to petition the court for temporary relief to address "emergency needs" of the alleged incapacitated person. The word « emergency » is not further defined in this statute. However, the meaning of that word may be interpreted more broadly in the guardianship context than the way most physicians do in the medical context. Physicians tend to define an emergency as something that will result in death or

In the case of a gravely disabled patient with a mental health disorder, pursuit of involuntary treatment under Chapter 71.05 RCW.

Upon a petition for instruction, the court may provide a guardian *ad litem* with additional, specific authority to solve a particular urgent problem. The court can directly authorize a care provider to provide a specific procedure or intervention. The court may also shorten time for the appointment of a guardian. The courts have generally been very helpful in these situations.

**1.3.6.5 Challenging Hospital Discharge Situaitons**

Hospitals are charged with facilitating safe discharge plans for their patients. This can be particularly difficult for patients who lack capacity and who lack a legal surrogate decision-maker. Consider the example of a patient who has severe dementia and who requires skilled nursing care for medication management. When the patient is ready to the leave the hospital, the receiving skilled nursing facility may decline to accept the patient in the absence of a legal decision-maker who can consent to the placement. This leaves the hospital in the position of continuing to care for a patient who has no acute medical care needs, but no alternative safe place to go. This situation is all too common. It forces hospitals to house non-medical patients for extended periods of time at great expense, using up resources that are intended to be used on patients who have acute medical care needs.

Increasingly, hospitals are forced to initiate guardianship actions to establish a guardianship for a patient who lacks capacity and has no legal surrogate. Sometimes this is the only way to help the patient transfer to a more appropriate level of care. Upon petition from a party, the court may authorize a transfer of the patient to another facility early in the guardianship process, rather than forcing the patient to wait in an acute care hospital bed for the entire pendency of the guardianship process. Nursing homes and other care facilities also initiate guardianship proceedings for their residents, most often to establish benefits for the resident so that the facility can get paid.

Legal intervention in the form of a guardianship action or petition for injunctive relief should be reserved as a last resort after all other options have been exhausted, including a search for family, search for existing power of attorney, and consideration of all possible less restrictive alternatives.

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serious injury within minutes to hours without proper treatment. In the legal world, emergencies may include problems that can be addressed on a longer timeframe.